# THE VOLUNTARY SECTOR IN PUBLIC HEALTH: PARTNERS OR PLAYTHINGS?

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## Introduction

Much discussion has taken place over the past few decades about the concept of network governance, and what it might mean for liberal democratic regimes. This notion, which goes by many other names, including collaborative governance (Ansell and Gash, 2008), New Public Service (Denhardt and Denhardt, 2002), Public Value Management (Stoker, 2006) and interorganizational innovations (Mandell and Steelman, 2003), is well described as "…a spectrum of structures that involve two or more actors and may include participants from public, private, and nonprofit sectors with varying degrees of interdependence to accomplish goals that otherwise could not be accomplished independently." (Mandell and Steelman, 2003: 202). Several writers have seen network governance as instrumental in strengthening liberal democracy in modern times by establishing a broader base for inclusion in public policy issues. (Stoker, 2006; Denhardt and Denhardt, 2002; Box *et al.*, 2001) The argument is advanced that the level of complexity surrounding many public policy issues today is such that, in order for issues to be successfully resolved, mechanisms need to be established that allow for the active participation of all interested stake-holders. It follows, therefore, that civil society, positioned as it is "outside the reach of state bureaucracy and beyond the interests of the private sector" (Morison, 2000: 105) has a key role to play in this notion of governance.

Few would dispute that the voluntary sector plays a key role in the public health sector. Although no precise figure is available for the number of voluntary sector organizations (VSOs) involved in the various facets of public health in Canada, only casual observation is needed to confirm that the number is impressive. Public health departments and agencies at the national, provincial, and local level routinely rely on VSOs to reach vulnerable clients at the community level. In addition, there is a myriad of organizations playing an advocacy role on a full range of issues, including mental health, infectious diseases, chronic disease and injury prevention. VSOs can also be repositories of considerable expertise, often playing a major role in research in such areas as heart disease, cancer, and mental health.

The purpose of this paper is to examine the role of VSOs in public heath - as a sector in which VSOs are particularly numerous and active - with a view of assessing to what extent the "vision" of network governance is actually reflected in reality. This paper will begin with a short review of the voluntary sector in general, as well as its place in Canada, specifically in the context of public health. Following this, a typology will be used to analyze the various types of relationships between VSOs in the public health sector with government at the national level, providing examples of each type of relationship for purposes of illustration. The paper concludes with a discussion of what the current pattern of relationships means for the prospects of network governance in the

public health sector in Canada. The general proposition of this paper is that the nature of the relationships between VSOs and government agencies in public health severely limits the potential of VSOs to play a significant role in the governance of the public health area. While there are a few recent examples which appear to break outside the conventional "mould," it is far from clear whether these should be seen as aberrations or as indications of new directions to come.

The research in this paper is based on document review, as well as 19 semi-structured interviews with government officials and with representatives of VSOs involved in public health. To protect anonymity, these interviews, when cited, will be identified by a number and the date on which the interview in question was conducted.

The voluntary sector – terminology and context

A number of different terms can be found in the literature related to this sector, with overlapping but not identical meanings which can lead to a certain amount of terminological confusion. In this paper, we will use the term "voluntary sector," which we take to mean all organizations led by boards, the members of which serve on a voluntary basis. This does not mean that these organizations are composed entirely of volunteers, as in many cases they have salaried personnel to carry out their activities. Moreover, these are organizations which operate on a not-for-profit basis for the purpose of achieving a public good. Finally, they are understood to be formally independent from government, even though, as will be discussed, they may work quite closely with government, or may indeed receive a significant portion (if not all) of their funding from government. (This definition is consistent with that used in *Building on Strength: Improving Governance and Accountability in Canada's Voluntary Sector, (Broadbent Report),* 1999: 7; see also Morison, 2000: 98)

The importance of the voluntary sector is not new in liberal democracies. de Tocqueville attached a great deal of importance to this sector as a "necessary guarantee against the tyranny of the majority." (de Tocqueville, 1945: 201-02) More recently, it has been quite common in U.S. literature to cite the importance of the "Iron Triangle" in public decision-making, the three points of the triangle being congressional committees, the bureaucracy, and "interest groups." (Pross, 1986: 97)

In the past few decades, the role of the voluntary sector, consistent with the notion of modern governance, has undergone a fairly significant transformation. A. Paul Pross observed that the diffusion of power in modern society "has transformed participating interest groups from useful adjuncts of agencies into vitally important allies." (1986: 243). As Stoker puts it: "The governance perspective demands that these voluntary sector third-force organizations be recognized for the scale and scope of their contribution to tackling collective concerns without reliance on the formal resources of government." (1998: 21) The increasing importance of the voluntary sector is evidenced by the fact that in the late 1990s, both the U.K. and Canada produced major reports on the role of the voluntary sector, followed by a "compact" (U.K.) or an "accord" (Canada)

between government and the voluntary sector. (*The Compact*, 1998; *Accord Between the Government of Canada and the Voluntary Sector*, 2001.)

