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Mutual Benefit and Status Quo Processes as Governance Mechanisms in Partnerships Between Organisations that Belong to Different Sectors and Organisational Models

Victoria Taras

Co-operatives are member-owned organisations that follow a set of Co-operative Principles. When they partner with non-co-operative organisations, they risk compromising those principles. However, when partner organisations share those principles in their approaches or aspirations, the partnership generates mutual benefit. Mutual benefit can act as a governance mechanism for the partnership; it promotes co-operation and co-ordination by bringing partners together, maintaining a cohesive strategic direction, and promoting a common vision of the future. Concern for the community, for example, is a co-operative principle but it is also a typical approach among non-co-operatives and the alignment can support the partnership. Close alignment generates a high level of mutual benefit, while broad alignment generates a low level and therefore acts as a weaker mechanism. This article examines the role of mutual benefit in partnerships between the healthcare co-operative Saskatoon Community Clinic (SCC) and several University of Saskatchewan colleges, schools, departments, and divisions. Through these partnerships, the SCC hosts healthcare clinics, specialist healthcare services, and student placements, and generates research. In these cases, co-operation and co-ordination are either supported by a high level of mutual benefit, rely on an available status quo procedure, or are minimised by low interdependence between partners.

Introduction

Unlikely partnerships emerge between organisations that are fundamentally different. These partnering organisations operate in different sectors, on different scales, with different kinds of stakeholders, funding, and accountability. Yet, these partnerships are often fruitful. The Saskatoon Community Clinic (SCC) and its independent clinics achieve the following with its partnerships with University of Saskatchewan colleges, schools, departments, and divisions: the creation, development, and operation of health clinics; the organisation and execution of student placements programmes; the provision of accessible specialist care and mentorship; and research. Furthermore, some of the Co-operative Principles flourish through these partnerships even though the SCC is the only partner that is a co-operative organisation. Namely, Co-operative Principle 7: Concern for Community — where actions are oriented toward the sustainable development of the community — and Co-operative Principle 4: Autonomy and Independence — where each partner retains autonomy — are promoted through these partnerships because they are shared with their partners under a different guise. In addition, Co-operative Principle 5: Education, Training, and Information about co-operatives frequently flourishes as an externality without cost to the University-affiliated partner. Again and again, the partnerships are fruitful and promote rather than compromise the partner organisations' principles.

How are these partnerships conceived? How do the partners remain engaged? How do they determine a collective strategy, and how do they execute it in concert? How do they promote the principles of the partner organisations? This article argues that two governance mechanisms, mutual benefit and the availability of status quo processes, support the partnerships.

Governance is the framework that describes roles (Raeymaeckers et al., 2017), communication (Crozier, 2008), and decision-making processes (Institute on Governance, 2021) within a given organisation or partnership. As such, co-operation and co-ordination are governance issues for interdependent relationships (Bapna et al., 2010; Grandori, 1997; Kleinwächter, 2006).

Mutual benefit and status quo are governance mechanisms that promote co-operation and co-ordination.

Various fields of research identify mutual benefit as an element of a successful partnership. According to some research, mutual benefit is a pragmatic ideal shared by partner organisations in different sectors, such as schools and corporations (e.g., Burbage et al., 2014; Radinsky et al., 2001). The attraction of benefiting from the partnership as it is envisioned — i.e., without intent to cheat or exploit — brings the partners together. Such research describes cases of partnerships based on the promise of mutual benefit and emphasises the processes followed by the partnership during the development stage, and evaluates the resulting project or product. It might present concrete elements of a successful partnership built on mutual benefit or reasons for failure that can be applied by others interested in pursing a similar partnership. This field of research provides evidence that it is difficult to overcome differences between partners.

According to game theory, mutual benefit is a potential outcome to a problem between interdependent individuals. Interdependence is reliance on another, usually for resources, including financial and physical resources, and knowledge and skills (Bevir, 2009). Game theory applies experimental conditions and mathematics to describe interdependent relationships and behaviour (Davis & Brams, 2021). Here, a goal might be to uncover the conditions that promote mutually beneficial behaviour, including opportunity to communicate with partners, repeated opportunities to make decisions alongside the same partners, and the adoption of an enforcement role (Ostrom, 2000).

While mutual benefit is an outcome in game theory, it can also be a prerequisite. An artificial intelligence study that examined computer-generated scenarios of interdependent decision-making found that, given the right conditions, the promise of mutual benefit alone could result in co-operation (Domingo-Ferrer et al., 2017).

