

Collaboration, Trust and Social Capital

The Dynamics and Effects of Collaboration in the New Health Charities Council of Canada

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Abstract

This paper is a case study of the social dynamics of collaboration and its effects (particularly the generation of trust) within the voluntary sector, with specific reference to the then relatively new (2001) Health Charities Council of Canada (HCCC). A review of the literature on collaboration (with particular attention to social capital) backgrounds the analysis of in-depth qualitative interviews with four leaders in the voluntary health sector. There is evidence that the creation of HCCC, with its extensive membership of large and small charities, inclusiveness toward staff and volunteers, and commitment to a broad range of issues, has impacted in real terms upon the dynamics of collaboration. Despite concern that problems of stable leadership and the need to grow resources might give rise to power-based relationships, there is no evidence for the growth of power politics or the erosion of trust-based stakeholder relationships within HCCC. Because the author establishes the importance of a non-economic interorganizational collaboration model, this paper will have particular relevance for those interested in collaborative efforts in the voluntary sector.

Acknowledgements

In the pages that follow, I write about collaboration, its dynamics and effects. While writing and research are fundamentally solitary enterprises, there are a number of collaborators to whom I am indebted, and without whose support this study would not have been successful.

Wendy Reid has been a professional mentor for more than a decade. As she deepens her own commitment to the arts and to the broader voluntary sector through her doctoral studies, there have been frequent opportunities for discussions of the literature and for this project to benefit from her wisdom. Penelope (Penny) Marrett serves as the Executive Director of the Health Charities Coalition of Canada (now the Health Charities Coalition of Canada). In this role, she facilitated access to interviewees and unpublished documents. In her own graduate work in Public Administration, she laid the groundwork for the formation of the HCCC.

In the course of my research interviews, colleagues and members of the HCCC provided insight, shared wisdom and always challenged assumptions. Understanding the pressures of their work, I thank them warmly for their time and flexibility.

My tutor, Nelson Phillips, guided my own learning and discovery throughout the McGill-McConnell Program. He was a sounding board for my initial musings, which were later framed into this project. His insights, encouragement and comments on earlier drafts of this paper were always generous. Thanks are also owed to Frances Westley: as Executive Director of the McGill-McConnell Program, she provided inspiration throughout the program on this important learning journey. I am indebted to her and to all members of the program's faculty for this tremendous privilege.

Tim Brodhead, President of the J. W. McConnell Foundation, was the visionary who identified the need for executive leadership development in the voluntary sector. He conceived of its benefits at many levels: for the participants, their sponsoring organizations, and the sector as a whole. I believe we share the deep conviction that Canadian society stands to benefit exponentially as voluntary sector organizations deepen their understanding of, and commitment to, collaborative efforts. Insofar as this paper can contribute to this process, it stands as a tribute to Tim's personal vision.

My involvement in the McGill-McConnell Program would not have been possible without the generous support of the members of the Board of the Muscular Dystrophy Association of Canada (MDAC). To them, and to my colleagues at MDAC, I owe an enormous debt of gratitude – particularly Elizabeth MacLean, who transcribed interviews

and edited early drafts of the paper. Needless to say, I remain responsible alone for the quality of the work and the possible errors in these pages.

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Introduction

In the winter and spring of 2000 the Government of Canada implemented a revolution in the way it funds health research. With the establishment of the Canadian Institutes of Health Research (CIHR) as the successor to the Medical Research of Canada came a doubling of the federal government's contribution in the area and a commitment to an integrative and transformative agenda for health research. What was less apparent to the public was the pressure that led to these changes, orchestrated in part by a loose coalition of health charities. With the birth of the CIHR, these charities had realized a major victory – a victory that would mark the dawn of major changes in the way health charities structure their collaborative efforts. Not long after the formation of the CIHR, in June 2000, the Health Charities Council of Canada (HCCC) was established (see HCCC 2001a).

Allan Rock, Canada's Minister of Health, had issued a direct challenge to sector leaders to create a "one-stop shopping" coalition for health charities. While this challenge was in part self-serving, as it would simplify the Minister's relationship with health charities, Rock also saw in the emerging coalition an opportunity to give Canadians a more effective voice on health care policy. While he may not have recognized the number of Canadians served by or contributing to the efforts of health charities, he understood that the health charities were organized to mobilize Canadians in support of initiatives that the Minister of Health would be called to lead.

While the Minister's call served to crystallize the initiative, the HCCC was evidence of much larger forces at work and of a more ambitious agenda for collaboration. The conviction underlying this development was that Canadian health charities would best be able to contribute to the improved health status of Canadians through collaboration. Evidence of this can be seen in the logical model developed as part of the Governance Policies of the Council (HCCC 2001a).

The formation of the Health Charities Council of Canada has its roots in earlier, smaller and more tightly focused collaborative efforts, of which the National Voluntary Health Agencies (NVHA) and the National Voluntary Health Organizations (NVHO) were

immediate precursors. The HCCC emerged at a time of growing turbulence in the health care environment, in no small part created by a realignment of provincial and federal government roles as both levels adjusted spending to deal with the problem of public indebtedness. The HCCC's expanded and more ambitious collaboration must therefore be examined against a backdrop of increasing competitiveness in fundraising practices and the continuing growth in the number of charitable organizations.

While the Health Charities Council of Canada is the principal focus, this study also examines the social dynamics of collaboration and its more intangible effects, including the generation of trust. In particular, it asks the question: has the expansion of HCCC membership generated trust-based or power-based approaches to collaboration? I also explore the question of interorganizational collaboration as a source of social capital, the convertibility of this social capital, and its potential uses. These uses may range from contacts available to individuals in the pursuit of career opportunities to the leadership development and learning available to volunteers formally or informally in the meetings organized by the Council. Given the breadth and scope of this exploration, I have chosen to focus on these key themes. Readers with a more detailed interest will find the references useful as a possible guide for additional reading.

A word of caution: I do not pretend that the logic of social capital is necessarily unidirectional. Social capital can be both a source of opportunities for collaboration, and collaboration itself can be a source of social capital. While I recognize the circularity of this argument, as Alejandro (1998, 18) does in commenting on Robert Putnam's work, I am more interested in the processes and dynamics at the heart of interorganizational collaborations than in the empirical investigations that would be required to clarify the logical model.

Section 1 of this study provides the context for an understanding of the institutional field of the voluntary health sector and for this case study. National health charities are actors in this larger institutional field, which has experienced significant growth in recent years. Section 2 examines the literature of collaboration, with a particular emphasis on its dynamics from a social perspective. Section 3 reviews the literature of social capital in order to establish the backdrop against which my exploratory interviews of leaders in the field will be analyzed. In section 4, I analyze these interviews to identify possible patterns

in the way social capital might be converted by the individual or organizational actors. In so doing, I hope that this study might reveal areas for future research.

This study is relevant at this time for many reasons. Much has been written about collaboration, but, while growing attention has been focused on collaboration within the voluntary sector, actual case studies are relatively rare.

Building a bridge between the study of collaboration and the current debate about social capital is of interest because the voluntary sector is the locus for many of the relationships that generate social capital – churches, trade unions, professional associations, arts and cultural organizations, health and social services charities, amateur athletic leagues and associations, leisure and recreation clubs. Also relevant is the opportunity to apply the construct of social capital at the interorganizational level of analysis rather than at the level of interpersonal relationships. I know of no other attempts to apply the construct of social capital interorganizational among voluntary sector organizations.

This is also the first opportunity for a formal exploration of the Health Charities Council of Canada as a collaborative enterprise.

When social issues are the focus of the collaboration the forces against success can be particularly great, partly because of the ambiguity that surrounds the nature of social issues themselves and partly because there tend to be many organizations with some, often ill-defined, stake in the issue. (Eden and Huxham 2001, 2)

1

The Health Charities Council of Canada: Background and Context

There are more than 175,000 nonprofit organizations in Canada, of which approximately 80,000 are registered as charitable organizations or foundations with the Canada Customs and Revenue Agency. A recent study by the Health Charities Council of Canada found that an estimated 5,500 of these registered charities place a strong emphasis on health (2000, 3). The actual number of national health charities is estimated at 300; of these, forty-five are current members of HCCC. In its initial planning exercise, the HCCC established a membership target of thirty by 31 December 2001. No new target has been established formally. HCCC Executive Director Penny Marrett explains that seventy members would be a reasonable target for the next few years; when the HCCC has 150 to 200 members, its membership will be mature. Attaining this level of membership, however, will be challenging, as many of the potential members are so new (and therefore relatively small) that they have yet to obtain registration as a charity from the federal government.¹

Another measure of the size of the voluntary health sector is available in the “approximately 12.3 million Canadians, or 52% of Canada’s population 15 years of age and older, [who] made financial donations to voluntary health organizations (VHOs) between November 1, 1996 and October 31, 1997. Their donations during this period totalled over \$772 million” (Heinz, 5).

