Voluntary Work in the Norwegian long-term Care Sector: Complementing or substituting formal Services?

The Version of Record of this manuscript has been published and is available in the European Journal of Social Work, 2018, http://www.tandfonline.com/, https://doi.org/10.1080/13691457.2018.1462767

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Abstract

Across Europe, governments call for increased involvement of volunteers to shoulder some of the welfare burden. Nevertheless, there is little research into what kind of work and how much volunteers currently contribute in the long-term care services and whether this has the potential to substitute formal services. Drawing on findings from a survey of employees in nursing homes and home care districts, we examine the nature and volume of voluntary, unpaid work in the long-term care services in Norway. Our data suggest that volunteers to a very limited degree carry out work that has traditionally been considered the formal system's domain: personal care and practical help. Nearly all the voluntary, unpaid contributions in our data takes place within cultural, social and other activities aimed at promoting mental stimulation and well-being, indicating a classic specialisation of tasks between volunteers and professionals. However, there has been an expansion of the formal care system to include activities aimed at promoting well-being in recent decades. This may indicate that there is a certain level of task sharing between voluntary and formal care. Thus, social workers need to consider voluntary service provision when assessing the needs of clients.

Keywords (3-5)

Voluntary work, long-term care, substitution, complementarity, care tasks

Norwegian title and abstract

Frivillig arbeid i de kommunale omsorgstjenestene: Et komplement eller substitutt for offentlige tjenester?

Sammendrag

I hele Europa signaliserer offentlige myndigheter at de ønsker økt involvering av frivillige for å bidra til å bære velferdsbyrden i årene som kommer. På tross av dette er det lite forskning på hva slags typer arbeid frivillige gjør, hvor mye frivillige bidrar i de kommunale omsorgstjenestene og hvorvidt bidraget deres har et potensial for å substituere offentlige tjenester. Vi anvender resultater fra en spørreundersøkelse utført blant ansatte i norske sykehjem og hjemmetjenester for å studere innholdet og volumet av frivillig, ubetalt arbeid i de kommunale omsorgstjenestene. Våre data tyder på at frivillige i veldig liten grad utfører oppgaver som tradisjonelt har vært sett på som det offentliges ansvarsområde: pleieoppgaver og praktisk hjelp. Nærmest all den frivillige, ubetalte innsatsen i våre data finner sted innenfor kulturelle, sosiale og andre aktiviteter med psykisk velvære og forbedret livskvalitet som hovedmål. Dette kan tolkes som en klassisk oppgavespesialisering mellom frivillige og profesjonelle. De offentlige tjenestene har imidlertid de siste årene utvidet sine ansvarsområder. I økende grad har de fått ansvar for også å organisere aktiviteter for å ivareta tjenestemottakeres sosiale, kulturelle, psykiske og eksistensielle behov. Det er med andre ord en viss grad av oppgavedeling mellom frivillig og offentlig omsorg. Sosialarbeidere og andre offentlig ansatte må derfor ta hensyn til frivillige tjenester når de vurderer tjenestemottakeres behov.

Nøkkelord: Frivillige, eldreomsorg, substitusjon, komplementaritet, omsorgsoppgaver

Introduction

During the last twenty-five years, the voluntary sector has assumed a key position in the international debate about changes in welfare states. Long-term challenges related to low fertility rates, ageing populations and changing public health patterns have made governments look for ways to increase the share of voluntary, unpaid contributions in the provision of health and social care services. The mobilisation of volunteers to provide care to older, disabled and sick people with care needs have in particular been seen by many politicians and administrators as a way of making future public services more sustainable. As social workers help find solutions for people and families to challenges of personal, social and organisational character and increased use of volunteers increases the social and organisational complexity within the long-term care services, the issue of volunteering in long-term care is of high relevance to the field of social work.

Norway is an example of the Nordic welfare model and has a universal welfare state characterised by extensive public funding and service provision (Esping-Andersen, 2002). Since the 1990s, a number of white papers and other government documents have pointed to the voluntary sector as an important resource in the provision of social care services (Ministry of Culture, 1997; Ministry of Health and Care Services, 2011, 2013). The provision of long-term care for older, disabled and sick people is an integral part of the universal welfare services offered by the state. In 2014, five percent of the population, or approximately 271,000 people, received long-term care services (Mørk, 2015, p. 39). This amounted to 148,000 full-time positions and operating costs of around 10.5 billion Euros (NOK 100 billion) per year (Ministry of Health and Care Services, 2016, p. 275)

While there is a large body of literature about overall volunteering and civil society in Norway (Folkestad, Christensen, Strømsnes, & Selle, 2015; Lorentzen, 2004; Wollebæk, Selle, & Lorentzen, 2000; Wollebæk & Sivesind, 2010; Wollebæk, Sætrang, & Fladmoe,

2015), there is little research into voluntary work in long-term care (Førland, 2015; Jeppsson Grassman, 2005; Rønning, Schanke, & Johansen, 2009). A few qualitative studies give some indication of how voluntary work in the long-term care services is organised (Abrahamsen, 2010; Rønning, 2011; Solbjør, Johansen, & Kleiven, 2012), how volunteers are recruited (Johansen & Lofthus, 2011) and how common it is to do voluntary work in the health and care services among the general population (Andfossen, 2016). However, there are no studies looking at what types of tasks and services are being carried out by volunteers in long-term care or how much time volunteers spend doing voluntary, unpaid work in nursing homes and home care services. This knowledge is essential for our understanding of the current role of volunteers in long-term care and to determine the extent to which the voluntary workforce is capable of aiding the formal care system in coming decades. These insights are also important to the social work profession, as recent research shows that it does make a difference to clients whether services are provided by volunteers or paid employees (Metz, Roza, Meijs, van Baren, & Hoogervorst, 2017).

