Intersectoral Relationships between Capital Health and the Voluntary Health Sector in Halifax, Nova Scotia

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Submitted in partial fulfillment of the requirements
for the degree of Masters of Health Services Administration
at
Dalhousie University
September, 2004

For Ramona.

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Abstract

Voluntary organizations have long been involved in health care, but are often not included in the spectrum of health care providers. They represent an underutilised resource for health system planners. This research study investigated how the voluntary health sector and the formal health care sector interact in pursuit of their respective goals, and it looked at how the two sectors can work more complementarily by discovering how they work together currently. A paper-based questionnaire was used to gather data on voluntary health organizations operating within the Halifax Regional Municipality, Nova Scotia. Using the responses, a typology of intersectoral relationships was devised, which was then used to uncover the associations between organizational characteristics and types of relationships. The findings can allow both sectors to optimise the ways in which they interact.

List of Abbreviations

The following abbreviations appear at some point in the body of the thesis:

CCRA	Canada Customs and Revenue Agency
CRA	Canada Revenue Agency
FHS	formal health sector
HRM	Halifax Regional Municipality
JHCNSP	Johns Hopkins Comparative Nonprofit Sector Program
MUSH	municipalities, universities, schools and hospitals
NGO	nongovernmental organization
NPO	nonprofit organization
quango	quasi-nongovernmental organization
VHO	voluntary health organization
VHS	voluntary health sector

Acknowledgements

I would like to thank my thesis supervisor, Dr. Thomas Rathwell, for his patience and for allowing me to pursue this project. I would also like to thank Dr. Nila Ipson from the School of Health and Human Performance at Dalhousie University for her guidance through the literature review process. Finally, I would like to thank the additional members of my examining committee, Prof. Lawrence Nestman from the School of Health Services Administration at Dalhousie University, and Prof. E. Grant MacDonald, director of the Non-Profit Sector Leadership Program at the Dalhousie University College of Continuing Education, for volunteering their time to read and grade my thesis.

Chapter 1. Introduction

This thesis paper describes a questionnaire-based study conducted on the voluntary health sector within the Halifax Regional Municipality (HRM), Nova Scotia, in 2004. The purpose of this study was first to construct a typology of the different ways the voluntary health sector interacts with the formal health sector, and then to link these types of relationships to characteristics found within voluntary health organizations.

Although the voluntary sector in Canada has had, and continues to have, a significant presence, there still remains a lack of information about the sector's role in Canadian society. Consensus dictates that the contribution of the voluntary sector to society is large, but its exact dimensions and roles are unclear (Dreessen, 2000). Canada has had a long history of community participation and civil action, but government cuts in the 1990s spawned a renewed interest in the potential role of voluntary organizations for filling the resultant gaps in social services (Hall & Banting, 2000). Health and wellness is an area in which voluntary organizations have long been present. As yet, though, there is a shortage of published literature which specifically addresses the issue of interactions and relationships between organizations in the voluntary health sector and the formal health sector (Birdsell, 2001).

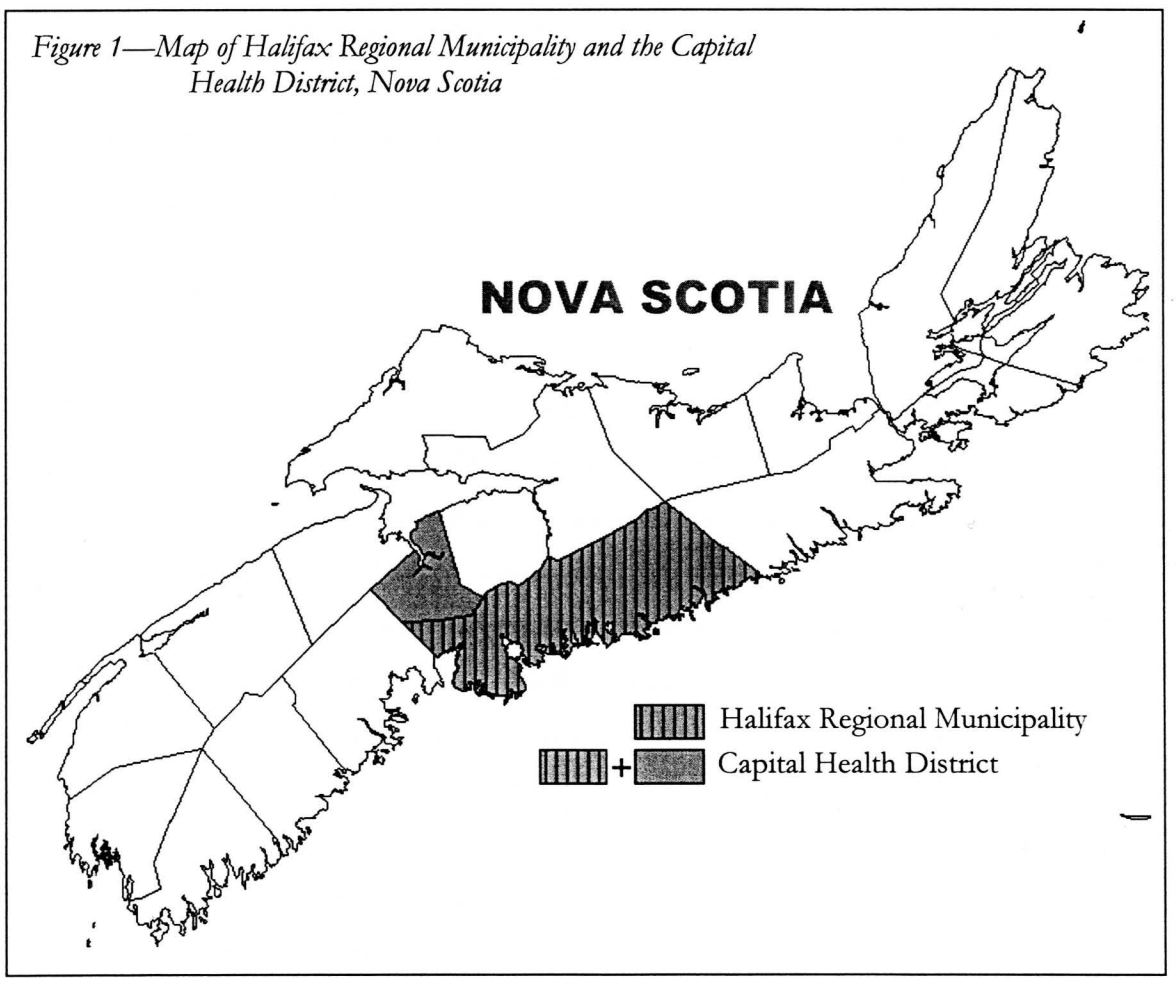
Given the potential for an increased role for voluntary organizations operating in the health arena, it would behove both the voluntary health sector and the formal health sector to better understand the ways in which they are currently working together. Organizations in the voluntary sector benefit from the official legitimacy gained through being involved in health care planning and delivery, and thus it is important for each organization to understand the contribution it can make. The formal health sector stands to gain from the technical competencies brought to the table by voluntary health organizations and the expansion of care made available to patients through cooperative or supportive relationships. Health care administrators and planners thus need to know how voluntary health organizations can be utilized and engaged. This research study looked at how the two sectors can work more complementarily by looking at how they work together currently.

1.1. Background

1.1.1. Halifax Regional Municipality

The Halifax Regional Municipality (HRM), the capital region of Nova Scotia, is located midway up the east coast of the province (see Figure 1). The region is made up of four amalgamated municipalities (Halifax, Dartmouth, Bedford and Halifax County), covering an area of 5,490.90 km^2.

Figure 1—Map of Halifax Regional Municipality and the Capital Health District, Nova Scotia



According to the 2001 Census, HRM had a population of just over 359,000 people, or 39.5% of the total population of Nova Scotia. Approximately 76% of the region's inhabitants live in urban areas (Statistics Canada, 2003). The population is predominantly of European

descent, with 7.0% identifying themselves as belonging to a visible minority, and less than 1% as Aboriginal (Statistics Canada, 2003).

The health of Nova Scotians is relatively poorer compared to the other Canadian provinces. According to a published brochure put out by Capital Health, Nova Scotia has the highest rate of death from cancer, respiratory disease and lung cancer; the highest rates of hospitalization for chronic diseases; the second highest rates of diabetes, psychiatric hospitalization, circulatory deaths, and heavy drinking; the third highest percentage of overweight adults; and the fourth highest spending rate of health dollars per capita (Capital Health, n.d./a). Regardless of explanations for why Nova Scotians overall should have relatively poorer health (such as an older population and determinants of health like higher smoking and drinking rates, lower incomes, lower levels of education, etc.), it still remains that such a state of health is a costly affair.

1.1.2. Capital Health District

The Nova Scotia health care system is divided among nine regional district health authorities, of which Capital Health is one. The nine districts are responsible for planning, managing, delivering and monitoring health services within each respective area, and are accountable to the Nova Scotia Ministry of Health. Capital Health provides core health services to residents living within its boundaries, as well as tertiary and quaternary care to all Atlantic Canada (Nova Scotia, Newfoundland and Labrador, Prince Edward Island and New Brunswick). Specialized adult health services are provided to a referral population from the rest of the province, and to residents of New Brunswick and Prince Edward Island.

The Capital Health District covers approximately the same geographic area as HRM, with the addition of West Hants and a portion of East Hants County (see Figure 1). There are over 8,500 staff members that are employed by Capital Health, located in 10 major facilities. Within the district there are seven volunteer Community Health Boards that work with the community to develop local health strategies and with Capital Health in district health planning (Capital Health, n.d./b).

1.2. Objectives

This study had three main objectives, which were:

1) to gather relevant organizational data about the individual voluntary health organizations;
2) to identify the types of relationships in which voluntary health organizations engage with the formal health sector; and
3) using the above information, to find the associations between organizational characteristics and types of intersectoral relationships.

The purpose of the study was to ascertain the different ways in which the voluntary health sector and the formal health sector interact in pursuit of their respective goals and on behalf of their respective clients. It was predicted that certain characteristics of organizations in the voluntary health sector would make some organizations more amenable to certain types of intersectoral collaboration than others. For example, an organization's size or formalized structure may dictate what partnership strategies are more appropriate for that organization.

This study did not purport to discover the most effective means of cooperating, nor whether current methods of collaboration are best. Rather, the focus of this study was observational: to uncover the correlations that already existed between the types of relationships and the inherent characteristics of the voluntary organizations involved.

1.3. Benefits

The knowledge gained from this study will primarily be of interest to the academic community, but it might also be of interest to Capital Health and members of the voluntary sector. The primary benefit of this study is clarification around how the two sectors interact, since this seems to be an area within voluntary sector research that has not yet been touched.

Although it is a distal, secondary benefit, the information uncovered in this study can also help inform both voluntary organizations and Capital Health when it comes to planning.

When looking for a voluntary health organization with which to partner, agencies, planners and professionals in the formal health care system will know what characteristics have been associated in the past with which type of relationship. Capital Health can use this information to consider the characteristics it would want to see in a potential partner from the voluntary sector. Conversely, voluntary health organizations will be more informed about what types of activities and relationships their organization might be best suited for based on their organizational characteristics.

1.4. Contents of the paper

To briefly preview the material covered in this paper, the next chapter contains a review of the relevant literature on the voluntary sector. It covers the definitions and theories of voluntary sector studies, including the role of the sector in society. It also looks at the literature surrounding intersectoral relationships between the government and the voluntary sector, with a special consideration for health. The chapter ends with some concluding remarks about the literature covered as well as an operational definition for a 'voluntary organization.'

The following chapter lays out the methods used in this study. Particular attention is paid to the questionnaire that was distributed to voluntary organizations in HRM and justifications for the inclusion of each question are provided. The fourth chapter presents the results of the administered survey. Using the answers that were received, a new typology for arranging intersectoral relationships was developed and is introduced here. This chapter also presents the results of the analysis that were performed on the data.

Following the results, the fifth chapter discusses the findings in light of the three objectives laid out above. Limitations to the findings and directions for future studies are discussed. The concluding chapter poses some final statements and puts forth modest recommendations.

Chapter 2. Literature review

This review of the literature begins with an investigation of the role of the voluntary sector in Canada, visiting upon the major theories of the voluntary sector that are found in the literature. It then looks at the relationship between the government and the voluntary sector, in particular as it relates to health care. At the end, there is a summary of conclusions drawn from reviewing the literature with regards to the conceptual frameworks that are used for the purposes of this thesis project.

2.1. Role of the voluntary sector in Canada

A discussion on the role of the voluntary sector needs to be preceded by a discussion on the definition of the voluntary sector: what it is, what it is not, and what its limits and distinguishing features are.

2.1.1. Definition of the voluntary sector

There are several names by which nonprofit organizations are collectively known, such as the nonprofit sector, the voluntary sector, the third sector, the independent sector, the civil sector, and the commons (Febbraro, Hall & Parmegiani, 1999; Lohmann, 1992; Salamon & Anheier, 1996a; Thayer Scott, 1997). Each term has its roots in different scholarly traditions, and each term focuses on certain characteristics that are deemed to be representative of the group as a whole (Hirshhorn, 1997).

For this paper, I have chosen to use the term 'voluntary sector.' In the language of sociologists, 'voluntary sector' reinforces the central defining characteristic of the sector as depending upon non-coercive participation; i.e., organizations that rely on volunteer labour to some extent to accomplish its purposes (Thayer Scott, 1997), although one should not forget that much of the activity in this sector is carried out by paid staff (Febbraro *et al.*, 1999). This definition traditionally excludes 'quangos' ('quasi-NGOs') such as hospitals and universities, in order to underscore the sector's independence from the state (Febbraro *et al.*, 1999).

The term 'nonprofit,' which is the vocabulary of economists, is used in this paper when the emphasis is on an organization's finances, and in particular on the 'non-redistribution constraint,' where net earnings through economic activities are not distributed to owners or shareholders, but ploughed back into the organization's activities in order to fulfil its mandate (Salamon & Anheier, 1996b).

The most widely cited definition for a nonprofit, voluntary organization is that laid out for the Johns Hopkins Comparative Nonprofit Sector Program (JHCNSP) (Salamon & Anheier, 1996b). The JHCNSP definition for nonprofit or voluntary is based on structural and operational characteristics of the organization. To be considered nonprofit or voluntary, an organization must possess five features:

1) it must be organized or formalized in structure;
2) it must be private and institutionally separate from government;
3) it must be self-governing and in control of its own activities;
4) it must abide by the so-called 'non-redistribution constraint' (i.e., non-profit-distributing); and
5) it must involve voluntary participation at the level of either management or operations (Salamon & Anheier, 1996b).

A formal structure implies stability and continuity as a result of a certain degree of accountability. Otherwise, the voluntary sector as a concept becomes far too unstructured to study (Salamon & Anheier, 1996b). Grønbjerg (1989) further operationalized the first JHCNSP criterion, possession of an organized or formalized structure, by considering any of the following features: holding IRS tax-exemption status; being legally incorporated; being included on a listing of support recipients from federated funders; or having revenues over US$10,000 annually. These can be 'translated' into a Canadian context by substituting the Canada Revenue Agency for the IRS, and substituting $10,000 in Canadian currency for U.S. dollars.

