
Abstract

Buurtzorg's practice has been labeled as an innovative management practice. Management innovation refers to the introduction of novelty in an established organization, mainly representing a particular form of organizational change (Birkinshaw et al. 2008, p. 826). Birkinshaw et al. (2008) define management innovation as 'a difference in form, quality, or state over time of the management activities in an organization, where the change is a novel or unprecedented departure from the past' (2008, p. 826). They describe management innovation as the invention and implementation of a management practice, process, structure, or technique that is new to the state of the art and is intended to advance organizational goals. The topic of organizational innovation has not received as much attention as other types of innovation such as technology driven, process innovation, strategic innovation and service innovations (Birkinshaw et al. 2008). Given the purpose of the current book it is interesting to see how Buurtzorg's organizational innovation identifies with the main concern of a client care focus and how it fits in the current management debates on organizational innovation and how it can contribute to the existing knowledge. An in-depth reflection will be presented in Chap. 11 of this book. This current chapter aims to provide some background of Buurtzorg and addresses the following questions: What did the motivation phase for starting Buurtzorg look like? What are the main phases of its organizational innovation? How is Buurtzorg organized? What are the lessons from Buurtzorg's start-up process of management innovation?

2.1 The Motivations for Founding Buurtzorg

2.1.1 Revitalizing Community Care

Buurtzorg Nederland was founded in 2006 as an alternative to existing home care organizations. Until 1990 the Netherlands was known for its good system of healthcare. The healthcare of those living at home was organized by nurses, community nurses, social workers and family doctors. Only those with a few years of professional experience in hospitals, additional completion of a 2-year specialist degree and high working standards were qualified as community nurses. These community nurses were responsible for home care, often for the elderly or they specialized in specific areas including healthcare for children. They worked in small teams in a community or district within a city. They were responsible for home care, prevention and healthcare in that area. They were employed by local private organizations. These organizations were structured based on several Christian religious beliefs, in the so-called cross organizations identifying themselves with a green, white or yellow cross (De Blok 2011). There was a national cross organization which administered the national standards for the services they provided to patients.

Due to reforms in the 1990s, different home care groups merged, followed by mergers between these new groups and Elderly homes, often with the aim to create economies of scale. This resulted in turning home care organizations and Elderly homes into primarily large organizations often tending toward bureaucratic organizational structures. The original contribution of the community nurse, who with colleagues, was responsible for a community or district and had the overview of the needs and what was really going on, got lost in the new structure. Their image and added value declined as their job roles changed in content and structure. The reforms were also applied in the education of nurses resulting in new types of nurses with less holistic competences and responsibilities.

At the same time, due to aging of the population, the demand for home care agencies to provide assistance with such things as bathing, giving injections, and caring for wounds has increased. However, the quality of care has become fragmented and ineffective. Patients often dealt with more than 30 different nurses in a month. The reforms also incited a change in attitude and approach of the healthcare. The image emerged as if this industry could operate on pure economic principles and business goals in terms of maximizing profit while the customer was not the same type of customer who was operating at the free market. The customer in healthcare was the patient who needed the best possible care to become independent and empowered again to live a life according to the highest norms in quality. Instead, due to the reforms, the overall view of the patients' needs were lost or ignored. The role of the community nurses changed. The autonomy they were used to decreased over the years and economic principles became more important than good care.

Jos de Blok, both as a community nurse and manager in different home care organizations, realized that economies of scale cannot be the sole initiative as it does not serve or lead to achieving the original purpose of the home care industry. It is interesting to note that the reforms did not lead to effectiveness or profit but rather it has resulted in loss and higher budget needs. Unfortunately, the healthcare

agencies and insurance offices moved further away from the primary process where the main objective was serving the patient in the best possible way. While thinking that business principles and approaches would solve the issues in healthcare in terms of efficiency and effectiveness, in fact none of these were realized. Instead, the expenditures were continuously increasing, patients were complaining and nurses experienced strains and a decline in job satisfaction and job pride occurred.

