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The Bureaucratic Steering of Local Governments and its Effects on Nursing Autonomy in Home Care for Elderly in the Netherlands and Shanghai

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Abstract

The purpose of this research is to identify how the bureaucratic steering of the Shanghai government influences the quality of Buurtzorg care through the nursing autonomy as a practice example of Chinese bureaucratic steering towards Western social innovations. Buurtzorg is an award-winning Dutch home care organization that started its first pilot in Shanghai in 2014. This present study looks at the transfer of the Buurtzorg model particularly with regard to the bureaucratic steering imposed by the Shanghai government. The bureaucratic steering will be assessed through the categorization into two dimensions; coercive/enabling and hard/soft bureaucratic steering. Moreover, one of the key drivers for the success of Buurtzorg in the Netherlands are the self-managed teams in which the nurses enjoy a high level of discretion. In order to explore the expected associations interviews were held with Buurtzorg professionals of different occupational levels in Shanghai and the Netherlands and other knowledgeable respondents. The interviews revealed that the bureaucratic steering of the Shanghai government indeed required an adjustment of the Buurtzorg model. Moreover, this research adds to the debate of whether external steering by government helps or hinders organizations in addressing wicked problems.

keywords: buurtzorg, government, shanghai, bureaucratic steering, bureaucracy, elderly care, home care

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1 Introduction

1.1 The Demographic Change and Elderly Care

Throughout the last century, the world's average age has increased significantly and it will increase even further. In 2000, the average age was at about 26,6 and it will rise to approximately 45,6 in 2100 (Lutz, Sanderson, & Scherbov, 2008). This brought up the issue of an increased demand for elderly care. Traditionally, elderly care was delivered by informal caregiver, e.g. neighbors and family members. However, due to the geographical scattering of family members, an overall decreased family size and the emancipation of women, the importance of formal caregiving has soared (Ting & Woo, 2009). Therefore, nursing homes were built in the 1980's and residential care became the prevailing approach in elderly care in Western Europe. In the following years, the number of people in need of care further increased and so did the costs. Subsequently, a rethinking of the elderly care was needed. In order to reduce the costs of care, most European countries pushed for a shift from costly institutional services to less costly home care services. In order to do this, nurses were put together in teams so that they can balance the workload and use their different skills to serve the patient in the best possible way (Laloux & Wilber, 2014). Besides, this gave the elderly the opportunity to stay in their familiar environment as long as possible (Da Roit, 2010). Until today, home care is one of the favored approaches to tackle the issue of elderly care.

1.2 The Governments' Role in providing Elderly Care

Not only in Europe did the policymakers realize that the government is not capable anymore to deliver all necessary services to its citizens without the help of non-governmental organizations. Accordingly, the former New York Governor, Mario Cuomo, once said, "It is not government's obligation to provide services, but to see that they're provided" (Reissman, 1997, p. 3). As a result, Osborne and Gaebler (1992) called for a reinvention of the government in a way that the government should be 'steering instead of rowing'. In their view, the governments had to re-empower communities to solve their own problems rather than simply delivering services on their own.

Da Roit (2010) also addresses the issue of the vanishing of the government. She compared the Netherlands and Italy regarding their health care systems and how it has changed from the beginning of the 1990's until today. In order to increase the productivity of care, the governments externalized the provision of elderly care which involved the introduction of new public management ideas. Especially the Dutch policymakers focused on home care and

fostered a marketization of the provision of elderly care in the 1990's (Blok, 2016). Other European countries (e.g. Belgium, Austria, France) introduced legal obligations which obliged the family members to care for the elderly in need, while such legislations remain absent in the Netherlands (Da Roit, 2010).

The vacuum that was left in the health care sector offered room for new management approaches. Shared governance highlights the importance of staff participation in the planning and decision-making process and has been subject to many studies in the field of health care quality (Howell et al., 2001). Laschinger and Finegan (2005) and Porter-O'Grady (2003) have found that the implementation of such structures lead to positive nurse and patient outcomes – including increased nursing autonomy. Besides, Glasscock (2012) discovered that the implementation of shared governance in various hospitals and nursing organizations in the U.S. led to an increased nursing autonomy and an overall improvement of the perceived quality of care and job satisfaction. Howell et al. (2001) have pioneered in testing whether shared governance can also work in highly bureaucratic fields with strong government steering. They found that there are certain dimensions that would constrain the full implementation of shared governance in highly bureaucratic systems. They concluded that law and federal regulation would threaten the implementation of shared governance. This raises the question how an approach like the shared governance in which the nurses are empowered and encouraged to take decisions autonomously would work in a different, more bureaucratic, context and what kind of bureaucratic steering in particular would prevent the full implementation.

Jos de Blok – a Dutch nurse with a radical idea for the revolution of the health care provision – jumped in the resulting vacuum in the elderly care provision and founded Buurtzorg, a home care organization that provides care with the help of informal caregivers. His core idea can be found in shared governance as well. He aimed to transfer the additional leeway, caused by the vanishing of the government, directly to the nurses so that they can perform their job more autonomously, and hence improve the quality of care. Buurtzorg became indeed very successful and has been implemented to different countries in Europe, America and Asia. In 2014, Buurtzorg opened up a branch in Shanghai, however, home care is completely new to Peoples Republic of China (PRC). Accordingly, only little research has been done on how the Chinese government deals with this new approach and whether the Buurtzorg nurses in Shanghai can draw on the same mechanisms that made the model so successful in the Netherlands. Therefore, this research aims to provide an answer to the following research question:

How does the bureaucratic steering of the Shanghai government influence the quality of care through the nursing autonomy?

In order to answer the overarching research question, the following three sub-questions will be addressed in the present study:

1. *What is the evidence of Buurtzorg in the literature?*
2. *How does the bureaucratic steering affect the nursing autonomy in the Chinese context?*
3. *To what extend can nursing autonomy be associated with quality of care?*

1.3 Societal Relevance

Although European and North American countries had to deal first with the challenges of the demographic change, it is now increasingly affecting Asian countries as well (Huang, Thang, & Toyota, 2012). The proportion of the Chinese aged 65 and older has increased from 7,0% in 2000 to 8,9% in 2010 whereas the share of those aged 0 to 14 has fallen from 22,9% to 16,6% in the same period (X. Peng, 2011). Moreover, the total amount of the population increased constantly throughout the last fifty years, although the working population decreased by 3,45 million in 2012 (Zhong, Li, Xiang, & Zhu, 2013). As a result, China's population ageing is not only about people living longer lives but also about there being more old people (Lutz et al., 2008). Therefore, population ageing is a major issue of the PRC and will have, and already has, a significant impact on health policies and programs. In Shanghai, the average age increased from 58 years in 1957 to about 82.5 in 2013 which is comparable to industrialized countries (J. Peng, Zhang, Lu, & Chen, 2003). Accordingly, since 1979 Shanghai is the 'oldest' city of China. Besides, more than 80% of those reaching age 60 are parents of the only-child generation (Chen, 2016). Since Shanghai is the largest and most developed city in China, it often serves for new policy reforms of the central government, e.g. it was the first major urban center that implemented the medical savings account (MSA) scheme in the PRC, in 2001 (Dong, 2008). Due to the already mentioned population ageing, a shift from communicable towards non-communicable diseases and the increasing costliness of advanced medical technology, the total health expenditure in Shanghai is soaring (Yu et al., 2011). Hence, the first Buurtzorg pilot in Shanghai has been launched in 2014.

