

Caring Like a Family
Value, Spirituality, and the Professionalisation of Palliative
Care Volunteering in Austria and Croatia

By
Anita Prša

Submitted to
Central European University
Department of Gender Studies

In partial fulfilment of the requirements for the degree of Doctor of Philosophy in
Comparative Gender Studies

Supervisors:
Professor Susan Carin Zimmermann
Dr. Monika Palmberger

Vienna, Austria
2025

Author's Declaration

I, the undersigned, Anita Prša, candidate for the PhD degree in Comparative Gender Studies declare herewith that the present thesis titled 'Caring Like a Family: Value, Spirituality, and the Professionalisation of Palliative Care Volunteering in Austria and Croatia' is exclusively my own work, based on my research and only such external information as properly credited in notes and bibliography. I declare that no unidentified and illegitimate use was made of the work of others, and no part of the thesis infringes on any person's or institution's copyright. I also declare that no part of the thesis has been submitted in this form to any other institution of higher education for an academic degree.

Vienna, August 07, 2025

A handwritten signature in black ink, reading 'Anita Prša' in a cursive script.

Signature

Copyright Notice

Caring Like a Family: Value, Spirituality, and the Professionalisation of Palliative Care Volunteering in Austria and Croatia © 2025 by Anita Prša is licensed under Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International. To view a copy of this license, visit <https://creativecommons.org/licenses/by-nc-nd/4.0/>

For bibliographic and reference purposes this dissertation should be referred to as: Prsa, Anita. 2025. Caring Like a Family: Value, Spirituality, and the Professionalisation of Palliative Care Volunteering in Austria and Croatia. Doctoral dissertation, Department of Gender Studies, Central European University, Vienna.

Abstract

Based on ethnographic fieldwork, this dissertation examines how volunteer care work for terminally ill and dying individuals is mobilised, enacted, and conceptualised in Austria and Croatia. It argues that palliative care volunteering plays a crucial role in shaping familial responsibilities in caring for frail family members, thereby influencing the familialistic welfare models characteristic of both countries. In addition to engaging with welfare state literature and its feminist variants, the research draws on and contributes to scholarship on volunteer work, as well as the anthropology and sociology of work and religion.

The comparative study is grounded in interdisciplinary qualitative research conducted with the two largest palliative care organisations in Vienna and Zagreb. Through interviews, participant observation, and discourse analysis, the dissertation explores how volunteer labour practices reflect and reshape broader cultural and welfare trends. Austria and Croatia – the countries with different economic development and third sector capacity, yet shared familialistic norms and Catholic traditions – provide fertile ground for such a comparative inquiry.

While volunteer care work has been previously analysed in the context of welfare state arrangements and its distinctions from other forms of care, palliative care volunteering has not yet been explored as a force actively shaping conceptions of family. Volunteers are often omitted from discussions on familialism and family-oriented care policies, despite being integral to sustaining the idea of the family as the primary care provider in both contexts. This dissertation argues that the meaning and practice of family care both converge and diverge in Austria and Croatia. Each country is characterised by its distinct volunteer arrangements – Austria’s conservative-corporatist model and Croatia’s post-socialist welfare regime – as well as by the differing roles religion plays in these (nominally) Catholic societies.

The analysis reveals two distinct familialistic welfare paths: *orderly corporatist* (Austria) and *custodially disorganised* (Croatia). In the former, institutions quietly embed and operationalise norms of care through their policies; in the latter, they promote these norms more explicitly but fail to provide adequate support. At the heart of this dynamic in both cases lies the notion of volunteer professionalism, which I refer to as *para-professionality* – an ethos shaped by the cultivation of specific emotional dispositions, such as love and empathy, and grounded in a particular vision of humanity. This study analyses these affective investments

within the broader framework of capitalist valorisation of social reproduction and the spiritual currents informed by locally grounded expressions of Catholicism.

In comparing palliative care volunteering in these two socio-economically divergent capitals of two Central European countries, the dissertation makes several scholarly contributions. It develops new typologies of familialistic welfare regimes and offers a more nuanced understanding of how volunteerism intersects with family care within evolving welfare state structures. Moreover, by analysing the practice and conceptualisation of volunteer work in two Catholic contexts, this dissertation brings much-needed nuance to understandings of religion's role in welfare arrangements. It moves beyond reductive modernisation or secularisation narratives to show how religious frameworks shape the meanings and boundaries of labour, value, and social reproduction in contemporary capitalist societies.

Acknowledgments

This dissertation has been shaped and supported by many people throughout the research and writing process. First and foremost, I am deeply grateful to all my research participants in Austria and Croatia, who generously shared their time, energy, and knowledge with me. I can only hope that, in return, I have managed to give something back. Without their stories, this study would not have been possible.

I extend my heartfelt thanks to my main supervisor, Professor Susan Carin Zimmermann, for agreeing to work with me in June 2021 and for expertly guiding me through the entire doctoral journey. Thanks to her pragmatic advice and constant availability, I was able to refine my research focus early on and bring this dissertation to the scholarly standard it required. One of her invaluable suggestions was to include a second supervisor with expertise in anthropology. In the spring of 2023, Dr. Monika Palmberger from the University of Vienna kindly agreed to take on this role. Her insightful guidance and anthropological perspective have greatly enriched this work.

I am very thankful to Dr. Andrea Kirchknopf from Academic Writing, who read each chapter with enthusiasm and provided valuable feedback on both writing and structure. I must also mention Kaja and Gabi, who played a key role in improving my German and made these five years of research much more comfortable – both professionally and personally.

This journey would have been much harder without the presence of two remarkable women – my dear colleagues and friends, Jelena and Jessica. Thank you for the laughter and tears, for reading my drafts, for the singing, dancing, swimming, and deep conversations. Thank you for listening to both my professional concerns and personal struggles. It is rare to meet such kind and generous people in a workplace, who become much more than colleagues. I know that our friendship and love will be long-lasting. God bless your hearts!

Last but not least, I owe my deepest gratitude to my mother and sister, who have stood by me whenever I needed them. Their unwavering love and support are woven into every line of this dissertation. Thank you, Ivana, for believing in me and in my work through all these years. I know it was not always easy.

Table of Contents

Chapter 1

Introduction.....	3
1.1 Scholarly Contributions and Dissertation Overview	7
1.2 An Interdisciplinary Qualitative Comparison in Times of Pandemic: Methodological Reflections.....	12

Chapter 2

The Conceptual and Theoretical Crossroads: Volunteering, Care, and Welfare Logics.....	23
2.1 Volunteering and the Question of Professionalism	24
2.2 Rethinking the Welfare State through Familialism	31
2.3 Value Beyond Wages: Spirituality, Human Capital, and the Ethics of Care	43

Chapter 3

To Care ‘Orderly’ or ‘Custodially’ and always Familialistically: The Arrangement of Palliative Care Volunteering in Austria and Croatia	51
3.1 From Global Trends to Local Realities: The Evolution of the Hospice Movement in Austria and Croatia	53
3.2 Integration of Palliative Care in the Austrian and Croatian Health and Social Care Systems.....	62
3.3 Palliative Care Volunteering as a Lens on Familialism: ‘Orderly Corporatism’ in Austria and ‘Custodial Disorganisation’ in Croatia.....	73

Chapter 4

The Price of the Priceless: The Unpayability of Palliative Care Volunteering	87
4.1 The Value of Time: Detecting the Unpayability of Palliative Care Volunteering.....	89
4.2 ‘I’m coming just as a human:’ The First Justification of Unpayability.....	99
4.3 ‘It is simply too important!’: The Second Justification of Unpayability	109

Chapter 5

A Catholic Inflection in the Spiritual Turn: Secular-Religious Intersections in End-of-Life Care	120
5.1 Palliative Care Volunteering as Personal and Spiritual Growth in Catholic-secular Austria and Croatia	122
5.2 Revisiting Catholicised Neoliberalism: Embracing Suffering and Diversity in Palliative Care Volunteering.....	137

Chapter 6

The Empathetic Loving Professional and the Creation of Caring Family through Palliative Care Volunteering	154
--	------------

6.1 From Experiential Knowledge to the Skill of the Divine: Love as a Signifier of Volunteers' Professionalism in Zagreb	156
6.2 De/essentialising Empathy among Viennese Volunteers	167
6.3 Reconsidering Familialistic Regimes: How Palliative Care Volunteering (In)directly Defines Family Care	178
Conclusion	193
Appendix: List of Interviewees	200
Bibliography	202

Chapter 1

Introduction

Reflecting on how I arrived at writing a dissertation on palliative care, I trace my academic journey back to writing my MA thesis at Utrecht University in 2019. That research focused on Croatian eldercare workers employed in Austrian and German households through 24-hour live-in care arrangements. The thesis aimed to highlight the multifaceted contributions of migrant care workers – not only to their clients but also to their families and the welfare state – through their diverse skills and what I termed the ‘micro-politics of care.’ I was particularly struck by how their care extended beyond physical tasks to encompass complex emotional and spiritual support, often addressing the frail elderly's profound concerns about impending death. At that time, I did not recognise that what they were providing was, in fact, palliative care.

Shortly after completing my MA and following the passing of my grandmother – who had been a significant influence on my scholarly interest in eldercare – I moved to Vienna to pursue a PhD that would initially build upon my previous research. The goal was to compare home care arrangements in Austria and Croatia, representing sending and receiving countries for care workers. I chose to concentrate on the capital cities, Vienna and Zagreb, due to existing contacts, ease of arranging accommodation, and the greater diversity of care services available compared to smaller towns and villages. The numerous differences and similarities in how care is organised in these two cities enabled a meaningful comparison, as discussed in the upcoming sections.

I began my fieldwork in Zagreb in the autumn of 2021, but the onset of the Covid-19 pandemic posed significant challenges. Restrictions, especially within the care sector, prevented me from accompanying care personnel on home visits as initially planned. To adapt, I broadened my focus to map the wider landscape of adult care arrangements and engaged with various initiatives providing care outside medical institutions. These initiatives, previously unknown to me, turned out to play a crucial role in addressing gaps in Croatia's weak and fragmented social and healthcare system, which struggled to meet the needs of an aging population and strong emigration trends.

One of these initiatives was LaVerna, a relatively young organisation dedicated to providing palliative care by recruiting volunteers to accompany the dying at home. It was the largest palliative care provider in Zagreb. Unlike several other associations I contacted,

LaVerna's coordinator welcomed my research enthusiastically and readily agreed to participate.

As I expanded my mapping of care services to the Viennese context, I found that volunteers here also played a crucial role in delivering palliative care despite significant institutional differences. In Austria's corporatist welfare model, NGO involvement in welfare services is well established and widely recognised by both the state and society. Large organisations like Caritas are indispensable to Austrian welfare provision, including palliative care, where Caritas Hospiz has emerged as a leading provider in Vienna. In contrast, Croatia's third sector, especially volunteerism, remains underdeveloped – a legacy of the decentralized, self-managed Yugoslav health and social care system, which resisted non-state providers more than other Central and Eastern European countries.

Despite these contrasts, one notable similarity stood out between the two largest palliative care organisations in Vienna and Zagreb: both are connected to the Catholic Church. LaVerna originated in 2009 as a branch of the Franciscan secular order and became an independent NGO in 2017 for financial reasons. When I began fieldwork, LaVerna had one employee (a volunteer coordinator) and about twenty volunteers; since then, it has grown to three employees and over thirty volunteers. Caritas Hospiz, part of a well-established Catholic organisation, was founded in the early 2000s and now employs more than twenty professionals – including doctors, nurses, therapists, pastors – and four volunteer coordinators, with a volunteer base exceeding sixty.

Both organisations visit palliative patients wherever they are but primarily provide care at home – the preferred place of death – thereby helping create a comfortable, de-medicalised environment. Central to this atmosphere are volunteers, who embody what Cecily Saunders, key initiator of the modern hospice movement, called the 'community spirit' (Saunders 2001). It is no coincidence that both organisations rely heavily on volunteers, as LaVerna and Caritas Hospiz are part of a broader movement known for its holistic approach to death and dying. Alongside physical pain, emotional, social, and spiritual pain are considered equally important to address, ensuring the final days of palliative patients are as meaningful and comfortable as possible (Saunders 2001; Scott 2018).

Palliative care as a concept spread relatively quickly from the UK in the 1960s to the rest of the world, taking its strongest hold in the most developed economies of the Global North. Initially known as 'hospice care,' referring to specialised institutions, the term 'palliative care' gradually became more common, reflecting a broader scope. While some of my research

participants used ‘hospice care,’ most preferred ‘palliative care’ when discussing care for the terminally ill. For consistency, I will also use the term ‘palliative care’ throughout.

In my fieldwork, volunteers brought the aforementioned ‘communal spirit’ to the palliative service by offering warm, empathetic encounters while remaining outside the family circle. This positioned them between patients’ families and paid staff, granting them a de facto professional status. From this intermediary position, volunteers were able to provide a form of care that neither relatives nor professionals could fully deliver. Volunteers typically took on the emotional aspects of care or performed errands such as pharmacy visits or accompanying patients to hospitals. In doing so, they not only relieved paid staff of certain duties they lacked time for, but also significantly supported patients’ families by giving them much-needed respite from caregiving and difficult communications. At the same time, volunteers helped ensure that patients could remain at home, allowing families to continue as the primary caregivers of their frail members.

This role of volunteers is particularly significant given that both Croatia and Austria are typically described as familialistic welfare states, where families – especially female relatives – are expected to bear the main responsibility for caregiving (Blum, Formánková, and Dobrotić 2014; Dobrotić 2018). These familialistic tendencies partly explain why women make up the vast majority (about 85%) of paid and unpaid palliative personnel in both countries. Another contributing factor lies in the long-standing tradition of assigning reproductive labour tasks to women (see Chapter Four).

By comparing the roles of palliative care volunteers in Vienna and Zagreb, this study offers a valuable opportunity through which to examine how a global phenomenon like the hospice movement is locally adapted within the health and social care systems of two European countries. While Vienna and Zagreb may not fully represent Austria and Croatia as a whole, the provision of palliative care in these capitals remains embedded within their respective national welfare frameworks. Examining how palliative care is organized and delivered in these settings can therefore illuminate key features of the Austrian and Croatian familialistic welfare states.

Moreover, I found studying palliative care volunteering particularly compelling as it brings together several topics I had long been interested in, but had struggled to connect. One of these is unpaid labour that is not informally provided by family or friends, but organized through NGOs, which is often excluded from feminist discussions on unpaid reproductive work. This is not to suggest that volunteer work exists in isolation from other paid and unpaid care arrangements or from broader institutional and cultural frameworks, economic

development, historical legacies, and social norms. Studying how volunteer palliative care coexists with these structures provides a nuanced understanding of how labour is valued across different spheres and remuneration spectrums, yielding important insights into how social reproduction is organized under capitalism.

Another distinctive aspect of palliative care is its engagement with existential questions – concerning meaning, purpose, and the possibility of life after death – which brings it into the realm of spirituality. Spirituality typically refers to the immaterial or transcendent aspects of life. The Oxford English Dictionary defines spirituality as ‘the quality of being connected with religion or the human spirit,’ (Oxford Learner’s Dictionaries 2025b) while religion is described as the system ‘of faith based on belief in the existence of a particular god or gods, or in the teachings of a spiritual leader.’ (Oxford Learner’s Dictionaries 2025a) Given the Catholic foundations of both contexts I studied, spirituality in my fieldwork was inseparable from Catholic teachings, whether implicitly or explicitly. As someone raised Catholic, this spiritual dimension caught my attention and motivated me to explore the role of the Catholic Church – and religion more broadly – in the work of palliative care volunteers. Studying palliative care volunteering allowed me to analyse the function and experience of spiritual and religious practices in two nominally Catholic environments with differing levels of secularization. When contextualized within their national socio-economic conditions, examining these practices provides valuable insights into the welfare regimes of Austria and Croatia.

From the above foundations, I developed my main research question(s) by asking: How does palliative care volunteering influence and reflect the development of welfare regimes in Austria and Croatia – typically categorized as corporatist/continental and post-socialist, respectively? Or, put differently: In what ways is palliative care volunteering shaped by, and how does it shape, the familialistic features of these two welfare models?

The main research questions are supported by the following sub-questions: How does palliative care volunteering contribute to defining and supporting the responsibilities of family carers within these welfare regimes? What kinds of skills, emotional stances, and caregiving approaches are cultivated in palliative care volunteering? In what ways is volunteering defined in relation to money, and how does this reflect broader patterns of valuing social reproduction under capitalism? What forms of professionalism emerge through palliative care volunteering, and how are they distinct from or aligned with both formal and informal care givers? How is this professionalism shaped by religious and spiritual dimensions, particularly in relation to Catholicism? How does Catholicism manifest in palliative care volunteering, and what does this reveal about the secular-religious dynamics in Austria and Croatia?

In engaging with these questions, my dissertation primarily contributes to welfare state scholarship by drawing on insights from three intersecting fields: the sociology and anthropology of work, the sociology of religion, and anthropological debates on humanitarianism. The following subchapter explores these scholarly contributions in greater detail, followed by a summary of all the chapters.

1.1 Scholarly Contributions and Dissertation Overview

Although volunteer work was initially overlooked in labour studies and scholarship on professionalism, it has increasingly been examined in terms of how volunteers develop a professional identity – often by distinguishing themselves from paid professionals through what is known as ‘boundary work’ (e.g., McAllum 2018; López-Cabrera et al. 2020; Järvinen & Kessing 2023). These discussions have gained particular traction regarding the healthcare sector, where volunteer professionalism has been studied in the context of recent welfare state restructuring, including processes like retrenchment and responsabilisation. Scholars argue that as citizens are made more responsible for their own well-being, volunteers increasingly fill gaps left by absent paid personnel or family carers, thereby reshaping both formal and informal care arrangements (Cour 2019; Dowling 2024). Some studies adopt a more nuanced approach, highlighting how volunteers develop ‘proto-professional’ identities (see De Swaan 1988; Dent 2006; van Bochove & Oldenhof 2020).

In the field of palliative care studies, sociologist Charlotte Overgaard (2015, 2016) examined volunteers’ boundary work related to women’s access to paid employment within two welfare models typically classified as liberal (Australia) and social-democratic (Denmark) (Overgaard 2015a; 2015b; 2016). Overgaard’s work clearly shows that volunteer professionalism is deeply intertwined with broader welfare infrastructures. However, while her study did not explore volunteers’ professionalism in relation to family care and familialism more broadly, other research on volunteer care work (e.g., Dowling 2024) has discussed volunteers’ roles vis-à-vis informal carers but did not analyse volunteering as a mechanism for defining familial caregiving responsibilities – especially in a comparative welfare state context. My dissertation fills this gap by exploring how palliative care volunteering not only supports family

carers, but also actively contributes to the formation and reproduction of familialistic welfare logics in Austria and Croatia.

I demonstrate that cultivating a specific kind of humanity – characterized by emotional dispositions, such as love, empathy, and sensitivity to suffering – is crucial for volunteers to attain a form of professionalism I term ‘para-professionality’ (see next Chapter). These emotional stances enact spiritual meaning, as the volunteer activities I observed resonate with larger cultural and spiritual trends, including the ‘spiritual turn’ (Houtman and Aupers 2007; Watts 2022) and ‘well-being culture’ (Heelas and Woodhead 2005), as well as ‘Catholicised neoliberalism’ (Muehlebach 2012; 2013). Yet these are always embedded within the secular-religious interplay characteristic of Austria’s and Croatia’s Catholic cultural contexts. By examining volunteer professionalism alongside spirituality, I challenge the standard modernization thesis in sociology of religion, which posits that secularization accompanies economic development. Instead, my work reveals the persistence of religion – particularly Catholicism – even where visible signs seem absent. In doing so, the dissertation makes an important contribution to understanding religion’s role in arranging palliative care volunteering and how secularization is experienced in nominally Catholic environments.

Furthermore, analysing the cultivation of certain type of professionalism among palliative care volunteers reveals the complex, multilayered relationship this form of volunteering has with money and profitability. By demonstrating how the value of volunteer work is simultaneously defined through the lens of monetary worth, its absence, and even as a form of resistance to economic valuation, I argue that economic reasoning plays a central role in shaping how palliative care volunteering is understood and practiced. I primarily draw on Battistoni’s ‘cost-disease’ analysis, which attributes the devaluation of care work not to patriarchal attitudes or worker identities but to the structural logic of capital investment and the inherent unprofitability of reproductive labour (Battistoni 2024). Examining this structural logic within the specific contexts of palliative care volunteering in Austria and Croatia allows this dissertation to offer a more precise analysis of the systemic dynamics involved, particularly the valorisation mechanisms of social reproduction under contemporary capitalism.

I use these aspects of palliative care volunteering – its valorisation, spiritual dimension, and professionalism – to differentiate volunteer roles from those of paid staff and family carers. This approach allows for new interpretations of Austrian and Croatian familialistic welfare regimes, not only by viewing them through the lens of volunteer palliative care, but also by applying conceptual frameworks rarely used in familialistic welfare state analyses, which traditionally focus almost exclusively on policy. By combining insights from anthropology and

sociology of work and religion with policy analysis, I develop new welfare typologies: in Croatia, the family's caregiving role is invoked in a somewhat disorganized and custodial manner, whereas Austria's more corporatist system affirms this role more subtly and with greater attention to social diversity. Consequently, I describe two familialistic models: the 'custodially disorganized' and the 'orderly corporatist.' The chapters that follow explore these arguments in greater depth.

Chapter Two presents the theoretical framework, starting with literature on volunteerism, particularly debates on professionalisation and the boundaries between formal and informal care. Key are studies that situate volunteering within broader welfare arrangements. I then turn to welfare state theory, focusing on regimes in Central and Eastern Europe (CEE) and Continental Europe – contexts central to the Austrian and Croatian case studies. Welfare typologies and clustering (e.g., Esping-Andersen 1990), along with feminist contributions on familism, offer essential tools. Drawing on scholars of family policy (Leitner 2003; 2006; Blum, Formánková, and Dobrotić 2014; Saraceno 2016; Dobrotić 2018), I compare how Austria and Croatia approach familism. The chapter concludes by engaging with anthropological and feminist theories of value, which I employ to analyse how volunteer work is conceptualised in palliative care. These theories are enriched by debates on humanitarianism, affect (especially love and empathy), and insights from the sociology of religion – particularly around secularisation, spiritual self-investment, and the formation of human capital.

Chapter Three provides a comparative analysis of palliative care development and organisation in Austria and Croatia. Both healthcare systems are highly medicalised and fragmented, posing challenges for palliative care. Austria has addressed these more effectively through a robust long-term care system underpinned by stronger economic performance – advantages Croatia lacks. Despite these differences, gendered patterns of care are strikingly similar, reflecting the familialistic orientation of both welfare states, where women remain primary caregivers.

A central difference lies in the role and development of volunteerism in the two countries. Austria's corporatist model, supported by non-profit and religious organisations, readily integrated volunteers. Croatia's underdeveloped non-profit sector and post-socialist legacy, by contrast, have limited volunteer involvement. One participant described Croatia as the 'custodial' state that neglects volunteerism in policy while maintaining control over its development. This reflects the legacy of Yugoslavia's self-managed, decentralised care system, which resisted non-state providers more than other CEE countries. Paradoxically, it also

enabled the creation of a professional, medically driven palliative care model. In Austria, volunteerism spurred early growth in the sector, but its professionalisation did not secure public funding for volunteering, highlighting persistent weaknesses in its fragmented system. Ultimately, palliative care volunteering exposes deeper contrasts between welfare regimes: Austria's 'orderly corporatist' familialism, marked by regulation and a strong female volunteer base, versus Croatia's 'custodial and disorganised' familialism, shaped by socialist legacies and transitional challenges.

Chapter Four shifts focus to the value of volunteer work in palliative care, asking why this labour remains unpaid. I examine the ideological and cultural rationales behind this, arguing that volunteering is seen as 'unpayable' because it is associated with 'humanisation' (Altman 2020) – that is, qualities like empathy and warmth, which are believed to be compromised by professionalisation and monetary exchange. Another common belief is that the work is 'too important to be paid,' echoing David Graeber's claim that the more socially valuable the work, the less it is compensated – especially in the case of reproductive labour, often devalued due to its association with women (Graeber 2018).

While Graeber exposes powerful ideologies about care and compensation, his account risks essentialism and does not fully reflect my participants' perspectives. I therefore draw on Alyssa Battistoni's reading of cost disease, which locates the devaluation of care not just in patriarchal norms but in capitalism's structural disregard for low-profit sectors like social reproduction (Battistoni 2024). This framework helps unpack the complex relationship between money, value, and volunteering in Croatian and Austrian palliative care. Whether seen as an absence, a metric, or a site of resistance, money – and its connection to profitability – shapes the meaning and function of volunteer labour.

Chapter Five examines the emotional and spiritual dimensions of volunteering, showing how volunteers support the dying while also experiencing personal and spiritual growth. The first subchapter situates these experiences within the broader 'spiritual turn' (Houtman and Aupers 2007; Watts 2022) and the rise of a 'subjective wellbeing culture' (Heelas and Woodhead 2005) in liberal democracies. To understand how volunteers articulate spirituality, I analyse their practices within national Catholic contexts. Volunteers in Zagreb, for instance, more often reference religious aspirations than those in Vienna – reflecting differing levels of secularisation and institutionalisation. This aligns with findings that modernisation and economic development often lead to greater secularisation, with religious organisations gaining legitimacy through service quality rather than overt religiosity (Putnam 2000).

The second subchapter explores how volunteers in both contexts express shared values of sensitivity to suffering and unconditional acceptance – traits that echo what Muehlebach calls ‘Catholicised neoliberalism’: a fusion of Christian compassion and neoliberal ideals of civic responsibility (Muehlebach 2012; 2013). Volunteers often described accompanying the dying as seeing people ‘as they are’ (my expression) guided by what many called a ‘love for people’ (Interview, Ingrid, 19/07/22). While rooted in hospice tradition, this ethos also draws on Catholic teachings about divine presence in the vulnerable. Notably, within this moral and emotional economy, volunteers often take on tasks that families cannot or will not perform, thus reinforcing familial care structures.

Chapter Six, the final analytical chapter, revisits the role of volunteers in supporting family carers, focusing on how they construct professional identities within two familialistic regimes. It highlights how volunteers help sustain specific ideals of family life through two emotional frameworks: love in Zagreb and empathy in Vienna. While both reflect attentiveness to patients, their meanings and uses differ. In Zagreb, the absence of formal training allows volunteers to define love as a marker of professionalism, distinguishing it from personal relationships to legitimise their role. Yet this framing can reinforce essentialist views of unpaid care it aims to challenge. In contrast, Vienna’s volunteer roles are formally regulated and used as a model across Europe. Empathy, while central, is not formally defined; instead, it is shaped – and arguably constrained – by professional norms.

Despite these different paths to professionalisation, both contexts reflect a shared assumption of the family as the primary caregiver. In Vienna, volunteers are trained to support and affirm families, with an emphasis on flexibility and recognition of diverse caregiving arrangements. In Zagreb, the approach is more interventionist, shaped by a weaker care infrastructure. Families are also often seen as needing education, particularly regarding their caregiving roles. Paradoxically, this educational role can de-essentialise traditional family duties, while in Vienna, the lack of explicit discourse on the responsibilities of family caregivers reinforces them as unspoken norms. By tracing these contradictory processes of de/essentialisation, the chapter highlights key differences between two familialistic welfare regimes and the nuanced roles volunteers play within them.

1.2 An Interdisciplinary Qualitative Comparison in Times of Pandemic: Methodological Reflections

As previously mentioned, before focusing exclusively on the palliative care sector, I spent several months in Zagreb mapping the landscape of existing care services and initiatives. This process involved extensive online research – such as familiarising myself with institutional and legal frameworks – as well as engaging directly with people in the field, primarily through interviews. Concurrently, I explored care arrangements in Vienna and Austria more broadly, though only through discourse analysis, due to physical constraints that prevented on-site research. Although most of the data collected during this preliminary phase is not directly referenced in the dissertation, it proved invaluable. It provided essential contextual knowledge and played a key role in refining my research focus.

While the restrictions brought on by the Covid-19 pandemic inadvertently helped direct my attention to the topic of palliative care, the negative impact of the pandemic became apparent once I began conducting fieldwork in this area. Engaging with one of the most vulnerable populations – the terminally ill – placed considerable limitations on ethnographic research, particularly during the peak of the pandemic. Direct contact with patients was often not feasible, as the risk of virus transmission could have had fatal consequences – something I was not willing to risk.

Moreover, the emotional burden borne by patients' family members during the dying process made it understandably difficult for them to engage with a stranger in such intimate circumstances. As a result, I had to seek alternative methods for data collection. One key method was interviewing. After our initial conversation, Tomislava¹, a volunteer coordinator in Zagreb, introduced me to several volunteers and helped organise my first formal interviews. I also connected with some volunteers through personal networks, which significantly helped in building trust and deepening relationships. One volunteer, Vesna, became particularly close to me. She began hosting interviews at her home and once even invited me to accompany her on a patient visit. With her help, I met family carers of palliative patients she had supported before their passing.

In retrospect, I realise I was unprepared to encounter the depth of grief these individuals continued to experience. Even years after the loss, some relatives would cry throughout our conversations. I often found myself at a loss for words, simply sharing those moments in

¹ To protect their anonymity, all research participants were assigned pseudonyms.

silence. Looking back, I wish I had been better prepared and had followed the recommendations of scholars who emphasize the importance of self-care in emotionally challenging qualitative research (e.g., Rager 2005). This could have involved seeking emotional or therapeutic support, or developing a deeper understanding of death and grief prior to fieldwork.

The interviews lasted between one and three hours. I typically began with a few introductory questions – such as what motivated them to engage in palliative care volunteering (in the case of volunteers) – before shifting the conversation toward the specificities of their tasks, the skills required, and the boundaries they navigated in their roles. Given the intention to follow respondents’ narratives while still using guiding questions, the interviews are best classified as semi-structured (R. S. Weiss 1995). Before each interview, I briefly introduced myself and the project, followed by obtaining informed consent, either orally or through a signed consent form. All consent records were securely stored and protected with a password known only to me.

Since I was particularly interested in how volunteers’ personal and professional lives shaped their involvement in palliative care, I made a point of asking about their occupations and family backgrounds. Situating volunteer work within the broader context of care and employment relationships was, in my view, essential for understanding how notions of volunteer professionalism and attitudes toward familial care were constructed (see Taylor 2005). For this reason, I sought to incorporate participants’ life trajectories into the overall analysis wherever possible.

Given the spiritual dimension of palliative care previously discussed, volunteers and other research participants were also asked about their spirituality and the spiritual aspects of their work. Asking such personal questions often required a degree of vulnerability on my part as well – I sometimes had to share elements of my own life, which was not always easy, particularly when I sensed significant differences in belief or worldview. To ease potential tensions and foster rapport, I often tried to highlight shared experiences or values. At times, however, I adopted a more formal ‘researcher’ stance to maintain professional distance. This shift was sometimes necessary not only for my own safety but also to uphold a sense of legitimacy and seriousness – particularly when interacting with individuals in positions of authority within ministries or healthcare institutions, as thoughtfully discussed and advised by ethnographers such as Farhana Sultana (2007).

Despite the uniqueness of each encounter, I consistently sought to ensure a degree of reciprocity in my relationships with research participants. Sometimes this took the form of

small tokens of appreciation; in other cases, I contributed more concretely, for example by assisting with promotional activities or translating materials for the organisation. Eventually, I formally joined the organisations as a volunteer in both research contexts. At the end of the day, all participants had generously invested their time and energy into my project, and offering something in return was a modest but meaningful way to express my gratitude. It was also a crucial step in building trust – something that, understandably, was not always easily granted.

Notwithstanding her initial enthusiasm, the volunteer coordinator, Tomislava, remained hesitant to grant me full access to the organisation's activities – especially those involving confidential information about patients, like supervision meetings. Every other week, the volunteers gathered for supervision meetings led by Tomislava, during which they discussed their recent visits. For many, these sessions were a crucial space for learning – offering guidance on how to navigate challenging situations they might encounter in the field. In addition to these meetings, LaVerna held an annual training course for volunteers each autumn. This course combined both theoretical and practical aspects of palliative care, typically spanning 20 hours across five to six block sessions. However, due to the Covid-19 pandemic, the training had to be moved online, eliminating its practical component. Many volunteers expressed dissatisfaction with the online format, citing their limited technological skills – a challenge many attributed to their age. As in the Viennese context, the majority of volunteers were women aged between sixty and eighty, with only a few in their fifties or thirties. Several people I spoke with remarked that dealing with death and dying required a certain maturity, while retirement afforded the time necessary for volunteering. Interestingly, while the age factor was often explained, the stark gender imbalance among volunteers usually went unquestioned. Many simply stated that there was no 'practical' reason for such a disparity.

Despite the drawbacks of online education, Tomislava recognised some unexpected benefits. One was the ability to invite guest lecturers from across the country – something that would have been difficult to coordinate in person. Another was the increased accessibility of the program. The training was open to anyone interested in palliative care, and Tomislava saw this as an opportunity to raise awareness about both the field and the organisation's work. She hoped this broader reach would attract new volunteers or help inform those in need of palliative services.

Beyond training and formal education, LaVerna also engaged in ongoing promotional activities, including regular events supported by the city and national government. One of the most visible initiatives was a campaign called 'The Spice of Love' (*Začin ljubavi*). The meaning behind this campaign is that just as spices enhance a meal, volunteers enrich palliative

care by bringing love to the service (see Chapter Six for more on this initiative). ‘The Spice of Love’ campaign began during the height of the Covid-19 pandemic, when in-person visits were severely restricted. The campaign allowed individuals or companies to purchase a spice and send it to loved ones, offering a symbolic gesture of care and connection. Following the easing of restrictions in early spring 2022, LaVerna resumed selling spices at street markets and churches as a form of both self-promotion and fundraising. Whenever I was in Zagreb, I helped transport and sell the spices, set up stands, and assist with logistics. These events offered a valuable opportunity to spend more time with volunteers in a relaxed setting. I observed how they spoke about their work – to each other and to the public – which gave me insight into how the value of volunteering was communicated and perceived, both within the group and by the broader community. To deepen my understanding of how palliative care volunteering is recognised and valued, it was also essential to connect with other institutions and people responsible for organising palliative care and managing volunteer work.

This was particularly important in light of the changes introduced in 2014, following the implementation of the ‘National Strategic Plan for Palliative Care’ (*Nacionalni strateški plan za razvoj palijativne skrbi*) – a milestone in the development of Croatian palliative care (see Chapter Three) – through which primary-level palliative care began to be organised via mobile palliative teams based at public healthcare centres (*Domovi zdravlja*). These teams are led by a coordinator and typically consist of a nurse and a medical doctor. In the city of Zagreb, there were a total of five such teams: one operating within the Public Healthcare Centre East, and two each within the Public Healthcare Centres West and Centre. The coordinators were responsible not only for organising patient care but also for informing patients about available services, including volunteer organisations, support groups, and the possibility of borrowing medical equipment. I conducted expert interviews with the coordinators from the Eastern and Western centres. Unfortunately, the coordinators from the Central centre were not permitted to speak with me, as their superior – the head of the healthcare centre – did not grant approval. However, one doctor from that team chose to speak with me independently, assuming personal responsibility for the conversation.

Given the pivotal role of the National Strategic Plan for Palliative Care in shaping the structure of Croatian palliative care, I also sought interviews with its creators. These discussions provided valuable insights into the rationale behind the plan and offered a historical overview of palliative care’s development in the country. To gain a broader perspective, I also spoke with individuals who were active during the earliest stages of the hospice movement in Croatia. These included members of the Croatian Association of Hospice Friends (*Hrvatska*

udruga prijatelja hospicija), as well as nurse Mila who joined Anica Jušić – the initiator of the Croatian hospice movement – on some of the first voluntary palliative care visits. Mila also taught at the first volunteer palliative care courses in the late 1990s.

Recognising that the organisation of palliative care volunteering is closely tied to the broader infrastructure of volunteerism in Croatia, I also conducted interviews with the president of the Croatian Volunteer Centre – the national umbrella organisation for volunteer initiatives – as well as the president of its Zagreb branch.

As my fieldwork in Zagreb progressed, I was able to better prepare for the upcoming phase in Vienna. The research focus and design became clearer, and I refined my interview questions to suit different categories of interlocutors – volunteers, coordinators, family carers, medical personnel, and key experts in the field. As in Zagreb, I chose to work with the largest NGO providing palliative care in the city: Caritas Hospiz. With a more defined research focus and greater familiarity with the contextual framework of palliative care and volunteering, I felt better equipped for this next stage. My experience in Zagreb had taught me how to approach the field, what to expect, and how to conduct myself in various research situations. An additional advantage was the greater accessibility of online materials related to palliative care in Vienna. Compared to Zagreb, it was relatively easy to identify existing services and initiatives, reflecting a more developed care infrastructure and third sector.

However, while online data was more accessible and informative than in Zagreb, accessing research participants in Vienna proved more challenging. Despite having a few acquaintances at Caritas who shared useful contacts and background information, Caritas Hospiz initially seemed reluctant to engage with my research. I had to contact the volunteer coordinator, Tara, several times before receiving a response. At the time, my German was still limited, and when Tara received my research invitation in English, she ignored it, as she did not speak the language. We eventually met in July 2022. During our first meeting, Tara introduced me to the organisation's work and explained the recruitment and training procedures for volunteers. This meeting proved crucial: Tara not only shared my research invitation with the volunteers but also provided internal documents outlining the skills and training required for palliative care volunteers.

Tara, originally from Hungary, had moved to Austria to study theology. By the time of our meeting, she had been working at Caritas Hospiz for over five years, serving as both a volunteer coordinator – together with her colleague Michaela – and as a pastor. Toward the end of my fieldwork, two additional coordinators joined the interdisciplinary palliative care team, each responsible for a different part of the city. Tara herself led the 'multicultural' team, whose

volunteers supported patients with migrant backgrounds. Later, I also became a member of this team.

Soon after our meeting, I conducted my first interviews in Vienna. With a few exceptions, all interviews were conducted in German. Although I initially felt uneasy, conducting interviews in German ultimately motivated me to improve my language skills – an essential step for all aspects of my fieldwork, from spending time with volunteers and attending training sessions, to carrying out discourse analysis.

To become a palliative care volunteer in Austria, one must complete a certified training course issued by the national hospice umbrella organization, Hospice Austria (*Hospiz Österreich*). The certification requires 80 hours of theoretical instruction, along with an additional 40 hours of practical training at a palliative care organisation of the volunteer's choosing. In Vienna, this training is offered by two institutions: Kardinal König Haus (KKH), a Catholic educational centre, and the Austrian Buddhist Religious Society (*Österreichische Buddhistische Religionsgesellschaft*, ÖBR). Due to its more extensive financial and infrastructural resources, KKH provides approximately 80 training spots twice a year. In contrast, the waiting list at ÖBR can extend for several years. As a result, many volunteers – including myself – opt for the KKH course. I completed the training between autumn 2022 and winter 2023. The course was held every Wednesday evening, with three intensive weekend blocks. It combined lectures with practical exercises that simulated real-life scenarios relevant to palliative care (see Chapter Six for more details on the training). This experience was invaluable – not only for observing how volunteer skills and roles are developed and conceptualised, but also for gaining foundational knowledge about how palliative care is organised in Austria.

To deepen my understanding of this organisational background and how volunteering is perceived at institutional levels, I conducted expert interviews with representatives from Hospice Austria, which is responsible for developing the national curriculum and standards for palliative care. I spoke with its managing director, Sandra, who, together with Hildegard Teuschl – the founder of the Austrian hospice movement – authored the first national standards for palliative care services, professional roles, and volunteer training in 2002, with subsequent updates in 2008, 2011, and 2013. Sandra also played a key role in the development of the now widely referenced 'Graded Hospice and Palliative Care System' (*Abgestufte Hospiz- und Palliativversorgung*) in 2004. This model became the cornerstone of Austria's palliative care system and has since served as a reference point for several other European countries. Sandra was an invaluable source of information, offering insights into both historical and current

developments in Austrian palliative care, as well as international perspectives through her role on the steering committee of the European Association for Palliative Care (EAPC). From Hospice Austria, I also spoke with Maria, head of the organisation's branch for children and young adults. Each federal state in Austria has a representative within Hospice Austria; in Vienna, this role is held by Patrik, who also serves as the president of Caritas Hospiz. Fortunately, Patrik was willing to share his expertise on the organisation and delivery of palliative care in Vienna specifically.

Another important organisation I contacted was the Austrian Association for Palliative Care (*Österreichische Palliativgesellschaft*, OPG). Although not as central as Hospice Austria in shaping national standards across the entire palliative care sector, OPG plays a significant role in promoting medical and hospital-based palliative care. Speaking with its president provided useful insights into this more clinical aspect of the field.

It is necessary to note that, although I used pseudonyms to protect the anonymity of my research participants, some individuals may still be identifiable due to their roles – such as coordinators within the studied organisations or initiators of the models and initiatives examined. The names of all organisations, legal frameworks (e.g., strategies, models, curricula), and positions have not been concealed. I believe this decision enhances the credibility of the doctoral research. Moreover, given the relevance and recognisability of these entities in the studied context, using alternative names would have diminished clarity and interpretive value. In particular, the names of the two key palliative care organisations – LaVerna and Caritas – carry specific meanings that are central to my arguments. For this reason, I approached all potentially identifiable participants, shared with them the relevant sections of the dissertation where their 'personas' appear, and sought their consent. Following oral discussions, each participant provided written consent acknowledging the possibility of being identified.

I tried to keep all the insights from my interviews in mind while observing and studying volunteer work during my training, as well as through interactions with volunteers and other members of the palliative care team. After completing the theoretical part of the training, I undertook my practicum at Caritas Hospiz in spring 2023. This practicum included an introductory and concluding conversation with the volunteer coordinator, a meeting with the entire interdisciplinary palliative team, a day spent at the day hospice, and opportunities to accompany a medical doctor, nurse, and social worker on patient visits. These experiences allowed me to gain first-hand insight into the work of different professionals and to observe how volunteers' roles are structured in relation to the broader organisation. Upon completing

the training, I officially became a palliative care volunteer. This status allowed me to participate in regular volunteer meetings and attend additional training sessions, as well as occasional events organised by Caritas Hospiz. These gatherings also served as valuable opportunities to connect with other volunteers – some of whom were later willing to participate in more formal interviews.

In total, I conducted 17 interviews in Vienna, including volunteers (10), organisational staff (3), family members/clients (1), and experts (3). In Zagreb, I conducted 29 interviews: volunteers (12), organisational staff (2), family members/clients (4), and experts (11) (see Appendix). As in Croatia, the interviews and field interactions in Vienna were supplemented by discourse analysis of official documents related to palliative care and volunteering – such as legislation, reports, and transcripts of thematic sessions – as well as promotional materials produced by relevant organisations (e.g., brochures, websites, and Facebook pages). To support cross-national comparison and provide broader contextualisation, I drew on international sources such as the UN Reports on Volunteering (United Nations Volunteers (UNV) programme 2021), the *CAF World Giving Index* (Charities Aid Foundation 2022), the *Global Atlas of Palliative Care* (Connor 2020), the *EAPC Atlas of Palliative Care in Europe* (Arias-Casais et al. 2019), and EAPC White Papers (Radbruch and Payne 2010; Goossensen et al. 2016), along with statistical data from Eurostat. All interviews were transcribed and, along with other collected data, coded using the qualitative analysis software NVivo. The data were then analysed through thematic analysis.

My methodological approach aligns in many ways with what Samuel and Dekker describe as a ‘multiscalar’ perspective in their study on palliative care across diverse socio-cultural contexts (Samuels and Lemos Dekker 2023). By examining the interplay of practices, policies, and discourses at the levels of international organisations, national institutions, and local care settings, this approach allowed me to link individual volunteer experiences to broader systemic trends and develop arguments concerning the development of the welfare state.

As evident from the abovementioned information, both the development and organisation of palliative care volunteering – as well as my own position within the field – differed significantly across the two research contexts. While my personal background and trajectory shaped how I navigated the field and gathered data, the data collection process also reflected the broader structural characteristics of each country’s palliative care system.

Being more familiar with the Croatian context – where I was born and raised – made it easier to access organisations and navigate the field. This sense of informality was reinforced by the relatively recent emergence and, therefore, lower level of institutional development of

the hospice movement in Croatia compared to Austria. The palliative care sector in Croatia is smaller, which facilitated smoother access to experts and institutions. However, this more intimate and informal research environment also came with certain limitations, such as weaker organisational structures and a lack of accessible or centralised data.

In contrast, Austria – with its longer tradition of hospice work, more developed care infrastructure, and one of the highest palliative care service coverage rates in Europe – offered much easier access to institutional and legal frameworks. Yet, this high level of institutionalisation also led to more formalised interactions, with individuals less inclined to go out of their way to assist. My status as a non-Austrian and a non-native German speaker further complicated my access, limiting opportunities to build rapport and find common ground with research participants in the same way I could in Zagreb.

Given these differences in both my positionality and the broader research contexts, the comparison between the two settings could not be strictly symmetrical. To maintain credibility, I aimed to work with comparable types and volumes of data in each context, ensuring that participants with similar roles were included and that each setting received balanced analytical attention. I also relied on statistical data from the same years and sources wherever possible. Where discrepancies were too large – such as in volunteer training requirements or the number of care services – these became analytical entry points for understanding structural and cultural divergences. The value of comparison lies not in measuring these differences, but in understanding them – precisely, as argued by scholars employing comparative methods (Lewis 2003; Palmberger and Gingrich 2014), where cases are approached as configurations, or combinations of characteristics, to be compared in their complexity.

The modes of comparison, as well as the cases – or units – of analysis, vary depending on the research design, contextual framework, and other factors². In this study, I address a globally relevant topic – palliative care volunteering – by drawing on specific, diverse cases. Through this approach, the comparison contributes to what are often referred to as ‘middle-range’ theories (Holy 1987), where the validity of insights is bounded by topic, region, and time frame. This differs from approaches that aim to generate broader generalisations about

² For instance, while binary comparison contrasts one set of cases with another, regional comparison juxtaposes a group of cases from the same geographical area within a similar time frame. However, both approaches carry potential pitfalls if not applied with care. Binary comparisons risk overemphasising differences and (re)producing stereotypes, whereas regional comparisons may unintentionally create enclosed ‘cultural circles’ if the comparative practice lacks critical reflection (Palmberger and Gingrich 2014, 101). Comparisons can also span greater distances in time and space, where the units of analysis are related to one another in more indirect or abstract ways. These units may include countries, regions, organisations, or social groups identified through various axes of social differentiation – such as gender, age, ethnicity, or urban-rural background (Palmberger and Gingrich 2014, 101).

clearly defined contexts by systematically comparing all available evidence, thereby allowing for more comprehensive conclusions within those specific cases (Palmberger and Gingrich 2014).

Rather than centring one particular context, the focus here is on the phenomenon itself: the use of volunteer labour in the delivery of palliative care – a practice observed in various locations across Europe and beyond. Following a multiscalar approach similar to that of Samuel and Dekker (2023), the aim is to explore how global and national developments in palliative care are locally negotiated, situated, and adapted. More specifically, I examine how different contextual frameworks shape the performance of palliative care volunteers, and what each case reveals about broader themes, including volunteering, moral orientations, and welfare state arrangements.

It is important to note that comparing similarities and differences is not a straightforward task. At times, different conditions produced similar outcomes; in other cases, similar structural elements led to divergent results. Uncovering these multi-directional relationships between difference and similarity is, in fact, one of the strengths of this dissertation. It adds nuance to the study and enhances the credibility of its overall argument by accounting for the complexity of the phenomena under investigation.

Moreover, even if the research contexts and my positionality had been identical, the data could never be entirely comparable, as this is not a quantitative study but a qualitative one – concerned with human beings, emotions, and subjective interpretations. While my study included ethnographic elements, I would not classify it as fully ethnographic in the traditional sense of deep immersion into participants' everyday lives (see McGranahan 2018). Several factors limited this possibility. First, the Covid-19 pandemic rendered close, sustained interaction with patients and their families in palliative care ethically and practically impossible. Second, although I spent over 18 months in the field (from November 2021 to July 2023), this was insufficient for immersive ethnography in two different national, cultural, and linguistic contexts. Third, coming from an interdisciplinary background that spans gender studies, the arts, humanities, and social sciences, I felt constrained by strictly following the conventions of ethnographic writing.

Consequently, thick ethnographic description is at times less prominent, while theoretical discussions occasionally take precedence over field-based narratives. This interdisciplinary approach is also reflected in my theoretical framework, which draws from diverse bodies of literature that are not commonly brought into conversation. While this multidimensionality may have limited the ethnographic depth of the research, it significantly

enhanced the complexity and, ultimately, the credibility of my findings. Indeed, a phenomenon as intricate as the welfare state cannot be fully understood without drawing on multiple types of data and analytical tools. Rather than viewing this multidimensionality as a weakness, I see it as an asset. And so, to demonstrate how I bring these varied strands of scholarship together, I now turn to the theoretical framework that underpins this dissertation.

Before proceeding, a brief note on the use of quotation marks: following British English conventions, I use single quotation marks as the default – for quotations, titles of shorter works, or to set apart specific words or phrases. Double quotation marks are reserved for quotations within quotations. According to this convention, titles of poems, songs, articles, short stories, essays, and individual episodes are enclosed in single quotation marks, while titles of longer works such as books, films, plays, journals, and music albums are italicised (Ellis 2023). Italics are also occasionally used for emphasis as well as titles and expressions in their original language.

Chapter 2

The Conceptual and Theoretical Crossroads: Volunteering, Care, and Welfare Logics

Introduction

This dissertation examines palliative care volunteering through the notion of familialism, exploring how it shapes the role of families in caring for their frail members within two familialistic welfare regimes. Central to this analysis is the question of volunteers' professional status in relation to both formal and informal carers – a status that depends heavily on context-specific notions of what constitutes appropriate care, or what Kremer calls 'care ideals' (Kremer 2005). While these ideals are significantly shaped by welfare arrangements, they are also informed by specific forms of spirituality and religiosity, particularly in the two Catholic contexts studied here. Together, these elements contribute to defining the nature of volunteer work and the production of values such as love, empathy, and humanity as key aspects of creating volunteer professionalism. The meanings attached to these values and emotional orientations are deeply contextual, yet they also reflect broader welfare trends – an issue further explored in the analytical chapters. This chapter lays the theoretical groundwork for that analysis. It begins by reviewing the scholarship on volunteerism, with a focus on debates around professionalisation and the boundaries between formal and informal care. Of particular relevance is literature that situates volunteering within the broader framework of welfare arrangements.

To that end, the next subchapter turns to welfare state theory, with an emphasis on the regimes of Central and Eastern Europe (CEE) and Continental Europe. This provides the necessary context for analysing the case studies in Croatia and Austria. Because this dissertation takes a comparative approach, the use of welfare typologies and clustering (e.g., Esping-Andersen 1990) proves especially useful. In this context, feminist interventions into welfare state literature – particularly those that work within typological frameworks – are critical. This is also true of the literature on familialism, a central concept in this dissertation, which is discussed in the following section. Familialism frames the family (or household more broadly) as a key provider of welfare and social security (Leitner 2006). Since the feminist turn in the 1990s, the familialisation – defamilialisation dichotomy has become a prominent tool for

examining patterns of care provision – specifically, the combination of providers in which the family, and its gendered dynamics, play a crucial role (Lister 1994; Leitner 2003; Saraceno 2016). My contribution to this scholarly field lies in interrogating familial obligations through the prism of palliative care volunteering. In doing so, I not only engage with welfare state literature – typical in analyses of familialistic typologies – but also draw on broader insights from the sociology and anthropology of work.

Finally, after mapping out key debates on volunteerism and welfare regimes, the last section of this chapter turns to anthropological and feminist theories of value. These provide a comprehensive framework for discussing the meaning and significance of volunteer work in palliative care. These debates are further enriched by anthropological discussions of humanitarianism and affect – particularly love and empathy – as well as insights from the sociology of religion. This latter field offers a way to examine the spiritual dimensions of volunteerism, including secularisation, spiritual self-investment, and the cultivation of human capital.

2.1 Volunteering and the Question of Professionalism

This theoretical chapter begins by identifying the main scholarly approaches to volunteering and professionalism, as one of the central aims of my research is to explore how palliative care volunteers acquire a sense of professionalism. To grasp the nature of volunteer professionalism within palliative care, it is first necessary to clarify the concepts of ‘profession’ and ‘professionalism’. I then examine how these concepts are applied to volunteer work – particularly in the care sector – before mapping broader debates that connect volunteer professionalisation to developments in welfare state structures.

Historically, volunteers have been largely excluded from discussions on professionalism, reflecting the initial neglect of volunteering in the sociology of work. This, however, has shifted in recent years. There is now growing interest in how volunteers attain professional status and how this intersects with transformations in both paid and unpaid labour. As with any form of work, it is crucial not to treat volunteering as a homogenous category. Instead, we must attend to the specific sector in which volunteer work occurs. In my case, that sector is palliative care. Especially relevant to my research is Overgaard’s comparative study of hospice volunteers in Denmark and Australia – one of the few cross-national analyses to

examine palliative care volunteering through the lens of welfare state developments and volunteer professionalism (Overgaard 2015b; 2015a; 2016). Before turning to that study, however, I begin by exploring the foundational concepts of ‘profession’ and ‘professionalism.’

Despite more than half a century of sociological inquiry into professionalism, there is still no consensus on when an occupation becomes a profession (Brante 2011). Early sociological frameworks were often criticized for uncritically adopting the self-definitions of professions, which tended to marginalize so-called ‘semi-professions’ such as nursing and management (Johnson 1972). Over time, however, scholars have converged on the notion that specialized knowledge is a key defining feature of professions (Macdonald 1995; Freidson 2001). More recent research has shifted focus away from determining whether an occupation qualifies as a profession, and toward understanding how occupations become professionalised and how individuals construct professional identities (Macdonald 1995, 6).

Although the terms ‘professionalisation’ and ‘professionalism’ remain conceptually ambiguous, Ganesh and McAllum (2012) help distinguish between them in their study of volunteering and trends in professionalisation (Ganesh and McAllum 2012). They argue that *professionalisation* generally refers to institutional structures and processes, particularly those related to organisational form – such as bureaucratisation, rationalisation, and their effects on strategies and core values (Ganesh 2005; Simpson and Cheney 2007). In contrast, *professionalism* pertains to occupational identity and is often associated with norms of impersonality, fairness, and the ability to separate personal and professional roles – features increasingly shaped by the conditions of late capitalist modernity (Cheney et al. 2010).

Throughout this dissertation, I demonstrate how the professional status of volunteers is both affirmed – through standardized education and codes of conduct – and undermined – by highlighting the humanized and unpaid nature of their work. Volunteers are perhaps best described as ‘para-professionals’ as they receive certified training but do not receive a salary like other staff in palliative care. Rather than offering a fixed definition of the professional identity of my research participants, I will focus more, following Ganesh and McAllum (2012), on the dynamic and often contradictory process of (de)professionalisation, which encompasses a range of professionalisation strategies. Examining how this dual movement of professionalising and de-professionalising unfolds in each context offers insight into the organization and evolution of the Croatian and Austrian welfare states.

The literature identifies a range of professionalisation strategies. Traditional approaches tend to model established professions, such as medical doctors, and involve forming professional associations, creating formal educational programs, and developing standardized

codes of ethics and protocols that govern technical skills and service values (van Bochove et al. 2018). These strategies may be implemented top-down by organisations seeking to enforce new work practices, or bottom-up by occupational groups striving to elevate their status (Evetts 2011; van Bochove and Oldenhof 2020).

Volunteers are typically not regarded as professionals, largely due to their limited formal training, lack of disciplinary knowledge, and minimal institutional power – even when their contributions hold considerable social value (Merrell 2000; Ganesh and McAllum 2012). Moreover, they often do not meet the criteria for professional competence outlined by Fournier, which include emotional neutrality and a strong sense of responsibility in decision-making (Fournier 1999).

One reason volunteerism has historically been excluded from studies of professions lies in its longstanding separation from the category of work. As sociologist Charlotte Overgaard astutely notes, research on volunteering developed largely independently from studies of paid labour – a divide that is not surprising given that volunteering only recently came to be officially recognised as a form of work (Overgaard 2019). It was not until 2013 that the International Labor Organization (ILO) adopted a statistical framework that explicitly included volunteer work, classifying it as a distinct, non-compulsory and unpaid form of work producing services and goods for others outside the volunteer’s household and family (International Labour Organization 2016). This non-compulsory nature originally situated volunteering within the field of leisure studies, especially during the 1990s (Cnaan, Handy, and Wadsworth 1996; R. A. Stebbins 1996; Overgaard 2019, 132). Scholars such as Stebbins (1996) coined the term ‘serious leisure’ to distinguish structured, purposeful volunteering from more casual recreational activities. Others, including Pearce (1993) and Merrell (2000), viewed volunteering as straddling the line between leisure and work – voluntary and personally rewarding on one hand, yet service-oriented and socially productive on the other. Over time, however, the leisure framework lost its dominance, and most contemporary scholarship now conceptualises volunteering primarily in relation to work rather than leisure (Mutchler, Burr, and Caro 2003; Oppenheimer and Edwards 2011).

This shift has led to increased scholarly attention on volunteer work in relation to professionalism and the strategies through which unpaid workers may engage in processes of professionalisation. For example, De Swaan (1988) and Dent (2006) introduced the concept of ‘proto-professionalisation’ to describe how patients and their families in Western contexts have begun expressing concerns using professionalised language. By adopting simplified forms of expert discourse, these individuals gain recognition from professionals, effectively

participating in a bottom-up form of professionalisation. However, as van Bochove and Oldenhof (2020, 115) argue, professionalisation can also be imposed from above. Public service organisations are increasingly delegating responsibilities to volunteers and family members – a development reflective of broader transformations in welfare state structures (see Bach, Kessler, and Heron 2007; Newman and Tonkens 2011; Oldenhof, Postma, and Bal 2016; van Bochove et al. 2018).

This dual process – both the de- and professionalisation of paid professionals and the rise of a new form of professionalism among volunteers and informal carers – has prompted many scholars to question the traditional binary between professional and volunteer care. Instead, they emphasize how professional and non-professional principles often intertwine in volunteer activities (Pearce 1993; Taylor 2004; R. Stebbins 2013; Overgaard 2015b; Steimel 2018).

Going a step further, however, Ganesh and McAllum (2012, 3) caution that it is insufficient to focus solely on the tensions between volunteering and professionalism. We must also examine how processes of professionalisation are actively reshaping what volunteering itself means. Research demonstrates that professionalisation has introduced market-driven principles – such as routinisation, formalisation, and rationalisation – into the nonprofit sector, significantly limiting volunteers’ autonomy and their capacity to engage deeply with social causes (Kreutzer and Jäger 2011; van Bochove and Oldenhof 2020, 128). In this context, professionalisation can be understood as a set of behavioural prescriptions – or, as Foucault (1997, 73) describes, ‘techniques and procedures for directing human behaviour’ – which encourage volunteers to adopt practices modelled on those from the for-profit sector (Ganesh and McAllum 2012, 4). Yet, it is important to recognize that volunteers do not simply absorb these norms passively; professionalism can also serve as a source of empowerment (Ganesh and McAllum 2012).

Equally important is the recognition that, much like paid employment, the professionalisation of volunteer work depends heavily on the sector in which it occurs. But unlike paid work – as argued by Overgaard (2019, 130) – all forms of volunteering are often bumped together, although care work, firefighting, coaching or union activism do not have anything in common, except the fact that they are unwaged activities. This is in stark contrast to the paid workforce that is usually studied within its own occupational boundaries (Overgaard 2019, 131). Overgaard (2019) attributes this divergence to the independent evolution of volunteering research apart from the study of paid work. Consequently, instead of focusing on the specific sectoral contexts of volunteering and the mechanisms that delineate paid and

unpaid labour within each field (Taylor 2005; Overgaard 2015a; 2019; Overgaard, Petrovski, and Hermansen 2018), much of the volunteer literature has concentrated on individual motivations and resources. One stream debates whether altruism or egoism primarily drives volunteering (Clary et al. 1998; Cloke, Johnsen, and May 2007), while another attempts to explain volunteering patterns through demographic factors such as education, social status, gender, and race (D. H. Smith 1994; Handy and Hustinx 2009). Many scholars in the latter group find a positive correlation between higher resource levels and volunteer participation (e.g., Smith 1994; Wilson and Musick 1997; Einolf and Chambré 2011).

While resource-based explanations may hold broadly, Overgaard, Petrovski, and Hermansen (2018, 156–57) demonstrate that they do not apply well to volunteering in the care sector, where many volunteers possess relatively few resources and where inequality, rather than privilege, is often linked to both paid and unpaid care work (Tronto 1993, 112–16). This brings us to another common assumption about volunteering: that it is always voluntary. In reality, volunteerism is not always freely chosen – for example, corporate volunteering programs (Kelemen, Mangan, and Moffat 2017) or unpaid work aimed at securing paid employment (J. Dean 2015; Allan 2019). Moreover, volunteering frequently relies on gendered care responsibilities (see Andersen et al. 2022) and, as feminists argue, is often shaped by ‘compulsory altruism’ – an ideology pressuring women to provide care without expecting compensation (Land and Rose 1985). Feminist scholars have also highlighted the exploitative nature of unpaid labour within a segmented labour market, where volunteering can sometimes be the only available form of work (Hartmann 1976; Baldock 1990). These insights make clear that volunteer palliative care work cannot be understood simply as part of volunteering in general, but must be studied within the specific context of care work, which involves unique skill and task requirements, gender relations, and broader structural arrangements, such as welfare state provisions – topics I will now turn to.

Recent scholarship has argued that volunteers play an increasingly significant role in the retrenching European welfare states (Bode and Brandsen 2014; Skinner, Sogstad, and Tingvold 2019). Volunteers are valued not only because they are cost-effective (Muehlebach 2012) but also because they provide a distinct type of care compared to paid professionals (Kirkegaard and Andersen 2018; van Bochove et al. 2018; Frederiksen and Grubb 2023). For instance, volunteers are often described as bringing more affection (Melow 2017; Ward and Greene 2018), friendship (Manthorpe et al. 2003), and authenticity (Cour 2019) to their work. The relationship between volunteers and care recipients tends to be more interdependent, in

contrast to the more one-directional dependency characteristic of professional (paid) care (Ariza-Montes, Roldán-Salgueiro, and Leal-Rodríguez 2015).

In the specific field of palliative care, it is unsurprising that there is a substantial body of research dedicated to volunteers, given their integral role in the hospice movement (Sévigny et al. 2010; Morris et al. 2013). For example, a systematic meta-ethnographic review by Kathrina Oliver and colleagues (2023) identified over 1,000 peer-reviewed qualitative studies on palliative care volunteering published up to December 2021. Many of these works examine – besides motives and characteristic of volunteers common to all research on volunteering – the emotional and psychological challenges of end-of-life care, and how volunteers navigate the environment of death and dying (Dein and Abbas 2005; Claxton-Oldfield 2015; M. V. Brown 2011; MacLeod, Skinner, and Low 2012).

However, the issue of defining the boundaries and professional status of volunteers has received comparatively less attention in palliative care research (see Overgaard 2015a; 2015b; 2016), unlike the broader care sector where the interaction between volunteers and paid professionals has sparked vibrant debate. Some studies have adopted a boundary perspective to explore how volunteers and professionals collaborate in co-producing welfare services (McAllum 2018; López-Cabrera et al. 2020a; Järvinen and Kessing 2023). This literature often focuses on the division of tasks and responsibilities, the ways volunteers assist or substitute paid staff, and the potential for professionals to replace volunteers (Saks and Van Bochove 2021). Within these interactions, boundaries are continuously constructed, maintained, or challenged through strategies such as monopolisation, expansion, exclusion, and protection (Gieryn 1995; van Bochove et al. 2018; Saks and Van Bochove 2021). While paid and unpaid carers often differ in identities, motivations, and other qualities, the distinctions between the two groups are not always clear-cut but instead remain ambiguous and dynamic (Handy and Srinivasan 2005; Kreutzer and Jäger 2011; Merrell 2000; Hoad 2002; Taylor 2005; Hardill and Baines 2011; van Bochove et al. 2018). Saks and Van Bochove (2021) highlight that one important reason for variations in boundary demarcation lies in differences among volunteers themselves, including their social and occupational backgrounds (Merrell 2000; Hoad 2002; van Bochove et al. 2018) as I will show while discussing if, how, and why palliative care volunteers adopt professional identities in the analytical chapters.

By analysing how boundaries between volunteers and other carers in palliative care are drawn and contested, I aim not only to clarify volunteers' roles but also to uncover key systemic features of the welfare states within which these roles and identities are shaped. For this, I build on the recent research by Marianne van Bochove and Lieke Oldenhof (2020) on

professionalisation strategies in paid and unpaid health and social care in the Netherlands. They argue that professionalisation strategies do more than transform individual occupations; by redefining jurisdictional, occupational, and educational boundaries, these strategies institutionalize existing or emerging occupational domains and thereby influence the broader institutional environment and dynamics within fields such as health care, social care, and primary care (van Bochove and Oldenhof 2020, 116).

