Quality of jobs and Innovation generated Employment outcomes

QuInnE.eu

LAUREN COMMITEAU[1]
BAS KOENE[2]
CLAUDIA BALHUIZEN[3]

WeCare: the district nurse and self-organising home care teams – when efficiency meets professional discretion

July, 2018

Work Package 2: QuInnE Developmental Tools

Deliverable 2.7: Home/Elderly Care - I-2C

[1] *Erasmus University, Rotterdam School of Management, Netherlands*
[2] *Erasmus University, Rotterdam School of Management, Netherlands*
[3] *Erasmus University, Rotterdam School of Management, Netherlands*

QuInnE - ***Qu****ality of jobs and* ***Inn****ovation generated* ***E****mployment outcomes* - was an interdisciplinary project investigating how job quality and innovation mutually impact each other, and the effects this has on job creation and the quality of these jobs.

Drawing on the Oslo Manual, both technological and non-technological innovation were investigated. Through quantitative analyses and qualitative organization-level case studies, the factors, as well as the mechanisms and processes by which job quality and innovation impact each other were identified.

The QuInnE project brought together a multidisciplinary team of experts from nine partner institutions across seven European countries.

QuInnE Project Member Institutions:

- *Lund University, Sweden*
- *The University of Warwick, UK*
- *Universitaet Duisberg-Essen, Germany*
- *Centre Pour La Recherche Economique Et Ses Applications (CEPREMAP), France*
- *Magyar Tudomanyos Akademia Tarsadalomtudomanyi Kutatokozpont, Hungary*
- *Universiteit van Amsterdam, The Netherlands*
- *Erasmus Universiteit Rotterdam, The Netherlands*
- *Universidad de Salamanca, Spain*
- *Malmö University, Sweden*

The project ran from April 2015 through July 2018. The QuInnE project was financed by the European Commission's Horizon 2020 Programme 'EURO-2-2014 - The European growth agenda', project reference number: 649497.

More information about the project and project generated publications and material can be found at www.quinne.eu.

QuInnE contact person: Chris Mathieu, Christopher.Mathieu@soc.lu.se or quinne@soc.lu.se.

The QuInnE teaching cases and teaching notes are based on the confidential field research conducted in the context of the QuInnE project. They are written to provide material for training and class discussion rather than to illustrate either effective or ineffective handling of a management situation. Personal names and identifying information from the research cases have been altered for the purpose of confidentiality. The case studies and teaching notes have been developed in cooperation with RSM Case Development Centre of Rotterdam School of Management, Erasmus University (www.rsm.nl/cdc).

The WeCare case is largely based on confidential Dutch field research cases conducted in the context of the QuInnE project, WP6. For the purpose of confidentiality, all company and personal names and identifying information from the research cases have been altered.

WeCare: the district nurse and self-organising home care teams – when efficiency meets professional discretion

Introduction

Sitting in his office in the South of the Netherlands, looking out over the pastures beyond, Bas Smit reflected on the future of his company's main organisational innovation in recent years: the introduction of self-organising neighbourhood care teams and the role of the district nurse. The CEO of WeCare, a Dutch regional care organisation providing home care, intramural nursing home care and extramural home care and social care, had just returned from a high-level funding session organised by the Dutch Healthcare Authority. In addition to people from the care sector, the meeting included representatives from insurance companies, government agencies and healthcare providers—all there on a rainy afternoon in late 2016 to assess recent attempts by care providers to improve the quality and personalization of home care while cutting costs.

Although all agreed on the move towards more local embedding with increased responsibility for nurses in neighbourhood-based, self-organising teams, there had been debate on precisely how to embed the teams in the organisation and their neighbourhoods. While some had argued for self-managing teams, following Dutch care organisation Buurtzorg's very successful approach with completely autonomous teams, Smit believed that WeCare's embedded self-organising teams featuring district nurses improved possibilities for local coordination.

Home care involved many stakeholders, and most found something of value in these decentralized solutions: autonomy for nurses and professional care workers, personalized attention to clients and a focus on inclusion and activation that involved clients' informal care networks, which took some of the pressure off the formal care system. Still, there were significant challenges to deal with in the sector. Funding for home care was under constant pressure, reoccurring tendering for contracts led to regular reorganisations and, since last year, a labour shortage put increasing pressure on nursing staff in the teams.

With district nurses in place, Smit felt WeCare was able to deal with both the volatility and the interconnectedness of care work in local environments. He very much believed in regional, local solutions. These were very important in the home care landscape that was rapidly changing due to both technological and societal developments. This required a level of coordination within and between organisations that benefited from the role of the district nurse. For the past four years, the district nurse's activities had been funded through the governmental 'Visible Link' program, but this now seemed to be coming to an end.

Smit concluded he would have to show the value of WeCare's approach to self-organisation once again. Smit reflected on the pros and cons of the district nurse model and its possibilities for the future. It had proven its worth at WeCare and in the communities it served. He felt strongly it was one answer to dealing with the internal challenges that the rapidly changing external world of home care was posing. He cleaned his whiteboard and got busy.