The Netherlands, however, have an even more aged society. The demographic transition has started earlier and already lost speed again. In 2013, 16% of the Dutch population was aged sixty-five and above. This number is expected to increase to 26% in 2035 (Smits, Van Den

Beld, Aartsen, & Schroots, 2014). Accordingly, the Dutch were facing the aftermath of the demographic transition much earlier than the Chinese were. The Dutch government did not succeed in providing sufficient elderly care in the first place. Therefore, they marketized the field of health care provision. Many organizations crowded into the market and elderly care became very profit-oriented and lacked profession. More organizations merged and they began to struggle with the administrative work. From 1990 to 1995, the number of organizations dropped from 295 to 86 (Laloux & Wilber, 2014). As a result, the frontline people lost contact with the organization and an increased fragmentation of the nurses' responsibilities took place (Blok, 2016). Furthermore, and most importantly, the nurses lost their discretion. The merging of the many health care providers triggered very hierarchical organization structures in which the working load was very much fragmented. This drastically decreased the autonomy in the decision-making. Besides, the hierarchic structure was very costly due to the increase in administrative personnel. Consequently, Jos de Blok founded Buurtzorg in 2007 in Almelo, in the Netherlands. Since then, it achieved remarkable success and serves as a role model for many other health care organizations. For instance, the overhead costs are as low as 8%, compared to more than 25% at the average health care organization (Leichsenring, 2015). Furthermore, within the Buurtzorg model the autonomy of nurses and the education of caregivers is a core aspect. Therefore, nurses are organized in self-steering teams (Alders, 2015). However, the acceleration of the health care expenditure has become a common phenomenon in many states and subsequently, affordable elderly care is nowadays a universal concern (Dong, 2008). Because of the immense success, the Buurtzorg model has been adapted to other states, e.g. Sweden, the U.S., Japan etc. and recently also to Shanghai, China.

As mentioned earlier, the bureaucratic steering aspect of the government plays a crucial role in implementing a health care model in which the nurses enjoy a very high level of autonomy. Howell et al. (2001) have shown that a more bureaucratic and hierarchical context can be a threat to nursing autonomy. In the PRC, the bureaucratic steering capacity of the state might be completely different than in the Netherlands. Zhou (2012) describes that the Chinese state and its local governments are often seen as 'predatory and captured'. Furthermore, local bureaucrats were expected to follow directives from above in order to get promoted on the one hand, but also to take the initiative in carrying out unfunded policy mandates, on the other hand (Ibid.). Besides, Das (2014) argues that China's strong state capacity has been the ultimate key to produce efficient outcomes. Rothstein (2015) argues that China lacks the rule-of-law-oriented, unpolitical, predictable and impersonal form of public administration that is called the Weberian bureaucracy. The distinctiveness of the Chinese bureaucracy from the Weberian

model in Western Europe makes the comparison of the Dutch and the Chinese context especially interesting.

1.4 Scientific Relevance

The transfer of social innovations from a Western context to an Eastern context has significantly gained importance, but remains understudied, although this study field contains a lot of unrevealed potential. Since China's economic reform in 1978, it has gradually opened up to new foreign policies and started to intensify the exchange of ideas and innovations with the EU. Gerven and Weiguo (2017), for instance, studied Chinese labor market reforms between 2000 and 2012 and found that the European solution of flexicurity diffused to the PRC.

Although, the immense success of the Buurtzorg model has been studied extensively (e.g. Kreitzer, Monsen, Nandram, and de Blok (2015); Leichsenring (2015); Nandram and Koster (2014)), all these studies were limited to the Dutch context. This research will give additional insights into the special characteristics of the Buurtzorg model in a completely new and different context. Due to the demographic change elderly care has become an urging issue. The affordability and quality of care has become a universal concern to many countries and raised the interest from scholars all around the world. Yet, with the invention of the Buurtzorg model, Jos de Blok has maybe given an alternative to ever-soaring health care expenditures.

One of Buurtzorg's core mechanisms is the autonomy of their nurses. Many of the already mentioned scholars concluded that the nursing autonomy in the Dutch Buurtzorg model is very much responsible for Buurtzorg's success. Other scholars, e.g. Laschinger, Shamian, and Thomson (2001), Kramer and Schmalenberg (2003) and Angermeier, Dunford, Boss, and Boss (2009), have proven associations between the empowerment of nurses and quality of care. Angermeier et al. (2009), for instance, found that nurses who perceive their working climate as participative instead of authoritative commit 26% fewer medication errors.

Much research has been conducted on which characteristics and mechanisms have made Buurtzorg so successful (e.g. Monsen and de Blok (2013); Johansen and van den Bosch (2017); (Alders, 2015)), but until now only little research has been done on the transfer of the Buurtzorg model to other countries. A different context can have a crucial impact on the relevant mechanisms and therefore can make it indispensable to change core principles of the original Buurtzorg model. As a result, this research especially focuses on the Shanghai government and its bureaucratic steering. Buurtzorg's decentralized and fluid structure that facilitates rapid adjustments might work well in the Netherlands, but how do Chinese bureaucrats deal with an organization that listens to its own purpose instead of taking orders from someone above in the

chain?

Regarding external bureaucratic steering, the existing literature offers contrasting answers to the question on how effective external steering might be. Martin and Guarneros-Meza (2013, p. 587) cite evidence that "targets and inspection regimes imposed by activist government departments corrupted local networks, preventing knowledge transfer within the health service". Therefore, local partnerships have to be free from any governmental intervention in order to be "equal, spontaneous, naturalistic and improvisatory, and less routine, hierarchical, structured and orchestrated... more self-managing and self-organising" (Bate & Robert, 2002, p. 600). However, other scholars argue that organizations are thriving on the imposed hierarchies and benefit from the external steering. Kooiman (2003) concludes that the bureaucratic state continues to be the most important actor when it comes to setting up the conditions in which networks operate. Besides, Turrini, Cristofoli, Frosini, and Nasi (2010) discovered that the performance of an organizational network can be enhanced under the fiscal control of a higher tier of government. Accordingly, the present study will further add to the understanding of external bureaucratic steering and to what extend it is beneficial to organizations.

Foremost, however, the findings of this study will contribute to more insights on what role the local Chinese government plays regarding the establishment of new social innovations in the health care sector for the purpose of addressing the needs of the rapidly ageing society.

2 Theory

2.1 The Wicked Problem of Elderly Care

The issue of elderly care in an ageing society is a wicked problem that is complex, unpredictable, open ended and almost intractable (Gerven, Torenvlied, Jing, & Zhu, 2016b), therefore, the solving of such problems through an "engineering" approach has ended (Head & Alford, 2015). As a result, governments have to adjust their steering efforts. Wicked problems reveal the limits of traditional forms of top-down government approaches which are unable to deal with the growing fragmentation, complexity and dynamism of contemporary societies. In order to tackle those wicked problems, governments had to realize that they could not provide all necessary services on their own, but rather provide resources to those organizations that are experts in providing the relevant services. Accordingly, many basic services that were originally provided by the government were privatized in Western Europe during the 1990's,

e.g. transportation, education and health care. However, China marketized its economy only in 1978 and the government remained much more involved in the provision of services than the governments in Western Europe. Therefore, Svensson, Trommel, and Lantink (2008) argue that the degree to which an organizational approach fits within the wider environment of beliefs, values and norms, will play a crucial role for the transfer of an innovation into a new context.