In Canada, laws play an important role in determining the boundaries of the governmental, market and voluntary sectors. Legislation and tax laws help shape the voluntary sector by

using incentives and disincentives to award tax exemption to certain activities. In Canada, the definition of 'nonprofit organization' that is most influential is the functional definition used by the Canada Revenue Agency (CRA).[1] In the *Income Tax Act* under paragraph 149(1)(l), the CRA definition of a 'non-profit organization' is:

> a club, society or association that, in the opinion of the Minister, was not a charity within the meaning assigned by subsection 149.1(1) and that was organized and operated exclusively for social welfare, civic improvement, pleasure or recreation or for any other purpose except profit, no part of the income of which was payable to, or was otherwise available for the personal benefit of, any proprietor, member or shareholder thereof unless the proprietor, member or shareholder was a club, society or association the primary purpose and function of which was the promotion of amateur athletics in Canada (Government of Canada, 1985).

In essence, an organization is exempt from tax under the *Income Tax Act* if it complies with the following conditions:

- it is not a registered charity;
- it is organized and operates for the purpose of social welfare, civic improvement, recreation, or any other non-profit-seeking purpose;
- it does not redistribute its profits (CCRA, 2001).

The difference between a nonprofit organization and a charitable organization is that charities: a) must register with the CRA; b) can issue charitable receipts to donors for tax purposes; and c) must disburse 80% of received tax-receipted donations on its own charitable activities (CCRA, 2002). Not all voluntary organizations that can register themselves as 'charitable' will do so. It is a long process to register, and eligible organizations may not apply if they are not soliciting donations (Reed & Howe, 1999).

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[1] The Canada Customs and Revenue Agency changed its name and as of December 12th, 2003, is now known as the Canada Revenue Agency. Responsibility for the customs program is now part of the new Canada Border Services Agency. References to publications written prior to this date retain the original CCRA authorship.

The CRA's definitions of 'non-profit' and 'charitable' are functional rather than conceptual: if an organization meets the requirements set by the CRA to receive tax-exempt status, then it is considered nonprofit; otherwise, no matter its societal role or its philosophical orientation, the organization is simply neither nonprofit nor charitable. As Reed & Howe (1999) point out:

> By default, if not by plan, the role of Revenue Canada [now the CRA] in granting charitable status has significantly shaped the way in which we define the nonprofit sector. The sector is normally considered to include: religious organizations; hospitals; universities; culture, arts and heritage organizations, all of which are charities, but not to include, for example, most political or adversary groups or co-operatives (pp. 7-8).

For the purposes of this study, the definition of 'voluntary organization' is an organization that qualifies as either nonprofit or charitable under the CRA guidelines and/or fulfils the JHCNSP definition for nonprofit. Therefore the entity must: be formalized in structure; be institutionally separate from government; not redistribute its profits; operate for the purpose of social welfare; and involve voluntary participation in its operations or management.

2.1.2. Theories on the sector

In order to study the voluntary sector, one needs to assume that a distinct voluntary sector exists at all. All of the major theories on the voluntary sector assume a three-sector model of society, largely introduced by Weisbrod (1977). The state represents the first sector and is responsible for governance. The market is the second sector, made up of rational, profit-maximizing, private firms. Finally, the voluntary sector is the third sector (hence the occasional use of the term, 'third sector'). (Occasionally, one will find reference to a fourth sector, which is the household or individual consumer [Weisbrod, 1977].)

The boundaries between the three sectors are not, however, impermeable. Firms and agencies in each sector can (and do) engage in activities that span and cross boundaries. Voluntary agencies engage in both policy formation and commercial activities; private, for-

profit organizations engage in charitable activities; and the government sets up its own nonprofit organizations. Indeed, an organization's membership to a sector is more a matter of degree than absoluteness. Despite the blurring of the sectoral lines, though, the concept of 'sectors' remains a useful conceptual tool (Billis & Glennerster, 1998).

Several have proffered explanations as to why citizens and individuals come together to participate and form voluntary, nonprofit organizations for the sake of social welfare. Four theories for the emergence of the voluntary sector are reviewed here: the sector failure theories, the social engagement theory, the voluntary failure theory, and the theory of comparative advantage. Each of these theories will lead to different assumptions about the role of the voluntary sector in society, and thus will lead to different expectations of intersectoral relationships between the voluntary and formal health sectors.

Sector failure theories: Possibly the single most influential group of theories in the field of voluntary sector studies, the sector failure theories, are based on the premise that the voluntary sector arose in response to failures in the public and private sectors (Hirshhorn, 1997). The theories explain the rise of the voluntary sector as a consequence of gaps left in service provision by the other two sectors.

In social services, where trust often plays a role, the private sector is prone to 'contract failure.' Contract failure refers to the inability of private, for-profit firms to assure clients that their need to satisfy shareholders' demands will not negatively impact patients (Hirshhorn, 1997). Voluntary organizations, on the other hand, are viewed to have less incentive to 'cheat' the client (Salamon, 1995), and are able to overcome problems of 'agency,' where those acting on behalf of the client betray the trust that was instilled in them to act in the client's best interests. Therefore, assuming there are no other inefficiencies in service delivery, voluntary organizations have an advantage in cases where trust plays a role.

The question then becomes, why should voluntary organizations fill the gap instead of the state providing the services publicly? The parallel to contract failure is 'political' or 'bureaucratic failure' (Hirshhorn, 1997). Public tastes are highly diverse, and governments often aim their activities at the median voter in order to satisfy the majority, leaving many

smaller population groups unsatisfied with the amount of services provided. Voluntary organizations grow out of this gap to meet the unmet demands (Weisbrod, 1977). In addition, voluntary organizations are less subject to bureaucratic control, and are therefore swifter at responding to specialised needs. Voluntary organizations are able to deliver locally and immediately, can attain lower labour costs through volunteers, and can participate in experimentation with new types of services and delivery (Hirshhorn, 1997).

The primary weakness of the failure theories is their focus on demand alone (Hirshhorn, 1997). The theories do not explain why individuals come together to form voluntary organizations from which they cannot benefit financially, or why these organizations sometimes operate for the benefit of others and not just for their own members.

Social engagement theory: The criticism of failure theories is that they hold limited conceptions of the benefits of voluntary activities. These theories see the contribution of the voluntary sector solely in terms of the services delivered, services that would otherwise not be adequately provided. In addition to these benefits, there are secondary benefits derived through the *process* of voluntary service production which can be as important as the output itself (Hirshhorn, 1997). The promotion of voluntary behaviour and social engagement is a large benefit to the community. By fostering awareness of individuals' roles and obligations in the community, the voluntary sector plays a 'socialization role' and enables multiple groups and persons to participate in society who might otherwise be marginalized (Hirshhorn, 1997).

Benevolence and charitable behaviour can be expressed personally and privately, but organizations give expression to individuals' kinder impulses and can provide vehicles for acts of kindness. The mere existence of voluntary organizations can help citizens identify worthy causes and achieve the satisfaction that comes from associating with those causes. Enabling people to participate in society builds cohesion and stronger communities, which in turn promotes democracy and even economic growth (Hirshhorn, 1997; Warren, 2003). The emergence of the voluntary sector, then, was to help people help others.

Voluntary failure theory: In the failure theories, it was the voluntary sector that picked up the slack when the other two sectors fell short. The voluntary failure theory turns the argument around and views the government as responding to 'voluntary failure,' complementing the voluntary sector when it proves insufficient in providing public goods and social services (Salamon, 1995). The government then supplements, instead of substitutes for, the voluntary sector.

Salamon (1995) identified four limitations of the voluntary sector for which the government would need to compensate:

1) *Philanthropic insufficiency*: The voluntary sector is often unable to generate resources (both in terms of capital and human resources) on a scale that is both adequate and reliable. For instance, in Canada, the majority of revenues are concentrated in a very small percentage of charitable organizations, and, conversely, the large majority of charitable organizations account for only a fraction of total revenue (Dreessen, 2001). Most charities also have inadequate levels of staffing to deal with increased demands on their services—more than half of Canadian charities have one or no paid staff members, and most rely on fewer than twenty volunteers per month (Hall & Reed, 1998).
2) *Philanthropic particularism*: Voluntary organizations tend to focus on particular subgroups of the population, which can result in inequitable coverage for some subpopulations in the community and duplication of services for others.
3) *Philanthropic paternalism*: Those who control charitable resources can determine what will be offered and whom it will serve. Thus, the community's needs are defined by those in command of donor dollars, leading to an undemocratic state of affairs. For instance, support for the arts and culture (often through large corporate donations) tends to be higher than for less socially-desirable causes like drug treatment centres (Hall & Reed, 1998).
4) *Philanthropic amateurism*: Small operating budgets translate into a lack of ability to offer trained professionals adequate wages, placing voluntary agencies in a weak position to attract professional personnel. Voluntary organizations must rely instead on amateur volunteers that have more enthusiasm than training, what Hall & Reed (1998) euphemistically refer to as "well-meaning amateurs" (p. 10).

Admitting that the voluntary sector has its limitations is not necessarily a pessimistic view. Salamon (1995) states:

> Significantly, however, the voluntary sector's weaknesses correspond well with government's strengths, and vice versa. Potentially, at least, government is in a position to generate a more reliable stream of resources, to set priorities on the basis of a democratic political process instead of the wishes of the wealthy, to offset part of the paternalism of the charitable system by making access to care a right instead of a privilege, and to improve the quality of care by instituting quality-control standards. By the same token, however, voluntary organizations are in a better position than government to personalize the provision of services, to operate on a smaller scale, to adjust care to the needs of the clients rather than to the structure of government agencies, and to permit a degree of competition among service providers (pp. 48-49).

Theory of comparative advantage: Billis and Glennerster (1998) have combined the sector failure theories and Salamon's (1995) voluntary failure theory into a framework that forms hypotheses around the comparative advantage that each of the three sectors holds over the others. The authors argue that different needs attract specific organizational responses that are deliverable more easily by agencies in one sector more so than others. Voluntary organizations have flexibility in their mission and policy, their sources of resources, and their internal divisions of labour, which gives them the advantage to overcome both contract failure and bureaucratic failure. Therefore, organizations in the voluntary sector possess inherent structural characteristics that provide them with a comparative advantage over the for-profit and public sectors with respect to certain disadvantaged users (Billis & Glennerster, 1998).

Billis & Glennerster (1998) summarize their explanation for the emergence of the voluntary sector thusly:

> In short, we have a sequence of economic theories that point to the weakness of whole systems: market failure, government failure and voluntary failure. Voluntary

> organisations thus end up doing things that they are relatively least bad at—a theory of comparative disadvantage (pp. 83-84).

While the theory explains why certain activities are best associated with certain sectors, it stops short of accounting for the emergence of the voluntary sector in the first place. Still, it presents a plausible theory for settling the issue of why the sector exists: the voluntary sector is the vehicle of choice for many goods and services because it is the "least bad" alternative.

2.1.3. Roles of the sector

Theories explaining the voluntary sector's existence often imply the role that the sector plays in society at large. Views on the sector's role can be grouped into two general types: those that stress the sector's position vis-à-vis the government, which highlights the relation between the two sectors; and those that focus on the activities of voluntary organizations pursuing their missions (Birdsell, 2001).

The failure theories assume the sector's role as picking up the slack in social services. As the state's involvement in social services shrinks, the society's needs do not lessen and therefore the welfare vacuum that is created will be filled primarily by the nonprofit, voluntary sector (Berman, 2002). This sets up the relationship between voluntary organizations and the government as being complementary, supplementary, or adversarial, depending on how services were transferred to the voluntary sector.

Similarly, the voluntary failure theory sees the role of the voluntary sector as being the preferred mode of collective action, but with severe limitations that the government must step in to cover. Because of voluntary insufficiency, particularism, paternalism and amateurism, the role of the voluntary sector in social service provision is reduced to services that are personalized, small scale, and flexible (Salamon, 1995). Social services that require universal, equitable, large scale and/or professional delivery are better left to the government to coordinate.

Focusing instead on activities, the social engagement theory sees the major role of the voluntary sector as providing a socially-recognized expression of beneficence. Already a great deal of health care provision in Canada is performed by unpaid volunteers, either through formal channels like the hospital or through informal settings like the home (Carr, 2001). The voluntary sector can therefore provide a means by which a large amount of dispersed goodwill can be effectively coordinated for the community. Participation and voluntary activity is then seen as aiding organizations to pursue their stated missions.

Finally, using Billis and Glennerster's (1998) theory of comparative advantage, one would expect to see more cooperation between the government and the voluntary sector in arranging service provision, rather than leaving one sector or the other to fill in the gaps.

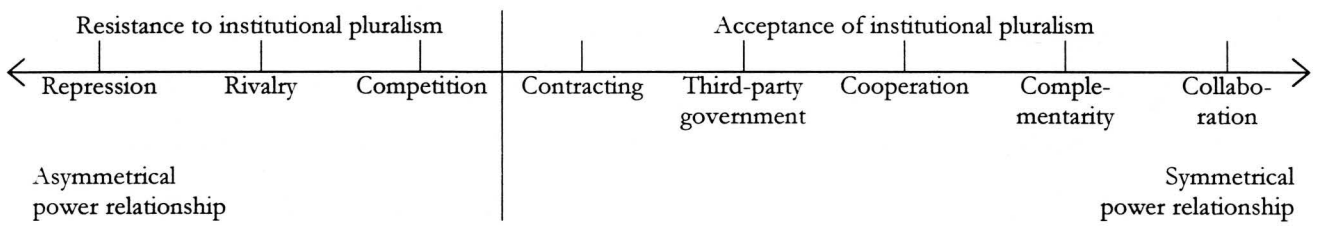
2.2. Government-voluntary sector relations

The literature encountered on intersectoral relations deals to a large extent with relations between the voluntary sector and the government. I was unable to find studies that dealt explicitly with relations between the voluntary health sector and the formal health sector at the regional level, which, in Nova Scotia, is the level at which all services are delivered. Nonetheless, by looking at what has been published on government-voluntary sector relations, analogies and parallels can be extrapolated.

Conservative economic theory has traditionally seen the relationship between sectors as a zero-sum game, with service provision by the government undermining and displacing voluntary action (and therefore community spirit)—an arrangement that has only limited support from empirical data (Salamon & Anheier, 1997). The state, quite to the contrary, is often not a competitor, but the largest contributor to voluntary organizations via funding. There is, in fact, a positive relationship between public expenditure as a percentage of GDP and people's membership in voluntary organizations (Woolley, 2001). This should not be a surprise to those who subscribe to the social engagement theory of voluntary organizations, since, as Woolley (2001) states, "the conditions required for effective collective action through government are similar to those required for effective voluntary association" (p. 22).

There have been attempts to develop a typology of government-voluntary sector relationships. Coston (1998) identifies eight possible relationship types based on several dimensions, including government's resistance to, or acceptance of, pluralism, the relative balance of power in the relationship, and the degree of formality in the relationship. The eight different possible relationship types in her model are: repression, rivalry, competition, contracting, third-party government, cooperation, complementarity, and collaboration. Figure 2 shows these eight relationship types arranged along a continuum representing the symmetry in power between the government and the voluntary sector. On the left, where power is asymmetrically tilted towards the government, one finds the most repressive types of relationships characterized by unfavourable government policies (Coston, 1998). At the other end of the continuum lie the relationships associated with a more equitable balance of power between the two actors; here one finds relationships characterised by collaboration and cooperation. As one moves from left to right, there is also a correlation with the government's increasing acceptance of institutional pluralism.