These facts present a very superficial picture of the voluntary sector, which, we will argue, has the characteristics of an institutional field. And this argument reflects a larger trend “to embed the study of collaboration in the larger institutional field with an aggregate focus, a necessary step if we are to understand the kinds of institutional

¹ Figures estimated or reported by Penelope (Penny) Marrett, Executive Director, HCCC (October 10, 2001).

antecedents that make collaboration more likely and that affect the sort of collaboration that results” (Lawrence et al.1999, 482).

In their seminal work on institutional theory, DiMaggio and Powell (1983, 148) define an institutional field as “those organizations that, in the aggregate, constitute a recognized area of institutional life.” This structuring of institutional fields, they explain, consists of four distinct processes, evidence of which is available in the experience of the voluntary health sector.

The increase in the extent of interaction between organizations reflects the broader trend of “the rapid proliferation of strategic alliances [which] has been one of the most enduring features of the business environment over the last two decades. This trend of multiple alliances with multiple partners has embedded firms in intricate webs of industry networks” (Koka and Prescott 2000, 3). Evidence of this is available in the voluntary sector in the formation of various coalitions and groups ranging from anti-smoking groups, AIDS support groups and health watchdog coalitions, to groups more definitely focused such as the HealthPartners Fund (workplace fundraising for national health charities), and the Association for Healthcare Philanthropy. Penny Marrett confirms this parallel trend in the voluntary health sector and suggests it might be explained by “the importance of health and the nature of health reform” (Marrett, 1999, 6–7).

The emergence of sharply defined structures of domination and patterns of coalition is well exemplified by the coalescence of the multifarious coalitions involving national health charities into the HCCC, while the development of an awareness that participants are involved in a common enterprise can be seen in the broad consensus achieved on a variety of issues: increased funding for health research, improved accountability to donors and the need for a better relationship between the sector and government. The increased information load with which organizations must contend is also evidenced in the voluntary health sector, though this could be related as much to today’s new and inexpensive information-sharing technologies as it is to the structuring of an institutional field.

It is important nonetheless to recognize that the HCCC is not the institutional field; it is certainly a sharply defined structure within the field that serves as the locus of

collaborative activity on the part of *some* of the actors. The HCCC does not include in its membership a number of stakeholders from the larger institutional field: government agencies that regulate and fund health charities, health care institutions, research institutes, consultants and other suppliers and the associations primarily concerned with practitioner regulation.

The development of the voluntary health sector and its institutional field parallels attempts to better understand the impact of health charities and to define a common language to describe this impact (see Legowski and Albert 1999; HCCC 2001).

The most recent, and possibly the best, study of definition and classification of the voluntary health sector proposes an approach that combines the International Classification of Nonprofit Organizations (ICNPO) and the United Kingdom Charity Commission Classification System. The ICNPO classification proposed five criteria to classify nonprofit or voluntary organizations:

1. Organized
2. Private (i.e., institutionally separate from government)
3. Self-governing
4. Nonprofit-distributing
5. Voluntary

The authors borrow from the multi-dimensional UK Charity Commission Classification System and propose two dimensions to better understand the voluntary health sector:

1. Beneficiaries and client groups: individuals, institutions or environments
2. Functions or methods of operation: financing and resourcing, facilities, services (e.g. training or health care), advocacy, information and research, representation

Finally, the authors recommend that investigations into the contributions of the voluntary health sector restrict their focus to those organizations that work directly in providing health services or that produce immediate or short-term health effects (Febbraro et al. 1999, 11).

One of the immediate predecessors to the HCCC was the National Voluntary Health Agencies (NVHA),² “a forum for CEOs of various health charities to come together to discuss issues and exchange information” (Marrett 1999, 17). NVHA was a small and relatively closed network of large national health charities. A larger and looser coalition of smaller health charities evolved in 1997, brought together by Health Canada’s unilateral cancellation of its core operating support program, which had provided grants to smaller health charities. NVHO’s efforts to lobby governments went beyond its more limited information-sharing role and, indirectly at least, challenged the NVHA to reconsider its scope and position.

The cancellation of Health Canada’s program for smaller charities had two effects: it served to catalyze collaboration efforts, and it created linkages among charities both large and small. The federal government responded by re-instating some transitional funds. At the same time, Health Canada shifted its funding emphasis from providing core operating funds to developing capacity in the sector. These Sector Development Grants have made workshops and other training opportunities available for small and medium-sized health charities, often drawing on the experienced leaders of larger health charities to conduct sessions.

The birth of the HCCC was also facilitated by Canada’s two largest health charities: the Canadian Cancer Society and the Heart & Stroke Foundation of Canada. They played a spirited leadership role in cementing the initial group that had framed the vision for a new and expanded coalition.

The coalition was born with the clear intention of encompassing a much larger group of health charities. The work leading to the creation of the HCCC was funded, in part, by Health Canada through grants made to create a *Health Issues Desk* and housed within the very large Coalition of National Voluntary Organizations (NVO). The HCCC continues to reside within the NVO, and through administrative arrangements has managed to avoid the costs and delays associated with incorporation.

² In the mid-1970s, the Coalition of National Voluntary Organizations established National Voluntary Health Agencies as a forum for information and exchange and learning among the CEOs of its member national health charities. At the time of its dissolution NVHA included twenty-eight CEOs, who meet two or three times a year (HCCC 2001b, 1).

Apart from the professional bodies such as the Canadian Nurses' Association and the Canadian Medical Association, today's voluntary health coalitions pursue fairly narrow and specific purposes. The Health Action Lobby (HEAL) has as its main focus the continuing adherence to the five principles of the Canada Health Act; its members are major health care professional associations as well as consumer organizations. The National Youth Service Agencies (NYSA) includes organizations such as YMCA Canada, Boys and Girls Club Canada, and Big Brothers-Big Sisters of Canada. Finally, the Council for Health Research in Canada includes some of the largest national health charities (including the Canadian Cancer Society and the Heart & Stroke Foundation), publicly funded research institutes and academic health sciences centres.

Legowski and Albert (1992, 2) propose the following definition for the voluntary health sector:

The group of formal organizations that are registered charities or nonprofit organizations without charitable status with a stated purpose of direct interest in health demonstrated through the following domains of activity that contribute to health outcomes – service provision as either disease and illness prevention/health promotion, and care; research; advocacy; fundraising; and practitioner regulation.

This definition is applicable to national health charities, with certain important qualifications, i.e., that they are national in their geographical reach, play no part in regulating practitioners and do not provide institutional or physician services insured under the Canada Health Act. Similarly, most health charities have focused their research role on funding the best possible extramural research housed in publicly funded institutions and evaluated on the basis of rigorous peer review.

We are reminded in Andrew Kimbrell's *Human Body Shop* (1998) that the boundaries between the political sphere, the market and the voluntary sector can be difficult to delineate. Robert Wuthnow characterizes the voluntary sector as encompassing "those activities in which neither the formal coercion nor the profit-oriented exchange of goods and services is the dominant principle" (1991, 7). This description is important, as it excludes those health charities that are extensions of government, whether largely government-funded or else providing services that have hitherto been provided directly

by the state, such as the Community Health Centres in Ontario, or the Local Community Service Centres (CLSCs)³ in Quebec.

The membership of the Health Charities Council of Canada is clearly defined, and also broader than the memberships of previous health charity alliances or coalitions.⁴ Its ambitions too are broader, in that its focus is on a multitude of issues of common interest rather than on a single issue. Another important aspect of the changes that led to its formation is the inclusion of both senior staff and senior volunteers as participants within the Council. “HCCC will strive to achieve equal input and participation from governance leaders (e.g. Board presidents) and senior staff (e.g. Executive Directors/CEO),” is the very tall order enshrined in the Governance Policies of the Council (2001, 5). The combined effect of these changes is to significantly reduce the homophily⁵ among the actors within the Council and to increase the complexity inherent in managing the collaboration.

³ CLSC = Centre local de services communautaires.

⁴ HCCC membership categories and fees define a national health charity as an organization that meets all of the following criteria: (1) registered charitable status; (2) primary focus on health issues; (3) commitment to serving the people of Canada in both official languages and (4) presence across Canada.

⁵ See p. 20.