Meier, Rutherford, and Avellaneda (2017) define contexts as situational opportunities and constraints affecting the appearance and meaning of behavior within a certain organization and its relationships with its environment. Several variables can shape the context, for instance time, place and technology. Furthermore, the general context is divided into two spheres, namely the external and the internal characteristics. In order to study the collaboration between the Buurtzorg professionals and the local government, the external characteristics of the context are especially important. Moreover, the external characteristic is defined by its political and general environment. Factors that shape the political environment are most importantly political power, separation of powers, federalism, corporatist versus adversarial processes, networks and performance appraisal. A static analysis of each of these factors, however, would fail to give a sound overview on how the political context of China influences the implementation of a social innovation adaption. Hence, this research will focus on China's state capacity in terms of its bureaucratic steering capability.

After years of disappointing results in the elderly care sector in China, the local governments urged to recentralize the competences. However, the central government did not have the financial means to provide the needed care (Gerven, Torenvlied, Jing, & Zhu, 2016a). As a result, many health care organizations crowded into the market. In the beginning, these health care organizations exclusively focused on institutionalized care.

Traditionally, children are legally obligated to take care of their parents, also known as filial piety (Chen, 2016). This means that the elderly can financially and emotionally rely on their children (Liu & Huang, 2009). The Shanghai government has recently introduced the "90-7-3" framework. This framework assumes that 90% of all elderly will primarily rely on filial piety whereas 7% are in need of community based care and 3% will need institutionalized care (Chen, 2016). Even if this framework will prove true, the absolute numbers of elderly in need of formalized care will significantly increase. However, due to the consequences of the one-child-policy, the change in family values and the emancipation of the woman, the need for formal care is projected to further increase (Ting & Woo, 2009). In order to keep up with the increasing demand for elderly care, the Chinese government has opened up its economy to foreign companies as well. One of the organizations that has entered the Chinese market is

Buurtzorg. Accordingly, their new branch in Shanghai will be the empirical case to this research.

2.2 Bureaucratic Steering affecting Nursing Autonomy

The bureaucratic steering of governmental institutions can be complex and multi-dimensional. Accordingly, there are different ways in assessing the bureaucratic collaboration between a government and an organization. This research, however, will conduct a one-sided analysis of the bureaucratic collaboration between a local government and an organization. The focus will be on the bureaucratic steering of the local government towards the organization, i.e. what kind of resources are provided and how much the organization and its employees have to comply with formalization imposed by the local government. The theoretical framework of Adler and Borys (1996) and Martin and Guarneros-Meza (2013) address these aspects perfectly. Adler and Borys (1996) focus on the imposition of workflow formalization. Workflow formalization concern the employees in a very direct way. The employees' discretion can be decreased by the imposition of too many formalization. On the other hand, Martin and Guarneros-Meza (2013) deal with the provision of resources which rather concerns the organization as a whole. The success of an organization is highly dependent on whether it has the necessary resources. If the organization lacks sufficient resources, an adjustment of the organizational model might be necessary. To sum up, these two frameworks will give this research the opportunity to investigate on the direct and indirect effect of bureaucratic steering on employee discretion and subsequently on nursing autonomy.

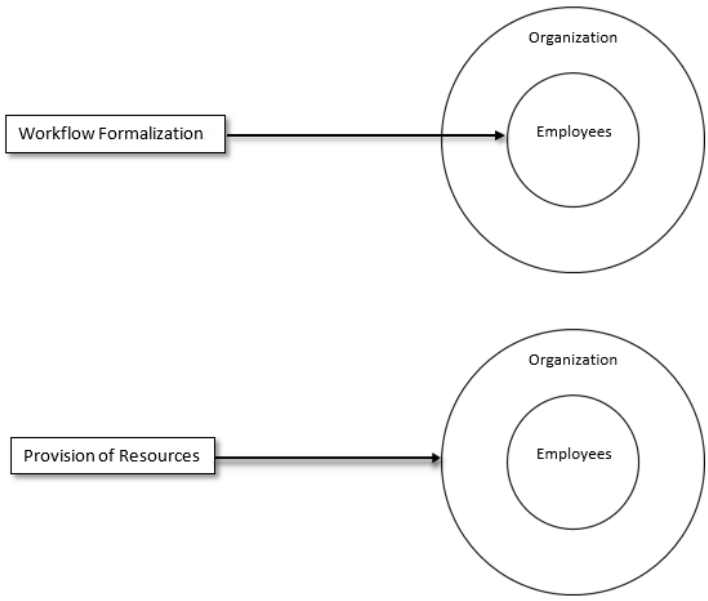

Figure 1: Workflow Formalization and Resource Provision towards an organization and its employees

According to Adler and Borys (1996), there are two styles of formalization; the first one enables the employees to master their tasks on their own and the second one coerces effort and compliance from the employee. They argue that bureaucratic steering can only be enabling if it is low on bureaucracy and formalization scales. Moreover, they say that coercive bureaucracy

includes written job descriptions, rules and procedure manuals, statistical quality control and total quality management. However, it is important how the health care professionals perceive the formalization. High levels of formalization will be perceived positively in the field of routine tasks and negatively in the field of non-routine tasks and vice versa (Ibid.). Pines and Maslach (1980) found, for example, that nurses in more structured daycare programs were less exhausted. Moreover, one has to take into account that as good perceived formalization are taken for granted and are rarely noticed whereas as bad perceived rules are felt more deeply (Adler & Borys, 1996).

In any case, high levels of formalization are associated with a decrease in the autonomy of the employees. The first expectation is therefore as following;

E1: Coercive bureaucratic steering is negatively associated with perceived autonomy of employees.

Besides, another way of identifying how bureaucrats might steer organizations is given by Martin and Guarneros-Meza (2013). They divide governmental actions in soft and hard steering. Moreover, soft steering includes, for example, the provision of recommendations to organizations. Soft steering governments provide funding, information and expertise if necessary. Organizations are supported by the government in order to improve its outcomes but they do not impose strict rules or objectives on them. On the contrary, hard steering is associated with the application of rules and targets that are enforced by the government. It involves instruments such as the imposition of top-down targets and performance regimes, i.e. if the bureaucrats dictate certain goals that should be achieved and monitor these for instance through total quality management (TQM). Similar to the other approaches, the hard and soft steering classification also distinguishes between a relationship of subordination and equality between the government and the organization. To sum up, hard steering is assumed to hinder employees to carry out their profession autonomously.

E2: Hard bureaucratic steering is negatively associated with perceived autonomy of employees.

2.3 Nursing Autonomy affecting the Quality of Care

The autonomy of nurses is one of the key mechanisms, in order to provide high quality care. Laloux and Wilber (2014) have conceptualized different periods in time in which different types of organizations have dominated. Very recently, they have introduced the new epoch of

"teal organizations". They argue that the epoch of "green" organizations, in which the well-being of the employees is essential, culture matters and people are not exclusively seen as productivity factors, will end. Therefore, "teal" organizations will dominate the market. Self-management, wholeness, and evolutionary purpose characterize these new organizations (Bremer, 2014). Furthermore, Kramer and Schmalenberg (2003) found in a study involving 279 nurses that there is an association between the degree of nurse autonomy and their job satisfaction. More satisfied employees will also be more willing to perform well throughout their job. Moreover, Laschinger et al. (2001) have conducted a study involving 3016 nurses and found that higher levels of autonomy, control and collaboration are related to patients' perceptions of care quality. Eventually, Almost and Laschinger (2002) have found that autonomy is indispensable for nurses who are employed in the home care sector. In their view, the nurses need the opportunity to take decisions autonomously. Otherwise, they will be stuck in tight schedules that will not give them any leeway to address their clients' needs more in depth. Higher degrees of autonomy are expected to lead to a higher quality of care.

