Executive Summaries :

The Voluntary Health Sector in Canada :

Outcomes and Measurement

The Voluntary Health Sector in Canada :

*Developing a Typology – Definition and Classification Issue*s

A DISCUSSION PAPER
ON OUTCOMES AND MEASUREMENT
IN THE VOLUNTARY HEALTH SECTOR IN CANADA

EXECUTIVE SUMMARY

Prepared for the

Voluntary Health Sector Project

October 1999

Barbara Legowski
Terry Albert

Foreword

Voluntary organizations are receiving increasing recognition for the role that they play in Canadian life. Although their contributions are evident in most communities, they have yet to be systematically documented. In 1999, the Canadian Centre for Philanthropy, Canadian Policy Research Networks, Health Canada and the Coalition of National Voluntary Organizations undertook a joint initiative to enable researchers to begin documenting the contributions of voluntary organizations working in the area of health. Two papers were commissioned to lay the foundation for further empirical studies in this area. *Developing a Typology of the Voluntary Health Sector in Canada: Definition and Classification Issues* was prepared to address the important issue of defining what organizations should be included in such studies and to develop an appropriate system for classifying these organizations. *A Discussion Paper on Outcomes and Measurement in the Voluntary Health Sector in Canada* was prepared to provide guidance about how to measure the economic and social contributions of voluntary health organizations. It is hoped that these two companion papers will help set the stage for further research into the social and economic value of voluntary health organizations in Canada. Copies of both papers and of their respective Executive Summaries can be obtained by contacting any of the respective partner organizations.

The Management Committee for this project would like to take this opportunity to thank the many people who made contributions to these studies. Individuals from a number of key organizations contributed their time and insights through discussions with the authors of the papers and we thank them for their valuable input. We also thank the five anonymous peer reviewers for their thoughtful comments and suggestions. In the final analysis, however, the papers reflect the views and opinions of the authors and any errors of omission or interpretation are their own.

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Introduction and Background

The Canadian Policy Research Networks, the Canadian Centre for Philanthropy (CCP), Health Canada and the Coalition of National Voluntary Organizations have entered into a partnership to conduct a study on the voluntary health sector. The object of the project, entitled The Voluntary Health Sector: An Assessment of its Size, Scope and Value, is to assess the contribution of the voluntary health sector by:

- giving the sector form and definition through boundary mapping and classification;
- analyzing and measuring both the qualitative and quantitative economic and non-economic contributions of the sector; and
- ensuring the dissemination of research findings to a variety of audiences, including the voluntary health sector, government, researchers and other interested parties.

The *Discussion Paper on Outcomes and Measurement in the Voluntary Health Sector*, which satisfies the project's second objective, is summarized below. The paper's objectives are:

- to review the literature on measuring health outcomes;
- to consider the feasibility of measuring the inputs, outputs and outcomes of health nonprofits; and
- to make recommendations on what can be measured to determine the contributions of health nonprofits to Canadians' health and/or to the health care system.

Hence, this paper is intended to partially address the second project objective. It was prepared in isolation of a typology of the VHS. As such, an intentionally generic approach to outcome and activity measurement was adopted. In other words, instead of focusing exclusively on outcomes and other measures in the health arena, the paper allows for a blurred boundary between health and social services. It is in this sense that the paper is a work in progress that should be updated once a typology for the VHS is developed. It is envisaged that this would also be accomplished through a substantive consultation process with the VHS. Ultimately, this initial work will inform the research design and methodological development for the empirical work on assessing the various dimensions of the value of the voluntary health sector in Canada.

Defining the Voluntary Health Sector

The research for this paper was undertaken without predefined boundaries or a classification for a voluntary health sector (VHS). Therefore, a working definition was developed for the sector to give it scope for the duration of the research. The process of definition had two steps: the first identified the health organizations or organizations working in health in such a sector; the second identified which of these organizations' activities had a health outcome.

Two existing organization-based classification systems were first considered: that of Revenue Canada and that of the International Classification of Nonprofit Organizations (ICNPO). Holistic

definitions of health and the population health paradigm were also considered in delineating the sector. These had the potential to significantly broaden the scope of a voluntary health sector.

The Revenue Canada classification of registered charities and unregistered nonprofits whose stated purpose is health was selected over the ICNPO health category even though at first glance there appears to be some overlap and ambiguity in the Revenue Canada categories[1]. The ICNPO appeared too institutionally selective while Revenue Canada's classification is broader. The very broad scope suggested by a population health paradigm was rejected 1) because of practical difficulties experienced by the field in relating program outcomes to population health determinants, and 2) because data collected to date describing potentially a voluntary health sector by, for example, Revenue Canada, had been limited to those organizations that recognized themselves as involved in health. As well, it seemed presumptuous to allocate organizations to a health sector that had not themselves identified their actions as directly contributing to health outcomes.

Next, an activity-based dimension with five domains was added to the Revenue Canada organization-based classification. The domains provide a means of relating discrete organizational processes to specific measurable health outcomes, where a health outcome is:

> a change in the health of an individual, a group of people or population that is attributable to an intervention or series of interventions (Rissel, Ward and Sainsbury, 1996).

Our working definition for a voluntary health sector was therefore:

> the group of formal organizations that are registered charities or nonprofit organizations without charitable status with a stated purpose or 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.

