

The potential for collaborative innovation between public services and volunteers in the long-term care sector

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ABSTRACT

Western societies with an ageing population and low fertility rates face significant demographic challenges. Political authorities are therefore looking for new solutions and innovative ways to deal with the increasing pressure on public healthcare. They point to innovative prospects in the interstices between various actors, and recommend collaboration with volunteers. However, little is known about the capacity of volunteers in the long-term care sector. In order to provide a comprehensive overview of the capacity of unpaid efforts that potentially may alleviate the challenges faced by long-term care services in Norway, this article uses a broad definition of volunteering when looking at the prevalence of organised voluntary work, unmanaged voluntary work and informal caregiving. The aim of this article is twofold. Firstly, the article discusses an innovation approach based on the potential contribution and the possibilities for voluntary actors in the interstices between the professionals and the care receivers in public long-term care services. Secondly, the article explores these innovative possibilities in a collaborative innovation perspective. Thirdly, the paper reveals the amount of voluntary work already occurring in Norway.

Keywords: volunteering, informal caregiving, long-term care services, municipalities, collaborative innovation.

Introduction

In western societies, governments are struggling to find solutions to the challenges posed by an ageing population and low fertility rates (Grudinschi et al., 2013; Ramm, 2013; Vetvik and Disch, 2014). The increasing demand for long-term care services is a particularly prominent issue on the political agenda. The expected growth in the number of people requiring care services in the future will not only be extremely costly for society, it may also entail a shortage of carers providing public care services.

Since the 1990s, political authorities have shown increasing interest in the activities of the voluntary sector. Governments have been looking for new ways to integrate volunteers in the provision of public welfare services. Musick and Wilson (2008) state that despite the expansion of governmental efforts, “volunteer labour will always be necessary to help government agencies to achieve their goals” (p. 4). In recent years, the Norwegian government has put increasing focus on the need to integrate the voluntary sector as well as other actors in the provision of long-term care services through cooperation and innovation (Ministry of Health and Care Services, 2011b; Ministry of Health and Care Services, 2013). A recent white paper pointed to innovative possibilities in the interstices between various actors (Ministry of Health and Care Services, 2013).

However, little is known about the volume of voluntary work in the Norwegian long-term care sector. What proportion of the Norwegian population does voluntary work in this sector, and how much time do they spend volunteering? This knowledge is important when discussing the potential future contribution of the voluntary sector to public long-term care services. Moreover, an official Norwegian report from 2011 suggested that authorities should adopt a goal for unpaid voluntary work of covering 25 percent of total operating expenses in long-term care services by 2025, and for innovation to take place in collaboration between different actors (Ministry of Health and Care Services, 2011b). At the same time the report encouraged an increase of unpaid care work within the private sphere in addition to mobilisation of capacity to exploit the resources in civil society overall through innovation.

With this in mind, and in order to provide a comprehensive overview of unpaid work that may alleviate the challenges faced by long-term care services in Norway, the aim of this article is twofold. Firstly, it describes and discusses the current volume of voluntary work in the long-term care sector, focusing on three types of volunteering: organised voluntary work, unmanaged voluntary work and informal care. Secondly, in light of the Norwegian government's calls for innovation and new ways of integrating volunteers in the welfare sector, it discusses an innovation approach based on the possibilities for voluntary actors in the interstices between the professionals and the care receivers.

Key Concepts

The purpose of this section is to outline key concepts in the article. It starts by presenting volunteering and continues by framing the care services in Norway. Finally, the three concepts of collaboration, innovation and collaborative innovation are processed.

Volunteering

Kendall and Knapp (1995) describe the voluntary sector as “a loose and baggy monster”. They also state “there is no single correct definition which can or should be uniquely applied in all circumstances” (p. 65). Thus, volunteering is defined differently in different countries and academic disciplines, and the definition of the phenomenon affects how it is measured and understood (Cnaan, Handy and Wadsworth, 1996; Musick and Wilson, 2008; Salamon, Sokolowski and Associates, 2004; Lee and Brudney, 2012). Hence, the next section attempts to bring order to the conceptual jungle for the three types of volunteering examined in this study: organised voluntary work, unmanaged voluntary work and informal care.

Firstly, a commonly used definition of voluntary work is the work a person does within voluntary organisations for others than family and close friends without receiving regular payment for it (Wollebæk and Sivesind, 2010). Occasionally these volunteers receive some skills training in advance of tasks they carry out for the organisation. This definition covers what is termed *organised voluntary work* in this study. Secondly, some researchers are reluctant to include informal helping in their studies (e.g. caring for a neighbour), as they argue it can easily be confused with the exchange of services between friends and neighbours (Musick and Wilson, 2008; Knapp, Koutsogeorgopoulou and Smith, 1996; Wilson and Musick, 1997). Other researchers, however, include informal caregiving, defining it broadly as help and caregiving –

from giving neighbours practical help on a mutual basis, to heavy involvement as a help/care-giver for an older relative with extensive help/care needs (family care) (Jegermalm and Grassman, 2013). In this study, both informal helping and informal caregiving are included in what is termed *informal care*. Finally, there is a type of volunteering that traditionally has not been included in research on the voluntary sector: namely voluntary work carried out outside of voluntary organisations. This applies to volunteers who sign up to the care sector as private individuals with a desire to be included in a way that satisfies their desire to contribute outside family and neighbours (RO, 2015). This is what Rochester (2013) refers to as “unmanaged volunteering” and this study uses a similar term: *unmanaged voluntary work*.