WeCare

In 2016, WeCare was a well-established Dutch care organisation offering welfare, care, living and comfort facilities to more than 20 municipalities in the south of the Netherlands. A broad regional organisation, WeCare placed a high value on the local networked nature of care services.

WeCare was organised as a holding company with a divisional structure (care, welfare, comfort). All divisions were governed by a two-person Board of Directors, which in turn was supervised by a Supervisory Board. The Welfare division included home support, regional help and youth support. Care and Comfort included both intramural (nursing homes) and extramural activities (home care). In 2015, WeCare employed 2,000 people (the equivalent of about 1,000 full-time employees). The Care and Comfort division cared for a total of just over 3,000 clients in 2015, of which half were home care clients.

WeCare had high ambitions regarding Human Resources Management (HRM): It valued its employees and aimed to provide highly skilled workers who delivered good quality work.

While these ambitions were genuine, the turbulence of the past years, including a reorganisation of the care organisation with personnel reductions in indirect functions in 2015, had put great pressure on the organisation and also the HR department, making it difficult to deliver on these promises.

Furthermore, due to the large number of temporary contracts, employee turnover had been relatively high over the past years. Providing a distinguishing HR profile for employees had thus been a challenge. The company had an initiative labelled 'local colour', with the intention of giving different locations the opportunity to create their own identities, although the basic services were not different for the different locations. More importantly, employees might be more connected to their clients and location than to WeCare, due to the dependence on public tenders for offering its services. If the organisation lost a contract, the sector collective agreement stipulated that people and work could then follow the contract. Under these conditions, the anchor for the employees was the client and the district. The organisation was a variable in this equation.

With clients staying home longer and receiving more complex care at home, HR strategies at WeCare were focused on education and skill development. Dictated by strict healthcare legislation (the BIG law), people needed to be formally qualified and capable to perform certain practices. One strategy was to educate employees ad hoc when a procedure needed to be performed. While employees could be taught fairly quickly, this was expensive and did not give them professional experience. An important strategic choice was to decide between buying the services from specialist providers versus educating employees.

Still, over the past years the developments at WeCare had not been just reactive to changed market requirements. The organisation had actively reorganised and engaged in both technological and organisational innovation to better cope with the changing environment and prepare the organisation for the future. Key developments were organisational innovations introducing self-organisation and the role of the district nurse, which was WeCare's response to the call for

increased local responsiveness of care organisations in the Netherlands. The introduction of self-organisation for the home care teams started with an operational excellence program, in hindsight labeled self-organisation 1.0. It was followed by self-organisation 2.0, a program aimed at service excellence and 'hostmanship'.

In all, trade unions and worker representation did not seem to have a large impact on the developments. The reorganisations of the past years had been relatively top-down changes in the organisation. Where needed, unions and work councils had been involved, but otherwise their influence was limited. In the reorganisations and the key organisational innovations over the past years, management had been driving the changes.

At the same time, employee participation was considered especially important when increasing self-organisation within the teams and, eventually, at all levels of the organisation. Self-organisation, autonomy, and control based on relevant and complete information were important elements of self-organisation 1.0, focusing on improvement of operational excellence.

Developments in Home care

It was in home care where WeCare's major changes between 2012 and 2016 took place. As a large, local organisation, WeCare switched from centrally-controlled neighbourhood teams to a structure of self-organising home care teams with a great deal of independence in the execution of their work and with specially assigned district nurses fulfilling a coordinating role for their teams.

In recent years, the Dutch home care sector had been subject to reforms, budget cuts, political considerations and other upheavals that made for a turbulent and complex environment for home care providers. Government policy sought to reign in increasing healthcare expenditure, but simultaneously, the population in the Netherlands was aging rapidly, meaning more people required home care. (see also appendix A and appendices B and C for a European perspective)

Yet in the face of budget cuts for health and home care, people were also being encouraged to leave hospitals as soon as they were able and to remain at home for as long as possible before entering a care facility. "In the near future you should really see a hospital as a pit stop," said WeCare's home care manager Anita Hemel. "You will arrive, be repaired and then you will leave again as soon as possible." Technological innovations expedited these developments. While some innovations facilitated the work and reduced travel time, such as video-calling and automated medication dispensers, some innovations also increased both the volume and complexity of work in home care, explained Hemel:

> *"Transfusions at home…. We now act as if it's the most common thing in the world. Well, to have a blood transfusion at home or antibiotics at home in a pump, that was unthinkable five years ago. That did not exist, perfusion therapies. …Chemotherapy at home? Impossible! Well, no, actually now this is common practice."*

Over the past years the pressures—on income, effectiveness and efficiency—meant cost-cutting, reorganisation and layoffs at WeCare and other home care organisations. But it also led to innovations, especially new initiatives to introduce geographically based self-organising teams embedded in the local community.

Dutch policy was emphasizing a shift towards a more client-focused model of home care, one that had its roots in local care. The initiatives were stimulated by the Netherlands Organisation for Health Research and Development's (ZonMW) 'Visible Link' program, which was aimed at rethinking the organisation of home care with an eye towards improving the role of district nurses in their respective neighbourhoods.