Notwithstanding the above, there is a high level of diversity in the nature of the relationships between government and the voluntary sector across different policy sectors of the same government. (Coleman and Skogstad, 1990: 25; Boris and Steuerle, 1999: 14-5; Salamon, 1999: 330.) What is true in agriculture, for example, may or may not resemble what takes place in human resource development, or in the cultural sector. One can often see a considerable amount of diversity within the same policy sector. (Coleman and Skogstad, 1990: 29). This, combined with the fact that this area has been relatively under-studied, means any generalization must be approached with caution. Focussing our discussion on the area of public health will help to narrow the range of circumstances to some degree, but even here, the relationships between government and voluntary organizations, as we shall see, can take radically different forms.

Susan Phillips has provided a useful distinction for an analysis of government-voluntary sector relationships – and one very consistent with network governance - by suggesting that increasingly, governments must make a shift from governing by programming to governing by relationship-building. As Phillips points out:

> The primary responsibilities of government in relationship building are to provide an appropriate enabling environment to permit the partners to fulfill its [sic] potential, to ensure that government commitments on particular standards of conduct can be met by relevant departments, and to facilitate collaboration, including means for reviewing and improving the relationship.

Phillips goes on to argue for the need to shift "from traditional programming that focuses on hierarchy, accountability, and funding within a single department to relationship building that involves collaboration, co-ordination, responsiveness, and flexible accountability…" (Phillips, 2001: 258.)

For our purposes, the question we will pose is: how close is the public health sector to making that shift?

## The Voluntary Sector in Canada

Canada's voluntary sector is quite robust, in comparison to many other countries. Based on a survey conducted in 2000 by Johns-Hopkins University and Imagine Canada, the share of the voluntary sector workforce (paid staff and volunteers) in the economically active workforce in Canada is second only to the Netherlands. (Hall *et al*, 2005: 9) Furthermore, this study found that the number of people involved in the voluntary sector in Canada was particularly high in the health and housing sectors. (Hall *et al*, 2005: 13) At the same time, however, the same report identified the lack of a coherent policy framework related to the voluntary sector in Canada as "one of the biggest constraints to its future development." (Hall *et al*, 2005: v)

The Voluntary Sector Initiative, which took place between 2000 and 2005, was a comprehensive attempt to establish a better basis for the relationship between the voluntary sector and the Government of Canada. As a part of its broad mandate, the VSI had a number of positive accomplishments, such as the development of non-binding codes of good practice in financing and policy development; regulatory reforms for charitable organizations, and a variety of research initiatives. (Hall *et al*, 2005: 24) Yet at this point, it does not appear that these initiatives have resulted in fundamental changes in the relationship between this sector and the Government of Canada.

Adding to the challenges facing the voluntary sector are the after-effects of the controversy in 2000 surrounding the contracting practices of HRDC, as well as the more recent events around the Sponsorship Program of the Department of Public Works and Government Services (PWGSC). In each case, the response to the "scandals" was to impose more stringent requirements on contracting arrangements, including those with voluntary sector organizations. This has had the effect of adding to the administrative burden for those organizations in applying and accounting for funding, as part of the new "web of rules" characterizing operations in the federal government. (The Treasury Board Secretariat acknowledges the problem, and has established a "Web of Rules Action Plan to attempt to address it.) This can not help but to have a dampening effect on the prospects for network governance in Canada, since, as Phillips points out, "collaborative governance involving voluntary and private sector partners will not succeed if it is weighted down by the rules and accountability mechanisms designed to work within departmental hierarchies." (2001: 184)

Even before the HRDC Grants and Contributions and the PWGSC Sponsorship controversies, the budget-cutting exercise of Program Review in the mid-1990s, as well as the increasing use of project funding, rather than "core" funding, had contributed to a more difficult environment for many VSOs. (Hall *et al*, 2005: 23; *Broadbent Report*, 1999: 5; *Blue Ribbon Panel on Grant and Contribution Programs*, 2006: 13) The Blue Ribbon Panel which examined Grant and Contribution Programs observed that many voluntary sector organizations "are in a fragile state, hostage to costly funding delays and to reporting requirements that many are ill-equipped to meet." (*Blue Ribbon Panel on Grant and Contribution Programs*, 2006: 13) In their submission to the Blue Ribbon Panel, the Canadian Council on Social Development wrote that: "Non-profits are being treated by government in a fashion that reflects a lack of faith in their trustworthiness and competence…" (2006: 15) The impact of these developments was felt in the public health area, among others, where relationships between the federal government and the voluntary sector were weakened. (McMillan and Nagpal, 2007: 62)

Furthermore, the worsening climate for voluntary sector organizations exacerbated a power imbalance between these organizations and governments, which has at times been likened to a David and Goliath relationship. (Phillips and Graham, 2000: 171) Although the language of "partnerships" is frequently used, "in most cases, the government has the weight and the authority to impose terms and conditions on its funding partners that they are hardly in a position to resist." (Blue Ribbon Panel on Grant and Contribution

Programs, 2006: 2) To use Pross' distinction, VSOs are often reduced to playing the role of members of the "attentive public," rather than that of a "sub-government." (1986: 149) The consequence is a pattern of relationships in which VSOs often find themselves at the consumer end of public policy, rather than having a significant role in shaping it.