Another key resource for my project is Charlotte Overgaard's comparative study of hospice volunteers in Australia and Denmark, which focuses on the boundaries between paid and unpaid work in hospice care (Overgaard 2016; 2015b; 2015a). This study is valuable for several reasons. First, cross-national comparisons of professional-volunteer collaboration remain scarce (Saks and Van Bochove 2021, 6), especially in the specialized setting of hospice and palliative care. Second, Overgaard successfully links volunteers' perceptions and practices to the welfare state contexts of the two countries, an approach I also seek to adopt. More specifically, Overgaard (2016; 2015b; 2015a) demonstrates how gender relations, volunteer care work, paid employment, and welfare state arrangements interact, showing that the nature of volunteering depends on how access to paid employment is organized and bounded within each welfare system.

To investigate how the same activities are perceived differently depending on context, Overgaard (2015a) applies the Total Social Organisation of Labour (TSOL) framework developed by Miriam A. Glucksmann (1995; 2005). TSOL conceptualizes labour along a continuum from more formal to more informal practices, intersecting with a spectrum from non-monetized (including in-kind and reciprocal) to monetized labour. By focusing on the relational organization of labour, TSOL treats labour processes as fluid rather than fixed, emphasizing how boundaries between work and non-work, paid and unpaid, and formal and informal can shift depending on context (Glucksmann 1995; 2005)³. This framework offers a valuable insight for my study: understanding how people work and construct themselves as workers requires examining the broader social arena and relational networks within which activities are defined (Taylor 2004, 15).

³ A TSOL perspective has been also (successfully) adopted by other scholars to engage with a range of topics: from insecure forms of employment (Charles and James 2003), the strategies of mining communities in the light of transformed economic activities (Parry 2003), voluntary work (Taylor 2004), eldercare (Lyon and Glucksmann 2008), community self-help (Williams 2005) or the implementation of information and communication technologies (ICTs) in care services (R. Wilson et al. 2017).

My contribution extends beyond merely studying new countries relative to Overgaard's work. I focus on how palliative care volunteering affects the role of families caring for their frail members in Austria and Croatia, thereby highlighting the specificities of these two familialistic welfare regimes. Alongside boundary-making between volunteers and other professionals, I also examine the professionalisation of volunteers in relation to family carers. In exploring the volunteer-family carer relationship, it is important to heed Saks and Van Bochove (2021, 6) warning against lumping all forms of unpaid care work together – a risk heightened by the growing numbers of clients involved in self-help (Mik-Meyer 2017) and the widespread prevalence of family carers across Europe (Verbakel 2014). Although this distinction has been challenged (Litwak 1985), it remains vital not to draw premature conclusions about 'de-professionalisation' trends, but rather to engage with the complex realities of healthcare labour divisions.

Emma Dowling's recent work on the boundary-work of volunteering in Germany offers a valuable contribution here by showing how volunteers help reconfigure informal care by stepping in for missing friends, neighbours, and family members. Volunteers do not merely replace families or commercial providers, but instead form a distinct type of close relationship, acting as a bridge between informal and professional care (Dowling 2024). My research advances this by placing greater emphasis on the role of family carers within palliative care volunteering, exploring what this dynamic reveals about family care more broadly in the Austrian and Croatian contexts. Achieving this requires a thorough understanding of the welfare state arrangements in each country – especially regarding family care – which will be the focus of the following subchapter.

2.2 Rethinking the Welfare State through Familialism

To establish the conceptual and theoretical framework for analysing the familialistic welfare regimes of Austria and Croatia, this subchapter draws on key literature in welfare state studies, with a particular focus on familialism – that is, policies that support families in their caregiving roles. Although both Austria and Croatia are commonly classified as familialistic welfare states, the nature of their familialism diverges significantly. In Austria, family policy reflects a combination of *explicit familialism* and *optional familialism* (often referred to as the 'freedom of choice' model). This is expressed through *positive familialisation* measures (such

as cash-for-care schemes) and *positive de-familialisation* initiatives (such as public investment in childcare services) (Blum, Formánková, and Dobrotić 2014). Croatia, by contrast, has struggled to establish a coherent family policy framework. As Dobrotić (2018) observes, Croatian family policy is marked by fragmented and inconsistently designed reforms that blend elements of *explicit familialism* (e.g., extended maternity leave), gender equality initiatives, and pronatalist measures (such as financial incentives for larger families).

These differences become clearer once the concept of familialism is defined in more detail, along with the typologies proposed by Sigrid Leitner and Chiara Saraceno (Leitner 2011; Saraceno 2016). However, family policy cannot be fully understood in isolation from the broader welfare state framework in which it is embedded. Therefore, this subchapter begins by introducing the concept of the welfare state and outlining the key debates in the field – particularly Esping-Andersen’s influential welfare regime typology, which continues to serve as a foundational tool for comparative welfare analysis (Gøsta Esping-Andersen 1990). The subchapter also examines the defining features of post-socialist and continental European welfare states, which provide the regional context within which Croatian and Austrian models are typically situated. Additionally, one section is devoted to the notion of ‘Yugoslav exceptionalism’, particularly in comparison with other socialist countries at the time. This includes Yugoslavia’s departure from administrative universalism, its semi-open economic and political system, and the relatively weak development of the third sector.

Given the wide-ranging implications of the welfare state, arriving at a single, universally accepted definition has proven difficult – likely because of its widespread use across various social science disciplines. At its narrowest, the welfare state can be understood as a country’s system for income maintenance. At its broadest, as defined by Béland et al. (2021) in *The Oxford Handbook of the Welfare State*, it encompasses a comprehensive set of social, economic, political, and cultural features that define a polity. The origins of the welfare state can be traced back to the final quarter of the nineteenth century, a period of profound transformation in Europe. Rapid industrialization, the rise of capitalism, urbanization, and population growth all contributed to increasing social demands and the emergence of a critical mass advocating for social protection (Polanyi 1957; Béland et al. 2021).

Pioneering theoretical explanations for variations among welfare states initially emerged from the socio-economic school, which argued that welfare state development is largely driven by economic growth and closely linked to processes of social and political modernization and differentiation (Wilensky 1975). In contrast, the power resources theory (e.g., Korpi 1998; 2022; Stephens 1979; Gøsta Esping-Andersen 1985; Gøsta Esping-Andersen

1990; Palme 1990) emphasized the influence of political parties, interest groups, and public opinion on welfare state development. Meanwhile, institutional theories (e.g., Lijphart 1999; Schmidt et al. 2007) focused more on existing institutional structures and the principle of path dependence (Stambolieva 2011, 347).

From its inception, welfare state literature has aimed to group countries into distinct welfare regimes, leading to various typologies. For instance, Titmuss (1972) proposed a classification based on residual, industrial-achievement, and institutional-redistributive models. Bonoli (1997) later distinguished between Bismarckian and Beveridgian models of social policy, based on levels of social spending and the organization of welfare systems. The most influential typology, however, was introduced by Gøsta Esping-Andersen in *The Three Worlds of Welfare Capitalism*, where he categorized Western democracies into three regimes according to levels of decommodification, stratification, and the relationship between the state, market, and family (Gøsta Esping-Andersen 1990).

The liberal or residual model, typical of English-speaking countries, limits state redistribution to means-tested assistance used only as a last resort. It prioritizes market solutions and private benefit schemes, resulting in higher levels of income and wealth inequality (Manow 2021). At the other end of the spectrum is the Scandinavian or social-democratic model, characterized by strong decommodification, universal benefits, high public spending, a high tax-to-GDP ratio, and support for the dual-earner family model (Lewis 2006; Hook 2015). The continental conservative regime (e.g., Germany, the Netherlands, Austria, France, Belgium) also features high public spending relative to GDP but differs in its lower female labour force participation, weaker redistribution, and reliance on occupationally segmented social insurance systems, primarily funded through social security contributions rather than taxes.

Despite the various criticisms it has faced (e.g., Lewis 1992; Orloff 1996; Sainsbury 1999; Huber and Stephens 2000; Bambra 2007; Chung and Muntaner 2007), Esping-Andersen's typology remains widely used and highly regarded. There are several reasons for its enduring influence. It offers a systematic and unified explanatory model of how different forms of capitalism function (Iversen and Soskice 2006), integrating multiple dimensions such as class coalitions, state formation, and administrative capacity (Orloff 2009). Furthermore, as a Weberian ideal-type model, it is adaptable and applicable to various global contexts, allowing scholars to trace ongoing and emerging welfare trends (Aspalter 2017). For these reasons, I also adopt this typology – albeit roughly – as it provides a useful comparative framework and facilitates broad, cross-national analysis.

In efforts to explain and classify Central and Eastern European (CEE) welfare states, two main approaches dominate the literature. The first examines whether CEE regimes are primarily shaped by path dependency or more influenced by recent socio-economic trends such as internationalisation, liberalisation, and deregulation (e.g., Schubert, de Villota, and Kuhlmann 2016; Cook 2015). The second focuses on clustering CEE countries either within existing typologies or as a distinct ‘post-communist European type’ (Fenger 2007; Golinowska 2009). Most scholars now agree that the CEE region cannot be neatly categorized either as a separate regime or within existing ones. It tends to occupy a hybrid position – more generous than liberal models but less so than continental regimes (Gans-Morse and Orenstein 2007; Offe and Fuchs 2007; Cook 2015).

Recent research highlights growing diversity within the region, with individual CEE countries increasingly aligning with different European models: the Czech Republic resembles the Nordic model, Hungary and Slovakia the continental one, and Poland aligns more closely with the Mediterranean regime (Tendera-Właszczuk and Szymański 2015). Other typologies divide the region into two groups: the Eastern European model (Lithuania, Latvia, Estonia, Bulgaria, Romania), reflecting more traditional post-communist structures; and the Central Eastern European model (Czechia, Croatia, Hungary, Poland, Slovakia, Slovenia), which mirrors Western European welfare systems more closely in terms of service provision (Lauzadyte-Tutliene, Balezentis, and Goculenko 2018).

Despite internal variation, the shared socialist past of CEE countries remains a key unifying factor. After World War I, most countries established Bismarckian social insurance systems for formal workers, which were later expanded under socialism into universal systems funded by employer contributions and managed by state bureaucracies or trade unions (Inglot 2008). The socialist era featured centralized economic planning, high employment for both genders, relatively equal income distribution, universal healthcare and education, and widespread social insurance – though living standards remained below those in Western Europe (Cook 2010; 2015; Cook and Inglot 2021). During socialism, the third sector was tightly controlled by the state, with only a few mass organizations (e.g., for women, veterans, or the disabled) granted official recognition and support (Ghodsee 2015; Kulmala and Tarasenko 2016). Although the 1990s brought economic reforms and EU integration – transforming the nonprofit landscape – the legacy of informal self-help traditions over formal civic engagement persists (Salamon and Sokolowski 2018).

In the 1990s, CEE welfare states shifted towards market-oriented reforms, ending the state monopoly on service provision and legalizing private healthcare and education (Cook

2015). Pension systems were restructured, returning to pay-as-you-go (PAYG) principles funded through payroll taxes. Foreign investment spurred growth but also widened inequality, especially in countries like Bulgaria, Croatia, Hungary, Lithuania, and Latvia, where insecure, informal employment became common (Cook and Inglot 2021). The 2008 financial crisis hit CEE countries particularly hard, prompting austerity measures and contributing to rising illiberalism, populism, and Euro-scepticism. Another shared trend is demographic decline – a drop in fertility rates since the 1990s compounded by large-scale emigration to Western Europe (Cook and Inglot 2021, 884–85). Although social spending in 2017 remained below the EU-28 average, some CEE countries exceeded spending levels in parts of Southern and Northwestern Europe, including Greece, the Netherlands, the UK, and Ireland (Eurostat 2017).

While a conservative political turn has been observed across the region, signs of so-called ‘Europeanisation’ are evident, particularly in family policy and gender relations – reflected in reforms to parental leave and childcare, often driven by EU directives (Inglot, Szikra, and Raţ 2012; 2022). At the same time, CEE welfare discourses have increasingly adopted the broader European shift from ‘social inclusion’ to ‘social investment’, prioritizing activation and fiscal discipline over passive protection (Lendvai and Stubbs 2015).

Notably, much of this scholarship focuses on EU member states in the region, with Croatia only recently included in comparative analyses and other former Yugoslav republics largely overlooked. This gap highlights the importance of examining ‘Yugoslav exceptionalism’, which has significantly shaped Croatia’s welfare state. Yugoslavia initially resembled other socialist countries by adopting administrative universalism, funded through the federal budget. However, it soon transitioned to a mixed welfare model, combining Bismarckian insurance principles with elements of universality. Social security was managed by insurance institutions and local authorities, forming a unique system within the socialist bloc (Stambolieva 2011). Unlike other Eastern European states, Yugoslavia maintained a semi-open economic and political system, enabling mass labour emigration in the 1970s and 1980s – a response to unemployment largely absent in other socialist regimes (Stambolieva 2011, 355).

The post-socialist transition was marked by war, economic collapse, and the rise of semi-authoritarian governments. Reforms – particularly in Croatia and Macedonia – were often guided by international organizations (Stambolieva, 2016). Pension reform was especially significant, introducing a multi-pillar system (adding mandatory and voluntary tiers to the existing PAYG model). In contrast, healthcare retained its universal character with over 90%

coverage, though access to services declined and private provision expanded (Stambolieva, 2016).

Yugoslavia's exceptionality also extended to third sector development. While civil society played a key role in democratization elsewhere in CEE, this was not the case in most Yugoslav republics. As Fink-Hafner (2015) notes, the strength, timing, and elite involvement in civil society varied considerably, shaped by war and the diverse paths to democracy. Slovenia was the exception, where third sector development resembled broader CEE patterns due to its peaceful transition, economic strength, and secular political culture (Fink-Hafner and Hafner-Fink 2009). These differences also influenced areas such as palliative care volunteering, which is addressed in Chapter Three. Now, I turn to the second welfare model central to this research – Austria – to explore its care and volunteer arrangements for comparative analysis.

The welfare states of continental (Western) Europe are typically negatively treated as 'conservative-corporatist' (Gøsta Esping-Andersen 1990). Austria, Belgium, Germany, France, and the Netherlands share a core institutional design: the primacy of social insurance, where entitlements are closely linked to formal employment and contribution records. This architecture reinforces social stratification, particularly through its historical orientation toward the male breadwinner model, in which women are insured through derived rights as spouses and mothers (Palier 2021, 831). These systems expanded during the post-war period of Fordist industrial capitalism, contrasting with the earlier liberal development in the UK and the later, post-industrial expansion of Scandinavian models (Palier 2021). A defining feature of continental welfare states is that social insurance is administered not by the state or private firms, but through occupational social insurance funds – non-profit bodies managed by representatives of employers and employees. These *Kassen* (in German) or *Caisses* (in French) originated in 19th-century workers' mutual aid societies, funded by wage contributions rather than general taxation (Palier 2021).

This structural arrangement reflects not only the legacy of industrial relations but also the influence of Catholic social doctrine⁴, which emerged in reaction to increasing state involvement in domains traditionally governed by the Church, such as education and poor relief. As van Kersbergen (1995) and others (Huber and Stephens 2001; van Kersbergen and

⁴ Catholic social doctrine is the body of theory with which the Church tried to reconcile secular individualist society and the radicalisation of the poor in the 19th century with Catholicism through Thomist philosophy – according to which rich and poor should be bounded together by charitable, mutually constituting each other. This mutual affection, rather than alter, reproduce social differences (Muehlebach 2013, 456). Redistribution of charity mechanisms, argues Muehlebach (2013), originally reflects the love of the father for his children, where emphasising the embeddedness of individual within a hierarchical, yet loving order, resulted in creating a notion of 'subsidiary' as the Church's key organising principle.

Manow 2009) argue, the Catholic emphasis on subsidiarity – assigning responsibilities first to families, then to religious or community institutions, and only finally to the state – helped shape both the design of continental welfare states and the rise of Christian Democratic parties as key political actors.

This subsidiarity principle also informs the development of the third sector in these countries. In contexts where industrialisation did not fully displace traditional elites, religiously affiliated voluntary organisations played a central role in welfare provision. Rather than serving as sites of protest or democratic mobilization (as seen in some post-socialist transitions) these organisations formed the backbone of what Salamon and Sokolowski (2018) term the ‘welfare partnership’ or ‘corporatist route’ of civil society development – particularly evident in Germany, Austria, and the Netherlands. Publicly funded but civically run, these service-oriented nonprofits provided a balance between state security and civil responsiveness, a model later admired and replicated elsewhere.

However, like all welfare regimes, the conservative-corporatist model has faced mounting internal and external pressures. The economic crises of the 1970s triggered early institutional adaptations, followed by more profound structural changes in the 2000s (Palier 2021). Across the region, two broad trends have emerged: a reemphasis on state intervention in social policy and a partial privatisation of welfare functions. To address rising poverty and gaps in insurance coverage, non-contributory minimum benefits have been introduced (Hassel and Palier 2020). In Austria, these shifts are particularly visible in the pension system, which has gradually moved away from early retirement options and introduced private pillars alongside the public PAYG scheme. Employment policy reforms have tightened eligibility, promoted activation, and focused on upskilling, especially for low-skilled workers – reflecting the broader ‘social investment’ turn (Hemerijck 2017). Healthcare has also seen rising co-payments and private expenditure (Obinger and Tálos 2010).

In the domain of care, several innovations have emerged. Germany and Austria introduced long-term care insurance schemes (*Pflegeversicherung*, *Pflegegeld*), while France established personalised allowances for dependent individuals (*allocation personnalisée à l'autonomie*) (Morel 2008; Palier 2021). While these schemes continue to rely heavily on family caregiving, they also reflect rising expectations for female labour market participation, often in low-paid care roles – contributing to the gradual erosion of the traditional breadwinner model (Morel 2008).

Compared to Central and Eastern European and post-Yugoslav welfare states, the continental model stands out in several key respects. First, while both traditions rely on social

insurance, the continental model developed through incremental, internally driven reforms, rooted in corporatist traditions and Christian Democratic ideologies. By contrast, CEE states, including Croatia, were shaped by a socialist legacy of state-planned universalism, followed by rapid market liberalisation and often externally imposed reforms in the 1990s. Second, the third sector in continental Europe has long been integrated into welfare delivery via public-civic partnerships, whereas in the socialist and post-socialist contexts, civil society was either suppressed or marginalised until the 1990s. Even after liberalisation, post-Yugoslav states (with the partial exception of Slovenia) saw weak or delayed third sector development, often tied to war recovery or donor dependence rather than longstanding corporatist traditions (Fink-Hafner 2015; Salamon and Sokolowski 2018). Third, family policy reforms in Austria and other continental regimes – while preserving the ideal of familial responsibility – have increasingly aligned with EU social investment strategies, particularly in expanding childcare and long-term care options. In contrast, family policies in Croatia and many CEE states remain fragmented and often reactive, blending pronatalist incentives, gender equality goals, and legacy features of the socialist welfare state without a cohesive policy paradigm (Dobrotić 2018).

Thus, while both continental and CEE welfare states continue to balance traditional social insurance frameworks with new demands for activation, care, and gender equality, their institutional paths, policy drivers, and civic infrastructures differ considerably. The conservative-corporatist model offers a historically embedded, relatively stable welfare configuration, while post-socialist regimes, including Croatia's hybrid system shaped by Yugoslav exceptionalism, illustrate more volatile and externally influenced trajectories. Understanding the development of welfare states in Austria and Croatia is essential for analysing palliative care volunteering, whose arrangement is shaped by each country's broader health and social care systems. To explore how volunteers support familial care, I now turn to the concept of familialism – a critical notion for understanding the evolving role of families in welfare provision across both regions. Before that, I briefly introduce the feminist critique of welfare state research, from which the concept of familialism directly emerged.

If the comparative analytical approach marked a foundational 'big bang' in welfare state studies, a parallel transformation occurred with the rise of gender scholarship in the 1970s and 1980s. Feminist scholars revealed that gender is both constituted by and constitutive of systems of social provision and regulation (Orloff 2009). Establishing gender as a valid category of analysis required a multifaceted critique – one that went beyond the prevailing concepts and theories of social policy to challenge the very methodologies, epistemologies, and theoretical frameworks that underpin socio-political inquiry more broadly (Butler and Scott 2013; Harding

2004; Orloff 2005). In the context of comparative welfare state research, this critique led to significant conceptual innovation. Fundamental terms were rethought – beginning with gender itself and extending to related concepts such as care, autonomy, citizenship, (in)dependence, political agency, and equality. Today, it would be nearly impossible to understand the constitutive relationship between gender and welfare states without these theoretical contributions (Orloff 2009).

Within this evolving framework, scholars began to classify welfare states into ‘gendered regime types,’ particularly through the lens of the male breadwinner model and the extent to which policies support personal autonomy (Lewis 1992; 2001; Leira 1992; Orloff 1993; Sainsbury 1996). Others, such as Sigrid Leitner and Chiara Saraceno, proposed expanding this typology by incorporating the familialisation–defamilialisation nexus alongside the traditional decommodification spectrum (Leitner 2003; Saraceno 2016). Given the central role of family care in my own research, I now turn to this second strand of scholarship, focusing in particular on the concept of familialism and the welfare typologies that have developed around it.

The concept of defamilialisation, first introduced by Ruth Lister in 1994, refers to ‘the degree to which individuals can uphold a socially acceptable standard of living independently of family relationships, either through paid work or social security provision’ (Lister 1994). As Chiara Saraceno (2016) underscores in her recent work on varieties of familialism, the notion of family obligations becomes particularly visible in care policy – arguably more so than in other areas of social policy. Crucially, the policy domain of care has helped further refine the distinction between defamilialisation and familialism. While defamilialising measures seek to unburden families by shifting caregiving responsibilities to the state or the market, familialistic policies aim to support families in maintaining these roles, often by allocating time and financial resources (Saraceno 1997; Leitner 2003).

In this context, familialism refers to the recognition of the family – or more broadly, the household – as a central provider of welfare and a foundational component of the social security system (Leitner 2006). According to Sigrid Leitner, familialising policies typically take the form of either time-based entitlements, such as parental or caregiving leaves, or cash benefits (Leitner 2014, 38–39). The extent of familialisation tends to rise with the length of leave entitlements, though extended leaves may also hinder labour market re-entry, particularly for women. Cash benefits can be delivered either as indirect transfers – such as tax relief or access to a spouse’s health insurance – or as direct, individualised payments like parental allowances (Leitner 2014, 38–39).

In 2003, Sigrid Leitner developed and empirically tested a typology of four familialistic welfare models. The first, *explicit familialism*, refers to policies that overtly promote family-based care for children and the elderly. Also known as *supported familialism* (Saraceno 2016), this model tends to reinforce traditional gender and social hierarchies by failing to promote shared caregiving responsibilities, such as paternity leave. Saraceno (2016) further refines this category by identifying *prescribed familialism*, a sub-type in which civic laws mandate financial or caregiving obligations within kinship networks or across generational lines. By contrast, *implicit familialism* – or *familialism by default* – is characterised by the absence of state support for care, thereby placing the responsibility squarely on families without explicitly stating so. In this model, care obligations fall to the family not by policy design, but by lack of alternatives (Leitner 2014, 39–40). In *optional familialism*, families are offered a mix of familialising and defamilialising policies, allowing them to choose whether or not to take on caregiving responsibilities. Here, unlike in explicit familialism, the right to care is not equated with the obligation to care. Finally, *defamilialism* (also referred to as *anti-familialism*) represents a model where state or market mechanisms take on the primary caregiving role. While such regimes may significantly relieve families of caregiving duties, they do so without formally recognising a family's right to provide care (Leitner 2014, 39–40).

As Saraceno notes, all countries exhibit elements of multiple types of familialism, and the distinctions between them often lie in the balance of policy emphases and sector-specific tendencies (Saraceno 2016, 317). These welfare orientations are not only institutional but also deeply embedded in cultural values and normative expectations. Cultural attitudes towards gender roles and intergenerational obligations both inform and are shaped by policies, creating feedback loops between ideals of care and institutional design (Van Oorschot, Opielka, and Pfau-Effinger 2008; Budig, Misra, and Boeckmann 2012; Saraceno 2016). In this context, Monique Kremer's (2005; 2007) notion of 'ideals of care' is particularly useful: it refers to prevailing social norms about what constitutes appropriate care, which are both shaped by and shaping of welfare policies and economic incentives.

In classifying welfare regimes by their orientation to familialism, Leitner (2014) identified several ideal types. The optional familialism found in Scandinavian welfare states combines high levels of direct cash transfers with well-developed defamilialising services, allowing families to choose between providing care themselves or relying on public support. In contrast, implicit familialism, typical of liberal regimes, delegates care responsibilities to families by default, offering public support only in cases of extreme need. While this model may appear defamilialising in theory, in practice it reinforces inequalities through reliance on

market-based solutions. Conservative-corporatist welfare regimes serve as prototypes of familialistic systems: they encourage the retention of care – especially for children and the elderly – within the family unit, a pattern also commonly observed in Southern European and Central and Eastern European (CEE) countries, as well as parts of East Asia (Leitner 2014, 41; Saraceno 2016).

Austria exemplifies the evolution of a conservative-corporatist model through various phases of familism. Initially marked by implicit familism, Austria, like Germany, began introducing explicit familialistic policies in the 1930s, such as health insurance co-membership, survivor pensions, and tax benefits for single-income families. The parental leave scheme introduced in 1957 provided Austrian mothers with one year of leave, later extended to three years due to the scarcity of childcare services (Obinger 2008). This extension exemplified a refamilialising policy orientation, whereby women were encouraged to remain in the home as caregivers.

The early 2000s saw a continuation of Austria's familist trajectory, particularly under the ÖVP–FPÖ coalition (1999–2006), which emphasized cash benefits for parental leave without expanding care services for children under three (Blum 2014). However, a shift occurred after 2006, when a grand coalition of the SPÖ and ÖVP reoriented family policy towards a more optional familism. Reforms included more flexible benefit schemes and the introduction of a ‘partner bonus’ in 2008, incentivizing fathers’ participation in childcare. These changes, combined with a significant expansion of early childhood education infrastructure and compulsory pre-school attendance, marked a partial move toward defamilialisation. Between 2007 and 2011, investment of €105 million contributed to increasing enrolment in under-three childcare from 11.3% to 19.7% (Blum, Formánková, and Dobrotić 2014). Thus, Austrian family policy came to blend explicit familism (cash-for-care schemes) with emerging defamilialising elements, reflecting a dual track of positive familialisation and positive defamilialisation.

Croatia, although initially absent from Leitner’s typology, illustrates a different path shaped by its socialist legacy and turbulent post-socialist transformation. While Croatia introduced its first paid leave as early as 1927 (Korintus and Stropnik 2009), it was during the socialist period that more substantial leave schemes emerged, particularly the 1973 introduction of a six-month leave, later extended to one year (Dobrotić 2018). Unlike Austria, which gradually moved towards optional familism, Croatia experienced a sharp policy shift during the 1990s, when the conservative Croatian Democratic Union (HDZ) government abandoned the socialist-era dual-earner model in favour of a pronounced pronatalist and

familialist agenda. Proposals included the institutionalisation of a ‘mother-caregiver’ profession and a three-year maternity leave. Although the full policy package was never implemented due to fiscal constraints, mothers of three or more children were granted extended leave (Puljiz and Zrinščak 2002; Dobroć 2012).

Croatia’s familialist turn was complicated by competing pressures: on the one hand, international financial institutions pushed for liberal-residual reforms; on the other, European Union accession introduced gender equality standards that encouraged paternal involvement in childcare. Father quotas were introduced in 2013, and the terminology shifted from ‘maternity’ to ‘parental’ leave. Yet, in practice, maternalist norms remained dominant, and reforms often lacked coherence or consistent implementation (Dobroć 2018). Croatian familialism today reflects a hybrid and somewhat contradictory configuration: explicit familialism (long maternity leaves, ‘parent-caregiver’ benefits in cities like Zagreb), gender-equality oriented policies (such as father quotas), and a lingering pronatalist ideology (cash incentives for larger families).

A comparison between Austria and Croatia thus reveals both common foundations in familialistic welfare frameworks and divergent developmental trajectories. Austria has followed a more stable and institutionally coherent path toward optional familialism, supported by sustained policy innovation and substantial investment in early childhood education. Croatia, by contrast, has experienced a more fragmented evolution, shaped by political instability, inconsistent policy implementation, and an ongoing tension between traditionalist agendas and modernising pressures. While both countries continue to position the family as a primary provider of welfare, Austria has more effectively combined familial support with public provision, whereas Croatia remains caught between conflicting paradigms, lacking a clearly defined or coherent family policy model.

A more detailed comparative analysis of family care policies – alongside broader questions of volunteering and gender relations – is developed in the following chapter. There, the extent to which palliative care volunteering reflects and reinforces these familialistic trends will be critically examined, including whether (and in what ways) it contributes to the emergence of new patterns of familialism. In the final section of this chapter, I turn to another crucial dimension in understanding how palliative care volunteering operates within familialistic welfare contexts: the production of value(s) and the forms of spirituality that underpin this unpaid labour.

2.3 Value Beyond Wages: Spirituality, Human Capital, and the Ethics of Care

Central to understanding the form of familialism both shaping and shaped by palliative care volunteering in this dissertation is the production of specific forms of value, spirituality, and emotion, all closely tied to the professionalization of volunteer care work. I begin by addressing the question of value. Because volunteer work involves unpaid labour, it often eludes traditional economic assessments. As such, its analysis requires theoretical frameworks that move beyond mainstream conceptions of value to capture the diverse and layered meanings embedded in palliative care volunteering. Anthropological and feminist critiques of economy and labour offer particularly productive approaches here. Graeber's (2018) thesis on 'bullshit jobs' and Battistoni's (2024) analysis of the 'cost disease' – which helps explain the low or absent remuneration of socially reproductive labour – are especially relevant. In the context of Austria and Croatia, a key justification for the 'unpayability' of palliative care volunteering lies in its framing as a deeply 'humanised' form of work (Altman, 2020). I locate this within anthropological discussions of humanitarianism, drawing in particular on Muehlebach's (2012, 2013) concept of *Catholicised neoliberalism* – a moral-economic style that blends market rationality with Christian ethics. This concept offers a useful lens through which to connect the practices of my research participants with broader spiritual and affective trends. My analysis of the spiritual and religious dimensions of palliative care volunteering also draws on sociological debates around secularization, modernization, and the rise of self-development discourses. These trends help frame volunteering not only as an act of care, but as a form of human capital production and self-investment – an increasingly central dynamic in the shifting landscapes of contemporary welfare states.

A central question guiding my research is how to conceptualize the value of work that is unpaid yet embedded in broader systems of welfare and capital. Specifically, what kinds of value do palliative care volunteer services generate – for clients, volunteers, and the welfare system? To explore this, I draw on anthropological debates, which have long examined how people navigate multiple regimes of value in daily life (e.g., Malinowski 2005; Mauss 2003; Appadurai 1988; Bloch and Parry 1989). Theories of exchange, particularly gift economies, question whether diverse values can be reduced to a singular value of exchange (Damon 1980; Gregory 1982; 1997; Godelier 1996; Graeber 2001). These discussions intersect with broader inquiries into money, 'special monies,' and valuation practices (Zelizer 1997; Guyer 2004; Maurer 2006). Anthropologists emphasize that not all values are commensurable; many resist

reduction to a single metric or market logic (Godelier 1996; Gudeman 2008). Even in market settings, people operate with multiple value scales, as seen in Guyer's notion of 'exchange performance' (Guyer 2004). Valuation often extends beyond calculation: people may assign the greatest worth to things that cannot be measured, compared, or exchanged (Shipton 2014).

This tension between social value and economic valuation was explicitly articulated by one of my respondents, Sara, who referenced David Graeber's *Bullshit Jobs* (2018) (see Chapter Four). Drawing on Graeber's argument, she noted the paradox that the more socially valuable the work, the less it is compensated – a dynamic particularly visible in reproductive and care labour. According to Graeber (2018), this stems from the long-standing ideological devaluation of care work, linked to its gendered association with women and its perceived incommensurability with economic value. While Graeber's critique is illuminating in its identification of persistent ideologies surrounding work and compensation, I find his explanation ultimately essentialist and insufficient to capture the complexity of perspectives voiced by my research participants. Gender roles undoubtedly shape the devaluation of care work, but I argue that the feminisation of palliative care is not the cause of its unpaid status – it serves as a justification for it.

To explore this further, I draw on Alyssa Battistoni's reading of the 'cost disease' and her critique of the 'naturalisation thesis' found in both earlier and more recent feminist accounts of reproductive labour (see Chapter Three) (Battistoni 2024). For Battistoni, patriarchal or other cultural attitudes are not the root cause of care work's devaluation, but rather serve to justify it. The underlying cause, she argues, lies in the structural organisation of labour under capitalism and the inherently low profitability of care work (Battistoni 2024). The concept of cost disease, originally coined by economist William Baumol, refers to the relatively stagnant productivity of labour-intensive, face-to-face services – such as care work – when compared to more mechanised and industrialised sectors. The necessity of human presence makes care work particularly resistant to automation (Baumol 2012; Battistoni 2024). The cost-disease framework does not offer a reductive causal explanation for why care work is often unpaid. Instead, it provides a broader analytical lens for interrogating the complex relationship between money, labour, and value in palliative care volunteering. It invites us to think beyond gender or ideology alone and consider how economic structures, labour dynamics, and valuation practices intersect in shaping the (non-)remuneration of care.

I argue that a central justification for the unpaid nature of palliative care volunteering lies in its association with what Tess Altman (2020) describes as 'humanisation'. In both of my research contexts, volunteer services were framed as expressions of shared human qualities –

such as empathy and warmth – that are understood to emerge most authentically outside the bounds of professional status and monetary compensation. Altman (2020) uses humanisation to describe the affective and ethical framework underlying the work of the Australian NGO Campaign for People Seeking Asylum. In her analysis, humanisation refers to a process that rescaled and personalized interactions between various actors – such as the state, citizens, and aid recipients – by emphasizing shared values and universal rights (Altman 2020). Rather than being *responsibilized* in the neoliberal sense, the campaigners in Altman’s study embodied a form of *response-ability*, following Donna Haraway’s concept (Haraway 2016). This term refers to the cultivation of shared feelings, capabilities, and moral obligations that emerge in reciprocal, ethical relationships.

Altman’s distinction is especially important in separating these practices from forms of humanitarianism that have been widely critiqued for perpetuating inequality – particularly the power asymmetry between givers (who act) and receivers (who are rendered passive) (Feldman and Ticktin 2010; Fassin 2012; Malkki 2015). While humanisation and humanitarianism are conceptually distinct, their shared etymological root in the term *human* is significant and should not be overlooked. As anthropologist Čarna Brković notes in her discussion of ‘vernacular humanitarianisms’ in *Social Anthropology*, both concepts rest on the idea of belonging to a universal moral community – a community of beings who share fundamental experiences and obligations (Brković 2023, 5). Brković also highlights the importance of understanding how humanitarianism has been practiced in diverse cultural and historical contexts⁵ (Brković 2023). This does not mean abandoning a critical perspective, however; she stresses the need to unpack the ‘baggage’ that comes with the notion of humanity as a universal category – especially its ties to European Enlightenment thought and colonial legacies (Barnett 2011; Barnett and Weiss 2008; Brković 2023). This insight is particularly useful for my own analysis, as it pushes me to consider the contextual meanings and political implications of terms like *humanised* and *humanitarian*.

Understanding the genealogy of humanitarianism is valuable not only because of its shared epistemological roots with humanisation, but also because palliative care volunteering often expresses a similar ethical orientation. Specifically, volunteers frequently demonstrate sensitivity to suffering – a moral imperative that echoes key tenets of humanitarianism. In my fieldwork, the idea of shared humanity often emerged through encounters with the suffering of

⁵ For the histories of humanitarianism in social contexts see Denéchère (2014), Hachmeister (2020), Andrews (2020); for human humanitarianism practiced in various moral repertoires such as Islam (Mostowlansky 2020), Indian religions (Bornstein 2012; Framke and Möller 2019) or Judaism (E. Weiss 2017).

the dying, whose visible vulnerability confronted volunteers with both their own mortality and a heightened sense of responsibility.

Humanitarianism, broadly defined, is an ethos and a mode of action grounded in the moral imperative to alleviate the suffering of others (Itzhak 2020, 278). Historically, it emerged in the context of capitalist expansion and growing global consciousness, where responsibility for the distant Other was framed not as a civic duty or human right, but as an ethical obligation rooted in compassion and personal virtue – distinct from state-led welfare or rights-based activism (Haskell 1985; Barnett 2011). Recent ethnographic work has shown how this ethos has been incorporated into welfare regimes, positioning citizens as responsible for unmet social needs through voluntary engagement (see Hyatt 2000; Muehlebach 2012; Rozakou 2016).

Andrea Muehlebach's (2012) concept of 'Catholicized neoliberalism' is especially helpful for understanding this shift. She describes Catholicised neoliberalism as a moral style – an ethic or sensibility – that marks a departure from the anti-statist neoliberalism of Reagan and Thatcher. In its place, a new model emerges that seeks to care for vulnerable populations by promoting nonprofit and civic initiatives. This blend of economic rationality with Catholic principles of charity emphasizes urgency, empathy, and the moral responsibility to act. Drawing on her fieldwork with volunteers in Italian Catholic organizations, Muehlebach (2012, 2013) argues that both post-Washington consensus neoliberalism and Catholic social doctrine rely on an ideal subject characterized by love, empathy, and attentiveness to suffering. These values resonate deeply within the field of palliative care, where love and empathy are not only moral imperatives but are framed as essential skills and markers of volunteer professionalism. In this context, Muehlebach's analysis provides valuable tools to locate my participants' activities within broader spiritual and moral currents rooted in Catholic teachings.

This connection is particularly relevant given the Catholic cultural contexts of both organizations I studied. The idea of 'unexceptional love' – the ability to empathize with and accept every patient regardless of their condition or background – was a recurring theme. While such nonjudgmental care has been central to palliative care since the early hospice movement, it also strongly aligns with Catholic theology, particularly the emphasis on the divine presence in every human being, especially the vulnerable. This theological underpinning helps explain how volunteers come to view their unpaid labour not only as care but as a form of moral and even spiritual obligation.

If the work of Croatian and Austrian palliative care volunteers aligns with the spiritual ethos of Catholicised neoliberalism, it also resonates with a broader cultural phenomenon known as the 'spiritual turn' (Houtman and Aupers 2007; Watts 2022). Since the late 1960s,

increasing numbers of people in the West have begun to identify as ‘spiritual but not religious’ (Lipka and Gecewicz 2017; Pew Research Center 2018). A defining feature of this shift, as cultural sociologist Galen Watts (2022) notes, is what Paul Heelas and Linda Woodhead (2005) call the ‘subjective well-being culture’ – a central element of liberal democracies. This culture is characterized by a growing emphasis on practices aimed at improving individual quality of life, self-realization, and personal growth (Heelas and Woodhead 2005; Watts 2022). During my fieldwork, many palliative care volunteers described their engagement in precisely these terms: as a form of self-development and personal transformation that enhanced their well-being.

I situate these findings within larger shifts in welfare state policy, particularly the emergence of the ‘social investment state’ (Hemerijck 2017). This model aims to maintain a competitive position in the global economy by investing in human capital – through education, health care, and social services (W. Brown 2016; Hemerijck 2017). In this paradigm, as political theorist Wendy Brown (2016) argues, individuals are increasingly conceptualized as human capital – not only for themselves but also for businesses, national economies, and transnational markets. In this context, virtually every aspect of life – from education and consumption to mate selection and volunteering – is reframed as a practice of self-investment. Volunteering, then, may be interpreted not only as altruistic service but also as a form of human capital enhancement.

Scholars working within the tradition of governmentality studies (Rose 1999; M. Dean 2010; Lemke 2015; Peeters 2019), including Brown (2016), have argued that this shift from ‘state care’ to ‘self-care’ is a hallmark of neoliberal governance. Under this model, individuals are increasingly expected to assume responsibility for managing social risks such as illness, unemployment, or old age, all in the name of personal growth and fulfillment. From this perspective, spiritual practices aimed at enhancing well-being – many of which originate from Eastern traditions – are often viewed as tools to boost productivity and performance (E. B. Dent, Higgins, and Wharff 2005; R. E. Purser and Milillo 2015; R. Purser 2019). Others, such as psychologist Zack Walsh, suggest that these practices may also offer avenues for resistance by affirming alternative ways of being that neoliberal systems attempt to marginalize (Giorgino and Walsh 2018).

Watts traces the cultural roots of this structure – understood as a ‘deep meaning system’ that informs a range of discourses – back to Romanticism, Transcendentalism, the New Thought movement, and therapeutic cultures of the 18th and 19th centuries (Watts 2022). These ideas remained marginal until the 1960s, when they entered the mainstream through

movements such as the New Age, Charismatic Christianity, and the Human Potential Movement. While the first two have received considerable attention in contemporary studies of spirituality, the Human Potential Movement is typically analysed through the lens of secular self-help and therapeutic culture. This, Watts argues, neglects the movement's spiritual and religious resonances (Watts 2022). Drawing on thinkers such as Philip Rieff and Micki McGee, Watts notes how self-help literature from the mid-20th century onward translated explicitly Christian concepts – such as ‘vocation’, ‘mission’, and ‘calling’ – into the secular language of psychology: ‘self-actualization’, ‘personal development’, and ‘self-growth’ (Rieff 1968; McGee 2005; Watts 2022). These shifts help explain why the language of personal development used by palliative care volunteers may carry spiritual or religious connotations, even when not explicitly framed as such.

I do not suggest that all my participants use the language of personal development to express spiritual or religious meanings. However, it is important to recognize that the vocabulary they employ – how they describe and make sense of their volunteer work – operates within broader cultural and religious frameworks. Given both the Christian roots of the modern hospice movement (as explored in the next chapter) and the institutional ties between the two studied organizations and the Catholic Church, analysing how this vocabulary is used can offer valuable insights into the lived experiences of spirituality and religiosity in two nominally Catholic European countries. Whether these discourses are interpreted in secular terms or not often depends on individuals' prior socialization (Ammerman 2014; Watts 2022) and the specific configurations of religious life in each national context – factors widely discussed in the sociology of religion (e.g., Putnam 2000; Pickel and Gladkich 2012; Stolz et al. 2016; Kallunki and Zrinščak 2021), which I now turn to.

Secularization theory traditionally posited that modernization and economic development would inevitably lead to political and social secularization. Scholars such as José Casanova have described secularism as a dominant ‘knowledge regime’ in Europe – one that often renders religion invisible or irrelevant in public life (Casanova 1994; 2007). Within this framework, being modern has frequently been equated with being non-religious (Mourão Permoser 2014). Yet recent developments – such as economic uncertainty, shifts in welfare regimes, and growing societal diversity – have reignited interest in the role of religion within ostensibly secular public spheres. Some scholars now speak of a ‘return of religion’ (Casanova 2007; Katzenstein 2006; Katzenstein and Byrnes 2006), with Jürgen Habermas famously declaring that European societies are entering a post-secular era (Habermas 2008). Rather than asking whether or why religion has returned – questions rooted in a binary view of secular and

religious domains – recent scholarship focuses on when, where, and how religion manifests in (post)secular societies (Mourão Permoser 2014). As Nilüfer Göle suggests, this requires us to move beyond rigid dichotomies and examine how religion is continually reinterpreted and reshaped within secular modernity (Göle 2010). My research engages this ongoing reconfiguration by examining palliative care volunteering as a site where religious and spiritual sensibilities are expressed, negotiated, and embedded within the distinct welfare regimes of the studied contexts.

In welfare state literature, interest in religion has only recently re-emerged, despite the historical involvement of religious organizations in welfare provision across Europe since World War II. The ongoing transformation of welfare systems has opened new avenues for religious associations to re-engage (F. G. Castles 2004; Palier 2010; Bonoli and Natali 2012; Kallunki and Zrinščak 2021). Paradoxically, even as religious affiliation declines across Europe, the presence of faith-based organizations in social and healthcare services continues to grow (Bäckström et al. 2013; Davie 2017). According to the theory of functional differentiation, religion becomes just one subsystem among many in modern society. When religious organizations engage in roles such as healthcare or social service provision, they are expected to align with the dominant logics of those systems (Luhmann 1990; Beyer 1994; Dobbelaere 2009). However, emerging evidence suggests these systems are increasingly interdependent, with processes of differentiation and de-differentiation – and secularization and de-secularization – unfolding simultaneously. This calls for a more nuanced understanding of religion’s evolving societal role (Beyer 1994; Casanova 2013; Kallunki and Zrinščak 2021).

In this spirit, my analysis examines the institutional role of religion in the two case studies by exploring how volunteers express their motivations and spiritual orientations through practices of care. As with humanitarianism, it is important to recognize that – even in Christian or specifically Catholic contexts (e.g., Scherz 2014; Itzhak 2020) – ethical and emotional sensibilities are not uniform; their meanings shift across social and institutional settings. In my research, this involves situating volunteers’ ‘humanised’ practices within specific welfare arrangements. These practices rely on a particular form of human capital – one that may be shaped by religious language to varying degrees but is almost always enacted through empathy and love. These emotional and moral dimensions are central to how volunteer professionalism is understood and performed.

This literature review showed that terms like welfare, well-being, professionalism, value, spirituality, humanity, and love are never neutral. Each carries a specific genealogy, shaped by broader socio-economic dynamics and local contexts. A key analytical task is to

trace how these structures intersect with lived experience. While theoretical frameworks guide interpretation, fieldwork findings can also challenge or redefine those concepts. With this in mind, the next chapter examines the development and organization of palliative care volunteering in Austria and Croatia. By analysing similarities and differences in practice, it offers a new understanding of the evolving nature of familialistic welfare in both countries.

Chapter 3

To Care ‘Orderly’ or ‘Custodially’ and always Familialistically: The Arrangement of Palliative Care Volunteering in Austria and Croatia

Introduction

After outlining the theoretical foundations in the previous chapter, this chapter turns to the contextual framework. Rather than simply presenting data on palliative care services and welfare provision in Austria and Croatia, I offer a comparative analysis of how palliative care has developed and is organized in both countries. This analysis is situated within their broader socio-economic trajectories and the historical evolution of the hospice movement, with reference to other European regions relevant to the case studies. In doing so, I begin to address one of the central research questions: how the welfare regimes in Austria and Croatia shape palliative care volunteering, and how this voluntary engagement, in turn, contributes to, transforms, or challenges the development of their respective welfare models. The discussion draws on official documents and data related to palliative care and welfare arrangements from each country, as well as from international organizations such as the European Association for Palliative Care (EAPC) and the World Health Organization (WHO). The analysis is also informed by expert interviews conducted during fieldwork and is grounded in scholarship on the welfare state – particularly in relation to its gendered dimensions, the role of the third sector, religious organizations, and the specific context of Central and Eastern Europe (CEE). It is important to note that, unlike the next three chapters, this one is the least ethnographic, with interviews and other ethnographic material playing a secondary role in supporting the arguments.

That said, after presenting a linear (i.e., mainstream) history of the hospice movement to provide a general understanding of how hospice and palliative care developed in the Global North, I turn to the integration of palliative care into the health and social care systems of Austria and Croatia. The second subchapter begins by identifying shared characteristics of the two systems – namely, their medicalization and fragmentation – which pose potential challenges to the implementation of palliative care. While Austria has largely managed to address these obstacles through a well-developed long-term care system and strong economic

performance, Croatia lags significantly behind in both areas, particularly in comparison with other European countries. These factors, along with additional socio-economic challenges such as migration trends and inadequate healthcare infrastructure, have contributed to the stark discrepancy in the availability of palliative care services between the two countries. Despite these differences, gendered patterns in the palliative care sector appear remarkably similar in both settings. I attribute this to the familialistic orientation of the Austrian and Croatian welfare states, where care responsibilities are largely delegated to families – especially to women. However, it is important to note that these gendered dynamics are not identical, as they emerge from divergent trajectories in family and care policy. For instance, Croatia has struggled to implement both pro-natalist policies and EU-recommended institutional childcare, largely due to Socialist legacies and insufficient resources. This has resulted in an ambivalent, poorly coordinated family policy framework. In contrast, Austria has developed a more structured form of familialism which, while more coherent in design, still relies heavily on women to provide care – typically within the home.

The final subchapter focuses on the organization of volunteerism, given its significance in explaining the differing directions of palliative care development in Austria and Croatia. Austria's long-standing reliance on non-profit and religious organizations for welfare provision has made its corporatist model more amenable to integrating volunteer labour. In contrast, Croatia's post-socialist model – where the non-profit sector has only recently begun to take shape – has proven less conducive to volunteer involvement. Highlighting the ambivalence of state authorities toward volunteering, one research participant described the Croatian state as 'custodial,' capturing its tendency to neglect volunteering in policy while still exerting control over its development. This custodial stance can be traced back to the decentralized, self-managed Yugoslav health and social care system, which was particularly resistant to the inclusion of non-state care providers – more so than in other CEE countries. Paradoxically, this same decentralization facilitated the successful implementation of a new, integrative model of palliative care in Croatia – one grounded not in humanitarian volunteering but in professional, medically based service delivery through public healthcare centres.

This path to professionalization diverges sharply from the Austrian experience, where volunteers were central to the development of palliative care from the outset. However, the professionalization of Austrian volunteers did not guarantee public funding, revealing limitations in Austria's fragmented healthcare system. Ultimately, analysing the role of palliative care volunteering has helped uncover additional distinctions between the two welfare regimes. In Austria, the high degree of regulation and the strong presence of women in the

volunteer sector reflect the ‘orderly corporatist’ nature of its familialism. In contrast, Croatian volunteers reveal a ‘custodial and disorganized’ form of familialism, shaped by the legacies of its socialist past and the challenges of post-socialist transition.

3.1 From Global Trends to Local Realities: The Evolution of the Hospice Movement in Austria and Croatia

This subchapter outlines the development of hospice and palliative care – tracing its trajectory from a global perspective to its specific evolution in Austria and Croatia. Originating in post-war Britain, during a period of unprecedented growth in the medical field and welfare state, modern palliative care followed a distinctly Western path shaped by prevailing socio-economic conditions and the legacy of Christian charity. Championed by its founder, Cicely Saunders, it promotes holistic care for terminally ill patients, addressing not only physical pain but also its psychological, social, and spiritual dimensions (Saunders 2001). A key element in the success of palliative care is the involvement of volunteers, whose contributions foster a sense of community within the clinical environment. However, palliative care does not develop in a vacuum; it is deeply embedded in the socio-economic context. Consequently, its full implementation has been most feasible in economically advanced countries of the Global North.

In Austria, the hospice movement began in the late 1970s, spearheaded by Catholic nun Hildegard Teuschl, initially through volunteer services within Caritas. The institutionalisation of Austrian palliative care was marked by the introduction of the Graded Hospice and Palliative Care System, which later served as a model for other European nations. In contrast, Croatia's hospice movement emerged nearly two decades later, led by neurologist Anica Jušić. After more than fifteen years of humanitarian work, a major milestone came with the adoption of the 2014–2016 National Strategic Plan for Palliative Care, which formally integrated palliative services into the national healthcare system. Before delving into these national developments, I would like to begin with an overview of the origins of the modern hospice movement.

The care of people with advanced, incurable illnesses and those nearing the end of life has long been a concern across societies, traditionally taking place within the family. However, philanthropic organizations, religious institutions, hospitals, nursing homes, and shelters for the poor and marginalized have also historically provided support and accommodation for the

chronically ill and dying (Payne and Morris 2018). Today, such care is commonly referred to as ‘hospice and palliative care.’ The term ‘hospice’ derives from the Latin *hospitium*, meaning hospitality or a place of shelter. In Europe, the concept dates back to the early Middle Ages, when hospices offered rest and relief to pilgrims who could no longer continue their journey. After the decline of crusades and pilgrimages, these hospices gradually evolved into guest houses and hospitals, forming the foundation of institutions that have continued to care for the sick and elderly to this day. The modern idea of hospice care was revived in the late 19th century in Ireland, with a specific focus on supporting long-term patients and the dying. However, it was not until the 1960s that hospice and palliative care became more firmly established, largely due to the pioneering work of Dame Cicely Saunders (HOSPIZ Österreich n.d.).

After her experience as a wartime nurse in the UK – working without the benefits of modern pharmacology – and witnessing firsthand the suffering of terminal cancer patients and their families, Cicely Saunders, a social worker and nurse who later qualified as a physician, recognized a profound and unmet need to alleviate the pain of those facing incurable illness. During seven years of voluntary nursing work in the 1950s, a period marked by rapid pharmaceutical advancement, she first observed the effectiveness of small, regular doses of oral morphine in managing pain (Saunders 2001). Although she deeply valued medical innovation, Saunders came to understand that the needs of dying patients extended beyond the boundaries of medicine. The traditional curative approach – focused on healing – was insufficient when the goal shifted to making the final phase of life as comfortable and pain-free as possible. Her philosophy is best captured by her now-famous expression: ‘Low tech and high touch.’ To support this holistic vision of end-of-life care, Saunders introduced the concept of ‘total pain,’ which includes physical, psychological, social, and spiritual dimensions (Saunders 2001; Scott 2018).

Recognizing that her vision for caring for the terminally ill could not be fully realized within the framework of the National Health Service (NHS), Saunders went on to establish the first modern hospice, St. Christopher's, in South London in 1967, funded by donations (Scott 2018). The hospice aimed to deliver excellent clinical care alongside education and research, all centred on the needs of dying patients and their families (Clark 2002). St. Christopher's offered space for 54 patients, a 16-bed residential wing for the elderly, a nursery for staff children, and a planned bereavement service. A home care service was added two years later (Saunders 2001). By naming the institution a ‘hospice,’ Saunders intentionally evoked the medieval tradition of hospices as places of rest and care for pilgrims. This historical connection

reflected her personal religious awakening, which infused her work with certain Christian ideals. As she later recounted in numerous interviews (BBC Radio 4 1995), one of her central concerns was how to integrate the spirit of religious charity into an increasingly secular society (Saunders 2001, 431). While she emphasized that the new hospice was built on a broad spiritual foundation, a chapel was nonetheless included – though it was designed to be inclusive, not obligatory, and open to people of all faiths (Saunders 2001, 431).

Beyond addressing the spiritual needs often manifested in fear and grief, another major challenge in hospice care was supporting staff tasked with reaching the most hidden sources of distress – an effort requiring a deeper, more flexible form of commitment than typically found in conventional hospitals or care institutions. Saunders believed that such commitment could only emerge from a strong sense of ‘community ethos’, which she sought to cultivate by inviting local community members to contribute their skills through volunteering (Saunders 2001; Scott 2018).

From the outset, volunteers became integral to ‘demedicalising’ hospice work, helping to establish palliative care as a philosophy rooted not only in physical infrastructure but in human attitudes and relational skills (Saunders 2001). A central part of this philosophy is the psychosocial support volunteers offer to patients and their families. This contribution is especially evident in raising awareness of palliative care among the wider public and providing non-clinical forms of emotional presence (Radbruch and Payne 2010). Unlike the ‘expert symptom relief’ of the Hippocratic tradition⁶, volunteers follow the Asklepiian approach to care, emphasizing healing from within – through presence, attentive listening, and honouring the integrity of the patient (Goossensen et al. 2016). Unsurprisingly, volunteers have become a cornerstone of the hospice movement. As the European Association for Palliative Care (EAPC) later declared in its official documents, ‘the hospice movement, as a civil rights movement, is based on volunteer work’ (Radbruch and Payne 2010, 26).

⁶ The Hippocratic tradition represents an analytical and scientific approach to medicine, where every disease is believed to have an identifiable cause that can be addressed through external intervention. Its focus lies in the generalizable knowledge of illness and symptoms, emphasizing diagnosis and cure. In contrast, the Asklepiian tradition, rooted in ancient Greek practice, viewed healing as a process that originated from within. In this tradition, the incurably ill would visit the temple of Asklepios, where healing was facilitated not through medical intervention but through symbolic practices – such as the gaze of sacred snakes, which came to represent the caregiver’s attentive presence. This gaze symbolizes the values of waiting, listening, and honouring the patient’s dignity, emphasizing care for the whole person. Both traditions are reflected in Saunders’ pioneering approach to hospice and palliative care, which combined expert pain and symptom management with holistic support addressing the physical, psychological, social, and spiritual needs of patients, as well as those of their families and friends (Saunders 1987; Goossensen et al. 2016).

Since then, the philosophy and practice of what was once called ‘hospice and terminal care’ has spread globally, initially across English-speaking countries. In 1975, Canadian physician Balfour Mount introduced the term ‘palliative care’ (from Latin *pallium*, meaning cloak or protective covering) to adapt the values of the hospice movement to the hospital and medical context. In French-speaking Canada, ‘hospice’ was already associated with nursing home care, prompting the adoption of a new term. Today, despite some variation in terminology across – and even within – countries, ‘palliative care’ has become the widely accepted umbrella term for care aimed at supporting people with life-limiting and terminal illnesses (Radbruch and Payne 2010; Payne and Morris 2018).

By the 1980s, palliative care began to receive formal institutional recognition. In 1987, it was approved as a medical specialty by the Royal College of Physicians in the United Kingdom and Ireland. The following year, the European Association for Palliative Care (EAPC) was founded to promote and advance palliative care throughout Europe and beyond. Its mission includes fostering education, research, policy development, and evidence-based practice, while advocating for high-quality palliative care as an essential part of health systems. Through its ‘White Papers,’ the EAPC provides recommendations and standards for delivering quality palliative care. Following this momentum, several international organizations were established to address specific needs and regions. These include the International Association for Hospice and Palliative Care (IAHPC) in 1997, the International Children’s Palliative Care Network (ICPCN) in 2003, and the Worldwide Palliative Care Alliance (WHPCA) in 2008 (Payne and Morris 2018).

In 2002 the World Health Organisation (WHO) adopted the definition of palliative care, which is still the main point of reference when it comes to discussing and organizing palliative care. It says:

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (World Health Organization 2023)

Given current socio-economic conditions, a holistic approach to death remains more aspirational than fully realized in many parts of the world. Demographic and epidemiological trends point to a growing need for such care. Populations in Europe, North America, Australia,

and parts of Asia are aging, while in other regions – particularly sub-Saharan Africa – communicable diseases such as HIV/AIDS, tuberculosis, and malaria place significant demands on palliative care systems (Payne and Morris 2018). Globally, the proportion of people over 60 is projected to double from 11% in 2020 to 22% by 2050, leading to a rise in chronic and advanced conditions and, consequently, more complex and widespread palliative care needs (Van den Block et al. 2015). According to the WHO and the WHPCA, approximately 20 million people require palliative care during their last year of life, with an additional 20 million in need of ongoing end-of-life support annually (Connor and Gwyther 2018).

Despite steady progress in the development of palliative care globally (Connor and Gwyther 2018; Lien Foundation 2015), stark disparities persist. These are largely driven by socio-economic inequalities, such as the uneven distribution of healthcare professionals, limited material resources, restrictive opioid regulations, and insufficient palliative care training, particularly in low- and middle-income countries (Lien Foundation 2015; Samuels and Lemos Dekker 2023). Sallnow and colleagues (2022) aptly describe the current global situation as a ‘story of paradox’ – where some people are overtreated in hospitals (and increasingly at home), while the majority are undertreated, with minimal access to healthcare, and often left to die without adequate support. This paradox underscores the historical roots of hospice and palliative care in Western capitalist modernity, where the holistic and individualized model of care can be meaningfully implemented only in the economically advanced contexts of the Global North.

Financing models for palliative care also vary widely. In the UK, services often rely on charitable donations; in the US, on medical reimbursement systems; and in Australia, on government funding. Many countries use complex mixed models to support different aspects of care (Payne and Morris 2018). In response, the WHO has advocated for a Public Health Model of palliative care, based on four key components: the development of appropriate national policies, availability of essential medicines including opioids, education of healthcare professionals and the public, and the implementation of palliative care services at all levels (Stjernswärd, Foley, and Ferris 2007). The first official WHO resolution calling for the integration of palliative care into national health systems was adopted at the 67th World Health Assembly in Geneva on May 23, 2014. Titled *Strengthening of Palliative Care as a Component of Integrated Treatment Within the Continuum of Care*, this resolution urged member states to embed palliative care into their broader health policies (HOSPIZ Österreich n.d.). However, the implementation of such international recommendations varies widely across countries and is shaped by local health and social care systems, demographic trends, levels of economic

development, and historical legacies. In the following chapter, I examine these factors in greater detail by focusing on the development and organization of palliative care in Austria and Croatia.

Shortly after palliative care began to spread throughout Anglo-Saxon countries, the hospice movement took root in Austria in the late 1970s. A key figure in this development was Hildegard Teuschl, a Catholic nun from the Caritas Socialis (CS) Sisters, who played a pioneering role in advancing palliative care and broader social reform. In 1979, she established the first palliative care course in Vienna, offered through Caritas' School for Social Work as part of its training programme for care and household assistance (HOSPIZ Österreich n.d.; Pelttari and Pissarek 2018). The evolution of hospice and palliative care in Austria was also shaped by external influences, including developments in neighbouring Germany and the work of Dame Cicely Saunders in the UK. Influential publications such as *On Death and Dying* (1969) and *Interviews with the Dying* (1971) by Swiss physician Elisabeth Kübler-Ross, as well as the documentary *16 Days to Go: Hospice Care for the Dying in London* by Roland Iblacker SJ, further contributed to the movement's momentum (HOSPIZ Österreich n.d.).

Recognising the lack of resources for establishing an inpatient hospice, Caritas – Austria's Catholic Church-affiliated charitable organisation – launched the country's first hospice service in 1989. This mobile team supported terminally ill patients in their homes, with doctors and nurses initially working on a voluntary basis. Over time, the team expanded and became one of Austria's largest home-based palliative care services, staffed by both paid professionals and volunteers (Pelttari and Pissarek 2018). In 1992, Vienna saw the establishment of its first palliative care unit, initially conceived as an inpatient hospice. Financial constraints, however, led to its conversion into a hospital-based palliative unit.

A year later, in 1993, Hildegard Teuschl and her supporters founded Hospice Austria (*Hospiz Österreich*), an independent national umbrella organisation for hospice and palliative care institutions. Beginning in 2002, Hospice Austria developed national standards for facilities, professional roles, and training, with updates in 2008, 2011, and 2013 (HOSPIZ Österreich n.d.; HOSPIZ Österreich n.d.). Legal recognition of hospice and palliative care at the national level came in 2001, paving the way for various policy developments. These included the regulation of funding for palliative units (2002), legal frameworks for family hospice leave (2002, with revisions in 2006 and 2012), the introduction of the Living Will Act (2006), and legislation on power of attorney and family representation (2007). As the sector evolved, education became increasingly professionalised. Palliative care was incorporated into healthcare training curricula in 1997, followed by the creation of a dedicated master's

programme at the IFF (*Die Fakultät für Interdisziplinäre Forschung und Fortbildung*) in Klagenfurt in 2001, and the appointment of the first professorship in palliative medicine at the University of Vienna in 2005 (HOSPIZ Österreich n.d.).

Perhaps the most influential development in shaping Austria's end-of-life care system was the introduction of the 'Graded Hospice and Palliative Care System' (*Abgestufte Hospiz- und Palliativversorgung*) in 2004 (HOSPIZ Österreich n.d.). Commissioned by the Ministry of Health (*Bundesministerium für Gesundheit*)⁷ and developed by the Austrian National Institute for Health Care Planning (*Österreichisches Bundesinstitut für Gesundheitswesen*, ÖBIG) in cooperation with Hospice Austria, this model proposed a two-level structure. The first level consists of general palliative care integrated into primary healthcare – such as outpatient services (GPs, therapists, home care), nursing homes, and hospitals. The second level involves specialised care, divided into two branches: counselling (including hospital and home-based palliative teams, often working in conjunction with volunteer hospice teams) and care (encompassing palliative care units, inpatient hospices, and day hospices) (HOSPIZ Österreich n.d.). While only the palliative care standards are legally binding, the entire Graded System has been integrated into Austria's national healthcare structure as a recommended model. These standards cover professional qualifications, service quality, and infrastructure for all specialised hospice and palliative organisations (Pelttari and Pissarek 2018). A parallel graded system for children and young adults was introduced in 2013. To date, this model has proven highly effective and has been endorsed by the European Association for Palliative Care (EAPC), featured prominently in its 2010 White Paper (Pelttari and Pissarek 2018; HOSPIZ Österreich n.d.).

In 2020, Austria had a well-developed palliative care infrastructure, including 173 hospice (volunteer) teams, 63 home palliative teams, 61 hospital palliative teams, 43 palliative care units, 14 inpatient hospices, and 6 day-hospices (HOSPIZ Österreich 2021). According to the *2019 EAPC Atlas of Palliative Care in Europe*, Austria was one of the leading countries in Europe in terms of service availability, with 187 specialised palliative care services – equating to 2.1 services per 100,000 inhabitants. This places it ahead of Ireland (1.9), Luxembourg (1.8), and Belgium (1.7) (Arias-Casais et al. 2019). As we will see in the following section, this level

⁷ From 2020 to 2025, the Ministry of Health was under the responsibility of the Federal Ministry of Social Affairs, Health, Care and Consumer Protection (*Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz*), and since 2025, it has been under the responsibility of the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection (*Bundesministerium für Arbeit, Soziales, Gesundheit, Pflege und Konsumentenschutz*) (Bundesministerium für Arbeit 2025).

of development stands in stark contrast to the situation in Croatia, where the first steps in developing hospice and palliative care began almost two decades later.

