

*Co-production between family caregivers and home care  
professionals: The case of Buurtzorg in the Netherlands and China*

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# Abstract

This study aimed to give an understanding of how the home care organisation Buurtzorg has been co-producing elderly care with informal family caregivers in the Netherlands and in China. Three aspects of Buurtzorg's approach to co-production with informal family caregivers have been analysed. The extent to which the Buurtzorg concept of integrating the family (as a part of the patients' surroundings) into the provision of care can be seen in practice in the Netherlands and in China, whether this co-production adheres to principles for co-production and to what extent the cultural context has played a role in the difference between Buurtzorg's approach towards informal family caregivers in the Netherlands and China. An analysis of the theory and contexts combined with qualitative interviews with relevant Buurtzorg actors came to the following results. In the Netherlands, the Buurtzorg concept of integrating the family into the care is seen in practice and the co-production with these informal family caregivers adheres to principles for effective co-production. In China, this concept is less visible and the co-production with informal family caregivers adheres less to principles for effective co-production. So far, the cultural context has played a decisive role in forming the Buurtzorg approach towards informal family caregivers in China.

# Table of contents

<b>CHAPTER I: Introduction.....</b>	<b>4</b>
1.1 General introduction.....	4
1.2 Cooperation between formal and informal caregivers.....	6
1.2.1 The concept of Co-production.....	6
1.2.2 Co-production in practice.....	8
1.2.3 Selected principles for co-production.....	10
1.3 Buurtzorg concept.....	12
1.3.1 Philosophy and organizational structure of Buurtzorg.....	12
1.3.2 Praise and critique.....	14
<b>CHAPTER II: Cultural context.....</b>	<b>15</b>
2.1 The Dutch context of home care to the elderly and family involvement.....	15
2.1.1 Evolution of family involvement in Dutch elderly care and home care.....	15
2.1.2 Challenges in Dutch elderly care.....	18
2.2 The Chinese context of home care to the elderly and family involvement.....	21
2.2.1 Evolution of family involvement in Chinese elderly care and home care.....	21
2.2.2 Challenges in Chinese elderly care.....	22
<b>CHAPTER III: Theory and expectations.....</b>	<b>24</b>
3.1 expectation 1.....	24
3.2 expectation 2.....	26
3.3 expectation 3.....	28
<b>CHAPTER IV: Methodology.....</b>	<b>30</b>
4.1 Interview sampling.....	30
4.2 Validity.....	30
<b>CHAPTER V: Results.....</b>	<b>32</b>
5.1 Perceptions of the Dutch and Chinese communities on informal family caregiving.....	32
5.2 Prevalence of Buurtzorg clients with informal family caregivers in the Netherlands and China.....	32
5.3 The extent of the involvement of informal family caregivers into the provision of care.....	33
5.4 Co-production between Buurtzorg nurses and informal family caregivers in practice.....	34
5.5 Nurse autonomy in practice.....	35
5.6 Future of Buurtzorg philosophy in China.....	36
5.7 The progress of the Buurtzorg project in China.....	36
5.8 What Buurtzorg can bring to China.....	37
5.9 Answer to sub question 1.....	37
5.10 Answer to sub question 2.....	38
5.11 Answer to sub question 3.....	41
<b>CHAPTER VI: Conclusion and discussion.....</b>	<b>42</b>
6.1 Conclusion.....	42
6.2 Discussion.....	45
6.2.1 Challenges faced during the research.....	45
6.2.2 Discussion about the research design.....	47
6.2.3 Recommendations for future research.....	49
<b>CHAPTER VII: Bibliography.....</b>	<b>50</b>
<b>APPENDIX.....</b>	<b>54</b>

# CHAPTER I: Introduction

## 1.1 General introduction

Informal family caregiving can be very burdensome for the informal care provider (Wentzel et al, 2015; Miura et al, 2005) and roughly 10% of all informal family caregivers in the Netherlands are heavily overburdened (de Klerk et al, 2015). This can negatively affect the care for a patient, overburdened informal family caregivers are more likely to yell at the patient or treat them roughly (Wentzel et al, 2015). As Wentzel et al. note, healthcare professionals can play a role in preventing informal family caregivers from being overburdened.

This study focuses on an organisation for elderly care which provides community care that deals with problems like overburdened care providers. The organization provides a unique research context to explore how differences in context affect elderly care provision, the co-production between Buurtzorg, an organisation that provides home care, and informal family caregivers to elderly patients will be analysed. One of the key philosophies of the Buurtzorg concept is that the environment of the patient, including the family, needs to be integrated into the provision of care (de Blok, 2011). In the scientific literature, this is known as co-production. In this co-production process, when the informal family caregiver provides bad care, this also affects the care that Buurtzorg provides. It is, thus, important for Buurtzorg that this co-production is effective.

Buurtzorg has been founded in the Netherlands, but has since been providing home care in many countries around the world, including in China. This study will compare their approach to co-production with informal family caregivers in the Netherlands and in China. Pawson & Tilley (1997) emphasize the role of (cultural) context in research. In specific about social programs, the cultural context can be decisive on whether such policy succeeds or fails.

This study has three aims. The first aim of this study is to find out how this philosophy is exported to the real situation and what it means in practice. The second aim is to find out how effective their cooperation, or from here on called co-production, with informal family caregivers is. The third aim is to find out to what extent this cultural context has played a role in the approach Buurtzorg has taken in their cooperation with informal family caregivers in both the Netherlands and China. Given these aims, that stem from a lack of knowledge on contextual effects of community care for the elderly, the research question of the study is:

*“How does Buurtzorg cooperate with informal family caregivers to provide home care in the Netherlands and in China?”*

In order to answer this research question, the following sub questions have been formulated:

- 1) To what extent can Buurtzorg’s concept of integrating the client’s network, and in specific their relatives, into the provision of their care be seen in practice in the Netherlands and in China?*
- 2) To what extent does Buurtzorg’s collaboration with informal family caregivers relate to principles of effective co-production in the Netherlands and in China?*
- 3) To what extent does cultural context play a role in the Buurtzorg approach to cooperating with informal family caregivers?*

These questions ask, in simple words, how (1) Buurtzorg’s own philosophy is seen in practice, (2) whether its co-production with informal family caregivers is effective according to co-production principles, and (3) whether this is different in the Netherlands than in China.

The study will contribute by filling these gaps of knowledge about Buurtzorg in the Netherlands and in China. Filling these gaps is relevant because it provides an insight into the effectiveness of Buurtzorg’s approach to informal family caregivers and can also be of interest for other, future studies that focus on the Buurtzorg model. For, it provides an insight into how Buurtzorg’s philosophy is exported into practice, in specific in the Chinese context about which is not much publicly known yet.

Further in the introduction, Buurtzorg and their philosophy will be explained, co-production will be addressed in greater detail and principles for effective co-production will be discussed. In chapter two, the Dutch and Chinese context concerning informal family caregivers and home care will be discussed. In the third chapter “theory and expectations”, the gaps that the theoretical parts cannot explain and that need to be answered by the interviews will be explored, as well as the expectations for the results. In the fourth chapter, the methodology will follow and in Chapter five the results of the interviews. Finally, there is a conclusion and discussion

## **1.2 Cooperation between formal and informal caregivers**

This chapter will discuss the important concepts and related theories on which this research is based and will explain the terminology. Firstly, “informal family caregivers” is broadly conceptualised as any relative that provides informal care to an elderly patient. In the Netherlands, the term “mantelzorger” is often used. Because mantelzorger is more strictly conceptualised than informal family caregiver, the concept will be briefly discussed in the section about the Dutch context. In this study, family members that provide informal care to their elderly will solely be referred to as informal family caregivers. There is only one exception, in the interviews with Dutch nurses, often the word mantelzorger is used, these terms are nearly identical. Clients, to differentiate from their family, are defined as the patients treated by the Buurtzorg professionals.

### **1.2.1. The concept of Co-production**

As has been noted in the general introduction, cooperation between Buurtzorg professionals and informal family caregivers would be a form of co-production, in which receivers of a service co-produce that service with the official providers. In this study, co-production with family caregivers is defined as “an arrangement where family members of clients produce a part of the services otherwise provided by Buurtzorg professionals, in agreement and in cooperation with the Buurtzorg professionals”. This definition is based on a combination of (partial) conceptualisations of co-production. Co-production is a broadly used concept in the social sciences and is an umbrella term for the involvement of so-called “customers” into the delivery of services. Co-production does not have a single definition, different scientists use different definitions of the same concept. In addition to that, there are many other related concepts that are frequently used to describe the involvement of these consumers into service delivery (Bilstein, 2011). According to Bilstein, a few of such concepts are “participation”, “co-production”, “integration” and “co-creation of value”. She notes that many scientific articles that make use of these concepts do not properly conceptualize these definitions and that, therefore, these concepts are often used interchangeably and have a different meaning in different studies. In this study, the word co-production has not directly been chosen to be used in the research question. In part, this is because there are so many different definitions of co-production that it is a rather broad and abstract concept. Nonetheless, some knowledge about co-production and its related concepts provides an understanding of the relevance of these concepts to the study as well as to highlight what is generally meant with these concepts and what is not. Another reason for this choice is that co-production, as mentioned above, is about cooperation on service delivery within the structure of the official organisation. The research question does not want to assume that this, by definition, is the case.

According to the definition of Brudney (1983), co-production in the case of public service delivery is the opposite of a government institution providing services to passive citizens. Co-production implies that other actors, primarily the receivers of the service, cooperate with the service providers on the service delivery to enhance the quality and often the cost-efficiency of these services. Early co-production theory focused almost exclusively on the role of the involvement of clients in the public service production. However, more recently, this concept has been expanded. Some examples are that the term co-production has been used to analyse the role of voluntary and community organizations in the United Kingdom and the production of welfare services by citizens without the involvement of the government at all (Brandsen & Pestoff, 2006). One of the reasons why this is interesting and noteworthy is because in recent co-production literature, co-production does not always solely refer to the clients and professionals, but is also used to describe the involvement of the civil society or even removes the professionals from the equation entirely. The conceptualization of co-production that Brandsen & Pestoff use themselves is that it concerns “[an] arrangement where citizens produce their own services at least in part” (p. 497). Interestingly, that is a far smaller conceptualisation of co-production than used by Ewert & Evers (2012), who define it as “a notion that refers to exchange relationships that include several dimensions of interaction (e.g. dialog, practical matters, and cooperation); it can relate to individual service relationships at the micro-level as well as to the links between organizations at the meso-level of the welfare system” (page 427). Rather than focussing on the production of a client’s services by the client himself, as the focus lies in the conceptualisation used by Brandsen & Pestoff, Ewert & Evers focus on the exchange relationships between the clients and the professionals. In this study, “co-production with family caregivers” is primarily based on Brandsen & Pestoff’s definition, but has slightly been expanded and nuanced. The focus in this study is, namely, on the tasks that the family caregivers take upon them, how this relates to the work of Buurtzorg and how this influences the quality of care. Co-production generally also includes co-decision making and communication. These are not excluded in this study, communication and decision making is an aspect and can be a tool of how these family caregivers collaborate with Buurtzorg professionals. Yet, they are not the focus of attention. For research on co-production could also focus on the extent of communication or the ability of clients to join the decision-making process in an organisation specifically. Brandsen & Pestoff’s definition reflects the focus of this study, and has further been expanded with “otherwise provided by Buurtzorg professionals, in agreement and in cooperation with the Buurtzorg professionals”, to draw a distinction between voluntary work and co-production. Namely, co-production differs from the classical voluntary work because it takes place in the context of professionalised service delivery (verschuere et al, 2012).

