

Not just “sweet old ladies” – Challenges in voluntary work in the municipal long-term care services

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Abstract

Introduction: The Norwegian government is addressing the need for increased voluntary work in the municipal care sector. Several reforms over the last decades have transferred important care tasks to the municipalities, as it is a political aim for people to live longer in their own homes. Despite important structural changes in the provision of public care services, less attention has been devoted to the investigation of how voluntary work interacts with the overall development of care tasks within municipal care services. This paper aims to discover how the contribution of volunteers matches the current needs of service recipients and the daily work of professional staff and, additionally, to discover what level of volunteer competence and qualifications are considered necessary when cooperating with staff.

Method: Eight case studies addressing opportunities and barriers to voluntary work in long-term care were carried out. Our study included participants from both voluntary organisations and long-term care.

Results: Volunteers were considered to fill important functions and gaps by providing social support, offering activities and by communicating with the service recipients. However, the poor health of service recipients risked putting undue strain on volunteers. Volunteers need to have personal qualifications, such as good observation and communication skills, in order to function well and be useful in their role as volunteers.

Discussion: Care is seen as a complex task requiring time, effort, and technical and social skills. Relational care is not easily distinguished from the overall care needs of service recipients. Service recipients in the municipalities are seen as increasingly frail and have complex health needs. With the expected increase in the number of elderly

with dementia in the future, we may need to question whether volunteers are equipped to take on such advanced health problems.

Keywords: Long-term care, volunteers, welfare state, professionals, dementia, service recipients, advanced practice nursing, future care planning

Introduction

The need for voluntary work

Since welfare states in the western world are under increasing fiscal pressure to provide safe, effective and sustainable health and social care, new models of service provision are being sought within civil society (Frederiksen, 2015; Trägårdh, Selle, Henriksen, & Hallin, 2013). Norway is no exception, as the costs of maintaining the current level of welfare are expected to increase in the near future. The demographic composition of the population is changing, and people are living longer. It is estimated that by 2030, a third of the citizens of Norway will be over 60 years old. Moreover, it is estimated that there will be a considerable deficit of nurses and care workers by that time (Helse- og omsorgsdepartementet, 2013).

There seems to be a general agreement amongst western governments that local communities and voluntary organisations are key elements in planning the future of the welfare state. In Norway, the government has repeatedly emphasised the need for third sector involvement in providing and co-producing welfare services at the municipal level. White Paper No. 25 addresses how care services must prepare for the growth in the elderly population (Helse- og omsorgsdepartementet, 2006), and White Paper No. 29, which followed, argues for the importance of stimulating the support of relatives and volunteers in tackling future welfare challenges (Helse- og omsorgsdepartementet, 2013). Along similar lines, primary stakeholders in the Norwegian Association of Local and Regional Authorities (KS) call for more volunteers and point out that: “Each and every one of us has the potential to become a volunteer” (Fagforbundet, 2016).

Long-term care services in the municipalities share the belief that volunteers will be increasingly important and necessary in future service development. Municipalities are encouraged to develop their own volunteering plans, and promoting voluntarism and participation in social and cultural activities organised by volunteers is presented as being beneficial both for the service user and the volunteer (Hunter & Linn, 1981; Post, 2005; van Campen, de Boer, & Iedema, 2013). Although Norway has an extensive public sector, the voluntary sector is generally seen as strong (Selle, 1993). For example, it is estimated that the adult population performed nearly 200 million hours of voluntary work in 2009 (Wollebæk & Sivesind, 2010). Most of these hours are related to sports, leisure or cultural activities (Folkestad, Christensen, Strømsnes, & Selle, 2015). However, a recent study concluded that only 1.1 percent is related to voluntary work in formal institutions of “old age care” (Andfossen, 2016:9). Over the last decade, researchers have stated repeatedly that we have limited knowledge of voluntary work in long-term care (Grassman, 2006; Rønning, Schanke, & Johansen, 2009). A few qualitative studies have emphasized variations in how municipalities proceed to recruit, train and organize the efforts from volunteers

in long-term care (Fensli, Skaar, & Söderhamn, 2012; Hansen, 2005; Johansen & Lofthus, 2011; Nødland, Bergsgard, Bjelland, & Leknes, 2007; Rønning et al., 2009), while a few other studies have looked at factors that promote or hinder voluntary work in the care services (Rønning, 2011; Solbjør, Ljunggren, & Kleiven, 2014). The field of knowledge is, however, largely inconclusive and leaves important questions about who the volunteers are, what tasks they undertake and what are the practical experiences of volunteers contributing to long-term care.

