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Health Policy Research Working Paper Series

The Voluntary Health Sector: Looking to the Future of Canadian Health Policy and Research Part I

Working Paper 02-09
February 2003

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Ce document est aussi offert en français sous le titre: *Le secteur bénévole de la santé : Regards sur l'avenir de la recherche et des politiques canadiennes de la santé (Partie I)*

The Working Paper Series (WPS) supports evidence-based decision making by highlighting and promoting Health Canada's policy research to a broad number of policy analysts and decision makers in Health Canada and its partners in the external research community. The WPS is part of a larger policy research communications program that includes the *Health Policy Research Bulletin*.

Note: These papers were prepared with support from the Quality Care Citizen Engagement Initiative, administered through the Health Human Resources Strategies Division. They are part of the Voluntary Health Sector Research Project, which is managed through the Office of the Voluntary Sector, Centre for Healthy Human Development, Population and Public Health Branch. Parts I and II of this Health Policy Working Paper contain highly abridged versions of these papers. The unabridged versions appear in *Voluntary Health Sector Working Papers*, available on the Health Canada website: **http://www.hc-sc.gc.ca/hppb/voluntarysector/knowledge/working_papers/index.html**.

Catalogue No. H13-5/02-9E
ISBN 0-662-32948-1

Health Policy Research
Working Paper Series

The Voluntary Health Sector: Looking to the Future of Canadian Health Policy and Research
Part I

Foreword

Canadians rely on and believe in the voluntary health sector. Voluntary health organizations build on the contributions of time and money of millions of Canadians to provide services in our communities, carry out research, advocate for improvement and raise funds, all in order to improve the well-being of Canadians across every population group and against every risk to health. They also build community capacity by involving Canadians as volunteers.

A majority of Health Canada's policy and program partners are voluntary organizations, and a substantial proportion of departmental expenditures is invested in the voluntary sector. While we know about the effectiveness of individual programs and organizations, there is little quantitative or qualitative evidence about the voluntary health sector itself. Because it is a key partner, we want to advance our understanding of this important subsector of what Prime Minister Jean Chrétien has called the "third pillar" of society.

The important contribution of the voluntary sector to the health of Canadians highlights the need for a comprehensive body of research on its role and impact in Canadian communities. Recognizing this, the Voluntary Sector and Strategic Frameworks Unit, Population and Public Health Branch, commissioned a number of research papers, collectively called the Voluntary Health Sector Working Papers 2002. This research contributes to the understanding of the unique knowledge, perspective and expertise of Canada's voluntary health sector and its important place in Canadian life.

The papers address knowledge gaps in government, academia and policy circles in Canada and internationally. They also complement other current Health Canada and federal government initiatives to improve the delivery of health services to Canadians and to strengthen partnerships with the voluntary sector.

Health Canada would like to thank the authors of these papers and the organizations with which they are affiliated for their generous contribution to increasing our understanding of the vital part the voluntary health sector plays in maintaining and improving the health of Canadians. Thanks also go to Mary Jane Lipkin, Manager of the Voluntary Sector and Strategic Frameworks Unit, and to Karen Hill, Senior Analyst, for bringing these papers to publication.

Amanda Cliff
Director General, Strategic Policy Directorate
Population and Public Health Branch, Health Canada

Résumé (partie I)

C'est dans le cadre de l'Initiative fédérale sur le secteur bénévole et en conformité avec son engagement de promouvoir l'acquisition de connaissances et la recherche que Santé Canada a publié le recueil *Secteur bénévole de la santé – Documents de travail 2002*. Toutes les études qui y figurent apportent les éléments initiaux d'une somme de connaissances sur le rôle et les responsabilités du secteur bénévole de la santé au Canada. À ce titre, elles aideront à susciter un intérêt pour l'élaboration d'un programme de recherche sur le secteur bénévole de la santé et à son intention. Elles façonneront l'élaboration des politiques et des programmes dans les secteurs public et bénévole et, nous l'espérons, inciteront les chercheurs à poursuivre leurs travaux dans cet important domaine.

Les parties I et II renferment les versions abrégées des études parues dans *Secteur bénévole de la santé — Documents de travail 2002*. La partie I regroupe les études basées sur des sources statistiques, notamment l'Enquête nationale sur le don, le bénévolat et la participation. Celles de la partie II portent sur un vaste éventail de sujets de recherche. La version intégrale de toutes les études est disponible sur le site Web du Bureau du secteur bénévole, Centre de développement de la santé humaine, à **http://www.hc-sc.gc.ca/hppb/secteurbenevole/connaissances/documents_travail/index.html**.

Dans **« Les ressources humaines en santé et le rôle du secteur bénévole »**, Jeff Carr examine la contribution à la santé du secteur bénévole en fonction de deux questions clés. Premièrement, quelle est la valeur économique de la contribution des bénévoles au système canadien des soins de santé? Deuxièmement, quels sont les déterminants clés du comportement bénévole? De cet examen se dégage une esquisse de l'étendue des ressources humaines que représentent les bénévoles pour la santé au Canada. En comparant la valeur économique des contributions des bénévoles à celle des contributions des travailleurs rémunérés de la santé, Carr détermine une gamme d'évaluations économiques possibles qui indiquent l'importance énorme du secteur bénévole dans la prestation des soins de santé au Canada.

L'étude de Paul B. Reed et L. Kevin Selbee, intitulée **« Les bénévoles ne se ressemblent pas tous : le cas des organismes de la santé »**, est la première en son genre à faire ressortir l'hétérogénéité de l'ensemble du secteur bénévole et les caractéristiques distinctives et non distinctives des bénévoles de la santé. Leur étude fait fond sur la richesse des données de l'Enquête nationale sur le don, le bénévolat et la participation, qui est unique par l'étendue de son échantillon et de son contenu. Comme le laisse entendre le titre de leur étude, les auteurs comparent les caractéristiques des bénévoles des organismes de la santé avec celles des bénévoles des organismes culturels et récréatifs, des services sociaux et des organismes religieux. Entre autres constatations, leur analyse établit en quoi les bénévoles de la santé sont considérablement différents de ceux des organismes culturels et récréatifs, mais conclut qu'ils diffèrent peu de ceux des services sociaux et de ceux des organismes religieux.

Dans l'étude du Centre canadien de philanthropie, intitulée **« Les organismes bénévoles de la santé au Canada : participation et soutien du public »**, les auteurs David M. Lasby et Don K. Embuldeniya présentent de l'information détaillée sur les Canadiens et les Canadiennes qui donnent de leur argent et de leur temps aux organismes du secteur bénévole de la santé. Leur étude compare les données des enquêtes de 2000 et de 1997 de l'Enquête nationale sur le don, le bénévolat et la participation afin de dégager les tendances qui caractérisent les dons et le bénévolat dans les organismes du secteur bénévole de la santé au Canada. Les auteurs signalent que les donateurs et les bénévoles du secteur de la santé jouent un rôle important dans le financement et la prestation des programmes et des services du secteur de la santé, et que toute réduction de leur nombre risquerait d'avoir des répercussions considérables sur les organismes de la santé. Ces répercussions seraient particulièrement graves à une époque où les gouvernements envisagent des changements au financement du secteur de la santé au Canada et où le recours à l'effort bénévole devrait vraisemblablement augmenter.

Executive Summary (Part I)

As part of the federal Voluntary Sector Initiative, and in keeping with its commitment to knowledge development and research, Health Canada has published Voluntary Health Sector Working Papers 2002. Each paper in this collection contributes to the beginnings of a body of knowledge about the role and responsibilities of the voluntary sector in health in Canada. As such, these papers will help build interest in the development of a research agenda about and for the voluntary sector in health. They will inform policy and program development in the public and voluntary sectors and, it is hoped, spark further research efforts into this important sector.

