

## ORIGINAL ARTICLE

## Buurtzorg Nederland: A Global Model of Social Innovation, Change, and Whole-Systems Healing

荷兰 Buurtzorg: 社会创新、变化和整个系统疗愈的全球模型

Buurtzorg Nederland: Modelo global de curación mediante innovación social, cambio y sistemas integrales

Mary Jo Kreitzer, PhD, RN, FAAN, *United States*; Karen A. Mosen, *United States*; Sharda Nandram, *Netherlands*; Jos de Blok, *Netherlands*

### Author Affiliations

Center for Spirituality & Healing, University of Minnesota, Minneapolis (Dr Kreitzer); School of Nursing, University of Minnesota (Drs Kreitzer and Mosen); Buurtzorg Nederland, Almelo, Netherlands (Mr de Blok); Nyenrode Business University, Breukelen, Netherlands, and Praan Solutions, Amsterdam, Netherlands (Ms Nandram).

### Correspondence

Mary Jo Kreitzer, PhD, RN, FAAN  
kreit003@umn.edu

### Citation

Global Adv Health Med. 2015;(4):1-40-44. DOI: 10.7453/gahmj.2014.030

### Key Words

Social innovation, whole-systems healing, whole-person care, wellbeing

### Disclosures

The authors completed the ICMJE Form for Disclosure of Potential Conflicts of Interest, and Ms Mosen disclosed that she was a paid consultant to Buurtzorg Nederland for implementation of an outcome management program. The other authors had no conflicts to disclose. Please note that Dr Kreitzer, one of the co-editors-in-chief of *Global Advances in Health and Medicine*, had no involvement in the review of this article for publication.

### INTRODUCTION

Countries around the world are facing very similar healthcare issues: the quality and cost of care, poor outcomes, lack of access to care, lack of transparency of information, and a growing dissatisfaction among both patients and caregivers. In the United States, healthcare constitutes 15.7% of the gross national product compared to 9.7% in the Netherlands, 8.9% in Norway, and 7.5% in Ireland. According to a report recently released by the World Economic Forum,<sup>1</sup> with no reforms underway that would affect the fundamental drivers of healthcare expenditures, some estimate that by 2040 total expenditures could grow by another 50% to 100%.

Increases in expenditures are often not commensurate with health outcomes, as illustrated by the United States, which spends more money on healthcare than any other country in the Western world and has health outcomes near the bottom of the Western world. In the United States, even after the passage of the Affordable Care Act, it is estimated that 30 million people will not be able to afford care. The topic of "healthcare reform" is a pressing issue for most countries as it is becoming more apparent that required investments in healthcare adversely impact the ability to invest in education, infrastructure, social welfare, and a host of other priorities.

The healthcare workforce itself is also a dominant issue. While the reasons for this are complex and differ around the world, in many countries, there is a growing dissatisfaction and disillusionment with practice. Most often when healthcare professionals retire early or leave the profession, it is not due to dissatisfaction with caring for people. Rather, it is dissatisfaction with bureaucratic systems that need to be contended with in order to deliver care. Within nursing, major drivers of dissatisfaction include loss of autonomy, frustration with bureaucracy, and adverse working conditions. Dissatisfaction contributes to workforce shortages.

The reform agenda around healthcare often focuses on the financing of healthcare and the coordination of care, given that care is highly fragmented, which leads to errors, poor quality, and poor outcomes. Ironically, both of these strategies strive to give access to healthcare systems that are inherently flawed, are not patient centered, emphasize the treatment of disease over pre-

vention, and are oriented more toward the provision of provider delivered goods and services rather than empowering people to better manage their own health and wellbeing. Healthcare is an excellent example of a social problem that is complex and "wicked" and not amenable to easy, predictable solutions. "Wicked" problems, as defined by Conklin,<sup>2</sup> are difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize. Solving wicked problems requires innovation, novel solutions, and a systems approach.

Innovations that radically and fundamentally change the what, how, and why of healthcare delivery are scarce and desperately needed. The fundamental root of many issues in healthcare is the failure to focus on the primary process of delivering care to patients. The focus is on the wrong issues. Instead of focusing on sustaining bureaucracy, new ways are needed to focus attention on humanity and the relationships between people who promote and optimize health.