Lastly, governance literature lists mutual benefit as a minor mechanism that strengthens partnerships alongside reciprocity and trust (Bevir, 2012). Here, mutual benefit is an attribute of the relationship between the partners. According to Sugden (2015):

> Mutual benefit is a partnership attribute when each partner views her action as her part of a practice that, if followed by all members of the group, will benefit all of them; and since she has reason to believe that the others will participate (or have already done so), she expects to share in the benefits of the practice (p. 164).

Mutual benefit encourages partners to think of themselves as a member of a group, which results in co-operation because when the group benefits, the partners, as group members, also benefit. The partners do not co-operate as an act of altruistic individual sacrifice, as a way to reward past co-operation, in pursuit of a superordinate goal, or because the action would benefit them without co-operation from the other partners (Sugden, 2015). Partners with similar aspirations and approaches can benefit from contributing to the group because it enables them to implement those aspirations and approaches with the confidence that, because it benefits the group, the partnership will succeed. Mutual benefit provides a common point of interest that brings organisations together, inspires their continued efforts, and keeps everyone on the same page.

This article describes mutual benefit as the alignment of partner organisations' aspirations and approaches. Every organisation has aspirations that are articulated in its strategies, goals, or missions, such as providing accessible healthcare to vulnerable populations. Organisations also strive to enact their approaches, which are articulated in their vision, values, and principles, such as concern for the community. When organisations' aspirations and/or approaches align, even when the organisations have little else in common, partnerships between them can be mutually beneficial.

Partnerships between co-operatives can be based upon or create mutual benefit when they highlight their common approach: the Co-operative Principles (International Co-operative

Alliance, 2018). Although these principles are not equally valued by all co-operatives, they can provide alignment that supports co-operation and co-ordination. Indeed, partnerships between co-operatives is explicitly promoted by Principle 6: Co-operation among Co-operatives.

Although the SCC is a co-operative, it is a non-profit organisation, as are universities and the units therein. Non-profit organisations do not share a set of principles or guidelines. However, they are all part of the broader third sector and carry social or environmental missions. They also frequently share approaches such as the values of inclusion and bottom-up/grassroots processes. If there is adequate alignment, then a partnership might flourish under the mutual benefit of reaching shared aspirations and/or enacting shared approaches.

In the absence of an adequate level of alignment, mutual benefit is a weak governance mechanism. For example, one partner organisation might believe that concern for the community is best addressed through free programmes and services, while another organisation might believe that it is best addressed through the divestment of free programmes and services because they create dependence on the organisations that offer them. Alternatively, one organisation might adhere to the paradigm of inclusion where mainstream programmes and services accommodate minority populations, while another organisation might think it is best that programmes and services are tailored to that minority population and offered at a dedicated facility.

Alongside mutual benefit, this article also examines status quo procedure as a governance mechanism that facilitates co-operation and co-ordination in partnerships. It is employed when all partners share ready-made instructions on how to achieve a joint aspiration. It can take the form of a written procedure, a formal agreement or simply a long established habit. As an observable process, it undercuts ambiguity and clarifies decision-making (Wilson, 1989). In short, an available status quo procedure is a shortcut that everyone already knows.

Different partnerships feature mutual benefit and status quo procedures to different degrees depending on the availability of a status quo procedure and the level of interdependence within the partnerships. If a partnership has access to a status quo procedure and low interdependence, then mutual benefit is of lesser importance for the success of the partnership. However, when there is no status quo available and there is high interdependence between partners, then mutual benefit plays a more prominent role. That is not to say that mutual benefit and status quo procedures are mutually exclusive. Mutual benefit can enhance any partnership and enrich the resulting clinics, programmes, services, and projects.

This article presents case studies of partnerships between parts of the SCC and various entities of the University of Saskatchewan and examines the role of mutual benefit and status quo procedures in each. The following section describes the SCC and the University of Saskatchewan. A clear understanding of the organisations — especially the SCC, which is unusual in many ways — is foundational to an understanding of the partnerships, described thereafter. The second half of the article describes and applies governance theory. It first describes governance generally, then mutual benefit. Following, each partnership discussed in this article is presented as a case for the ways mutual benefit affects governance and how those partnerships are further supported by attributes of the partnerships themselves. It concludes by highlighting how mutual benefit within the partnerships allows the Co-operative Principles to flourish.

Partners and Partnerships

The SCC and University of Saskatchewan entities are both complex and divergent in many ways. The SCC and its different University-affiliated partners have different organisational models, governance structures, purposes, and norms. The fundamental activities of the SCC involve healthcare and health promotion rather than education and research. Also, interprofessional teams in the SCC are an organisational norm rather than an innovation, and major decisions are made within the SCC's governing body and voted upon by its membership rather than by directors, deans, and department heads.