The Broadbent Report identified many key challenges confronting the voluntary sector in Canada, and made a number of far-reaching recommendations. Unfortunately, many of the key recommendations, such as establishing a Voluntary Sector Commission, identifying a Cabinet minister to articulate the concerns of the sector at the Cabinet table, and assisting VSOs to develop the capacity for improved public reporting, have not been implemented. Indeed, the Blue Ribbon Panel remarked in 2006 that the uncertainty and instability affecting the voluntary sector was worse than ever. (2006: 7) The consequence is the perpetuation of a relationship with government that in many respects fails to live up to its potential.

Compounding the issue from a public health sector perspective is the multiplicity and diversity of the VSO community involved in public health. The relationship between the voluntary sector and government agencies in the health field has deep roots. In what may be seen as an early step in the direction of collaborative governance, the federal government established in 1919 the Dominion Council of Health (DCH), which was composed of the Deputy Minister of Health, the provincial chief officers of health, as well as representatives of organized labour, women's groups, social service agencies, agriculture, and universities. (Rutty and Sullivan, 2010: 2.19) The purpose of the DCH was to advise the newly established federal Department of Health. A recent history of public health in Canada suggests that the DCH was in some ways "more important to the development of public health during the 1920s than the fledgling department it served." (Rutty and Sullivan, 2010: 3.1) The Canadian Red Cross also played a major role, funding its own public health programs, and providing salaries for public health nurses to supplement what provincial governments, such as the one in Ontario, were providing. (Rutty and Sullivan, 2010: 3.3) In the area of emergency response both the St. John Ambulance and the Canadian Red Cross were heavily involved in efforts to contain the 1918 influenza pandemic and continue to act as major responders in crisis situations.

In more contemporary times, the length and breadth of public heath has inevitably led to a wide range of VSOs involved in one of the many aspects of public health. Organizations might be engaged in preventing infectious disease such as avian flu, the West Nile virus, HIV/AIDS; behaviour-based strategies, such as smoking-cessation, alcoholism, unsafe sex, family violence, use of personal communication devices in automobiles, promoting physical activity, healthy eating habits, and sun safety; life stage related issues, related to children and seniors; gender-based concerns, most often related to women's health, including maternal health; planning for emergency response; generic chronic disease prevention and control as well as disease specific activities (cancer, heart, lung etc.); settings-based strategies (school, work, communities, etc.); and groups taking a determinants of health approach, which tend to focus on poverty, housing, and social justice. There are also a number of professional associations of physicians, nurses, nutritionists, physical therapists, psychologists and others which play an active role in the

field. The end result is that it can be very challenging for government agencies to determine with whom to collaborate and how, and even for the organizations themselves to know which players are involved in the issues that affect them.

Three types of Government-VSO relationships

From the above, questions can be asked about the nature of the relationships between government agencies at the national level– primarily Health Canada and the Public Health Agency of Canada – and VSOs, and in particular, the role of VSOs in shaping public health policy; the mechanisms in place to allow for effective dialogue between government agencies and VSOs; and the extent to which power imbalances hinder these relationships.

As a first step toward answering these questions, it is necessary to distinguish the types of relationships that exist in the sector. For this we will use Dennis R. Young's typology of state/voluntary sector relationships at the national level in the U.S. (1999: 33) Young proposes these relationships be divided into three broad categories. What he calls the "adversarial" model is one where the main objective of the VSO is to pressure government to make public policy changes it considers necessary or advisable. This is typical of what have traditionally been called "pressure groups" or "lobby groups" in the literature. (See for example Pross, 1986) What Young calls the "complementary model" is one where VSOs – he uses the term "non-profit organizations" – are seen as extensions of government, in that they deliver programs and services financed by governments according to criteria and conditions established by government. Finally, the "supplementary model," is one where the VSO fills a gap that the state, for whatever reason, either can not or will not fill itself.

Interestingly, Young's typology corresponds quite closely to the one proposed by Coleman and Skogstad some years earlier to describe different types of policy networks: "pressure pluralism" (adversarial model), "state-directed networks" (complementary model), and "clientele pluralism" (broadly, supplementary model). (Coleman and Skogstad, 1990: 26-30) We will draw from both in applying these three categories to the public health sector in Canada.

1) The Adversarial Model

In this instance, the ultimate objective of the VSO is to influence public policy in a way to advance its particular cause. However, the use of the term "adversarial" can be misleading, since the relationship with the government agency can be positive as well as negative. The state agency can not control this type of VSO, but it may well be sympathetic to its objectives and at times even lend some form of "moral" support. In this model, whether by choice or necessity, the VSO is not dependant on the state agency for financial support or other resources. While financial independence frees it from "the 'whims and rules' of the funding agency," (Grieve, 2003: 117) it could also mean that the organization pays a high price for its "freedom," in that it lacks the resources to be effective in advancing its cause. We include in this category VSOs which receive no

funding or direct assistance from PHAC or Health Canada, as well as the larger VSOs who may receive some support from those agencies, but whose funding base is so large and diverse (including from different sources within the federal government) that this support does not put them in a position of dependence. On the other hand, the relationship inherent in the adversarial model is such that it tends to put considerable distance between the VSO and the public policy development process.

Without attempting to claim that these are necessarily "representative" – an impossible claim to make in the absence of a systemic study of all VSOs involved in public health in Canada, a truly mammoth task – the examples below are meant to illustrate these types of relationships.