The initial ZonMW program ran from 2009 to 2013; it was followed by a second program, 'Visible Link2', which ran until 2016. The ZonMW program reflected the broad consensus that it was important to strengthen the role of nurses in home care provision. Many organisations came up with innovative solutions. A highly successful initiative was *Buurtzorg's* "nurse-led model of holistic care", where nurses organised in local self-managing neighbourhood teams. This new organisation operated with a very limited central organisation that was set up to support the independent local self-managing teams. *Buurtzorg* was lauded for its effective use of funding, its local flavour and its popularity among patients who needed home care. The rapid growth and cost-efficient way of working with independent teams of nurses who seemed to be able to use the informal network of clients in an unorthodox way made *Buurtzorg* the darling of politicians: more personal care at a lower cost was proving to be a win-win situation for all.

For larger, established home care organisations such as WeCare, implementing such a radically different organising principle seemed impossible, and to some extent, undesirable. Like most older home care organisations, WeCare followed the trend and developed from a rather centralized organisation into a more decentralized structure with neighbourhood-based self-organising nursing teams, but in implementing the changes, WeCare was careful not to throw out the baby with the bathwater. It introduced self-organisation in combination with the role of the district nurse, an approach that also received special recognition as a ZonMW 'pearl project' in 2012.

The District Nurse

WeCare introduced the district nurse in a cooperative effort with a regional health care association and five other home care organisations. The name of the district nurse, which in Dutch would literally translate as 'neighbourhood sister', refers back to the historical role of local neighbourhood nurses who were called 'neighborhood sisters'. These nostalgic figures fulfilled a central role in their neighbourhoods, providing and helping people organise the support that they needed from cradle to grave.

Smit felt the reintroduction of the district nurse perfectly suited WeCare, which had a strong local presence in the neighbourhoods where it worked. Its many connections and personalized care also proved invaluable to its clients.

In the district nurse model, the district nurse was again positioned as the key person in neighbourhood care provisions. She was not only the lynchpin to providing the care network surrounding a client, but she acted as a liaison between the different care organisations, the clients and the district. In the local network, the district nurse served as a neutral party that did the intake for home care. This neutral role was guaranteed in agreements regarding training and certification, education and rules of conduct that were arranged in a cooperative.

By 2016, more than 60 district nurses worked through the cooperative of five regional care organisations. They were employed by one of the five partner institutions, together covering the whole region of the south of the Netherlands. The district nurses fulfilled a dual role. WeCare's district nurses were each responsible for two neighbourhoods. On the one hand, they served the independent networking role, acting as visiting nurses[4] and establishing care with individual clients. On the other hand, the district nurse was a key actor in WeCare's self-organising nursing teams in "her" (most district nurses were female) two neighbourhoods.

The neutral networking role of the district nurse aimed to fulfil the care need of individual clients by offering them the possibilities of all local actors offering services, ranging from social care to highly specialized medical care. In other words, clients were free to choose the providers they wanted; they did not have to opt for WeCare. The duality of the district nurse's role was further dictated by the financing structure, and an independent certification and control procedure maintained by the cooperative ensured the independence of the district nurses in their neutral role.

At WeCare, all district nurses worked 32-hour weeks, in which they split their time between their two responsibilities. The financing was activity-based and provided separate amounts for both roles the district nurse fulfilled in the district. Segment 1 funds were designated for the independent networking role that the district nurse performed as part of the cooperative. It was provided as part of ZonMW's 'visible link' and 'visible link2' program. The financing was received through the municipality, and the nurses were paid by their individual care organisations.

The moment that a person was granted official care provided by one of the home care organisations, the role of the district nurse changed. In case the client had chosen for another care provider, she handed the client over to that care organisation. When the client chose for WeCare, she then operated as an employee of WeCare and part of the local self-organising nursing team in the neighbourhood where the client lived. The activities done in this capacity were financed through the segment 2 funding provided by the medical insurance company or the municipality, depending on the nature and context of the work. (See also appendix D)

In this capacity, the district nurse acted as coach and coordinator of the local self-organising nursing team. The district nurse was not hierarchically, but

---

[4] *See appendix D for explanation of role visiting nurse in Dutch healthcare*

functionally responsible for the team. She had a central organisational role within the team and kept the overview. With the further development of self-organisation, the district nurse was expected to become more an equal player and less the 'captain' of the team.

While the district nurse initiative was successful, the segment 1 financing was a temporary source of funding that ended in 2016 as part of the ZonMW projects. An official extension of the funding was not granted, as at the national level the policy choice was to include the funding for this work in the general funding for home care provision. The argument was that the segment 1 and segment 2 roles for nurses should basically not be separated in funding streams and that there was no need for separate funding for the district nurse as a neutral connecting party, because self-managing neighbourhood teams would make the same connections and provide the same care without that central figure.

