Knowledge Development
Canada Volunteerism Initiative

# The View from the Top

## How Hospital CEOs Perceive Volunteer Resources


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# The View from the Top:

## How hospital CEOs perceive volunteer contributions

## Introduction

At a time when hospitals are experiencing increases in the demand for healthcare services and uncertainty in the level of funding from all levels of government,[1] hospital CEOs must devote considerable attention to obtaining donations of money and time from individuals and institutions to support new and ongoing projects and services. In many cases, professional fundraisers and administrators have been hired to increase donations and efficiently manage resources. However, while CEOs aggressively seek financial donations, it is not clear, either from the literature or from anecdotal observations, whether they have a similar zeal for donations of time.

[1] Federal funding for healthcare has been reduced by $1.7 billion in Ontario since 1995. Although the recent provincial government has made up the earlier deficits faced by hospitals, it has done so by significantly restructuring healthcare provision with cutbacks in traditional hospital services. (http://www.premier.gov.on.ca/english/speeches/HealthStatement040300.htm).

This study focuses on the resources that hospitals devote to securing and managing contributions of time by volunteers who deliver services to patients. It does not include volunteers who are board members or who are involved in hospital fundraising. The research examined how contributions of time are viewed by senior hospital management and how senior management perceives volunteer resources. In other words, do hospital CEOs see volunteers as essential to the delivery of healthcare? Are volunteers viewed as cost effective? What contribution do volunteers make to the quality of patient care?

Raising money and recruiting volunteers put heavy demands on a hospital's human and financial resources. Because the CEO ultimately determines the allocation of these resources, it is important to understand his or her decision-making process. The CEO must decide, explicitly or implicitly, how much to spend on securing contributions of money and

time. How CEOs view these contributions — e.g., the degree to which they see donations of time and money as interchangeable, and the relative importance they assign to both types of donations — will affect this decision-making.

A qualitative analysis of the mission and value statements of hospitals shows that most hospitals include in their goals the provision of optimal healthcare, and deliberately focus on enhancing the quality of non-medical care. For example, many hospitals refer explicitly to care that involves the spiritual and emotional needs of patients, the need to provide compassionate care, and the need to enhance the quality of life for patients and families, as the following hospital vision statement illustrates: "We believe that compassion, caring and technical excellence are equally important."[2] Earlier research on the role of volunteers in providing non-medical care suggests that volunteers enhance patient well being and play a critical role in the quality of patient care by providing human contact and other important services (Handy & Srinivasan, 2002b). One implication of this finding is that the effectiveness of volunteers and their ability to contribute to quality of care are affected by how hospital CEOs allocate resources and whether resources are put towards volunteer programs and volunteer management. This, in turn, affects how well CEOs are able to meet the goals of their hospital's mission statements.

## Methodology

The sample used for this research was chosen to replicate the sample used in our previous studies (Handy & Srinivasan, 2002a, 2002b, 2002c) in which we interviewed professional managers of volunteer resources, staff working closely with volunteers, and volunteers themselves in 31 hospitals. This allows us to compare the responses of CEOs with the perspectives of those directly involved with volunteers.

For this research, we focused on 29 hospitals in and around the greater metropolitan area of Toronto, Canada.[3] Each hospital had at least 100 volunteers and at least one paid staff responsible for volunteer administration. These criteria helped to ensure that the focus remained on hospitals with professionally managed volunteer programs. We conducted 27 interviews with the CEOs or their designates at these 29 hospitals.

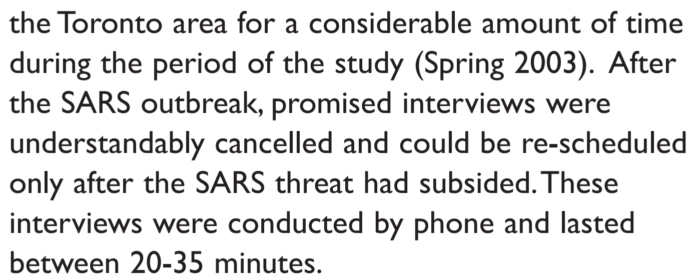
The 27 hospitals in our study had an average of over 450 beds each. Nearly two thirds of the hospitals described themselves as acute and general hospitals; the rest described themselves as providing long-term rehabilitation or psychiatric care. Due to recent mergers, some hospitals in our sample operated at more than one location, sometimes with separate volunteer programs and distinct sets of volunteers. An average of 700 volunteers was involved at each site.[4] However, we do not use hospital sites as our unit of analysis; we use hospital CEOs, some of whom were responsible for more than one site.