E3: More nursing autonomy is positively associated with quality of care.

These expectations deal with the correlations between the four variables Hardness of Bureaucratic Steering, Coerciveness of Bureaucratic Steering, Nursing Autonomy and Quality of Care. This research expects that the Hardness and Coerciveness of Bureaucratic Steering will decrease the Quality of Care through the Nursing Autonomy. A corresponding causal model looks like this:

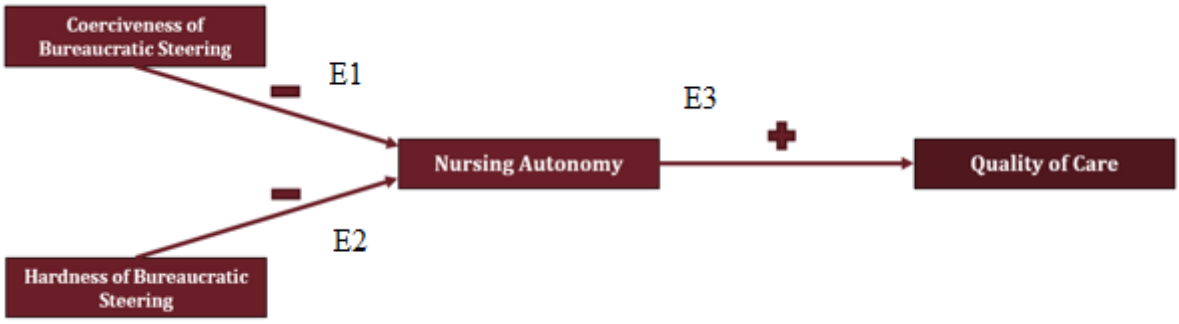

Figure 2: Causal model

2.4 Comparing Buurtzorg Netherlands to Buurtzorg Shanghai

The three expectations will be explored by comparing the original Buurtzorg model in the Netherlands with the recently established Buurtzorg branch in China. Due to the sharp differences in context, crucial differences in the appearance of the Buurtzorg models between those two are expected. In the Netherlands, the municipalities are expected to be the most influential government actor while in Shanghai, the Shanghai Municipal Health and Family Planning Commission seems to be the most important stakeholder when it comes to bureaucratic steering. It is one of the Shanghai government's agencies and it is responsible for the implementation of reproductive health initiatives. Moreover, regarding the actual policy-making, organizations often have to deal with lower government levels as well, e.g. Residents Committees and Street Offices (Lei, 2014). Nevertheless, the Shanghai government, and therefore its agencies as well, is immediately subject to the orders of the Communist Party of the PRC. Accordingly, one can predict that the role of bureaucratic steering might be different from the Dutch context. In the field of environmental policy, for instance, Zhan, Wing-Hung Lo, and Tang (2014) have found that the bureaucrats in China are facing a static top-down perspective which neglects local factors that affect the work situation and the effectiveness of bureaucracy. Moreover, the Chinese government seeks to control potential risks that a developed non-profit sector would impose in order to obtain the benefits of their service function (Zhao, Wu, & Tao, 2016). Therefore, the bureaucratic steering in China is expected to be harder and more coercive.

E4: Buurtzorg faces harder and more coercive bureaucratic steering in Shanghai than in the Netherlands. This will lead to decreased nursing autonomy and a lower quality of care.

For the present study, this means that if the Shanghai government imposes high levels of formalization on Buurtzorg, the nurses will have decreased autonomy, which would require an adjustment of the Buurtzorg model. Regarding its cost-efficiency and the quality of care, the Buurtzorg model seemed to be a tailor-made solution. Nonetheless, its nurses need to have discretion in order to cope with the nature of service provision which calls for human judgment (Buffat, 2015). The Buurtzorg model achieved to contradict the increasing tendency of decreasing discretion through control by the deployment of extensive systems of procedures, budgets and surveillance (Evans, 2016; Svensson, 2016). Nevertheless, it is not yet known whether this also applies to Shanghai Buurtzorg. Consequently, it will be very crucial to find out what degree of formalization the local authorities impose on the Buurtzorg professionals.

Furthermore, it will be important to identify the form of formalization and how it is perceived by the Buurtzorg nurses. Svensson (2016), for instance, argues that a higher degree of formalization can also lead to more discretion since this will give the opportunity to potentially forget about some rules.

3 Methodology

3.1 Research Design

A qualitative and exploratory research design was chosen for this study in order to address the research objective in the best possible way. This study aims at exploring how the Shanghai government influences the autonomy of the Buurtzorg professionals which is essential to its original model and the high quality of care. As a result, the findings of this study will contribute to more insights on what role the local Chinese governments play regarding the establishment of new social innovations in the health care sector for the purpose of addressing the needs of the rapidly ageing society.

Due to the qualitative research design, the two recently established Buurtzorg nursing teams in Shanghai could be studied in-depth in terms of the nursing autonomy. As mentioned earlier, the self-steering nursing teams are the central mechanism to the Buurtzorg model. Moreover, the distinct Chinese context was taken into account by analyzing the external political environment (Meier et al., 2017) of Buurtzorg Shanghai in terms of the bureaucratic steering capability of the Shanghai government. Following Pawson and Tilley (1997) – who formulated the proposition 'causal outcomes follow from mechanisms acting in contexts' – the quality of care, and therefore the success of the Buurtzorg implementation, would be dependent on how well the autonomy mechanism works under the bureaucratic steering capability of the Shanghai government. In their view, it is almost impossible to prove causality, especially in different contextual environments. The issue of a social innovation adaption from the Dutch to the Chinese context contains many interwoven variables which stresses the characteristic of a wicked problem. A cause-effect, non-contextual method of analysis would have failed to consider the distinctiveness of the Chinese and Dutch bureaucratic steering. One can see that the effectiveness of Buurtzorg Shanghai is very much dependent on the mechanisms and the context in which they are applied. Before in-depth interviews were conducted, a review of the existing literature was carried out. The relevant literature compromises various interviews with Buurtzorg professionals (Blok, 2016), studies on the distinctiveness and innovativeness of the

Buurtzorg model (Kreitzer et al., 2015; Leichsenring, 2015; Nandram & Koster, 2014) and literature on the three variables of this research, namely; (i) bureaucratic steering (Adler & Borys, 1996; Martin & Guarneros-Meza, 2013), (ii) nursing autonomy (Laloux & Wilber, 2014) and (iii) quality of care (Harris, 1997).

In order to address the issue of social innovation adaption in elderly care properly, this research focuses on one particular case, namely Buurtzorg Shanghai in comparison to the original model. A popular definition of a case study is given by Yin (2003, p. 13); "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." Therefore, case studies are tailor-made research strategies to deal with complex situations in unexplored contexts.