Conceptual Framework for Outcomes and Measurement

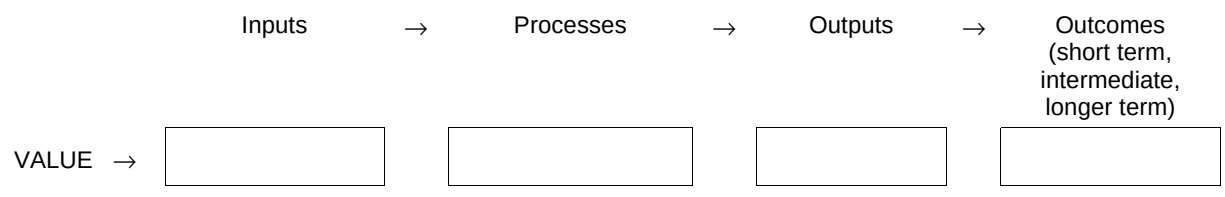
Having identified a voluntary health sector for our research, we combined the organizational activity domains defining the sector with a traditional inputs-through-outcomes model of organizational performance, where outcomes are the benefits for participants during and after program activities (Plantz, Greenway and Hendricks, 1997 - see Figure 1). Osborne and Tricker (1996) refer to this same model as the different parts of a service production process that make up a conceptual framework for studying organizational performance.

Figure 1: Inputs through Outcomes

Inputs → Activities → Outputs → Initial Outcomes → Intermediate Outcomes → Longer-term Outcomes

Not only do inputs through outcomes create the framework through which organizational performance can be measured, they also represent the spectrum across which value can be derived. There is inherent value that can be measured at each point in the spectrum (see Figure 2).

Figure 2: The Spectrum of Value: Inputs through Outcomes



Combining the organizational activity domains with the spectrum of organizational value formed the basis for a conceptual framework for our research. We added to this a societal domain recognizing that products and services of nonprofits are returned to the community. They add value to social capital and cohesion, that is, add value that is more socially than privately distributed (The Steering Committee for the Social Accounting Framework Project, 1998 – subsequently referred to as The Steering Committee; Jensen, 1998; Veenstra, 1995). In this way, the conceptual framework for the research respects the standard model of how an organization can measure performance at the same time that it advances the discussion of the kinds of value or impact that can be attributed to the activities undertaken (See Table 1).

To understand what the field is experiencing in terms of general measurement and outcomes measurement in particular, the paper explored briefly the performance measurement methods that evaluation science makes available to nonprofits. Historically, nonprofits have measured organizational and program-related inputs and outputs, largely driven by the reporting requirements of their funders (Plantz, Greenway and Hendricks, 1997). Examples of inputs are revenues, assets, paid staff, volunteers and volunteer time; examples of outputs are numbers of clients served and programs provided. More sophisticated measures of outputs add the dimension of quality of services provided, such as infection rates in hospitals. Generally, organizations have shown how much effort has been generated for how many people.

More recently, funders and the public are placing greater emphasis on value-for-money decisions for resource allocation which require program outcome information – they want to know if anyone is better off as a result of the services provided and they want to know the cost-benefit (The Panel on Accountability and Governance in the Voluntary Sector, 1999).

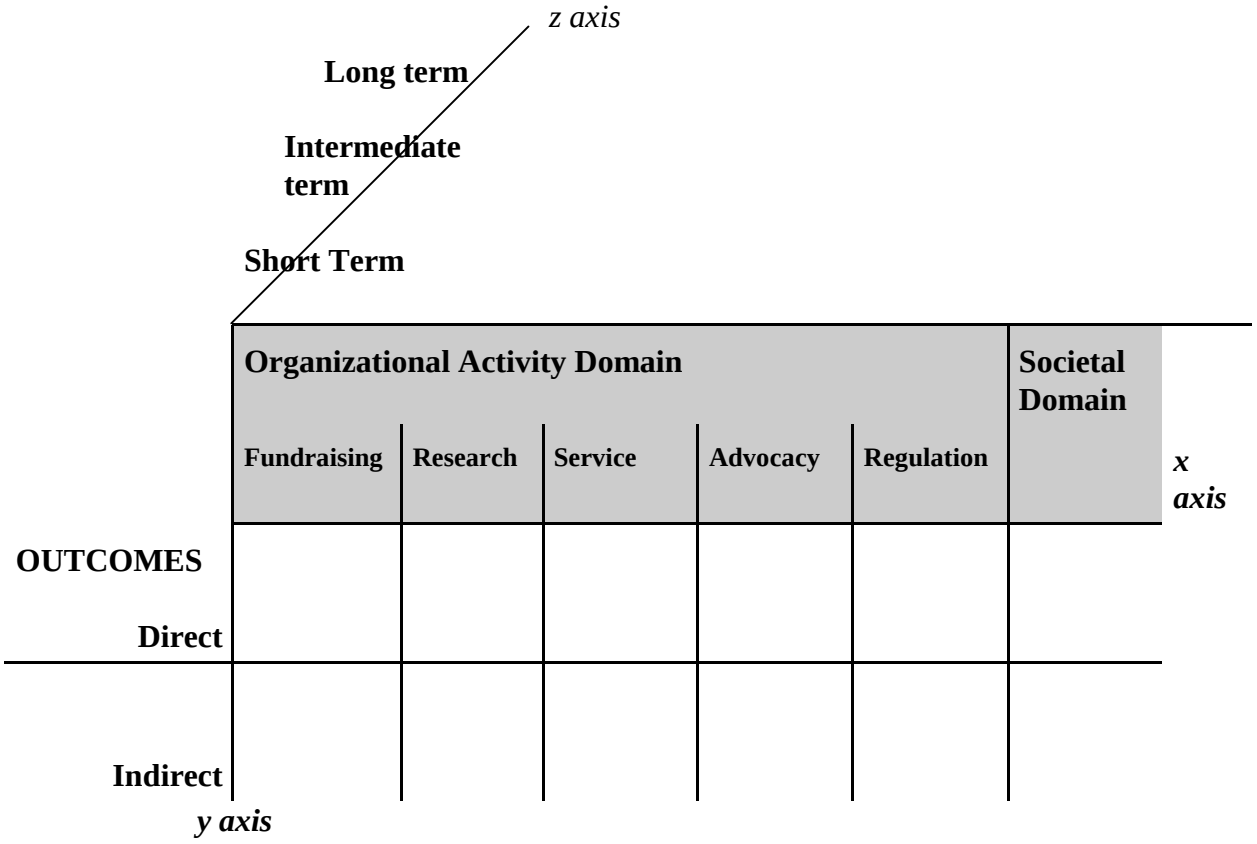
Table 1: Proposed Data for Determining the Value of the Voluntary Health Sector