**Prevention of Violence Canada**

POVC is a network composed of a range of stake-holders which include governments at the local, regional, provincial/territorial, and to a lesser extent, federal representatives, provincial and territorial public health associations, other VSOs, research organizations, individual university researchers, and private sector parties. Although its roots go back to the mid-1990s with a position paper by the Canadian Public Health Association titled *Violence in Society: A Public Health Perspective*, it was initiated by a resolution at the 1998 Ontario Public Health Association to create a violence prevention workgroup with a view of raising consciousness about the importance of violence prevention as a public health issue. Since operating at the provincial level was felt to be inadequate, the initiative was then raised to the national level through a resolution passed by the Canadian Public Health Association (CPHA) in 2004. What emerged was a coalition of members which met through "town hall" meetings, often as part of the CPHA's annual conference, the first being held in 2005. There were also a series of meetings of the Steering Committee, as well as six workgroups, which met primarily through teleconferences, and e-mail. Although the goals of the initiative varied somewhat over the years, the Fifth Annual Town Hall meeting (2009) identified its goals as: developing a national violence prevention strategy for Canada; garnering support for a public health approach to violence prevention; putting violence prevention at the same level of priority as law enforcement; developing a methodology to measure results. (POVC, 2009) There is no dedicated secretariat and the co-chairs take their role on a rotational basis. The POVC actively draws from the international community, adopting the WHO *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health* as the framework for the national violence prevention strategy. (POVC, 2009.)

The POVC is an advocacy organization; it does not seek a programmatic role for itself. The funding it seeks to support violence prevention, largely from the Public Health Agency of Canada, is intended for organizations working in the area, depending on the nature of the activity, rather than attempting to carry out the activities itself. Over the years, it has received small amounts of funding to allow it to stage a town hall meeting, to allow its members to travel to some international meetings, or to cover the costs of some teleconferences for its members. The level of funding received, however, was not

significant or regular enough to compromise its independence. However, the key informants interviewed felt quite distant from the government apparatus and the public policy-making decision-making process. (Interview #1, July 12, 2010; Interview #2 July 2010) Indeed, a good part of their advocacy work revolved around strengthening their relationship with the federal government agencies, so that it could have a stronger role in the policy process as it relates to the prevention of violence. (Interview # 1)

Federal representatives, primarily from the Public Health Agency of Canada, have provided "moral support" to the POVC, and at times have provided advice to POVC leaders on strategy and tactics, while at the same time abstaining from voting on initiatives, conscious of their ambivalent status. Representatives from provincial and territorial governments also participate in POVC discussions, which are less problematic for provincial/territorial representatives, since the network primarily seeks to influence policy primarily at the federal level.

**Safe Communities Canada**

Safe Communities Canada is a national VSO that was established with the objective of building capacity in communities across Canada to mount coordinated and collaborative injury prevention campaigns. Its core programme is the Safe Community "Designation," by which it recognizes communities which are addressing injury prevention in an effective way. In addition, it also produces a "National Report Card" which provides a national profile on injury prevention and individual community score cards by which those in the network of Canadian Safe Communities can measure their standing vis-à-vis the national profile. It is also active internationally as an accredited certifying centre for the WHO Collaborating Centre on Community Safety Promotion.

Historically, Safe Communities Canada has not received significant funding from the federal government. Its financial support derives from essentially three sources: project grants from provincial workers' safety boards (47%); contributions from the corporate sector (23%); and sales of products and tools to provincial agencies and foreign countries, such as Australia (30%). Although its main focus has been at the programmatic level, Safe Communities Canada has come to the conclusion that it needs to have much more impact at the national policy level. As a result, it entered into discussions with the three other major injury prevention VSOs – Safe Kids Canada, Smartrisk, and ThinkFirst Canada – to discuss the possibility of merging into a single organization. The motivation for this integration is precisely to be more effective at engaging the federal government in policy discussions, with the objective of establishing injury as a stand-alone health category, which the organizations believe is not now the case. The new organization would be expected to compete more effectively with other public health VSOs for the attention of federal government agencies, such as Health Canada and PHAC, including the opportunity to receive funding from those agencies. Ideally, the new organization would eventually find itself in a position of participating in joint planning and decision-making processes with the federal government.

Although Safe Communities Canada has maintained its independence from the federal government, and therefore its ability to take the policy positions it considers appropriate, its formal relationship with that government is sub-optimal. (Interview #3, July 14, 2010) Specifically, its ability to enter into policy discussions is at best sporadic. The government's decision, announced in the March, 2010 Speech from the Throne, to fund an national strategy on childhood injury prevention, while providing some modest funding to the organizations, has not led to any significant changes in the relationship between these groups and the federal government. (Interview # 4, March 2, 2011) The decision of the four injury prevention groups to even discuss seriously the possibility of merging into one can be seen as an eloquent expression of the perception of these organizations that they are marginalized in the policy process. The possibility of integration with others is no doubt a painful decision for many in those organizations, implying as it does not only having to abandon their respective institutional "brand," but also that several staff positions will be affected, starting at the top, where three individuals would have to relinquish their leadership positions in favour of the fourth. Although these efforts ultimately may or may not ultimately bear fruit, the incentive to seriously consider taking this step would need to be very powerful, demonstrating that for these groups, the *status quo ante* is seen as being unacceptable.

