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Realising the transformative potential of healthcare partnerships: Insights from divergent literatures and contrasting cases in high- and low-income country contexts☆

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ABSTRACT

Partnership is a prominent approach to delivering healthcare globally, with advocates arguing that partnership has distinctive advantages over alternatives such as hierarchies or markets. There is much debate as to whether partnerships represent a distinctive mode of coordination *in practice*, however. Furthermore, despite evidence from diverse settings of the challenges of putting partnerships into practice, there has been little cross-pollination between literature from different fields. We bring together existing literature and two partnership case studies in the contrasting contexts of the UK National Health Service and an internationally-funded health intervention in Cambodia. The case studies were conducted between 2005 and 2008.

Based on our synthesis of the literature, we propose an analytical distinction between instrumental and transformative partnerships, arguing that it is transformative partnerships that can deliver the unique advantages set out in theory. Comparative analysis of the cases illustrates that although both were able to achieve some valuable successes, they fell short of realising their transformative potential. We identify five common issues that impeded or facilitated transformative partnership-working, at micro, meso- and macro-levels: starting conditions; programme set-up; funding asymmetries and interdependence; accountability mechanisms; and relationships and distance from the field. Through systematic comparison we offer a more nuanced understanding of how programmes themselves create particular architectures for partnership, how underlying globalised institutional logics of managerialism promote instrumental partnerships, and how local-level, interpersonal relationships may help to overcome barriers to partnership's transformative potential.

Introduction

'Partnership' is a prominent feature of contemporary healthcare delivery globally (Crisp, 2007). A polysemic term, 'partnership' is invoked to describe collaboration between different arrays of stakeholders in diverse contexts. Common across these, however, is a discourse that suggests it has distinctive advantages over other approaches to service delivery, such as hierarchies or markets, including more equitable relations among a broader range of stakeholders. However, there is much debate as to whether partnerships represent a distinctive approach with unique advantages *in practice*. Some critiques have suggested that partnership discourse may be no more than a rhetorical veil, masking the perpetuation of power asymmetries and the exclusion or co-optation of certain stakeholders.

Despite evidence from diverse settings of the challenges of putting partnerships into practice, to date there has been little cross-pollination between literatures from different fields; for example, between the literatures on partnerships with private-sector organisations and with community groups, or the literatures on partnership working in high-income countries and in international development (for an exception, see Townsend & Townsend, 2004). Yet examination of these literatures suggests that comparative analysis of partnership working in contrasting contexts may yield valuable insights into the potential challenges and disappointments of partnership approaches to delivering healthcare.

In this paper we bring together existing literature and two empirical case studies of partnership in the contrasting contexts of high-income and low-income countries (HICs/LICs), and use

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comparative analysis to deepen understanding of the processes shaping and constraining partnerships. We focus on partnerships in healthcare between state agencies, multi-lateral organisations, non-governmental organisations (international and national charities) and publics (communities and patients). Such partnerships are typically presented as moving away from historically dominant modes of organisation: in HICs, healthcare delivery has traditionally been the preserve of state and professions, with patients and other stakeholders positioned as passive recipients (Hogg, 2008); similarly, health development projects in LICs have classically been characterised by top-down interventions driven by international stakeholders, rather than local stakeholders such as civil society groups and/or communities (Mosse, 2005).

First, we provide a brief overview of the parallel literatures on partnership in HIC healthcare and internationally-funded health development in LICs. These constitute very different contexts for partnership, given differing levels of prior healthcare infrastructure, contrasting social and organisational structures, divergent relationships between recipients and providers, and different agencies spearheading partnership. Yet we note considerable overlap between the rationales for partnership and the challenges of realising it in both contexts. Drawing on this, we describe what we term 'transformative partnership', which we suggest constitutes a distinctive model with unique advantages over traditional models and more 'instrumental' partnerships in these fields. Finally, we present a comparative analysis of findings from two case studies of partnerships-in-practice, and elucidate the processes shaping the realisation of partnerships. Through this comparison of partnerships in contrasting contexts, we contribute to a more nuanced understanding of how programmes themselves create particular 'architectures' for partnership, and how and why the resulting partnerships manage or fail to become 'transformative'.

Partnership in high- and low-income countries: rationales and critiques

Partnership is often contrasted with the bureaucratic-hierarchical organisational approaches to healthcare delivery that have traditionally dominated many OECD healthcare systems (Schmid, Cacace, Götze, & Rothgang, 2010) and internationally-funded healthcare interventions in LICs (Mosse, 2005). In hierarchies, those at the top decide on, for example, health priorities, strategies for intervention and resource allocation, while the role of those further down is to effect those decisions in accordance with goals and rules set by superiors.

By contrast, 'partnership' can be defined as collaboration between organisations and/or groups in the delivery of services that is rooted in the principle of mutuality, with working relationships characterised by "horizontal (as opposed to hierarchical) coordination and accountability, and […] equality in decision making, as opposed to domination by one or more partners" (Brinkerhoff, 2002, p. 4). Partnerships are thus commonly presented as shifting towards a 'two-way traffic' model of service design and delivery (Kooiman, 1993, p. 4). Decision-making power is redistributed amongst a broad range of stakeholder-partners, repositioning groups historically marginalised or excluded from the development and implementation of health interventions (e.g. patients or 'recipient' communities in LICs, grass-roots organisations and local NGOs) as more active participants in determining their content and form. Hence partnership is frequently characterised in normative terms emphasising 'inclusion' of diverse perspectives and knowledge, 'reciprocity' of learning and benefits, 'equality' and 'shared responsibility' (Dahl, 2001; Syed, Dadwal, & Pittet, 2011).