Parts I and II include the abridged versions of some of the papers in Voluntary Health Sector Working Papers 2002. Part I focusses on papers that draw on statistical sources, including the National Survey of Giving, Volunteering and Participating, and Part II includes papers about a broad range of research interests. The full version of all papers is available at the Voluntary Sector and Strategic Frameworks Unit, Population and Public Health Branch, website (**http://www.hc-sc.gc.ca/hppb/voluntarysector/knowledge/working_papers/index.html**).

In **"Health Human Resources: The Role of the Voluntary Sector"**, Jeff Carr looks at the contribution of the voluntary sector to health, focussing on two key questions. First, what is the economic value of the contribution of volunteers to the Canadian health care system? Second, what are the key determinants of voluntary behaviour? The result is a sketch of the scope of human resources provided by individual volunteers to health in Canada. By comparing the economic value of contributions of health volunteers to that of paid health workers, Carr comes up with a range of possible economic valuations that communicates the huge importance of the voluntary sector to the provision of health care services in Canada.

"Volunteers Are Not All the Same: The Case of Health Organizations", by Paul B. Reed and L. Kevin Selbee, is the first study of its kind on the heterogeneity of the voluntary sector in general, and the distinctive and non-distinctive features of health volunteers in particular. The study was enabled by the National Survey of Giving, Volunteering and Participating, of which both the sample size and content are unique. As the title of their study suggests, the authors compared the characteristics of individuals who volunteer for health organizations with those who volunteer for culture and recreation, social service and religious organizations. Among other findings, their analysis explains how health volunteers are significantly different from volunteers for culture and recreation organizations, but not very different from social service volunteers and volunteers from religious organizations.

In **"Voluntary Health Organizations in Canada: Public Involvement and Support"**, a Canadian Centre for Philanthropy paper, authors David M. Lasby and Don K. Embuldeniya provide information about Canadians who donate money and volunteer time to voluntary health organizations. The current paper compares data from the 2000 and 1997 editions of the National Survey of Giving, Volunteering and Participating to give an indication of trends in giving and volunteering to voluntary health organizations in Canada. The authors note that health donors and volunteers play an important role in financing and delivering health programs and services. Any reduction in their number could have a serious impact on health organizations. The effect could be particularly significant at a time when governments are considering changes to the financing of the health sector in Canada, and reliance on voluntary effort is likely to grow.

The Authors

Jeff Carr graduated from the University of Toronto with a master's degree in economics. For the past two years he has worked at Health Canada, where his research has focussed on labour issues in the health field and the sustainability of the health system. Jeff lives and works in Ottawa.

Don K. Embuldeniya is a Research Associate at the Canadian Centre for Philanthropy. He has worked in international development and the social/human services fields, both in Canada and abroad. He has published several articles on Canada's civil society, economic reforms in Sri Lanka, and women and development. Don holds a master's degree in international development from Clark University, Worcester, Massachusetts. He is currently a doctoral candidate at York University.

David M. Lasby is a Research Associate at the Canadian Centre for Philanthropy. He has worked as a field archaeologist specializing in lithic technology and quantitative methods in Jordan, England and Canada. David holds a master's degree in philosophy from Cambridge University and is currently a doctoral candidate at the University of Toronto.

Paul B. Reed, PhD, is a Senior Social Scientist with Statistics Canada and a faculty member in the departments of law and sociology/anthropology at Carleton University in Ottawa. His study (see chapter 2) was done as part of the Nonprofit Sector Knowledge Base Project, which Paul has directed since 1997. Paul's broader area of interest is contributory behaviour.

L. Kevin Selbee is a researcher with Statistics Canada and a PhD student at Carleton University in Ottawa.

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Acknowledgments
I would like to thank Allan Pollock, Jeremy Friesen and Charles Mallory for their valuable assistance in the development and refinement of this paper.

Introduction

In 1997, the various levels of the Canadian government combined to spend slightly more than $51 billion on health care, and private individuals contributed another $22 billion. This money paid for doctors, hospitals and drugs, among many other things, but these items do not represent the total involvement of society in the production of health care services. A great deal of the provision of health care in Canada takes place through the efforts of unpaid volunteers, whether it is in the formal setting of a hospital or the more informal setting of a neighbour's home. In fact, this paper estimates that 2.4 billion hours were volunteered in the area of health care in 1997, with the value of this time estimated at $20–$30 billion.

This paper has two clear and distinct purposes. In the first section, the contribution of volunteers to the health care system is identified and quantified. In isolation, this information would have little value, so a comparison is made to the contribution of paid health workers. The comparison can only be an imperfect measure of the effort of volunteers, since they undoubtedly perform different tasks from those paid workers carry out, and have less specifically developed skills in the health care field. However, volunteers represent an important human resource best explored in the context of the other human resources of the health care system. There is an attempt to put a value on the work of health volunteers, which is difficult because the value the volunteer sees is certainly different from the value society as a whole places on this work. This paper does not argue that there is a single right value for this time, but rather a range of possible values that communicates the importance of the voluntary sector to the provision of health care services in Canada.

The second section of this paper moves to a closer examination of the volunteers themselves, and seeks to distinguish those people who volunteer in health care from other volunteers. Statistical regression techniques are employed to examine the factors that weigh in the decision to volunteer and the choice of the number of hours that an individual volunteers. Studies have previously been performed on the decision to volunteer and the choice of how many hours to volunteer, but this study extends previous work in four key ways. First of all, a detailed new data set, the 2000 National Survey of Giving, Volunteering and Participating (NSGVP), allows the examination of many demographic and social factors not previously explored. Second, health volunteers have never been examined in isolation and very little work has been done to try to distinguish this group of volunteers from other groups.

Third, almost all previous work has focussed on formal volunteers, those who volunteer through recognized organizations, to the exclusion of a very important group, particularly in health care, the informal volunteers. Informal volunteers are those people who help out their friends, family members and neighbours with the daily activities of life. This group is a key component of the health sector because these volunteers provide an incredible amount of care that both complements and substitutes for the care formally provided through provincial governments. This paper extends the work done in the past with formal volunteers to include informal volunteers, and hopes to establish a comprehensive picture of volunteering, particularly in the provision of health services. Finally, a Heckman two-step procedure is used to estimate hours volunteered, while accounting for the selection bias introduced by only observing the hours of those who chose to volunteer.

Volunteering

What exactly is meant by voluntary labour? Volunteer work is essentially any work that is undertaken without receipt of payment. There are two distinct classes of volunteers examined in this paper. Formal volunteers are those individuals who donate their time through formally recognized organizations, such as the United Way or the local hospital. Informal volunteers are people who provide assistance on their own in the community, without going through an organization. An example of an informal volunteer is someone who helps to prepare a meal for an elderly neighbour or coaches a children's sports team.

Literature Review

Menchik and Weisbrod (1987) introduced a labour supply model for the voluntary sector and performed some simple empirical examinations. In their model, two motivations for volunteering were identified: consumption and investment. The consumption motive argues that the donation of volunteer time is a normal utility-bearing good—that is, individuals derive value from the act of volunteering. The second motive, investment, relates to the expected future financial gains from participation in the paid labour force that could result from volunteering. These gains could be generated in several ways: through the accumulation of human capital, which makes the individual a more productive worker; through the making of valuable contacts that can aid the individual in the future; or through the signalling value of volunteer work on a résumé that helps an individual find employment. A 1997 study by Freeman introduced another interesting possibility. Volunteering might be a "conscience good" that individuals would rather not perform but feel compelled to do when asked; the social pressure of being personally asked to volunteer makes the individual feel morally obligated to help. Another possibility is that the individual has a latent demand for the good produced through volunteering and being asked brings this demand forward. Basically, this is a search-cost argument, which maintains that individuals may want to volunteer but the cost involved in finding out about an opportunity, usually time and effort, is too high. Being personally asked eliminates these costs and thus makes an individual more likely to volunteer.

Paid Health Sector

When considering the role of volunteers in the provision of health care services, it is important to look at paid health workers as a reference group. Because the exact nature of the volunteer work is unknown from the data set, the best group for comparison is likely just the collection of all people working in the health industry. Individuals working in the health industry earned an average wage of $18.87 and worked a total of 1.7 billion hours in 1997.

