Intersections and Innovations

Change for Canada's Voluntary and Nonprofit Sector

The Muttart Foundation

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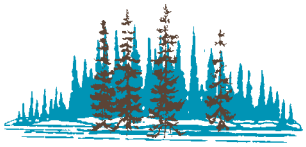

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Acknowledgements

For far too long, Canada has lacked a comprehensive resource examining Canada's charitable sector. That has now ended.

The Muttart Foundation has spent many years focusing on building the capacity of charities in this country. The publication of this collection is another contribution to that effort. By understanding more about itself, the sector can continue to develop and find new ways to serve Canadians and those in need outside our nation.

The authors of these essays bring different perspectives on the role and inner workings of Canada's charities. Collectively, they bring an unprecedented insight into the work of organizations whose diversity is exceeded only by their desire to serve.

It is difficult to express adequate appreciation to Dr. Susan Phillips of Carleton University for her leadership of this project. She has been a source of encouragement, persuasion, cajoling and improving authors from across the country. Her efforts now bear fruit as we make this material available to students, academics, practitioners and others interested in the history and future of Canada's charities.

Amanda Mayer of the Lawson Foundation volunteered at the outset to be the administrative overlord of the project, keeping the editors and authors up to date and keeping track of various versions of articles. We are so grateful for her skills, her patience and her friendship.

None of this would have been possible, of course, without the work of authors, themselves academics and/or practitioners. They took time from their schedules to contribute to a resource we hope many will find valuable.

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The work of all of these individuals has come together in this resource which we dedicate to all of those in, or interested in, Canada's charitable sector.

Malcolm Burrows, President

Bob Wyatt, Executive Director

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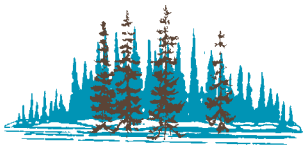

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Intersections with Governments: Services and Policy Engagement

Chapter 27

Transforming Health and Social Services Delivery Systems in Canada: Implications for Government–Nonprofit Relations

Rachel Laforest
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In today's world, policy problems are increasingly intricate and call on all sectors of the economy for solutions (Ansell & Bartenberger, 2017). Not surprisingly, service delivery systems have come to rely on a complex mix of networks and providers from the public, private, and nonprofit sectors (Hofstad & Torfing, 2016). In Canada, significant reforms of service delivery systems are currently underway in areas of health, housing, immigration settlement, employment services, and child and family services. These reforms, which call for greater horizontal integration of services, reflect a shift away from the "new public management" (NPM) paradigm toward that of "new public governance" (NPG). This significant change in public-administration paradigms is occurring in the context of increased competition for public resources and is driving pressures for performance and accountability across service delivery systems. As a result, governance processes are in a moment of transition as the ebb and flow of political and institutional changes are restructuring the funding and the delivery mechanisms of social services.

The latest health and social services models recognize the interconnectedness of people's often complex needs and focus on inter-organizational and inter-sectorial collaborations in policy development and design (Osborne, 2006). Across provinces, these shifts in governance processes have had a significant impact on the nonprofit sector. Nonprofit organizations, however, are not merely passive subjects of these changes; they are themselves active partners in the process of seeking to shape delivery mechanisms and, ultimately, improve the quality of patient outcomes. With federal and provincial governments under pressure to do more with less, the tools of collaboration are increasingly innovative, providing more opportunities for real power-sharing and engagement.

This chapter proceeds in three parts. First, we start with an overview of the legacy of new public management and the changing role of the nonprofit sector. We then situate these changes in the context of health- and social-services-delivery systems in Canada. Our focus is on the evolving nature of government–nonprofit relations in welfare provision. Second, we turn to an overview of the literature on new public governance to identify broad trends in modes of collaboration that are emerging between government and nonprofits. The final part looks more specifically at provincial dynamics to identify NPG dynamics in practice. Because health and social services are areas of provincial jurisdiction, there is bound to be some variation in the implementation of these new governance reforms. We examine the discourses and broad practices of governance across provinces to begin to draw a detailed picture of the opportunities and challenges for nonprofit organizations that might arise from a shift toward NPG processes (Voorberg, Bekkers, & Tummers, 2015; Emerson et al., 2012; Fung, 2007). The analysis is supplemented by semi-structured interviews conducted with senior civil servants in the field of health and social services in seven provinces. While there is evidence that new collaborative ways of engaging nonprofit organizations as partners and co-creators of policy are emerging, we still know very little about how these changing delivery systems will affect nonprofit organizations (Torfing, Peters, Pierre & Sørensen, 2012). We hope this chapter begins to fill that void.