In order to prevent confusion, it is appropriate to mention that the concept of *informal volunteering* is also used in research (Lee and Brudney, 2012), and covers both informal caregiving and unmanaged volunteering as used in this study. Since exclusion of unmanaged volunteers *and* informal caregivers as a kind of voluntary action is characterised as a major weakness and a serious gap in the knowledge of volunteering (Lee and Brudney, 2012; Rochester, 2013), this study focuses on the aforementioned three types of volunteering: organised voluntary work, informal care and unmanaged voluntary work. The study thus adds a broadened understanding of volunteering capacities.

Care services in Norway

In Norway, municipalities have the main responsibility for providing and organising care services for their inhabitants. However, the municipalities, the state and the care receivers share the cost of the services (Hagen et al., 2011; Ministry of Health and Care Services, 2011b). The municipalities are responsible for providing care services to all patient and user groups who require personal or practical help to cope in daily life, i.e. people with physical or mental illness or injury, alcohol or drug abuse, social problems or disabilities (Ministry of Health and Care Services, 2011a). People’s assistance needs are identified when they apply for care services; care services are offered in nursing homes and/or as home care services (Mørk et al., 2013). In 2014, employees in the long-term care services in Norwegian municipalities performed 134,300 full time equivalents (FTEs¹) (Statistisk Sentralbyrå [Statistics Norway], 2015). Norway’s welfare state has been classified as “*the social democratic*” regime-type (Esping-Andersen, 1990). In this regime type, the welfare state has the primary responsibility for providing care, but families also remain care providers. The professionals perform the heavier and more private care tasks, while relatives take care of lighter tasks, such as social and emotional support (Daatland, Herlofson and Slagsvold, 2013).

The following section introduces the collaborative approach to innovation in the public sector.

Collaboration

It is argued that future challenges will require multiple actors to participate and cooperate in the delivery of care services (Ministry of Health and Care Services, 2013). As mentioned initially, several actors can be identified as contributors and collaborators in long-term care

¹ One FTE is taken to be 1,750 hours, in line with the definition used by Statistics Norway (SSB, 2016).

services in the public sector. These are professionals in public services, organised volunteers, unmanaged volunteers and informal caregivers.

In collaboration with public services, voluntary organisations may experience that their autonomy is jeopardized, because they establish too close relationships with other actors. On the other hand, in keeping with the unique volunteer spirit, voluntary organisations are often very adaptable to new conditions (Pedersen, 2011). Additionally, as even more collaboration occurs between public actors and voluntary organisations, professionalisation is detected in voluntary work, while the opposite, *voluntarisation*—which occurs when voluntary organisations are involved to a greater extent in solving public services problems—is detected within public services (Pedersen, 2011: 207), leading to greater similarity between the actors. Nevertheless, according to Ibsen (2006), members of voluntary organisations often do not know the conceptual structure of the organisation, and they do not find this essential for their work there.

Despite formidable efforts over the years, informal caregivers do not have any obligations to contribute either as care providers or as collaborators with public sector services. However, there has been discussion of whether the volume of formal services affects informal caregiving and vice versa (Berge, Øien and Jakobsson, 2014; Chappell and Blandford, 1991; Frederiksen, 2015; Jakobsson, Hansen and Kotsadam, 2012). A concern related to the same topic is whether care tasks provided by formal and informal caregivers substitute or complement each other. Norwegian researchers argue that although informal care decreases with comprehensive formal care services, the welfare state does not exclude family care; rather, the family contributes with tasks other than formal public services (Jakobsson, Hansen and Kotsadam, 2012). Chappell and Blandford (1991) point to the complementarity of the two care systems, admittedly not in terms of tasks, but in terms of “sharing an overall task load”.

Knowledge of collaboration between unmanaged volunteers and public services is scarce because unmanaged volunteers have not been present in research. However, the Resource Centre for readjustment within local councils² (RO) reports that unmanaged volunteers have to be and want to be managed by the municipality through binding agreements (RO, 2015).

Innovation

When political authorities in Norway and elsewhere are looking for innovative ways to integrate volunteers in the welfare sector as providers of care services, they do not specify *how* this innovation is going to take place. Meanwhile, innovation is assumed to take place in the interstices between various actors. (Ministry of Health and Care Services, 2011b). In order to understand how innovation will take place in these interstices, it is necessary to understand what kind of innovation might be relevant here.