First, we sent a letter inviting the CEOs to participate in the study. We then telephoned to schedule a meeting. Face-to-face interviews with CEOs lasted between 30 and 45 minutes. However, SARS (severe acute respiratory syndrome), a highly infectious disease, closed down all major hospitals in

[2] Lake Ridge Health Corporation www.lakeridgehealth.on.ca/get/vision.htm (June 2003)

[3] We use the same 31 hospitals as in the previous study (Handy & Srinivasan, 2002a). However, in the case of multiple hospital sites, we conducted only one interview with the CEO in charge, resulting in a sample size of 29.

[4] These numbers are from the sample of the 31 hospitals that participated in a previous study carried out a year earlier (Handy & Srinivasan, 2002a). Two hospitals were excluded from this sample. The hospitals that withdrew were not large enough or small enough to change findings; however the statistics do correspond to the year 2001.



the Toronto area for a considerable amount of time during the period of the study (Spring 2003). After the SARS outbreak, promised interviews were understandably cancelled and could be re-scheduled only after the SARS threat had subsided. These interviews were conducted by phone and lasted between 20-35 minutes.

In cases when the CEO was not available,[5] we interviewed an individual designated by the CEO. Although designates' titles varied from Chief Financial Officer to Vice President of Human Resources, these individuals usually worked closely with their CEOs, were involved in key decision-making, and were often responsible for overseeing volunteer resources in an administrative role. For the sake of simplicity, we refer to all of the senior management we interviewed as CEOs.

We used a structured questionnaire, with many open-ended questions, that was administered either face-to-face or by telephone. To understand CEOs' perspectives on volunteer resources, we asked questions on a variety of topics ranging from overall satisfaction with the volunteer program to detailed and specific questions on how CEOs made budget decisions for their hospitals' volunteer programs. The open-ended questions generated considerable response in many of the interviews and provided a rich base for our qualitative analysis. All interviewees were granted confidentiality; the findings that follow are reported in the aggregate. Some respondents are quoted, but not identified by name or hospital affiliation.

[5] This was generally due to the SARS oubreak.

# Findings

Our discussion of findings is divided into six categories: Volunteer Programs, Benefits and Costs, Volunteer Trends, Quality of Care, Policy Questions, and Labour Unions and Auxiliaries.

## Volunteer programs

### Volunteer programs and hospital mission statements

We examined each hospital's mission statement or statement of goals, available on their Web sites, to see whether volunteers were mentioned in any capacity. Fewer than half (12) of the 29 hospitals we studied mentioned their volunteers or volunteer program in their mission statement. Of these, some simply mentioned volunteers as part of the team that provides healthcare. A few made a point of recognizing the contributions of volunteers and pledged to make this an integral part of their healthcare provision.

Just over half (15) made no mention of volunteers or a volunteer program. This is surprising, given that our sample consisted only of hospitals that had at least 100 volunteers and a professionally managed volunteer program. Although this might suggest that the majority of hospitals do not regard their volunteer programs as essential to their ability to provide services and, therefore, warranting mention in their mission statement, it may also be the result of hospitals not updating their mission statements as volunteer programs became integral to service provision. It would require further investigation to draw firm conclusions.

### CEOs' perceptions of volunteer activities

We asked CEOs to rate their satisfaction with their volunteer programs on a scale of 1 to 10, with 1 being extremely dissatisfied and 10 being extremely satisfied. More than half of CEOs were extremely satisfied. Their average satisfaction rating was 8.7. This suggests that CEOs were well aware of their volunteer programs and that they valued the role of volunteers in their hospitals.

