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ORIGINAL ARTICLE

Strategizing in an Inter-organizational Setting—The Case of a German Healthcare Partnership

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Abstract Solving complex societal problems requires collaboration across organizational boundaries. Such collaboration inherently involves strategizing across these boundaries, which is linked to a high degree of complexity and ambiguity. Despite its critical relevance, there is a paucity of empirical studies on the practices of inter-organizational strategizing. To address this research gap, we conducted a longitudinal case study of a healthcare partnership in a major metropolitan city of Germany involving eleven different organizations. Operating in a socially deprived area, the healthcare partnership aimed at tackling the problem of poor health outcomes arising from a lack of alignment among providers and payers of healthcare. Drawing on a rich data set of our single case study, we analysed the different phases of a strategizing process from 2012 to 2019. We identify and propose three core practices of inter-organizational strategizing that influence strategic alignment: structuring conflicts, gaining commitment, and agreeing on objectives. Our results also suggest the presence of two distinct modes of strategizing that relate to these practices, one characterized by exclusiveness and the other by inclusiveness. Further theorizing from these findings leads us to propose that these practices and the modes of strategizing interrelate and ultimately result in either strategic alignment or strategic disorder.

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Our findings are particularly relevant to strategy and policy-makers who are faced with the challenge to solve wicked problems.

Keywords Strategy formation · Inter-organizational collaboration · Participation in strategy-making · Cross-sector · Healthcare

JEL codes I1 · L1 · M1

1 Introduction

How can societies effectively address problems characterized by high complexity and interdependence? For instance, issues like poor health and increased crime rates may be interlinked, both driven by low levels of educational attainment and inadequate healthcare provision in a particular area or societal subgrouping. These, in turn, might stem from disparities in wages and wealth distribution, as well as unequal access to education and healthcare resources (Hoebel et al. 2017; Lampert et al. 2018; Marmot and Allen 2014). Addressing wicked problems can rarely be accomplished by a single organization (Pittz et al. 2018). According to the Law of Requisite Variety, only the variety (or complexity) of a system can destroy variety (Ashby 1961). This implies that addressing wicked problems may require organizations to increase their own complexity, for example by resource pooling and collaborative efforts across organizational boundaries (Hardy et al. 2006; Langley et al. 2019; Ungureanu et al. 2020). However, the process of forming a shared intention or strategy amidst divergent and sometimes conflicting goals and interests presents a major challenge (de Gooyert et al. 2019).

Our study aims to identify core practices of inter-organizational strategizing that influence strategic alignment in a complex setting. Strategic alignment refers to the extent to which "decision makers place importance on strategic priorities that are responsive to, or fit, the demands of the external environment faced by the organization" (Walter et al. 2013). Transferred to our context of inter-organizational strategizing, strategic alignment is a result of strategy work that either appreciates and includes different organization's points of view in consensual strategy outputs or ends in strategic disorder because it is not possible to develop a joint course of action. To explore relevant practices, we conducted a longitudinal single case study in an inter-organizational setting aimed at addressing a wicked societal problem. Such indicative case studies are well suited to analysing phenomena characterized by great complexity and ambiguity (Flyvbjerg 2016). We chose an inter-organizational setting involving the formation of a healthcare partnership a major metropolitan city of Germany, which consisted of eleven different organizations, including health insurers, healthcare consultancies, a network of physicians, and a community centre. The purpose of this partnership was to address the extremely poor health outcomes attributed to a lack of alignment among healthcare providers and third-party payers in a socially deprived area—a wicked problem that no single organization could resolve. We tracked how the strategizing process within this partnership evolved over

an eight-year period, from 2012 to 2019, during which actors from the partnering organizations attempted to agree on goals, objectives, and plans for the partnership.

The structure of this paper is as follows: First, we review the literature on inter-organizational partnerships and explain the theoretical concepts that guided our analysis. Second, we describe our case context and approach to data collection and second-order theorizing to address our research question. Third, we present our findings regarding the core practices shaping this process of achieving strategic alignment in inter-organizational strategizing and how they evolved over time. Lastly, we discuss the contribution of our findings to the literature on inter-organizational strategizing, their relevance to similar contexts, and their implications for management practice.

2 Addressing Wicked Problems through Inter-organizational Partnerships

When organizations tackle complex social problems, they must deal with uncertainty and blurred boundaries, resulting in a high degree of complexity (Hardy et al. 2006; Seidl and Werle 2018). Such problems are often referred to as "wicked problems". Rittel and Webber (1973) define them as complex and ambiguous challenges in policy that cannot be comprehensively described; the inherent public good claim is continuously disputed. Wicked problems are multidimensional and often hold a strategic significance that spans various organizations (Seidl and Werle 2018). Essentially, they are "systems of problems" characterized by a multitude of interconnected factors (Cartwright 1987; Trist 1983).

Tackling wicked problems is highly challenging due to their inherent complexity. Because they can rarely be addressed by a single organization (Gray 1985; Hardy et al. 2006; Trist 1983), inter-organizational partnerships are needed to find appropriate solutions. Specifically, the collaborating partners need to engage in inter-organizational strategizing, a term we use to refer to the process of developing a specific course of action (Mintzberg 1987) and, more broadly, the range of activities that lead to the creation of strategies (Vaara and Whittington 2012). This includes both emergent and deliberate forms of strategy formulation, as well as the organizational activities undertaken to implement these strategies (Vaara and Whittington 2012). As a result, the related strategy outputs consist of various elements, such as strategic plans, strategic decision documents, action or implementation plans, and partnership agreements that outline the agreed-upon courses of action and goals.

Achieving joint strategy outputs in inter-organizational strategizing is a complex process shaped by the challenges of overcoming organizational boundaries (Maguire and Hardy 2005; Ungureanu et al. 2020; Villani and Phillips 2020). Stakeholders from various organizations often differ on the same issue with regard to their missions, goals, approaches, governance structures, and perspectives (Babiak and Thibault 2009; Cloutier and Langley 2017; Selsky and Parker 2005).

Establishing relationships of trust and overcoming cultural differences among stakeholders can be particularly challenging in this setting (Bromley et al. 2018; Noble and Jones 2006). Additionally, organizations may vary in how they organize

strategy work, with their approaches ranging from deliberative and forward-looking to autonomous venturing (Mintzberg et al. 2018). These differences can lead to complexity and high transaction costs, which may involve mitigating the effects of opportunistic behaviour, having to spend more time and effort on communication and negotiation (Adelaja et al. 2010; White and Lui 2005), implementing measures to reduce uncertainty, and ensuring compliance (Adelaja et al. 2010; Brown and Potoski 2003).

Previous research has explored factors that facilitate or hinder the development of inter-organizational partnerships, aiming to find ways to address challenges like those described above. A recurring theme in these studies is the key role played by the relationships among organizations. Nelson et al. (1999) observed that these relationships evolve similarly to personal ones, and that they are shaped by the principles, values, interests, and visions of the organizations involved (Nelson et al. 1999). Successful partnerships tend to thrive when stakeholders trust one another and share similar values (Alam et al. 2014; Nelson et al. 1999; Pratt et al. 2017; Probandari et al. 2011; Wright et al. 2017). Effective communication, mutual understanding, and mutual awareness are fundamental to this process (Alam et al. 2014; Nelson et al. 1999; Pratt et al. 2017; Wright et al. 2017). Several studies have emphasized the importance of an intermediary actor (Probandari et al. 2011) or boundary spanner (Hassink et al. 2015; Noble and Jones 2006) who can bridge potential divides between organizations by serving as a communication interface and assuming project management responsibilities (Noble and Jones 2006). Additionally, formalized procedures (Alam et al. 2014; Pratt et al. 2017; Probandari et al. 2011) and a supportive environment, including top-level management support (Hassink et al. 2015), can have a positive impact on the growth of inter-organizational partnerships.