	ORGANIZATIONAL ACTIVITY DOMAINS						SOCIETAL DOMAIN
	Fundraising	**Research**	**Service**		**Advocacy**	**Regulation**	
			Prevention/ health promotion/ education	**Care**			
Inputs – resources	- volunteer hours; paid staff hours; volunteer training hours; volunteer training expenses; program and service budgets						
Processes	- descriptive information about the types of programs and services offered						- volunteers' evaluations of personal benefits
Outputs	- # donors - $ raised	- # publications - # citations - # presentations - findings	- # materials published - # information campaigns	- # clients/ patients served	- # policy people contacted - # communiques	- # licenses issued - # licenses revoked - # professional practice complaints/ investigations	
Outcomes	- diversity of donor base - sustainability of donor base - expansion of donor base	- evidence of uptake and application of findings by practitioners and public - other evidence of knowledge transfer	- % target population reached - changes in knowledge, attitudes and behaviour - effect on disease incidence	- maintenance of current health state - reduced rate of decline - cure rate	- evidence of policy changes - issues acknowledged or given profile - measurable improvements in quality of life - services added or adjusted to meet needs	- evidence of public trust in a health profession	- social return-on-investment

The shift away from traditional inputs and outputs has intuitive logic. In response, evaluation science is delivering an increasing array of methodologies for measuring not only program outcomes but also various other aspects of the program delivery process. Methods range from rigorously scientific experiments with control groups, to evaluations that deliberately involve many participants and collect numerous viewpoints in order to attach as large a constituency as possible to a particular program rendering a collateral benefit to the program operation.

Many issues arise with such a growing emphasis on outcomes measurement. For one, defining and measuring outcomes can be complex because outcomes have multiple dimensions. For example, the combination of possible measurement methods and time frames for measurement can create a number of different outcomes for any activity being evaluated. This is illustrated in Diagram 1 below, where outcomes have three dimensions, placed along three axes. Along the *X* axis are the organizational and societal activity domains. Along the *Y* axis are direct and indirect outcomes, direct being those that are the ultimate intention of an activity and indirect being proxies for the ultimate outcomes or bridges to them. The *Z* axis represents outcomes determined by time. The time periods range from short to intermediate to long term.

Diagram 1: The Dimensions of Outcomes



Legend

x axis represents organizational and societal activity domains.
y axis represents the nature of outcomes.
z axis represents the timeframe in which outcomes may be measured.

Most outcome measurement focuses on the shorter terms. Evaluations of interventions that have a long lag time between the delivery of the service and the manifestation of an outcome are not common due to the complexities associated with longitudinal data collection, multi-year expenses and a largely funder driven bias for demonstrating short term or quick results.

Nonprofits' Self-evaluation and Measurement

The choice of evaluation methods is a continuing debate for nonprofits. They often find themselves providing complex social and health services, which in some respects is their niche (Hirshhorn, 1997; Webber, 1994). Outcomes for these services are inherently difficult to assess, or are too diffuse or broadly based to be readily measured with quantitative techniques that are favoured within a positivist frame of thinking. As well, nonprofits typically have a wide and complex range of stakeholders, making the selection of what to measure, and how, a difficult decision especially given limited resources (Voluntary Sector Roundtable, 1997).

Viewpoint or perspective concerning the choice of measure is an important consideration. For example, some argue that what is perceived to be of value regarding an organization's services or products is subjective and negotiable, created by individuals involved in a specific context and capable of evolving as the individuals interact (Forbes, 1998). The evaluation literature encourages organizations to identify for themselves the outcomes or other aspects of program delivery for which evaluation results will optimize program effectiveness, as opposed to measuring only what is of interest to powerful stakeholders such as funders (Plantz, Greenway and Hendricks, 1997). Funders are in fact cautioned against imposing outcome measurement onto the voluntary sector without a full understanding of its limitations and possible negative impacts. For example, inappropriate linkage of funding to specific outcomes measurement can lead to: resources shifting from services to measurement with no direct benefit to programs; prevention and development programs with harder-to-measure outcomes being penalized; "creaming" being promoted (the deliberate selection of clients or programs most likely to have positive outcomes leading to increases in inequalities in health status); the discouraging of risk taking and innovation; and the fuelling of interagency competition as opposed to cooperation (Plantz, Greenway and Hendricks, 1997).