To determine their level of awareness of their volunteer programs, we asked CEOs to identify volunteer activities that "most reduce staff workload," those that "most enhance the quality of patient care," and those that provide "other valuable services provided by volunteers."

Many CEOs disliked the word 'reduce' in the question about workload, and made it clear that volunteers were not there to replace staff, but to augment staff roles. This was an especially sensitive issue in hospitals with unionized employees. There were also restrictions on volunteers being directly involved in 'medical' care because of liability insurance issues. One CEO refused to answer the question, stating that reducing staff workload was not the purpose of the volunteer program. Such sensitivity is evidence of the potential for conflict between unions and management and of a desire not to push any issue that may cause tension.

The volunteer activities perceived as most important by CEOs (52%) were those that involved patient contact (e.g., helping take patients about on the premises). Next most important (29%) were labour intensive activities such as helping with the mail and running the reception desk. Less frequently mentioned activities included those relating to family contact (15%) and those that enhanced the hospital's links with the community (14%).

When asked to identify how volunteers most contribute to enhancing patient care, CEOs named activities that fell predominantly into the category of patient contact. Spending time with patients and providing human contact was the most frequently mentioned activity (72%), followed by interacting with families and providing information (17%).

CEOs were also asked about other valuable services performed by volunteers. The three most frequently mentioned were fundraising, governance on the board of directors, and helping with retail services such as the gift shop (52% of all responses). To ascertain how informed the CEOs were about the contributions made by volunteers in their hospitals, we asked them what reports they received on the activities and the performance of their volunteer resources and from whom they received these reports. The reporting structure varied from hospital to hospital, and ranged from reports from directors of volunteer programs on the number of hours contributed, to more general information gathered through requests for budgets, and at events, such as fundraising events and events honoring volunteers.

We grouped the information CEOs receive into two types of reports: quantitative reports, which provide information on the number of hours contributed and the number of volunteers, activities, and programs; and qualitative reports, which include information gathered at events, descriptions of services provided, attendance at training or recruitment sessions, and information dealing with specific, volunteer-related problems and issues. Of the 27 CEOs we interviewed, two received only quantitative reports and three received only qualitative reports. The vast majority of CEOs (22 out of 27) received both types of reports. This suggests that the majority of CEOs had good reporting mechanisms in place and were well aware of the contributions made by volunteers.

## CEOs' perceptions of volunteer administration

To gauge CEOs' perceptions of volunteer management in their hospitals, we asked them to identify the top three strengths of their program. Most CEOs (80%) praised the way that their volunteer programs handled the intake of volunteers—from recruitment, to having a community focus.[6] The same percentage also said that their programs had good leadership, were administered with professionalism, and created a positive environment for patients and volunteers. In response to a question about the quality of volunteers in their hospitals, over three quarters of CEOs said that the strength of their volunteer program reflected the quality of the volunteers, and highlighted commitment, generosity, and loyalty as significant characteristics of their volunteers.

[6] Hospitals recruit volunteers locally, and pay attention to representing the diversity found throughout their communities.

## Benefits and costs

### Cost effectiveness of volunteer programs

Without exception, all 27 CEOs believed that their volunteer programs were cost effective. On the face of it, volunteers who render valuable services for free must be cost effective. Implicit in the CEOs' responses is the assumption that the indirect and direct costs of volunteer programs, such as those incurred in recruiting, training, and managing volunteers, are easily outweighed by the benefits delivered by the volunteers. One CEO's comment, "Four hundred volunteers managed by a staff of three is a good management ratio," typified the general tenor of responses to this question. In general, CEOs saw volunteers as not only providing valuable services in the hospital at little cost, but also as playing a 'public relations role,' and often diffusing complaints received from patients and their families. CEOs also rated volunteers as a very important link to the community in which the hospital was located. We saw no evidence, however, that any of the CEOs had performed any type of cost-benefit analysis of the use of volunteers.

### Impacts of volunteer programs

To better understand how CEOs viewed the impact of volunteers on non-patient related benefits, we asked them to rate on a scale of 1 to 5, with 1 being minimally beneficial and 5 being highly beneficial, the following benefits: workload reduction, money saved,[7] community development and participation, and fundraising. Community development and participation (4.5) and fundraising (3.9) scored significantly higher than the others (3.0).