Since the organisation of the municipal health service in Norway has undergone rapid changes in recent years, the constellation of service users has also changed, as have the severity of their problems and consequent needs. However, there is limited knowledge about what role and functions volunteers can and should play, and how their current efforts harmonise with that of the professional staff in the practice field. There seems to be a consensus that volunteers should provide social support and engage care receivers in social contact and in activities. Nevertheless, little is known about what this entails and whether any challenges are emerging between professional staff and volunteers in relation to each other and the needs of service users. Drawing on a study of voluntary work in long-term care, the aim of this article is to explore the experiences of leaders in care services and voluntary organisations. The focus of the exploration will be the experiences in respect to voluntary workers in the context of long-term care services, including both nursing homes and home care facilities. One of the questions to be discussed is: How is the contribution of volunteers seen to fit the current needs of service recipients and the daily work of professional staff? A related question concerns whether the transfer of aspects of care provision to volunteers underestimates the skills involved in caring for the elderly population in today's nursing homes. Based on an analysis of the findings, we suggest that the present enthusiasm for contributions from volunteers in long-term care rests on an assumption that care work can be separated into discrete tasks that can be divided between professional and non-professional workers, regardless of context and complexity of needs. We start by introducing a theoretical perspective on care work in bureaucratic institutions before we go on to present an outline of the changing role of the municipal health service and how it affects formal care in nursing homes. We then move on to present the study methodology before we elaborate on the findings and discuss their implication for the use of volunteers in long-term care.

Care in health service institutions

Care work is a complex activity that requires time, effort, and technical and social skills. In the literature on care, it is common to highlight time and discretion as key components in care work because it takes time to build a trusting relationship and to organise the work around the needs of the recipients of care (Abel & Nelson, 1990). There has long been an agreement in the research that paid care work in bureaucratically organised institutions leads to tension for caregivers since the organisation, rigid scheduling and managerial control of work contradicts the flexibility and affective involvement required to give individually tailored care (Abel & Nelson, 1990; Glasdam, Praestegaard, & Henriksen, 2013; Wærness, 2004). Wærness (2004), one of the staunchest critics of the socio-political planning of public care, claims that the modernisation processes of recent years run counter to what is distinctive about the rationality of care work. Wærness emphasises that in proposals for changes and reforms in the sector, plans and policies that aim to improve the quality and efficiency of public care work tend to neglect central components of caregiving. Those who

perform the specific everyday care of the sick, disabled and elderly in institutions and in the home need to have some personal knowledge of the person cared for and some control over time in order to care well. Thus, specifying and dividing care into discrete tasks to be performed within a set time and in a standardised manner may undermine caring as a skilled, emotionally-involved practice. Nurses, for example, see it as their responsibility to care for the patient holistically, and also hold that certain aspects of their work are best carried out in relation to a broader scope of caring activities (Mellow, 2007). Doing a physical assessment of a patient whilst giving a bed bath, observing how a patient manages specific activities of daily living by being present at mealtimes or sharing a cup of coffee are examples of how nurses can gather important patient knowledge (Mellow, 2007). At the present, however, there is a tendency for care work to be rigidly specified and scheduled on the basis of patient classification systems and divided between different types of care workers, paid and unpaid, as well as skilled and unskilled, with qualified nurses increasingly being driven to perform both medical and administrative work (Kristiansen, Obstfelder, & Lotherington, 2015; Kristiansen, Westeren, Obstfelder, & Lotherington, 2016), as we shall outline below.