As has been mentioned before, co-production has many related terms. This paper will further discuss also briefly discuss participation and co-creation of value. There are more relevant terms, such as engagement and involvement. However, these concepts are almost identical to the above-mentioned concepts and attempting to map all conceptions of co-production and its related terms would deserve a study on its own. Participation is often used in similar situations as co-production. However, it is a commonly used word which is used in different settings. It is defined by the Oxford Dictionary as “the action of taking part in something”. This broad definition is also mirrored in the scientific literature. For example, Smith & Vawda (2003) conceptualised participation their study as participation in service delivery, implying a similar definition to co-production whereas in Perenboom and Chorus’ study (2003), in which they conduct a literature review to find surveys for measuring participation, participation means being autonomous and being involved in everyday-life situations. In the online blog of scientist Allison J. Metz (2015), she discusses the difference between several concepts that start with “co-” such as co-production and co-creation of value. Interestingly, she describes these concepts as, in the case of co-production, as participation in administration and delivery. As shown, participation can be used in similar contexts as co-production but often the concept is then specified such as participation in service delivery.

Co-creation of value implies the active involvement of the so-called “end-user” into the production process (Voorberg et al., 2015). This is very similar to the several conceptualisations of co-production. Voorberg mentions that other authors have noted that these two concepts are very similar and that some even claim that they are interchangeable. It does have a slightly more narrow implication than the concept of participation because according to Voorberg, participation can also include passive participation in a production process, whereas co-creation of value only implies active participation. According to Allison Metz (2015), co-creation is often used to refer to processes in the private sector.

### **1.2.2. Co-production in practice**

The previous paragraphs have primarily discussed the many aspects of co-production and its related concepts. This has largely been theoretical, discussing ideal concepts. This paragraph will discuss what co-production looks like in practice. From here on, this study will use the term co-production to refer not only to co-production, but also to co-creation of value and participation in service delivery. Co-production might come across as a very abstract concept. However, that should not imply that it has not shown its worth. Already in the 1980’s, scientists claimed that co-production could lower costs of services and increase their quality (Verschuere, 2012). In a study of Vamstad (2012), two educational preschool systems in Sweden were compared. He compared the professionals-oriented



system, which has been the most dominant one, with the less common system in which the staff actively tries to co-produce with the parents of students. To visualise the dominance of the first system, between 85% and 90% of all preschools institutions follow this model, the remaining group follows the second model. In the co-production model, parent involvement included participating in the management board and/or by regularly taking over simple tasks such as cleaning and repairing in the school. In Sweden, there was a strong belief that professionals would be best equipped to provide high quality child care, their superior knowledge was believed to be more valuable than the knowledge of amateur volunteers and co-producers. As Vamstad noted, the more professional service providers in Sweden are, the more inclined they are to resist co-production. Interestingly, his results of his study indicated that both from the perspective of the staff and the perspective of the parents, the parent co-production model produced the highest quality of care. He noted that some of the co-production preschools also tended to be smaller, which might have contributed to their perceived quality of care, but the results were interesting nonetheless. Another practical example of co-production is how the city of Mumbai has achieved to create a constant water supply for many of its middle class citizens (Button, 2017). Mumbai has had increasingly large problems with its water supply. Its original supply system was not designed for universal use and has had difficulties with handling the grow of the population. A changing climate and more extreme weather events have also made this more difficult. It happens very frequently that the water supply is cut off for short moments. The middle class in Mumbai has dealt with this problem by collecting rain water to complement their water supply in case of a shortage. Additionally, they have also become very aware of the value of water and often have different taps in the house for different uses of the water, not to waste relatively clean water on acts such as flushing a toilet. This co-production, in which the state provides a part of the service and where the citizens have been careful in using their water supply and produced a part of the service themselves, has been very successful and has allowed to the middle class in Mumbai a constant flow of water despite the water shortages.

Co-production has also faced criticism. An example of such a potential problem is the topic of accountability. If several actors, including both the official producers and official consumers are involved with co-producing, then it might be unclear who is to blame and who's responsibility it is to solve it (Vamstad, 2012). Another potential risk of co-production, as noted by Vamstad, is that despite that co-production has the potential to give consumers a larger voice in the production of their required service, persons who make most use of this might be people who already have a strong position in society, and thus not necessarily empower the consumers in a truly weak position. Lastly, another criticism that has been given is that co-production is sometimes unrightfully used for merely an attempt of the producer of a service to provide less without any benefit for the consumer.

For example, if a producer of a product requests that the consumer takes over a part of the reduction, this may not have positive effects for the consumer if the costs of the product do not get lower and/or the quality of the product gets higher.

### **1.2.3 Selected principles for co-production**

Verschuere (2012) has mentioned many characteristics and policies of organisations that can allow for a good application of co-production. This list does not cover all possible aspects of the organisational structure and their policies that are important when applying co-production, but it does provide an understanding of what an organisation needs and these characteristics and policies will be used in this study to compare them with the situation of Buurtzorg.

Five principles have been selected from Verschuere's work, these principles will be used as guidelines to compare them with Buurtzorg in the interviews to get an understanding of the effectiveness of Buurtzorg's potential co-production with informal family caregivers:

- (1) Have a good mutual understanding between the producers and consumers about what both sides expect from each other in the co-production process.
- (2) The organisational structure needs to be highly decentralised. The professionals who directly deal with the consumers need to be able to make judgments and decisions about the clients on the spot
- (3) The organisation needs to create a sense of shared responsibility between them and the consumers regarding the services they provide
- (4) The consumers who join the co-production process need to acquire the relevant skills to be able to do this effectively
- (5) The network surrounding the producer and co-producers, such as their community, needs to be supportive of the co-production process

To make it more concrete, some of these necessities will be further clarified. Regarding the first necessity, Verschuere (2012) notes that it is vital to understand co-producers' needs, but the reverse is equally important. The co-producers need to understand what values an organisation is seeking, what the organisation is trying to achieve. An example which Verschuere took from Alford is that of programs for unemployed citizens. It is important for the professionals in this program to be clear to the unemployed citizens whether their immediate task is to get them a job and income on the first possible occasion, or a sustainable job on the long run. Regarding the last necessity, an example Verschuere gives to emphasize the influence of the community surrounding the producer and co-producer is that of a school. Not only the relationship between, in this case, the student and the

teacher is important, but the parents of the children also have a large influence on the behaviour of the student. This, however, also extends to the students' friends, other family members, and others. If the community surrounding the teacher and the student is not supportive of the attempts of the teacher to involve the student actively in his classes, his attempts will have difficulties succeeding. If this community is, instead, very supportive, it will be easier to engage the student in a co-productive role.

### **1.3 Buurtzorg concept**

Buurtzorg, the organization of analysis in this study, is a healthcare organization that provides home care. It has been founded by Jos de Blok in 2006. Buurtzorg managed to get a 70% share of the market for home care provision in the Netherlands in a decade (IEC, 2015). It has also spread to foreign countries, notably the USA, Sweden and since 2015, China. De Blok noted that he founded buurtzorg because of his dissatisfaction with home care institutions in the Netherlands at the time. According to him, they have become too bureaucratic and too impersonal, some patients had to deal with over 30 different nurses every month and because of that, no nurse had a complete understanding of the needs of a patient (de Blok, 2011).

#### **1.3.1 Philosophy and organizational structure of Buurtzorg**

The philosophy of Buurtzorg is that “unnecessary” bureaucracy and layers of management need to be avoided and that instead the nurses themselves should have large amounts of autonomy to be able to make decisions themselves (de Blok, 2011). According to de Blok, relationships between professionals in the organization function based on trust and respect. This works because all members of the organization share the same common values of Buurtzorg. Another key Buurtzorg concept is that the patients’ networks should be included into the provision of care (Widén et al, 2016). As quoted from Jos de Blok, the founder of Buurtzorg, “the idea of neighborhood care is to mobilize existing resources to create ecological systems of self-supporting environments. In these environments, professional care is the only care people need. The focus must be on sustaining these dynamic networks.” (Widén et al, 2016; p. 2).

The organizational structure of Buurtzorg is very simple. Below is the official organizational structure, translated by me into English.

## Organogram Buurtzorg Nederland

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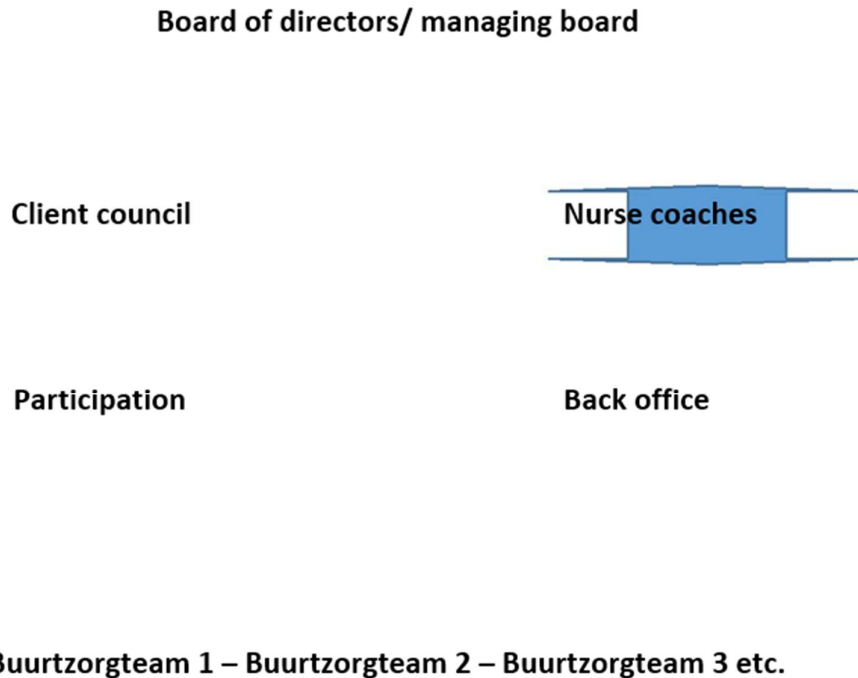


Figure 1: Buurtzorg organogram, translated version. Original can be found in the appendix. Personal communication with Buurtzorg (2017)

Nurses are divided into groups, or Buurtzorgteams, who are responsible for the provision of home care in their assigned region. They are supported by a regional nurse coach, who advises the local buurtzorg teams. In 2015, there were 8000 nurses in 700 nurse teams, providing care for over 65.000 patients (Gray et al, 2015). The only “true” management layer of Buurtzorg is the Board of Directors, who are accountable to the supervisory board in accordance to the national code of governance in the Netherlands (van Roessel: personal communication, 2017). It is very clear that there are similarities between the organizational structure of Buurtzorg, in which community nurses have a lot of autonomy, and the old-style community nurses that disappeared in the 80’s who delivered autonomous home care.