### THE BUURTZORG MODEL

Buurtzorg ("Neighborhood Care") Nederland is a rapidly growing not for profit healthcare company in the Netherlands that is making bold and transformative changes. Buurtzorg has the potential to permanently change the landscape of the healthcare sector. It is a company that is driven by a belief in "humanity over bureaucracy," and that belief deeply impacts the patients and those who care for them.<sup>3,4</sup> As we will describe in this article, this social innovation goes beyond healthcare and in many ways reflects whole-systems healing—healing that is oriented to advancing the health and wellbeing of people, families, and communities.

### Buurtzorg Nederland

In 2006, Jos deBlok reintroduced the concept of district (community) nursing in the Netherlands at a time when the traditional and commercial home care industry was characterized as being costly, fragmented, and populated with caregivers who were overworked and dissatisfied. The focus had shifted from care to production, protocols, and administration. De Blok's idea was very simple and practical—eliminate overpaid managers, luxurious offices, and layers of bureaucracy

and give teams of nurses the authority and responsibility for providing care to groups of patients in neighborhoods or districts. In 2007, Buurtzorg Nederland launched with 1 team. By 2010, there were more than 250 teams scattered throughout the country and by the end of 2013, there were 630 teams employing 7188 nurses, providing care to about 55 000 clients. As of March 2014, there are 650 teams.

Key features of the Buurtzorg Model are described below.

**Self-directed Teams:** Buurtzorg employs teams of professional nurses and nurse assistants, provides coaching support, and trusts that professionals do not need to be managed. Buurtzorg exemplifies successful adoption and use of a business strategy known as self-directed work teams.<sup>5</sup> Teams of up to 12 nurses manage themselves and their work, performing all of the tasks necessary to provide care for 50 to 60 patients. Team members decide how best to perform the work, determine schedules, assign roles, and optimize team outcomes. The microscale of Buurtzorg neighborhood-focused teams makes it possible to know and use the local resources, build and support formal and informal networks, and initiate prevention activities that enhance health and wellbeing.

**Scope of Practice:** Buurtzorg nurses work closely with general practitioners and other community healthcare providers. Decisions about what clients need are not based in a corporate office where knowledge is limited; rather, decisions are made in the home by the client and the nurse. The nurses provide comprehensive, holistic care based on what they and the client and family determine the client needs. This may include everything from a bath and bowel care to dressing changes and medications to preparing a simple lunch. Care is less fragmented when it is provided by the nurse rather than divided among a series of providers that could include personal care attendants and nurse specialists as well as generalist home care nurses.

**Relationship-based Practice:** Buurtzorg nurses are interested in clients' life circumstances, the environment, and spiritual and social needs in addition to physical needs. The relationship between the nurse and the client is the core strategy of the organization. Teams work together to schedule and plan care for clients and to ensure that clients receive services from only 3 to 4 nurses to optimize relationships and decrease fragmentation of care. Buurtzorg clients appreciate the consistent, compassionate care, and this is reflected in the highest level of satisfaction in national surveys.

**Empowerment of Clients:** The Buurtzorg model emphasizes returning clients to independence as quickly as possible. The nurses "front load" care, working intensively with clients from the beginning, teaching and supporting them as they learn self-care and gain confidence. Clients value their independence and strive to achieve self care goals. This is mutually beneficial for

clients, families, the healthcare system, and Buurtzorg.

**Simplified Billing:** Common in the industry is billing based on who provides the care or service, how much time they use, and what they do. Buurtzorg proposed to private and governmental contracts that the billing be simplified. Rather than having multiple rate structures that require significant bureaucracy to record and process, Buurtzorg proposed using one rate (57 euros per hour in 2013) for a visit, regardless of duration.