Figure 2—Model of government-voluntary sector relationships



Adapted from: Coston, 1998: 363.

This typology of intersectoral relationships focuses primarily on the characteristics of the government sector and not on the formal health care system or the voluntary sector. It is built upon a continuum that is appropriate to the government and therefore does not apply to this study. However, for this study, Coston's (1998) approach to classifying government-voluntary sector relationships was taken and applied in reverse. Instead of beginning with characteristics of the government affecting the types of relationships, the existing types of relationships were identified first and characteristics of the voluntary sector (rather than the government) were inspected afterwards in a bottom-up approach.

2.2.1. Drawbacks to intersectoral relations

Even though the government (or the formal health sector) and the voluntary sector are not necessarily at odds with each other, there are potential negative consequences that come from some types of intersectoral relations. A voluntary organization is prone to three dangers, particularly when it is contracted by the government to run a program: it can become overwhelmed, it can become overdependent, and it can lose sight of its goal.

One way in which the two sectors come into contact is through 'downloading,' which is the pejorative term given to the scenario where the government stops providing a program or service and opts instead to fund a third party to carry out the task. Downloading can come about either through the planned transfer of responsibility and operations of a program to voluntary agencies, or through the termination of a program and subsequent adoption of that program by the voluntary sector (Hall & Reed, 1998). The proponents of downloading (although probably not referring to it by that name) claim it to be the most desirable way to reduce social program costs without losing the essential programs (Hall & Reed, 1998). However, the voluntary sector's own innate limitations suggest that it is not a perfect substitute for hitherto publicly-administered social services. As has already been mentioned, the voluntary sector is best at providing small quantities of highly personal services. Most voluntary organizations have only modest levels of human resources to deal with increased demands on their services that result from downloading. As Hall & Reed (1998) point out, "Even if government chooses to accompany social-program downloading with funding to support it, only a minority of organizations will have the human-resources strength to respond in any significant way" (p. 5). Voluntary organizations can easily be overwhelmed.

Contracting is a popular way in which the government seeks the involvement of the voluntary sector. However, voluntary organizations are at risk of becoming overdependent on the funds that a government contract brings. Contracting can represent a secure revenue source, but may, ironically, undermine an organization's financial stability in the long run by creating a condition of dependency. Uncertainties that accompany contract renewals also make it difficult for organizations to manage their long-term affairs. Contract termination may leave an organization's internal structure irreversibly altered to the point where it is now

inappropriately oriented to serve its former clientele, leaving it without purpose (Rathgeb Smith, 1994).

Contracting, as well as jeopardizing the programs and services that are being downloaded, also tends to bring about internal changes within the organization (Gibelman & Gelman, 2001). Voluntary agencies receiving government contracts are now bound to the conditions set by the government, which simultaneously constrict free reign and create incentives for certain managerial behaviour (Rathgeb Smith, 1994). Contracting inextricably links the organization to governmental budgetary politics and complex funding issues, which require increased bureaucratization and professionalization in the organization's management practices. In smaller voluntary organizations particularly, this can divert the organization from their own mission towards the government's priorities. The larger body of volunteers can be left out of decision-making altogether, creating disaffection in a formerly democratic system (Woolley, 2001).

All in all, while the voluntary sector is important in contemporary society, it is not a good substitute for government. Hall & Reed (1998) found no basis for assuming that downloading would save programs being eliminated, while Woolley (2001) warns that universal access to services and the welfare of service recipients are at risk. There is no reason to think the dangers are any different when discussing the relationship between the voluntary sector and the formal health sector as represented by Capital Health.

2.2.2. The health sector

The voluntary sector is not homogeneous, but consists of diverse institutions and players. Similarly, the public sector is not one, unified entity. The government itself is arranged in several tiers (federal, provincial, territorial, municipal). Each tier has its different branches with different responsibilities, and each department may view the voluntary sector's usefulness differently.

Most of the literature on the voluntary sector discusses the government in general terms and the voluntary sector in its theoretical entirety. Certain 'subdisciplines' of voluntary sector

research have received more attention, such as sports, the arts, and religious organizations. However, as Birdsell (2001) points out, "There is very little published literature which specifically addresses the issue of interactions and relationships between organizations in the VHS [voluntary health sector] and FHS [formal health sector]" (p. 72).

Health care reform in Canada has not formally included the services of the voluntary sector, but voluntary health organizations will inevitably become involved with the public system as it strives to achieve increased effectiveness (Birdsell, 2001). There are two levels at which voluntary health organizations interact with the formal health system: organizations can interact with the various levels of the government, and they can interact with the actual deliverers of health services and programs (such as regional health authorities, community health boards, and hospitals) (Birdsell, 2001).

In Canada's health care system, one must not confuse 'delivery' with 'financing.' Most of Canada's hospitals, community health boards and (in provinces with regionalization) regional health authorities are, technically, nonprofit and are guided by voluntary boards of directors. These types of institutions are, along with universities, sometimes called 'quasi-nongovernmental organizations,' or 'quangos': entities that are formally separate from government, but receive a vast proportion of their budgets directly from governmental departments and are subject to much governmental control. This is also known as the 'MUSH' sector (Municipalities, Universities, Schools and Hospitals) (Deber, 2002).

The voluntary health sector, as opposed to sports or arts, is a special case because it has to operate within the context of a universal health care system in Canada. Basic health care needs are covered, so it is services not covered under the *Canada Health Act*, yet nevertheless provided by the province or the federal government, that are in danger of being downloaded. These are, to a great extent, the social services that fall under a definition of health that extends beyond the hospital or physician's office. Housing, food, support networks, recreation and other determinants of health are the areas in which voluntary health organizations are concentrated. Hospitals themselves employ large numbers of volunteers in a variety of capacities, and also establish their own voluntary health organizations in the form of auxiliaries and foundations to help raise additional funds for the hospital. Capital

Health itself makes use of more than 2,000 volunteers supporting over 300 programs (Capital Health, n.d./b).

Birdsell (2001) conducted a content analysis of the annual reports of a convenience sample of 17 national health charities in Canada to determine how these organizations described their interactions, directly and indirectly, with the formal health care system. She looked for evidence of relationships beyond simple funding from Health Canada, and turned up examples of collaborative activities, contracted services, program reviews and advocacy (Birdsell, 2001). These instances of interaction crossed the entire spectrum of health, from prevention to palliation. To a degree, this study examined the same topic as Birdsell (2001), but at the local regional level using surveys instead of a content analysis strategy.

2.3. Concluding remarks about the reviewed literature

This study followed Billis and Glennerster's (1998) theory of comparative advantage because it is a framework that incorporates most of the other theories surrounding the sector. However, at the same time, the additional, social roles of organizations in the sector as promoted by the social engagement theory were acknowledged, since economics alone cannot explain individuals' participation.

While I agree in principle with Salamon's (1995) theory of voluntary failure, that the voluntary sector has its limitations which the government must supplement, when it comes to health care in Canada I would argue that it is the public sector that takes the lead and the voluntary and private sectors that respond, as predicted by the sector failure theories. Due to legislation, the federal and provincial governments are mandated to provide certain services; yet public resources are finite and the health care system cannot be all things to all people. The comparative advantage theory comes into play when explaining why the voluntary sector is the vehicle of choice for providing services that fall outside the *Canada Health Act* instead of for-profit firms, or vice versa.

To reiterate, as a definition of 'voluntary,' an organization qualified for the study if it was either nonprofit or charitable under the CRA guidelines, and/or it fulfilled the JHCNSP

definition for nonprofit. Therefore, the entity had to be formalized in structure, had to be institutionally separate from government, could not redistribute its profits, had to operate for the purpose of social welfare, and had to involve voluntary participation in its operations or management. One additional stipulation was that hospitals, community health boards, and other quangos were to be excluded from the voluntary sector.

The next chapter on methods presents the process used in identifying and approaching voluntary health organizations. The chapter also introduces in depth the questions found on the questionnaire that was distributed to voluntary health organizations in HRM.

Chapter 3. Methods.

This chapter outlines the process of identifying potential participants and approaching the organizations. This chapter also outlines the questionnaire itself in detail.

3.1. Identifying voluntary organizations

Since organizations have different legal status and there is no central registry of all voluntary organizations, different information sources were used to compile a list of organizations. Using various published sources (including the Canada Revenue Agency charitable organization database, The Help Line Society Directory of Community Services [Help Line Society, 2003] and the Halifax Public Library database of community organizations [Halifax Regional Library, 2003]), a list of 149 voluntary health organizations within the borders of HRM was drawn up.

The inclusion criteria were three-fold. Organizations had to be: (a) operating within the boundaries of HRM; (b) health-related; and (c) voluntary according to the definition given above (see p. 9).

A broad definition of 'health' was taken to determine 'health-related activities.' It included services offered directly to patients (both provision of care and support services, such as transportation), as well as indirect services to patients and the public (such as education, disease prevention, research and fund-granting). It also included organizations offering services to caretakers, friends and families of patients.

The entire list of identified voluntary health organizations in HRM (n=149) was used in the study. The section detailing the questionnaire gives more information on the inclusion criteria and how they were verified (see p. 24).

It was impossible to verify the completeness of this list because the total number of voluntary health organizations in HRM is unknown (and arguably unknowable). While a

complete list would have been ideal, the ratio of marginal return to efforts spent was likely to diminish over time. Once reasonable efforts had been made to make a comprehensive list, attention was then shifted to the remaining portions of this study. This probably produced a list biased towards the inclusion of larger, more well-connected organizations.

3.2. Approaching voluntary organizations

This study was a questionnaire-based survey conducted through the mail. A questionnaire was chosen as the most appropriate means of collecting data because the nature of many of the questions required information that might not readily be on-hand or might require several persons to answer. A physical, paper-based questionnaire provided participants with ample time to carefully consider and verify their responses in a way that a face-to-face or telephone interview would not. The questionnaire also allowed for close-ended questions to be viewed all at once rather than having the items read one after the other. Drawbacks to using this method included the potential of having the questionnaires lost or ignored, as well as there being no opportunity for verbal clarification on ambiguous or misunderstood questions.

Introductory letters, accompanied by an information sheet describing the study and a copy of the paper-based questionnaire, were sent to the entire list of identified voluntary health organizations (see Appendix A for a sample letter and Appendix B for the information sheet). The letters were addressed to the director or most senior manager of each organization, by name where known. Organizations were encouraged to have the staff person most knowledgeable about the organization's activities in 2003 complete the questionnaire.

Recipients of the package were asked to complete a questionnaire on behalf of their organization (see Appendix C) consisting of 19 questions regarding various characteristics of their organizations. It was communicated in the introductory letter that consent was assumed to have been given upon completion and return of the questionnaire.

The time required to complete the questionnaire was estimated to be between 10 and 15 minutes, depending on the amount of knowledge about the organization immediately at hand. The actual amount of time taken is unknown.

For ethical considerations, participants were requested not to disclose personal information of any kind about themselves or their clients, members or patients.

3.3. The questionnaire

The questionnaire that was distributed to voluntary health organizations in HRM consisted of 19 questions. The first eighteen questions sought information on the organizations' features and characteristics, while the last question was an open-ended question asking about the types of intersectoral activities linking the organization to Capital Health.

This section goes through the questionnaire and explains the theoretical bases for the choice of questions. The explanations are given thematically rather than in the order they appear on the questionnaire, and a summary follows at the end. The first 18 questions fall into three different categories: inclusion criteria questions, voluntary organization typology questions, and organizational characteristic questions. Throughout, please refer to the copy of the questionnaire that can be found in Appendix C.

3.3.1. Inclusion criteria questions

The first thematic group of questions attempted to determine whether an organization qualified under various definitions for 'nonprofit' or 'voluntary,' and thus for inclusion in the study.

The criteria set for inclusion in the study were:

1) the organization must have operated within the geographic boundaries of HRM.
2) the organization must have been involved in a health-related activity.
3) the organization must have been voluntary, as defined in the background section above (see p. 9).

With respect to the first inclusion criterion, only those organizations whose main addresses were located within Halifax County were approached to participate. It was expected that all respondents would meet the first criterion. To be sure, Question 2 asked whether the organization operates within the boundaries of HRM.

Similarly, only organizations involved in some aspect of health were selected and sent an information package. In the questionnaire, there were no questions that explicitly verified whether the organizations considered themselves to be 'health-related'. Question 9, based on the United Kingdom Charity Commission typology (see p. 26, below), does include such options as 'Medical/health/sickness' and 'Disability' for the respondent to select as their major area of activity; however, as discussed in the results section (see p. 36, below), the typology did not contribute much in the way of useful information for this study, and therefore was not a good indicator of satisfying this criterion for inclusion. Alternatively, any responses to Question 19, indicating a relationship with Capital Health, were considered as indicative of involvement in health care in some capacity. As well, Question 8 asked for a brief description of the organization's primary activity, which clarified any suspicions regarding an organization's involvement in health care.

The questions included in the questionnaire that tested the third criterion, an organization's status as 'voluntary', were guided by the definition of 'voluntary' as given in the literature review section (see section 2.1.1.). The entity had to: a) be formalized in structure; b) be institutionally separate from government; c) abide by the non-redistribution constraint; and d) involve voluntary participation in its operations or management.

To test for formalization of structure, Question 6a directly asked whether the organization possessed a formal organizational structure. Failing that, however, a modified version of the operational definition used by the Urban Institute's Nonprofit Sector Study was used (Grønbjerg, 1989). The organization was considered to have an institutional or formal structure if it:

a) held CRA tax-exemption status;
b) was legally incorporated;

c) was a recipient of government support; or

d) had revenues over C$10,000 annually.

The first condition, having tax-exempt status, was covered in Questions 10 and 11, which asked whether the organization filed a T3010/T3010A *Registered Charities Information Return* or a T1044 *Non-Profit Organization (NPO) Information Return* in 2003. An affirmative for either question would have given the organization tax-exempt status. For the second condition, Question 4 asked whether the organization was unincorporated or grassroots, an incorporated non-profit, or a registered charity. Replying 'incorporated non-profit' or 'registered charity' would have fulfilled this criterion. For the third condition, if the respondent indicated that it received funds from the government in Question 16, then it was assumed that the organization was formal enough to be considered legitimate by the government. Finally, if the organization indicated revenues in excess of C$10,000 in response to Question 15, then the organization was large enough to be considered under the fourth condition.

To test for institutional separation, Question 7 asked whether an organization considered itself to be self-governing. Answering in the affirmative implied sufficient autonomy from either government or other private businesses. As well, affirmative responses to Questions 6a through 6d provided evidence that the organization possessed elements of their own internal governance structure—i.e., a formal organizational structure, an advisory board, a board of directors or trustees, an executive director—elements that would not have been necessary if the organization was controlled externally.

For the purposes of this study, both charitable and non-charitable nonprofit organizations, as defined by the CRA, were included. Questions 10 and 11 asked whether the organization had filed, respectively, a T3010/T3010A *Registered Charities Information Return* or a T1044 *Non-Profit Organization (NPO) Information Return* in 2003. An affirmative for either question meant the organization fulfilled the CRA condition for non-redistribution of profits.

Finally, voluntary participation at the level of either management or operations was captured by Question 3. The existence of either volunteers or members on a board of directors or governors was taken as evidence of an element of voluntarism.

These were the inclusion criteria questions to test whether an organization should have been included in the study. Many of these same questions were also used as organizational characteristic questions.