The Legacy of New Public Management in the Field of Health and Social Services

Nonprofits have long been recognized as playing a prominent role in service delivery (Weisbrod, 1975; Hansmann, 1987). In 1987, Salamon was the first to point out that nonprofits had become third-party agents delivering services funded through programs steered by governments. Smith and Lipsky's *Nonprofits for Hire* (1993) also detailed how government contracting had shaped and transformed nonprofit organizations into agents of the state, or "street-level bureaucrats." They noted that nonprofits had to adjust their internal priorities and management practices to meet government demands. The management of the relationship between government and nonprofits can have a significant impact on the nonprofit sector. These government practices were informed by NPM scholarship and discourses (Pollitt & Bouckaert, 2011).

New public management emerged in the mid-1980s as a new approach for public administration (Hood, 1991). Although it was not a coherent paradigm, many governments at the time were facing severe economic constraints and recognized that welfare services couldn't continue to grow at the same rate of the past two decades. Instead, public management needed to be improved to gain more efficiency and effectiveness from the services provided. NPM was appealing because it embraced private-sector management practices and the creation of quasi-markets (Osborne, 2006). Under NPM, competition and market forces were viewed as the best mechanism to drive these delivery systems. To create a market for service provision, many governments introduced competitive tendering processes, which led to significant outsourcing and privatization of public services.

This paradigm provided a financing and delivery model that allowed governments to "steer" and set policy direction through performance agreements while relying on a vast network of partners within the community to "row" and deliver the services (Hood, 1991; Osborne & Gaebler, 1992). With the introduction of greater competition, governments determined who could provide services most cost-effectively. Competitive tendering and contracting arrangements also imposed strict top-down accountability pressures on both private- and nonprofit-sector organizations through performance management systems (Pollitt, 2005). As van Gestel et al. suggest (2019: 59), "The NPM model strongly emphasizes the use of targets, performance indicators and measurement to specify the desired output of government, or of the services that have been delegated to public or private agencies."

For the nonprofit sector, the widespread adoption of NPM instruments and techniques meant that private sector practices and values would become more prevalent and embedded in the service delivery systems. As a result, many researchers observed a professionalization and bureaucratization of nonprofit organizations (Suárez, 2011; Hwang & Powell, 2009; Smith & Lipsky, 1993). In many respects, the nonprofit sector was susceptible to these shifts in management practices because organizations are highly dependent on governments for funding.

In Canada, the majority of provinces adopted NPM reforms in the 1990s in a bid to improve responsiveness, efficiency, productivity, and the quality of health and social services (Aucoin, 2012). Many moved toward a regionalized model in an attempt to reorganize the structure of their delivery systems (Philippon & Braithwaite, 2008; Kouri, 2002; Marchildon, 2005). According to Barker and Church (2016: 334), "The proposed reform, adopted by nine of the ten provinces, involved a bold scheme to decentralize responsibility for the administration of major health programs and to centralize authority over the operation of these same programs by eliminating hospital boards and other local health agencies." Indeed, most provinces established semi-independent regional health authorities (RHAs) to be the hubs in the delivery of health and social services. When Alberta, which was the first to adopt a regional model, initiated consolidation in 1989, it had more than 200 governance structures in the field of health and social services. Saskatchewan had 400 local health boards in 1990; New Brunswick had 51 separate hospital boards in 1992, and Quebec had 146 local community service centres (CLSCs) by the mid-1990s – to give a few provincial examples.