This article aims to fill some of this gap in the literature, seeking to answer the following research questions: What kind of tasks and activities do volunteers in the Norwegian long-term care services perform? And how much time do volunteers spend doing voluntary, unpaid work in nursing homes and home care? Whereas most research in the area takes the volunteer perspective, this study looks at long-term care volunteering from the perspective of the public services/professionals. We present and discuss results from a survey conducted in 2015 and 2016 in a sample of 50 Norwegian municipalities, comprising of 316 long-term care units (primarily nursing homes and home care districts). In order to better understand voluntary work in the overall provision of long-term care services, the results are discussed in light of two interpretative perspectives that feature in the literature on informal caregiving. These are the perspectives of complementarity and substitution (Jegermalm & Jeppsson Grassman,

2013; Lingsom, 1997; Litwak, 1985). Whereas the complementarity thesis posits that formal and voluntary (or informal) care sources carry out different tasks and complement each other, the substitution thesis holds that the one care source can take over or substitute tasks from the other.

The article is divided into four parts. The first part provides background to volunteering and long-term care services in Norway and gives details about the article's analytical framework. The second part introduces the data and methods used, while the third presents the results from the survey. The fourth part discusses the results in light of the theoretical perspectives presented in part one.

The Norwegian Context

In Norway, the provision of long-term care for older, sick and disabled persons is the responsibility of the individual municipality. The long-term care services constitutes the biggest spending post in the municipal budget. In 2007, long-term care spending accounted for around 29 percent of the budget. In comparison, the education sector took up 25 percent of the budget the same year (Vabo, 2012, p. 99). Long-term care services in Norway are typically organised in institutional care (nursing homes) and home care services. Older persons represent the largest user group in the long-term care services and make up over 90 percent of care recipients in institutional care (Mørk, 2015, p. 39). Nevertheless, in the last twenty years, the number of home care recipients under 67 years of age has almost tripled, and younger users now account for the majority of home care spending (Otnes, 2015, p. 53; Romøren, 2007, pp. 6-7).

Compared to most other non-Nordic countries, the total volume of voluntary work in Norway is high (Wollebæk & Sivesind, 2010). The most recent national survey shows that 61 percent of the population has participated in some kind of voluntary work in the last year

(Folkestad et al., 2015). Respectively 7 and 6 percent of the population carry out voluntary work in organisations classified as 'health, care and rescue work' and 'social services and abuse treatment'. Additionally, approximately 2 percent report that they do voluntary work for formal institutions in the areas of 'old-age care' and 'other care' (Andfossen, 2016, p. 9). The latter are volunteers who operate independently of voluntary organisations. Although existing research tells us that the contribution of the volunteers in these four categories equals an estimated 22,000 full-time equivalents (Andfossen, 2016, p. 9), we do not know much about what kind of work the volunteers do or how many hours of voluntary work they carry out in nursing homes and home care services.

Analytical Framework

We define voluntary work as all kinds of contributions that are given freely without reward or other compensation and that benefit individuals or groups outside pre-existing relationships (Snyder & Omoto, 2008; Wollebæk et al., 2000). Although voluntary work is often carried out through formal voluntary organisations, it can also be carried out for public institutions such as hospitals, nurseries, nursing homes, without any connection to voluntary organisations. We also include this kind of voluntary work in our definition. Informal care or help given to members of one's family, friends or neighbours is not defined as voluntary work. This is because helping friends, neighbours and family members is characterised by personal relationships and, very often, a sense of obligation and responsibility. In volunteering, on the other hand, volunteers typically carry out work on behalf of causes or people they do not know, or the work is administered by a formal organisation, like a nursing home or voluntary organisation. Many other countries such as Germany, France and the United States have relatively large voluntary sectors which provide a range of care services for adults as well as children (Daly & Lewis, 2000; L. S. Henriksen, Smith, & Zimmer, 2012).

However, paid work carried out by professionals in voluntary organisations falls outside the remit of this study. Our focus is on unpaid efforts by volunteers in municipal long-term services, coordinated by voluntary organisations or municipalities.

We utilise the perspective of complementarity versus substitution in our analysis. The complementarity perspective holds that the state and non-state caregivers carry out different tasks and services, that there is a certain division of labour between the public and voluntary (or informal) care providers. The idea is that the services provided by the two complement each other (Chappell & Blandford, 1991; Jegermalm & Jeppsson Grassman, 2013; Lingsom, 1997; Litwak, 1985). Complementarity is assumed to increase the efficiency of care provision through specialisation of tasks or pooling of resources. This results in an increase in welfare for the care recipient (Lingsom, 1997). The substitution perspective, on the other hand, holds that public welfare services and voluntary (or informal) care are characterised by mutual exclusiveness – more of one gives less of the other. It is argued that expansive welfare state policy and involvement can undermine or take over voluntary or informal care tasks and contributions (Daatland & Herlofson, 2001; Lingsom, 1997). In times of cutbacks, however, voluntary or informal care resources can take over tasks previously covered by formal services (Jegermalm & Jeppsson Grassman, 2013; Jegermalm & Sundström, 2015). In our analysis, we focus on complementarity and substitution by discussing the voluntary workforce's capability of taking over care tasks previously or currently covered by formal care services.