The pioneer of the Croatian hospice movement was neurologist Anica Jušić, who in 1994 founded the Croatian Association for Palliative Care (*Hrvatsko društvo za palijativnu medicinu*) within the Croatian Medical Association. That same year saw the publication of Croatia's first three books on palliative care: Jušić's *Hospice and Palliative Care (Hospicij i palijativna skrb)*, and two translations – Cicely Saunders and Nigel Sykes' *Palliative Care in the Terminal Stage of Malignant Diseases (Palijativna skrb u terminalnoj fazi malignih oboljenja)*, and Robert Buckman's *I Don't Know What to Say (Ne znam što reći)*. Following a series of international congresses and collaboration with British palliative care experts, the Association of Friends of Hope Zagreb was established in 1997 to support the umbrella organisation at the city level. That same year, the association began publishing a semi-annual bulletin on palliative care and medicine, edited by Jušić (Jusić 2009).

In 1999, a national counterpart – the Croatian Association of Hospice Friends (*Hrvatska udruga prijatelja hospicija*) – was formed. It launched the first interdisciplinary training course for palliative care volunteers, organised by Anica Jušić and nurse Stana Lovrić. In 2000, hospice house calls began taking place in Jušić's private apartment in Zagreb. Weekly team meetings and supervision sessions for non-health professionals also started, including regular training sessions at a local care home. Two years later, the opening of a regional hospice centre in the former laundry facility of the Community Health Centre Zagreb allowed these services to move into a more suitable public space (Jusić 2009).

A significant milestone came in 2003 with the new Health Care Act (*Zakon o zdravstvenoj zaštiti*), which, for the first time, legally recognised palliative care as a right. The act also made it possible to fund independent institutions at the primary healthcare level to provide hospice home visits, outpatient services, and day care. However, a second proposal by the Croatian Association of Hospice Friends – to establish an inpatient hospice – was rejected (Jusić 2009). Despite this legal progress, the lack of institutional support and the absence of inpatient facilities⁸ meant that hospice home visits lacked a solid foundation. As a result, the initial momentum began to wane (Jusić 2009).

The most significant breakthrough in the development of palliative care in Croatia occurred in 2012. Following the 2011 parliamentary elections and a wave of civic initiatives

⁸ For example, the transformation of nursing homes into social institutions (from the 1980s) made it impossible to build palliative departments or a hospice there (Jusić 2009).

and media coverage that highlighted the shortcomings of existing palliative care services, the new government adopted the ‘National Health Strategy 2012–2020’ (*Nacionalni plan razvoja zdravstva*). This strategy acknowledged the limitations of the 2003 legal framework and expanded palliative care provision from the primary level (health centres, public health services, and pharmacies) to secondary (general and specialised hospitals) and tertiary care (university hospital centres) (Lončarek et al. 2018). In February 2012, the Ministry of Health (*Ministarstvo zdravstva*) established the National Board for Palliative Care (*Nacionalna zaklada za palijativnu skrb*), which went on to propose the ‘National Strategic Plan for Palliative Care 2014–2016’ (*Nacionalni strateški plan za razvoj palijativne skrbi*) in September 2013. The plan was officially adopted in December of the same year (Lončarek et al. 2018). This framework was based on two key international documents: the EAPC’s ‘White Paper on the Standards and Norms for Hospice and Palliative Care’ (Radbruch and Payne 2010) and the Council of Europe’s Recommendation REC(2003)24 on the organisation of palliative care. The Board also drew inspiration from the experiences of Bosnia and Herzegovina, Poland, and the UK – countries with similar healthcare systems or well-established palliative care models (Lončarek et al. 2018).

By 2021, after an extension of the Strategic Plan through 2020, it became evident that Croatia had made substantial progress in building organisational structures and expanding palliative services (Vočanec, Džakula, et al. 2022). A major development was the formal introduction of county coordinators, recognised in the 2019 Health Care Act as key components of the system. Palliative care was now integrated across all three levels of healthcare, with minimum standards established for facilities, personnel, equipment, and training. Specialised education became mandatory for healthcare professionals providing palliative care, and the subject was introduced as both compulsory and elective in nursing and medical education at secondary and university levels (Vočanec, Džakula, et al. 2022).

In 2012, palliative care services were almost non-existent, limited to four mobile teams, basic mobility aid rentals, and just 12 palliative beds nationwide. However, by 2020, significant improvements had taken place. Over 1,000 professionals had undergone advanced training in palliative care (Vočanec et al. 2022). Service availability also increased dramatically: between 2016 and 2020, the number of county coordination centres rose from 5 to 17 (out of 21 counties), coordinators increased from 29 to 42, mobile palliative teams from 21 to 33, and palliative beds per million inhabitants from 48 to 88. The number of mobility aid rentals (21), hospital-based palliative teams (16), and pain clinics (21) remained unchanged (Vočanec, Džakula, et al. 2022).

Despite these notable advancements, Croatia still lags behind leading European countries in palliative care provision. As of 2020, with only 32 mobile teams and 0.8 palliative care services per 100,000 inhabitants, it ranked 25th in Europe – far behind Austria (2.1), and also behind several Central and Eastern European countries such as Lithuania (1.7), Poland (1.5), Bulgaria (1.4), Estonia (1.4), Hungary (1.1), and Slovenia (1.1) (Arias-Casais et al. 2019). What explains this discrepancy? One factor is economic development and the availability of resources. Another lies in differences in welfare state models, particularly the role of the third sector and volunteering, which are essential in palliative care delivery. However, such explanations are not sufficient to fully account for Croatia's position relative to other post-socialist countries with similar socio-economic legacies. A deeper comparative analysis is needed – one that examines how palliative care is implemented within the distinct welfare regimes of Austria and Croatia, taking into account their underlying social, religious, and economic contexts.

3.2 Integration of Palliative Care in the Austrian and Croatian Health and Social Care Systems

This analysis of hospice and palliative care in the Austrian and Croatian welfare states begins by highlighting shared challenges, particularly the medicalisation of care and the fragmentation between health and social care systems. The focus then shifts to key differences between the two welfare models, most notably in the development of long-term care (LTC) and overall material conditions, which have influenced the distinct trajectories and outcomes of palliative care in each country. These differences, in turn, reveal two types of familialistic welfare systems, both of which continue to place significant caregiving responsibilities on women and families. In Croatia, limited material resources hindered the implementation of both familializing (e.g., cash benefits and time allocation) and defamilializing policies (e.g., the socialisation or marketisation of care), particularly in the LTC sector, fostering a system of 'disorganised familialism.' In contrast, Austria's more robust socio-economic infrastructure enabled the successful implementation of both types of policies, resulting in a more 'orderly' form of familialism.

The full implementation of a holistic and individualized approach to patient needs – which is central to the hospice movement – not only depends on a country's available resources

but also requires a healthcare system willing to move away from the curative and compartmentalised models typical of traditional (Western) medicine. As several scholars have argued (e.g., Saunders 2001; Scott 2018), palliative care is still at times perceived by healthcare professionals as a failure of modern medicine, as shifting focus away from cure may be interpreted as ‘giving up’ on the patient (Lončarek et al. 2018). Moreover, palliative care challenges longstanding medical hierarchies. By emphasizing dignified death, shared decision-making, and strong partnerships between providers and recipients of care, palliative principles disrupt the traditionally paternalistic relationship between physicians and patients (Vočanec, Džakula, et al. 2022). In short, the successful implementation of palliative care hinges on the broader de-medicalisation of healthcare.

A key feature of medicalised healthcare systems is their heavy reliance on hospitals as the primary sites of care. This poses a particular challenge for palliative care, which seeks to relocate services away from hospital settings, ideally to patients’ homes – often the most preferred place of death. Both Austria and Croatia maintain hospital-centred healthcare systems, where inpatient palliative care remains the dominant model. This is evident in the high number of palliative care beds per million inhabitants – 92 in Croatia and 55 in Austria – and the fact that approximately 50% of deaths in both countries occur in hospitals⁹. The roots of this hospital-based approach lie in the historical association of the hospice movement with oncology and the care of cancer patients. Prioritising hospital care over community- or home-based services significantly increases costs, particularly in Austria, where health spending reaches 11.2% of GDP and \$4,751 per capita – well above the EU averages of 10.4% and \$3,685, respectively (Eurostat 2024a). Although Croatia’s health expenditures are lower (7.2% of GDP and \$1,858 per capita), they remain among the highest in Central and Eastern Europe, alongside Slovenia (Eurostat 2024a; Džakula et al. 2021; Lončarek et al. 2018).

One of the main obstacles to shifting healthcare provision in Austria toward ambulatory, specialist, and day care settings is the lack of clarity in financing such a transition, rooted in the fragmented allocation of responsibilities across different governance levels. The federal government regulates social insurance and most healthcare services – except hospital care, which falls under the jurisdiction of the federal states. Meanwhile, inpatient care, staffing of healthcare facilities, and even funerals are overseen by the federal states, and social health

⁹ In 2020, 50% of the Croatian population died in hospitals, 18% in nursing homes, and only 28% at home (Saborska TV - odbori 2022). These figures are quite similar to those in Austria, where in 2019, 48.9% of deaths occurred in hospitals, 20.1% in nursing homes, and 25.2% at home (Koordination Palliativbetreuung Steiermark 2019).

insurance (SHI) funds and professional bodies operate as self-governing entities. Financing is also inconsistent within each level, further complicating systemic reform (Hofmarcher and Quentin 2013; Bachner et al. 2018). Compounding this issue is the growing number of ambulatory care practitioners operating outside contracts with SHI – currently around 55%. These non-contracted physicians can set their own fees and choose their practice location freely, which has led to an increasingly uneven distribution of specialist care across regions (Bachner et al. 2018). As a result, despite recent policy efforts aimed at reducing hospital dependence – such as the Federal Target-Based Governance Agreements (2013–2016, 2017–2021) and the Primary Health Care Act (2017) – hospitals remain the primary point of care for many patients. Austria now ranks second in the EU, after Bulgaria, in hospital utilisation, with 256 hospital discharges per 100,000 inhabitants. This is significantly higher than both the EU average (173) and the Croatian rate (178) (Bachner et al. 2018).

Palliative care services in Austria fall under the jurisdiction of the federal states, a decentralised arrangement that has drawn criticism from many professionals working in the field. During an interview with Sandra, the managing director of Hospice Austria, she expressed concern over the implications of this structure. She noted that delegating responsibility to the federal states had resulted in uneven financing and service provision across regions, making it difficult to establish a stable, long-term funding model for palliative care nationwide (Interview, Sandra, 24/11/22) This fragmentation means that, although parts of palliative care are publicly funded, many institutions still rely heavily on donations and annual grants to operate (HOSPIZ Österreich n.d.). As a consequence, numerous hospices have been integrated into hospital infrastructure as palliative care units – spaces more likely to receive federal funding.

By the end of my fieldwork, a new regulation was set to be implemented in 2023, aimed at shifting the financing of hospice and palliative care from the federal states to the national level. While this move promised greater centralisation, the specifics – particularly the allocation and distribution of resources – remained unclear. Sandra voiced her apprehension about this uncertainty. She worried that state funding, while welcome, might not be sufficient to cover all operational costs. At the same time, she feared that the appearance of public financial support could dissuade private donors: ‘People might think, “Well, now the state pays for it, so they don’t need us anymore.” But that’s not how it works.’ (Interview, Sandra, 24/11/22)

To better understand the current structure of healthcare provision in Austria, it is useful to consider the historical roots of its fragmentation. This fragmentation began to take shape

between the mid-19th century and the end of World War I. In 1888, Austria introduced industrial accident and health insurance schemes for workers, based on self-governing, independent funds. By 1918, there were over 600 health, pension, and work insurance funds operating across what is now Austria (Bachner et al. 2018). After World War II, following the dissolution of self-governing bodies during the Nazi period (1938–1945), social insurance funds were re-established and gradually expanded to include broader segments of the population (Bachner et al. 2018). Today, 21 social insurance funds cover health, pension, and accident insurance, with 18 of them offering statutory health insurance (SHI). Most individuals are assigned to a specific fund based on their profession. Each of Austria's nine federal states has its own regional SHI fund, in addition to five company-specific insurance funds (Bachner et al. 2018). In recent years, efforts have been made to centralise aspects of the healthcare system to improve its organisational and financial efficiency. These reforms have introduced joint governance and planning mechanisms at the federal level¹⁰. However, they have not significantly altered the system, as constitutional decision-making powers remain largely decentralised (Bachner et al. 2018).

In contrast, Croatia's healthcare fragmentation is less a matter of financing structures and more a result of weak coordination between different levels and types of care – particularly between health and social services. This, too, reflects a specific historical trajectory. As a federal republic within the Socialist Federal Republic of Yugoslavia, Croatia maintained its own Ministry of Health, and introduced mandatory health insurance in 1945, funded through income-based contributions and the state budget. In the 1980s, decentralisation was strengthened through community management of public services, as stipulated in the 1974 Constitution. Following Croatia's independence in 1991, the system shifted toward centralisation and privatisation – especially in primary care – while retaining principles of universality and solidarity (Džakula et al. 2021). A new wave of decentralisation began in 2001, granting local authorities more control over the coordination and management of healthcare services at county and municipal levels (Džakula et al. 2021).

¹⁰ The 2013 health reform established a joint, target-based health governance system overseen by the Federal Target-Based Governance Commission. A few years later, the 2017 Federal Target-Based Governance Agreement aimed to reduce publicly financed health expenditures and strengthen primary care, including the establishment of 75 primary health care units and the promotion of health literacy and health initiatives (Bachner et al. 2018).

Despite some inefficiencies¹¹, this structure proved conducive to implementing an integrated model of palliative care. The system relies on county-level coordinators to organise services locally, while funding remains centralised through national healthcare financing. This ensures stable resources, efficient management, and, importantly, services that remain free of charge (Lončarek et al. 2018). This model has enabled rapid progress: between 2012 and 2020, Croatia achieved remarkable improvements in the provision of palliative care services, illustrating how a locally coordinated yet centrally funded system can support effective integration.

Although Croatia's integrative model of palliative care aligns with the principles of the existing health system, the longstanding fragmentation between health and social care has hindered its full and sustained implementation (Vočanec, Džakula, et al. 2022). This issue was acknowledged in the National Health Care Strategy 2012–2020 – which also introduced the new palliative care model – by stressing the need for intersectoral cooperation, both across government sectors and within society at large (Džakula et al. 2021). However, rather than resolving fragmentation, the Strategy seemed to expose the extent of systemic disconnection: poor or non-existent coordination between the health, social welfare, and war veterans' systems, between various levels of governance (national, county, municipal), and among public, private/for-profit, and non-profit service providers (Džakula et al. 2021).

Nowhere is this fragmentation more evident than in the area of long-term care (LTC), a crucial pillar of palliative care. Croatia's LTC system remains underdeveloped, with benefits that are fragmented, unevenly accessible, and often inadequate to meet even basic needs. The result is a heavy burden placed on families and the expansion of informal caregiving through the grey economy (Stubbs and Zrinščak 2018). LTC in Croatia consists of both cash and in-kind benefits. Cash benefits include the assistance and care allowance and the personal disability allowance. In-kind support encompasses home-based services (such as home assistance and housing support) and institutional care in residential settings like nursing homes, family homes, and adult foster families. Counties are responsible for financing homes for older people and those with disabilities (Oliveira Hashiguchi and Llana-Nozal 2020). Yet the reach of these services remains limited. In 2018, only 4% of people over 65 received the assistance and care allowance, 0.7% received the disability allowance, and less than 1% received formal home-based in-kind assistance – largely because eligibility is often determined by the

¹¹ Many counties lacked the technical expertise and administrative capacity to effectively govern healthcare institutions. As a result, by centralizing healthcare financing and resource allocation at the state level, local needs were often overlooked, leading to growing regional disparities that persist to this day (Džakula 2005).

presumed availability of support from family or friends¹² (Džakula et al. 2021). Residential care is provided by a mix of public, private, and non-profit actors, including NGOs and religious organisations, but remains insufficient in scope.

Given these gaps, it is not surprising that hospitals – especially emergency departments – often serve as the default providers of long-term and palliative care. In 2018, people aged 65 and older accounted for 37% of all hospital discharges, including hospital-based rehabilitation (Džakula et al. 2021), highlighting the extent to which institutional healthcare continues to compensate for the lack of integrated, community-based care options.

In contrast to Croatia, Austria's situation regarding long-term care (LTC) is very different. LTC is under the responsibility of state governments and is separate from the healthcare system in terms of legislation, competencies, and financing. This arrangement complicates communication between care providers and creates substantial differences in coverage, structural quality regulations, and quality assurance mechanisms across the country (Riedel and Kraus 2010; Leichsenring 2017). Since 2018, the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection (*Bundesministerium für Arbeit, Soziales, Gesundheit, Pflege und Konsumentenschutz*) has overseen LTC at the federal level.

Prior to the 1990s, the system was fragmented, with various stakeholders managing different allowances (Leichsenring 2017). In response to protests from disability organisations in the 1980s, which highlighted inconsistencies and coverage gaps, Austria adopted the Federal Long-Term-Care Allowance Act (*Bundespflegegeldgesetz*) in 1993. This made Austria the first European country to introduce comprehensive, need-based cash benefits for people with LTC needs, funded by general taxes (Leichsenring 2017). The Act led to a significant increase in the availability of home and residential care services across all nine federal states, although the extent of these services varied. It also spurred the development of a legal 24-hour care sector (Österle and Bauer 2012). By 2016, 5% of Austria's population (455,354 people) and 18% of those aged 60 or older received care allowances, with two-thirds of recipients being women. These allowances were used across various settings: 32% for formal homecare, 19% for residential care, 5% for 24-hour homecare, and 2% for day-care centres. Notably, 42% of recipients did not use formal services but instead relied on informal care from family members (Nagel 2015; Bachner et al. 2018).

¹² Despite changes in societal structure and the weakening of traditional intergenerational support, spouses and children remain the primary caregivers (Stubbs and Zrinščak 2018).

With a well-developed LTC infrastructure, Austria was better positioned to implement an integrative model of palliative care and shift services from hospitals to patients' homes compared to Croatia. However, the success of such a model depends not only on legal frameworks but also on available resources – whether financial, infrastructural, or human. In this regard, Croatia lags behind. In 2022, Croatia allocated only 2,8% of its health expenditure to LTC, far below Austria's 13.5% and the EU average of 16.2% (Eurostat 2024b). Additionally, the overall healthcare expenditure discrepancy is notable: Austria spends 11.2% of its GDP and 16.3% of its total state budget on health, compared to Croatia's 7.2% and 13.7%, respectively (Eurostat 2024a; World Health Organization - Global Health Observatory 2025). These figures are even more significant when considering the countries' GDPs – Austria's stands at \$472,339 billion (\$46,350 per capita), while Croatia's is \$71,260 billion (\$15,640 per capita). This stark difference positions Austria 6th and Croatia 25th out of 27 EU countries in terms of economic size (Eurostat 2022).

While neoliberal reforms and the 2008 economic crisis affected much of Europe, post-socialist transitional economies like Croatia's were particularly vulnerable to these socio-economic shifts. Since the dissolution of Yugoslavia, Croatia's welfare state has been under continual pressure to reform, with neoliberal elements gradually introduced across key sectors – especially pensions, healthcare, and social assistance (Stubbs and Zrinscak 2007; Puljiz 2008; Dobrotić 2016). Although the weakening of social protection was less severe than initially expected – largely due to the high politicisation and weak enforcement of reforms (Dobrotić 2020) – the increasing privatisation of primary care (notably in dental services and specialist clinics) and the expansion of co-payments for many services have undermined public trust in primary care. This has, in turn, diminished the role of health centres as key coordinators of local healthcare provision (Džakula et al. 2021). This erosion of public health centres has had a particularly negative impact on palliative care, which relies on these institutions – through county coordinators and palliative teams – for organisation and delivery (Vočanec, Džakula, et al. 2022).

The effects are especially acute in rural areas and on islands, where primary care is scarce due to uneven regional development, urban-centric infrastructure, depopulation, and a chronic shortage of medical personnel. As a result, palliative care remains unevenly distributed: four of Croatia's 21 counties still lack a palliative care coordinator. While this disparity is often associated with remote regions, the shortage of healthcare workers affects the entire country. Croatia's healthcare workforce – 396 physicians and 235 nurses per 100,000 people – remains far behind Austria, which has the third-highest physician density in the EU (545 per 100,000)

and 1069 nurses in 2022 (Eurostat 2024c). Croatia's accession to the EU has exacerbated an ongoing outmigration of healthcare professionals. Between 2013 and 2016 alone, 1,259 doctors left the country, primarily for Germany, Austria, Italy, and Slovenia. The main reasons cited were better working conditions (74%), higher salaries (64%), and more stable, well-regulated healthcare systems (64%) (Župarić Iljić 2016; Džakula et al. 2021)¹³.

This is not to suggest that Austria's welfare state has been immune to socio-economic pressures such as privatisation, globalisation, and demographic ageing, or to the complications caused by its fragmented health and social care systems – as discussed here and in the previous chapter. However, Austria's stronger economic position and larger healthcare workforce have allowed it to respond more effectively to these challenges. These favourable conditions enabled the development of structured, well-funded initiatives in LTC and palliative care. As a result, Austria has been able to partially de-hospitalise care and implement an integrative palliative model across all levels of its healthcare system, embodied in the now widely recognised Graded Hospice and Palliative Care System.

In Croatia, by contrast, despite a well-designed and relatively successful model of integrative palliative care, full implementation has been hampered by the weakening of primary care and broader socio-economic constraints. Ironically, instead of reducing reliance on hospital-based care – as initially envisioned – the system has remained highly medicalised. This is reflected in the number of palliative care beds, which stands at 92 per million inhabitants (a total of 372 beds), surpassing Austria's 55 beds per million (total 498) (Bachner et al. 2018; Džakula et al. 2021; Lončarek et al. 2018).

An important factor in the de-medicalisation of palliative care – and thus in the successful implementation of its integrative model – is the mobilisation of community involvement, particularly through volunteering. Given the relevance of volunteering to this dissertation, the following subchapter will explore this topic in depth. Before doing so, however, it is worth highlighting one important similarity in palliative care provision in both countries: the gendered nature of care work. This dynamic provides a meaningful lens through which to further examine the familialistic tendencies of both welfare regimes.

According to its 2021 annual report, Hospice Austria recorded that 89% of all palliative care volunteers in the country are women (HOSPIZ Österreich 2022). This gender imbalance mirrors broader disparities across the third sector, where women make up 71.8% of all employees – a trend often linked to the sector's typically low wages (Pennerstorfer, Schneider,

¹³ There is no data for nurses.

and Badelt 2013; Pennerstorfer, Schneider, and Reitzinger 2015). The proportion is even higher in welfare services, where women account for 80% of the workforce (Leisch, Pennerstorfer, and Schneider 2016). Although there are no official statistics available for Croatia, my fieldwork suggests a similarly pronounced gender pattern in palliative care. Among the various individuals I interacted with – including doctors, nurses, county coordinators, volunteer coordinators, and volunteers – only a handful were men. This is not surprising, given the findings discussed in the previous chapter: in both Austria and Croatia, caregiving remains predominantly assigned to women, a characteristic feature of familialistic welfare regimes. However, the ways in which these gendered expectations are embedded, and the historical and policy trajectories leading to them, differ significantly between the two countries. This warrants a closer examination of their respective family policies.

Austria's family policy framework reflects a combination of explicit familialism – where the family is expected to provide care for children and the elderly, often in the absence of alternatives – and a growing emphasis on individual choice. Recent policy developments point to both positive familialisation (through cash-for-care schemes) and positive defamilialisation (via investment in childcare services) (Blum, Formánková, and Dobrotić 2014). For example, Austria has made considerable progress toward meeting the EU's Barcelona targets, which call for at least 33% of children under the age of three and 95% of pre-school-aged children to be enrolled in formal childcare by 2020. Between 2007 and 2016, the proportion of children under the age three in institutional care in Austria increased from 11.8% to 20.5%, while 94.9% of pre-school-aged children were enrolled in kindergartens by 2016 (Dobrotić 2019, 85). These developments reflect Austria's alignment with the EU's broader push for work-family balance, which encourages member states to reform parental leave policies and expand flexible employment options within a social investment framework (Dobrotić 2019). By contrast, Croatia has made more limited progress. In 2016, only 15.6% of children under the age of three were enrolled in kindergartens – placing it near the bottom among EU member states, alongside other post-socialist countries. When it comes to pre-school enrolment (75.1%), only Greece had a lower rate at the time (Dobrotić 2019).

Although Croatia offers one of the longest paid parental leaves – characteristic of many post-socialist countries – it joins Austria (alongside only Germany, Luxembourg, and Slovakia) in lacking a mandatory father's leave entitlement (Dobrotić 2019). This reinforces the expectation that women will assume the bulk of caregiving responsibilities in both countries. In Austria, this gender imbalance is evident in the fact that only 4% of fathers take parental leave, while 96% of fathers with children under 15 (aged 25–49) were employed in 2017,

compared to 79% of mothers. Moreover, just 7% of fathers worked part-time, compared to 73% of mothers (Österle and Heitzmann 2020). This division underscores the role of women as secondary earners and primary carers, reflected in Austria's exceptionally high female part-time employment rate of 47.4% - one of the highest in the EU. This unpaid caregiving role is further reinforced through various public supports, including cash transfers and social insurance contributions that cover non-employed carers (Österle and Heitzmann 2020). Austria also has one of the largest gender pay gaps in the EU, with women earning 21.7% less than men in gross hourly wages in 2016, compared to the EU average of 16.2%. Despite Austria's extensive LTC benefits, informal care remains central to the system: in 2010, it was estimated that eight out of ten people requiring LTC relied on informal caregivers (Bachner et al. 2018, 172). This corresponds to at least 40,000 informal carers in Austria, most of whom are women aged 50–64, with about one-third also engaged in paid work (Leichsenring 2017; Bachner et al. 2018).

A comparable situation is evident in Croatia. Data from the Survey of Health, Ageing and Retirement in Europe (SHARE) indicate that 55% of informal caregivers over the age of 50 are women, a figure that rises to 64% among those providing daily care (Džakula et al. 2021, 103). A separate study by Štambuk and colleagues focusing on informal carers of older adults in Zagreb found that 83% were women (Štambuk, Rusac, and Skokandić 2019, 193). However, unlike Austria, these trends in Croatia are not primarily explained by labour market dynamics. Part-time work is rare – only 4.8% overall and 6.7% for women in 2017 (Dobrotić 2020) – and does not serve as a mechanism for balancing work and care. Yet, employment rates still reflect gender disparities: 93% for fathers versus 81.1% for mothers (Eurostat 2025a). Women and younger workers are disproportionately represented in insecure and lower-quality jobs, and there is a visible feminisation of the public sector (Dobrotić 2015). Interestingly, the gender employment gap among the core working-age population is one of the smallest in the EU (8.7%), a trend that Dobrotić and colleagues attribute partly to Croatia's post-war context, where widespread early retirement among male veterans lowered male labour force participation (Dobrotić, Matković, and Zrinščak 2013).

At the same time, the relatively high female employment rate in Croatia also reflects the limited success of efforts to reinforce a familialist model of care. Since the 1990s, conservative governments and the Catholic Church have promoted pronatalist policies and sought to prioritise family policy reform. Although some measures – such as long maternity leaves and generous allowances for families with multiple children – have been introduced (Dobrotić, Matković, and Zrinščak 2013; Dobrotić 2018), Croatia still lags behind in this area:

family-related benefits account for only 6.9% of total social spending, compared to 9.33% in Austria (Österle and Heitzmann 2020; Dobrotić 2020). This suggests that the dual-earner family model promoted during socialism could not be entirely dismantled. Yet, as in many post-socialist Central and Eastern European countries, traditional gender roles remain persistent (Pascall and Kwak 2010; Klenner and Hašková 2010). Scholars attribute this to the fact that, during socialism, the male role was never fundamentally challenged. While women gained access to education and employment, their caregiving responsibilities were not openly debated or redistributed. As Klenner and Leber (2010) argue, policies promoting female employment were implemented top-down, often disconnected from the lived realities of women, and in the absence of basic civic freedoms that would have allowed women to publicly critique or organize around issues of gender inequality.

The transition process, compounded by economic hardships and the legacy of war, reinforced traditional gender roles, making women among the biggest ‘losers’ of the transition period. They were particularly vulnerable to growing social insecurity and poverty. Female employment rates across the post-socialist block declined significantly, with childbirth further limiting mothers’ chances of re-entering the workforce (Saxonberg and Sirovátka 2007; Glass and Fodor 2007; Pascall and Kwak 2010). In countries like the Czech Republic, Slovakia, and Hungary¹⁴, the lack of part-time work and underdeveloped policies on work-life balance have kept mothers out of employment (Robila 2012; Burcar 2020). Similarly, in Croatia, only 4-5% of parental leaves are taken by fathers, reflecting the lack of policies encouraging men’s involvement in childcare (Pascall and Kwak 2010; Dobrotić 2020; 2018).

These socio-economic conditions help explain how gender norms inherited from the socialist era, such as female emancipation and traditional caregiving roles, persist in contemporary Croatia. The lack of economic resources played a crucial role in the poorly implemented reforms and the conflicting family policies, whether pronatalist or gender-equality focused, aligned with EU goals. Although there was pressure on women to leave paid employment for caregiving, many families simply could not afford this option. The scarce resources – evident in low spending on family policies and LTC – prevented meaningful reforms that could alleviate caregiving burdens for working women and men. Instead, families had to rely on precarious work conditions, informal caregiving networks, traditional gender roles, and women’s income. These factors culminated in what can be described as a form of

¹⁴ For instance, in 2010, only 32% of Hungarian mothers with children under the age of six were employed, while the employment rates for mothers in the Czech Republic and Slovakia were 34% and 37%, respectively (Robila 2012).

‘disorganised familialism,’ where caregiving responsibilities implicitly – or by default – fell predominantly on families, especially women, who were expected to provide care at home.

Taken together, Croatia’s familialistic welfare model is characterized by ambitious but poorly executed reforms that create the impression of a state eager to provide care in a traditional manner but unable to do so effectively. Austria, by contrast, has created a more structured and sustainable welfare system. Despite maintaining a breadwinner model, even if only in its ‘one-and-a-half earner’ form, Austria has invested significantly in both familializing and defamilializing policies, particularly for children and dependent individuals. These policies, aligned with recent EU trends advocating family-work reconciliation and social investment strategies, have been better implemented due to Austria’s stronger socio-economic infrastructure. However, various cash transfer schemes, high part-time employment and unemployment of women show that care in Austria is still expected to be provided by families (at home) and indeed by women.

After exploring the gendered dynamics of healthcare provision, we now proceed to an examination of volunteering and the third sector in both countries. This exploration is crucial for understanding the distinct approaches to palliative care in Austria and Croatia, as these sectors have played significant roles in shaping palliative caregiving practices.

3.3 Palliative Care Volunteering as a Lens on Familialism: ‘Orderly Corporatism’ in Austria and ‘Custodial Disorganisation’ in Croatia

This subchapter examines the stark contrast in volunteer participation in palliative care between Croatia and Austria, attributing it to their divergent welfare state trajectories. Austria’s long-standing corporatist model has fostered strong cooperation between the public and third sectors, creating favourable conditions for the development of a robust third-sector environment. In contrast, Croatia’s post-socialist legacy is marked by weak coordination between third sector and the state, low volunteer engagement, and limited institutional support. This divergence is particularly evident in the regulation of palliative care volunteering: while Austria has established formal structures for volunteer involvement, Croatia lacks such regulation.

Religious communities also play a significant role in shaping this difference. Although Catholicism is influential in both countries, religious organizations have had a far greater

impact on the development of palliative care in Austria and other countries with similar socio-economic profiles, such as Poland. This disparity can be partly explained through modernisation theory, which links lower economic development and secularisation in Croatia to reduced engagement by religious institutions. However, a more decisive factor lies in Croatia's decentralized Yugoslav-era healthcare system, which historically resisted the inclusion of non-state actors and thus limited early third-sector involvement.

Paradoxically, this same decentralization facilitated the development of an integrative palliative care model grounded in public infrastructure and medical professionalism, rather than humanitarianism and volunteerism. This approach preserved existing medical hierarchies and reinforced a 'custodial' welfare state model – state-controlled and resistant to collaboration with volunteers. Consequently, professionalisation of palliative care in Croatia differs from Austria's approach, where volunteering was institutionalised from the outset and legally recognized alongside other healthcare roles. Nonetheless, Austrian palliative care volunteering still depends on donations, reflecting both a strong donation culture and the fragility of Austria's fragmented corporatism. In conclusion, while Austria exemplifies an 'orderly corporatist' path of familialism with regulated but donation-dependent palliative care volunteering, Croatia follows a 'custodially disorganised' model marked by professional dominance and marginalised volunteerism.

I would like to begin this subchapter by presenting data on palliative care institutions in Austria and Croatia. Over the past two decades, Austria has seen a steady rise in all types of palliative care services, with the most significant growth occurring in volunteer hospice teams. By 2020, there were 173 such teams operating across the country, involving more than 3,430 volunteers (HOSPIZ Österreich 2021). This is in stark contrast to Croatia, where, in the same year, only 16 organisations provided palliative care services across 12 counties (Vočanec, Lončarek, et al. 2022). One key factor behind the remarkable expansion of Austria's volunteer hospice teams is the consistent support provided since 2007 by the Savings Bank Group and the Erste Foundation (Pelttari and Pissarek 2018). This funding covers a broad range of needs – from office space and basic infrastructure to public relations and event organisation. Most importantly, it is used to finance training, supervision, and team coordination, ensuring that hospice teams can function effectively at national, regional, and local levels. Without this financial support, it would not be possible to organise international symposiums for volunteers or to maintain paid volunteer coordinator roles in cities like Vienna (Pelttari and Pissarek 2018).

Another major contributor to Austria's well-developed volunteer infrastructure is its long-standing third-sector tradition. Many non-profit organisations active today trace their

roots back to the eighteenth century (Simsa, Schober, and Schober 2006), laying the foundation for Austria's corporatist welfare model. This model is characterised by strong collaboration between government and social partners, including the third sector (Tálos 2006). Nowhere is this cooperation more evident than in the provision of social and health services, which are frequently delivered by non-profit organisations with state funding (Dawid and Heitzmann 2015).

Following the Nazi era – during which many organisations with ‘undesirable aims’ were dismantled – the re-establishment of a social partnership was key to the formation of Austria's neo-corporatist governance structure. Many non-profit organisations were either founded or supported by dominant political parties such as the Social Democratic Party (SPÖ) and the Austrian People's Party (ÖVP, Christian Democrats) (Ruth Simsa, Schober, and Schober 2006). As the Church gradually withdrew from direct political engagement, some church-affiliated non-profits began working closely with the ÖVP (Ibid.). The 1970s witnessed a surge in civil society activism, spurred by ecological, cultural, and political awareness movements. This led to the formation of numerous associations and self-help groups. Since then, the number of registered associations in Austria has continued to grow – especially during pivotal moments such as the refugee crises of the 1990s and 2015 (Neumayr et al. 2007). Today, the sheer number of registered organisations attests to the vibrancy of Austria's civil society, with a significant portion of the population actively participating in or supporting these associations.

Despite the proliferation of various associations in Austria, five major organisations dominate the provision of social services. These leading providers – Caritas, Diakonie, Volkshilfe, Hilfswerk, and Rotes Kreuz – are closely affiliated with either the state or the Church (Neumayr et al. 2007). Reflecting Austria's federalist structure and strong tradition of self-administration, these organisations operate across federal, state, and local levels. However, their state-level branches tend to be more influential and autonomous than their federal counterparts, owing to the significant responsibilities devolved to regional and local authorities. These include healthcare, housing, social services, child and youth welfare, and needs-based minimum income support (Heitzmann and Österle 2008; Pennerstorfer and Zierer 2018).

The third sector is especially dominant in the field of health services. Non-profit organisations are responsible for nearly 90% of all personal health services and 83% of ambulance and patient transport (U. Schneider and Hagleitner 2005). Volunteer involvement is particularly high in the health sector, where 70.7% of volunteers are active, and somewhat lower – but still significant – in social welfare activities, where 63.7% of volunteers participate

(Leisch, Pennerstorfer, and Schneider 2016). These figures become more meaningful when considered within the broader context of volunteering in Austria. In 2016, 46% of the population reported being engaged in voluntary work. Of these, 31% volunteered formally within organisations, 30% volunteered informally (direct help outside formal institutions), and 15% participated in both types of volunteering (Bundesministerium für Soziales 2019). Gender patterns also reveal notable differences: men were more active in formal volunteering (34% of all men, compared to 28% of women), while women were more engaged in informal volunteering (33% versus 28% of men) (Bundesministerium für Soziales 2019).

In Croatia – as in much of Central and Eastern Europe (CEE) – the development of the third sector began relatively late, emerging during the transition processes of the 1990s. Accession to the European Union significantly accelerated this development, as the EU promoted the European Social Model, which emphasizes social rights and inclusion, policy negotiation among social partners, and widespread reliance on government-non-profit partnerships for delivering social services (Cook 2015)¹⁵. By 2008 and 2013, all CEE accession countries had introduced legal and institutional frameworks to support collaboration between governments and non-profit organisations, including mechanisms for awarding public contracts for social service provision (Moore, Hadzi-Miceva, and Bullain 2008; Cook 2015). In Croatia, this shift led to a dramatic increase in the number of civil society organisations: between 1985 and 2014, the total grew from 11,391 to nearly 52,000. However, the majority of these are sports and cultural associations, which account for 33.4% - significantly more than those operating in social care (3.6%) or health care (3.0%) (Petak and Vidaček 2015). Despite the legal framework and increasing number of organisations, employment in the third sector remains relatively low, comprising only 1.55% of the total workforce – far below Austria's 3.4% (Petak and Vidaček 2015; Neumayr et al. 2007).

This shortage of human resources is particularly evident in low membership and volunteer participation, often cited as the weakest dimensions of civil society in Croatia (Petak and Vidaček 2015). For instance, according to the 2022 CAF World Giving Index, only 10% of Croatians reported participating in formal volunteering – among the lowest rates in Europe. Comparable figures were reported only in neighbouring Serbia (9%) and Bosnia and

¹⁵ Key legal milestones leading up to Croatia's EU accession included the establishment of the Council for the Development of Civil Society in 2002 and the National Foundation for Civil Society Development in 2003. The most significant policy documents promoting the third sector were the 'National Strategy for Creating an Enabling Environment for Civil Society Development' (covering the periods 2006–2011 and 2012–2016), and the 'Code of Practice on Consultation with the Interested Public in Procedures of Adopting Laws, Other Regulations and Acts', adopted in 2009 (Petak and Vidaček 2015).

Herzegovina (10%) (Charities Aid Foundation 2022). These numbers, especially when compared with Austria and other CEE countries, reinforce the argument that the development of the third sector in former Yugoslav republics was severely delayed by the wars of the 1990s (Fink-Hafner 2015)¹⁶. This so-called ‘Yugoslav exceptionalism’ is perhaps most clearly reflected in the palliative care sector, where – despite some efforts to institutionalise volunteer engagement – volunteering remains limited and underdeveloped.

Palliative care volunteers are formally recognised in Croatia by the 2018 Health Care Act as key stakeholders in the delivery of palliative care at the primary healthcare level. Strategic documents related to palliative care development also acknowledge their role in providing specialist support in settings such as acute hospitals, long-term care facilities, and home care (Vočanec, Lončarek, et al. 2022). Similarly, the Social Welfare Act (*Zakon o socijalnoj skrbi*) mentions volunteering in the context of social care institutions, encouraging its development. The Act also recognises non-profit organisations – key organisers of volunteer work – as partners in the preparation, adoption, and implementation of social programs (Ministarstvo rada 2025). Despite these legal frameworks, the role of volunteers in healthcare institutions remains undefined, making it difficult, if not impossible, for them to access inpatient palliative care settings such as hospitals.

Additionally, there is no national curriculum for palliative care volunteers, leaving a gap in the official standards that would define qualifications and responsibilities. The lack of clarity is compounded by the fact that volunteer management falls under the Ministry of Labour, Pension System, Family and Social Policy (*Ministarstvo rada, mirovinskog sustava, obitelji i socijalne politike*), while palliative care is overseen by the Ministry of Health, creating confusion about which ministry should take responsibility. In Austria, for comparison, the umbrella organisation Hospice Austria has been providing clear manual standards for volunteers and their managers. The first national curriculum for volunteer education was introduced in 2004, alongside the training of other key personnel such as coordinators and medical staff, and was revised in 2011 (HOSPIZ Österreich n.d.).

Beyond the absence of clear guidelines for managing volunteer programs and education in Croatia, another major challenge to the sustainability and autonomy of palliative care volunteering is the limited development of organized philanthropy at the local level. Croatia

¹⁶ For example, the institutionalization of the government–non-profit relationship and civil dialogue in Croatia began only in 1998, following the end of the 1991–1995 war and the weakening of the semi-authoritarian regime of the 1990s. During this period, civil initiatives and NGOs primarily focused on addressing the immediate consequences of the war, such as the humanitarian crisis, refugees, ethnic intolerance, and poverty (Županov 1995; Škrabalo 2006).

has only 202 registered foundations, with just 30% actively operating (Petak and Vidaček 2015). On the contrary, in Austria, organizations like the Savings Bank Group and Erste Foundation play a central role in funding palliative care volunteer programs. Another factor contributing to the disparity in volunteer engagement is the role of religious communities, which have been instrumental in developing the third sector and promoting the hospice movement, particularly in Austria.

In his influential work on the impact of social capital on democracies, Robert Putnam argues that religion plays a significant role in shaping a country's civil society (Putnam 1993; 2000). Religious traditions contribute heavily to social capital, fostering interpersonal trust and supporting democracy – key attributes identified by Émile Durkheim (Putnam 1993; 2000). Putnam emphasizes the importance of religious networks, which, unlike passive church membership, produce bridging social capital and enhance trust across different population groups (Putnam 2000; Gert Pickel and Gladkich 2012). He finds that the development of religious social capital is stronger in socio-economically modernized contexts. Therefore, greater membership in religious networks correlates with higher interpersonal trust and civic engagement, contributing to a more democratic and modern society (Putnam 2000; Gert Pickel and Gladkich 2012).

This 'modernization' logic can explain the significantly higher levels of civic engagement and religious network membership in Austria compared to Croatia, where two of the five major social service providers – Caritas and Diakonie – are affiliated with the Church. The influence of church organizations in providing social services in Austria is tied to the country's corporatist welfare model, or what might better be described as a 'welfare partnership' between the state and religious institutions. Since the 19th century, this model has aimed to suppress protest and advocacy by channeling social protection through politically 'safe' and religiously affiliated non-profit organizations (Salamon and Sokolowski 2018). Moreover, while religion still shapes the dominant cultural narrative in Austria, particularly during national holidays, it is also worth noting that secularization and migration have led to a more diverse society that is distancing itself from the Catholic Church's social and moral teachings. This shift is reflected in the decline of self-identified Catholics (from 87.4% in 1971 to 70% in 2016) and the increase in the non-religious population (from 4.3% to 12%) (Polak and Schachinger 2011; Mourão Permoser 2014; Bachner et al. 2018).

In contrast to that, Croatia has experienced a notable increase in the number of self-identified Catholics over recent decades – from 73.9% in 1953 to 86.3% in 2018 (Nikodem 2011; Džakula et al. 2021). This shift can largely be attributed to socio-political changes, post-

war migrations, the 1990s conflict, and the new democratic regime's markedly different approach to religion (Nikodem 2011; 2012; Nikodem and Zrinščak 2009). During the socialist period, there was a strict separation between church and state, with the Catholic Church officially excluded from welfare provision. However, since the democratic transition, the Church has gradually reasserted its role in society, including limited involvement in social service delivery (Kallunki and Zrinščak 2021). Today, as in many European countries, religious organisations in Croatia offer a range of social services, often in cooperation with public authorities and partly financed by the state. Nevertheless, their role remains relatively marginal, occupying only a portion of the Catholic Church's broader, privileged position in Croatian society (Kallunki and Zrinščak 2021). Unlike in other post-socialist countries such as Poland, where the strong influence of the Catholic Church (with 87.6% identifying as believers) played a significant role in the development of the hospice movement (Krakowiak and Pawłowski 2018), Croatia has not witnessed a similar pattern.

In Poland – much like in Austria – the hospice movement began in the 1970s, following a lecture by Dame Cicely Saunders. In 1981, the first hospice association in Central and Eastern Europe was established in Kraków. It was also the first independent charity organisation in Poland based on volunteer work (Krakowiak and Pawłowski 2018). Notably, the Polish hospice movement emerged as a joint response by the Solidarity movement (*Solidarność*) and the Catholic Church to the repressive communist regime and the lack of institutional care for the seriously ill. This period marked a strategic shift in the Church's role, as it sought new ways to serve the public (Krakowiak and Pawłowski 2018). Thanks to the efforts of numerous doctors, nurses, and volunteers – supported by Catholic clergy such as Reverend Eugeniusz Dutkiewicz, widely regarded as the 'father of the Polish hospice movement' – the movement quickly spread. Even under communism, over 80 hospice home care teams were established by volunteers (Krakowiak and Pawłowski 2018). By 2019, Poland had over 500 palliative care centres, most of which actively involve volunteers, placing it among the top six countries in Europe for palliative care provision (Arias-Casais et al. 2019).

In contrast to both Poland and Austria, Croatia's hospice movement did not originate from church or lay religious initiatives, but was led primarily by medical professionals. This distinction may partly explain the relatively weaker volunteer engagement in the sector. Yet when considering the broader landscape of welfare provision, a critical question arises: Why has the Catholic Church – or other non-profit organisations – not assumed a more prominent role beyond palliative care in Croatia, where their involvement remains largely complementary to their primary religious mission?

While examining how the transition to capitalism has negatively impacted women's emancipation in Central and Eastern Europe (CEE), Lilijana Burcar, in her book *Restoration of Capitalism: Repatriarchalisation of Society*, argues that the non-profit (and for-profit) sectors in the former Yugoslav republics were less able to take over service provision previously managed by the state – unlike in other post-socialist countries (Burcar 2020). This, she explains, is due to the distinct way social and healthcare services were financed in Yugoslavia. In most CEE countries, including Poland, formal care followed a Soviet-style corporatist model, where social and health services were directly tied to workplaces, with institutions built around companies (Tomšič 1980; Burcar 2020). While Yugoslavia initially adopted a similar approach, it soon shifted to a community-based model of service provision, where care was organised within local communities rather than exclusively through employers. This shift aimed to provide broader population coverage and integrate a greater number of children into institutional care (Tomšič 1980).

The Yugoslav health and social care was financed collectively through multiple sources – not just companies – including specially designed public funds and self-contribution institutes (Burcar 2020). This enabled the development of a decentralised and extensive system of care, characteristic of Yugoslavia's unique self-management governance model – also evident, as mentioned earlier, in the healthcare system. Especially following the 1974 Constitution, the Yugoslav health system became known for its emphasis on community management, with local authorities enjoying significant autonomy and both health workers and users (ideally) participating in decision-making processes (Džakula et al. 2021). The roots of this approach can be traced back to the pre-socialist era and the work of Professor Andrija Štampar, who pioneered the concept of primary healthcare centres and played a key role in introducing a wide range of public health services in the 1920s and 1930s. He later became the first president of the World Health Assembly in 1946 (Džakula et al. 2021).

Given the complexity of Yugoslavia's financial structure – characterised by self-management and decentralisation – welfare service provision could not be dismantled as easily during the transition period as it was in other parts of the Eastern Bloc (Burcar 2020). This structural legacy contributed to a stronger path dependency and greater resistance to non-public care providers. Moreover, since voluntary engagement and government–non-profit cooperation were not actively promoted, it is unsurprising that the concept and practice of voluntarism remained largely confined to two forms: collective volunteer action coordinated by the state, typical of the socialist era, or reactive mobilisation in response to humanitarian crises such as the Yugoslav wars, the major floods of the 2010s, and the earthquakes in 2020 and 2021.

Although these conditions were not conducive to the development of a robust hospice movement rooted in volunteerism, it was precisely this heritage of decentralised Yugoslav health and social care that enabled the successful implementation of an integrative model of palliative care. Notably, this reform remains one of the few successfully implemented healthcare initiatives in Croatia since independence (Lončarek et al. 2018). A key factor in its success was the deliberate decision by the architects of the new palliative care plan to move away from a humanitarian, volunteer-based model. Although the National Board for Palliative Care, which proposed the National Strategic Plan for Palliative Care in 2013, drew inspiration from countries like Poland – with similar societal, cultural, and healthcare structures – and from the UK, a global pioneer in palliative care, it was also critical of both countries' insufficient integration of palliative care into mainstream health systems and their heavy reliance on the voluntary sector, not just for service provision but also for funding (Lončarek et al. 2018). Instead, the Board chose to build on Croatia's existing infrastructure – particularly community healthcare centres – ensuring a stable source of funding and enabling the delivery of more professionalised and efficient palliative care.

While both Austria and Croatia have institutionalised palliative care, the meanings and implications of this process diverged notably between the two countries. In Austria, the professionalisation of palliative care included volunteers from the very beginning. Their involvement was not incidental but woven into the institutional fabric: over two decades ago, national-level regulations began defining volunteers' roles, training, and responsibilities alongside those of medical professionals and other team members. This early integration positioned volunteers as recognised members of multiprofessional teams, rather than auxiliary helpers. A more detailed exploration of volunteer training and professionalism appears in Chapter Six. Here, however, it is important to note that this integrated model helps explain why my interlocutors in Vienna – both volunteers and paid personnel – consistently described volunteers as team members with defined tasks and shared responsibilities. This framing was echoed in institutional documents, such as the Caritas Hospiz brochure (Caritas Hospiz, n.d.) outlining volunteer duties. The brochure notes that volunteering 'is characterised by the same professionalism as every other working group within the palliative team' (Caritas Hospiz, n.d., 14). As such, volunteers are required to complete basic training, a practicum, regular supervision, and ongoing education – all embedded within the context of team meetings.

This sense of professional belonging came up frequently in my interviews. Sabine, a 64-year-old volunteer from Vienna, captured this sentiment poignantly. 'Caritas is the background,' she said, listing it among the most important conditions for volunteering

(Interview, Sabine, 22/07/22). Although Sabine had cared for her dying parents and accumulated significant personal experience in end-of-life care outside Caritas Hospiz, she emphasised the primacy of formal training and team affiliation in shaping her role. ‘Caritas,’ for her meant more than an organisation; it was a support network, a source of knowledge, and an anchor in emotionally complex situations. Like many others I spoke with in Vienna, she described her role not in isolation, but in relation to the team and the institution she represented.

In some cases, volunteers were even referred to as ‘partners’ in palliative care provision. Their position – hovering between emotional closeness and professional distance – allowed them to serve as crucial intermediaries. Caritas Hospiz documents repeatedly underscore this point: volunteers often act as communicative bridges between patients and their families, and between patients and healthcare professionals (Caritas Hospiz, n.d., 10,12,14). On a broader scale, their role embodies the Austrian model of ‘welfare partnership’ – a feature of corporatist welfare regimes that depend on collaboration between state actors, civil society organisations, and volunteers. This arrangement is not only institutional but also historical. Austria’s long-standing tradition of including the third sector in welfare provision, often through Catholic organisations, has enabled a steady inflow of committed volunteers into palliative care. While the strength of the country’s Catholic heritage may be waning, its legacy remains a powerful resource in sustaining both civic engagement and palliative care volunteerism.

Yet this model of partnership, successful in integrating volunteers into Austrian palliative care, could not guarantee a steady and unified source of funding. Fragmented responsibilities between the state, federal provinces, and insurance funds created a patchwork system. In contrast, palliative care in Croatia developed under a different logic – one shaped by the legacies of socialism, where the state remains the principal provider of healthcare funding and infrastructure. This centralisation enabled a more coherent institutionalisation of palliative care but came at a cost: the near-total exclusion of volunteers from the healthcare system. In Croatia, professionalisation was largely synonymous with medicalisation. The process privileged formally trained medical personnel – doctors and nurses – as the core of palliative provision. This emphasis strengthened existing hierarchies within the health system, positioning non-medical actors, especially volunteers, on the margins. To illustrate this, it is helpful to introduce Micika, an oncologist based in Rijeka. At the time of my fieldwork, her city was home to the country’s only operational hospice. When I asked her about the role of volunteers in the palliative sector, she offered a candid response:

Volunteers are a valuable and welcoming addition to the palliative care system. But nothing revolves around them. The needs of palliative patients are so enormous and complex that volunteers alone cannot do anything about it. ... You cannot turn something as serious as palliative care into a humanitarian feat. There has been an attempt to do it, and it failed quite miserably. In fact, it didn't even develop. The basis is the system, professionals employed full-time for an indefinite period.

(Interview, Micika, 18/04/22)

Micika was unequivocal: while volunteers might offer emotional support or companionship, the foundation of palliative care must rest on permanent, medically trained professionals. When she spoke of 'necessary work,' she consistently referred to clinical responsibilities – particularly pain management. Her framing echoed a broader trend within Croatian palliative care, one that gained institutional backing with the adoption of the National Strategic Plan for Palliative Care. Notably, Micika was one of the co-authors of this Plan, alongside another physician and a nurse. The National Strategic Plan for Palliative Care marked a turning point. It sought to shift palliative care away from its earlier, loosely structured and volunteer-led 'humanitarian phase' – a period Micika alluded to dismissively – and integrate it firmly into the public healthcare system. A key innovation was the introduction of palliative teams based in health centres, led by nurses with master's-level qualifications. This move aligned palliative care with the broader hospital-centred model of Croatian healthcare, reinforcing the dominance of medical expertise.

The Croatian system consistently uses the term *palliative care* rather than *hospice and palliative care*, as is common in Austria. This choice of language is telling. It draws directly from Balfour Mount's original concept, which envisaged palliative care as a medicalised extension of the hospice philosophy within hospital settings. In Croatia, this interpretation found fertile ground in a system that continues to elevate doctors and nurses above all other actors. The result is a healthcare landscape where volunteers are often viewed not as partners, but as potential intruders. This was a recurring theme in my conversations with volunteers in Zagreb, many of whom had recently started visiting palliative patients in hospitals.

One such volunteer is Božena – whose story is detailed in the next chapter – who repeatedly described the resistance she faced from hospital staff. Some professionals, she recounted, were openly dismissive, questioning why anyone would choose to volunteer in such a field. Others refused to collaborate altogether (Interview, Božena, 23/05/22). Given these institutional logics and the deep-rooted medical hierarchies within Croatian healthcare, it is

perhaps unsurprising that volunteers and other non-medical personnel have not been recognised as equal contributors to care. As a result, little effort has been directed toward their training, supervision, or organisational development. The Croatian model of professionalisation, while effective in building structural capacity, has thus reinforced the exclusion of volunteers – those whose work remains peripheral, and often misunderstood.

This broader attitude toward volunteering was perhaps best captured by Selma, the president of the Croatian Centre for Volunteer Development (*Hrvatski centar za razvoj volonterstva*), the national umbrella organisation for volunteer coordination. In one particularly striking moment during our conversation, Selma referred to Croatia as a ‘custodial state’ – a term she used to describe the government’s persistent need to control the civil sector while simultaneously stifling its growth (Interview, Selma, 26/04/22). Her words revealed a deep ambivalence at the heart of state–civil society relations: a desire to supervise without truly supporting. Selma’s reflections were shaped by decades of experience. She had been involved in volunteer work since the war-era humanitarian efforts of the 1990s, giving her a long view of how volunteerism in Croatia has evolved – and, in many ways, stalled. Her criticism centred on two persistent problems: the absence of a robust legal framework for civil society organisations, and the state’s ongoing reluctance to provide stable funding for the third sector. But even more troubling, she noted, was the pervasive mistrust with which the state views non-governmental actors. As she put it, civil society is treated not as a partner, but as a problematic child still struggling to earn the trust of an overbearing parent. This paternalistic attitude, Selma argued, undermines the development of volunteer infrastructure and constrains the potential of organisations working outside the state apparatus (Interview, Selma, 26/04/22).

When this deep-seated mistrust is compounded by the entrenched hierarchies of Croatia’s highly medicalised healthcare system – where non-medical personnel are often sidelined – it is not surprising that palliative care volunteers struggle for recognition. Their competencies are not only overlooked but, in some cases, systematically denied. In effect, volunteers find themselves caught between two disconnected systems – health and social care – neither of which fully acknowledges their role. The result is a kind of institutional no man’s land, where palliative care volunteers operate often invisibly, despite their critical contributions. Rather than being integrated into care provision, they remain on the margins, their work undervalued and unsupported.

While palliative care volunteering got lost in the fragmentation of Croatian welfare state, what was lost in the Austrian fragmentation was a steady source of funding. Yet, this financial instability was mitigated by other factors – Austria’s strong culture of charitable

giving, its robust third sector, and more favourable economic conditions overall. These conditions allowed Austria's 'volunteer child' to grow and mature into a more equal relationship with the 'father' – that is, the state. I use 'father' deliberately here, as Austrian welfare, despite its 'progressiveness', still leans on traditional gender assumptions: men are seen as providers, women as carers. Yet in Austria, caring roles – such as those taken up by palliative care volunteers, who are predominantly women – are formally acknowledged, supported, and regulated through public policies and institutional structures. In this way, Austria edges closer to EU ideals of gender equality, shifting from a traditional familialist model toward what might be called a 'softened' corporatist welfare regime. Here, the 'father' has become less authoritarian, the 'children' more autonomous, but the familial roles are still clearly defined, in line with Austria's 'orderly' model of welfare corporatism.

Croatia, by contrast, has not taken such steps to transform the paternal role of the state. If anything, this role has been rhetorically reinforced in recent years – especially through pronatalist discourse and policy ambitions aimed at asserting control over the population. However, due to limited economic resources and ongoing pressures from the EU and international financial institutions, the Croatian state has struggled to embody this paternal authority in practice. It talks loudly, but acts inconsistently. It wants control, but lacks coordination. This paradox gives rise to what I describe as a 'custodially disorganised' model: a state that insists on managing its 'children,' while offering few coherent resources to support them.

This model is particularly visible in the field of palliative care. Like Austria, Croatia assumes women will carry the bulk of caregiving responsibilities. But unlike Austria, their work in this field remains largely unsupported and unregulated, creating a patchwork of care shaped by improvisation and uneven resources. Palliative care volunteering in Croatia is emblematic of this 'custodially disorganised' familialism – marked by traditional gender norms, high female employment, a fragmented and heavily medicalised health and social care system, and widespread institutional mistrust toward volunteerism. By contrast, palliative care volunteering in Austria reflects its own 'orderly corporatist' logic of familialism: one shaped by corporatist order, long-standing partnerships with religious and non-profit organisations, and gender roles that, while traditional, are formally integrated into welfare provision. These systems are not immune to external pressures, but they are differently configured, offering distinct paths for how volunteering is institutionalised and recognised – or not – within each national context. How these two paths of familialisation are enacted in practice will be further

explored in the next chapter, which focuses on the value that volunteers bring to clients, palliative care services, and society more broadly.

Chapter 4

The Price of the Priceless: The Unpayability of Palliative Care Volunteering

Volunteers don't get paid, not because they're worthless, but because they're priceless.

Sherry Anderson (Anderson 2024)

Introduction

The president of the palliative care organisation in Zagreb often opened her speeches at events promoting or educating volunteers with the well-known quote mentioned above. This quote encapsulates the central theme of this chapter: the value of volunteer work and its ambiguous relationship to money. While the previous chapter provided contextual background and identified two familialistic welfare trajectories through an interrogation of palliative care volunteering, this chapter examines the role and professionalisation of volunteers through the lens of the value they contribute to the palliative care sector. Here, the emphasis is on money – not because volunteers are paid, but because monetary transactions play a key role in defining the boundaries between paid personnel and volunteers. This distinction is crucial in shaping both the professional identity of volunteers and their function within systems of family care in the Austrian and Croatian welfare regimes.

This chapter seeks to unpack the reasons, conceptualisations, and justifications behind the absence of wages in palliative care volunteering. More specifically, it explores the notion of volunteering as ‘priceless,’ asking: Why is this labour considered priceless? I argue that the value or ‘unpayability’ of volunteer work stems from the ‘cost disease’ of the palliative care sector. The term ‘cost disease,’ first introduced by economist William Baumol, describes how labour-intensive, interpersonal services – like care work – experience slower productivity growth compared to more mechanized and industrialized sectors. Because these services rely heavily on human interaction, they are especially difficult to automate (Baumol 2012; Battistoni 2024). This framework enables a discussion of the complex, layered relationship between volunteering and money as it is understood within Croatian and Austrian palliative care, while also exposing the systemic logic of how social reproduction is organised under capitalism.

I begin with reflections from my research participants on the value of volunteer work. In both contexts, the economic and social contribution of volunteers is seen as so immense that it would be virtually impossible for the state to fully compensate it. This inability, I argue, can be traced back to the cost disease of palliative care – more precisely, to the time-intensive labour of being present with the dying, where volunteers often step in to fill the gaps left by paid staff. The importance of this time is widely acknowledged, even in mainstream economics, where volunteer labour is typically measured in terms of time (i.e., labour hours). However, in the case of palliative care, volunteer time must be symbolically *de-valorised* – or more accurately, *de-monetised*. The next two subchapters delve into the justifications for this lack of remuneration.

The second subchapter examines how volunteer services are ‘humanised’ (Altman 2020) – that is, framed as expressions of shared human qualities such as empathy and warmth, which are said to be achievable only in the absence of professional status and monetary compensation. Despite differences in how volunteer professionalism is understood in Zagreb and Vienna, in both contexts volunteers are clearly distinguished from paid staff through the emphasis on their ‘human approach’ in otherwise impersonal medical settings. This framing not only legitimises their unpaid status but also enables volunteers to support family care – either by fostering a ‘family-like’ atmosphere or by relieving the burden on family caregivers.

The final subchapter explores how the ‘unpayability’ of volunteering is justified by the belief of my research participants that this work is ‘too important to be paid.’ In this view, working without pay becomes an act of resistance to a dominant materialist culture. One of my respondents, Sara, explicitly referenced anthropologist David Graeber’s *Bullshit Jobs*, drawing on his argument that the more socially valuable the work, the less it is compensated – a dynamic seen clearly in reproductive labour (Interview, Sara, 30/11/22; Graeber 2018). According to Graeber, this reflects a long-standing ideological devaluation of care work due to its association with women and its perceived incommensurability (Graeber 2018). While Graeber’s analysis sheds light on persistent ideologies surrounding work and compensation, I find his explanation ultimately essentialist and insufficient to account for the diverse perspectives expressed by my research participants.

Instead, I turn to Alyssa Battistoni’s reading of cost disease, which locates the devaluation of reproductive labour not in patriarchal biases alone, but in the capitalist organisation of labour and the inherent low profitability of care work (Battistoni 2024). Her reading helps illuminate the more precise and multidimensional relationship between money

and palliative care volunteering, where the economic value of volunteer work is simultaneously recognised, subtly implied, and actively contested.

4.1 The Value of Time: Detecting the Unpayability of Palliative Care Volunteering

I begin the discussion on the value of palliative care volunteering with the voices of volunteers themselves, who spoke clearly and passionately about the immense economic and social contributions of their work. According to many of my research participants, this value is so substantial that it would be nearly impossible for governments to fully compensate for it through formal employment. I argue that this inability is rooted in the inherent unproductivity of caring labour when measured through quantifiable outputs – a phenomenon often described as ‘cost disease’ (Baumol 1967; 2012). Because this type of labour involves close, embodied, and relational care – working with the human body and engaging in face-to-face interaction – it resists standardisation and mechanisation, which makes it difficult to increase productivity in economic terms.

In the context of palliative care, this ‘cost disease’ becomes especially apparent in the need to attune to the unique pace of the dying. Volunteers play a particularly important role here, as they are able to spend time with patients without the temporal constraints that structure the work of paid staff within the palliative care team. It was frequently emphasized in interviews that the most meaningful contribution volunteers offer is precisely this: time. Their presence is valuable not in spite of being unpaid, but because of the absence of monetary exchange. By contributing unpaid time, volunteers help mitigate the sector’s poor performance in conventional productivity terms. Paradoxically, however, this same time – unpaid and freely given – also becomes a basis for measuring and recognising the economic value of volunteer work. Before turning to that contradiction in detail, I will begin with discussing an official policy document that outlines the contributions of volunteers, offering insight into how their value is publicly recognised in one of the research contexts I studied.

In the most recent edition of the ‘Volunteers Report’ (*Freiwilligenbericht*) from 2019, published by the Federal Ministry for Social Affairs, Health, Care and Consumer Protection, then-Minister Rudolf Anschober described Austria as a ‘land of volunteers’ (Bundesministerium für Soziales 2019). Highlighting that 3.5 million Austrians over the age

of 15 engage in volunteer work – representing 43 percent of the total population – he emphasized the vital role volunteers play across numerous sectors, from disaster relief and emergency services to sports, culture, environmental protection, and health and social care. According to Anschöber, volunteers form the backbone of Austria’s vibrant civil society, and without their contributions, the country would not be what it is today (Bundesministerium für Soziales 2019). While the report does not quantify the economic value of this volunteer work, it nonetheless clearly signals the official recognition of volunteers’ importance in delivering welfare services. In the field of palliative care, their contribution seems particularly vital – something echoed by many volunteers I had the chance to speak with.