In addition to the numerous foundational differences between the SCC and the University-affiliated partners, both are internally heterogenous, and their components have autonomy. The SCC is interprofessional; it houses multiple departments that offer complementary but distinct services, and its two locations target distinct patient populations and provide their own programmes and services. Meanwhile, the University has equally distinct schools and colleges that are typically larger but more siloed than SCC departments. It is common for these to be sub-divided into their own departments and divisions, each of which is endowed with autonomy to seek its own partnerships and develop its own programmes. The heterogeneity creates many kinds of partnerships between the SCC and the University entities.

Saskatoon Community Clinic

The SCC has several traits that are not commonly associated with most other health co-operatives or clinics. The SCC and its sister community clinics developed alongside universal healthcare in Canada (Gruending, 1974; Rands, 1994/2012). In 1962, Saskatchewan was the first Canadian province to propose a single-payer healthcare model — i.e., public, tax-funded — and to enable affordable access to most physician services. The Saskatchewan model also promoted community clinics. However, a physician strike that same year forced amendments to the model that excised the language that promoted the clinics. The resulting model of universal healthcare closely reflects the one that exists today and was thereafter adopted by the rest of the country. Today, the SCC and the other community clinics are rare in Saskatchewan, but they endure.

The SCC has two locations in Saskatoon. The Downtown Clinic, established in 1962, serves the general population of Saskatoon and area. It is from this site that most of its members and patients receive services. In 1973, the Board of Directors opened a second site, the Westside Clinic, in response to the need for primary health care services in a low-income neighbourhood of Saskatoon. The Westside Clinic serves inner-city patients who have few accessible, targeted healthcare alternatives.

The SCC is both a co-operative and a community clinic. As a co-operative, it is incorporated under the Province of Saskatchewan's Co-operatives Act and its member-owners are ultimate decision-makers. Membership is open rather than limited to a single stakeholder group; any individual or family can become a member. Anyone, even those who are not SCC patients, workers, or otherwise affiliated with the SCC, can become a member. Members can engage with the SCC through members' meetings, service on the Board of Directors, and participation in consultation opportunities such as patient advisory councils. They also receive a quarterly newsletter, email communication and are offered some financial discounts on services that are not publicly funded. However, membership neither grants access to SCC programmes and services, nor is it a prerequisite for access. Instead, membership is tied to the opportunity to engage with SCC decision-making and receiving SCC communications. To join, members purchase a lifetime membership and have the option of paying a yearly service fee that supports non-publicly funded SCC programmes and services.

As a community clinic, the SCC follows the community health centre model of healthcare provision, which has five defining features (see Canadian Association of Community Health Centres, n.d.). First, community clinics are not-for-profit organisations, but they are not typically co-operatives. Meanwhile, most primary healthcare clinics are privately owned by the physicians who operate them. Most SCC funding comes from the Saskatchewan Ministry of Health's Primary Health Services branch and what can be raised through the SCC Foundation Inc. The SCC Foundation is a separately incorporated registered charity. It invests in new programming, buildings, infrastructure, therapies, research and resources that improve the quality of health care for members and the community. Second, programmes and services are provided by interprofessional collaborative teams, while a typical primary healthcare clinic houses one type of healthcare professional such as a family physician. Third, services are tailored to community rather than ignoring community-specific needs or concerns as beyond the scope of the clinic. Fourth, the primary care provided is comprehensive rather than limited to a prescription or referral, for example. It incorporates health promotion, illness prevention, and community health.

Fifth, community clinics engage in advocacy to promote health equity and social justice, while a typical primary health clinic does not engage in advocacy. The SCC has distinct historic roots and follows the organisational principles of co-operatives and of community clinics.

University of Saskatchewan's entities

The University of Saskatchewan belongs to Canada's U15 Group of Research Universities (U15 Group of Canadian Research Universities, n.d.), which ranks it among the country's most research-intensive universities. Like the SCC, it is located in Saskatoon, Saskatchewan, and is one of two universities in the province. In the reporting year 2019-20, there were 25,740 students enrolled in its 17 schools and colleges (University of Saskatchewan, 2021). The schools and colleges have operational flexibility. For example, they can create projects and partnerships without consulting University-level decision-makers. Their departments and divisions, in turn, have some autonomy within the school or college. In addition, the schools and colleges often have their own strategic directions that, while aligned with the University's, are developed autonomously. The University colleges, schools, departments, and divisions are similar to their analogues across the country.

Partnerships

SCC and University partnerships create and manage clinics, programmes, services, and projects. Table 1, below, summarises those that are examined later in this article.