**Financial Sustainability:** When Buurtzorg Nederland began, there was great skepticism as to whether it would work and whether it was scalable. The fear was that without "controls" and with using highly skilled nurse caregivers, the costs would soar. The opposite occurred. On the average, Buurtzorg nurses use only 40% of the care hours that are allocated per client, resulting in significant annualized savings by the government. Buurtzorg has also demonstrated internal fiscal sustainability. Reported revenue at the end of 2013 exceeded 200 million euros.

**Low Overhead:** An explicit goal of Buurtzorg was to empower teams of nurses to provide care and to eliminate management that isn't necessary and doesn't add value. As the number of teams soared, the administrative costs have remained exceedingly low. Forty-nine staff members and 14 coaches support the teams.

**Employee Engagement and Satisfaction:** Humanity over bureaucracy is the mantra of the organization. Buurtzorg nurses are highly creative and skilled human beings, nurses, and entrepreneurs. They have autonomy to work with clients and those in their networks to develop creative solutions for client problems. The psychological impact of this autonomy fosters a sense of satisfaction and wellbeing among nurses that extends to their clients and their families.<sup>6</sup> In 2011 and 2012, Buurtzorg was recognized as the best employer in the Netherlands, edging out the previous winner Royal Dutch Airlines KLM.

**Buurtzorg Web:** Teams are interconnected through the Buurtzorg web, an intranet that enables all nurses to share knowledge and extend and receive support. In addition to the online community dialogue, business processes are managed through the web. The award-winning Buurtzorg web design was developed through a series of meetings with Buurtzorg nurses. Health information technology (IT) functions enable all teams to use online scheduling, billing, and documentation. Real-time financial reports are transparent at the organizational and team levels, which allows teams to self-monitor productivity and self-manage budgets. The Buurtzorg web is accessible through desktop and mobile applications. It is estimated that use of the IT platform for administrative functions saves approximately 20% of the costs of a typical home care agency.

**Outcome Measurement:** Buurtzorg uses the Omaha System<sup>7</sup> within the IT platform to record nursing assessments and to document care. The networked electronic health record aids in individualized care planning and generates robust outcome data. In addi-

tion to tracking individual patient outcomes, Buurtzorg nurses can assess population health status by team and population of interest using the Omaha System data. Future plans are to use large data sets for intervention effectiveness research.

### Theoretical Frameworks Underlying the Buurtzorg Model

The Buurtzorg Model reflects a merged theoretical perspective of the whole that overlays the notion of a patient centered social ecological framework<sup>8</sup> on the science of networks.<sup>9</sup> The key relationships between clients, informal networks, Buurtzorg teams, and formal networks are embedded within neighborhood networks. Buurtzorg nurses leverage powerful client and team networks to cultivate the health and wellbeing of the client and community as they provide care and support client independence. The positive outcomes of care have a ripple effect on the wellbeing of the neighborhood, community, and health system.

### Social Innovation and Change

Social innovation, as noted by Phillis et al,<sup>10</sup> is the best construct for understanding and producing social change. They define social innovation as a "novel solution to a social problem that is more effective, efficient, sustainable, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals." According to their definition, an innovation is social only if the balance is tilted toward social value—benefits to the public or to society as a whole. They also note that a social innovation can be a product, production process, or technology as well as a principle, an idea, a piece of legislation, a social movement, an intervention, or some combination of these elements.

Evaluated against this definition, Buurtzorg Nederland meets all of the requisite criteria. Healthcare across the globe is a social problem—access to care, as well as the cost, quality, and coordination of care. The solution or innovation offered by Buurtzorg produces a product or outcome that is more effective (improved clinical outcomes, client and family satisfaction, nurse satisfaction and engagement), efficient (utilizes fewer resources than other home care models), sustainable (generates significant cost savings), and just (provides access to clients and positive work environment for staff). The benefits to society are both indirect and tangible. The tangible benefits can be measured in improvement in healthcare access, cost, and quality. Indirect but not insignificant benefits include the impact on the community or neighborhood. Creating social networks strengthens the social fabric of the community and improves the overall quality of life and wellbeing of the citizens.

The magnitude and speed with which Buurtzorg grew is unusual and striking. The interest within the Ministry of Health of the Netherlands remains high and attempts are underway to replicate aspects of the

The Buurtzorg "microsystem" reduces distance between clients, community, and healthcare providers, creating efficiencies that optimize client care and cost-effectiveness.