### **1.3.2 Praise and critique**

Surveys have shown that both patients and nurses are highly satisfied with home care, Buurtzorg has continuously been ranked as the best employer in the Netherlands for many consecutive years and in a study conducted from 2008 till 2010, Buurtzorg patients graded the organisation with a 9.1 out of 10 (Gray et al, 2015). Gray et al (2015) noted that Buurtzorg managed to grow rapidly due to a few factors. One such factor is that the Buurtzorg model is very popular among experienced home care nurses, Buurtzorg managed to attract many talented nurses in a short time. The high satisfaction from patients and nurses, as mentioned earlier, also led to many physicians and hospitals to recommend Buurtzorg to their patients and refer them to the organisation. Gray noted that other studies found that Buurtzorg patients require less care to recover compared to care from other home care organisations, they regain their autonomy faster and had to go to the hospital for emergency care less often. Buurtzorg has also faced some criticism. According to Gray, competitors have argued that Buurtzorg has difficulty coping with unplanned care for their patients and that these patients needed to receive help from other home care organisations or from hospitals to provide for these needs. Gray did not find any substantial evidence to back up this claim, though. Jos de Blok mentioned to him that due to effective home care in Buurtzorg, this demand for unplanned care is very low and that it happens only very rarely that patients need care from other home care organisations. In a study from de Veer et al. (2008), interviews with nurses revealed that, although the overall conclusion was that Buurtzorg was very successful, a downside of the small autonomous teams is the huge workload for the nurses and an often-changing working schedule. Another criticism from de Veer was that the absence of management layers implied that nurses were more responsible for, for example, financial matters, and that nurses noted to not be fully qualified for that work. To conclude, although Buurtzorg has had its share of criticism, overall the patients, staff and critics have been very positive of the organisation.

## **CHAPTER II: Cultural context**

This Chapter will discuss the Dutch and Chinese history of home and family care, as well as societal attitudes towards these concepts and other relevant factors that could or has influenced the Buurtzorg initiatives. The Dutch and the Chinese contexts are both discussed in a separate section, both sections are subdivided in “evolution of family involvement and home care”, which analyses the historical and contemporary family involvement and home care initiatives for the elderly, and “challenges in the elderly care”, which analyses the future problems the country will face and how this may affect elderly care.

### **1.2 The Dutch context of home care to the elderly and family**

#### **1.2.1 Evolution of family involvement in Dutch elderly care and home care**

In the 17<sup>th</sup> till the 19<sup>th</sup> century, especially in the south of the Netherlands, many people lived on a farm in a small village with a very large family (Verschuere, 1987). The elderly and those who fell ill were taken care of at home. The size of the families allowed for this. In some cases, more care was needed than the family household could provide for themselves. Other relatives living in the village or neighbours would support the provision of care. According to Verschuere (1987), there were unwritten laws that the community would always support their citizens in need, including taking care of each other's elderly. It was, thus, usual for citizens in the Netherlands to take care of their elderly relatives in the past. Yet, the disappearance of the large households and the increased mobility of Dutch citizens, who no longer necessarily settle in the same village where they grew up, made this old family-oriented system less feasible. When the welfare of Dutch citizens started to rise at the end of the 19<sup>th</sup> century and when more Dutch citizens reached a senior age, the Dutch government eventually created the “onderhoudsplicht” (mandatory care) in 1912, the family of the elderly citizens were obliged by law to take care of them (van Lange, 2013). To cope with the decrease of family involvement of elderly care, the Dutch government became increasingly involved in elderly care in the 20<sup>th</sup> century. In 1957, the Algemene Ouderdomswet (AOW, general elderly law) which marked the larger role of the government in the involvement of care.

Despite the historical role of the family in the provision of elderly care, institutional care is also not a new phenomenon in Dutch society. Already in the 13<sup>th</sup> century have there been examples of so-called “hofjes” (little courts) or “liefdadigheidshofjes” (little charity courts) where poor elderly, especially elderly women could live till the end of their days (kijkopzutfen.nl, 2016). From the 17<sup>th</sup> century onward, these hofjes were built more frequently (van Dijke & van der Meiden, 2011). In the

16<sup>th</sup> century, the first “oudemannenhuisen” (old men houses) were founded (Boer, 2014), which provided elderly care for men. The first of these elderly houses were only designed for men because they were thought to have more difficulty taking care of themselves when they reached a high age but “oudevrouwenhuizen” (old lady houses) and elderly houses for both men and women later also came into existence. The first “modern” elderly care institute was founded in 1965 in Eygelshoven (Vroegindewey, 2011).

The beginning of the 20<sup>th</sup> century also saw the start of home care. Neighbourhood nurses already existed around 1900 (Florence Nightingale Instituut, 2006), the concept of home care is thus not new to the Dutch society. Home care does not exclude institutional care, home care is generally provided to elderly citizens that can no longer completely take care of themselves, but who generally are still partially able to participate in society. Generally, when the need for healthcare becomes too large, these elderly patients move on to institutional care. The concept of neighbourhood nurses was rather normal in the Dutch society until the 1980's. In the 1970's, the Dutch government attempted to motivate elderly citizens to remain living at their home for as long as possible. In their 1975 note report regarding elderly care, the Dutch government strived to have a maximum of only 7% of elderly citizens living in elderly institutions (Boer, 2014). Neighbourhood care was a good means of allowing large proportions of elderly citizens to stay at home till they reached an older age. In the 1980's, however, the public opinion about neighbourhood nurses became more negative and according to Gertje van Roessel, former neighbourhood nurse in the 1980's and nowadays working for Buurtzorg (Widén et al, 2016) in the Netherlands, the Dutch government stimulated the home care institutes to become larger and create a stronger and more central management. This led to more bureaucratization and neighbourhood nurses, who were formally very self-sufficient and independent from the higher management levels, became more occupied with administrative tasks which further led to an increased involvement of assistant nurses in the provision of care. Nowadays, 18% of all Dutch citizens older than 65 years old receive home care, which is more than in any other European country (Smits et al., 2013). Buurtzorg, a modern Dutch neighbourhood care organization and the object of this study, was founded in 2006 (de Veer et al., 2008).

Regarding co-production, the Dutch government has historically played an active role in stimulating patient participation in healthcare (Vennik, 2016). Law obliges healthcare institutions to have client councils in which clients can participate in the decision-making process and have a commission for complaints from patients. According to Vennik, the Dutch government has financially supported projects in healthcare.



To tackle costs in healthcare, the Dutch Prime Minister Mark Rutte wanted that the family of elderly citizens would get more involved with their care and, instead, that they would be less involved with the care of their children by sending them to day care to stimulate parents to work full-time (de Koning, 2016). This has also not been the first time that the Dutch government has attempted to stimulate the involvement of family members into the care of their elderly. As mentioned earlier, in the early 20<sup>th</sup> century the Dutch government even made it mandatory for family members to be responsible for the care of their elderly. Interestingly, a report from the Sociaal en Cultureel Planbureau (SCP, Social and Cultural Planning Agency) concluded that Dutch citizens would like the opposite to be true (2015). Two thirds of the Dutch citizens involved in the research thought that elderly care should be a task for the government to provide. Dutch citizens do want to be involved with the care for their children as much as possible, but they prefer to be less involved with the care for their elderly. That should not imply that Dutch citizens are not involved in the care for their elderly at all. Firstly, a somewhat contradictory finding of the Centraal Bureau voor Statistiek (CBS, Central Agency for Statistics) was that roughly half of the Dutch population thought that it was the children's task to care for their elderly parents if this care was needed (2015). Though government involvement and family involvement does not necessarily exclude one another and these findings might very well complement each other. Most of the respondents also preferred to help solely in lighter tasks of the care. For example, only 10% of the respondents were willing to take in their elderly parents in their own house. Roughly 2.6 million Dutch citizens are so-called "mantelzorgers" (CBS, 2016). Mantelzorgers are people who, according to the CBS, take upon them at least 8 hours of informal care for a specific person per week or have been taking care for a person for at least 3 months. Mantelzorg is always unpaid and informal. Volunteers working for a non-profit healthcare organization are not considered mantelzorgers. Of these mantelzorgers, 40% provide care for one of their elderly parents (Ouderenfonds, 2017), which are roughly 1 million Dutch citizens.

The Netherlands has had a long history in both institutional and home care. As mentioned above, already in the 13<sup>th</sup> century, there have been examples of early forms of elderly care institutes. Similarly, neighbourhood nurses, who had much autonomy in their decision-making, already existed at the beginning of the 20<sup>th</sup> century. Home care and neighbourhood nurses are, thus, not so much a new Dutch invention, but a part of Dutch traditional elderly care and well-embedded in traditional Dutch society. The Dutch government has also attempted to stimulate co-production in healthcare, including the involvement of the family in the elderly care. This has had mixed success. Through the mandatory establishment of client councils and commissions for complaints, patients have means of being involved in the decision-making of their healthcare. Roughly half of the Dutch

population sees providing healthcare for the elderly as a plight for their children, yet 80% of the population (also) believes that this is a responsibility for the government. Dutch citizens preferably contribute by helping with daily tasks, but not by taking in their elderly parents in their home. Roughly 1 million Dutch citizens informally (partially) provide care for their parents at least 8 hours per week or longer than 3 months. The Dutch government wants to stimulate this informal care, but Dutch citizens find this more of a task for the government.