Considering this, Jos de Blok founded Buurtzorg Nederland. His former colleague Ard Leferink was involved already from the start. Ard contributed with his ICT expertise and creative thinking abilities while Jos could provide his strategic ideal to revitalize the community nursing practices and nursing expertise. From conception, his life partner Gonnie Kronenberg contributed with her extensive insight and expertise in administrative organizing and her pragmatic down to earth attitude. Jos introduced the idea of establishing a foundation as the most suitable business entity for Buurtzorg. He received many objections for this idea throughout his network. Some were advising a private limited company as the most suitable form. He noticed how dominant the economic model of profit making was in many minds around him. This suggestion was also raised several times in the supervisory board which was formally established a few years later, as of January 1st, 2009. It was Gonnie from whom he received full support to keep the foundation as an entity instead of a private limited company.

Jos, being a strategic thinker, community nurse, former manager and a person with a high drive to be a change agent could integrate his vision with the contributions he received from Ard and Gonnie beyond the start-up phase. Now seven and a half years later, in practice Jos, Ard and Gonnie form the main players when important decisions need to be made. Ard contributes as driving force for innovations under the label of Buurtzorg concepts while Gonnie is the managing director for all internal affairs. When it comes to strategic decisions and corporate communication, it is Jos who plays the most important role. In practice he usually asks for advice from external sources as Buurtzorg has a flat organizational structure, trying to keep hierarchy out as much as possible.

2.1.2 Founder's Drive Towards a Higher Purpose and His Entrepreneurial Drive

Jos de Blok's actions as the founder of Buurtzorg are based on a deeper drive of serving a higher purpose. His humanistic and positive psychological perspective on human nature and relationships are perfectly adapted to his goal to deliver the highest quality of care. Jos de Blok grew up as a devout Roman Catholic. As a teenager, he noticed, even the most religious people often do not practice what they preach. He became disillusioned and took a distance from the Church. At 19, he described himself as an atheist. He often reflected upon inequality issues and problems in the community. In college, he excelled at economics and earned a living doing bookkeeping for companies. He felt depressed due to a lack of sense of meaning in his work and life and dropped out of university. He found a job in a

hospital and finally experienced a feeling of fulfillment and ‘being at home’ that he found contributing to people’s lives. He often reflected on problems which lead him to deep thinking about organizational issues such as: power, bureaucracy and inefficiency. His sense of solidarity with disadvantaged people, his drive to help and connect with people, his urge to understand how to lead people in a way that inspires them to bring forward their best potential and act as authentic human beings and not as machines, made him realize how much impact an organization’s structure has on people’s behavior. He was inspired a bit by the philosopher Sartre’s ideas on co-existence and the potential each one of us has to make choices. He realized that it is something that holds for all cultures and all religions. He has a deep longing for understanding how things work and how things are related to each other, how to empower people, how to make them realize their potential and to gain a big picture perspective on existence.

He found ways to bring all of these ideals into practice at Buurtzorg. As a result, its employees think of it as a kind of freedom movement in the home care industry. The environment at Buurtzorg has created much hope, is refreshing, and confirms that giving attention to people and being authentic is effective. Providing space for freedom, creativity, love for your profession and simplicity can lead to a positive economic outcome along with experiencing a sense of meaning and serving a purpose.

While he does not have extensive experience in managing organizations his strength is his deep knowledge of the industry and a mature understanding of the community nurse gained from many years of personal experience as a community nurse himself. He has obtained some training and education in management and based on that learning he has developed his preferences for a management style that puts humane values above the bureaucratic administration; simplicity above complexity; practical above hypothetical. He is continuously open to new insights from management but his main concern lies in reforming the Healthcare Industry. Therefore on a daily basis he engages himself in institutional issues and examines the role of governmental bodies, insurance companies, doctors, the position of nurses and client related policies and the role of other relevant stakeholders involved in healthcare. This insures that he knows his market and its developments very well. While in the early years he devoted much time in presenting his ideas to other healthcare organizations, nowadays his focus lies on influencing the conversation at the institutional level (industry stakeholders, national and local governments and ministries); sharing his best practice at an international level and initiating discussions on establishing nursing education according to the principles of Buurtzorg as he predicts a shortage of community nurses in the future.

Jos de Blok and other community nurses suggest that the current universities of applied sciences do not pay enough attention in lessons for analyzing and solving clients’ problems from a holistic approach and with practical assignments as was done a few decades ago. They are more trained as specialized nurses while Buurtzorg’s concept requires a generalist. From the nursing population who were trained as integrated community nurses it is estimated (based on the interviews with community nurses and the founder) that about 55 % already works for Buurtzorg.