Take, for example, Tamara, a 35-year-old volunteer from Vienna who has been involved with her organization since her early twenties. She shared her perspective on the importance of volunteers in this area:

I would say it’s a huge role that we take on. And... that’s the foundation, really. Not in medical or nursing terms, of course, but in terms of numbers – we form the base. I mean, the only reason a hospice care setting like this can even exist is because there are so many volunteers, right? The state of Austria would never fund this kind of workforce. So, it’s also a bit sad, you know... at the beginning of life, you have doctors, midwives – they’re all paid. But when it comes to dying, it’s all voluntary. So, from a broader perspective, I really think the state should be financing this more.

Later in our conversation, as we shifted to the broader significance of volunteer labour, she added:

I think when you ask about value... well, there’s a huge social and societal value to it, because volunteers are probably the ones taking care of things that just aren’t covered by jobs. I can’t imagine a world without voluntary work – and they [the state, society] are paying for it. (Interview, Tamara, 27/06/22)

Tamara’s reflections – marked by a sharp social awareness – underscore a crucial, often-overlooked reality: in Austria’s palliative care system, it is volunteers who form the bulk of the workforce, sustaining the very possibility of such care. Her words resonate with the ethos of the modern hospice movement, which, from its inception, has relied heavily on the voluntary

engagement of local citizens to deliver what is often framed as a ‘community spirit’ of care. From an ethnographic perspective, Tamara’s account does more than describe her experience – it illuminates a structural dependence on unpaid labour in a domain that, like other aspects of social reproduction, has long been undervalued. Feminist political economists (e.g., Bakker 2007; Kofman and Raghuram 2015) have consistently argued that care work is devalued under capitalist logics.

Palliative care, in particular, is positioned at the margins: essential yet economically invisible, framed more as a moral or emotional commitment than a public responsibility. This marginalisation is sharpened by the temporal dynamics of care. While early life is often medically attended and publicly funded – birth accompanied by midwives, doctors, and institutional protocols – end-of-life care remains largely in the hands of volunteers. As Tamara observed, the contrast is striking: the arrival into life is (monetary) compensated; the departure from it is not. The state, in this light, appears more invested in the future labour power of citizens than in those who have already passed their productive peak. This reflects a broader political economy of care, in which the social reproduction of workers is minimised in cost, particularly when the expected economic return is negligible (Kofman and Raghuram 2015, 82). This chapter will further explore these dynamics, with particular attention to the gendered nature of social reproduction and the persistent undervaluation of care work traditionally associated with women. For now, Tamara’s account stands as a powerful entry point into understanding how voluntary labour not only sustains the palliative care system but also reveals the state’s ambivalence toward those at the end of life.

This is not to suggest that mobilising volunteer labour comes at no cost. Participation in volunteer training sessions, various events, and conversations with individuals at different levels of the palliative care system made it clear that sustaining a steady pool of volunteers capable of fulfilling their roles requires a significant degree of structure and professionalisation – both of which demand appropriate resources. Effective volunteer engagement relies not only on professional supervision and coordination, but also on robust systems of training, administration, and physical infrastructure. These components must be in place to ensure that volunteer labour is deployed efficiently and meaningfully. Nevertheless, even when these associated costs are considered, the contributions of volunteers – and the substantial benefits derived by governments – should not be underestimated. In 2021 alone, volunteers in Austria contributed an astounding 304,113 hours to palliative care services (HOSPIZ Österreich 2022). This contribution holds remarkable value, and its significance is not limited to economic terms.

A useful comparison comes from a study by Femida Handy and Narasimhan Srinivasan, who evaluated the net benefits of hospital volunteers in Toronto, Canada (Handy and Srinivasan 2005). Drawing on both quantitative and qualitative data, they found that for every dollar hospitals spent on volunteer-related expenses (including recruitment, screening, training, supervision, recognition, and administrative costs), they received, on average, \$6.84 in value – a return on investment of 684% (Handy and Srinivasan 2005). This striking figure vividly illustrates the kind of social value Tamara alluded to: the immense worth of services that would otherwise require state funding.

In (post-socialist) Croatia, where volunteer labour – particularly in palliative care – has yet to receive formal recognition from state authorities and where no systematic records exist, similar reflections on the significance of volunteering emerged in my conversation with Mirjana, the president of a Zagreb-based organisation dedicated to palliative care volunteering. An economist by profession with over two decades of experience in the corporate sector, Mirjana manages many of the organisation's administrative and funding-related tasks. She emphasized the mutual transfer of skills between her paid professional life and her voluntary engagement, highlighting how competencies developed in one sphere often proved valuable in the other. Although her reflections were largely based on estimates rather than formal data, they were deeply informed by long-term, first-hand involvement in both the nonprofit and business sectors. Her observations shed light on a key theme of this chapter: the economic contribution of volunteers in welfare provisioning – particularly in contexts where the state remains reluctant or unable to monetarily compensate such labour. For Mirjana, the value of volunteer work lied precisely in its ability to respond flexibly to unmet needs. She articulated this clearly:

No society is so rich that it can pay for everything. That would be too expensive. We'd have to be highly developed societies to afford that. Through volunteering, we monitor what is missing... We sort of replace what's not there at the time. It's more adaptable. And over time, some things that start out as volunteer-based become accepted and institutionalised. For example, in the early days of palliative care, doctors did home visits as volunteers. Today, that's done by mobile palliative teams – doctors and nurses. So now, a volunteer doctor isn't needed anymore, but say there's no social worker – then we fill that gap. Volunteers won't be entirely replaced, but parts of what we do will be.

She continued by referring to volunteer work more generally:

Some functions transition into the institutional sphere, but others will always remain voluntary, because you simply cannot pay for all these different needs. Society can't afford to pay for every minute spent with a person, or every moment spent cleaning up the environment. Volunteers are everywhere, and when you're volunteering, you're really tuned in – you understand your environment better. And that's how you can respond to needs more easily. I believe volunteering will always be necessary. That's why it's so important. (Interview, Mirjana, 15/03/22)

Though grounded in her specific work in Croatian palliative care, Mirjana's reflections transcend this local context. She articulated a broader, systemic reality: volunteer labour is not simply a supplement to formal services, but often a precursor to them. While Tamara (in Austria) pointed to the need for greater state support, Mirjana did not call for more public funding. Instead, she suggested that the magnitude of volunteer contributions is so vast that no state could realistically afford to pay for them in full. In this vision, volunteering is not only cost-saving but foundational – laying the groundwork for many of the services that eventually become institutionalised. Indeed, even in the absence of a comprehensive system for tracking volunteer hours in Croatian palliative care, the scale of volunteer engagement in the country is significant. In 2022 alone, organisations officially reported 3,236,883.5 volunteer hours to the Ministry of Labour, Pension System, Family and Social Policy (Ministarstvo rada 2022). While this number reflects all fields of volunteering, it underscores the immense and often invisible labour sustaining the social fabric.

Moreover, Mirjana emphasised that volunteers are uniquely attuned to the needs of everyday life – often more so than formal institutions. This proximity enables them to identify gaps in care and initiate new services, many of which later receive formal recognition and funding. In this sense, volunteers do not simply replace paid services; they anticipate and co-create them. The social and healthcare infrastructure we know today, with its institutionalised and professionalised systems, often owes its origins to grassroots volunteer efforts. Whether or not states should – or even could – adequately compensate for all the work done by volunteers remains debatable. But one point stands out clearly in Tamara and Mirjana's accounts: the value of volunteer labour is immense, both economically and socially.

I argue that the state's inability to compensate for the extensive volunteer services in Austria and Croatia – though shaped by local contexts – reveals a broader, systemic feature of how social reproduction is organized under capitalism. This phenomenon is often referred to

as ‘cost disease’. As Battistoni (2024) summarises, economist William Baumol coined the term to describe the relatively low productivity of reproductive labour and other forms of work that rely on face-to-face interaction, especially when compared to more mechanized, industrial forms of labour. In sectors like healthcare, for example, productivity increases – such as seeing more patients per hour – often come at the cost of service quality. Meanwhile, the prices of goods in technologically advanced sectors continue to fall, whereas services that depend on human interaction are becoming increasingly unaffordable, even though wages in these sectors remain low or nonexistent (Battistoni 2024, 9). Baumol’s analysis highlights how the undervaluation of caring and reproductive labour stems from its inherently psychical and relational nature, which resists the productivity gains typical of automation and industrialization (Battistoni 2024, 9).

In palliative care – as in all forms of care work – this involves attentiveness to the unpredictability of the human body and a respect for its own pace. This has been explored extensively in research on ‘body work’ (see Wolkowitz 2002; Cohen 2011; Prsa 2022). The term ‘body work’, popularised by Carol Wolkowitz, refers to labour that involves physical contact with and manipulation of another person’s body (Wolkowitz 2002). Scholars have examined the challenges of working with the body as a material – highlighting, for example, the impossibility of full standardisation (Cohen 2011; Cohen and Wolkowitz 2018) and the presence of intimate or messy moments (Twigg 2000; England and Dyck 2011), which resist the neoliberal push for rationalisation and efficiency.

Although the palliative care volunteers I spoke with rarely provided hands-on care, they often emphasised the individuality of each patient and their specific needs. To respond meaningfully, they had to attune themselves to the unique pace of the dying body. This dimension of palliative care was poignantly expressed by Jasna, a long-time volunteer in Zagreb. A member of the association since its founding in 2009 – well before its official separation from the Franciscan secular order – Jasna reflected on the unique role volunteers play in the lives of patients and their families. When asked about this, she described the difference between professional care and what volunteers offer:

They [clients] have their own doctor, their specialist, maybe a physiotherapist, a nurse... but that’s – They come, do what they need to do, and go. It’s the volunteer who stays, who spends time with them. And you know, time is precious. They appreciate that. They want that.

In distinguishing between paid and unpaid work, she touched on the emotional and existential dimensions of volunteering:

You gain a lot, you grow as a person. You learn to be humble, patient, contrite. All those human qualities... Today, everyone's in a rush, always chasing something. Everything's on a schedule. But with patients like this, time stops. Their time is different – they live from hour to hour, from day to day. Every minute is precious. And then you realise: so much of what we think matters in life really doesn't. At the end of life, the only thing that truly matters is presence – that someone is there, and that they are not alone. (Interview, Jasna, 20/12/21)

This temporality – what Jasna calls ‘a different kind of time’ – is one of the defining features of palliative care. Unlike the clock-time that structures most paid labour, especially under capitalist demands for efficiency and productivity, the care of the dying resists such standardisation. Later, I will show how through temporality expressed in working hours volunteer work also gets quantified and economically valorised. For now, it is worth noting that time in palliative care volunteering serves a dual – and at times contradictory – function: it both enables and resists monetisation. Before turning to this tension, I want to first consider the inherent impossibility of fully standardising palliative care.

As scholars of ‘body work’ have noted, care that involves the body – particularly its vulnerabilities, slowness, and unpredictability – cannot be made faster without compromising its very essence (Twigg 2006; Cohen 2011; Cohen and Wolkowitz 2018). As Twigg (2006) puts it, ‘the body has its own timing’ – a statement that captures the reversal of control in palliative care: it is the patient’s body, not the care system, that dictates the schedule. This is precisely why the labour of palliative care is so difficult to commodify. Standardising such work would require accelerating it, but here, time itself is the gift. The volunteer’s role is not to do more in less time, but to be present, to dwell in the slow rhythm of a life approaching its end. In this sense, the only option left to fight this inefficiency of palliative care is by providing that ‘slow’ time for free.

Political economists Alyssa Battistoni (2024) and Gabriel Winant (2024) have recently argued that activities central to social reproduction – especially those with low or no profitability – tend to attract little capital investment. The drive to cut costs often results in wage suppression, or in the case of palliative care volunteering, the absence of wages altogether. As Battistoni notes, some sectors of reproductive labour, such as household chores,

are so labour-intensive and resistant to automation that they receive no investment at all (Battistoni 2024, 9). In this context, palliative care – where the irreducibility of time is central – exemplifies the structural limits of capitalist valuation.

By engaging in what many might perceive as a delayed or seemingly unproductive path, volunteers develop a different relationship with time – one that is both new and unexpected. Instead of viewing slowness as something to be managed or overcome, they come to value it, often finding comfort and meaning in the very absence of urgency. For Jasna, a long-time volunteer, these experiences became lessons in humility and patience – qualities she came to cherish deeply, especially in a world increasingly driven by acceleration: of capital, of lifestyles, of expectations. But beyond this, Jasna spoke of something even more profound. Through the quiet companionship of those nearing the end of life, she came to realize that the most precious gift one can offer is presence – the simple act of *being there*. This, she felt, was the essence of palliative care volunteering: not about doing, but about *being with*.

This perspective echoes the principles articulated in the EAPC White Paper, which distinguish the work of palliative care volunteers from the clinical precision of the Hippocratic tradition (Goossensen et al. 2016). As the authors write, ‘The contribution of volunteers does not lie in the “expert symptom relief” characteristic of the Hippocratic approach. They have much more to offer – their time, their attention – within the Asklepiian tradition.’ This Asklepiian ethos, grounded in presence and attentiveness, is captured in cultural notions like *er zijn* in Dutch or *Dasein* in German – core concepts that have shaped hospice and palliative care volunteering across Europe (Goossensen et al. 2016, 189).

Volunteers, then, are not healers in the medical sense, but companions who help create space for emotional, spiritual, and social forms of healing – forms that only emerge once physical pain is under control. As one Croatian volunteer, Božena, volunteer put it, ‘You are there to listen, to be with them in the silence, to witness their stories’ (Interview, Božena, 23/05/22). Such interactions move beyond the curative logic of Western medicine. Rather than treating disease as something to be externally fixed, this form of care honours internal processes of coming to terms, letting go, and meaning-making. Here, healing is less about curing and more about connecting. Božena captured this beautifully when she said, ‘It’s not even important what you do, but that you give your time’ (Interview, Božena, 23/05/22). For her, giving time was far more meaningful than donating money or unused clothing. Her words reveal something central to the ethos of this work: that in the quiet, attentive presence of another human being, there lies a kind of care that cannot be bought or rushed. Since this requires presence and human interaction, and first of all, available time that paid staff usually does not

have, the value of palliative care volunteering lies exactly in offering that time.

The gift of time – so often taken for granted in everyday life – emerged again as a defining feature of volunteer work in palliative care. Maria, who has worked for over two decades with Hospice Austria, the national umbrella association for palliative care, spoke passionately about this. Having dedicated much of her career to paediatric palliative care, she was deeply attuned to the delicate emotional terrain that surrounds children and young adults facing terminal illness. In this field, she explained, care extends far beyond medical intervention – it’s about supporting the whole family, creating spaces that feel safe, familiar, even intimate. Hospice Austria has long advocated for high standards in care, developing national guidelines for professionals, including volunteers. Yet, Maria emphasized that it is precisely the ‘para-professional’ status of volunteers (see Chapter Two) that enables something unique: the ability to offer presence unbound by clinical timeframes. Or in her words:

Volunteers can give families something very special – time. The palliative care teams, they provide professional support, of course. They can do medical things, yes. But they have to stay within a schedule. A nurse can’t spend half a day with a family. Maybe in an emergency – but not every day. (Interview, Maria, 06/12/22)

The next subchapter will explore the notion of para-professional status in greater detail. Here, it suffices to say that, unlike other members of the palliative care team, volunteers are not bound by quotas or fixed shift lengths. They should ideally have the temporal flexibility to stay with one family for as long as needed, to sit beside a child without glancing at the clock, to simply *be there* – a recurring theme across my conversations. This temporal freedom, Maria explained, creates a relaxed atmosphere that feels closer to home than hospital, allowing for a kind of care that is deeply relational rather than merely functional. This is especially vital in paediatric palliative contexts, where the emotional needs of families are often complex and urgent. By stepping in as companions rather than clinicians, volunteers help sustain a sense of continuity and ‘normalcy’.

Their presence allows parents a moment to breathe, to step away from caregiving without guilt. And because they are not professionals like other team members, their interactions often preserve the illusion – or perhaps the ideal – of a family-centred care setting untouched by institutional detachment. In this way, volunteers enact a quiet kind of support that complements medical expertise. Their contribution does not lie in symptom management, but in making space for connection – just as Jasna and Božena described. Sometimes, Maria reflected, this

company is even more healing than the medications administered or the procedures carried out. It is not what volunteers *do* that matters most, but how they *are* with those they accompany.

I would now like to turn our attention to an aspect I consider essential for fully understanding the meaning and value of volunteer time in palliative care. When Jasna remarked, ‘You know that time is precious,’ she shifted the conversation beyond the specific setting of palliative care, pointing instead to a broader cultural understanding of time’s value. In today’s world, few have escaped the mantra ‘Time is money.’ This association is no coincidence. Since the development of liberal political economy in the 18th century – through the writings of Adam Smith and David Ricardo – labour time has been central to how economic value is understood. By measuring how much time a worker invests in producing a good, economists sought to determine that good’s value, allowing it to be priced, traded, and commodified. This quantification transformed time into a unit of measurement – a means to translate human activity into exchange value. As Marx famously put it, labour power – the human capacity to work – was transformed into actual labour through this process of value creation. Labour became measurable, and thus economically legible (Marx 1977). Today, this logic continues to dominate, with labour hours still the primary metric for calculating the economic value of work – including, notably, volunteer work (Salamon, Sokolowski, and Haddock 2011).

A clear example of this is found in the most comprehensive attempt to quantify the economic value of global volunteering: the Johns Hopkins Comparative Nonprofit Sector Project. Using the replacement cost approach, researchers Salamon, Sokolowski, and Haddock calculated the value of volunteer work by estimating what it would cost to hire professionals to do equivalent tasks (Salamon, Sokolowski, and Haddock 2011). This method relies on two key data points: the total number of hours volunteered and the prevailing market wage for comparable work. According to their findings, nearly 971 million people volunteer each year across the globe – either directly with individuals or through organizations. If these volunteers formed a nation, it would represent the second-largest adult population (aged 15+) in the world, second only to China (Salamon, Sokolowski, and Haddock 2011). Economically, this hypothetical ‘Volunteerland,’ as the authors call it, would have been the seventh-largest economy in the world in 2005, with an estimated value of US\$1.348 trillion. This represented 17.5% of global government final consumption expenditures and 2.4% of the entire global economy (Salamon, Sokolowski, and Haddock 2011). And given the inflation and rising labour costs since then, these numbers would be significantly higher today.

These statistics illustrate the immense value of volunteer work – an insight echoed by Tamara and Mirjana, who stressed how indispensable volunteers have become. The scale is such that governments would struggle, if not fail entirely, to replace this unpaid labour through formal employment. But what the numbers also show is something more subtle: volunteer work becomes valuable through *time*. It is time that allows volunteer contributions to be quantified, acknowledged, and rendered visible in economic terms. This is especially true in the context of palliative care, where volunteers often step in once a patient’s medical symptoms are under control. Their time – freed from rigid cost-accounting structures – fills a critical gap in a sector plagued by what economists call ‘cost-disease:’ the rising costs of human-intensive services like healthcare, which cannot easily increase productivity. Volunteers, in this sense, provide a service that is economically *measurable* but culturally understood as *priceless*. Here lies a paradox. Although volunteer time is the very thing that allows for its economic valuation, it simultaneously resists being monetised. As many of my interlocutors repeatedly emphasized, what makes volunteer work *truly valuable* is the very fact that it is unpaid. In other words, the absence of money becomes a condition for a different kind of relationality – one not governed by market logics.

How this contradiction between value and non-payment is justified, and how volunteer time becomes ‘demonetised’ in practice, will be explored in the next subchapters. One form of ‘demonetisation’ involves humanising the work, while another frames it as too important to be paid – each of these justifications is explored in a separate subchapter.

4.2 ‘I’m coming just as a human:’ The First Justification of Unpayability

In this subchapter, I argue that a key justification for the unpayability of palliative care volunteering lies in its association with what Altman (2020) refers to as ‘humanisation.’ Across both research contexts, this humanisation was enacted through the ‘de-monetisation’ of volunteer labour and depriving volunteers of (full) professional status. That is, volunteers were perceived as most valuable precisely when their work was stripped of formal credentials and monetary compensation. Only in the absence of (full) professional status and financial reward could volunteers approach patients as ‘just humans,’ offering care that was seen as stemming from the heart rather than from economic necessity. To develop this argument, I draw on both official policy documents on palliative care and interview excerpts from a diverse group of

research participants, who differed in their geographical locations and institutional roles within palliative care provision. Despite these differences, a shared sentiment emerged: the greatest contribution of volunteers is their ability to provide warm, human companionship during moments of profound vulnerability. Before turning to how this emotional labour becomes central to the perceived value of volunteers, I first examine the institutional safeguards that were put in place to ensure that volunteers do not replace – but rather supplement – the work of paid professionals. This principle, strongly advocated by the European Association for Palliative Care (EAPC), was also echoed consistently by my interlocutors in both field sites.

In its White Paper on standards and norms for palliative care across Europe, the EAPC affirms the indispensable role that volunteers play in the field. It emphasizes that ‘the hospice movement, as a civil rights movement, is based on volunteer work.’ Yet the document also carefully distinguishes between complementing and replacing paid labour: volunteer workers, it states, ‘do not substitute for any staff member but supplement the work of the team’ (Radbruch and Payne 2010, 22,33). Even in contexts like the Netherlands – where, in the wake of healthcare restructuring, volunteers have increasingly assumed responsibilities once carried out by paid professionals – EAPC member states maintain a shared consensus that volunteering should never be a replacement for paid employment (Goossensen et al. 2016). National-level policies echo this stance. In both Austria and Croatia, key documents on palliative care standards similarly assert that volunteers are not substitutes for paid workers, but rather contributors to the overall quality of care. These volunteers, the documents claim, bring in skills, experiences, and forms of knowledge that are not otherwise accessible within conventional healthcare settings (Ministarstvo zdravstva 2017; HOSPIZ Österreich 2008).

This official framing, however, diverges significantly from how some volunteers themselves talk about their work. In my conversations with Tamara and Mirjana, for instance, the value of volunteering was often discussed not in terms of ‘supplementing’ professional care, but rather in relation to the absence of services that the state fails to provide. For them, volunteering was not just a gesture of civic engagement, but an urgent response to unmet needs, a way to patch over the systemic holes left by underfunded or unavailable formal care. This tension between institutional narratives and lived realities invites closer examination.

While it is tempting to read such discrepancies as evidence of neglect – by the state, by international bodies, or both – they also reveal a more complex terrain of value. Through fieldwork, I came to understand that the contributions of palliative care volunteers cannot be fully captured by the binary of paid versus unpaid labour. Even as their work responds to what some might call the ‘cost disease’ of palliative care, it generates forms of value that resist easy

economic classification. Official documents speak vaguely of volunteers offering skills and knowledge not otherwise available (Ministarstvo zdravstva 2017; HOSPIZ Österreich 2008) But what are these capacities, exactly? And more crucially for this chapter: what kinds of value do volunteers actually bring to palliative care? How do their contributions coexist with – or diverge from – those of paid professionals and institutional providers? Put differently, how is the unpayability of volunteering justified, and what does that reveal about the moral, social, and affective economies shaping palliative care?

To begin answering these questions, let me turn to an excerpt from an interview with Božena, a volunteer I met during fieldwork in Zagreb. In her mid-forties at the time, Božena had been volunteering with the organization for ten years when we spoke. Not long after, she was hired and became part of the small paid staff, working alongside Tomislava, the volunteer coordinator, and Tina, the administrator – who herself had joined only two years earlier. Božena had a unique trajectory: she had supported patients in their homes as well as within institutional settings, thanks to her participation in a pilot project involving LaVerna, a palliative care team in Zagreb and the City of Zagreb. The project sought to introduce volunteers into hospital environments, challenging prevailing assumptions about the place of non-medical personnel in terminal care. The initiative was, in many ways, an experiment in cultural translation – an effort to make medical staff more comfortable with the presence of volunteers as meaningful collaborators in the care of the dying. What follows is Božena's reflection on her work, and on what it means to volunteer in palliative care – both for patients and for the broader system of care in which she operates.

I think the importance of volunteers is enormous, but still unrecognized. On the one hand, I understand why. Professionals who organize palliative care, who manage everything, are just that – professionals. So, it's difficult for them to accept that someone who isn't trained, someone who comes 'only with their heart,' could be part of that team. That human dimension is missing.

She paused, then offered a story that had clearly stayed with her.

I was talking once with my cousin, who's an oncologist. I mentioned volunteers working in children's oncology wards. And he [the cousin] said, 'But these are children. You need someone trained – someone who understands psychology, child development, all that.' And I told him, 'Sure, but those professionals are already

there. That child doesn't need another expert at that moment. They need someone who will laugh with them, tickle them, play a board game. They need a friend. They need a human.' (Interview, Božena, 23/05/22)

Božena's reflections, grounded in both her personal experience and professional proximity to medical institutions, highlight a core tension in how volunteers are perceived in the field of palliative care. Through years of volunteering – visiting patients in hospitals and homes, participating in supervision meetings, public outreach campaigns, and collaborative projects – she has developed a keen sense of how volunteers are often undervalued, particularly in highly medicalized settings. Her critique points to a broader structural issue: the persistent divide between the healthcare system and the civil sector, especially visible in hospitals, where the presence of non-medical personnel is frequently treated with scepticism. In many ways, this mirrors the origins of palliative care itself – rooted in medical institutions, dominated by physicians and nurses, and shaped by clinical models of care.

Within such frameworks, the contributions of volunteers can appear secondary, if not entirely irrelevant, especially when viewed through the narrow lens of formal qualifications. Božena's cousin, working in paediatric oncology, reflects this prevailing view. For the cousin, the emotional and social support offered by volunteers seemed insufficient, even inappropriate, without the backing of professional credentials. While the cousin's stance may seem rigid, it is not uncommon. Even those more supportive of volunteer involvement – such as Micika, an oncologist and one of the authors of the National Strategic Plan for Palliative Care – tend to view volunteers as auxiliary at best, useful only insofar as they operate within boundaries defined by the medical field.

Well, volunteers are a valuable and welcome addition to the palliative care system. But nothing revolves around them. Nothing is addressed exclusively by them. The needs of palliative patients are so enormous and complex that volunteers alone simply can't respond to them... You can't turn something as serious as palliative care into a humanitarian feat. That's been tried – and it failed quite miserably. In fact, it never even took off. The foundation has to be the system: professionals employed full-time, with stable contracts. And what the volunteers can offer is human company – a warm hand, a hug, a presence. But that comes only after all the other needs are already met. And that kind of care... it can't be bought or sold.

Micika recognized the emotional value of volunteers in the care of the terminally ill – but she was equally clear about the limits of their role. For her, volunteering was a welcomed supplement, but never a substitute. Palliative care, she emphasized, must rest on a foundation of paid professional labour – on full-time, securely employed staff with the training and institutional backing to meet the complex, multidimensional needs of patients. Volunteers, while perhaps offering comfort and warmth, entered the picture only after these core needs had been addressed. Later in our conversation, she elaborated on her view:

It's not that we underestimate volunteers, or that we don't like or understand them. But we just don't have the strength – meaning the resources, the time – to seriously and professionally manage the selection and organization of volunteers. And when we talk about volunteering, we always have to think about the professional network that manages them. That professional structure must be in place. (Interview, Micika, 18/04/22)

Micika's qualified scepticism about the role of volunteers also reflected broader systemic issues. She pointed to what she saw as the underdevelopment of voluntarism in Croatia: low volunteer rates, limited institutional support, and a lack of clear frameworks for training and managing volunteers. Compared to countries like Austria – where, as we saw in Chapter Three, volunteer work in palliative care is more formally integrated – Croatian volunteers were often perceived as less professional. This perception has consequences. In both Božena's and Micika's narratives, despite their differing perspectives, volunteers were often positioned in contrast to professionals. Even when volunteers sought to claim forms of legitimacy – through training, experience, or boundary-making practices (as discussed in Chapter Six) – they were rarely viewed as part of the professional core. And notably, Božena did not attempt to frame volunteers as professionals. Rather, she used this contrast to highlight the limitations of paid professional care itself. For her, what paid professionals could not offer – particularly in paediatric settings – was precisely what volunteers brought: a relaxed, non-clinical, and deeply human form of interaction. In her words, what sick children needed most was not another psychologist, but someone to laugh with them, tickle them, or play a game. A friend. A human. This tension – between professionalism and presence, between technical care and emotional connection – ran throughout the fieldwork.

A perspective that both echoed and diverged from those of Božena and Micika came from Patrik, the president of Caritas Hospiz, one of the largest palliative care organizations in

Vienna. With more than 30 staff and 60 volunteers, Caritas Hospiz reaches patients across multiple settings – private homes, nursing facilities, and hospitals. In addition to its mobile palliative care services, the organization runs a day hospice twice a week, where patients can spend up to eight hours a day, and recently opened a 16-bed inpatient hospice within a nursing home. Patrik's role is primarily administrative – he oversees the coordination of the interdisciplinary palliative care team – but his involvement in the field is far more personal. He began his career as a care worker in a nursing home, where he first witnessed the specific needs of people approaching the end of life. That experience stayed with him. For Patrik, palliative care is not just a profession – it's a calling. Even now, alongside his paid position, he continues to volunteer in his free time. When I asked him about the contribution of volunteers to palliative care, he responded thoughtfully, drawing on both his managerial role and personal experience:

It has to do with the fact that volunteers can contribute to the service in an entirely different way than professionals. I mean, volunteers are also professional – in the sense that they're trained, they go through courses on skills and so on. But what they offer is something else. Something that's not part of paid service. And that's good – people do paid work well. But the two together, I think, make a really strong and valuable combination. For example, you simply couldn't run a daily hospice without volunteers. And things like presence, deep listening, talking, and paying attention – those are hugely important.

As our conversation continued, Patrik expanded on how volunteers fit into the broader structure of palliative care in Austria – not only as emotional companions, but as essential supports to the entire system:

There are times when what's needed isn't a doctor or a nurse. Sometimes it's not even a psychologist or a therapist. Sometimes, a person just needs someone to talk to. And in that sense, volunteers help people stay at home longer. I actually think volunteering is a huge resource – and a real financial relief for the system. Take this: a volunteer can spend an entire afternoon with a patient, which means their caregiver – usually a relative – can take a break, go shopping, get some rest. That's relief. That's health prevention for the family members. And that's very important. (Interview, Patrik, 19/11/22)

Patrik's reflections point to a model of palliative care in which volunteers are not marginal or symbolic figures, but integral to how care is both delivered and sustained. Unlike in Zagreb, where the institutional position of volunteers remains fragile and often contested, Vienna's system appears not only more inclusive but increasingly reliant on volunteer contributions. Yet Patrik's framing carefully balances appreciation with structure: volunteers are not valued for substituting paid professionals, but for contributing something qualitatively different – presence, time, and attentiveness. His account offers a vision of care in which paid and unpaid professionals are not opposites, but co-providers of a complex, multi-layered service.

The context from which Patrik spoke helps explain how his perspective diverges from those of Božena and Micika. As president of Caritas Hospiz, and a representative of Vienna in the national steering committee of Hospice Austria, Patrik is situated within a well-resourced and well-established palliative care infrastructure. His daily work includes coordinating multidisciplinary teams, dealing with budgets, reviewing policy documents, and – importantly – volunteering himself. This multi-level involvement, from the personal to the structural, gives him a nuanced understanding of where and how volunteers fit into the broader care landscape.

According to Patrik, the Austrian system of palliative care, especially in Vienna, simply could not function as it does without volunteers. He spoke candidly about their practical importance: volunteers offer families vital respite, enabling relatives to take breaks from exhausting caregiving routines. This is not just about comfort, he insisted – it is a form of healthcare prevention for family members themselves. Volunteers also make certain services possible that would otherwise not exist – like the day hospice, which depends almost entirely on volunteer support. And although Patrik did not shy away from acknowledging the economic benefits of this unpaid labour, he, like Božena and Micika, maintained that volunteers should not replace paid staff. Instead, he viewed them as essential complements to the palliative team. Where he diverged from Micika, and aligned more closely with Božena, was in his sense that volunteers are not just a 'nice addition,' but a necessary one. What unites all three perspectives, however, is the recognition of one unique feature that volunteers bring: humanity.

Even as Patrik emphasized that volunteers undergo standardized training – thereby acquiring certain competencies and professional status – he still drew a clear boundary between them and 'real' professionals. Like Božena and Micika, he positioned volunteers outside the formal categories of doctor, nurse, psychologist, or therapist. They came not with professional authority, but – as he put it – *as people*. Their value lay precisely in that distinction: the ability to engage with patients not as experts, but as warm, emotionally present companions.

This framing of volunteer labour as ‘humanity without profession’ is not unique to individual actors; it is echoed in the official discourse of palliative care in both Austria and Croatia. For instance, the ‘National Plan for the Development of Palliative Care in the Republic of Croatia’ 2017–2020 (*Nacionalni program razvoja palijativne skrbi u Republici Hrvatskoj 2017. – 2020.*) refers to volunteers as having a ‘precious and *human* role’ in the development and delivery of care [my emphasis] (Ministarstvo zdravstva 2017, 20). Similarly, Hospice Austria’s standards document for volunteers (*Standards für ehrenamtlich tätige Hospizbegleiterinnen*) describes volunteers as providing ‘*human* support to palliative patients and their relatives during illness, pain, farewell, and mourning’ [my emphasis] (HOSPIZ Österreich 2008, 1). This language – *precious, human, supportive* – positions volunteers as agents of emotional care, not technical intervention.

Especially telling in this regard is how the EAPC characterizes volunteers in its White Paper: as those ‘who bring a unique human approach to the care of people at the end of life in very medical environments,’ helping to bridge the often stark gap between professionals and patients [my emphasis] (Goossensen et al. 2016, 188). This ‘human approach’ is later elaborated as the capacity to offer social and emotional support – listening attentively to patients’ concerns and anxieties, engaging with their interests and hobbies – forms of connection that can significantly alleviate feelings of loneliness and isolation (Goossensen et al. 2016, 188). What makes this kind of care possible, according to both policy and practice, is precisely that volunteers do not enter the space of care as professionals. They are not there because they are paid to be; rather, they are there ‘from the heart,’ as Božena put it. The metaphor of the heart – so frequently invoked in both Zagreb and Vienna – served as a powerful shorthand for a kind of care that resists professionalisation. It evoked sincerity, warmth, and emotional presence: qualities that, in this framing, risk being eroded by monetary compensation or formal job expectations. Positioned this way, volunteers are more readily imagined as part of the family – or at least as its most faithful substitute.

In both field sites, the metaphor of the heart was used to draw a line between paid and unpaid care work. While (paid) professional roles came with defined duties and institutional responsibilities, the work of the heart allowed for something else: a lighter, more spontaneous relationship, unburdened by protocol. As Božena emphasized, volunteers could bring joy into spaces dominated by illness and grief precisely because they were not required to meet quotas, follow charts, or manage clinical outcomes. Their freedom from professional obligations enabled a kind of presence – playful, relaxed, emotionally attuned—that might otherwise be absent in the medical environment of dying.

By stripping palliative care volunteers of professional status and financial compensation (i.e., a wage), they are reduced to their essential human core – ‘humanity’ – characterised by traits presumed to be universally shared. This reduction resonates with the concept of ‘humanising,’ as employed by anthropologist Tess Altman to describe an affective and political strategy used by an NGO campaign in Australia (Altman 2020). In her study, Altman shows how campaigners invoked humanisation to reframe asylum policy debates, fostering inclusive affective ties among diverse actors – such as people seeking asylum, state officials, and citizens – by appealing to shared human values (e.g., safety, family, community) and rights. The campaign sought to move away from abstract stereotypes, instead personalising each actor: not just a refugee, but a person seeking asylum; not just a bureaucrat, but a state agent; not just a voter, but a deterrence voter (Altman 2020). While many ethnographers have examined how volunteers are increasingly ‘responsibilised’ in the neoliberal delegation of welfare services (e.g., Hyatt 2000; Muehlebach 2012; Rozakou 2016), Altman’s case illustrates an attempt to foster what she, drawing on Donna Haraway, calls ‘response-ability’ – an ethical relationality grounded in shared affect, capacities, and mutual obligation (Haraway 2016; Altman 2020) .

The search for common ground between actors – as evoked by humanisation – stands in sharp contrast to a term that is etymologically similar but analytically distinct: ‘humanitarianism.’ Although humanitarianism also imagines a universal moral community to alleviate global injustice, scholars have argued (Ticktin 2014; Fassin 2012; Malkki 2015) that its focus on suffering and victimhood often reinforces inequalities between the giver (endowed with agency) and the receiver (cast as a passive victim). I do not delve further into that critique here. What is important is that humanitarianism assumes asymmetry between those who help and those who are helped; without such inequality, there would be no need for humanitarian intervention. Humanisation, by contrast, is grounded in the *similarities* between those who give and those who receive care. In palliative care – as in Altman’s case – service must be personified. Help can only be truly received when offered from one human to another. Otherwise, care risks becoming cold, medicalised, or depersonalised. Yet unlike Altman’s context, where humanisation bridges differences among professions and actors, in palliative care it applies specifically to volunteers. That is, the humanising of palliative services hinges on the removal of professionalism and payment. For this reason, palliative care volunteers must be de-professionalised and de-monetised.

By offering intimate, warm companionship unbound by the societal expectations of task completion and monetary compensation, volunteer care reveals qualities believed to lie deep

within all of us. As such, it can easily be perceived as something that has always already existed. Yet to avoid such overly simplistic conclusions, it is essential to consider another key distinction between humanising and humanitarianism in the context of palliative care. Volunteering in palliative care in both Zagreb and Vienna does not occur everywhere or at all times. Despite the universalist implications of the concept of humanity, the conditions under which palliative volunteering takes place are always shaped by specific local and temporal factors. Volunteering happens within particular institutional frameworks. Immediately after extolling the humanistic contributions of volunteers, official Croatian and Austrian documents explicitly state that the full value and purpose of volunteer work is only realised when it is integrated into the broader palliative care system – conducted in close cooperation with other care providers and, crucially, organised within formal associations (Ministarstvo zdravstva 2017; HOSPIZ Österreich 2008).

In other words, volunteers must be professionally guided and, to some extent, professionalised. The specific forms this professionalisation takes in each context are discussed in Chapter Six. What I want to emphasise here is that, despite contextual differences, reducing palliative care volunteers to their humanity in both Vienna and Zagreb does not equate to reducing their contributions to occasional humanitarian gestures – something Micika clearly pointed out. Rather, there was a conscious effort to shift palliative volunteering away from the logic of humanitarianism and towards formal institutionalisation within the care system. Importantly, this move did not contradict the emphasis on the ‘de-professionalised’ and ‘de-monetised’ nature of volunteer work – quite the opposite. We might say that in both Austria and Croatia, there was a deliberate shift from ‘humanitarianising’ to ‘humanising’ palliative care volunteering.

The following and final subchapter explores a second justification for the de-monetisation of palliative care volunteering. This enables a more nuanced discussion of the so-called ‘cost disease’ in palliative care, and how it reveals deeper connections between volunteering, money, and gender.

4.3 ‘It is simply too important!’: The Second Justification of Unpayability

Beyond the notion of humanisation, another reason why palliative care volunteering was seen by my interlocutors as incompatible with financial compensation lay in its perceived moral weight: it was, as several of them put it, simply ‘too important to be paid for.’ For many, the act of volunteering was not just about helping others – it was also a subtle form of resistance to what they saw as an overly materialistic society. By distancing themselves from activities associated with monetary exchange, volunteers asserted a different set of values rooted in care, presence, and moral obligation. This view resonates with David Graeber’s (2018) now widely discussed thesis on ‘bullshit jobs,’ which critiques the disconnect between societal value and economic compensation. One of my Viennese interlocutors, Sara, explicitly referenced Graeber to explain why she found her unpaid volunteer work more meaningful than many paid positions. Graeber argues that care work has long been devalued due to entrenched stereotypes about what constitutes ‘real’ work (Graeber 2018). While he and some feminist scholars attribute the low wages in care sectors to patriarchal views on reproductive labour, I suggest a complementary angle: that the difficulty of industrialising and mechanising care work has made it less profitable and therefore less attractive to capital investment (Battistoni 2024). This structural dynamic, often referred to as ‘cost disease’, helps illuminate the broader political economy of care – and, crucially, its gendered dimensions.

To illustrate this notion of conceptualising volunteer palliative care as ‘too important to be paid for,’ let me introduce Vesna, a long-time volunteer from Zagreb. When we met, Vesna was in her late sixties and had been volunteering with a local palliative care association for over a decade. She described herself as someone who would help anyone, anytime. But this commitment occasionally drew criticism from others in the association, who felt she did not set enough boundaries with clients and gave too much of herself. At the time of our conversations, she was regularly visiting Tanja, a cancer patient with little to no family support. Although the official role of volunteers was to offer companionship – through conversation, music, games, or prayer – Vesna often went beyond this mandate. She cooked for Tanja regularly, even though it was not expected or required. Tanja, for her part, did not always show gratitude. Sometimes she would critique the meals or take them for granted. Still, Vesna found it difficult to stop. She saw the absence of other support in Tanja’s life as a moral call to act – regardless of formal roles or the lack of appreciation.

By taking on extra responsibilities for palliative patients, Vesna felt she was acting in accordance with her moral beliefs – helping those in need simply because it was the right thing to do. That was, after all, why she began volunteering in the first place. Over the years, she grew increasingly critical of the institutionalisation of volunteering, which, in her view, was beginning to undermine its original purpose. The formalisation of roles and procedures, she said, made it harder to ‘just give a hand’ to those who needed it most – especially individuals who, due to bureaucratic or financial barriers, were often left without adequate care. To Vesna, volunteerism was losing its altruistic, ‘true’ essence. Helping others for its own sake – without expecting recognition or reward – was especially important in today’s world, she believed, where ‘everything is about calculation and profit’ (Interview, Vesna, 18/01/22).

I remember one conversation vividly. As we were traveling to visit her client, Tanja, Vesna shared an anecdote about a neighbour who had questioned her commitment: “Are you still doing that?! And you really haven’t gotten *anything* out of it after all these years?! ... I would never do that – there’s no amount of money that would convince me!” Vesna had laughed, but her reply was sharp: ‘I wouldn’t do it either—for money! I would definitely *not* do it for money!’ [my emphasis] (Prsa 2022b). This exchange highlights the social incomprehension Vesna often encountered regarding her volunteer work. In her neighbourhood – and more broadly in Croatian society – unpaid labour is frequently viewed as a waste of time, even a source of ridicule. Vesna’s response was not just defensive; it was principled. She often spoke critically of a culture she saw as increasingly materialistic, one in which the presence of money, in her words, ‘only worsens people,’ making them less capable of empathy and compassion. For her, volunteering was a way to push back against that culture, to uphold what she called ‘true values’ and to cultivate a more humane society (Interview, Vesna, 18/01/22; Prsa 2022b).

This moral stance was echoed, though differently articulated, by Sabine, a volunteer in Vienna. Unlike Vesna, Sabine did not lament the institutionalisation of volunteering. In fact, she appreciated it. Being part of an organisation meant she never had to visit patients alone and could always rely on other members of the palliative care team for support. Still, Sabine, too, saw the absence of payment as central to the meaning of her work. Like Vesna, and perhaps reflective of their similar generational backgrounds, Sabine found the unpaid nature of her care work to be precisely what gave it value. As she put it:

I think the world would be a much happier place if there was no money. Really much happier, because in that case everything would be about giving and taking –

not motivated by material things like money and coins, but coming from the heart. And that's why volunteering is so valuable: because there's no money involved. That gives it a completely different quality. A quality that matters not just for the patient, but for me, too – as I said at the beginning.

Later in our conversation, when I asked about the gendered dimensions of palliative care volunteering, Sabine expanded on this idea of 'heart work:'

Men have their hearts just as much as women. And that's why I think it doesn't make any difference who is doing the volunteering – because it comes from the heart, not from how much muscle we have. So whether men are stronger [physically] than women, it doesn't matter. It's about the heart. Both men and women have this. (Interview, Sabine, 22/07/22)

Sabine's reflections were clear and deliberate. Like other volunteers I spoke with, she saw her unpaid care work as a quiet refusal of the dominant materialist culture, where monetary exchange defines value. For her, volunteering remained one of the few spaces untouched by money – a space where value could be imagined differently, in terms of compassion, reciprocity, and shared humanity. Sabine repeatedly returned to the metaphor of the heart, using it to describe a kind of value that stands apart from economic logic. The 'labour of the heart,' as she called it, was meaningful precisely *because* it was unpaid. And in contrast to many gendered assumptions about care work, she insisted that this kind of labour was not inherently feminine. 'The heart,' she said, 'belongs to everyone.' Her framing suggests a subtle but important argument: that the ethical foundation of volunteering – its emotional labour, its interpersonal sensitivity – is not bound to gender. Instead, it emerges from a shared human capacity, one that becomes visible only when work is decoupled from financial reward. Before turning more fully to the gendered dynamics of palliative care volunteering, I now introduce another interlocutor: Sara. Her views bring a different lens to the conversation – one focused on money, unpaid labour, and the broader (in)visibility of social reproduction.

Sara was 33 when we met. At the time, she was working as a nurse in a Viennese intensive care unit, where caring for the dying was part of her everyday reality. Before becoming a nurse, however, she had trained and worked as a graphic designer. It was her experience volunteering in a local hospice that prompted her to reconsider her professional path. Although she was not actively volunteering at the time of our interview, Sara described

volunteering as something that had shaped much of her adult life – a lens through which she encountered the world. Her dual experience in both paid and unpaid care work gave her a rare perspective. Having cared for the dying in both contexts, Sara could articulate the subtle but significant differences between them. In our conversations, she reflected on how her paid nursing work helped her better understand the emotional and ethical value of her previous voluntary engagements. ‘It’s not a trading thing, you know,’ she told me. ‘That’s what I liked about the voluntary work. It’s important that it’s unpaid. I’m not trading something – I’m giving.’ I asked her why that distinction mattered so much to her – what was so meaningful about unpaid work?

I think we live in a society where we’re used to putting value on things by measuring them – quantifying them. And money is how we do that. But I wish our society valued other things more. The pandemic really showed who is actually holding everything together. Do you know David Graeber’s book *Bullshit Jobs*? He argues that the most important jobs – the ones with real purpose – often pay the least. And that’s exactly it. You’re doing the work even if it’s unpaid – because it’s so important. That’s why they can get away with paying so little. Look at supermarket workers, cleaners... these are some of the lowest paid jobs, and they’re essential. [my emphasis] (Interview, Sara, 30/11/22)

Sara’s reflections echo some of the core ideas in Marxist labour theory of value, though her account emerges from lived experience rather than theory. She identified a deeply ingrained cultural logic: that value must be measured, and money is the dominant measure. On one hand, this system makes it difficult to imagine worth outside of economic terms. On the other, it exploits precisely those activities that people are willing to do without financial reward – because they find them meaningful, necessary, or morally compelling. Like other participants in this study, Sara recognised that society depends on such unpaid labour, particularly in the realm of care and social reproduction. But the paradox she pointed to was striking: the more essential the work is to survival, the less it tends to be paid.

Sara’s statements align closely with David Graeber’s central argument in *Bullshit Jobs*: that there is often an inverse relationship between a job’s social value and its compensation (Graeber 2018). First introduced in his 2013 essay for *Strike!*, Graeber argues that this dynamic is not rooted in economics but in politics (Graeber 2013). I will briefly explore Graeber’s core thesis – not only because Sara directly references his work, but also because his analysis offers

a compelling insight into how society imagines and validates different forms of labour. His argument will later be expanded through the lens of the ‘cost disease’ framework (Battistoni 2024), to better understand the structural ‘unpayability’ of palliative care volunteering.

Graeber contends that ruling elites maintain control by proliferating meaningless jobs – roles like HR consultants, communication coordinators, or corporate lawyers – that are often well-compensated despite contributing little or even harming society. He contrasts these with undervalued yet socially vital roles – such as nurses, sanitation workers, and hospital cleaners – which, according to studies¹⁷, can generate up to £12 of public benefit for every £1 earned. Conversely, some high-paying jobs may result in societal losses of up to £11 per £1 earned (Graeber 2018, 210–11).

Graeber traces the devaluation of purposeful work to a late-19th-century shift from producerism to consumerism, driven by bureaucratised corporations and scientific management. This ‘managerial revolution’ redefined capital, not labour, as the source of value, reducing workers to cogs in a machine (Graeber 2018, 233). He links this to a flaw in the labour theory of value, which privileged material (and male-associated) production while sidelining reproductive labour – echoing theological and patriarchal assumptions that shaped economic thought, most notably the medieval Christian view of God as a male craftsman who creates the world from nothing (Graeber 2018, 234).

This narrow definition of productivity became further entrenched during the Industrial Revolution, even though, historically, far more people worked as maids, teachers, sex workers, nurses, or caregivers than in factories or mines. The ambiguity of these jobs’ productivity meant they were excluded from dominant conversations about economic value. To clarify this exclusion, Graeber distinguishes between *value* and *values*. The former refers to economic worth, which can be measured, quantified, and exchanged – typically through money. The latter refers to ethical, aesthetic, or moral ideals – like family, faith, justice, or beauty – that resist quantification. These ‘values’ cannot be priced or traded on a market, and it is precisely their resistance to measurement that gives them their significance (Graeber 2018, 203–4). As both Graeber and many of my interlocutors emphasized, the greatest worth of these values lies in their very refusal to be measured. They are incommensurable, irreducible, and – returning to

¹⁷ In a 2017 paper, U.S. economists Benjamin B. Lockwood, Charles G. Nathanson, and E. Glen Weyl attempted to calculate the economic impact of various professions by reviewing existing literature on the ‘externalities’ (social costs) and ‘spillover effects’ (social benefits) associated with highly paid jobs (Lockwood, Nathanson, and Weyl 2017). A broader study conducted by the New Economics Foundation in the UK used a ‘Social Return on Investment’ analysis to examine six representative occupations: three high-income (city banker, advertising executive, tax accountant) and three low-income (hospital cleaner, recycling worker, nursery worker) (Graeber 2018, 210–11).

the words of the opening quote – priceless.

Given how much of all work involves some form of care, the erasure of caring labour from mainstream discussions of value, as Graeber rightly notes, distorts our understanding of working-class labour performed by both women and men (Graeber 2018, 235). This erasure is especially striking given that much of what we typically think of as ‘women’s work’ – looking after people’s needs, attending to plants, animals, machines, and objects – is central to many jobs across sectors. Graeber argues that this oversight might have been avoided had the archetypal ‘worker’ in the popular imagination been a cook or a gardener, rather than a factory hand or, more recently, a businessman (Graeber 2018, 238). His claim that care work is devalued because of its historical association with femininity offers a compelling framework for understanding the disproportionately high number of female volunteers in palliative care, where women make up around 85% of both paid and unpaid staff in Austria and Croatia. However, as I show in what follows, this explanation does not fully capture the complexity of care work’s valuation.

While Graeber rightly emphasizes the ideological production of value through popular imaginaries, we must ask whether this alone can explain the (de)valuation of care under contemporary capitalism. Is it sufficient to say that care is undervalued simply because it has been feminized? As noted earlier in the discussion of Sara’s account, Graeber attributes the roots of this devaluation to political rather than economic factors. But can we so easily separate the two? Is it entirely accurate to say that care work holds no economic value, when many of the examples in this chapter explicitly assert its economic importance, even within voluntary settings?

Graeber’s analysis partly resonates with what political economist Alyssa Battistoni (2024) terms the ‘naturalisation thesis,’ a theme she identifies in both earlier and more recent feminist discussions of reproductive labour (e.g., Dalla Costa and James 1975; Mies and Vandana Shiva 1993; Salleh 1997; Federici 2012; Arruzza, Bhattacharya, and Fraser 2019; Barca 2020). While I will not directly engage with these feminist accounts here, I draw on Battistoni’s critique to advance my argument grounded in Graeber’s notion of the ‘unpayability’ of care work.

According to Battistoni’s interpretation, the naturalisation thesis explains the devaluation of care work through two interrelated claims: first, care is naturalised as women’s work and therefore accepted at little or no pay; second, because it is performed by women, it is perceived as inherently less valuable (Battistoni 2024, 7). This framework extends Graeber’s analysis by not only accounting for the devaluation of care work but also highlighting the

gendered distribution of this labour. However, as Battistoni astutely notes, each argument has its theoretical limits: the first risks an overly idealist view, while the second tends toward functionalism. Together, they present a contradictory understanding of the relationship between gender and capitalism. To argue that gender roles merely serve capital suggests gender is a cultural layer superimposed on an economic base (Butler 1997), while claiming that gender ideologies determine labour value implies that ideology overrides economic logic (Battistoni 2024, 8).

If capital – or ‘social elites,’ as Graeber (2017) puts it – has the power to make certain forms of labour cheap or free by naturalising or feminising them, then why does not it simply appropriate even more types of work? To answer this question, and to better understand the position of reproductive labour under the current regime of value production – and the reasons behind its low or absent remuneration – we must, following Battistoni (2024), shift our analytical standpoint. Rather than adopting the perspective of the (unpaid) housewife or a caregiver, as Graeber does, we should take the standpoint of capital itself and examine how it organises all kinds of labour. Capitalist firms, after all, are compelled to allocate and divide labour based on profitability, not ideology. The aim of capital is to reproduce itself through profit generation – not to reproduce specific gender roles. This does not imply that capital is all-powerful. As existing research on the service sector has shown (J. E. Smith 2020), and as the concept of ‘cost disease’ illustrates, some types of work resist mechanisation or industrialisation despite capital’s best efforts (Battistoni 2024, 9). Likewise, some values – such as companionship, care, safety, or love – cannot be easily quantified or commodified.

From this perspective, and given the inherent difficulty of standardising palliative care – as discussed earlier – it can be argued that there is simply no viable way to remunerate such labour under the current logic by which capital organises work (Battistoni 2024). In this light, the remark from Vesna’s neighbour – ‘there’s no money for which I would do that’ – can be read not just as a dismissal of volunteerism but as an implicit recognition of the labour intensity of palliative care and the financial impracticality of adequately compensating it. Thus, the ‘cost disease’ framework not only helps explain my interlocutors’ experiences and statements by highlighting the unique qualities of their work, but it also challenges Graeber’s assumption that the low or absent wages in reproductive labour are primarily due to cultural misrecognition or the absence of a proper ‘cultural techne’ (Haslanger 2017). In short, the undervaluation of care work cannot be fully explained by ideology alone. It also reflects structural constraints within capitalism itself – particularly the limits of profitability under current economic arrangements. The low and absent wages in care sector do not automatically reflect the state underinvestment

in this sector.

Despite widespread critiques of neoliberal retrenchment, welfare states have not simply shrunk. On the contrary, they continue to expand – both in breadth (covering more people) and depth (offering more services and benefits) – much as they have for the past century (Aspalter 2017; Hemerijck 2017). For example, between 2011 and 2021, all but seven EU member states increased their spending on social protection as a share of GDP, with the EU average rising from 28.3% to 29.9% (Croatia from 20.6% to 22.2%; Austria from 28.8% to 32.9%) (Eurostat 2025b). In healthcare, all EU countries saw spending increases between 2014 and 2022, averaging 39.9% (Croatia: 69.7%, Austria: 44.5%) (Eurostat 2024a). This only confirms the cost disease of healthcare that requires a lot of investment (e.g., in infrastructure and educating personnel) not followed by the concomitant increase in productivity (i.e., profitability). Even in sectors where much of the labour is unpaid – such as volunteer work – basic infrastructure and organisational support are still necessary. Cuts have occurred in some areas, particularly through service closures, but they often coexist with the expansion of new services and entitlements. Care work, in particular, has grown in scope and visibility, driven by demographic shifts (e.g., ageing populations, more dual-income households) and rising public awareness. As Fraser (2016) and Winant (2024) observe, care is now more likely than ever before to be performed by non-family members in waged capacities – something that signals not abandonment but a recognition of its importance by both governments and society at large.

The emergence of institutionalised palliative care offers a clear example of this shift. Just a few decades ago, the hospice movement was virtually absent from state systems in both Austria and Croatia. Today, while still underdeveloped and heavily reliant on unpaid labour – as my interlocutors Tamara and Sara made clear – palliative care has gained unprecedented recognition. Economically, legally, and discursively, it now holds a place in the formal care landscape that it never had before. What is particularly striking from an ethnographic perspective is how volunteers themselves understand this shift. They are not naïve or unaware of the broader economic context, nor do they see themselves as ‘duped’ into working for free. Quite the opposite. For many, the decision not to receive wages is precisely what allows them to maintain high standards of care. As Vesna and Sara repeatedly emphasised, introducing money would compromise the quality of their service by subjecting it to logics of productivity and efficiency. In this view, palliative care is too meaningful to be monetised – an idea that echoes Graeber’s argument that some kinds of work are too important to be paid for (Graeber 2018).

Yet, this elevation of unpaid care work is not merely a personal conviction of my research participants. It is actively reinforced by how palliative volunteering is publicly framed: as a form of labour rooted in ‘true humanity,’ untainted by market logic. Its value is presented as incommensurable, resting on qualities that are assumed to exist in all humans and emerge most clearly in the absence of monetary exchange. This framing constitutes a form of naturalisation. It constructs care as something beyond value, and therefore outside the realm of wages, even while the broader system relies on and quietly benefits from its existence.

The attraction of women to the palliative care sector can also be interpreted as a result of a specific kind of naturalisation – namely, the association of caring attitudes (such as love or empathy) with femininity. This perspective frames women as inherently more suited for care work – something they are assumed to do anyway – which, in turn, reinforces the notion that such labour should remain unpaid, particularly when performed by women. To challenge these naturalised assumptions about care work, I often asked volunteers whether they believe there is a difference between men and women in palliative care roles. Most responded negatively, as did Sabine, who said that men and women are ‘first of all humans’ and therefore equally possess the capacity for empathy – what she described as having the same ‘hearts.’ The emphasis on the heart is telling here, as palliative care volunteering is often described as something that ‘comes from the heart.’ Sabine’s effort to de-naturalise care as inherently female is important. However, by shifting the basis of care from gender to a shared human nature, she ultimately replaces one naturalisation (of gender roles) with another (of universal humanity).

What I aim to do is take this critique further – to de-naturalise both gendered and humanised framings of care work. This is where the cost-disease analysis becomes particularly valuable. It challenges the argument, advanced by Graeber (2018), that palliative care volunteering is unpaid because it is humanised and feminised. Instead, volunteer work fills the gap created by the inherent low productivity of palliative care – a type of work that defies commodification because it requires spending time with patients after all the ‘standardised’ tasks are completed. This time-intensive component is precisely what states often struggle to fund.

It is crucial to distinguish between two arguments: first, that care work tends to be performed by those with the least power in the labour market (e.g., women and racial minorities) because it is labour-intensive and poorly paid; and second, that care work is poorly paid *because* it is done by marginalised groups (Battistoni 2024, 8). Similarly, there is a difference between claiming that people are seen as suitable for low-paid jobs because they

have been socialised into certain skills (e.g., women being nurturing), and arguing that these jobs are underpaid *because* those who do them have been ‘defined to nature’ or feminised. In the first case, ideology serves a justificatory role; in the second, it plays a causal one (Battistoni 2024, 8). Following Battistoni's logic, I see the humanisation and feminisation of palliative care volunteering not as the cause of its unpaid status, but as its justification. These narratives make voluntary engagement appear natural and morally commendable – acceptable precisely because it stands in stark contrast to paid service. If volunteer contributions were recognised as equivalent to those of paid workers, it would be far harder to justify their lack of compensation.

The devaluation of palliative volunteering – and care work more broadly – should be traced not primarily to patriarchal or any other cultural attitudes, but to the structural logic of capital investment. The issue lies in how capital disinvests from sectors that are less productive in economic terms (Battistoni 2024, 10). This does not mean that gender or ideology are irrelevant; on the contrary, they play a demonstrable role in how reproductive labour like palliative care is organised and perceived. Nor should we disregard cultural imaginaries around work and money, as Graeber insightfully shows (Graeber 2018). Such imaginaries shape the very concept of paid labour, rooted in broader historical and societal understandings. Yet, by focusing on the specific characteristics of labour processes – rather than their symbolic representations or the identities of workers – we move away from functionalist and essentialist accounts. This shift enables a more precise analysis of the systemic dynamics at play, such as cost-disease, and how these are embedded in the working environments of palliative care in Austria and Croatia (Battistoni 2024, 10). In this way, the cost-disease framework offers not a reductive causal explanation for the unpaid nature of care work, but a more comprehensive interrogation of the value of palliative care volunteering and its complex relationship with money, labour, and economy.

For instance, volunteers help bridge the gap created by the cost-disease in the palliative care sector by offering their time – time that is not subject to standardised, cost-increasing mechanisms. Yet paradoxically, this same time becomes a basis for the quantification – and thus the economic valorisation – of volunteer work. The unpayability of volunteering is often justified through the claim that it is a deeply humanised activity, one that is positioned as too meaningful to be commodified. At times, this very humanisation becomes a platform for resisting the logic of monetary valuation altogether. Whether it is used to compensate for palliative care's structural unprofitability (i.e., to make it more financially sustainable) or to actively oppose the commodification of care, economic reasoning plays a central role in

shaping how palliative care volunteering is understood and enacted. Also noteworthy is the way volunteering is framed in relation to family caregiving. By highlighting the human aspect of their work, volunteers help create a family-like atmosphere, offering support not only to patients' relatives but also reinforcing a normative ideal of care. In doing so, they occupy an important role within the family care systems of the Austrian and Croatian welfare regimes.

This chapter has demonstrated that the relationship between money and voluntarism carries multiple, sometimes contradictory meanings. The economic value of palliative care volunteering is at once acknowledged, subtly implied, and strongly contested. These contradictions are evident even in the narratives of individual volunteers – such as Sara – who, while advocating for greater economic recognition of volunteering, also emphasised her deep commitment to unpaid care and the importance of working without financial compensation. This complexity is not surprising, given that the relationship between money and volunteering is far from linear or unidirectional.

Building on these insights, the following chapter explores another key dimension of volunteer work – its spiritual aspects. This shift in focus reveals deeper systemic features of welfare state development and the role of religiosity as it is experienced in two Catholic contexts. Here, humanity continues to play an important role, but it is located in the patients rather than the volunteers. Specifically, working in palliative care offers volunteers access to what they perceive as a more authentic or profound form of humanity. This experience becomes central to their spiritual development. While this spiritual growth is shaped differently depending on the degree and nature of secularisation in each national setting, it also reflects a broader trend: the cultivation of human investment, which is increasingly vital to liberal democratic societies.

Chapter 5

A Catholic Inflection in the Spiritual Turn: Secular-Religious Intersections in End-of-Life Care

Introduction

In the previous chapter, I explored how palliative care volunteering is framed to emphasise both its intrinsic value and its distinctive relationship with money, positioning volunteers as unique (or ‘para’) professionals situated between paid staff and family caregivers. In this chapter, I delve more deeply into the specific nature of this work and the role volunteers play in supporting patients’ families, with a particular focus on the emotional and spiritual care they provide to clients. This care not only supports dying individuals, but also fosters the spiritual growth of the volunteers themselves. Often, it involves sitting with patients in their final moments, fulfilling last wishes – whether through listening, praying, or simply sharing silence. In accompanying clients toward a dignified death, such care takes on a spiritual dimension, sometimes drawing on religious practices. By exploring the spiritual dimensions of palliative care volunteering, new layers of volunteer professionalism emerge – particularly in relation to the roles of family carers. This focus is significant not only because of the inherently spiritual nature of end-of-life care, but also due to the connection both studied organizations maintain with the Catholic Church. These connections shape the work of volunteers in ways that shed light on the functioning of the Austrian and Croatian (familial) welfare states.

The chapter is divided into two subchapters. The first situates volunteer work within broader spiritual landscapes and Catholic contexts of the studied settings. The second explores how global spiritual trends take on a distinctly Catholic character in these contexts, especially through volunteers’ attitudes, such as unexceptional love and sensitivity to suffering. Before proceeding, however, I clarify my use of the terms ‘spirituality’ and ‘religion.’

Drawing on a sociological perspective (see Mossière 2022), I define spirituality as the ways in which individuals engage with existential questions – including human vulnerability, the search for meaning, and the desire for continuity. It typically relates to the immaterial or transcendent dimensions of life. Unlike religion, which is often rooted in institutional structures, codified beliefs, and prescribed practices, spirituality tends to be more personal and experiential, shaped by individual stories, relationships, and contexts (Ammerman 2013;

Mossière 2022). However, the two terms are not necessarily mutually exclusive. As will become clear later in the chapter, many religious volunteers understand religion as a specific expression or subcategory of a broader spiritual orientation.

The first subchapter begins by exploring how palliative care volunteering contributes to volunteers' well-being and personal development. Regardless of religious background, cultural context, or individual approach to spirituality, many volunteers described the spiritual aspects of their work through the vocabulary of self-care and personal development. I situate these interpretations within the broader cultural shift known as the 'spiritual turn' (Houtman and Aupers 2007; Watts 2022), which cultural sociologist Galen Watts (2018; 2020) describes as part of a 'subjective wellbeing culture' (Heelas and Woodhead 2005) that has become central to liberal democracies since the 1960s. This trend aligns with neoliberal forms of governance that place responsibility for well-being on individuals – a dynamic also reflected in welfare states' investments in human capital.