3.3.2. Voluntary organization typology questions

The questionnaire included three different typologies that served as variables for organizational characteristics. There are many examples in the literature of categorization systems for the voluntary sector. Typologies ideally employ discrete, mutually exclusive, non-overlapping designations that have high differentiation *between* categories, and high homogeneity *within* categories (Sokal, 1974). Organizations can be organized along any number of dimensions and axes, of which an organization's activities is just one. Sources of support, beneficiaries, size, legal status and organizational structure are others (Hirshhorn, 1997). They can also be combined to form a multidimensional system of categorization.

Question 9 of the questionnaire reproduced the United Kingdom Charity Commission system of classification in its entirety (Charity Commission for England and Wales, 2002). This multidimensional typology categorizes organizations along three dimensions: the major industry (the 'what'), the main beneficiaries (the 'who'), and the primary method of operation (the 'how').

There were three questions relating to organizations' membership, which were used both as organizational characteristics and as a system of classification. Boucher, Pablo & Roberts (1979) divide voluntary organizations into two broad categories: 'citizen-member' organizations, which draw their membership from the community at large, and 'patient-member' organizations, which are composed mainly of patients, but also their relatives. Using the same model, Question 12 asked about the composition of the organization's membership.

Questions 13 and 14 were similar to the patient-member versus citizen-member question, but they separated an organization's membership from its target beneficiaries, which could be two different populations. These two questions were drawn from a sociological classification system designed by Gordon & Babchuk (1959), who base their typology on:

1) the degree of accessibility of membership—either 'high' (almost completely unqualified membership) or 'low' (limited by selective criteria);
2) the status-conferring capacity of the organization—the capacity "to bestow prestige or to be associated with prestige which accrues to its members" (p.27); and
3) the categorization of organizational functions as either 'instrumental' (seeking to benefit those outside the immediate membership), 'expressive' (functioning primarily for the benefit of its members), or an intermediate 'instrumental-expressive,' consciously incorporating both functions.

Because it is impolite to directly ask an organization about its status-conferring capacity, and it was not my place to judge the relative social merit or prestige of an organization in society, the second dimension of this typology was shed. The other two dimensions were covered by asking, "Does your organization function primarily for the benefit of its members, for some group outside its membership, or both?" (Question 13) and, "Is your organization's membership open to all, or limited by certain criteria?" (Question 14).

There are other typologies that were not included in this study that have otherwise been used in the past for other voluntary sector studies. These were originally included in the questionnaire but later jettisoned as they increased the length of the questionnaire without adding much value to the study. The following bodies employ their own systems of classification:

- Canada Revenue Agency
- International Classification of Non-Profit Organizations (ICNPO)
- National Taxonomy of Exempt Entities (NTEE)
- The International Standard Industrial Classification System (ISIC)
- North American Industrial Classification System (NAICS)

For a review of these typologies and others, please refer to the paper prepared by Febbraro *et al.* (1999), which gives good explanations and comparisons of each.

3.3.3. Organizational characteristic questions

There are several organizational characteristics that might influence the ability or likelihood that an organization will form a relationship with Capital Health and what that relationship might be. Going through the questionnaire in order, the relevant questions are mentioned here.

Question 1 asked how long the organization had been in existence. A longer history might not only give an organization more time during which a relationship with Capital Health could have been established, but it might also suggest long-term stability and a maturity through growth over the years, which in turn could be an attractive characteristic to Capital Health.

Question 3 asked for the organization's size according to the number of volunteers, paid staff members and board members that are involved with the organization. It was hypothesized that the larger the workforce, the more likely the organization would be able to run programs and hold a relationship with Capital Health.

Question 5 asked whether an organization primarily carried out its own programs or services, or fulfilled its vision indirectly through funding others. How an organization seeks to fulfil its mission could have some bearing on a potential relationship with Capital Health.

In addition to being used to test for eligibility for inclusion in this study, the six sub-questions in Question 6 were also used to assess the elements an organization possesses in its structure. The six elements were:

1) a formal organizational structure
2) an advisory board
3) a board of directors or trustees
4) an executive director responsible for the management of day-to-day operations

5) an affiliation with a provincial, national or international body
6) operational autonomy from the provincial, national or international body (if applicable).

Questions 12 through 14 were part of the Gordon & Babchuk (1959) and Boucher *et al.* (1979) typologies. The questions also provided information on the organizations' membership and focus.

Questions 15 through 18 dealt with finances, which is another dimension of an organization's size. Questions 15 and 17 asked about the organization's revenues and assets, respectively. Question 16 looked for the sources of revenue (e.g., government, funding agencies, donations, etc.) and their relative amounts. Question 18 determined the proportion of revenues that were used in pursuing the organization's mission.

3.3.4. Question 19 – Types of relationships

Labelled "the most important question in this study" in the questionnaire, Question 19 sought to uncover all the different instances where the responding organization had any dealings with Capital Health, and what those were. This was not a quantitative question looking for the absolute number of connections an organization holds with Capital Health. Rather, it was trying to elicit which types of relationships an organization engaged in instead of how many.

The second column was for respondents to give a brief, one- or two-sentence description of the activities that connected the voluntary organization to Capital Health. The first column encouraged respondents to give a category heading to the type of relationship that they were describing. These labels were then used to help in the process of coding and sorting the responses into categories.

Several examples that intended to cover a wide range of possibilities were given in the text of the question in an effort to stimulate creativity and broad thinking. Two of the boxes were

filled in with examples as well to demonstrate the idea of including both a label and an explanation for each response.

Once the responses were collected, they were analyzed collectively and sorted into a classification scheme. A list of types of relationships was not given to the respondents in order to allow the classification scheme to emerge straight from the data empirically. Please see p. 44 in the results section below for more on this.

3.3.5. Follow-up questions

The remaining three questions were follow-up questions requesting permission to use the organization's name in the final write-up of the thesis (Question 20); enquiring as to whether the respondent would be interested in participating in an interview (Question 21); and asking if the respondent would like to receive a copy of the final report (Question 22).

3.3.6. Summary of the questionnaire

The following table (Table 1) lists the first 18 questions on the questionnaire and indicates whether they are related to inclusion criteria, typologies, and/or organizational characteristics.

Table 1—Summary of the questions from the questionnaire

Question	Inclusion criteria	Typology	Organizational characteristics
1			✓
2	✓		
3a	✓		✓
3b			✓
3c	✓		✓
4	✓	✓	
5	✓		✓
6a	✓		✓
6b	✓		✓
6c	✓		✓
6d	✓		✓
6e	✓		✓
6f	✓		✓
7	✓		✓
8	✓		
9		✓	
10	✓		
11	✓		
12		✓	✓
13		✓	✓
14		✓	✓
15		✓	✓
16			✓
17			✓
18			✓

3.4. Data analysis

After the data was collected from the returned questionnaires, the results were subjected to statistical analysis to uncover any associations between the organizational characteristics and Question 19. A simple Pearson correlation matrix tested for correlations between each of the types of relationships from Question 19 and every individual organizational characteristic. From there, chi-square tests were used to see if there was a difference in the distribution of characteristics between voluntary organizations that engaged in a particular relationship type and those that did not. Finally, odds ratios were performed to determine if an organization engaging in a particular type of relationship was more or less likely to possess each organizational characteristic versus organizations that did not. The relevance of these

statistical tests was to build towards a composite image of voluntary organizations that were involved in each type of relationship.

The next chapter presents the findings from the survey as well as the typology of intersectoral relationships that was devised. The chapter also presents the statistical analysis of the data connecting organizational characteristics to relationship types.

Chapter 4. Results.

A question-by-question summary of the tabulated results can be found in Appendix D. The results presented here are arranged thematically.

4.1. Participation

A number of the voluntary organizations on the list of potential participants had either relocated or dissolved, and in either instance could no longer be located. Others had amalgamated, while still others were not institutionally separate but were programs within the same organization. Of the 149 questionnaire packages sent out:

- 41 were returned completed;
- one was returned with a note attached saying that they were not nonprofit;
- two organizations telephoned to say they no longer existed;
- seven were sent to wrong or nonexistent addresses, for which a more current address could not be found; and
- two organizations returned surveys that were not their own (the identification number on the survey did not match).

Removing the nonexistent, not nonprofit and duplicate organizations, the response rate was 41 out of 137, or 29.9%.

Other survey-based studies on the nonprofit sector have reported response rates ranging from 29.0% (Brown, 2002) to 71% (Milligan, 1998). This places the response rate attained in this study at the lower end of the range of response rates for mail-based surveys sent to nonprofit organizations. A comprehensive literature review of response rates to mail-based questionnaires showed a weighted average response rate of 47.3% with a standard deviation of 19.6% (Yu & Cooper, 1983), which places this study within one standard deviation of the norm. On the other hand, a more recent meta-analysis of response rates in academic studies reported an average response rate of 55.6% with a standard deviation of 19.7% (Baruch, 1999). Even though the response rate for this study was low, it was not entirely out of line with other surveys of this type and one can be reasonably confident in the results drawn here.

4.2. Inclusion criteria questions

Once again, the inclusion criteria set for this study included:

1) the organization must have operated within the geographic boundaries of HRM.
2) the organization must have been involved in a health-related activity.
3) the organization must have been voluntary, as defined in the background section above (see p. 9).

To satisfy the first criterion, Question 2 asked, "Does your organization operate within the Halifax Regional Municipality?" All the respondents indicated that their organizations did indeed operate within HRM and therefore qualified for inclusion under this criterion.

While there was no question that directly asked whether organizations considered themselves to be 'health-related,' 23 respondents (56.1%) selected either 'Medical/health/sickness' or 'Disability' (25 respondents [61.0%] if those who checked multiple answers are included) as their major area of activity under the United Kingdom Charity Commission typology (Question 9). Of those that answered another area of activity, 12 said they had some connection to Capital Health on Question 19. Of the remaining four organizations, the short descriptive response in Question 8 ("How would you describe your organization's primary activity?") clearly indicated involvement to some degree in health and/or health care. Therefore, one way or another, all 41 respondents satisfied the second inclusion criterion.

The third inclusion criterion—being voluntary—was tested using a number of questions. To recap, the entity must have been formalized in structure; must have been institutionally separate from the government; must not have redistributed its profits; and must have involved voluntary participation in its operations or management.

To test for a formalized organizational structure, Question 6a directly asked whether the organization possessed a formal organizational structure. Thirty-two respondents (78.0%) answered 'Yes.' In addition to this question, the modified Urban Institute's operational definition of 'formalized structure' deemed that an organization had to either a) hold CRA

tax-exemption status; b) be legally incorporated; c) be a recipient of government funds; or d) have revenues over $10,000 annually. This was tested using the following questions from the questionnaire:

- Questions 10 and 11 showed that all 41 respondents held tax-exemption status.
- Question 4 asked whether the organization was unincorporated or grassroots, an incorporated non-profit, or a registered charity. All but one of the respondents (97.6%) answered either 'incorporated non-profit' or 'registered charity.' The remaining organization answered 'none of the above or unsure.'
- In Question 16, where respondents indicated their sources of revenue, 21 (51.2%) listed the government as one of those sources (19 stated that the government was their largest or second largest source of revenue).
- Finally, Question 15 asked for the total amount of revenue the organizations received in 2003. Thirty-one of the 41 organizations (75.6%) had revenues of over $10,000.

All participating organizations satisfied at least one of the four conditions and demonstrated an institutional or formal structure.

Testing for institutional separation, Question 7 asked whether an organization considered itself to be self-governing. Thirty-nine respondents (95.1%) answered in the affirmative, which implied sufficient autonomy from either the government or other private businesses. As well, all 41 organizations gave an affirmative response to at least one of Questions 6a through 6d, which provided evidence that the organizations possessed elements of their own internal governance structure—i.e., a formal organizational structure, an advisory board, a board of directors or trustees, and/or an executive director.

Questions 10 and 11 tested for the non-redistribution constraint by using information returns with the CRA as a proxy. Indicating the filing of a T3010/T3010A or T1044 information return was sufficient to meet this criterion. Only one respondent replied 'No' to filing either information return, but that organization was part of a larger organization that did file for itself. One organization did not supply any answer at all, but it is a regional branch of a national organization that has filed a T3010A (available online) and therefore qualified.

Question 3 captured to a degree the involvement of volunteers at the level of either management or operations. The existence of either volunteers or members on a board of directors or governors was taken as evidence of voluntarism. Only one organization had neither volunteers nor a board of directors (but it was associated with a community organization that did).

In the end, all 41 organizations provided sufficient evidence of being part of the voluntary sector, and were therefore included in the study.

4.3. Voluntary organization typology questions

Question 9 reproduced the United Kingdom Charity Commission system of classifying charitable organizations. The results of this question showed a large clustering around medical/health/sickness as an area of activity, either the public in general or groups with particular disabilities or special needs as the beneficiaries, and the provision of services as the main mode of operation (see Table 2, below).

Table 2—Results of the United Kingdom Charity Commission typology

Section 1: Area of activities	Frequency	Percent
General charitable purposes	5	12.2%
Education/training	5	12.2%
Medical/health/sickness	19	46.3%
Disability	4	9.8%
Relief of poverty	0	
Overseas aid/famine relief	0	
Accommodation/housing	0	
Religious activities	0	
Arts/culture	0	
Sport/recreation	0	
Animals	0	
Environment/conservation/ heritage	0	
Economic/community development/ employment	0	
Other or none of these	5	12.2%
Multiple answers	3	7.3%

Table 2 (cont'd)

Section 2: Beneficiaries	Frequency	Percent
Children/young people	1	2.4%
Elderly/old people	8	19.5%
People with disabilities/special needs	11	26.8%
People of a particular ethnic or racial origin	1	2.4%
Other charities/voluntary bodies	2	4.9%
Other defined group not listed	4	9.8%
The general public/humankind	12	29.3%
Multiple answers	2	4.9%

Section 3: Method of operation	Frequency	Percent
Makes grants to individuals	0	
Makes grants to organizations	4	9.8%
Provides other finance (e.g., pensions/investment fund)	0	
Provides human resources (e.g., staff/volunteers)	2	4.9%
Provides buildings/facilities/open space	2	4.9%
Provides services (e.g., care/counselling)	14	34.1%
Provides advocacy/advice/information	5	12.2%
Sponsors or undertakes research	1	2.4%
Acts as an umbrella or resource body	4	9.8%
Other or none of these	4	9.8%
Multiple answers	5	12.2%

For this study, Question 9 did not prove very informative. It did not help in deciding which voluntary organizations were health-related, especially since each organization had already been judged to be at least partially related to the field of health. A number of respondents wilfully (sometimes apologetically) disregarded instructions and checked more than one box. On the other hand, respondents were mistakenly asked to select only one item in each list, whereas the United Kingdom Charity Commission's application form instructs organizations to "tick at least one box in each" (Charity Commission for England and Wales, 2002: 19). This question was not included in the analysis of the results because the information drawn from these results was regarded as faulty and would not contribute to the study's objectives.

The Boucher *et al.* (1979) typology, which distinguishes between citizen-member and patient-member organizations, was covered in Question 12. About half (20 of 41, or 48.8%)

indicated that their membership was drawn from the community at large, while only three (7.3%) said that their membership consisted mainly of patients and/or their friends and relatives. An additional 14 organizations (34.1%) said that their membership came from both sources. Overall, 34 (82.9%) were citizen-member, and 17 (41.5%) were patient-member organizations. Four (9.8%) gave no answer.