Therefore, Buurtzorg has a matured working population compared to other organizations. Due to the aging forecast of the population the relative need for home care will increase. And due to expected reforms of decreasing the number of elderly home organizations there is another reason that the demand on home care will grow. This suggests that next to the higher purpose, the founder has an entrepreneurial orientation (taking initiative, open to risks and innovative).

2.1.3 ICT as the Necessary Wing to Take Off

Before Buurtzorg was founded in 2006, according to Ard Leferink, ICT was mainly applied as a control mechanism rather than a supportive tool in the Dutch Healthcare Industry. The ICT instruments were used to manage the increased bureaucracy and comprised mainly of administrative systems that helped to generate statistics for the two financing bodies: healthcare financing agencies and local municipalities. It became obvious that their entrepreneurial rational was essentially commercial and opportunistic oriented. Commercial entrepreneurship became their norm.

Failing to solve problems of the clients was not the main process of concern but whether your productivity as care provider was high enough. Thus cost efficiency became the main focus. Expenses grew as the need for care started to rise and technological advances created more possibilities, thus also more demand. At the macro-economic level the expenditures are higher than the income. As healthcare is a public service in the Netherlands the high expenditures raised several public debates as well. This resulted in a common belief that a market-driven and commercial perspective would solve the inefficiencies and lower the expenditures. At governmental level, expansion by merging care providing organizations was seen as one of the most feasible and efficient solutions. But instead, they became bureaucratic systems that were difficult to manage in the same way as when they were smaller. The shift from healthcare as a public services to a more entrepreneurial approach was a trend in many EU countries.

As a consequence borrowed terms like product, target and deliverables emerged in the Dutch Healthcare system. Ideas were implemented from bureaucratic organizational systems such as the introduction of various management layers next to professionals who were part of the primary process responsible for delivering care. Subsequently, within a few decades, there was a fundamental cultural shift from a social and public health management orientation to a pure economic orientation in the Dutch Healthcare Industry. This change in culture could be recognized almost everywhere in the healthcare industry. When assessing and evaluating healthcare providers, the financing bodies created to measure their performance, mainly by business indicators, lost perspective of the specific context of the client who needs care, nursing, guidance and other support. Nurses were seen as providers of products.

The accountability system facilitated by ICT became more sophisticated, yet it moved further away from its contextual practices. The main problem it created was

the existence of two independent processes in most of the healthcare organizations. There was a primary process for serving the client by nurses and nurse assistants and an accounting process for generating statistics on finance. The primary process was facilitated by written material archived in files while the accounting process was facilitated by expensive ICT programs. There was a gap between the language used by the care providers and that of the financing bodies. While more data was collected the complexity of the ICT systems increased. Hence less insight could be gained from the statistics produced by these systems. Healthcare providers often could not induce their performance status from these statistics. Consequently, we knew exactly how much care was provided but not the impact of it. Nor could we identify what the differences were between the various healthcare providers, because the ICT support did not aim to gain these types of insights. “It was meant for the automation of the bureaucratic system and not for gaining data in order to support the primary process,” Ard expresses.

Therefore this turned out to be a big challenge for Buurtzorg who wanted to make and be the difference in the healthcare industry. The main ICT task therefore was developing and implementing tools to support the primary process in which the government and financing bodies could be convinced that such an approach could lead to transparency and more insightful accounting.

As there was no software available that suited the Buurtzorg profile it was decided by the founders and the creative thinker, Ard Leferink, that they start an ICT company focused and capable of working according to a few principles. Given the fact that the architecture of the organizational structure was built on Self-Managed Teams the system targeted to fully facilitate this process. As the Self-Managed Teams would be located in small offices throughout the Netherlands there was a need for web-based software applications that were easily accessible. Nurses needed access to all information required for autonomous functioning while working locally in offices, on the road and in patient’s homes. The idea also created reduced wastage and inefficiency by minimizing paper flow and effective use of time for the client. Another idea was to develop and build a user interactive system. The ICT was an important division in facilitating the launch and served as enabler for the organizational innovation which targeted the following features: a bottom up approach; trust rather than control; a client-professional relationship; Self-Managed Teams; knowledge sharing with room for the power of a crowd rather than the power of a few experts who serve from a hierarchical setting. In Chap. 7 of this book the role and implementation of ICT as the Pragmatic Will of Integrating Simplification will be discussed and presented further.