Along with the above hazards of an overemphasis on outcomes measurement are ethical issues surrounding information disclosure by nonprofits. Outcomes measurement delivers new information to the public domain creating the potential for linking, for example, inputs to outcomes (cost-benefit). Having in the public domain new information about a nonprofit's performance can jeopardize the value that an organization places on the privacy of certain clients or staff; the exposure may encourage organizations to adjust results to be more favourable; information may be misinterpreted if released or used out of context; and organizations may be placed at a disadvantage among their competitors, particularly for-profit agencies, that are not obliged to expose their performance results to the same degree.

While evaluation science is furnishing numerous approaches to performance measurement, the barriers to program evaluation by nonprofits are for the most part related to capacity, referring to lack of funding, the need for more training and assistance and the need for research-based

comparative indicators (Zacharakis-Jutz and Gajenayake, 1994; Rodriguez-Spagnolo, 1992; Taylor and Sumariwalla, 1993). In some cases, organizations are reluctant to measure performance for fear of negative repercussions by funders if results are poor. Reluctance also stems on the one hand from a lack of direction from funders as to what evaluation results will be recognized, and, on the other hand, from a sense that funding decisions are more political than rational rendering even positive evaluations as no guarantee of funding.

Despite the reluctance, parent organizations and some funding agencies are encouraging and assisting smaller organizations to measure outcomes by offering training, workshops, pilot projects, and by providing measurement tools. Larger organizations have the advantage of greater resources so are likely ahead regarding measuring outcomes. Some, in fact, use positive outcomes as promotional tools to attract donations and other funds. Nonetheless, on the whole, in the absence of standardized measures of impact and with the perceived strong need for nonprofit sector accountability, outcomes measurement is at this time reactive and ad hoc (The Steering Committee, 1998). Individual organizationally-defined outcomes can derive value, but lack a common unit of measure across organizations.

Hence, to address this dilemma, social accounting or social audit would be a measurement approach worthy of further examination. Using evaluation criteria and a participatory evaluation approach appropriate to nonprofit culture, the method attributes a comparative economic value to nonprofit activities and highlights their contributions in the social domain. Specifically, it delivers a social return-on-investment ratio per organization or program whose components may be additive across a voluntary health sector (The Steering Committee, 1998; Richmond, 1999). Again, more investigation is warranted.

Other common unit or universal measures of outcome in the health arena include measures such as the quality adjusted life years (QALYs) produced by specific interventions and programs. QALYs are generic composite measures that combine gains in length of life with gains in quality of life as opposed to disease-specific natural measures such as blood pressure, blood sugar, cholesterol, etc. As such, QALYs could theoretically be used to measure health outcomes produced by the programs of individual organizations and across organizations in a community or a province. The tool box of the health economist has four major approaches to economic appraisal, two of which can include QALYs in the denominator of the cost-effectiveness ratio where the costs of programs or interventions are related to consequences or outcomes (Drummond et al., 1987). The feasibility of employing this measure of health outcome should be considered within the research design phase of future evaluative research concerning the VHS.

Conclusions

The relevance of the paper to the major objectives of the larger study on the voluntary health sector boils down to the feasibility of the subsequent research design and methodology in determining the value of the sector. Presumably the unit of observation for the sector is the organization. The paper demonstrates that economic and otherwise quantitative value can be extracted discretely from organizational inputs and outputs. While the importance and relevance of measuring contributions to the organizational activity domains and the societal domain are

undisputed, the first order priority may best be confined to some crude additive measures that can represent the whole sector. These could be inputs and outputs by activity domain.

The research design and methodological issues that remain unresolved for the larger voluntary health sector project have a major bearing on the selection of variables to be measured and, moreover, on how any data are brought to bear on the research objectives. For example, if the organization is the unit of observation, then it follows that the universe must next be defined – presumably the geographic universe is Canada. While we developed a working definition and scope for the voluntary health sector for this paper, the final typology will inform the actual boundaries of the sector. In the meantime, a key methodological issue is whether a statistical sample of voluntary health sector organizations will be needed. If so, different approaches need discussion. For example, if a multi-pronged method were selected that focussed on the national and provincial level organizations and on a sample of cities (small, medium and large), then it might be possible to construct a composite picture and collect the measures of this geographical universe through extrapolation and other estimating techniques. Another approach may be a component modelling one, with the identification of "natural laboratories" such as Peterborough or Sherbrooke where the cities' compactness and generalizability have allowed corporate marketing studies and surveys. On the other hand, case studies would provide the opportunity for gaining a depth of understanding on organizational and programmatic inputs, outputs and outcomes.

In terms of what should be measured, the possible data elements for collection are in Table 1, which is a simplification of the original conceptual framework. A preliminary compilation and a sectoral consultation and peer review would be necessary prior to any launching of data collection. As well, the ethical issues described in the paper would require discussion.