How does the amount of time volunteered compare to the amount of paid work in the sector? Estimates place the amount of formally volunteered hours in the health sector at 93 million and informally volunteered hours at 2 to 2.6 billion hours.[1] This implies that of the 4.1 billion hours[2] of health work done in Canada in 1997, 59 percent was provided by health volunteers.

[1] Formal hours come from the 1997 NSGVP; informal hours come from the Statistics Canada General Social Survey 1998 and the 1996 Census.

[2] 1.7 billion paid hours + 2.4 billion volunteer hours.

Valuing Volunteer Time

Valuing time in the paid labour force is relatively simple: health employees worked for 1.7 billion hours at an average wage of $18.87 per hour, leading to a total value of paid health labour of slightly more than $32 billion. This calculation is far more difficult for voluntary labour because no wage is paid. There are two primary methods that could be used to estimate a wage rate for this unpaid source of labour.

Value to Volunteer

From the point of view of the volunteer, the value of the volunteer service must be worth enough to convince him or her to donate time. Therefore, the value of the volunteer service can be measured as the opportunity cost of that time. Theoretically, individuals choose their amount of labour force participation so that at the margin the value of leisure time is the same as the value of time spent in the labour force, which carries with it a value of the wage rate the individual could earn. Therefore, one possible way to value volunteer time is to value it at the wage rate the individual could earn in the labour force.

While this method is well grounded in economic theory, there are many issues that need to be addressed. First of all, how does one value the time of someone who is not in the labour force, and hence who has no wage rate? This issue has been explored in the labour economics literature, and the wage is typically imputed based on the demographic characteristics of the individual. The job characteristics of voluntary activities are often quite different from those of paid jobs. There are also the many external benefits of volunteering, the consumption and investment values, which accrue to the volunteer. If one wants to accurately estimate the value to the volunteer of performing a voluntary service, one would have to net out those benefits that accrue to the individual. This would likely result in the external value of volunteering to the volunteer being significantly less than the wage the individual could have earned if he or she worked for pay instead of volunteering. A decent rough estimate of the wage of a given volunteer would be the average wage earned in the economy.

Value to the Organization and Society

The appropriate value measure of volunteering for a specific organization, or for society as a whole, is the cost of replacing the volunteer with a paid worker. Again, theoretically this is sound but difficult to measure in practice. First of all, we do not know the exact nature of the volunteer's activities, so it is impossible to directly link them to paid alternatives. As discussed above, volunteer work is not the same as paid work. It is reasonable to assume that if the level of familiarity and relaxed atmosphere that is necessary to attract volunteers were implemented in a workplace, a lower wage would be demanded. Also, due to the nature of volunteering, people often have less developed specialized skills than a paid counterpart would, causing less output to be generated for a given labour input. Despite all of these issues, it is possible to estimate an upper limit for the value of the volunteer activity as the wage that is earned by paid employees in the sector. A lower limit might be the minimum wage, which is the lowest possible wage the organization could pay an individual to replace the work done by a volunteer. The minimum wage might not be the lower limit if one person hired at the minimum could be more productive than multiple volunteers. In the health sector, a variety of possible wages exist, such as the average wage paid to workers in the health industry, the wage paid to workers in an industry segment that most closely resembles the work done by volunteers (for example, home care) or

the wage earned by workers in the health occupation that most closely resembles the work done by volunteers, likely assisting occupations in support of health services.[3]

Given the lack of certainty about an optimal approach to valuing volunteer time, the chart below offers a variety of possible estimates for the year 1997. It should be remembered that the narrowest possible definition of a health volunteer was employed for both formal and informal volunteers. Thus, each value below represents a lower limit for health volunteering at each wage level. Given the discussion above, the best estimate of the value of volunteering in 1997 is likely somewhere in the $20–$30 billion range.

Table 1-1: Estimates of the Value of Volunteering, 1997

Method	**Wage Rate per Hour ($)**	**Volunteering Value (using 2.4 billion hours) ($)**
Minimum wage	6.48	15.6 billion
Assisting occupations	12.70	30.5 billion
Home care	14.31	34.3 billion
Economy-wide average	15.56	37.3 billion
Health industry	18.87	45.3 billion

Regression Results in Volunteering Decisions

Now that volunteering has been placed into the context of the paid health sector, and established as a major provider of health services, we turn to the examination of the personal characteristics that influence an individual's decision to volunteer and his or her choice of volunteer hours.

Classification of Variables

First, what are the broad factors that determine an individual's propensity to volunteer and the amount of time volunteered? Second, how do individual variables fit into these broad categories? A description of the various categories can be found below, followed by a table showing how the individual variables fit into these categories. It should be noted that individual variables typically affect more than one broad category, often in contradictory ways. Variables are only included in the area they best match.

Time

The first broad factor that influences an individual's volunteering decision is how much time the individual has available. Volunteering takes time, of which each person has a limited supply; in fact, the price of volunteering to an individual is the opportunity cost of the time used. Given the limited supply of time available to an individual, any time used in non-volunteering activities would be expected to take away from the time spent in the voluntary sector.

[3] The seven Labour Force Survey occupation classifications in health are physicians, dental health occupations, other diagnosing and technical professionals, other professionals, nursing, technical occupations, and assisting occupations in support of health services.

Knowledge and Ability

A prerequisite for any decision is the knowledge of the options available and the ability to perform the service. An individual's knowledge of what volunteering opportunities exist is essential in determining his or her time allocation. The more potential voluntary activities that a person is aware of, the more likely that individual is to find one that appeals to him or her. Unfortunately, we have no way to measure a person's knowledge of the options available; however, one would imagine that there are factors we can measure that would be correlated with this knowledge. For example, the longer an individual resides in a community and the more people that an individual meets, the more likely this person is to acquire knowledge of the voluntary possibilities to choose from. Likewise, the more able a person is, either physically or mentally, the more options that individual has to choose from and the more likely this individual will volunteer.

Knowledge of opportunity is actually another way of interpreting Freeman's finding, described above, that being asked is the key determinant of volunteering. The more people in the voluntary sector individuals know, the more likely they will be asked to volunteer. Being asked to volunteer is really just one way that a person can realize an opportunity to volunteer exists.

Social Attitudes and Individual Preferences

The way that society, or a unique culture within society, views the role of an individual as a volunteer makes up a key input into the decision process of an individual. These societal factors are components of an individual's preferences, since one's attitudes are at least partially shaped by society, and one's behavioural choices take society's reactions into account. As a result, environmental factors that surround an individual will have an important impact on the choices that are made.

Table 1-2: Classification of Variables

Time	Knowledge and Ability	Attitudes and Preferences
Marital status Kids 0–5 years Employment	Age Kids 6–18 years Education Health Duration Birth country	Sex City size Religious devotion Religion Province Youth experience Income Year

The Model and Methodology

We are essentially concerned with answering two questions for a variety of groupings of volunteers. First, what are the key determinants that weigh in an individual's decision to volunteer? Second, what are the key factors that determine the number of hours volunteered by an individual? These two questions will be asked about six classes of volunteers: formal volunteers, formal health volunteers, other formal volunteers, informal volunteers, informal health volunteers and other informal volunteers. For each group two equations need to be estimated:

Participation = f (time, knowledge and ability, social attitudes and preferences)
Hours = f (time, knowledge and ability, social attitudes and preferences)

Each of these equations poses econometric problems, and their combination even more so. Fortunately, the Heckman selection model, or Heckman two-step estimator, was developed by James Heckman (Heckman, 1979) to deal specifically with the problems encountered here, though it has usually been applied in the paid labour supply literature. In the first step, the decision to volunteer is examined using a Probit model that allows the yes/no decision to be examined. The second step then examines the hours volunteered using the standard ordinary least squares model, including the inverse Mill's ratio, to account for the selection bias of only observing the hours for individuals who choose to volunteer.

Sex and Time

By employing a dummy variable to capture the difference between males and females and between 1997 and 2000, it is being assumed that there is only a fixed difference between them and that the coefficients on the other variables are the same. This simply might not be so.