The Gordon & Babchuk (1959) typology (minus the prestige-bestowing dimension) gives six possible categories along two axes (see p. 27, above). Accessibility was rated according to the answer given for Question 14, "Is the membership of your organization open to all, or limited by certain criteria?" Twenty-three respondents (56.1%) indicated high accessibility, while 14 (34.1%) indicated low accessibility. Four (9.8%) gave no answer.

From the responses to Question 13, an organization could be considered instrumental, expressive, or instrumental-expressive (exhibiting both traits). Ten (24.4%) gave indication of being instrumental, nine (22.0%) were expressive, and 18 (43.9%) were instrumental-expressive. Again, four (9.8%) gave no response.

The results of both Question 13 and 14 together are summarised in Table 3.

Table 3—Results of the Gordon & Babchuk (1959) typology (Questions 13 & 14)

	Number of Respondents			
	High Accessibility	Low Accessibility	No answer	**Total**
Instrumental	6	4	–	**10**
Instrumental-Expressive	15	2	1	**18**
Expressive	2	7	–	**9**
No answer	–	1	3	**4**
Total	**23**	**14**	**4**	

The implications of the results from the Boucher *et al.* (1979) and Gordon & Babchuk (1959) typologies are discussed when they are compared to the responses given for Question 19. See the section on data analysis, p. 48, below.

4.4. Organizational characteristic questions

The organizations that responded to the questionnaire were varied in terms of their organizational characteristics. The results of these questions are presented here in the order they appeared on the questionnaire. Throughout, please refer to Appendix D, which summarizes all the tabulations of the results.

Question 1: "In years, approximately how long has your organization been in existence?"

The majority of organizations that responded had been in operation for 30 years or fewer—28 out of 41, or 68.3%. Of the remaining 13, seven (17.1%) were between 41 and 60 years old, and six (14.6%) had been operating for over 71 years. For analysis purposes later on, organizations' ages were grouped into these three clusters (under 30, 41-60, and 71 and over).

Question 3: "Approximately how many people in your organization are volunteers, paid staff, or board members?"

The size of the volunteer force ranged dramatically. Thirteen (31.7%) said they had over 200 volunteers each, even as many as 2,000; the equivalent number said they had fewer than 20. Eight more organizations (19.5%) said that they did not use any volunteers whatsoever. Of those that did use volunteers, the average, which was skewed because of the size of the larger organizations, was 204 volunteers per organization; the median was 35 volunteers.

Although 39 organizations indicated that they had a board of directors in Question 6c, only 35 respondents gave a numerical value to the size of the board. Boards ranged in size from four members to as large as 25 members. The average board size of those organizations that had a board of directors was 11.4 members; the median was 11 members. Four organizations (9.8%) said they had no board members at all. Only one organization answered zero for both size of volunteer force and number of board members.

The paid workforce also ranged dramatically. Ten organizations (24.4%) had no paid staff members, while one organization had as many as 1,300. Of those that employed staff, the average was 81.2 positions per organization; the median was six paid positions.

Using all the organizations' responses, there was no significant correlation between the number of volunteers, number of paid staff, and number of board members ($p>0.05$). However, once two outliers that were skewing the data were removed (the two organizations with over 1,000 volunteers each), there was a significant correlation ($p\leq0.05$) between the number of volunteers and the number of paid staff ($r=0.680$, $p=0.000$) and the number of volunteers and the size of the board of directors ($r=0.498$, $p=0.001$). The correlation between the number of paid staff and the size of the board of directors was not significant ($r=0.204$, $p=0.213$).

Question 5: "In attaining its mission or goals, does your organization carry out its own programs and services, fund others to do so, or both?"

The majority of respondents said they carried out their own programs and services. Thirty-one organizations (75.6%) carried out their own programs, two (4.9%) funded others exclusively, and another six (14.6%) did both. Of the two organizations that indicated 'neither,' one was a support group and the other gave research awards.

Question 6: "Which of the following does your organization possess?"

The responses to Question 6 are summarised in Table 4, below.

Table 4—Organizational features possessed by respondents (Question 6).

	Feature	Number of Respondents Yes	No	Percent 'Yes'
a)	a formal organizational structure	32	9	78.0%
b)	an advisory board	5	36	12.2%
c)	a board of directors or trustees	39	2	95.1%
d)	an executive director responsible for the management of day-to-day operations	24	17	58.5%
e)	an affiliation with a provincial, national, or international body	23	18	56.1%
f)	operational autonomy from the provincial, national, or international body (if applicable) *	11	12	47.8%

* Only those that indicated an affiliation with a provincial, national, or international body (part e) were included in the count.

It can be seen that a majority of respondents claimed to have a formal organizational structure and that all but two of the organizations had a board of directors or trustees (despite the fact that four respondents wrote in zero for the number of board members in Question 3). Few organizations (12.2%) made use of an advisory board. Over half of the respondents (58.5%) were from organizations that were large enough to employ an executive director.

Just over half of the organizations that responded (56.1%) were affiliated with a larger body either at the provincial, national, or international level. Approximately half of those organizations considered themselves to have operational autonomy from the parent organization. This suggests that almost a third of all respondents (29.3%) had to abide by guidelines set elsewhere, which could have had an impact on flexibility when working in the local setting with the health region.

Question 12: "From where is your membership drawn? From the community at large, from patients and/or their friends and family, or both?"

This Boucher *et al.* (1979) typology question is discussed above (p. 37). Incorporating those who answered 'both,' 34 (82.9%) of responding organizations could be classified as citizen-member organizations, according to the Boucher *et al.* (1979) nomenclature, and 17 (41.5%) as patient-member. Only three organizations considered themselves patient-member exclusively. Four organizations (9.8%) gave no answer.

Question 13: "Does your organization function primarily for the benefit of its members, non-members, or both?"

This question and the next (Question 14) are discussed above in the section on typology questions (section 4.3, p. 35). Responses were roughly equal between respondents that were inwardly focused and those that were outwardly focused. Nine (22.0%) answered that the members were the beneficiaries of the organization's services, and 10 (24.4%) said the beneficiaries were non-members. If those who answered 'both' are incorporated into the other two categories, the numbers became 27 (65.9%) and 28 (68.3%), respectively. Four respondents (9.8%) did not provide an answer.

Question 14: "Is the membership of your organization open to all, or limited by certain criteria?"

Twenty-three (56.1%) said their memberships were open to all, while 14 (34.1%) said that membership was limited based on certain criteria. Space was provided for respondents to write down just what the criteria were, but they cannot be reported for reasons of confidentiality since reporting them here would identify individual organizations. Four respondents (9.8%) did not provide an answer.

Question 15: "What was your organization's approximate total revenue in 2003?"

The total revenue of the responding organizations covered a wide spectrum, from zero to $47 million. Eight (19.5%) of the organizations that responded had revenues of under $10,000 in 2003. Most organizations, however, received more than $10,000 (31 of 41 respondents, or 75.6%), which is the threshold for the CRA to require a nonprofit

organization to file a T1044 information return if it is not already a registered charity. Thirteen organizations (31.7%) had revenues of over $1,000,000. Two organizations did not answer this question.

Question 16: "Please indicate your organization's sources of revenue in 2003, and the approximate percentage of each."

For each different source of revenues, the most frequently indicated source was private donations, followed by the government. Thirty-one organizations (75.6%) said that they received at least a portion of their revenue from private donations, while twenty-one (51.2%) listed the government as a source.

In terms of the proportion that each source of funding represented, for those that listed the government as a source of revenue it made up, on average, 51.0% of their revenues. The next proportionately largest source was commercial activity, contributing 32.5% of revenues on average.

In terms of the ranking of each source (whether it was listed as the first, second or third largest source of revenue), the government was listed most often as the primary source of revenue. Eleven organizations (26.8%) relied on the government as a primary source of revenue, while nine (22.0%) cited private donations as their number one source.

Question 17: "What were your organization's total assets at the end of the last fiscal period?"

Sixteen respondents (39.0%) stated they had less than $50,000 in assets, and seven (17.1%) had between $50,000 and $200,000 in assets. Fifteen (36.6%) indicated that their organizations' assets totalled more than $200,000, which, incidentally, is the threshold for the CRA to require a nonprofit organization to file a T1044 information return if it is not already a registered charity. In this case, though, all 15 organizations with over $200,000 in assets were already registered charities. Three organizations gave no answer.

Question 18: "Approximately what percentage (%) of the organization's funds are disbursed through its activities?"

It is possible that this question was not written clearly enough and that the phrase "disbursed through its activities" was interpreted differently. It was intended to capture the proportion of an organization's spending that went towards direct service provision or the funding of others. In other words, the question attempted to ascertain the amount that was used after costs for administration, overhead, salaries, fundraising and the like were subtracted.

Using the responses from the returned questionnaires, 20 organizations (48.8%) said they used 100% of their funds on their activities, which is possible, but not probable. Seven organizations (17.1%) said they disburse 80% or less of their funds through their activities. Four organizations (9.8%) did not answer this question.

4.5. Question 19 – Types of relationships

Because the responses to Question 19 were open-ended, I faced the freedom and challenge of making order out of the diverse responses. Each response was first considered individually, using the labels given by the participants themselves to describe the type of relationship and to create a tentative coding system. The responses were then considered collectively, with similar responses grouped together. Eventually all the responses were sorted into categories guided by the principles of the ideal typology: discrete, mutually exclusive, non-overlapping designations that have high differentiation *between* categories, and high homogeneity *within* categories (Sokal, 1974).

The open-ended nature of the question allowed for the classification of the responses, and the testing of a number of coding schemes in a way that would not have been possible using an *a priori* checklist. Indeed, the final coding scheme selected was based on a theme that was much different from what was initially envisioned. Originally, the responses were going to be grouped according to activity. In the end, the responses were arranged according to how the voluntary health organization was positioned vis-à-vis Capital Health.

Table 5, below, lists the 10 different categories from the first attempt at developing a classification scheme, as well as the number of organizations that fell within each category. Because many organizations worked in several different ways with Capital Health, there were more responses than there were respondents.

Table 5—Typology of relationships based on activities.

	Type of relationship	Number of Respondents Yes	No	Percent 'Yes'
a)	Consultation	5	36	12.2%
b)	Funding/Procurement	8	33	19.5%
c)	Human Resources	8	33	19.5%
d)	Information	12	29	29.3%
e)	Referral	10	31	24.4%
f)	Research	3	38	7.3%
g)	Resources/Services	8	33	19.5%
h)	Special Projects	7	34	17.1%
i)	Vending	7	34	17.1%
j)	None	10	31	24.4%

However, some of the responses could have fit under two (or more) categories. The initial classification system was therefore scrapped and the responses were recombined into new categories. The new typology of Capital Health-voluntary health sector relationships is based on how they relate to each other, not on what they do, and how they are positioned and what their role is relative to each other. Table 6 summarises the results:

Table 6—Typology of relationships based on roles.

	Type of relationship	Number of Respondents Yes	No	Percent 'Yes'
a)	Capital Health supports VHO	11	30	26.8%
b)	VHO supports Capital Health	18	23	43.9%
c)	Collaboration	11	30	26.8%
d)	Via medium	9	32	22.0%
e)	Via patient	12	29	29.3%
f)	None	11	30	26.8%

This is not at all similar to Coston's (1998) model of government-voluntary sector relationships (see Figure 2, page 16). The questionnaire asked for instances of connection between the organization and Capital Health, and therefore relationships of repression, rivalry or competition would not have been captured. Coston's model really describes the state of the government as it impacts on the voluntary sector. This typology shows in wha ways the two sectors work together without giving precedence to either sector.

Relationships categorized as 'Capital Health supports voluntary health organization [VHO include such examples as direct funding, provision of space, core services such as payroll, This category includes all instances where Capital Health is providing the kind of support that helps a voluntary organization operate and pursue its mission.

The category 'VHO supports Capital Health' represents relationships whereby, either through the pursuit of its own mission or as a special service, the voluntary organization lends support to Capital Health. Examples include providing volunteer staff, running educational workshops and seminars, purchasing equipment, and assisting in research. Support can either be donated in cash or in kind by the voluntary organization, or it can be purchased under contract by Capital Health. In a contractual relationship, the voluntary organization is still providing expertise that Capital Health would otherwise need to provid for itself, and for that reason contracts were classified under this category.

Collaborative relationships are those instances where Capital Health and a voluntary health organization are working in conjunction toward a common goal. One party is not necessarily buttressing the other, but rather each is a collaborator. Special projects, planni sessions, committee involvement and research are examples of collaborative efforts that a not in exclusive support of one party or the other.

There are two categories where the voluntary organization and Capital Health do not have direct contact with each other, but their connection is mediated through a third party. Th categories are to be distinguished from a relationship of support and/or reliance. The firs such type of relationship is through a medium, such as information, educational material, shared resources. The bridging medium can be produced by either Capital Health or the

voluntary organization and used by the other, but it has to have been produced for general usage and not for the express purpose of supporting the recipient.

The other type of mediated relationship is through patients. Referrals are the most prominent example of patient-mediated relationships, but there are also services rendered to mutual patients, such as visitation programs.

Finally, if the respondent indicated that there were no formal or informal relationships between their organization and Capital Health, their activities were classified as 'None.' This category is just as legitimate as the other categories because it is equally important to know what kind of voluntary organizations do not work with the formal health care system as it is to know who does.

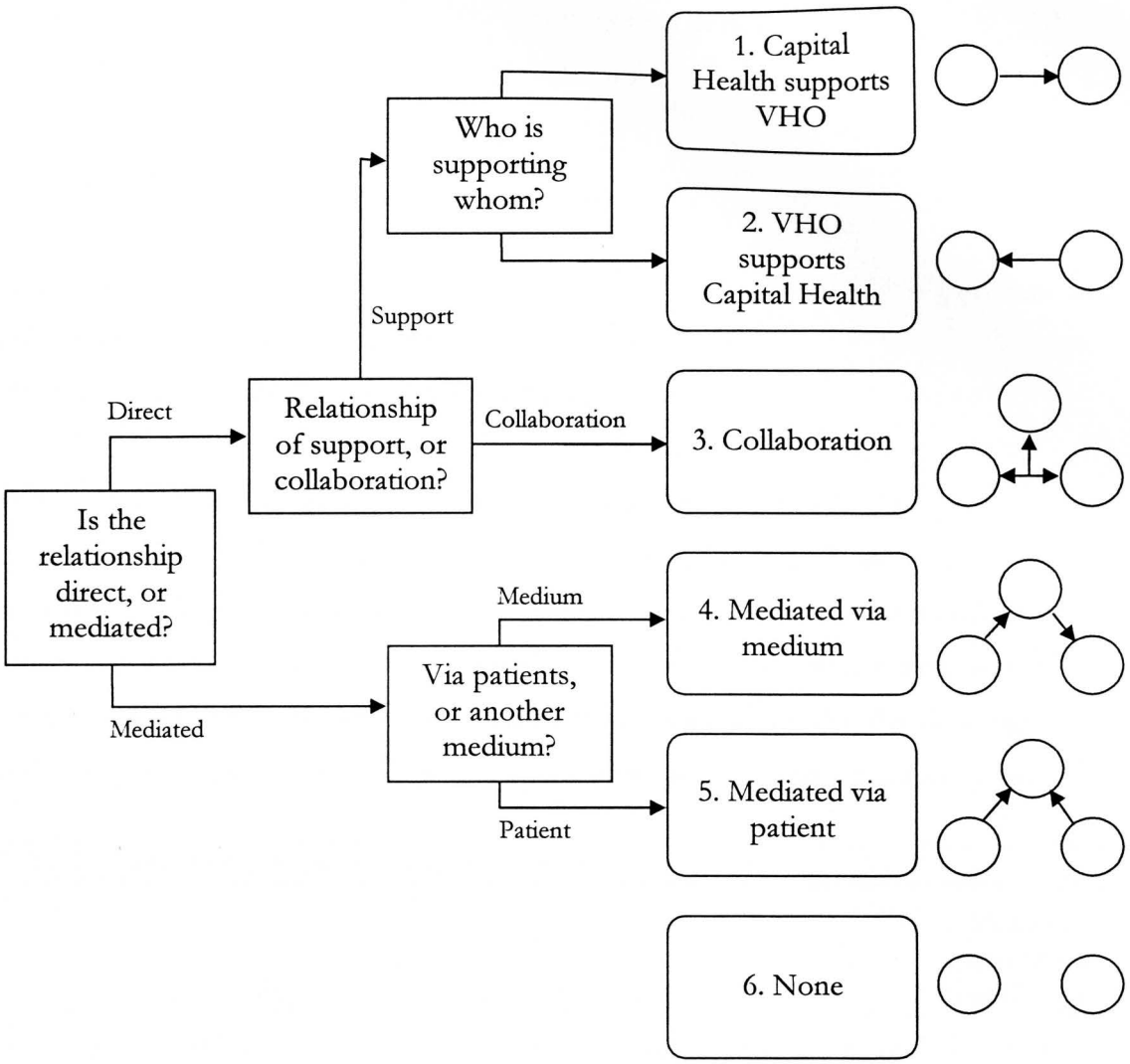
Rarely, but occasionally, some responses were ignored because they clearly did not involve Capital Health.