The original intent of regionalization was to separate policy-making (steering) from implementation in a typical NPM fashion. By allowing partners within a region to collaborate, governments hoped there would be more opportunities to foster greater integration of services and be more responsive to local needs. However, the top-down accountability requirements and the inherent competition among organizations for contracts became barriers to coordination across the system. Through competitive tendering processes, an RHA could identify who was best suited to deliver services (Abelson et al., 2004; Marier, forthcoming). Although service delivery was devolved through contracting out to both the private and nonprofit sectors, the open competitive bidding process benefited private sector organizations. It undermined the privileged role nonprofit organizations had come to play in these delivery systems (Jenson & Phillips, 2000). Not surprisingly, the reforms failed to fulfill their promises, particularly in relation to accountability and citizen participation (Barker & Church, 2006).

The multiple, at times overlapping, funding arrangements meant that there were often competing values driving the regionalization process, from cost reduction to efficiency and effectiveness. With a complex mix of actors involved at different points in service delivery, provinces across Canada had, in effect, developed a fragmented and highly disjointed system. According to Fafard, "there has been a mish mash of 'indicators,' 'targets,' and 'benchmarks' suggesting confusion over the nature and goals of the performance management regime" (Fafard, 2013: 39). For example, it was not uncommon to have upwards of 22 different activities or programs delivered through at least nine distinct organizations, supported by seven different funders – all within one community. This complexity alone created redundancies and inconsistencies in assessments and treatment approaches (Kania & Kramer, 2011).

The fragmentation also created important gaps in services. Users could access health and social services through different access points and, as a result, faced different eligibility requirements. The point of access for services not only had an impact on the quality of care, with implications for equity of care, but the lack of consistency also created prolonged waiting times in service transition and greater stigmatization of users in some services. A representative from the Newfoundland and Labrador Department of Children, Seniors and Social Development echoes these views:

> We had concerns about accessibility, stigma, equality of care in some instances. People didn't know how to navigate the system. They didn't know how to receive the services. People within healthcare didn't always know how to refer to mental health and addictions. There were many different points of entry into this system, and the waitlists, in many instances, were prohibitive. So, we really needed to take a broader approach. There is much focus on looking at integrated service delivery models now for young people so that they can access services easier. (Interview conducted March 1, 2018)

Other respondents I interviewed highlighted similar trends in client feedback: difficulties and confusion in accessing services when needed, gaps in service transition, redundancies and inconsistencies in assessments and treatment approaches, and ongoing issues with stigma.

By the early 2000s, NPM approaches had come under increased scrutiny. As Osborne has noted (2010: 1–2), "the time of the New Public Management (NPM) has in fact been a relatively short-lived and transient one between the statist and bureaucratic tradition of Public Administration and the embryonic plural and pluralist tradition of the New Public Governance (NPG)." Indeed, at least in the case of Canada, the policy terrain on which health and social delivery systems had developed had increased substantially in complexity.

Dynamics of New Public Governance in the Field of Health and Social Services

Internationally, scholars of public administration were recognizing that the field of governance was changing profoundly (Rhodes, 2000; Newman, 2001). NPM and the contract culture had created an increasingly fragmented and disjointed policy environment. As Osborne (2010) contends, NPG is both a product of and a response to this increasingly complex, plural, and fragmented nature of service delivery. Much like NPM, there isn't a broadly agreed-upon definition of the NPG paradigm. Collaborative governance refers broadly to "the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres" (Emerson, Nabatchi, & Balogh, 2012: 2). What distinguishes NPG from NPM is the emphasis on a horizontal or networked approach to coordination (Brandsen & Johnston, 2018). What is more, NPG recognizes the intrinsic value that nonprofit organizations bring to service delivery, such as their knowledge of and proximity to distinctive user groups, their ability to tailor services to user needs, their flexibility and ability to innovate, and their ability to mobilize community (Pestoff & Brandsen, 2010).