2

Collaboration: From Rational Actor to Complex Social Processes

The literature of collaboration is vast. It can be usefully organized into two broad schools. One is founded on the study of economics, and proposes a model of a rational actor who collaborates to improve organizational effectiveness (Pfeffer and Salanick 1978; Hamel et al. 1989; Grant 1991). The other is founded on institutional theory with its roots in sociology (DiMaggio and Powell 1983); it seeks to explain many of the non-rational and social aspects of collaboration. Many attempts have been made to bridge these approaches and there is empirical evidence that an integrative model may better reflect the reality of collaboration. At heart the questions asked about collaboration are simple: Why do collaborative efforts emerge (sources)? What are the dynamics of collaboration? And what is the impact of collaboration (ends or effects)?

Pfeffer and Salanick (1978) developed the resource dependency model to show how corporations collaborate in efforts to acquire the resources that are fundamental to their competitive advantage. Japanese-American strategic alliances, with their classic exchange of new technology and management practices for access to American markets, best exemplify this view. Hamel, Doz and Prahalad suggest that “a strategic alliance can strengthen both companies against outsiders even as it weakens one partner vis-à-vis the other. In particular, alliances between Asian companies and Western rivals seem to work against the Western partner. Cooperation becomes a low-cost route for new competitors to gain technology and market access” (1989, 133).

Inkpen borrows this framework in his study of learning and strategic alliances, which he defines as “relatively enduring interorganizational cooperative arrangements that utilize resources and/or governance structures from autonomous organizations” (1998, 70). This focus on the acquisition of resources in collaboration extends to non-tangible assets. The tangible effects are strategic and financial: generating additional profits, improving market share and sustaining competitive advantage; the intangible effects are knowledge-

based: learning specific skills and competencies, learning about interorganizational cooperation, and learning how to behave co-operatively (Simonin 1997, 5).

Neither this narrow focus on resources nor Inkpen's definition resonate much with the HCCC's experience of collaboration. Like the critics of the rational-actor model, I believe it provides a very incomplete picture of collaboration in the voluntary sector: first, because of the absence of a financial evaluative criterion (i.e., profit) to serve as an organizing principle and gauge the impact of collaboration; and, secondly, because of the ambiguous goals discussed earlier. For these reasons, theorists who have extended the scope of studies of economic collaboration to the voluntary sector have either built on the rational-actor model or departed from it altogether (Gray 1989; Huxham and Vangen 1996, 2000; Lawrence et al. 1999; Oliver 1990).

The rational-actor model isolates collaboration from its field. In *Collaborating*, (1989) Barbara Gray, by contrast, explores the notion of collaboration in a much broader political and social context. She focuses her discussion on multi-party collaborations. "Gray's overall goal is nothing less than to set society moving toward a negotiated order," explains Eric Trist in his foreword to this seminal work. Gray describes collaboration as "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (p. 5). Gray's work has much relevance to the study of collaboration, particularly when it involves many actors and is embedded in its institutional field.

Like Gray, others have defined collaboration as an organizational strategy to deal with a turbulent environment (Carney 1987, 342). Emery and Trist (1965) argued that a multilateral organizational agreement is the only appropriate coping strategy under conditions of severe environmental turbulence. In his study of strategies for collective action, Carney suggests two types of collective strategy in framing collaboration: consolidative and innovative (344–45). The transition from the NVHA to the HCCC is a transition from a consolidative strategy, in which the partners seek to maintain the environment in a particular shape, to an innovative strategy, which is designed to reshape and adapt the group to important environmental changes. Carney contrasts these two strategies and suggests that "the innovative strategy involves the pooling of skills,

abilities and information rather than the pooling of interests as seen in the consolidative strategy” (ibid.).

Some of these authors have also been critical of the rational-actor model, even when applied to the for-profit sector, as it fails to explain irrational behaviours. “Although economic activity is inextricably linked with social and political life, there is a mistaken tendency, encouraged by contemporary economic discourse, to regard the economy as a facet of life with its own laws, separate from the rest of society” (Fukuyama, 1995, 7). In his essay, *L’esprit du don* (1995), Jacques Godbout argues that there is a need to understand gift giving as a *system*, which exists apart from the fundamental transactions of the market economy, and the hierarchy and coercion which are instruments of the state. This makes it possible to explain behaviours that are neither the product of coercion nor the product of an economic exchange.

Que loin d’être mort ou moribond, le don soit encore bien vivant, voilà qui doit maintenant paraître plausible. Mais sans doute convient-il d’aller au-delà du simple constat et de faire l’hypothèse que cette pérennité ne résulte pas seulement et négativement de l’universelle nécessité d’apporter un supplément d’âme aux seules logiques solidement constituées qui seraient celles de l’intérêt marchand et du pouvoir d’État, mais qu’elle témoigne du fait que le don, lui aussi, comme le marché et l’État justement, forme système. (Godbout, 21)⁶

Institutional theorists broaden the discussion of collaboration, beyond its economic discourse, to examine features of the social organization – networks, norms, trust. In doing so, they examine questions of legitimacy, power, and meaning through the lens of collaboration. This field has its broad roots in organizational sociology, sociolinguistics and psychology.

Lawrence, Phillips and Hardy discuss the question of outcomes and call for broadening the set beyond questions of performance to include “noneconomic impacts such as social ties, political power, and technological innovation” (1999, 3). In a discursive approach to collaboration that focuses on the communicative processes that are at the heart of

⁶ “Far from being extinct or moribund, giving, it now seems apparent, is alive and well. But apart from that simple fact, it surely seems worth suggesting that its survival is not merely the negative result of the universal need to add a spiritual dimension to the rigidly exclusive logic of commercial interest and state power; rather it is living proof that giving too forms a system, exactly as do the market and the state.”

collaborative process, they suggest that “understanding collaboration as a discursive phenomenon leads to a theoretical position that highlights both the social production of collaboration and its social products.”

Others have explored the psychodynamic aspects of collaboration – the deeper, less conscious, more irrational processes that may infuse organizational alliances. Gould, Ebers and Clinchy (1999, 2) explain that “anxieties are mobilized by the concerns each partner has about losing control, particularly as the necessity for mutual dependence and authentic partnership – with everything that they may mean – become increasingly obvious. This is especially true in large, successful organizations which have a considerable degree of control over most aspects of their enterprises, and in which, dependence on others, no matter how appropriate or realistic, is usually anathema, even when necessary and desirable.” The question they beg is “whether alliance partners have the emotional wherewithal and capacity to relinquish the identity, control, and hence safety of their original or home-based organizational (group) boundaries, and to fully locate themselves within the uncertain boundaries of their newly created, joint enterprises” (ibid., 4).

Network theorists have also examined various aspects of interorganizational relations. In his seminal work, *Structure Holes* (1992, 7), Burt explores the density of connections in networks and argues that the more loosely connected networks – the ones with more structural holes – are those that create “entrepreneurial opportunities for certain players to affect the terms of their relationships.” The HCCC collaboration, because of its much broader scope, is much looser. Would we deduce from Burt’s argument that it provides certain players more entrepreneurial opportunities – more opportunities to wield power and acquire resources or legitimacy?

Max Gluckman (1967) introduced the distinction between *simplex* and *multiplex* relations. Simplex relations are those that involve collaborative partners exclusively in one collaborative process. By contrast, “the central property of a multiplex relation is that it allows the resources of one relationship to be appropriated for use in others” (Coleman 1988, 109). The broadening of the NVHA and NVHO into the larger HCCC provides evidence of a change from simplex to multiplex relations. The HCCC involves various groups and sub-groups in subsets, coalescing around various issues and shaping different

outcomes. One of the clearest manifestations of this transformation is that the HCCC encompasses both VHO volunteers and staff leaders, and provides opportunities for members of both groups to work together and separately on a wide range of issues.

The identity of the HCCC as a collaborative enterprise is both formalized and formally bounded, with clearly defined criteria both for membership and for exclusion. Collaboration has also made it possible to pool resources so as to create a small secretariat and dedicated staff – another potential source of legitimacy. HCCC also engages in relationships with the media and with public officials. Its predecessors, NVHA and NVHO, were not organized in a way that would allow them to speak on behalf of their members (with one exception in the case of the NVHO, on the single issue that was the impetus for its creation, as discussed earlier). And even though HCCC may gain identity and legitimacy within this new collaborative framework, its members may well face anxiety about their own identities; the management of the collaboration thus becomes far more complex.

Evidence of this can be seen in the challenge faced by the HCCC in designing mechanisms for consultation that would allow both input from members and speed in responding to policy issues. A good example, at the time of writing this paper, is the HCCC's attempt to prepare a brief to the Commission on the Future of Health Care in Canada (the Romanow Commission). Members have had little time to frame their own views on the complex issues that are central to a debate about the sustainability of Canada's public health care system.