### **1.2.2 Challenges in Dutch elderly care**

Roughly 16% of the Dutch population is above 65 years of age (Smits et al, 2014), slightly lower than the European average, which is 17%. According to the CBS institute, more than a quarter of the Dutch population will be above 65 years of age in 2040 (2010). Within the coming 20 years, the percentage of Dutch citizens who are 65 years old or higher will multiply by 1.5 which will put a much larger pressure on the existing healthcare provision for the elderly. Due to the strong Dutch pension system and extensive house ownership, the Dutch elderly is financially relatively well off (Smits et al, 2014). It is also noted that this pension system can be cause for a problem in the future. When people die at an older age, they will draw more money from the retirement funds while simultaneously a larger percentage of the population will receive these benefits and fewer people will be employed. Motivating family members of elderly citizens to participate in their healthcare can, thus, be a potential solution for managing the rising costs. Yet, informal family caregivers can be a heavy burden for the informal caregiver. The Volkskrant (2016) noted that 1 out of 7 informal family caregivers allegedly feels overburdened, this group of informal family caregivers spends on average 28 hours per week on providing care, much higher than the 8 hours of caregiving that most informal family caregivers provide per week. Another specifically bothersome problem is dementia. Dementia is on the rise in the Netherlands (Smits et al, 2014). Currently, more than 270.000 Dutch citizens suffer from dementia and this is expected to have doubled in 2040 (Stichting Alzheimer Nederland, 2016). Family care is an especially stressful task when dementia is involved. 54% of all informal family caregivers for elderly family members with dementia felt that their work was rather or quite a burden, 1 out of 6 informal family caregivers experiences this work as an extreme burden. Another risk, related to the increase of informal family caregivers, is that 18% of the informal family caregivers do not consider themselves knowledgeable enough to provide their informal care. Examples they gave are to help the patient shower or get out of bed, without making the situation uncomfortable (SCP, 2015). The report also noted that a substantial group of 56% of the informal family caregivers did not know where how to take care of practical matters, such as arranging help

or arranging for a wheelchair, for their patients. The “Wet Maatschappelijke Ondersteuning” (law of societal support) obliges municipalities to support informal family caregivers with practical, financial and emotional means. Generally, other organizations offer support as well, including professional healthcare institutes that work with the clients. Only 18% of the informal family caregivers receive advice, information or support. Roughly half of the informal family caregivers is not aware of the possibility to receive support in terms of information and advice, 25% of the informal family caregivers would like to have more information, advice and support. Of the responding informal family caregivers who provided informal care to a patient in combination with a home care institution, 73% felt that they could ask these professionals for advice and that collaboration with them went well. However, almost half of the respondents noted that this collaboration was sometimes difficult. Informal family caregiver is being stimulated by the Dutch government, but the burden of this caregiving could be a risk for informal family caregivers, as well as the need for more information and advice for a portion of these informal caregivers. Collaboration between home care professionals and informal family caregivers in the Netherlands seems to be alright, but one out of four informal family caregivers nonetheless find this collaboration difficult, which is not an insignificant number.

Regarding the professional elderly care, The Dutch elderly care system has often been criticized for being overly complex and some professionals even argue that cuts in the bureaucracy of healthcare could save up to two billion euros (Leijen, J.). Another, final, interesting thing to note is that 25% of the elderly in the Netherlands feels lonely. More family involvement in elderly care may not solve this problem entirely, not all elderly patients have family, or family members that are willing or able to support and frequently visit them. However, family involvement in combination with more involvement from the whole of civil society could be a solution for tackling loneliness among the elderly.

To conclude, the percentage of Dutch citizens older than 65 is compared to other countries not dramatically high. However, it is expected to sharply increase in the coming decades, and because the Dutch elderly care relies on part on money from the society, this burden on the society will likewise increase. One of the responses of the Dutch government to tackle this problem has been to promote the involvement of the family in healthcare. This is a possible solution, but not without risks. It is important that these informal caregivers do not have such a burden in their care that they become patients themselves. Additionally, to ensure that informal caregivers who take upon them tasks that otherwise professionals would provide nonetheless produce services of similar quality, they need to have sufficient access to advice and information. Research shows that in most cases, this works out well, but a proportion of these informal family caregivers needs more support.

When informal family caregivers work alongside home care professionals, this collaboration is rated well. Yet, a non-insignificant proportion of these informal family caregivers note that this collaboration is not always optimal. When society will rely more on informal family caregivers in the future, it is essential that they can provide or contribute to the provision of high quality care. The inclusion of family in the provision of elderly care could also be part of the solution to tackle loneliness among elderly, though that would need a broader inclusion of the whole of civil society. A last problem in Dutch healthcare are the costs of the bureaucratic complexity. In the light of rising costs for society in the future, some professionals argue that less complex care could make it more affordable.

### **1.3 The Chinese context of home care to the elderly and family involvement**

#### **1.3.1 Evolution of family involvement in Chinese elderly care and home care**

Traditional Chinese elderly care has been based on Confucian principles, in which filial piety played a large role (Chen & Powell, 2012). The family was, according to these principles, responsible for the care of their elderly. Institutional care is not usual in Chinese history and for the elderly it is strongly preferred to age at home (Zhou et al, 2015). This view is echoed by their children, who feel equally obliged to care for their elderly (Zhang et al, 2014). Chinese families have traditionally been large and family members, including those who are more distantly related, were heavily involved in the care for elderly. Chen (2016) notes that traditionally, the son was responsible for his aging parents. His wife would become a part of his family and, in practice, take upon her this care. This system was stable due to most Chinese families living in rural areas, and because their children often stayed in the same area and were, thus, physically close to their elderly and other family members.

Globalisation and the economic reforms of China in the 70's have led to an increase in mobility among the Chinese (rural) population, many have left the local villages and moved to urban areas. This, in combination with the shrinking family sizes due to the one-child policy and the increase in female labour participation, who formally used to most involved in elderly care, led to problems for the traditional elderly care system (Chen & Powell, 2012). Zhang et al. (2007) considered the traditional family system to no longer be feasible. Nowadays, the Chinese elderly still expects this same intensive elderly care from their children, yet their children, though likewise finding care for their elderly important, see their obligation as more instrumental and less intensive as the elderly see it (Chen, 2016). These factors have already had an impact in the evolution of Chinese elderly care, and since the 70's, the Chinese elderly have increasingly been expecting that the government would fill this gap. This, however, has not been sufficient which led to a new, modern variant of traditional family-centered elderly care, in which the elderly takes upon them care for their grandchildren while their children work, while their children simultaneously provide them with financial support and the promise that they would be more involved in their care later, potentially when their financial situation is more stable (Chen & Powell, 2012).

In modern China, to supplement the family care, the children often hire a caregiver for their elderly family member (Chen, 2016). This caregiver has some similarities with home care in Western countries. They visit the patients at home and provide them with both care and company. Yet, a difference between this care and the care from, for example, Buurtzorg, is that Buurtzorg caregivers are professional nurses, many of such caregivers in China do not have such expertise. Buurtzorg is also not the first organization that has been providing this professional form of home care. Deloitte

published a paper in 2014 in which it analysed the Chinese elderly care market, its opportunities and its future. It mentioned several (often foreign) companies that offered elderly care in China, of which some such as Pinetree Senior Care and Haiyang Elderly Development and Service Centre, to mention a few examples, also provided home care services. China does not have the same background in home care as the Netherlands, but home care concepts are upcoming and Deloitte even predicts in their paper (2014) that home care will become the primary care model in China in the future. Wan et al. (2008) consider home care to be very applicable to the Chinese society, because it can be a good intermediate between traditional family-based care and professionals-based care. The home care market in China does is facing different attitudes than in the Netherlands. Obedience and hierarchical relations are very important in China, as well as avoiding conflict (Tyler et al, 2000). Although the study was conducted in other Asian countries and not in China, Claramita (2012) found that in many Asian countries there is a strong hierarchy in patient-doctor relations. Arguably, attitudes in China differ sharply from those in the Netherlands, where the Buurtzorg model created its philosophy based on principles of interactive decision-making between patients and nurses and autonomy for the nurses. Though this is speculation, Chinese nurses might be less used to having the autonomy that Buurtzorg nurses have and likewise, Buurtzorg patients and their family might be less used to join interactive decision-making. Claramita (2012) did also note in her work that both patients and doctors that were interviewed in her study, though not used to the concept, were seemingly open to experiment with a larger voice for patients in healthcare if this would be attempted. Concerning co-production in general, because the Buurtzorg model of including the client and their surroundings, such as their family, into the healthcare process is basically a form of co-production, China has not implemented many co-production schemes. The strong vertical bureaucratic control from the government does not easily facilitate co-production relationships (Li, 2014). Yet, according to Li, in some areas the local governments worked on a co-production basis with their residents and these initiatives have been very successful. In general, co-production is not very common in China and attitudes towards hierarchy and conflict avoidance may not seem to be an easy context in which to implement such initiatives. Yet, the few examples of co-production in China did have been successful, and perhaps when co-production processes are focused on the Chinese mindset instead of the Dutch mindset, these might still be successful.

### **1.3.2 Challenges in Chinese elderly care**

The Chinese elderly care is facing many problems in the future. According to Nie (2016), 15% of China's population is 65 years of age or above. By 2050, It is expected that 30% of China's population will be 65 or older (Chen, 2016). This is comparable to the estimated aging in the Netherlands by

2050, as discussed in the section about the Netherlands. China is aging so quickly, compared to other developing countries, due to two reasons. China has had two birth peaks in the 20<sup>th</sup> century during the Communist era, the people born in this period are now reaching a higher age with less people born outside of these peaks and secondly, because of the one-child policy (Wan et al, 2008). Yet, compared to the Netherlands, China has considerably less (financial) resources available than the to take care of their elderly. Especially in the rural areas, financial resources lack to take care of the elderly. And, as the modern variant of the Chinese elderly care system, as noted in the first paragraph of this section, is more dependent on the increasingly better financial capacities of the children to invest in their parents' care, this means that in rural areas this financial support from the family is smaller (Chen & Powell, 2012). To demonstrate the difficulties some of the Chinese elderly, 44% of all suicides in moderns China are committed by the elderly (Nie, 2016). It should, thus, also be noted that many "alternatives" for the traditional Chinese elderly care model are not a complete solution for the problems China is facing with their elderly care. Buurtzorg has the potential to provide a bridge between family care and professional care, yet home care like this is not feasible for people that do not have the necessary financial means. Zhang et al. (2007) suggests that more involvement from the community could be a solution for the Chinese elderly care problems. It should be noted, thus, that Buurtzorg cannot be a magical solution for all the problems mentioned above. It can, however, potentially contribute to specific parts in China and in specific social groups and be a part of the solution, even in the suggestion to involve the community more in the care, for Buurtzorg in the Netherlands is known for building bridges between patients and their community.

## CHAPTER III: Theory and expectations

Having described the theory and the context of the intervention, we can now formulate expectations about the sub questions. All three expectations are presented in a separate paragraph. The expectation is first mentioned, then explained and finally, the gaps in the information from the theory and context are discussed and the relevant interview question to get more knowledgeable on the topic is presented and explained. The interview protocol paragraph of the methodology chapter contains the full list of interview questions. Some of the questions are presented under the sections of more than one expectation because they relate to multiple expectations.

### Expectation 1

*The buurtzorg model in practice adheres to the buurtzorg concept in both the Netherlands and China.*

The Buurtzorg model stands on a few principles such as the autonomy of the nurses, the idea that the care must be provided by professionals and that the surrounding network of the patient, including the patient's family, must be included in the provision of care. The theory and context have not been able to confirm with certainty that this is in practice also the case.

In the Netherlands, the theory and context have neither provided a reason to doubt that this is the case. Buurtzorg has been active in the Netherlands since 2006. During the decade that Buurtzorg has been active, it has gained many positive reviews from both employees, patients and critics. It has gained much attention and a large share of the market for home care. If the Buurtzorg philosophy would not have been executed in practice, or to a lower extent than that Buurtzorg claims it to be, it would likely have been noticed. The Buurtzorg philosophy, particularly the autonomy of the nurses, originates from traditional Dutch elderly care practices. Many employees of Buurtzorg joined Buurtzorg to return to this autonomous status of the nurse. With the absence of such widespread criticism on the execution of their model in the Netherlands, there is little reason to assume that the Buurtzorg model in practice does not adhere to the Buurtzorg model in theory.