2) The Complementary Model

In the complementary model, the relationship between the state and the VSO is one in which there is a clear power imbalance, with the state being the dominant actor. In these cases, the state agency maintains its control, consciously or otherwise, through the use of financial transfers. As Phillips and Graham observe: "Governments tend to assume that "the weight of their dollars give them the authority to dictate accountability mechanisms and policy directions, rather than to negotiate them." (Phillips and Graham, 2000: 180) With the federal government, financial transfers generally take two forms: grants and contribution agreements. The former is meant to refer to transfers where there are fewer conditions and less onerous reporting requirements than in the case of contribution agreements. In reality, the two mechanisms often resemble each other, with more conditions attached to grants than might normally be expected. (*Blue Ribbon Panel on Grant and Contribution Programs*, 2006: 3) Although care is taken to avoid a principal-agent relationship in the strict sense, (see Salamon, 1999: 349 for a discussion of this relationship), the funds are provided to a VSO as part of a policy or programme objective the government wishes to pursue.

Because many VSOs in this situation essentially depend on government transfers to remain in existence, the priorities and original mandate of the organizations can easily become distorted as they pursue government funding opportunities. (*Broadbent Report*, 1999: 5) Over the long term, this tends to diminish the independence of an organization that falls within this category, as it begins to resemble "a quasi-governmental entity." (O'Connell, 1996: 224) In such instances, the VSO risks losing credibility in the eyes of other VSOs as well as with of its own members. (Pross, 1986: 198; Interview # 5, Sept. 8, 2011; Interview # 6, June 23, 2010)

As stated earlier, the tendency of VSOs to be more tightly controlled by the state has probably increased since the mid-nineties. While VSOs are often quite creative in finding ways to express their views on policy issues, directly or indirectly, dependence on government funding remains an inescapable factor in shaping their relationship with government and ultimately to the broader VSO community. This is in particular the case with smaller organizations dependent primarily on one revenue source. Even in the case of the Voluntary Sector Initiative (VSI), a joint federal government-voluntary sector intervention which was designed to reflect a spirit of partnership and horizontality, the accountability mechanisms in the contracting arrangements essentially undermined the collaborative aspect of the relationships. (Phillips, 2004: 13)

Examples of VSOs in the public health sector which fall in this category include the multitude of organizations receiving funding under the PHAC's community-based programs, such as the Community Action Program for Children (CAPC), and the Canada Pre-natal Nutrition Program (CPNP). CAPC and CPNP - which are PHAC's largest contribution programs by a considerable margin, with annual budgets of $55M and $26M respectively - are structured to involve consortia of local organizations to engage in a range of initiatives to improve the circumstances of children at-risk. Organizations involved might be hospitals, housing corporations, service organizations, professional associations, and many others. Large organizations can be involved, but the majority tend to be relatively small community organizations. Although a high percentage of these groups receive funding from other sources, the federal government funding is often seen as the centre-piece around which other funding is assembled. (Interview # 7, July 20, 2010) In many cases, without the funding from PHAC, they would cease to exist.

The point is not that these organizations necessarily feel frustrated that they do not have a stronger role in the policy process. In many cases, their primary goal is to provide a service they consider important and beneficial, not to participate in policy discussions. In general, however, what these relationships reflect is a significant power imbalance in favour of the state. The fact that most of the funding agreements are of short duration – recently they have been held to one-year or two-year renewals - serves only to underscore the unbalanced and rather limited nature of these relationships.

3) Supplementary Model

As referenced earlier, Young describes this model as one where outside agencies perform a role or provide a service that the state agency either will not or can not provide. In these cases, the level of the relationship may be on a much more equal basis than is the case with the complementary model. The VSO may be dependent on the state agency for financial support, but at the same time, the state agency is dependent on the expertise and resources that the VSO possesses. Entering into such relationships may be viewed as an admission by the state agency (sometimes grudgingly made) that it does not possess the knowledge or capacity to carry out a particular activity or strategy. In such cases, the role of the state agency is quite circumscribed, largely restricted to providing funding, and allowing the VSO a greater than usual amount of discretion with the use that funding.

Using the terminology described earlier, the VSO involved in such a relationship is acting more in terms of a "sub-government" than as a member of the "attentive public."

Interestingly, this type of relationship is both young and old in the health sector. In the early part of the twentieth century, for example, many health institutions in some provinces, such as TB sanatoriums and hospices, were left to the private sector, particularly faith-based organizations, to administer. (Rutty and Sullivan, 2010: 3.7) Similarly, Catholic and Anglican missionaries were also left to operate small hospitals in the North. The more modern manifestation of this model, however, provides an interesting and promising departure from the more conventional models. Two recent cases can be made to illustrate this point.