Separate regressions were run for each time period and each sex and the results were tested using a Wald test. The results found that there was more than a fixed difference between sexes and between time periods, implying the dummy variable specification was not ideal; however, while the size of the estimates changes, their analytic interpretation remained the same. As a result, for the sake of simplicity, the findings of the more general regression are described here.

Regression Results

There is insufficient space to discuss each variable in detail, but a table of the impact of each variable is included below. For a fuller discussion of these results, see the full version of the paper.

Table 1-3: Impact of Variables, Summary

Variable	Formal Participation	Formal Hours	Informal Participation	Informal Hours[1]
Married	Positive	Negative	Positive	Insignificant
Kids 0–5	Negative	Insignificant	Insignificant	Negative
Employed	Mixed	Negative	Insignificant	Negative
Age	Insignificant	Insignificant	Insignificant	Positive
Kids 6–18	Positive	N/A	Insignificant	N/A
Education	Positive	Positive	Positive	Insignificant
Health	Positive	N/A	Positive	N/A
Duration in community	Mixed	Insignificant	Positive	N/A
Foreign born	Negative	N/A	Negative	N/A
Male	Negative	Positive	Negative	Negative
Small city size	Positive	Insignificant	Insignificant	N/A
Religious	Positive	Positive	Positive	Insignificant
Denomination	Mixed	Mixed	Mixed	Insignificant
Province	Mixed	Mixed	Mixed	Insignificant
Youth experience	Positive	N/A	Mixed	N/A
Income	Positive	Negative	Insignificant	N/A
Year 2001	Negative	Negative	Positive	N/A

1. The estimation of the determinants of informal hours required the use of a different data set (the General Social Survey), which had fewer variables available.

Discussion of Key Results and Policy Implications

Education

Education is likely the single largest factor that determines whether or not an individual will volunteer. The key question to examine when looking at policy options is why education is so important to the decision to volunteer. One suggestion is that more educated people have access to a wider variety of volunteering opportunities, either through an increased range of abilities or an increased knowledge of the options available. One policy response, then, would be to educate people regarding volunteering opportunities.

Another possible explanation is that more highly educated people have a wider group of contacts that might induce an individual to volunteer. This is possibly tied to the likelihood of being personally asked to volunteer, something we could not measure directly but that Freeman (1997) found clearly to be the dominant determinant of the decision to volunteer. If this is the case, the initiative would likely have to come from the individual charities to get their members to try to personally request aid from either their acquaintances or members of the public.

The third possibility is that, as Gibson (1999) found, education does not increase participation in volunteering; in regressions, it is merely picking up unobserved individual characteristics such as ability or family background. It is hard to imagine a policy proposal that would have a significant effect if this were the case. The key point is that with so many possible explanations, implementing any policy before further study can identify what underlying factors are driving education is a risky proposition.

Youth Experiences

Something new in this study that has not been examined before is how important youth experiences are in contributing to adult volunteering behaviour. Being exposed to volunteering at an early age through the example of parents or role models, or being on the receiving end of voluntary behaviour, greatly increases the chance of volunteering later in life. Some provinces in Canada have instituted policies that require young people to volunteer in order to complete secondary school, hoping that the youth experience will translate into adult volunteering. It is doubtful that the forced interaction with the voluntary sector is likely to be as beneficial as seeing one's parents doing so from personal choice, but perhaps creating knowledge about the sector will increase the number of volunteers in the future. The other thing that the significance of youth experiences introduces is the potential, and danger, of cumulative causation. As more people volunteer, more youths will come into contact with the sector, and more will likely volunteer later in life, thus creating a virtuous circle. However, the opposite is also true: if the number of volunteers falls this could lead to a downward spiral in the rate of volunteering over time. With this in mind, the data showing people being 11 percent less likely to formally volunteer in 2000 than in 1997, all other things being equal, looks particularly ominous. Granted, this is partially offset by increased informal volunteering, but whether informal volunteering leads to the same positive impact on adult behaviour is unknown.

Health

Another variable that is not often studied, but that has an enormous impact on voluntary behaviour, is the health of an individual. It is intuitively simple to recognize that a person in poor health is far less likely to contribute time and effort to help others. The positive externality of a strong health system contributing to healthier workers and hence more output in the paid sector has often been discussed. The impact of health on the voluntary provision of time is likely far greater, since there is not the same pressure to show up as there would be in a place of employment. When looking at volunteering in the health sectors, another potential issue of cumulative causation arises. A strong health system needs fewer volunteers, due to fewer people being ill, and has more volunteers available since they themselves are healthy. In contrast, if the health system weakens more people fall ill, causing more care to be required. This will create a higher demand for health volunteers, particularly since they likely serve as substitutes for paid health workers in at least some cases; however, the supply of health volunteers will shrink due to a lower level of health among volunteers, which will put even more stress on the system. The obvious policy conclusion is to sufficiently invest in the health system to prevent this negative spiral from happening.

Finally, what makes health volunteers different from other volunteers? The specific nature of the question creates problems due to the limited sample of health volunteers available for analysis. With more data available it is likely that other distinctive characteristics would emerge, but even with the data that exist two key distinctions are visible. First of all, men are far less likely than women to volunteer in the health sector; in fact, the general observation that men are less likely to volunteer is entirely driven by the health sector. This corresponds directly with the observation that the majority of employees in the paid health sector are also women. The second distinction is that while small towns increase volunteering in general they decrease formal volunteering in health. This is undoubtedly caused by the fact that the hospitals and nursing homes, where formal health volunteers participate, are not found in the same density in more rural areas. This raises the potential of an untapped pool of individuals in the smaller towns who would be willing to provide their time if a suitable institution were to be put in place.

Conclusion

This paper has been an exploration of the voluntary sector in relation to health focussing on two questions. First, what is the contribution of volunteers to the Canadian health care system? Second, what are the key determinants of voluntary behaviour?

The contribution of volunteers to the health care system is huge. Formal volunteers, who have been the focus of most study, contribute approximately 93 million hours per year, a sizeable amount, but not striking when compared to the 1.7 billion paid hours in the sector. However, the 2.3 billion informally volunteered hours in health represent a resource that is even larger than the paid workforce. The valuation of this time is highly problematic depending on the methodology chosen. Estimates here range from $15 billion to $45 billion, though most likely the estimate should lie in the $20–$30 billion range; this implies that volunteers in health represent an extremely valuable resource that is never discussed when the purely monetary costs of the health system are examined. The exact value is not what is most important; rather, it is the huge role volunteers play in the provision of health.

The second question has a longer history of examination both within Canada and in other countries. This study benefits from four key features. The first feature is the National Survey of Giving, Volunteering and Participating, a rich new data set that allows many new issues to be examined. From this data set two new key determinants of voluntary behaviour, youth experience and health, have been identified; these, along with education, appear to be the dominant determinants of volunteering. The second unique feature is a focus on health volunteers. Unfortunately, due to a limited quantity of data, little concrete can be said other than it is a female-driven volunteer force. It is actually solely this health component that has led researchers in the past to claim that females volunteer more often than males; other sectors see equal male and female volunteering. The third feature, and likely the most important, is that informal volunteering was looked at. Due to data problems the analysis was somewhat limited but did confirm that informal volunteers behave similarly to formal volunteers in many ways. A key point arising from the analysis is the identification of just how large a contribution informal volunteers make, particularly in health. Finally, the Heckman two-step estimation procedure is extended into the study of volunteering.

The only question that remains is, where to go from here? The key result from this study is that informal volunteering is of huge importance in health. As a result, more detailed study of the sector is needed; in particular, better data on the hours volunteered informally needs to be collected. The activities performed and how these are integrated with the activities of paid workers is also an important area for further research; this applies to both formal and informal volunteers. Finally, how the sector itself is organized and how this has changed, or could be changed, is a possibly valuable avenue to pursue.