In China, not much is known about the extent to which Buurtzorg implemented their home care model in adherence to their philosophy. There are differences between Dutch and Chinese attitudes on the role of the family, autonomy of nurses and joint decision-making. The role of the family in China is larger, there are most likely more patients with informal family caregivers on the side. Yet,



hierarchy plays a larger role in the Chinese society, both in organisations and in patient-doctor relations. People also tend to avoid conflict. It is, thus, questionable whether Chinese nurses would be as enthusiastic about working in autonomous teams as Dutch nurses are, and it is also questionable whether the Chinese patients, and in this case their family, are as willing to join an interactive communication process with the Buurtzorg nurses as patients in the Netherlands might do. Nonetheless, this is no proof that the Buurtzorg philosophy would not work in China, nor that in China Buurtzorg has deviated from its philosophy. With no knowledge about this available, and keeping in mind that Buurtzorg tends to promote its organisation with its philosophy, it is not expected that the Buurtzorg philosophy is not seen in China in practice. Furthermore, the few small examples of co-production in China were a success and studies in other Asian countries suggested co-production in healthcare could be experimented with. The Buurtzorg philosophy may have been adapted to the Chinese context, but this deviation is not expected to be large.

The main gap in the information from the theory and context on the first sub question is on how the Buurtzorg philosophy to include the family into the provision of care works in practice. The buurtzorg philosophy is somewhat abstract. For this, the following interview question has been constructed.

1. Providing mantelzorg is for some mantelzorgers very burdensome. Do you think that home care professionals always have a good overview on what mantelzorgers can take upon them and what they cannot take upon them?
  - a. What role does Buurtzorg play in providing support and advice to mantelzorgers?
  - b. Does buurtzorg stimulate (or provide by themselves) mantelzorgers to find training to successfully provide their care? How does Buurtzorg make sure that mantelzorgers are successfully able to provide informal care in collaboration with Buurtzorg? If so, can you give examples?

The theory and context have discussed the dangers of overburdened informal (family) caregivers. When these informal family caregivers are overburdened, the care for the patient will lower in quality. This is a threat for Buurtzorg nurses who provide care to the same patient. To maximise the quality of care for their patient, Buurtzorg nurses need to make sure that the informal family caregiver is not taking upon them too much work. The question to ask whether the nurses have an overview on the capabilities of the informal family caregivers also provides information on how much the nurses engage with the family of the patients. To be able to have an overview on the

capabilities and limits of an informal family caregiver, regular contact needs to be made. A and b of the question delve further in what Buurtzorg or nurses in specific do when they notice an informal family caregiver is overburdened or has trouble providing the right care. This is, in specific, interesting because the Buurtzorg philosophy is rather abstract. Even if Buurtzorg nurses actively engage with the family of clients, to what extent do they do this, will they even provide training or do they limit it to giving advice?

## **Expectation 2**

*The organisational structure of Buurtzorg allows for effective co-production with informal family caregivers in both the Netherlands and China*

Buurtzorg is expected to allow for effective co-production with the informal family caregivers. Below, the five selected principles for co-production, as established in the theory, will be compared to the knowledge on Buurtzorg to reflect on the theory and context. Most of the knowledge on Buurtzorg's co-production with informal family caregivers stems from the Buurtzorg philosophy. As discussed with expectation 1, it is assumed that this is also the case in practice. Thus, there is no reason to doubt that for the second expectation either, for both the Netherlands or China.

- (1) Have a good mutual understanding between the producers and consumers about what both sides expect from each other in the co-production process.

One of the philosophies of Buurtzorg is to include the family into the provision of care for the patients. This, naturally, would require frequent communication between the nurses and the patient's family members to establish a joint care plan. Patients and their family are not obliged to hire Buurtzorg for (additional) care. If preferred, they could hire a different organisation or solely provide their own informal care. When considering that Buurtzorg advertises itself with its philosophy and that new clients are probably informed about the Buurtzorg philosophy prior to hiring them, family members of Buurtzorg patients and the Buurtzorg nurses probably have a good mutual understanding about what both sides expect from each other in the co-production process.

- (2) The organisational structure needs to be highly decentralised. The professionals who directly deal with the consumers need to be able to make judgments and decisions about the clients on the spot.

The organisational structure of Buurtzorg is highly decentralised, with few layers of management. How this works for individual nurses in practice cannot be entirely confirmed by the theory and context, but it is strongly indicated that this is the case.

- (3) The organisation needs to create a sense of shared responsibility between itself and the consumers regarding the services provided.

According to the Buurtzorg philosophy, the family of the patient should be integrated into the provision of care. The co-production between family and the nurses is also voluntary for the family. If these family members might voluntarily provide care for the patient on the side, it is logical that they also feel jointly responsible for the co-production. If they do not want to join the co-production, they are not obliged to and Buurtzorg looks for alternatives.

- (4) The consumers who join the co-production process need to acquire the relevant skills to be able to do this effectively.

This is the sole selected principle that the theory and context do not provide clues for. This needs to be answered during the interviews.

- (5) The network surrounding the producer and co-producers, such as their community, needs to be supportive of the co-production process.

The Dutch network seems to be supportive, yet people do not like to give intensive care. When the family co-producers are, thus, involved in intensive care, the community may be less supportive. In China, family involvement in elderly care is more common and the community may be more supportive of the co-production process compared to in the Netherlands.

To give better insight on the remaining gaps for this sub question, the following interview questions have been formulated.

1. What type of clients does Buurtzorg mostly have in the Netherlands/China, clients that do not have any family caregivers, or clients with family caregivers that would like to have professional support on the side?
2. How do people in the Netherlands/China, in your opinion, perceive mantelzorg? Are these opinions about mantelzorg changing?
3. What kinds of tasks do mantelzorgers usually take upon them, when they work alongside Buurtzorg?

4. Providing mantelzorg is for some mantelzorgers very burdensome. Do you think that home care professionals always have a good overview on what the mantelzorgers are capable of to take upon them and what they are not capable of taking upon them?
  - a. What role does Buurtzorg play in providing support and advice to mantelzorgers?
  - b. Does buurtzorg stimulate (or provide by themselves) mantelzorgers to find training to successfully provide their care? How does Buurtzorg make sure that mantelzorgers are successfully able to provide informal care in collaboration with Buurtzorg? If so, can you give me examples?

All the interview questions relate to the second sub question. The first serves to understand the relevance for co-production for Buurtzorg. It is unclear how common it is that informal family caregivers of elderly patients would like to have additional Buurtzorg care. If this number is low, the co-production between these informal family caregivers would than for Buurtzorg be less important. If the number is very high, the co-production would be vital for the care that Buurtzorg provides. The second question refers to the co-production principle for community support. The third is important in combination with the fourth question about the advice and skills provided by Buurtzorg to the informal family caregivers, which refers to the co-production principle about the relevant skills, because additional advice and skills may not be necessary if the family only takes upon them easy tasks. If the family takes upon them difficult tasks, such as taking care of a wound or giving medicines, skills and advice might be more important.

### **Expectation 3**

*Context plays a minor role. The Chinese Buurtzorg may differ slightly from the Dutch Buurtzorg.*

As has been noted on the first expectation, there are cultural differences related to family involvement of elderly care and co-production between the Netherlands and China that might make the Buurtzorg approach more difficult to realise in China as compared to the Netherlands. In addition to that, it is assumed by scientific realism that context plays a large role in the effectiveness of policy. Despite this, Buurtzorg is known for their philosophy and it is a non-profit organisation. There is no obvious incentive for Buurtzorg to expand to another country to export their philosophy, and to then drop this philosophy and be a different organisation. Considering the possible cultural difficulties, it can be expected that Buurtzorg has slightly adapted to the different Chinese cultural context. Yet, there is no reason to suspect that the differing context has played a major role in Buurtzorg's approach to the family involvement. Regarding the effectiveness of co-production, even

though the philosophy might be the same in the Dutch and Chinese Buurtzorg, the different Chinese attitudes towards co-production processes might negatively affect the effectiveness of the co-production. Yet, there is no evidence for this, and it is thus not assumed that there is a major difference.

All interview questions relate to the third question because they compare the Dutch and the Chinese situation.

## Chapter IV: Methodology

This study includes a qualitative research, in the form of semi-structured interviews, to test the hypotheses derived from the contextual and theoretical sections. Six interviews have been conducted with Buurtzorg professionals with mixed experience on the Dutch and Chinese case. To ensure the privacy of the interviewees, the interviewees have been anonymised. The choice for qualitative research instead of quantitative research was made because of logistical limitations and suitability for answering the research question. It was not feasible to conduct statistical tests on already existing data or to collect such data personally, for example by broadly distributed questionnaires, because of limitations in money, language skills and access to Buurtzorg. Furthermore, a qualitative approach allowed for more flexibility, semi-structured interviews allowed for more interactive discussion with the relevant Buurtzorg professionals. The interviews have been conducted online through Skype, with one exception which has been conducted in person. The interview questions can be found in the appendix.

### 4.1 Interview sampling

The case of this study is Buurtzorg in the Netherlands and in China. The units of observation are the Buurtzorg Professionals who have insight in the collaboration between informal family caregivers and Buurtzorg nurses in the Netherlands and in China. The Buurtzorg professionals who have been interviewed have been selected in collaboration and acceptance of the Buurtzorg organization.

### 4.2 Validity

To use the validity terms for qualitative research as used by Trochim (2006), which have originally been constructed by Guba and Lincoln, the main aspects of validity are “credibility”, “transferability”, “dependability” and “confirmability”. Credibility implies that the results from the study are acceptable and believable from the perspective of the participant. In this study, the interviews that have been conducted are also an opportunity to share the preliminary assumptions and conclusions with these participants. To safeguard the credibility, the results of the study at the end have been shared with these participants to allow a reflection on the conclusions. Strong transferability implies that the findings of the study can be generalized or exported to other contexts. This study has analysed both the Chinese and Dutch elderly healthcare context related to co-production between informal family caregivers and home care providers. The apparent strengths and weaknesses of the Buurtzorg approach might also be of use for similar organisations, though this study focusses on Buurtzorg and does not aim to produce generalizable results. Dependability

refers to the changing environment of the research during the data collection and to the extent that the researcher takes note of this. This study only used limited amounts of interviews and not for a long period of time, which makes this aspect of validity less of a concern. Lastly, confirmability concerns the personal assessment of the results by the researcher. Although this cannot entirely be avoided, the interviews have not been transcribed onto a scale, and feedback on the use of the information from the interviews has been requested from the interviewees and taken into account to assure that the interpretation is in line with the intended answers.