The reasons given for the desirability of a move towards partnership are remarkably similar in the literatures on HICs and health development in LICs. Partnership reflects one response (alongside marketisation) to the perceived shortcomings of bureaucratic structures—such as inflexibility and directiveness—in providing appropriate and effective healthcare. Like markets, partnerships are argued to improve the responsiveness of services to the preferences of recipients, but by enfranchising them rather than through consumer choice. Partnerships are thus seen as an important means of improving the *efficacy* of systems and interventions (Barnes, Newman, & Sullivan, 2007; Syed et al., 2011), through inclusion of users and stakeholder groups (such as NGOs) with greater understanding of the communities they serve (Johnson & Osborne, 2003). The literature on both HICs (e.g. Marinetto, 2003) and health development in LICs (e.g. Campbell, Nair, & Maimane, 2007) claims that partnerships may build *capacity* in affected groups to deal with problems themselves, moving from dependency to 'ownership' and 'self-aid' by developing the skills and responsibility for their own fate (Dahl, 2001).

The rationale goes beyond the instrumental, however. In both contexts, advocates make strong *normative* arguments for partnership. In the international development literature in particular, partnership is proposed as addressing the moral imperative to take account of local perspectives (Campbell & Jovchelovitch, 2000). Though such arguments resemble rationales for partnership put forward in HICs (e.g. Barnes et al., 2007), they are made particularly strongly in relation to LICs, perhaps because of the historical legacy of relations between richer and poorer countries, and the inherent tensions created by external, 'foreign' interventions.

Notwithstanding these claimed functional and normative advantages, both literatures highlight many challenges to partnership-*in-practice*. Again, there are striking parallels between the two contexts. Firstly, partnerships are often found to be incapable of addressing profound *asymmetries* of power between incipient partners. Those in superordinate positions, such as professionals and managers who have traditionally dominated decision-making, often dominate partnerships (Milewa, Dowswell, & Harrison, 2002). In LICs, this problem can be deep-rooted, owing to historically embedded views on the relative validity and utility of 'scientific'/'professional' and 'traditional'/'local' knowledge bases (Escobar, 1995; Pigg, 2001). In both contexts, the result can be unequal partnerships, prioritising the views of those already in positions of authority. The ways partnerships are *structured* and organised can sometimes perpetuate, rather than mitigate, such asymmetries. Communities and other newly constituted partners, such as local NGOs, may find themselves in subordinate roles, their contributions limited to matters of service delivery rather than design (Lowndes & Sullivan, 2004). In LICs, where donors retain control over access to aid, they may determine the management and priorities of international partnerships (Perin & Attaran, 2003). A related risk is 'elite capture' (Mansuri & Rao, 2003), wherein those with the requisite skills or resources to engage donors and health professionals (e.g. middle-class publics or larger NGOs) dominate partnerships (Aveling, 2010a; Lowndes & Sullivan, 2004).

Overall, then, there exist many commonalities in the theory and practice of partnership in HICs and LICs, despite contextual differences. Partnership seeks to engender a different kind of relationship between stakeholder groups, but this potential is often stymied due to challenges at multiple levels. Consequently, although they may deliver certain outputs (e.g. providing a service), partnerships often fail to engender the very things they purport to be uniquely able to offer.

Transformative and instrumental partnerships: a conceptual framework

Evidence of the failure of many partnerships-in-practice to realise the unique potential claimed for them in theory has led

some to propose an analytical distinction between *transformative* and *instrumental* partnerships (Aveling, 2011). The crux of this conceptual distinction is the degree of recognition of the legitimacy of new partners' perspectives, knowledge and interests, and the degree to which this feeds back into the operation of the partnership. This distinction parallels Habermasian categories of communicative and strategic action: the former involves participants in cooperative negotiation oriented towards mutual understanding; the latter constitutes instrumental action to influence the actions of another actor (Habermas, 1984). The two poles are ideal types, between which lies a continuum of partnerships.

At the instrumental pole, partnerships reinforce a status quo where control over interventions is retained by powerful players, and 'partnership' offers a way of accomplishing their objectives. The dominant values remain concerns with economic and administrative efficiency, with the 'rhetorical veil' of partnership serving other functions, such as securing political or popular legitimacy (Mosse, 2005). As such, instrumental partnerships are compatible with existing dependencies and inequalities (Crawford, 2003; Fowler, 1998; Rutter, Manley, Weaver, Crawford, & Fulop, 2004). While benefits may accrue (including to weaker partners), these could arguably be achieved through other modes of organising, such as hierarchies. Instrumental partnerships may therefore be effective, but this does not derive from the distinctive potential of partnership set out above.