Rather than taking a command-and-control approach to engaging the nonprofit sector, NPG tends to be more open to experimenting and collaborating in new ways. Although much of the public administration literature has focused on technical and institutional mechanisms to identify the best design that leads to collaboration (Alford, 2015; Bovaird, 2007; Brandsen & Honingh, 2015), I contend that NPG, as a paradigm, is better understood as a process rather than as a set of outcomes. Variations across policy designs can promote or inhibit collaboration, but they do not in and of themselves predetermine the outcomes. Agency (strategy and action) remains an essential variable in the analyses, as networked partners engaged in collaborative governance seek to influence the process in light of the context and of the balance of political forces. As Osborne reminds us, "such networks are rarely alliances of equals but are rather riven with power inequalities" (2010: 9). Governments play a central role in promoting collaborative governance, but whether these opportunities for collaboration are capitalized upon, and how, depends on the ability and capacity of networked partners. Collaborative governance, therefore, is a political process in that the success of collaboration depends on the actors involved, their capacity to shape the process, and, ultimately, how they negotiate their interaction with new partners.

It is also important to recognize that under the NPG paradigm, the power dynamics between governments and the nonprofit sector are changing. With NPM, governments lost a lot of internal policy capacity and must now rely on their network partners' knowledge of front-line issues (Laforest, 2013). The involvement of nonprofit organizations that are delivering programs and services has become vital to effective policy-making and delivery. In this new context, the design of governance arrangements increasingly relies on notions of consultation, communication, and local involvement. There is also a recognition of the democratic potential of these new collaborative arrangements since nonprofit organizations can bring policy legitimacy to courses of action (Rothstein, 2014; Dalton, 2004). Collaboration is viewed as a learning process with

space for adjustments on both sides. According to Torfing (2016), "collaboration tends to facilitate expansive and transformative learning, which in turn tends to spur policy innovation."

By its very nature, collaborative governance is a process fraught with tension as actors try to navigate new roles and responsibilities. Hence, it translates into very different institutional arrangements on the ground as partners try to influence the direction of collaboration. Burdened with a more complex policy environment, many provinces sought to increase coherence and coordination by consolidating local service networks and adopting a collaborative governance approach. In most provinces, a lead agency was identified in each geographical area and given responsibility for the planning of services, resource allocation, and system management to support the effective delivery of core services within the community across the continuum of services. The lead agency took many forms, depending on the jurisdiction. BC went from 20 regional boards and 82 community health councils to five regional health authorities in 2002. These RHAs were responsible for identifying their population's health needs, planning appropriate programs and services, ensuring that programs and services were properly funded and managed, and meeting performance objectives. Alberta went from 17 RHAs to nine in 2003, and then to one single authority, Alberta Health Services, in 2008. Similarly, Saskatchewan decreased from 400 healthcare boards to 12 RHAs in 2002. Manitoba established 13 RHAs in 1997, and the number gradually diminished to five following the 2012 reform. These RHAs were given overall responsibility for implementing and establishing a sustainable, integrated system of health services. Quebec went from 146 CLSCs in the late 1990s to 95 health and social services centres in 2004, and then 22 integrated health and social services centres (CISSS) in 2015. Ontario was the last province to adopt a similar approach, in 2006, with the creation of 14 local health integration networks (LHINs).

The consolidation of services at a regional level was a way to coordinate and integrate services horizontally while remaining responsive to local needs (Philippon & Braithwaite, 2008). This consolidation of local networks enabled a system-wide focus on the continuity of care, bridging the boundaries of health and social services within regional areas. A representative of the Manitoba Ministry of Families noted:

> There's been a lot of efforts in Winnipeg in particular, but across the province, to integrate health and social services at the community level. A huge restructuring in Winnipeg of how we deliver services, that began in 2004 and really has culminated in access centres in all of our community areas in Winnipeg, and the idea of colocation and case coordination, particularly on complex cases – primary care right there with income assistance. This isn't just government agencies working together; this is also community and how we can sort of integrate. Quite a few of the committees at the operational level are involved in [a kind of] intersectoral approach. (Interview conducted February 23, 2018)

A similar consolidation occurred within the nonprofit sector as well, as contracts were given to large multipurpose nonprofits willing to scale up their activities to cater to a wide range of constituencies. Nonprofit organizations merged as a means of integrating services and creating greater control over the quality of services offered (Acheson & Laforest, 2014). We see similar patterns of amalgamation in Europe (Crozier, 2010; Peters, 2011; Rothstein, 2009) and the United States (Smith & Phillips, 2016). We also see greater vertical collaboration – connecting both health- and social-care providers across institutional barriers and traditional silos of service delivery.