But Bas Smit had his doubts: he believed WeCare's district nurse system and support staff had provided the self-organising teams with more support and had been able to offer richer care and services to their clients, especially in case of more complex, multifaceted care requirements. To cope with the emerging situation, two insurance companies had stepped in to secure the survival of the initiative. The search for further sustainable ways to formally embed the role of the district nurse was still underway.

Self-organisation in home care

The introduction of the district nurse was part of WeCare's reorganisation towards self-organising teams over the past years. Before the district nurse and her teams became the organising principle for home care, there were already teams in place in various neighbourhoods. But they were all centrally organised. After the revival of the district nurse, responsibilities in WeCare shifted: Many central activities now became the work of the teams. This decentralization of responsibilities led to friction between the district nurses and central staff departments.

> *"It's much more difficult to create a turnaround in an existing organisation," said Martina Fehmers, a member of WeCare's executive board. "We have been working on the district nurse model for seven years now, and that has really turned the organisation here upside-down. That's because the management and staff training is done by the department of staff and training. But when we placed the district nurse in a central position, she said: 'No, I see what clients are coming in…. I decide what training is needed here. So I am fine with your forms, as long as they do not bother me. I do not need much dealings with the customer service bureau.' So yes, a lot of friction occurred in the organisation."*

With the introduction of the district nurse and self-organisation, team size played an important role in maintaining efficiency, with an average of 10-15 people per team, dependent on the size of the district covered. Previously, the composition of the team was more diverse, featuring level 2, 3 and 4 carers. For the self-organising teams, the minimum education level was raised to level 3-IG (Individual Healthcare) carers, complemented by level 4 nurses. A district nurse

had to be a level 5 nurse. On average a team consisted of about 12 people with two nurses per team.

Within the new teams, the members developed their own roles and specialties. One person planned, another took care of the routes, and all had their own medical specialties (wound care, dementia, etc…). Every team member also had primary responsibility for a few clients; they weren't the sole caretakers of their clients, but they did oversee the delivery of care. The teams were also self-policing, discussing ways of handling specific clients within the context of the clients' care indication, developing shared approaches so all carers performed the same amount and level of care, especially important, for example, when the approach was intended to stimulate the client to learn and become more self-reliant and less dependent.

The nurses were happy with their new position and responsibilities within the teams. The self-organising model reduced bureaucracy and centralization, increased their professional discretion and control over their work, and created a more client-centred approach focusing on personalized home care.

Uncertainty arose over the role of the district nurse in the self-organising teams. Was the district nurse to become a new team leader? In order to clarify her position, WeCare began using the analogy of a soccer team: The district nurse was the team captain, informally steering the team and acting as representative and contact person for the team when required, but leaving most of the discretion to team members in the execution of their work. District nurse Ilse Janssen explained:

> *"On that playing field is a team captain who ensures that everyone in that field is connected to each other. But that captain also gets input from the sidelines, from the coach, from the trainers—overviews, information, tips such as, 'Try to play more offensively or try playing more defensively.' And she then goes, with her own group, to do it herself. But at a certain moment, as more security arises in that playing field and people are better aligned, she needs to do less and the captain can actually get out of that field a bit. She still participates in the team, but she can do something more. She no longer has to play such a central role, but she does keep the overview. This metaphor proved quite helpful."*

The self-organising teams were not self-managing, however. While the district nurse was responsible for the functioning of 'her' teams, the team leader remained hierarchically responsible. However, with the introduction of the district nurse, the role of the team leader had also changed. The care-related responsibilities within the team were transferred to the district nurse, who acted as coach to the team. Team leaders were now covering a larger geographical area and were also hierarchically responsible for the district nurses in those areas. Their role became more of a facilitating and administrative one, with team leaders becoming involved when formal interventions were deemed necessary.

For the team leader, this meant that the meetings were the only way to keep in touch with the teams.

> *"The meetings are in my diary, that's just blocked, and I think that's important," said Team leader Gwenyth Peterich. "Because otherwise I am some scary person*

at a distance and I do not want that. Then I am such a monster who is only there when something is wrong, I do not want that either. Because they can also come to me if they have good news."

For the nurses the situation was similar. There was less face-to-face interaction within the teams. Self-organisation has led to an experienced distance to the team by both the team members and the team leader. And similarly, the nurses experienced the loss of a location where they could always, albeit briefly, meet up with colleagues in the office:

"This location is empty for us now. Before, a nursing colleague was there, or the district nurse, someone you could have a chat with. But that has disappeared," said WeCare nurse Hanneke Boom of the increasing alienation of her job. "You would meet each other here briefly, and in the past, we had a system where you clocked in when arriving at people's homes, and every week I had to go to the office for this device to be read. So you came to the office every week and then you would run into your colleagues. Not anymore."

Pros and cons

The nurses and carers were very satisfied with their new positions and responsibilities. The self-organising teams reduced bureaucracy and centralization, increased professional discretion and gave nurses the opportunity to organise personalized care better, leading to a more client-centred approach to home care—things all home care nurses appreciated.

The increased independence of the nurses proved to be a motivating factor; finally, their self-styled work was appreciated and rewarded. For the district nurses, their neutral role coordinating neighbourhood care was especially visible and highly rewarding.