When sorting all the responses to Question 19, two questions were asked:

1) was the relationship direct, or was it mediated through patients or via information?
2) if it was direct, was the relationship one of support? Was one party providing something that the other needed?

Figure 3 (following page) maps out a decision-making flowchart for typing the relationships. The figure also shows small schematic images of the six different kinds of relationships with Capital Health and the voluntary sector represented by small circles.

Figure 3—Decision-making flowchart for relationship typing



4.6. Data analysis

Three different approaches in increasing complexity were performed to analyze the data: simple correlations, chi-square testing, and odds ratios.

4.6.1. Correlations

A simple table matrix of Pearson correlation coefficients between each pair of questions was set up, and those pairs where the correlation was significant ($p \leq 0.05$, $n=41$, two tails) were highlighted. At $n=41$, the threshold for significance for r was ± 0.316.

There are two matters of caution when creating a large correlation matrix. On average, one can expect to see 5% of the correlation coefficients to be falsely significant purely by random chance if a 95% level of confidence is set ($p \leq 0.05$). As well, a correlation does not imply causality. Therefore, any significant correlations found at this stage were simply used to serve as a flag for further investigation. Nevertheless, the questions that did show significant correlation ($p \leq 0.05$, $n=41$, two tails) with the categories derived from Question 19 were:

Table 7—Correlation of relationship types and characteristics.

	Type of relationship	Characteristic(s)	Pearson correlation coefficient
a)	Capital Health supports VHO	• Corporate donations as source of revenue (Question 16)	+0.336
b)	VHO supports Capital Health	• Funding agency as source of revenue (Question 16)	-0.326
c)	Collaboration	• Number of paid staff (Question 3)	+0.417
		• Size of revenue (Question 15)	+0.387
		• Government as source of revenue (Question 16)	+0.371
		• Amount of assets (Question 17)	+0.348
d)	Via medium	• Self-governing (Question 7)	+0.427
e)	Via patient	• Mode of operation (Question 5)	-0.343
		• Government as source of revenue (Question 16)	+0.521

Table 7 (cont'd)

	Type of relationship	Characteristic(s)	Pearson correlation coefficient
f)	None	• Incorporated status (Question 4)	-0.354
		• Filing of a T1044 information return (Question 11)	-0.396
		• Percentage of funds disbursed through activities (Question 18)	-0.419

These results did not provide a very detailed picture about the voluntary organizations that engaged in each type of relationship. A simple correlation was not sufficient to illustrate the connections between their characteristics and their behaviours. Indeed, upon closer examination, some correlations broke down when the characteristic was divided into ranges. For instance, when the size of revenue (Question 15) was divided into a low range (under $10,000), a medium range ($10,001 to $1,000,000) and a high range (over $1,000,000), all correlation with a collaborative type of relationship was lost (r=+0.000, +0.065, and +0.296, respectively; n=41, p>0.05, two tails). In some cases, outlying data points exerted such a distorting force that correlation was over-exaggerated. The three organizations with the most paid staff members stretched the trend line so far that it would have made any bunch of data points look good, statistically speaking. Once those data were removed, however, the correlation coefficient fell to r=+0.276, and the p-value then exceeded 0.05 (n=41, two tails).

Incidentally, the category 'none' correlated with all the other five types of relationships, which was expected. The only two relationship types that correlated with each other were collaborative relationships and those mediated via patient.

4.6.2. Chi-square tests

The chi-square tests showed whether the distribution of the types of relationships (or the quantities for each type) were significantly different for each characteristic. For dichotomous variables, the presence of that characteristic was tested against its absence. For categorical or continuous variables, ranges were applied and tested against each other.

If certain characteristics were more associated with specific types of relationships, one would have expected there to be 'clumping' that would have differed in each profile. However, listing the government as a source of revenue (from Question 16) was the only characteristic that showed a statistically significant difference in distributions, with a chi-square value of $\chi^2(5, n=41) = 11.28$, $p=0.046$. Every other organizational characteristic showed no difference. This was attributable to both the small sample size and the fact that many of the cells in the chi-square tables contained fewer than five samples.

4.6.3. Odds ratios

This study followed a strategy that is analogous to finding risk factors for a disease. Epidemiological tools, such as relative risk and odds ratios, were used to see which organizational characteristics were more associated with each type of relationship. Each relationship, as derived from Question 19, was treated independently as a separate 'disease.' Individual 'risk factors' (organizational characteristics) were studied as potential predictive indicators of relationship types.

Relative risk is to assess the increased or decreased risk of an outcome given exposure to a certain risk factor; the odds ratio is used in retrospective cohort studies as an estimate of relative risk (Fleming, Scutchfield & Tucker, 2000). In this case, the odds ratio estimated whether an organizational characteristic (the 'risk factor') was more or less likely to have resulted in a particular relationship type (the outcome or 'disease').

An odds ratio of more than one (unity) indicated the number of times more likely an organization was to engage in that type of relationship given a particular characteristic; a value of less than unity suggested the opposite. If all the organizations that engaged in a particular type of relationship also possessed a certain characteristic, the result was an odds ratio of infinite. Conversely, if no organization possessed a particular characteristic, the odds ratio was zero. The confidence interval gave a range within which one expects the true odds ratio was likely to fall. If this range did not include unity (it did not cross the value one), then the odds ratio was reasonably significant.

Initially, a 95% confidence interval was used to test the odds ratios, which would test for significance at a p-value of less than 0.05. However, the level of significance had to be increased to $p \leq 0.10$ because too few results emerged. Therefore, there is a 10% chance that the odds ratios presented below were not truly above or below unity, and the result was false.

Table 8, below, summarizes the organizational characteristics that were significantly ($p \leq 0.10$) more or less likely to be associated with each type of relationship.

Table 8—Odds ratios of relationship types and characteristics.

	Type of relationship	Characteristic(s)	Odds ratio	90% confidence interval
a)	Capital Health supports VHO	• In existence thirty years or fewer (Question 1)	6.667	(1.074 - 41.369)
		• Aged 31-70 (Question 1)	0.000	–
		• Advisory board (Question 6)	0.000	–
		• Board of directors (Question 6)	∞	–
		• Revenue under $10,000 (Question 15)	7.429	(1.526 - 36.162)
		• Commercial activity as a source of revenue (Question 16)	4.800	(1.384 - 16.647)
b)	VHO supports Capital Health	• Funding agencies as a source of revenue (Question 16)	0.218	(0.063 - 0.756)
		• Assets over $200,000 (Question 17)	3.429	(1.097 - 10.720)
c)	Collaboration	• Fewer than 10 paid staff (Question 3)	0.261	(0.072 - 0.939)
		• 10 or more paid staff (Question 3)	3.833	(1.065 - 13.801)
		• Carries out own programs or services (Question 5)	∞	–
		• Board of directors (Question 6)	∞	–
		• Executive director (Question 6)	4.500	(1.093 - 18.524)
		• Revenue under $10,000 (Question 15)	0.000	–
		• Revenue over $1,000,000 (Question 15)	8.944	(2.299 - 34.803)
		• Government as a source of revenue (Question 16)	6.750	(1.631 - 27.933)
		• Assets over $200,000 (Question 17)	5.833	(1.553 - 21.911)

Table 8 (cont'd)

	Type of relationship	Characteristic(s)	Odds ratio	90% confidence interval
d)	Via medium	• Over 70 years in existence (Question 1)	0.000	–
		• Carries out own programs or services (Question 5)	∞	–
		• Advisory board (Question 6)	0.000	–
		• Board of directors (Question 6)	∞	–
e)	Via patient	• In existence 30 years or fewer (Question 1)	0.186	(0.055 - 0.631)
		• Over 70 years in existence (Question 1)	6.750	(1.410 - 32.322)
		• Fewer than 10 paid staff (Question 3)	0.227	(0.065 - 0.791)
		• 10 or more paid staff (Question 3)	4.400	(1.264 - 15.322)
		• Carries out own programs or services (Question 5)	∞	–
		• Funds others (Question 5)	0.000	–
		• Board of directors (Question 6)	∞	–
		• Government as a source of revenue (Question 16)	20.900	(3.357 - 130.136)
		• Government as largest source of revenue (Question 16)	0.163	(0.031 - 0.866)
f)	None	• Fewer than 100 volunteers (Question 3)	7.500	(1.202 - 46.778)
		• More than 100 volunteers (Question 3)	0.133	(0.021 - 0.832)
		• Carries out own programs or services (Question 5)	0.092	(0.012 - 0.682)
		• Between $10,000 and $1,000,000 in revenue (Question 15)	6.955	(1.663 - 29.076)
		• Revenue over $1,000,000 (Question 15)	0.133	(0.021 - 0.832)
		• Government as a source of revenue (Question 16)	0.250	(0.070 - 0.888)
		• Government as largest source of revenue (Question 16)	∞	–
		• Assets under $50,000 (Question 17)	3.500	(1.026 - 11.935)

The next chapter discusses the possible implications of these results.

Chapter 5. Discussion.

5.1. Reviewing the main objectives

This study had three main objectives, which will be discussed in turn:

1) to gather relevant organizational data about the individual voluntary health organizations;
2) to identify the types of relationships in which voluntary health organizations engage with the formal health sector; and
3) using the above information, to find the associations between organizational characteristics and types of intersectoral relationships.

5.1.1. Organizational data

The findings for organizational characteristics have already been summarized in Chapter 4, the section on results. The questionnaire produced some interesting cumulative data on the voluntary health sector, and here the sample is viewed as a whole. Inferences made from the collected data, however, cannot be extrapolated to the entire voluntary health sector in HRM based on only 41 responses. The respondents might not truly have been representative of the entire voluntary health organization population, and therefore the discussion must be read with this in mind.

In the sample, there were a number of organizations that were relatively young, while at the same time there were organizations that had survived and continued to operate after a long time—over 100 years, in one case. Twenty-eight organizations (68.3%) were established after the *Medical Care Act* of 1966 (18 [43.9%] since the enactment of the *Canada Health Act* in 1984), which means they had been set up in a climate where socialized health care already existed. If one subscribes to the sector failure theories, these organizations were presumably formed in response to demands left unmet by medicare. Those organizations established before 1966, of which there were 13 (31.7%) in this sample, would have had to adapt to accommodate the new publicly-funded health care system and the new legislation setting boundaries on health delivery practices.

The size of voluntary health organizations also covered a wide range. With voluntary forces of up to 2,000 people, staff as high as 1,300, and annual revenue of as much as $47 million, some organizations were quite large. At the same time, there were organizations that employed only one person (some none at all), operated with only a small body of volunteers, and made do with a miniscule budget. In this sample, the size of the organization as measured by the number of volunteers was highly correlated with the age of the organization (r=+0.399, n=41, $p<0.05$, two tails)—the older the organization, the higher the number of volunteers it attracted, possibly due in part to public familiarity and reputation, and possibly in part to its ability to coordinate more activities. The number of paid staff members was also correlated to the size of revenue (r=+0.957, n=41, $p<0.05$, two tails) and to total assets (r=+0.325, n=41, $p<0.05$, two tails), which makes intuitive sense: the more staff there are, a higher budget is necessary to support them.

The memberships of organizations were more often composed of community members than they were of patients and their friends and family members. As well, the focus of membership activity was split almost equally between an outward focus (or 'expressive' according to Gordon & Babchuk [1959] terminology—see p. 28) and an inward focus (or 'instrumental'). In nearly half the cases, it was both. In only about a third of the cases was membership limited to individuals meeting certain requirements. This means that these voluntary organizations in HRM existed for diverse reasons, and drew membership from, and operated for the benefit of, different population groups.

5.1.2. Relationship types

The voluntary health sector is obviously not homogenous, yet presumably every organization serves a useful function or they would not still be operating. How each organization currently involves itself and positions itself vis-à-vis the formal health care system was the topic of the second objective. The typology of intersectoral relations that was developed after closely examining the responses to Question 19 highlights the role of voluntary organizations more so than their actual activities.

To summarize the typology, there are six ways in which an organization's activities can connect it to the formal health care system. The voluntary organization can support Capital Health through its services, or Capital Health can provide support to the voluntary organization. The two parties can collaborate together on an activity that is of mutual benefit. Their connection can be indirect via a medium, or it can be through their patients. Finally, the voluntary organization and Capital Health can have no relationship at all.

The different relationship types themselves can be grouped into two general types already presented in the literature review with regards to voluntary organizations' roles (see p. 14): those that position the organization vis-à-vis the formal health sector, and those that focus on the activities conducted in pursuit of corporate missions. Three relationship types—'VHO supporting Capital Health,' 'Capital Health supporting VHO,' and 'None'—highlight the relation between the two sectors, explainable using Billis and Glennerster's (1998) theory of comparative advantage. The voluntary organization either supplies a service in support of Capital Health (or vice versa) because it is in a better position to do so, or conducts its business with no contact with Capital Health. The three remaining types—'Collaboration,' 'Mediated via medium,' and 'Mediated via patient'—place the focus on relationships that further the voluntary organization's mission and objectives.

Just over a quarter of respondents (11, or 26.8%) said that they had no ties to Capital Health, which meant that nearly three-quarters (73.2%) were involved to some degree with the formal health care system. In this sample, the most common type of relationship was 'VHO supporting Capital Health,' with 18 organizations (43.9%) giving indication that they conducted activities that directly supported the formal health system. One implication of this type of relationship being the largest is that it lends credence to the sector failure theories, which would presume that Capital Health is buttressed by the voluntary sector to overcome its shortcomings. Nevertheless, 14 of those 18 organizations also held evidence of another type of relationship, which meant supporting Capital Health was not their only role. Indeed, eight of the 18 organizations that supported Capital Health also had a relationship that was mediated via the patient, and five both supported and were supported by Capital Health. It seems that voluntary health organizations are capable of playing

multiple roles depending on what is required, which is consistent with the comparative advantage theory of voluntary organizations.