### Resource allocation for volunteer programs

CEOs appeared to regard their volunteer programs as not only efficient and important in enhancing the quality of patient care, but also as highly important in creating links to their communities for fundraising purposes. They also recognized that the volunteer programs were a cost-effective way to recruit the type of volunteers needed to create value added[8] in their hospitals. This being the case, we would expect that the CEOs would put resources in place to nurture their volunteer programs.

To determine how budget decisions were made, we asked CEOs how resources are allocated to the volunteer programs in their hospitals. Our findings indicate that, in most cases, the budgets for volunteer programs are based on the previous year's allocations, with adjustments made according to planned changes in programs, number of volunteers, and activities. In other cases, the budget for the volunteer program was part of the overall hospital budgeting process, with particular attention paid to the needs of the volunteer program within the context of the overall needs of the hospital. Over two thirds of the CEOs we interviewed did not anticipate any significant changes to the budgets of their volunteer programs in the near future. In cases where CEOs did expect changes, the reasons varied and included the need to recruit more volunteers, add language (and cultural) interpreters, and increase the recruitment of student volunteers in response to the increased supply.

In more than half of the cases, the director of volunteer services sets a budget and presents it to senior management (e.g., the vice president of human resources, the board of directors, the CEO) for approval. We found that despite cutbacks in funding from governments, volunteer services appeared to be fairly well protected, although in some cases there was pressure to reduce support. In one case, volunteers actually contributed monetarily to the budget to help defray costs that the hospital was unable to cover.

[7] Several CEOs commented that if volunteers did not provide certain services, they would not necessarily be replaced by paid staff; therefore, the question about 'money saved' by using volunteers was difficult to answer.

[8] A volunteer's input makes the service of greater value (to the patient and/or organization) than it would otherwise have been.

Previous research indicated that many of the hospitals in this sample would have liked to increase their volunteer base, but found it difficult to do so because of a lack of resources available to manage new volunteers (Handy & Srinivasan, 2004). We asked the CEOs of these hospitals what constraints they faced in expanding their volunteer base; a large majority (72%) identified a lack of resources to recruit and supervise larger number of volunteers, and to train volunteers and staff. More than one quarter (29.6%) stated that the supply of volunteers was limited and indicated that this was one of the major reasons for their inability to expand. Another 30% reported that there were certain positions that they were unable to fill from their pool of volunteers and that, therefore, they could not expand. Other constraints identified were issues relating to existing union contracts, and the need to retain a specific staff-to-volunteer balance. Only one CEO said that the hospital did not expand its volunteer base because of a lack of demand for volunteers within the hospital.

## Volunteer trends

### Fundamental changes

Just over 85% (85.2%) of the CEOs we interviewed recognized that there have been significant changes in the supply of volunteers over the years. The demographics of volunteers are changing (e.g., more students, more males, greater cultural diversity). Volunteers are placing more constraints on when they are available. Volunteer turnover has generally increased.

We asked CEOs to identify three challenges that their hospitals face in relation to their volunteer programs. Almost three quarters (74.1%) said that their hospitals lack the resources to support their volunteer programs adequately; 70% said that recruitment of volunteers to fill certain types of positions was getting difficult because volunteers are unable or unwilling to take on specific tasks. This is exacerbated by competition from other institutions for volunteers. Nearly all of the CEOs who were interviewed following the SARS outbreak suggested that it was going to be difficult to recruit and retain volunteers in the future.[9]

### How CEOs are dealing with change

Only a few CEOs identified ways in which they were responding to the new challenges in their volunteer programs. Measures included: creating more interesting opportunities for volunteers, allowing volunteers to do assignments from home where possible, and creating flexible volunteer hours, especially for student volunteers. Short-term volunteers were, however, seen as a drain on resources because of the effort needed to recruit and train them; one hospital CEO suggested that the involvement of these volunteers should be reconsidered.