Table 1. Outline of SCC and University partnerships

Partnership	SCC Partners	Description
Student Placements	Colleges of Education, of Medicine, of Nursing, of Pharmacy and of Nutrition, and the School of Physical Therapy	Students work alongside SCC practitioners and staff as part of a practicum or a clinical or residency programme.
Saskatoon West Dental Clinic	College of Dentistry	The College owns and operates the dental clinic, which provides services to inner-city and disadvantaged populations.
Visiting Specialists	Varies from case-to-case depending on the individual specialist: college, school, department, or individual practitioner	Medical specialists affiliated with the University provide specialised medical services to patients at the Downtown and Westside Clinics. They also mentor and support physicians and staff in providing health care for patients with particular medical conditions or concerns, such as HIV or mental health. As much as possible, patient care decisions are made collaboratively with the SCC through a joint patient care strategy.
Student Wellness Initiative Toward Community Health (SWITCH)	SWITCH partners individually with the SCC, the College of Medicine and other University schools and colleges, and the Saskatchewan Health Authority	SWITCH is an autonomous organisation that is owned, operated, and staffed by students from local post-secondary institutions. It provides a myriad of services (e.g., health and social support) to inner-city and disadvantaged populations.
Refugee Engagement and Community Health (REACH)	College of Medicine Departments of Family Medicine, Paediatrics, Community Health and Epidemiology, other community-based organisations	The collaboratively owned clinic provides refugees with initial health assessments and follow-ups. Each partner plays a distinct role in its operations, such as the provision of medical care or administration. Major decisions are made collaboratively.
Research	The SCC or one of its employees partners individually with University colleges, schools, departments, and divisions or directly with researchers therein	Studies initiated by the University-affilitated partner are conducted with varying levels of involvement from the SCC.

The College of Medicine has a particularly long relationship with the SCC. At the SCC's conception in 1962, there was tension throughout Saskatchewan that resulted in a physician strike. A faculty member of the College's Department of Social and Preventive Medicine, Dr. Samuel Wolfe, was a champion of the initial version of universal healthcare that promoted the development of clinics like the SCC. This contradicted the position of neutrality declared by the College dean (Saskatchewan Council for Archives and Archivists, n.d.). Wolfe was a member of the government Commission tasked with setting up the province's universal healthcare programme, and later recruited physicians from the United Kingdom to provide care during the physicians' strike. He finally left his position at the University to help organise the SCC and become its first Medical Director (Rands, 1994/2012).

The Governance of Partnerships

The partnerships discussed follow different organisational types: co-operative community healthcare clinic (the SCC) and public post-secondary institution (the University-affiliated partners). There is no default alignment between them. However, three Co-operative Principles appear frequently within the SCC-University affiliate partnerships. Principle 4: Autonomy and Independence ensures that even when in partnerships, co-operatives are controlled democratically by members and maintain autonomy. As such, partner relationships must be collaborative rather than controlling; partner organisations must simultaneously act in their own interest and within the interest of the group. This is achieved when the partnership is underpinned by mutal benefit. Co-operative Principle 7, Concern for the Community, underlies the purpose of the partnerships and is articulated in the SCC and University-affiliated partners' values, principles, and mission statements. The partnerships address a mutual concern for the community and therefore create mutual benefit. In addition, Co-operative Principle 5: Education, Training, and Information, which promotes sharing information about co-operatives to the general public, is often a one-sided benefit to the SCC that is generated through the partnerships but does not harm the University-affiliated partner. The University-affiliated partner's exposure to a co-operative through partnership promotes learning about a) what is a co-operative, b) how co-operatives work, and c) co-operative benefits. Other approaches and aspirations are shared between the SCC and its University-affiliated partners, including a desire to promote services that reflect Indigenous culture for Indigenous patients and/or cultural responsibility; that celebrate diversity, such as physical accessibility, affordability, and compatibility for disadvantaged and minority populations.

Formal statements are not always enough to achieve the facilitation afforded by mutual benefit. They are often too vague to generate concrete action. Alignment must persist in actionable details (Edgar et al., 2006). How does each partner define community? Geographically? If so, is the community boundary around the inner city? The municipality? The province? The country? Is it defined by one type of population? Then which one and how is that population defined? Hypothetical partners might create a clinic that addresses the needs of those living in poverty, but how is that population differentiated from those not living in poverty? By income? If so, then what threshold should be used and how should it be assessed? Should the target population be instead differentiated by address or lack thereof? By needs that are chronic among the population? By self-identification? Mutual benefit will not activate as a strong governance mechanism unless there is sufficient alignment of aspirations and approaches.

Although mutual benefit enriches all partnerships, an available status quo procedure and low interdependence between partners can largely replace mutual benefit in its role of facilitating co-operation and co-ordination. Status quo procedures reduce the effort required for co-operation and co-ordination because they reduce the number of decisions that need to be made. Meanwhile, partners with low interdependence have distinct and complementary roles, and the decisions of one partner have little impact on the other partners. When a status quo procedure is available or a partnership has low interdependence, mutual benefit plays a lesser role as a governance mechanism to promote co-operation and co-ordination between partners.