But there were some problems. The nurses still believed that many decisions were taken by the central office. And the self-organisation model presented a bit of a double-edged sword: The added freedom and responsibilities the nurses appreciated also led to more work pressure.

Reflecting on the position of the nurses in the self-organising teams, WeCare's manager of home care Anita Hemel noted:

"There are more things the nurses must do. On the one hand, they are convinced that these things should have always been part of their function, but they have never been able to do them. I think we are still at the beginning, and they experience a lot of work pressure. But I think they're still a little bit in that flow of 'Oh, how wonderful, we can finally do the beautiful work we were actually trained for.'"

For daily activities, the organisation of work increased choices and added complexity to the job. Organisational solutions to support teams in the management of their activities were under-developed. Add to that a labour shortage that left nurses working longer hours for the same pay and job satisfaction took a hit. Management saw these as serious threats that needed clear attention. Anita Hemel says:

"… Work has increased somewhat in complexity. And level 3 and level 4 nurses notice that too…. It does make them much more aware of the importance of their role and that of the team, what they are doing…. It also makes them wonder that if they are not there, a family system can really be disrupted. I think that awareness has become much greater. And I do think that people experience this as pressure, as well as when you cannot sort it out … and think you actually provide too little care in a certain client situation."

Technological advances, too, were impacting the home care sector and the work of the nurses. Procedures such as blood transfusions, fluid and antibiotic treatments and even chemotherapy were being done at people's homes. While these tasks enriched the work of the home care nurses, it also required more highly trained personnel and the training of existing staff. Technology, too, meant some check-ups could be done by video link, freeing up home care workers who didn't have to travel to each client's home, making care more efficient. But at the same time, it removed some of the nurse's simpler tasks, meaning her workload became more intense.

Self-organisation also led to challenges for those who were not as adept at organising their own work and time.

"It's a very vulnerable position to be in if you have no direction in such a team, and there are some people who are still developing and maybe have a hard time catching up for a moment," said team leader Gwenyth Peterich. "They can be completely overruled by a group of people who can arrange things very well for themselves. And then they always end up with the difficult shifts at Christmas."

The district nurses at WeCare also felt the increased work pressure, as team leaders often contacted them before reaching out to the team directly. The double role that the district nurse fulfilled—as both coach and coordinator—did ask for more tasks in the same, or even somewhat less, time. The tasks, also within the team, had become more complex. There was an increased realization that their presence in people's homes was crucial, which was accompanied by higher received pressure, especially when some things could not be done with the means available. In general, the manager of home care was wary about the developments regarding work pressure:

"I hear more and more people say that it is becoming busier and busier and the job market is getting painfully tight," said Hemel. "It puts us in a squeeze. So I think we should keep a very sharp eye that this is not going to become a problem. But still, I've never really heard anyone say, 'Actually, please, do not give me this responsibility.' … All the same, we are now at a point, like, it's a lot of work that we are doing with each other. And when you add the increased responsibilities, it becomes quite intense."

Voltage on the system

The rapid growth and changes in the home care system led to much turbulence at WeCare, whose reorganisation also included layoffs and re-training. With the HR Department under strain, it became difficult for the company to deliver on its promises, meaning it couldn't yet fully support its own self-managing teams.

> *"In recent years, it was difficult because it was really about reorganising and keeping our head above water," said WeCare HR Director Jasper Bloom. "The financial pressure was so dominant that, in fact, this department here, there were 12 people and when the gunpowder smoke had disappeared, there were just three left. Then you understand that for the moment, this ambitious attitude was not so visible. But still, it has not been lost."*

But in 2016, the market situation changed. By mid-2016, there was an extreme shortage of qualified nurses and carers. Furthermore, the demand for care was increasing, while the national workforce remained tight and was expected to stay that way for the coming years. Especially level 3 IG carers and level 4 nurses—the employees who have to do the operational work and provide the volume to do the work—had become difficult to find.

Dealing with the employee shortage had become an important issue for WeCare by the end of 2016. They looked around for solutions, including possibly retraining and upskilling, tapping the Belgian labour market and hiring back former employees.

> *"We are investigating how we can retrain people as soon as possible so they can get to a higher level where they can easily handle the complicated care, or at least the care at home," said WeCare's Hemel, who also emphasized the need for cooperation between care organisations. "Competition is now no longer meaningful, because then we only make life miserable for each other, and that does not work. This is a concern in the labor market, so it must also lead to a structural change."*

WeCare increased its emphasis on cooperation both internally and externally. The district nurse was the first step towards that cooperation. Furthermore, WeCare wanted to better integrate welfare and care activities, as well as diminish the gap between intramural (nursing home) and extramural (home care) care. The company believed that was one solution to the labour shortages and would increase the flexibility and responsibilities of employees. It also made career switches for nurses possible. Experienced nurses could be deployed both intramurally and extramurally, or could transfer from intramural to extramural roles where they had to operate more independently. It helped them think outside of the box. For example, the expertise of an entrepreneurial and client-oriented home care nurse relocated to a nursing home could breathe new life and creative approaches into more cautious nursing home care.