In contrast, transformative partnerships entail challenging traditional hierarchies, supporting greater involvement of marginalised groups and mutual respect for the knowledge of *all* partners. Despite challenges, partners commit to equitable involvement in agenda-setting, priority determination and implementation. Partnership-working in this sense relies on facilitating dialogue between, say, professionals and patients, or international and local NGOs, through which new understandings and creative approaches to social problems may be generated. Only transformative partnerships can deliver the unique advantages set out in the theoretical literature, including the normative ideals but also instrumental benefits. There are of course costs associated with transformative partnerships (both transaction costs that affect all parties, and losses for the more powerful partners who are asked to cede some of that power), but the argument in their favour is functional as well as normative: that transformation, and the pains associated with it, are necessary if partnership is to achieve something different from other approaches.

Realising the transformative potential of partnership?

Despite the transformative potential of partnership, the literature from HICs and LICs describes the difficulty of achieving transformative partnerships, and the frequency with which the involvement of marginalised groups remains instrumental or tokenistic (Aveling, 2010a; Fudge, Wolfe, & McKevitt, 2008; Martin, 2008; Rutter et al., 2004). Clearly, a better understanding is needed of the processes whereby partnerships are established, maintained and shaped. Evidence of obstacles at multiple levels points to the need for a systemic perspective: that is, one incorporating the full range of partners whose diverse agendas influence partnership-working, and focussing on how the whole contextually-embedded system shapes project activities (Fowler, 2000; Sridhar & Craig, 2011).

The value of case studies in illuminating causal mechanisms and differential influence of contextual variables is well established in social-scientific research; *comparative* case studies are capable of producing more compelling and generalisable understandings of relevant processes (Flyvbjerg, 2006). In the remainder of this paper, therefore, we analyse the structures and mechanisms of two partnerships, in high- and low-income contexts, to examine the factors that influence the realisation of partnership's transformative potential.

Methodology

We comparatively analysed two ethnographic case studies of partnership-in-practice, the findings from which have been published separately elsewhere (Aveling, 2010a, 2011, 2012; Martin, 2008, 2011a, 2011b). Our choice of these two cases was both pragmatic and serendipitous, but also constituted what Flyvbjerg (2006, pp. 230–231) calls a 'critical case' sample. That is, the contextual conditions in the two cases differ considerably in ways that—following the theoretical and empirical literature cited above—one might expect to result in divergent consequences when an 'intervention' such as partnership-working is implemented. Our sample is theoretically justified on this basis (rather than on the basis of being representative), which is well suited to identifying the "deeper causes" (Flyvbjerg, 2006, p. 229) behind the form(s) that partnerships-in-practice take, including whether and how contextual divergences affect partnership's 'transformative' potential. Of course, this sampling strategy is imperfect in a number of ways: the choice of cases is guided by pragmatism as well as theoretical concerns, and (as we see below) the 'intervention'—such as it is—is not identical. Our intent, however, is not to isolate and analyse variables atomistically, but to draw on two critically divergent cases to examine their consequences through rigorous, systemic, qualitative comparison.

We drew on prior papers and original analyses to conduct a secondary analysis of the two cases. To achieve the necessary systemic perspective, we took a socio-ecological approach that considered the structures, mechanisms and relationships through which partnerships function, as well as the influence of socio-cultural, professional and institutional contexts (Valsiner, 2000).

Case study methods and settings

Partnership I: a community-based reproductive health intervention in Cambodia

Case 1 was an intervention which aimed to improve the reproductive health of Cambodian military families through peer education. The partnership included five key stakeholders: the funder, Global Fund (GF), an international NGO (INGO), two local Cambodian NGOs (LNGOs) and the Cambodian military (see Fig. 1).

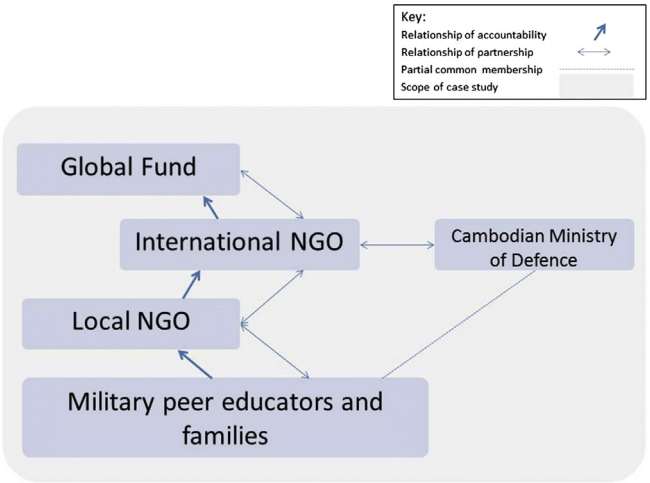

Fig. 1. Cambodian partnership.

The INGO designed the programme strategy and curriculum, made a successful application to the GF, and negotiated access to military camps with the Ministry of Defence (MoD). The INGO was responsible for overall programme management, and was accountable to the GF through a system of performance-based funding. Under this system, annual targets (e.g. number of families reached) had to be met before the following year's disbursement was made. The two LNGOs were contracted by the INGO as 'partners' to train soldiers and soldiers' wives as peer-educators (using the INGO's curriculum), and support them to deliver peer-education for other soldiers and wives. The programme also included provision of free condoms and access to reproductive healthcare for military couples.