A changing municipal healthcare sector

In recent years, the municipalities' responsibility for healthcare has greatly increased due to organisational reforms and legal regulations imposed by central government. The latest and most important of these was the Coordination Reform that was introduced by the health authorities in 2012. The reform extended the municipalities' responsibility for service provision by changing the functional division between hospital or specialised care and primary health care (Gautun & Grødem, 2015). Key features of the reform, such as financial incentives promoting shorter hospital stays and the implementation of low-threshold acute care wards in the municipalities, call for new institutional arrangements and higher staff competence. Whereas elderly persons with complex care needs used to receive medical care in hospitals, they are now to a large extent treated in nursing homes, municipal acute wards or in their homes. Recent studies show that service recipients in nursing homes and home care are increasingly frail older people characterised by multi-morbidities, cognitive failure and polypharmacy (Helvik, Engedal, & Selbæk, 2010; Selbæk, Kirkevold, & Engedal, 2008). This development leads to increased job demands and a need for more advanced nursing competence in nursing homes and home care (Bing-Jonsson, Hofoss, Kirkevold, Bjørk, & Foss, 2016; Bing-Jonsson, Bjørk, Hofoss, Kirkevold, & Foss, 2015; Tyrholm, Kvangarsnes, & Bergem, 2016). Seen against a service context that is becoming more task-driven and where nurses are expected to play an extended role in the medical management of residents, including the acute and critically ill, the capacity to meet the social needs of service users has become limited. Furthermore, health professionals must carry out more tasks related to documentation and reporting, reinforcing the trend that care professionals have less time to spend in direct social contact with residents (Vabø, 2012). There is a legal requirement to meet social needs, such as enabling service users to interact with and form relationships with other residents and staff, as well as for service users to experience a sense of community and engage in meaningful activities (Helse og omsorgsdepartementet, 2003), and this is now considered to be an arena for volunteers to enter. In accordance with these rights, nursing homes are responsible for meeting the social needs of residents. However, few studies have scrutinised how volunteers contribute to this aspect of care and how it finds its shape in the practice field.

Material and Method

The case studies

In 2016, eight case studies were completed in various nursing home and home care locations. Activities that required communication and coordination between volunteers and professionals in the municipal care services were selected, while the activities of volunteers who operated autonomously with various tasks not requiring involvement from staff in the caring facility were left out. We also prioritised the inclusion of activities that had been in operation for more than a year in order to gain the insights of experience. Lastly, we picked activities from different regions in Norway that represented both small rural communities and urban areas.

The activities included in the case studies were visiting schemes, physical activities and exercise, and cultural arrangements. Visiting schemes and participation in physical activities, in particular, fostered interaction and communication between volunteers and service recipients, while participation in cultural activities was organised more as entertainment that required little involvement from the attending residents. In this paper, our findings stem from the data related to the visiting schemes and physical activities that required considerable interaction and communication between volunteers, service recipients and professional staff.

The purpose of *Visiting schemes* is to link lonely residents with volunteers, thus providing increased social contact. Volunteers who wish to participate in a visiting scheme receive some training in the voluntary organisation before they start. The visiting schemes are organised both for home residents and residents in nursing homes. The volunteers visit the service recipients (visiting host) on the basis of their common interests and what activities are practical and feasible. The aim of the scheme is to develop a social relationship over time.

Physical activities include various activities related to indoor and outdoor exercise where volunteers accompany residents.

Definitions

A commonly used definition of “voluntary work” is the work a person does within voluntary organisations for individuals other than family and close friends without receiving regular payment for it (Wollebæk & Sivesind, 2010). Unpaid work, informal care or help given to members of one’s family, friends or neighbours is not defined as voluntary work in our study. “Service recipients” is applied to persons receiving care either in nursing homes or from home care services.

The interviews

The first author carried out qualitative interviews with one activity leader from each of the voluntary organisations and one manager in each municipal care service who was responsible for voluntary work. By interviewing the leaders in the voluntary organisations and the care services, we were able to compare their experiences and opinions of the voluntary activities that took place. The leaders brought forward their own thoughts and ideas in response to the questions, but also the voices and opinions of their staff and volunteers that had been shared with them in both formal and informal meetings.

The interviews took place on the premises of voluntary organisations or in the workplace of the care staff and lasted from 45-80 minutes. The interviews followed a structured interview guide consisting of five main topics (the volunteers, the service recipients, organisational procedures, mobilisation and coordination). Adhering to a qualitative methodology, the interviewer was keenly aware of the participant's voice and reasoning (Malterud, 2012). All respondents allowed the interview to be recorded provided that they remained anonymous in any written reports.