Overall, we did not get a clear picture of how these CEOs would meet the challenges arising from fundamental changes in the availability and nature of volunteers. It may be that they felt removed from these issues and thought that such decisions were better left to middle management.

## Quality of care

### Overall value of volunteer services

The mission and vision statements of all 27 hospitals in our study refer to the delivery of excellent holistic healthcare that goes beyond technical medical care. Many refer to quality of life that encompasses compassion and the holistic well-being of patients, their families, and the community. Just under half mentioned volunteers explicitly, often as part of a team of professionals who were committed to service delivery of the highest quality. It is, therefore, not surprising that CEOs did not hesitate to stress how

[9] Healthcare workers in the Toronto area were particularly impacted by SARS and all Toronto area hospitals were closed to the public, with the exception of emergency cases. Volunteer programs were suspended and volunteers were asked to stay away until the outbreak was over and hospital protocols were established.

valuable volunteers are in the delivery of healthcare in their facilities. One CEO remarked that the SARS outbreak, which restricted volunteers' access to hospitals, "makes you realize the value of volunteer services." This sentiment was echoed by all of the CEOs who were interviewed after the SARS outbreak had abated.

When asked specifically how they would rate the contribution of volunteers to 'quality of care' on a scale of 1 to 10, where 1 means not at all and 10 meaning indispensable, CEOs rated the volunteer contribution at an average of 8.3. They were asked if they had a formal way to measure the contribution of volunteers to quality of care, such as exit surveys completed by patients, staff surveys, or any other type of feedback mechanism. All but one said that they did. Thirty seven percent of hospitals conducted formal surveys, such as exit surveys done by patients; 22% conducted staff surveys. Other formal measures used were feedback forms and the Ontario Hospital Association survey.[10] Forty percent reported that they relied on informal feedback, such as comments from staff, patients, and families; unsolicited letters; and their own observations. Only one CEO reported using both formal and informal measures.

### Components of "quality of care"

We asked CEOs to rate the importance of two components of 'quality of care' on a scale of 1 to 5, where 1 is low and 5 is indispensable. The two components were:

1. Factors contributing to patient satisfaction (i.e., that improve the capacity of the patient to interact or, as one CEO put it, "maintain a continuum of care by simply being there"); and,
2. Anxiety reduction for families (i.e., by providing timely information).

They rated volunteers' contribution to patient satisfaction at 4.3 and their contribution to anxiety reduction at 4.0.

As we discuss later in this report, these views are very similar to those of managers of volunteer resources, hospital staff, and volunteers themselves (Handy & Srinivasan, 2003).

## Policy questions

### Donations of time versus donations of money

There has been little attention given to whether donations of time should receive the same attention from government as do donations of money. Donors who contribute financially to registered charitable organizations receive tax credits for their donations that, in effect, reduce the cost of the donation to the donor. For example, with a 30% tax credit, the actual cost to the donor of a one-dollar donation is 70 cents. However, individuals who contribute time receive no such credit. Some have argued that tax credits for volunteering would remove the altruistic and voluntary nature of the exchange, while others have maintained that tax credits would encourage more volunteering by decreasing the cost to volunteers.[11] There have been several studies that measure the impact of tax rates on financial donations, which have shown that such a relationship exists, but not by the amounts predicted (Steinberg, 1990).

We asked CEOs two questions about government policy relating to volunteers. First, we asked if government should base at least some of its funding to hospitals on the number of volunteer hours a

[10] The OHA survey had only one question regarding volunteers. This question asked whether the patient found the volunteers to be polite.

[11] Assume that the costs to the volunteer, who currently pays all out of pocket expenses, such as transportation, babysitting, etc. is $10 per week. If a tax credit gives the volunteer $3 per week, then the costs of volunteering per week decrease from $10 to $7.

hospital uses. Second, we asked CEOs if they supported the idea of giving volunteers a tax credit for the time they contribute.

More than half of the CEOs (56%) responded negatively to the first question. In general, they did not like the idea of funding being tied to the number of volunteer hours and believed that such an incentive might unfavourably bias hospitals' behaviour with regard to recruiting and using volunteers. Most indicated that they did not want any government interference in their volunteer programs. However, others suggested that the government could pay the salaries of the manager of volunteer resources.