Innovations in the public sector differ from private sector innovations (Sørensen and Torfing, 2011c; Rønning and Knutagård, 2015). Public services and resources are subject to democratic control, and they are often more complex than private services (Rønning and

² The Resource Centre is focusing on the development of professional care as a special field.

Knutagård, 2015). Innovation can be defined as “an intentional and proactive process that involves the generation and practical adoption and spread of new and creative ideas, which aim to produce a qualitative change in a specific context” (Sørensen and Torfing, 2011a: 849). Additionally, several authors describe innovation as a cycle consisting of the generation and selection of ideas, the implementation of new ideas and dissemination of new practices (Bommert, 2010; Hartley, Sørensen and Torfing, 2013; Osborne and Brown, 2013; Sørensen and Torfing, 2011a). However, this is not a linear process but rather innovation processes consisting of complex pathways and feedback loops combining the elements in the cycle (Sørensen and Torfing, 2011b). In this process, three parameters have crucial importance for creating innovation: *collaboration*, *transformative learning* and *shared ownership*. Collaboration amplifies the exchange of information, knowledge, ideas and critical assessments, and coordinates individual and collective actions, in addition to co-creating solutions. The article considers this more fully later. Transformative learning is an important factor in innovation: it leads to new insights, understanding and ideas that, in turn, might create new forms of practice and relations between the actors. A feeling of shared ownership is important, because a broad ownership of innovations might reduce possible resistance to implementation and also promote new ideas and forms of practices (Sørensen and Torfing, 2011b). Nevertheless, “innovation always represents discontinuity of the past” (Jäppinen, 2015: 708).

Collaborative innovation

Collaboration does not always lead to public innovation (Sørensen and Torfing, 2011c). However, Torfing, Sørensen and Aagaard (2014) expect a causal relationship to exist between collaboration and innovation, meaning that, if the right conditions exist, collaboration will lead to innovation. One condition is that the actors acknowledge the need for innovation, which in turn initiates an open and interactive process. In relation to barriers to and drivers of innovation, the actors must realise that continuing in the same direction does not make any sense. There must be a reciprocal understanding that creating new solutions and objectives is necessary for a future cooperation platform and further discussions. Furthermore, mutual trust is also important (Sørensen and Torfing, 2011c).

For professionals in the public sector, collaborative innovation means finding and developing new solutions together with other employees, politicians, service receivers and organisations, and accepting that the competencies they possess are crucial (Sehested and Leonardsen, 2011). Professionals have a high level of independence, which is both an advantage and a disadvantage in collaboration. Independence is an advantage in that the competencies professionals possess are crucial for progress, but a disadvantage in that they may not be open to initiatives or solutions other than those related to their own professional knowledge. Collaborative innovation can challenge professionals’ perceptions of quality. These perceptions may be a barrier to collaboration. Other barriers are stalled professional cultures and silo thinking (Sehested and Leonardsen, 2011). Additionally, if rules and routines are followed slavishly by officials, there will not be much room for changes and innovation, consequently, according to Torfing (2011), different professions in the public sector tend to “enclose their own professionalism” (p. 120), and in collaboration with volunteers this can represent a barrier in

mutual communication and learning. Others have pointed to the additional development of relational skills among employees in the public sector, in that acquiring such skills is important for establishing networks around people and their problems (Byskov-Nielsen, Gemal and Ulrich, 2015).

The empirical part of this study presents the contributions of three different voluntary actors. The survey uncovers the potential for voluntary contributions in collaborative innovation, and that the potential for collaborative innovation requires further discussion. At present, little insight exists into how to explain the roles of different type of volunteers in the context of public services.

Method

The study makes use of data from a population survey conducted in Norway between November 2014 and January 2015. Statistics Norway, Norway's central institution for producing official statistics, conducted all the interviews. Norwegian population surveys of voluntary work were carried out at 4–5 year intervals from 1998–2014.

Data collection

A random gross sample of 3,400 people ages 16–79 years was drawn from the National Registry. The National Registry holds up-to-date information about the Norwegian population for tax, election and population statistics purposes. Respondents were contacted in two stages: first, they received a letter by post containing information about the research project and the upcoming interview; and shortly thereafter, they were contacted by phone and interviewed. Out of the gross sample, 1,479 could not or did not want to participate for various reasons. Altogether 1,921 interviews were completed, giving a final sample of 1,921 or a 56.5 per cent response rate.

Screening and follow-up questions

The respondents were asked to answer questions about *voluntary, unpaid work*, and were given the following definition at the start of the interview: *By voluntary work, we mean work you do for organisations or individuals without being regularly paid for this*. The survey contained four main screening questions related to volunteering in long-term care. The first two screening questions covered organised voluntary work. These two questions included: (1) voluntary work performed in nursing homes, homecare services and residential homecare facilities for elderly people and people with various disabilities; and (2) may also include services not belonging to the long-term care sector, such as specialised health services and the kindergarten sector. The third screening question covered unmanaged voluntary work for other formal institutions such as public welfare services, nursing homes etc. The fourth screening question covered informal care. This category could include work provided to persons defined as without special needs.