The typology developed here is a way of envisioning how the voluntary sector complements and broadens the formal health care system. Health care provision should be viewed as extending beyond the formal settings of hospitals and professionals' offices. Often the role of the individual person or family in managing one's own health is promoted by health care planners, so there is no reason not to consider the role of collective groups and associations. A similar typology exercise can be done with the other key sectors that have a role to play, namely private firms and the individual households. By highlighting the roles voluntary organizations, private firms and households currently play in health care, the model for health care planning can be extended to encompass all actual players.

5.1.3. Associating characteristics with relationship types

The last objective of the study was to link organizational characteristics to the types of relationships. It was predicted that certain characteristics would make some organizations more or less amenable to certain types of intersectoral connection than others. Indeed, this turned out to be statistically so. There were some factors that increased the likelihood of an organization taking on a particular role, and there were other characteristics that were found to decrease that probability.

Statistical analysis uncovered many associations between the relationship types and the organizational characteristics, which is what was hoped for. When the individual 'risk factors' are viewed together, they form a composite image of the 'typical' organization for each relationship type:

> *Capital Health supports the voluntary health organization:* This type of relationship was more than six times as likely to occur if the voluntary organization had been around for thirty years or fewer. It was over seven times as likely when the voluntary organizations revenues were under $10,000, and 4.8 times as likely if commercial activity was a source of that revenue. None of these organizations were between 31

and 70 years old, none made use of an advisory board, and all had an executive director. The image that forms is of an organization that is younger and smaller in size, one requiring help to sustain itself.

Voluntary health organization supports Capital Health: This type of relationship was less likely to occur for organizations that had funding agencies as a source of revenue. Also, an organization was 3.4 times more likely to support Capital Health if its assets were over $200,000. The image this evokes is not very clear based solely on those two characteristics.

Collaboration: Organizations that had 10 or more paid staff members were 3.8 times more likely to enter into a collaborative relationship with Capital Health. All the organizations carried out their own services and/or programs, and all had a board of directors. This type of relationship was 4.5 times as likely to be associated with organizations that employed an executive director. Collaboration was almost nine times more likely for organizations with revenues of over $1,000,000; in fact, none of the organizations had revenues under $10,000. Additionally, they were 5.8 times as likely if they had assets of over $200,000. Organizations supported to some degree by government organizations were 6.75 times more likely to collaborate. The picture this paints is one of an organization that has official government recognition, that is large—lots of staff, lots of assets, and lots of resources—and that carries out its own programs.

Mediated via medium: All the organizations associated with this type of relationship carried out its own programs or services and had a board of directors. None of these organizations, however, was over 70 years old or made use of an advisory board. This is a fairly vague picture of organizations that connect to Capital Health through a third medium.

Mediated via patients: Organizations that reported themselves to be under 30 years of age were 83% less likely to relate to Capital Health through patients, whereas those who had been in existence for over 70 years were 6.75 times more likely. Those with

10 or more paid staff members were 4.4 times more likely to engage in this type of relationship, and all had boards of directors. All the organizations carried out their own programs; none funded others to do so. Patient-mediated relationships were nearly 21 times more likely to occur if the organization received part of its revenue from the government; however, paradoxically, they were less likely to cite the government as their largest source of revenue. The image this conjures is of an older organization that has a large body of staff, carries out its own programs, and is funded by the government.

None: The organization with fewer than 100 volunteers was 7.5 times more likely to report that it did not have any ties to Capital Health. An organization that carried out its own programs was 91% less likely to have ***no*** relationship with Capital Health. Voluntary organizations were more likely not to have a relationship if they had revenues between $10,000 and $1,000,000 (which, granted, is a large range), but less likely if they had revenues of over $1,000,000. Indeed, these organizations were 3.5 times more likely if they had assets of less than $50,000. These organizations were less likely to list the government as a source of revenue, but all of those who did so claimed that government was their largest source. The image of those that did not have any relationship with Capital Health was of an organization that was medium-sized with fewer assets, less dependent on government for revenue, and more likely to fund other organizations.

These synopses are neither definitive nor predictive. An organization's programs and services do not remain static, and as they change, the organization's role and relationship in relation to the formal health care system will alter over time. As stated in the introduction, the primary benefit of this study was clarification around how the two sectors interacted in the past year. The results drawn here can be useful for raising future research questions about why these tendencies should be.

If lessons are to be drawn from the results, however, health planners can assess the type of relationship it is seeking to form, look at the portraits given above, and select a voluntary organization that fits that description (if one exists). From the other perspective, a voluntary

organization can look at its own size, structure, assets, etc. and judge how it can interact with the formal health care system. Of course, not all organizations operate with objectives that require a relationship with Capital Health, but for those that do, the following may apply. Based on past tendencies, younger and smaller organizations should think about seeking support from Capital Health in order to help sustain itself and grow. Organizations with large amounts of assets can think about mobilizing those assets in support of Capital Health as other organizations do already. Those organizations that carry out their own programs and have high levels of staff and resources are in a position to work collaboratively with Capital Health on projects or programs. For a voluntary organization that has information or material that may be of use to Capital Health, there has been little precedence for organizational characteristics associated with relationships that are mediated via a medium. For an organization that serves clientele and might be seeking referrals to or from Capital Health, it would be best to keep in mind that it has been the older, larger, governmentally-funded organizations that have been successful in the past.

5.2. Limitations and future directions

As with all studies, there were limitations to this study. A small sample size has already been mentioned. On top of this, there were a number of variables that were not included in the questionnaire because they would not have been easy to operationalize, such as the composition or demographics of the volunteer force, the overall purpose of the organization, or the organization's reputation. These are characteristics that could perceivably have an impact on an organization's potential to work with Capital Health.

In looking for associations between organizational characteristics and relationship types, the magnitude of the relationship was not considered. For instance, if Capital Health was supporting an organization, it could have been in the form of a large operating or research grant, or it could have been as little as Capital Health staff volunteering a few hours. It is debatable whether the amount of resources mobilized for an activity is more important than the activity itself. The involvement of a voluntary organization could be what is important rather than its overall impact, which is the assumption that is implicitly made here.

Armed with a new typology for intersectoral relations between the voluntary health sector and the formal health care system, it can be tested to see if it will provide consistent results. Rather than leaving Question 19 open-ended, participating voluntary organizations can be presented with the list (with explanatory notes) and asked to check off the appropriate boxes. The trade-off in risk is that the list may not be complete, or may be presumptuous. It is important that the list be carefully reviewed.

Research carrying this typology forward can take several forms. The next step is to test the robustness of the typology through replicating the project in reverse. Instead of querying individual organizations in the voluntary sector, one could survey the individual departments and units within Capital Health about their relationships with the voluntary sector. A number of characteristics for each department can be identified and correlated to the types of relationships in which they engage. Preliminary hypotheses could then be made about the most effective types of relationships not just between a voluntary organization and Capital Health, but between that organization and a specific department within Capital Health.

The study can also be replicated in different geographic areas, perhaps within regional health authorities that correspond to major urban centres in other provinces, to see if the same patterns of organizational characteristics emerge. Moreover, one relationship type—for instance, 'Capital Health supports voluntary health organization'—can be selected for detailed investigation on its own to flesh it out and uncover other hidden tendencies within that one type.

Chapter 6. Conclusion.

As stated in the introductory section, the purpose of this study was to first construct a typology of the different ways the voluntary health sector interacts with the formal health sector, and then link these types of relationships to characteristics found within voluntary health organizations.

The typology that was constructed is unlike others found in the literature, most of which focus on the activities of the voluntary sector. Some will include other elements such as the beneficiaries and the primary method of carrying out activities—for example, the United Kingdom Charity Commission and the multidimensional typology proposed by Febbraro *et al.* (1999). None of the systems of classification is intended explicitly for intersectoral relations, with the possible exception of the Coston (1998) system, but even that system focuses on governmental attitudes rather than processes.

With respect to linking the typology's categories to organizational characteristics, it is unfortunate that a wider margin of error had to be introduced in order to begin uncovering possible 'risk factors.' This was a consequence of low respondent numbers, resulting in insufficient statistical power to detect differences. Nevertheless, even allowing for a 10% chance of random error, there remained a 90% level of confidence that the associated characteristics were worth looking into further.

The implications of the findings are that Capital Health and members of the voluntary sector can now look more closely at how they interact. The formal health care system seems predisposed to work in particular ways with certain voluntary organizations, and vice versa. Capital Health, in pursuing policy objectives, can involve the voluntary sector and approach voluntary organizations that possess certain characteristics depending on the type of relationship that entails. The implication of these unexamined trends for the voluntary sector, conversely, can lead to planning decisions by organizations on how to become best involved in the public health care system. A voluntary health organization can conduct a self-assessment and, based on its characteristics, either determine the optimal way in which

to involve itself with the formal health care system, or else identify how it wishes to become involved and adapt to better achieve that goal.

If Capital Health wishes to formalize the way in which it interacts with and involves the voluntary health sector, it should consider drafting and implementing policy similar to *An Accord between the Government of Canada and the Voluntary Sector* (Voluntary Sector Task Force, 2001), which was designed to guide the relationship between the two sectors and which produced codes of practice for funding and policy dialogue (Voluntary Sector Initiative, 2002a; 2002b). The typology developed here can be used to provide such policy a framework for covering all intersectoral interactions—different policy considerations for different types of relationships.

One large, unanswered question is 'why': Why do organizations with characteristic x tend to engage in relationship y? The findings of this study were historical, which means the patterns in the existence of relationships could have been due to tradition, an accident of coincidence, or an intentional policy decision on the part of Capital Health. In the end, an association between characteristics and relationships does not dictate future relationships. The point of this study was to investigate the state of affairs in the recent past to uncover patterns, which it did. Why a voluntary health organization and the formal health care sector engaged in a type of relationship, and whether it was the most effective and efficient use of resources, will have to be left for another day. Until then, this typology of intersectoral relationships and process of linking it to inherent organizational characteristics was an important first foray into previously-underexplored territory.

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List of Appendices

Appendix A: Introductory letter

Mr./Ms. Participant
Executive Director
Voluntary Organization of Halifax Regional Municipality
123 Any Street
Halifax, NS B0A 0A0

April 12, 2004

Re: Participation in a research study on the nonprofit sector

Dear Mr./Ms. Participant,

We would like to invite your organization to participate in a research study being conducted at Dalhousie University as part of the principal investigator's Masters thesis on the nonprofit health sector in Halifax, Nova Scotia.

Please find attached an information sheet detailing the study, as well as a copy of the questionnaire itself. We have provided a stamped, addressed envelope to make it possible to return the questionnaire more easily.

If you have any questions, please feel free to contact any of the people listed on the reverse side of the information sheet.

Sincerely,

[Signature]

Jonathan Snider,
Principal Investigator/Master's Candidate.

Appendix B: Information sheet

HEALTH CARE AND THE VOLUNTARY SECTOR IN HALIFAX

There has been renewed interest lately in the role of the nonprofit sector, and in particular the possibilities of collaboration between the health care system and nonprofit, voluntary organizations. It is often felt that cutbacks in public spending over the last decade, as well as an increase in the number of people seeking services, has put pressure on nonprofit organizations to seek new ways of 'doing business.'

The purpose of this study is to look at the ways in which the nonprofit sector has been working with the Capital District Health Authority (CDHA) to provide better services for their clientele and patients. The results of the study will be used to suggest ways of improving partnerships between the nonprofit sector and the CDHA.

The study

Attached is a questionnaire that we would like you to complete on behalf of your organization. In the questionnaire, we are looking for information about your organization—its size, its structure, its finances, etc. All of the questions are related to characteristics and activities of the organization itself. In other words, we are *not* looking for information about your members or the clientele you serve.

The most important question we ask is about the types of activities that connect your organization to the larger health care system. We want to know how your organization works with the CDHA, how it supports the CDHA, and how it is supported by the CDHA. Examples of activities include a partnership in a project, referrals of patients, fund-raising, partnership in research, advocacy, the education of health professionals, participation in task forces, shared resources, etc.

A stamped, addressed envelope has been provided for you to return the questionnaire. We would appreciate it if the survey could be completed and returned by April 26th, 2004.

Possible risks and possible benefits

There are no identified risks that would be incurred as a result of partaking in this study.

Because we are not seeking information regarding your clientele/membership/patients, there is no risk to them either. Should personal information regarding your clientele/ membership/patients accidentally be divulged, it will be disregarded.

There are no immediate benefits to partaking in this study. However, the information gathered from this study may help inform both the voluntary sector and health planners within CDHA in the future.

Confidentiality/anonymity

Completed questionnaires are kept in locked storage. Data from the questionnaire are kept in a database protected by password. Results of the study will be reported in aggregate form, so no individual organization will be singled out, *unless* permission is granted to use the organization's name in the final report.

Compensation

Participants will not be compensated or reimbursed for their participation in this study. However, a copy of the final report can be sent to your organization if desired. If you would like to receive a copy, please indicate so on question 22 of the questionnaire.

...over

Questions, problems or concerns

In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance.

Patricia Lindley
Director of Dalhousie University's Office of
Human Research Ethics Administration
phone: (902) 494-1462
e-mail: patricia.lindley@dal.ca

Consent

Please be advised that by completing and returning the survey, you are consenting to participate in this research study and that you are allowing the investigator to compile and analyse the provided information.

Please remember to return your questionnaire by April 26th, 2004!

If you have any questions or concerns regarding this study, please feel free to contact any of the people listed below:

Principal investigator	**Supervisor**	**Research Ethics Administration**
Jonathan Snider e-mail: jjsnider@dal.ca phone: (902) 454-0725; (902) 209-5219	Dr. Thomas Rathwell e-mail: thomas.rathwell@dal.ca phone: (902) 494-7097	Patricia Lindley e-mail: patricia.lindley@dal.ca phone: (902) 494-1462

Please complete and return the questionnaire in the enclosed envelope by April 26th, 2004 to:

Nonprofit Sector Study
c/o Jonathan Snider
School of Health Services Administration
5599 Fenwick Street
Halifax, Nova Scotia
B3H 1R2

Thank you!

Appendix C: The questionnaire

INTERSECTORAL RELATIONSHIPS BETWEEN THE CAPITAL DISTRICT HEALTH AUTHORITY AND THE VOLUNTARY HEALTH SECTOR IN HALIFAX, NOVA SCOTIA

The purpose of this questionnaire is to learn about your organization and its relationship with the Capital District Health Authority. The survey should take between 10 and 15 minutes to complete. Once it has been completed, please return the questionnaire in the stamped, addressed envelope that has been provided to you.

If you have any questions or concerns regarding this study, please feel free to contact any of the people listed at the end of the questionnaire.

The first set of questions asks about some of the **characteristics of your organization**.