A Buurtzorg nurse's description allows us to see how the Buurtzorg networks supporting nurses and families extend to and through the communities and systems:

*This morning I was visiting 3 clients, one after another. All 3 are terminally ill but all had very different needs, were surrounded by family members, and all differed in the way that they looked at their illness and family situation. Everywhere I visited, I was asked to talk with them about their last days in the world. All 3 clients required very different care for that day than had been originally planned. But this created no problems for me or my team members. I just phoned the other clients [and said] that I was going to be later than usual. And when I came back to the office, the team was there for me to talk to about the morning and the things that are so hard to witness: a young family losing their father, a loving partner losing the only person she holds dear, and the loneliness dying sometimes brings. But I felt all this time supported by a team, only a phone call away, and family doctors who will help wherever they can. And I know that I made a difference because I was given the opportunity.*

Buurtzorg model within other sectors of healthcare, including hospitals and long-term care. There is also interest in evaluating whether this model of social innovation and change could be applied in sectors outside of healthcare such as education where self-directed teams, empowered teachers and learner administration could positively impact school budgets and performance.

The interest in Buurtzorg is rapidly becoming a global phenomenon. Buurtzorg teams were launched in Sweden in 2011, in Minnesota in 2013, and it is anticipated that organizations modeled after Buurtzorg will emerge in Japan, Switzerland, and Belgium within 2 years.

### Social Entrepreneurship

Buurtzorg has clear social entrepreneurial features. Austin et al define social entrepreneurship as an innovative activity that creates value and can occur within or between two or more organizations in the nonprofit, business, and governmental sectors.<sup>11</sup> Social entrepreneurship is often associated with initiatives and processes that have been set up by non-government organizations or social enterprises.<sup>12,13</sup> Experts Dorado,<sup>14</sup> Mair and Marti,<sup>15</sup> and Zahra et al<sup>16</sup> argue that the fundamental distinction between social entrepreneurship and commercial entrepreneurship is that social entrepreneurship creates both economic and social value. By this definition, Buurtzorg meets the criteria for a model of social entrepreneurship.

Innovation is an important aspect of social entrepreneurship.<sup>17</sup> Three types of innovations in social

entrepreneurship have been described by Alvord, Brown, and Letts.<sup>18</sup> These innovations focus on:

- increasing the ability of local actors to solve their own problems,
- disseminating a package of innovations to serve a need, and
- setting up a structure to challenge the structural causes of social problems.

At Buurtzorg, encouraging the clients toward self-management of their problems is one of the main goals. Clients should not become dependent on the care they receive. To enhance the quality of their lives, they learn how to mobilize their social ties to significant others such as family members and neighbors. This allows Buurtzorg to expand services to larger target groups so that more people can benefit from their care.

The populations served—the elderly, people with serious chronic disease, and youth with mental health issues—have significant needs and create a financial burden on the Dutch healthcare system. The establishment of a neighborhood Buurtzorg team in many ways creates an infrastructure that begins to ease social problems experienced by clients and their families.

#### Whole-Systems Healing

In many ways, Buurtzorg is illustrative of whole-systems healing—a way of cultivating the health and wellbeing of individuals, communities, organizations, societies, and the environment by living and acting with awareness of the wholeness and interconnectedness of all living systems.<sup>19,20</sup> Buurtzorg embodies whole-systems healing in the way that it is embedded in neighborhoods. The central tenet is that care needs to be provided within the context of an individual's life—home, family, and neighborhood.

Whole-systems healing requires an understanding of several critical key concepts:

- **Complexity science/Chaos theory:** All living systems, from individual humans and communities to the ecosystem of the planet, are complex systems that are constantly adapting and evolving in response to changing conditions from within and outside.
- **Social networks:** Social networks are social structures made up of individuals or organizations that are connected or inter-related. The ties can be social, economic or organizational.
- **Social change:** Social change is a process where by values, attitudes or institutions of society become modified.
- **Gentle action:** As articulated by Peat, gentle action is the use of grassroots efforts and collective intelligence to focus many small, coordinated efforts on the best point of leverage within a given system.<sup>21</sup> It is the strategic implementation of highly coordinated, low-intensity actions.