Cases

This section presents a series of cases about the partnerships between the SCC and various University entities. It starts with partnerships that have little reliance on mutual benefit and that feature status quo procedure more prominently. Then, it progresses to partnerships where there is high mutual benefit and details the role of mutual benefit in facilitating co-operation and co-ordination. Each case will end with a descriptive typology that lists: the Co-operative Principles that are enacted and if they generate a one-sided or mutual benefit; the availability of a status quo procedure; and the level of interdependence between partners.

Student placements

The Colleges of Education, Medicine, Nursing, Pharmacy and Nutrition, and the School of Physical Therapy frequently partner independently with the SCC on practicum, clinical or residency placements. A similar administrative procedure is followed regardless of discipline. Each partner's role is predictable. Students who have acquired an expected level of knowledge and skills at the University are sent to the SCC and SCC workers provide them with hands-on learning. This continues for a pre-defined amount of time, then the programme is essentially over until the next cohort is ready. This process is similar to the procedure used in other organisations that provide practical training to post-secondary students.

The student placement programmes follow a status quo process, which acts as a scaffold around which co-operation and co-ordination can take place. Mutual benefit is a less prominent mechanism. Therefore, broad alignment of aspirations and approaches, rather than close alignment, is a sufficient complement to the status quo process.

The partners are moderately interdependent because, although both are needed for the student placement programme to function, their roles and decisions are distinct. Each partner makes its own decisions about how it will play its own role in the partnership, and collaborative decision-making between partners is minimal.

This structure does not require either partner to compromise its autonomy or independence, only to play a role. Therefore, the partners preserve their autonomy and independence throughout the partnership. Likewise, it allows both to address their concern for the community by: creating awareness of community-based programmes and services as options where students can apply their education, welcoming students as workers that help provide community-based programmes and services, and training students in how to address community needs. Finally, the placement might also teach students about co-operatives.

Typology:

- Co-operative Principles:
    - 4: Autonomy and Independence (of the partners): Mutual benefit.
    - 5: Education, Training, and Information (about co-operatives): Incidental one-sided benefit.
    - 7: Concern for the Community: Mutual benefit.
- Availability of status quo process: Yes.
- Level of interdependence: Moderate.

Saskatoon West Dental Clinic

Saskatoon West Dental Clinic is located at the SCC's Westside Clinic and provides dental care in an inclusive and culturally-appropriate manner to inner-city and disadvantaged patients (University of Saskatchewan/College of Dentistry, n.d.). Owned and operated by the College

of Dentistry, it also serves as a transition space for senior dental students from an academic setting to a private clinic setting. Patients are treated by experienced dentists, dental residents, and senior dental students under experienced supervision. The clinic operates as a typical private clinic and follows the fees guide of the College of Dental Surgeons of Saskatchewan with a sliding scale for patients in financial need.

Only at the clinic's inception were decisions made collaboratively to determine the SCC and the College of Dentistry's respective roles, responsibilities and expectations. Today, the decision-making role of the SCC is largely limited to that of a landlord. Shared patients between the SCC and the dental clinic, some of whom are referred by the SCC, are treated independently of a SCC patient care strategy. The College of Dentistry might not have a partnership with the SCC at all if not for the prime location; the SCC Westside Clinic, at which the Saskatoon West Dental Clinic is housed. The Westside Clinic is accessible and familiar to the patients whom the clinic is designed to serve. Inner-city and disadvantaged populations already visit it for their health needs, so it is convenient to serve their dental health needs.

Because the clinic could function without the SCC and the partners' decision-making roles have so little overlap, the partnership has little interdependence. Therefore, co-operation and co-ordination between partners is not difficult. Broad alignment of aspirations provides adequate mutual benefit: they both aspire to accessible, quality care for inner-city populations. Meanwhile, the joint strategy is executed by allowing each partner the autonomy to perform their respective roles.

Typology:

- Co-operative Principles:
    - 4: Autonomy and Independence (of the organisations): Mutual benefit.
    - 5: Education, Training, and Information (about co-operatives): Not a benefit.
    - 7: Concern for the Community: Mutual benefit.
- Availability of status quo procedure: Yes.
- Level of interdependence: Low.

Visiting specialists

Visiting medical specialists provide on-site services that complement other healthcare services offered at the SCC Downtown and Westside Clinics. They also mentor SCC practitioners. The specialists are employees of the University and work independently of one another; there is no visiting specialist clinic and visiting specialist positions are arranged on a case-by-case basis. Operational decisions are made collaboratively with the SCC. These include which providers will attend to patients and which days the care will be provided. The specialists also have a collaborative role in the development and implementation of joint patient care strategies.