Additional studies emphasise that openness is a prerequisite for long-lasting cross-sector collaboration (Alam et al. 2014; Cloutier and Langley 2017; Manning and Roessler 2014) and is crucial for developing collectively legitimized solutions (Seidl et al. 2019). The open strategy literature refers to openness in strategy-making as a process of strategy development that includes different stakeholders from inside and outside an organization (Hautz et al. 2017; Whittington et al. 2011). It is defined along the dimensions of transparency and inclusiveness, whereby transparency refers to the visibility of and access to (sensitive) information (Dobusch et al. 2019; Whittington et al. 2011) and inclusiveness refers to the inclusion of actors in the organization's strategic conversation (Whittington et al. 2011). Strategy-making is not a monolithic or binary phenomenon, i.e. open versus closed, but rather a set of processes, each of which can vary in its degree of openness (Whittington et al. 2011). Indeed, it is the interplay of open and closed elements that might enable open qualities in strategy-making (Dobusch et al. 2019). Dobusch et al. (2019), argue that certain forms of closure might be required with regard to the overall design of the strategy endeavour, which should be characterized by a predefined schedule, including relevant milestones, in order to provide orientation throughout the strategy-making process. Defining particular structures a priori might be necessary to establish openness later in the strategy-making process. In the context of inter-organizational open strategizing, goal interdependence of stakeholders and connect-

edness have been observed as facilitators of the strategizing process (Pittz and Adler 2016; Pittz et al. 2019).

While these studies contribute to our understanding of the factors driving inter-organizational collaboration and strategizing, they fall short in explaining how stakeholders in this setting—who often possess diverse professional backgrounds and perspectives, lack pre-existing communication structures, and exhibit widely varying levels of trust—are able to reach *strategic alignment*. Considering that many inter-organizational partnerships are destined to fail (Gulati et al. 2012; Kale and Singh 2009; Lunnan and Haugland 2008), it is important to understand the practices of inter-organizational strategizing that lead to strategic alignment or strategic disorder and how these practices evolve over time. Given the complexity, diversity, and ambiguity of inter-organizational settings, we ask: *which practices enable or constrain strategic alignment in inter-organizational strategizing?*

3 Methods

3.1 Case Selection and Context

We employed a case-selection process following the approach outlined by Yin (2014), with the aim of choosing a case that would best reflect the phenomenon under investigation. For our research question, this meant selecting a case that (a) promised to offer rich and diverse insights into inter-organizational strategizing, (b) involved inter-organizational strategizing aimed at solving a wicked problem, and (c) allowed us to obtain all relevant data.

Our case centred on the complex challenge of addressing the poor health conditions and outcomes observed in a socially deprived urban area in Germany over many years. The area is located in one of the major metropolitan cities of Germany and has an above-average number of socioeconomically disadvantaged residents, including unemployed individuals, migrants, children (under 15 years of age), and single parents with low income, as well as people with lower-than-average educational attainment. In terms of population health, the average onset of chronic diseases in the area occurs ten years earlier than the city-wide average, and life expectancy is 13 years lower than in the city's most affluent areas. Moreover, the area faces a shortage of physicians and higher-than-average physician workloads. In summary, the area is confronted by the complex and boundary-crossing challenge of how to improve the health of a vulnerable, low-income population faced with cultural and language barriers, a shortage of health service providers, and overburdened physicians.

To tackle this wicked problem, various entities, such as health insurers, the state health authority, healthcare consultancies, and a network of physicians opted for an inter-organizational approach. This involved establishing a healthcare partnership with the goal of developing and providing integrated care spanning disease prevention, acute care, chronic care, rehabilitation, community care, and palliative care to the nearly 60,000 individuals residing in the area. Specifically, the healthcare partnership aimed to implement multilingual low-threshold healthcare counselling and

information services and establish concrete measures that enable a better connection of health and social care providers.

The inception of the healthcare partnership can be traced back to a conversation between a local physician and the head of a healthcare consultancy in 2012. Following this initial discussion, the healthcare consultancy contacted the state health authority and several health insurers to explore the feasibility of a partnership for an innovative healthcare model in the socially deprived area.

By 2015, the organizations involved in the partnership became aware of the possibility of national funding for their project, leading to a joint application and the subsequent granting of national funding in 2016. In 2017, the healthcare model was officially implemented, with active involvement from physicians, community workers, and a regional management office. However, recognizing that national funding would cease at the end of 2019, actors in the partnership, especially the health insurers, intensified their strategic efforts around mid-2018. This ultimately resulted in a joint agreement to continue the healthcare partnership beyond the end of national funding. More details regarding the case are provided in the case narrative in the results section.

Table 1 gives an overview of the main organizations involved in the partnership.

3.2 Data Collection

We collected data from multiple sources to capture different views and perspectives and reconstruct a shared understanding of events, circumstances, and developments (Tracy 2010). To cover the eight-year period of strategizing and implementation, we drew upon retrospective data from 2012 to 2014, real-time data from 2015 to 2018, and follow-up data from 2019 (see Fig. 1).

Our primary source of data consisted of semi-structured, face-to-face interviews with key actors in the healthcare partnership. The interviews took place at the interviewees' offices between September and November 2017. Two years later, we conducted, whenever possible, follow-up interviews with the same interviewees, as well as interviews with additional actors who had become involved in the partnership in the meantime.

Table 1 Main organizations involved in our case of inter-organizational strategizing

Organization	Key attributes, roles, and actions
Healthcare consultancy (HC)	Provided the initial concept for improving population health
Regional management office (RMO)	Was founded by the healthcare consultancy as a local office with coordination and project management tasks; became an independent organization in 2017
Physician network (PN)	Association of office-based physicians located in the socially deprived urban area
Health insurers (HI)	Involved in data-driven care management and funding (two participating health insurers in 2017, three in 2019)
State health authority (SHA)	Acted as a supporter of and mediator in the partnership
Community centre (CC)	Coordinates and offers social care services in the socially deprived urban area

To identify and select interviewees for the first round of interviews, we employed a combination of purposeful and snowball sampling. We used the partnership agreement and minutes from bilateral and multilateral meetings to identify all parties involved in the partnership. In total, we sent out 28 interview invitations, accompanied by an explanation of the purpose of the study, and followed up with non-respondents. Additionally, if interviewees mentioned other closely involved actors during the interviews, we extended invitations to them if they had not been previously invited. Ultimately, 21 individuals from eleven organizations accepted our invitation and took part in an interview. At the beginning of each interview, interview partners provided informed consent for the conversation to be audio-recorded, transcribed, anonymized, and used for scientific purposes. On average, the interviews lasted one hour, with durations ranging from 25 to 90 min.

We used an interview guide to give structure to the interviews. The guide consisted of four open-ended main questions along with several sub-questions. The main questions focused on the drivers, barriers, and contextual conditions influencing strategy work in the interviewees' organizations and the broader inter-organizational setting. We also sought a general overview of the strategizing process and the interviewees' perceptions regarding its inclusiveness. The interview guide was developed and pilot-tested with four experts, two specialized in developing and implementing integrated care programmes and two with expertise in qualitative research methods. After completing our data analysis, we conducted the follow-up interviews.

Our follow-up interviews took place between October 2019 and December 2019. In total, 19 individuals accepted the invitation and participated as interview partners, 12 of whom had participated in the first round in 2017. In this second round of interviews, we focused on key strategic decisions made over the past three years. We also explored how and why the influence of different organizational entities on strategy outputs evolved over time. Additionally, we used the second round of interviews to present and discuss our findings with the interviewees, thus performing a member check, or *member reflection* to increase the credibility and validity of our findings (Tracy 2010). To encourage our interviewees to engage in reflexive elaboration, we invited them to critique or confirm our findings, discuss various possible interpretations, and share how their own experiences aligned with, or diverged, from our findings (Tracy 2010).

As a participatory observer, one of the authors of this study actively engaged as a scientific evaluator of the project in four decisive meetings among participants, including employees of the healthcare consultancy and physicians. During these meetings, the researcher took notes relevant to our research question. In addition, we attended two press conferences held by the CEOs of the health insurers, civil servants from the state health authority, physicians, and employees of the regional management office and the healthcare consultancy. Other data sources consisted of minutes of bilateral and multilateral meetings, strategy-related email threads, presentations, letters, reports, and formal agreements produced between 2012 and 2019 (N = 81 documents). Actors in the healthcare partnership followed an open data approach, making all reports and minutes from the monthly multilateral meetings accessible to all project participants. Having the different data sources at our disposal

enabled us to triangulate our findings, increasing the confidence with which we could draw conclusions. Table 2 gives details on our data sources.

