Personal care by highly professional self-managing teams – the fast growing Neighbourhoood Care The Netherlands (Buurtzorg Nederland), Wim Sprenger

2.4.3. Medewerkers

De toekomst van de thuiszorg is gebaat bij professionele en betrokken medewerkers. Buurtzorg stelt zich ten doel de beste werkgever te zijn. Dit betekent dat de CAO voorwaarden als minimumgrens wordt gezien en dat er ruimschoots mogelijkheden zijn voor opleiding en ontwikkeling, overleg en communicatie. Dit alles om een optimale cliëntenzorg te kunnen realiseren. Dat dit gewaardeerd wordt door medewerkers mag blijken uit de aanmelding van honderden nieuwe medewerkers, vaak in groepsverband.

Bovendien blijkt de waardering uit de 'Beste werkgeversaward': een extreem hoge waardering op het onderdeel 'betrokkenheid' (9,5!) toont het positieve effect aan van het Buurtzorgmodel op medewerkers. Samen met hogescholen en ROC's wordt getracht de belangstelling voor studenten te vergroten voor het werken in de thuiszorg. Ook in 2011 weten (wijk)verpleegkundigen en wijkziekenverzorgenden Buurtzorg nog steeds in toenemende mate te vinden. Tussen de 100 en 150 nieuwe medewerkers melden zich maandelijks, vaak in groepsverband. Een bijzondere rol is weggelegd voor de coaches; zij ondersteunen de teams bij de start en de verdere ontwikkeling naar zelfsturing. De samenwerking met IvS (Instituut voor Samenwerkingsvraagstukken) is hierin onmisbaar gebleken. Zelfsturing en zelforganisatie vraagt continue om reflectie en verdere ontwikkeling.

Small teams in a taylorized sector – Dutch home care on the move

Health care has to a certain degree been privatised since years in The Netherlands. Most hospitals and academic hospitals are still under government control, although private clinics have been developing during recent years. The government controls the prices of medical help by doctors and

provision of medicine (pharmacies), even if most of these services have private owners.
Elderly care and home care are relatively more privatised. The state still can influence general principles, general wage levels and the system by which these activities are financed. It decides which of these financial elements are collectively funded (by taxes or obligation to be part of an including insurance system).
However, private companies are allowed to enter the market, bid for concessions with local public authorities and compete on price and quality.

Within home care this has resulted in taylorisation of home care activities, the development of huge institutions offering care, clients being served by a vast group of incidental carers or cleaners. This industrialisation of (home)care services has led to broad discussions about quality and sustainability of professional care. These discussions have intensified since the beginning of the economic crisis as the national government and local authorities have been cutting budgets for clients as a result of austerity politics. For the future the perspectives are even worse, now that the new coalition government of liberals and social democrats has agreed on further cuts in budgets. Those suffering from chronic diseases and old age handicaps have been told they will more dependent of family and non professional care in the years to come.

In 2006 Jos de Blok, a former health professional, frustrated with the poor quality and ineffectiveness of formal care services, initiated Buurtzorg (Neighbourhood Care) as an alternative. Without success he had tried to change existing home care organisations as a manager. *"The crisis had not really showed up then, but I knew we could not afford to continue like this. In the US people speak of the 'health care bubble': a system creating incentive for more and more care consumption, as the planners operate far from their clients and are busy with the survival of their business. Moreover the prospects for the future labour market in European countries are worsening. There will not be enough professionals available to provide the care needed as a result of ageing workforces and professionals moving away from their profession, disappointed by the impossibility to maintain and develop their professionalism within these huge industrialized institutions."*