There is a broad status quo procedure and set of assumptions about specialists working in primary care clinics that are also applied to the independent arrangements of each visiting specialist position. However, status quo procedure is not a strong mechanism when the visiting specialists collaborate with other SCC healthcare practitioners on joint patient care strategies.

The same binary pattern is found in the level of interdependence within the partnerships. In one way, interdependence is moderate because the specialists are employees of the University and therefore they do not have the same reliance on the SCC as its regular practitioners. The SCC in turn is not dependent on specialist services. The visiting specialists could practise elsewhere and the SCC could refrain from offering specialist services. However, the visiting specialists and the SCC practitioners are highly interdependent when they make collaborative decisions about joint patient care strategies. In this way, the visiting specialists are integrated into the SCC

patient care team (i.e., there is a high level of co-operation and co-ordination), patient care is improved, and the shared concern for the community is addressed in greater depth.

This analysis assumes that the visiting specialists each share the SCC's concern for the community and likely other aspirations and approaches common among healthcare practitioners. Indeed, the increased level of interdependence might be possible only if the level of alignment in concern for the community and other aspirations and assumptions exceeds what is necessary for the basic partnership. The collaboration suggests a cascade whereby increased alignment generates excess capacity to co-operate and co-ordinate, which in turn creates the opportunity to increase interdependence to generate additional mutual benefit. Although visiting specialists and the SCC practitioners do not require a high level of interdependence to offer specialist services at the SCC, the high level of alignment of their approaches and aspirations allows them to achieve a greater mutual benefit by increasing interdependence.

Typology:

- Co-operative Principles:
    - 4: Autonomy and Independence (of the organisations): Mutual benefit.
    - 5: Education, Training, and Information (about co-operatives): Potential one-sided benefit for the SCC.
    - 7: Concern for the Community: Mutual benefit.
- Availability of status quo procedure: Yes, but not during the collaborative creation and implementation of a joint patient care strategy.
- Level of interdependence: Moderate, but high as part of a patient care team.

SWITCH

The SWITCH clinic is an autonomous organisation. It is the ultimate decision maker of its own governance and operations. SWITCH is owned, managed, and staffed by students enrolled in various programmes at the University and other local post-secondary institutions. It offers a large variety of services to the same patient population as the SCC's Westside Clinic at which it operates — inner-city and disadvantaged — by co-ordinating student volunteers and experienced mentors.

SWITCH's multiple partners include the SCC, a number of colleges, schools, departments and divisions within the University and the Saskatchewan Health Authority. Each partner has a one-on-one relationship with SWITCH. Partners might never interact with each other except at regular meetings where SWITCH provides updates and occasionally asks for advice. Among these partners, post-secondary institutions create programmes where student volunteers gain credit for working shifts and provide scope of practice guidelines that indicate the tasks that students at a particular level of a particular programme are qualified to perform. They might also encourage faculty members to work as mentors.

These relationships have a moderate level of interdependence because, although the programmes cannot exist without active participation from both partners and SWITCH cannot exist without partnerships, SWITCH is the ultimate decision-maker and does not require any given partner to exist. Furthermore, a status quo procedure is followed. Like student placements, this procedure acts as a mechanism that overrides the need for close alignment of aspirations and approaches. Mutual benefit brings the partners to the table, but the procedure provides default norms for sustained co-operation and co-ordination.

However, the partnerships that the SCC and the College of Medicine each have with SWITCH cannot rely on a status quo procedure. Although SWITCH is an independent organisation from both the SCC and the College of Medicine, these partnerships are complex and play important roles in SWITCH's governance and operations. The following is a non-exhaustive

list of in-kind services that are or were provided by the SCC: Human Resource Management, payroll management for mentors, management of health records of shared patients between SWITCH and the SCC, verification of volunteer liability insurance, and orientation assistance for volunteers and mentors. Furthermore, major decisions that affect either partner are made after detailed and repeated consultations. For example, there is SWITCH representation at Westside Clinic staff meetings where decisions regarding logistics and other joint concerns are made. The College of Medicine, meanwhile, provides funding to SWITCH and regular, ongoing mentorship to the SWITCH executive. The details of the contributions by each the SCC and the College of Medicine are determined jointly in close partnership with SWITCH. Despite the important role the partners play, SWITCH remains the ultimate decision-maker concerning all its own governance and operations.