3.3 Data Analysis

We used an iterative and collaborative coding approach. The first researcher was involved in all aspects of preparing the fieldwork and collecting data, and provided insights into the case and how data were collected. The three other researchers held an outsider position and scrutinized the analysis and results. We transcribed all interviews and coded them, as well as the documents and observation notes, using MAXQDA version 18.2.0 (VERBI Software 2018). Overall, our analysis was influenced by temporal bracketing as a concept for gaining insights from longitudinal data sets (Gioia et al. 2022; Langley 1999; Langley et al. 2013) and by inductive qualitative coding in multiple coding cycles as analytical strategy (Gioia et al. 2013; Kuckartz 2014; Saldaña 2013). After obtaining preliminary results, we engaged in detailed discussions of the results from each phase, facilitating comparisons of different perspectives within the data. These discussions also explored potential explanations for the phenomena we had identified, ultimately leading to a shared interpretation of the data. Our analysis procedure can be divided into three steps, as follows:

3.3.1 Step 1: Developing a Case Narrative

First, we developed a rich case narrative to identify temporal brackets that were "separated by identifiable discontinuities in the temporal flow" (Langley et al. 2013: 7). Temporal bracketing can serve as a means to identify mechanisms that explain changes in a specific era (Langley et al. 2013). The following case narrative describes the phases and turning points that we identified.

In **Phase I**, the state health authority initially collaborated on several projects with a community centre in the socially deprived urban area. However, this approach proved insufficient to address the area's health disparities and lack of alignment among providers. In 2012, the idea to create an inter-organizational healthcare partnership emerged from a discussion between a local physician and a representative of a healthcare consultancy. The physician described the challenging situation in the area, highlighting the urgent need for change, and suggested that the company might be able to offer a solution. The consultancy develops integrated care initiatives that focus on the triple aim of improving population health, economic efficiency, and patient satisfaction (Berwick et al. 2008). As a result of the discussion, the consultancy reached out to the state health authority, which expressed its support for the proposal and referred the consultancy and physician to the community centre. In 2013, the consultancy approached several large health insurers to present its vision and potential implementation strategies. One of the leading health insurers expressed tentative support for the idea. At the time, a range of public funding options were explored, but the necessary financing remained elusive. In 2014, the state health authority commissioned a field analysis to identify the health and social care needs of the area and develop an action plan to address them. Simultaneously, a promis-

Table 2 Data Sources

Total: 40 interviews
First round in 2017: 21 interviews
3 healthcare consultancy (HC) employees
3 regional management office (RMO) employees
5 office-based physicians
4 employees of different health insurers (HI)
2 civil servants from the state health authority (SHA)
1 hospital manager
1 community worker
1 researcher from a centre for psychosocial medicine
1 employee of an IT company
Second round in 2019: 19 interviews (12 recurring interviews)
2 healthcare consultancy employees
2 regional management office employees
3 office-based physicians
2 hospital physicians
4 employees of different health insurers
1 civil servant from the state health authority
2 hospital managers
2 community workers
1 researcher from a centre for psychosocial medicine
Total: 81 documents (652 pages)
16 sets of minutes from strategic meetings (38 pages)
12 sets of minutes from information meetings (102 pages)
23 press clippings (41 pages)
2 sets of minutes from workshops (15 pages)
4 provisional partnership contracts (93 pages)
1 application for national funding (119 pages)
9 strategy-related email threads (16 pages)
10 interim reports (97 pages)
1 official action plan (127 pages)
3 official press statements (4 pages)
6 observations (5 h)
2 press conferences (30 September 2017, 5 December 2019)
4 strategic meetings (date/duration/participants) – 9 Oct. 2017/1 h/HC, HI 1, HI 2, HI 3, SHA, evaluation institute – 29 Nov. 2017/1 h/HC, HI 1, HI 2, HI3, SHA, evaluation institute – 7 Dec. 2018/1 h/HC, HI 1, HI 2, HI 3, SHA, RMO, physicians, evaluation institute – 6 Mar. 2019/1 h/HC, HI 1, HI 2, HI 3, SHA, physicians, evaluation institute

ing funding opportunity arose from a recently established national funding initiative aimed at supporting inter-organizational healthcare models of this nature. Collaboration within and across health services and among various professional groups from different organizations was one of the main requirements of the initiative. In 2015, the prospect of national funding became the catalyst for significant inter-organiza-

tional strategizing efforts in the partnership. To secure this funding, all participating organizations had to work together strategically to develop a joint action plan to address the health disparities in the deprived urban area. The healthcare consultancy took on the leadership role in the strategizing process, providing an initial concept that required modification and unanimous acceptance from the partner organizations. During strategy workshops, bilateral and multilateral talks, the organizations involved succeeded in developing a joint action plan and a joint proposal for public funding. Our data indicate that this strategy output reflects different organization's point of views in a joint document—indicating strategic alignment: "We got into dialogue and also accepted things from each other. That was, of course, important in order to make progress along this path. The interim results from the workshop were then also incorporated into the proposal for public funding" (community worker, 2017). The prospect of national funding was a powerful motivator during this phase, culminating in the successful acquisition of the grant in mid-2016, with major implications for the strategizing process: "We had this carrot [of national funding], which in hindsight glossed over several unresolved issues and objectives [...]. We could entice stakeholders with the carrot without hurting anyone. All we had to do was talk about [the project] and not implement it, but the implementation hurts more now" (RMO employee, 2017). The grant marked a major **turning point** in the strategizing process, as it necessitated the establishment of a partnership contract that would be signed by all participating organizations and define legal obligations, particularly concerning data management, financial aspects, and exit options.

In **Phase II** (as of 2017), the newly formed regional management office began implementing measures in collaboration with service providers in the area while also refining these measures. Despite this shift towards implementation, strategizing efforts persisted, mainly concerning changes to the partnership contract because especially involved health insurers had crucial concerns and experienced severe difficulties in developing a joint contract with the healthcare consultancy. Overall, this situation was characterized by strategic disorder.

The continuation of strategizing was largely due to the anticipated expiration of national funding at the end of 2019. The intensity of strategy discussions increased after mid-2018 because the partner organizations had to reach a consensus on the continuation of the project. Reaching this consensus successfully marked the second **turning point** in the strategizing process. Interviewees emphasized that "the transition from national funding of care into standard funding was the key decision. [...] No one wanted to jeopardize the project, so despite all frictions we were still able to find common ground" (health insurer employee, 2019). The turning point also influenced negotiations with the health insurers: "It was important to anchor the project again in the minds of the senior staff of the health insurers, to clarify success; this was an important step for transitioning to regular care—and also that the project was presented again but more clearly by the [state health authority] so it became clear to the staff what was being done in the area" (physician, 2019).

Phase III witnessed intensive strategy work and substantial disagreements among the organizations. However, a consensus on the continuation of the project was ultimately reached in December 2019—without the healthcare consultancy that was dropped out of the partnership. Strategy work, thus, resulted in strategic alignment

between some organizations (especially the health insurers, the state health authority, the physicians, the regional management office, and the community centre), and strategic disorder between the majority of organizations and the healthcare consultancy.

Figure 1 provides a graphical illustration of this case narrative.

3.3.2 Step 2: Investigating Modes of Strategizing

While seeking to identify different phases of strategizing, a puzzle emerged: the presence of what appeared to be two modes of strategizing used by the different actors in the healthcare partnership: inclusiveness and exclusiveness. To examine this puzzle in more detail, we began to focus our iterative coding process on the extent to which inclusiveness or exclusiveness was used by various actors in their strategy work.

In this context, we operationalized inclusiveness as a mode of strategizing characterized by intensive and regular communication among stakeholders affected by a given strategy output, as well as by joint decision-making. We defined intensive and regular communication as the active gathering of ideas and opinions—"a two-way symmetrical form of conversation around strategy with those responsible for strategic decision-making" (Morton et al. 2018, p. 10682). In turn, we defined joint decision-making as participatory decision-making among multiple actors according to the definition by Dobusch et al. (2019). In this context, we defined strategizing according to Hart's (1992) definition of transactive strategizing processes, characterized as "strategy driven by internal process and mutual adjustment" (Hart 1992: 334). Accordingly, in inclusive strategy work, leadership should seek to empower and enable actors to participate in strategizing processes (Hart 1992).

Conversely, we operationalized an exclusive mode of strategizing as a lack of communication around strategy, the disregarding of ideas and opinions from other relevant actors, and minimal participation in decision-making related to strategizing. This mode corresponded with 'command' as an approach to strategizing, typified by "strategy driven by a leader or small top team" providing direction (Hart 1992: 334).