To further inform the discussion about complementarity and substitution, we borrow a categorisation scheme of care tasks from Jegermalm's (2004) study on informal care in Sweden. Drawing on Parker and Lawson's (1994) typology of care, Jegermalm (2004) bases his analysis on seven different types of care tasks that are relevant to the Scandinavian context of formal and informal care:

1) *Keeping company (e.g. visiting, sitting with)*
2) *Keeping an eye on (e.g. checking that everything is alright, regular phone contact)*
3) *Personal care (e.g. dressing, bathing, feeding, using the toilet, giving medicines)*
4) *Housework (e.g. preparing meals, cleaning, shopping, laundry)*
5) *Paperwork (e.g. filling in forms, dealing with bills, banking)*
6) *Taking out (e.g. taking out for a drive or walk)*
7) *Gardening, household repairs, etc.*

(Jegermalm, 2004, p. 12)

Jegermalm groups the seven types of care tasks into three overall categories of care tasks, namely 'keeping company/an eye on' (covering tasks 1-2 above), 'personal care' (covering task 3 above) and 'practical help' (covering tasks 4-7 above) (Jegermalm, 2004). We use an adapted version of Jegermalm's typology to assist the analysis of our results. To more accurately reflect social and mentally stimulating care tasks such as social visits and entertainment in the long-term care services in its entirety (including nursing homes), we label our first category 'social and cultural activities' instead of 'keeping company/an eye on'. Moreover, we add a new category, 'physical exercise', to the scheme, in order to cover the whole spectrum of tasks covered by formal and voluntary care. This leaves us with four main categories of care tasks: 1) social and cultural care; 2) personal care; 3) practical help; and 4) physical exercise. Our point of departure is that the care tasks that traditionally 'belong' to the formal care services in the Scandinavian welfare model are those of personal care and, to some extent, practical help (cf. Vabø, 2012, p. 285). Social and cultural care and physical exercise have traditionally been more peripheral to the formal care system.

Data and Methods

The study comprised of a main survey conducted among healthcare professionals in 2015 and a follow-up mini-survey from 2016. The surveys were conducted in a sample of 50 Norwegian municipalities. The sample was stratified by size and region, representing both urban and rural, small, medium-sized and large municipalities in all five regions of Norway. The data were collected in electronic questionnaires distributed by e-mail. Prior to the distribution of the questionnaire, a comprehensive recruitment process was undertaken in which a team of researchers e-mailed and/or phoned contacts in each of the municipalities to identify all the nursing homes and home care districts (long-term care/LTC units) in the sample. We asked each of the municipalities to identify one key respondent in each care unit and provide their e-mail addresses. We asked for respondents who were municipal employees working in or for the individual LTC unit and had specific knowledge of voluntary activities in their work place. The municipalities reported on 316 LTC units in total. The majority of these were nursing homes and home care districts, but some municipalities with alternative organisational models for their long-term care services also registered sheltered housing units and/or day centres. 48 municipalities reported that their lists of LTC units and respondents' e-mail addresses were complete; only two municipalities returned incomplete lists. Thus, the list of units/respondents from the 50 municipalities covered nearly all their existing units. The response rate for the main survey was 77.2 percent, while the response rate for the 2016 mini-survey was 62.5 percent[1]. As Table 1 shows, there were no notable differences between the response rates among the nursing homes and home care units in the main survey. The response to the 2016 survey question followed the same pattern. Considering the spread of participating municipalities in terms of geography and size, we judge the sample to be fairly representative of the Norwegian long-term care services as a whole.

Table 1: Survey response rates, main survey

Long-term care unit	Respondents	Non-respondents	Response rate
Nursing home	128	34	79%
Home care	94	35	73%
Other[2]	22	3	88%
Total	244	72	77%

The questionnaire consisted of primarily closed-end, multiple-choice questions. It was informed by a review of available literature on volunteering in the Norwegian long-term care services as well as qualitative interviews with informants from five different municipalities, carried out by the second author in 2015. It was stated at the beginning of the questionnaire that questions would be asked about *voluntary activities that were organised in cooperation with the formal services/municipalities*. Voluntary activities were defined as *activities or services that were carried out using unpaid labour*. Cooperation was defined as *municipal involvement, such as economic support or direct municipal coordination of voluntary activities*. Cases of volunteers giving help to long-term care recipients independent of the municipality's involvement or awareness were not included in the study. This was because we judged voluntary activities that had some kind of engagement with the formal long-term care services in the care units to be of primary interest to our study, due to our focus on the potential of voluntary work to substitute for municipal long-term care services. Substitution and/or complementarity cannot be obtained without a certain level of transparency between the involved parties when it comes to task sharing or task division. Besides, the research design precluded the detection and measurement of voluntary activity that the formal care services had no part in.

The study used a screening question which asked whether the LTC unit in the last four weeks had had any activities *with volunteer involvement* in thirteen different areas. The

question was used to determine what types of voluntary activities are the most common in the long-term care services. The choice of categories was informed by the aforementioned literature review and qualitative interviews in five municipalities. The thirteen categories were:

Cultural activities (music, dance, theatre, etc.)

Social activities (trips, social gatherings, etc.)

Visiting schemes

Library/reading services

Activities certified by the foundation 'Joy of Life for the Elderly[3]

Day centres run by or with volunteers

Physical activities and exercise

Practical help for care recipients living at home (e.g. snow clearing, food shopping),

Food delivery for care recipients living at home

Transport/taking out

Helplines/counselling services

Self-help groups (for anxiety, grief, loneliness, etc.)