Nearly two thirds (63%) of the CEOs responded positively to the second question. They recognized that "time is important," that it has the "same value as a charitable (i.e., financial) donation," and that because volunteering "takes time away from work and family, people should be compensated for it." Those who favoured a tax credit said it would provide an incentive to volunteer. Those who were opposed said that the incentive to volunteer would be suspect, that people would volunteer for the wrong reasons, and that this would "affect the spirit of volunteering." Some were opposed to tax credits for practical reasons, such as the increased record-keeping that would be required, suggesting that the administrative costs would outweigh the benefits, and that such a system would be "open to abuse."

### The monetary value of donations of time

CEOs are often highly involved in raising funds for their hospitals. We wanted to ascertain the relative importance of donations of money and donations of time, and to find out how CEOs allocate resources to fundraising and volunteer recruitment. This would allow us to understand the extent to which CEOs see donations of money and time as interchangeable (i.e., whether a donation of money is viewed as a substitute for a donation of time, or whether these donations are considered complements) and to assign an implicit monetary value to donations of time.

We posed the following question to CEOs: "Which would you prefer—a donation of five dollars or a contribution of one hour of time? " We raised the dollar amount in increments of five dollars until the CEO chose a financial donation over a contribution of one hour of volunteer time. Some CEOs found this question difficult, and either declined to answer or gave very high values that we omitted in our calculations as 'protest' answers (e.g., "$500" and "$1000"). Most of the values ranged from $15 to $50, with an average of $25.90. The median value was $20.[12] This is somewhat higher than the replacement value of $17.57 for an hour of volunteer time that we arrived at in an earlier study (Handy & Srinivasan, 2004).

It is worth noting that several CEOs indicated that if they had to pay for the services provided by volunteers, they might not be able to offer all of these services. In other words, these CEOs do not see contributions of time as substitutes for financial donations. Whether there is a complementary relationship between donations of time and money would require further data on the 'giving behaviour' of volunteers. From the CEOs' perspectives, if fundraising is augmented by the role of volunteers, then there may be a complementary relationship.

## Labour unions and auxiliaries

Finally, we raise two areas of concern that had been flagged in our previous work with hospital volunteers: the relationship between professionally managed volunteer programs on the one hand, and labour unions and volunteer auxiliaries on the other.

All but one of the hospitals in our sample had unionized employees, but only one was experiencing major problems arising from its volunteer program. More than half (60%) reported no problems with their unions and said that this was because management

[12] That is, half the CEOs said less than $20 and half said more than $20.

was careful "not to cross the line" when posting volunteer positions and assigning volunteer tasks. The rest reported that they did not experience problems because their unions were either very supportive or too small.

Six hospital CEOs (22%) said that they had experienced problems from time to time. One CEO said that all clerical and service work done by volunteers was closely monitored by the unions. Also, because volunteer service assignments were not to exceed four hours per day (five days a week), assignments were often divided into smaller tasks to avoid problems with the union. Many CEOs stated that volunteers did not 'reduce' the staff workload, which would contravene union agreements, but that volunteers supported staff by playing complementary roles.

Previous research noted tensions between professionally managed volunteer programs and hospital auxiliaries, the historical antecedents of many volunteer initiatives in hospitals. Each hospital has a unique history of volunteer activity that started and evolved in different ways. Auxiliaries were initially composed of well-to-do women in the community who helped with fundraising or other activities over which they had complete control (e.g., running a gift shop). They often reported directly to the hospital's governing board. The role of auxiliaries changed over years and, with a greater number of volunteers providing a greater variety of hospital services, a need arose for professional management of volunteers.

Sixty percent of the hospitals we surveyed had volunteer auxiliary departments, 24% reported that the auxiliary had recently disbanded, and 16% reported that they had never had auxiliaries (these were relatively new hospitals). Of the 18 hospitals that still had auxiliaries, only five reported a good relationship between the auxiliary and the volunteer program.