Step 2 of our analysis procedure resulted in the following data structure (Table 3).

3.3.3 Step 3: Identifying Practices of Inter-organizational Strategizing that Influence Strategic Alignment

Steps one and two of our analytical approach allowed us to identify inclusive and exclusive modes of strategizing over time and for different strategizing processes. However, the resulting insights were not sufficient for us to pinpoint the practices of inter-organizational strategizing that enable or constrain strategic alignment. We operationalized strategic alignment as the result of strategy work that either (1) appreciates and includes different organization's points of view in a consensual strategy output or (2) is characterized by strategic disorder because it is not possible to develop a joint course of action.

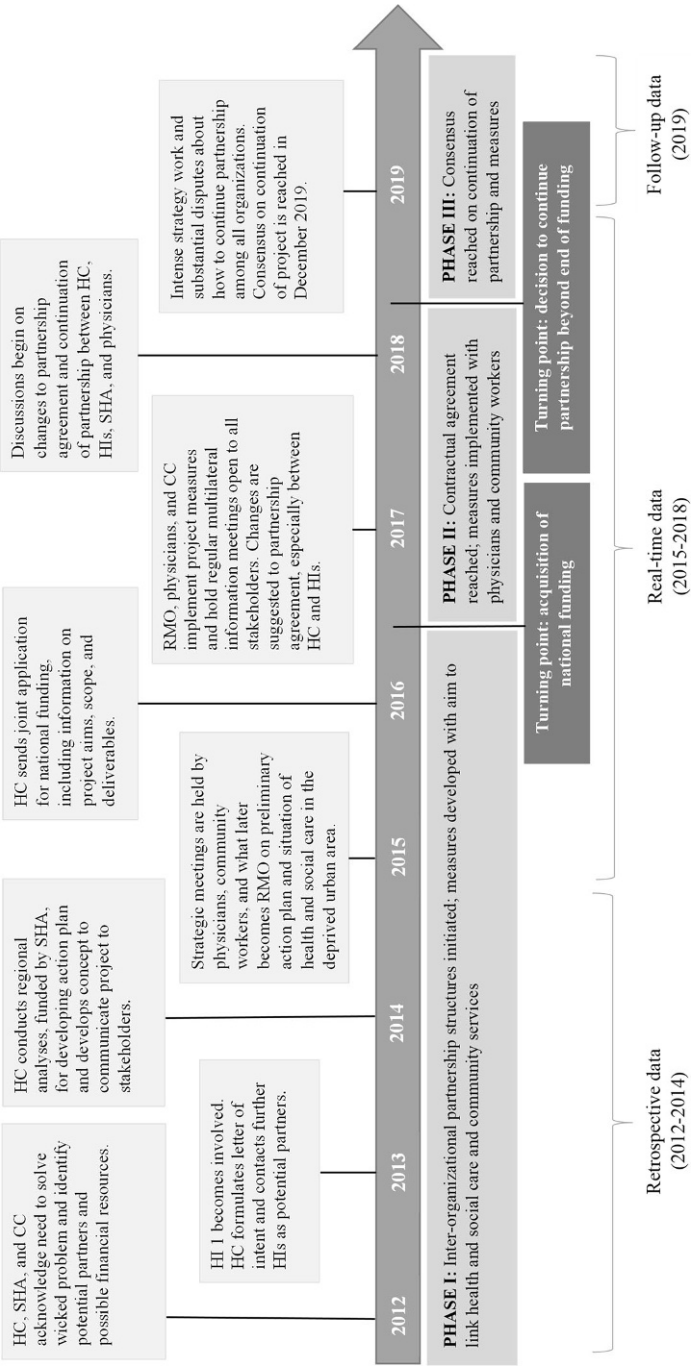

Fig. 1 Graphical case narrative

Table 3 Data structure—Modes of strategizing in inter-organizational strategizing

Reference from data material	First order concepts	Second order themes	Aggregate dimension
"There are regular meetings where we strategically agree on how to proceed and we are well informed, especially when it comes to negotiations with health insurers. I have the feeling that it's not so nebulous and non-transparent, but everything is relatively clear and you always get feedback" (community worker, 2017)	Transparency	*Inclusive*	*Mode of strategizing*
"– Communication about subgroup meetings and their activities to keep all partners up to date. – Weekly Update to all partners, and sent to all partners every Friday. – The partners would like to meet regularly, once a month" (minutes from 9 February 2017)			
"[In the strategy workshops] we succeeded in something that's normally not so easy—getting some of the physicians to actually show up to our expert talks. [...]. At the same time, [the regional management office] had much more intensive contact with the doctors through the interviews, and that all fit together rather well. Many of the physicians found the kind of expert discussions we organized to be appealing because they were inter-organizational" (community worker, 2017)	Equal participation		
"We've become more active as doctors. We have more self-confidence and have spoken directly with the decision-makers at the health insurers and the state health authority. Inclusiveness was facilitated by the fact that we no longer had an intermediary but were able to have the conversations directly" (physician, 2019)			
"If [the healthcare consultancy] had talked to all of the health insurers at once, they would have had to deal with a bunch of insured, or a bunch of health insurers, at the same time. But by negotiating with everyone individually and then telling them, 'That [partner] has agreed to this, and so you absolutely have to participate. It's not negotiable'—that is a strategic approach. From [the healthcare consultancy's] point of view, this was probably a wise and focused way of going about things, but for us, and for me in particular, it gave the impression that one partner was being played off against another as part of a strategy" (health insurer, 2017)	Lacking transparency	*Exclusive*	
"One has to bear in mind that [the healthcare consultancy] earns money with it. If others are thrown back on their intrinsic motivation and a third party earns money, then this has to happen extremely transparently. And the transparency is very expandable" (senior civil servant, 2017)			
"Due to certain political, legal and data protection concerns, several parts in the partnership contract have to be changed, particularly from the perspective of the [health insurers]" (minutes from 9 October 2017)	Non-equal participation		
"This is not an open process—we were not an equal partner" (health insurer, 2019)			

We thus conducted further coding of our data, focusing on practices associated with the ability of actors to jointly develop strategy outputs, including joint decisions or a joint partnership agreement. These included concrete conscious or unconscious actions of actors that affected the way involved organizations interacted in strategy work. Again, we analysed how these practices evolved over time. This approach ultimately led us to identify and analyse the evolution of core practices of inter-organizational strategizing that enable or constrain strategic alignment.

Table 4 provides the concerning data structure, outlining how references from our data informed the first order concepts, second order themes and strategic alignment or strategic disorder as aggregated dimension.

4 Findings

Our findings on the evolvement of modes of strategizing and practices of inter-organizational strategizing that influence strategic alignment are summarized in Table 5 and structured along the three core practices.

4.1 Structuring Conflicts

A core practice of inter-organizational strategizing that evolved in our data and is likely to enable or constrain strategic alignment, was structuring conflicts. The way conflicts were structured and managed varied substantially based on involved organizations, time, and the mode of strategizing being employed. For instance, health insurer 1 and the healthcare consultancy had bilateral communication channels during the first phase of strategizing, largely based on their pre-existing business relations (minutes from 21 May 2013 and 18 July 2013). However, this bilateral exchange of information created the impression among the other two health insurers that they "were being played off against each other" (health insurer, 2017). An employee of a health insurer perceived the situation as follows: "If [the healthcare consultancy] had talked to all of the health insurers at once, they would have had to deal with a bunch of insured, or a bunch of health insurers, at the same time. But by negotiating with everyone individually and then telling them, 'That [partner] has agreed to this, and so you absolutely have to participate. It's not negotiable'—that is a strategic approach. From [the healthcare consultancy's] point of view, this was probably a wise and focused way of going about things, but for us, and for me in particular, it gave the impression that one partner was being played off against another as part of a strategy" (health insurer employee, 2017).

During the second phase, the deadlock between health insurers and the healthcare consultancy was broken by the intensive conflict management of the senior civil servant, explicitly referred to as the "facilitator of the process" (minutes from 9 October 2017): "[The healthcare consultancy] has clearly indicated that they are not prepared to focus on questions like this until the arbitration meeting with [the senior civil servant] has taken place, where [the senior civil servant] very much sees himself as being responsible for doing something about [the healthcare consultancy's] knee-jerk refusal to open up to differing positions" (health insurer employee, 2017).