Other activities

The final category, 'other activities', was an open category where respondents could describe any voluntary activities that fell outside of the remit of the predefined categories. Furthermore, the categories *food delivery* and *practical help* were only relevant to respondents from LTC units providing home care services.

Another three questions were used to determine how many hours of voluntary involvement each LTC unit had per week in each of the categories of activities/services.

Respondents were first asked to give *an estimate* of how many times voluntary activities were held in each of the categories in the last four weeks, then how many volunteers contributed each time and finally, the duration of the activities each time. The results were recalculated into the mean number of hours spent by volunteers doing unpaid work in an LTC unit per week, potentially representative of several occurrences of activities and several volunteers.

When asked to specify average duration per activity, respondents were urged to round the number of hours up or down to the nearest half hour. In response to this question, a few respondents entered zero number of hours of volunteer involvement despite reporting voluntary activity in the screening question. These respondents were not left out of the analysis, as it was assumed that they had rounded the duration of the average activity from e.g. 10 minutes to zero.

Regrettably, Jegermalm's (2004) categorisation scheme was not brought into the study until the analysing phase in 2015. In other words, it was not used in the design of the 2015 questionnaire and 'personal care' was not listed as a category. The findings from the survey showed no mention of personal care tasks in the *other activities* category. Although this indicated non-existing volunteer involvement in personal care tasks, we could not be sure of this. So, to confirm, a fourteenth category, 'personal care', was added through a mini-survey that was sent out to the sample in 2016. The question asked: *Does your long-term care unit in an ordinary four-week period involve volunteers in carrying out personal care tasks, such as getting dressed, showering, feeding, helping to the toilet or giving medication?* Respondents who answered 'yes' to this question were, like in the main survey, asked to give estimates of frequency, number of volunteers and duration.

Results

The survey results show that 83 percent of the LTC units had one or more activities with volunteer involvement; only 17 percent of the LTC units surveyed reported that they had no voluntary activities. Table 2 shows the prevalence of voluntary activities by category, while Table 3 displays the results by type of activity. As Table 2 shows, social and cultural care is by far the most common category for voluntary activities. Eight out of ten units report that they have voluntary involvement in this category. As Table 3 shows, 61 and 55 percent of LTC units have cultural (music, dance, theatre, etc.) and social (trips, social gatherings, etc.) activities, respectively. Visiting schemes are also quite common; 44 percent of the LTC units have this. Examples of these are volunteers signing up to regularly visit care recipients and 'visiting dogs', an arrangement whereby volunteers bring dogs along to nursing homes or sheltered housing so residents can interact with them. Fewer than one in five have reading services, Joy of Life-certified activities and day centres.

The second most common main category in which volunteers do work is physical exercise. Around three out of ten LTC units have volunteers who initiate and/or participate in the provision of physical activities for care recipients, such as going for walks. The third most common is practical help: 27 percent have volunteers participating in the activities transport, food delivery or practical help.

A meagre two percent of LTC units use volunteers in the provision of personal care services. Furthermore, the prevalence of voluntary involvement in the provision of other activities and services, like self-help groups and support phone lines, is very marginal; only four percent have this. In addition, 17 percent of the LTC units report that they have 'other' voluntary activities. Examples of these are religious services, knitting groups, cycle rickshaw trips, various parties and gatherings and bingo. We note that quite a few of the activities

reported under 'other' in the survey might as well have been registered under cultural or social activities.

Table 2: Percentage of long-term care units with voluntary activities by category

Category (n=244)	**Percent**
Social and cultural care	79
Physical exercise	29
Practical help	27
Personal care (n=193)	2
Other	21

Source: Long-term care survey

Table 3: Percentage of long-term care units with voluntary involvement, by type of activity (n=244)[4]

Category	**Type of activity/service**	**Percent**
Social and cultural care	Cultural activities (music, dance, theatre, etc.)	61
	Social activities (trips, social gatherings, etc.)	55
	Visiting schemes	44
	Library/reading services	19
	Joy of Life-certified activities	18
	Day centres run by or with volunteers	9
Physical exercise	Physical activities and exercise	29
Practical help	Transport/taking out	20
	Food delivery for recipients of home care services	22 (11)
	Practical help for recipients of home care services (e.g. snow clearing, food shopping)	16 (9)
Personal care	Personal care (e.g. getting dressed, showering, feeding, helping to the toilet or giving medication)	2
Other	Helplines, support/counselling services	4
	Self-help groups (for anxiety, grief, loneliness, etc.)	4
	Other activities	17

Source: Long-term care survey

Table 4 displays the mean number of hours volunteers spend doing unpaid work in the LTC units each week in the 14 categories,[5] whereas Table 5 displays the mean number of hours contributed in the five main categories. It is important to note that the means displayed in these two tables are averages of the LTC units that reported activities in the respective categories, not the sample as a whole.

Table 4 shows that day centres and Joy of Life-certified activities are the activity types that have the highest volume of volunteer labour, with a mean of 26 and 15 hours a week, respectively. This is not surprising considering that the units that have reported high numbers in these categories are likely to be day centres run by voluntary organisations or Joy of Life-certified nursing homes with a high level of volunteer involvement. In the activities that are the most common among the LTC units (cultural and social activites cf. Table 3), the mean volume of voluntary hours contributed is relatively modest. Cultural and social activities average at 8-9 hours of voluntary contributions a week. In practise, this may represent for example one 30-minute-long concert with a choir consisting of 18 people or four volunteers organising a two-hour excursion for care recipients. The average for the social and cultural care category as a whole is 21 hours (Table 5).