Although shared spiritual elements enable me to situate volunteering within a broader socio-cultural and spiritual landscape, it is equally important to account for the diversity of individual interpretations. These variations help contextualize volunteers' practices within distinct national Catholic frameworks. For instance, volunteers in Zagreb tend to express their motivations and experiences in more explicitly religious terms than their Viennese counterparts. I attribute this difference to varying degrees of secularisation, as well as to the divergent institutional development of volunteer work – shaped by Austria's tradition of corporatism and Croatia's more 'custodial' approach to the third sector.

Drawing on the work of sociologists of religion such as Casanova (2007), Pickel and Sammet (2012), I understand secularisation as a multidimensional process involving the separation of church and state, the privatisation of religion, and a general decline in religious belief and practice. My findings align with scholarship that links higher levels of modernisation and economic prosperity with both political and social secularisation. In such contexts, religious organisations often gain legitimacy more through the quality of their services than through their explicitly religious identity (Putnam 2000).

Following this contextual analysis, I examine in the second subchapter how volunteers in both settings draw on similar aspects of palliative care, such as a sensitivity to suffering and an ethos of unconditional acceptance. These attitudes reflect what anthropologist Andrea Muehlebach (2012; 2013) calls 'Catholicised neoliberalism': a moral sensibility that merges Christian compassion with neoliberal values of civic engagement and individual responsibility. Research participants frequently described accompanying the dying as an opportunity to see

people ‘as they are,’ stripped of the social layers that shape everyday life. These moments were enabled by the volunteers’ capacity to remain present with suffering and to accept individuals unconditionally – regardless of religion, ethnicity, class, or other social markers. Many described this stance as grounded in a ‘love for people,’ a phrase used to express tolerance and openness. While a nonjudgmental approach has been central to palliative care since the hospice movement’s beginnings, such unconditional acceptance is also a key component of Catholic teaching – particularly its emphasis on the divine incarnation in every human being, especially the vulnerable. In this way, palliative care volunteers embody what Muehlebach terms the ‘loving compassionate subject,’ while also operating within a distinct moral and emotional economy (Muehlebach 2012; 2013). A notable aspect of this distinction is that volunteers often perform tasks that family members are unable or unwilling to undertake, thus playing a vital role in supporting familial care structures.

5.1 Palliative Care Volunteering as Personal and Spiritual Growth in Catholic-secular Austria and Croatia

This subchapter explores the spiritual dimension of palliative care volunteering by situating my participants’ practices within broader global and national religious and spiritual trends. I begin by examining how the act of accompanying the dying contributes to volunteers’ own spiritual growth, framing this engagement as a form of personal development. This interpretation resonates with what Paul Heelas and Linda Woodhead describe as the ‘subjective-wellbeing culture’ – practices aimed at enhancing individuals’ perceived quality of life (Heelas and Woodhead 2005). Scholars such as Galen Watts further link this orientation to the broader ‘spiritual turn’ that has shaped Western societies since the 1960s (Watts 2018; 2022; Houtman and Aupers 2007). Finally, I consider how discourses of self-development function as a form of neoliberal governmentality, in which individuals are increasingly held responsible for their own wellbeing – a logic that has been progressively adopted by welfare states oriented toward the cultivation of human capital.

In the second part of the subchapter, I contextualize the ‘spiritual turn’ alongside the ways palliative care volunteers articulate spirituality within the Catholic settings of my fieldwork. I show how differing approaches to spirituality of my research participants are shaped by the degree of institutionalising volunteer work in each context. In Zagreb, the

absence of religious professionals within palliative teams enables volunteers to provide spiritual care themselves – either by liaising with priests or fulfilling spiritual needs directly. This expands their roles and reflects a greater comfort with religious expression. In contrast, Viennese volunteers – operating within a more secular and institutionalised context – avoid explicitly religious language. These contrasts mirror broader societal dynamics: Croatia’s weaker secularisation permits open religious expression, while Austria’s strong church-state consensus tends to obscure the Church’s institutional role, even in faith-based settings.

It was a rainy Good Friday afternoon, and I was working on my chapter about spirituality when a report on the midday journal (*Mittagsjournal*) of the national broadcaster ORF (*Österreichischer Rundfunk*) caught my attention (ORF 2025). The timing felt uncanny. The segment discussed a cultural shift I was writing about at that very moment: the so-called ‘spiritual turn’ (Houtman and Aupers 2007; Watts 2022), marked by the growing number of individuals in Western societies who identify as ‘spiritual but not religious’ (Lipka and Gecewicz 2017; Pew Research Center 2018). In precisely these words, the religious pedagogue Anton Bucher explained in the interview for ORF the main reason behind the steady decline in the number of denominational believers – particularly Catholics – in Austria over the past few decades (ORF 2025).

His interview, aired before the Easter holidays, was part of a broader thematic report reflecting on Europe’s religious landscape. Two reporters discussed the current state of Catholicism in Europe – now accounting for barely 50% of the population – and noted that in 2023 alone, 85,000 Austrians formally left the Church. One even remarked that today, Austrian classrooms often have more atheist or Muslim students than Catholic ones. The report did not shy away from the deeper reasons behind this transformation. The legacy of clerical abuse scandals loomed large, as did the broader processes of individualisation in late modern societies (ORF 2025). Bucher emphasized that many now turn away from institutional religion not because they have abandoned meaning-making entirely, but because they seek it elsewhere – often in forms of spirituality that feel more attuned to personal experience and everyday life. Practices like yoga, mindfulness, and veganism, he said, have become markers of a ‘cool lifestyle,’ signalling a spiritual sensibility no longer tethered to dogma or doctrine (ORF 2025).

This shift continues to animate debates within the sociology of religion. Some interpret it as a symptom of secularisation, a final, thinned-out residue of the sacred in a disenchanted world (Voas 2008; Hindmarsh 2017). Others see it as a reconfiguration of religiosity itself – more individualised, vicarious, and diffuse, albeit lacking the structural cohesion of traditional faiths (Watts, 2022:36). Galen Watts, building on cultural theorists like Houtman and Aupers

(2007) argues that what we now call ‘spirituality’ is underpinned by a distinct cultural logic he terms the ‘religion of the heart’ (Watts 2018). This ethos, he suggests, is marked by a trust in personal experience, a sense of the divine as immanent, and a romantic expressivism rooted in the search for the ‘true self’ and a narrative of self-realisation (Watts 2018; 2022).

These ideas resonated deeply with the stories I was hearing from my research participants in Vienna. Many of them spoke in strikingly similar terms when describing their engagement with palliative care – a domain where spirituality often emerges through the backdoor, as a felt need rather than a formal doctrine. Take, for instance, Sabine, a 63-year-old volunteer introduced in the previous chapters. Active in both home visits and public outreach, she was particularly open about the spiritual dimensions of her work. For her, death was not merely a medical or biological event – it was also a threshold laden with emotional, existential, and even metaphysical significance. When I asked Sabine whether she saw her volunteer work as spiritual, she paused for a moment, then said:

If a patient wants to talk about spirituality, I’m happy to listen. There was one patient who was very glad to have the Bible read to her – it was her wish, and it needed to be fulfilled. So, it really depends. For me, my role is simply to be present. I think that’s a big part of staying balanced. Spirituality, for me, is closely connected to the spirit (*Geist*) and the spiritual level of things. I meditate a lot and take good care of myself – that’s all part of self-care, which is also deeply spiritual. That includes my diet, exercise, and how I treat my body. I don’t go to church, but I have my own faith. I pay attention to how my body feels – when I wake up and meditate, I can really sense it. That, too, is part of my spirituality. I don’t follow a religion that defines what is sacred. Instead, I see spirituality as a great opportunity to learn from the outside world and integrate different aspects into my own life – things that help me stay balanced, recognize my joy, and reconnect with myself. In my life, spirituality is everything. It’s living fully in the here and now, on this earth that I know I belong to. It’s about asking: What is my purpose? And at the same time, trusting in the support of the universe. For me, spirituality is the balance between the above and the below – a harmony I find within myself. And it doesn’t have to come from any religion. (Interview, Sabine, 22/07/22)

As this excerpt illustrates, Sabine’s support for the dying was closely tied to her understanding of self-care and the daily practices she used to maintain well-being and nourish

her spirituality. She approached spirituality in a broad, inclusive way – one that encompassed all aspects of life rather than being confined to a particular space, time, or religious framework. For Sabine, practicing self-care was essential to being truly ‘present’ in her role as a volunteer. Her engagement in palliative care not only reinforced these daily rituals but also introduced new experiences and insights that she integrated into her life, enhancing her sense of balance and happiness. On the one hand, her volunteer work motivated her to continue cultivating her personal and spiritual growth; on the other, it actively enriched her life and contributed to her overall well-being. During our conversation, Sabine frequently mentioned how busy she was within the organization and how important it was to manage her time effectively to juggle responsibilities in both her private and professional life – even in retirement. At the time, she was also helping her daughter care for her grandchildren and did not hesitate to point out that she had taken on the main responsibility for end-of-life care for her own parents.

Sabine appeared genuinely enthusiastic about palliative care, a sentiment reflected not only in her active involvement within the organization, but also in the fact that she reached out to me directly after my call for participation, eager to share her experiences. For her, supporting any work related to palliative care was essential – both as a personal commitment and as a way to contribute to the broader development of the hospice movement. She was particularly passionate about the spiritual dimensions of accompanying the dying, firmly believing that, in the final phase of life, it is the spirit (*Geist*) – rather than the physical body – that takes precedence. From her perspective, recognizing and responding to the spiritual needs of palliative patients was crucial to easing their transition to what she described as ‘another dimension.’ Sabine attributed her ability to attune to these needs to her heightened sensitivity to people’s ‘energies’, a capacity she connected to her self-care practices and holistic way of living. At one point, she even remarked that ‘energy is everywhere.’

Her statements, along with her overall demeanour, gave her an unmistakably esoteric presence, aligning her closely with a New Age lifestyle. New Age refers to a broad spiritual and cultural movement that emerged in the late 20th century, emphasizing personal spiritual growth, holistic health, and a belief in the interconnectedness of all life. It draws from a wide range of traditions, including Eastern religions, Western esotericism, psychology, and metaphysics (Heelas 1996). Esotericism typically involves the pursuit of hidden or inner truths, symbolic interpretations of reality, and the idea that ultimate knowledge is accessible through personal insight or initiation. It is often positioned as a counter-current to both mainstream religion and scientific rationalism (Hanegraaff 2012).

As discussed in the previous chapter, Sabine was critical of modern Western values centred on profit and consumption. She viewed her volunteer work as a way to counter that mindset and instead live in accordance with her spiritual ideals – ideals shaped by Eastern practices and vocabulary typical of New Age spirituality, such as meditation, energy, balance, and the universe. Like many other Viennese volunteers, Sabine had formally left the Catholic Church and emphasized the importance of distinguishing her personal spirituality from any institutionalized religion.

What stood out to me was how frequently similar language emerged among volunteers in both cities, who, on the surface, came from very different religious and social backgrounds. Even those with strong ties to traditional faiths described their engagement in palliative care using a spiritual vocabulary that resonated with this broader ‘spiritual turn.’ This convergence highlighted how global cultural currents are refracted through local experience. In Zagreb, for instance, many of my participants identified as devout Catholics, yet they too spoke of volunteering as a path of spiritual growth. One of them was Božena, whom I introduced in the previous chapter. When we first met, she was working as an administrator at an agricultural firm. She was also an active member of the Franciscan Secular Order, a lay branch of the Franciscan tradition. For Božena, spirituality was firmly rooted in Catholic doctrine and practice – reflected in her background as a trained religious education teacher and her deep involvement in the Franciscan community. She spoke with conviction about her faith as the driving force behind her commitment to palliative care. When I asked how her journey into volunteering began, she explained:

First of all, I start from a deep religious conviction. I am a true believer, a Catholic. And the first thing that comes to mind is what Christ said: ‘What you did to one of the least of these brothers of mine, you did to me.’ That look in the patient’s eyes, that weakness – it really reminds me of the Lord, like Jesus on the cross. And I don’t know... if you give him [the patient] a glass of water, it’s like giving water to Jesus. It doesn’t have to be someone close to you – it can be any person. And through these kinds of moments, not only do I grow spiritually, but also, as you’d say, I learn to balance my inner feelings and fears. You grow as a person. You really grow. (Interview, Božena, 23/05/22)

Božena’s reflection reveals a spirituality deeply rooted in Catholic doctrine. Her motivation for volunteering is framed through the lens of Christian service, evoking Christ’s

teachings on compassion and identifying with the suffering. For her, the spiritual dimension of palliative care was not abstract; it was immediate and embodied – encountered in the patient’s gaze, in acts of caregiving, and in the vulnerability shared at the bedside. As explored in the next subchapter, this understanding of spirituality is closely tied to a Catholic theology of suffering, where responding to the pain of others is a direct expression of one’s faith. In this sense, Božena’s spiritual framework differs significantly from that of Sabine, whose engagement was informed by a more eclectic set of New Age practices and an explicit distancing from institutional religion.

But Božena’s narrative reveals more than just her religious convictions. While she opens with firm doctrinal statements, her language soon shifts toward a more universal and emotionally resonant register – speaking of ‘balance,’ ‘fears,’ and ‘personal growth.’ This movement from doctrinal to affective language suggests that her experience of being with the dying transcends rigid theological boundaries. Volunteering becomes not just a religious duty but a space for emotional self-work and existential reflection. Some volunteers went even further, emphasizing how their encounters with the dying profoundly enriched their own lives. Tamara, a Viennese volunteer, offers a compelling example. She spoke candidly about the personal fulfilment she found in this work, openly acknowledging the ways in which volunteering fostered her own growth and deepened her self-awareness:

What I always tell people when they say this must be something heavy and depressing, is that I’m not doing it purely for altruistic reasons. I’m honest enough to say that I’m also doing it for myself – because it changes the way I look at my life. ... You feel the immediate impact, and it also affects your own life. That creates a lot of meaning. As I said, it confronts you with your own priorities, your own values. And for me, it really clarifies them in a single moment. I don’t need to go to therapy to figure out what matters most to me. When you work with dying people, your priorities just become clear. They’re right there – because you’re with those people. (Interview, Tamara, 27/06/22)

Despite being only 35 at the time, Tamara had already spent nearly a decade volunteering with Caritas in Vienna when we met in the summer of 2022. Like Sabine, she was eager to share her experiences and was among the first Viennese volunteers to agree to an interview. She also showed keen interest in participating in various projects aimed at exploring the perspectives of palliative care practitioners. As noted in the previous chapter – particularly

through her critique of inadequate state support for end-of-life care – Tamara believed that palliative care remained underrecognized in society. For her, speaking about it was a way to help shift that perception. Her passion for palliative care was deeply personal. Working with people at the end of life brought her face-to-face with fundamental existential questions, as dying often stripped away the superficial layers of identity. Though she avoided explicitly spiritual language, many of my research participants viewed such encounters as deeply spiritual – an interpretation devout Catholics like Božena would frame within Church teachings. Tamara, while not religious herself, acknowledged the presence of a spiritual dimension in her life. As she once put it, she is ‘spiritual by not calling it spiritual’ – a phrase that captured her reluctance to rely on religious terminology, yet reflected a profound inner awareness (Interview, Tamara, 27/06/22). As a result, her reflections on volunteering were free of overt religious references, yet infused with a quiet, reflective depth that resonated with others in the field.

What made palliative care particularly meaningful for Tamara was the honesty and openness of terminally ill patients. These encounters allowed her to witness the immediate impact of her presence and support – something she found lacking in her earlier volunteer work, such as environmental protection, where the absence of direct human interaction left her feeling disconnected from the results. In her view, contact with the dying compels volunteers to grapple with life’s most essential questions. This confrontation helped her clarify her own priorities to such a degree that, as she remarked with a smile, she did not need professional therapy to find answers. In this way, volunteering in palliative care became a form of emotional sustenance – almost a substitute for psychotherapy. By offering care to others, Tamara found herself also receiving something deeply nourishing in return. Through her unpaid labour, she was gaining something profoundly valuable for her own well-being.

It is no coincidence that research participants from such diverse backgrounds – varying in age, occupation, religious background and country of residence – described the spiritual aspects of palliative care volunteering in strikingly similar ways. Their shared framing of volunteer engagement as a means of enhancing spiritual growth and overall well-being reflects what Paul Heelas and Linda Woodhead have identified as the rise of a ‘subjective wellbeing culture’ (Heelas and Woodhead 2005). This term refers to a broad array of cultural activities and provisions that explicitly aim to improve the quality of subjective life – a development that, according to the authors, has profoundly shaped the culture of liberal democracies (Heelas and Woodhead 2005, 85). The contemporary proliferation of practices such as yoga, meditation, therapy, wellness tourism, and entertainment is increasingly legitimised through

the logic of self-realisation and personal growth, helping individuals to discover their ‘true selves,’ pursue self-knowledge, and fulfil their potential (Heelas and Woodhead 2005). Palliative care volunteering, I argue, belongs on this list of practices.

A growing body of scholarship suggests that these practices have increasingly been co-opted to support neoliberal forms of governmentality. They shape individuals into neoliberal subjects by promoting autonomy, self-responsibility, and the pursuit of personal potential – particularly in areas such as education, health, and moral behaviour (Altglass 2021; Lavrence and Lozanski 2014; Rose 1999; Scharff 2016). Individuals are now expected to cultivate their human capital through continuous self-improvement – via training, experience, emotional intelligence, and even happiness – often drawing selectively on religious or spiritual resources that align with this imperative (Meintel and Géraldine Mossière 2011).

Welfare state scholars have noted a parallel shift, as many governments increasingly frame social policy in terms of investment in human capital, aiming to produce a healthy, educated, and resilient workforce capable of competing in the global economy (W. Brown 2016; Hemerijck 2018). Political theorist Wendy Brown argues that neoliberalism discursively constructs individuals as units of human capital – whether for personal advancement, corporate productivity, or national economic projects. As a result, nearly all aspects of life – education, consumption, career planning, even romantic relationships – are reframed as strategic investments in the self (W. Brown 2016). Palliative care volunteering, I suggest, is one such form of self-investment.

After outlining the shared spiritual dimensions of volunteering – through which I positioned volunteer work within broader cultural, spiritual, and socio-economic trends – it becomes equally important to account for the differences in how volunteers interpret these aspects. Attending to these variations enables me to trace not a global tendency, but one situated on a national scale. In particular, it sheds light on the differing levels of secularisation and the varying degrees of institutional development of volunteering in Austria and Croatia.

This national framing is especially relevant given that both organisations I studied are affiliated with the Catholic Church, and that both countries where I conducted fieldwork are predominantly Catholic. As a result, the so-called ‘spiritual turn’ takes on a distinctly Catholic character – though its nature and intensity vary depending on the Church’s role within each national setting. Understanding these configurations is crucial not only for contextualising the spiritual turn more accurately, but also for grasping the specific forms of spiritual labour carried out by palliative care volunteers. This includes the diverse ways in which individuals such as

Sabine, Božena, and Tamara articulate their sense of spirituality. It is to these issues that I now turn.

To explain and account for these differing approaches to spirituality and religion, it is also essential to consider the influence of those responsible for recruiting and orienting volunteers in Zagreb and Vienna. They play a key role in shaping how volunteers come to understand and engage with their work – including its spiritual dimensions. Let us begin with Tomislava, the volunteer coordinator in Zagreb. I met her when she was in her early forties. Like many members of the organization, she was part of the Franciscan secular order, which she had joined after being involved with the Franciscan youth group, *Frama (Franjevačka mladež)*. While she was open about her religious background, Tomislava also highlighted the spiritual significance of the volunteers' work. A social worker by profession, Tomislava had been with the organization for over ten years, primarily overseeing volunteer supervision and administrative tasks. Her role provided her with valuable insight into the overall needs of patients and their families within the current palliative care system, as well as the specific contributions of volunteers. When I asked her about the spiritual role of volunteers, this is what she shared:

I do believe it [volunteer service] has a spiritual role. First of all, there's the arrival of another person – someone unknown, who's motivated purely by the desire to help. That altruistic act sends an important message to both the patient and their family. It helps build trust and creates space to talk about deeply personal topics – things patients sometimes can't even share with their closest family members. The very fact that this is someone they don't know makes it easier for the patient to speak freely, without reservation. They won't say these things in front of family because they're trying to protect them, or because they're afraid of how their words might be received. So yes, the volunteer's role includes providing spiritual support. And then there's the name of our organization itself. It can carry meaning... especially since we come from the Franciscan Secular Order, and LaVerna is tied to the life of St. Francis – the place where he received the stigmata. For those who know what our association stands for, it might encourage them to open up about spiritual matters – whether it's faith and religion, or questions of meaning and purpose for those who aren't believers. We visit everyone, regardless of their religious background. (Interview, Tomislava, 08/12/21)

For Tomislava, the spiritual role of volunteers was closely tied to the altruistic nature of their work. The presence of someone outside the patient's familiar circle – motivated solely by the desire to help – created a safe and open space where conversations about spirituality could naturally emerge. Volunteers, in this way, held a unique position in initiating and engaging in such discussions, though this was not necessarily framed within the context of Catholicism. Still, the organisation's roots in the Franciscan Secular Order were, according to Tomislava, significant. The name 'LaVerna,' with its associations to St. Francis and Catholic tradition, could subtly encourage patients to open up about matters of faith and religion – or, for those without a religious affiliation, to explore broader questions of meaning and spirituality. This created a clear link between the volunteers' spiritual support and the religious orientation of the organisation, one grounded in Catholic teaching.

The unique role of volunteers in addressing the spiritual dimensions of care was also recognized by Michaela, a volunteer coordinator in Vienna. For her, it was precisely the intimate, non-professional nature of the volunteer-patient relationship that created space for spiritual themes to emerge:

I believe volunteers are the ones most often confronted with spiritual issues, because it's only within this non-professional setting that a truly human relationship with the patient can develop. They often have to engage with spiritual questions. And of course, for me, when you're dealing with death and dying, you're inevitably faced with those issues.

However, when it came to the religious identity of both the volunteers and the organization itself, Michaela clearly distanced the work of the hospice team from the Catholic Church, despite the organization's formal ties:

Well, Caritas is a church-based organization, but the hospice itself is non-denominational, and our team reflects that. I think we have a bit of everything – from Buddhists to very devout Catholics. We don't have any Muslims at the moment, but we do have some very esoteric people. That's something we talk about during the admission interview. I ask about their spiritual outlook – not because it matters what they believe, but because it's important that they're self-aware, that they can keep it to themselves, and that they don't proselytize.

(Interview, Michaela, 11/10/22)

Like Sabine, Michaela was raised Catholic, but officially left the Church many years ago. She did not affiliate herself with any religious group afterward and preferred to define her spirituality outside of traditional or confessional boundaries. In line with Tomislava, Michaela was also not hesitant to recognize the spiritual role of volunteers in the provision of hospice and palliative care. On the contrary, she believed that volunteers were often the ones most deeply engaged with spiritual issues, even more so than other members of the palliative team. For Michaela, this was largely due to what I call the ‘para-professional’ status of volunteers, which allowed them to form more personal, human relationships with patients. From her perspective, it was precisely this humanisation of care that created space for spiritual dimensions to emerge. In other words, volunteers are uniquely positioned to address spiritual concerns in a setting that, by its very nature – being centred on death and dying – inevitably involves such issues.

While both volunteer coordinators acknowledged the important role volunteers play in addressing the spiritual needs of palliative patients, they differed significantly in how they connected this role to the sphere of religiosity. For Michaela, it was particularly important that volunteers set aside their personal religious affiliations while volunteering, in order to prevent any possibility of proselytizing. Beyond avoiding missionary behaviour, Michaela saw the detachment from religious connotations as essential for maintaining the non-denominational character of the palliative team – even though it operates under the umbrella of the well-known Catholic organization, Caritas. In contrast to Tomislava, Michaela actively sought to ensure that the services offered to patients and their families carried no religious undertones or visible ties to the Church. In her view, the organization’s Catholic background should be effectively erased for the sake of preserving a secular approach. This distancing from Caritas’ religious identity also served another function: it helped attract volunteers from a wide range of spiritual and religious backgrounds. Even among those who identified as Catholic or Christian, many volunteers were quick to assert that their personal beliefs had no influence on their volunteer work. In fact, several were so eager to affirm the non-religious nature of their involvement that they explicitly distanced themselves not only from religion, but from any association with spirituality.

Thomas, an 81-year-old volunteer with over two decades of experience, was particularly forthright. On a warm July afternoon in Vienna, he sat on a bench outside a Caritas nursing home, speaking with quiet confidence, his hands folded neatly in his lap:

A spiritual role? No. I've spoken with some clients about spiritual matters, but I'm not the one to give them hope or offer any kind of explanation about what's going on. No, I don't see that as my role.

When asked whether his personal faith and religious background played a part in his volunteer work, his response followed the same line:

I'm a Christian – Evangelical Lutheran – but it doesn't matter. In my work, it plays no role. No. That's what Tara is for – for those who want religious guidance. Tara is the *Seelsorgerin* [pastor] they can call if they want to talk. But that's not my job. (Interview, Thomas, 04/07/22)

What emerged from conversations like these was a pattern: while some volunteers were open to redefining spirituality in broader, non-religious terms, there was a consistent emphasis on preserving the secular and inclusive character of palliative care. Yet, this insistence on neutrality paradoxically served to uphold a religious framework. In stripping everyday care of its spiritual dimensions and relegating them to a designated professional – the pastor (or *Seelsorger*in*) – the Catholic context of the organisation was not merely backgrounded, but actively effaced. Still, the religious architecture quietly endures. When patients express spiritual needs, they are referred to a trained specialist whose role is embedded within a specific tradition. In the case of the Caritas palliative team, that specialist is a Catholic theologian. Should a patient's beliefs fall outside the bounds of Catholicism, the *Seelsorger* is expected to make an appropriate referral. But by positioning Catholicism as the institutional default, spiritual care remains tethered to a particular religious worldview – even as the team publicly maintains a secular and inclusive ethos. This division of labour effectively quarantines religion, keeping it both present and out of sight, unexamined and unchallenged.

This was not an option for volunteers in Zagreb, where no spiritual professional is part of the palliative team. While they could invite a priest to administer sacraments associated with the final phase of life, patients were often hesitant to do so, as such a visit would symbolically mark their impending death. As a result, it was often easier and more comforting for patients to turn to volunteers for less formal spiritual support – such as prayer or reflective conversations – typically grounded in the teachings of the Catholic Church. The absence of clear guidelines around hospice volunteering in Croatia, especially when compared to Austria (see Chapters

Three and Six), further enabled volunteers to take on spiritual roles. The willingness of volunteers in Zagreb to engage with the spiritual journeys of their clients, and to link this support directly to their own religious backgrounds, can be attributed to two interrelated factors: the relatively underdeveloped state of both palliative care and organized volunteerism in Croatia, and the lack of formal spiritual professionals within palliative teams. Unlike Austria, where volunteers' roles are more formally defined and institutionally bounded, the greater flexibility in the Croatian context allows for more spontaneous and personalized forms of spiritual engagement.

Another important factor lies in the religious identification of volunteers and the role of religion – particularly Catholicism, which remains the dominant religion in both contexts. For instance, most volunteers in Zagreb identified as Catholic, with many actively participating in Church-related activities and groups, such as the Franciscan Secular Order. In contrast, Viennese volunteers often described themselves as not adhering to the teachings of any specific religion, with many having formally left the Catholic Church. These differences can be partly attributed to the unique characteristics of the two organizations studied, but they also reflect broader societal trends. Croatia, for example, has a significantly higher percentage of self-identified Catholics (86%) compared to Austria (70%) (see Chapter Three).

This higher rate of religious identification in Croatia has remained relatively stable since the country gained independence in the 1990s. Many scholars argue that this trend stems from the fusion of national and religious identity, a process that began during the socialist period as a form of resistance to the enforced secularism of the central government and peaked in the nationalist politics of the 1990s (see Grzymała-Busse 2015). The existential insecurity of the transition period further reinforced this trend, as one strand of secularization theory suggests (Inglehart and Norris 2007). According to this theory, holding onto religiosity provides a sense of security in the face of various social risks, which in turn ensures religion's continued influence across different areas of life. Moreover, Catholic dominance in Croatia has a stronger hold compared to the more competitive Protestant-Catholic landscape in other post-socialist countries, such as Hungary, the Czech Republic, and the Baltic states (Grzymała-Busse 2015).

This is not to suggest that Catholicism is absent from Austrian society. On the contrary, its presence is evident, particularly through the significant role Catholic organizations play in providing welfare services in partnership with the state. While the roots of this partnership were firmly established in the 19th century, the influence of Catholicism in Austrian society can be traced much earlier, especially considering that the Austrian monarchy was a key force behind

the Counter-Reformation in the 16th and 17th centuries (Mourão Permoser 2014). Moreover, attitudes toward religion continue to shape the self-definition of dominant political parties, a legacy inherited from the period of the First Austrian Republic during the interwar years (Mourão Permoser 2014).

Mourão Permoser argued that this long-standing institutional presence of the Church in Austrian society has contributed to the creation of a strong consensus surrounding the state-Church partnership. As a result, political debates often took place in the symbolic rather than institutional realm – such as discussions on desacralizing public spaces, framing same-sex partnerships, or using religion (particularly Christian heritage) as a rhetorical tool against (mostly Muslim) migrants (Mourão Permoser 2014).

This institutionalized, almost taken-for-granted role of the Catholic Church in welfare provisioning might help explain why many of my respondents refused to acknowledge or question the religious background of the organization in which they work. The mere fact that they did not identify as Catholic, refrained from using explicitly Catholic terminology, or avoided practicing certain rituals seemed sufficient for them to claim that Catholic influence was absent from their work. This claim also reflects the ongoing secularization of Austrian society, particularly in the multicultural city of Vienna, where cohesive Catholic belonging has significantly decreased in recent years (see Chapter Three). In this context, as argued by sociologists of religion (Putnam 2000; Gert Pickel and Gladkich 2012), religious networks like Caritas are becoming increasingly secularized, gaining recognition in society more for the services they provide than for their religious orientation. Churches must consequently appeal to the broader population by embracing universal values (Putnam 2000; Gert Pickel and Gladkich 2012). This example of secularizing the services of a well-known Catholic organization in Austria further supports the core tenets of modernization theory, which posits that economic development leads to the secularization of society and its religious organizations, even though these organizations continue to play a significant role in welfare provisioning (Putnam 2000; see Chapter Three).

The weaker economic development, greater mistrust toward the third sector, and lower level of secularization in Croatia also mean that religious welfare organizations must approach the fight for recognition differently. For example, Kallunki and Zrinščak (2021) highlighted in their study on welfare provisioning in Croatia that, despite these organizations' efforts to downplay their religious character in order to treat all clients equally, religious elements or even the promotion of religion have still been evident (Kallunki and Zrinščak 2021). These religious features distinguished them from other welfare providers, creating a space where

workers could express their religious devotion in practice (Kallunki and Zrinščak 2021). Given this context, it is not surprising that palliative care volunteers in Zagreb did not hesitate – often with pride – to display their religious affiliation and discuss how it influenced their work, particularly in terms of the spiritual impact it had on their clients.

However, the ongoing process of secularization should not be disregarded in both Croatian society and the work of palliative care volunteers. For example, shifts away from living strictly according to Catholic teachings – such as a growing mistrust of the Church and changing attitudes toward family and sexuality – have been observed in Croatia (Nikodem 2011). These changes have led some scholars to suggest the end of religious revitalization and the detraditionalization process that began in the 1990s (Jerolimov and Zrinščak 2006; Nikodem and Zrinščak 2009). In the case of the organization I studied, it is important to note that by emphasizing the provision of services regardless of clients’ religious, national, or ethnic backgrounds, as almost all my research participants indicated – such as Tomislava’s statement – volunteers’ work could be disentangled from explicit religious connotations and reach a broader audience. This suggests that secularization and the influence of religion are not unidirectional processes. Similarly, the presence of Catholicism in Viennese palliative care should not be mistaken for a purely secular vocabulary as discussed earlier.

To better understand this presence and assess the universality of values promoted, the next section will unpack these values within the context of the moral sensibility of ‘Catholicised neoliberalism’ (Muehlebach 2012; 2013), which is central not only to the work of volunteers, but also to the particular conception of humanity that underpins it.

5.2 Revisiting Catholicised Neoliberalism: Embracing Suffering and Diversity in Palliative Care Volunteering

In the previous subchapter, we saw that the self-development strategies of palliative care volunteers are incompletely understood as long as we do not pay attention to a crucial element: helping others in need. In this section, I build on that insight by further exploring the specifically Catholic inflection of the ‘spiritual turn.’ The volunteers in my study not only operate within predominantly Catholic contexts, but also articulate their work in ways that resonate with what anthropologist Andrea Muehlebach describes as ‘Catholicised neoliberalism’ – a moral sensibility grounded in voluntary engagement, authentic interpersonal care, brotherly love, and responsiveness to suffering (Muehlebach 2012; 2013). What makes this moral sensibility neoliberal is its emphasis on personal responsibility for both one’s own and others’ well-being, expressed through compassionate acts and civic participation. The increase of individual ‘responsibilisation’ contributes to the emergence of indirect and informal forms of governance at both supranational and local levels (see Foucault 1997; Lemke 2015; Rose 1996; M. Dean 2010). As Rozakou argues, these governing practices often involve the redistribution of social welfare responsibilities from the state to non-state actors, entangling them with market and private interests (Rozakou 2016). According to Muehlebach, what gives this form of neoliberal governmentality its distinctly Catholic character is precisely its moral emphasis on attentiveness to the needs of others (Muehlebach 2012; 2013).

I expand on Catholicised neoliberalism by examining how volunteers articulate an ethic of unexceptional love and heightened sensitivity to suffering. These emotional and moral orientations offer further insight into the complex interplay between religion and secularity. They also inform how volunteers relate to patients’ families and understand their own roles within the broader network of care.

While the previous section highlighted how differing definitions and practices of spiritual care reflect national religious contexts and degrees of institutionalisation in Croatia and Austria, this part of the chapter shifts attention to a shared ethical commitment across both settings: accepting each individual regardless of their background, behaviour, or medical condition. This inclusive ethos carries both Catholic and secular-liberal connotations. Volunteering in palliative care exposes individuals to the full spectrum of human experience – often stripped of pretence – as those nearing the end of life have little left to conceal. This rawness invites honest, direct human interaction, but also confronts volunteers with profound physical and emotional suffering, which they need to be prepared to face. In doing so, they

push back against what one volunteer described as a ‘culture of toxic positivity’ – the tendency to downplay or ignore suffering (Interview, Katharina, 10/08/22). I examine this stance in relation to Catholic teachings that emphasize the spiritual meaning of suffering. Within this moral framework, every person, especially the most vulnerable, is seen as embodying the divine and is therefore inherently worthy of care. This ethos of unconditional acceptance, often articulated as ‘love for people’ (*Menschenliebe*), is not confined to explicitly Catholic volunteers or institutions. It also appears among participants from other religious traditions or secular backgrounds.

This is not to suggest that every expression of acceptance arises from an unspoken Catholic conviction. Rather, what stands out is that the value placed on embracing human diversity held comparable significance – and was articulated in remarkably similar ways – across both research contexts and among volunteers of varying beliefs. At the same time, it is important to recognize that unconditional love for every person occupies a central place in the Christian tradition, and that both organizations I studied are affiliated with the Catholic Church. The distinct yet ongoing processes of secularization in Austria and Croatia further shape how these values are interpreted and practiced. By examining how suffering and inclusivity inform volunteer work, this section highlights the subtle interweaving of Catholic and secular values within these predominantly Catholic cultural settings. I conclude by exploring how these values extend to volunteers’ relationships with patients’ families. Positioned outside the intimate circles of relatives and friends, volunteers are uniquely able to provide forms of support that family caregivers often cannot. This allows them to practice what they describe as ‘unexceptional love’ in ways that are both meaningful and distinct.

To explore this further, I use the above-mentioned concept of Catholicized neoliberalism. Anthropologist Andrea Muehlebach employs this term to describe a cultural sensibility that increasingly relies on voluntary work and compassionate interactions among citizens (Muehlebach 2012; 2013). Her argument, based on research with Catholic volunteers in Northern Italy, proposes that this form of neoliberalism – by insisting that some portion of wealth should be redistributed through charitable acts – differs fundamentally from the messianic, salvational logic associated with Protestant ethics. As seen at the turn of the millennium in figures such as Wall Street bankers and Pentecostal movements, the Protestant-inflected model often treated the market as an end in itself, promising prosperity through quasi-magical means (Comaroff and Comaroff 2000; Muehlebach 2013). By contrast, Catholicized neoliberalism, as an ethical orientation, combines material wealth with what Muehlebach calls ‘an opulence of clean conscience and good feeling’ (Muehlebach 2013). This shift parallels a

trend identified by Anna Rigney (2012), who describes an emerging global ethic focused on finding a moral compass for market-based approaches to poverty alleviation. These strategies are often enacted through intimate, human-centred practices such as volunteering and philanthropy. However, Muehlebach cautions that this is not simply a façade for neoliberal exploitation, but part of a broader transformation in moral expectations surrounding collective and individual responsibility. Catholicized neoliberalism, she argues, requires a particular moral subject: a loving, compassionate individual who feels duty-bound to support society's most vulnerable members (Muehlebach 2013).

At the global level, the articulation of Catholicized neoliberalism is closely linked to the post-Washington Consensus – a shift from the rigid, anti-statist neoliberalism of the Reagan-Thatcher era to a more 'benign' version promoted by figures like Bill Clinton, Gerhard Schröder, and Tony Blair (Muehlebach 2013, 460). While Margaret Thatcher famously declared that "there is no such thing as society," post-Washington Consensus neoliberalism reintroduced the idea of society by elevating nonprofits, voluntary organizations, and the third sector as key players in welfare provision and policy-making. Here, the calculative, self-interested individual is replaced by the ideal of a caring local citizen whose empathetic actions are seen as capable of reducing suffering and healing communities (Fine 2001; Rigney 2012; Muehlebach 2013).

Second, both post-Washington Consensus neoliberalism and Catholic social doctrine¹⁸ emphasize reciprocal relations: trust, cooperation, civic engagement, and collective well-being. These values underpin the investment in social capital (Putnam, Leonardi, and Nanetti 1993). In this view, the wealth of nations is measured not only in economic terms but also through vibrant social relations – signalling the integration of *homo relationalis* into the logic of *homo oeconomicus* (Muehlebach 2013, 460–61). Like Catholicism, this ethical and political vision holds together apparent contradictions: it affirms both profit and trust, the autonomous property-holder and the embedded social being, accumulation and reciprocity (Muehlebach 2013). Most importantly, both are oriented toward the recognition of human suffering and the cultivation of sensitivity to it.

To show how these themes are expressed in practice, I will now address Katharina, one of the volunteers in my study. Her reflections exemplify how suffering becomes a focal point in the experience of volunteering in palliative care. I will argue that volunteers' attunement to suffering is inseparable from how they frame love – as an acceptance of others regardless of

¹⁸ See Chapter Two (foot note 3, page 35) for the explanation of Catholic social doctrine.

medical condition, social status, or ethnic background. In many ways, this expands upon Muehlebach's idea of the 'loving compassionate subject,' situating it within the specific moral and emotional economy of palliative care.

Katharina, at 30, was the youngest volunteer I met during my fieldwork in Vienna. She spoke openly about her Catholic upbringing – being an altar girl, attending a private Catholic high school – experiences that, as she put it, 'shaped' her in ways she could still recognize, even though she no longer aligned herself with many of the Church's teachings. Religion, spirituality, Catholicism – all of these were topics she approached with curiosity and critical interest, more as intellectual material than as sources of personal guidance. And yet, when it came to her volunteering, she didn't see any of it – religion, spirituality – as playing a role. When I asked her directly whether she saw a spiritual dimension in her work, she paused briefly, then smiled as if anticipating the complexity of the question. This is what she said:

I tend to say no – half-jokingly – when asked about spirituality in my volunteer work. But I know we could debate that 'no,' because spirituality can be present in any kind of human interaction. Even talking to you right now carries a kind of spiritual exchange, from me to you and vice versa. Still, I'd say no, because the way I see my role as a volunteer is simply to be a connection point – like a knot between two threads, or a small hook where people can hang on. And I don't mean that I want to be the centre of connection, but rather to offer others the possibility to connect. I'm just there as a social link. In that space, people don't have to think about spirituality, or God, or anything like that. What matters is being a person – *just a human being* – interacting with another human being. For me, it's not so much about playing a spiritual role as it is about saying, 'I'm here, and I see you.' [my emphasis] (Interview, Katharina, 10/08/22)

In Katharina's framing, even a broad and inclusive understanding of spirituality felt misaligned with how she understood her role. Her reluctance to attribute spiritual meaning to her volunteer work echoed a broader tendency among Viennese volunteers to distance themselves from both religious and spiritual narratives, even while working within institutions historically tied to the Catholic Church. As discussed earlier, this secular framing served to underline the nondenominational nature of their work. But in Katharina's case, it also did something else: it protected what she considered the 'core' of palliative care – honest, human communication. She explained that explicit references to religious belief could, in her

experience, disrupt the delicate emotional space that palliative care creates. Introducing theological ideas, even with good intentions, risked placing a burden on patients who might not share those views – or who simply had more pressing needs in that moment. For Katharina, to volunteer in palliative care meant setting aside those frameworks entirely. It meant showing up not as a representative of an institution or worldview, but simply as a person. This insistence on stripping the role down to its essence – being with someone, seeing them, listening – was not just a personal ethic, but a quiet resistance to the social roles and identities that can get in the way of genuine connection.

She was not alone in this view. Many volunteers in both Vienna and Zagreb spoke about the ways terminally ill patients seemed to inhabit a space of ‘raw humanity’ or ‘true human behaviour.’ While volunteers made a conscious effort to shed social markers such as profession, status, or belief system, patients often arrived already disrobed of these identities. Time, illness, and proximity to death had peeled away the layers. What remained was a kind of relational honesty – interactions uncluttered by performance or pretence. This state of mutual vulnerability created a space for what Katharina called ‘being human together.’ Tamara, another Viennese volunteer, described such moments as the most rewarding part of her work: the conversations that happened when all roles fell away, and what was left was just one person accompanying another in the face of the unknown.

What I really love about volunteering is that you get to talk to people who truly let their guard down. They don’t have to pretend or hide anything – none of the usual masks people wear in everyday life. Not everyone, of course, but many of them are just incredibly honest. And there’s something really profound in that honesty.
(Interview, Tamara, 27/06/22)

For Tamara, this raw honesty – what she described as the shedding of masks – was one of the most powerful aspects of her work. As she saw it, people nearing the end of life often abandoned the need for strategic self-presentation. There was no longer a future to plan for, no status to uphold, no persona to maintain. In this final stage, what emerged instead were deep emotional truths: fears, regrets, hopes, reconciliations. It was this unfiltered presence that she found so moving – and so rare outside these encounters. This process of ‘demasking’ – the letting go of socially constructed identities – surfaced repeatedly in my conversations with volunteers, across both Austria and Croatia. It was a theme that resonated regardless of religious affiliation yet was often interpreted in distinct ways. For some, like Tamara, the

encounter felt secular but profound: a moment of human recognition stripped of societal roles. For others, like Božena in Zagreb, it carried unmistakably spiritual meaning, rooted in Catholic teachings. Božena also spoke about the honesty of dying patients, but framed it as part of a sacred process. When I asked her what spirituality meant in the context of her volunteering, she paused before answering, choosing her words with care:

A palliative patient, to me, bears the face of the crucified Jesus – because in a palliative patient, all that is irrelevant has fallen away. Everything else fades into the background, and what remains is only the essence of what it means to be human. That essence, which must be pure and true, stands before the face of God. This is the naked, vulnerable human being God created. For me, palliative care is the closest expression of that part of the Catholic faith – and that’s probably why I’m here [in volunteering]. (Interview, Božena, 23/05/22)

Earlier in our conversation, Božena mentioned that the dying held a special meaning for her because of their closeness to death – and, by extension, to eternity. In Christian belief, eternity represents the ultimate goal of life on Earth, entered into after death. It is therefore not surprising that, for many Catholic volunteers, accompanying someone in their final days is considered one of the greatest honours imaginable. At this stage of life, all worldly concerns lose their relevance. The protective mechanisms people rely on throughout life – social roles, routines, ambitions – begin to dissipate. What remains is a person’s bare human existence. While this stripped-down state leaves the dying profoundly vulnerable, Božena sees this very vulnerability as a form of purification. In shedding layers of worldly identity, the dying become prepared to face God in the same nakedness with which they entered the world.

This process, according to Božena, allows the dying to take on divine qualities, echoing a core tenet of Christian – particularly Catholic – theology: that humans are made in the image of God. Unlike Protestantism, where faith is often expressed through a worldly vocation and good works serve as tools of divine will on Earth, Catholicism places central emphasis on the God’s incarnation in the human form (Napolitano 2017, 276). It is in moments of suffering that this divine presence becomes most visible. The crucifixion of Christ, and his agonising death, holds, therefore, profound significance in Catholic teaching – a connection reflected in Božena’s own words, as she described palliative patients as bearing the face of the crucified Jesus.

By linking death to Christ's crucifixion, Božena emphasized that dying entails not only spiritual transformation but also profound physical and emotional suffering. Her perspective resonated with a broader theme in my fieldwork: many volunteers spoke of the importance of being able to hold space for a wide range of patient emotions – fear, anxiety, anger, and even aggression. This support, they often stressed, was less about offering answers or comfort, and more about *aushalten* – a German word volunteers in Vienna used often, meaning to endure or bear witness without flinching. Tamara articulated this point clearly during one of our conversations. In her view, the ability to sit with another person's pain – without trying to fix or minimize it – was essential to hospice work. 'If you're a negative emotions avoider,' she told me, 'you're not the right person for hospice care' (Interview, Tamara, 27/06/22). For her, as for many others, the work demanded a willingness to remain present through discomfort, to listen without judgment, and to make space for whatever the patient needed to express. Božena viewed this capacity to confront suffering not just as an emotional skill but as a moral stance – one that challenged dominant cultural narratives about health, happiness, and control. As she put it:

Disease, by its very nature, is suffering. It's not a pleasant experience – there is pain, fear, and, of course, anxiety. But today's world doesn't want to acknowledge that. People today strive for a life without pain, always in a 'super mood,' believing that happiness means being healthy and free from discomfort. Today's world refuses to accept suffering – and everything that comes with it. It's only when suffering enters their own family that people are forced to face it.
(Interview, Božena, 23/05/22)

For Božena, palliative care was not only about easing suffering but ensuring it remained visible – recognised as a fundamental aspect of human existence rather than something to be denied, hidden, or pathologized. She saw volunteers as counter-cultural figures, confronting what society often seeks to suppress. Katharina, the Viennese volunteer introduced earlier, echoed this critique but framed it in secular terms. She spoke of a pervasive cultural attitude she called 'toxic positivity:' the insistence on cheerfulness, optimism, and emotional control, even in the face of grief or loss. In her view, this mindset discouraged genuine emotional expression and left little room for mourning. For her, volunteering in hospice care was a quiet act of resistance (Interview, Katharina, 10/08/22). By engaging openly with sadness, fear, and

pain, she and other volunteers made space for emotions that are often excluded from everyday social life.

This critique of widespread indifference to suffering has also been acknowledged at higher institutional levels. In his first papal exhortation, *Evangelii Gaudium*, Pope Francis¹⁹ warned against what he called an ‘ideology of callousness’ (Papa Francesca 2013). He argued that such indifference was not incidental but cultivated – necessary to sustain a lifestyle built on exclusion and self-interest. He wrote:

To sustain a lifestyle which excludes others, or to sustain enthusiasm for that selfish ideal, a globalization of indifference has developed. Almost without being aware of it, we end up being incapable of feeling compassion at the outcry of the poor, weeping from other people’s pain, and feeling a need to help them, as though all this is someone else’s responsibility and not our own. (Papa Francesca 2013)

In this light, palliative care volunteering – as practiced by Božena, Tamara, and Katharina – can be understood not merely as service, but as a form of moral and emotional labour that challenges broader cultural patterns of indifference. Through their everyday actions, these volunteers highlight an ethical imperative of acknowledging suffering and responding with presence, honesty, and care. When situated within a neoliberal socio-economic context, this orientation can be read as a call for increased personal responsibility – a call that Pope Francis has explicitly embraced. Yet, he infuses this characteristically neoliberal appeal with a distinctly Catholic sensibility by merging individual responsibility with a systemic critique of the capitalist structures that generate social inequality. In this regard, the near simultaneity of Muehlebach’s coining of the term ‘Catholicised neoliberalism’ (2012) and the publication of Pope Francis’s first encyclical (2013) is more than coincidental. More than a decade later, this moral call – for both personal accountability and a more just world – continued to resonate in the field sites I studied. It was most vividly expressed in volunteers’ sensibility toward suffering, a sensibility closely tied to the next dimension I will now examine: the importance of approaching palliative patients with *unexceptional love*.

Pope Francis highlights how contemporary economic systems – driven by greed and indifference – have rendered the suffering and needs of many people invisible. Anthropologist

¹⁹ During my fieldwork and while writing this chapter, Pope Francis (Jorge Mario Bergoglio) was still the reigning head of the Catholic Church. He passed away on April 21, 2025, and was succeeded by Pope Leo XVI (Robert Prevost) on May 8.

Valentina Napolitano interprets this as a denunciation of what she terms ‘global indifference,’ drawing on the theological concept of *acedia*. Originating in fourth-century monastic thought and later elaborated in post-Reformation theology, *acedia* refers to a kind of spiritual and emotional numbness: a habitual inattention, a failure to care, and an incapacity to engage meaningfully with the world (Napolitano 2017).

In Napolitano’s reading, *acedia* is more than a form of personal lethargy; it is an embodied sin that reflects the erosion of fraternal bonds under neoliberal capitalism. It produces a disconnection from one’s immediate surroundings – surroundings that, in Catholic theology, are understood as manifestations of divine creation (Napolitano 2017). While classical Weberian analysis interpreted capitalism as an expression of divine order and moral discipline, Pope Francis offers a contrasting vision: for him, the world’s economic systems are not signs of divine perfection, but flawed human constructs subject to moral scrutiny. He calls for a shift in focus – from systems that cultivate emotional detachment and spiritual blindness to those attuned to God’s presence as revealed in the suffering of others (Napolitano 2017, 278; see also Ticktin (2011) on suffering and humanitarianism). In response to this moral alienation, Francis advocates for an ethical renewal grounded in ‘brotherly love’ – a form of love enacted through compassionate, empathetic encounters (Napolitano 2017).

This ethical stance also finds institutional expression. In its most recent ethics brochure, Austrian Caritas explicitly invokes the idea of divine presence in the suffering Other to articulate its mission of supporting people in crisis. On the opening pages, the organization affirms that every human being is invaluable and unique, deserving of love and acceptance regardless of origin, gender, age, living situation, religion, worldview, personal history, health status, or any other social attribute (Ethikteam der Caritas, n.d., 2). This principle of unconditional acceptance is reaffirmed at the conclusion of the brochure, which celebrates the diversity of the Caritas workforce and the people it serves – highlighting a broad range of ethnicities, backgrounds, gender identities, and faiths reflected in its daily work (Ethikteam der Caritas, n.d., 12).

This commitment to inclusivity reflects Caritas’s ongoing secularization: a deliberate shift away from an overtly religious identity toward a more universal, pluralistic ethic, while still remaining grounded in its Catholic foundations. Inclusivity and tolerance are also central to the ethos of the modern hospice movement. From its origins with Dame Cicely Saunders to contemporary palliative care guidelines at national and international levels, there has been a consistent emphasis on equitable access to care. No one, it is repeatedly stated, should be denied

appropriate palliative treatment due to ethnicity, religion, gender identity, socioeconomic status, or other forms of social difference (Radbruch and Payne 2010).

Volunteers in both Austria and Croatia affirmed this inclusive ethos. Beyond addressing the medical and emotional realities of dying, they were also expected to accompany individuals from diverse social, religious, and cultural backgrounds. As Michaela, a volunteer coordinator in Vienna, explained when I asked what matters most in hospice work:

Tolerance is also very important. It might sound strange, but there are people who have a lot of ‘no-gos’ – ‘That doesn’t work. That’s impossible. I can’t do that!’ That makes things really difficult. I need to have a big heart for people, no matter their situation, opinion, or background. I would like volunteers to be able to express their needs and beliefs in their intimate environment, so that they can be generous at the hospice. The patient doesn’t need to share my political views, and they don’t need to be happy to see me either. (Interview, Michaela, 11/10/22)

On several occasions, I had the opportunity to speak with Michaela, who consistently emphasized the importance of matching volunteers with patients in a way that fosters a long-lasting and trusting relationship. The coordinator’s role is to find volunteers who align well with palliative patients based on factors such as interests, location, spiritual needs, language skills, and other personal attributes. To help with this, volunteers are asked to fill out a form during the application process, outlining their skills and specifying any ‘no-gos’ – patients they feel they cannot work with (Prsa 2023b).

During the volunteer training I attended in autumn and winter 2022/23 one entire session was dedicated to discussing these ‘no-gos.’ Volunteers would sit in a circle and discuss various social attributes of patients that might trigger personal discomfort, potentially hindering a productive relationship. For example, some volunteers identified patients with a history of committing rape and other violent acts, or those displaying explicit racist behaviour, as their ‘no-gos.’ This exercise not only helped us reflect on the personal biases and baggage we bring to the service, but also encouraged us to set clear boundaries. However, the instructor also guided the discussion toward the challenge of providing care to such patients, emphasizing the importance of offering palliative services ‘even’ to them. We discussed then when and how certain behaviours should be accepted. Although no definitive conclusion was reached, one point was made clear: everyone, regardless of their past or background, has the right to receive

palliative care, and as volunteers, we must learn to navigate our personal triggers to ensure that this right is upheld (Prsa 2023a).

A similar conclusion can be drawn from Michaela's earlier statement. While it is acceptable for a volunteer to recognize the types of patients they may not be able to support, it is important that the list of 'no-gos' does not become too long. Volunteers should avoid being overly selective – otherwise, finding a suitable match becomes increasingly difficult. Michaela emphasized that volunteers need to understand not only that palliative patients exist in a wide range of physical and emotional states, but also that these individuals may not share the same worldviews or values. According to her, it is unrealistic to expect people in palliative care to behave like those in our personal lives. Unlike our friends or family, palliative patients may not always be kind, appreciative, or even happy to see us. This distinction between our private lives and the palliative care environment requires volunteers to set clear boundaries – and to leave their political beliefs and personal values at the door.

Michaela captured this inclusive ethos with a simple phrase: the ability to have 'a big heart for people.' For her, caring becomes easier when we move beyond labels – whether tied to someone's opinions, background, mood, or medical condition – and encounter the person simply as another human being. In this way, she expanded on the idea of 'humanising' volunteer work discussed in the previous chapter, suggesting that such work requires not only emotional openness but a practiced form of tolerance rooted in a specific kind of love. This notion of 'love for people' as a defining quality of palliative care volunteers was also echoed by Ingrid, a 76-year-old volunteer from Vienna. For her, it was essential that:

there is a love for people (*Menschenliebe*). You have to like people, no matter who they are. I learned this as a teacher as well. I have to like my students – if I don't, I can't teach them, and that would be wrong. So, this basic requirement can also be understood as love. It's also crucial that everyone is allowed to be who they are. I don't have the right to tell anyone, 'This is the only way.' No. If that's how it is for you, that's also an essential value. (Interview, Ingrid, 19/07/22)

Accepting people 'as they are' – regardless of whether she liked them or agreed with them – was a skill Ingrid had developed over her long career as an elementary school teacher. In our conversation she often referred back to her teaching background to explain her use of a very proper, standardized form of German. She proudly recalled how her neighbours used to comment, with amazement, that she spoke 'like someone on TV.' Ingrid also struck me as

someone with a sharp mind who valued precision, both in language and in handling interpersonal interactions. At our regular volunteer meetings by Caritas Hospiz, she never hesitated to correct someone's German if they made a grammatical mistake. She was definitely not one of those overly accommodating teachers; a fact which often made me feel nervous when interacting with her (Prsa 2023d).

However, despite her strictness, Ingrid placed great importance on not judging others. She believed she had no right to do so – just as she had no right to impose her personal beliefs on others. This openness to difference had allowed her to do her teaching job well; after all, she could not choose which pupils she taught. Tolerance, for her, was not just a moral principle but also a practical tool for maintaining professionalism – something she carried over into her volunteer work. But Ingrid's acceptance of others went beyond what might be called 'professional' or even 'political correctness.' For her, embracing people 'as they are' was an expression of love – a kind of love that moved beyond the boundaries of the workplace and became an ethical stance toward the world. This understanding of *Menschenliebe* – a love for people that transcends social categories – was echoed by another volunteer I met in Zagreb in the spring of 2022: Dubravka. According to her, love meant:

It's the feeling of truly empathizing with another person – not focusing on their citizenship, nationality, or any other labels, but seeing them simply as a human being. You accept them as they are, without judgment or prejudice. Essentially, love means recognizing the good in every person, regardless of their reputation. After all, each of us has both good and bad sides. So, you should seek out what is good in a person and love that part of them.

When I asked whether she found it challenging to put this definition of love into practice, Dubravka responded:

I have to admit, I never really had a problem with that. Maybe it's different if you spend a lot of time with someone – when you're with a person for too long, you start to see both their good and bad sides, and naturally, you form a certain image of them. But with palliative patients, you're never with them long enough for that. You accept them as they are in that moment. None of us know what the client was like before their illness – just like we often don't know what a family member was like before they got sick. (Interview, Dubravka, 05/05/22)

Like Ingrid, Dubravka believed it was essential for palliative care volunteers not to differentiate between patients, as every person deserves respect and love. A patient's ethnicity, reputation, or past behaviour should never be grounds for withholding that love. To truly put this belief into practice, Dubravka emphasized, again, the importance of approaching each patient simply as a human being – with their unique needs in the here and now. She felt that additional information about a dying person's past could easily lead to unnecessary prejudices on the volunteer's part, ultimately clouding the purity of the patient's 'human essence.' Dubravka, almost ten years younger than Ingrid, had also begun volunteering shortly after retiring, around a decade before I met her. While she came across as warmer in demeanour, she too was precise and deliberate in the way she expressed herself – something especially evident in how she spoke about love. Every statement she made seemed carefully considered, whether during interviews, casual conversations with fellow volunteers, or public events organized by the volunteer association. She was also highly dependable and took her responsibilities seriously. Dubravka knew when and how to set boundaries with patients and their families – an important dimension of palliative care volunteering that I will explore in the next chapter.

What set Dubravka apart from Ingrid – besides their occupations and countries of residence – was her religious background. Ingrid had distanced herself from the Church, drawing a clear line between personal spirituality and affiliation with organized religion. She was openly critical of religious institutions and, during our volunteer gatherings, would occasionally make remarks highlighting what she saw as the absurdity of living strictly according to religious rules (Prsa 2022d). In contrast, Dubravka, like many volunteers in Zagreb, was a member of the Franciscan Secular Order, and her Catholic faith played a significant role in her life. However, this did not mean she used her volunteering as a platform to promote her beliefs or to pass judgment on patients whose worldviews differed from her own. On the contrary, her deep Catholic convictions not only aligned with an open, nonjudgmental approach to others, but actively supported it. Her faith gave her both the rationale and the inner resources to encounter each patient with compassion and without prejudice. Knowing her religious background, it becomes clear that Dubravka's belief in the inherent worth of every individual closely reflects the Catholic (and more broadly Christian) teaching on the unconditional value of every human being – a principle discussed earlier.

This is not to suggest that every expression of tolerance stems from a deep, unspoken Catholic conviction that volunteers are unwilling to acknowledge. Rather, what is important to

recognize is that the value of embracing diversity held similar weight – and was articulated in strikingly similar ways – across both research contexts and among volunteers of diverse religious backgrounds. This value was championed by deeply Catholic volunteers, as well as by those who were non-religious or had distanced themselves from the Church. Its justification, in other words, could be found at both ends of the ‘religious spectrum’ – from liberal secularism to devout Catholicism. Still, it is important not to overlook the fact that unconditional love for every person occupies a central place in the Christian tradition, and that both organizations I worked with are connected to the Catholic Church. Similarly, the ongoing, but distinct, processes of secularization in the two research settings (Austria and Croatia) also play a role in shaping these perspectives. Taken together, these dynamics reveal how the promotion of inclusiveness offers valuable and nuanced insights into the ways religion and secularism intersect and are lived out in the everyday practices of palliative care volunteers in two Catholic cultural contexts.

These interwoven religious and secular sensibilities also point to the contextual specificity of Catholicised neoliberalism. The experiences of Austrian and Croatian palliative care volunteers enrich this concept by revealing how helping others in need is, for many of my research participants, simultaneously a form of self-care that enhances their overall well-being – as discussed in the previous subchapter. Drawing on the idea of a morally responsible, loving subject who is obligated to care for the most vulnerable members of society while also attending to their own spiritual and personal development, I outlined two interrelated dimensions of neoliberal responsabilisation: responsibility for oneself and others. Both are embedded within broader cultural and socio-economic currents. Seen from this angle, the notion of personal development through palliative care volunteering not only offers an additional lens through which to analyse Catholicised neoliberalism, but also becomes essential to understanding the immaterial and spiritual labour involved in this work.

In the concluding part of this chapter, I introduce a third dimension of this labour by examining its significance for the family carers of palliative patients – thereby linking this chapter more directly to the dissertation’s central focus on the role of volunteers in supporting familial care. This connection becomes particularly clear in the reflections of Dubravka, a volunteer who articulated the emotional boundaries that distinguish her role from that of family members. In the second part of her reflection, Dubravka explained that she did not find it difficult to put her understanding of love into practice with palliative patients, precisely because she did not spend extended periods of time with them. Unlike the patients’ closest relatives, who often live with them and bear the greatest burden of caregiving, volunteers typically spend

only a few hours per week with the dying. Even when visits occurred more than once a week, this time commitment was still minimal compared to that of family members. This limited temporal engagement – and the fact that volunteers did not usually know the patients prior to their illness – allowed them, as Dubravka put it, to focus on the patients’ ‘good’ sides and to accept them simply ‘as they are.’ Volunteers were not burdened by the patient’s full personality or life history, and could therefore approach them without prejudice. This, in turn, made it possible to offer the kind of unconditional love and presence that people nearing the end of life often long for – but which family members may struggle to provide due to exhaustion, emotional strain, or difficult family histories.

It was often noted that volunteers, as individuals coming from outside the family, held a unique role in engaging with issues that patients either could not or did not want to discuss with their loved ones. This idea was also highlighted by Tomislava, a volunteer coordinator in Zagreb, as mentioned earlier in the chapter. These conversations often served the form of emotional release, allowing palliative patients to share deeply held secrets, regrets, or worries. Because volunteers are not entangled in the emotional complexities of family relationships, they are often better positioned to listen without judgment and to bear witness to the patient’s suffering. Sometimes, patients simply needed someone to hear their stories – stories their relatives no longer wanted to listen to, perhaps because they had heard them many times before or found them irrelevant, even tedious. Whatever the specific motivation behind these conversations, one thing remained clear: being a good listener was a vital part of the volunteer’s role in palliative care. This aspect was beautifully articulated by Thomas, a Viennese volunteer introduced in the previous subchapter.

Many times, patients just want someone by their side – someone who’s simply willing to listen, if they can speak at all. And sometimes, they want to be told things. My impression, quite often, was that their wives or children couldn’t bear to hear the same story anymore. But the patients still want to tell it – again, and again, and again – if there’s someone willing to listen. And they’re very grateful for that. Usually, when I’m there, they feel they can say whatever they’re feeling. There’s no comment, no judgment, no criticism. If they ask for my opinion, I’ll give it – but most of the time, they don’t. I’m just a wall they talk to. And if that wall has ears, listens, and understands what they’re trying to say – that’s usually enough. (Interview, Thomas, 04/07/22)

As this and many other accounts make clear, the central task of palliative care volunteers was often considered ‘just’ to be present: to sit quietly beside those who were dying, to ease their loneliness, and to offer solace primarily through attentive listening – listening to stories, struggles, and final wishes shared at the threshold of life. These intimate narratives, however, remained tucked away in the quiet space between the patient and the volunteer. It was precisely this confidentiality – combined with the volunteer’s position as a trusted outsider – that made space for revelations: thoughts, regrets, or memories that patients felt unable to share with anyone else. For Tomislava this kind of listening carried an unmistakable spiritual charge. It gave meaning to the volunteers’ role and allowed them to frame it as a form of sacred accompaniment. Thomas, by contrast, did not describe the experience in spiritual terms. Yet despite these different frameworks, a common element persisted: the creation of a safe space, a moral zone of intimacy in which patients could speak freely, without fear of judgment.

Volunteers seemed especially capable of cultivating such spaces – not only through their openness or warmth, but through a willingness to remain present in the discomfort and uncertainty of another’s suffering. In these fragile end-of-life moments, when a person’s defences are down and the scaffolding of identity begins to fall away, what emerges is something volunteers often described as the ‘human essence’ – a presence that transcends nationality, gender, or social status. Volunteers offered comfort in such moments of vulnerability by providing a form of egalitarian love – an acceptance that was not contingent on background or biography.

This big heart for the people, as Michaela would say, or simply ‘love for people’, according to others, that at same time comprises sensitivity towards suffering and accepting differences, a deep spiritual calling and a pathway to self-realisation, is best summarised by the volunteer Dubravka.