Because the feasibility of collecting individual program outcomes data and contributions to a societal domain is low compared to input and output data, asking for a simpler version of these contributions is worth consideration. For example, volunteers in an organization could be asked for their personal perceptions of what volunteering has added to their lives according to their contributions by activity domain (for example, through fundraising). Finally, in terms of deriving a macro measure of social value, it is recommend that the social accounting method be investigated further and brought for consideration to sectoral consultations and peer review.

Notes

1. Revenue Canada's registered charitable organizations include hospitals, health service organizations other than hospitals, health charitable corporations, health charitable trusts, and health organizations not classified in the above categories. Unregistered health nonprofits are organizations classified as health-related.

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DEVELOPING A TYPOLOGY OF THE VOLUNTARY HEALTH SECTOR IN CANADA: DEFINITION AND CLASSIFICATION ISSUES

EXECUTIVE SUMMARY

Prepared for the

Voluntary Health Sector Project

October 1999

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Executive Summary

The development of an understanding of the role that voluntary health sector organizations play in Canadian society is hindered by the lack of a common language to describe the voluntary/nonprofit sector as well as a lack of agreement about which dimensions of the sector are most important for researchers to focus upon. This paper addresses the need for more clarity in language regarding the voluntary/nonprofit sector and proposes an initial classificatory framework for structuring investigations into the role that voluntary health organizations play in Canadian society.

The paper has two main components. First, it reviews and discusses the many labels that have been used to describe voluntary/nonprofit organizations (e.g., *nonprofit, not-for-profit, voluntary, charitable sector)* and proposes a label and definitional framework for use in future research. Second, it reviews a number of classification systems that have been developed for voluntary/nonprofit sector organizations and outlines some principles that may be used to guide decisions about the suitability of any given classification system. We identify key organizational features that researchers need to consider when assessing the economic and social contributions of voluntary/nonprofit organizations and propose a system for classifying these organizations. Ultimately, such a classification system may be used to document the ways in which voluntary health organizations, such as health charities, community health clinics, or grass-roots health organizations, contribute to the health and lives of individual Canadians.

Labels and Definitions

Before developing a classification system that will facilitate an assessment of the economic and social contributions of voluntary organizations working in health, we need to arrive at a common language – a system of labels and definitions – for the voluntary/nonprofit sector. To inform the working typology, we reviewed a number of labels commonly used to refer to the voluntary/nonprofit sector. These labels and their key definitional elements are displayed in Table 1. As shown in the table, some

definitions include or exclude certain types of organizations and some definitions have their origins in specific academic disciplines, such as economics or sociology.

Each of these labels has its own strengths and weaknesses for use in studies of the contributions of voluntary health organizations in Canada. For example, the label *charitable sector* emphasizes the support that organizations such as hospitals and other health organizations may receive from private, charitable donations, but ignores the fact that such contributions do not necessarily constitute the only or major source of their income (Martin, 1985; Sharpe, 1994). The label *independent sector* emphasizes the important role that such organizations play as a "third force" outside government and private business, but overlooks the fact that many of these organizations (e.g., hospitals and other health organizations) are far from financially independent (Salamon & Anheier, 1992). *Civil society* is a very broad term that refers to all organizations that have a role in mediating between the individual and state (Holloway, 1998). The label *social economy* is generally thought of as occupying that area of the economy between the private, for-profit sector and the public (government) sector. However, the label lacks a clear definition, particularly in the way in which it is employed in Canada. It may also be misleading in that it implies an integrated system of institutions working toward common social goals, rather than the present Canadian reality of a highly fragmented group of organizations that function in the "shadow" of the private, for-profit sector (Quarter, 1992).

The label *voluntary sector* may be the preferred term for many in this sector (Klatt, 1997). It emphasizes the significant input that volunteers make in the management or operations of organizations in the sector, although it obscures the fact that most of the activity within the sector is carried out by paid employees (Sharpe, 1994). *Nonprofit sector* is a slightly different label that emphasizes the idea that organizations in this sector do not exist primarily to generate profits for their owners; however, it fails to acknowledge that these organizations sometimes do earn substantial profits (Salamon &

Table 1. Labels and Key Definitional Elements

Labels	Origin	Includes	Excludes
Nonprofit Sector	Economics	Non-market, non-state, non-household part of the social order; traditional voluntary organizations, hospitals, universities, religious organizations, economic and trade associations.	May exclude mutual benefit organizations (e.g., credit unions, country clubs, labour unions, trade associations and business leagues).
Civil Society	---	Organizations that mediate between the individual and state, that are separate from the process of voting but that allow citizens to participate in the development of a democracy; may include member-serving organizations (e.g., co-operatives, religious societies, trade organizations) and other types of organizations (e.g., non-governmental organizations).	Organizations directly involved in the process of voting/the ballot; state organizations.
Not-for-profit	Economics/ Accounting/ Law	Mutual benefit and public benefit organizations; organizations subject to a nondistribution constraint.	Labour unions, professional associations and business associations.
Social Economy	---	Co-operatives, nonprofits in public service, mutual nonprofits serving a membership.	Organizations not independently governed; those with operations that are strictly commercial; those with non-democratic models of governance.
The Commons	Sociology	Outside the home and away from the family; independent of political states and economic markets.	Organizations that are non-philanthropic and non-charitable.
Voluntary Sector	Sociology	Clubs, associations and groups characterized largely or exclusively by non-coercive membership or free unconstrained participation; organizations independent from the state and non-profit-making.	All quasi-state institutions (e.g., hospitals and universities).
Third Sector and Independent Sector	Political Science	May include quasi-state organizations (e.g., hospitals and universities).	Public and private sector organizations.
Non-governmental Sector	---	Organizations outside the formal apparatus of the political state.	Government organizations.
Charitable Sector and Philanthropic Sector	Law & Philanthropy	Broadly includes organizations devoted to private action for the public good; organizations doing good for others; and legally registered charitable organizations and charitable foundations (i.e., those working in health, relief of poverty, advancement of education, advancement of religion or other activities of benefit to the community as a whole).	Non-registered charities.