The mean number of hours contributed by volunteers in personal care is high – at 19 hours, due to the small sample size (only four cases) and the high number of voluntary hours in one of the units (70 vs. 4, 1 and 0.75).[6] Arguably, the median of 2.5 is more representative as an average for the category, and is therefore displayed in Table 4 and 5.

The volume of voluntary work in practical help is considerable: Food delivery has one of the highest averages in the survey, with 13 hours per week in the home care units with this kind of activity. Moreover, the activity ‘practical help’ has an average of seven hours of

voluntary work a week, and 'transport' four hours. Physical exercise has an average of four hours of volunteer time weekly and 'other' activities averages at five hours (Table 5).

Table 4: Number of hours of voluntary labour per week in units with voluntary activity

Category	Type of activity/service	Mean	Min	Max	Std. Deviation	N
Social and cultural care	Day centres run by or with volunteers	25.8	0	108	35	20
	Joy of Life-certified activities	14.7	0	150	25.9	40
	Cultural activities (music, dance, theatre, etc.)	8.8	0	146	18.3	140
	Social activities (trips, social gatherings, etc.)	7.8	0	60	10.3	127
	Visiting schemes	4.1	0	35	5.4	89
	Library/reading services	1.3	0.13	10	2	43
Personal care	Personal care (e.g. getting dressed, showering, feeding, helping to the toilet or giving medication)	2.5*	0.75	70	34.1	4
Practical help	Food delivery for care recipients living at home	12.6	0	84	20.4	22
	Practical help for care recipients living at home (e.g. snow clearing, food shopping)	6.6	0.13	50	12.5	16
	Transport/taking out	4.1	0	25	6.2	40
Physical exercise	Physical activities and exercise	4.2	0.13	30	6.9	65
Other	Self-help groups (for anxiety, grief, loneliness, etc.)	1.6	0.25	4	1.4	7
	Helplines, support/counselling services	0.7	0	2	0.7	8
	Other activities	5.3	0	48	9.1	33

Source: Long-term care survey
* Median

Table 5: Average number of hours of voluntary labour per week in units with voluntary activity, by category

Category	Mean	N=
Social and cultural care	21.3	192
Practical help	10.4	67
Physical exercise	4.2	71
Personal care	2.5*	4
Other	4.6	52

Source: Long-term care survey
* Median

The means for the individual categories based on the whole sample are presented in Table 6. We find that the voluntary contributions in all the categories amount to an average of 22 hours per LTC unit per week. The six activity types sorting under *social and cultural care* account for almost 17 hours a week or three quarters of the total volume of voluntary contributions in the LTC units. Cultural (music, dance, theatre, etc.) and social (trips, social gatherings, etc.) activities have the largest volume of voluntary involvement, followed by Joy of Life-certified activities, day centres and visiting schemes. The three activities that belong to the category *practical help* account for just 13 percent of the total volume – three hours in sum. Physical exercise accounts for one hour per week or five percent of the total and personal care only 20 minutes, or one percent. The 'other' category makes up the remaining five percent of the total volume.

Table 6: Average number of hours of voluntary contributions per week in the whole sample (n=244)[7]

Main category	Type of activity/service	Mean
Social and cultural care	Cultural activities (music, dance, theatre, etc.)	5.4
	Social activities (trips, social gatherings, etc.)	4.2
	Joy of Life-certified activities	2.6
	Day centres run by or with volunteers	2.4
	Visiting schemes	1.8
	Library/reading services	0.3
	SUM	**16.7**
Practical help	Food delivery for care recipients living at home	1.4
	Transport/taking out	0.8
	Practical help for care recipients living at home	0.6
	SUM	**2.8**
Physical exercise	Physical activities and exercise	**1.2**
Personal care	Personal care (e.g. getting dressed, showering, feeding, helping to the toilet or giving medication)	**0.3**
Other	Self-help groups	0.1
	Helplines, support/counselling services	0
	Other activities	0.9
	SUM	**1.0**
	Total	*22.0*

Source: Long-term care survey

Discussion

Although our results are based on a limited sample of municipalities and therefore should be interpreted with some caution, they suggest that the volume of voluntary contributions in the Norwegian long-term care services is relatively modest. Our study indicates that the average LTC unit has the benefit of 22 hours of voluntary labour each week. Of this, three quarters constitutes involvement in social and cultural care activities, so there is no doubt that involvement in cultural and social activities by far constitutes the dominant type of voluntary

contributions in the long-term care services in Norway. Our study also suggests that voluntary labour to a very limited degree is used to carry out what has traditionally been considered the formal care system's domain: personal care and practical help. Therefore, it can be argued that the tasks and services the voluntary workforce carries out in the long-term care services are complementary to the formal care services' traditional tasks, not substitutionary. This is a clear indication that voluntary tasks do not and cannot, in their current form, substitute for cutbacks in core tasks and services of the formal care system. From this perspective, our results show a clear division of labour between formal and voluntary care – a classic specialisation of tasks (Lingsom, 1997). The formal care system provides personal care and practical help to care recipients, while volunteers complement the formal services by providing social and mental stimulation for care recipients in the form of company and cultural events and entertainment.