But there were bottlenecks to the integration of care: complicated and separate funding flows and rules and regulations that prohibited non-medically trained staff from performing small care procedures stood in the way. This made restructuring challenging. The different bases for financing welfare and care

were a key issue, often mentioned by management. WeCare executive board member Martina Fehmers explained:

> *"We are organised categorically from the funding flows. So the sector manager is responsible for the welfare section because it is financed by the municipality. Then we have home care, which is completely contracted by health insurance. Then we have our intramurality organised by long-term care."*

While it was clear that WeCare wished to integrate and cooperate within the organisation, a further key restriction that stood in the way of blurring the lines between the welfare and care activities were the rules and regulations surrounding education levels and the activities within the scope of the lower level welfare employees. Rules and regulations prohibit non-medically trained employees from performing small care procedures, or even assisting with personal hygiene.

There were, however, some grey areas: family members, friends and volunteers were free to learn and perform such activities.

> *"You can teach the care procedure to family, but you can't teach it to a buddy, because he needs a diploma. That is already a professional caregiver. But can't a volunteer be a buddy? It's exploring grey areas for sure," said Team Leader Gwenyth Peterich.*

External, inter-organisational cooperation was aimed at adding specialized services and developing novel care solutions requested by the market. Adding specialized services to WeCare's portfolio was important to deal with the need for specialized skills that were too costly to maintain within WeCare, such as the medical technical team that was shared between five care organisations in the area.

But it was also about the development of novel care solutions required in the market. The need for transmural care, a kind of portal between hospital care and home care, led to increased cooperation between WeCare and other care organisations, GP practices and hospitals and a quicker and smoother transition for patients leaving hospitals or care centres for home.

Transmural care had a strong external mindset, focusing on getting people back in their own homes. At WeCare, the transmural possibilities were integrated into the care process under 'The Bridge' project, improving the flow of people back into their homes.

> *"Transmural care is a kind of buffer between hospital and home care, a kind of front porch or portal," said WeCare executive board member Martina Fehmers, pointing out that it worked both ways: As an option to avoiding or delaying hospitalization but also as an intermediate care solution for people leaving the hospital but not quite ready for home.*

Integration and the different forms of collaboration seemed to hold the potential to improve job quality and, with further organisational support, provide growth opportunities for WeCare in the future.

The future of the district nurse and self-organisation at WeCare

WeCare's model of self-organising teams with district nurses increased the job quality of nurses as it reduced bureaucracy, increased professional discretion and replaced business as usual with a positive client-orientation. At the same time, the cocktail of pressures driving the initiatives created a situation where growing professional discretion and responsibility coupled with cost-reductions and the growing demands on the sector led to increased work pressure and work intensification—developments that challenged job quality.

The WeCare model seemed dependent on finding the right balance: There's a possibility to increase the job quality of nurses if it's done well; but if not, the massive increase in work for nurses could backfire.

Although Smit believed they had done well introducing the model of self-organisation with district nurses and was happy with many of its benefits, there was still pressure on his organisation, on the self-organising teams and on the district nurses. Add to that funding dilemmas, and Smit had his work cut out for him. How could he highlight the value of the approach he still believed in? Could and should it be improved? Given the shortage of nursing staff, a positive interaction between organisational innovation and job quality seemed to be key (with job quality providing a basis to unleash and nurture the innovative potential in the self-organising teams). What were the basic challenges? What were the strong elements in their model? How should they move forward?

Other stakeholders also weighed in: Insurers were satisfied and wanted to continue to finance, at least temporarily, the role of the district nurse separately in the event of government funding falling away, as it appeared to be doing by the autumn of 2016. Inter-organisational cooperation with hospitals and other care organizations was evolving.

Smit believed the role of the district nurse should be funded at the national level.

> *"It's about infrastructure in the Netherlands," Smit had told those present at the November funding meeting. "What do we think there should be? If you think about GPs, or the need for an ambulance service, that's something that also isn't covered per ride. But we have the ambulance facility in the Netherlands because we think everyone should have access to one within fifteen minutes."*

Smit also spoke about what he believed was the added value of the district nurses.

> *"They are the link between the social and the medical domain. They look broader than those two things. And that is exactly the tilt we want to have in the Netherlands."*

Aging home care clients seemed happy with the personal and locally embedded level of care provided by the district nurse, who reminded them of their beloved and nostalgic *neighbourhood sister*.

But as the meeting at the health authority had made clear, not all agreed. What should the future model for WeCare be?

Appendix A

Home Care in the Netherlands

Public health expenditure has been a growing issue in the Netherlands. While expenditure in the health sector had been quite stable at 14.5% of GDP since 2012, it increased strongly in absolute numbers. With an increase of almost 55 billion euro over a period of 22 years, the stabilization and reduction of health expenditure had become a priority government objective. Parallel to this increase in expenditure, the population was aging rapidly and this was not expected to slow down in the future. In 1950, 7.7% of the Dutch population was 65 years or older; by 2015, the percentage of people 65 and older had increased to 17.8%. The home care target group mainly consisted of elderly people, making this development important for the industry. (QuInnE, 2016)

Companies and employment in the Netherlands

The home care sector has seen a dramatic change in the number and size of companies that are active. In the period from 2008-2016, the total number of companies in the sector increased 7.5-fold from 1,680 to 12,555 (see Table 1 below). This increase stemmed from the enormous number of self-employed individuals that became active in home care.