Because interpretations of quality of care may be highly subjective, we asked CEOs, managers, staff, and volunteers to identify the components that they thought were essential to enhancing the quality of patient care. We posed this as an open-ended question to avoid influencing respondents. Their responses are presented in Table 1 (in a descending order of importance). The results show that all four groups viewed time spent with patients and human contact provided by volunteers as important contributions to enhancing the quality of care. The general agreement on the components of quality of care suggests that volunteers, CEOs, staff, and managers share the same expectations. The one difference we noted is that CEOs did not mention reduction of anxiety in patients and/or their families. This may be because CEOs do not often witness volunteers' interaction with patients.

Six hospital CEOs (22%) said that they had experienced problems from time to time. One CEO said that all clerical and service work done by volunteers was closely monitored by the unions. Also, because volunteer service assignments were not to exceed four hours per day (five days a week), assignments were often divided into smaller tasks to avoid problems with the union. Many CEOs stated that volunteers did not 'reduce' the staff workload, which would contravene union agreements, but that volunteers supported staff by playing complementary roles.

Our findings show that, in some cases, auxiliaries and volunteer resource departments can coexist and cooperate. In other cases, they can coexist independently with well defined roles. In the extreme, the auxiliary may have to be disbanded. In these cases, a professionally run volunteer program assumes responsibility for managing all volunteers and the hospital foundation becomes responsible for all fundraising. Generally, hospital foundations are formally responsible for fundraising; volunteer resource departments are responsible for the management of volunteers; and auxiliaries are involved in one or both of the roles designated to foundations and volunteer resource departments.

## The view from the top versus the view from the ground

Many of the questions we raised with the CEOs had been posed earlier to professional managers of volunteer resources, staff who work closely with volunteers, and to volunteers themselves. In the following tables we compare our findings from the current study with those from our earlier study. Overall, we found that the view from the top is similar to the view from the ground.

We asked staff, CEOs, and volunteers to rate their satisfaction with the volunteer program/experience on a scale of 1 to 10, with 1 being extremely dissatisfied and 10 being extremely satisfied. We did not ask this question to managers of volunteer resources because they might have a bias in evaluating the contribution of volunteers whom they manage and because their own evaluations depend on the volunteers' contributions to the hospital. The results, presented in Table 2, indicate that staff who work closely with volunteers were somewhat less satisfied than were volunteers and CEOs.

We asked professional managers of volunteer resources, staff who worked closely with volunteers, volunteers themselves, and CEOs to rate volunteers' contribution to patient care. Although we recognized

Table 1. Components of Quality of Care Provided by Volunteers*

| Managers (n=31) | Staff (n=49) | Volunteers (n=804) | CEOs (n=27) |
|---|---|---|---|
| Spending time with patients and establishing patient trust | Spending time with patients and families | Providing Human Contact | Spending time with patients and providing human contact |
| Reducing anxiety through care, compassion and emotional support | Volunteers' attitudes, abilities and skills | Promoting patient satisfaction. | Interacting with families |
| Providing information and reduction of staff workload. | Supporting staff workload by being available for patients and running errands | Reducing anxiety for patents and families | Providing care and compassion |
| Supporting the families of patients | Reducing anxiety and acting as safe, non-medical professionals with whom the patients can interact | Providing prompt service | Providing services such as greeting people and taking patients around |

* In order of importance

that many volunteers were not involved directly in patient care, we nevertheless assumed that all activities performed by volunteers have at least an indirect effect on this care. Our findings, reported in Table 3, show that all four groups rated this contribution highly.