## Chapter V: Results

This chapter presents and discusses the results from the interviews. First, topics are discussed in which the interviews have provided much insight. After these topics, the sub questions will be answered and the expectations are reflected upon. Some of the topics use information that have been gathered by interview questions which were not constructed in this thesis. Namely, we have cooperated among other students who similarly studied Buurtzorg for their thesis by holding joint interviews. Some of the questions from these students overlapped with each other's topics and it was agreed upon that all the data stemming from these joint interviews would be available for all theses.

To ensure confidentiality, all the interviewed persons will be referred to as "person 1 – 6". The order has randomly been chosen.

### 5.1 Perceptions of the Dutch and Chinese communities on informal family caregiving

The Chinese community seems to be more supportive of informal family caregiving than the Dutch community. Nonetheless, the perception on family involvement in elderly care is slowly changing in both countries. In the Netherlands, the interviewees note that they think people are becoming more positive about family involvement (person 5; person 3). Yet, there remain many practical problems, such as the long distances between the family and their elderly and busy jobs that the family may have that interfere with their willingness to contribute to their elderly's care (person 5). China shows a different change in perception. Although this perception is allegedly still more positive than in the Netherlands, this positive perception on family involvement in elderly care is decreasing and it is becoming more acceptable in society if the family is less involved in the care for their elderly.

### 5.2 Prevalence of Buurtzorg clients with informal family caregivers in the Netherlands and China

The interviews have also given more insight in how prevalent patients are who simultaneously receive care from Buurtzorg as well as from informal family caregivers. In the Netherlands, this seems to be very diverse. The types of clients for Buurtzorg in the Netherlands are so diverse that none of the interviewees could make any other estimation than to say both types are very prevalent (person 3; person 4). A small, yet interesting finding about the prevalence of combined informal family care and Buurtzorg in the Netherlands is that allegedly, patients living in urban areas are less likely to receive simultaneous family care than patients living in rural areas (person 3). Interestingly, it also takes more effort from Buurtzorg to find other volunteering informal caregivers for patients in



urban areas (person 4), which would normally be searched for in the case of an absence of informal family caregivers, though this is another topic. In the Netherlands, thus, Buurtzorg patients who simultaneously receive care from informal family caregivers are ~~very~~ prevalent, efficient co-production with these caregivers is very relevant for Buurtzorg.

In China, there are more patients who simultaneously receive care from Buurtzorg and informal family caregivers than in the Netherlands (person 1; person 2; person 6). Yet, an interesting finding is that it is not exceptional for Chinese Buurtzorg patients to not have any informal family caregivers either (person 2). According to person 2, a not-exceptional amount of Buurtzorg patients in China has no family involvement in their care, nowadays. This might be attributable the earlier finding mentioned in the first paragraph that it is becoming more acceptable in China that the family is less involved in the care for their elderly and that this change of perception on family involvement is, thus, also seen in practice. However, that is not clear from the interviews, it might be attributable to another factor that was not addressed in this research.

### **5.3 The extent of the involvement of informal family caregivers into the provision of care**

Although it was common knowledge that some Buurtzorg patients simultaneously received care from informal family caregivers, it was not clear what kinds of tasks these informal family caregivers would take upon them in practice. If this would be limited to very simple tasks, the question whether they possess the relevant skills and receive the necessary guidance from Buurtzorg nurses would be less relevant. The interviews have provided more insights in this. The main interesting finding was that the extent to which informal family caregivers are involved in the care can be far-reaching and sometimes even, in the Dutch case, involve giving medicines to the patient and taking care of wounds (person 5). The Buurtzorg nurses are in charge of the caregiving, and medical treatments are the competence of the professionals (person 3), and, thus, primarily conducted by the nurses. In China, the role division between the informal caregivers and the nurses are slightly different and are more strictly divided. Buurtzorg nurses in China do not involve themselves with everyday care (person 6) and limit themselves solely to providing medical care. The informal family caregivers are solely responsible for the everyday, non-medical care. Although, as will later in the Results chapter be explained in more detail, Buurtzorg does not yet possess a medical license of its own in China and can only provide this medical care in the areas in which Buurtzorg cooperates with other companies (person 6).

#### **5.4 Co-production between Buurtzorg nurses and informal family caregivers in practice**

The findings suggest that there is extensive co-production between Buurtzorg nurses and informal family caregivers. In the Netherlands, Buurtzorg nurses take upon them a coordinating role in the entire care situation of a client (person 3). One of the interviewees mentioned they used the slogan “eerst buurten, dan zorgen” (first having a chat, then providing care) (Person 4) which illustrates the mentality. Nurses must first oversee the whole care situation and communicate with family and possible other informal caregivers before starting the caregiving process. Communication with informal family caregivers seems to be very extensive (person 3, person 4, person 5). The nurses are responsible for the decisions on the treatments, but the interviewees noted the value of the knowledge from the informal caregivers and that their opinion is taken serious in the decision-making process (person 3).

In the Netherlands, Nurses consider it their duty to see whether the informal (family) caregivers are not overburdened (person 3, person 4, person 5). Although person 4 admitted that it may in practice not always be possible for the Buurtzorg nurses to pick up the signals that an informal caregiver is overburdened, they give much attention to that. Person 4 also noted that, to support the informal caregiver, openly talking about the difficulties of informal care is often already relieving and solves the problems. Sometimes the situation is more serious and the nurses have to find a solution together with the overburdened informal family caregiver.

As noted in the paragraph concerning the extent of the family involvement in the care, sometimes informal caregivers even support the care by giving medicines to the patients or by taking care of wounds. The interviewees indicated that Buurtzorg supports the informal caregivers in the Netherlands by providing them with advice and if necessary, training (person 4, person 5). Training by nurses in the Netherlands is organised on a local level. The nurses are expected to support the informal caregivers in the care they provide, but have the autonomy to organise this in the way they deem most appropriate (person 5). Person 5 noted that the approach differs among local nurse teams. Some organise training on specific topics every year, others provide training more loosely, on a case-by-case basis. Some examples of topics on which Buurtzorg nurses have given training to informal caregivers are to help the patient get in and out of bed, getting out of the chair or into a wheelchair and how to change diapers (person 4). In the Netherlands, there are also opportunities for informal caregivers to find advice and support outside of Buurtzorg. Buurtzorg nurses forward informal caregivers to, for example, Alzheimer cafes where informal caregivers of patients with dementia can find support and advice and other initiatives (person 3, person 4).

In China, the situation seems to be different. The Buurtzorg nurses have less of a coordinating role (person 3). Person 3 noted that in China it has been more difficult to integrate the family into the provision of care as it is done by Buurtzorg in the Netherlands. In practice, Buurtzorg nurses in China seem to limit their activities more to the activities for which they have specifically been hired. Contrary to the Netherlands, where Buurtzorg nurses assess the situation of a patient and their environment. Person 3 gave the example of a Chinese Buurtzorg nurse who was tasked with taking care of an old man's wound. When they entered the room together, no attention was paid to his wife who laid next to him in bed and who suffered from dementia. Person 3 was surprised because in the Netherlands they are used to look at the whole situation, but the Chinese Buurtzorg nurse replied that she was not supposed to do that, that the family specifically would not want her to interfere with any other situation than that for what she was hired to take care of. At first sight seemingly a bit contradictory, person 6 noted that there was very extensive contact with the family of patients. Partially because they often pay, but also because the family of patients sometimes become very aggressive when they are unsatisfied with the provision of care. To prevent the family from being unhappy, Buurtzorg nurses attempt to communicate extensively with them. These at first sight seemingly contradictory statements have been interpreted as that the Buurtzorg nurses in China restrict their activities to what the family demands from them. Outside of these demands, communication is less than in the Netherlands. Yet, within this scope of assigned tasks, the nurses extensively communicate about the progress of the activities.

Another interesting finding from the Chinese case was the absence of training provided by the nurses for informal caregivers (person 1, person 6). Interestingly, person 1 did consider the informal caregivers in China to have insufficient knowledge and skills to properly provide their care. The Dutch government gave much support to Dutch informal caregivers, but in China this government support is lacking (person 2). Although person 2 did note that the government has slowly started to provide this. With less other sources for knowledge and expertise available, Chinese informal caregivers are more reliant on the training and advice from Buurtzorg. Advice is still given (person 6), though it is unclear from the interviews how this compares to the advice given to Dutch informal caregivers. As of date, no training is provided by Buurtzorg nurses to informal caregivers in China (person 6), but plans have been made to provide this in the future.

### **5.5 Nurse autonomy in practice**

Nurse autonomy was not a direct topic of analysis in the interview questions that have previously been constructed. Yet, it is not completely unrelated to the topic and provide a second example of a

key Buurtzorg philosophy in practice. Most of these findings came from questions constructed by the other students that cooperated in the interviews.

In the Netherlands, everything suggests that the Buurtzorg nurses truly have the autonomy in practice that they are claimed to have (person 1, person 2, person 3). A previously mentioned finding, that training for informal caregivers is provided locally and differs in form and set-up sharply among the different nurse teams, is a good example of this autonomy. Similarly, in the decision-making process of the course of the treatments, nurses have much autonomy.

In China, it seems to be radically different. Buurtzorg nurses in China do not seem to have the same autonomy as Buurtzorg nurses have in the Netherlands (person 1, person 2, person 6). Teams are, for example, led by head nurses (person 1). Nurses in China have received training from Buurtzorg to teach them to, among other things, operate autonomously (person 1). Nonetheless, it seems to have been very difficult to teach them to operate more autonomously (person 3). Person 1 did note that because of the cultural differences regarding autonomy, perhaps more training on this topic could have been effective.

### **5.6 Future of Buurtzorg philosophy in China**

Previously, the Buurtzorg philosophies in practice have been discussed. The results were that in although these seem to be present in the Netherlands, in China the approach to informal caregivers and nurse autonomy is different. Some of the interviewees discussed how they thought this approach in China should develop in the future and what the preferred result for Buurtzorg would be. Person 3 noted that the long-term goal for the Buurtzorg approach in China was to converge more with that of the Netherlands. Person 1 and 6 agreed that this should eventually happen. Person 6 did note that the Chinese culture is distinctively different from the Dutch culture and, thus, that is not simply possible to export a Dutch philosophy to China without making adaptations. Person 3 likewise noted that the Buurtzorg philosophies had to be seen more as a tool, rather than a definite goal. If an altered version of the Dutch approach would eventually be adopted in China, if it is more efficient than that is no problem.

### **5.7 The progress of the Buurtzorg project in China**

An interesting finding from the interviews is that the Buurtzorg project in China is in a much earlier phase than anticipated at the start of this study. It is still evolving and faces many starting problems. For example, Buurtzorg does not yet have a medical license of their own in China (person 6).