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2. Volunteers Are Not All the Same:

The Case of Health Organizations

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Introduction

This study compares individuals who volunteer for health organizations with those who volunteer for culture and recreation, social service and religious organizations. Three questions directed our inquiry. Do health volunteers differ from volunteers for other kinds of organizations? If so, in terms of what traits do health volunteers differ? And, what characteristics do health volunteers have in common with each other? Answers to these questions will enhance our understanding of the voluntary sector as a whole, and could also provide health organizations with information about the socio-demographic characteristics and social dynamics associated with health organization volunteers, thereby identifying components of the population they currently do not draw volunteers from and enabling them to adapt their recruitment strategies to tap such resources.

This analysis lies on uncharted terrain: there is little research on the interesting questions of **who volunteers** for **what** and **why**? Even a brief review of the literature reveals a considerable number of studies of who volunteers; nonetheless, there are still a substantial number of inconsistent, even contradictory, findings. A systematic picture of who volunteers and why is beginning to emerge but remains far from complete (Wilson 2000; Smith 1994), in part because research on who volunteers typically treats all volunteers as a homogeneous group.

Our research here examines the traits of volunteers in several types of organizations that can be differentiated along two dimensions, one that follows the distinction between religious and secular organizations, and another axis of classification that is similar to the expressive-instrumental and the mutual benefit-program volunteer distinctions. However, our classification rests not on who benefits from the activity (members versus clients), but rather on whether the service or product provided is an amenity or fills a basic human need.

The distinctions between amenity and need, and between secular and religious activities, are two of numerous possible dimensions of differentiation in volunteer activities. These are not discrete categories in clear binary sets; instead, each represents one defining polarity of a continuum along which volunteer activities can be located. The distinction between activities providing amenities and those filling needs is a matter of degree, not of absolute difference. In assigning organization types to either pole of one or the other of these dimensions, we are proposing that the large proportion of activities in question are of that particular type. The extent to which these dimensions reflect observable differences in the traits, values and motives of volunteers lends credence to the idea that they are important in some way.

Data and Analysis Strategy

Our analysis uses data from Statistics Canada's 2000 National Survey of Giving, Volunteering and Participating (NSGVP). The data file consisted of completed cases from 14,724 respondents, containing 44 variables, which are listed in the Appendix (available in the full version of this paper). The dependent variable throughout is formal volunteering, defined as unpaid work for a formal non-profit organization. In the 2000 edition of the NSGVP, 26.7 percent of respondents reported having done formal volunteering during the preceding 12 months.

The first task was to identify the individuals who volunteered for each of the types of organizations we wanted to examine. We used the two-digit level of the International Classification of Non-Profit Organizations (ICNPO) developed at Johns Hopkins University. This classification scheme assigns non-profit organizations to 12 broad groups on the basis of each organization's principal activity or field of work (Salamon and Anheier, 1996). Assignment of volunteers' organizations in the NSGVP to this classification was made by a panel of experts associated with the survey at Statistics Canada.

All organizations that were cited by NSGVP respondents were distributed among these 12 categories: culture and recreation; education and research; health; social services; environment; development and housing; law, advocacy and politics; philanthropic intermediaries and volunteer promotion; international; religion; business and professional associations, and unions; and not elsewhere classified.

The four categories we selected for comparison were health, culture and recreation, social services, and religion. For the first three, the types of organizations they encompass are fairly straightforward. Health organizations include those associated with hospitals and rehabilitation, nursing homes, mental health and crisis intervention services, and other services such as public health and emergency services. Culture and recreation includes groups that foster and support culture and the arts, sports, and recreation and social clubs. Social service organizations are those involved with child, youth and family services, services for people with disabilities and the elderly, emergency and relief services, and income and literacy assistance. The fourth category, religion, covers associations and auxiliaries of religious congregations that promote religious beliefs and administer religious services. This category does not include religion-based organizations whose primary function is to address needs in other fields, such as social services. Thus the Salvation Army and Saint Vincent de Paul Society, for example, are assigned to the social service rather than the religion category.

In the ICNPO system, the method of assigning organizations to the categories leaves some ambiguity as to the essential nature of, and activities undertaken by, the organizations in each group. In the absence of detail about specific activities undertaken by a respondent's organization, there is less than full certainty as to what the ICNPO groups actually represent in terms of the behaviour of volunteers. To minimize that uncertainty while still retaining enough cases to achieve reasonably generalizable results, we restricted our comparison to the above-mentioned four largest categories of organization.

We focussed our analysis on those four organization types in order to distinguish as clearly as possible between at least three main types of activity: amenity, need and religion. In practice, the distinction is not made so easily, since each volunteer can be involved in a number of organizations and reported on up to three in the survey. To maintain the purity of the four types, we excluded any respondent who had volunteered for more than one of the four organization types, which amounted to 10 percent of all volunteers. As a result, there is no overlap in our data among the four groups; if a respondent volunteered for one type, then he or she was not associated with any of the three other types. However, we did allow volunteers in each of the main groups to also be volunteers for any of the other eight excluded groups. This decision reduced the purity of the distinction made between the four main categories, but by only a negligible amount. This was confirmed in a sensitivity test, comparing the trait profile of the pure and mixed versions. They were virtually identical. The size of each of the resulting groups is presented in Table 2-1.

Table 2-1: Distribution of Respondents Across Organization Types

	Count	Percent of Sample	Percent of Volunteers in Sample	Percent of Volunteers in the Analysis
Non-volunteers	10,791	73.3		
Volunteers for:				
Health organizations	386	2.6	9.8	15.8
Culture and recreation organizations	854	5.8	21.7	35.0
Social service organizations	684	4.6	17.4	28.0
Religious organizations	518	3.5	13.2	21.2
Sub-total (of volunteers)	2,442	16.5	62.1	100.0
Combination of the above, or other organizations[1]	1,491	10.1	37.9	
Total	14,724	100.0	100.0	100.0

1. These cases are excluded from the analysis because they (1) were people who volunteered for a health organization and one or more of the culture and recreation, social service or religion organizations, or (2) were people who did not volunteer for any of these four organization types.

Analysis Strategy

Our analysis was undertaken in four successive steps. We first compared health volunteers with all non-volunteers in the sample. In the second stage, health volunteers were compared with volunteers in all three of the non-health groups combined. Third, the health volunteer group was compared with each of the culture and recreation, social service and religious organization groups individually. Comparisons were made in pair-wise form for every one of 37 variables in stage 1 and 44 variables in stages 2 and 3. For every comparison, the level of statistical significance of Cramer's V was computed as the basis for determining whether the groups being compared were different; we adopted a significance level of five percent as the threshold for identifying a variable as differentiating the two groups. The fourth step produced, via logistic regressions, profiles of distinctive traits of health volunteers relative to volunteers in the other three categories. This provided a direct test of whether or not health volunteers are unique in some way. The advantage of the logistic analysis is that the independent variables identified by the procedure as significant are those that are important in distinguishing between the two groups of volunteers in question. They are a direct measure of how health volunteers differ from (or are the same as) the other types of volunteers.

Analysis Results

Health Volunteers Compared With Non-volunteers

Across 37 variables, health volunteers were significantly different from non-volunteers on 30 variables. The principal differences can be summarized as follows.

Health volunteers are *more likely* than non-volunteers to be:

- a charitable donor, and in the core group of charitable givers who account for two thirds of total giving
- in the core group for civic participation
- engaged in direct personal helping of others
- individuals who give money directly to others
- residents of Ontario and the Atlantic and Prairie regions
- in the middle-age range (35–64)
- in households with children ages 6–17
- female
- from the upper range of household income (above $100,000)
- from higher categories of education and occupational status
- Protestant
- more religious and more frequent church attenders
- of British or "other" ethnic background
- in better health (self-reported)
- more active voters
- more satisfied with and in control of their lives
- more involved during their youth in sports, school and religious groups and volunteering.

In sum, health volunteers are about as different from non-volunteers, and in much the same ways, as volunteers as a whole are different from non-volunteers. Expressed another way, health volunteers are very typical in their differentness from non-volunteers.