Table 2. Rating of Satisfaction with the Volunteer Program/Experience

| Respondent Group | Average Satisfaction |
|---|---|
| Staff (n=49): Satisfaction with the contributions of volunteers | 7.9 |
| CEOs (n=27): Satisfaction with the contributions of volunteers | 8.7 |
| Volunteers (n=804): Satisfaction with their volunteer experience | 8.7 |

Note: On a scale of 1 to 10, where 1= not at all and 10 = indispensable

Table 3. Rating of the Contribution of Volunteers to Patient Quality of Care

| Respondent Group | Contribution of Volunteers to Patient Quality of Care |
|---|---|
| Managers (n=31) | 9.0 |
| Volunteers (n=804) | 8.7 |
| Staff (n=49) | 8.4 |
| CEOs (n=27) | 8.3 |

Note: on a scale of 1 to 10, where 1= not at all and 10 =indispensable

## Discussion

### Quality of care

Quality of care is not limited to medical and technological care. Tasks such as providing information and anxiety reduction are not medical services, but affect how patients and their families feel. In some cases, there may be some overlap between the duties assumed by volunteers and those of paid staff, but staff appear to understand that if volunteers were let go, they would not be replaced by paid staff.

The SARS crisis in the spring of 2003 provided an opportunity for hospital personnel to reflect on the role of volunteers. Only essential medical personnel were permitted into hospitals; volunteers were told to stay away. CEOs were quite explicit in their appreciation of the critical role that volunteers played, which was made clear to them when volunteer services were not available for some time. CEOs also felt that their volunteer programs were cost effective, even though we found no systematic quantitative reporting on the returns on investment in volunteer programs.

### Policy-related issues

The policy questions yielded mixed results. While allocating government funding based on the number of volunteer hours seems to be one way of strengthening the use of volunteers, many CEOs were not in favour of such a policy. Perhaps this is because it might lead to an increased burden of accountability or to pressure to maintain or increase the quantity and quality of volunteers and to possible negative consequences if goals were not met. One suggestion was for volunteer programs to be directly funded by the provincial government. This might be feasible, as an incremental approach (Handy and Srinivasan, 2000a).

There was more support among the CEOs for the idea that volunteers be given a tax benefit. Is it still volunteering if a volunteer receives a tax credit in return? Since volunteers typically assume some costs (e.g., out-of-pocket expenses, foregone wages, etc.), it could be argued that a tax benefit simply reduces these costs and therefore does not violate the altruistic nature of volunteering (Handy, et al., 2000). Tax credits in return for volunteering may have a potential benefit: managers of volunteers may reasonably have higher expectations and demand greater commitment from volunteers who may be receiving such a benefit. On the other hand, they may also create a greater administrative burden. And, one cannot dismiss the concern, frequently mentioned by some managers and staff, that such a policy may change the character of volunteering.

## The view from the top

In several key areas we found a convergence of views among CEOs, who are generally removed from day-to-day interactions between volunteers, managers of volunteer resources, and staff who work closely with CEOs. This suggests that senior management considers volunteers to be valued resources.

Although CEOs were familiar with changing trends in the volunteer pool and how these might affect the future of hospitals, they were generally only able to identify challenges, not solutions. We suggest that policy implications for hospitals are important and need further discussion, as the trends in volunteer supply and changes in volunteers' expectations will make it difficult to maintain the status quo.

## Hospital auxiliaries

Our research suggests that, where hospital auxiliaries exist, it is important to clearly define the roles and responsibilities of the auxiliary in relation to the volunteer program. The auxiliary could, for example, be responsible for fundraising efforts such as gift shops or coffee kiosks,[13] or for rewards and scholarships, while the volunteer resource department could responsible for the management of volunteers and other volunteer programs and services. The volunteer department can support the auxiliary, where one exists, by including auxiliaries in recruiting opportunities, and in screening and orientation programs. In addition, there is less room for conflict, and relationships are more positive, when there are separate governance and reporting structures.

[13] This may, however, increase conflict between the auxiliary and the hospital foundation.

## Conclusion

This study was designed to understand how hospital CEOs perceive the role and contributions of volunteers. Our findings suggest that CEOs have high regard for their professionally managed volunteer programs, that they are satisfied with the performance of these programs, and that they see these programs as integral to their services. How many resources CEOs allocate to their volunteer department depends on their view of volunteers' impact on healthcare. The more positive their views, the greater the likelihood that volunteer programs will receive adequate resources. CEOs' responses to our questions and the general convergence of views from the top and from the ground suggest that CEOs have positive and realistic knowledge of their volunteer programs. As such, the overall picture for volunteers in hospitals looks good.

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