The HCCC's advocacy role provides evidence of Carney's innovative strategy discussed earlier. Like Kukuyama and Godbout, Carney oversteps the narrow confines of the rational model of the economic man: his study of the structure and dynamics of collaboration shows that an innovative strategy cannot rely simply on rules. Because innovation is too complex, it must rely on trust (Carney 1987, 346).

A picture of the HCCC as a collaborative enterprise now emerges: innovative, complex, multiplex, and marked by deep anxieties about identity and boundaries – yet nonetheless rendered functional through similarly complex processes and dynamics. Lawrence, Phillips and Hardy argue that collaboration can be defined as the management of

communication processes or discursive processes; collaboration is a “cooperative, interorganizational relationship, that relies neither on market nor hierarchical mechanism of control but is instead negotiated in an ongoing communicative process” (1999, 4). But if there is no single, legitimate authority empowered to control the collaborative enterprise, on what grounds can we predict its success? Maguire, Phillips and Hardy (1999) explore this question of the dynamics of control and trust as a functional equivalent of legitimate authority and power in a collaboration. Francis Fukuyama also writes (1995, 26):

Trust is the expectation that arises within a community of regular, honest and cooperative behaviour, based on commonly shared norms, on the part of other members of the community. Those norms can be about deep “value” questions like the nature of God or justice, but they also encompass secular norms like professional standards and codes of behaviour . . .

Thus in a complex collaborative setting, trust becomes very important to manage differences. Kim and Cannella explain that social *homophily* (the degree to which pairs of individuals or tightly knit groups share values, beliefs and social or demographic variables) plays an important role in boosting trust by making reciprocal relationships more predictable. Maguire, Phillips, and Hardy (1999, 11) suggest we know little about how to generate trust in a collaborative setting.

This will be particularly interesting, since by broadening its membership and including both professionals and volunteers as stakeholders in the collaboration, the Health Charities Council of Canada has eroded the homophily that was a strength in NVHA (and, to a lesser extent, in NVHO). The identification-based trust and social control or control through meaning (Maguire et al. 1999, 6–9) may also have been eroded. The small group of CEOs who were members of the NVHA (all professionals located at the apex of the hierarchy of their organization) has now been replaced by a much more diverse membership in the HCCC, which now includes professionals and volunteers who are not necessarily all similarly located in their volunteer and staff organizational hierarchies.

3

Collaboration and Social Capital

If, as has been demonstrated, cooperation can be either trust-based or power-based (Hardy et al. 1998), a central question our investigation must answer is whether or not (and if so, how) the collaborators in HCCC are boosting trust so as to deal with the increasing complexity of their collaboration. The importance of trust in managing a complex set of interrelationships in a collaborative enterprise serves as the bridge to a discussion of the literature of social capital, to which we now turn.

Social capital has major consequences for the nature of the industrial economy that society will be able to create. If people who have to work together in an enterprise trust one another because they are operating according to a common set of ethical norms, doing business costs less. Such a society will be better able to innovate organizationally, since the high degree of trust will permit a wide variety of social relationships to emerge. . . . By contrast, people who do not trust one another will end up cooperating only under a system of formal rules and regulations, which have to be negotiated, agreed to, litigated, and enforced, sometimes by coercive means. This legal apparatus, services as a substitute for trust, entails what economists call “transaction costs.” (Fukuyama, 1995, 27)

There is a significant interrelationship between trust and social capital. Koka and Prescott explain that “trust affects a firm’s social capital in intangible ways. It affects the quality of the information that is exchanged . . . [while] such flows enhance learning which accentuated by rapid feedback creates opportunities for joint problem solving” (2000, 13).

Social capital is the resource consumed by a purposive actor that has as its value the connectedness between the parts of the network. Unlike the flow of information through networks, social capital is embedded in the network itself; but in order to serve as an authentic resource, it must be appropriated and consumed.

In *Bowling Alone: The Collapse and Revival of American Community* (2000), Robert Putnam examines the nature of social capital as norms of reciprocity between individuals, and examines the impact of these on the quality of community and public life in the United States. In essence, he is interested in *civisme*, or the quality of relationships

between *citizens* and their manifestation in the quality of life in the polity. Alejandro Portes, on the other hand, is critical of Putnam: he warns of the danger present in “equating social capital with the resources acquired through it [as this] can easily lead to tautological statements”. Portes goes on to suggest that “social capital stands for the ability of actors to secure benefits by virtue of membership in social networks or other social structures”(1998, 6–7). In his critical essay about social capital, Portes reminds the reader that the current excitement with the notion of social capital obscures the reality that it can serve as the source of positive and negative benefits for a community (ibid., 4).

James S. Coleman points out that social capital is generated through changes in the relations between actors. “Social capital, however, comes about through changes in the relations among persons that facilitate action” (1988, 101). This leads to one of the important questions I propose to explore in the case study. *Will the changes in relations among national health charities through the creation of the HCCC provide evidence of the generation of social capital, as an asset available to the voluntary health sector in Canada?*

This question triggers another important question as to how social capital can be applied at the interorganizational level of analysis. Adler and Kwon (1999) defined social capital as a “resource for individual and collective actors” while Coleman (1998, 98) explains that “because purposive organizations can be actors (‘corporate actors’) just as persons can, relations among corporate actors can constitute social capital for them as well.” Portes explains that “the greatest theoretical promise of social capital lies at the individual level”; yet, he also notes that “there is nothing intrinsically wrong with redefining it as a structural property of large aggregates” (1998, 19).

Asakawa (2000) and Koka and Prescott (2000a; 2000b) explore how social capital accrues to firms in strategic alliances. Koka and Prescott explain that the “conclusion is not clear as to whether collaboration positively affects performance,” and they attribute the conflicting results, in part, to the “variations in constructs, measures and levels of analysis.”

In their discussion of the liquidity and convertibility of different forms of capital, Anheier, Gerhards and Romo suggest that “the convertibility of social capital into

economic capital is costlier and more contingent; social capital is less liquid, ‘stickier,’ and subject to attrition” (1995, 862). Koka and Prescott, on the other hand, in discussing the conditions under which the resources are converted, have framed the notion of the “contingent” value of social capital and introduced three contextual factors: environmental change, network density and firm strategy (2000a, 4). Others have explored the benefits of social capital. Coleman’s work on social capital in the family (1998) and its conversion to human capital in children is a classic example of this type of analysis at the individual level. Portes (1998) also focuses his definition of the functions of social capital at the individual level of analysis.

Koka and Prescott apply the construct of social capital at the level of the organization. They define it as the “sum of resources that accrue to a firm by virtue of possessing a durable network of interorganizational relationships” and “focus on the flow of resources – knowledge, information and other capital – to the firm through its alliances” (2000b, 3). They then provide evidence for the existence between firms of obligations, expectations, and norms of reciprocity that underlie the idea of social capital (ibid.).

I have examined the way in which social capital has been applied at the interorganizational level of analysis. In the context of the Health Charities Council of Canada, this raises another related question as to who benefits from the social capital generated through the collaboration. Is it the sector as a whole, the individual organization, or the executive who represents the organization in the work of the HCCC?

My belief is that the formation of the Health Charities Council of Canada in 2000, as a broader and more complex framework for interorganizational relationship among national health charities, shifted collaboration from a trust-based approach to a power-based approach within HCCC. Yet the broader network of interrelationships among participants has also been a source of social capital, and this capital may be available to be converted into other benefits for member organizations.

In section 4 I will explore these relationships through data collected in interviews with individuals who played a critical or determining role in HCCC. This exploratory case study has been designed and is intended to answer the following research question:

What are the impacts on the dynamics and effects of collaboration among health charities of the creation of a broader coalition that is both larger in numbers and inclusive of both professional staff and senior volunteers?

The foregoing examination of the creation of HCCC will serve as a backdrop to an exploration of the non-tangible effects of collaboration, including the impact on trust generated among its participants. In doing so, I build a bridge to the growing social capital literature, with a particular focus at the interorganizational level of analysis. Thus from the bounded and closed confines of the HCCC I can now explore the dynamics of the generation of trust, the resulting social capital, and the potential benefits that may accrue to members or to the sector as a whole.

4

The Case Study

A brief description of the methodology developed for this exploratory case study follows. It will serve to illustrate the linkages between the dynamics and effects of collaboration, and the generation of social capital.

Methodology

Four in-depth interviews were conducted with senior staff and volunteers serving as members of the HCCC or its Secretariat. The sample included small, medium and large national health charities. I generated the list of interviewees using a “snowball technique,” in which each respondent is asked to identify potential respondents for further interview. In selecting the interviewees, my focus was on individuals who had or are having a determining or lasting impact on the Council.