Table 4 Data structure—Practices in inter-organizational strategizing that enable or constrain strategic alignment

Reference from data material	First order concepts	Second order themes	Aggregate dimension
"[The healthcare consultancy] has clearly indicated that they are not prepared to focus on questions like this until the arbitration meeting with [the senior civil servant] has taken place, where [the senior civil servant] very much sees himself as being responsible for doing something about [the healthcare consultancy's] knee-jerk refusal to open up to differing positions" (health insurance employee, 2017)	Mitigation	*Structuring conflicts*	*Degree of strategic alignment*
"All parties involved agree that the outstanding clarifications for the pending contractual solution will be completed by the end of March 2019" (minutes from 7 December 2018)			
"were being played off against each other" (health insurer, 2017)	Reinforcement		
"It is not a kind of negotiation if one partner says, we have a set contract, you can accept it or not" (health insurer, 2017)			
"They started to identify with the project in a way that was definitely not there in 2017 because it was only a theoretical construct. This led to greater commitment" (RMO employee, 2019)	Generation	*Gaining commitment*	
"It only makes sense if the majority of physicians participate. I don't understand why my colleagues find it so difficult to at least try it" (physician, 2017)			
"[The strategy work with the healthcare consultancy] has taken an enormous amount of time and, above all, has destroyed trust and confidence to the core" (health insurer, 2017)	Reduction		
"The trust that what you say is going to reach your counterpart, [and that they will] acknowledge what was said and treat it seriously—that was gone. It also proved true again and again that we were simply not taken seriously" (health insurance employee, 2019)			
"[the project] represents an important programmatic approach for the further development of the healthcare system in [the area] and nationwide and is therefore still worthy of unrestricted support" (minutes from 9 October 2017)	Striving	*Agreeing on objectives*	
"We want to approach it with a common impulse to change something. We have seen [that] we all feel the same way. We're all in the same boat, and we can work together, which doesn't mean that we take anything away from each other, but that we can perhaps do [the work] more easily" (physician, 2017)			
"Of course, it's always problematic when someone [i.e., the healthcare consultancy] has goals that aren't openly communicated in a project—that's really problematic. Someone who has achieves something that no one knows about and only benefits them can never be good for a project" (health insurer, 2019)	Hiding		
"there is a culture that is really based on compartmentalisation" (RMO employee, 2017)			

Table 5 Modes of strategizing and practices of inter-organizational strategizing

	PHASE I			PHASE II			PHASE III	
Organizations	*HC, HI 1*	*HC, HI 2, HI 3, SHA*	*RMO, CC, physicians*	*HC, HI 1*	*HC, HI 2, HI 3, SHA*	*RMO, CC, physicians*	*Joint consortium (HI 1, HI 2, HI 3, SHA, RMO, physicians, HC)*	
Mode of strategizing	Exclusive	Exclusive	Inclusive	Inclusive	Exclusive	Inclusive	Inclusive	
Structuring conflicts	Engaged in bilateral exchange based on existing relationships	Mediator respected by all stakeholders initiated first conflict management	Established first network and communication structures	Intensified business relationships	Mediator respected by all stakeholders intensified conflict management	Manifesting established network and communication structures	Built on extensive conflict management run by mediator respected by all stakeholders	Used established and intensified network and communication structures
Gaining commitment	Relied on pre-existing personal ties, restricted by limited commitment	Faced barrier of extensive mistrust and weak commitment of HIs	First sign of commitment by those actors affected by the strategy outcome	Developed first trust in negotiations	Faced barriers of extensive mistrust, but built on intensified commitment of HIs	Commitment increased in quantity and quality	Enabled trustworthy negotiations, withdrawal of stakeholder with exclusive mode of strategizing	Built on strong commitment by actors affected by the strategy outcome
Agreeing on objectives	Faced differences in objectives	Hid objectives	Created shared vision based on evidence on and perception of a wicked problem	Converged objectives	Hid objectives	Relied on shared vision based on evidence on and perception of a wicked problem	Shared objectives transparently, followed joint agenda	Followed joint objectives based on evidence on and perception of a wicked problem

HC healthcare consultancy, *HI* health insurer, *SHA* state health authority, *RMO* regional management office, *CC* community centre

In phase three, two health insurers and the network of physicians became increasingly dissatisfied with the exclusive and untransparent strategy work conducted by the healthcare consultancy. Participants expressed their frustration in comments such as "This is so exhausting and so unfruitful, we won't continue [the collaboration] this way" (physician, 2019) and "This is not an open process—we were not an equal partner" (health insurer, 2019). This exclusive mode of strategizing became the main reason for the healthcare consultancy's withdrawal from the partnership in late 2019. As a result, the consultancy lost its role as a contract partner and shareholder and faced significant opposition, especially from the network of physicians: "The doctors blackmailed us, saying, 'Either you quit the project or we leave'. It was a really stark case of blackmail" (HC employee, 2019). At the same time, the senior civil servant succeeded in structuring these conflicts by organizing two strategy meetings with 13 participants each, representing the three health insurers, the network of physicians, the regional management office, the healthcare consultancy, hospital management, the scientific evaluation team, and the state health authority (minutes from 7 December 2018 and 6 March 2019). This inclusive approach of bringing together all relevant organizations facilitated the exchange of experiences, arguments, and objectives and led to an agreement on further steps: "All parties involved agree that the outstanding clarifications for the pending contractual solution will be completed by the end of March 2019" (minutes from 7 December 2018).

In strategy work involving the network of physicians, the community centre and the regional management office, building on existing network and communication structures was beneficial for preventing or mitigating conflicts: "There are many associations here, also institutions like [the community centre] that provide access to [stakeholders in] the area and provide us with communication structures for networking. We had [an event during which interested stakeholders could discuss topics related to area development], and there were regular meetings [afterwards]" (HC employee, 2017). This environment proved especially advantageous for the regional management office, which strove to use inclusive forms of strategy work to ensure that the planned measures would be accepted by service providers. As one employee from the regional management office explained, "Actors who will be needed later need to be involved in some way right from the beginning [...]. The best thing that can happen is when they think [the measures were] their idea" (RMO employee, 2017). In essence, the regional management office was able to build on existing network structures in the area and expand them through their inclusive approach. During phases two and three, the network of physicians—a pivotal organization in the partnership—experienced rapid growth both in terms of quality and quantity. It expanded from seven members who had occasional meetings in 2017 to 61 members with regular network meetings in 2019. As one physician summarized in 2019, they succeeded in "establishing a network between physicians and other service providers in the regional healthcare structures and optimized communication between the involved actors" (physician, 2019). These intensified network and communication structures in phase three provided a conducive environment for structuring—or preventing—conflicts and enabled strategic alignment.

4.2 Gaining Commitment

Our data revealed that gaining commitment was a crucial practice of inter-organizational strategizing and is strongly linked to levels of trust. This became especially clear in situations where trust was lacking—leading to minimal commitment of involved organizations. Representatives from the health insurers repeatedly mentioned in their interviews that trust was in short supply, particularly towards the healthcare consultancy, and they described this as a major obstacle to collaboration, especially in phases one and two: "[The strategy work with the healthcare consultancy] has taken an enormous amount of time and, above all, has destroyed trust and confidence to the core" (health insurer, 2017). Mistrust between the health insurers (especially two and three) and the healthcare consultancy was still dominant in phase three: "The trust that what you say is going to reach your counterpart, [and that they will] acknowledge what was said and treat it seriously—that was gone. It also proved true again and again that we were simply not taken seriously" (health insurer, 2019). The lack of trust was strongly connected to the lack of transparency and the healthcare consultancy's exclusive mode of strategizing. The senior civil servant, acting as a moderator of the strategizing process, reasoned that "ultimately, [the lack of] transparency was one of the reasons why the two primary partners split up" (senior civil servant in the SHA, 2019). In this environment, joint strategy work became impossible, and the commitment of health insurers (especially two and three) was minimal.