2.2 Phases in the Start-Up Process

The founder was motivated to create a home care organization in such a way that he could revitalize community care by re-introducing its original working principles that existed in previous decades. He aimed to create room for the core focus which was, care to the client. He believed that such an approach would solve the problems

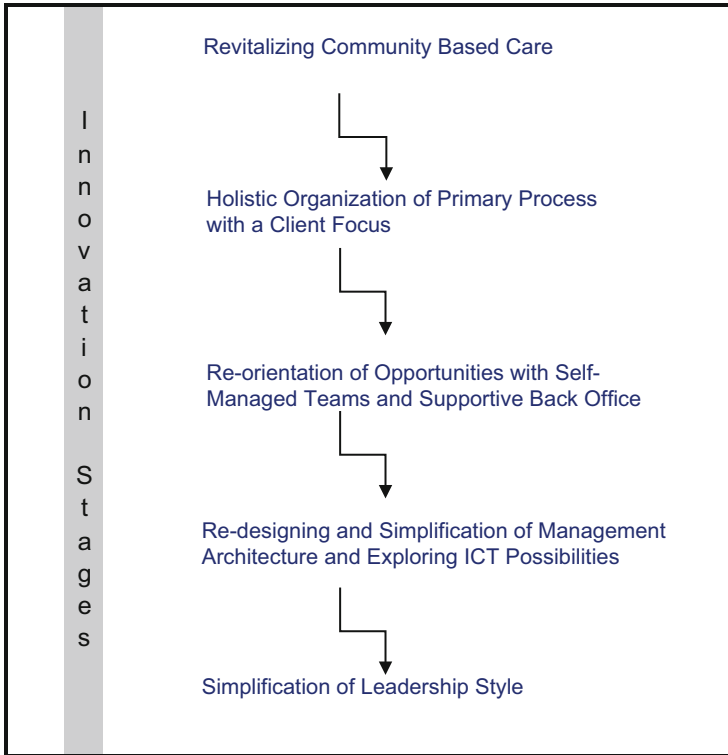


Fig. 2.1 Organizational innovation stages at Buurtzorg Nederland

faced by clients and align with the needs they experienced, as well as nurses and nurse assistants could center themselves on what brings them their professional pride, which is often to serve the client to the best of their ability and expertise. He imagined the possibility of a holistic approach to the client and a community based care. He also identified the opportunity to realize this by simplifying the financial structure. He introduced a financial structure for the home care sector by integrating all related tasks and created the community nurse position (a general position instead of various specializations).

Furthermore he redesigned the architecture by introducing the idea of a management practice of Self-Managed Teams. Ard Leferink helped him to explore ICT possibilities. Together they conceived the idea of leading management processes through a virtual web that integrates and connects the knowledge available in the organization and that inspires new ideas to improve the core business which is care. For realizing this he introduced a simple leadership style that limits management layers and management positions (See Fig. 2.1).

He suggests re-introducing the original principles of community care which fits the natural instincts of community nurses. It would give them meaning at the workplace, create professional pride, uplift the employees' spirit and it will lead

Table 2.1 Reimbursement fees for nursing, personal care and guidance

Activity	Fee in Euros
Nursing	76.02
Personal care	51.35
Guidance	55.34

to fulfill a purpose in life which is caring for the client based on humane principles. The ICT possibilities are explored and renewed as the organization grows and new needs are created. Buurtzorg has close ties with Ecare, the organization that supports all areas related to ICT designing, implementation and maintenance.

2.3 Main Approaches in the Start-Up Process

2.3.1 Integrated Fee and Simple Business Model

Let us look at the financial strategy which is very simple in nature but was not considered or implemented by others in the home care industry. How to simplify the financial structure was one of the founder's main concerns. Currently, there are four parties involved in paying for the care services, in the Dutch reimbursement system.¹ On average the nurses and the nurse assistants are providing three types of intervention and the average costs are indicated by the Dutch Healthcare System, the fees given to every healthcare institute varies for these interventions. The following fees per hour are based on information of 2014 (Table 2.1).²