**Canadian Partnership Against Cancer Corporation (CPACC)**

The origins of the CPACC date from 1999, when four leading organizations decided to collaborate to develop a strategy against cancer. These organizations were: the Canadian Cancer Society; the National Cancer Institute of Canada; The Canadian Association of Provincial Cancer Agencies; and Health Canada. This collaboration, which also involved a large number of smaller cancer-related organizations in Canada, led to the development of the Canadian Strategy on Cancer Control (CSCC), which was finalized in 2006. A decision was made in that year by the Government of Canada, to provide funding ($287M over 5 years) to the CPACC to implement the CSCC. The CAPCC does not include a direct service delivery capacity, since this falls in the jurisdiction of provincial governments. Furthermore, it does not seek to address the entire cancer control universe. Rather, the CSCC is a knowledge-based strategy whose purpose is to "maximize the development, translation, and transfer of knowledge and expertise across Canada." (*The Canadian Strategy for Cancer Control,* 2006: 4) The CSCC works on the basis of eight strategic priorities: primary prevention; screening/early detection; surveillance; development of evidence-based diagnostic and treatment standards; clinical practice guidelines; research; health human resources; and patient-centred support. Once the decision was made to fund the CSCC, CPACC incorporated as a non-profit organization, led by a Board of Directors of between 15 and 18 members, which include a broad constituency of VSOs, as well as federal (1 seat on the board) and provincial/territorial government representatives (5 seats on the board, in addition to Quebec, which has an *ex officio* representative).

The CPACC model is a major departure from either from the adversarial model or the complementary model. In his case study of the CPACC, Michael Prince described the Cancer Strategy as "a platform for communication between governments, non-government agencies, health professionals, and cancer survivors and families" as well as "an opportunity to modernize the management of chronic diseases and to further democratize the conduct of intergovernmental relations." (Prince, 2006: 468) In fact, the CPACC's mandate goes well beyond this. The CPACC is a case where the VSO, as a result of a decision made by Cabinet, has been given policy authority and financial resources to implement a national cancer prevention strategy. In a sense, CPACC represents a case where the tables have been turned on government agencies. Health

Canada and the Public Health Agency of Canada often find themselves in the position of participating, not as parties with a stronger role than any other organization, but as one among many other parties. If either agency has a particular interest in one of the eight strategic priorities, or in a sub-strategy within them, it may decide to participate more actively by contributing funding for a particular purpose. This was the case recently when PHAC and Heart and Stroke Canada contributed funding to CPACC for the Collaboration Linking Science and Action (CLASP) programs to integrate cancer and other chronic disease prevention programs. Because they were providing funding, both organizations received a seat at the table to participate in steering those programs. As if to underline further the non-hierarchical relationship between the two, CAPCC and the Health Portfolio (Health Canada and the Public Health Agency of Canada), have been instructed, where there are instances of joint interest, to ensure the actions of one informs the other.

Although funded by the federal government (primarily Health Canada) and reporting to the Minister of Health, the CPACC clearly enjoys a considerable amount of autonomy from the government. The fact that the government's funding commitment was over a five-year time horizon, and can be extended, further reinforces this level of autonomy. CPACC was also given the authority to provide funding to third parties, thus conducting its own calls for proposals, and the flexibility to reallocate funding across priorities. (Interview #10, September 27, 2010) Instead of a power imbalance in favour of the state agency, as in the other two categories, the establishment of the CPACC represents an attempt to establish a radically different type of relationship.

There has been some speculation about the motives behind the federal government's decision to establish and fund the CPACC as it did. Prince suggests that the Strategy may have been a response to public pressure for federal and provincial governments to work more closely together on cancer control and other health issues. If true, this would be somewhat ironic, since provincial governments were less than enthusiastic about the establishment of CPACC, mostly because this represented a disease-specific strategy. However, provincial and territorial governments consider generic "common risk-factor" strategies to be more effective and sustainable, as do many public health professionals. Prince also suggests that the reports from the Kirby Senate Committee and the Naylor Report, (Discussed in chapter 4) as well as the report from the Romanow Commission may have contributed by adding pressure to the calls for reforms to health care policy, delivery and governance in Canada. (Prince, 2006: 471) Whether the motivations were policy or political, the fact that all three major political parties supported the CSCC in the 2006 election campaign suggests a consensus that the existing governmental apparatus, for whatever reason, was not capable of achieving the goals of a national cancer strategy as successfully as a VSO operating at arm's length. In the end, the fact remains that what was created was a significantly different model from what has typically been the case in public health.

**The Mental Health Commission of Canada**

The Mental Health Commission of Canada (MHCC) is in many ways similar to the CPACC, but stops short of going to that extent. The MHCC stemmed out of the recommendations of *Out of the Shadows at Last,* a voluminous report produced by the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senators Michael Kirby and Wilbert Keon. The recommendation to establish an arm's length commission to focus on mental health was accepted by the federal government, with the support of provinces and territories. The MHCC was established as a non-profit organization in 2007, with four major goals in mind: to act as a catalyst for reform of mental health policies; to act as a facilitator, enabler, and supporter for a national approach to mental health; to work to diminish the stigma and discrimination associated with mental illness; and to disseminate evidence on all aspects of mental health to governments, stake-holders, and the public. It is funded over ten years, with the possibility of renewal beyond that period.

Since its inception, the MHCC has worked on developing a mental health strategy, which it is doing in two stages. In the first stage, it developed a framework for such a strategy, titled *Toward Recovery and Well-being,* which was released in November, 2009. The second stage consists of developing a comprehensive strategic plan for how to achieve the framework. In addition, it is working on developing anti-stigma initiatives; conducting research demonstration projects on homelessness issues; engaging in knowledge exchange; and developing a network of partners in the mental health area.