Concerning the network of physician and the community centre, gaining commitment was equally linked to levels of trust but evolved differently. On the one hand, several physicians had reservations: "It only makes sense if the majority of physicians participate. I don't understand why my colleagues find it so difficult to at least try it" (physician, 2017). A health insurer employee believed that "it has to be made clear what this project stands for. It is still quite abstract at the moment, which I think also prevents some people from getting involved because they have not yet really understood what is actually happening" (health insurer employee, 2017). On the other hand, employees of what would later become the regional management office and staff from the community centre explicitly called for commitment and organized strategy workshops in 2015 involving 40 to 50 participants with diverse occupational backgrounds, including physicians and other health care providers, community workers, and politicians. Although the community centre had previously organized other workshops on health and social care, this was the first time they had successfully facilitated an inter-organizational discussion: "[In the strategy workshops] we succeeded in something that's normally not so easy—getting some of the physicians to actually show up to our expert talks. [...] Because the whole problem of excessive workload is, of course, also depressing for physicians, and they also felt affected by it. [...] Many of the physicians found the kind of expert discussions we organized to be appealing because they were inter-organizational" (community worker, 2017). Understanding and identification with the project rapidly evolved over time, leading to increased commitment of physicians: "They started to identify with the project in a way that was definitely not there in 2017 because it was only a theoretical construct. This led to greater commitment" (RMO em-

ployee, 2019). Ultimately, it was the combination of inclusive forms of strategy work by the regional management office and increased identification and interest among physicians that led to a substantial increase in physicians' commitment over time.

4.3 Agreeing on Objectives

Lastly, agreeing on joint objectives comprises the third core practice of inter-organizational strategizing that is linked to achieving strategic alignment. This was particularly evident in strategy work with the healthcare consultancy. The healthcare consultancy was repeatedly criticized for pursuing a 'hidden agenda' or, at the very least, being opaque about its objectives: "Of course, it's always problematic when someone [i.e., the healthcare consultancy] has goals that aren't openly communicated in a project—that's really problematic. Someone who has achieves something that no one knows about and only benefits them can never be good for a project" (health insurer, 2019). This exclusive approach to strategy work posed an obstacle to forming a joint strategy. In phase two, the senior civil servant managed to secure a joint agreement that "[the project] represents an important programmatic approach for the further development of the healthcare system in [the area] and nationwide and is therefore still worthy of unrestricted support" (minutes from 9 October 2017). This led to the overarching objective of a "contractually secured continuation of the project" (minutes from 7 December 2018) in phase three.

Strategy work involving the network of physicians, the community centre and the regional management office was more closely related to and inspired by a 'shared vision' rather than 'joint objectives'. The impetus for this shared vision became particularly evident in phase one, as physicians experienced severe challenges in their daily work: "We have a lot of patients, we have too little time for the individual patient, we have an awful lot of bureaucracy, the patients don't understand us, and we need translators" (physician, 2017). Employees of what later became the regional management office successfully brought together service providers in the area, allowing them to develop a sense of belonging and work towards their shared vision of improving healthcare in the area: "We want to approach it with a common impulse to change something. We have seen [that] we all feel the same way. We're all in the same boat, and we can work together, which doesn't mean that we take anything away from each other, but that we can perhaps do [the work] more easily" (physician, 2017). As physicians and other service providers became more involved in the strategizing processes in phase two, they faced the challenge of reconciling 'their' vision with that of the healthcare consultancy: "It's important for me as a doctor that it's not the consultancy that intervenes and tries to push through a certain concept, but that it has to be a joint development, joint work" (physician, 2019). In phase three, the talk of a shared vision fed into the joint discussions moderated by the senior civil servant. Here, physicians had to become more concrete about their aims, resulting in joint objectives, most notably the request to continue existing measures in the area.

5 Discussion

We conducted a case study examining eight years of strategy and implementation work within a healthcare partnership in Germany. The partnership was designed to deliver integrated, effective, and affordable healthcare in a socially deprived urban area. Our aim was to identify the core practices of inter-organizational strategizing that enable or constrain strategic alignment and to explore how these practices evolved over time.

Our analysis of the different phases of the strategizing process identified its three critical practices: structuring conflicts, gaining commitment, and agreeing on objectives. Our results also suggest the presence of two distinct modes of strategizing, one characterized by exclusiveness and the other by inclusiveness. Drawing on second-order theorizing (see Cornelissen et al. 2021) leads us to propose a model that integrates these considerations. This model suggests that the mode of strategizing that is chosen manifests itself differently in each practice, ultimately leading to different outcomes (see Fig. 2).

Specifically, following the path of inclusive strategizing appears more likely to mitigate conflict structures, cultivate commitment among actors, and help ensure that actors follow shared objectives (because they are transparently communicated), ultimately resulting in strategic alignment. Conflicts or tensions are inherently intertwined with inclusive strategy work, and resolving them has also been recognized as a crucial factor in joint strategy formation in various contexts (Heracleous et al. 2018). With regard to commitment, Hautz et al. (2017) and Nketia (2016) argue that inclusive strategy work increases the commitment of organizational members to the outcomes of strategizing processes.

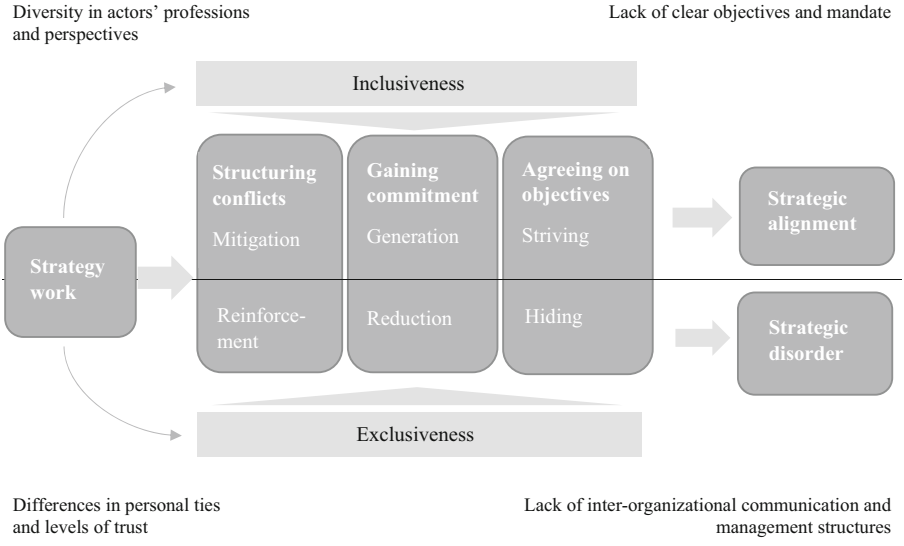

Fig. 2 Practices of inter-organizational strategizing

Our findings extend this understanding by suggesting that an intentional inclusive mode of strategizing can foster early commitment among stakeholders, motivating them to invest time and effort in shaping a joint course of action. In contrast, an exclusive mode of strategizing is likely to dampen commitment, reinforce conflict structures, and prevent stakeholders from revealing their intended objectives, leading to strategic disorder and an inability to formulate a joint course of action. This being said, the paths of strategy work may evolve over time, including adjustments in modes of strategizing.

In summary, our findings suggest that the interplay between inclusive strategy work and the following practices play a crucial role in enabling the formation of joint strategies in inter-organizational settings: (a) mitigating conflicts, (b) generating commitment, and (c) striving for joint objectives.

With these findings, we contribute both to the literature on inter-organizational strategizing and to the open strategy literature. In the context of inter-organizational strategizing, Pittz and Adler (2016) argue that such collaboration goes beyond mere knowledge and information sharing because it is inherently open and incorporates input from internal and external stakeholders. Generally, addressing wicked problems through inter-organizational collaboration aims to increase the variety of perspectives, expertise, and resources, enabling organizations to "sense accurately the variety present in ecological changes outside" (Weick 1979: 188). In doing so, organizations tend to open up their internal strategizing processes (Hautz et al. 2017; Whittington et al. 2011). However, our case challenges these propositions regarding openness in inter-organizational strategizing. We describe how a substantial part of such strategizing might be shaped by exclusive strategizing modes. This could be attributable to diverging interests among organizations and objectives that extend beyond solving the wicked problem and are not transparently communicated in the partnership. In addition, dependencies between organizations and the allocation of required financial and other resources to address the wicked problem tend to be unevenly distributed among stakeholders, leading to power imbalances and different capacities to shape the strategizing process. Thus, in practice, inclusiveness as a mode of strategizing is not necessarily an inherent characteristic of inter-organizational partnerships; instead, it might substantially change over time and influences stakeholder's ability to reach strategic alignment.