Analysis

All interviews were transcribed by the first author, with the material consisting of approximately 200 pages. Firstly, and in line with thematic analysis (Braun & Clarke, 2006), the texts were read several times in order to gain a thorough overview of the data, looking for patterns and emerging themes both related to the five main topics and in relation to other topics that were raised during the interviews. Data-driven coding was then carried out on the entire data set to condense and organise the data into meaningful and analytically interesting groups. Interviews with leaders of the municipal care services were compared systematically to the interviews with the activity leaders, with a focus on similarities and differences in their statements on all five main topics. Interviews were analysed together (seen in connection with each other) for the same activity and separately with regard to how the activities were viewed and experienced independently of each other. The analysis as a whole proceeded in an iterative and interpretive manner, moving back and forth between the empirical codes, the research questions and the theoretical perspectives on caregiving (Tjora, 2017). This process led to the identification of two thematic groups: a) the needs and situation of care receivers and b) the views on volunteers and what is required of them. Finally, thick descriptions were written to detail as much as possible of the leaders' experiences with tasks related to (a) and (b) above. The various steps of the analysis were discussed continuously with a research group of participants who all worked with the development of services in long-term care and with voluntary work, in particular. A few of the respondents were re-contacted to double-check the meaning of some aspects of the content to ensure our understanding was correct.

Ethics

The project was registered and approved by the Norwegian Centre for Research Data. All informants who participated in the study consented to the recording of the interviews. We have omitted the names of municipalities and nursing homes or any information that can be traced back to the participants in order to safeguard their anonymity.

Findings

The findings are presented in two thematic groups. First, we present findings pertaining to the views on the needs and situation of care receivers by leaders in care services and voluntary organisations, and second, we present findings on their views of volunteers and what is required of them.

Multifaceted needs and demanding service users

In line with recent studies, our findings confirm the impression that service recipients are generally considered more frail than a decade ago (Pedersen & Tingvoll, 2014). The everyday work of staff in municipal care services was hectic and involved a number of professional nursing tasks that required technical expertise. Social contact with residents often had to give way to more acute and urgent needs. One leader in a nursing home thought that the volunteers could help out in this area:

“The users are frailer now than before. They have poor health before they are admitted to the nursing home. Now they tend to stay at home as long as possible. They have home care up to six times a day. So, when they are finally admitted to the nursing home, they are in quite poor health. This means that much more is required of our nurses! And now that there is – on top of a lot more wound treatment and care – much more documentation... yes, and then there is the social aspect and having good conversations that they [the staff] don't have time for at work. And I think that volunteers can contribute here.”

In addition to the frail elderly, leaders in home care also experienced a greater complexity of needs among users of all ages. Many needed help with ordinary care tasks, but there was also an increase in the number of recipients with mental illnesses, substance abuse and terminal illness. One leader in home care pointed out that she generally believed that volunteers could contribute a lot, but she was often unsure whether she could send them to some of the more challenging service recipients:

“I think volunteers, in general, have a lot to contribute. Particularly [when it comes to] shopping and small practical things, but... The persons who need the most care are often those who have psychological challenges or alcohol or drug problems. These people are very demanding. I have many times wondered whether it is justifiable to send out volunteers to visit a service recipient...”

Managers in both voluntary organisations and care services thought that volunteers could play an important role for care service recipients, but were concerned that the physical and mental health problems of care receivers might prove to be too complex and challenging. In particular, they were concerned about those volunteers who visited care receivers in their homes. In the event of something happening, the volunteers would have less opportunity to seek guidance and support as compared to volunteers in a nursing home with staff members present at all times.

Although the leaders thought that volunteers could help with practical assistance and social contact, they argued that not everyone could work as a volunteer in the municipal care services. In particular, leaders considered service recipients with more severe problems to represent a challenge and one leader pointed out that she made assessments with regard to safety before she involved a volunteer:

“In many cases, I have chosen not to do that [send out volunteers] because I consider the user[s] to be in too poor health. They will eat these volunteers alive! They [the volunteers] don't have any competence in setting limits! As a professional, you learn to set limits for yourself, so you are not overwhelmed”.

Leaders in voluntary organisations sometimes experienced volunteers asking to visit the healthiest elderly. Some volunteers explicitly stated that they wanted a visiting host with few complaints, while others were willing to take a challenge and attach themselves to a person with fairly large or complex care needs. A leader in a voluntary organisation pointed to the importance of clarifying expectations with volunteers in advance:

“There are a few young people who come and say that they miss their grandparents and that it would be nice with a sweet old lady who lives right by [their] flat... Then we have to go in and ... we have to bring home the reality, which is that there are no sweet old ladies out there... The few sweet old ladies are taken straight away – they get taken by others – or – they aren’t difficult to connect, to put it like that. Not that we want to scare anyone, but there is a reason why people contact the visitor service... They [the volunteers] are often altruistic when they come, and value-wise concerned about being ‘good people’, but they have to be able to handle difficult things – and that is the challenge!”