Health Volunteers Compared With the Three Other Types Combined

Volunteers associated with health organizations differed from those in culture and recreation, social service and religious organizations on 15 of 46 variables.

Health volunteers had elevated probabilities of:

- being residents of Ontario
- living in cities with a population of one million or more
- having fewer children ages 6–12 in the household

- being female (64 percent versus 49 percent)
- being Protestant.

Health volunteers had *lower probabilities of*:

- being in the volunteering core
- being religious and attending church frequently.

The average annual hours volunteered (111.3) for this group was markedly below the level for the combined group (150.8), as was its average annual charitable giving ($286 compared to $381). A higher proportion of this charitable giving was secular (75 percent versus 65 percent).

We can conclude, then, that health volunteers are only moderately different from the three other types treated as a single whole.

Health Volunteers Compared With Culture and Recreation Volunteers

Health volunteers manifest differences on 19 of 46 variables.

Health volunteers are *more* likely to be:

- female (much more)
- Protestant and attend church often.

Health volunteers are *less* likely to:

- have children at home
- be in the labour force
- live in Quebec or the Prairies
- be involved in social and civic participation.
- Volunteers for health organizations contributed an annual average of 111 hours, compared with 157 hours for cultural and recreation volunteers.

Health Volunteers Compared With Social Service Volunteers

Health volunteers differed on only 8 of 46 variables.

Health volunteers are *more likely* to be:

- female
- married
- of British ethnic background (a little more)
- older (a little more); younger ages were slightly and relatively more prevalent among culture and recreation volunteers.
- Health volunteers, then, differed little and on few variables, from their counterparts in social service organizations.

Health Volunteers Compared With Religious Organization Volunteers

Health volunteers differed on 17 of 46 variables.

Health volunteers were *more likely to*:

- live in large cities
- have smaller families
- be Catholic or "no religion"
- be Canadian-born and of British ethnic background
- be in the middle age range.

Health volunteers were *less likely to*:

- attend church often
- be in the core group for charitable giving and civic participation.

Health volunteers and religious volunteers did not differ in total annual time volunteered but differed very significantly in their giving behaviour: health volunteers contributed one third the annual amount of religious volunteers ($286 compared to $796), with a much greater proportion of it going to secular organizations (75 percent compared to 40 percent).

Identifying the Distinctive Characteristics of Health Volunteers: From Bivariate to Multivariate Analysis

Contributory behaviours such as volunteering and charitable giving are known to be complex, multidimensional phenomena that are not always captured fully and effectively by simple bivariate analysis, even when done in many increments. This prompted us to estimate four logistic regression models to provide a more holistic, multivariate portrait of the distinguishing traits of health volunteers. As previously done, health volunteers were examined in four comparisons: with culture and recreation, social services and religious organization volunteers all combined, and then with each of these three types individually. A summary of the results is presented in Table 2-2 and we comment here on the content of these four models.

Model 1, **a comparison of health volunteers with those in all of the other three types**, has a very low level (5 percent) of explained variation (R^2). This indicates that the combined group of three types is relatively heterogeneous and overlaps considerably with the health group's traits. This suggests it is inappropriate to group the three types together because of the considerable heterogeneity among them.

Model 2, **health compared with culture and recreation volunteers**, has the largest number of significantly differentiating traits (12) of the three non-health types. In socio-demographic terms, health volunteers are most different from culture and recreation volunteers (relative to social service or religious volunteers). The moderate level of 21 percent of explained variation suggests there are yet more unmeasured dimensions, possibly non-socio-demographic.

Model 3, **health versus social service organization volunteers**, contains only six significant variables but they do not present a coherent or systematic picture of the differences, explaining only 7 percent of total variation. This indicates that health and social service

organizations are not systematically different, at least in their socio-demographic traits. If they differ, it is on other unmeasured factors.

Model 4, **health versus religious organization volunteers**, contains five significant variables and *all* relate to religion and religiosity. R^2 is a high 46 percent, suggesting that the principal difference between health and religious volunteers arises from the secular/religious aspect of the organizations they work for. For practical purposes, these two types of volunteers are effectively identical on all other characteristics.

Table 2-2: Summary of Significant Variables in the Logistic Regression Models

Model 1 **Health vs.** **Three Groups**	**Model 2** **Health vs.** **Culture-Recreation**	**Model 3** **Health vs.** **Social Service**	**Model 4** **Health vs. Religion**
– Hours volunteered annually	– Hours volunteered annually	– Hours volunteered annually	
+ % of giving that is secular			+ % of giving that is secular
– Church attendance	+ Church attendance		– Church attendance
Religion (vs. no religion)			Religion (vs. no religion)
+ Catholic			+ Catholic
			– Other
+ Resides in CMA*	+ Resides in CMA*		
Region (vs. Ontario)	Region (vs. Ontario)	Region (vs. Ontario)	
+ Quebec	– Quebec	– Quebec	
+ Prairies	– Prairies		
+ Female	+ Female		
– Canvassed as a youth	– Canvassed as a youth	– Canvassed as a youth	
+ Student gov't as a youth		+ Student gov't as a youth	
– Years resident			
		Age (vs. 15–24)	
		+ 55–64	
		Family income (vs. 100K+)	
		+ 60–100K	
	– Children 6–12		
	+ # informal helping types		
	+ Total charitable giving ($)		
	– Civic participation		
	– Social participation		
			– Religious group as a youth
			– Religiosity
X^2 108.9	184.7	53.8	356.4
df 10	13	6	6
pseudo-R^2 5 percent	21 percent	7 percent	46 percent

Note: Only effects significant at the 0.05 alpha level or better are displayed. Variables preceded by a minus sign have a negative effect on the probability of being a health volunteer; those preceded by a plus sign have a positive effect.

*CMA: Census Metropolitan Area

Social Dynamics: The How and Why of Being a Volunteer

Our findings are summarized in the tables below. (Please see the unabridged version of this paper for a text commentary on these tables.)

Table 2-3: Reasons for Being a Volunteer

Reason for Being a Volunteer	Health	Culture and Recreation	Social Services	Religion
	Percent who agree[1]			
Personal cause	94	94	95	96
Personally affected	74	70	68*	72
Friends volunteer	24	35*	29	27
Job opportunities	21	22	25	15*
Religious beliefs	15	12	17	73*
Explore own strengths	50	55	58*	65*
Use skills and experience	68	86*	81*	81*
Required by school, etc.	9	6*	9	7

*Comparison to health volunteers is significantly different at alpha=0.05.

1. Percentages round to nearest whole number.

Table 2-4: Reasons for Not Volunteering More

Reason for Not Volunteering More	Health	Culture and Recreation	Social Services	Religion
	Percent who agree[1]			
Have already made a contribution	28	34*	25	28
Have no extra time	76	78	68*	76
Have health problems	18	14*	16	21
No one asked	18	16	16	15
Don't know how to connect	8	8	10	10
Cost of volunteering	11	13	14	12
Fear being sued	3	8*	5	5
No interest	13	19*	13	16
Give money instead	29	22*	23*	30
Unwilling to commit	38	33	32	34
Disaffected with prior experience	7	9	7	8

*Comparison to health volunteers is significantly different at alpha= 0.05

1. Percentages round to nearest whole number.

Concluding Discussion

The series of analyses comprising this study provides answers to the three guiding questions. We now know that health volunteers differ primarily and significantly from volunteers for culture and recreation organizations (differences on 19 of 46 traits). Health volunteers are relatively less engaged in varied forms of contributory and community activities, are more frequent church attendees, are more likely to be female and not in the labour force, and volunteer

only about two thirds as much time each year. On the other hand, health volunteers differed hardly at all from social service volunteers (differences on only 8 of 46 variables). They are, in socio-demographic terms, essentially the same kind of people. Health volunteers were a little more likely, in relative terms, to be married, female, older and of British extraction. Given the strong similarities between providing health services and providing social services, this naturally makes sense. Health volunteers also manifested considerable similarity to volunteers for religious organizations, showing no differences on 29 of 46 variables; many of the 17 variables-of-difference pertained to religious characteristics, permitting us to say that, by and large, health volunteers are the secular version of religious organization volunteers (and vice-versa). The principal and very clear fault line runs between culture and recreation volunteers on one side and health, social service and religious organization volunteers on the other. This fault line is easily understood in terms of the presence of a leisure activity aspect in culture and recreation organizations, and the strong element of ideals and principles associated with the health/social service/religious constellation of volunteering. This is evidently a dimension of differentiation that requires deeper exploration.