The SCC and College of Medicine partners are each interdependent with SWITCH and co-operation and co-ordination are important. Without either the SCC or the College of Medicine, SWITCH would lose a major source of support; without SWITCH, the SCC would lose a host of services for patients and community members; and the College of Medicine would lose an enriching programme for its students that offers skill-building and empowerment beyond what the College could offer alone. In the absence of a status quo procedure, mutual benefit is relied upon to facilitate co-operation and co-ordination. Because there is no direct relationship between the SCC and the College of Medicine, SWITCH has the unique burden of ensuring that the co-ordinated strategy is understood by both partners. SWITCH, as an organisation that makes all ultimate decisions in the partnerships, nonetheless leverages mutual benefit for its interdependent partnerships.

Typology:

- Co-operative Principles:
    - 4: Autonomy and Independence (of the organisation): Mutual benefit.
    - 5: Education, Training, and Information (about co-operatives): Incidental one-sided benefit for the SCC.
    - 7: Concern for the Community: Mutual benefit.
- Availability of status quo procedure: For some partners.
- Level of interdependence: Moderate overall, but high in some relationships.

REACH

The Refugee Engagement and Community Health (REACH) clinic is housed at the SCC Downtown Clinic and offers local refugees initial health assessments and follow-up services. It was jointly created by seven community partners and its smooth operation depends on their collective active participation. Partners include the SCC, the College of Medicine Departments of Family Medicine, Paediatrics, and Community Health and Epidemiology and several other community-based organisations. Each has its own distinct and complementary role within the operation of the weekly clinic. For example, the SCC provides the venue, everyday administration, and non-physician healthcare (e.g., x-ray services, nurse practitioner support, registered nurse services, reception services, and pharmacy services), while the College of Medicine departments provide physician care. However, all the partners share identical roles when major decisions are made. Those decisions are made collaboratively and by consensus. REACH partners have a high level of interdependence.

The daily operation of the clinic and its regular governance are reliant on alignment of aspirations and approaches. REACH functions according to a common strategy that incorporates each of the seven partners' distinct and complementary roles. The strategy cannot be executed without the participation of all the partners. Alignment facilitates this by ensuring

that to act according to the strategy is also to act in each partner's self-interest. In addition, all the partners engage in governance-level decision-making. They agreed that these decisions will be made by consensus, and they maintain that standard even if 'consensus' might be defined as 'something all partners can live with' rather than a universally preferred option. This is perhaps a more ambitious undertaking than following a joint strategy because it requires all partners to actively engage, discuss, listen, reflect, and maybe compromise during meetings. Although one partner might take a facilitation or leadership role, all partners have an equal voice and equal ownership over the decision. This can require a lot of dedicated time and effort. However, when successful, it can create a positive feedback loop that bolsters mutual benefit with two other facilitating attributes: love and strong loyalty (Brandsen et al., 2005).

Typology:

- Co-operative Principles:
    - 4: Autonomy and Independence (of the organisation): Mutual benefit.
    - 5: Education, Training, and Information(about co-operatives): Potential one-sided benefit for the SCC.
    - 7: Concern for the Community: Mutual benefit.
- Availability of status quo procedure: None.
- Level of interdependence: High.

Research projects

The degree to which mutual benefit is relied upon is more sundry in SCC-University entity partnerships around research projects. Such research is conducted by a variety of the University's colleges, schools, departments, and divisions. Therefore, the type of research and the type of partnership likewise varies greatly. Research requests to the SCC might include collaborative study design, access to data and/or interviews with administrators, workers, or patients. Each request is associated with different levels of status quo procedure and interdependence. The partnerships furthermore might be dyads or networks of multiple partners. Studies with high interdependence (e.g., a collaborative study design) and no rigid procedure (e.g., grounded theory methodology) rely more on mutual benefit from the research to keep the SCC engaged and acting toward the co-ordinated strategy.

Despite their variety, all SCC-University entity research projects have two elements in common. First, mutual benefit is obtained by all partners through the potential to generate insight that can be applied to help patients. It is their shared approach to "concern for the community". Second, all prospective studies undergo a screening procedure by the SCC before the partnerships are created. During a past research project, the partnership failed because it unexpectedly required too much physician time toward the research and away from patient care. The unbalance was not intentional; no selfish or insidious motives were at play. Instead, the extent of the demands was unknown to both partners until the execution of the study design. The mutual benefit obtained through shared aspirations and approaches was no longer enough to justify the increased demand on the SCC. To prevent a repetition of the occurrence, the SCC developed screening criteria, i.e, a status quo procedure. It afforded the SCC greater certainty, which eased the reliance on mutual benefit. Creating a status quo procedure helps to protect the partnership against unexpected and onerous developments.

Typology:

- Co-operative Principles:
    - 4: Autonomy and Independence (of the organisation): Mutual benefit.

    - 5: Education, Training, and Information (about co-operatives): Potential one-sided benefit for the SCC.
    - 7: Concern for the Community: Mutual benefit.
- Availability of status quo procedure: Screening criteria must be met by all perspective partners, while other status quo procedures vary according to the partnership.
- Level of interdependence: Varies according to the relationship.