The results, however, need to be treated with caution since it is not known to what extent the unpaid work in the study can be considered as ‘long-term care’ or not. Although salary costs do not constitute all the operating expenses in long-term care services, and the results include more than what can be related to the long-term care services, in total the results give an indication of the level of voluntary work in the sector. Table 1 gives an overview of the screening and follow-up questions:

Table 1: Screening and follow-up questions

SCREENING QUESTION 1
Have you performed any voluntary work for an organisation related to health, care or rescue work during the last 12 months?
Follow-up questions
Have you performed voluntary work during the past four weeks?
Approximately how many hours did this constitute?
SCREENING QUESTION 2
Have you performed any voluntary work for an organisation related to social services and abuse treatment during the last 12 months?
Follow-up questions
Have you performed voluntary work during the past four weeks?
Approximately how many hours did this constitute?
SCREENING QUESTION 3
Have you performed voluntary work for other formal institutions, such as public welfare services, nursing homes etc. during the last 12 months?
Follow-up questions
For which municipal service sectors have you performed voluntary, unpaid work?*
Approximately how many hours have you spent during the last four weeks on voluntary, unpaid work in a) elderly care, and b) other care?*
SCREENING QUESTION 4
Do you regularly give help to relatives you do not live together with, or neighbours, friends or colleagues?
Follow-up question
Does the respondent you helped the most live in the same household or in another household?
Approximately how many hours have you spent during the last four weeks on helping this person?

* Data from the *Respons Analyse* survey's follow-up questions were used to calculate estimates for sub-categories on unmanaged voluntary work

Screening question 3, which asks about voluntary work for other formal institutions, also captures unmanaged voluntary work that is not related to long-term care. The Statistics Norway survey did not ask follow-up questions. However, the *Respons Analyse* survey, which was conducted in the same year and contained the same screening question, did filter the area in which the voluntary work was carried out. Altogether 4,000 people were interviewed for the *Respons Analyse* survey, representing a response rate of 25.5%. Two categories in the survey are relevant for the purposes of this study: elderly care and other care (marked * in Table 1). Both the *Respons Analyse* and Statistics Norway surveys had similar results on this screening question, so data from the *Respons Analyse* survey's follow-up questions have been used to calculate estimates for sub-categories on unmanaged voluntary work (see Andfossen and Skinner, 2016 for a complete overview of the *Respons Analyse* results on long-term care, and Arnesen, 2015 for methodological documentation of the survey).

Previous surveys conducted by the Institute for Social Research³ have contained questions related to organised and unmanaged voluntary work, and it is possible to compare data from surveys in the period 1998–2014 (Arnesen, 2015). As in the 2014 survey and the previous three surveys, the questions on organised voluntary work were formulated in accordance with definitions and categories from the Johns Hopkins Comparative Non-profit Sector Project (Sivesind et al., 2002). To calculate full time equivalents (FTEs) for the different categories of voluntary work, one FTE is taken to be 1,750 hours, in keeping with the definition used by Statistics Norway (2016). Furthermore, the voluntary work is calculated to be carried out over a period of 52 weeks. The size of the population between 16 and 79 years of age is recorded as 3,894,435.

Results

Altogether 61% of the Norwegian population aged 16 and older have been engaged in voluntary work for at least one organisation *during the last 12 months*. This is the highest proportion recorded since the first survey in 1998 (Folkestad et al., 2015, Wollebæk and

Table 2: Results

	Voluntary work (last 12 months) n=1921	Voluntary work (last 4 weeks) n=1921	Average number of hours per volunteer (last four weeks)	Estimated average hours per volunteer per year (52 weeks)	Estimated FTEs
ORGANISED VOLUNTARY WORK	61%	39.3%	-	-	-
Health, care & rescue work	7%	3.5%	10.2	135	10,531
Social services & abuse treatment	6%	3%	9.9	130	8,679
UNMANAGED VOLUNTARY WORK	8%	7.7%	-	-	-
Elderly care	1.1%*	1.1%*	7*	91*	2,228*
Other care	0.6%*	0.6%*	4*	52*	694*
INFORMAL CAREGIVING	58%	54%	-	-	-
Outside own household	54%	51.5%	9.3	120	137,071
Inside own household	8%	6.2%	17.5	229	31,569

Source: 2014 Statistics Norway survey, *statistics based on the 2014 Respons Analyse survey (Andfossen and Skinner 2016)

³ The Institute for Social Research was established in 1950 as an independent foundation in Oslo, Norway. The aim of the institute is to produce knowledge and understanding in areas that are significant for society and to work close to the cutting edge of international social science (<http://www.socialresearch.no/>). It is an independent foundation, originally founded by the former Ministry of Social Affairs and The Norwegian Association of Local and Regional Authorities (KS). RO operates today as a small, independent and commercial consulting firm with a board, prioritising health and care services in Norwegian municipalities and cooperating with research institutions and university colleges when producing services (<http://ro.no/>).