As for the distinctive traits of health volunteers relative to other volunteer types, our logistic regression models uncovered approximately 15, of which 10 were significant, namely that health volunteers:

- contribute about one third fewer hours annually
- attend church more than do culture and recreation volunteers
- are more likely to be Roman Catholic
- live in greater numbers in metropolitan Ontario
- are female
- were less involved in volunteering in their youth than other types of volunteers
- are in their later middle years (55–64)
- are in high income categories ($80,000+)
- have fewer young children in the household
- are less involved in general civic activities.

In sum, health volunteers do stand out from other types, but not in sharp relief; they differ mainly from only one of the three comparison groups, and they do not manifest a high-contrast set of shared characteristics.

The analysis has revealed, further, that the voluntary sector can be considered textured or "grainy" in terms of the distribution of volunteer traits; it is neither seamless, nor extremely "lumpy." Rather than an undifferentiated population of volunteers, or discrete, largely mutually different groupings or types of volunteers, the pattern is one of overlapping sets of similarities separated by blocks of differences of varying size, in a patchwork. For some purposes, those differences are of small importance, while for other purposes they are of signal importance.

It is clear from the patterns we have identified that there are both strongly deterministic, and a mixture of weakly deterministic or random, social processes producing the clusters of similarities and differences. Religious organization volunteers, for example, are the product of

powerful forces of family background and early life experiences related to religious practice, but not of life cycle stage (or of numerous socio-demographic traits), while the reverse holds true for the other three volunteer types. And it is early life cycle stage (under age 35) adults who are more involved as culture and recreation volunteers, and later life cycle stage adults who are involved as health volunteers, i.e., when the contingencies of family and career have diminished.

All of our generalizations are limited to the four categories of volunteer organizations this analysis focussed on but can be broadened with a larger volume of data pertaining to more purely defined categories of volunteer organizations such as those for education, environment, housing, law/advocacy/politics and international service.

Implications for Further Inquiry

This study has illuminated the social sorting processes of volunteer types. It advances our understanding of the axes or dimensions of similarity and difference that run through the voluntary sector. As well, it points to further inquiry in several directions. One is the social ethos of different types of volunteers: do health volunteers, for example, embrace a set of values and beliefs (or even just one or two prime values and beliefs) that differ from those of other volunteer types? Another is the need to understand the nature of the social logic or reasoning volunteers of various kinds use when making decisions—to begin volunteering, to continue volunteering, in selecting an organization and choosing which tasks to perform—in order to better understand the social sorting processes that lead particular kinds of individuals to be volunteers of particular kinds. This also bears on the link between formal volunteering and direct, personal helping and caring: many health volunteers do both, and there is value in knowing in extended detail how "health carers" think about the connection between these two modes of contributory behaviour. Each of these directions of inquiry can be pursued best and perhaps only via small-sample but high-detail content studies. They offer potential for the voluntary health sector to better understand and utilize its key resource.

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3. Voluntary Health Organizations in Canada:

Public Involvement and Support

Results from the 2000 National Survey of Giving, Volunteering and Participating

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Introduction

Many people consider Canada's health care system to be a distinguishing feature of Canadian society. When Canadians think of the organizations that make up the health care system, they often think first of hospitals and other institutions such as rehabilitation facilities, nursing homes and psychiatric hospitals. But Canada's voluntary health sector also includes community health centres, crisis intervention services, public health services, walk-in clinics and physical therapy centres, emergency medical services, and organizations that focus on specific health issues.[1]

One way that Canadians demonstrate their support for these voluntary health organizations is through voluntary effort—by donating money and time to health organizations. This support has become increasingly important as the health care system continues to undergo change. Hospital restructuring has taken place, or is taking place, in most provinces. Hospitals have shortened in-patient stays and have come to rely more on community supports for newly discharged patients. Community health organizations have felt the pressure to provide more care for these patients and for the growing number of frail seniors. Organizations that serve and support those with specific illnesses are highly dependent on contributions of time and money. Reliance on voluntary effort will likely grow as governments implement changes to the financing of the health sector in Canada.

This report provides information about Canadians who donate money and volunteer time to voluntary health organizations. It updates a previous report, *Voluntary Health Organizations in Canada: Public Involvement and Support,* which was based on data from the 1997 National Survey of Giving, Volunteering and Participating (NSGVP).[2] The current report compares the 2000 and 1997 data to give an indication of trends in giving and volunteering to voluntary health organizations in Canada.

Giving to Voluntary Health Organizations

Health organizations are the most broadly supported type of voluntary organization in Canada. As Table 3-1 indicates, more than half of Canadian donors (54 percent) made at least one donation to a voluntary health organization during 2000.

[1] Note that the definition of the voluntary health sector used in this report does not include medical research, which is considered part of the education and research sector, although it does include special-focus health organizations, such as the Kidney Foundation of Canada and The Arthritis Society.

[2] *Voluntary Health Organizations in Canada: Public Involvement and Support* can be found at **http://www.givingandvolunteering.ca/reports.asp?fn=view&id=23117**.

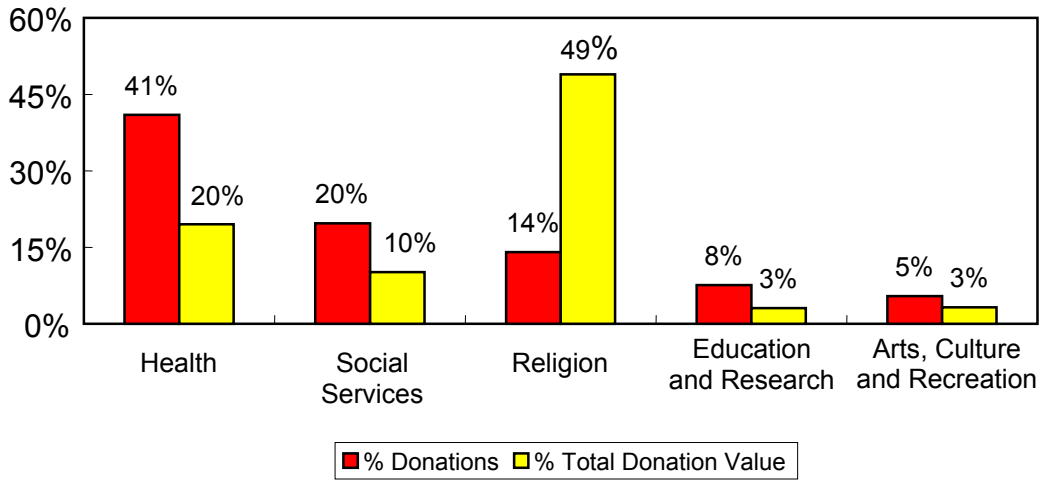
Table 3-1: Number of Donors, Donation Rate, Number of Donations, Amounts Donated and Average Donation, All Organizations and Health Organizations, 2000 and 1997

	2000		**1997**	
Total population ('000)	24,383		23,808	
	All Organizations	**Health Organizations**	**All Organizations**	**Health Organizations**
Number of donors ('000)	19,036	13,106	18,563	12,146
Donation rate (percent)	78	54	78	51
Total number of donations ('000)	70,465	28,867	74,413	28,338
Total amount donated ($'000,000)	4,938.8	963.3	4,435.1	747.6
Average donation ($)	259	74	239	62

The donors to health organizations gave an average of $74 each, for a complete total of $963 million. This is a substantial increase from 1997, when 51 percent of Canadian donors gave an average of $62 each for a total of just under $748 million.