Partnership working and "equal stakeholder involvement from every sector" were key principles of the GF (Global Fund, 2010; Sherry, Mookherji, & Ryan, 2009). To support 'equal stakeholder involvement' from in-country partners, the GF required that programmes "respect country-led formulation and implementation processes" (Sherry et al., 2009), and contribute to building partners' 'capacity'. The INGO similarly sought to "work in partnership with government, multilateral agencies, non-governmental organisations and community groups to strengthen the capacity of resource-constrained countries" (INGO proposal to the GF).

The programme was studied ethnographically. Ninety in-depth interviews were completed with representatives from all partner groups. Extensive observation of programme activities (28 peer-education/training sessions across five military camps and 10 stakeholder meetings between the GF, INGO and LNGOs) was undertaken over a nine-month period in 2007–2008. In addition, programme documents were collated. Ethical approval was received from the Cambridge Psychology Research Ethics Committee and the Cambodian National Ethics Committee for Health Research.

Partnership II: implementing new cancer-genetics care pathways in the UK

The second case was a multilateral partnership to develop and implement a new way of organising care for people with possible inherited cancer. This was a field of healthcare provision that had long been seen as problematic in the UK. Organisational and professional boundaries between the groups responsible for cancer-genetics service resulted in inconsistency and poorly co-ordinated services. In the early 2000s, the British government sought to remedy this by putting forward a model care pathway, involving structured progression of patients between services, and standardisation of provision for patients with different levels of genetic risk across the country. From the start, this process involved a multi-lateral partnership between the UK Department of Health (DoH), the charity Macmillan, professionals involved in delivering cancer-genetics services, and patients (see Secretary of State for Health, 2003, p. 37 for details).

The commitment to partnership-working among various stakeholders continued into the pilot implementation of the model pathway (see Fig. 2), which was the focus of this study. Seven teams were selected to pilot the model's implementation. They were expected to include patients as partners in their work, and throughout the course of the programme regular meetings were convened bringing together healthcare professionals, Macmillan staff, DoH policymakers, and patients. Partnerships were formed at pilot site-level between patients and professionals, and a national-level partnership forum including Macmillan staff and patients from all the sites was formed to ensure programme-level partnership.

The rationale here was both normative and instrumental. DoH policy emphasised both that "patients and the public rightly expect to be involved" and that such partnerships could give rise to a "service that genuinely responds to patients" (DoH, 2003, p. iii). Similarly Macmillan (2005, p. 4) saw partnership in terms of the difference it could make to services through "patients, carers and health professionals work[ing] collaboratively to bring about tangible service improvements."

Fieldwork (2005–2008) in this case comprised 56 in-depth interviews with representatives from government, Macmillan, professionals and managers in the pilot sites, and patients involved in national- and local-level partnership forums (see Fig. 2). Observation of 39 events at which partners came together at pilot site-level and programme-level (meetings, forums and conferences) was also undertaken, along with analysis of programme documents. Ethical approval was received from the Trent Multi-centre Research Ethics Committee.

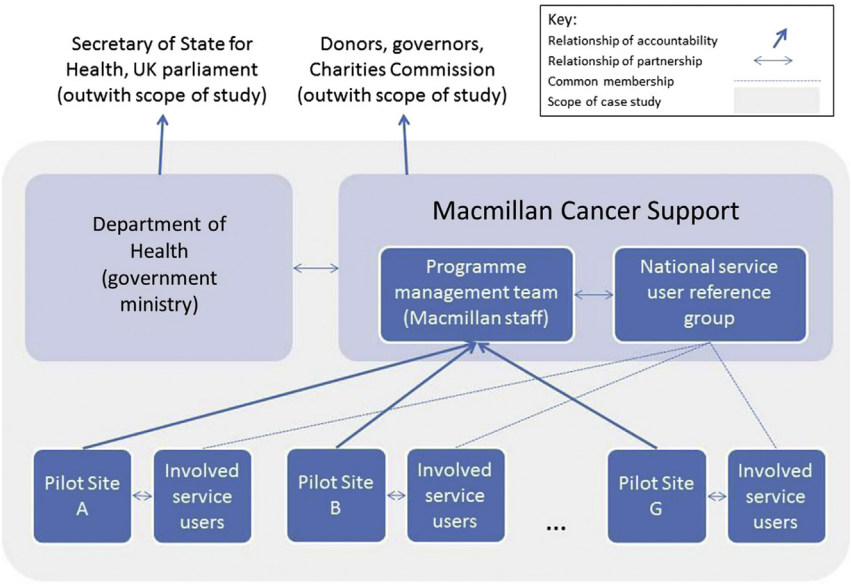

Fig. 2. UK partnership.

Analysis

Each case was originally analysed separately (Aveling, 2010b; Martin, 2009). We undertook a secondary analysis of our published and unpublished accounts of the cases, seeking to identify points of commonality and difference in the construction and practice of partnership. We were specifically interested in identifying enabling and constraining factors in realising transformative partnerships. Each author read the other's analysis, and then we brought together and analysed findings from both studies on: how far partnerships met the professed aims of 'equal stakeholder involvement'; common features of partnership working, even if differently manifested; and factors and practices undermining transformative partnership (including structures and mechanisms of the partnership, relationships between partners, and the wider context); factors and practices supporting transformative partnership. In comparing and contrasting findings from the two studies, we sought to shed further light on each. However, we were also keen to ensure that despite the increasing time since the studies were carried out, our work remained grounded in the original findings, and so always ensured that new insights and interpretations were clearly justified and evidenced in our empirical data. Here, the fact that this was a new analysis of our own work was helpful (and mitigated a key limitation of secondary analysis as a research method), though it was not of course possible to return to the field to follow up emerging ideas as we had done in the original ethnographies.