Anheier, 1992). The term *nonprofit* has been criticized for defining the sector in residual or negative terms (i.e., in terms of what it is not, rather than in terms of what it is), and for emphasizing the economic aspects of the sector at the expense of its social or other less tangible contributions (Lohmann, 1992; Salamon & Anheier, 1992; Scott, 1997).

A useful label for the voluntary *health* sector should allow for connotations of social and health-related contributions in addition to purely economic ones. Ideally, the term should be broad enough to encompass the diversity of organizations involved in health-promoting activities, but not so broad that it is rendered meaningless or impractical. Similarly, the ideal label should be positive, in that it should define the sector in terms of what it *is* and what it contributes to the lives of Canadians, rather than in terms of what it is *not*. Finally, the label should be acceptable to members of the sector itself. Given these considerations, it is suggested that a useful label for the voluntary health sector in Canada is one that combines the terms *voluntary and nonprofit.* Within this combined label, the *voluntary* element portrays the sector in a positive or active light, while the *nonprofit* element expresses the sector's distinction from both market and state. Such a label also avoids unrealistic assumptions regarding the nature of labour participation in the sector (i.e., that all work is done by volunteers).

Developing A Classification System

The preceding review of labels and definitions demonstrates that a variety of distinctions may be drawn among voluntary/nonprofit organizations. Some of these distinctions may need to be included in any classification system developed for the voluntary/nonprofit sector, including the voluntary health sector. In the following sections we review existing classification systems and recommend a preliminary classification framework for use in future research into the economic and social contributions of voluntary organizations working in health.

The terms *typology*, *taxonomy*, *classification* and *categorization* are all used to describe approaches to organizing objects into groups on the basis of their similarities or differences on some set of predetermined characteristics. The purpose of classification is to show the structure and relationship of objects to each other and to similar objects and to simplify these relationships in order to enable general statements about classes of objects (McKelvey, 1982; Sokal, 1974).

In their review of nonprofit sector classification systems, Salamon and Anheier (1992, 1997) present five criteria for assessing classification systems. These are:

1. *Economy*: An effective classification system must organize the vast number of entities in the voluntary sector into a reasonable number of groupings, using a limited number of organizing criteria.

2. *Significance*: The system must organize its groupings according to truly significant and meaningful differences in the entities being studied. In other words, the distinguishing characteristics used to separate thousands of voluntary sector organizations should create relatively homogeneous groups.

3. *Rigor*: The system should be rigorous and reliable. The criteria should also be clear enough and based on widely obtainable information so that different people will group the same organizations in the same way.

4. *Combinatorial richness*: The system should provide enough diversity within it to highlight interesting relationships, comparisons and contrasts. This criterion needs to be balanced with the need for economy.

5. *Organizing power*: The system should be flexible enough to fit circumstances other than those it was originally developed to fit. (This is especially important for international work.)

Existing Classification Systems

It is useful to examine existing classification systems in order to assess whether they are applicable to research on Canadian voluntary/nonprofit sector organizations working in health or whether they at least provide a starting point for efforts in this area. Table 2 provides an overview of the key features of existing classification systems and their organizing dimensions.

Table 2. Classification Systems

CLASSIFICATION SYSTEM	UNIT OF ANALYSIS	ORGANIZING DIMENSIONS	ORIGIN/USE	VOLUNTARY/ NONPROFIT ORGANIZATION CRITERIA
International Standard Industrial Classification (ISIC)	Enterprise	The character of the goods and services produced (e.g., health). The uses to which the goods and services are put (e.g., human health services). The inputs, the process, and technology of production) (Primary activity, e.g., research).	Designed by the UN for international industrial/economic comparisons.	No more than 50% of the organization's funding may come from either government or revenue generating operations (membership or commercial activities).
North American Industrial Classification System (NAICS)	Establishment	The inputs, the process, and technology of production (Primary activity, e.g., research).	Designed by Canadian, US and Mexican governments to provide pan-North American industrial/economic statistics.	No more than 50% of the organization's funding may come from either government or revenue generating operations (membership or commercial activities).
National Taxonomy of Exempt Entities (NTEE)	Organization	The economic area – domain/sector (e.g., health). The process or activity the organization is engaged in (e.g., research).	Designed by the National Centre for Charitable Statistics in the US to provide a means for organizing IRS data on tax-exempt organizations.	Only those organizations that are classified as tax-exempt entities by the IRS in the United States.
Canadian Charitable Sector Classifications/ Revenue Canada	Organization	Legal designation (charitable organization, charitable foundation, nonprofit organization). Sector/domain, (e.g., health, education). Primary purpose/goal (e.g., education, health services).	Developed for tax collection/information purposes in Canada.	Only those organizations that are legally classified as registered charities under Canadian tax law.