As Figure 3-1, below, indicates, voluntary health organizations received from Canadians in 2000 almost 41 percent of the total *number* of donations, and 20 percent of the total *amount* donated.

Figure 3-1: Percentage of Donations and Percentage of Total Donation Value, by Organization Type, 2000



It is also worth noting that both the percentage of Canadians who gave to health organizations and the average annual health donation increased in almost every province between 1997 and 2000.

While broadly typical of Canadians as a whole, health donors were more likely to be well educated, employed (particularly full time) and to have higher than average household incomes. They were also more likely than other donors to give because of a personal connection to the

work of the organizations they supported. These characteristics suggest an ability and a willingness to give that could be further tapped by voluntary health organizations.

The 2000 data also point to some areas that may be of concern to voluntary health organizations. As in 1997, the bulk of the money donated to health organizations came from a relatively small number of Canadians. The 25 percent of health donors who donated more than $69 during the year to health organizations accounted for 76 percent of the total value of health donations. Voluntary health organizations may want to consider how they can broaden this base of support. They may also want to re-examine the ways in which they solicit and address donors in uncertain economic times. As the table below indicates, almost half of health donors (48 percent) said that they did not give more because they did not like the way in which requests for donations were made. An equal number (48 percent) said they preferred to save their money for their own future needs.

Table 3-2: Barriers to Donating More: Health and Non-health Donors, 2000 and 1997

	2000		1997	
	Health Donors (%)	Non-health Donors (%)	Health Donors (%)	Non-health Donors (%)
Do not like the way requests are made for contributions	48	44	44	37
Want to save money for own future needs	48	57	52	58
Would prefer to spend money other ways	44	52	46	55
Think money will not be used efficiently	43	50	41	39
Already give enough money directly to people	35	38	32	34
Give voluntary time instead of money	26	28	27	31
Hard to find a cause worth supporting	12	22	9	16
Do not know where to make a contribution	7	14	6	11

Summary of Key Findings About Donors

- Health donors tended to be over the age of 35, female, well educated, employed, affiliated with a religious faith and to have higher than average household incomes.
- The overwhelming majority of health donors (93 percent) made a donation to help a cause in which they personally believed or because they or someone they knew were personally affected by the cause (76 percent).
- The percentage of Canadians who donated to health organizations was highest in Newfoundland (71 percent) and lowest in Quebec (42 percent). The average annual health donation ranged from a high of $90 in Ontario to a low of $35 in Newfoundland.
- Health donors gave to fewer types of organizations, on average, than any other type of donor. They were more likely to support arts, culture and recreation, and social services organizations and less likely to support international and religious organizations.
- The most common methods of making health donations were door-to-door solicitation (24 percent of the number of donations), paying to attend a sponsored event (20 percent) and responding to a mail request (17 percent). Some of these methods brought in more money than others. The most lucrative methods were mail requests (24 percent of the total value of health donations), in memoriam gifts (22 percent) and paying to attend a sponsored event (13 percent).

Volunteering for Voluntary Health Organizations

Volunteer support is vital to most health organizations. While the percentage of Canadians who volunteered for health organizations declined slightly (from 5 percent in 1997 to 4.5 percent in 2000), health volunteers contributed more hours each on average (87 hours in 2000, up from 73 hours in 1997). As Table 3-3 indicates, they volunteered a total of slightly more than 96.4 million hours, up from 92.6 million hours in 1997.

Table 3-3: Volunteer Rate, Total and Average Hours Volunteered, All Organizations and Health Organizations, 2000 and 1997

	2000	**1997**
Total population ('000)	24,383	23,808
All organizations		
Number of volunteers ('000)	6,513	7,472
Volunteer rate (%)	26.7	31.4
Total hours volunteered ('000,000)	1,053.2	1,108.9
Average number of hours	162	149
Health organizations		
Number of volunteers ('000)	1,105	1,275
Volunteer rate (%)	4.5	5.4
Total hours volunteered ('000,000)	96.4	92.6
Average number of hours	87	73

Health organizations received 13 percent of the total number of volunteering events and 9 percent of the total number of volunteer hours in 2000. This is similar to the 1997 figures.

Personal connection was a strong motivator for health volunteers. The vast majority of health volunteers (96 percent) got involved primarily out of a personal belief in the cause the organization supported or because they, or someone they knew, were personally affected by the cause (75 percent). Indeed, health volunteers were markedly more likely than non-health volunteers to cite this personal connection.

The personal touch also drew people to volunteering. More health volunteers got involved as a result of being asked by a health organization than in any other way (41 percent). Another 12 percent got involved because they were asked by a friend. Nearly one in five (18 percent) got involved by approaching the organization on their own.

While the dedication and personal commitment of health volunteers was strong, there are a couple of areas that may be of concern to voluntary health organizations. A relatively small number of health volunteers did most of the work. The 25 percent of health volunteers who volunteered 72 hours or more annually to health organizations accounted for 85 percent of the total number of health volunteer hours. Health volunteers, like other volunteers, are increasingly time-stressed. As Table 3-4, below, shows, more than three quarters (76 percent) of health volunteers cited lack of time as a barrier to increased participation. This is up from 71 percent in 1997. More than one third (34 percent) of volunteers said they were unwilling to make a year-round commitment. Health organizations may need to restructure their volunteer opportunities to accommodate volunteers who have only a limited amount of time to give.

Table 3-4: Barriers to Volunteering More, Health and Non-health Volunteers, 2000 and 1997

	2000		1997	
	Health Volunteers (%)	Non-health Volunteers (%)	Health Volunteers (%)	Non-health Volunteers (%)
Do not have any extra time	76	75	71	75
Unwilling to make year-round commitment	34	33	35	35
Have already made contribution to volunteering	30	29	30	31
Give money instead of time	25	23	21	19
No one you know has personally asked you	19	17	18	18
Have health problems or physically unable	18	15	15	13
Have no interest	12	17	10	13
Financial cost of volunteering	11	13	11	14
Do not know how to become involved	8	10	7	8
Dissatisfied with previous volunteer experience	7	8	—	—
Concerns could be sued/taken to court	3	6	3	4

Summary of Key Findings About Volunteers

- Health volunteers tended to be female, between the ages of 45 and 54, employed, and to have higher levels of education and higher than average household incomes.
- Health volunteers were important to the fundraising efforts of health organizations. The majority (51 percent) were involved in fundraising. Fewer (36 percent) organized or supervised events or activities and only one quarter (26 percent) provided care and support, such as counselling and friendly visiting.
- The percentage of Canadians who volunteered for health organizations was highest in the Atlantic provinces (seven percent each in Newfoundland, P.E.I. and Nova Scotia, five percent in New Brunswick) and lowest in Quebec (two percent). The volunteer rate declined slightly between 1997 and 2000 or held steady in every province except Newfoundland, where it increased slightly (six percent in 1997, seven percent in 2000). Except in western Canada, the average number of hours volunteered annually increased from 1997 to 2000.
- Health volunteers contributed their time to more types of organizations than other volunteers. They were more likely to support social services, arts, culture and recreation, religious, and education and research organizations. They allocated the majority of their volunteer time (51 percent) to health organizations and, compared to all volunteers, gave much less time to other organization types.
- The most common barrier to increased participation by health volunteers was a lack of time (76 percent). More than one third (34 percent) said they were unwilling to make a year-round commitment. Thirty percent said they felt that they had already made a sufficient volunteer contribution.
- More health volunteers got involved because they were asked by the organization itself than in any other way (41 percent of health volunteer events). The next most common ways of getting involved were approaching the organization (18 percent) and being asked by a friend (12 percent).

Summary of Conclusions

Health donors and volunteers play an important role in financing and delivering health programs and services. Any reduction in their number could have a serious impact on health organizations. The impact could be particularly significant at a time when governments are considering changes to the financing of the health sector in Canada and reliance on voluntary effort is likely to grow.

Voluntary health organizations may need to reach out to more Canadians and to find ways to increase the level of support of current health donors and volunteers.