With regard to open strategy literature, openness in strategizing processes has been found to be a prerequisite for long-lasting inter-organizational collaboration (Alam et al. 2014; Cloutier and Langley 2017). It is considered crucial for developing collectively legitimized solutions (Seidl et al. 2019). However, our study adds nuance to these findings by highlighting that positive outcomes in strategy work, such as achieving strategic alignment, are not solely dependent on openness. Instead, we identify three core practices that both influence and are influenced by openness. This reciprocal relationship, in turn, influences the ability of organizations to develop joint strategic solutions. This is particularly relevant in contexts characterized by high diversity in actors' professions and perspectives, a lack of clear objectives and mandates, differences in personal and professional relationships and levels of trust, and a lack of pre-existing communication and management structures. Additionally, our findings underscore the dynamic nature of openness over time (see Whittington

et al. 2011; Dobusch et al. 2019). We observed that the extent of inclusiveness in strategy work may also vary depending on which content organizations negotiate. Inclusive strategy work may be less conducive to negotiating funding matters and legal agreements, because stakeholders may be less transparent about their objectives and interests in these areas. In contrast, inclusiveness may play a more prominent role in gathering ideas and perspectives on how to design specific services or products.

6 Practical Implications and Limitations

Our framework for developing joint strategies in inter-organizational settings can serve as a conceptual model for future research and as a guide for strategy and policy-makers to tackle wicked problems. Inter-organizational strategizing is inherently linked to a variety of perspectives, approaches, and strategic positions among stakeholders. While this variety is essential for pooling resources and knowledge to confront wicked problems, it simultaneously introduces complexities that can hinder coordination (Seidl and Werle 2018; Villani and Phillips 2020).

Our case study underscores how this variety and complexity can result in distinctive conflict structures when stakeholders use exclusive modes of strategizing. To navigate this environment effectively, strategy- and policy-makers should prioritize the mitigation of conflict structures. This can be achieved by applying, enabling, or even presupposing participatory strategizing processes in the development and implementation of solutions to wicked problems. However, the mere implementation of inclusiveness is not sufficient; it must be coupled with clear rules and instructions. Without these, there is a risk of perpetuating existing biases among stakeholders throughout the strategizing process (Dobusch et al. 2019). Thus, establishing an organizational framework for engaging stakeholders, fostering transparent sharing of goals and objectives, and facilitating trustworthy negotiations becomes a necessity. By considering the practices that enable or constrain strategic alignment in inter-organizational strategizing, stakeholders can increase the likelihood of formulating collectively legitimized strategic solutions to wicked problems.

Although our study addresses a significant research need, its findings are subject to several important limitations, each of which offers avenues for future research. While our single case study design offered the opportunity to analyse a phenomenon of great complexity and ambiguity (Flyvbjerg 2016), the generalizability of our findings is limited. Although our results are similar to those of other qualitative studies from the inter-organizational strategizing literature, further research is needed to validate our framework in other contexts. This also includes the generalizability of our findings regarding strategizing processes in single organizations. We identified some parallels between the practices found in our study and the factors that have been identified by others for single-organizational strategizing processes such as managing tensions (Heracleous et al. 2018) and trust between stakeholders (Morton and Amrollahi 2018). It is likely, however, that the requirements for meeting the conditions differ between these settings. While the single-organization setting provides some pre-existing structures for strategy work, the organizational structures for inter-organizational strategizing must be built from scratch. Thus, practitioners

might have to pay more attention to building appropriate organizational structures in the inter-organizational setting than in the single-organization setting. Moreover, it is likely that practitioners have to deal with a broader variety of positions in the inter-organizational setting than in the single-organization setting given the differences between professional groups and institutional logics. Future research should explore these similarities and differences more closely.

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References

Adelaja, A.O., M.A. Gibson, and L.A. Racevskis. 2010. Transaction costs and inter-jurisdictional cooperation: an application to land use collaboration. *Journal of Public Affairs* 10(4):265–279. https://doi.org/10.1002/pa.358.

Alam, Q., M.H. Kabir, and V. Chaudhri. 2014. Managing infrastructure projects in Australia. *Administration & Society* 46(4):422–449. https://doi.org/10.1177/0095399712459728.

Ashby, W.R. 1961. *An introduction to cybernetics*, 4th edn., London: William Clowes.

Babiak, K., and L. Thibault. 2009. Challenges in multiple cross-sector partnerships. *Nonprofit and Voluntary Sector Quarterly* 38(1):117–143. https://doi.org/10.1177/0899764008316054.

Berwick, D.M., T.W. Nolan, and J. Whittington. 2008. The triple aim: care, health, and cost. *Health Affairs* 27(3):759–769. https://doi.org/10.1377/hlthaff.27.3.759.

Bromley, E., C. Figueroa, E.G. Castillo, F. Kadkhoda, B. Chung, J. Miranda, K. Menon, Y. Whittington, F. Jones, K.B. Wells, and S.H. Kataoka. 2018. Community partnering for behavioral health equity: public agency and community leaders' views of its promise and challenge. *Ethnicity & Disease* 28(2):397–406. https://doi.org/10.18865/ed.28.S2.397.

Brown, T.L., and M. Potoski. 2003. Transaction costs and institutional explanations for government service production decisions. *Journal of Public Administration Research and Theory* 13(4):441–468.

Cartwright, T.J. 1987. The lost art of planning. *Long Range Planning* 20(2):92–99.

Cloutier, C., and A. Langley. 2017. Negotiating the moral aspects of purpose in single and cross-sectoral collaborations. *Journal of Business Ethics* 141(1):103–131. https://doi.org/10.1007/s10551-015-2680-7.

Cornelissen, J., M.A. Höllerer, and D. Seidl. 2021. What theory is and can be: forms of theorizing in organizational scholarship. *Organization Theory* 2:1–19.https://doi.org/10.1177/263178772110203.

Dobusch, L., L. Dobusch, and G. Müller-Seitz. 2019. Closing for the Benefit of Openness? The case of Wikimedia's open strategy process. *Organization Studies* 40(3):343–370. https://doi.org/10.1177/0170840617736930.

Flyvbjerg, B. 2016. Five misunderstandings about case-study research. *Qualitative Inquiry* 12(2):219–245.

Gioia, D.A., K.G. Corley, and A.L. Hamilton. 2013. Seeking qualitative rigor in inductive research: notes on the Gioia methodology. *Organizational Research Methods* 00(0):1–17.

Gioia, D.A., K.G. Corley, K. Eisenhardt, M. Feldman, A. Langley, J. Lê, K. Golden-Biddle, K. Locke, J. Mees-Buss, R. Piekkari, D. Ravasi, C. Rerup, T. Schmid, D. Silverman, and C. Welch. 2022. A curated debate: on using "templates" in qualitative research. *Journal of Management Inquiry* 31(3):231–252.

de Gooyert, V., E. Rouwette, and H. van Kranenburg. 2019. 'Interorganizational strategizing. In *Cambridge handbook of open strategy*, ed. D. Seidl, G. von Krogh, and R. Whittington. Cambridge: Cambrige University Press.

Gray, B. 1985. Conditions facilitating Interorganizational collaboration. *Human Relations* 38(10):911–936.

Gulati, R., F. Wohlgezogen, and P. Zhelyazkov. 2012. The two facets of collaboration: cooperation and coordination in strategic alliances. *Academy of Management Annals* 6:541–583.

Hardy, C., T.B. Lawrence, and N. Phillips. 2006. Swimming with sharks: creating strategic change through multi-sector collaboration. *International Journal of Strategic Change Management* 1(1/2):11105–11196. https://doi.org/10.1504/IJSCM.2006.011105.

Hart, S.L. 1992. An integrative framework for strategy-making processes. *Academy of Management Review* 17(2):327–351.

Hassink, J., J. Grin, and W. Hulsink. 2015. New practices of farm-based community-oriented social care services in the Netherlands. *Journal of Social Service Research* 41(1):49–63. https://doi.org/10.1080/01488376.2014.937889.

Hautz, J., D. Seidl, and R. Whittington. 2017. Open strategy: dimensions, dilemmas, dynamics. *Long Range Planning* 50(3):298–309. https://doi.org/10.1016/j.lrp.2016.12.001.

Heracleous, L., J. Gößwein, and P. Beaudette. 2018. Open strategy-making at the Wikimedia foundation: a dialogic perspective. *The Journal of Applied Behavioral Science* 54(1):5–35. https://doi.org/10.1177/0021886317712665.