One matures through experiences in palliative care, learning to face challenges with greater resilience. He [a volunteer] approaches every difficulty with equal dedication, values each person, and accepts them as they are – despite their differences. That, in essence, is love. (Interview, Dubravka, 05/05/22)

This is how Dubravka – with a cigarette in her hand, while finishing her last sup of coffee on the warm, albeit sticky afternoon at one coffee bar in Zagreb – concluded our conversation in a more informal tone, a long time after the ‘official’ interview ended. It made sense for her to finalise her testimony by providing the ‘ultimate’ definition of love given the significance

love had in designating the most important aspects of her volunteer work, namely, unconditional tolerance and self-development. It might be tempting to argue how volunteering makes her more resilient, preparing her to deal better with all the adversities of life in the current socio-economic order, with love being just one of the tools to justify the unpayability of her care work she undertakes for both clients and herself. While this is true to certain extent, it is equally important to recall Muehlebach's warning of not interpreting Dubravka's (and other volunteers) statements as merely a mask of or corrective to the realities of exploitation, but as speaking to a larger shift in moral conventions governing collective and moral responsibilities. Crucial for that morality are the feelings of love, empathy, and compassion through which a desirable reaction to the reality is expressed (Muehlebach 2013).

Unsurprisingly, exactly these emotional stances have been repeatedly mentioned in both Vienna and Zagreb as the key qualities palliative care volunteers should embody. The next chapter, therefore, focuses on love and empathy as means through which volunteers' skills and para-professionality are defined. It is significant for that professionalism, again, how volunteers are positioned in relation to patients' families, having an important role in preserving a certain image of family care.

Chapter 6

The Empathetic Loving Professional and the Creation of Caring Family through Palliative Care Volunteering

Introduction

While the previous chapter briefly addressed the role of volunteers in supporting patients' family carers, this chapter explores that role more deeply. It examines how palliative care volunteers develop a distinct form of professional identity – or more precisely, a para-professional one (see Chapter Two) – revealing key features of two familistic welfare regimes, where volunteers help sustain particular ideals of family life. Central to this dynamic is the construction of two key emotions: love in Zagreb and empathy in Vienna. Though both convey attunement to patients' needs and various conditions, their meanings and applications differ across contexts. In the first subchapter, I show how LaVerna's volunteers are often described as performing a 'flavour of love,' a form of care that complements formal palliative services. Here, love is contrasted with paid labour and professional expertise, drawing on essentialist notions while reflecting the limited institutionalisation of palliative care volunteering in Croatia. In the absence of formal state-supported training, volunteers rely on alternative sources of knowledge, including personal caregiving experience and the association's Catholic ethos. Some scholars argue that this lack of institutional support limits the public recognition of volunteers' emotional labour, especially when compared to contexts with stronger third-sector infrastructure (Nussbaum 2013; Brković 2026). While this may be partly true, I argue that the absence of formalisation also allows volunteers to develop their own conceptions of love as a professional marker. Rather than confining love to the private sphere, they use it to distinguish their work from personal relationships. Yet, this framing risks reproducing essentialist ideas about unpaid care – ultimately reinforcing the very private/familial boundaries they seek to overcome.

This situation contrasts sharply with the Viennese context, as discussed in the second subchapter, where the education and roles of palliative care volunteers are clearly defined at the statutory level – serving even as a model for organising palliative care in other European countries. I show how the institutionalisation of volunteer education reduces the importance of informal skill acquisition. Participation in formal training becomes a prerequisite for gaining

para-professional status and being recognised as an equal member of the palliative care team. Yet, volunteers remain distinct from other professionals: they are unpaid contributors whose most valued input is the provision of empathy. Although volunteers' duties and responsibilities are thoroughly outlined in several official documents, empathy itself is not formally defined. This gap has allowed certain conceptions of empathy – particularly phenomenological and humanitarian ones introduced during training – to become dominant, if only implicitly. Unlike love in the Zagreb context, which demarcates boundaries and signals volunteers' professional identity, empathy in Vienna is shaped – or perhaps more accurately, tamed – by professional norms. Here, empathy is measured, regulated, and integrated as a tool within the framework of formalised care.

Despite these divergent paths to volunteer professionalism, I argue in the final section that volunteers' roles and boundaries are defined in both contexts in relation to a similar image of the family as the primary caregiver for frail relatives. In both Vienna and Zagreb, though through different mechanisms, reinforcing family-based care emerges as a central response to the ongoing care crisis driven by demographic and familial changes. In Vienna, volunteers are trained not only to support but also to honour families for their caregiving roles. There is a strong emphasis on inclusivity and flexibility, encouraging volunteers to accept diverse family forms and caregiving arrangements. This inclusive stance stems from a fear that losing familial care would undermine the system. In Zagreb, by contrast, this fear is met with a more direct and explicit approach: volunteers are trained to support and even intervene in family caregiving dynamics, reflecting the weaker institutional care infrastructure. Moreover, families themselves are often seen as needing education, particularly around their caregiving roles.

While one might expect traditional family duties to be reaffirmed in a context with limited state support, their re-articulation through education paradoxically serves to de-essentialise them. Conversely, in Vienna, the absence of explicit articulation preserves traditional roles as implicit norms, thereby reinforcing essentialist understandings of familial responsibility. By examining these often contradictory processes of de/essentialisation, this chapter sheds light on the distinct features of two familistic welfare regimes and the nuanced roles volunteers play within them.

From a methodological standpoint, it is important to note that institutional differences between the two settings shaped the materials used in my analysis. For example, the training programme in Zagreb offered significantly less content than that in Vienna. Accordingly, my examination of the Viennese case draws heavily on materials from training seminars and official documents on educating volunteers, whereas in Zagreb, I placed greater emphasis on

other organisational activities, such as promotional campaigns. In both cases, these materials are supplemented with interviews conducted with a range of individuals involved in palliative care provision.

6.1 From Experiential Knowledge to the Skill of the Divine: Love as a Signifier of Volunteers' Professionalism in Zagreb

It is a sunny, albeit chilly, early fall morning in 2022 at one of Zagreb's most prominent street markets. The still-sleepy atmosphere is occasionally broken by sounds from the nearby stands, where vendors are making their final preparations before the Saturday crowd arrives for their weekly shopping. I'm waiting in the parking lot with Draga – one of the few volunteers who joins nearly every event and stays from beginning to end – and Tina, our newly hired administrator. We are all waiting for Mirjana to arrive with the spices and other essentials for our stand. Mirjana is the president of LaVerna, the association of palliative care volunteers in Zagreb. She has been involved since the group's informal beginnings within the Franciscan secular order back in 2009, long before it became an independent, non-religious NGO in 2017 for legal and administrative reasons. With her background in economics, Mirjana supports the association not only strategically but also in hands-on ways – like today, by organizing public events. Earlier this morning, she picked up a dozen cases of spices from a small family business in the Zagreb outskirts. Once she arrives, we will transfer the boxes from her car to the stand, where they will be arranged alongside the association's other promotional items – T-shirts, postcards, aprons, and hand-made flowerpots. The trickiest part is always figuring out how to set up the large banner so it stays upright and does not collapse mid-event. Our spice collection includes familiar favourites – basil, rosemary, mint, oregano – but these aren't just any spices. These are the *spices of love*. The idea behind them is that, just as spices enhance a meal, volunteers enrich palliative care with their love and presence (Prsa 2022d).

The 'Spice of Love' (*Začin ljubavi*) initiative began during the Covid-19 lockdown, when visiting patients in person was no longer possible. As a symbolic gesture of love and remembrance, volunteers sent spices to patients and loved ones. Soon, anyone could order a spice to be sent to someone dear, and businesses began purchasing them to support and promote the association's work. Since pandemic restrictions eased, Spice of Love has become our most visible campaign, taking place at street markets and in front of churches, where we set up stands

like this one. But what exactly makes love such a central part of this work? Why is it the defining trait of what volunteers do? And is there a particular kind of love they must have?

This subchapter addresses these questions by exploring the concept of love from two perspectives: that of the organisation and of one volunteer, Dubravka. The organisation, LaVerna, grounds its understanding of love in a Catholic framework, referencing St. Francis and the stigmata he received on La Verna hill in Tuscany during a period of intense fasting and prayer. Building on this, the chapter turns to more practical expressions of love, beginning with the training and education of palliative care volunteers in Zagreb. It then focuses on Dubravka's personal reflections, particularly her approach to setting boundaries with patients and achieving para-professionality. For Dubravka, a key element of this professionalism is what she terms 'pure love.' In addition to showing compassion and accepting patients 'as they are' – as discussed in the previous chapter – this form of love also allows her to maintain emotional distance, preventing her from becoming overwhelmed by patient suffering.

Dubravka's account challenges the idea, put forth by philosopher Martha Nussbaum, that love is an intense emotion requiring control and public education (Nussbaum 2013). Instead, for Dubravka, love is a cultivated, professional practice. Yet, in the absence of institutionalised training for palliative care volunteers in Zagreb, this form of love tends to be essentialised – as merely an added 'flavour' to professional and institutional care. In this way, it reflects the often ineffective pedagogies of love present in the third sector across the post-Yugoslav region, especially when compared to the more developed third-sector practices in other liberal democracies (Brković 2026).

When I asked my interlocutors in Zagreb what they believed to be the most important skill or attitude for volunteers in palliative care, many responded without hesitation: 'Love!' This typically referred to love for fellow human beings and the ability to accept others as they are. Before returning to Dubravka's reflections and her conceptualization of love, I want to explore another equally powerful interpretation – one expressed in a regular Facebook post by the association, which invoked the metaphor of the 'fire of love' (*požar ljubavi*). Referring to the wounds of St. Francis, the post declared: 'The fire of love with which St. Francis was burned is the inspiration and motivation for all our volunteers' (LaVerna - Palijativna skrb 2024) While I cannot claim that this vision of love guided the actions of every volunteer, the statement nonetheless reveals the emotional and moral foundations through which key figures within the organization understood its work and mission. The post was shared in connection with the Feast of the Stigmata of St. Francis – commemorating the wounds he is believed to have received on Mount La Verna, near Florence in Tuscany, the very site that gave the association its name. The

metaphor of the ‘fire of love’ was further expanded through a reference to an article from the Catholic news portal *Bitno.net* (meaning ‘important.net’) (fra Bonaventura Duda 2024).

Drawing on the writings of the renowned mystic and theologian St. Bonaventure (1259), the article described how St. Francis spent the period between the Feast of the Assumption of Mary and the Feast of the Archangel Michael (August 16 to September 29) in 1224 fasting and praying on Mount La Verna in preparation for his death. His ultimate aspiration was beautifully captured in his famous prayer: ‘Lord, may my soul detach itself from everything under the sky, and may the fiery and sweet power of Your love consume me completely – so that I may die of love for You, who died of love for me.’ (fra Bonaventura Duda 2024) Immersed in an intense, transcendent state of communion with God over many days, St. Francis experienced what is often regarded as the most profound mystical union a believer can attain – what St. Paul, in Galatians 2:19-20, described as co-crucifixion with Christ. Through this spiritual union, he received the sacred wounds – *stigmata* – believed to have been impressed upon him by the ‘fire of divine love.’ These wounds, then, were not marks of suffering alone, but visible signs of God’s overwhelming love – a divine imprint on the body, and a reflection of St. Francis’s deepest longing to be united with Christ (fra Bonaventura Duda 2024).

As an expression of the divine, love occupies a central place in Catholic doctrine, where it is regarded not only as a theological principle but also as an ontological foundation – a ‘force on which being itself is based’ (Mayblin 2012, 246–48). This understanding draws from a long Christian tradition that dates back to St. Augustine, who conceived of divine love as the initiating act of creation: a free and boundless gift so immense that it cannot be fully reciprocated by humans, constrained as they are by their finite and sinful nature (Fitzgerald 1999, 391–92). Yet love – like Catholicism itself – can be expressed in varied, and at times even contradictory, ways. The official doctrine proclaimed at the institutional ‘core’ of the Church is often reinterpreted, reshaped, or transformed by beliefs and practices emerging from its peripheries (J. Schneider 1991, 183). For instance, within the current moral framework of Catholicised neoliberalism, Muehlebach – drawing on Giorgio Vittadini, president of the Foundation for Subsidiarity and an advocate for blending free-market principles with interpersonal compassion – describes love as a sentiment felt by spiritual beings: a desire to alleviate suffering through acts of goodness (Muehlebach 2013, 453).

For palliative care volunteers, such ‘good works’ involved accompanying dying patients and their families through one of life’s most profound and difficult transitions. And while St. Francis famously spent six weeks fasting and praying on Mount La Verna – devoting

himself to a life of sanctuary and spiritual discipline – in pursuit of the highest form of divine love, from which LaVerna’s volunteers are said to draw inspiration, it raises important questions: What does it take for volunteers today to cultivate the kind of love their work demands? Are there specific skills involved? And how are those skills learned and put into practice? To begin answering these questions, we must turn to the training and education of LaVerna’s volunteers.

When I began my fieldwork in Zagreb at the end of 2021, LaVerna’s annual volunteer training – usually held each autumn – had been moved online due to pandemic restrictions. Prior to Covid-19, the training was conducted in person at the Catholic University in collaboration with the Faculty of Medicine in Zagreb. The shift to an online format meant that certain hands-on components, such as practical exercises in emergency care or communication techniques, could no longer be included. However, as the volunteer coordinator Tomislava noted during our conversation, the online format also brought advantages. It made the training more accessible – not only by allowing more participants to attend, but also by enabling guest lecturers from across the country to join without the logistical challenges of travel and accommodation. The training was delivered through three-hour sessions held over six consecutive Mondays. Across these six sessions, volunteers – and anyone interested in palliative care volunteering – were introduced to various dimensions of palliative care, including physical, emotional, and spiritual aspects. The program also provided an overview of the main principles of palliative care, how it is organized within the city, and examples of good practices from other regions of Croatia. In addition to the core training, volunteers were occasionally invited to attend external lectures and events not organized by LaVerna, allowing them to further expand their knowledge and understanding of palliative care (LaVerna 2020).

However, many volunteers found that sharing practical experiences during biweekly supervision sessions – led by the coordinator – was often more valuable than any formal or ‘theoretical’ training. These meetings offered a crucial space for self-reflection and peer learning, allowing volunteers to gain insights from each other’s encounters and challenges in the field. Even the coordinator herself emphasized the importance of these sessions. A social worker by profession, Tomislava had been involved with the association since its informal beginnings and assumed a paid coordinating role seven years ago, when the organization expanded and professionalized its services. In the meantime, she also began training to become a therapist, which enhanced her ability not only to supervise volunteers but also to lead grief support groups for those who had lost loved ones. For Tomislava, the annual training sessions served only as a foundation – insufficient, on its own, to prepare volunteers for the complexities

of working with the dying. It was through regular supervision and peer exchange that volunteers gained a more realistic understanding of what a patient visit might entail. These sessions also offered critical guidance on practical matters: how to set appropriate boundaries with clients, what tasks to take on, and how to manage their own emotions and well-being (Interview, Tomislava, 08/12/21). In this sense, supervisory meetings were essential not only for improving the quality of care volunteers provided but also for protecting them from burnout and exploitation. They were, in other words, a vital mechanism for cultivating volunteer professionalism within a context that is often emotionally demanding and deeply personal.

Another important source of learning and attaining volunteers' professionalism came from their own encounters with clients, as well as their broader life experience beyond the sphere of palliative care. Some long-time volunteers even claimed that, after years of service, supervision sessions became less relevant to them, as their accumulated experience allowed them to intuitively know how to respond in various situations. Their personal and professional backgrounds often played a key role in shaping this intuitive knowledge, becoming central to the development of their volunteer expertise.

Dubravka, a retired saleswoman in her late sixties, exemplified this idea. Like many others, she believed that love was the most essential quality a palliative care volunteer could possess. Her journey as a volunteer began at a homeless shelter run by the Sisters of Mother Teresa's order, where she first encountered terminally ill individuals – many of whom also struggled with mental illness or social hardship. In addition to performing routine tasks like cleaning, laundry, cooking, and providing hands-on care, Dubravka also learned an invaluable skill at the shelter: how to maintain professional distance from clients in order to avoid becoming emotionally overwhelmed by their stories. This ability, she later found, was particularly useful in her work as a palliative care volunteer. Or in her words:

The empathy those nuns showed toward people, and the way they approached care – it was with so much love and heart. But at the same time, they didn't allow it to weigh them down. I think that's one of the qualities I picked up there. At the core of it, everyone lives their own life – you can't take that life over for them. You can empathise, and you can help as much as you're able. But what's beyond your power simply isn't yours to carry.

Explaining further how she maintains professional boundaries in her volunteer work, she continued:

I guess I learned that from work: ‘business is business, and friendship is friendship’ (*posel je posel, družba je družba*). I see volunteering as my work – not my private life. I do it out of love and because I truly enjoy it. It’s something that matters to me deeply – I want to help – but that doesn’t mean my clients become part of my personal circle or family. I have my own friends. For example, right now I’m visiting someone I’ve known for over 30 years. But even then, it’s a different kind of relationship. I can see that she understands I’m doing this out of love – because she’s my friend. But that doesn’t mean she should take advantage of that. And to me, that’s a beautiful thing. She accepts me as her friend and also that I really do this out of love as a volunteer and that there is no need for that ‘you are my friend, so you will be able to come more often, or you will be able to do this or that’. So really, it’s a kind of partnership. (Interview, Dubravka, 05/05/22)

At first glance, Dubravka’s ability to maintain professional distance appeared to stem from her earlier volunteer experiences, which she herself linked to her broader employment history. In doing so, she affirmed the findings of several studies that argue the motivations and practices of volunteering cannot be understood solely within the confines of volunteer service. Rather, they are deeply interwoven with other spheres of life, institutional frameworks, and identity markers such as gender, religiosity, and class (e.g., J. Wilson 2000; Taylor 2005; Overgaard 2019; van Bochove and Oldenhof 2020). Viewed through Miriam Glucksmann’s lens of the total social organization of labour (TSOL) – which conceptualizes formal and informal, public and private, paid and unpaid work as existing on a continuum – the central question becomes how individuals organize their labour and draw boundaries around their work identities at specific historical moments (Glucksmann 1995).

In Dubravka’s case, the key to establishing these boundaries was the concept of *love*. She invoked love not only to distinguish her volunteer role from paid employment, but also – and crucially – to separate it from her private life and the intimate relationships that belonged to that domain. A particularly striking example was her relationship with a long-time friend whom she began visiting in her capacity as a LaVerna volunteer. Despite the potential for confusion or blurred lines, their friendship did not compromise the professional boundaries of her role. This was, in part, because the patient respected their friendship, but even more importantly, because she recognized that Dubravka’s care came from a place of genuine love. In this sense, love functioned as a marker of Dubravka’s professional identity, helping to maintain

appropriate boundaries. It was precisely this recognition from her friend – that her volunteer work was both loving and professional – that Dubravka valued most.

To further explain what love meant to her, Dubravka returned to her early volunteering days with the Sisters of Mother Teresa. Beyond teaching her how to maintain emotional distance from clients' suffering, the nuns also modeled a particular kind of love that deeply shaped her understanding of what Dubravka referred to as 'pure love.' Reflecting on this period, she acknowledged her initial uncertainty and even judgment toward those in the shelter, admitting that she sometimes questioned their needs or worthiness of care:

At first glance, he [a client] looked like a strong man – intelligent, communicating normally and everything. And I asked myself, 'What are you going to do for him? Who knows – maybe he's not that sick. Maybe it's a good day, and he could get out of bed and go outside?' But no – the nuns didn't see it that way. They just did their work out of *pure love*. ... You work pretty hard but when you see those nuns and how much love they give to every person they care for, you realize how little you're actually giving in comparison. ... That's what I mean by *pure love* – the love they have for these people. [my emphasis] (Interview, Dubravka, 05/05/22)

In describing the work of the nuns as something done out of 'pure love,' Dubravka evoked an ethic of care stripped of judgment or personal bias. Pure love here implied serving others without seeking to change their circumstances – an approach in which the volunteer must set aside her own desires, assumptions, and opinions in order to be fully attuned to the client's needs. In this way, it deepens and enriches the notion of 'love for people' discussed in the previous chapter.

Paradoxically, practicing love in its most genuine form required volunteers to suppress personal emotions that might otherwise 'taint' that purity. For Dubravka, then, the ability to maintain the right degree of emotional distance – neither indifferent nor overwhelmed – was essential. Pure love signified the ideal form of professionalism in palliative care: a love directed entirely toward the suffering of the other in the present moment, yet one that firmly marked the boundary between professional caregiving and the volunteer's private life. This 'disinterested' form of love, unburdened by judgment or emotional excess, echoed the divine love described earlier – a love purified of sinful thoughts and worldly prejudices. While St. Francis attained such spiritual clarity through intense periods of fasting and prayer, Dubravka attributed her understanding of this form of love to the pedagogical influence of the nuns. Their example

taught her how to love ‘correctly’ – not through sentimentality or moral judgment, but through disciplined compassion. In practice, this meant approaching clients without assumptions about their worth or condition, and protecting herself from emotional exhaustion by preserving professional boundaries.

This idea – that love must be cultivated through the ‘right kind of pedagogy’ – resonates with philosopher Martha Nussbaum’s argument about the emotional foundations of a just society. In her book *Political Emotions: Why Love Matters for Justice*, Nussbaum critiques liberal traditions for neglecting the role of emotion in political life (Nussbaum 2013). According to her, all political principles – regardless of how rational or well-intentioned – require emotional support to endure over time. For societies committed to equality and inclusion, emotions like sympathy and love are not merely desirable; they are essential (Nussbaum 2013, 3). Love, as Nussbaum defines it, is ‘an intense attachment to things outside the control of our will,’ and it gives meaning and purpose to both individual lives and shared political commitments (Nussbaum 2013, 15). The central challenge, however, lies in mobilizing such emotions publicly without slipping into illiberalism or allowing them to be co-opted by dominant groups. To that end, Nussbaum argues that love must be properly cultivated and regulated – an endeavour in which the state plays a vital role. This can be done through direct means such as political rhetoric, symbolic gestures, and public pedagogy, or indirectly, through institutional structures that reflect and reinforce compassionate values (e.g., a just tax system that expresses solidarity) (Nussbaum 2013, 16–17).

According to these standards, and following anthropologist Čarna Brković, the pedagogy of love has not been entirely successful in the post-Yugoslav region – largely due to the lack of institutional support for civil society (Brković 2026). In this context, it seems that these countries still face considerable challenges in educating their citizens to ‘love properly’ and thereby qualify, symbolically and politically, as full members of Western liberal democracies. Brković bases this claim on her ethnographic work on humanitarian practices in Montenegro, particularly the ways in which local NGOs have been critiqued by well-established Western counterparts (Brković 2026). These critiques often centre on insufficient cooperation with state authorities, with the third sector operating in parallel to – or even in opposition to – the government, rather than as its ‘extended hand.’ Without robust statutory support, Brković argues, volunteers are left to shoulder excessive emotional and practical burdens. Stronger institutionalisation of volunteer services – and thus, greater integration with the state – could theoretically help volunteers maintain emotional boundaries and protect

themselves from burnout. In this sense, institutionalisation becomes a way of teaching volunteers how to feel and love in the correct, that is, professionalised, manner (Brković 2026).

Yet, as Brković rightly notes, this view of humanitarianism reflects the broader hierarchies of what Elizabeth Povinelli has called the ‘liberal imperium of love’ – a geopolitical order in which both material resources and normative discourses about care and compassion flow unidirectionally from the global centre to the (semi-)periphery (Povinelli 2006). This dynamic often overlooks or undermines the agency and cultural frameworks of local actors. For example, in a Montenegrin refugee camp, Brković observed both compliance with and resistance to externally imposed “pedagogies of love” among local volunteers. These responses were deeply entangled with local social hierarchies, including racialized discourses, suggesting that global humanitarian scripts are always interpreted through specific cultural and historical lenses (Brković 2026).

This lack of institutionalisation also resonates strongly with the Croatian context. To briefly summarise an argument made earlier in the dissertation, despite the increasing ‘NGOisation’ of the Croatian welfare state over recent decades, volunteer participation – particularly in the health and social care sectors – remains well below the levels seen in other Central and Western European countries. The Croatian state has historically adopted a ‘custodial’ approach to volunteerism: one that seeks to control third-sector activity without adequately supporting it. This dynamic reflects the legacy of a highly medicalised healthcare system and a decentralised governance structure inherited from socialism. As a result, volunteers in palliative care have not yet been formally recognised as equal or even legitimate contributors alongside paid professionals.

To this day, there is no official curriculum or national directive for training or integrating palliative care volunteers into the healthcare system. In the absence of statutory guidance, organisations are left to develop their own training programs and to determine independently how volunteers fit into broader institutional structures. Given this gap, volunteers must often rely on alternative sources for cultivating their expertise: supervision meetings, organisation’s values, accumulated experience, or personal life and work trajectories – including their religious backgrounds. Crucial in this respect is LaVerna’s strong symbolic and philosophical connection to St. Francis, as well as many volunteers’ previous engagements with other Catholic organisations. These experiences have provided a moral and emotional foundation through which volunteers have encountered and internalised a particular kind of love – often framed as ‘pure’ – which then shapes their approach to palliative care.

While Nussbaum highlights the importance of ‘approaching general ideas through deep personal attachments’ (Nussbaum 2013, 386) – where religious symbols can be reinterpreted and integrated into a shared public language – without institutionalised pedagogy, the form of love cultivated by LaVerna’s volunteers risks remaining exclusionary. That is, it may struggle to resonate with a broader public and continue to exist at the margins of the formal care system. Without official recognition, volunteer work is often perceived as a supplementary aspect of palliative care – a mere ‘flavour’ added to the service. And a crucial trait of this flavour is its unpaid nature: it is free. Were it otherwise, it would cease to be called ‘love.’

This framing relies on an enduring essentialist notion – long critiqued by feminist scholars (e.g., Folbre and Nelson 2000; Zelizer 2005; Stacey and Ayers 2012) – which posits love in opposition to money and formal employment. Across the literature on care work and social reproduction, it is argued that emotions like love and empathy have been systematically mobilised to justify the devaluation of labour, particularly in feminised sectors (e.g., Glucksmann 2005; Dalla Costa and James 1975; Federici 2012). However, among palliative care volunteers in Zagreb, love holds an additional, more agentic meaning. Like the Montenegrin volunteers in Brković’s study, these individuals actively navigate and shape their professional identities. But while Brković’s interlocutors were seen as ‘loving too much,’ mine appear to do the opposite: they love ‘too professionally’ – transforming love itself into a professional practice.

For Dubravka, for instance, love was not an emotional resource that originated in the private sphere only to be exploited in the public domain – as many feminist critiques have argued (e.g., Folbre 2001; Ehrenreich and Hochschild 2003; Hondagneu-Sotelo 2007). Rather, in her account, love became the very boundary that distinguished her voluntary work from her intimate personal life. Even when someone occupied overlapping roles – such as her friend, who is also her patient – it is not the setting that determined the nature of the relationship, but the volunteer’s understanding and practice of love. In this sense, the proper exercise of love not only guided ethical conduct but also served as a mechanism of self-protection. It allowed volunteers to avoid exploitation and emotional exhaustion.

This approach to love stands in stark contrast to the emotional labour described in Arlie Hochschild’s seminal work, *The Managed Heart* (Hochschild 2012). Hochschild was among the first to theorise the commodification of emotion in the service economy, showing how workers – flight attendants, in her case – are required to induce or suppress feelings to achieve desired emotional states in others. Through this process, emotions become ‘transmuted’ by the organisation, leading to a loss of personal autonomy and emotional authenticity (Hochschild

2012). The most sublime form of love explained by Dubravka, on the other hand, required setting appropriate boundaries with clients, including owning a clear agency over how, where and with whom she utilises her feelings. It is, in short, a love that safeguards the self, even as it serves others.

After learning how to cultivate – or more precisely, to purify – love, Dubravka took an important additional step in defining it within her current volunteer practice. For her, love was not something that needed to be externally governed or disciplined through institutional means, as envisioned by Nussbaum (2013). Rather, love itself functioned as the very marker of her professional identity. Her patient respected her boundaries – and by extension, her professionalism – precisely because she acted out of love. This sharply contrasts with Nussbaum’s conception of love as ‘an intense attachment to things outside the control of our will’ (Nussbaum 2013, 15) In Dubravka’s view, ‘pure love’ was instead a manifestation of controlled will, reversing Nussbaum’s ‘essentialism’ and reframing love as a cultivated, regulated, and professional emotion.

However, this ‘de-essentialisation’ of love – achieved through practice and boundary-setting – was paradoxically followed by its re-essentialisation. In the absence of formal institutional recognition, the love expressed by LaVerna’s volunteers was once again framed as something transcending professional norms, positioned outside of the monetary economy. Only by distancing love from payment and codified professionalism could their contribution be fully appreciated – rendering love both a divine ideal and a symbolic ‘flavour’ added to institutionalised palliative care. Thus, the absence of statutory support simultaneously stripped love of its essentialist foundations and elevated it to the realm of the sacred, only to return it to a familiar, earthly form: a ‘spice’ – a feminised, unpaid supplement to formal care structures and an essentialist emblem of emotional labour. For this reason, volunteer professionalism cannot be equated with that of paid professionals and is more accurately described as ‘para-professionalism’, as discussed in Chapter Two.

In the following section, I turn to a context in which palliative care volunteering is significantly more institutionalised: Vienna, where education for palliative care volunteers has been in place at the statutory level for over two decades. While the name of the organisation I worked with – Caritas – literally translates from Latin as ‘love,’ the emotional stance most emphasised in its training and practice was not love, but empathy.

6.2 De/essentialising Empathy among Viennese Volunteers

This subchapter examines how volunteer professionalism in palliative care is cultivated through a particular emotional stance: empathy. In Vienna, empathy was frequently cited as a key skill for effectively performing the role of a palliative care volunteer. Defined as an exclusive, non-judgemental attentiveness to patients' needs, empathy closely resembles how volunteers in Zagreb described love. As in the Zagreb context – where volunteers enrich the palliative care service with love – Viennese volunteers similarly contribute empathy to the professional care environment. The key difference, however, lies in the absence of direct Catholic connotations in Vienna; unlike love in Zagreb, empathy in the Viennese context is not explicitly religious. Volunteers in Vienna also hold a more formalised, professional status within the interdisciplinary palliative team. These differences can be attributed to the distinct role of the Catholic Church in Austrian society, as well as to the more institutionalised nature of palliative care volunteering – evident in the detailed documentation of volunteer education and responsibilities. Despite the greater degree of professionalisation, empathy in Vienna remains loosely defined. It is not framed as a professional competency, but rather as an innate human quality. This ambiguity allows various interpretations of empathy – such as phenomenological (i.e., essentialist) or Christian (i.e., humanitarian) perspectives – to circulate and remain unexamined within volunteer training programs and Caritas materials.

Empathy as an essential volunteer quality emerged consistently in interviews, training sessions, and institutional literature. According to the national curriculum for palliative care volunteers issued by Hospice Austria, one of the key learning outcomes – alongside the ability to reflect on care situations and build professional relationships with clients and care staff – is the ability to interact with others in an empathetic, respectful, and authentic manner (HOOSPIZ Österreich 2011). What exactly constitutes such empathetic interaction was explored in depth throughout the training course, particularly in the communication module. Here, empathy was framed as the capacity to understand and acknowledge the diverse experiences of clients. Volunteers were taught to be aware of the emotional and physical suffering experienced by patients and their families, and to avoid imposing their own beliefs or assumptions about how one should heal, die, or experience illness (Prsa 2022f).

This understanding of empathy was echoed by Sophie, a 74-year-old volunteer in Vienna, during our conversation about the most important skills for palliative care volunteers. For her, empathy means 'being there, carefully listening, and holding back from your own things – your own idea of how to die, whether or not to die, or how to be ill' (Interview, Sophie,

24/07/23) Sophie defined it as the ability to be present for the client (*da sein*), while deliberately withholding advice or projecting her own desires. The aim, she explained, was to pay close attention (*zuhören*) to clients' stories and current needs. Only through this attentive presence could empathy be genuinely practiced and patients' suffering truly understood (Interview, Sophie, 24/07/23).

Given the central role of empathy in the work of palliative care volunteers, it was no surprise that the theoretical part of their training concluded with a dedicated lecture on the topic. The session was led by Marieke, a German specialist in haematology, internal oncology, and palliative medicine. In addition to heading a hospice and palliative care centre on a North Sea island, Marieke holds a PhD in philosophy and is active in the field of clinical ethics from a Zen Buddhist perspective. Two decades ago, she also founded a small Buddhist association alongside her medical career. In her lecture, Marieke defined empathy as 'seeing with the heart' – a quality she described as innate, encoded in human DNA. For her, empathy is both a feeling and an attitude. Translated into the context of palliative care, it means being fully present for another person – attentively listening to their stories (if they can speak), and being receptive to their pain and suffering (Prsa 2023c). This emphasis on attuned presence was echoed by Tamara, a volunteer from Vienna, who described her role as 'an empty glass waiting to be filled with the patient's material' (Interview, Tamara, 27/06/22). Her analogy vividly captures the essence of empathy in this setting: the volunteer as a vessel, entirely open and focused on the patient's needs during each visit.

The metaphor of a glass filled with the client's content was taken to another level in Marieke's talk. For her, an empathetic encounter not only required full personal involvement in the experience of the other but also entailed the blurring – or even dissolution – of boundaries between self and other. She described this merging as a kind of falling in love between two personhoods: 'when my self falls in love with your self' (*wenn mein Ich in dein Ich verliebt ist*) (Prsa 2023c). In doing so, she evoked the concept of ego dissolution found in Zen Buddhism, where full presence in the moment – achieved through meditation and other spiritual practices – leads to the fading of the individual ego. Yet, Marieke emphasized that such deep empathetic encounters are not as unattainable as they may seem. As previously mentioned, empathy is something that exists naturally within all of us. Acknowledging this, she reassured palliative care volunteers that they need not hesitate to practice empathy, as it is a fundamental human capacity (Prsa 2023c).

This perspective aligns with the views of early phenomenologists such as Edmund Husserl, Max Scheler, and Edith Stein, who understood empathy as the basic form of more

complex intersubjective experiences – a primary mode of existing with others. According to them, empathy occurs through a range of sensual encounters – cognitive, affective, or connotative – that allow for the co-creation of a shared world (Throop and Zahavi 2020, 85). However, even if understood as an innate human quality, empathy is never exercised in isolation. Anthropologists studying empathy (e.g., Hollan and Throop 2008; Throop and Zahavi 2020) emphasize that it is always embedded within specific socio-political contexts that either encourage or inhibit its expression. This was particularly relevant in the context of palliative care in Vienna, where empathy was framed in relation to the development of a specific kind of volunteer professionalism.

In March 2023, during my final preparatory conversation with a volunteer coordinator – where we reflected on the practical training preceding my official start – I noticed a headline in the office that caught my attention: ‘Professionality and Empathy’ (*Professionalität und Empathie*) (Caritas aktiv 2023). This was the title of a featured article in Caritas’ monthly magazine, which focused on parish activities. The article reported on leadership changes within the regional coordination of Parish Caritas. The outgoing coordinator, Kerstin Schultes, emphasized that helping people in need – the core mission of Caritas – had always been carried out in a manner characteristic of the organization: by combining professionalism with empathy (Schultes 2023). The article went on to outline Caritas’ ongoing commitment to the Christian principle of active community involvement, realized through a wide range of initiatives. Since World War I, Caritas has built an expansive network across Austria to support people in precarious living conditions – organizing warm shelters, soup kitchens, social markets, and educational programs. Despite its evolution into one of the country’s leading welfare service providers, Caritas has retained its identity as a humanitarian organization. This identity was reflected in the magazine’s content, which covered topics ranging from spiritual reflections and organizational news to caritative efforts, such as support for women’s shelters, aid campaigns for rural Africa, dementia care programs, food drives, and employment initiatives for Ukrainian women (Caritas aktiv 2023).

This approach to addressing poverty reflects a broader humanitarian ethic, in which empathy – and its emotional counterparts, sympathy and compassion – serve as moral drivers of international aid, peace-building, and human rights work (e.g., Fassin 2012; Feldman and Ticktin 2010). In this context, what some call ‘humanitarian empathy’ is a specific ethical practice, distinct from more universal phenomenological notions of empathy. It implies a duty to protect and assist those perceived to be suffering (E. Weiss 2015, 280). Some scholars trace the roots of this ethic to Christian traditions, particularly the valorization of Christ’s suffering

on the cross (Bornstein Erica and Redfield Peter 2010; Fassin 2012) and St. Augustine's concept of ethical empathy (Pandolfi 2010, 236; Fassin 2012, 251). Others argue that the modern resurgence of empathy is part of a cultural shift that began during the Enlightenment, when Europeans began to see themselves as morally responsible for distant suffering. Even early liberal thinkers such as Adam Smith, David Hume, and Francis Hutcheson viewed empathy (then referred to as 'sympathy') as a natural psychological foundation for moral behaviour and ethical judgment (E. Weiss 2015, 281).

The (often unintended) consequences of empathy have recently become a central concern for scholars critical of humanitarianism, especially regarding its limitations in addressing contemporary political challenges. These critics argue that concepts such as suffering, trauma, and compassion have served to depoliticize discussions of violence and justice (Fassin 2012, 8; Pandolfi 2010, 246; Ticktin 2011, 3). As already discussed in Chapter Four – rather than bridging divides, humanitarian efforts often reinforce or even deepen the inequalities between aid providers and recipients (Ticktin 2014).

While these critiques are essential for exposing the problematic effects of humanitarian governance, they tend to overlook the interpretive, lived, and negotiated dimensions of ethical practice. As anthropologist Erica Weiss points out, such theoretical perspectives often neglect the complex ways in which humanitarian values are enacted in everyday life (E. Weiss 2015). Building on Dipesh Chakrabarty's concept of 'provincializing Europe' – which challenges not European thought itself but its claims to universality – Weiss argues that humanitarian values are not inherently flawed. Rather, she calls for a 'provincialization of empathy,' urging scholars to consider empathy not as a universal ethical ideal, but as a value shaped by specific cultural and social contexts (E. Weiss 2015, 278). This approach encourages a shift from viewing empathy purely as political ideology to understanding it as a situated practice, grounded in local lifeworlds and moral frameworks. In my research, this situated perspective is examined through the lens of palliative care volunteering, particularly in relation to how empathy is practiced alongside ideas of volunteer professionalism.

Viennese volunteers frequently described their use of empathy in terms of what they referred to as 'inner distance' (*innere Distanz*) or 'professional closeness' (*professionale Nähe*), which suggests cultivating emotional intimacy while maintaining a professional boundary. For example, Sophie – introduced earlier – emphasized that maintaining this inner distance was essential for protecting herself from becoming overwhelmed by the suffering of patients. She explained:

This [inner distance] is, of course, easier with so-called strangers. That's why I said: only when you're not accompanying your parents, siblings, or close friends is this inner distance really possible – and it's something every psychiatrist or therapist must have. This doesn't mean you don't feel compassion, but you don't let your own pity overwhelm you. I know people – a friend of mine – who suffer so much from their compassion when working in hospice care. She becomes almost paralyzed by it because it overwhelms her. She couldn't do the work because, naturally, it turns into her own suffering. And then you can't be there for others. (Interview, Sophie, 24/07/23)

In contrast to Marieke's lecture, where the boundaries between client and caregiver were envisioned as dissolving in a moment of deep empathetic connection, the perspective expressed here emphasizes the necessity of consciously maintaining those boundaries. Rather than striving for a complete fusion of identities, a successful caring relationship in palliative care depends on preserving a certain emotional distance. This distance serves as a form of self-protection, shielding volunteers from emotional exhaustion and burnout that can result from intense empathic engagement with a patient's suffering. Without this inner distancing, volunteers risk becoming overwhelmed by their own emotional responses, rendering them unable to be fully present for the patients or to effectively perceive and respond to their needs. According to Sophie, this skill of boundary-setting was particularly important in professional caregiving contexts and was not typically applicable – or even possible – within personal relationships involving close family or friends.

By referencing established professions such as psychiatry and therapy, Sophie reinforced her point that this kind of emotional management was a marker of professional competence. In this way, she framed inner distance not only as a coping mechanism but as a key element of volunteer professionalism. It became a defining feature that distinguished caregiving in the palliative setting from more emotionally entangled forms of care within the private sphere. Only by maintaining this boundary, she argued, could volunteers be fully present for their patients and practice empathy in a way that is both ethically responsible and emotionally sustainable.

Sophie's emphasis on the need to protect oneself from becoming overly emotionally invested in a patient's situation closely echoed the competence described by Dubravka – a volunteer in Zagreb discussed in the previous section – who learned this skill at a homeless shelter run by the Sisters of Mother Teresa's order. Remarkably, Sophie's own volunteer path

before joining palliative care was also shaped by an encounter with this same religious order, though in a very different setting: a shelter founded by Mother Teresa herself in Calcutta. Early in her career as a religious education teacher, Sophie spent several years teaching in a primary school in Papua New Guinea. On her return journey, she visited one of the shelters established by Mother Teresa before her global recognition. Sophie was struck by the profound suffering she witnessed on the streets of Calcutta and by the dedication of the nuns caring for the sick and dying. This experience, which marked her first direct encounter with death and dying, left a lasting impression and significantly influenced her later decision to become involved in the hospice movement (Interview, Sophie, 24/07/23).

Yet, despite the formative nature of this encounter, it did not play the same foundational role in shaping her current caregiving practices as it did for Dubravka. When asked what had most helped her navigate the emotional challenges of working with palliative patients, Sophie did not cite her earlier experience in Calcutta. Instead, she immediately emphasized the importance of regular supervision sessions and the training she received at the start of her volunteering, as illustrated in the following quote:

I find the education very important. During the course, I reflected on these topics together with other participants, and what I really liked was the eulogy – or whatever it is you have to write. It was all a challenge, something you wouldn't normally do. And then of course, the theoretical input, whether it came from doctors or others. Also, ongoing reading on the subject: if you find interesting books, maybe something about dementia or something that really speaks to you... or further training, like the programs at Kardinal König Haus, for example. It's always good to revisit that material. (Interview, Sophie, 24/07/23)

Even more explicit about the value of structured training and education was another Viennese volunteer, Johanna:

What's important to me is the training in life, death, and grief support. This training, along with meetings with other volunteers and occasional supervision, is really helpful. And also the conversations with the full-time staff member – the one who supports us, so to speak – those conversations are very important when you're facing a problem. Well, Caritas is the background, of course. But fundamentally,

it's the initial training – and then, perhaps, further training – that really matters.

(Interview, Johanna, 28/06/22)

At the time of the interview, Johanna was 64. Her motivation to begin volunteering in palliative care stemmed from the death of her husband. Having gained firsthand experience while caring for him, she felt compelled to share the skills she had developed with others facing similar situations. Before entering the field of palliative care, Johanna had also volunteered with a hiking organization. Yet, as with Sophie, her previous volunteer experiences – though influential in shaping her decision – did not play a central role in developing the competencies she now applies in her palliative care work. Instead, Johanna, like many others, credited her preparedness to the formal training course all volunteers are required to complete at the outset of their service: 'Training in Life, Death, and Bereavement Support' (*Ausbildung zur Lebens-, Sterbe- und Trauerbegleitung*).

I took this course myself between late 2022 and early 2023. In addition to covering theoretical knowledge on topics such as pain management, the history of the hospice movement, and the organization of palliative care in Austria, the course placed a strong emphasis on personal reflection. Participants were encouraged to engage with their own experiences of loss and mortality – for instance, by writing a eulogy to a loved one or imagining how they would respond to receiving a terminal diagnosis. These reflective exercises aimed to help volunteers distinguish between their own emotional responses and those of the patients. The ability to maintain this inner clarity, often described as achieving a state of 'neutrality,' was repeatedly stressed as essential for entering patients' spaces with openness while setting aside personal emotional baggage (Prsa 2022e).

The volunteer training course spans 80 hours over five months and is structured around modules set by Austria's national hospice umbrella organization, Hospice Austria. The first national curriculum for volunteer education was introduced in 2004 and revised in 2011, along with training frameworks for coordinators and medical professionals (HOSPIZ Österreich n.d.). In Vienna, the course is offered twice a year (Autumn–Winter and Spring–Summer) by two certified providers: Kardinal König Haus (KKH), a Catholic educational centre, and the Austrian Buddhist Religious Society (*Österreichische Buddhistische Religionsgesellschaft – ÖBR*). KKH, with its greater financial and infrastructural resources, provides approximately 80 training spots per semester, whereas the waiting time at ÖBR can stretch to several years. As a result, many volunteers – myself included – opt to complete their training at KKH. Despite KKH's Catholic affiliation, the course itself follows the non-denominational principles of

palliative care and does not promote religious teachings. While the course leader was a member of a Catholic order, openness to diverse perspectives was evident – for example, in the inclusion of Buddhist instructors like Marieke.

The course fee of €530²⁰ could be reimbursed after one year of active volunteering by the host organization. Before officially starting, prospective volunteers are also required to complete a 40-hour practical training with a palliative care provider of their choice. This involves shadowing various members of the care team and becoming acquainted with the organization's structure and ethos (HOOSPIZ Österreich 2011). At Caritas Hospiz, where I completed my training, the mobile palliative team includes over 50 professionals – doctors, nurses, physiotherapists, psychotherapists, volunteer coordinators, and a pastor (*Seelsorger*in*).

As part of the training, I joined patient visits with social workers, physicians, nurses, and volunteers; spent time at the day hospice; attended a lecture on the organization's operations; and participated in a team-wide monthly meeting that concluded with a farewell ceremony for recently deceased patients. Before and after the practical component, volunteers met with the volunteer coordinator to reflect on their expectations, perceived challenges, and personal strengths and weaknesses in approaching their future roles. Once officially integrated into the team, volunteers were expected to attend monthly meetings and were offered supervision by certified therapists every two months. Continuing education – in the form of workshops and lectures – was not only viewed as beneficial, as both Sophie and Johanna emphasized, but was also mandatory. According to Hospice Austria guidelines, all volunteers must complete at least eight hours of additional training per year. These requirements are outlined in the official documents of Hospice Austria (HOOSPIZ Österreich 2011) and elaborated further in the internal regulations of Caritas Hospiz (Caritas Hospiz, n.d.).

The strong institutionalization and detailed formalization of volunteer roles in Austria's palliative care system can be traced to the country's long-standing emphasis on education as a foundation for developing hospice and palliative care. As Sandra, the managing director of Hospice Austria, explained, the establishment of educational programs was central to building a robust and integrated hospice movement in which volunteers play an essential role. Reflecting on her early involvement in the field, she noted:

²⁰ That was the price in 2022. This year the price went to 830 EUR (Kardinal König Haus 2025).

At the time, I was initially organizing the volunteer training courses that Hildegard Teuschl had already begun. We then launched palliative care courses for doctors and nurses, which eventually evolved into the university-level master's program we have today. So, I've been heavily involved in developing education. We really believed that we could change the world through training and education. ... We created this tiered hospice and palliative care system, which is functioning well and also served as a model for the EAPC framework. For us, it was crucial to include volunteers as part of this system. In many other countries, as I've seen through my work with the EAPC task force, volunteers are treated as a separate element. But for us, it was always important that they be fully integrated into the overall structure. I believe this integration has been key to our development.

(Interview, Sandra, 24/11/22)

Sandra has been active in Austria's hospice movement since its institutional beginnings in the 1990s. A major influence on her decision to enter the field of palliative care was Hildegard Teuschl, the founder of the Austrian hospice movement, who invited Sandra to help organize volunteer training courses. Shortly thereafter, they launched educational programs for medical professionals, which would eventually evolve into university-level courses. Throughout our conversation, Sandra openly acknowledged her role in institutionalizing palliative care services at the national level, particularly through the development of the Graded Hospice and Palliative Care System – a model now recognized across Europe (HOSPIZ Österreich n.d.).

This tiered system, encompassing mobile palliative care teams, palliative units in hospitals and nursing homes, and dedicated hospices, has become a benchmark for structuring palliative care, as endorsed by the European Association for Palliative Care (EAPC). According to Sandra, the key to this success was their unwavering emphasis on education. Only through comprehensive training, she argued, could the systemic changes required to fully integrate palliative care into Austria's health and social care frameworks be achieved. Equally crucial was the integration of volunteers into the institutional fabric of palliative care. For volunteers to be seen as legitimate and valued members of the professional care team, they too had to be properly trained. In this way, palliative care could be delivered with professional standards while still relying heavily on a volunteer workforce.

The concept of professionalism plays a crucial role in this context, as it is through this framework that volunteers gain 'full' membership within the multidisciplinary palliative care

team. This is made particularly clear in the Caritas Hospiz brochure outlining the responsibilities of palliative care volunteers. At one point, the brochure explicitly acknowledges that the professionalism of volunteers is on par with that of other team members. Accordingly, volunteers are required to complete a basic qualification course, practical training, and engage in ongoing education, supervision, and reflective practice as part of team meetings (Caritas Hospiz, n.d., 14). Education and training thus emerge as key determinants of volunteers' professionalism and serve as prerequisites for their integration into the organisation's palliative care team. This integration provides volunteers with a sense of security, particularly when seeking guidance on patient visits, as previously discussed by Johanna. Furthermore, it facilitates the establishment of professional boundaries with clients, helping distinguish volunteers' roles from other, non-institutional forms of care. In this regard, a section of the chapter in the brochure dedicated to the professional role of volunteers emphasizes the importance of understanding that they do not engage with clients as private individuals, but rather as representatives of the organisation's structured service (Caritas Hospiz, n.d., 14).

Although the contribution of volunteers to the palliative care team is equally professional as that of other members, it remains distinct in important ways – a distinction emphasized throughout the brochure (Caritas Hospiz, n.d.). It is crucial that volunteers respect the boundaries of their role, refraining from offering or advising on medical, psychological, or spiritual care. Instead, they are expected to stay in close communication with the professional team, reporting any notable changes in a patient's condition (Caritas Hospiz, n.d.). Their primary responsibility lies in accompanying the dying – engaging in conversations, participating in recreational activities, or simply offering their presence to ensure patients are not alone. A central aspect of this role is the ability to sensitively perceive the patient's state of mind, body, and soul. In this regard, volunteers are uniquely positioned within the team to embody and express empathy. The brochure frequently links empathy to the notion of 'being human,' highlighting how volunteers offer care through a blend of humanity and professionalism (Caritas Hospiz, n.d.). Their professionalism is thus deeply humanised, setting them apart as a distinct category of professionals – para-professionals: individuals who provide dedicated, institutionalised care without financial compensation, as further explored in Chapter Four.

While the brochure clearly states that maintaining professional distance does not preclude empathetic engagement, it stops short of elaborating on the concept of empathy itself. Instead, empathy is assumed to accompany professionalism, whose meaning and implementation are

explained in far greater detail (Caritas Hospiz, n.d.). This imbalance risks essentialising empathy as an innate human trait, echoing the phenomenological approach discussed in Marieke's lecture. Her notion of 'boundless' empathy, hence, does not necessarily conflict with the Austrian palliative care context, where empathy is shaped and bounded by institutional training and further codified through Caritas Hospiz's formal guidelines. Although empathy and professionalism inevitably influence one another – forming a particular blend, as noted in Caritas magazine – they are still conceptualised as distinct entities. As a result, both Buddhist and Christian (i.e., humanitarian) understandings of empathy are left unexplored: not explicitly referenced, yet not openly contested either.

In doing so, and in line with the increased secularisation of Austrian society and the role of Catholic Church in welfare provisioning in the country, Catholic elements of the Viennese palliative care environment can safely remain in the background, while simultaneously showing off its religious diversity through hosting Buddhist lecturers like Marieke. This openness to non-Christian religions – particularly Far Eastern ones – resonates with the broader 'spiritual turn' and the spiritual diversity among Caritas Hospiz volunteers. As noted by their coordinator Michaela (see previous chapter), the team includes members from various spiritual backgrounds – except Islam, which remains conspicuously absent. While there is no space here to fully unpack the deep-rooted Islamophobia in Austrian society – evident, for instance, in media portrayals of Muslim immigrants as threats or in the public support for the ethnic cleansing in Gaza – it is worth noting that Buddhist teachings, by contrast, appear to pose no such challenge to the Catholic-inflected model of Austrian secularism. The phenomenological or essentialist framing of empathy not only aligns neatly with the vague definitions found in official palliative care documents, but any potential disruption is further diffused by the unequal distribution of resources between KKH and ÖBR. This imbalance ensures that the Catholic Church maintains its near-monopoly over the training and organisation of palliative care in Austria.

By conceptualising empathy through the lens of openness – both to religious diversity and to a non-judgemental approach to patients – empathy takes on a meaning similar to how volunteers in Zagreb previously described love. Exclusive devotion and attentiveness to patients' needs strongly echo Dubravka's definition of love. And just as volunteers in Zagreb bring love into the palliative care service, Viennese volunteers contribute empathy – though with a crucial distinction.

In Zagreb, love is imbued with explicit Catholic meaning, reflecting the different role the Church plays in Croatian society. In Austria, by contrast, a different model of secularism –

paired with more robust state support – allows this volunteer-driven empathy to reach a wider public and become institutionalised. Central to this institutionalisation is the implementation of statutory-level training and education. This process has diminished the perceived value of volunteers’ prior experiences outside formal courses and training, even though such experiences often play a critical role in motivating individuals to enter the field of palliative care. While this formalised education has enabled the professionalisation of palliative care volunteering and its integration into interdisciplinary teams, it has also left little room for volunteers – or the broader palliative care field – to explore or critically reflect on the concept of empathy. As a result, empathy is implicitly treated as an essentialised quality. Much like love, which according to Nussbaum requires guidance and regulation, empathy here must be appropriately managed (Nussbaum 2013). Professionalism, therefore, is not defined in opposition to empathy, nor entirely through it, but rather alongside it – where empathy must be delivered in measured, proper ways.

Despite the differences in how education and volunteer professionalism are cultivated in each context, the next subchapter demonstrates that setting boundaries in palliative care volunteering in both Vienna and Zagreb ultimately draws on and promotes the ideal of the family as the primary caregiver for its vulnerable members.

6.3 Reconsidering Familialistic Regimes: How Palliative Care Volunteering (In)directly Defines Family Care

In this subchapter, I examine how the definition of volunteer work in relation to patients’ families plays a crucial role in understanding the setting of boundaries and the para-professional conduct of volunteers. I argue that palliative care volunteers in the two research contexts contribute to sustaining a similar – idealised – image of the family as the primary caregiver for its frail members. However, the way this ideal is put into practice differs significantly between the two cases. These differences reflect distinct pathways toward familialistic welfare regimes, which are evident, among other factors, in how precisely family norms and responsibilities are articulated. In Vienna, my research participants were notably careful in describing how families should assume caregiving responsibilities, consistently acknowledging the diversity of family configurations. In contrast, in Zagreb, volunteers and other palliative care staff adopted a more explicit stance on relatives’ caregiving duties and

showed a greater tendency to intervene in family matters. The subchapter begins with an analysis of family roles within the Viennese palliative care setting, followed by a comparative discussion of findings from Zagreb.

Just as there are clear boundaries between volunteers and other professionals within the palliative care team in Vienna, the role of volunteers should also be clearly distinguished from that of relatives and friends. Developing overly intimate relationships with clients can prevent volunteers from maintaining the necessary distance from family dynamics and from remaining ‘neutral.’ Both the Caritas Hospiz brochure and training materials emphasize that neutrality is essential to the professionalism of volunteer work, as it enables volunteers to refrain from judging or intervening in family matters (Caritas Hospiz, n.d.; Prsa 2022d). Without neutrality, volunteers may struggle to reflect on their own emotional responses to the client’s family and to establish appropriate boundaries.

According to the brochure, what sets the volunteer role apart from relationships with family and friends is precisely this ability to reflect and to set boundaries. In contrast, relationships with relatives or close friends often involve emotional involvement, constant availability, gift exchanges, and a tendency to influence or change the other person (Caritas Hospiz, n.d., 14). Assuming that intimate relationships lack boundaries altogether is not only inaccurate and problematic – it also enforces a strict division between the professional and the private domain, as if the latter were devoid of skills, training, or ethical norms. Much like empathy, when family and friendship are defined solely in contrast to professionalism, there is a risk of essentializing these roles.

This understanding of family is also used to highlight the autonomy and complexity of the family as a system with its own long-standing history and unique dynamics. Both the Caritas Hospiz’ brochure and training course for volunteers stressed that when entering a client’s family environment, volunteers must first and foremost show respect for this system and refrain from making immediate evaluations or judgments (Caritas Hospiz, n.d., 13–14; Prsa 2022e). Developing such a respectful attitude requires an awareness of the diversity of family constellations, which can help volunteers empathise with – rather than attempt to change – the various family situations they encounter.

Equally important is recognizing the different roles within a family and their individual relationships to the dying person (Caritas Hospiz, n.d., 13–14). To explore this, a training module on supporting relatives included an exercise where course participants were divided into five smaller teams. Each was tasked with reflecting on the specific challenges faced by a particular family role (e.g., husband, mother, teenage daughter, four-year-old child, or friend).

The session was led by Hilda, a nurse at a palliative care unit in Vienna who began her career as a volunteer. Her dual perspective – first as a volunteer, later as a trained nurse – gave her valuable insights into the interplay between various care providers, especially the unique role of volunteers. Exercises like this aimed to deepen volunteers’ understanding of the complex nature of family systems, which come in diverse forms and exist within particular socio-economic contexts. Each family member may cope with emotions like guilt, exhaustion, or grief in their own way, and acknowledging this is key to providing sensitive and supportive care (Prsa 2022f).

Throughout the session, facilitators repeatedly emphasized that, even in the face of intense emotions and difficult living conditions, volunteers were not expected to offer solutions. Instead, their role was to be fully present – to listen attentively, tune into unspoken needs, and respond with empathy rather than action. This often meant becoming a kind of emotional outlet for patients – someone with whom they could ‘discharge’ feelings and thoughts they felt unable to share with close family members. It was precisely here that the value of the volunteer’s neutrality became most apparent. Positioned outside the familial structure, volunteers were uniquely suited to offer this form of emotional release – an ability closely tied to the listening skills explored in the previous chapter. In such moments, volunteers frequently acted as intermediaries, quietly relaying a patient’s unspoken wishes to family members. In cases where relationships had been strained or ties severed, volunteers were encouraged to gently explore whether there were people the patient wished to see or reconcile with before dying (Prsa 2022f).

There was also a recurring theme in the session: that relatives often needed as much, if not more, support than the dying person themselves. Volunteers, then, found themselves engaged in various forms of emotional and practical labour – not only offering a supportive presence but also relieving family caregivers by watching over the patient or running errands, such as picking up medications or navigating bureaucratic tasks. In homes where someone was responsible for a dying relative around the clock, such assistance was far from trivial. It could mean the difference between coping and collapse. As several trainers noted, small acts – an hour of quiet presence, a completed chore – could significantly ease the strain and help protect families from the burnout that so often accompanies terminal care at home (Prsa 2022f).

When the needs of clients or their families extended beyond a volunteer’s scope – whether medical, psychological, or financial – it was expected that the volunteer would consult the broader palliative care team. Yet what was repeatedly emphasized during the training was that any action taken had to be guided by a deep attentiveness to the needs and rhythms of

family care. Volunteers were encouraged to support relatives where needed, but not to intervene in ways that might override or replace them. As one facilitator put it, ‘We give a hand, but we don’t take over’ (Prsa 2022f). This point was brought into sharp focus during Hilda’s closing remarks. Drawing on her own experiences, she urged volunteers to honour the work of families by recognizing their role as primary caregivers – an expertise grounded in daily, often invisible labour. Volunteers, she stressed, should understand themselves not as substitutes, but as assistants to the family, much like the rest of the professional team. ‘We preserve their role and importance,’ she said, framing volunteer work not only as support for individual patients but as part of a broader effort to sustain the cultural and moral value of family caregiving itself (Prsa 2022f).

This emphasis on the centrality of the family was echoed in conversations with others in the field. Patrik, the president of Caritas Hospiz, whom I introduced in Chapter Four, articulated a similar perspective during an interview in November 2022. When asked about the relationship between palliative care professionals – both paid and unpaid – and the family, he responded:

But no matter what, family is always the most important point. We never just work with patients or for patients, but always with and for relatives. Although nowadays, you have to say that a family is no longer what it was 50 years ago. So what family is today is a lot of different ways of life, but also a lot of different types, from formal, official families to unofficial neighbourhoods, friendships, whatever... It is more of a challenge today and will be even more so in the future, that people live alone – meaning that they have no family, but also no friends or no contact with friends, and are very, very alone. So, to put it positively, very autonomous. That’s wonderful. Yes, but when illness occurs or care is needed, then things can become critical very quickly. That’s a challenge. Yeah, and I have the impression that there will be significantly more. And I think the demographics say that too.

(Interview, Patrik, 19/11/22)

Patrik’s reflections resonated strongly with what I observed during the course. Like many others in the field, Patrik emphasized the central role that relatives still play in palliative care – both as partners in caregiving and as recipients of care themselves. Yet, he was clear that ‘family’ was not a fixed category. Rather, it was something fluid and context-dependent, a form of belonging that could take many shapes: long-term friendships, cohabiting companions, or

loosely defined circles of support, some of them formalized, others entirely informal. At the same time, Patrik pointed to another, more unsettling trend: the rising number of people living entirely alone, without any embeddedness in a care network. This, he suggested, was an inevitable byproduct of the liberal emphasis on autonomy and individual rights. But it also presented a profound challenge for those tasked with organizing care at the margins of kinship. If these demographic shifts continue – as both he and the data suggest – they may strain an already fragile system.

Despite these concerns, one thing remained consistent across my interviews: a deep-seated commitment to preserving the role of the family, however it might be configured. No one I spoke with seriously questioned the family's place as the primary provider of care. On the contrary, there seemed to be an unspoken consensus that its contribution was too vital to lose. This might help explain the hesitancy among my informants to define, in precise terms, what responsibilities relatives should bear. Instead, the focus was on training professionals to meet families where they are – to respond with openness, without judgment, and without imposing rigid expectations. In other words, the notion of love and empathy mentioned earlier was extended from patients to their families. The emphasis was not on fixing the family, but on adapting care to fit its many possible forms.

Michaela was one of those professionals. A trained social worker, she coordinated volunteer teams at Caritas Hospiz, covering both the southern and northern districts of Vienna. Not long after my fieldwork concluded, two new volunteer teams were established – including a multicultural team – each with their own coordinators. Michaela stepped into a lead coordinating role, overseeing the expanded structure. From the start of our conversation, Michaela was open about how the themes of death and dying had shaped her life. She spoke of caring for close relatives and friends in their final days – experiences that left a lasting imprint. Still, she was clear that things did not have to always unfold that way. 'Sometimes there's no family around,' she explained. 'And sometimes the relationships are so damaged that there's no way to bring people back together before someone dies.' In her view, no crisis – no matter how urgent – could undo a family's long and complicated history:

A family cannot suddenly take on a different role at the end of life. Family relationships have existed for a lifetime. But if – just imagine – you could afford home care, if you understood pain management and palliative medicine, then yes, people could safely die at home. The family's role would be to make that possible. That would be ideal for me. But there's still a long way to go. We look after many

families. It's good when they're involved in care, but they need real support to take on other roles. There's still a lot that can be done. (Interview, Michaela, 11/10/22)

What mattered most to Michaela was not prescribing a fixed role for families, but recognizing the uniqueness of each situation. Family dynamics, shaped by years of emotional entanglements, as well as by financial, social, and cultural conditions, influenced how care could be given at home. And crucially, she emphasized, families could not do it alone. 'We' – the mobile palliative care team – were that outside support that made home-based care possible. In her view, this was the direction palliative care needed to go: enabling families to continue caring, while not being overwhelmed by it. Volunteers, Michaela added, played a vital part in this process. She shared the story of one volunteer who supported a family where the mother, seriously ill, still lived at home with her husband and children. 'The volunteer visited every week,' Michaela said, 'spending afternoons with them, cooking meals, just being there. The idea was to help the mother stay connected with her children – not through big gestures, but through small, familiar routines like sharing a meal' (Interview, Michaela, 11/10/22).

This example was part of a larger point Michaela wanted to make about setting clear boundaries for volunteers. As a coordinator, she took care to ensure that volunteers did not take on the tasks of medical staff or family caregivers. Occasional help with errands or hands-on support in emergencies was acceptable, but such involvement was not meant to become routine. Her responsibility, as she saw it, was to prevent exploitation – intentional or otherwise – of volunteers' goodwill. Still, she acknowledged that there were exceptions. The cooking volunteer was one of them. Helping the family maintain their everyday rituals was reason enough to stretch the boundaries. In this case, cooking – typically the domain of the mother – was not just a practical need but a deeply symbolic one. The volunteer, also a woman, was not replacing the mother, but supporting her in continuing to fulfil her role within the family. To Michaela, this was a powerful illustration of how volunteers and the palliative care team together could support families – not by taking over, but by enabling them to remain themselves, even in the midst of dying. The family, with their help, could do what Michaela believed was ideal: allow the patient to die at home. 'It doesn't always work that way,' she admitted. 'And that's okay.' But for Michaela, this kind of care remained a deeply held aspiration – what she called, quite simply, 'a fantasy' (Michaela, Interview, 11/10/22).