Findings

We abstracted five themes that cut across the cases: starting conditions; programme set-up; funding asymmetry and interdependence; accountability mechanisms and performance management; relationships and distance from 'the field'. We consider each in turn, but first offer an overview of the outcomes of each partnership.

Partnership and its outcomes

Both partnerships produced some concrete outputs and gains for stakeholders, but they struggled to engage traditionally marginalised groups on a more equal footing.

The Cambodian programme met many of its targets (e.g. peer-educators trained, attendance at peer-education sessions). There were also gains for local partners (e.g. income for LNGOs, access to reproductive healthcare for military families). These achievements reflected co-operative relationships between partners: the MoD allowed LNGOs access to military camps; international and local NGOs coordinated their efforts to meet targets on time; peer-educators worked hard to recruit participants and deliver the curriculum "accurately and smoothly" (peer-educator).

The programme was less successful, however, in incorporating local knowledge and interests to create a "two way traffic" model (Kooiman, 1993) of partnership. Both LNGO staff and peer-educators interpreted their role as an instrumental one: delivering the programme according to the guidelines of the GF and INGO. Even where these partners doubted the feasibility or appropriateness of programme strategies, their views were rarely taken into account by more senior staff in the INGO or GF. For example, local staff felt that some targets were unfeasibly high, and that some programme strategies were culturally unacceptable and unlikely to impact behaviours, but no changes were incorporated into official programme strategy or reports (Aveling, 2011).

Yet despite constraints on interactions between LNGO and INGO staff, more transformative relations between LNGO staff and peer-educators did begin to emerge informally. Observations and interviews revealed that local partners made pragmatic adaptations to peer-education sessions and programme messages, for example constructing condom use during extra-marital sex as an alternative way of 'being faithful' for soldiers, who they felt could not realistically be expected to be monogamous (Aveling, 2011). Similarly, local partners began to provide 'gifts' at peer-education sessions, rather than the stipulated 'refreshments', in order to attract more participants. Such changes were rarely discussed in interactions with INGO staff, however:

> *Participants don't need snacks, they need something they can use, like soap. So we follow the participants' need. On the other hand, in the invoice we list items like snacks to fulfil the need of [INGO].*
>
> Cambodian LNGO field officer

In practice, then, there was little scope to include LNGOs' or peer-educators' knowledge, views or priorities in determining programme practices.

In many ways, the UK case followed a similar pattern. The partnership was viewed as a success, to the extent that it funded pilot sites that managed to reconfigure care pathways according to the new model, and attract referrals of at-risk patients. Following the pilot period, the new care pathways were sustained and embedded in several sites, resulting in more consistent and equitable access to cancer-genetic risk assessment as intended by the programme.

In terms of the incorporation of patients as partners in this process, however, the picture was mixed. All seven sites did include some form of patient participation, but this varied considerably in quantity and scope (Martin, 2008). While there was considerable effort to involve patients as partners at the *programme* level (design and oversight), at pilot level, there was a sense from both patients and Macmillan representatives that the involvement of patients had been somewhat tokenistic—a process of 'box ticking' rather than anything approaching a transformative partnership with true exchange of knowledge to the benefit of the pilots (Martin & Finn, 2011).

There was variability in this perception, and one notable exception. In this outlying site, partnership between professionals and patients was characterised by more contact, collaboration and joint knowledge production (Martin & Finn, 2011b), such that it was held up by Macmillan officers as a model of "absolutely true partnership working" for the other sites. Overall, however, there was a sense that—as in Cambodia—the notable instrumental successes secured by the partnerships were not matched by the level of transformative engagement.

Next we consider the reasons for these outcomes, despite the apparent commitment of partners to a "more equal" (in-country INGO director) way of working.

Starting conditions

A common theme was the challenging starting conditions for a collaborative partnership of 'equals'. In both cases, the local socio-cultural context was characterised by historically established hierarchical dynamics between certain partners, although to differing extents and due to divergent mechanisms.

In Cambodia, a history of violent conflict, authoritarianism and deeply ingrained hierarchies made it challenging for local staff to engage as 'equal partners'. Deference and respect for seniors were valued behaviours. In addition, Cambodia's history had generated considerable reliance on international aid. These circumstances contributed to a perception of international organisations as knowledge- and resource-rich, relative to local organisations

(O'Leary & Meas, 2001). Furthermore, international aid agencies represented lucrative opportunities for employment and contracts for local practitioners. Taken together, these dynamics encouraged hierarchical relations between international and local partners.

While in the UK there were similar inequalities of power between professional and laypeople, there was also a *de*creasingly deferential culture and considerable support for patient partnerships in government policy. In contrast to Cambodia, partnership here did not constitute an employment opportunity, but rather involved commitment to an unpaid role requiring engagement with professionals—something which tended to exclude those of lower socio-economic and educational status, and result in rather a selective cohort of patient partners. These were often constructed as 'unrepresentative' by professionals involved in the pilot sites, and their contributions as consequently less valid and useful (Martin, 2008).