There are similarities between the MHCC and the CAPCC in that in both cases the government considered it necessary to go outside the formal bureaucracy to accomplish its objectives in these areas. More specifically, the government considered that it lacked the capacity, or was not strategically placed, to deal effectively with the issues of cancer prevention or mental health respectively. The MHCC falls short of the CAPCC mandate in that it is charged only with developing a mental health strategy, and did not receive the policy authority or the funding to implement this strategy, although it is conceivable that this could be viewed as a next step. Furthermore, the MHCC did not receive a mandate from Cabinet, but was established using the Prime Minister's prerogative. (Interview # 8, April 1, 2011) Still, it represents a departure from the more typical relationships represented by the "adversarial" and "complementary" categories. To begin with, its agreement with Health Canada that it will not engage in advocacy differentiates it from the "adversarial" category. While this can be seen as a restriction to its activities, it is more significant in underlining that rather than being on the outside advocating for changes, it is a central part of the public policy apparatus dealing with a difficult issue. In other words, it is not an outsider looking in, but rather the other way around.

Second, while the MHCC receives its "core" budget from Health Canada, its ten-year mandate, as well as the latitude it has received to develop a framework and a strategy for mental health, does not reflect the same type of power imbalance as in the case of organizations in the "complementary" category. Similar to the CPACC, it acts as a funding agent in its own right, providing funding to other VSOs in the mental health area. Furthermore, as with the CPACC, government departments, such as PHAC and Human Resources and Skills Development Canada have provided funding to partner for specific

projects, but in these cases, it is the MHCC, and not the government department, that is the "senior" partner. While not being as ground-breaking as in the former case, the MHCC remains significant in that it establishes the basis for a different relationship between the state agency and the VSO. Perhaps the best indicator of the "out of the box" nature of both the CPACC and the MHCC is that central agencies, such as the Treasury Board Secretariat, are reported to have expressed a considerable amount of concern and even discomfort about the terms for the establishment of both entities. (Interview # 8, April 1, 2011)

4) Hybrids

Categorizing the many relationships that exist in the public health sector runs the risk of over-simplifying what are often very complex situations. As Young acknowledges, the categories above should not be seen as mutually exclusive. Many combinations and permutations can and do exist in the "real" world. We will look at just two such examples.

Peter Tsasis conducted a case study of the **Canadian Strategy on HIV/AIDS** during the 2000-04 period. At that time, five national VSOs formed a coalition for the purpose of delivering Health Canada's HIV/AIDS program. Each organization was dependent on federal government funding, as that represented over 50% of the total budget of each . The author makes a convincing case that a significant power imbalance existed in that relationship, which was used by Health Canada to "exercise power in many integral facets of their activities." (Tsasis, 2008: 271) He goes on to say that while Health Canada referred to the arrangement as a "partnership," from the perspectives of the VSO participants, the power imbalance inherent in the relationship made it a "pseudo partnership." (Tsasis, 2008: 273)

Tsasis shows that over time, the VSOs were able to neutralize, to some extent at least, that imbalance by forging strong relationships between each other, and drawing on the social capital they had built as a result of their activities at the community level. Tsasis concludes from this that "a dependent organization can gain leverage over the dominant organization by co-opting actors who can constrain, through their influence, the actions of the dominant organization in a way that favours the dependent organization." (Tsasis, 2008: 285) In the end, however, although the VSOs were pushing back against Health Canada's dominance, their actions were essentially defensive in nature, and did not alter the fact that what was involved was at base an "us" and "them" relationship, seemingly based on a lack of trust.

Malcolm Grieve's case study on **Canadian Breast Cancer Initiative** provides an interesting example of supplementary and complementary models co-existing within the same policy community. In this case, Grieve sees a hierarchy in the networks that are involved in this issue. On one side are the members of an "epistemic" community, that is, professional organizations and research institutions which are involved in breast cancer, such as the Canadian Cancer Society, the National Cancer Institute of Canada, and the Medical Research Council (now the Canadian Institutes for Health Research.)

Grieve uses the Coleman and Skogstad terminology, described above, to categorize the relationship between these groups and Health Canada as an example of "clientele pluralism," (what we have called, using Young's terminology, the supplementary model). The basis for this categorization is that they offer a resource – knowledge – which the state can not easily provide itself. (Grieve, 2003: 105) This relationship is characterized by the presence of long-established groups from the medical profession which have a previously established relationship with government officials, in this case Health Canada. In many cases, individuals from both sides will have partnered in the allocation of funds, and participated together on peer review panels. (Grieve, 2003: 105)

On the other side are voluntary sector representatives, in particular those involved in the Canadian Breast Cancer Network. In contrast to the professional groups, Grieve describes the relationship in these cases as being more characteristic of the complementary model, that is, essentially acting as delivery agents for the state. Rather than being part of the "sub-government," as was the case with the professional organizations, these tend to be confined to the role of the "attentive public," whose main levers to influence policy is through the media. (Grieve, 2003: 105) What emerges from this is a complex picture where there are different levels of inclusion within the same policy community, between those who have a previously established relationship to government and those who must play on the margins. Based on the proliferation of groups, leading to further fragmentation of views and competition, rather than collaboration between them, and a weakening relationship between the government and the Canadian Breast Cancer Network, Grieve sees reasons to doubt the long-term influence of the voluntary sector in this area. (Grieve, 2003: 120)

Conclusions – A base to build on?