But Michaela's perspective was not unique. Many scholars have noted a strong emphasis on family-based care within the Austrian welfare system, where access to social rights is often closely tied to either employment or family relationships (Badelt and Österle

2001; Hammer and Österle 2003; Österle and Heitzmann 2020). As discussed in Chapter Three, the image of the caring family – tending to its frail members – is reinforced through various state benefits designed to support informal caregiving (Hammer and Österle 2003; Österle and Heitzmann 2020). This ideal, however, is not gender-neutral. Around 80 percent of all long-term carers in Austria are women, a pattern that aligns with one of the highest rates of female part-time employment in Europe. Women also predominate in the field of palliative care²¹. Despite demographic shifts, such as an ageing population and evolving family structures, the traditional model of family caregiving continues to hold sway in both public and political discourse (Weicht 2011). Bernhard Weicht, for example, has shown how media portrayals of live-in migrant care workers – who have become central to the care landscape since the early 2000s – often frame them using familial language. These workers are celebrated not just for their labour, but for embodying traits typically associated with close kin: love, emotional devotion, and family-like commitment (Weicht 2011).

Yet within palliative care contexts, these live-in carers were largely absent from the narratives I encountered in the field work. While they were occasionally mentioned during the more informal interactions with volunteers, their roles were often overlooked or excluded in the volunteer course or expert interviews. My interlocutors and course facilitators clearly expressed openness to diverse family structures and care arrangements, yet support from outside the household was most commonly imagined as institutional. Informal caregiving by non-family members – apart from friends – was rarely acknowledged (Prsa 2022f). There may be several explanations for this omission, including the specific focus of palliative care itself. Still, I saw it as a sign of how the idealised image of the family as the primary caregiver continues to shape expectations and perceptions within this field. Of course, this ideal does reflect much of the reality: Austrian families do shoulder the majority of long-term care responsibilities. In 2010, it was estimated that eight out of ten individuals in need of long-term care relied on informal carers (Bachner et al. 2018, 172).

What stands out in the palliative care setting, however, is how this image of the family is not only reflected but actively encouraged – especially by volunteers. Their work reinforces the significance of family involvement, framed through the hospice ethos of unconditional acceptance and empathy. There is no single ‘right’ way to care for a dying relative, nor one correct form of family. Professionals (both paid and unpaid) are expected to meet each family where they are, support them however they can, and recognise their efforts, no matter how

²¹ 85% of palliative care volunteers in 2021 were women (HOSPIZ Österreich 2022).

modest. In the end, what mattered most was that care came from the family. The specifics – who did what, how much, or how well – were secondary. The central idea was clear: family care was both the foundation and the ideal.

Emphasizing the significance of volunteers in supporting the relatives of palliative patients was a recurring theme in conversations with interlocutors in Zagreb as well. Volunteers not only assisted with bureaucratic hurdles but were also a vital emotional support for both clients and their families. Yet, they were explicitly discouraged from directly intervening in family dynamics. This boundary was clearly articulated during a session on family care within a training course for palliative care volunteers in Zagreb. The course coordinator stressed unequivocally: ‘There is no interference into the family – family is the sanctum (*svetinja*)!’ She went on to underscore that the family must always remain central, occupying the most meaningful space within the broader palliative care framework. Her caution extended especially to the delicate issue of financial matters, warning volunteers of the ethical risks tied to overstepping the trust placed in them by relatives (Prsa 2022c).

Volunteers were trained to enter each household with sensitivity – alert to the emotional and practical needs of the situation, yet mindful not to impose. Still, when it came to repairing fractured family ties, they were, unlike their Viennese counterparts, strongly encouraged to engage – gently, and only if the circumstances allowed. As the coordinator put it, given the limited time left in terminal cases, palliative care ‘enables us to do things “forever and ever” (*za vijeke vjekova*).’ In her view, this enduring potential called for volunteers to take seriously the opportunity – and, indeed, the responsibility – of facilitating reconciliation among estranged family members (Prsa 2022c).

In my regular conversations with volunteers, many echoed this sentiment. It was crucial, they felt, to discern whether the patient had unresolved relationships – often involving a close relative with whom communication had ceased. Like the course facilitator, volunteers spoke of terminal illness as a unique moment for healing: a rare and fleeting chance to mend broken ties. Such efforts might mean helping a patient forgive, or to be forgiven. And while locating estranged relatives and broaching family rifts was never easy, and reconciliation was far from guaranteed, even failed attempts served to reinforce their commitment. Volunteers were deeply motivated not to let patients pass away burdened by unresolved conflicts.

One story – shared by Marija – offers a poignant illustration of this. At the time, she had been visiting a woman in her final days, a woman whose ex-husband and son had not spoken in years. Through Marija’s persistent yet gentle efforts, the two men reconnected just before the woman’s death. She recalled this experience with particular pride:

When the end was near, the association informed the son. In short, I invited him over. Of course, I was at home when he arrived. At some point during our conversation, I casually mentioned, ‘Yeah, that’s already taken care of. Dad handled it.’ He fell silent. Then the conversation moved on – I’m not even sure to what exactly – but again I found myself saying, ‘Dad took care of everything.’ He had. Especially when it came to the finances, Dad managed it all. The son seemed stunned – he couldn’t believe it – but he didn’t say anything. Eventually, I said to him, ‘You’re angry with Dad. I understand. But that’s in the past. Don’t be unfair and overlook the present – he was the only one who stayed by your mother’s side. If you love her as much as I can see you do, then you need to honour him for everything he did and still does for her. Don’t let your heart ache one day from having been unjust.’ He didn’t respond. Just like she didn’t when I once brought up religion. But then, the other day, I saw Dad arrive – and the son opened the door for him. They... talked. He accepted him. And so, I think that may be the greatest achievement of my life: that I brought them together. That even after the mother passed, I helped reconcile them. (Interview, Marija, 18/12/21)

Just as Marija did not hesitate to intervene in the spiritual life of a dying patient – openly praying for her – she also took it upon herself to mend a fractured relationship between the patient’s ex-husband and son. The son, still hurt by his father leaving his mother for another woman, had long been living in the USA by the time his mother became terminally ill. Due to his physical absence, Marija took on much of the caregiving organisation, while the father covered the financial responsibilities. Positioned as an outsider, Marija was able to mediate between family members more effectively, offering a realistic view informed by all sides. At one point, she reflected, ‘The truth was somewhere in the middle. The mother wasn’t a sunshine either’ (Interview, Marija, 18/12/22).

At 81, Marija remained sharp and articulate – skills likely rooted in her former profession as an English teacher. Even after retirement, she stayed active in both formal and informal volunteering. Within Zagreb’s palliative care community, she was known for her thoughtful reflections and soothing voice, which made her a natural speaker on a Catholic radio station. Given her eloquence and experience, she often contributed to training sessions, reinforcing the course material with real-life examples. Our interview, which lasted over three hours, reflected her enthusiasm for sharing her extensive volunteer work. Her communication

skills not only helped her gain recognition but also served as a vital tool for supporting patients and their families. They gave her the confidence to offer spiritual care and to step into complex family dynamics when needed. One could argue that the underdevelopment of palliative care in Croatia gave Marija greater freedom to act – particularly in situations like the estranged father-son relationship, which she believed required intervention. As in the Viennese case with Michaela, maintaining family cohesion in its ‘original’ form was central. However, unlike Michaela – who saw certain rifts as irreparable – volunteers in Zagreb believed that dying presents an urgent opportunity for reconciliation. Where Michaela claimed that no crisis could undo a family’s long, complicated history, Zagreb volunteers saw the end of life precisely as the moment to bring people back together.

This willingness to directly intervene in family dynamics also reflects a more assertive approach to the role of families in caregiving. In both Vienna and Zagreb, families were seen as central to palliative care, with paid and unpaid (or volunteer) professionals positioned in a supportive role. But in Zagreb, volunteers more openly and explicitly defined the family’s responsibilities. Consider the example of Draga. At the time of our conversation, she was in her late sixties and had already been volunteering in palliative care for about a decade. When asked about the role of family in caring for terminally ill relatives, she responded:

I think the daughter of this current patient is truly exceptional. She has taken care of everything. On the mornings when she’s at work, she’s arranged for a caregiver to come for two hours to be with her mother, and then another one takes over, and so on – there’s a seamless schedule in place every day of the week. In my view, it’s a perfect example of what it means to care for one’s mother. There was a brief period – just two weeks – when she placed her mother in a nursing home. But during that time, her mother deteriorated even more. She broke her glasses without knowing how, seemed completely disoriented, and was clearly not herself. Her daughter couldn’t bear to watch her like that, so she reorganized everything and set up the current arrangement. (Interview, Draga, 14/04/22)

Unlike my participants in Vienna, Draga was not content with families simply providing *some* form of care, unless it met certain expectations. She had a clear idea of what proper care should look like. In her view, children – in this case daughters – should take on the main caregiving role. If hands-on care was not possible, they were still responsible for ensuring it was provided. Draga shared an example to illustrate how even busy women can – and should

– find ways to care for their aging parents. Unsurprisingly, her example featured a daughter, reflecting a familiar pattern of gendered caregiving roles. This mirrors findings from Štambuk and colleagues, whose research on informal eldercare in Zagreb conducted in 2013 and 2014 shows that 83% of caregivers are women (Štambuk, Rusac, and Skokandić 2019)²².

In addition to hiring paid carers, the daughter in Draga's example also relied on her – a palliative care volunteer – to help cover all care shifts. Draga was not shy about the significance of her role. Over several years, she and the patient developed a close bond. She recalled how the patient's granddaughter once expressed jealousy, joking that her grandmother was more excited to see Draga than her own family. Draga attributed this closeness to her widely recognised caregiving skills and deep commitment, which at times meant crossing professional boundaries to meet patients' emotional and practical needs. In her view, this dedication not only compensated for the daughter's limited involvement but also filled gaps left by other family members, such as the granddaughter who lived in another city. Draga also shared an anecdote about an unsuccessful attempt to place the patient in a nursing home – an experience that reinforced her strong belief that home is the best place for end-of-life care. And given her extraordinary caring skills, it could be said that this would not be possible without Draga.

To better understand Draga's views on ideal end-of-life care, it is important to consider her broader life and caregiving trajectory. During our conversation, she described how she cared for her dying mother. Upon learning of her mother's stroke, she immediately left work and travelled by bus to her hometown in Western Herzegovina. Although her siblings offered support, she proudly emphasized that she bore the primary burden of care. She even slept beside her mother to monitor her condition around the clock. As she put it, 'I was paralysed, I didn't move from her for 24 hours!' (Interview, Draga, 14/04/22). According to Draga, this constant attention extended her mother's life from the three days doctors had predicted to a full month. This deeply personal story was her response to my question about what she considered ideal care. She concluded emphatically: 'I would never forgive myself if we [the family] put her in an institution. She wouldn't get that kind of care anywhere else' (Interview, Draga, 14/04/22). Her belief that only close relatives can provide truly meaningful end-of-life care in the familiar setting of home was further reinforced by witnessing institutional care failures during her volunteer work. While she acknowledged that not everyone – especially working women and

²² See more on gendered division of labour in both Croatia and Austria in Chapter Three.

men – can provide care as she did, she insisted they must still take the lead in organising it. And she was always ready to help them do so.

Even more explicit in articulating the role of families in caring for frail relatives – this time from an institutional perspective – was Veronika, the coordinator of a palliative care team covering eastern Zagreb. Two other teams served the city’s central and western districts. These teams were established in 2016, following a 2012 pilot project at the Zagreb Centre community health centre. All three are based in local community health centres (*Dom zdravlja*). While the central and western areas each have two coordinators and (sub)teams, the eastern district, under Veronika’s leadership, operates with fewer resources. Ideally, each palliative care team should include a medical doctor, nurse, psychologist or psychiatrist, and a pastor. In reality, however, teams often consist only of a doctor and a nurse – as is the case in Veronika’s team – falling far short of the support required to address the complexity of palliative care needs. These needs frequently go beyond medical issues, and the shortage of medical staff only compounds the problem. Veronika wryly remarked, ‘Everyone has moved to Austria,’ referencing the recent wave of emigration from Croatia, particularly among healthcare professionals (see Chapter Three) (Interview, Veronika, 13/12/21).

Like other coordinators, Veronika is a nurse with a master’s degree and further specialisation in palliative care. The coordinator role offered a rare chance for nurses to hold authority over doctors, representing a step forward in professional recognition. Still, Veronika – and the other coordinators I spoke with – felt that nursing remains undervalued within the medical hierarchy. They often emphasised their dual expertise: practical experience and academic knowledge. Yet, despite her qualifications, Veronika did not see the solution to palliative care challenges in further medicalisation. Instead, she argued that informal family care should be reinforced, with families taking on even more responsibility than they already do. As she put it:

We have, I’d say, a distorted image of society, where people – probably in Austria too – believe that someone else should do everything for them. That the state must take care of everything. But the state is not the foundation of society! The family is the basic unit! And when people don’t understand that, they start demanding rights. Then you get this kind of home care that, in my opinion, sometimes goes too far. I once saw a woman who was chopping wood and receiving home care. She had recovered from a hip fracture and was already sweeping her yard... In my view, the most important thing is to teach children from the age of four or five that

they must care for their parents and grandparents. Even if we were the richest economy in the world, we couldn't afford to pay for that much care. For example, here we have highly qualified nurses bathing patients, while the family – say, the grandmother's children – stand in the hallway with their hands behind their backs saying, 'But we have the right!' And I ask, 'Why can't you wash your own mother?' They say, 'Well... she might fall if I did it. It's better when a nurse does it.' But why? (Interview, Veronika, 13/12/21)

For Veronika, one of the main challenges facing palliative care in Croatia – alongside insufficient service coverage – was what she described as a mentality shaped by overreliance on social benefits. In her view, this reliance discouraged people from taking on caregiving roles they were capable of fulfilling without professional help. She saw this as a consequence of Croatia's socialist legacy, which she felt had 'spoiled' citizens by granting excessive rights while diminishing their perceived responsibilities in social reproduction. Her reference to Austria implied that this trend of shifting care responsibilities away from the family might reflect broader European developments, where the family's central role in caregiving was increasingly eroded.

Later in our conversation, Veronika recalled similar concerns raised by Patrik, the Caritas Hospiz director introduced earlier. He worried about the rising number of people living alone and the growing difficulty of arranging care for them. Veronika agreed that more resources should be directed toward such cases – and she saw volunteers as uniquely positioned to help. Volunteers, she believed, could provide essential companionship to lonely or distressed patients, especially those without family support. She repeatedly mentioned LaVerna as a key partner in navigating complex family situations. Tomislava, the volunteer coordinator, was particularly valuable – not only for her background as a social worker but also for her ability to mobilise volunteers to provide emotional support or assist with everyday tasks, such as running errands or accompanying patients to medical appointments (Interview, Veronika, 13/12/22).

Unlike Patrik, Veronika offered a concrete solution to the problem of securing care for the lonely individuals. She was particularly concerned about the younger generation's reluctance to care for elderly or frail family members, which she traced to a widespread misconception: that the state, not the family, is the foundation of society. Her frustration stemmed largely from what she saw as the irrational use of state resources. In her view, there was no valid reason why families could not take on hands-on care responsibilities, thereby

relieving the public system and reserving highly qualified professionals for acute cases. Even the wealthiest economies, she argued, could not afford to provide all care through paid professionals. Her proposed solution was the creation of a new category of qualified caregivers – unpaid family members trained to deliver practical, everyday care.

In stressing the need to educate families, Veronika extended Draga's belief in the moral duty of relatives to care for their own. But Veronika went further, offering a practical remedy for situations in which family members felt unprepared for hands-on care: formal training in caregiving skills. This training – or rather, 're-education' – should begin in early childhood and become a core part of socialisation. If properly educated, families would feel more confident in caring for dying relatives, and more importantly, the so-called 'spoiled' mindset of entitlement and avoidance of responsibility could begin to shift. Through this process, families could reclaim their central role in caregiving. While Veronika clearly distinguished family care from that provided by formal, professional staff, her emphasis on education suggests that such caregiving is neither natural nor self-evident. If it were, there would be no need for systematic training from such an early age.

Whereas the explicit articulation of family duties in Zagreb might suggest a stronger persistence of traditional family roles compared to Vienna, this overt familialisation also – perhaps paradoxically – created space to de-essentialise family care. By framing caregiving as a skill that must be learned through training, it became something to be acquired rather than assumed. The emphatic proclamation of familial responsibilities in Zagreb partly reflected the stark lack of palliative care services, where families were often the last – and only – line of support (see Chapter Three). It may also indicate a lesser anxiety about the erosion of family care compared to Austria. For participants in Zagreb, the best way to address this concern was by actively educating families on how to care for their frail relatives.

In the Austrian context, by contrast, familial responsibilities were affirmed in a more indirect but still explicit manner. Here, the fear of losing family involvement was addressed by recognising and validating diverse family forms and contributions. While this approach allowed for more flexible interpretations of what family caregiving could entail, it left the traditional role of the family – as the primary caregiver for dying relatives – largely unquestioned. That role was subtly reinforced through policy measures and welfare benefits (see Chapter Three), continuing to shape the idealised image of the family. In both contexts, palliative care volunteers – whether in Zagreb or Vienna – played an important role in keeping this caregiving model alive. And although rarely stated outright, this role remained highly gendered. In both settings, women predominantly assumed traditional 'female' tasks such as

cooking and caregiving, reflecting the broader support for conventional gender roles in familialistic welfare regimes.

As demonstrated throughout this chapter, while the role of the family in care was similar across the two settings, it was not identical. Understanding these similarities and differences requires attention to how volunteers developed their sense of professionalism, which I term ‘para-professionalism’, as it diverges from that of paid staff, particularly in its distinct emotional orientation and the absence of financial compensation. To justify their status as para-professional caregivers, volunteers navigated contradictory processes of de- and re-essentialising care. Examining these tensions sheds light on the unique characteristics of the two familialistic welfare regimes, often classified respectively as post-socialist and conservative-corporatist. In Croatia, the family’s caregiving role was directly invoked in a somewhat disorganised and custodial manner, while Austria’s more corporately structured regime affirmed this role more subtly and with greater sensitivity to social diversity. Finally, I argued that this emerging typology of welfare regimes remains incomplete without considering the role of religion – particularly Catholicism – and the dynamics of secularisation in both countries. These influences were evident in how love and empathy were differently defined and mobilised in each context. A more thorough discussion of these broader welfare state particularities follows in the concluding chapter.

Conclusion

In this concluding chapter, I present a comprehensive synthesis of my arguments and their theoretical relevance, advancing several overarching claims. I begin with a general overview of the dissertation and its core contributions, followed by a more detailed exposition of the key findings.

This dissertation has demonstrated how palliative care volunteers in both Austria and Croatia support families in caring for their frail relatives. In doing so, volunteers help sustain a particular ideal of the family as the central caregiving unit within the national care infrastructure. This expectation aligns with the broader familialistic orientation of both welfare systems, a characteristic well-documented in welfare state typologies. However, the ways in which volunteers contribute to maintaining this image of familial care are context-specific, shedding light on the distinctive features of Austrian and Croatian familialistic regimes.

Throughout the analysis, I argued that the practice, experience, and conceptualisation of palliative volunteer work are both shaped by and shape broader global trends – such as the evolving discourse on spirituality, transformations in welfare state structures, and the mechanisms by which reproductive labour is valued under capitalism. Central to understanding volunteers' roles in these familialistic settings was an examination of volunteer professionalism – or 'para-professionalism' – which delineates their responsibilities and skills in relation to both paid professionals and informal family caregivers. This approach enabled the dissertation to make several key scholarly contributions.

First, by addressing the central research question – how palliative care volunteering is shaped by, and in turn shapes, the familialistic characteristics of the Austrian and Croatian welfare models – I contributed to welfare state literature, particularly to the typologies of continental-corporatist and post-socialist regimes. I proposed two distinct familialistic trajectories: a 'custodially disorganised' model in Croatia, and an 'orderly corporatist' model in Austria. This new typology also provided fresh insight into the meaning of volunteer work and the delineation of roles among care providers, thereby enriching scholarship on both voluntarism and professionalism. By linking volunteer professionalism to questions of remuneration and profitability, I was able to examine how the valorisation of social reproduction in capitalist systems operates in contextually specific ways. This analysis positions the dissertation within ongoing feminist debates on reproductive labour. Finally, the study contributes to the sociology of religion by illuminating how secular-religious tensions manifest in two nominally Catholic societies.

In the first analytical chapter – Chapter Three – I contextualised the development and organisation of palliative care volunteering within the Austrian and Croatian health and social care systems. Compared to other European countries, both systems are characterised by medicalisation and fragmentation, which hinders the full implementation of the holistic approach to death and dying that palliative care advocates. Austria, with one of the highest GDPs in the EU, has been able to partially overcome these challenges through substantial investment in its health and social care sectors. Croatia, by contrast, lags significantly behind – not only Austria but also other Central and Eastern European (CEE) countries – in terms of palliative care service coverage. I attributed this disparity not only to Croatia’s weaker economic development but also to the underdevelopment of its third sector, and voluntarism in particular. Volunteers have played a crucial role in shaping palliative care, and their limited presence in Croatia reflects the legacy of Yugoslav socialism. Specifically, the heritage of self-management and decentralisation in former Yugoslav republics fostered resistance within healthcare institutions to collaboration with non-state actors, including volunteers.

Paradoxically, however, this same legacy facilitated the implementation of ‘The New Strategic Plan for Palliative Care’ in Croatia, which significantly expanded palliative services in the country through their professionalisation and institutionalisation. The plan capitalised on the existing infrastructure – particularly the hierarchical and medicalised healthcare system – which traditionally excludes volunteers and other non-medical actors. Rather than dismantling established hierarchies, the plan reinforced them, consolidating the dominance of medical professionals. This reflects the custodial nature of the Croatian welfare state, which tends to control and exclude rather than cooperate with volunteer initiatives.

This trajectory contrasts sharply with Austria’s approach to palliative care, where volunteering was integrated from the outset. Over two decades ago, Austria established regulatory frameworks for volunteers alongside other palliative care personnel, including formal curricula for volunteer training and clearly defined roles. In Croatia, conversely, a national curriculum for volunteer education is still lacking. Austria’s more effective integration of volunteers reflects its long-standing tradition of close collaboration between government and non-profit sectors – a hallmark of corporatist welfare regimes. Nevertheless, despite its official recognition, palliative care volunteering in Austria continues to rely heavily on donations. This reliance reveals both a robust donation culture and the growing fissures within Austria’s fragmented corporatism. Thus, while Croatia’s fragmentation led to the marginalisation of volunteers, Austria’s fragmentation resulted in a lack of stable funding.

Throughout this dissertation, I have argued that drawing conclusions about volunteer professionalism based solely on institutional recognition is overly simplistic. In both contexts studied, volunteers were ascribed a specific form of professionalism – ‘para-professionalism’ – which differs from that of paid professionals, particularly in the absence of financial compensation and the use of distinct emotional practices. However, the form this para-professional status took, and the way volunteers came to embody it, varied between the two settings. In Chapter Six, I demonstrated that, in the absence of formal, state-supported training, volunteers in Zagreb turn to alternative sources of knowledge – such as personal caregiving experience and the Catholic ethos of their association. Within this framework, they develop their own conceptions of love as a marker of professional identity. Rather than associating love solely with the private sphere, they use it to distinguish their work from personal relationships. Yet, this framing risks reinforcing essentialist notions of unpaid care, ultimately reproducing the very private/familial boundaries it seeks to transcend.

In contrast, Viennese volunteers achieve para-professional status through formal training, which positions them as equal members of the palliative care team. Nevertheless, they remain distinct from other professionals: they are unpaid contributors, whose most valued input is their capacity for empathy. While other aspects of their role are formally codified in official documents, empathy itself remains undefined. This ambiguity has allowed certain interpretations – particularly phenomenological and humanitarian conceptions introduced during training – to become dominant, albeit implicitly. Unlike love in the Zagreb context, which demarcates boundaries and asserts a professional identity, empathy in Vienna is shaped – perhaps even tamed – by professional norms.

Despite these different paths to volunteer professionalisation, both contexts share a fundamental assumption: that the family is the primary caregiver. Volunteers play a central role in sustaining this ideal. In Vienna, their role involves supporting and affirming families, with an emphasis on flexibility and acknowledgement of diverse caregiving arrangements. In Zagreb, by contrast, the weaker care infrastructure leads to a more interventionist approach. Families are often seen as requiring guidance, especially concerning their caregiving responsibilities. Paradoxically, this educational function can challenge traditional family roles by de-essentialising them, while in Vienna, the absence of explicit discourse reinforces these roles as implicit norms.

By unpacking these tensions, I highlight the distinctive features of two familialistic welfare regimes, typically categorised as post-socialist (Croatia) and conservative-corporatist (Austria). In Croatia, the family’s caregiving role is overtly invoked in a manner that is both

disorganised and custodial. In Austria, this role is reaffirmed more subtly, through a corporately structured system that is more attuned to social diversity. In both settings, women continue to perform traditionally ‘feminine’ tasks such as cooking and caregiving, underscoring the persistence of conventional gender roles within familialistic welfare regimes.

In Chapter Two, I demonstrated that gender bias – like familialism – is not maintained in the same way, nor does it stem from the same sources, in Croatia and Austria. In Austria, for example, the traditional gendered division of labour associated with conservative-corporatist welfare states has recently been softened through significant investments in institutional childcare, aligning with EU recommendations on work-life balance. At the same time, however, Austria maintains various policies and benefits that support the role of women as secondary earners and primary caregivers. This contradiction is reflected in one of the highest rates of part-time employment for women and one of the largest gender pay gaps in the EU (Österle and Heitzmann 2020).

Croatia, by contrast, exhibits markedly different labour participation patterns, with part-time work being rare and the gender employment gap among the smallest in the EU (Dobrotić 2020). The persistence of traditional gender roles there can be traced to how socialism addressed gender inequality, where gender roles did not seem to be much questioned (Pascall and Kwak 2010). As in other Central and Eastern European (CEE) countries, Croatia experienced a process of re-traditionalisation during the post-socialist transition, driven by pronatalist rhetoric – further intensified by the wartime context. However, familialistic measures have never been fully implemented in Croatia, whether due to path dependency, insufficient material conditions, external pressures (from the EU or international financial agencies), or a combination of these factors (Dobrotić 2020).

Building on this contextual specificity, in Chapter Three I argued that the association of reproductive labour with women is not the cause of its low or absent remuneration but rather its justification. The true cause of the ‘unpayability’ of care work lies in its low profitability, a phenomenon known as ‘cost disease’ (Battistoni 2024). For example, volunteers help mitigate the effects of cost disease in palliative care by offering their time – a resource not subject to the same cost-escalating mechanisms as paid labour. Paradoxically, this same ‘free’ time becomes a basis for quantifying and economically valorising volunteer work. By explaining the low valuation of care work through the material characteristics of its labour processes – rather than through symbolic representations or the identities of workers – I was able to move beyond functionalist and essentialist frameworks. This shift allowed for a more precise analysis of the systemic dynamics at play, particularly the valorisation mechanisms of social reproduction

under capitalism, and how they are embedded in the specific working conditions of the palliative care sectors in Austria and Croatia (Battistoni 2024, 10).

While the feminisation of palliative care volunteering serves as one justification for its unpaid nature, another is its ‘humanisation’ (Altman 2020). In both research contexts, volunteer work was framed as expressing inherently human qualities – such as warmth and empathy – that are thought to be possible only outside the realms of money and profession. At times, this humanisation becomes a means of resisting the logic of commodification altogether.

The chapter revealed the complex and layered relationship between money (or profitability more broadly) and volunteering. On the one hand, volunteer work compensates for the structural unprofitability of palliative care by making it more financially sustainable. On the other hand, it serves as a form of resistance to the commodification of care. Central to understanding this dual role is how volunteer professionalism is defined – not only in relation to paid professionals but, crucially, in relation to family caregivers. Volunteers, unmotivated by money and unbound by time constraints, help create a family-like atmosphere in the absence of actual family members. In this way, they support both the relatives of patients and a normative ideal of care anchored in familial values.

Although volunteers are often engaged to help create a family-like environment, their significance lies precisely in the ways they differ from family caregivers, as I argued in Chapter Five. Coming from outside the patients’ circles of relatives and friends, volunteers are uniquely positioned to engage in conversations that patients may not feel comfortable having with loved ones. These often involve the spiritual dimensions of care, such as existential questions or religious rituals.

Because volunteers typically spend limited time with patients and lack a shared personal history, they can approach patients more easily and without judgment. For many of my research participants, this ability to accept people ‘as they are’ represented the ideal expression of love – specifically, a form of ‘love for people’ that is central to the ethos of palliative care volunteering. This form of acceptance goes beyond social markers like gender, ethnicity, religiosity, or class. It also encompasses an unflinching recognition of patients’ physical and mental suffering as they near the end of life.

While a nonjudgmental attitude has long been a cornerstone of palliative care since the hospice movement’s inception, I demonstrated that such unconditional acceptance also reflects a key aspect of Catholic teaching – particularly the belief in divine incarnation within every human being, especially the vulnerable and suffering. In this sense, palliative care volunteers embody what Muehlebach describes as the ‘loving, compassionate subject’ central to

Catholicised neoliberalism: a moral disposition that merges Christian compassion with neoliberal ideals of civic engagement and individual responsibility (Muehlebach 2012; 2013).

This is not to suggest that all research participants perceived their work in explicitly Catholic terms. Understanding how volunteers conceptualise the spiritual dimensions of their work requires attention to national Catholic contexts. For example, Zagreb volunteers tended to make more direct references to religious aspirations than their Viennese counterparts – something I attribute to differing levels of secularisation and the institutionalisation of volunteer work in the two settings. These findings are consistent with scholarship linking higher levels of modernisation and economic prosperity with increased political and social secularisation. In such contexts, religious organisations often gain legitimacy not through religious identity *per se*, but through the quality and effectiveness of their services (Putnam 2000).

I complicated this modernisation thesis by showing that Catholicism remains embedded in volunteers' practices – not only through overt religious references, but also in their compassion with the suffering and their commitment to nonjudgmental tolerance. At the same time, I argued that volunteers' conceptualisations of their work reflect a broader 'spiritual turn' (Houtman and Aupers 2007; Watts 2022), marked by a growing emphasis on personal wellbeing and inner development. For many participants, regardless of religious or national background, engaging with the dying became a form of self-investment – one that contributed profoundly to their emotional and spiritual growth.

Situating palliative care volunteering within the broader spiritual landscapes of the Global North enabled me to explore how larger cultural and spiritual trends shape volunteer practices. At the same time, these practices reflect a distinctly Catholic inflection, emerging from the secular-religious interplay specific to two nominally Catholic European countries. The form this inflection takes is deeply intertwined with the institutionalisation and para-professionalisation of palliative care volunteering – and with how volunteers are positioned relative to family caregivers.

To conclude, this dissertation has demonstrated that palliative care volunteering – though rarely used as the entry point for analysing familialistic welfare regimes – offers a powerful perspective for developing new typologies and understandings of familism. More broadly, this study of palliative care volunteers provides critical insights into systemic dynamics shaping contemporary social orders. One such dynamic is the ongoing post-socialist transition, which – despite unfolding over three decades on European soil – continues to influence patterns of capital flow and welfare state development. Another is the contradictory

logic through which social reproduction is valorised under capitalism, where its value is defined through, against, and in the absence of money and profitability. Closely related to the issue is how boundaries are drawn between different forms of labour and personal identities – particularly those related to gender, profession, and family. This is crucial for understanding what constitutes ‘work.’ Defining the meaning of work becomes especially complex when the labour in question is immaterial and deeply tied to the worker’s own self-development, as in the case of self-investment practices. It is precisely this immateriality that has allowed for a mapping of the religious and spiritual landscape of late modernity.

Although death and dying have begun to receive attention within debates on boundary work, they have yet to be fully integrated into feminist and political economy discussions of the labours of social reproduction, with all the specificities that end-of-life care entails. This dissertation offers one modest contribution toward advancing that conversation.

Appendix: List of Interviewees

	Name	Position	Organisation	Place (of the interview)	Date
1.	Tomislava	Volunteer coordinator	LaVerna	Zagreb	08/12/2021
2.	Veronika	Palliative team coordinator	Healthcare Centre Zagreb-East	Zagreb	13/12/2021
3.	Ivana	Volunteer	LaVerna	Zagreb	16/12/2021
4.	Marija	Volunteer	LaVerna	Zagreb	18/12/2021
5.	Sanja	Palliative team coordinator	Healthcare Centre Zagreb-West	Zagreb	20/12/2021
6.	Irena	Palliative team coordinator	Healthcare Centre Zagreb-West	Zagreb	20/12/2021
7.	Jasna	Volunteer	LaVerna	Zagreb	20/12/2021
8.	Slavica	Volunteer	LaVerna	Zagreb	07/01/2022
9.	Vesna	Volunteer	LaVerna	Zagreb	18/01/2022
10.	Stjepan	Volunteer	LaVerna	Zagreb	20/01/2022
11.	Ljubica	Family caregiver	LaVerna	Zagreb	21/01/2022.
12.	Marta	Family caregiver	LaVerna	Zagreb	21/01/2022.
13.	Nevenka	Volunteer	LaVerna	Zagreb	22/01/2022
14.	Iva	Volunteer	LaVerna	Zagreb	22/02/2022
15.	Dragana	Creator of the National Strategic Plan for Palliative Care, Palliative team coordinator	Healthcare Centre of Međimurje county	Prelog, Croatia	12/03/2022
16.	Mirjana	President	LaVerna	Zagreb	15/03/2022
17.	Gordana	Family caregiver	LaVerna	Zagreb	21/03/2022
18.	Marko	Creator of the National Strategic Plan for Palliative Care	Andrija Štampar School of Public Health	Zagreb	28/03/2022
19.	Mila	The nurse in the first mobile palliative team	Croatian Association of Hospice Friends	Zagreb	11/04/2022
20.	Lana	President	Volunteer Centre Zagreb	Zagreb	12/04/2022
21.	Svijetlana	Palliative team coordinator	Healthcare centre of Varaždin county	Zagreb	13/04/2022

22.	Draga	Volunteer	LaVerna	Zagreb	14/04/2022
23.	Micika	Creator of the National Strategic Plan for Palliative Care	Head of the Palliative Care Centre, University of Rijeka	Online via Zoom	18/04/2022
24.	Jelena	Volunteer	LaVerna	Zagreb	21/04/2022
25.	Selma	President	Croatian Centre for Volunteer Development	Online via zoom	26/04/2022
26.	Dora	Family caregiver	LaVerna	Zagreb	27/04/2022
27.	Dubravka	Volunteer	LaVerna	Zagreb	05/05/2022
28.	Božena	Volunteer	LaVerna	Zagreb	23/05/2022
29.	Darko	Palliative medical doctor	Healthcare centre Zagreb-Centre	Zagreb	26/05/2022
30.	Tamara	Volunteer	Caritas Hospiz	Vienna	27/06/2022
31.	Johanna	Volunteer	Caritas Hospiz	Vienna	28/06/2022
32.	Thomas	Volunteer	Caritas Hospiz	Vienna	04/07/2022
33.	Ingrid	Volunteer	Caritas Hospiz	Vienna	19/07/2022
34.	Sabine	Volunteer	Caritas Hospiz	Vienna	22/07/2022
35.	Gerhard	Volunteer	Caritas Hospiz	Vienna	22/07/2022
36.	Katharina	Volunteer	Caritas Hospiz	Vienna	10/08/2022
37.	Michaela	Volunteer coordinator	Caritas Hospiz	Vienna	11/10/2022
38.	Jasmina	Volunteer	Caritas Hospiz	Vienna	24/10/2022
39.	Patrik	President	Caritas Hospiz	Vienna	19/11/2022
40.	Tobias	President	Österreichische Palliativgesellschaft (Austrian Palliative Society)	Vienna	21/11/2022
41.	Sandra	Managing director	Hospiz Österreich	Vienna	24/11/2022
42.	Sara	Volunteer	Caritas Socialis	Vienna	30/11/2022
43.	Maria	Head of Hospice and Palliative Care for Children, Adolescents, and Young Adults	Hospiz Österreich	Vienna	06/12/2022
44.	Andrea	Volunteer coordinator	Caritas Socialis	Vienna	20/12/2022
45.	Corina	Family caregiver	-	Vienna	21/01/2023
46.	Sophie	Volunteer	Caritas Hospiz	Vienna	24/07/2023

Bibliography

The links are valid as of 29/06/2025.

- Allan, Kori. 2019. "Volunteering as Hope Labour: The Potential Value of Unpaid Work Experience for the Un- and under-Employed." *Culture, Theory and Critique* 60 (1): 66–83. <https://doi.org/10.1080/14735784.2018.1548300>.
- Altglas, Véronique. 2021. "French Cult Controversy at the Turn of the New Millennium: Escalation, Dissensions and New Forms of Mobilisations across the Battlefield1." In *The Centrality of Religion in Social Life*, edited by Eileen Barker, 1st ed., 55–68. London: Routledge. <https://doi.org/10.4324/9781315240831-6>.
- Altman, Tess. 2020. "Making the State Blush: Humanizing Relations in an Australian NGO Campaign for People Seeking Asylum." *Social Analysis* 64 (1). <https://doi.org/10.3167/sa.2020.640101>.
- Ammerman, Nancy T. 2013. "Spiritual But Not Religious? Beyond Binary Choices in the Study of Religion." *Journal for the Scientific Study of Religion* 52 (2): 258–78. <https://doi.org/10.1111/jssr.12024>.
- . 2014. "Finding Religion in Everyday Life." *Sociology of Religion* 75 (2): 189–207. <https://doi.org/10.1093/socrel/sru013>.
- Andersen, Ditte, Jonas Toubøl, Sine Kirkegaard, and Hjalmar Bang Carlsen. 2022. "Imposed Volunteering: Gender and Caring Responsibilities during the COVID-19 Lockdown." *The Sociological Review* 70 (1): 39–56. <https://doi.org/10.1177/003802612111052396>.
- Anderson, Sherry. 2024. Volunteers don't get paid, not because they're worthless, but because they're priceless, issued May 23, 2024. <https://volunteero.org/knowledge-center/volunteering-quotes>.
- Andrews, Naomi J. 2020. "THE ROMANTIC SOCIALIST ORIGINS OF HUMANITARIANISM." *Modern Intellectual History* 17 (3): 737–68. <https://doi.org/10.1017/S1479244318000550>.
- Appadurai, Arjun. 1988. *The Social Life of Things: Commodities in Cultural Perspective*. Cambridge: Cambridge University Press.
- Arias-Casais, Natalia, Eduardo Garralda, John Y Rhee, Liliana De-Lima, Juan José Pons, David Clark, Jeroen Hasselaar, Julie Ling, Daniela Mosoiu, and Carlos Centeno. 2019. *EAPC Atlas of Palliative Care in Europe 2019*. Vilvoorde: EAPC Press. Vilvoorde: EAPC Press.
- Ariza-Montes, Antonio, José Luis Roldán-Salgueiro, and Antonio Leal-Rodríguez. 2015. "Employee and Volunteer: An Unlikely Cocktail?" *Nonprofit Management and Leadership* 25 (3): 255–68. <https://doi.org/10.1002/nml.21121>.
- Arruzza, Cinzia, Tithi Bhattacharya, and Nancy Fraser. 2019. *Feminism for the 99%*. New York: Verso.
- Aspalter, Christian, ed. 2017. *The Routledge International Handbook to Welfare State Systems*. London and New York: Routledge. <https://doi.org/10.4324/9781315613758>.

- Bach, Stephen, Ian Kessler, and Paul Heron. 2007. "The Consequences of Assistant Roles in the Public Services: Degradation or Empowerment?" *Human Relations* 60 (9): 1267–92. <https://doi.org/10.1177/0018726707082848>.
- Bachner, Florian, Julia Bobek, Katharina Habimana, Joy Ladurner, Lena Lepuschütz, Herwig Lepuschütz, Lukas Rainer, et al., eds. 2018. "Austria: Health System Review 2018." *Health Systems in Transition*. European Observatory on Health Systems and Policies.
- Bäckström, Anders, Grace Davie, Ninna Edgardh, and Per Pettersson, eds. 2013. *Welfare and Religion in 21st Century Europe: Volume 2 Gendered, Religious and Social Change*. *Welfare and Religion in 21st Century Europe: Volume 2 Gendered, Religious and Social Change*. Vol. 2. Farnham, Surrey: Ashgate. <https://doi.org/10.1080/13537903.2012.675771>.
- Badelt, Christoph, and August Österle. 2001. *Grundzüge Der Sozialpolitik. Spezieller Teil: Sozialpolitik in Österreich*. Wien: MANZ Verlag.
- Bakker, Isabella. 2007. "Social Reproduction and the Constitution of a Gendered Political Economy." *New Political Economy* 12 (4): 541–56. <https://doi.org/10.1080/13563460701661561>.
- Baldock, Cora Vellekoop. 1990. *Volunteers in Welfare*. Sydney: Allan & Unwin.
- Bambra, Claire. 2007. "Going beyond The Three Worlds of Welfare Capitalism: Regime Theory and Public Health Research." *Journal of Epidemiology & Community Health* 61 (12): 1098–1102. <https://doi.org/10.1136/jech.2007.064295>.
- Barca, Stefania. 2020. *Forces of Reproduction*. Cambridge: Cambridge University Press.
- Barnett, Michael. 2011. *Empire of Humanity: A History of Humanitarianism*. Ithaca, NY: Cornell University Press.
- Barnett, Michael, and Thomas G. Weiss. 2008. *Humanitarianism in Question: Politics, Power, Ethics*. Ithaca, NY: Cornell University Press.
- Battistoni, Alyssa. 2024. "Ideology at Work? Rethinking Reproduction." *American Political Science Review*, October, 1–14. <https://doi.org/10.1017/S0003055424000868>.
- Baumol, William J. 2012. *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't*. New Haven, CT: Yale University Press.
- Baumol, William J. 1967. "Macroeconomics of Unbalanced Growth." *The American Economic Review* 57 (3): 415–26.
- BBC Radio 4. 1995. "Dame Cicely Saunders." <https://www.bbc.co.uk/programmes/p0093qyn>.
- Béland, Daniel, Stephan Leibfried, Kimberly J. Morgan, Herbert Obinger, and Christopher Pierson, eds. 2021. *The Oxford Handbook of the Welfare State*. 2nd ed. Oxford: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780198828389.001.0001>.
- Beyer, Peter. 1994. *Religion and Globalization*. London: Sage Publications.
- Bloch, Maurice, and Jonathan Parry. 1989. "Introduction: Money and the Morality of Exchange." In *Money and the Morality of Exchange*, edited by Maurice Bloch and Jonathan Parry, 1–32. Cambridge: Cambridge University Press.

- Block, Lieve Van den, Lara Pivodic, Koen Pardon, Gé Donker, Guido Miccinesi, Sarah Moreels, Tomas Vega Alonso, Luc Deliens, and Bregje Onwuteaka-Philipsen. 2015. "Transitions between Health Care Settings in the Final Three Months of Life in Four EU Countries." *The European Journal of Public Health* 25 (4): 569–75. <https://doi.org/10.1093/eurpub/ckv039>.
- Blum, Sonja. 2014. "No Need to Reinvent the Wheel: Family Policy Transfers in Germany and Austria." *Policy Studies* 35 (4): 357–76. <https://doi.org/10.1080/01442872.2013.875153>.
- Blum, Sonja, Lenka Formánková, and Ivana Dobrotić. 2014. "Family Policies in 'Hybrid' Welfare States after the Crisis: Pathways between Policy Expansion and Retrenchment." *Social Policy & Administration* 48 (4): 468–91. <https://doi.org/10.1111/spol.12071>.
- Bochove, Marianne van, and Lieke Oldenhof. 2020. "Institutional Work in Changing Public Service Organizations: The Interplay Between Professionalization Strategies of Non-Elite Actors." *Administration and Society* 52 (1). <https://doi.org/10.1177/0095399718786880>.
- Bochove, Marianne van, Evelien Tonkens, Loes Verplanke, and Suzanne Roggeveen. 2018. "Reconstructing the Professional Domain: Boundary Work of Professionals and Volunteers in the Context of Social Service Reform." *Current Sociology* 66 (3): 392. <https://doi.org/10.1177/0011392116677300>.
- Bode, Ingo, and Taco Brandsen. 2014. "State–Third Sector Partnerships: A Short Overview of Key Issues in the Debate." *Public Management Review*. <https://doi.org/10.1080/14719037.2014.957344>.
- Bonoli, Giuliano. 1997. "Classifying Welfare States: A Two-Dimension Approach." *Journal of Social Policy* 26 (3): 351–72. <https://doi.org/10.1017/S0047279497005059>.
- Bonoli, Giuliano, and David Natali, eds. 2012. *The Politics of the New Welfare State*. Oxford: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199645244.001.0001>.
- Bornstein, Erica. 2012. *Disquieting Gift s: Humanitarianism in New Delhi*. Stanford, CA: Stanford University Press.
- Bornstein Erica, and Redfield Peter, eds. 2010. *Forces of Compassion: Humanitarianism between Ethics and Politics*. Santa Fe: School for Advanced Research Press.
- Brante, Thomas. 2011. "Professions as Science-Based Occupations." *Professions and Professionalism* 1 (1). <https://doi.org/10.7577/pp.v1i1.147>.
- Brković, Čarna. 2023. "Vernacular Humanitarianisms." *Social Anthropology/Anthropologie Sociale* 31 (1): 1–13. <https://doi.org/10.3167/saas.2023.310102>.
- . 2026. *Realigning Humanitarianism in the Balkans. From Cold War Politics to Neoliberal Ethics*. Indiana University Press.
- Brown, Mary V. 2011. "How They Cope." *American Journal of Hospice and Palliative Medicine*® 28 (6): 398–402. <https://doi.org/10.1177/1049909110393946>.
- Brown, Wendy. 2016. "Sacrificial Citizenship: Neoliberalism, Human Capital, and Austerity Politics." *Constellations* 23 (1): 3–14. <https://doi.org/10.1111/1467-8675.12166>.
- Budig, Michele, Joya Misra, and Irene Boeckmann. 2012. "The Motherhood Penalty in

- Cross-National Perspective: The Importance of Work-Family Policies and Cultural Attitudes.” *Social Politics: International Studies in Gender, State & Society* 19 (2): 163–93. <https://doi.org/10.1093/sp/jxs006>.
- Bundesministerium für Arbeit, Soziales, Gesundheit, Pflege und Konsumentenschutz. 2025. “Organisation Des Bundesministeriums Für Arbeit, Soziales, Gesundheit, Pflege Und Konsumentenschutz.” April 10, 2025. <https://www.sozialministerium.gv.at/Ministerium/Organisation.html>.
- Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz. 2019. “3. Bericht Zum Freiwilligen Engagement in Österreich. Freiwilligenbericht 2019.” Wien.
- Burcar, Lilijana. 2020. *Restauracija Kapitalizma: Repatrijarhalizacija Društva*. Zagreb: Institut za etnologiju i folkloristiku.
- Butler, Judith. 1997. “Merely Cultural.” *Social Text*, no. 52/53: 265–77. <https://doi.org/10.2307/466744>.
- Butler, Judith, and Joan W. Scott, eds. 2013. *Feminists Theorize the Political*. New York: Routledge. <https://doi.org/10.4324/9780203723999>.
- Caritas aktiv. 2023. “Professionalität Und Empathie.” Wien: PfarrCaritas.
- Caritas Hospiz. n.d. “Wichtige Grundinfos Für Ehrenamtliche.” Wien: Caritas Erzdiözese Wien.
- Casanova, José. 1994. *Public Religions in the Modern World*. Chicago: University of Chicago Press. <https://doi.org/10.7208/chicago/9780226190204.001.0001>.
- . 2007. “Rethinking Secularization: A Global Comparative Perspective.” In *Religion, Globalization, and Culture*, edited by Peter Beyer and Lori G. Beaman, 101–20. BRILL. <https://doi.org/10.1163/ej.9789004154070.i-608.39>.
- . 2013. “The Two Dimensions, Temporal and Spatial, of the Secular.” In *Secular and Sacred? The Scandinavian Case of Religion in Human Rights, Law, and Public Space*, edited by Trygve Wyller, Rosemarie van den Breemer, and José Casanova, 22–35. Göttingen: Vandenhoeck & Ruprecht.
- Castles, Francis G. 2004. *The Future of the Welfare State*. Oxford: Oxford University PressOxford. <https://doi.org/10.1093/0199270171.001.0001>.
- Charities Aid Foundation. 2022. “World Giving Index 2022. A Global View of Giving Trends.”
- Charles, Nickie, and Emma James. 2003. “The Gender Dimensions of Job Insecurity in a Local Labour Market.” *Work, Employment and Society* 17 (3): 531–52. <https://doi.org/10.1177/09500170030173007>.
- Cheney, George, Dean Ritz, Daniel J. Lair, and Brenden E. Kendall. 2010. *Just a Job? Communication, Ethics and Professional Life*. Oxford: Oxford University Press.
- Chung, Haejoo, and Carles Muntaner. 2007. “Welfare State Matters: A Typological Multilevel Analysis of Wealthy Countries.” *Health Policy* 80 (2): 328–39. <https://doi.org/10.1016/j.healthpol.2006.03.004>.
- Clark, David. 2002. “Between Hope and Acceptance: The Medicalisation of Dying.” *BMJ* 324 (7342): 905–7. <https://doi.org/10.1136/bmj.324.7342.905>.

- Clary, E. Gil, Robert D. Ridge, Arthur A. Stukas, Mark Snyder, John Copeland, Julie Haugen, and Peter Miene. 1998. "Understanding and Assessing the Motivations of Volunteers: A Functional Approach." *Journal of Personality and Social Psychology* 74 (6): 1516–30. <https://doi.org/10.1037/0022-3514.74.6.1516>.
- Claxton-Oldfield, Stephen. 2015. "Got Volunteers? The Selection, Training, Roles, and Impact of Hospice Palliative Care Volunteers in Canada's Community-Based Volunteer Programs." *Home Health Care Management & Practice* 27 (1): 36–40. <https://doi.org/10.1177/1084822314535089>.
- Cloke, Paul, Sarah Johnsen, and Jon May. 2007. "Ethical Citizenship? Volunteers and the Ethics of Providing Services for Homeless People." *Geoforum* 38 (6). <https://doi.org/10.1016/j.geoforum.2006.07.005>.
- Cnaan, Ram A., Femida Handy, and Margaret Wadsworth. 1996. "Defining Who Is a Volunteer: Conceptual and Empirical Considerations." *Nonprofit and Voluntary Sector Quarterly* 25 (3): 364–83. <https://doi.org/10.1177/0899764096253006>.
- Cohen, Rachel Lara. 2011. "Time, Space and Touch at Work: Body Work and Labour Process (Re)Organisation." *Sociology of Health & Illness* 33 (2): 189–205. <https://doi.org/10.1111/j.1467-9566.2010.01306.x>.
- Cohen, Rachel Lara, and Carol Wolkowitz. 2018. "The Feminization of Body Work." *Gender, Work & Organization* 25 (1): 42–62. <https://doi.org/10.1111/gwao.12186>.
- Comaroff, Jean, and John L. Comaroff. 2000. "Millennial Capitalism: First Thoughts on a Second Coming." *Public Culture* 12 (2): 291–343. <https://doi.org/10.1215/08992363-12-2-291>.
- Connor, Stephen R. 2020. "Global Atlas of Palliative Care." London.
- Connor, Stephen R., and Elizabeth Gwyther. 2018. "The Worldwide Hospice Palliative Care Alliance." *Journal of Pain and Symptom Management* 55 (2): S112–16. <https://doi.org/10.1016/j.jpainsymman.2017.03.020>.
- Cook, Linda J. 2010. "Eastern Europe and Russia." In *The Oxford Handbook of the Welfare State*, edited by Frances Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger, and Christopher Pierson, 1st ed., 671–88. Oxford: Oxford University Press.
- . 2015. "New Winds of Social Policy in the East." *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 26 (6): 2330–50. <https://doi.org/10.1007/s11266-015-9642-7>.
- Cook, Linda J., and Tomasz Inglot. 2021. "Central and Eastern European Countries." In *The Oxford Handbook of the Welfare State*, edited by Daniel Béland, Stephan Leibfried, Kimberly J. Morgan, Herbert Obinger, and Christopher Pierson, 881–98. Oxford: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780198828389.013.50>.
- Cour, Anders la. 2019. "The Management Quest for Authentic Relationships in Voluntary Social Care." *Journal of Civil Society* 15 (1): 1–17. <https://doi.org/10.1080/17448689.2018.1551864>.
- Dalla Costa, Mariarosa, and Selma James. 1975. *The Power of Women and the Subversion of the Community*. 3rd ed. Bristol: Falling Wall Press.
- Damon, Frederick H. 1980. "The Kula and Generalised Exchange: Considering Some

- Unconsidered Aspects of the Elementary Structures of Kinship.” *Man* 15 (2): 267–92. <https://doi.org/10.2307/2801671>.
- Davie, Grace. 2017. “Afterword.” In *Religion and Welfare in Europe*, edited by Lina Molokotos-Liederman, 291–98. Bristol: Bristol University Press. <https://doi.org/10.2307/j.ctt22p7k5k.18>.
- Dawid, Evelyn, and Karin Heitzmann. 2015. *Österreichische Nichtregierungsorganisationen in Der Armutsbekämpfung: Entwicklungen, Leistungen, Lücken. Endbericht*. Wien: BMASK.
- Dean, Jon. 2015. “Volunteering, the Market, and Neoliberalism.” *People, Place and Policy Online* 9 (2): 139–48. <https://doi.org/10.3351/ppp.0009.0002.0005>.
- Dean, Mitchell. 2010. *Governmentality: Power and Rule in Modern Society*. 2nd ed. Sage Publications.
- Dein, Simon, and Syed Qamar Abbas. 2005. “The Stresses of Volunteering in a Hospice: A Qualitative Study.” *Palliative Medicine* 19 (1): 58–64. <https://doi.org/10.1191/0269216305pm969oa>.
- Denéchère, Yves. 2014. “Eastern Europe: A New Field of Humanitarian History.” *Eastern Journal of Euro- Pean Studies* 5: 5–11.
- Dent, Eric B., M. Eileen Higgins, and Deborah M. Wharff. 2005. “Spirituality and Leadership: An Empirical Review of Definitions, Distinctions, and Embedded Assumptions.” *The Leadership Quarterly* 16 (5): 625–53. <https://doi.org/10.1016/j.leaqua.2005.07.002>.
- Dent, Mike. 2006. “Patient Choice and Medicine in Health Care: Responsibilization, Governance and Proto-Professionalization.” *Public Management Review* 8 (3). <https://doi.org/10.1080/14719030600853360>.
- Dobbelaere, Karel. 2009. “China Challenges Secularization Theory.” *Social Compass* 56 (3): 362–70. <https://doi.org/10.1177/0037768609338758>.
- Dobrotić, Ivana. 2012. “Dejavnik Politik Usklajevanja Plačane Dela in Družinskih Obveznosti v Posocialističnih Državah.” Ljubljana: Sveučilište u Ljubljani.
- . 2015. “Politike Usklađivanja Obiteljskih Obaveza i Plaćenog Rada i Položaj Roditelja Na Tržištu Rada.” *Revija Za Socijalnu Politiku* 22 (3): 353–74. <https://doi.org/10.3935/rsp.v22i3.1258>.
- . 2016. “Crisis and Croatian Welfare State: A New Opportunity for Welfare State Retrenchment?” In *Challenges to European Welfare Systems*, edited by Schubert Klaus, Paloma de Villota, and Johanna Kuhlmann, 301–24. Cham: Springer International Publishing. https://doi.org/10.1007/978-3-319-07680-5_14.
- . 2018. “Ambivalent Character of Leave Policies Development in Croatia: Between Pronatalist and Gender Equality Agenda.” *Revista Del Ministerio de Empleo y Seguridad Social* 136.
- . 2019. “Politike Usklađivanja Obiteljskih Obaveza i Plaćenog Rada Hrvatske u Kompartivnoj Perspektivi.” *Socijalno-Demografska Reprodukcijska Hrvatske*, 59–99.
- . 2020. “The Croatian Welfare System: A Lack of Coherent Policy Paradigm

- Followed by Inconsistent Reforms?” In *Routledge Handbook of European Welfare Systems*, edited by Sonja Blum, Johanna Kuhlmann, and Klaus Schubert, 2nd ed. London, New York: Routledge.
- Dobrotić, Ivana, Teo Matković, and Siniša Zrinščak. 2013. “Gender Equality Policies and Practices in Croatia – The Interplay of Transition and Late Europeanization.” *Social Policy & Administration* 47 (2): 218–40. <https://doi.org/10.1111/spol.12016>.
- Dowling, Emma. 2024. “The Boundary-Work of Volunteering and the Value of Unwaged Work in the Dual Crisis of Care.” *The Sociological Review* 00 (0): 1–19. <https://doi.org/10.1177/00380261241305259>.
- Dzakula, Aleksandar. 2005. “Health Care Based on Priorities Is Lost in Decentralisation.” *BMJ* 331 (7510): 235.1. <https://doi.org/10.1136/bmj.331.7510.235>.
- Džakula, Aleksandar, Dorja Vočanec, Maja Banadinović, Maja Vajagić, Karmen Lončarek, Iva Lukačević Lovrenčić, Dagmar Radin, and Bernd Rechel, eds. 2021. “Croatia: Health System Review 2021.” *Health Systems in Transition*. European Observatory on Health Systems and Policies.
- Ehrenreich, Barbara, and Arlie Russell Hochschild, eds. 2003. *Global Woman*. London: Granta Books.
- Einolf, Christopher, and Susan M. Chambré. 2011. “Who Volunteers? Constructing a Hybrid Theory.” *International Journal of Nonprofit and Voluntary Sector Marketing* 16 (4): 298–310. <https://doi.org/10.1002/nvsm.429>.
- Ellis, Matt. 2023. “Single vs. Double Quotation Marks.” Grammarly. May 10, 2023. <https://www.grammarly.com/blog/commonly-confused-words/single-vs-double-quotes/>.
- England, Kim, and Isabel Dyck. 2011. “Managing the Body Work of Home Care.” *Sociology of Health & Illness* 33 (2): 206–19. <https://doi.org/10.1111/j.1467-9566.2010.01331.x>.
- Esping-Andersen, Gosta. 1985. “Power and Distributional Regimes.” *Politics & Society* 14 (2): 223–56. <https://doi.org/10.1177/003232928501400204>.
- Esping-Andersen, Gøsta. 1990. *The Three Worlds of Welfare Capitalism*. Oxford: Polity Press.
- Ethikteam der Caritas. n.d. “Ethik in Der Caritas.” Wien: Caritas Erzdiözese Wien.
- Eurostat. 2017. “Social Expenditure Data.” [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Expenditure_on_social_protection,_2007-2017_\(%25_of_GDP\)_SPS20.png](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Expenditure_on_social_protection,_2007-2017_(%25_of_GDP)_SPS20.png).
- . 2022. “Real GDP per Capita.” <https://ec.europa.eu/eurostat/databrowser/view/tipsna40/default/table?lang=ene?lang=en>.
- . 2024a. “Healthcare Expenditure Statistics - Overview.” https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics_-_overview.
- . 2024b. “Healthcare Expenditure Statistics by Function, Provider and Financing Scheme.” https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics_by_function,_provider_an

- d_financing_scheme#Healthcare_expenditure_by_function.
- . 2024c. “Healthcare Personnel Statistics - Nursing and Caring Professionals.” 2024. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_personnel_statistics_-_nursing_and_caring_professionals.
- . 2025a. “Employment Rate by Sex, Age Groups, Educational Attainment Level and Household Composition (%).” https://ec.europa.eu/eurostat/databrowser/view/lfst_hheredty__custom_17081427/bookmark/table?lang=en&bookmarkId=1c310cee-cd32-41a5-8bba-605c9acc40a8&c=1749559298115.
- . 2025b. “Social Protection Statistics - Overview.” https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Social_protection_statistics_-_overview.
- Evetts, Julia. 2011. “A New Professionalism? Challenges and Opportunities.” *Current Sociology* 59 (4): 406–22. <https://doi.org/10.1177/0011392111402585>.
- Fassin, Didier. 2012. *Humanitarian Reason: A Moral History of the Present*. Berkeley, CA: University of California Press.
- Federici, Silvia. 2012. *Revolution at Point Zero*. Oakland, CA: PM Press.
- Feldman, Ilana, and Miriam Ticktin. 2010. *In the Name of Humanity: The Government of Threat and Care*. Durham, NC: Duke University Press.
- Fenger, Menno H.J. 2007. “Welfare Regimes in Central and Eastern Europe: Incorporating Post-Communist Countries in a Welfare Regime Typology.” *Contemporary Issues and Ideas in Social Sciences* 3 (2): 1–30.
- Fine, Ben. 2001. *Social Capital vs. Social Theory: Political Economy and Social Science at the Turn of the Millennium*. New York: Routledge.
- Fink-Hafner, Danica, ed. 2015. *The Development of Civil Society in the Countries on the Territory of the Former Yugoslavia Since the 1980s*. Ljubljana: Faculty of Social Sciences.
- Fink-Hafner, Danica, and Mitja Hafner-Fink. 2009. “The Determinants of the Success of Transitions to Democracy.” *Europe-Asia Studies* 61 (9): 1603–25. <https://doi.org/10.1080/09668130903209152>.
- Fitzgerald, Allan D, ed. 1999. *Augustine through the Ages*. Grand Rapids, MI: William B. Eerdmans.
- Folbre, Nancy. 2001. *The Invisible Heart: Economics and Family Values*. New York: New Press.
- Folbre, Nancy, and Julie A Nelson. 2000. “For Love or Money—Or Both?” *Journal of Economic Perspectives* 14 (4): 123–40. <https://doi.org/10.1257/jep.14.4.123>.
- Foucault, Michel. 1997. “Ethics: Subjectivity and Truth; The Essential Works of Michel Foucault, 1954-1984. Vol 1.” *Library Journal* 122.
- Fournier, Valérie. 1999. “The Appeal to ‘professionalism’ as a Disciplinary Mechanism.” *Sociological Review* 47 (2): 280–307. <https://doi.org/10.1111/1467-954X.00173>.

- fra Bonaventura Duda. 2024. "Rane Sv. Franje – 'Požar Ljubavi' Opisan Perom Fra Bonaventure Dude ." *Bitno.NET*, September 17, 2024.
- Framke, Maria, and Esther Möller. 2019. *From Local Philanthropy to Political Humanitarianism: South Asian and Egyptian Humanitarian Aid during the Period of Decolonisation*. ZMO Working Papers. Berlin: Leibniz-Zentrum Moderner Orient.
- Fraser, Nancy. 2016. "Contradictions of Capital and Care." *New Left Review*.
- Frederiksen, Morten, and Ane Grubb. 2023. "The Politics of Insufficiency: Ambivalence and Boundary Work in the Co-Production of Welfare Services." *Public Management Review* 25 (3). <https://doi.org/10.1080/14719037.2021.1978759>.
- Freidson, Eliot. 2001. *Professionalism, the Third Logic*. Cambridge: Polity Press.
- Ganesh, Shiv. 2005. "The Myth of the Non-Governmental Organization: Governmentality and Transnationalism in an Indian NGO." In *International and Multicultural Organizational Communication*, edited by Cheney G and Barnett G, 7:193–219. Creskill, NJ: Hampton Press.
- Ganesh, Shiv, and Kirstie McAllum. 2012. "Volunteering and Professionalization: Trends in Tension?" *Management Communication Quarterly* 26 (1). <https://doi.org/10.1177/0893318911423762>.
- Gans-Morse, Jordan, and Mitchell A. Orenstein. 2007. "East-Central European Welfare Regimes." Berkeley .
- Ghodsee, Kristen. 2015. "Socialist Internationalism and State Feminism during the Cold War: The Case of Bulgaria and Zambia." *Clio*, no. 41 (May): 114–37. <https://doi.org/10.4000/cliowgh.903>.
- Gieryn, Thomas F. 1995. "Boundaries of Science." In *Science and the Quest for Reality*, edited by Alfred I. Tauber, 293–332. London: Palgrave Macmillan UK. https://doi.org/10.1007/978-1-349-25249-7_12.
- Giorgino, Vincenzo Mario Bruno, and Zack Walsh, eds. 2018. *Co-Designing Economies in Transition*. Cham: Springer International Publishing. <https://doi.org/10.1007/978-3-319-66592-4>.
- Glass, Christy, and Eva Fodor. 2007. "From Public to Private Maternalism? Gender and Welfare in Poland and Hungary after 1989." *Social Politics: International Studies in Gender, State & Society* 14 (3): 323–50. <https://doi.org/10.1093/sp/jxm013>.
- Glucksmann, Miriam A. 1995. "Why 'Work'? Gender and the 'Total Social Organization of Labour.'" *Gender, Work & Organization* 2 (2): 63–75. <https://doi.org/10.1111/j.1468-0432.1995.tb00028.x>.
- . 2005. "Shifting Boundaries and Interconnections: Extending the 'Total Social Organisation of Labour.'" *The Sociological Review* 53 (2_suppl): 19–36. <https://doi.org/10.1111/j.1467-954X.2005.00570.x>.
- Godelier, Maurice. 1996. *L'énigme Du Don*. Paris: Fayard.
- Göle, Nilüfer. 2010. "Manifestations of the Religious-Secular Divide: Self, State, and the Public Sphere." In *Comparative Secularisms in a Global Age*, edited by Linell E. Cady and Elizabeth Shakman Hurd, 41–53. New York: Palgrave Macmillan US.

https://doi.org/10.1057/9780230106703_3.