The assumption behind these fees is that nursing is done by nurses and personal care is done by nurse assistants. This resulted in fragmentation of the care for the client. The client is not being considered in this view. It is not based on the problems that the clients are facing and how they could be helped in a holistic way to solve their problems. The assumptions made for specializing the fees was not based on the client's needs but rather for controlling the expenditures. In the tendency to gain efficiency by applying business principles only, the dominant rule became saving costs. Intensive work was carried out with lower educated people to keep the costs down. Originally in many institutes nursing was done by nurses; personal care activities and guidance were done by nurse assistants. During the reform, to follow the tendency of efficiency as was advised by accountancy firms, nurses were required to do jobs other than for which they were trained. They became managers with tasks such as arranging schedules, maintaining contact

¹ These are: ABWZ, Insurance, WMO, and clients.

² Nederlandse Zorgautoriteit, Bijlage 13 bij circulaire CARE/ABWZ/13/05c. Prestatiebeschrijvingen en tarieven extramurale zorg 2014, pp. 1–30.

with the family doctors, administrative and coordinative tasks. The idea was that their job became more complex and justified for the hourly rate paid by the reimbursement system. The consequence was that nurses were kept away from their main expertise and chosen profession which was nursing, not management or administration. The actual care giving work at the clients' homes was done by the nurse assistant.

Driven by efficiency and saving costs the healthcare organizations started to schedule their work in such a manner that going cheap became the main policy. The consequence for the client was that he received care by several nurse assistants who were scheduled in such a manner that tasks were specialized to spend as little time as possible, often resulting that for each activity another nurse assistant was responsible. At the end of the day the client felt how fragmented the care he received had become.

However, in practice, nurses and nurse assistants do not care so much about the fees that are paid for the activities they need to conduct. When they face a client with a certain problem, they are trained to come up with a solution to solve the problem. That is their natural tendency: to give the best possible care. They do not think, now I am hired for a certain task and I need to look only at that aspect of the client; another colleague from personal care will come and do the other tasks or she will solve other parts of the problem. The system however, driven by the efficiency perspective asked them to act opposite to their natural tendency which resulted in strain and stress.

At Buurtzorg the following innovative solutions were implemented regarding the financial structure.

- a. All the services were grouped together, resulting in an average fee of around 57 Euros per hour and then the tasks that could be delivered for this fee were scheduled and offered while keeping the client as a main focus.
- b. Attention to overhead was observed and it was considered that high expenditures were partially caused by the increase of healthcare managers in many organizations. An aim at Buurtzorg was to keep the overhead costs as low as possible.
- c. It was also decided to keep the organization of the work as simple as possible while bearing in mind the needs of the client to offer him the best possible care.
- d. Another aim was to reduce the fragmentation of care per client by scheduling the work in such a way that the number of nurses and nurse assistants per client is reduced.
- e. The profession of the nurses was arranged in such a way that there was room again for their natural tendency to serve the client in the best possible way which will revive the meaningful work they were trained for.

The simplicity in the business model at Buurtzorg, led to both efficiency and effectiveness. Assuming, a productivity rate of 60 % and a reimbursement of 57 Euros, they save 3 Euros per hour. If the total number of hours per year is about 3 million hours, the profit is 9 million Euros. This productivity is chosen on

purpose to give nurses enough room to do their work effectively while also establishing and maintaining their local networks. In many healthcare organizations the manager targets a productivity of 70 % often leading to high constraints, poor quality of the work and high levels of stress. At Buurtzorg the perspective is that managing on productivity only will not gain sustainable results for a client care focus: nurses should have enough time to know their client. It should be noted that at the same time Buurtzorg aimed low overhead costs and the Self-Managed Team structure without management layers contributes to the positive impact of the simplified business model.

Every team is aware of the productivity indicators and has internet access to the numbers per team so they can follow the developments. Each team knows how much can be spent for renting offices and other expenses. There is also accountability on how profits are invested, for example for innovative projects, education and training.