1. In years, approximately how long has your organization been in existence?

_____ years.

2. Does your organization operate within the Halifax Regional Municipality?

Yes ☐ No ☐

3. Approximately how many people in your organization are:

a) volunteers (excluding board members)? _____
b) paid staff members (full and part time)? _____
c) on the board of governors/directors? _____

4. Is your organization: (please select one)

a) unincorporated or grassroots? ☐
b) an incorporated non-profit? ☐
c) a registered charity? ☐
d) none of the above or unsure? ☐

5. In attaining its mission or goals, does your organization: (please choose one)

a) carry out its own programs/services? ☐
b) fund others to do so? ☐
c) both of the above? ☐
d) neither of the above? ☐

6. Which of the following does your organization possess? (Please select **all** that apply)

a) a formal organizational structure. ☐
b) an advisory board. ☐
c) a board of directors or trustees. ☐
d) an executive director responsible for the management of day-to-day operations. ☐
e) an affiliation with a provincial, national, or international body. ☐
f) operational autonomy from the provincial, national, or international body (if applicable). ☐

7. Would you consider your organization to be 'self-governing'? In other words, are decisions largely made locally by your organization, or are they made by an external body (e.g., a national affiliate, a funder, the government)?

Yes ☐ No ☐

8. How would you describe your organization's primary activity?

_____
_____
_____
_____

9. For your organization's **primary activity**, please select **one** box from **each** of the following three sections.

Section 1: Area of activities – check one

- General charitable purposes ☐
- Education/training ☐
- Medical/health/sickness ☐
- Disability ☐
- Relief of poverty ☐
- Overseas aid/famine relief ☐
- Accommodation/housing ☐
- Religious activities ☐
- Arts/culture ☐
- Sport/recreation ☐
- Animals ☐
- Environment/conservation/ heritage ☐
- Economic/community development/ employment ☐
- Other or none of these ☐

Section 2: Beneficiaries – check one

- Children/young people ☐
- Elderly/old people ☐
- People with disabilities/special needs ☐
- People of a particular ethnic or racial origin ☐
- Other charities/voluntary bodies ☐
- Other defined group not listed ☐
- The general public/humankind ☐

Section 3: Method of Operation – check one

- Makes grants to individuals ☐
- Makes grants to organisations ☐
- Provides other finance (e.g., pensions/investment fund) ☐
- Provides human resources (e.g., staff/volunteers) ☐
- Provides buildings/facilities/open space ☐
- Provides services (e.g., care/counselling) ☐
- Provides advocacy/advice/information ☐
- Sponsors or undertakes research ☐
- Acts as an umbrella or resource body ☐
- Other or none of these ☐

10. Did your organization file a **T3010 or T3010A** *Registered Charities Information Return* with the Canada Customs and Revenue Agency (CCRA) last year?

Yes ☐ No ☐

If 'no,' was it because:

a) the organization is not a registered charity. ☐
b) the form was not required. ☐
c) other (please elaborate) ☐

_____

_____

_____

11. Has your organization ever filed a **T1044** *Non-Profit Organization (NPO) Information Return* with the CCRA in a previous fiscal year?

Yes ☐ No ☐

If 'no,' was it because:

a) the organization is not nonprofit. ☐
b) the form was not required. ☐
c) the organization's revenues and assets were below a certain amount. ☐
d) other (please elaborate) ☐

_____

_____

_____

The next set of questions is about your organization's **membership**.

12. From where is your membership drawn? (please choose one)

a) Membership is drawn from the community at large. ☐

b) Membership is composed mainly of patients and/or their friends and relatives. ☐

c) Both of the above. ☐

13. Does your organization function primarily for the benefit of: (please select one)

a) its members? ☐

b) others/non-members? ☐

c) both of the above? ☐

14. Is the membership of your organization: (please select one)

a) open to all? ☐

b) limited by certain criteria? ☐

(please briefly describe the criteria.)

_____

_____

_____

The next set of questions asks questions about your organization's **finances**.

15. What was your organization's approximate total revenue in 2003?

$_____

16. Please indicate your organization's sources of revenue in 2003, and the approximate percentage (%) of each:

Source		Amt (%)
Government (provincial or federal)	☐	_____%
Funding agencies	☐	_____%
Private donations	☐	_____%
Corporate donations	☐	_____%
Commercial activity	☐	_____%
_____	☐	_____%
_____	☐	_____%

17. What were your organization's total assets at the end of the last fiscal period?

Less than $50,000 ☐

$50,000 - $200,000 ☐

Over $200,000 ☐

18. Approximately what percentage (%) of the organization's funds are disbursed through its activities?

_____ %

The next section asks the **most important question** of this study. It concerns your organization's relationship with the formal health care system.

19. Please describe **all** the different types of activities that connect your organization to the Capital District Health Authority. (For example: a partnership in a project, referrals of patients, fund-raising, partnership in research, coordination of services, education of health professionals, task forces, shared resources, services to family members, etc.) Two examples are given.

(If your organization has nothing to do with the CDHA, please write 'none' below and skip ahead.)

Type of relationship	Brief description	Type of relationship	Brief description
e.g. Public information	Co-production of an information pamphlet for patients	5.	
e.g. Contractual	CDHA purchases services from our organization	6.	
1.		7.	
2.		8.	
3.		9.	
4.		10.	

*(If you require additional space, please feel free to use the back side of this sheet.)

20. Please **check this box** if you will allow your organization's name to be used in the final report. It may be useful at times to mention a voluntary organization with which readers are familiar in order to explain and illustrate the study's results. ☐

21. Would you be willing to participate in a follow-up interview regarding the findings of this research project? Your views would benefit the study by providing insights on the interpretation of the results.

Yes ☐ No ☐

Name _____

Phone _____

22. Would you be interested in receiving a copy of the final report?

Yes ☐ No ☐

We sincerely thank you and your organization for participating. Remember, if you have any questions or concerns regarding this study, please feel free to contact any of the people listed below:

Principal investigator
Jonathan Snider
e-mail: jjsnider@dal.ca
phone: (902) 454-0725;
(902) 209-5219

Supervisor
Dr. Thomas Rathwell
e-mail: thomas.rathwell@dal.ca
phone: (902) 494-7097

Research Ethics Administration
Patricia Lindley
e-mail: patricia.lindley@dal.ca
phone: (902) 494-1462

Please return this questionnaire in the stamped, addressed envelope to:

Voluntary Sector Study
c/o Jonathan Snider
School of Health Services Administration
5599 Fenwick Street
Halifax, Nova Scotia
B3H 1R2

Appendix D: Summary of results

In this appendix, the frequency counts are summarised on a question-by-question basis, with the exception of Question 8 ("How would you describe your organization's primary activity?") which, for reasons of confidentiality, cannot be reported.

Question 1

"In years, approximately how long has your organization been in existence?"

Age (years)	Frequency	Percent
0-10	12	29.3%
11-20	6	14.6%
21-30	10	24.4%
31-40	0	
41-50	5	12.2%
51-60	2	4.9%
61-70	0	
71-80	1	2.4%
81-90	2	4.9%
91-100	2	4.9%
101+	1	2.4%

Question 2

"Does your organization operate within the Halifax Regional Municipality?"

	Frequency	Percent
Yes	41	100%
No	0	
No answer	0	

Question 3

"Approximately how many people in your organization are volunteers (excluding board members)?"

Volunteers	Frequency	Percent
0	8	19.5%
1-10	5	12.2%
11-20	8	19.5%
21-50	5	12.2%
51-100	0	
101-200	7	17.1%
201-300	2	4.9%
301+	4	9.8%
No answer	2	4.9%

"Approximately how many people in your organization are paid staff members (full and part time)?"

Staff	Frequency	Percent
0	10	24.4%
1-2	5	12.2%
3-4	6	14.6%
5-6	5	12.2%
7-8	0	
9-10	3	7.3%
11-15	1	2.4%
16-20	1	2.4%
21-50	3	7.3%
51-100	2	4.9%
101-150	0	
151-200	0	
201+	3	7.3%
No answer	2	4.9%

"Approximately how many people in your organization are on the board of governors/directors?"

Board members	Frequency	Percent
0	4	9.8%
1-5	6	14.6%
6-10	8	19.5%
11-15	16	39.0%
16-20	3	7.3%
21-25	2	4.9%
26-30	0	
30+	0	
No answer	2	4.9%

Question 4

"Is your organization: (please select one)"

		Frequency	Percent
a)	unincorporated or grassroots?	0	
b)	an incorporated non-profit?	4	9.8%
c)	a registered charity?	36	87.8%
d)	none of the above or unsure?	1	2.4%

Question 5

"In attaining its mission or goals, does your organization: (please choose one)"

		Frequency	Percent
a)	carry out its own programs/services?	31	75.6%
b)	fund others to do so?	2	4.9%
c)	both of the above?	6	14.6%
d)	neither of the above?	2	4.9%

Question 6

"Which of the following does your organization possess? (Please select all that apply)"

	Feature	Yes	No	Percent
a)	a formal organizational structure	32	9	78.0%
b)	an advisory board	5	36	12.2%
c)	a board of directors or trustees	39	2	95.1%
d)	an executive director responsible for the management of day-to-day operations	24	17	58.5%
e)	an affiliation with a provincial, national, or international body	23	18	56.1%
f)	operational autonomy from the provincial, national, or international body (if applicable)	11	12*	47.8%

* Only those that indicated an affiliation with a provincial, national, or international body (part e) were included in the count.

Question 7

"Would you consider your organization to be 'self-governing'? In other words, are decisions largely made locally by your organization, or are they made by an external body (e.g., a national affiliate, a funder, the government)?"

	Frequency	Percent
Yes	39	95.1%
No	2	4.9%
No answer	0	

Question 9

"For your organization's primary activity, please select one box from each of the following three sections."

Section 1: Area of activities	Frequency	Percent
General charitable purposes	5	12.2%
Education/training	5	12.2%
Medical/health/sickness	19	46.3%
Disability	4	9.8%
Relief of poverty	0	
Overseas aid/famine relief	0	
Accommodation/housing	0	
Religious activities	0	
Arts/culture	0	
Sport/recreation	0	
Animals	0	
Environment/conservation/ heritage	0	
Economic/community development/ employment	0	
Other or none of these	5	12.2%
Multiple answers	3	7.3%

Section 2: Beneficiaries	Frequency	Percent
Children/young people	1	2.4%
Elderly/old people	8	19.5%
People with disabilities/special needs	11	26.8%
People of a particular ethnic or racial origin	1	2.4%
Other charities/voluntary bodies	2	4.9%
Other defined group not listed	4	9.8%
The general public/humankind	12	29.3%
Multiple answers	2	4.9%

Section 3: Method of operation	Frequency	Percent
Makes grants to individuals	0	
Makes grants to organisations	4	9.8%
Provides other finance (e.g., pensions/investment fund)	0	
Provides human resources (e.g., staff/volunteers)	2	4.9%
Provides buildings/facilities/open space	2	4.9%
Provides services (e.g., care/counselling)	14	34.1%
Provides advocacy/advice/information	5	12.2%
Sponsors or undertakes research	1	2.4%
Acts as an umbrella or resource body	4	9.8%
Other or none of these	4	9.8%
Multiple answers	5	12.2%

Question 10

Did your organization file a T3010 or T3010A *Registered Charities Information Return* with the Canada Customs and Revenue Agency (CCRA) last year?"

	Frequency	Percent
Yes	37	90.2%
No	3	7.3%
No answer	1	2.4%

"If 'no,' was it because:"

		Frequency	Percent
a)	the organization is not a registered charity.	1	33.3%
b)	the form was not required.	0	
c)	other.	2	66.7%
	No answer	0	

Question 11

"Has your organization ever filed a T1044 *Non-Profit Organization (NPO) Information Return* with the CCRA in a previous fiscal year?"

	Frequency	Percent
Yes	13	31.7%
No	25	61.0%
No answer	3	7.3%

"If 'no,' was it because:"

		Frequency	Percent
a)	the organization is not nonprofit.	2	8.0%
b)	the form was not required.	12	48.0%
c)	the organization's revenues and assets were below a certain amount.	1	4.0%
d)	other.	8	32.0%
	No answer	2	8.0%

Question 12
"From where is your membership drawn? (please choose one)"

		Frequency	Percent
a)	Membership is drawn from the community at large.	20	48.8%
b)	Membership is composed mainly of patients and/or their friends and relatives.	3	7.3%
c)	Both of the above.	14	34.1%
	No answer	4	9.8%

Question 13
"Does your organization function primarily for the benefit of: (please select one)"

		Frequency	Percent
a)	its members?	9	22.0%
b)	others/non-members?	10	24.4%
c)	both of the above?	18	43.9%
	No answer	4	9.8%

Question 14
"Is the membership of your organization: (please select one)"

		Frequency	Percent
a)	open to all?	23	56.1%
b)	limited by certain criteria?	14	34.1%
	No answer	4	9.8%

Due to issues of confidentiality, the criteria by which membership is limited to some organizations cannot be summarised.

Question 15
"What was your organization's approximate total revenue in 2003?"

Revenue	Frequency	Percent
$0-$100	1	2.4%
$101-$1,000	1	2.4%
$1,001-$10,000	6	14.6%
$10,001-$100,000	8	19.5%
$100,001-$1,000,000	10	24.4%
$1,000,001-$10,000,000	11	26.8%
$10,000,001+	2	4.9%
No answer	2	4.9%

Question 16

"Please indicate your organization's sources of revenue in 2003, and the approximate percentage (%) of each:"

	Source	Yes	No	Percent	Frequency of ranking 1st	2nd	3rd
a)	Government	21	20	51.2%	11	8	1
b)	Funding agencies	14	27	34.1%	4	4	4
c)	Private donations	31	10	75.6%	9	10	6
d)	Corporate donations	13	28	31.7%	5	3	3
e)	Commercial activity	12	29	29.3%	5	2	4
f)	Other	14	27	34.1%	7	7	1

'Other' included member dues, user fees, bequests, fundraising, investment income, special project funding, rent, social events, community activity, and miscellaneous. Five respondents (12.2%) listed more than one source under 'other.'

Question 17

"What were your organization's total assets at the end of the last fiscal period?"

Assets	Frequency	Percent
Less than $50,000	16	39.0%
$50,000 - $200,000	7	17.1%
Over $200,000	15	36.6%
No answer	3	7.3%

Question 18

"Approximately what percentage (%) of the organization's funds are disbursed through its activities?"

Percentage	Frequency	Percent
0-5%	1	2.4%
6-10%	1	2.4%
11-45%	0	
46-50%	1	2.4%
51-55%	1	2.4%
56-60%	0	
61-65%	1	2.4%
66-75%	0	
76-80%	2	4.9%
81-85%	2	4.9%
86-90%	6	14.6%
91-95%	2	4.9%
96-100%	20	48.8%
No answer	4	9.8%

Question 19

"Please describe all the different types of activities that connect your organization to the Capital District Health Authority."

Type of relationship based on activities:

	Type of relationship	Yes	No	Percent
a)	Consultation	5	36	12.2%
b)	Funding/Procurement	8	33	19.5%
c)	Human Resources	8	33	19.5%
d)	Information	12	29	29.3%
e)	Referral	10	31	24.4%
f)	Research	3	38	7.3%
g)	Resources/Services	8	33	19.5%
h)	Special Projects	7	34	17.1%
i)	Vending	7	34	17.1%
j)	None	10	31	24.4%

Type of relationship based on roles:

	Type of relationship	Yes	No	Percent
a)	Capital Health supports VHO	11	30	26.8%
b)	VHO supports Capital Health	18	23	43.9%
c)	Collaboration	11	30	26.8%
d)	Via medium	9	32	22.0%
e)	Via patient	12	29	29.3%
f)	None	11	30	26.8%