3.2 Case Selection

Since this research is a case study, sampling criteria will not be applied. The case itself, namely Buurtzorg Shanghai, has been chosen due to its recent implementation, data availability, interview opportunities due to a research cooperation between the University of Twente and the Fudan University in Shanghai. Nonetheless, the case of Buurtzorg Shanghai is highly interesting. Shanghai is a prime example of an urban Chinese region and serves therefore very well as a comparison to the highly urbanized European context. Nowadays, Shanghai is one of the most bustling metropolises in the world with roughly 13 million citizens and since the 1978 economic reform, Shanghai has experienced a tremendous economic growth (Yu et al., 2011). Furthermore, the market-oriented reform and the resulting decentralization and devolution of regulatory responsibility have established a more powerful local government that can make use of its policy implementation power. Therefore, the responsibility has shifted from the senior to the junior levels of government (Skinner, 2003). The success of the implementation of the Buurtzorg model, i.e. the transfer of the various mechanisms of the model, especially the nursing autonomy, is therefore very much dependent on the Shanghai government. One of its agencies is the Shanghai Municipal Health and Family Planning Policy Commission which is responsible for tackling problems of population and family planning in all 16 Shanghai districts. Besides many other tasks, it is responsible for coordinating and promoting implementations of reproductive health initiatives and coordinating the integration of the rules and procedures concerning population and family (Gusmano, 2015). Thus, the Shanghai government with its bureaucratic steering towards the Buurtzorg organization is a crucial actor for the successful

implementation of the Buurtzorg model.

Within the case of Buurtzorg Shanghai, two Buurtzorg teams have been established which will, however, be treated as one. The research itself rather intends to focus on those Buurtzorg professionals that interact externally with people employed by the government and those people employed by the government that interact with Buurtzorg professionals. These individuals will also be the units of observation whereas the entirety of the Buurtzorg professionals and the Shanghai government will be the units of analysis.

3.3 Operationalization

3.3.1 Bureaucratic Steering

As described earlier, the bureaucratic steering capability of the Shanghai government will be measured through two dimensions. An overall definition of external bureaucratic steering is given by Bache (2000) and Martin and Guarneros-Meza (2013) who define governmental steering as the ability to enact legislation, issue guidance, confer legitimacy, provide funding, impose standards, monitor performance, and share information and expertise. Governments can use these instruments in order to shape local partnerships between themselves and organizations according to their notions. Therefore, different governments will use different instruments for different cases. Consequently, diverse bureaucratic steering styles evoke. This present study will focus on the following two dimensions of bureaucratic steering; hard/soft and coercive/enabling steering.

Tollefson, Zito, and Gale (2012) categorize different styles of bureaucratic steering into hard and soft by three simple criteria:

(1) its precision; to what extend does the steering constrain private action?
(2) obligation; how legally binding is the obligation? and
(3) delegation; does the regulator enforce the obligation or is this vested in an independent third party?

In the present case, especially the obligation and its bindingness will play a crucial role.

Hard steering, as the name predicts, includes strong and far-reaching government involvement. In the European Union, for instance, hard policy instruments involve directives and regulations with which the policy makers in the member states have to comply. In regard to their bindingness, hard policy instruments are mandatory instead of voluntary (Steurer, 2013). Therefore, the above defined steering instruments will be performed more intensively. Besides, the instruments are used to dictate the partnerships through imposing top-down targets

and performance regimes (Martin & Guarneros-Meza, 2013). The interviews therefore focused on whether and if so, to what extend performance goals are imposed by the Shanghai government. On the other hand, soft steering involves the government as a resource provider. The method of soft policy implementation produces 'non-binding 'soft policies', such as recommendations, information campaigns, and action plans rather than collectively binding decisions' (Torenvlied & Akkerman, 2004). For instance, the 'open method of coordination is a prime example of soft policy in the European Union. Robertson and Swan (2004) describe soft bureaucracy as a new subtle for of bureaucratic control and domination that is conditional on the following four aspects;

(1) a specific combination of impersonal and personal obedience;
(2) centralization as a means of legitimating political decisions;
(3) governance based on soft coercion and protection, and
(4) governance which fuses external and internal legitimacies.

Through these instruments, soft steering governments provide funding, expertise, information and confer legitimacy if necessary.

Moreover, the degree of workflow formalization has been addressed. A high degree of workflow formalization can be perceived as coercive bureaucratic steering. Rousseau (1978) has found that higher workflow formalization are positively correlated with absences, physical and psychological stress etc. According to Adler and Borys (1996) workflow formalization include written rules, procedures, and instructions that coerce effort and compliance from employees. Throughout the interviews, the nurses' perceptions of the workflow formalization were addressed in detail. However, workflow formalization can be perceived in very different ways. For instance, Clawson (1980) states that asymmetries of power and divergence of economic interests in capitalist firms will turn formalization into a coercive mechanism. This might also happen in competitive non-profit organizations like Buurtzorg. Yet, workflow formalization can be also perceived as enabling, if, for instance, "the employees see at least some overlap between their goals and those of the organization as a whole, they might also welcome the potential contribution of formalization to efficiency" (Adler & Borys, 1996). Otherwise, the steering needs to be low on bureaucracy and formalization in order to be perceived as enabling. In the interviews, the Buurtzorg professionals were asked to what extend the governmental steering fits Buurtzorg's and their personal goals and to what extend the formalization help the nurses to do their work.

3.3.2 Nursing Autonomy

Regarding the nursing autonomy, this research especially linked this concept back to the original Buurtzorg model. The reference for the autonomy of the Buurtzorg Shanghai nurses is the autonomy of the Buurtzorg nurses in the Netherlands. As a guideline Laloux' & Wilber's (2014, p. 65) observations of the autonomy within the original Buurtzorg model were used.

> "They are responsible not only for providing care, but for deciding how many and which patients to serve. They do the intake, the planning, the vacation and holiday scheduling, and the administration. They decide where to rent an office and how to decorate it. They determine how best to integrate with the local community, which doctors and pharmacies to reach out to, and how to best work with local hospitals. They decide when they meet and how they will distribute tasks among themselves, and they make up their individual and team training plans. They decide if they need to expand the team or split it in two if there are more patients than they can keep up with, and they monitor their own performance and decide on corrective action if productivity drops. There is no leader within the team; important decisions are made collectively."

They have found that Buurtzorg nurses in the Netherlands have far-reaching autonomy in the fields of;

(1) which patients they serve;
(2) how many patients they serve;
(3) the holiday scheduling;
(4) which doctors and pharmacies they reach out to;
(5) the distribution of tasks;
(6) how they monitor their performance, and
(7) the expansion of their team.

However, these findings by Laloux and Wilber (2014) will only serve as a guideline but this research does not per se assume that they have been right. During the interviews with the Dutch nurses, these aspects were also questioned. Moreover, the nurses were also asked how collectively they make decisions in order to address their individual but also their team autonomy.

3.3.3 Quality of Care

Eventually, this research aims to figure out how the quality of the Buurtzorg care is affected by the local bureaucratic steering through the autonomy of the nursing teams. There are various ways in which health care quality can be assessed, e.g. through the vignette method

in order to make the patients' judgement comparable (Poksinska & Cronemyr, 2017) or through the Assessing Care of Vulnerable Elders (ACOVE) survey which addresses the general medical conditions, the geriatric conditions and the cross-cutting indicators. Furthermore, Polat, Kahraman, Kaynak, and Gorgulu (2016) state that health care quality cannot be assessed without taking both dimensions, the physical and the mental, into account and thus created the Short Form Health Survey (SF-36) questionnaire.