The interviews were tape recorded and transcribed. Data from the interviews are reported in the aggregate only, thus protecting the anonymity of the respondents. Where respondents are quoted directly, permission has been sought from them individually to do so. The analysis involved the coding of the transcripts to explore relationships between the concepts and to reveal patterns in the responses.

Beyond these empirical data, policy documents and other reports prepared by or for the HCCC were surveyed. As well, I have had the opportunity since before its inception to play an active role as a participant at most of the HCCC Roundtables (periodic meetings of representatives from member organizations) and, more recently, to serve on the Science and Research Committee of the Council’s Executive Board. This opportunity to share personally in the work of the HCCC may possibly have obscured some evidence that would not have escaped a more independent researcher. However, as my findings are not intended to be definitive or conclusive, I will allow myself to draw on this personal experience and to weave some of those reflections into the analysis. In effect, in doing so, this study is not unlike some action-research projects.

Analysis

While the snowball technique was not meant to provide an intentionally randomized sample, it so happens that the four interviewees offered a tremendous variety of perspectives on the Council and its work. In terms of position, they included a member of staff of the Council, the chair of a volunteer board of directors and two executive directors of national health charities. It is important to note that one of the respondents is an HCCC Executive Board member. This also introduced another element of variation in the sample: some respondents were involved formally in the work of HCCC as staff or volunteers, while others' involvement was informal (e.g. participation in consultation, Roundtables, etc.). All of the representatives of health charities were hierarchically situated at the apex of either their staff or volunteer structures and, as such, had had opportunity to consider these issues from a privileged vantage point. The national health charities thus represented ranged in size from large to relatively small; only two of the organizations represented in the sample had been members of NVHA.

In one significant respect, the respondents did not vary: all were strong advocates and supporters of the Council. The overwhelming impression left from the interviews is one of optimism about and confidence in the future of the Health Charities Council of Canada. While some potential risks surfaced in discussion and some caveats were noted, respondents were convincing in their strong belief in and support for the notion of a broader and more complex collaboration among health charities.

This strong support for HCCC is not surprising since the respondents were selected on the basis of their determining or lasting impact on the Council. Data were not collected from individuals more remotely involved in the Council – nor, for that matter, from government officials or non-members.

One respondent remarked on his own optimism: he explained because the Council is young and has experienced early successes, it has yet to be tested. While confident that the Council would be strengthened by such a test, the respondent did identify the potential for differences and disagreements to emerge.

Those interviewed confirmed my own analysis that the HCCC represents a significant change in the framework for collaboration among national health charities. Three aspects

of this change – all significant – were noted: the growing number and variety of members within the collaboration, the inclusion of both volunteers and staff in the work of the Council, and the broader range of issues and potential issues that the Council may from time to time seek to advance. Together, they amount to nothing less than a revolution in the way we collaborate.

While the antecedents of this collaborative venture are not the primary focus of this study, respondents did comment on the genesis of the Council, and expanded my understanding of its history and formation. Health Canada's Sector Development Grants and the opportunities for collaboration that these grants spurred were cited repeatedly as an important stepping-stone in creating the conditions for the Council to emerge. This was identified as a far more tangible contribution to the development of the HCCC than federal Health Minister Allan Rock's invitation to provide for one-stop shopping in his relations with national health charities. On the other hand, the political reality – that numbers count and that only a larger collaboration would be able to mobilize Canadians to have a major impact on health care policy – was also identified as a factor that led to the creation of the Council.

Other factors mentioned in the genesis of HCCC were the need for volunteer involvement – and, even possibly, volunteer oversight – of the work led by senior staff through NVHA. Finally, the perception that NVHA was exclusive and exclusionary may have contributed to the realignment of relations among small and large charities. The vision of the Canadian Cancer Society (CCS) and the Heart & Stroke Foundation of Canada and their leaders was also cited as a contributing factor to the establishment of the HCCC. The late Dorothy Lamont, the then CEO of CCS, is often cited as an example of organizational leaders who were prepared to assume a broad mantle of leadership on behalf of the sector. Ms. Lamont exemplified this in her role as Vice-Chair of the Interim Governing Council of the Canadian Institutes of Health Research (CIHR), where she was the voice of the voluntary health sector in the very critical months that led to the creation of the CIHR by Parliament.

Two aspects of the early stages of development of the HCCC collaboration cited by many respondents as reasons for optimism were (1) the strength of leadership in its early stages, and (2) the role of early successes in influencing health policy.

Bill Tholl, former CEO of the Heart & Stroke Foundation of Canada, was likewise often mentioned for his vision and early leadership. There is also recognition that the Council has enjoyed strong staff leadership from its inception. In Penny Marrett, the Council has enjoyed strong leadership, which has been particularly sensitive to the meaningful inclusion of member organizations, regardless of size – many of whose representatives have expressed appreciation of her leadership style.

Two early successes in shaping public policy were underlined as particularly significant contributions to the momentum with which the HCCC collaborative effort was launched. One was the creation of the CIHR, which resulted in the doubling of public monies dedicated to health research in Canada. Another early success (particularly important for smaller organizations) was the Government’s decision to reinstate some funds (albeit not as a secured program) to cover the transitional period after the abrupt cancellation of its core operating support program. But, in this latter case, there was more to it than the monies that continued to be available from Health Canada. Evidence that the largest health charities would rise to the defence of much smaller ones contributed to the erosion of previously held perceptions.

This is such a greater understanding . . . that for the last three years, two or three of the largest organizations, in their briefs to the Finance Committee [of the House of Commons], talk about the fact that the smaller organizations need funding from Government, and that they can’t do their work without those organizations.

This evidence is again available in the brief that the Council will be presenting to the Standing Committee of the House of Commons on November, which includes a request for Health Canada to create a \$5 million capacity-building fund for small to medium-size national health charities.

The Dynamics of Collaboration

One of the central questions raised in this study concerns the nature and extent of the changes in the framework for collaboration among national health charities, and the impact of these changes upon the quality of relations among its participants.

The observation shared by all respondents was that the simple fact of providing the opportunity for people to meet and get acquainted with one another was an important part of the trust-building taking place in the Council's early days.

Over the last couple of years, you've seen a strengthening of relationships. There has been a great deal of trust-building that has taken place, and people have gotten to know each other as individuals, it has become easier for people who potentially may not agree with the discussion to actually speak out, and people have respected, that there might be differences of opinion and have worked hard to try to find where the consensus lies.

This recalls the notion, introduced above, of identification-based trust that “develops as one not only knows and predicts the other's needs, choices and preferences, but also recognizes the validity and perhaps shares those same needs, choices and preferences ... it implies common understandings and goodwill between actors (Maguire et al. 1999, 4).

Trust is also based on commonly held norms, as noted in the discussion of Fukuyama's work earlier. These are important so as to add to this reservoir of goodwill among the actors. One colleague highlighted the importance of the norms developed early by members of the Council, which have since guided the priority-setting process at each of the members' Roundtables. These norms have been formalized and documented in the Council's Governance Policies. Among them are a commitment to the following guidelines: “HCCC will strive to complement and support the missions and mandates of its members organizations, never duplicate or compete; the autonomy of individual organizations members will always be respected and valued; HCCC will be transparent; our work will be responsive to and open to the scrutiny of our members, prospective members, and the general public; HCCC will respect the diverse and differing needs of small, medium and large health charities; and, members will be equal regardless of size” (HCCC 2001a, 5).

Embedding Trust in Organizational Practices

I have noted that these norms have been formalized. Of greater importance is the fact that they have been reinforced and applied in the early work of the Council, and have been evidenced in the approach of its leaders. One respondent specifically noted the instrumental role of volunteer leaders in framing and reinforcing norms that have guided the work of the Council. Another respondent commented, “We have moved to where the

health charities are really on an equal footing in terms of voice . . . from the HCCC's point of view, I think one of our biggest accomplishments is breaking down barriers of size and influence."

The application of these norms has been particularly important in the priority-setting process designed annually to identify the health policy issues that will be at the core of the Council's work. It is a very collaborative process and there is a good understanding of the vetting process. Priority is afforded to issues that generate a strong consensus among participants.

I do believe, though, that if too many actors change too quickly, we would become immobilized, because we're too young, still, as an organization. . . . But I guess on the other hand, I sit there and say to myself, we have been very careful, as a collective, to choose our issues.