Hoebel, J., A. Rommel, S.L. Schröder, J. Fuchs, E. Nowossadeck, and T. Lampert. 2017. Socioeconomic inequalities in health and perceived unmet needs for healthcare among the elderly in Germany. *International journal of environmental research and public health* 14:1127.

Kale, P., and H. Singh. 2009. Managing strategic alliances: what do we know now, and where do we go from here? *Academy of Management Perspectives* 23(3):45–62.

Kuckartz, U. 2014. *Qualitative text analysis: a guide to methods, practice and using software*. Thousand Oaks: SAGE.

Lampert, T., L.E. Kroll, B. Kuntz, and J. Hoebel. 2018. Health inequalities in Germany and in international comparison: trends and developments over time. *Journal of Health Monitoring* 3(S1):1–24. https://doi.org/10.17886/RKI-GBE-2018-036.

Langley, A. 1999. Strategies for theorizing from process data. *Academy of Management Review* 24(4):691–710. https://doi.org/10.5465/amr.1999.2553248.

Langley, A., C. Smallman, H. Tsoukas, and A.H. Van de Ven. 2013. Process studies of change in organization and management: unveiling temporality, activity, and flow. *Academy of Management Journal* 56(1):1–13. https://doi.org/10.5465/amj.2013.4001.

Langley, A., K. Lindberg, B.E. Mørk, D. Nicolini, E. Raviola, and L. Walter. 2019. Boundary work among groups, occupations, and organizations: from cartography to process. *Academy of Management Annals* 13(2):704–736. https://doi.org/10.5465/annals.2017.0089.

Lunnan, R., and S.A. Haugland. 2008. Predicting and measuring alliance performance: a multidimensional analysis. *Strategic Management Journal* 29(5):545–556. https://doi.org/10.1002/smj.660.

Maguire, S., and C. Hardy. 2005. Identity and collaborative strategy in the Canadian HIV/AIDS treatment domain. *Strategic Organization* 3(1):11–45. https://doi.org/10.1177/1476127005050112.

Manning, S., and D. Roessler. 2014. The formation of cross-sector development partnerships: how bridging agents shape project agendas and longer-term alliances. *Journal of Business Ethics* 123:527–547. https://doi.org/10.1007/s10551-013-1853-5.

Marmot, M., and J.J. Allen. 2014. Social determinants of health equity. *American Journal of Public Health* 104(4):S517–S519. https://doi.org/10.2105/AJPH.2014.302200.

Mintzberg, H. 1987. The strategy concept I: five Ps for strategy. *California Management Review* 3(0):11–24.

Mintzberg, H., D. Etzion, and S. Mantere. 2018. Worldly strategy for global climate. *Stanford Social Innovation Review* 16(4):42–47.
Morton, J., and A. Amrollahi. 2018. *Open strategy intermediaries? A framework for understanding the role of facilitators in open strategy-making*. 26th European Conference on Information Systems (Conference Paper).
Morton, J., A. Wilson, and L. Cooke. 2018. *Managing organizational legitimacy through modes of open strategizing*. Academy of Management Proceedings, 78th Annual of the Academy of Management (Conference Paper).
Nelson, J.C., H. Rashid, V.G. Galvin, J. Essien, and L.M. Levine. 1999. Public/private partners. Key factors in creating a strategic alliance for community health. *American Journal of Preventive Medicine* 16:94–102.
Nketia, B.A. 2016. The influence of open strategizing on organizational members' commitment to strategy. *Procedia—Social and Behavioral Sciences* 235:473–483. https://doi.org/10.1016/j.sbspro.2016.11.058.
Noble, G., and R. Jones. 2006. The roles of boundary-spanning managers in the establishment of public-private partnerships. *Public Administration* 84(4):891–917.
Pittz, T.G., and T. Adler. 2016. An exemplar of open strategy: decision-making within multi-sector collaborations. *Management Decision* 54(7):1595–1614. https://doi.org/10.1108/MD-04-2015-0153.
Pittz, T.G., M.L. Intindola, T. Adler, S. Rogers, and C. Gard. 2018. Collaborating smartly: the role of open strategy in absorptive capacity. *Journal of Small Business Management* 41(3):61. https://doi.org/10.1111/jsbm.12430.
Pittz, T.G., T. Adler, S.E. Rogers, and C. Flinchbaugh. 2019. Catalyzing collective social entrepreneurship: toward a theoretical refinement and validation of the open strategy construct. *Academy of Management Proceedings* 1:10774.
Pratt, R., B. Gyllstrom, K. Gearin, D. Hahn, L. VanRaemdonck, K. Peterson, and L.-M. Baldwin. 2017. Primary care and public health perspectives on integration at the local level: a multi-state study. *Journal of the American Board of Family Medicine* 30(5):601–607. https://doi.org/10.3122/jabfm.2017.05.170034.
Probandari, A., A. Utarini, L. Lindholm, and A.-K. Hurtig. 2011. Life of a partnership: The process of collaboration between the National Tuberculosis Program and the hospitals in Yogyakarta, Indonesia. *Social Science & Medicin* 73(9):1386–1394. https://doi.org/10.1016/j.socscimed.2011.08.017.
Rittel, H.W.J., and M.M. Webber. 1973. Dilemmas in a general theory of planning. *Policy Sciences* 4:155–169.
Saldaña, J. 2013. *The coding manual for qualitative researchers*, 2nd edn., Thousand Oaks: SAGE.
Seidl, D., G. von Krogh, and R. Whittington. 2019. Defining open strategy: dimensions, practices, impacts, and perspectives. In *Cambridge handbook of open strategy*, ed. D. Seidl, G. von Krogh, and R. Whittington. Cambridge: Cambrige University Press.
Seidl, D., and F. Werle. 2018. Inter-organizational sensemaking in the face of strategic meta-problems: requisite variety and dynamics of participation. *Strategic Management Journal* 39(3):830–858. https://doi.org/10.1002/smj.2723.
Selsky, J.W., and B. Parker. 2005. Cross-sector partnerships to address social issues: challenges to theory and practice. *Journal of Management* 31(6):849–873. https://doi.org/10.1177/0149206305279601.
Tracy, S.J. 2010. Qualitative quality: eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry* 16(10):837–851. https://doi.org/10.1177/1077800410383121.
Trist, E. 1983. Referent organizations and the development of inter-organizational domains. *Human Relations* 36(3):269–284.
Ungureanu, P., F. Bertolotti, E. Mattarelli, and F. Bellesia. 2020. Collaboration and identity formation in strategic interorganizational partnerships: An exploration of swift identity processes. *Strategic Organization* 18(1):171–211. https://doi.org/10.1177/1476127019840148.
Vaara, E., and R. Whittington. 2012. Strategy-as-practice: taking social practices seriously. *Academy of Management Annals* 6(1):285–336.
VERBI Software. 2018. *MAXQDA Analytics pro*. VERBI.
Villani, E., and N. Phillips. 2020. Formal organizations and interstitial spaces: catalysts, complexity, and the initiation of cross-field collaboration. *Strategic Organization* 19(1):5–36. https://doi.org/10.1177/1476127019897235.
Walter, J., F.W. Kellermanns, S.W. Floyd, J.F. Veiga, and C. Matherne. 2013. Strategic alignment: a missing link in the relationship between strategic consensus and organizational performance. *Strategic Organization* 11(3):304–328. https://doi.org/10.1177/1476127013481155.
Weick, K.E. 1979. *The social psychology of organizing*, 2nd edn., New York: Random House.

White, S., and Siu-Yun S. Lui. 2005. Distinguishing costs of cooperation and control in alliances. *Strategic Management Journal* 26(10):913–932. https://doi.org/10.1002/smj.490.

Whittington, R., L. Cailluet, and B. Yakis-Douglas. 2011. Opening strategy: evolution of a precarious profession. *British Journal of Management* 22(3):531–544. https://doi.org/10.1111/j.1467-8551.2011.00762.x.

Wright, L.A., D.K. King, J.H. Retrum, K. Helander, S. Wilkins, J.M. Boggs, J.D. Portz, K. Nearing, and W.S. Gozansky. 2017. Lessons learned from community-based participatory research: establishing a partnership to support lesbian, gay, bisexual and transgender ageing in place. *Family Practice* 34(3):330–335. https://doi.org/10.1093/fampra/cmx005.

Yin, R.K. 2014. *Case study research: design and methods*, 5th edn., Thousand Oaks: SAGE.