8 principles for self-managed local care teams

De Blok and a group of sympathizers developed Neighbourhood Care, based on 8 principles:
Employees of Buurtzorg Netherlands manage their work by the principle of care independence (1), finding a solution together with the client and his or her 'care system' in order to make care (2) unnecessary as soon as possible. The care will be provided by a provider with the highest possible level of expertise. This should give a client esteemed concern. The (3) personal relationship between caregiver and client is therefore a key stone of Buurtzorg.
In the organizational structure of Buurtzorg Netherlands self-managing local teams are the dominant element (4). The teams are supported by (5) innovative ICT applications and by regional coaches. There is (6) no management layer controlling or organizing the care. The central office in Almelo (in the eastern part of the country, where de Blok started his initiative) supports these teams in issues such as indication/assessment of the clients situation and needs, medical insurance conditions and municipal tender procedures, labour contracts and client administration. Starting point is (7) 'keep it simple'. The system should be based on trust (8) and not on management forward control.
Buurtzorg organises and facilitates self managing teams of 5 to 12 professionals, each team concentrating on care in one quarter or neighbourhood, and offering patients and elderly people high standard care. Each team can be reached 24/24 by (potential) clients and is taught how to organise permanent accessibility for clients, doctors and hospitals. Once registered, the client no longer has to deal with an ever changing collective of carers from a big organisation, but in principle gets care from a small number (1 ï 5) professionals . In fact this idea intends to combine

patient interests and professional interests in a new model of servicing. Co-operation with other neighbourhood professionals like doctors is high on the agenda. This should in the end save money and cut costs, as teams are anticipating on specific needs preventing very expensive care in a later phase.

A fast growing business

In its first complete year of existence, 2007, Buurtzorg Nederland had 57 employees in 13 teams and served 540 clients. Two years later Buurtzorg employed 2100 employees, working in 215 teams. In 2010 the number had risen to 3000 employees, working in just over 300 self-managing teams. At the end of 2011 4300 employees provided care from 410 teams. And in spring 2013 these numbers were around 6000 employees ï 95 % women ï in 545 teams. The employees are covered by the sectoral collective contract and get training facilities from the company to improve their professional skills.
During the first years the main employee category consisted of experienced nurses of 50 years and older. Among them managers who had '*fled from practical work because of frustration, and now wanted to be back in their profession on a self-managing base'* (Interview Jos de Blok, 2013). Recently a new group of employees enters the company: youngsters, fresh from VET of higher education.

Per month on average 10 locations and 100 ï 150 employees join Buurtzorg. Partly the growth of the number of teams is a result of team decisions to split up. 5 % of the employees leaves the business yearly because of age or career steps. The illness rate rose from 3.9 (2010) to 4.4 % (2011), but is still substantially lower than the 7% in the Care sector as a whole.

The relations with local doctors are in general good and productive. More difficult is the co-operation with hospitals. Their 'transfer points', the departments organising transfer from hospital to home care, are mostly staffed by people from 'traditional' home care providers, who still prefer to move the clients to their institutions.
However turnover of Buurtzorg Nederland rose quickly: from just over ú 1,000,000.00 in 2007 to ú 129,000,000.00, four years later. It is expected to be about doubled again in 2013. Hourly costs are relatively high for insurance providers and the state (AWBZ, General Law on Specific Illness Costs). But the time spent per client is lower than average in the sector for two main reasons:

- overhead is extremely low with 25 employees ad headquarters plus 20 'in the chain' (mainly coaches and advisers) ï thus 99% of the employees work in self-managing teams and are directly productive. Although each team is accessible 24/24, productivity per team is on average high: 57,9% in 2011 with an expectation of rising to 60% in the coming years. For an hourly tariff of ú 55,50 high qualified care can be delivered by each of the teams
- the number of hours care provided per client is lower than average, in particular the care for the 3000 terminal patients helped at home in 2011. As Buurtzorg teams do not 'follow' the oficial indications for the quantity of care needed,. In general the team spends more time during the starting phase with a client (home visit of the client with more than one team member, team indication of help needed, investigation of the networks of family/neighboors/friends and neighbourhood professional carers like doctors and specialised institutes). But teams tend to be 'cheaper' in the number of hours spent per client, as the team is focused on maintaining clients' interdependence by using family and local networks and restricting its own services to those really needed and asked for by the client.