HCCC member organizations vary significantly in organizational design and hierarchy. Some are highly centralized corporate structures with a single board of directors and staff throughout the country accountable to one senior executive. Others are highly decentralized federations, in which there tends to be more latitude for decision making at the local level and thus greater potential motivation for local involvement. The decentralized organizations are more vulnerable to internecine battles over the control and distribution of resources. The more centralized organizations, by contrast, have the advantage of being able to make decisions more quickly about the enterprise as a whole, and possibly with greater responsiveness to changes in the external environment; but they may have greater difficulty in recruiting and motivating volunteers at the local level. One respondent, commenting on these differences, noted that membership in the Council is causing some organizations to adapt their decision-making models.

You'll recall that members make decisions about certain types of policies, [the] Executive Board is responsible for ensuring that they're implemented. So, it has caused challenges in the past, but interestingly enough, there's been enough of a movement forward that . . . [some] are finding ways within their organization to be able to respond in a [quicker] fashion.

Prompted to consider whether this would mean that, through collaboration, members would come to adopt a basic common denominator in terms of their speed, their internal

ability to make decisions, the respondent said that it might instead cause organizations to opt into or out of processes and decisions, depending on the time available and the complexity of the issue at stake.

This discussion of the extent to which collaboration impacts upon decision making within the member organizations raises the question of whether norms and values for governance and decision making within the HCCC are being embedded in the organization beyond its current leaders. Evidence of this process of embedding norms and nurturing trust both within the Council and also within its members is already available, but it is not definitive.

The evidence for embedding practices is stronger and more readily available at the Council itself. There is a strong consensus among the respondents that the norms to guide decision making formalized in the Governance Policies of the Council are and have been applied. At the most recent Roundtable (Toronto, September 2001), I was impressed by the frequency with which the facilitator guiding the development of HCCC's response to the Romanow Commission reminded us about the Governance Policies approved many months earlier. In examining the sustainability of Canada's health care system, the issues that the Romanow Commission faces are systemic, numerous and complex. The discussion about how to frame the HCCC's position was not an easy one; but the Governance Policies survived the test and allowed the Council to move quickly and take advantage of an invitation to present a brief in the first round of consultations.

There is also valuable evidence of this process of embedding trust and organizational practices, beyond the individuals who have guided the Council's work in its early stages of development, in the way the Council has managed its Executive Director's short-term leave of absence. Ms. Marrett is on parental leave for the late summer and fall of 2001. While she remains available informally to the acting Executive Director, it is important to note that the consultative process designed for the Roundtables, and implemented again this fall, was already well developed and could survive the temporary absence of the Executive Director.

This process of embedding trust and organizational practices also operates at the level of the Executive Board of the Council, which has experienced some transitions in its membership. One respondent commented on this process:

Probably what I would consider to be the most important part has been this building of trust, and it has not only occurred within staff, but it has occurred within volunteers, and that, to me, that's a huge step forward. . . . Even when there's been a change in volunteers, like if Board chairs have changed . . . that trust is still there. So that to me indicates that trust has not just occurred within individuals, but has begun to pervade the organization, which is an important step forward, because there will always be changes.

The process of embedding some of the values, norms and practices of the Council in its member organizations is a more difficult one, and the evidence for this process is therefore less convincing. In commenting about this process, one of the Executive Directors explained that “there is a growing recognition that the HCCC becomes a vital extension of our organizational work.” While there is growing recognition of mutuality, interdependence and of the value of the work of all members of the coalition among the actors within the coalition, it is less clear whether the broader constituents of the member organizations also share this recognition.

A number of respondents explained that this process relied in large part on “having products to sell.” The early successes noted above have been critical to this process, as will be future successes. “An argument that there are some things that you simply have to be at, simply doesn't swing it.” This reality puts pressure on the Council to deliver health policy results that are visible as well as beneficial.

Although consensus is not the norm for decision making in the Governance Policies of the Council, a number of respondents commented on the need to focus on issues that generate both strong and broad consensus. The danger identified here is twofold. First, there is a fear that the government could overwhelm the Council with requests for participation in consultations on issues that are important to the government's agenda but do not necessarily reflect a broad consensus. This is a danger, in part, because people realize that the present Minister of Health has discovered the political advantage of mobilizing Canadians through the health charities for important planks on his agenda. Secondly, there is a fear that some issues brought to the Council might be better addressed by individual organizations or small subsets of the larger coalition.

Owing to these dangers, the practice of choosing and focusing priorities through the highly consultative Roundtables is extremely important. Because the Roundtables are held semi-annually, it will be important to establish practices that will allow the Council to respond to, or deal with, emerging issues.

Those interviewed considered the challenge of gaining commitment to and support of the HCCC at the level of the governing board within their own organization. “I see it as part of my responsibility to bring our organization on board, in relation to the value of HCCC,” one respondent explained. Another said, “I think there are real challenges in embedding it [the trust] beyond the current people, I think that happens all the time. The commitment is almost always there at the staff level. . . . It is always a challenge, and is currently a challenge, to sell to our board the value-added.”

In these early stages of the formation of the HCCC, respondents also commented on the challenge of ensuring some modicum of stability in the actors within the coalition, both at the formal and informal levels. One respondent said, “I think there is a balance between the HCCC trying to be an inclusive kind of organization and, in some way, having consistent players around the table that are committed to it.”

The challenge of managing transitions in those who play an active role in the Council’s work was explored in discussion with all respondents. “We all have very different styles, but at the end of the day we have to sign on, on the basis that’s it’s not just us that are there but our organizations,” said one. Another commented on the fact that both the Canadian Cancer Society and the Heart & Stroke Foundation of Canada appointed new chief executive officers earlier this fall, and added that this will not transform the relationship of the two largest health charities to the Council. This was possible because, in both cases, other senior leaders will continue to be actively involved in the work of the HCCC. In one case, this included both a past Chair of the national Board of Directors and the Acting CEO. In the other, the chair of the national Board of Directors and other members of the senior staff, were and continue to be actively involved. The reality is that the members of the coalition are connected to it through more than one person, because of this commitment to the involvement of both volunteers and staff. This dual linkage has facilitates the process of embedding support of the Council at various levels, and makes the transition less painful for senior volunteers or staff.

Learning

Earlier in this paper, I identified learning as one of the key knowledge-based effects of collaboration. This effect is also evidenced in my discussion of the dynamics of collaboration with the Council.

From the perspective of one of the small health charities, an interviewee explained that “now, more quickly, we’ll pick up the phone and call one of [our] colleagues or another organization and say, ‘You’re part of the health charities group. We’re working on this—have you done any work in that area?’ So I think there’s much more communication and collaboration on trying to get the work of the respective organizations done, trying to eliminate some of the duplication of effort. Why reinvent the wheel?” In this way, collaboration contributes directly to learning specific skills or competencies.

Some respondents frame this learning potential at the individual level. Others see evidence that it operates at the organizational level.

I think, from an individual point of view, you have a stronger network from which you can draw on. Too many of the individuals, in their capacity as CEO, are working alone. Alone, not meaning “alone,” being the only one in the office, but in that they are the ones where the buck stops there, from the staff perspective. So, who do they go to when they need support, information, when they need to find out what other organizations are doing related to a particular topic? I think by virtue of, or because of, the situation we’re in, we have been able to feel much freer in calling other individuals to discuss issues.

Another example cited, flowing directly from the HCCC collaboration, is interesting both in terms of the learning facilitated and also in terms of the measure of change it represents in the nature of relationships between large and small organizations. A large health charity had planned, in conjunction with its annual general meeting, some organizational development activities to involve senior volunteers. The organization chose, of its own volition, to extend the invitation to representatives of smaller charities who may not have opportunities for learning in a similar context.

The most direct impact on skills acquisition at the organizational level is in the realm of analyzing and formulating public policy. “There is an increased sophistication in our ability to look at an issue and get some data or perspective on it,” as one respondent said; and this sophistication is available through HCCC collaboration with member

organizations, few of which have the internal capacity to participate in the public policy process.

But beyond the many examples of learning about skills and competencies, as Simonin (1997, 5) reminds us, people also learn a great deal about interorganizational cooperation, and how to behave cooperatively themselves. We have seen much evidence of this earlier in the discussion of the development of norms and organizational practices to guide the work of the Council.

Discursive Effects of Collaboration

I discussed earlier the work of Lawrence, Phillips and Hardy (1999) and their approach to collaboration as a discursive process – a social process that generates meaning. While I do not claim that the collaborative activity found within the Health Charities Council of Canada is alone responsible for changes in our understanding of the meaning of health, it is important to note that the creation of the HCCC parallels the development of a more encompassing notion of health.

No longer are we satisfied, as Canadians, to understand health as only the medically required and publicly insured services covered by the Canada Health Act. The understanding of health has shifted to include a broader set of responses. These include responses to improve environmental conditions, prevention strategies to decrease the incidence of certain conditions, and genetic detection to provide information for family planning. Individual attitudes and lifestyle choices ranging from fitness to active and independent living have also shifted. Finally, a focus on the quality of life for people living with chronic disorders or severe disability, on palliative care, and on patient input and family participation in decision making at the point of care have triggered important debates about the medicalization of our health care system.