Leaders in the care services mentioned repeatedly that the volunteers had to understand that service recipients could often be unstable. In their experience, it was fairly common for service recipients to break or forget a scheduled appointment or to change plans. When having experienced this, many volunteers felt their personal motivation for volunteering decreased. One leader in the care services noted that being an unpredictable host was fairly common in younger hosts with mental challenges and in hosts with dementia.

A need for experience and commitment

Communication skills were considered very important for volunteers. People with dementia were mentioned specifically, and training and instruction regarding dementia was given regularly. A leader in a voluntary organisation explained:

“It is most demanding [for the volunteers] to visit persons with severe dementia. Then you have to know quite a bit about dementia... We try to provide some subject-related top-ups through ‘theme nights’ (1-2 times a year), and these have been about dementia because that is the most relevant [topic]. There is a particular way to handle them, a technique, a conversational technique, which you should know about and practice a little... I have experienced volunteers who want to give up if they haven’t handled residents like that, so keeping the volunteer... then you have to do it in a way that they find interesting”.

Several of the informants pointed out that today’s volunteer cannot be just “anyone”. Specifically, individuals with cognitive impairment are known to be a very demanding group to visit. To ease the burden, one nursing home paired new volunteers with more experienced volunteers in order to teach the new volunteers practical techniques for dealing with situations involving people with dementia. This was arranged after the volunteer coordinator had to terminate agreements with some of the volunteers because of communication difficulties. The coordinator did not want to lose more volunteers:

“Some of our users have additional psychiatric symptoms as well as their dementia diagnosis, and then it can go completely pear-shaped if the volunteer doesn’t speak clearly and concisely”.

Another challenge concerning people with dementia was their need for frequent contact. Leaders in care services pointed out that the volunteers had to visit people with dementia regularly for them to be able to remember their visitor. One informant emphasised that some volunteers felt the need for frequent visits was too demanding, and so they chose to give up:

“The volunteer’s commitment to four hours a month is too little for the recipient! The volunteers are new to the people with dementia every time they come... they [the residents] forget everything after just a few hours! There is a difference between the person with dementia’s needs for contact and the activity companion’s capacity. I don’t think that the volunteers would want to come more than four hours a month”.

In activities where people with dementia were involved, the staff often had to be present. They had to check that the communication between users and residents was satisfactory. Another aspect involving additional work for the staff was that they had to have consent from the families of residents:

“But it is clear that [the residents] who used [the volunteer service] were those who were healthier. But there were also people with cognitive decline and that was why we had to do so much and involve relatives to get their consent. Persons with cognitive decline are a major challenge, also when it comes to cooperation with volunteers...”

Informants pointed out that it is important to think about when it is most suitable to introduce a volunteer. For people with dementia, it was important that support from volunteers did not come too late in the course of the illness:

“The question is how far the dementia has progressed for the person to have use of and enjoy the presence of a volunteer visitor?”

This meant that employees had to carry out an ongoing assessment of the health of the service recipients and evaluate the individual benefit of their having contact with volunteers.

In some cases, the care facilities preferred to use retirees from their own care facility rather than relying on individual volunteers or volunteers from organisations. At some care facilities, agreements were signed with the employees shortly after they retired. Retired employees had the necessary knowledge and experience to work with service recipients. They were also familiar with the routines and procedures of the care services and knew how it all worked:

“It’s much easier for us who work in the [municipal care] service to use people who are former employees. Then we almost don’t have to get involved at all. That’s much easier for everyone! They know our routines, can order taxis themselves and organise everything. So, a volunteer who doesn’t have care training or any kind of knowledge of the ideas behind our work... it is harder to make it work. And then there is the issue of confidentiality, competence and many things”.

The benefit of understanding routines and procedures in the caring facility seemed especially important seen against the background of the rapid pace and busy workdays of the staff.