In 2009 Ernst&Young analysed the business model and performances of then still small Buurtzorg Nederland. Its main conclusions:

1. Buurtzorg provides more effective and more efficient care than traditional care providers

('better care'), as it spends less hours per client, has shorter throughput times and diminishes the so called unplanned (crisis) care
2. Buurtzorg also organises more effective and efiicient ('cheaper care'), as a result of higher productivity, lower overhead and lower illness rates and lower staff turnover (Ernst&Young 2009)

In 2012 Buurtzorg was awarded Best Employer of the country in the category of 1000+ employees institutions for the second consecutive time. Employees' satisfaction scored 9 out of 10 points, 'involvement' scored even a 9.7.

Recently Buurtzorg has added new services to its package, closely aligned with Buurtzorg teams:

- Team based private services for clients like helping with shopping, doing the dishes, walking the dog, cleaning the balcony ï provided by a team for a standardised tariff (Buurtzorg Nederland 2013)
- Team based Youth care
- Team based Psychiatric help at local level

Essentials of team based care (input for the next three paragraphes mainly comes from van Dalen 2012)

Buurtzorg Nederland does not control or manage its teams in a hierarchic way, even in the start-up phase. The span of control of each team is restricted by two elements:

1. a framework and guidelines for setting up a team
2. the 'rules of the game' for BZ as a whole

Van Dalen, who spent two years participating/researching in the developing Buurtzorg (2008-2010), summarizes these rules of the game:

- a mix of competencies (levels 3 ï 5, nurses and nurse's aids)
- a maximum 12 team members ï when more people want to join the team should split up or a new team with a new local territory should be formed
- 40 ï 60 clients from 15,000 ï 20,000 inhabitants of which at least 17% over 65
- the team can carry out the whole of nursing and caring needed, includingpermitted medical technical treatments; it is responsible for organisation and justification from intake until 'out of care', co-operates with local doctors and is in contact with hospitals, other insitutions referring clients and (informal) care providers
- all team members are responsible for the co-ordination of the work
- teams divide tasks and activities mutually
- regular team discussions have to be organised (about clients,planning, team co-operation, co-operation with other stakeholders, work organisation)
- teams plan intervison sessions, reflecting on (difficult) care situations, dilemma's, their own role in it)
- teams provide an annual plan (which activities directed towards cklients and quality, training of team members, care organisation, new solutions for experienced problems)
- team members are responsible for maintenance of personal qualifications and individual professional development; teams can spend 3% of their wage sum for training and development ï 1% for regular formal courses, 2% depending their own views
- a productivity guideline for a stable/experienced team is between 55 and 60% of its time
- decision making in the team is by consent, the teams as a whole is responsible for its results (supporting regional coaches help teams do thios by suggesting a consent decision can be

temporary, and will then be evaluated and eventually changed; a nurse: *'In my previous job the manager always decided after consulting us. The decision was often for a long period of time. If people disagreed they fled into desobidience. Me too. It's good that we agree upon a point and then try out if it wiorks in practice. If it does, it's ok. If it doesn't we can adjust it. Once the responsibility is your own, you make your own choices and want to honour them.'*

Role and position of the coaches

The regional coaches have no hierarchical position towards the teams. The support they provide tends to have five dimensions:

- practical support at the start, when new members are sought (but still decison making on the actual selection of a new member is a responsibility of the team only)
- help reinforce team processes
- call attention to team problems not (yet) seen by its members (tendencies within hourly work registration of the team, how to do this more effective, point out latent tensions in the team and make this open to discussion)
- reflecting the work and behaviour of a team from the general Buurtzorg vision, without pushing or forcing the team to change its orientations
- eventually take responsibility for personal problems in a team (long term illnesses of team members and the legal procedures to be followed, team conflicts and eventual 'solutions' by moving people to other teams or to a job outside Buurtzorg)