In most provinces, the restructuring of the system was accompanied by a new funding model that allows the lead agency to subcontract to respond effectively to local demands and ensure that the accountability requirements focus on tracking desired outcomes, quality, and patient satisfaction and engagement. This new funding model allows organizations to move beyond a siloed approach by encouraging them to innovate and cooperate across their specialty areas to address multiple or complex community needs and use space efficiently. It fosters opportunities for intra-organizational coordination and efficiency in building partnerships. In some parts of Ontario, for example, we observed that the responsibility for resource allocation within communities was conferred to the nonprofit sector to redistribute to public agencies based on need. Nonprofits have seen their role shift from one of direct service-provision to one of responsibility for service outcomes and resource allocation, a real reversal from traditional hierarchical approaches to accountability. It was an experiment that was possible because the collaborative process was open and not predetermined.

Another feature of NPG is a focus on the realignment of services in a way that is "people-centred" or "user-centred" (Smith & Phillips, 2016; Bovaird et al., 2013). Traditionally, government policies and services were designed internally, with some ad hoc stakeholder engagement at various stages of the policy process. Now, we are observing the collaboration of professionals and citizens in both the planning and delivery of a service (i.e. co-design and co-delivery). According to Philippon and Braithwaite, "Many commentators note that one of the objectives of regionalization in Canada was to achieve enhanced public participation in decision-making to reflect regional health needs" (2004). This commitment to democratic governance, translated in practice to patient-centred design, was an important innovation driving the restructuring. To make the process more transparent and responsive, users were invited to consult and contribute to the design of delivery systems alongside service providers (Bovaird et al., 2013; Fledderus, Brandesen, & Honingh, 2015).

Such governance arrangements involve citizens and users in the planning, design, delivery, and evaluation of public services from the outset. For example, a representative of the Alberta Ministry of Community and Social Services noted that there is a recognition of "How can we make it more citizen-centred? How can we bring all the services to the client? We have thirty-four programs that are currently integrated within this service delivery model, and that's quite significant" (interview conducted February 27, 2018). Engaging the public is vital to addressing the expectations users may have of their healthcare system. In their mandates, Alberta Health Services and the Ontario LHINs were tasked specifically with fostering community and stakeholder engagement to ensure that local needs drive regional plans. Alberta, for example, partnered with United Way to obtain community input on specific issues. Indeed, many users reported falling through the cracks during the moments of transition because of a lack of system-wide vision. Through user-centred design, client pathways were mapped at a system-wide level, allowing service providers to identify gaps and ensure better transitions across services.

With this new approach comes a recognition of the importance of civic participation in policy design and development (Pestoff & Brandsen, 2010). Voorberg et al. (2015) note that "there seems to be an implicit assumption that involvement of citizens is a virtue in itself, like democracy and transparency, thereby also stressing that co-creation as a process is a goal in itself." But the discourse is complex, and we need to be sensitive to how specific ideas about citizen engagement are actualized. In many provinces, we are seeing a growing emphasis on experiential knowledge and how it can improve the quality of services. This signals a critical

discursive shift because it recognizes and celebrates the value of user experience. It is quite distinct from the focus on engaging the "ordinary citizen" in the policy process that dominated in the 1990s (Laforest & Phillips, 2006). The "ordinary citizen" is understood to be a layperson contributing their "common sense" or "ordinary knowledge" to policy discussions, often in opposition to "organized interests" who have a stake in the process (Lindblom & Cohen, 1979). The discourse on experiential knowledge lends value and legitimacy to the knowledge grounded in the user experience. The integration of broader forms of knowledge deemed "valid" into the participatory design process recognizes the problem-oriented nature of collaborative governance and results in a deeper contextual understanding of the problem.