Sivesind, 2010). A total of 39.3% reported that they had done voluntary work *in the last four weeks*. In the categories *health, care and rescue work* and *social services and abuse treatment* (organised voluntary work), the proportion of the population doing voluntary work during the course of a year is 7 and 6 percent respectively. Altogether 1.7 percent do unmanaged voluntary work in care, and 58 percent are providers of informal care. Table 2 presents the results.

The average time spent per organised volunteer during the last four weeks in health, care and rescue work was 10.2 hours, while in social services it was 9.9 hours. Among the unmanaged volunteers, the average time spent was 7 hours in elderly care, and 4 hours in other care. The informal caregivers outside and inside their own household gave up 9.3 and 17.5 hours of their time respectively. When calculating this as FTEs, this results in an estimate of 19,210 FTEs of organised voluntary work. Similarly, the estimated number of FTEs in unmanaged volunteering in care is 2,922 FTEs, and in informal care, the estimate is 168,640 FTEs.

Based on the results highlighted here, three visible interstices, i.e. helpers between public services and the care receivers have been identified. Interstice 1 consists of the organised volunteers, while interstice 2 represents informal caregivers, and interstice 3 includes the unmanaged volunteers. The three interstices represent different voluntary contributions concerning both capacity and content and consequently it is reasonable to assume that the different contributors have disparate requirements regarding the collaboration. Further, this reflects differences that should be taken into account when making formal agreements with public services. Table 3 below provides a systematic presentation of what characterises and differentiates the three interstices. Furthermore, the descriptions of what distinguishes the actors are linked to the discussion of the different interstices.

Table 3: What characterises and differentiates the three interstices

	THE THREE INTERSTICES		
	<i>Organised volunteers</i>	<i>Unmanaged volunteers</i>	<i>Informal caregivers</i>
<i>Characteristics:</i>			
<i>System level</i>	Organisational	Individual/collective	Individual
<i>Agreements with public services</i>	Yes	Yes - individual initiatives No - have to be managed	No
<i>Relation to the care-receiver</i>	Non-personal	Non-personal – might be personal	Personal
<i>Skills training</i>	Yes	Yes/no	No

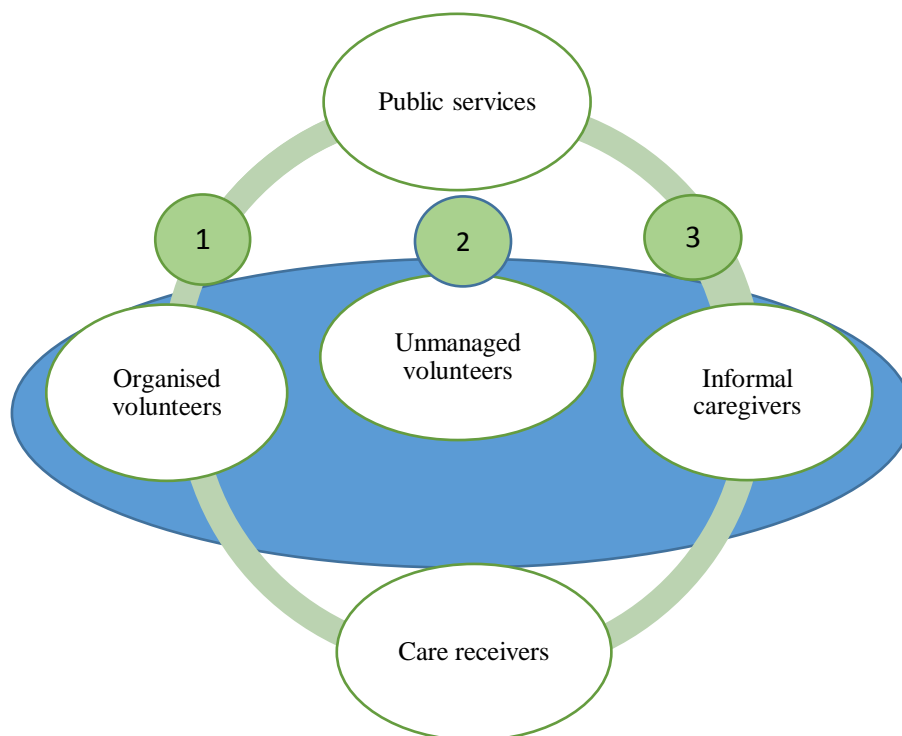
Discussion

The different forms of voluntary work identified have been measured regarding their contribution to providing help and care in the municipalities. In total, by measured FTEs, the results show that the contributions of organised and unmanaged volunteers to long-term care services are considerable, and today's volunteering efforts in the public care sector correspond to two-thirds of the government's 25 % goal. This capacity, however, is already an important part

of the total care activity provided in society. On top of this comes the substantial contribution from informal carers, whose work equals 168,500 FTEs – more than the total of FTEs in the sector itself. With reference to the political challenges described in *Official Norwegian Report (NOU) 2011* (Ministry of Health and Care Services, 2011b: 11), which admittedly does not quantify any goal in respect of informal caregiving, ambitions regarding voluntary contributions are more than satisfied already.