Training and clarifying expectations

Several informants stressed the importance of training the volunteers. Training was seen as important, but the scope of the training and courses varied. Generally, leaders in the caring facilities were concerned about establishing contracts with volunteers regulating which activities they should take part in and how often. Volunteers were offered training as a benefit whereby they would increase their competence and strengthen their relationship with service recipients. A leader in a nursing home explained:

“I have different topics: setting limits, special diagnoses, dementia, how to relate to residents ... I don't have a set program, but I plan it depending on which activities the volunteers have and which residents they go to see”.

In addition, mutual contracts with the volunteers were seen as important:

“It is very important to be clear ... especially the first time I deal with volunteers. We have confidentiality statements, registration forms, and [we] write a contract that can be revised. I go carefully through the tasks [and] all the points thoroughly, and this is very useful”.

A leader of the voluntary activity at a care facility had deliberately terminated the contract with some volunteers because they had motives that were not considered compatible with being a volunteer:

“I have tried to get rid of a few [volunteers] who were there before I started. I got rid of them because it was their needs that came first ... they just wanted work experience ... and this didn't fit very well with being a volunteer here. It is about spending time with vulnerable people. Psychosocial insight, ability to empathise, and being able to take control if a situation arises and patients get unsettled. There is a reason why they need help, and not everyone is suitable to do this, to be frank”.

There are several requirements that volunteers must meet, including understanding the needs of the vulnerable service recipient and gaining knowledge of various health conditions and how to manage them. In addition, staff and leaders assess the volunteers' motives. Many stressed that it is more important than ever to formalise contracts with volunteers in order to specify what their responsibility will be. Concerning this point, it might be worth noting that too much administration of volunteers is controversial, as it may reduce the volunteers' interest to remain active (Nødland et al., 2007; Studer & von Schnurbein, 2013). The leaders in this study also carried out frequent appraisals of volunteers to ensure that their contribution was in line with the wishes of the care sector.

Discussion

Since professional staff in long-term care are increasingly pressured by the complex needs of residents and by administrative demands, less time is available for social activities and personalised care. To compensate, the health authorities wish to bring in an increasing number of volunteer care workers to meet the social needs of residents, for example, by involving them in conversation, taking them for a walk or arranging social events. However, our findings show that relational care is not easily split off from the overall care needs of residents. In particular, caring for residents with serious mental and/or physical health problems requires competence, experience and commitment,

characteristics that were not always forthcoming in volunteers. Furthermore, our findings show that the expectations of staff and volunteers were not always in tune. Whereas volunteers wanted to visit “sweet old ladies”, staff needed volunteers that were willing and able to visit residents with dementia and other demanding conditions. Thus, while it may seem sensible to let volunteers take over the emotional and social care needs of residents, it is important to recognise that this rests in part on a reductionist understanding of care.

In the introduction, we suggested that bureaucratic or public caring tends to undermine central aspects of care, such as time, personal commitment and knowledge of the person being cared for (Wærness, 2004). In addition, the competence and skills required to care well are generally underestimated, as the feminist literature on care has argued for decades (Davies, 1995). Dividing care into discrete tasks to be provided by different types of carers not only poses the risk of deskilling care work but also risks reducing the overall quality of care. Several studies question whether the process of splitting up care work affects its quality. While it can be argued that care and care work is subject to differing social, political, ethical and cultural interpretations, Milligan and Power (2010) state that good care involves a typical holistic approach to the provision of “appropriate physical, social, and emotional supports to meet the [self-defined] needs of the person requiring help in order to maintain as much independence as possible in their own lives” (Milligan & Power, 2010, p. 569). The holistic approach states that biological, psychological and social needs are interconnected and need to be understood simultaneously in caring for a person (Povlsen & Borup, 2011). Furthermore, Fjær & Vabø (2013) point out that caring in nursing homes is not only directed at individuals but also at the residents’ social environment as a whole. An ethnographic study of two nursing homes in Norway found that care workers actively shape social situations by manipulating the physical environment and the composition of groups and that this was considered an integral aspect of good care by the care workers themselves (Fjær & Vabø, 2013). It is crucial to understand and allow for all aspects of care to be met in order to care well. It is repeatedly documented that ignorance of the psychosocial dimension of health is likely to result in failure to provide effective, efficient and equitable healthcare (Tones & Tilford, 2001).