Programme set-up

Further constraints on the involvement of local groups and patients derived from mechanisms and processes of programme set-up that excluded some partners from influencing programme design.

In Cambodia, the organisation of the GF application system meant the application for funding—including details of strategies and output targets—had to be made by the INGO, and only once this application was approved could LNGOs be recruited. Thus LNGOs were positioned from the outset as instrumental partners, commissioned to deliver a pre-designed programme according to pre-agreed targets. Moreover, under GF's strict performance-based funding system, once approved, programmes could only be changed through formal re-programming requests, and, on principle, *reductions* in targets were proscribed. Thus, for example, even though in-country INGO staff acknowledged that local staff were likely correct in insisting that some targets were unfeasibly high, neither party was able to change this.

In contrast, *before* making the application, the INGO had to secure the support of the MoD, which had the power to grant or withhold access to its military camps. Without access, the INGO could not deliver the programme; yet in order to align with national priorities, it had to focus on high-risk groups such as military couples. Consequently, the views of the MoD were recognised and acted on.

In the UK case, there was also differential involvement at different levels of the partnership. At programme level, patients were included in the committee that designed the model care pathway, and some continued as partners in the management of the programme. At the *pilot* level, however, partnership largely appeared *after* the set-up process. While in some pilots there had been consultations with patients, this was relatively shallow, and in no site were the individuals who had been consulted during pilot *design* the same as those who were co-opted as partners for pilot *implementation*. There was thus a lack of continuity in partnership at pilot level, and while in theory plans could be rewritten during implementation, patient partners were reluctant to demand major changes to blueprints to which they had not contributed and about which they had limited knowledge. Therefore they, like the LNGOs in Cambodia, were less-equal partners than the professionals who were involved from the start.

Funding asymmetry and interdependence

The transfer of funds—from funders to implementers—created inevitable material asymmetries between partners. In the Cambodian case (Fig. 1), the donor provided funds to the INGO, which provided funds to the LNGOs, which provided military families with access healthcare, small 'gifts' and, for peer-educators, small financial incentives. In the UK case, funding was similarly controlled by the partners at the 'top' (Fig. 2), although disbursements of funding were not so tightly linked to performance targets. Involved patients did not have any financial incentive or material dependency to tie them to the programme, but derived esteem and experience from their participation; it was clear that having invested considerable time and effort, they felt that the success or otherwise of the programme reflected on them as much as on pilot professionals and Macmillan.

This situation created power asymmetries between those who provided money and those who received it, asymmetries that were replicated all the way down the 'chain' of partners. It oriented accountability back *up* the chain such that ultimately, funders held most power to determine what counted as 'success' and whether or not funding—on which jobs, contracts, community resources depended—would continue. Moreover, this system created *interdependencies* between partners, whereby all partners had a 'stake' and something to gain from the continuation of funding (though this was more symbolic than material for the patients in the UK case). Consequently, all partners had an interest in portraying the programme as a 'success'. This promoted cooperation—but crucially, cooperation to deliver on *the funders'* definitions of success. Our analysis suggests, however, that while asymmetries may inevitably arise from such funding patterns, the extent to which this undermines the potential for transformative partnership is crucially influenced by funders' accountability mechanisms—in particular, as discussed next, the extent to which accountability systems prioritise and account for different definitions of success.

Accountability mechanisms and performance management

In the Cambodian case, success from the GF's perspective was clearly defined in the performance indicators of the performance-based accountability system, whereby continued funding was tightly linked to meeting targets. The rigidity and extent of the accompanying administrative demands in this system meant that relationships between the in-country INGO and LNGOs focused on monitoring and correcting local partners (Aveling, 2011). Since "continued funding depends on proven results and targets achieved" (GF representative), in order to meet its own contractual obligations to the GF, the INGO spent most of its time with LNGOs tutoring them in how to count targets and produce the required evidence in the correct format. Thus technical 'assistance' became a mechanism of control over partners by external agencies, with international organisations determining what kind of 'capacity' local staff needed.

On the face of it, the performance management and accountability mechanisms deployed in the UK case were considerably more flexible. Ongoing funding was not contingent on hitting targets; pilot sites were permitted some leeway in altering their plans. Sites were required to submit quarterly reports on their activity and progress, and (with a view to encouraging partnership-working) these included mandatory sections on patient participation. This, then, was not partnership by contract—as in the Cambodian case—and accountability mechanisms actively included work towards partnership as well as work towards narrow outcome measures.