CLASSIFICATION SYSTEM	UNIT OF ANALYSIS	ORGANIZING DIMENSIONS	ORIGIN/USE	VOLUNTARY/ NONPROFIT ORGANIZATION CRITERIA
Classifications Derived From Revenue Canada Categories: Sharpe (1994) and Hall & Macpherson (1995)	Organization	Legal designation (charitable organization, charitable foundation, nonprofit organization). Sector/domain (e.g., health, education). Primary purpose or goal (e.g., education, health services).	Developed to help researchers investigating the charitable sector.	Only those organizations that are legally classified as registered charities under Canadian tax law.
International Classification of Non-Profit Organizations (ICNPO)	Establishment	Primary economic activity (e.g., culture and recreation, education and research, health).	Developed to permit international comparisons of nonprofit sectors.	The ICNPO employs five criteria for inclusion in the nonprofit/voluntary sector: 1. Organized. The organization must be institutionalized to some extent. 2. Private. The organization must be institutionally separate from government. 3. Non-profit-distributing. The organization must not return any profits generated to the owners or directors. 4. Self-governing. The organization must be equipped to control their own activities and not be so tightly controlled by government or private business that they essentially function as parts of these institutions. 5. Voluntary. The organization must have a significant degree of voluntary participation, either in the conduct of its activities (program volunteers) or the management of its affairs (voluntary members of the board of directors).

CLASSIFICATION SYSTEM	UNIT OF ANALYSIS	ORGANIZING DIMENSIONS	ORIGIN/USE	VOLUNTARY/ NONPROFIT ORGANIZATION CRITERIA
Proposed HRDC Study Classification	Organization	Domain of activity (e.g., health, education, research). Organizational type (e.g., public service, mutual benefit, co-operative). Type of activity (social rights and regulations, community ties, legal services). Legal status (e.g., registered charity, private foundation, nonprofit organization).	Developed to help assess human resource issues in the nonprofit/voluntary sector (adopted from the ICNPO).	Same as ICNPO, but modified and proposes additional classification dimensions to integrate a measure of flexibility into the system for the Canadian case. In its boundary with the public sector, it is suggested that researchers should be allowed to either include or exclude hospitals and universities, depending on the needs of analysis. Along the border of the private sector, it is suggested that replacing the non-profit distribution constraint with a non-profit maximization criterion would be more useful. This would allow for the inclusion of co-operatives and credit unions, which have played an important and historical role in the development of the Canadian nonprofit sector (see Davidman, Betcherman, Hall, & White, 1998).
National Survey of Giving, Volunteering and Participating (NSGVP)	Organization	Primary activity (e.g., health, education and research).	Developed for the purposes of categorizing organizations named in a Canadian national survey of donor behaviour, voluntary activity and civic participation.	Same as ICNPO, but modified and proposes additional classification dimensions to integrate a measure of flexibility into the system for the Canadian case. In its boundary with the public sector, it is suggested that researchers should be allowed to either include or exclude hospitals and universities, depending on the needs of analysis. Along the border of the private sector, it is suggested that replacing the non-profit distribution constraint with a non-profit maximization criterion would be more useful. This would allow for the inclusion of co-operatives and credit unions, which have played an important and historical role in the development of the Canadian nonprofit sector (see Davidman, Betcherman, Hall, & White, 1998).

CLASSIFICATION SYSTEM	UNIT OF ANALYSIS	ORGANIZING DIMENSIONS	ORIGIN/USE	VOLUNTARY/ NONPROFIT ORGANIZATION CRITERIA
UK Charity Commission Classification System	Organization	The beneficiaries/client groups (e.g., individuals, institutions, environment). The function of the organization/method of operation (e.g., finance/resources, advocacy, information and research). The industry/field (domain) of operation (education and training, health).	Developed by the Charity Commission to: a) provide policy makers, researchers, practitioners and other commentators with a recognizable economic map of the UK voluntary sector. b) provide, on an annual basis, the most up-to-date and reliable statistics on the voluntary sector. Attempts to overcome the deficiencies of the ISIC, ICNPO, and the NTEE.	Organizations defined as general charities must meet four key criteria: 1. Independent governance. Organizations that are separate from government and business, excluding: (a) registered charities that are non-departmental public bodies or quasi-governmental organizations (e.g., British Museums); and (b) financial institutions that are classified in the corporate sector in the system of national accounts (e.g., Charities Official Investment Fund or COIF). 2. Non-profit distributing. Organizations that do not distribute profits to shareholders, excluding co-operatives. 3. Objectives that confer a wider public benefit. Organizations that provide a public benefit beyond any membership. Those excluded are: (a) friendly societies and building societies; (b) housing associations; (c) sports and social clubs; (d) independent schools; and (e) trade unions. 4. Non-sacramental religious bodies/places of worship. Organizations that are predominantly sacramental religious bodies or places of worship are excluded from the definition of general charities.

Although a variety of organizing dimensions have been proposed, our review of existing classification systems shows that most employ a single economic organizing dimension that focuses on the major activity of an organization. Such systems may be useful for understanding economic contributions but may limit our ability to understand organizations according to their broader, social or health-related contributions.