Figure 1 below illustrates identified relationships between the three interstices, public services and the care receivers. The ellipse, which encircles the different actors, not only depicts how three types of voluntary contributors can serve as a total resource for public services and the long-term care sector, but also how they stand as single independent contributors.

Figure 1: Identified interstices between public services and voluntary actors involved in providing care



Source: Author

Norwegian researchers have previously investigated the interstice between public services and care receivers with the aim of identifying actions strengthening the link between the two systems (Rønning, 2013). This linkage between these two systems was termed “a marriage of convenience” (p. 123), mainly because of the interdependency between the partners and the diverse qualities they represent. Rønning (2013) developed a total care form aimed at the care receivers, intending to highlight who (i.e. from the public or other actors in civil society) is doing what for whom at which time. Although recommended by researchers, the care services have never adopted this care form. Interstices scrutinized here go further by including several types of actors; i.e., organised volunteers, unmanaged volunteers and informal caregivers, providing unpaid voluntary work between public/professional helpers and the care receivers in the long-

term care sector. The results outlined in Table 3 indicate that it is also appropriate to distinguish the interstices by the characteristics manifested towards the care receiver. Therefore, the following discussion includes and follows up on these characteristics.

Interstice 1 - organised volunteers

Focusing on interstice 1, organised volunteers have a long tradition and possess considerable experience in contributing towards long-term care services (Lorentzen and Selle, 2000). In comparison with results from previous studies, this study shows an increase for both categories of organised volunteers scrutinised. However, despite the increase, the numbers remain consistently low in these organisations compared to other areas where people contribute with voluntary work (Folkestad et al., 2015). Nevertheless, every volunteer in the health, care and rescue work category spends on average 2.55 hours per week on voluntary work, and on average 2.48 hours a week on work in the social services and abuse treatment category. Altogether 73% of Norwegian municipalities cooperate with voluntary organisations to follow up with volunteers, e.g. in providing information related to the volunteers' rights and guidance around statutory public care services (Johansen and Lofthus, 2011). These represent a substantial resource in the collaboration. In the collaboration with public services, voluntary organisations may experience their autonomy as jeopardized, because public services interfere in tasks carried out by the voluntary organisation, with the result that the issue the organisation focuses on becomes blurred. On the other hand, because of the unique volunteer spirit, voluntary organisations are very adaptable to new conditions (Pedersen, 2011). One hallmark of volunteerism is the amateur-based participation, which might be challenging in cooperation with professionals (Solbjør, Ljunggren and Kleiven, 2014). However, 69% of municipalities cooperate with the voluntary organisations in providing guidance to volunteers in order to increase their skills in providing care (Johansen and Lofthus, 2011), and binding agreements are common in this collaboration. Organised volunteers are formal in their relationship with the care receivers in that they have agreements to cooperate with them, administered via the voluntary organisation. Their relation to and their caring role towards the care receiver is non-personal, in the sense that they do not have a special relationship with them. Nevertheless, the work is voluntary, unpaid and non-professional, even though they might have some training and receive instructions for the work.

Interstice 2 - unmanaged volunteers

Turning to interstice 2, the unmanaged volunteers perform voluntary work on their own initiative, and to the extent the work is organised, the public services are responsible. There is no requirement for training related to the work, but volunteers have to abide by the organisers' decisions. Like the organised volunteers, the unmanaged volunteers are nonprofessional and unpaid. They might develop, or have already developed, a relationship with the care receiver. Such a relationship can affect the non-personal caring role, in the sense of making it more personal. Altogether 82% of all Norwegian nursing homes have had contact with volunteers (Abrahamsen, 2010) and professionals in Norwegian municipalities do cooperate with unmanaged volunteers. As touched upon initially, there is little research on unmanaged voluntary work so results are lacking. A national survey in Norway in 1998 showed that 7% of the adult population participated in unmanaged voluntary work in the public sector (Wollebæk, Selle and Lorentzen, 2000). Subsequently, this has received little attention. However, as this study reveals,

the development of the numbers of people volunteering in this group between 1998 and 2014 is relatively stable (Folkestad et al., 2015).