These important shifts are manifest, in different ways, in the Governance Policies of the HCCC (2001a, 5):

We believe that health is not simply a medical matter; health involves the total person and his/her lifestyle and environment; although medical care is often critical, the concept of

health also includes individual self-help and self-care, family care and support, and community empowerment.

The broadening of our understanding of health is reflected in the broader membership of the HCCC. It includes organizations that are interested in social marketing and prevention, among other things, with a view to reducing the incidence of preventable illnesses such as cancer, cardiovascular diseases and diabetes. It also includes organizations that are interested in improving the quality of life of people living with congenital, genetic and chronic disorders (e.g. Thalidomide Victim's Association, The Cystic Fibrosis Foundation of Canada, and the Muscular Dystrophy Association of Canada). And, it is also reflected in the various approaches to health, beyond those that are medically required or provided in the institutional health system. Peer support, palliative care, self-help, diet and lifestyle counselling are among the many new modes of thinking about and delivering health services, many of which have been pioneered in the voluntary health sector.

Perhaps the best example of an important transformation in approaches to health spurred very directly by the work of voluntary health organizations, is in the thinking about and in the delivery of services to people living with AIDS. The very fact that few ever talk of "victims" of AIDS anymore but rather speak of "people living with AIDS" is evidence of this transformation. While less visible, the same could be said about the changes in our perception of Canadians living with disability, as it is through the voluntary health sector that approaches to independent living, life skills development and peer support have been pioneered, resulting in the expectation of people living with disability to live independently and avoid institutionalization.

The HCCC collaboration has also caused some to explore the interconnectedness of many conditions and disorders that have hitherto been considered in isolation. The relationships between the incidence of diabetes and cardiovascular disease, between celiac disease and osteoporosis, and between various neurodegenerative disorders (including Alzheimer's) have been brought to the surface or reinforced in the context of this emerging collaboration.

One respondent commented that she hoped the HCCC collaboration would also change the understanding Canadians have of the voluntary health sector. "Hopefully, Canadians

will start understanding and talking about the voluntary sector and not only the public and private sectors when they envision a sustainable future for the health care system.”

Trust-based or Power-based Relations

We have noted the overall optimism and confidence with which the Council has been greeted. In the interviews, we prompted discussions of some of the risks and pitfalls of collaboration to explore how fragile the HCCC effort might actually be. In particular, we hoped to find evidence that would show whether the growing diversity of members in the collaboration – or the reduction in the homophily among its members – would cause a shift from trust-based to power-based interactions. While our hunch was that the growing diversity in the membership would, in fact, erode the potential for trust-based relations, we have witnessed the opposite in interviews. In my own personal experience, I have also seen evidence of tremendous trust between the actors and very few examples of the types of politics that are divisive.

The best explanation for this lies, first, in the quality of the processes designed to establish priorities and, secondly, in the fact that these priorities reflect a strong and broad consensus among HCCC members. In this finding, there is an important lesson for the current and future leaders of the HCCC: avoid the temptation of extending the Council’s reach to a broad range of issues without a similarly broad consensus, even if funding to do so were to become available from public or private sources.

Lest I leave the impression that respondents were unrealistically optimistic in their evaluation of the Council’s potential for success, it is important to note that they pointed to many factors that underscore how fragile the collaboration is at this early stage of its development. They cited the challenge of future transitions in senior staff and in the dedicated members of the Executive Board, though they also noted, as we saw earlier, that some of these have already been successfully managed. They discussed the importance of focusing on an agenda that is both broad and the source of strong consensus. In this context, they noted the risk of subsets of members causing issues to be on the table without the strong consensus required. Others highlighted the related risk of the Council becoming burdened by the issues of survival and strength of the smaller

health charities. In the same vein, they acknowledged the importance of the Council's continuing lobby for capacity-building funds to palliate this situation.

One respondent in particular discussed the process of institutionalization – though not in these terms – and noted that new collaborative ventures are particularly at risk in their infancy. His argument was a recognition that the Council, with growing legitimacy and organizational practices more strongly embedded both within and beyond the HCCC collaboration itself, would be better equipped to survive challenges from its own members or from the Government of Canada.

Of all the pitfalls mentioned, two were cited as being particularly problematic. The question of how to fund the work of the Council was mentioned by all respondents, and they readily acknowledged that the Council has not satisfactorily or definitely resolved this complex issue. One respondent summed it up by explaining how much easier it is to generate issues of common interest than to pool resources in fighting those same issues. The second pitfall lies in the relationships between charities that fragment each other's work, as is the case with the Canadian Cancer Society and the Breast Cancer Foundation of Canada, or (to use an example that I know intimately) the Muscular Dystrophy Association of Canada and the Amyotrophic Lateral Sclerosis (ALS) Society of Canada.

The question of resources raised many complex issues. Respondents acknowledged that the Council's staff is already stretched in the work required to advance the interest of its members on issues already identified jointly. This raises the question of the optimal level of resources required by the Council in the conduct of its work. Although respondents acknowledge that the HCCC is not currently funded at an optimal level, there is also recognition that the current level is far greater than that available to its predecessor organizations.

The question of fee schedules and the extent to which fees will vary, from time to time, to reflect the capacity to pay of various members was identified, but respondents suggested that the balance struck in the early days of the Council was a healthy one in this regard.

[The] question really becomes, "Why are we really supporting all of these mom and pa organizations?" And the focus suddenly shifts from how is this coalition adding value to "Are they paying their fair share?" So the resource issue, I think, is one which drives, you have to be careful that it doesn't become the dominant issue or the dominant

characteristic that people focus on. The current fee structure, and maybe it's not quite right, but my sense is that we have struck a balance where that kind of criticism would be kind of muted or perhaps even blunted completely.

Other potentially divisive issues on the resource front include the question of what level of resources should be funded by HCCC members so as to maintain the Council's independence from the Government that it seeks to influence, and the related question of how the Council might secure other resources in the private sector without jeopardizing already established sources of funding for its members. In the case of the first one, a strong argument was presented that the Council should fund at least 50 percent of its core operating resources from membership fees. In the latter case, the view was easily agreed upon that the Council's fundraising should not compete with established sources of funding for its members. In my estimation, while these are very important and worthy principles, they are more easily articulated than translated into practice.

The power politics and competition among charities that fragment the work of other, often more established ones are well known. The common source of heated disagreements and epic battles, often condemned by donors, is the question how to balance resources so as to support programs and research for a particular disorder or condition. In some ways, this fragmentation is evidence of a competitive marketplace for fundraising dollars, and some would argue that a healthy dose of competition is required in order to force improvements in organizational practices.

Because the umbrella nature of the Muscular Dystrophy Association of Canada has often led to the creation of smaller organizations with a focus on a single neuromuscular disorder, I am very familiar with this dynamic. And, while the dynamic can be a source of competition, it can also spur collaboration as it has done, in our case, with the ALS Society of Canada.

The challenge for the Council is to continue to ensure that these issues are not on its agenda or mediated through its work. Unlike HealthPartners, the workplace fundraising coalition, which excludes from its ranks any organization that fragments the work of another member organization, the HCCC does not limit access to membership on this basis. This reflects the very important fact that HCCC is not a fundraising coalition and that its work is focused on far broader issues of common interest. In this way, the work of

the Council may have the opposite effect of reversing fragmentation and spurring collaboration among competitors. Evidence to this effect in some of the interviews was a surprise.

I just suggest that perhaps the HCCC will help organizations to bring back to their home organizations enough value that people will say, “You know what, we can work within this framework. We still have problems; we need to deal with those problems internally, but there are other things happening and we’ll all benefit from those other things.”

The HCCC as a Source of Social Capital

We discussed earlier the construct of social capital in the hope of applying it at the interorganizational level among health charities and of testing the notion that the Council might be a source of social capital. We also raised the question, of the possible uses to which this capital could be applied and at what level the benefit would accrue, in the event that social capital were generated through this collaboration.

I think that the more interconnections or interconnective branches, strings, relationships within our society, the stronger our society. I think it does a number of things, it enhances the development of social policy . . . and you need that connectedness to have social policy that addresses those issues in a more meaningful way. It keeps those who are making decisions more connected with the impact of their decisions. And I think that there is an asset that is built up with these connections, there is an asset of talent, an asset of knowledge, and an asset of ideas, and an asset of people ready to move into action, and to assist and support.