Table 1 The Netherlands Home Care Industry: Number of Companies by Size (# of employees) 2008 – 2016

		Number of employees per company									
	Total # of companies	1	2	3 to 5	5 to 10	10 to 20	20 to 50	50 to 100	100 or more	0 to 50	0 to 250
2008	1680	1180	90	65	65	65	65	45	105	1530	1610
2009	4080	3565	115	65	75	65	60	40	95	3950	4020
2010	6135	5620	110	90	75	65	60	25	90	6015	6065
2011	7700	7100	145	100	95	65	70	25	95	7575	7630
2012	8535	7915	145	100	95	90	60	35	95	8405	8475
2013	10120	9445	180	100	110	80	70	40	95	9985	10055
2014	11130	10410	210	115	110	85	70	45	80	11005	11080
2015	12100	11320	230	115	130	100	80	50	75	11975	12050
2016	12555	11745	215	140	125	115	90	50	80	12425	12505

Note: 2016 data until 2nd quarter
Source: NL CBS, 2016

Whereas in 2008 there were only 1,180 'self-employed without personnel[5]' active, in 2016 their numbers had increased tenfold to 11,745. Also, the number of companies with between two and 50 employees increased, but much slower. On the contrary, the number of companies with 100 or more employees declined from 105 to 80 following downsizing and bankruptcies. The sometimes tumultuous developments in the sector were exemplified by the bankruptcy of TSN in 2015. TSN was a large national domestic help organisation employing 10,000 domestic help workers. In 2016, about half of its activities were taken over by *Buurtzorg* and the other half by local solutions where municipalities made agreements with smaller, sometimes new, organisations to secure the continuity of help provision to its former clients. Hence there has been a fragmentation of the sector in terms of the number of companies.

At the same time, there were still a number of very large companies active in the sector that employed several thousands of people, such as the fast-growing *Stichting Buurtzorg*, which in early 2016 had some 9,300 employees. Some of these large companies are part of multinationals: Incluzio, for example, is active in all areas of home care (not to mention construction, safety and cleaning, too) and forms part of the Facilicom Services Group, a multinational also operating in the UK, France and Belgium.

In 2015, the Dutch home care sector employed some 144,000 people; more than 90% of those were women. The number of employees had declined by some 18,000 over the past five years, while during the period between 2006-2011, it had increased by roughly the same number. According to sector representatives, the bottom was reached in 2015, and for 2016, a rise in employment by some 5% was predicted.

The development of employment in the sector proved hard to predict due to the unclarity of reforms. In 2015, a number of the larger companies in the sector were facing difficulties concerning their continuity, while some of the newcomers were growing rapidly. In terms of employment statistics, sometimes it was not entirely clear to which sector a job or a worker belonged, as a number of companies that traditionally came from other sectors such as cleaning had become active in the home care sector. For the near future, however, a serious shortage of qualified workers in the field of home care is foreseen given demographic developments.

[5] These are self-employed that have their own business, but do not have employees working for them.

Appendix B

From the Foreword to 'WHO 2008', a publication on Home Care in Europe[6]

There is an intrinsic appeal to the term home care that has caught the imagination of politicians, professionals and the public. "Back to the future" is an expression that could accurately reflect the potential to explore, exploit and implement an old idea with today's knowledge and new means. Home care offers the possibility to receive a wide range of services in one's familiar surroundings. Home care emerges now as an increasingly promising option for providing health and social care for many conditions that are especially associated with older age, disability and chronic diseases. Many factors drive the need and demand for home care: demographic trends, changes in the epidemiological landscape of disease, the increased focus on user-centred services, the availability of new support technologies and the pressing need to reconfigure health systems to improve responsiveness, continuity, efficiency and equity. Home care is understood and practised differently around the European Region.

History of home care

There is no single, uniform history of the evolution of home care services policy and provision across Europe. The development of home nursing and home help are bound up with the emergence of complex systems of welfare, social security and health care that have followed different trajectories and given rise to different patterns of funding and provision within each country. Adding to this diversity, prevailing social and cultural institutions at the national level colour the welfare reforms and policy mix. The result is a rich mix of approaches and strategies for funding, organising and delivering home care services, tax-based provision, municipal, regional and national levels of responsibility, differences in health and social service boundaries and greater or lesser policy support for informal care.

Home care provision across all European countries has relied historically on informal care (primarily family) and voluntary or church provision. The central place of the family and extended kinship networks in delivering support to older and disabled people is a consistent theme across all European welfare regimes. Only during the late 19th century did growing state involvement in health and social welfare begin to augment, but not displace, this form of provision.