Buurtzorg is, therefore, not allowed to provide medical care on their own. In some of the areas in which Buurtzorg operates, temporary solutions have been found by cooperating with other companies that do possess a medical license, but without such cooperation their activities are constrained (person 6). Another example of is the argument person 6 gave for why no training to informal caregivers is provided yet by Buurtzorg nurses in China. Person 6 considers the Buurtzorg nurse teams in China to be too few in number as of now to organise such training on specific topics. Instead, person 6 argues that there are plans to launch this in the future, but that they are waiting for Buurtzorg in China to become larger. The implication of this finding is that Buurtzorg might be operating very differently in China in a few years from now. If the interviews would be repeated at a later point in time, some of the results may or may not be different. Lastly, Buurtzorg seems to be facing with the problem that home care nurses in China have had a different education than in the Netherlands. They are trained in hospitals, which is a different environment than which they face in a home care organisation. Buurtzorg needed to provide additional training for the nurses to be able to adapt to their home care model, some interviewees suggested this training has not yet proven to be extensive enough to accomplish that, and that this has led to the decision to implement head nurses in China for the time being (person 1).

### **5.8 What Buurtzorg can bring to China**

A final interesting topic the interviews have given insight into is how the interviewees view, especially in the light of the Buurtzorg philosophy being less present in the Chinese branch, the added value of Buurtzorg for the Chinese elderly care sector. Person 1 and person 6 agree that China lacks well-educated home care professionals and consider the strength of Buurtzorg that it brings professional home care to China. Additionally, China has a weak general practitioner system (person 6). Buurtzorg nurses are professionals and can, thus, provide care for many possible patients and regular support and advice. Person 6 also noted that in the Chinese elderly care market, there are many people who offer to provide care in daily activities, such as cooking and buying groceries. Buurtzorg could, thus, fill the gap by limiting itself in China to providing medical care.

### **5.9 Answer to sub question 1**

*“To what extent can Buurtzorg’s concept of integrating the client’s network, and in specific their relatives, into the provision of their care be seen in practice in the Netherlands and in China?”*

I expected the following results:

*“The buurtzorg model in practice adheres to the buurtzorg concept in both the Netherlands and China.”*

The results from the interviews indicate that for Buurtzorg in the Netherlands, the expectation was correct. The informal family caregivers are strongly integrated in the provision of care. Nurses assess the entire care situation, including the problems that these informal family caregivers might be facing. The nurses further communicate extensively with the informal family caregivers and if they think they lack relevant skills or need more information, they frequently offer training or forward them to other organisations and initiatives where they could find this support.

In China, Buurtzorg nurses do not seem to have the same coordinative role as their counterparts in the Netherlands. Communication with the family still seems to happen frequently but is more limited to the tasks they have specifically been hired to take care of. They seem to be less involved, as compared to the Netherlands, with assessing the situation of the entire household. The Buurtzorg concept, thus, seems to be less visible in China. Results about a different Buurtzorg concept, the concept of nurse autonomy, have showed a similar story.

The expectation was, thus, partially correct, but wrong in the Chinese case.

#### **5.10 Answer to sub question 2**

*“To what extent does Buurtzorg’s collaboration with informal family caregivers relate to principles of effective co-production in the Netherlands and in China?”*

I expected the following:

*“The organisational structure of Buurtzorg allows for effective co-production with informal family caregivers in both the Netherlands and China”*

In the Chapter on Theory and Expectations five principles were mentioned that define effective co-production. In the following paragraphs these five principles are restated, each followed by results from the interviews on these.

- (1) Have a good mutual understanding between the producers and consumers about what both sides expect from each other in the co-production process.

In the Netherlands, the theory and context already expected a good mutual understanding between the Buurtzorg nurses and informal family caregivers, because the Buurtzorg concept of integrating the family and other surrounding actors into the provision of care in theory leads to frequent communication between the actors. Furthermore, because hiring Buurtzorg is a voluntary decision, it was expected that informal family caregivers are generally knowledgeable about Buurtzorg's values before hiring them. The results from the interviews have shown that there is indeed frequent contact between nurses and informal family caregivers and that before the provision of care starts, the nurses have extensive communication with the patient and other caregivers. In the Netherlands, it could be argued that both sides have most likely a good understanding about what they both expect from each other in the co-production process.

In China, the expectation was the same. However, although the Buurtzorg concept of integrating the family into the care seems to be less visible than in the Netherlands, regarding the tasks that they are hired for, there does seem to be extensive contact. Perhaps in absolute terms, there is less contact with the family, but limiting their work to solely what they are hired for does indicate that clear boundaries have been set. In their way, it can be argued that in China too, both sides have most likely a good understanding about what they both expect from each other in the co-production process.

- (2) The organisational structure needs to be highly decentralised. The professionals who directly deal with the consumers need to be able to make judgments and decisions about the clients on the spot

In the Netherlands, it was expected that the organisational structure was highly decentralised, due to the prominent place of the nurse autonomy concept in the Buurtzorg philosophy. The results from the interviews seem to indicate that Buurtzorg nurses in the Netherlands indeed enjoy such autonomy and that they can make judgments and decisions about the clients on the spot.

In China, the expectation was the same. However, the results from the interviews indicated that Chinese Buurtzorg nurses have significantly less autonomy than Dutch Buurtzorg nurses and that nurse teams are led by head nurses. Buurtzorg nurses in China seem to be less able to make judgments and decisions about the clients on the spot.

- (3) The organisation needs to create a sense of shared responsibility between itself and the consumers regarding the services provided.

Both for the Netherlands and China, the expectation was that there is a sense of shared responsibility of the Buurtzorg nurses and the informal family caregivers for the care of the patients because it is the Buurtzorg philosophy to integrate the family into the provision of care and because this co-production, the shared responsibility, is voluntary. Family members that do not feel responsible for the care are not obliged to participate alongside the Buurtzorg nurses. The results from the interviews suggest that family members are indeed well-integrated into the provision of care. This could be an indication that the expectation was true and that there is a shared sense of responsibility among the nurses and informal family caregivers. However, this has neither directly been confirmed by the results from the interviews so it cannot be conclusively answered. For the Chinese case, no results from the interviews have been able to give much insights into how the Buurtzorg approach relates to this principle.

- (4) The consumers who join the co-production process need to acquire the relevant skills to be able to do this effectively.

Both for the Netherlands and China, from the theory and the context it was uncertain if this could be expected. In the Netherlands, the interviews seem to suggest that Buurtzorg provides training to informal family caregivers and if applicable, forwards them to other institutions where they can receive support or information. In the Netherlands, therefore, it seems informal family caregivers can acquire these relevant skills to be able to provide care effectively.

In China, the interviews have suggested that Buurtzorg does not provide training to informal family caregivers. Yet, it was noted that many such informal family caregivers lack the necessary skills and options outside of what Buurtzorg could provide are similarly limited. In China, it seems thus that informal family caregivers cannot always acquire the relevant skills to be able to provide care effectively. Although it should be noted that there are plans from Buurtzorg to change this in the future.

- (5) The network surrounding the producer and co-producers, such as their community, needs to be supportive of the co-production process



In the Netherlands, it was expected that the Dutch community is relatively positive regarding the family involvement in elderly care, but that this positive perception is limited to non-intensive care. The results from the interviews suggest that this was correct, some interviewees noted that they think this support is increasing.

In China, it was expected that it was very important for the family to be involved in the care for their elderly. The results from the interview underlined this. Although interestingly, the results also seemed to indicate that it is no longer exceptional in China that the family is not involved in elderly care and that the support for this involvement is decreasing in the community.

To conclude. In the Netherlands, the Buurtzorg collaboration with informal family caregivers seems to adhere to the five principles for effective co-production. In China, the Buurtzorg collaboration with informal family caregivers seems to adhere less to these principles for effective co-production, though on some topics, such as having a good mutual understanding between the informal family caregivers and the Buurtzorg nurses, it seems to do.

The expectation was, thus, partially correct. It seems to be correct in the Dutch case, but only partially correct in the Chinese case.

### **5.11 Answer to sub question 3**

*“To what extent does cultural context play a role in the Buurtzorg approach to cooperating with informal family caregivers”*

I expected the following:

*“Context plays a minor role. The Chinese Buurtzorg may differ slightly from the Dutch Buurtzorg.”*

The results from the interviews have suggested that cultural context has played a decisive role in defining the Buurtzorg approach to informal family caregivers in China. Whereas in the Netherlands the Buurtzorg nurses have a coordinative role in the care provision and the family is strongly encouraged to participate in the care progress, Chinese Buurtzorg nurses seem to have a less coordinative role and are less involved with other tasks than what they have specifically been hired for. This includes less encouragement to be involved in the care process. The Buurtzorg approach

towards nurse autonomy has similarly been altered in the Chinese case. Chinese Buurtzorg nurses do not seem to have the same autonomy as Dutch nurses have in their provision of care.

The expectation was, thus, wrong. Contact played a significant role in defining the Chinese Buurtzorg approach.

# Chapter VI: Conclusion and discussion

## 6.1 Conclusion

In the introduction, the following research question was presented, alongside three sub questions:

*“How does Buurtzorg cooperate with informal family caregivers to provide home care in the Netherlands and in China?”*

The Results chapter has attempted to answer the main question and its three sub questions. It came to the following conclusions. The first conclusion was that the Buurtzorg concept of integrating the environment, and in this case the family, into the provision of care for elderly patients is seen in practice in the Netherlands. The second conclusion was that in the Netherlands, Buurtzorg’s collaboration with informal family caregivers seems to relate well to the selected principles for effective co-production. The third and final conclusion was that Buurtzorg’s approach to informal family caregivers in China is distinctly different from the approach as seen in the Netherlands. The Buurtzorg philosophy to integrate the family into the provision of care is differently executed in China than in the Netherlands. Likewise, the collaboration between these informal family caregivers and Buurtzorg nurses in China seems to relate less to the selected principles for co-production than the collaboration does in the Netherlands. The cultural context thus, so far, has played a decisive role in defining the Buurtzorg approach towards informal family caregivers in China.

To answer the research question. It seems that Buurtzorg cooperates extensively with informal family caregivers in the Netherlands. Nurses consider it their duty to pay attention to the problems and burdens of the informal family caregivers and they are supportive and give advice. If deemed necessary, the Buurtzorg nurses occasionally provide training to informal caregivers and forward them to other institutions and initiatives where they can get the necessary support and information. This cooperation also highly relates to the selected principles for co-production. In China, this approach to informal family caregivers seems different. Communication with the family is still extensive, but mostly limited to the specific tasks they have been hired for. Training provided by Buurtzorg, as of now, is not yet available for informal family caregivers in China. The cooperation with informal family caregivers in China does not completely deviate from the selected principles for effective co-production, but seem to relate less strongly than in the Netherlands.

Something else that should be mentioned is how much the Chinese Buurtzorg still seems to be a work in progress. Buurtzorg in China is still facing start-up challenges, for examples by lacking a medical license which allows Buurtzorg nurses to provide medical care on their own. Buurtzorg in China also had plans to provide more training to informal family caregivers, but these have not yet been possible to execute due to the currently still small size of the Chinese Buurtzorg branch. The absence of such training contributed partially to the conclusion that the co-production between Buurtzorg nurses and informal family caregivers did not relate to the principles for effective co-production. Another example is that the Chinese Buurtzorg nurses have been educated in hospitals, which is a different environment than a home care organisation. Buurtzorg has attempted to train them to be, for example, more autonomous, but this has not yet been successful and head nurses have been installed for the time being. This finding, thus, gave the realisation that it might be too early to provide final conclusions about how Buurtzorg approaches the co-production with informal family caregivers in China. If this research would be repeated in a few years, the conclusions might be different. On the other hand, until these plans have been realised and have shown to be a success it cannot be assumed with certainty that the future will differ from the present.