The respondent here assumes that the relationship between connectedness and the quality of the relations in the larger polity is necessarily a positive one. Portes (1998, 4) reminded us earlier that this not necessarily so; nonetheless all respondents identified the impact of the Council in this regard in very positive terms. And this is not surprising given the fact that the members of the Council share the objective to improve the health of Canadians.

Another respondent commented on this relationship more specifically at the level of the organization. “There’s a lot of stealing of ideas. When you get back to a board table, and people start saying, ‘Did you know this organization was doing such and such in the area

of fundraising? You know with a different plan. Why aren't we doing that?' Not so much stealing of an idea, but using it within their own constituency.”

At the individual level, the value of the social capital created through and among the volunteer representatives from the various organizations was often cited as particularly important. This largely reflects the fact that volunteers from the different national health charities have had few opportunities to have meaningful dialogue and exchange, with fewer opportunities still for genuine concerted action.

There was also acknowledgement of the value of the links created among staff, and among staff and volunteers. One respondent described it as “a very important early-warning and mutual support system.”

Two respondents had had direct personal experience where connections made through the Council had led to their being considered for executive positions. This serves as an example of the way in which the networks created through the Council may generate private benefits for the individuals active in its work. In this same vein, another respondent insisted that the bonds of friendship and the personal enjoyment derived from the work were also personal benefits enjoyed through the HCCC collaboration.

All respondents recognized that social capital is generated through collaboration among health charities. Individually, they recognized the potential for its conversion at the individual, organizational and societal level, reflecting the many levels at which the Council works. They also recognized that it was a wasting asset, and that its value needed to be renewed or generated in an ongoing process of collaborative activity.

5

Conclusion

We have demonstrated that the creation of the Health Charities Council of Canada, with its broadened membership of large and small charities, the inclusion of both staff and volunteers as actors and its interest in a broad range of issues, has had an impact both on the dynamics of the collaboration and also on its effects.

We have explored how norms have been developed and are being embedded in organizational practices both at the level of the collaboration and the member charities. We have discussed the learning processes at work in the collaborative context and revealed the discursive effects of the collaboration on the changing meaning of health.

The real surprise in these findings is that the broadening of the collaboration has not changed the nature of trust-based relationships among its actors. While we assumed earlier that the increasing complexity and size of the collaboration might generate a rise in power-based relations, this has not proven to be the case in the Council's formation and early development.

The expanded HCCC collaboration has eroded perceptions of exclusiveness that had marked the relationships between the largest health charities and the many smaller ones. In commenting on the quality of relations among the members of the Council, one of the Executive Directors said, "I think I would say it has improved them, and it has, in fact, developed relationships."

While there is no evidence for the growth of power politics within the coalition, there were many cautionary words. There was recognition that strong and stable leadership had been and would continue to be important to this process; and, there was broad consensus that the focus should be on those issues where there was a pre-existing and strong consensus. But there was also recognition that the Council had not yet been tested and, in this regard, two issues were surfaced that are potentially troubling for the Council as it evolves over the coming years. These include the question of how to fund its work and

the risk for spillover into the Council's arena of the power politics that characterize the relations of many, but not necessarily all, of the charities who are in direct competition with others, with the resulting fragmentation of their work.

Beyond the sometimes immediate and direct outcomes of the work of the Council, in terms of changes in public policy, we revealed another less visible output of the Council's work: the generation of social capital at both the individual and the interorganizational levels of analysis. In reaching this conclusion, I am not trying to suggest that there was no such capital in the web of relations that pre-dated the Health Charities Council of Canada. Quite to the contrary, these networks and the resulting capital generated through them were noted by a number of respondents. Further, I am not trying to suggest that the social capital available in the earlier webs of relations did not contribute to the emergence of the Council. My only conclusion is to suggest that the webs of relations now present in the Council constitute a source of constant renewal of social capital, and that this capital now is available to be converted into a larger number of ways. I also recognize, as others do, that social capital is a wasting asset and that it is only through the dynamics of collaboration that it can be sustained.

We thus recognize the importance of understanding collaboration as a social process, one that extends far beyond the "rational actor" model of collaboration developed by economists. We also come to appreciate why a model of collaboration with roots beyond economics is important for application in the voluntary sector. For one, it allows one to integrate those relations and transactions that are motivated neither by profit nor by edict, but that are motivated by the "gift" or by voluntary action (Godbout, 1995).

This research project, to the best of my knowledge, was the first to apply the construct of social capital at the interorganizational level of analysis in the voluntary sector. It was also the first study of the Health Charities Council of Canada since its inception some two years ago. Because of the exploratory nature of our investigation, many questions remain.

Understanding more fully the logic of the relationship between collaboration and social capital is the largest question left unexplored at this stage. From the perspective of the voluntary sector, where collaborative activity has been strengthened by donor

expectations and by government initiative, there is a need – and I might add, it is an urgent one – to develop models or an understanding to wrestle the challenge of resources as an inhibiting factor in collaborative activity. Related to this is the challenge of better understanding the nature of competition and competitive pressures in the voluntary sector to develop and understanding of the costs and benefits of the growing fragmentation of the work of health charities over the last quarter of a century.

I hold a deep conviction that Canadians stand to benefit exponentially as voluntary sector organizations deepen their understanding of and commitment to collaborative efforts. I hope this paper and my reflections contribute in a small way to nurture collaborative activity in our sector.

APPENDIX

Interview Request Letter

As part of the requirements of the McGill-McConnell Program for National Voluntary Sector Leaders, I am conducting a small research project on the Health Charities Council of Canada to reveal some of the outcomes of interorganizational collaborations in the voluntary health sector in Canada. This project will apply the construct of social capital to the web of interorganizational collaborations that are formed by national health charities in Canada, with a focus on the broadest and most inclusive of these collaborations, the HCCC. To achieve this purpose I am conducting interviews with a few individuals who are active in or have played a determining role in the formation of the HCCC.

I would like to ask you to participate in this project. Your identity is not needed for this study and will be kept confidential at all times. The interviews will be approximately 1 hour in length and will be tape-recorded. The interview is completely voluntary and you may choose not to answer any question if you choose. The interviews will be conducted over the telephone.

The information gathered during these interviews will form the basis of this research project and may serve to strengthen our sector's capacity to collaborate. I will be pleased to share a copy of the paper resulting from this project.

Please review the consent material on the following page. Before the interview commences, I will be asking for your verbal consent to participate in this project. If you were prepared to participate in this study, I would appreciate it if you would call my assistant to confirm a time that would be convenient for you. Rosanne can be reached at (416) 488-0030, extension 135. If you have any questions, do not hesitate to contact me directly at (416) 488-0030, extension 130 or at ysavoie@mdac.ca. My hope is to complete the interviews during the period of September 21 to October 10.

If you agree to participate in the interview, I would be grateful if you would also identify a few other individuals whose involvement with the HCCC has been significant or determining and who might be well disposed to my request for an interview.

Thank you for your collaboration.

McGill-McConnell Program for National Voluntary Sector Leaders

The Health Charities Council of Canada (HCCC): Outcomes of Interorganizational Collaboration (*Working Title*)

Interview Outline

Consent: Interviewees understand that the purpose of this study is to reveal some of the outcomes of interorganizational collaborations in the voluntary health sector in Canada, possibly with the view to strengthen our capacity to collaborate. You have been identified as an individual who is active in or has played a determining role in the formation of the HCCC and thus are being asked to participate in this interview voluntarily. The interview will be tape-recorded and then transcribed at which point the original tape will be destroyed. You are free to withdraw your participation at any point during this process. You are also free to refrain from responding to specific questions if you wish. The information you provide may be used for presentation and publication, but your anonymity and that of your organization will be ensured.

Participants: As part of the sampling technique for this research, you will be asked to provide the name of one individual who has played a particularly active role or has been particularly determining in the formation of the HCCC. If the name of the person you offer has already been identified, you will be asked for a second suggestion, and so forth.

Interview Outline: The following is an outline of the key areas to be covered in the interview. The interview will not be highly structured and the discussion may depart from this outline.

Collaboration and its context:

Nature of active involvement in HCCC, in other collaborations, are such collaborations on the increase for your organization for others, strategic relevance of collaboration for your organization

Outcomes of collaboration (positive):

Resources garnered by the organization; type of resources garnered;

Improvements in organizational performance or effectiveness in influencing public policy, shaping a national research agenda or in other spheres of activity;

Trust generated in relationship with colleagues and/or other organizations;

Impact at the level of the individual executive (career mobility of executive promotion).

Risks and Downside of collaboration:

Loss of autonomy;

Loss of distinct identity; increasing homogeneity in activities accomplished through the collaboration.

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