The picture of the relationships between the government and the voluntary sector in the public health field is thus a complex one. How does one put this in perspective and what does it this mean for the prospects for network governance? Returning to Phillips' point about the need to shift from governing by programming to governing by relationship-building, one can legitimately ask how far we have progressed down this road. Our conclusions will need to be tentative, in part because, as Klitgaard and Treverton have noted, "we are not even close to having a model to assess partnerships." (2004: 50) Still, some preliminary observations are warranted.

First, the adversarial model represents only a very weak form of collaboration, if indeed it is one at all. In these cases, neither the state party nor the voluntary sector party is committed to working together, although this can change if the government decides to commit to a particular objective or course of action. Although there may in some instances be joint tables or fora, these will tend to be more informal and *ad hoc*, unless the organization has an independent funding source. There is far less possibility that there will be an agreement on joint planning and activities. There may be participation of government officials in some discussions led by the VSO, as we have seen, but the conflict in roles will inhibit full participation by the government representative. In this

model, the VSO will be in the position of the "attentive public," with very few levers to effectuate policy change.

The complementary model, by which the state will attempt to achieve its policy objectives by using the voluntary sector as its delivery vehicle, is different from this in the sense that it is based on a formal relationship, usually with fairly rigid accountability requirements. The state agency and the VSO will have agreed to some common goals which the VSO will carry out with agency funding. The VSO, if it is creative, can enjoy a fair measure of autonomy, which from a legal liability perspective, the government will seek to encourage. (Interview # 9, Sept. 23, 2010) Whether this remains ultimately a principal-agent relationship can be debated, but the fact remains that this is a relationship of dependency favouring the government party. The power imbalance implied in such a relationship is hardly conducive to trust-building or collaboration.

CPACC and the MHCC, as the clearest examples of the supplementary model, seem to go furthest in levelling the playing field. Although funded primarily through the federal government, they function in a sub-government capacity, each acting as a third-party funder while maintaining an arm's-length relationship with government. It is possible that the CPACC/MHCC model may simply have turned the complementary model on its head. Instead of the VSO party being the junior partner to government, it is now the VSOs which are in the driver's seat with the federal government party confined to a secondary role. Interviews with key informants about the CPACC, however, suggest that the relationship in this case appears to be evolving. (Interview # 10, Sept. 27, 2010; Interview # 11, September 27, 2010; Interview # 12, Sept. 23, 2010) Whereas in the first years, both parties seemed to be eager to keep each other at a significant distance, more recently some joint activities have been initiated, as with the CLASP initiative mentioned above. Something similar may be occurring with the MHCC. How these relationships will evolve still remains to be seen, as does the question of whether the government will choose to replicate this model more widely. It does, nonetheless, create the potential for a qualitatively different type of relationship which is more consistent with modern governance than what has previously been established. To use Phillips' criteria, cited earlier, these appear, on the surface at least, as examples of relationship-building involving "collaboration, co-ordination, responsiveness, and flexible accountability."

Aside from the two cases mentioned above, the overall picture that emerges regarding the relationship between the government at the national level, primarily the Public Health Agency of Canada and Health Canada, and the public health voluntary sector can be described as follows:

1) There is a considerable amount of diversity in this area, with a number of different arrangements that have been negotiated over time. Moreover, there does not appear to be an overarching strategic approach or framework to guide arrangements with the voluntary sector. Instead, such relationships seem to emerge on a case-by-case basis, depending on the circumstances. Some key informants with which we spoke suggested that the nature and level of engagement with VSOs was often dependent on the personality and

inclination of the senior official responsible for that area. (Interview # 13, Feb. 17, 2011; Interview # 14, Feb. 15, 2011)

2) The relationships are typically characterized by a distinct power imbalance between the government agencies and the VSOs. The adversarial model and the complementary model are not such as to allow for joint planning or inclusive policy making discussions, and thus tend to keep VSOs on the margins of the development of public policy.

3) There is a lack of a mechanism to nurture relationships with the voluntary sector, and to conduct a systematic and transparent review of these relationships to determine their level of effectiveness and satisfaction from the perspectives of the parties involved and to learn from these experiences. Health Canada did conduct a survey on "stakeholder discussions" in 2010, but this was not made public and was carried out as a "one-off" initiative. (Interview # 13, Feb. 17, 2011)

We seem, then, to be some distance away from a clear direction toward governance by relationship building. Although partnerships are frequently referenced by the government agencies as being central to public health (see for example, *Report of the Chief Public Officer of Health*, 2008: 8), the reality, as least in relation to VSOs, seems to fall far short of this vision. This is not to be unduly critical of the PHAC or Health Canada. As stated, there is a large number of VSOs involved in public health, making the challenge of how to build and maintain effective relationships rather daunting. It may well be that the public health sector has gone further than most in including outside parties in its activities. Yet, much more remains to be done if governance by relationship-building is to be realized. CPACC and MHCC may provide a platform on which new relationships can be developed. There is a need to find mechanisms that are less one-sided and that will involve VSOs more meaningfully in the public policy process. This will not be easy to accomplish within the context of the Government of Canada's overall relationship with the voluntary sector. Without those steps, however, the opportunities of realizing appropriate forms of network governance in the public health area will be lost.

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