However, these measures would require the contribution of the health care recipients in Shanghai. On the one hand, the language barrier would probably distort the results and would make them hardly comparable to the Dutch context. On the other hand, addressing the quality of care through the perception of the Buurtzorg professionals is more appropriate since this research especially focuses on the autonomy of the Buurtzorg nurses. Lohr (1990, p. 128) gives a more general definition of quality of care, which is more related to the nurses, by quoting the U.S. Institute of Medicine which states that health care quality is "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Although this definition is rather vague, it clearly highlights the importance of professional knowledge, thus effectiveness. However, increased know-how and resources will not per se lead to a higher quality of care (World Health Organization, 2006). Hence, more aspects of the health care provision have to be assessed.

The fact that Buurtzorg operates only since a few months in Shanghai puts a challenge to the measurement of the quality of care. Normally, Buurtzorg uses the Omaha system to monitor their health care outcomes. However, Omaha has not been implemented yet in Shanghai. As a result, it is to early measure the precise quality of care. Therefore, this research addresses rather abstract aspects of quality of care. According to Harris (1997), effectiveness, efficiency, equity, patient centeredness, safety and timeliness are addressing the issue of health care quality in a holistic, objective and evident way. Effectiveness relates to scientific knowledge and how frequently this is used to improve the health care quality. Efficiency refers to the quality of a comparable unit of health care for a given set of health care resources. Moreover, equity of health care means that every patient gets the same quality of health care. Prioritizing the patients' satisfaction while providing education and support is labelled as patient centeredness. Safety refers to actual or potential bodily harm. Eventually, timeliness relates to the punctuality of the professionals. During the interviews, the issue of safety will not be addressed since this might put the nurses, especially the Chinese, into an uncomfortable situation and they might want to withdraw from the interview. The other aspects will be

addressed correspondingly.

3.4 Data Collection and Analysis

Until now, empirical data is not available for Buurtzorg Shanghai since the pilot started only in 2014. This research is based on qualitative data that is conducted through nine interviews with current and former Buurtzorg professionals, two researchers in Chinese affairs and one Dutch government official. The Buurtzorg professionals are employed in different levels and positions, from nurses to higher management positions of the Buurtzorg organization, in either Shanghai or the Netherlands. Many of the respondents were familiar with the Dutch and the Chinese context so that they were able to put their experiences into relation. The potential respondents were contacted via e-Mail, however, most of the respondents had to be approached more than once. Through the head office of Buurtzorg in Almelo, the contact with other Buurtzorg professionals was established. Furthermore, the head office helped to get into contact with already approached respondents which were reluctant to participate in the first place. After conducting the face-to-face interviews, the interviews were transcribed. Some interview respondents were contacted a second time to clarify questions that arose from the transcriptions of the face-to-face interviews. Beforehand, four expectations on the basis of an extensive literature review on bureaucratic steering, nursing autonomy and quality of care were formulated. With the help of a comparison between Buurtzorg Netherlands and Buurtzorg Shanghai, this research aims to tentatively explore the formulated expectations.

4 Analysis

4.1 Bureaucratic Steering

In order to compare the consequences of the bureaucratic steering of the Dutch as well as the Chinese government, Buurtzorg professionals in the higher management positions in the Netherlands and in China were interviewed.

In the Netherlands, the Buurtzorg care is completely financed by health care insurances. Therefore, respondent A, a Dutch nurse, said, that they do not have so much contact with the local government. Besides, respondent B, a Dutch head nurse, confirmed the financing issue of Buurtzorg and said that the cooperation with the local government “is not about funding”. It is rather about information sharing and prevention while most of the times the government benefits from the expertise of the Buurtzorg professionals. Since the government has

externalized the provision of health care services, health care organizations gradually increased their independence from the government. Accordingly, the government does not impose any formalization on Buurtzorg. Respondent A also said that they indeed have rules and procedures but that these are rather imposed by the national government. Moreover, these rules and procedures deal with the overall outcome of the health care provision. Therefore, Buurtzorg Netherlands works together with the Dutch government to improve the Omaha system – a practice, documentation and information system, in which they also address the quality of care. Respondent B, on the other hand, said that the potential imposition of burdens by local Dutch governments depends on the region. She said that "with some local governments, there is a really good collaboration and a good working together for the community." Nevertheless, there are also other local governments with whom there is no collaboration at all.

Depending on the region, the hardness or rather the softness of the bureaucratic steering differs. With some local governments, Buurtzorg has good cooperation in which they especially share information and expertise whereas with other local governments they do not have any cooperation. However, none of the nurses reported that governmental top-down approaches were imposed on them. Therefore, it becomes clear that if there is any cooperation between the Buurtzorg professionals and the local government, it is based on soft steering.

Anyway, the Dutch government does not impose formalization on the actual health care provision. The nurses are, as respondent B puts it, in 99% to 100% of their daily work routines free from any formalization. Accordingly, there are almost no formalization of the Buurtzorg professionals' daily work routines. None of the respondents reported that the nurses would have fixed job descriptions, procedure manuals or verbal arrangements. Respondent A perceived this as a much better way to provide health care than former systems when static formalization were imposed on the nurses. Therefore, the bureaucratic steering of the local Dutch governments is much more enabling than coercive.

In Shanghai, the government imposes many formalization. Respondent C, employed at the management level of Buurtzorg, said that the government gives "rough description of the type of care" that is needed. Subsequently, respondent C perceives the existing formalization as "counterproductive". From his point of view, the best practice for the government would be to "focus on the outcome and to leave the 'how' to the care organization/nurses". Moreover, respondent C said that Buurtzorg Shanghai has to comply with a lot of requirements and that the local government produces high levels of formalization. However, he has also shown understanding for the local government; he said that "it is no surprise since it is new to them.

They don't have any knowledge about it." Besides, respondent D, another Dutch head nurse, said that the local government in the PRC is often much more involved than the local government in the Netherlands. She thinks that they need to be more flexible in order to keep health care affordable in the future. Furthermore, Buurtzorg has to provide a lot of documentation to the local government. Respondent C puts it this way; "it is more a revision of what we do rather than agreeing on any goals with us." Respondent E, a Chinese nursing coach, reported that the practice of the Shanghai government is similar to what the Dutch government did 20 to 30 years ago. He said that the Shanghai government provides a list with 25 types of activities of daily living (ADL) help and in addition a list with 17 kinds of nursing treatment which are used as procedure manuals for the care delivery. He concluded that the Shanghai government makes 'the rule of the game' and decides what organization and what kind of professionals deliver the care. Furthermore, respondent E said that Buurtzorg Shanghai is doing a project with the government in which Buurtzorg has to deliver 30 minutes of care per week to those elderly above 90. However, respondent E criticizes that some of the elderly might need more and others less care but there is no individual assessment of the elderly's needs.

Although the respondents did not report about the very specific formalization that the Shanghai government imposes on the daily work routines of the nurses, the respondents perceived the government interventions as restrictive and hindering. The Shanghai government seems to take decisions without adjusting it to the capabilities of Buurtzorg Shanghai or the needs of the elderly. Therefore, one can conclude that the bureaucratic steering of the Shanghai government is coercive.