Yet surprisingly, the result of this was not very different from the outcome in Cambodia. Why was this so? What was clear was that while seeking to value and encourage the realisation of partnership, this remained a means to an end. As one Macmillan facilitator explained, the organisation's commitment to partnership was

based on a view that it constituted an effective route to tangible changes in NHS provision:

> *When we give people grants for their partnership group activity, we ask for information back: […] an impact, that's something that they've achieved, that is a service improvement.*

Instrumental impact on service provision, rather than transformative partnership, remained the ultimate goal. This focus was even more evident in the way pilot staff accounted for their work on partnership with patients, in quarterly reports and in meetings. Staff tended to focus much more on increasing clinical activity than on a productive partnership with patients. Staff knew that ultimately, the worth of their projects would be judged in terms of clinical activity and health outcomes—if not by Macmillan, then by managers in the NHS who would decide whether the new care pathways deserved ongoing funding. Thus the wider, future context was one dominated by narrow constructions of performance. And while Macmillan may have held the view that partnership with patients would improve 'performance' in these narrow terms, this view was not shared by pilot staff: they did not consider taking on-board patients' views to be even an instrumentally effective way of increasing 'impact' (Martin, 2011).

Furthermore, despite the apparent importance ascribed to partnership working by Macmillan in quarterly reports, these and other accountability mechanisms did little to counteract this prevailing view. While progress towards narrow performance objectives could be readily measured and quantified, the quality of pilots' work to develop partnerships with patients was more difficult to assess. Consequently, patients perceived that site-level professionals were treating partnership as a 'tick-box' exercise: something for which they had to account in their quarterly reports, but which could safely be sidelined since Macmillan had no means of assessing the quality of their efforts.

Relationships and distance from 'the field'

In both cases, there were moments when despite all these constraints, more transformative interactions did emerge (for example, the reinterpretation of 'marital fidelity' in Cambodia, and the more active participation of patients in the outlying UK site). One key factor distinguishing these instances was the strength of interpersonal relationships established between partners 'at ground level' (programme staff and communities/patients). Here, greater contact and interaction between partners sometimes allowed trusting relationships to emerge.

In the Cambodian case, because military camps were far from the LNGO's offices, LNGO staff spent many hours in the camps, often eating with peer-educators, spending time in their homes between sessions or staying overnight nearby. In contrast, in-country INGO staff rarely visited the field, and when they did, most could not speak the local language. Unlike LNGO staff, who arrived on motorbikes of the kind participants might have, INGO staff arrived in luxury sports vehicles and rarely stayed beyond formal activities.

In the UK, meanwhile, one of the pilot sites was held up as an example of how to do partnership with patients meaningfully. Various factors seemed to facilitate this (Martin & Finn, 2011), but above all what seemed crucial in moderating the pressures towards instrumentalism in this outlier was the closer working relationship between patients and staff. Meetings were more frequent; extended discussions about the purpose of partnership occurred at site level; overall, partnership was founded on much closer interpersonal relationships which did not develop in other sites, and this resulted in a range of joint activities (for example, awareness-raising information events carried out jointly by staff and patients) which did not contribute to the (narrowly defined) 'performance' of the service, but which were seen as valuable by both parties. As with LNGO staff and peer-educators in Cambodia, close, sustained relationships between partners acting in good faith proved a surprisingly powerful antidote to the powerful structural forces that oriented partnerships towards instrumental aims and the reproduction of existing asymmetries—but how far these could scale up beyond the local is perhaps doubtful.

Discussion

Our analysis illustrates that although both partnerships were able to achieve some valuable successes, they fell short of establishing transformative partnerships. Concrete achievements were clearly evidenced—but these successes could arguably have been realised through traditional, non-partnership approaches such as hierarchical command. Indeed, in many ways the partnerships retained hierarchical dynamics of power and control. Both were largely characterised by cooperation, but this reflected the interdependence of partners and the stake each held in ensuring programme success; it did not extend to a sense of ownership or influence amongst partners 'on the ground'. The roles of LNGOs, peer-educators and patients became essentially instrumental—a means of optimising programme delivery, creating morally viable relations between rich and poor countries, or 'ticking the box' that required patient participation.

Underlying these outcomes, we identified a number of common themes, despite radically different contexts. These operated at multiple, inter-related levels, underscoring the importance of a systemic approach. At the micro-level, issues such as the 'communicative capacity' of partners to interact openly and without coercion seemed important: for example, LNGO staff's willingness to 'speak up' to INGO managers given their aspirations for continued and future contracts, or, in the UK, professionals' lack of belief in the value of patient input. While conscious efforts to develop partners' communicative capacity and create 'safe' spaces for dialogue are important, failure to realise the potential for transformative partnerships cannot simply be attributed to a lack of inclination or capacity on the part of involved professionals (Fudge et al., 2008; Rutter et al., 2004) or to 'the problem with the locals' (Harrison, 2002).

Rather, asymmetrical relationships of power, tutelage and control were perpetuated and exacerbated by forces operating at the meso-level of programme mechanisms and structures. While the persistence of some degree of material dependence in the relationship between funders and other partners may be inevitable—as may established partners' inclination to maintain their relative power—we argue that the lack of ownership and influence experienced by subordinate 'partners' is not. Mechanisms for programme set-up, accountability and performance management, and the rigidity of structures that proved unresponsive to 'bottom-up' pressures, all served to marginalise the input of 'grass-roots'-level partners. Thus the partnerships-in-practice exacerbated inimical starting conditions, while promoting instrumental cooperation oriented towards satisfying funder definitions of success—to the detriment of other partners' priorities—and thereby ensure continuation of programmes. Paradoxically, the force of this tendency is highlighted in the UK case, where the pressure to produce 'success' as narrowly defined by the funder won out *despite* less rigid guidelines, an apparently flatter partnership structure and mandatory reports to account for patient involvement.