However, cultural, social and other activities directed at promoting mental stimulation and well-being have in the last few decades been added to the responsibilities of the formal care system. Activities aimed at promoting mental stimulation and well-being represent an expansion of the care professions' domain. For example, in recent years there has been increasing policy emphasis on active ageing, well-being and quality of life among care recipients in Norway (Kjøs & Havig, 2016; Ministry of Health and Care Services, 2006, 2013) which in turn has put more pressure on municipalities and professionals to incorporate social, cultural and physical activities in formal service provision. For example, the current government has signalled that singing and playing music should be part of the panorama of formal care services for older people. They want employees in the municipal care service to take on tasks such as singing with or playing music for service recipients (A. Henriksen, 2014). Moreover, in recent years there have been considerable cutbacks in the provision of

practical help to older people living at home (Otnes, 2015), which would suggest that there is a gap in formal home care service provision.

So, what we may be witnessing in the spheres of social and cultural activities, physical exercise and practical help seems to be a *partial transfer of responsibility* (Lingsom 1997) between the formal care system and voluntary actors. There is a certain level of task sharing between formal and voluntary care. According to Lingsom (1997), partial transfer of responsibility can be consistent with both complementarity and substitution theory. If what we are seeing is a pooling of public and voluntary resources that represent an increase in welfare for care recipients, then we can conclude that the tasks the two perform are complementary. The total amount of care grows. In LTC units with well-functioning cooperation with volunteers, this is likely to be a result of specialisation founded on a dynamic, interactive adaptation between volunteers and professionals (Lingsom, 1997, p. 21). The professionals are in a position to identify unmet care needs that the care recipients in their units have and direct freed-up capacity there (Lingsom, 1997, p. 20-21). On the other hand, if delegation of tasks to voluntary actors does not result in a reallocation of freed capacity to produce a welfare increment for care recipients, then what we are witnessing could be a substitution of tasks between formal and voluntary care. Volunteer groups take over new welfare tasks associated with the policy emphasis on active ageing, well-being and quality of life through the organisation of social and cultural activities for care recipients.

The difficulties in defining voluntary, unpaid contributions in long-term care as complementary or substitutionary to formal service provision illuminate the challenges involved for social workers to clarify the relationship between the voluntary and the formal care systems. What is clear from our results, however, is that social workers need to take both voluntary and formal care service provision into account when discussing clients' support systems.

On a more theoretical level, our results show that when the theories of substitution and complementarity are taken to convey the simple dualist view that voluntary and public care *either* complement *or* substitute each other, then they fall short of illuminating the relationship between voluntary and public care. We argue that the complexity in the interaction between the voluntary and public sectors cannot be captured by such a simple dualism. The dynamic nature of the field of long-term care makes it difficult to conduct empirical tests of theories about substitution and complementarity. Over time, the nature of the long-term care services changes, as does society's conception of what long-term care is – that is, what services the formal care system should provide. When the interaction between voluntary and public resources change over time, it might be due to new division of tasks and new or expanded roles.

Theories of substitution and complementarity are based on the idea of a clear demarcation between the voluntary and public sectors. However, in modern society, this division is gradually broken down. Healthcare professionals assume responsibility for activities that previously were the domain of civil society, whereas volunteers to an increasing degree are administered by public institutions that do not belong to the civil sphere. When it no longer is straight-forward to categorise voluntary contributions as 'voluntary' or 'public', it also becomes difficult to ascertain whether they are an expression of subsidiarity or complementarity. Therefore, there is a need for both empirical and theoretical studies in this field which can reflect the new diversity in collaborative relationships between professionals and volunteers, how they adapt and interact with each other. This kind of research ought to integrate the new, hybrid ways of working together, which now appear to replace previously clear-cut divisions of labour between the voluntary sector of 'amateurism' and the public sector of 'professionalism'.

Methodological Limitations

The study is based on municipal employees' knowledge and perception of the content and volume of voluntary contributions in long-term care, not observation or reports by volunteers. We are aware that the pre-defined categories in the questionnaire did not cover the entire array of voluntary activities and care tasks. We hope, however, that most of the voluntary activities that did not fit into any of our predefined categories were registered under the 'other activities' category, but we acknowledge that it is possible that some unspecified voluntary activities might have gone undetected in our study due to the 'other' category's lack of the trigger factor that specified categories have.

Another limitation in our study is that the questionnaire focused only on voluntary activities that were organised in cooperation with the formal services/municipalities. Thus, any activities or services provided by volunteers or voluntary organisations to recipients without the knowledge or involvement of the formal care services will have gone undetected in our study. Nor can we guarantee that respondents, especially in home care, had sufficient knowledge about the full extent of voluntary activities, since staff in home care typically see clients only for short periods of time. This has implications in particular for the accuracy of the time estimates provided by our respondents in the survey. Our results as regards time use should therefore be interpreted with some caution.

The strength of the study lies in the new insights it provides into healthcare professionals' perceptions of voluntary contributions in the services. Nevertheless, we would like to re-emphasise that the results on hours of voluntary contributions reported in the article are based on reports by healthcare professionals, and not on observation or reports by volunteers. Self-reported estimates by volunteers themselves might have yielded different, and potentially higher, numbers. Andfossen's (2016) study shows that the average number of hours reported by volunteers in health and social services is 2.5 hours a week, but it remains

unclear how this translates to the group level. Comparisons of data from both sides would be essential to get a more accurate picture of the volume of voluntary contributions on a group level in long-term care.

Acknowledgements

The authors would like to thank Nina Beate Andfossen for her contributions in the design of the questionnaire and Håkon Lorentzen for invaluable input in the design and writing process. We would also like to thank professor Aud Obstfelder and professor Magnus Jegermalm for helpful comments on early drafts of the article.

Funding

This work was supported by the Research Council of Norway through the HELSEVEL Programme (Health, care and welfare services research) as part of the research project 'Voluntary work in Norwegian Long Term Care - Prevalence, Forms, Interaction with Professionals and Potentials for the Future' [grant number 222312].