Furthermore, respondent C said that the Shanghai government fails to provide resources like funding, information and expertise in a satisfying way. For government purchased projects, the government indeed provides the funding but according to respondent D, this funding is hardly enough to cover the costs. Consequently, she demands for "a little bit more support", also financially in order to give Buurtzorg the opportunity to reinvest into the company. In order to give a wider spectrum of elderly the opportunity to receive health care, the Chinese government said they would set up a long-term care insurance in 15 cities. However, before the pilot was launched, the Shanghai government said they would first try it in three city parts only. Respondent E also said that he would wish for more support of the local government regarding the medical license in order to be able to offer medical treatment to the clients. However, they are applying for it since two years and they still do not get it. In addition, respondent C said that

the only resource that the local government provides to Buurtzorg is information about elderly who are in need of care; "at least they should have information about elderly who are in need of care which is not always the case". On the other hand, the local government imposes top-down approaches, regardless of the actual needed care, e.g. in the project with the elderly above 90. Moreover, they make use of TQM tools. For example, they monitor the process of caregiving by conducting interviews with the patients.

Having the poor provision of resources and the static top-down approaches in mind, one can clearly classify hard bureaucratic steering.

Figure 3: Coercive/Enabling and Hard/Soft Steering in China and the Netherlands

This table shows how the bureaucratic steering of the local Dutch governments and the Shanghai government, as observed in this research, fit into the two dimensions of coercive/enabling and hard/soft steering. As explained earlier, the coercive/enabling dimension on the x-axis addresses the direct effect of government regulations on the nursing autonomy, whereas the y-axis and the hard/soft steering dimension deals with the overall burdens that the government imposes on the Buurtzorg organization, and therefore addresses the indirect effect of bureaucratic steering on the nursing autonomy.

4.2 Nursing Autonomy

Respondent A reported that she and her colleagues have far-reaching discretion in the Netherlands. Within the team they distribute tasks, but these tasks change from time to time so that one particular task does not become the exclusive responsibility of one nurse. Depending on the region, the hardness or rather the softness of the bureaucratic steering differs. Nonetheless, one can see that if there is any cooperation between the Buurtzorg professionals

and the local government, it is based on soft steering. Besides, they have to take care that they spent 61% of their working time for the client. However, how they do this is completely up to the nurse. Respondent B said that there is a certain framework in the Netherlands. For instance, they cannot simply decide that they are not available during the night or hire a manager for their team. However, regarding the working with the clients and the whole organization of the whole care, "they are fully 100% making their decisions". Respondent D adds that the nurses are "quite independent in Holland" and that they work in 'independent teams'.

Accordingly, one can say that the nurses have far-reaching autonomy regarding the actual provision of care.

Respondent F, who is employed at a Dutch municipality, said that in China "everyone is doing standard things, step by step but if you do home care you need to have your own judgement about each customer, you should not do standard things. You have to think "what do they need?" Respondent D underlined this impression. In her point of view, "Chinese are always really used to work with a supervisor who gives them a duty". As a result, they are not quite flexible in doing other things and therefore, she said, "the Buurtzorg way of working is dead". Furthermore, she added that she does not think that the nurses are not qualified enough but they are simply not used to work in independent teams since they have worked and trained in hospitals what is totally different from providing home care and working in independent teams. Respondent B sees the problem in the Asian culture. She said that not only in China but also in Japan, the implementation of self-organizing teams and self-relying nurses is quite challenging. However, she also said that the self-organizing aspect is not essential about the Buurtzorg model. It is rather a tool that has worked well in Buurtzorg in the Netherlands but it is not a goal in itself. Therefore, "there will be from the start […] a sort of team leader or head nurse" in each team in Shanghai. According to respondent C, they start with a hierarchical nurse model, and over the time, they will assign more responsibilities to the nurses.

Therefore, the core mechanism of autonomous nurses and self-steering nursing teams has been completely abolished in Buurtzorg Shanghai for now.

4.3 Quality of Care

In the Netherlands, the nursing teams are already using the Omaha system. The Omaha system is a classification system that has been adapted from the U.S. to Buurtzorg's IT system. The assessment also takes plays in this system and immediately after the submission of the health assessment of the client, protocols and best practices pop up that can be used by the

nurses. Nonetheless, according to respondent B it is still up to the nurses to make the decision. Furthermore, respondent B said that the clients would really appreciate that the Buurtzorg nurses are always on time. In her point of view, punctuality is also important in order to be transparent about the time schedule and foremost to adapt to the wishes of the client. Respondent A said that Buurtzorg definitely makes use of scientific knowledge. They already do so by hiring only highly educated nurses. Moreover, she said that she does not know about any differences in the delivered quality of care, however, she assumes that there are differences which are due to the different capabilities of the nurses within each team. Besides, in 2012, the national quality of care assessment in the Netherlands revealed that Buurtzorg has the highest patient satisfaction among all home care organizations (Blok, 2016) and in addition Veer (2008) found that not only the patients but also the general practitioners and local authorities are highly satisfied about the cooperation with Buurtzorg. Consequently, Buurtzorg constantly increased its share in the Dutch elderly care market.

According to the previously defined aspects of the quality of care and the different rewards Buurtzorg achieved, one can conclude that Buurtzorg delivers a high quality of care in the Netherlands.

Whether Buurtzorg Shanghai delivers a high or low quality of care cannot be answered yet. The respondents avoided this issue. Respondent C, for instance, said it is too early at this stage in China in order to assess the quality of care. He added that home care is really pioneering in China and that it did not exist before 2011. As soon as the Buurtzorg model has been completely implemented, indicators like the re-hospitalization rate and the re-entry rate of nursing homes will play an important role. Respondent D underlined this: “For now, it is indeed too early to say something about it [quality of care].” She added that Buurtzorg Shanghai is currently working on a solution to implement the Omaha system in Shanghai. However, it will take some time until it is ready to be used by the Chinese nurses.

Accordingly, one has to infer that at the current stage it is too early in the implementation process to conclude anything about the quality of care for Buurtzorg Shanghai.

4.4 Expectation Exploring

4.4.1 Expectation 1

In the Netherlands, one can clearly see an enabling bureaucratic steering, while coercive steering is absent. As already mentioned, respondent B said that in 99% to 100% the nurses are

free from any formalization in their daily work routine. Therefore, they would be able to work much more autonomously. It seems as if enabling steering in which the government is low on bureaucratic formalization indeed leads to more nursing autonomy. In China, one can see a contradictory picture. The respondents reported that there are quite some formalization that inhibit the daily work routines of the nurses. They perceive the government actions as contra productive and think the government should leave the 'how' of the care delivery to the nurses. Expectedly, the first expectation can be considered as true. Contexts in which the Buurtzorg nurses have to deal with more coercive bureaucratic steering are less likely to produce an environment in which nurses can work autonomously.

4.4.2 Expectation 2

For the second expectation, a similar picture becomes visible. The Dutch Buurtzorg nurses do not experience any static top-down approaches. However, they often work completely independent from the government. Through the health insurance companies, Buurtzorg Netherlands receives a sufficient funding but the degree to which the local governments and the Buurtzorg professionals exchange information and expertise is rather low and depends on the particular government. In China, however, one can see that Buurtzorg clearly lacks sufficient funding and would like to receive more information. On the other hand, they face performance regimes imposed by the Shanghai government that do not really fit their health care approach.