One area where this new form of collaborative dialogue emerges is around performance management systems. There has been a real push under NPG for higher performance because of the underperformance of many contracting arrangements (Carmel & Harlock, 2008; Heins et al., 2010). Rather than focusing on narrow performance targets dictated from the top, community engagement in the field of health and social services has paved the way for developing system-wide performance indicators. This focus on performance is seen as a way to unify and mobilize broad segments of the population in public value creation. Users share their expectations, needs, and experiences, which feed into the design of the system but also become benchmarks for performance within the system (Osborne, Radnor, & Nasi, 2013; Bovaird et al., 2016). Under NPG, the focus is on shared outcomes and impacts within the community. In Ontario, for example, in the field of mental health and addictions, this has taken the form of community mental health reports, which have become benchmarks to build community capacity across the continuity of care. These community reports, combined with user pathways identified through consultations, form the basis to establish metrics for describing and monitoring the "value" generated by the sector in terms of community and client outcome (Osborne, 2017, 2018).

This new performance focus also provides an impetus for collaboration and data-sharing for better or improved policies. As Osborne has noted, this requires a "shared value" approach, where all actors in the system work toward the same goal (Osborne, 2017, 2018). It also leads to a simplification of the accountability requirement. NPM agreements imposed strict top-down accountability pressures on both private and voluntary organizations that entered into contractual agreements. New forms of collaboration, however, have been facilitated by new technologies that allow greater integration of reporting systems and streamlining of data management systems. Through knowledge-sharing, collective knowledge develops around which policy performance can be monitored and strengthened. It is essential to recognize that the regional consolidation has allowed for the development of information- and communications-technology (ICT) systems and greater coordination of the reporting systems on the back end of operations. A representative for the New Brunswick Department of Health noted, "They changed the legislation to allow us to share information. Those are big steps to take. It's taken us years to get where we are" (interview conducted March 1, 2018). Under NPM, it was challenging to implement standardized tools and protocols given the fragmentation of services. NPG was a way to build more transparency, equity, and responsiveness into the system.

Implications for Government–Nonprofit Relations

This study contributes to understanding the new roles the nonprofit sector has come to play in health- and social-services-delivery systems as a result of NPG reforms. While some aspects of NPM remain influential in government–nonprofit relations (Phillips & Smith, 2014), new dynamics that emphasize interdependence and collaboration have created opportunities for organizations to be involved in the design and structure of the new delivery systems. The leadership role of governments and regional authorities has shifted from command and control to supporting collaboration, sharing information, and fostering learning and innovation. Already, we see successful collaborative initiatives around homelessness, mental health, and addictions.

A critical insight that emerged is that relationships between governments and nonprofits are highly contextualized and vary depending on existing local capacity. Nonprofit organizations need to have a built-in capacity to take advantage of these opportunities. In some contexts – in Ontario, for instance – nonprofits have been able to position themselves as lead organizations helping to define community priorities.

Governance arrangements are spaces of information exchange, discussion, and debate. They must be analyzed not only in light of their outcomes, but also in relation to their broader impact on participation and engagement. NPG can play an essential role in expanding forms of participation and legitimizing experiential knowledge. As we have seen, the collaborative governance process makes possible the identification of "shared value" and, ultimately, the development of new tools for coordinating the actions of multiple actors involved across the delivery systems.

As of 2015, patterns of governance for health and social services have shifted again. The overall picture is of a growing tendency toward centralization of responsibility for health and social services at the provincial level. This latest shift may again have huge repercussions for nonprofit organizations across Canada; the governance process can provide access and legitimacy to the sector. At times of centralization, the elimination of governance structures at the regional level constricts the influence of nonprofit organizations, which may have to turn to informal channels to be heard. Further research and individual case studies are needed to understand better how the role of the nonprofit sector in governance is changing once more.

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Biography

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