Disclosure statement

No financial interest or benefit has arisen from the direct applications of the research.

References

Abrahamsen, J. F. (2010). Undersøkelse om frivillige tjenester på norske sykehjem [Study of voluntary services in Norwegian nursing homes]. *Omsorg, 1/2010*, 31-32.

Andfossen, N. B. (2016). The potential for collaborative innovation between public services and volunteers in the long-term care sector. *The Innovation Journal: The Public Sector Innovation Journal, 21*(3), 1-21.

Chappell, N., & Blandford, A. (1991). Informal and Formal Care: Exploring the Complementarity. *Ageing and Society, 11*, 299-317. doi:https://doi.org/10.1017/s0144686x00004189

Daly, M., & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *The British Journal of Sociology, 51*(2), 281-298. doi:https://doi.org/10.1080/00071310050030181

Daatland, S. O., & Herlofson, K. (2001). Service systems and family care - substitution or complementarity? In S. O. Daatland & K. Herlofson (Eds.), *Ageing, intergenerational relations, care systems and quality of life – an introduction to the OASIS project* (pp. 53-62). Oslo: NOVA.

Esping-Andersen, G. e. (2002). *Why we need a new welfare state*. Oxford: Oxford University Press.

Folkestad, B., Christensen, D. A., Strømsnes, K., & Selle, P. (2015). *Frivillig innsats i Noreg 1998-2014: Kva kjenneteikner dei frivillige og kva har endra seg? [Voluntary efforts in Norway 1998-2014: What characterises the volunteers and what has changed?]* (Vol. Report No. 2015:4). Oslo: Senter for forskning på sivilsamfunn og frivillig sektor.

Førland, O. (2015). Oppsummering av litteraturen om frivillig innsats og samspillet med offentlige omsorgstjenester [Review of the literature about voluntary work and the interaction with the public care services]. In L. H. Jensen (Ed.), *Frivillighet i omsorgssektoren [Volunteering in the care sector]* (pp. 123-136). Tønsberg: Forlaget Aldring og helse.

Henriksen, A. (2014, 23 October). Nå må helsearbeidere underholde sykehjemsbeboere [Now health professionals have to entertain nursing home residents]. *Aftenposten*. Retrieved from http://www.aftenposten.no/kultur/Na-ma-helsearbeidere-underholde-sykehjemsbeboere-76429b.html

Henriksen, L. S., Smith, S. R., & Zimmer, A. (2012). At the Eve of Convergence? Transformations of Social Service Provision in Denmark, Germany, and the United States. *Voluntas, 23*(2), 458-501. doi:https://doi.org/10.1007/s11266-011-9221-5

Jegermalm, M. (2004). Informal care and support for carers in Sweden: Patterns of service receipt among informal caregivers and care recipients. *European Journal of Social Work, 7*(1), 7-24. doi:https://doi.org/10.1080/13691914504200021746 5

Jegermalm, M., & Jeppsson Grassman, E. (2013). Links between informal caregiving and volunteering in Sweden: a 17 year perspective. *European Journal of Social Work, 16*(2), 205-219. doi:https://doi.org/10.1080/13691457.2011.611796

Jegermalm, M., & Sundström, G. (2015). Stereotypes about caregiving and lessons from the Swedish panorama of care. *European Journal of Social Work, 18*(185-197). doi:https://doi.org/10.1080/13691457.2014.892476

Jeppsson Grassman, E. (2005). På jakt efter den frivilliga sektorns roll innom nordisk äldreomsorg [Searching for the voluntary sector's role in Nordic eldercare]. In M. Szebehely (Ed.), *Äldreomsorg i Norden: En kunskapsöversikt [Eldercare in the Nordic countries: A literature review]* (pp. 281-320). Copenhagen: Nordiska ministerrådet.

Johansen, V., & Lofthus, A. (2011). *Kommunenes rekruttering til og oppfølging av frivillig omsorg [The municipalities' recruitment to and supervision of voluntary care]*. Lillehammer.

Kjøs, B. Ø., & Havig, A. K. (2016). An examination of quality of care in Norwegian nursing homes - a change to more activities? . *Scandinavian Journal of Caring Sciences, 30*, 330-339. doi: https://doi.org/10.1111/scs.12249

Lingsom, S. (1997). *The substitution issue: Care policies and their consequences for family care* (Vol. Report No. 6/1997). Oslo: NOVA.

Litwak, E. (1985). *Helping the Elderly: The Complementary Roles of Informal Networks and Formal Systems*. New York, NY: Guildford.

Lorentzen, H. (2004). *Fellesskapets fundament: Sivilsamfunnet og individualismen [The community's foundations: Civil society and individualism]*. Oslo: Pax forlag.

Metz, J., Roza, L., Meijs, L., van Baren, E., & Hoogervorst, N. (2017). Differences between paid and unpaid social services for beneficiaries. *European Journal of Social Work, 20*(2), 153-166. doi:http://dx.doi.org/10.1080/13691457.2016.1188772

Ministry of Culture. (1997). *St.meld. nr. 27 (1996-1997) Om statens forhold til frivillige organisasjoner [White paper no. 27 (1996-1997) About the state's relationship to voluntary organisations*. Oslo.

Ministry of Health and Care Services. (2006). *St.meld. nr. 25 (2005–2006) Mestring, muligheter og mening: Framtidas omsorgsutfordringer [White paper no. 25 (2005-2006) Mastering, opportunities and meaning: the care challenges of the future]*. Oslo.