In contrast to the first expectation, the respondents did not report a direct effect on the nursing autonomy. The harder bureaucratic steering in China was rather seen as an obstacle to the organization in itself. Therefore, it is not clear whether hard/soft steering really has an effect on the nursing autonomy but it affects the Buurtzorg organization as a whole and subsequently threatens the nursing autonomy as one of its core mechanisms.

4.4.3 Expectation 3

We see very clearly that the Buurtzorg nurses in the Netherlands can work autonomously while the nurses in Shanghai cannot. Respondent D reported that in Shanghai the original Buurtzorg model is 'dead'. In a policy paper, the president of Buurtzorg Asia reveals that they need a lead nurse per team in Shanghai and transform stepwise to less and less hierarchy and more self-responsibility (Dyckerhoff, 2017). In the Netherlands, one can also see a high level and rewarded quality of care which is according to respondent B due to the

autonomy of the nurses. However, she also stated that the self-steering teams are an important tool to deliver care but it is not an objective in itself. Accordingly, high quality of care could be still achieved in Shanghai even though the nurses cannot draw on the same nursing autonomy as their counterparts in the Netherlands. However, during the interviews the respondents revealed that there is no assessment of the quality of care in Shanghai yet. Furthermore, respondent D reported that Buurtzorg Shanghai is currently working on the adaption of the Omaha system but it is too early to make any statements regarding the delivered quality of care.

4.4.4 Expectation 4

As already mentioned, Buurtzorg Shanghai indeed faces more coercive and bureaucratic steering and in addition the nurses can work considerably less autonomously than the Dutch nurses. Unfortunately, it is too early to predict differences in the level of the quality of care in Shanghai and the Netherlands. Therefore, the expectation can be considered as partially true.

5 Conclusion and Discussion

5.1 General Conclusions

In summary, the four expectations have shown that the Chinese context, regarding the local governments, indeed requires an adjustment of the core principles of the Buurtzorg model. The nurses in Shanghai cannot draw on the same mechanisms as their counter parts in the Netherlands.

As mentioned earlier, previous studies have given contrasting answers to the question how effective external steering is. While some scholars argue that external steering enhances the productivity of networks and organizations (Kooiman, 2003; Turrini et al., 2010), others think external steering is an obstacle to effective network governance (Bate & Robert, 2002). This study contributes to this debate by exploring which kinds of bureaucratic steering have a positive or negative effect on Buurtzorg Shanghai, its nurses and their autonomy.

The Shanghai government was assumed to have a direct effect on the appearance of the Buurtzorg model. This effect has been proven throughout the various interviews. However, before the interviews it has not always been clear with which governmental agencies Buurtzorg has to deal. In the interviews, we found that in Shanghai, the Bureau of Health is responsible for medical nursing while the Bureau of Civil Affairs is responsible for elderly care. The resulting confusions due to overlapping responsibilities are an obstacle to a fruitful cooperation.

Furthermore, we have seen that the Buurtzorg professionals especially wish for a closer cooperation with the Shanghai government when it comes to exchanging information and the distribution of resources. For instance, Buurtzorg Shanghai requires a medical license in order to perform medical nursing. However, they are applying for such a medical license for two years – unsuccessfully. In the view of the Buurtzorg professionals, the Shanghai government fails to provide sufficient funding and other resources to the cooperation. Instead, they impose strict top-down approaches, for instance project goals which require the Buurtzorg professionals to deliver a predetermined amount of care to preselected clients without any individual assessment. This crucially contradicts Buurtzorg's original model with a unique and tailored provision of care instead of standardized care. Although this hard bureaucratic steering seems to not directly affect the nursing autonomy, it forces Buurtzorg to adjust the model in order to be able to deliver the proper and needed care. In summary, it seems as if the dimension of coercive/enabling bureaucratic steering addresses the Buurtzorg nurses and their autonomy directly, while the dimension of hard/soft steering rather affects the higher levels of the Buurtzorg organization, i.e. management tasks like financial and licensing issues.

Nonetheless, the autonomy of the Buurtzorg Shanghai nurses is directly threatened through the coerciveness of the bureaucratic steering of the Shanghai government. Buurtzorg has to provide many documents in which they have to describe the exact process of care delivery. The respondents reported that there are indeed workflow formalization and that they experience the government involvement as problematic. Buurtzorg has to comply with a lot of requirements. Future research would need to unwrap the vague term of 'requirements' and reveal what kind of workflow formalization are imposed in specific.

Leading Buurtzorg professionals also reported that China lacks human capital in the field of health care and especially in home care. Traditionally, care was delivered through very informal ways and filial care has been the central mechanism in the Chinese health care system. As a result, Buurtzorg Shanghai lacks properly educated nurses. The existence of the 'Laoban' culture in the Chinese context further complicates the issue of autonomously working nurses. Most nurses were educated in hospitals and are used to follow instructions and not to take initiative by themselves. Consequently, Buurtzorg Shanghai introduced the position of a lead nurse in every team. The lead nurses will perform management tasks and work as supervisors within their teams. The goal is to reduce the hierarchy stepwise and increase the nursing autonomy correspondingly.

5.2 Limitations and Recommendations for Future Research

The explorative character of the present study made a hypothesis testing impossible. Consequently, the exploration of previously formulated expectations suited the pioneering character of this research best. As a result, the present study does not provide reliable causal relations; instead, the expectations were tentatively explored and provided a first investigation on the associations between bureaucratic steering, nursing autonomy and the quality of care in the field of home care in Shanghai. The whole issue of home care in China is very new and lacks proper prior literature which is also the main reason for the explorative character of the research. Moreover, the described associations would have to be checked for third variables. Besides, the empirical data of this research has been drawn from interviews which makes the data vulnerable due to the self-reporting character. Having interviewed mainly Buurtzorg professionals increases the threat of biased empirical data. Eventually, the access to interview respondents was limited by language barriers since the Buurtzorg nurses in Shanghai are not capable of speaking English. Unexpectedly, some of the previously promising respondents delayed or withdrew their participation due to time concerns.

The choice of an exploratory instead of explanatory research significantly decreases the degree to which causal relationships can be proven. However, due to the guiding research character an exploratory research design with the formulation of expectations instead of hypotheses was the only way to make any valuable predictions about the described associations. The exploratory research design increased the flexibility of data sources while explanatory research would have required more reliable interview partners. Furthermore, this research introduced a combination of concept testing made of coercive/enabling and hard/soft bureaucratic steering. A check for third variables would have maybe revealed other factors that affect the nursing autonomy more than the bureaucratic steering. Due to the language barriers and time limitation of this project, the pool of potential interview respondents was limited. Nonetheless, some of the most influential Buurtzorg professionals were won over the participation in this study. The pool of potential respondents having insider knowledge on the Buurtzorg model and its transfer to Shanghai are expectedly very much congruent with the pool of respondents currently employed at Buurtzorg. Therefore, the problem of potential bias regarding selective memory, telescoping, attribution and exaggeration in favor of Buurtzorg were inevitable. Most importantly, Buurtzorg Shanghai is still at a very early stage in the implementation process and the issue of quality of care cannot be addressed properly.

The present study produces insights on hypothesis formulation in future research. Following this argumentation, future research should aim to overcome the explorative research

character. Accordingly, the bureaucratic steering of the Chinese government could not to be addressed more precisely since this research foremost discusses the perceptions of the bureaucratic steering. Therefore, a better access to the Chinese governmental agencies and the Chinese Buurtzorg nurses would be needed.

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