Service recipients in the municipalities are increasingly frail and have complex health needs. With the expected increase of elderly with dementia in the near future, we might question whether informal carers are equipped to take on such advanced health problems. Studies have shown that care work with people with cognitive and mental impairments, such as dementia, can be challenging, and informal carers for this group are more likely to experience a decline in their own mental and/or physical health status than those caring for individuals with physical impairments (Schofield, Murphy, Herrman, Bloch, & Singh, 1998). The professionals in our study were aware of the challenges involved in using volunteers and tried to resolve the problem by strategically recruiting retired staff that were familiar with both the content and context of care. The tendency to prefer retired staff when engaging volunteers is also found in other studies. As Baines (2004) explains, ex-staff are skilled and require no training or orientation, and no more supervision than paid workers. They also understand “the details of the service environment, thus avoiding expensive gaffes or insensitivity” (Baines, 2004), p. 289). If such persons were not available, however, care professionals provided support and arranged courses for volunteer workers. In our study, care professionals also shielded volunteers from the most demanding residents, clarified expectations, set up contracts and screened volunteers for suitability. In other words, they carried out a substantial amount of largely invisible work to facilitate the work of the volunteers. Apart from the extra strain this unacknowledged work puts on professional staff, it also calls into question

whether all citizens can take on a role as a volunteer in the long-term care services, as is assumed in the political rhetoric about voluntary work. Our findings show that professionals in the care services claim that caring for persons whose physical and mental health is poor requires volunteers to have a range of personal qualifications, for example, communication skills, empathy, reliability, psychosocial insight and an ability to observe and handle symptoms of declining health in service recipients. Even when providing a small fraction of care, such as being a volunteer in a visiting scheme, there is a need for skills like commitment and timeliness. The voluntary organisations and care services in this study offered courses, training and transfer of know-how to a varying degree to their volunteers. Formal contracts were used to make sure that the volunteers understood what their role entailed, especially regarding frequency of visits.

This study raises a number of questions concerning the role of the voluntary sector in long-term care and the expediency of dividing care into professional tasks and tasks that supposedly can be done by unpaid and unskilled voluntary workers. Firstly, our study has shown that the complex nature of care recipients' needs requires care workers to have expertise in all aspects of care. Secondly, the division of care gives rise to delineation and coordination issues between formal providers and informal caregivers (Weinberg, Lusenhop, Gittel, & Kautz, 2007). Consequently, it's important to attend to questions concerning the communication and information needs of different care providers, as well as to attend to how tasks should be distributed in terms of content and scope, and how they should be coordinated between formal and informal caregivers. The definition of a volunteer is not fixed and includes notions that a volunteer is a helper at the side of the trained professional (Hussein & Manthorpe, 2014) and is a person that "fills gaps" within the services (Butler & Eckart, 2007). Several researchers have, however, addressed how the boundaries between services have a tendency to become blurred (Anttonen & Häikiö, 2011; Pfau-Effinger & Rostgaard, 2011) and that there is ambiguity concerning which roles volunteers should take on as opposed to paid care (Hoad, 2002). The consequences of a new welfare mix have so far been sparsely studied.

Limitations

This study represents a relatively small qualitative study. The design has been exploratory and more targeted research is needed to understand this complexity. We have deliberately chosen to include activities run by volunteers that required communication with the care facilities and, hence, we have not addressed the effort provided by volunteers operating autonomously.

Conclusion

The growing demand for health and care services and the concern that fewer personnel will be available in the future to meet these demands are active factors triggering redefinitions of care tasks and who should perform them. Questions that ought to be asked in this regard are: What shall the content of care be? How should it be delivered? Who shall carry out the tasks involved? What should be the responsibility of public welfare services, of the voluntary sector, the family and the local community, in the future?

A growing proportion of service recipients in long-term care are people with dementia, frail elderly people with multiple chronic diseases, and those with complex health needs in all age groups. Their needs sit uneasily with the current

enthusiasm for advancing unpaid voluntary care work as one solution to the potential future “crisis in care”.

In examining the ability of advanced capitalist states to meet the welfare needs of their populations, Fyfe and Milligan (2003) claim that “voluntarism raises a range of fundamental questions about the extent to which it is capable of addressing welfare needs”. Our study supports that concern, and we argue that the fragmentation of care in long-term care institutions needs to be subject to critical scrutiny. More research is needed to address the potential match or mismatch between the political view of voluntary work as a way to “help out” professional staff and the actual role and contribution that volunteers have and may have in the future long-term care services.

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