Lastly, to reflect on the export of Buurtzorg's co-production model to China, this study has shown that it has been very difficult for Buurtzorg to implement their co-production model as it has been implemented in the Netherlands. The cultural context has been a large challenge for them to work in a co-production model in China, which includes dimensions such as autonomy and the coordinative role of the nurses. The case of Buurtzorg could be an example for the challenges that similar organisations with a co-production model may face when trying to implement their models in China.

## 6.2 Discussion

### 6.2.1 Challenges faced during the research

In hindsight, one of the potential difficulties faced during this research was the heavy reliance on collaboration with Buurtzorg. The interviewees have been related to Buurtzorg and I was, thus, to a large extent dependent on the willingness of Buurtzorg to allow me to interview their employees. I have been lucky that Buurtzorg has been willing to provide me that opportunity. Communication with Buurtzorg went smoothly, it was easy to get in contact with the organization.

Another, related, challenge was that I was not the only student who needed to interview Buurtzorg employees. To avoid overflowing them with interview requests, we decided to cooperate on the interviews and to hold them jointly. This cooperation has been successful. Sometimes our questions overlapped and this allowed us to gather more data as a group with considerably less time lost in contacting the interviewees, holding the interviews and to transcribe them. It also allowed us to be flexible with the planning of the interviews. With four students in total, at almost any time one or two of us were available to hold an interview.

The cooperation with the other students on the interviews did bring a new challenge to all of us. Namely, we were not always on the same pace. In my situation, in the beginning of my research I had to put in a lot of work to finish the theory and context. These were very extensive parts of my study and the interviews sought to fill in the gaps. To construct the interview questions, all the chapters before the methodology had to be completed. However, some of my fellow students needed the interview results in an earlier stage of their work. The result of the difference in pace between the cooperating students was that some had to wait one or two weeks until they could hold their first interview while others, including me, had to start conducting the interviews at an earlier stage than preferred. I solved this by focusing on quickly finishing the most essential parts of the theory and context so that in big lines, I already had an overview on what the questions should be. In addition to that, I also included an extra question in my interview which I later left out from my thesis. I considered it to be better to remove some irrelevant data at a later stage than to find out that I should have asked more questions in hindsight.

Finally, I also had difficulty in finding the right structure for my thesis. On part, this was because I was not used to explorative research and I wondered for a long time how I had to present my results. In the end, I hope I found a good format. I also received support from my second supervisor,

Professor Torenvlied, on structuring large texts. I considered this thesis a good learning opportunity, and with this support I have found my way to structure this thesis, and I am satisfied with the result.

### **6.2.2 Discussion about the research design**

I would also like to reflect on the content of my research. The first and most major possible remark about my research design I would like to discuss is why I chose to solely interview Buurtzorg professionals. My study delved into the cooperation between Buurtzorg nurses and informal family caregivers. Buurtzorg professionals are only on one side of this cooperation, I did not interview informal family caregivers. This has been a decision I made carefully, and something I have been aware of from the start of my research. I think that interviewing informal family caregivers would have been a good addition, but I considered it to be unfeasible for this study. The first difficulty would be to approach an informal family caregiver. Approaching Buurtzorg professionals was relatively simple because they are all aligned to the Buurtzorg organisation. Informal family caregivers are, as is already a part of their name, informal. To find informal family caregivers that are also related to Buurtzorg, I would most likely have had to approach Buurtzorg to help me approach them. However, this would lead to more difficulties. Firstly, Buurtzorg cannot guarantee the possibilities of such interviews, since these informal family caregivers are not their employees. Secondly, how reliable would this sample of informal family caregivers be? Would they bring me into contact with informal family caregivers who are very critical of Buurtzorg, or would most of my interviewees then be on good terms with their nurses and maybe not represent the group as a whole? There was a final problem I would have faced if I had attempted to interview informal family caregivers in general. I would need a large sample. Buurtzorg nurses have seen many examples of cooperation with informal family caregivers. Informal family caregivers, however, usually only know about their own specific experiences. To get a representative overview from the side of the informal family caregivers, I may have had to hold many interviews. To hold that many interviews I would have need more financial resources and time available for the study. I decided to focus for this study on the Buurtzorg professionals, to avoid drowning in the size of my thesis. Though I think that attempting to interview informal family caregivers would be a good follow-up research on this thesis.

A second thing I would like to reflect on is the third selected principle for effective co-production:

*The organisation needs to create a sense of shared responsibility between them and the consumers regarding the services they provide*

I found this principle difficult to test. This principle was only one of out five that were used to asses one of the sub questions, and I concluded that there was some indication that this was the case. However, I found this principle difficult to test and I could not provide a strong result. I was not able to directly ask this question during the interviews, because only the perspectives of the nurses could have been asked, and I could not asses whether that was representative for the entire situation. The principle was a logical follow-up on other results. Namely, the shared responsibility for the care was voluntary and there was extensive communication. In total, the fact that this principle could not completely be assessed did not seem to have any effects on the conclusion because it was so related to other principles that did have clear conclusions, but for further research, especially if informal family caregivers could be included in the interviews, it would be interesting to attempt to more concretely asses this principle.

A final matter I would like to discuss is how conflicting opinions from interviewees should be compared. Most of the results from the interviews supplemented each other, but there was one instance in which I had to puzzle how some results related to each other. This was in the case of communication with the family in China. Initially, all the results gave me the impression that there was less contact with the family as compared to in the Netherlands. Nurses in China seemed to be limited to the tasks they had been hired for, whereas in the Netherlands the nurses communicate with the family about the situation as a whole. Later findings suggested that in China, there was in fact a lot of communication with the family, that they were quite demanding. But the way this was presented to me in the interview was as if the first assessment that Buurtzorg nurses in China played a less coordinative role. In the end, I concluded that this seemingly contradiction was in fact just a cultural difference. The interviewees with primarily a background in the Netherlands most likely assessed the situation from a Dutch perspective, and in the Netherlands the nurses have a very coordinative role in the care. The interviewees with primary background in China most likely assessed the situation from a Chinese perspective and, thus, interpreted my questions as solely about the frequency of communication, but not about the scope of topics that was communicated. When I realised this cultural difference in how my question may have been interpreted, I concluded that it was in fact not a contradiction. The Chinese perspective was right, namely that there was frequent communication with the family, but the Dutch perspective was similarly right, that this communication was limited to a smaller scope of topics. This example does show that it is sometimes difficult to weigh the different opinions from the interviewees and to derive results from that.

### **6.2.3 Recommendations for future research**

To conclude this thesis, I will make a few recommendations for further research. My first recommendation concerns the Dutch policy to stimulate informal family caregiving. The Dutch government has been motivating its citizens to become more involved with the care for their elderly. They have been motivating their citizens to do this to cope with the costs of elderly care in an increasingly ageing society. A topic that I did not further explore and which is worthy of a research of its own is whether this policy is feasible and will effectively solve the problems in the Dutch elderly care. Another interesting study to conduct would be the potential for co-production initiatives in the Chinese society. This study has explored how Buurtzorg co-produces with informal family caregivers in China, and very briefly touched the subject of co-production in China as a whole, but this is one specific example. A study on this topic could compare many co-production initiatives and also give an answer to the question whether a co-production model in China would be effective.



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# Appendix

## Interview questions

1. What type of clients does Buurtzorg mostly have in the Netherlands/China: clients that do not have any family caregivers, or clients with family caregivers that would like to have professional support on the side?
2. How do people in the Netherlands/China, in your opinion, perceive mantelzorg? Are these opinions about mantelzorg changing?
3. What kinds of tasks do mantelzorgers usually take upon them, when they work alongside Buurtzorg professionals?
4. Providing mantelzorg is for some mantelzorgers very burdensome. Do you think that home care professionals always have a good overview on what the mantelzorgers are capable to take upon them and what they are not capable of taking upon them?
  - c. What role does Buurtzorg play in providing support and advice to mantelzorgers?
  - d. Does Buurtzorg stimulate (or provide by themselves) mantelzorgers to find training to successfully provide their care? How does Buurtzorg make sure that mantelzorgers are successfully able to provide informal care in collaboration with Buurtzorg? If so, can you give examples?

## Removed interview question

The following interview question was used during the interviews but later removed from the results because it was not relevant.

5. Do you think that more mantelzorg (more involvement of the family) is one of the solutions for making elderly care more affordable and sustaining the quality of care in the Netherlands, or do you think the solution must be found elsewhere?

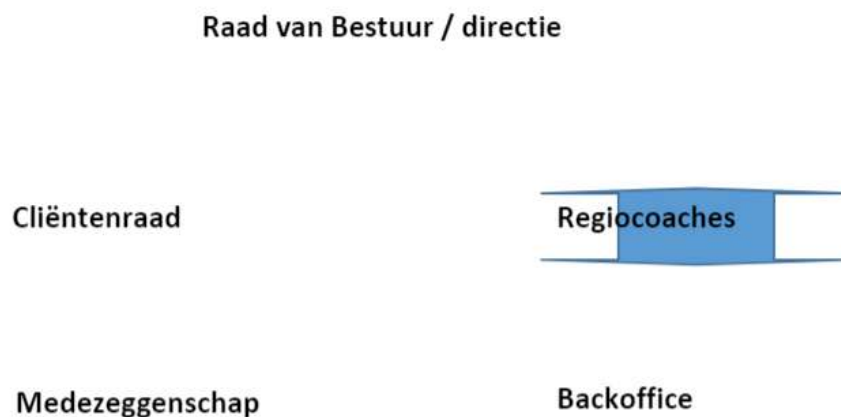
### Original version of figure 1

Figure one was originally acquired in Dutch. Some of the text has been translated into English. This was the original image, including the explanation of the organogram in the e-mail.



## Organogram Buurtzorg Nederland

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### Buurtzorgteam 1 – Buurtzorgteam 2 – Buurtzorgteam 3 etc.

Buurtzorg Nederland kiest voor een 'platte' organisatiestructuur zonder managementlagen. In feite is er slechts een managementlaag: de directie. De decentrale Buurtzorgteams hebben een eigen resultaatverantwoordelijkheid en worden indien nodig ondersteund door een regiocoach. De teams werken binnen centraal afgesproken kaders ten aanzien van kwaliteit, bedrijfsprocessen en resultaten.

De directeur / bestuurder legt verantwoording af aan de Raad van Toezicht. De rolverdeling tussen de bestuurder en de Raad van Toezicht is gebaseerd op de landelijk erkende Governance Code voor Zorginstellingen.