During the 20th century, large-scale institutions and hospitals became the dominant forms of provision for supporting a range of groups including older people, children, disabled people and people with mental disorders. Nevertheless, professional and consumer criticism of the place of these institutions grew from the 1950s across western Europe and the Nordic countries.

---

[6] Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe.

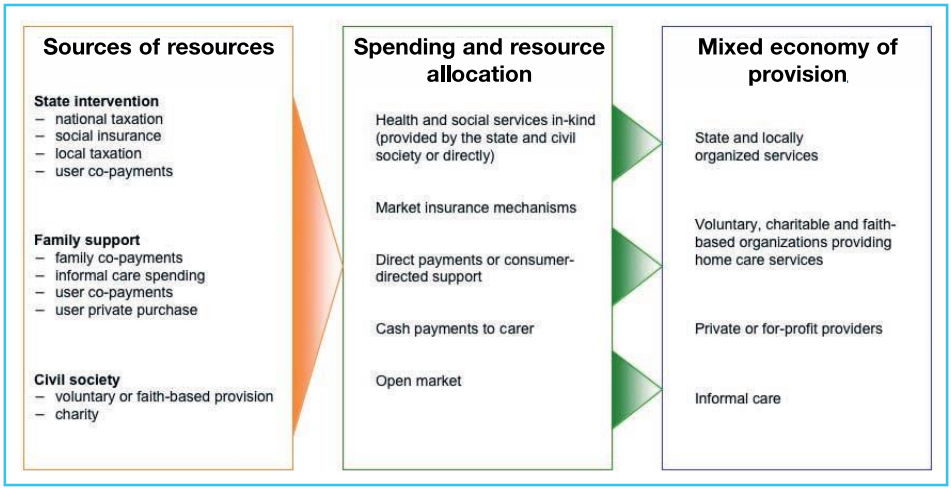
There have been moves since the 1960s to reduce the number of long-stay beds for older people and children in hospitals, to improve nursing homes and residential homes for older people, children and people with disability and to close long-stay mental institutions. Policies known variously as deinstitutionalization, community care, continuous care, integrated care and home-based care were promoted as an alternative to or replacement for institutionalized and acute provision. A major push was to acknowledge the key role and enhance the provision of informal and family care across these groups. In such countries as the Scandinavian countries and England, there was not a direct policy shift from institution-based to family care but a shift from institutional care to community-based formal services and only subsequently to a greater emphasis on family-based care.

Institutionalization and deinstitutionalization processes took place at very different times and paces across Europe. Both were much more recent phenomena in countries in southern and eastern Europe. In countries in eastern Europe, for example, institutional care persisted as a dominant form of provision until the early 1990's.

Adding to traditional forms of home care, hospital and hospice-at-home schemes, home nursing and home help are more recent and complex forms of intervention that reflect developments in medical and information technology. All European countries currently emphasize the importance of providing a spectrum of care for vulnerable groups, but the precise meaning of this and the policy challenges vary within each country according to the contingencies of history and context. In many southern European countries, for example, formal home care has still not been developed fully, whereas some Nordic countries have comparatively underdeveloped voluntary sectors. These differences are explained in part by the differing histories, inherited levels of provision, traditional roles of state and civil society and evolving expectations about where responsibility for home care should lie.

Appendix C

Funding, Allocation and Provision of Home Care in Europe



Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe, p.18.

Influences on the Supply of and Demand for Home Care

Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe, p.3.

Appendix D

Four legislative and financial pillars

Major policy reforms regarding care have led to a significant reorganisation of responsibilities and financing structures in the Netherlands. With some of the care responsibilities having been transferred from the Dutch Government to local municipalities, this has led to significant changes in the home care sector. The activities of WeCare had four legislative and financial foundations.

First, the *Law on long-term care* (WLZ) regulated mostly Intramural (nursing home) care, i.e. care provided in nursing homes. WLZ care was still a national responsibility and eligibility for this care was established by CIZ (Centrum Indicatiestelling Zorg).

Second, *medical and personal care* was regulated by the health care insurance law (ZVW) and was financed through the obligatory health insurance, sometimes expanded with a personal contribution. The care indication was made by a visiting nurse of a home care organisation, who in her assessment had to connect the medical and social domains. The role of the visiting nurse was strengthened by the policy reforms and was reinforced at WeCare as an indispensable link between the home care elements in the role of the district nurse. (QuInnE, 2016)

Third and fourth, personal care for people below the age of 18 (regulated by the *Youth Law)* and *assistance and domestic help* (regulated by the Law on Societal Support – WMO) had become the responsibility of the municipalities in 2015. The municipalities were responsible for supporting self-reliance of those who are not able to cope on their own. Besides a decentralization of responsibilities to municipalities, the policy reforms also entailed a general budget cut of the available finances for assistance and domestic help by one-third, leaving this type of home care almost as a last resort, when informal care arrangements had been exhausted and the patient's need was extremely high. (QuInnE, 2016) For WeCare, although the company preferred to operate in a more integrated manner, the funding flows were the basis for its formal organisation.