A coach: *'I now act totally different from the time I was a care manager, and I also look different. Despite having more distance from the team in a way, I now have much more feeling for what is really at stake.'*

Buurtzorg 'headquarters'

Headquarters in Almelo provides services and knowhow for the teams. Since 2008 a virtual network has been installed. *Buurtzorgweb* is accesible for each individual team member. Actual information, practical support for teams and team decisions, relevant knowledge can be shared. The web facilitates teams in their administrative and formal responsibilities. Once a client has been taken in by a team and got an intake module, a copy is sent to headqarters. From here the external financiers are served. Team members registrate the number of hours spent on a client on Buurtzorgweb, and 'Almelo' translates these data into declarations. Each months productivity data of all teams are available for each employee. Teams can compare their productivty rates with other teams. They thus can decide to consult teams with higher rates about improving productivity or introducing better time registration systems. The web facilitates discussion forums and exchange of knowledge or network relations.

The work of the central administration in Almelo is based on the assumption that 'team practice is leading': administrators should be accesible for team members, react quick and look for solutions fitting teams dayly work processes. Buurtzorg tries to restrict special 'support staff jobs' to the minimum. This should help and challenge teams to:

- maintain ownership of problem and solutions
- produce situation specific solutions instead of general policy making for the whole company
- flexible decision making: in case the solution does not work out, teams can directly take action

Social dialogue – self management and the Works Council Law

In principle trade unions are positive about the Buurtzorg Nederland concept. Strenghtening craftmanship and professional development for care workers is certainly in line with what members and officials promote themselves. The same for the tendency to stop building bigger and more taylorized care organisations. Moreover Buurtzorg employees are paid according the sectoral labour agreement the unions have negotiated, and invest in their own training and development. In general new employees get an open ended contract with Buurtzorg after the first two months, which gives more employment secrurity than in other organisations.

However there are also critical reactions. The fact that employees themselves take responsibility for division and intensity of care can be threatening.In a union meeting reactions on the Buurtzorg organisation were positive, but strengthening the role and influence of clients was also seen as partly problematic for care employees: *'Together with the client and/or family you can decide on what is responsible care at a certain moment. Nowadays we see client organisations claiming more influence. The union should have a policy towards these developments. Not totally against it. But together.'* (CNV Publieke Zaak, 2012)

The self-managed teams in combination with a very lean support system has also created difficulties in following up regulation on works councils. As teams decide on most issues regarding their own work (organisation), Buurtzorg has not chosen for a regular works council, dialoguing with the direction of the organisation. Instead, four times per year regional employee meetings take place, in which employees meet and discuss actual and future tendenceis. Buurtzorg claims this is in line with the legal obligations. However some unionists see this as weakening employee countervailing powers and the position of works councils in general.

Internationalisation of the model

1 December 2011 Buurtzorg Nederland helped start a Swedish initiative, inspired by the Dutch example. Grännvard Sverige AG in Bälsta (http://www.grannvard.se/) seems successful. This year 10 Swedish self-managing teams will be operating.
Initiatives have been taken in USA and Japan to follow the Swedish example. Director de Blok expects the first experiments in those countries will be starting in 2013 or 2014.

Conclusions

Self-managing local teams in care, as initiated by Buurtzorg Nederland, not only tend to improve the quality of labour and work satisfaction for the professionals working. They also seem to produce more satisfied and care-independent clients and clients relatives, as well as effective and cheaper care on the long run. These effects are not reached by rising the level of external flexibility, employing lower educated employees or lowering hourly wages and secondary labour conditions. Based on multi skilled local team decision making and a very low overhead, the Buurtzorg case could be an alternative for ever lower standards and care fragmentation in public services as a result of crisis and restructuring.
Trade unions are positive about the initiative, but also see dangers. In particular the change from works council towards employee meetings ias seen as a threat for the system. Still many unionists are among the new groups joining Buurtzorg every month. It is to be seen what their input will be in future union policiy making in care.

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