2.3.2 Self-Managed Teams

At Buurtzorg there is a management structure in the organization which is particularly suited for the business of community care. For implementing the idea of Self-Managed Teams, a concept that already existed in a few organizations, Ben Wenting and Astrid Vermeer from the institute IVS, were asked to guide the teams. As experts in coaching and team building they had experimented with the concept of Self-Managed Teams in other organizations in the past. At Buurtzorg they could more efficiently test whether the way they implement the concept was valid because Buurtzorg was a new organization where they could more easily apply several aspects of the concept compared to an established organization. In the past 7 years they have experienced how the Self-Managed Team approach works more effective and under what circumstances it does not. They followed a process of trial and error which provided valuable lessons and helped them to develop the concept further. There was no predetermined model for Self-Management available to follow, only a few basic principles. In some teams personal characteristics of team members did not match well and teams experienced conflicts. Some team members were not used to sharing the decisive power and tended to coordinate instead of sharing the tasks and responsibilities. Other teams grew fast and therefore had to establish an additional team. Some teams flourished right from the start while others required more time to adjust to each other's strengths and weaknesses. Based on their findings, Ben and Astrid have written instructions on the internal website and in booklets about the principles of Self-Managed Teams. Every new team is requested to ask for their guidance. Some ask their input at the start-up while others do this at a later stage of their team building process.

2.3.3 Virtual Platforms

At Buurtzorg there are virtual platforms to enable effective schedule planning for the nurses, a forum for sharing experiences and developing innovative solutions to problems through joint effort, sharing knowledge and E-learning modules. As a result, while nurses at other healthcare organizations need to fill in printed forms which, in turn need to be administered by others, nurses at Buurtzorg, can log in to their system whenever they need to retrieve or add information such as client registration, treatment times and communication history. Due to ease of use and access, this frees up nurses to do this at their leisure. This creates flexibility and the feeling of autonomy. In order to achieve a standard of quality, Buurtzorg uses the Omaha system that has been developed in the USA. This system includes practices guide, documentation methods and a framework for information management. Omaha is a computerized management information system that incorporates and integrates clinical information about clients and the services they receive (more about this in Chap. 7).

2.3.4 The Regional Coaches

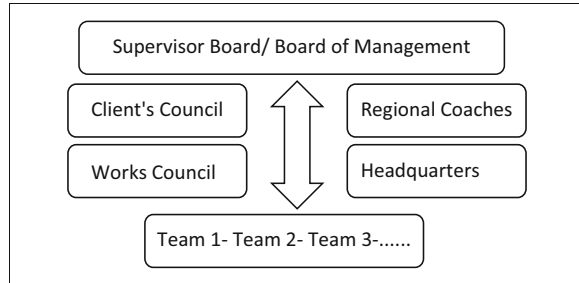
The professional coaches act as facilitators to the teams. They usually have a background as community nurse as well to ensure that their facilitating expertise suits the context of community care. Their main tasks are:

- Support new start-ups as well as established teams.
- Encourage taking responsibility and problem solving abilities within the teams.
- Coach and support teams and individual members in increasing their productivity and realizing other team output.
- Coach a team in coping with illness absences.
- Discuss the trends perceived in a team. A coach often facilitates about 45 teams and develops expertise to be shared when coaching other teams. He can share what has been a good practice somewhere else without proposing a specific approach as teams have their autonomy in developing approaches for their specific context.
- Discuss any deviances in regard to arrangements that have been agreed within a team, if there are deviances in team practices considering where policy and norms have been agreed upon in the whole organization.

2.4 Organizing Structure and Some Facts

Buurtzorg has a flat organization structure as illustrated in Fig. 2.2. For the governance a Supervisory Board has been appointed. The staff at the Headquarters supports the coaches, the teams and the Board of Management. Informally, Ard

Fig. 2.2 Organizational structure at Buurtzorg



Leferink, Ecare and IVS are important partners of Buurtzorg and often act as the sounding board for the management.

The extensive growth in the past 7 years is obvious.³ At the end of 2007 there were 300 clients with Buurtzorg. By the end of 2013 there were 55,000 clients served by 698 teams spread across the country. The latest growth is about 100 new locations in the period of 2012–2013.

The teams were supported by a small Headquarters comprising of 39.44 Full Time Equivalent (FTE) staff, 12.72 FTE regional coaches and 6.77 FTE working on projects. By the end of 2013, the total number of employees was 7,188 and the turnover was 220 million Euros.

Based on the Consumer (Client) Quality Index it can be concluded that the clients' satisfaction is high with a score of 9.1. The employee satisfaction score of 8.9 in 2013, is high as well, based on the study by Effactory, an independent market research institute.

³The numbers on 2013 are based on the Buurtzorg Annual Report 2013.



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