A report from the Resource Centre for readjustment within local councils (RO) (2015) shows that unmanaged volunteers in Norwegian municipalities commonly contact the service location (e.g. the nursing home) themselves to “contribute with something” (p. 49), or they are recruited by municipal care services through targeted marketing. Currently, according to public documents, long-term care services need more volunteers. Thus far, the extent to which the municipalities try to recruit unmanaged volunteers is unknown, but since the contributions of unmanaged volunteers constitute approximately half those of organised volunteers *and* the unmanaged volunteers in addition commonly contact service locations themselves, there may be additional capacity to expand unmanaged voluntary work. As the government is concerned to formalise agreements between formal care services and volunteers in legal reports (describing e.g. who are responsible for which tasks at which time) and individual plans (a tailored plan describing all services a care receiver with extended needs is entitled to, who to be responsible for providing these services and one person responsible for coordinating the services), the position of unmanaged volunteers must also be clarified. Binding agreements, containing some of the abovementioned factors, are common in the collaboration between formal care services and organised volunteers, and others can also transfer and apply such agreements.

Interstice 3 - informal caregivers

Focusing on interstice 3, the relationship between the care receivers and the informal caregivers may vary, but often a family member, next of kin, friend or neighbour is involved. In contrast to organised and unmanaged volunteers, the informal caregiver is personal in his/her caring role in the sense that a relationship to the care receiver already exists. Even though informal help might be viewed as voluntary, the informal caregiver nevertheless frequently experiences a commitment to provide help. Although the work of informal caregivers is unpaid and non-professional, one might expect that a number of them would receive some training in the caring role from the public services.

Norwegian municipalities reported in 2014 that 271,743 persons received public care services (Mørk, 2015). Seven out of ten care service recipients live in their own homes. A stated goal of municipalities is to provide even more home care services (Ministry of Health and Care Services, 2015a). Future planning assumes that the contribution from informal caregivers should maintain the same volume (Ministry of Health and Care Services, 2013). However, informal caregiving in Norway has been stable during the last decades (Ministry of Health and Care Services, 2013). When comparing the contributions of the actors in this study, the greatest contributions come from informal caregivers *outside one's own household*. However, average hours spent on voluntary work over the last four-week period from this group are in line with the organised volunteers. Yet looking at hours spent on voluntary work over the same period from informal caregivers *inside one's own household*, the contribution is almost double that of other actors. In future planning, the government assumes that the same volume of informal caregiving will be maintained *and* expresses a need for increased voluntary efforts. Consequently, the difference revealed in hours spent among informal caregivers is an important factor. Meanwhile, as Jakobsson, Hansen and Kotsadam (2012) point out, informal care mainly consists of practical help, while formal caregivers carry out more extensive care tasks. The government is concerned

to ensure that agreements between formal care services and informal caregivers are incorporated in legal reports and individual plans (Ministry of Health and Care Services, 2015a). Nevertheless, the informal caregivers do not have any obligations to contribute, and any increase in their contribution must be based on their experiencing it as positive to contribute. This is also dependent on a sincere desire to do so.

The potential for collaborative innovation

It is important to recall that Norwegian municipalities have the main responsibility to provide and organise care services to local populations. They manage formal agreements with the care receiver. Public services are provided by paid, trained employees who are professional in their encounters with the care receivers and are intended to be impersonal in their caring role. In order to handle future care tasks within long-term care services, policy documents have encouraged the municipalities to collaborate with volunteers. However, none of the documents specifies which tasks should be performed where and by whom. Nor do they prescribe how collaboration should be organised. Even some current policy documents refer to next of kin, family and volunteers as if they are similar contributors towards care services both in terms of capacity and in terms of content (Ministry of Health and Care Services, 2015b). Macmillan and Townsend (2006) state that the voluntary and community sectors “serve as putative solutions to a number of governing dilemmas” (p. 15) and point to a *community turn* where relationships between local governments and voluntary organisations are being reshaped even though there is no agreement on a settled, uncontested solution.

This study revealed that in collaboration with the public sector, the actors represent different voluntary contributions concerning *both* capacity and content. Table 3, and to a certain extent Figure 1, reveal that unmanaged volunteers play an intermediate role between organised volunteers and informal caregivers. The characteristics of unmanaged volunteers are similar to both other groups, but the group also stands out as a distinct, separate group. As depicted in Table 3, the two other groups do not have overlapping roles. This suggests that the three groups should not be treated as a common unit; each should be treated separately in its own right and not with a straightforward link to public services. Wilson and Musick (1997) confirm the view that the actors cannot be treated as if they were the same, which makes it appropriate to point to *variation* as an important factor in collaborative innovation. As already shown, the interstices represent considerable variety⁴.