This points to a third level: the macro-level context beyond the programme itself. Historically established, socio-culturally inscribed patterns of relations between some partners meant partnerships were characterised by hierarchical relationships from the start. In addition, and perhaps explaining the paradoxical finding in

the UK case, was the influence of a global institutional logic underlying managerialist accountability systems that promotes a primarily instrumental form of partnership. Our comparative analysis attests not only to the way this ideology permeates programmes themselves, but also to the global ubiquity of its reach: the interconnected system of global healthcare facilitates not only the flow of resources and medical expertise, but also of discourses and practices associated with neoliberal governance into all aspects of healthcare delivery worldwide, including partnerships (Sridhar & Craig, 2011).

Thus while powerful partners such as funders make claims to a model that supports more equal stakeholder involvement, managerialist processes serve to reinforce the very practices they seek to eliminate (Cornish, Campbell, Shukla, & Banerji, 2012)—excluding and marginalising certain groups and perpetuating hierarchical relations between 'partners'. What our analysis also illustrates, however, is that occasionally more transformative elements could emerge in the nexus of partnerships—between staff and patients in the outlying UK case, and between LNGO staff and military families. Common to both cases was the nature of the interpersonal relationships that developed between partners. These more proximal relationships, built over time, appeared to help overcome obstacles to transformative partnership deriving from the meso- and macro-levels. This finding underscores the importance of close integration of different partners (Cornish & Campbell, 2009), and the need for programmes to create opportunities for partners to develop relationships and experience first-hand the lifeworlds of other partners (Cornish et al., 2012). However, sustaining such relationships under these external pressures may be challenging, and they are by definition difficult to scale up beyond the local.

Taken together, our findings point to several ways in which the transformative potential of partnership might be more fully realised. First, our findings suggest that a systemic approach is needed, since intervening only at one level is unlikely to mitigate constraints operating at others. Second, partnership structures need to be inclusive, engaging all partners early in the process to avoid creating a hierarchy of 'partners' that disenfranchises some before they have even begun, and building in flexibility to make those structures responsive to bottom-up influences. This might include, for example, funders agreeing to finance an additional *pre*-implementation planning phase, involving all partners, during which strategies and output details may still be negotiated and refined. These structures also need to allow for continuity of relationships, including the same partners from start to finish. Third, architectures for partnership should make space for developing relationships and proactively addressing often inimical starting conditions. That these relationships are cooperative and respectful is not enough in itself: as in both cases, this can result merely in the reproduction of dominant expectations around performance—a conspiracy of acquiescence—since all partners have a stake in such (narrow) criteria of success. Related to this is the fourth implication: accountability mechanisms must be understood as socially constructed systems that embed particular perspectives (Power, 2003) and potentially exclude particular groups from the articulation of 'success' (Seckinelgin, 2012). The design of accountability needs to avoid orienting all accountability towards funder goals, incorporating instead wider definitions of 'success' that reflect other partners' values and priorities. Here, we would include embedding the goal of transformative partnership-working itself in programme goals, and providing the necessary resources to support its development in programme proposals. Thus we are not advocating the removal of accountability mechanisms, but a rebalancing of which—and whose—priorities are valorised by those systems. Such an accountability mechanism would need to be designed to transcend problems of quantification and instrumentalism which, as in the UK case, can result in the subordination of achieving partnership to narrower, more readily measurable objectives. While the seemingly intractable, macro-level influence of a global managerialist logic represents a significant challenge to any such efforts, it also makes it imperative that attention be given to understanding and seeking to mitigate its adverse consequences.

Conclusion

Through comparative analysis of two case studies of multi-level partnerships in divergent contexts, we advocate greater cross-pollination between these fields. The benefit of this comparative and systemic approach, we argue, is more nuanced understanding of how programmes themselves create particular architectures for partnership, of the underlying global institutional logics, and of possibilities for local-level intervention to help realise the potential of partnership. Our analysis highlights common features with differential causes (e.g. power inequalities that derived from the Cambodian socio-cultural context, and from the construction within the UK programme of patients' knowledge as less valid), and divergent structures and processes which, in the ubiquitous managerialist institutional logic that we describe, ultimately resulted in isomorphic outcomes (e.g. a less-dependent set of relationships in the UK context that nevertheless gave rise to an all-encompassing focus on narrow notions of 'performance'). Comparative, systemic work of this kind holds much analytical promise for a greater understanding of pressures and tendencies common to all partnerships (especially in such a forceful institutional context)—and how these might be moderated. At a time when cutbacks in the public sectors of HICs are increasing calls for partnership-based approaches to service delivery that have been commonplace in international health development interventions for some time, comparative study may hold particular potential for anticipating the consequences.

Significant questions remain. To what extent can transformative partnership be 'scaled-up' if interpersonal relationships are critical? Can those at the interface between participants and organisations be better supported to translate the fruits of their interpersonal relationships into transformative impact on the wider partnerships? What kinds of accountability can capture alternative notions of 'success', which (while perhaps unquantifiable) still retain legitimacy in an era of contracting healthcare resources worldwide? We suggest the answers to these questions are less likely to be found within a single literature than through constructive—perhaps transformative—dialogue between fields of research in diverse contexts.

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