Conclusion

The cases of partnership between the SCC and the University entities demonstrate that partnerships can be fruitful despite fundamental organisational differences. The partners create, develop, and operate health clinics; organise and execute student placements programmes; provide accessible specialist care and mentorship; and generate research. Moreover, they do so while promoting rather than compromising each other's assumptions and aspirations. When the partnerships are interdependent, they overcome their differences to co-operate and co-ordinate with each other. Governance mechanisms enable them to do so. Mutual benefit and available status quo procedure are governance mechanisms that provide a scaffold on which divergent partners can find common ground. Either mechanism can be strong or weak compared to the other. Meanwhile, both mechanisms might be weak when little co-operation or co-ordination are required in the partnerships. Such partnerships have low interdependence.

Mutual benefit is possible when partner organisations share approaches and aspirations; a high level of mutual benefit is possible when the shared approaches and aspirations are highly aligned. This analysis measures three approaches and aspirations within the partnerships, which are all Co-operative Principles: Principle 4: Autonomy and Independence of each partner organisation; Principle 5: Education, Training, and Information about co-operatives; and Principle 7: Concern for Community, where actions are oriented toward the sustainable development of the community. The findings indicate that all partners share a concern for the community to some degree and retain their autonomy. However, Education, Training, and Information about co-operatives is important only to the SCC and it is unclear to what extent it is realised in any of the partnerships. Potentially, the partnerships expose the co-operative governance model to students, practitioners, other organisations, and researchers, and promote learning about a) what is a co-operative, b) how co-operatives work, and c) co-operative benefits. Indeed, many current SCC practitioners were introduced to the SCC as students.

The partnerships whose alignment of approaches and aspirations is weak are found to have an available status quo procedure and/or a low level of interdependence. Interestingly, one of the partnership types has the opportunity to rely on both an available status quo procedure and a low level of interdependence but instead generates higher interdependence, lower availably of a status quo procedure, and, as a result, higher mutual benefit. Visiting specialists, who are employees of the University but practise at the SCC, have the option of working parallel to the practitioners employed by the SCC, but instead choose to collaborate with them to develop and implement joint patient care strategies. These partnerships suggest that a high level of alignment of approaches and aspirations between the partners can be leveraged to deepen co-operation and co-ordination and generate additional mutual benefit. It is congruent with the argument of this analysis that mutual benefit — which is a product of alignment — promotes co-operation and co-ordination — which are necessary attributes of successful interdependent relationships.

This analysis suggests that mutual benefit and available status quo procedure promote co-operation and co-ordination among partners in four ways: partnership creation, partner engagement, the creation of a joint strategy, and the harmonised execution of the strategy:

1. *Partnership creation*: Mutual benefit motivates organisations to pool their resources into a

partnership, including specialised skills and knowledge, towards their shared aspirations or approaches.

2. *Partner engagement*: Engagement in a partnership occurs when all partners shoulder their responsibility rather than coasting on the efforts of the other partners or otherwise acting in a way that does not promote the partners' collective benefit. It is to take an active role rather than free-ride (Choi & Robertson, 2019). In partnerships where mutual benefit is a strong governance mechanism, free-riding is detrimental to both the organisation and the partnership. Meanwhile, an available status quo procedure lowers the effort required to engage. It is relatively less taxing to follow a procedure that is the universal default.

3. *Creation of a joint strategy*: The creation of a joint strategy can be difficult given the complexity of issues that bring the partners together, and misaligned strategic directions cannot sustain a partnership (Edgar et al., 2006). Mutual benefit and available status quo procedure provide common bases upon which joint strategies can be developed.

4. *Harmonised execution of a strategy*: Harmonised execution of a joint strategy requires all partners to know what they should do to act in concert with the partners (i.e., co-ordination) and to agree to do so (i.e., co-operation). Co-ordination is primarily a problem of information about each other's actions (Grandori, 1997). An available status quo procedure solves this problem by providing ready-made roles and responsibilities. Co-operation is a problem when partners understand what they should do, but choose to do otherwise. The problem might be that the partner is acting according to how it thinks the other partners will behave (Sugden 2016). If it believes partners will act contrary to the strategy, then it might choose to defect its strategic role. Mutual benefit mitigates the risk of mistrust among partners because, when there is a high level of alignment between partners, to act contrary to the strategy is to act contrary to one's own interests.

Mutual benefit, available status quo procedure, and interdependence might be found at different levels in different partnerships between organisations that might belong to different sectors and follow different internal governance models. They are attributes of partnership governance that describe how partnerships function. Future research might apply the attributes to other past and present cases to gain a fuller understanding of the governance of partnerships between disparate organisations.

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