A Proposed Classification System

The first task in developing any classification system is to define precisely what types of organizations are being classified. We recommend that researchers employ the operational definition established by the International Classification of Nonprofit Organizations (INCPO) (Salamon & Anheier, 1997). The INCPO considers voluntary/nonprofit organizations to be those that are: (1) *organized* (i.e., institutionalized to some extent, but not necessarily legally incorporated); (2) *private* (i.e., institutionally separate from government); (3) *self-governing* (i.e., equipped to control their own activities); (4) *non-profit-distributing* (i.e., not returning profits generated to their owners or directors); and (5) *voluntary* (i.e., involving some degree of voluntary participation, either in the actual conduct of the agency's activities or in the management of its affairs). Accordingly, the voluntary/nonprofit sector as a whole may include organizations as diverse as universities, orchestras, daycare centres, hospitals, mutual insurance companies, labour unions, religious organizations, political parties, self-help groups, and soup kitchens for homeless people.

Having defined the larger universe of voluntary/nonprofit organizations, the next task is to define what is meant by voluntary nonprofit *health* organizations. Although health may be defined in broad terms, and many types of voluntary organizations may be involved indirectly in health-promoting activities, it is recommended that initial 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 (e.g., local community health clinics). This approach is consistent with the ICNPO, which defines health organizations as those that are directly engaged in health-

related activities, providing health care, both general and specialized services, the administration of health care services, and health support services (Salamon & Anheier, 1992). The ICNPO groups health organizations into four categories: (1) hospitals and rehabilitation; (2) nursing homes; (3) mental health and crisis intervention; and (4) other health services (i.e., public health and wellness education, out-patient health treatment, rehabilitative medical services, and emergency medical services). The ICNPO framework has already been used successfully within the Canadian context in the National Survey of Giving, Volunteering and Participating (NSGVP). Thus, it provides a useful start for a study of the voluntary health sector in Canada.

Choosing the Dimensions of Classifications

A number of principles may be used to guide decisions regarding the appropriate dimensions to employ in a classification system: (a) the system should be sufficiently general to allow it to be used for a variety of purposes; (b) the system should have linkages with existing classifications in use; (c) the system should organize information in a way that is relevant to policy considerations; and (d) the system should favour dimensions which have been found to have practical utility in other settings.

On the basis of the above criteria, we propose that the most useful classification system for the voluntary/nonprofit health sector in Canada is a system that combines the International Classification of Non-Profit Organizations (ICNPO) and the United Kingdom Charity Commission Classification System (see Table 2). The ICNPO demonstrates economy in its structure and strikes a balance between the need to capture the diversity of voluntary/nonprofit activities without creating too large a number of categories. Although the ICNPO uses only one organizing principle (area of economic activity), the definition of nonprofit organizations that is employed in the ICNPO is sufficiently broad to give it wide applicability for understanding many of the contributions of voluntary/nonprofit health organizations (e.g., grass-roots health organizations or self-help organizations), yet specific enough to exclude those

organizations (e.g., hospitals) that are so tightly controlled by government that they cannot be considered self-governing.

The UK Charity Commission Classification System, developed by the National Council for Voluntary Organizations (NCVO) in the United Kingdom, has a number of advantages over other classification systems. Its greatest advantage is its use of a multi-dimensional classification system that uses categories that are likely to have some policy relevance for assessing value within the health sector. For example, policy development in the areas of service provision would be aided by an understanding not only of the area of economic activity (e.g., health vs. social service) but also by an understanding of who the recipients of these services are and what the function of the organization is. We therefore suggest that a classification of the voluntary/nonprofit health sector should include the following two dimensions: (1) *beneficiaries/client* groups – individuals (e.g., elderly, children), institutions (e.g., hospitals), or the environment (e.g., conservation, heritage); and (2) *functions/methods of operation* – financing/resourcing (e.g., grantmaker, fundraiser), provision of buildings/facilities (e.g., residential, recreational), provision of services (e.g., training, health care), advocacy, information and research (e.g., campaigning, advice), and representation (e.g., umbrella group, trade association).

We also recommend that the classification system should acknowledge two key characteristics of organizations that are likely to have an effect on their operations: (1) their legal status (e.g., whether or not they are registered as charities); and (2) the size of the organization (as measured by organizational revenues).

We therefore propose a classification system of the voluntary/nonprofit health sector in Canada that includes the following five organizing dimensions:

(a) major area of activity using the ICNPO categories;

(b) beneficiary of services, using the UK Charity Commission categories (individuals vs. institutions vs. environment);

(c) function of the organization, using the UK Charity Commission categories (finance/resourcing; provision of buildings/facilities; provision of services; advocacy, information, and research; and representation);

(d) legal status (unincorporated vs. grass-roots association vs. incorporated nonprofit vs. registered charity); and

(e) size of revenue (small, medium, large).

In addition, our review of existing classification systems, and the strengths and weaknesses of these systems, leads us to suggest that an initial classification of voluntary/nonprofit organizations working in health should be constructed in a nonhierarchical fashion and that categories should be treated as overlapping rather than discrete.

It is important to emphasize the preliminary nature of our proposed classification system. It is atheoretical and requires empirical testing in order to determine if it has validity, practical utility, applicability and is policy relevant. In particular, a key consideration will be its usefulness for empirical studies of the contributions and value of voluntary/nonprofit organizations working in health. More generally, in order to maximize its usefulness to the voluntary health sector in Canada, any proposed label, definition, or classification system will need to be informed and validated through additional mechanisms, such as feedback obtained from consultations with members of the voluntary/nonprofit health sector, surveys, and case studies.

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