- Golinowska, Stanisława. 2009. "A Case Study of the European Welfare System Model in the Post-Communist Countries-Poland." *Polish Sociological Review* 166 (2).
- Goossensen, Anne, Jos Somsen, Ros Scott, and Leena Pelttari. 2016. "Defining Volunteering in Hospice and Palliative Care in Europe: An EAPC White Paper." *European Journal of Palliative Care*.
- Graeber, David. 2001. *Toward an Anthropological Theory of Value: The False Coin of Our Own Dreams*. New York: Palgrave.
- . 2013. "On the Phenomenon of Bullshit Jobs: A Work Rant." *STRIKE!*, 2013. <https://doi.org/https://strikemag.org/bullshit-jobs>.
- . 2018. *Bullshit Jobs: A Theory*. *Bull Shit Jobs : A Theory*. Penguin Books.
- Gregory, Chris. 1982. *Gifts and Commodities*. Cambridge: Cambridge University Press.
- . 1997. *Savage Money: The Anthropology and Politics of Commodity Exchange*. Amsterdam: Harwood Academic.
- Grzymała-Busse, Anna. 2015. "Thy Will Be Done? Religious Nationalism and Its Effects in East Central Europe." *East European Politics and Societies: And Cultures* 29 (2): 338–51. <https://doi.org/10.1177/0888325414550363>.
- Gudeman, Stephen. 2008. *Economy's Tension: The Dialectics of Community and Market*. New York: Berghahn.
- Guyer, Jane. 2004. *Marginal Gains: Monetary Transactions in Atlantic Africa*. Chicago: The University of Chicago Press.
- Habermas, Jürgen. 2008. "Notes on a Post-Secular Society." *Signandsight*. <http://www.signandsight.com/features/1714.html>.
- Hachmeister, Maren. 2020. *Selbstorganisation Im Sozialismus. Das Rote Kreuz in Polen Und Der Tschecho-Slowakei 1945–1989*. Göttingen: Vandenhoeck & Ruprecht.
- Hammer, Elisabeth, and August Österle. 2003. "Welfare State Policy and Informal Long-Term Care Giving in Austria: Old Gender Divisions and New Stratification Processes Among Women." *Journal of Social Policy* 32 (1): 37–53. <https://doi.org/10.1017/S0047279402006888>.
- Handy, Femida, and Lesley Hustinx. 2009. "The Why and How of Volunteering." *Nonprofit Management and Leadership* 19 (4): 549–58. <https://doi.org/10.1002/nml.236>.
- Handy, Femida, and Narasimhan Srinivasan. 2005. "The Demand for Volunteer Labor: A Study of Hospital Volunteers." *Nonprofit and Voluntary Sector Quarterly* 34 (4): 491–509. <https://doi.org/10.1177/0899764005278037>.
- Hanegraaff, Wouter J. 2012. *Esotericism and the Academy: Rejected Knowledge in Western Culture*. Cambridge: Cambridge University Press.
- Haraway, Donna J. 2016. *Staying with the Trouble: Making Kin in the Chthulucene*. Durham, NC: Duke University Press.
- Hardill, Irene, and Susan Baines. 2011. *Enterprising Care? Unpaid Voluntary Action in the 21st Century*. Bristol: Policy Press.

- <https://doi.org/10.1332/policypress/9781847427212.001.0001>.
- Harding, Sandra. 2004. *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. New York: Routledge.
- Hartmann, Heidi I. 1976. "Comment on Marnie W. Mueller's 'The Economic Determinants of Volunteer Work by Women' (Vol. 1, No. 2)." *Signs: Journal of Women in Culture and Society* 1 (3, Part 1): 773–76. <https://doi.org/10.1086/493264>.
- Haskell, Thomas L. 1985. "Capitalism and the Origins of the Humanitarian Sensibility, Part 1." *The American Historical Review* 90 (2): 339–61. <https://doi.org/10.2307/1852669>.
- Haslanger, Sally. 2017. "Culture and Critique." *Aristotelian Society Supplementary* 91 (1): 149–73.
- Hassel, Anke, and Bruno Palier, eds. 2020. *Growth and Welfare in Advanced Capitalist Economies*. Oxford: Oxford University Press. <https://doi.org/10.1093/oso/9780198866176.001.0001>.
- Heelas, Paul. 1996. *The New Age Movement: The Celebration of the Self and the Sacralization of Modernity*. Cambridge: Blackwell.
- Heelas, Paul, and Linda Woodhead. 2005. *The Spiritual Revolution: Why Religion Is Giving Way to Spirituality*. Wiley-Blackwell.
- Heitzmann, Karin, and August Österle. 2008. "Lange Traditionen Und Neue Herausforderungen: Das Österreichische Wohlfahrtssystem." In *Europäische Wohlfahrtssysteme*, 47–69. Wiesbaden: VS Verlag für Sozialwissenschaften. https://doi.org/10.1007/978-3-531-90852-6_2.
- Hemerijck, Anton, ed. 2017. *The Uses of Social Investment*. Oxford: Oxford University Press.
- . 2018. "Social Investment as a Policy Paradigm." *Journal of European Public Policy* 25 (6): 810–27. <https://doi.org/10.1080/13501763.2017.1401111>.
- Hindmarsh, D. Bruce. 2017. "Contours of Evangelical Spirituality." *Journal of Spiritual Formation and Soul Care* 10 (2): 195–206. <https://doi.org/10.1177/193979091701000208>.
- Hoad, Peter. 2002. "Drawing the Line: The Boundaries of Volunteering in the Community Care of Older People." *Health & Social Care in the Community* 10 (4): 239–46. <https://doi.org/10.1046/j.1365-2524.2002.00361.x>.
- Hochschild, Arlie Russell. 2012. *The Managed Heart: Commercialization of Human Feeling*. University of California Press. <https://doi.org/10.2307/3324333>.
- Hofmarcher, Maria M., and Wilm Quentin. 2013. "Austria: Health System Review 2013." *Health Systems in Transition*.
- Hollan, Douglas, and C. Jason Throop. 2008. "Whatever Happened to Empathy?: Introduction." *Ethos* 36 (4): 385–401. <https://doi.org/10.1111/j.1548-1352.2008.00023.x>.
- Holy, Ladislav. 1987. *Comparative Anthropology*. Oxford: Blackwell.
- Hondagneu-Sotelo, Pierette. 2007. *Domestica: Immigrant Workers Cleaning and Caring in the Shadows of Affluence*. London: University of California Press.

- Hook, Jennifer L. 2015. "Incorporating 'Class' into Work–Family Arrangements: Insights from and for *Three Worlds*." *Journal of European Social Policy* 25 (1): 14–31. <https://doi.org/10.1177/0958928714556968>.
- HOSPIZ Österreich. 2011. "Curriculum Für Die Befähigungskurse Ehrenamtlicher Hospizbegleiterinnen ." Wien.
- HOSPIZ Österreich. n.d. "Geschichte." Accessed July 11, 2025. <https://www.hospiz.at/hospiz-palliative-care/geschichte/>.
- HOSPIZ Österreich. n.d. "Abgestuften Hospiz- Und Palliativversorgung Für Erwachsene." Accessed July 11, 2025a. <https://www.hospiz.at/hospiz-palliative-care/abgestufte-hospiz-und-palliativversorgung/>.
- . n.d. "Ehrenamt in Österreich Und Europa." Accessed July 12, 2025b. <https://www.hospiz.at/hospiz-palliative-care/ehrenamt-in-oesterreich-und-europa/>.
- . n.d. "Qualitätsmanagement." Accessed July 11, 2025c. <https://www.hospiz.at/fachwelt/qualitaetsmanagement/>.
- . 2008. "Standards Für Ehrenamtlich Tätige Hospizbegleiterinnen." Wien.
- . 2021. "Hospiz- Und Palliative Care in Österreich 2020: Datenbericht Der Hospiz- Und Palliativeinrichtungen in Österreich." https://www.hospiz.at/wordpress/wp-content/uploads/2022/02/HOSPIZ_datenerhebung_12-21_202112.pdf.
- . 2022. "Hospiz- Und Palliative Care in Österreich 2021: Datenbericht Der Hospiz- Und Palliativeinrichtungen in Österreich." https://www.hospiz.at/wordpress/wp-content/uploads/2023/07/Datenbericht_DVHospizOesterreich_2021_v1_WEB.pdf.
- Houtman, Dick, and Step Aupers. 2007. "The Spiritual Turn and the Decline of Tradition: The Spread of Post-Christian Spirituality in 14 Western Countries, 1981-2000." *Journal for the Scientific Study of Religion* 46 (3). <https://doi.org/10.1111/j.1468-5906.2007.00360.x>.
- Huber, Evelyne, and John D. Stephens. 2000. "Partisan Governance, Women's Employment, and the Social Democratic Service State." *American Sociological Review* 65 (3): 323. <https://doi.org/10.2307/2657460>.
- . 2001. *Development and Crisis of the Welfare State. Parties and Policies in Global Markets*. Chicago, IL: University of Chicago Press.
- Hyatt, Susan Brin. 2000. "From Citizen to Volunteer: Neoliberal Governance and the Erasure of Poverty." In *The New Poverty Studies: The Ethnography of Power, Politics, and Impoverished People in the United States*, edited by Judith Goode and Jeff Maskovsky, 201–35. New York: New York University Press.
- Inglehart, Ronald, and Pippa Norris. 2007. *Sveto i Svjetovno: Religija i Politika u Svijetu*. Zagreb: Politička kultura.
- Inglot, Tomasz. 2008. *Welfare States in East Central Europe, 1919–2004*. New York, Cambridge: Cambridge University Press. <https://doi.org/10.1017/CBO9780511510175>.
- Inglot, Tomasz, Dorottya Szikra, and Cristina Raț. 2012. "Reforming Post-Communist Welfare States." *Problems of Post-Communism* 59 (6): 27–49. <https://doi.org/10.2753/PPC1075-8216590603>.

- . 2022. *Mothers, Families or Children? Family Policy in Poland, Hungary, and Romania, 1945-2020*. Pittsburg: University of Pittsburgh Press.
<https://doi.org/10.2307/j.ctv2z862f7>.
- International Labour Organization. 2016. “Volunteer Work.” April 14, 2016.
<https://www.ilo.org/resource/volunteer-work>.
- Itzhak, Nofit. 2020. “Signifiers for the Divine.” *American Ethnologist* 47 (3): 276–88.
<https://doi.org/10.1111/amet.12910>.
- Iversen, Torben, and David Soskice. 2006. “Electoral Institutions and the Politics of Coalitions: Why Some Democracies Redistribute More Than Others.” *American Political Science Review* 100 (2): 165–81. <https://doi.org/10.1017/S0003055406062083>.
- Järvinen, Margaretha, and Malene Lue Kessing. 2023. “Self-Casting and Alter-Casting: Healthcare Professionals’ Boundary Work in Response to Peer Workers.” *Current Sociology* 71 (3). <https://doi.org/10.1177/00113921211048532>.
- Jerolimov, Dinka Marinović, and Siniša Zrinščak. 2006. “Religion Within and Beyond Borders: The Case of Croatia.” *Social Compass* 53 (2): 279–90.
<https://doi.org/10.1177/0037768606064340>.
- Johnson, Terence J. 1972. *Professions and Power*. London and Basingstoke: The MacMillan Press.
- Jusić, Anica. 2009. “[The Hospice Movement in Croatia--Short Review].” *Acta Medica Croatica : Casopis Hrvatske Akademije Medicinskih Znanostisti* 63 (4): 335–40.
- Kallunki, Valdemar, and Siniša Zrinščak. 2021. “Interdependence and Competition between the Religious and the Secular: The Welfare Role of the Church in Croatia and Finland.” *Journal of Contemporary Religion* 36 (1): 123–42.
<https://doi.org/10.1080/13537903.2021.1879446>.
- Kardinal König Haus. 2025. “Einführungskurs Lebens-, Sterbe- Und Trauer- Begleitung.” Wien. https://www.kardinal-koenig-haus.at/media/pal_einfuehrungskurs_kst_25.pdf.
- Katzenstein, Peter J. 2006. “Multiple Modernities as Limits to Secular Europeanization?” In *Religion in an Expanding Europe*, edited by Timothy A. Byrnes and Peter J. Katzenstein, 1–33. Cambridge: Cambridge University Press.
<https://doi.org/10.1017/CBO9780511491917.002>.
- Katzenstein, Peter J., and Timothy A. Byrnes. 2006. “Transnational Religion in an Expanding Europe.” *Perspectives on Politics* 4 (04): 679–94.
<https://doi.org/10.1017/S1537592706060439>.
- Kelemen, Mihaela, Anita Mangan, and Susan Moffat. 2017. “More Than a ‘Little Act of Kindness’? Towards a Typology of Volunteering as Unpaid Work.” *Sociology* 51 (6): 1239–56. <https://doi.org/10.1177/0038038517692512>.
- Kersbergen, Kees van. 1995. *Social Capitalism*. London: Routledge.
<https://doi.org/10.4324/9780203429587>.
- Kersbergen, Kees van, and Philip Manow, eds. 2009. *Religion, Class Coalitions, and Welfare States*. Cambridge: Cambridge University Press.
<https://doi.org/10.1017/CBO9780511626784>.

- Kirkegaard, Sine, and Ditte Andersen. 2018. "Co-Production in Community Mental Health Services: Blurred Boundaries or a Game of Pretend?" *Sociology of Health and Illness* 40 (5): 828–42. <https://doi.org/10.1111/1467-9566.12722>.
- Klenner, Christina, and Hana Hašková. 2010. "Variations of the Dual Earner Model: A Comparison of the Czech Republic and Germany ." In *Welfare States and Gender Inequality in Central and Eastern Europe*, edited by Christina Klenner and Simone Leiber. Brussels: ETUI, The European Trade Union Institute.
- Kofman, Eleonore, and Parvati Raghuram. 2015. *Gendered Migrations and Global Social Reproduction*. London: Palgrave Macmillan UK. <https://doi.org/10.1057/9781137510143>.
- Koordination Palliativbetreuung Steiermark. 2019. "Sterbeorte Österreich." https://www.hospiz.at/wordpress/wp-content/uploads/2021/02/Sterbeorte_Alle_18_2019.pdf.
- Korintus, Marta, and Nada Stropnik. 2009. "Hungary and Slovenia: Long Leave or Short?" In *The Politics of Parental Leave Policies*, edited by S.B. Kamerman and P. Moss, 135–58. Bristol: The Policy Press. <https://doi.org/10.51952/9781847427779.ch009>.
- Korpi, Walter. 1998. "The Iceberg of Power below the Surface: A Preface to Power Resources Theory." In *Power Resource Theory and the Welfare State*, edited by Julia S. O'connor and Gregg M. Olsen, vii–xiv. Toronto: University Toronto Press. <https://doi.org/10.3138/9781442678675-001>.
- . 2022. *The Working Class in Welfare Capitalism*. London: Routledge. <https://doi.org/10.4324/9781003326922>.
- Krakowiak, Piotr, and Leszek Pawłowski. 2018. "Volunteering in Hospice and Palliative Care in Poland and Eastern Europe." In *The Changing Face of Volunteering in Hospice and Palliative Care*, edited by Ros Scott and Steven Howlett, 1:83–95. Oxford: Oxford University Press. <https://doi.org/10.1093/oso/9780198788270.003.0007>.
- Kremer, Monique. 2005. "The Cultural Dimension of Welfare States Ideals of Care and Women's Work." In *RC19 Meeting: Re-Theorizing Welfare States: Restructuring States, Restructuring Analysis*. Chicago: RC19 Meeting .
- . 2007. *How Welfare States Care : Culture, Gender and Parenting in Europe*. Amsterdam: Amsterdam University Press. <https://doi.org/10.5117/9789053569757>.
- Kreutzer, Karin, and Urs Jäger. 2011. "Volunteering versus Managerialism: Conflict over Organizational Identity in Voluntary Associations." *Nonprofit and Voluntary Sector Quarterly* 40 (4): 634–61. <https://doi.org/10.1177/0899764010369386>.
- Kulmala, Meri, and Anna Tarasenko. 2016. "Interest Representation and Social Policy Making: Russian Veterans' Organisations as Brokers between the State and Society." *Europe-Asia Studies* 68 (1): 138–63. <https://doi.org/10.1080/09668136.2015.1124842>.
- Land, Hilary, and Hilary Rose. 1985. "Compulsory Altruism for Some or an Altruistic Society for All?" In *In Defense of Welfare*. London: Tavistock.
- Lauzadyte-Tutliene, Agne, Tomas Balezentis, and Egle Goculenko. 2018. "Welfare State in Central and Eastern Europe." *Economics & Sociology* 11 (1): 100–123. <https://doi.org/10.14254/2071-789X.2018/11-1/7>.

- LaVerna. 2020. "Edukacija o Palijativnoj Skrbi Za Volontere." 2020.
<https://www.facebook.com/palijativna.skrb/videos>.
- LaVerna - Palijativna skrb. 2024. "Blagdan Je Rana Sv. Franje." September 17, 2024.
[https://www.facebook.com/profile/100064388574317/search/?q=Rane sv. Franje](https://www.facebook.com/profile/100064388574317/search/?q=Rane+sv.+Franje).
- Lavrence, Christine, and Kristin Lozanski. 2014. "'This Is Not Your Practice Life': Lululemon and the Neoliberal Governance of Self." *Canadian Review of Sociology/Revue Canadienne de Sociologie* 51 (1): 76–94.
<https://doi.org/10.1111/cars.12034>.
- Leichsenring, Kai. 2017. "The Austrian Welfare State System: With Special Reference to Welfare Conditionality – the Case of the Income Management System." In *The Routledge International Handbook to Welfare State Systems*, edited by Christian Aspalter, 103–18. Milton Park: Routledge. <https://doi.org/10.4324/9781315613758-12>.
- Leira, Arnlaug. 1992. *Welfare States and Working Mothers: The Scandinavian Experience*. Cambridge: Cambridge University Press.
- Leisch, Robert, Astrid Pennerstorfer, and Ulrike Schneider. 2016. "Aktualisierte Daten Für Den Nonprofit Bereich." *Statistische Nachrichten*, no. 5: 377–82.
- Leitner, Sigrid. 2003. "Varieties of Familialism: The Caring Function of the Family in Comparative Perspective." *European Societies* 5 (4): 353–75.
<https://doi.org/10.1080/1461669032000127642>.
- . 2006. "Familialism." In *International Encyclopedia of Social Policy*, edited by Toni Fitzpatrick, Huck-ju Kwon, Nick Manning, James Midgley, and Gilian Pascal, 447–49. London: Routledge.
- . 2011. "Familialism in Germany, Italy and Switzerland: A Frame for Succession in Family Enterprises?" In *Doing Succession in Europe. Generational Transfers in Family Businesses in Comparative Perspective*, edited by I Stamm, P Breitschmid, and M Kohli, 85–97. Opladen: Budrich UniPress.
- . 2014. "Varieties of Familialism: Developing Care Policies in Conservative Welfare States." In *The End of Welfare as We Know It?*, edited by Philipp Sandermann, 37–51. Opladen, Berlin, Toronto: Barbara Budrich Publishers.
- Lemke, Thomas. 2015. *Foucault, Governmentality, and Critique*. London: Routledge.
<https://doi.org/10.4324/9781315634609>.
- Lendvai, Noémi, and Paul Stubbs. 2015. "Europeanization, Welfare and Variegated Austerity Capitalisms – Hungary and Croatia." *Social Policy & Administration* 49 (4): 445–65. <https://doi.org/10.1111/spol.12142>.
- Lewis, Jane. 1992. "Gender and the Development of Welfare Regimes." *Journal of European Social Policy* 2 (3): 159–73. <https://doi.org/10.1177/095892879200200301>.
- . 2001. "The Decline of the Male Breadwinner Model: Implications for Work and Care." *Social Politics: International Studies in Gender, State & Society* 8 (2): 152–69.
<https://doi.org/10.1093/sp/8.2.152>.
- . 2003. "Design Issues." In *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, edited by Jane Ritchie and Jane Lewis, 47–76. London: Sage Publications.

- . 2006. “Men, Women, Work, Care and Policies.” *Journal of European Social Policy* 16 (4): 387–92. <https://doi.org/10.1177/0958928706068276>.
- Lien Foundation. 2015. “Quality of Death Index.” <https://lienfoundation.org/project/quality-of-death-index/>.
- Lijphart, Arend. 1999. *Patterns of Democracy: Government Forms and Performance in Thirty-Six Countries*. *Patterns of Democracy: Government Forms and Performance in Thirty-Six Countries*. New Heaven: Yale University Press. <https://doi.org/10.2307/3331092>.
- Lipka, Michael, and Claire Gecewicz. 2017. “More Americans Now Say They’re Spiritual but Not Religious.” *Pew Research Center*, September. <https://www.pewresearch.org/short-reads/2017/09/06/more-americans-now-say-theyre-spiritual-but-not-religious/>.
- Lister, Ruth. 1994. “She Has Other Duties: Women, Citizenship and Social Security.” In *Social Security and Social Change: New Challenges to the Beveridge Model*, edited by S., Falkingham, J. Baldwin, 31–44. New York, London: Harvester Wheatsheaf.
- Litwak, Eugene. 1985. *Helping the Elderly: The Complementary Roles of Informal Networks and Formal Systems*. New York: Guilford Press.
- Lockwood, Benjamin B., Charles G. Nathanson, and E. Glen Weyl. 2017. “Taxation and the Allocation of Talent.” *Journal of Political Economy* 125 (5): 1635–82. <https://doi.org/10.1086/693393>.
- Lončarek, Karmen, Aleksandar Džakula, Renata Marđetko, and Anna Sagan. 2018. “Origins and Effects of the 2014–2016 National Strategy for Palliative Care in Croatia.” *Health Policy* 122 (8): 808–14. <https://doi.org/10.1016/j.healthpol.2018.07.011>.
- López-Cabrera, Rocío, Alicia Arenas, Francisco J. Medina, Martin Euwema, and Lourdes Munduate. 2020a. “Inside ‘Pandora’s Box’ of Solidarity: Conflicts Between Paid Staff and Volunteers in the Non-Profit Sector.” *Frontiers in Psychology* 11. <https://doi.org/10.3389/fpsyg.2020.00556>.
- . 2020b. “Inside ‘Pandora’s Box’ of Solidarity: Conflicts Between Paid Staff and Volunteers in the Non-Profit Sector.” *Frontiers in Psychology* 11 (May). <https://doi.org/10.3389/fpsyg.2020.00556>.
- Luhmann, Niklas. 1990. “The Paradox of System Differentiation and the Evolution of Society.” In *Differentiation Theory and Social Change: Comparative and Historical Perspectives*, edited by Jeffrey C. Alexander and Paul Colomy, 409–40. New York: Columbia University Press.
- Lyon, Dawn, and Miriam A. Glucksmann. 2008. “Comparative Configurations of Care Work across Europe.” *Sociology* 42 (1): 101–18. <https://doi.org/10.1177/0038038507084827>.
- Macdonald, Keith M. 1995. *The Sociology of the Professions*. London: Sage Publications.
- MacLeod, Ann, Mark W. Skinner, and Eleanor Low. 2012. “Supporting Hospice Volunteers and Caregivers through Community-Based Participatory Research.” *Health and Social Care in the Community* 20 (2). <https://doi.org/10.1111/j.1365-2524.2011.01030.x>.
- Malinowski, Bronislaw. 2005. *Argonauts of the Western Pacific: An Account of Native Enterprise and Adventure in the Archipelagoes of Melanesian New Guinea*. *Argonauts*

- of the Western Pacific: An Account of Native Enterprise and Adventure in the Archipelagoes of Melanesian New Guinea.* Taylor & Francis e-Library. <https://doi.org/10.1017/9781315772158>.
- Malkki, Liisa. 2015. *The Need to Help: The Domestic Arts of International Humanitarianism.* Durham, NC: Duke University Press.
- Manow, Philip. 2021. "Models of the Welfare State." In *The Oxford Handbook of the Welfare State*, edited by Daniel Béland, Stephen Leibfried, Kimberly J. Morgan, Herbert Obinger, and Christopher Pierson, 787–802. Oxford: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780198828389.013.45>.
- Manthorpe, Jill, Joyann Andrews, Mieke Agelink, Sanne Zegers, Michelle Cornes, Melanie Smith, and Roger Watson. 2003. "Volunteers in Intermediate Care: Flexible Friends?" *Journal of Integrated Care*. <https://doi.org/10.1108/14769018200300056>.
- Marx, Karl. 1977. *Capital: A Critique of Political Economy. Volume One.* New York: Vintage.
- Maurer, Bill. 2006. "The Anthropology of Money." *Annual Review of Anthropology* 35 (1): 15–36. <https://doi.org/10.1146/annurev.anthro.35.081705.123127>.
- Mauss, Marcel. 2003. "Essai Sur Le Don: Forme et Raison de l'échange Dans Les Sociétés Archaiques." In *Sociologie et Anthropologie*. Paris: Presses Universitaires de France.
- Mayblin, Maya. 2012. "The Madness of Mothers: Agape Love and The Maternal Myth in Northeast Brazil." *American Anthropologist* 114 (2): 240–52.
- McAllum, Kirstie. 2018. "Volunteers as Boundary Workers: Negotiating Tensions Between Volunteerism and Professionalism in Nonprofit Organizations." *Management Communication Quarterly* 32 (4). <https://doi.org/10.1177/0893318918792094>.
- McGee, Micki. 2005. *Self-Help, Inc.* Oxford: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195171242.001.0001>.
- McGranahan, Carole. 2018. "Ethnography Beyond Method: The Importance of an Ethnographic Sensibility." *Sites: A Journal of Social Anthropology and Cultural Studies* 15 (1). <https://doi.org/10.11157/sites-id373>.
- Meintel, Deirdre, and Géraldine Mossière. 2011. "Reflections on Healing Rituals, Practices and Discourse in Contemporary Religious Groups." *Ethnologies* 33 (1): 19–32.
- Melow, Muriel. 2017. "Voluntary Caregiving? Constraints and Opportunities for Hospital Volunteers." In *Valuing Care Work*, edited by Cecilia Benoit and Helga Hallgrimsdottir, 215–35. Toronto: University of Toronto Press.
- Merrell, Joy. 2000. "Ambiguity: Exploring the Complexity of Roles and Boundaries When Working with Volunteers in Well Woman Clinics." *Social Science and Medicine* 51 (1): 93–102. [https://doi.org/10.1016/S0277-9536\(99\)00442-6](https://doi.org/10.1016/S0277-9536(99)00442-6).
- Mies, Maria, and Vandana Shiva. 1993. *Ecofeminism*. London: Zed Books.
- Mik-Meyer, Nanna. 2017. *The Power of Citizens and Professionals in Welfare Encounters*. Manchester: Manchester University Press. <https://doi.org/10.7765/9781526110305>.
- Ministarstvo rada, mirovinskog sustava, obitelji i socijalne politike). 2025. *Zakon o Socijalnoj Skrb*i. Republic of Croatia. <https://www.zakon.hr/z/222/zakon-o-socijalnoj->

skrbi.

- Ministarstvo rada, mirovinskog sustava, obitelji i socijalne politike. 2022. "Izvešća o Obavljenim Uslugama Ili Aktivnostima Organizatora Volontiranja." Zagreb. <https://mrosp.gov.hr/obitelj-i-socijalna-politika/socijalna-politika-11977/udruge-humanitarni-rad-i-volonterstvo-12006/volonterstvo-12023/izvjesca-o-obavljenim-uslugama-ili-aktivnostima-organizatora-volontiranja-12029/12029>.
- Ministarstvo zdravstva, Republika Hrvatsks. 2017. "NACIONALNI PROGRAM RAZVOJA PALIJATIVNE SKRBI U REPUBLICI HRVATSKOJ 2017. - 2020."
- Moore, David, Katerina Hadzi-Miceva, and Nilda Bullain. 2008. "A Comparative Overview of Public Benefit Status in Europe." *The International Journal of Not-for-Profit Law* 11 (1).
- Morel, Nathalie. 2008. "From Subsidiarity to 'Free Choice': Child- and Elderly-Care Policy Reforms in France, Belgium, Germany and the Netherlands." In *Reforming the Bismarckian Welfare Systems. Broadening Perspectives in Social Policy*, edited by Bruno Palier and Claude Martin, 82–101. Oxford: Blackwell.
- Morris, Sara, Amanda Wilmot, Matthew Hill, Nick Ockenden, and Sheila Payne. 2013. "A Narrative Literature Review of the Contribution of Volunteers in End-of-Life Care Services." *Palliative Medicine* 27 (5): 428–36. <https://doi.org/10.1177/0269216312453608>.
- Mossière, Géraldine. 2022. "Introduction: Spirituality, Well-Being and the Neoliberal Canopy." In *New Spiritualities and the Cultures of Well-Being*, edited by Géraldine Mossière, 1–14. Cham: Springer. https://doi.org/10.1007/978-3-031-06263-6_12.
- Mostowlansky, Till. 2020. "Humanitarian Affect: Islam, Aid and Emotional Impulse in Northern Pakistan." *History and Anthropology* 31 (2): 236–56. <https://doi.org/10.1080/02757206.2019.1689971>.
- Mourão Permoser, Julia. 2014. "Austrian MEPs: Between Privatisation and Politicisation of Religion." *Religion, State and Society* 42 (2–3): 251–65. <https://doi.org/10.1080/09637494.2014.941616>.
- Muehlebach, Andrea. 2012. *The Moral Neoliberal: Welfare and Citizenship in Italy*. Chicago: The University of Chicago Press.
- . 2013. "The Catholicization of Neoliberalism: On Love and Welfare in Lombardy, Italy." *American Anthropologist* 115 (3). <https://doi.org/10.1111/aman.12028>.
- Mutchler, Jan E., Jeffrey A. Burr, and Francis G. Caro. 2003. "From Paid Worker to Volunteer: Leaving the Paid Workforce and Volunteering in Later Life." *Social Forces*. <https://doi.org/10.1353/sof.2003.0067>.
- Nagel, Roland. 2015. "Aktuelle Entwicklungen Und Eine Zwischenbilanz Der 24-Stunden-Betreuung Nach 7 Jahren." In *Pflegekongress 2015*. Vienna.
- Napolitano, Valentina. 2017. "'The Globalization of Indifference': On Pope Francis, Migration and Global Acedia." In *Religion and the Morality of the Market*, edited by Daromir Rudnyckyj and Filippo Osella, 263–84. Cambridge: Cambridge University Press. <https://doi.org/10.1017/9781316888704.013>.
- Neumayr, Michaela, Ulrike Schneider, Michael Meyer, and Astrid Haider. 2007. "The Non-

- Profit Sector in Austria. An Economic, Legal Und Political Appraisal Working.”
- Newman, Janet, and Evelien Tonkens. 2011. *Participation, Responsibility and Choice : Summoning the Active Citizen in Western European Welfare States. Participation, Responsibility and Choice : Summoning the Active Citizen in Western European Welfare States*. Amsterdam: Amsterdam University Press.
<https://doi.org/10.5117/9789089642752>.
- Nikodem, Krunoslav. 2011. “RELIGIJA I CRKVA: Pitanja Institucionalne Religioznosti u Suvremenom Hrvatskom Društvu.” *Socijalna Ekologija* 20 (1): 5–30.
- . 2012. “Religiosity and Marriage. Family Attitudes in Croatia.” In *Transformations of Religiosity: Religion and Religiosity in Eastern Europe 1989-2010*, edited by Gert Pickel and Kornelia Sammet, 175–96. Wiesbaden: VS Verlag für Sozialwissenschaften.
https://doi.org/10.1007/978-3-531-93326-9_10.
- Nikodem, Krunoslav, and Siniša Zrinščak. 2009. “Croatian Religious Story. Coexistence of Firm Institutionalized and Individualized Religiosity.”
- Nussbaum, Martha. 2013. *Political Emotions: Why Love Matters for Justice*. Cambridge, Mass.: Belknap/Harvard University Press.
- Obinger, Herbert. 2008. “Sozialpolitische Bilanz Der Großen Koalition in Österreich.” Osnabrück.
- Obinger, Herbert, and Emmerich Tálos. 2010. “Janus-Faced Developments in a Proto-Typical Bismarckian Welfare State: Welfare Reforms in Austria since the 1970s.” In *A Long Goodbye to Bismarck? The Politics of Welfare Reforms in Continental Europe*, edited by Bruno Palier, 101–28. Amsterdam: Amsterdam University Press,.
- Offe, Claus, and Susanne Fuchs. 2007. “Welfare State Formation in the Enlarged European Union—Patterns of Reform in the Post-Communist New Member States.” Berlin.
- Oldenhof, Lieke, Jeroen Postma, and Roland Bal. 2016. “Re-Placing Care: Governing HealthCare through Spatial Arrangements.” In *The Oxford Handbook of Health Care Management*, edited by E. Ferlie, K. Montgomery, and A. R. Pedersen, 1:415–33. Oxford: Oxford University Press.
- Oliveira Hashiguchi, Tiago Cravo, and Ana Llana-Nozal. 2020. “The Effectiveness of Social Protection for Long-Term Care in Old Age.” *OECD Health Working Papers*. Paris: OECD Publishing. <https://doi.org/10.1787/2592f06e-en>.
- Oliver, Katherine, Michelle Brown, Catherine Walshe, and Yakubu Salifu. 2023. “A Meta-Ethnographic Review of Paid Staff and Volunteers Working Together in Palliative Care.” *Journal of Pain and Symptom Management* 66 (6): 656-670.e11.
<https://doi.org/10.1016/j.jpainsymman.2023.08.004>.
- Oorschot, Wim Van, Michael Opielka, and Birgit Pfau-Effinger. 2008. *Culture and Welfare State*. Cheltenham: Edward Elgar Publishing.
- Oppenheimer, Melanie, and Adam Edwards. 2011. “Protection of Volunteers in the Workplace: A Pilot Study of GREAT Community Transport (GCT) Inc, Blue Mountains and Penrith, NSW.”
- ORF. 2025. “Ö1 Mittagsjournal, Podcast ‘Gehört Vertieft’: Die Zukunft Der Kirche Feiertag Wird Nur Selten in Anspruch Genommen.” Austria: ORF.

- <https://oe1.orf.at/programm/20250418#791764/Oe1-Mittagsjournal>.
- Orloff, Ann Shola. 1993. "Gender and the Social Rights of Citizenship: The Comparative Analysis of Gender Relations and Welfare States." *American Sociological Review* 58 (3): 303–28. <https://doi.org/10.2307/2095903>.
- . 1996. "Gender in the Welfare State." *Annual Review of Sociology* 22 (1): 51–78. <https://doi.org/10.1146/annurev.soc.22.1.51>.
- . 2005. "Social Provision and Regulation: Theories of States, Social Policies, and Modernity." In *Remaking Modernity: Politics, History, and Sociology*, edited by Julia Adams, Elisabeth S. Clemens, and Ann Shola Orloff, 190–224. Durham: Duke University Press. <https://doi.org/10.2307/j.ctv11smmq3.9>.
- . 2009. "Gendering the Comparative Analysis of Welfare States: An Unfinished Agenda." *Sociological Theory* 27 (3): 317–43. <https://doi.org/10.1111/j.1467-9558.2009.01350.x>.
- Österle, August, and Gudrun Bauer. 2012. "Home Care in Austria: The Interplay of Family Orientation, Cash-for-Care and Migrant Care." *Health & Social Care in the Community* 20 (3): 265–73. <https://doi.org/10.1111/j.1365-2524.2011.01049.x>.
- Österle, August, and Karin Heitzmann. 2020. "Austification in Welfare System Change? An Analysis of Welfare System Developments in Austria between 1998 and 2018." In *Routledge Handbook of European Welfare Systems*, edited by Sonja Blum, Johanna Kuhlmann, and Klaus Schubert, 21–37. London, New York: Routledge.
- Overgaard, Charlotte. 2015a. "Volunteer Care Work: A Comparative Study of Volunteers, Cultures of Care and Gender in Australia and Denmark." Macquarie, Sydney, Australia. <https://doi.org/http://www.researchonline.mq.edu.au/vital/access/manager/Repository/mq:44479>.
- . 2015b. "The Boundaries of Care Work: A Comparative Study of Professionals and Volunteers in Denmark and Australia." *Health & Social Care in the Community* 23 (4): 380–88. <https://doi.org/10.1111/hsc.12154>.
- . 2016. "When to Work for Pay, When Not to: A Comparative Study of Australian and Danish Volunteer Care Workers." *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 27 (2): 810–30. <https://doi.org/10.1007/s11266-015-9620-0>.
- . 2019. "Rethinking Volunteering as a Form of Unpaid Work." *Nonprofit and Voluntary Sector Quarterly* 48 (1): 128–45. <https://doi.org/10.1177/0899764018809419>.
- Overgaard, Charlotte, Erik Petrovski, and Jonathan Hermansen. 2018. "Volunteer Care Workers: A Case for Challenging Resource Theories on Volunteering." *Journal of Civil Society* 14 (2): 153–72. <https://doi.org/10.1080/17448689.2018.1464708>.
- Oxford Learner's Dictionaries. 2025a. "Religion." Oxford University Press. 2025. <https://www.oxfordlearnersdictionaries.com/definition/english/religion?q=religion>.
- . 2025b. "Spirituality." Oxford University Press. 2025. <https://www.oxfordlearnersdictionaries.com/definition/english/spirituality?q=spirituality>.
- Palier, Bruno, ed. 2010. *A Long Goodbye to Bismarck? : The Politics of Welfare Reform in*

- Continental Europe*. Amsterdam: Amsterdam University Press.
<https://doi.org/10.5117/9789089642349>.
- . 2021. “Continental Western Europe.” In *The Oxford Handbook of the Welfare State*, edited by Daniel Béland, Stephan Leibfried, Kimberly J. Morgan, Herbert Obinger, and Christopher Pierson, 826–43. Oxford: Oxford University Press.
<https://doi.org/10.1093/oxfordhb/9780198828389.013.47>.
- Palmberger, Monika, and Andre Gingrich. 2014. “Qualitative Comparative Practices: Dimensions, Cases and Strategies.” In *The SAGE Handbook of Qualitative Data Analysis*, edited by Uwe Flick. Los Angeles, London, New Delhi, Singapore, Washington DC: Sage Publications. <https://doi.org/10.4135/9781446282243.n7>.
- Palme, Joakim. 1990. “Pension Rights in Welfare Capitalism.” Stockholm: Swedish Institute for Social Research, Stockholm University.
- Pandolfi, Mariella. 2010. “Humanitarianism and Its Discontents.” In *Forces of Compassion: Humanitarianism between Ethics and Politics.*, edited by Erica Bornstein and Peter Redfield, 227–48. Santa Fe: School for Advanced Research Press.
- Papa Francesca. 2013. “Evangelii Gaudium .” *APOSTOLIC EXHORTATION EVANGELII GAUDIUM OF THE HOLY FATHER FRANCIS TO THE BISHOPS, CLERGY, CONSECRATED PERSONS AND THE LAY FAITHFUL ON THE PROCLAMATION OF THE GOSPEL IN TODAY’S WORLD* .
https://www.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html.
- Parry, Jane. 2003. “The Changing Meaning of Work: Restructuring in the Former Coalmining Communities of the South Wales Valleys.” *Work, Employment and Society* 17 (2): 227–46. <https://doi.org/10.1177/0950017003017002001>.
- Pascall, Gillian, and Anna Kwak. 2010. “Gender Regimes in Transition: Gender Equality in CEE Countries?” In *Welfare States and Gender in Central and Eastern Europe: Continuity and Post-Socialist Transformation in the EU Member States*, edited by Christina Klenner and Simone Leiber. Brussels: ETUI, The European Trade Union Institute.
- Payne, Sheila Alison, and Sara Margaret Morris. 2018. “The Modern Context of Palliative Care.” In *The Changing Face of Volunteering in Hospice and Palliative Care : An International Perspective*, edited by Ros Scott and Steven Howlett, 15–27. Oxford: Oxford University Press.
- Pearce, Jone L. 1993. *The Organizational Behavior of Unpaid Workers. People and Organizations*. London: Routledge.
- Peeters, Rik. 2019. “Manufacturing Responsibility: The Governmentality of Behavioural Power in Social Policies.” *Social Policy and Society* 18 (1): 51–65.
<https://doi.org/10.1017/S147474641700046X>.
- Pelttari, Leena, and Anna H. Pissarek. 2018. “Volunteering in Hospice and Palliative Care in Austria.” In *The Changing Face of Volunteering in Hospice and Palliative Care* , edited by Ros Scott and Steven Howlett, 1:42–54. Oxford: Oxford University Press.
<https://doi.org/10.1093/oso/9780198788270.003.0004>.
- Pennerstorfer, Astrid, U. Schneider, and C. Badelt. 2013. “Der Nonprofit-Sektor in

- Österreich.” In *Handbuch Der Nonprofit-Organisation: Strukturen Und Management*, Schäffer-Poeschel, edited by R. Simsa, M. Meyer, and C. Badelt, 55–75. Stuttgart: Schäffer-Poeschel.
- Pennerstorfer, Astrid, Ulrike Schneider, and Stephanie Reitzinger. 2015. “Nonprofit Organisationen in Österreich 2014.” Vienna.
- Pennerstorfer, Astrid, and Brigitta Zierer. 2018. “Country Profile Austria : Social Policy, Social Economy and Social Work.” <https://www.socialnet.de/en/international/Austria>.
- Petak, Zdravko, and Igor Vidaček. 2015. “The Political and Institutional Determinants of Civil Society Development in Croatia since the 1980s.” In *The Development of Civil Society in the Countries on the Territory of the Former Yugoslavia since the 1980s*, edited by Danica Fink-Hafner, 95–120. Ljubljana: Faculty of Social Sciences.
- Pew Research Center. 2018. “Being Christian in Western Europe.” <https://www.pewresearch.org/religion/2018/05/29/being-christian-in-western-europe/>.
- Pickel, Gert, and Anja Gladkich. 2012. “Religious Social Capital in Europe Connections between Religiosity and Civil Society.” In *Transformations of Religiosity*, edited by G. Pickel and K. Sammet, 69–94. Wiesbaden: VS Verlag für Sozialwissenschaften. https://doi.org/10.1007/978-3-531-93326-9_5.
- Pickel, Gert, and Kornelia Sammet. 2012. “Introduction – Transformations of Religiosity in Central and Eastern Europe Twenty Years after the Breakdown of Communism.” In *Transformations of Religiosity. Religion and Religiosity in Eastern Europe 1989-2010*, edited by Gert Pickel and Kornelia Sammet, 7–20. Wiesbaden: VS Verlag für Sozialwissenschaften. https://doi.org/10.1007/978-3-531-93326-9_1.
- Polak, Regina, and Christoph Schachinger. 2011. “Stabil in Veränderung: Konfessionsnahe Religiosität in Europa.” In *Zukunft. Werte. Europa*, edited by Regina Polak, 191–220. Wien: Böhlau Verlag. <https://doi.org/10.7767/boehlau.9783205791638.191>.
- Polanyi, Karl. 1957. *The Great Transformation: The Political and Economic Origins of Our Time*. Boston, MA: Beacon Press.
- Povinelli, Elizabeth A. 2006. *The Empire of Love*. Duke University Press. <https://doi.org/10.1215/9780822388487>.
- Prsa, Anita. 2022a. “The Bodily Ambiguity of Social Reproduction: Navigating Body Work in Migrant Eldercare.” *Sociologija* 64 (4): 584–604. <https://doi.org/10.2298/SOC2204584P>.
- . 2022b. “Field Notes, Vesna.” Zagreb.
- . 2022c. “Field Notes, Training for Volunteers_Obitelj.” Zagreb.
- . 2022d. “Field Notes, Akcija ‘Začin Ljubavi.’” Zagreb.
- . 2022e. “Field Notes, Training for Volunteers_Kommunikation.” Wien.
- . 2022f. “Field Notes, Training for Volunteers_Angehörige Begleiten.” Wien.
- . 2023a. “Field Notes, Training for Volunteers_Selbstsorge, Spirituelle Aspekte, Abschied.” Wien.
- . 2023b. “Field Notes, Praktikum.” Wien.

- . 2023c. “Field Notes, Training for Volunteers_Vortrag: Empathie Lebendig Halten Zwischen Ohnmacht Und Berufung Im Gesundheitswesen.” Wien.
- . 2023d. “Field Notes, Teamtreffen.” Wien.
- Puljiz, Vlado. 2008. “Socijalna Politika Hrvatske (Povijest, Zadanosti, Usmjerenja).” In *Socijalna Politika Hrvatske*, edited by Vlado Puljiz, 1–71. Zagreb: Pravni fakultet.
- Puljiz, Vlado, and Siniša Zrinščak. 2002. “Hrvatska Obiteljska Politika u Europskom Kontekstu.” *Revija Za Socijalnu Politiku* 9 (2): 117–37. <https://doi.org/10.3935/rsp.v9i2.170>.
- Purser, Ron. 2019. “McMindfulness: How Mindfulness Became the New Capitalist Spirituality .” *Psychotherapy.Net* , 2019. <https://www.psychotherapy.net/article/mcmindfulness-how-mindfulness-became-new-capitalist-spirituality>.
- Purser, Ronald E., and Joseph Milillo. 2015. “Mindfulness Revisited.” *Journal of Management Inquiry* 24 (1): 3–24. <https://doi.org/10.1177/1056492614532315>.
- Putnam, Robert. 1993. *Making Democracy Work*. Princeton, NJ: Princeton University Press.
- . 2000. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon and Schuster.
- Putnam, Robert, Robert Leonardi, and Raffaella Nanetti. 1993. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, NJ: Princeton University Press.
- Radbruch, Lukas, and Sheila Payne. 2010. “White Paper on Standards and Norms for Hospice and Palliative Care in Europe: Part 2.” *European Journal of Palliative Care* 17 (1): 22–33.
- Rager, Kathleen B. 2005. “Self-Care and the Qualitative Researcher: When Collecting Data Can Break Your Heart.” *Educational Researcher* 34 (4): 23–27. <https://doi.org/10.3102/0013189X034004023>.
- Riedel, Monika, and Markus Kraus. 2010. “The Long-Term Care System for the Elderly in Austria.” *ENEPRI Research Report No 69*. Brussels: European Observatory on Health Systems and Policies.
- Rieff, Philip. 1968. *The Triumph of the Therapeutic: Uses of Faith after Freud*. New York: Harper&Row.
- Rigney, Ann. 2012. *The Afterlives of Walter Scott : Memory on the Move*. Oxford University Press.
- Robila, Mihaela. 2012. “Family Policies in Eastern Europe: A Focus on Parental Leave.” *Journal of Child and Family Studies* 21 (1): 32–41. <https://doi.org/10.1007/s10826-010-9421-4>.
- Rose, Nikolas. 1996. “The Death of the Social? Re-Figuring the Territory of Government.” *Economy and Society* 25 (3): 327–56. <https://doi.org/10.1080/03085149600000018>.
- . 1999. *Governing the Soul: The Shaping of the Private Self*. 2nd ed. London and New York: Free Association Books.
- Rozakou, Katerina. 2016. “Crafting the Volunteer: Voluntary Associations and the

- Reformation of Sociality.” *Journal of Modern Greek Studies* 34 (1): 79–102.
<https://doi.org/10.1353/mgs.2016.0014>.
- Saborska TV - odbori. 2022. “75. Tematska Sjednica Odbora Za Zdravstvo i Socijalnu Politiku.” October 22. https://www.youtube.com/watch?v=wiJ_SwU4IfY.
- Sainsbury, Diane. 1996. *Gender, Equality, and Welfare States*. Cambridge: Cambridge University Press.
- . , ed. 1999. *Gender and Welfare State Regimes*. Oxford, New York: Oxford University PressOxford. <https://doi.org/10.1093/0198294166.001.0001>.
- Saks, Mike, and Marianne Van Bochove. 2021. “Professionals and Volunteers: The Importance of Recognising Diversification in the Healthcare Division of Labour.” *Professions and Professionalism* 11 (1). <https://doi.org/10.7577/pp.3970>.
- Salamon, Lester M., S. Wojciech Sokolowski, and Megan A. Haddock. 2011. “Measuring the Economic Value of Volunteer Work Globally: Concepts, Estimates, and a Roadmap to the Future.” *Annals of Public and Cooperative Economics* 82 (3): 217–52.
<https://doi.org/10.1111/j.1467-8292.2011.00437.x>.
- Salamon, Lester M., and Wojciech Sokolowski. 2018. “Beyond Nonprofits: In Search of the Third Sector.” In *The Third Sector as a Renewable Resource for Europe*, edited by Bernard Enjolras, Lester M. Salamon, Karl Henrik Sivesind, and Annette Zimme, 7–48. Cham: Springer International Publishing. https://doi.org/10.1007/978-3-319-71473-8_2.
- Salleh, Ariel. 1997. *Ecofeminism as Politics*. London: Zed Books.
- Sallnow, Libby, Richard Smith, Sam H Ahmedzai, Afsan Bhadelia, Charlotte Chamberlain, Yali Cong, Brett Doble, et al. 2022. “Report of the Lancet Commission on the Value of Death: Bringing Death Back into Life.” *The Lancet* 399 (10327): 837–84.
[https://doi.org/10.1016/S0140-6736\(21\)02314-X](https://doi.org/10.1016/S0140-6736(21)02314-X).
- Samuels, Annemarie, and Natashe Lemos Dekker. 2023. “Palliative Care Practices and Policies in Diverse Socio-Cultural Contexts: Aims and Framework of the ERC Globalizing Palliative Care Comparative Ethnographic Study.” *Palliative Care and Social Practice* 17 (January): 1–9. <https://doi.org/10.1177/26323524231198546>.
- Saraceno, Chiara. 1997. “Family Change, Family Policies and the Restructuring of Welfare.” In *Family, Market and Community: Equity and Efficiency in Social Policy*, edited by OECD, 21st ed., 81–100. Paris: OECD.
- . 2016. “Varieties of Familialism: Comparing Four Southern European and East Asian Welfare Regimes.” *Journal of European Social Policy* 26 (4).
<https://doi.org/10.1177/0958928716657275>.
- Saunders, Dame Cicely. 1987. “What’s in a Name?” *Palliative Medicine* 1 (1): 57–61.
<https://doi.org/10.1177/026921638700100108>.
- . 2001. “The Evolution of Palliative Care.” *Journal of the Royal Society of Medicine* 94 (9): 430–32. <https://doi.org/10.1177/014107680109400904>.
- Saxonberg, Steven, and Tomáš Sirovátka. 2007. “Re-Familisation of the Czech Family Policy and Its Causes.” *International Review of Sociology* 17 (2): 319–41.
<https://doi.org/10.1080/03906700701357307>.

- Scharff, Christina. 2016. "The Psychic Life of Neoliberalism: Mapping the Contours of Entrepreneurial Subjectivity." *Theory, Culture & Society* 33 (6): 107–22. <https://doi.org/10.1177/0263276415590164>.
- Scherz, China. 2014. *Having People, Having Heart: Charity, Sustainable Development, and Problems of Dependence in Central Uganda*. Chicago: The University of Chicago Press.
- Schmidt, Manfred G., Tobias Ostheim, Nico A. Siegel and Reimut Zohlnhöfer, eds. 2007. *Der Wohlfahrtsstaat, Eine Einführung in Den Historischen Und Internationalen Vergleich*. Wiesbaden: VS Verlag für Sozialwissenschaften/GWV Fachverlage GmbH.
- Schneider, Jane. 1991. "Spirits and the Spirits of Capitalism." In *Religious Regimes and State-Formation: Perspectives from European Ethnology*, edited by Eric Wolf. Albany: State University of New York Press.
- Schneider, Ulrike, and Joachim Hagleitner. 2005. "Österreichische NPO Im Spiegel Der Arbeitsstättenzählung 2001 [Situation of Austrian NPO Sector in 2001]." Wien.
- Schubert, Klaus, Paloma de Villota, and Johanna Kuhlmann, eds. 2016. *Challenges to European Welfare Systems*. Cham: Springer International Publishing. <https://doi.org/10.1007/978-3-319-07680-5>.
- Schultes, Kerstin. 2023. "Professionalität Und Empathie." *Caritas Aktiv*, March 2023.
- Scott, Ros. 2018. "Volunteering in Hospice and Palliative Care in the United Kingdom." In *The Changing Face of Volunteering in Hospice and Palliative Care*, edited by Ros Scott and Steven Howlett, 1:28–41. Oxford: Oxford University Press. <https://doi.org/10.1093/oso/9780198788270.003.0003>.
- Sévigny, Andrée, Serge Dumont, S. Robin Cohen, and Annie Frappier. 2010. "Helping Them Live Until They Die: Volunteer Practices in Palliative Home Care." *Nonprofit and Voluntary Sector Quarterly* 39 (4): 734–52. <https://doi.org/10.1177/0899764009339074>.
- Shipton, Parker. 2014. "Trusting and Transcending." *Current Anthropology* 55 (S9): S51–61. <https://doi.org/10.1086/676593>.
- Simpson, Mary, and George Cheney. 2007. "Marketization, Participation, and Communication within New Zealand Retirement Villages: A Critical rhetorical and Discursive Analysis." *Discourse & Communication* 1 (2). <https://doi.org/10.1177/1750481307076006>.
- Simsa, Ruth, Christian Schober, and Doris Schober. 2006. *Das Wiener Vereinswesen Im 20. Jahrhundert – Geschichte, Entwicklung Und Hintergründe*. Wiena: Studienendbericht.
- Skinner, Marianne Sundlisæter, Maren Kristine Raknes Sogstad, and Laila Tingvold. 2019. "Voluntary Work in the Norwegian Long-Term Care Sector: Complementing or Substituting Formal Services?" *European Journal of Social Work* 22 (6): 1–13. <https://doi.org/10.1080/13691457.2018.1462767>.
- Škrabalo, Marina. 2006. "Izgradnja Mira i Razvoj Zajednice – Povezanost Pristupa." In *Mobilizacija i Razvoj Zajednice – Akcijsko Istraživanje u Hrvatskoj*, edited by Marina Škrabalo, Nives Miošić Lisjak, and Jasmina Papa, 63–105. Zagreb: MAP savjetovanja.
- Smith, David Horton. 1994. "Determinants of Voluntary Association Participation and Volunteering: A Literature Review." *Nonprofit and Voluntary Sector Quarterly* 23 (3): 243–63. <https://doi.org/10.1177/089976409402300305>.

- Smith, Jason E. 2020. *Smart Machines and Service Work*. London: Reaktion.
- Stacey, Clare L., and Lindsey L. Ayers. 2012. "Caught Between Love and Money: The Experiences of Paid Family Caregivers." *Qualitative Sociology* 35 (1): 47–64. <https://doi.org/10.1007/s11133-011-9210-4>.
- Stambolieva, Marija. 2011. "The Post-Yugoslav Welfare States – from Legacies to Actor Shaped Transformations." In *Welfare States in Transition: 20 Years after the Yugoslav Welfare Model*, edited by Marija Stambolieva and Stefan Stefan Dehnert. Sofia: Friedrich Ebert Stiftung.
- Štambuk, Ana, Silvia Rusac, and Lea Skokandić. 2019. "Profil Neformalnih Njegovatelja Starijih Osoba u Gradu Zagrebu." *Revija Za Socijalnu Politiku* 26 (2): 189–206. <https://doi.org/10.3935/rsp.v26i2.1579>.
- Stebbins, Robert. 2013. "Unpaid Work of Love: Defining the Work-Leisure Axis of Volunteering." *Leisure Studies* 32 (3): 339. <https://doi.org/10.1080/02614367.2012.667822>.
- Stebbins, Robert A. 1996. "Volunteering: A Serious Leisure Perspective." *Nonprofit and Voluntary Sector Quarterly*. <https://doi.org/10.1177/0899764096252005>.
- Steimel, Sarah. 2018. "Skills-Based Volunteering as Both Work and Not Work: A Tension-Centered Examination of Constructions of 'Volunteer.'" *Voluntas* 29 (1): 133–43. <https://doi.org/10.1007/s11266-017-9859-8>.
- Stephens, John D. 1979. "Beyond the Welfare State: The Swedish Case." In *The Transition from Capitalism to Socialism*, 177–94. London: Macmillan Education UK. https://doi.org/10.1007/978-1-349-16171-3_6.
- Stjernswärd, Jan, Kathleen M. Foley, and Frank D. Ferris. 2007. "The Public Health Strategy for Palliative Care." *Journal of Pain and Symptom Management* 33 (5): 486–93. <https://doi.org/10.1016/j.jpainsymman.2007.02.016>.
- Stolz, Jörg, Judith Könemann, Mallory Schneuwly Purdie, Thomas Englberger, and Michael Krüggeler. 2016. *(Un)Believing in Modern Society: Religion, Spirituality, and Religious-Secular Competition*. Routledge. <https://doi.org/10.1080/14755610.2019.1572099>.
- Stubbs, Paul, and Sinisa Zrinscak. 2007. "Croatia." In *Social Policy and International Interventions in South East Europe*, edited by Deacon Bob and Stubbs Paul, 85–102. Edward Elgar Publishing. <https://doi.org/10.4337/9781847208606.00012>.
- Stubbs, Paul, and Siniša Zrinščak. 2018. "Paul Stubbs and Siniša Zrinščak March 2018 ESPN Thematic Report on Challenges in Long-Term Care. Croatia." Brussels. [file:///C:/Users/prsaa/Downloads/HR_ESPN thematic report on LTC.pdf](file:///C:/Users/prsaa/Downloads/HR_ESPN%20thematic%20report%20on%20LTC.pdf).
- Sultana, Farhana. 2007. "Reflexivity, Positionality and Participatory Ethics: Negotiating Fieldwork Dilemmas in International Research." *ACME* 6 (3).
- Swaan, Abram De. 1988. *In Care of the State: Health Care, Education and Welfare in Europe and the USA in the Modern Era*. Oxford: Oxford University Press.
- Tálos, Emmerich. 2006. *Sozialstaat Österreich Zwischen Kontinuität Und Umbau. Eine Bilanz Der ÖVP/FPÖ/BZÖ-Regierung*. Wiesbaden: Verlag für Sozialwissenschaften.

- Taylor, Rebecca F. 2004. "Extending Conceptual Boundaries: Work, Voluntary Work and Employment." *Work, Employment and Society* 18 (1): 29–49. <https://doi.org/10.1177/0950017004040761>.
- . 2005. "Rethinking Voluntary Work." *The Sociological Review* 53 (2_suppl): 117–35. <https://doi.org/10.1111/j.1467-954X.2005.00576.x>.
- Tendera-Właszczuk, Helena, and Michał Szymański. 2015. "Implementation of the Welfare State in the Visegrád Countries." *Economics & Sociology* 8 (2): 126–42. <https://doi.org/10.14254/2071-789X.2015/8-2/10>.
- Throop, C. Jason, and Dan Zahavi. 2020. "Dark and Bright Empathy." *Current Anthropology* 61 (3): 283–303. <https://doi.org/10.1086/708844>.
- Ticktin, Miriam. 2011. *Casualties of CareImmigration and the Politics of Humanitarianism in France*. University of California Press. <https://doi.org/10.1525/california/9780520269040.001.0001>.
- . 2014. "Transnational Humanitarianism." *Annual Review of Anthropology* 43 (1): 273–89. <https://doi.org/10.1146/annurev-anthro-102313-030403>.
- Titmuss, Richard Morris. 1972. *The Gift Relationship: From Human Blood to Social Policy*. Vintage Books.
- Tomšič, Vida. 1980. *Woman in the Development of Socialist Self-Managing Yugoslavia*. Jugoslovenska stvarnost.
- Tronto, Joan C. 1993. *Moral Boundaries: A Political Argument for an Ethics of Care*. New York: Routledge.
- Twigg, Julia. 2000. "Carework as a Form of Bodywork." *Ageing and Society* 20 (4): 389–411. <https://doi.org/10.1017/S0144686X99007801>.
- . 2006. *The Body in Health and Social Care*. Basingstoke: Palgrave.
- United Nations Volunteers (UNV) programme. 2021. "2022 State of the World's Volunteerism Report. Building Equal and Inclusive Societies." Bonn.
- Verbakel, Ellen. 2014. "Informal Caregiving and Well-Being in Europe: What Can Ease the Negative Consequences for Caregivers?" *Journal of European Social Policy* 24 (5): 424–41. <https://doi.org/10.1177/0958928714543902>.
- Voas, David. 2008. "The Rise and Fall of Fuzzy Fidelity in Europe." *European Sociological Review* 25 (2): 155–68. <https://doi.org/10.1093/esr/jcn044>.
- Vočanec, Dorja, Aleksandar Džakula, Karmen Lončarek, Slavica Sović, and Bernd Rechel. 2022. "Integration Processes within the Croatian Palliative Care Model in 2014 – 2020." *Health Policy* 126 (3): 207–15. <https://doi.org/10.1016/j.healthpol.2022.01.009>.
- Vočanec, Dorja, Karmen Lončarek, Maja Banadinović, Slavica Sović, and Aleksandar Džakula. 2022. "A Qualitative Study on the Position and Role of Volunteers in Integrated Care—An Example of Palliative Care in Croatia." *International Journal of Environmental Research and Public Health* 19 (13): 8203. <https://doi.org/10.3390/ijerph19138203>.
- Ward, Jenna, and Anne-marie Greene. 2018. "Too Much of a Good Thing? The Emotional Challenges of Managing Affectively Committed Volunteers." *Nonprofit and Voluntary*

- Sector Quarterly* 47 (6): 1155–77. <https://doi.org/10.1177/0899764018783276>.
- Watts, Galen. 2018. “Missing the Forest for the Trees: ‘Spiritual’ Religion in a Secular Age.” *Toronto Journal of Theology* 34 (2): 243–56. <https://doi.org/10.3138/tjt.2018-0112>.
- . 2022. “Spirituality, Self-Help, and Subjective Wellbeing Culture.” In *Religion, Spirituality and Health: A Social Scientific Approach*, edited by Géraldine Mossière. Vol. 6. Springer Cham. https://doi.org/10.1007/978-3-031-06263-6_3.
- Weicht, Bernhard. 2011. “Embodying the Ideal Carer: The Austrian Discourse on Migrant Carers’.” *International Journal of Ageing and Later Life* 5 (2): 17–52. <https://doi.org/10.3384/ijal.1652-8670.105217>.
- Weiss, Erica. 2015. “Provincializing Empathy: Humanitarian Sentiment and the Israeli–Palestinian Conflict.” *Anthropological Theory* 15 (3): 275–92. <https://doi.org/10.1177/1463499614568571>.
- . 2017. “Competing Ethical Regimes in a Diverse Society: Israeli Military Refusers.” *American Ethnologist* 44 (1): 52–64. <https://doi.org/10.1111/amet.12425>.
- Weiss, Robert Stuart. 1995. *Learning from Strangers : The Art and Method of Qualitative Interview Studies*. New York: Free Press.
- Wilensky, H. 1975. *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures*. Berkeley and Los Angeles: University of California Press.
- Williams, Colin C. 2005. “Cultivating Community Self-Help in Deprived Urban Neighborhoods.” *City & Community* 4 (2): 171–88. <https://doi.org/10.1111/j.1540-6040.2005.00110.x>.
- Wilson, John. 2000. “Volunteering.” *Annual Review of Sociology* 26: 215–40.
- Wilson, John, and Marc Musick. 1997. “Who Cares? Toward an Integrated Theory of Volunteer Work.” *American Sociological Review* 62 (5): 694. <https://doi.org/10.2307/2657355>.
- Wilson, Rob, Sue Baines, Mike Martin, Paul Richter, Ian McLoughlin, and Gregory Maniatopoulos. 2017. “Who Is Telecaring Whom? Exploring the Total Social Organisation of Care Work in an Italian Municipality.” *New Technology, Work and Employment* 32 (3): 268–82. <https://doi.org/10.1111/ntwe.12101>.
- Winant, Gabriel. 2024. “The Baby and the Bathwater: Class Analysis and Class Formation after Deindustrialisation.” *Historical Materialism* 32 (2): 3–30.
- Wolkowitz, Carol. 2002. “The Social Relations of Body Work.” *Work, Employment and Society* 16 (3): 497–510. <https://doi.org/10.1177/095001702762217452>.
- World Health Organization. 2023. “Palliative Care.” June 1, 2023. <https://www.who.int/europe/news-room/fact-sheets/item/palliative-care>.
- World Health Organization - Global Health Observatory. 2025. “Health Spending as a Share of Total Government Spending.” <https://ourworldindata.org/grapher/health-expenditure-government-expenditure?mapSelect=AUT~HRV>.
- Zelizer, Viviana. n.d. *The Purchase of Intimacy*. Princeton, NJ: Princeton University Press.
- . 1997. *The Social Meaning of Money: Pin Money, Paychecks, Poor Relief, and Other*

Currencies. Princeton, NJ: Princeton University Press.

Županov, Josip. 1995. *Poslije Potopa*. Zagreb: Nakladni zavod Globus.

Župarić Iljić, Drago. 2016. *Emigration from the Republic of Croatia after the Accession to the European Union*. Zagreb: Friedrich Ebert Stiftung.