Within the complex system of healthcare in the Netherlands, Buurtzorg stepped in and peeled away complexity to enable the nurses to provide care and receive the support they needed. Simplified billing, sophisticated IT, supplies distributed and delivered to the client's homes, and coaching made available to the teams created a healthcare product or service that is superior and less expensive. Buurtzorg has also demonstrated the capacity to be nimble and responsive to changing conditions.

The capacity to build and leverage social networks is one of the most distinguishing features of Buurtzorg. The networks are multi-level and include networks of physicians and other health professional colleagues that interface with local teams of nurses; networks of nurse-led teams that interact with each other; strong connections between local nurse teams and community-based organizations; and on a national level, Buurtzorg has a strong network with governmental entities.

The Buurtzorg values that are embodied in self-directed teams and the phrase "humanity over bureaucracy" represent radical departures from the inclination of modern society to manage, control, create bureaucracy and in the process, dehumanize patients. This new organizational form represents social change of a large magnitude.

#### Embracing Emergence

Finally, the Buurtzorg model is emerging as a novel social innovation with the potential for considerable collective impact in and beyond the Netherlands. In a recent article on collective impact and complexity, Kania and Kramer identify five conditions of collective impact.<sup>22</sup> The five conditions are described below, with commentary on the Buurtzorg related to each condition.

- **Common agenda:** a shared vision for change and a joint approach to solving it through agreed-upon actions. The Buurtzorg common agenda is shared across all teams and is explicitly stated and understood by nurses and patients alike.
- **Shared measurement:** collecting data and measuring results consistently. Buurtzorg data collection for outcomes measurement is embedded within the electronic documentation system as part of the nursing process and workflow.
- **Mutually reinforcing activities:** a balance of differentiated and coordinated activities. Buurtzorg teams balance community and system actions with personalized individual services. All nurses are community leaders, and all nurses are empowered to solve individual and community problems.
- **Continuous communication:** consistent and open communication is needed to build trust, assure mutual objectives, and create common motivation. Robust team communication underlies the Buurtzorg way of working, with weekly team meetings and frequent shared casual contacts as well. The Buurtzorg web enables dialogue at the organizational level for all nurses.

- **Backbone support:** staff and specific skill sets that support the coordination. The streamlined IT system is designed to ensure that nurses can do their work and support each other with a minimum of administration. Nurses may specialize in particular skills that support team functioning. The simplicity of the Buurtzorg model minimizes the need for extensive administrative support at the organizational level.

As described earlier, healthcare operates in a world of complexity where predetermined solutions rarely work. As noted by Kania and Kramer, even when successful interventions are found for complex social problems, adoption spreads very gradually, if at all.<sup>22</sup> The phenomenon of collective impact, they explain, works differently: the process and results are emergent rather than predetermined. As such, collective impact is not just a new process that supports the same social sector solutions; rather, it is an entirely different model of social progress. This may explain the slow emergence of the self directed nursing team concept, which transformed into unusual success of the Buurtzorg model as an emerging social change in healthcare.

As Buurtzorg begins to support entities on multiple continents, the organization is facing issues of scalability and sustainability. Questions are emerging regarding the applicability and relevance of the model within different cultural contexts and the potential of the model to produce both local and global impact. In alignment with Buurtzorg's growth strategy within the Netherlands, there is strong support for adaptation of the model to local contexts while maintaining fidelity to core principles. There is also a strong commitment to creating systems that support continuous learning, communication, and measurement. Over the next 5 years, scholars, practitioners, and educators are needed to engage in evaluating the global impact of this innovative care delivery model.