Additionally, in order to create innovation, *collaboration* must be present (Sørensen and Torfing, 2011c). By being the main provider and responsible for care services, municipalities already collaborate with all the actors. Their position indicates that they possess a huge amount of information about the actors and their characteristics. Despite this, there is still a lack of knowledge about how municipalities collaborate with the different actors and use of the voluntary capacity overall. Here municipalities interact with the different actors in various venues, in dissimilar groups and/or as individuals. Even though variation is important for creating innovation, this might be a conflict area. When collaborating with one actor, a risk of undermining other actors could occur. Since the municipalities have formal agreements separately with the voluntary organisations when collaborating with the organised volunteers,

⁴ However, as stated by Musick and Wilson (2008) a common characteristic in volunteering is the altruistic behavior.

this may make it more favourable to work with them. Furthermore, in order to understand why, despite this, the municipalities try to recruit unmanaged volunteers, public services are commonly believed to prioritise creating their own internal projects instead of involving others (Aagaard, Sørensen and Torfing, 2014). This could be done in order to protect resources, as this desire is common in public innovation (Aagaard, Sørensen and Torfing, 2014; Rønning and Knutagård, 2015). Thus, when recruiting unmanaged volunteers, the municipalities can proceed without any interference from others. This silo thinking, however, is likely to be a barrier for collaboration between professionals and voluntary actors, in the sense that volunteers possess different knowledge than the professionals (Sehested and Leonardsen, 2011).

When creating innovation, *transformative learning* must also be present (Sørensen and Torfing, 2011c). Transformative learning is important for innovation because it leads to new insights, understanding and ideas that, in turn, could create new forms of practice and relations between actors (Sørensen and Torfing, 2011b, c). By the same token, it is advisable to ask whether all the voluntary actors desire this. It is not known which actors want to collaborate with whom, and under what conditions. For instance, voluntary organisations are autonomous, and they can perform important tasks for public services. Despite this, 60% of municipalities want to establish their own volunteer service (Abrahamsen, 2010). Finally, in order to create innovation, a feeling of *shared ownership* is important, because broad ownership of innovations might reduce possible resistance to implementation and, in addition, promotion of new ideas and forms of practices (Sørensen and Torfing, 2011b). As already acknowledged, volunteers contributing to the long-term care sector are not a uniform group, and although Norwegian municipalities have long traditions collaborating with different voluntary actors in long-term care services, important factors for creating innovation have not been emphasized in this collaboration. The different forms of unpaid voluntary work under scrutiny are based on different logics and possess disparate features. This indicates that public services and voluntary actors do not exploit common resources to the maximum extent. The various actors operate in separate silos and tend to “feather their own nests”. They might collaborate, but they might also compete for the same human resources to reach goals. In light of this, however, it might be more expedient to look at co-production as a tool and framework. User and community co-production can be defined as “the provision of services through regular, long-term relationships between professionalized service providers (in any sector) and service users or other members of the community, where all parties make substantial resource contributions” (Bovaird and Loeffler, 2012). This applies to the collaboration between the three interstices, the municipalities and the care receivers as shown in this study.

Table 4 tentatively describes future potential for the three groups of actors in order to increase voluntary capacity in the long-term care sector.

Table 4: Future potential for the three group of actors

	THE THREE INTERSTICES		
	<i>Organised volunteers</i>	<i>Unmanaged volunteers</i>	<i>Informal caregivers</i>
<i>Future potential</i>	The organisations get more responsibility	Contribute more, representing a mix of the two other groups	Facilitate skills training and good contact with public services

Nevertheless, assessing the volunteers as a total resource bank *and* as independent resources respectively gives the municipalities additional opportunities. Even though the future 25% goal for voluntary contribution in the care sector has already been reached, the government wants more voluntary work into the sector while also maintaining the same volume of efforts from informal caregivers. With reference to Esping-Andersen's "social democratic" regime-type, a reverse turn might be identified in Norway. The expansion in public care services in Norway 40 years ago is referred to as a huge innovation. However, the innovative solution then was the transfer of care tasks from the family sphere to the public sphere (Ministry of Health and Care Services, 2011b). The aim at present seems to be the opposite.

Conclusions and areas for future research

This study has identified and measured the unpaid voluntary efforts of three groups: organised volunteers, unmanaged volunteers and informal caregivers, showing that the contributions from the three different actors are considerable when using a broad definition of volunteering. As the numbers reveal, their contributions have been stable over time and show even increasing efforts in some areas. Additionally, the three groups set different requirements regarding collaboration with the public services. The future potential for innovation, however, is for the municipalities to be more conscious of the variation between the three groups of voluntary actors and to support them all without conflicts of interest when planning future activities. More research is needed about who participates in the different interstices and how the municipalities will manage future collaboration. Moreover, in future research on the topic it might also be fruitful to look at co-production as a theoretical approach. The professional system has to continually protect the unique voluntary spirit by treating the participants as what they are – namely volunteers. In addition, the volunteers have to be comfortable with this type of collaboration. A more optimal use of and possible increase of voluntary resources must be based on a better knowledge of the activity in the interstices. This research puts in context the government's goal of covering 25 percent of total operating expenses in long-term care services with volunteers by 2025, discovering that today's volunteering efforts in the public care sector already correspond to two-thirds of the government's goal.

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