Ministry of Health and Care Services. (2011). *Norges offentlige utredninger 2011:11 - Innovasjon i omsorg [Official Norwegian Reports 2011:11 - Innovation in care]*. Oslo.

Ministry of Health and Care Services. (2013). *St.meld. 29 (2012-2013) Morgendagens omsorg [White paper no. 29 (2012-2013) The care of tomorrow]*. Oslo.

Ministry of Health and Care Services. (2016). *Prop. 1 S Proposisjon til Stortinget (forslag til stortingsvedtak) [Bill 1 S to the Storting [proposition for decision by the Storting)]*. Oslo.

Mørk, E. (2015). *Kommunale helse- og omsorgstjenester 2014: Statistikk om tjenester og tjenestemottakere [Municipal health and care services 2014: Statistics about services and service recipients]* (Vol. Report No. 2015/42). Oslo: Statistics Norway.

Otnes, B. (2015). Utviklingen i pleie- og omsorgstjenestene 1994-2013 [Developments in the long-term care services 1994-2013]. *Tidsskrift for omsorgsforskning, 1*(1), 48-61.

Parker, G., & Lawton, D. (1994). *Different Types of Care, Different Types of Carer: Evidence from the General Household Survey*. London.

Romøren, T. I. (2007). Kommunale hjemmetjenester - fra eldreomsorg til "yngreomsorg"? [Municipal home-based care services - from old-age care to "young-age care"?]. *Aldring og livsløp, 6*(1), 2-10.

Rønning, R. (2011). *Frivillige og lønnede på samme lag: Om styrking av den frivillige innsatsen i omsorgsarbeidet – i samspill med offentlig sektor [Volunteers and paid workers on the same team: About the strengthening of the voluntary efforts in care - in interaction with the public sector]* (Vol. ØF-rapport nr. 18/2011). Lillehammer: Østlandsforskning.

Rønning, R., Schanke, T., & Johansen, V. (2009). *Frivillighetens muligheter i eldreomsorgen [The opportunities of volunteering in eldercare]* (Vol. Report No. 11/2009). Lillehammer: Østlandsforskning.

Snyder, M., & Omoto, A. M. (2008). Volunteerism: Social Issues Perspectives and Social Policy Implications. *Social Issues and Policy Review, 2*(1), 1-36. doi:https://doi.org/10.1111/j.1751-2409.2008.00009.x

Solbjør, M., Johansen, B., & Kleiven, H. H. (2012). *Samarbeid mellom kommuner og frivillig sektor på pleie- og omsorgsfeltet - en kartlegging [Cooperation between municipalities and voluntary sector in long-term care - an assessment]*. Steinkjer.

Vabo, S. I. (2012). Tiltakende styring av kommunesektoren - også på eldreområdet? [Increasing governance of the municipal sector - also in the old-age area?] In M. Reitan, J. Saglie, & E. Smith (Eds.), *Det norske flernivådemokratiet [The Norwegian multilevel democracy]* (pp. 97-135). Oslo: Abstrakt.

Vabø, M. (2012). Norwegian home care in transition – heading for accountability, off-loading responsibilities. *Health and Social Care in the Community, 20*(3), 283-291. doi:https://doi.org/10.1111/j.1365-2524.2012.01058.x

Wollebæk, D., Selle, P., & Lorentzen, H. (2000). *Frivillig innsats: Sosial integrasjon, demokrati og økonomi [Voluntary efforts: Social integration, democracy and economy]*. Bergen: Fagbokforlaget.

Wollebæk, D., & Sivesind, K. H. (2010). *Fra folkebevegelse til filantropi? Frivillig innsats i Norge 1997-2009 [From people's movement to philanthropy? Voluntary efforts in Norway 1997-2009]* (Vol. Report No. 2010-3). Oslo: Senter for forskning på sivilsamfunn og frivillig sektor.

Wollebæk, D., Sætrang, S., & Fladmoe, A. (2015). *Betingelser for frivillig innsats: Motivasjon og kontekst [Preconditions for voluntary efforts: Motivation and context]*. Oslo.

NOTES

[1] The gross sample for the main survey conducted in 2015 was 316, and the net sample 244. By 2016, some e-mail addresses were invalid (presumably due to staff leaving or changing jobs), so the gross sample for the follow-up question was 309 and the net sample 193.

[2] Examples of 'other' were LTC units with both institutional *and* home care services; sheltered housing; day centres; etc.

[3] *Joy of Life for the Elderly* is a foundation which aims to give old people a good and meaningful life by focusing on fulfilling their social, spiritual and cultural needs. It is based on voluntary work, and nursing homes can apply to be certified Joy of Life institutions.

[4] The categories *food delivery* and *practical help* were only relevant to LTC units providing home care services, so n=128. For these two categories, the percentages based on the whole sample (n=244) are presented in brackets.

[5] Several respondents did not provide complete information regarding volume (duration, frequency and number of volunteers). We believe that the reasons for this was that some respondents found it too difficult to give an estimate of the volume of voluntary activity, or

that they simply did not feel they had sufficient knowledge about it to give an estimate. However, this means that there are one or several cases of missing data in each category.

[6] Because the number of hours provided in the survey was so high, we contacted the respondent by e-mail to confirm that the number was correct. The respondent confirmed that the LTC unit had two volunteers who each did voluntary work seven hours a day five days a week (=70 hours).

[7] In the calculations of the means for the whole sample, mean values were registered for units which had reported that they had voluntary involvement in a category but had not reported complete information about hours.