#### REFERENCES

1. World Economic Forum. Sustainable health systems, visions, strategies, critical uncertainties and scenarios. A report from the World Economic Forum prepared in collaboration with McKinsey & Company. [http://www3.weforum.org/docs/WEF\\_SustainableHealthSystems\\_Report\\_2013.pdf](http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf). Accessed November 13, 2014.
2. Conklin J. Dialogue mapping: building shared understanding of wicked problems. 1st ed. Hoboken, NJ: Wiley; 2005.
3. Mosen KA, de Blok J. Buurtzorg Nederland: A nurse-led model of care has revolutionized home care in the Netherlands. *Am J Nurs*. 2013;113(8):55-59.
4. Mosen KA, de Blok J. Buurtzorg: Nurse-led community care. *Great Nurs*. 2013;19(3):22-7.
5. Becker WS. Key topics and issues self directed work teams. In: Encyclopedia of human resource management. Vol 1. Prescott RK, editor. Hoboken, NJ: Pfeiffer; 2012.
6. Rock D. SCARF: a brain based model for collaborating with and influencing others. *Neuroleadership J*. 2008;1:1-9.
7. Martin KS. The Omaha system: a key to practice, documentation, and information management. 2nd edition. Omaha, NE: Health Connections Press; 2005.
8. Bronfenbrenner U. The ecology of human development. Cambridge, MA: Harvard University Press; 1979.
9. Barabási A, Frangos J. Linked: the new science of networks. New York: Perseus Press; 2002.
10. Phills JA, Deiglmeier K, Miller D. Rediscovering social innovation. *Stanford Soc Innov Rev*. [http://www.ssiireview.org/articles/entry/rediscovering\\_social\\_innovation/](http://www.ssiireview.org/articles/entry/rediscovering_social_innovation/). Accessed November 13, 2014.
11. Austin J, Stevenson H, Wei-Skillern J. Social and commercial entrepreneurship: same, different, or both? Working paper series no. 04-029. Harvard Business School Publishing Corporation: Harvard Business Review; 2003.
12. Dees JG. The meaning of social entrepreneurship. Stanford University; Draft report for the Kauffman Center for Entrepreneurial Leadership. 1998. <http://csi.gsb.stanford.edu/sites/csi.gsb.stanford.edu/files/TheMeaningofsocialEntrepreneurship.pdf>. Accessed November 17, 2014.
13. Buschee J, McClurg J. Towards a better understanding of social entrepreneurship: some important distinctions. <http://www.setoolbelt.org/resources/180>. Accessed November 17, 2014.
14. Dorado S. Social entrepreneurial ventures: different values so different process of creation, no? *J Dev Entrepren*. 2006;11(4):319-43.
15. Mair J, Marti I. Social entrepreneurship research: a source of explanation, prediction, and delight. *J World Bus*. 2006;41(1):36-44.
16. Zahra SA, Gedajlovic E, Neubaum DO, Shulman JM. A typology of social entrepreneurs: motives, search processes and ethical challenges. *J Business Ventur*. 2009;24(5):519-32.
17. Hoogendoorn R, Pennings E, Thuriik R. What do we know about social entrepreneurship? An analysis of empirical research. [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1462018](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1462018). Accessed November 17, 2014.
18. Alvord SH, Brown LD, Letts CW. Social entrepreneurship and social transformation: an exploratory study. *J Appl Behav Sci*. 2004;40:260-82.
19. Kreitzer MJ. Whole systems healing. <http://www.csh.umn.edu/wsh/leadership/>. Accessed November 17, 2014.
20. Kreitzer MJ, Felgen J, Roach P. Whole systems healing: a new leadership path. In: Kreitzer MJ, Koithan M, editors. *Integrative nursing*. New York: Oxford University Press; 2014:47-55.
21. Peat D. Gentle action: bringing creative change to a turbulent world. Paris, Italy: Pari Publishing; 2005.
22. Kania J, Kramer M. Embracing emergence: how collective impact addresses complexity. *Stanford Soc Innov Rev*. [http://www.ssiireview.org/blog/entry/embracing\\_emergence\\_how\\_collective\\_impact\\_addresses\\_complexity](http://www.ssiireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity). Accessed November 17, 2014.

**GAHMJ's mission is to engage, inform, and inspire the global community of practicing healthcare professionals to more effectively promote health and treat illness.**



**Subscribe now at [gahmj.com](http://gahmj.com)**