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Cooperation In Civil Society Organisation Networks And Quality Of Community Care For The Elderly

The case of Buurtzorg in the Netherlands and China

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Abstract

This study aims at answering the question, how the inclusion of civil society organisations into Buurtzorg networks influences the implementation of high quality elderly home care in China and the Netherlands. By comparing the formal network of Buurtzorg in the Netherlands with the formal network of Buurtzorg in China, differences regarding type and shape of the network as well as efficiency in form of providing high quality care are investigated. The network theory and the social capital theory are both used to answer this question. Buurtzorg networks will be one of three types of networks: participant governed network, lead organisation network and administrative entity network in each country according to the network theory of Provan and Kenis (2008). In order to decide which one, structure, size, decision-making process and information flow (trust) will be used as measurements by Burt's social capital theory (2001). Based on finding from literature and interviews, this case study will provide findings about elderly care in China. New findings from the Buurtzorg pilots in China and the differences to the original Dutch network will be provided, by doing interviews with Buurtzorg professionals and experts. Context differences between the Netherlands and China influence the model implementation and the network as such, in a great way. The relevance of this study and its findings is high due to the currency of demographic change and the process of implementing home care to China at this point of time

Keywords: elderly care, home care, community care, networks, Buurtzorg, Netherlands, China, social capital theory, network governance theory, civil society organisations

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1. Introduction

This study will focus on networks in the context of heath care. Community health care is a common form of home care for the elderly. It "is being increasingly promoted as a solution to address the issues of ageing populations and increased pressure on health care systems" (Cramm & Niebeor 2015:394). Social shifts are the composition of a society's age changes. These changes are due to smaller families, and increased growing female force at the labour market and a change of life-style, especially in the Western countries. Thus, the need for elderly care increases. Community care and home care are subsidized and sponsored by many European countries, since this is a "cost effective way of maintaining people's independence, but is also the model of care preferred by clients*" (Genet et al 2001:1).* Nevertheless, the quality of community care alters between different countries and or even between regions. The following sub chapters will explain how elderly care is provided in the Netherlands and China and will lead to the research question.

1.1 Elderly care in the Netherlands

In 2050 the amount of people aged 65 and older in the Netherlands will 4.193.400, compared to 783.000 in 1950. In 2050, 26.5 percent of the population in the Netherlands will be older than 65; whereas in 1950 the population of 65+ generation was only 7.7 percent of the entire population (Population Division, DESA, United Nations).

Within the Netherlands, home care is a common form of elderly care. Home care is defined as "professional care provided at home to adult people with formally assessed needs, which includes rehabilitative, supportive and technical nursing care, domestic aid and personal care, as well as respite care provided to informal caregivers. Home care can range from care for persons with complex needs to care for those who only need help occasionally with relatively simple tasks" (Genet et al. 2011:2). Home care is financed through national social – compulsory insurance and client co-payment which is related to the income, or financial assets of the recipient. Moreover, the financial situation and availability of informal care, are two of guided by eligibility criteria, which do the allocation of home care service function in the Netherlands. Furthermore, home care is usually funded from social insurance, general taxation, regional and local budgets as well as private payments. The public expenditure on long term care in the Netherlands is among the highest in Europe. Long term care, which is often community based, consists out of household help, personal and/or nursing care. A high amount of responsibility is with the government. Since 2005 the referral system is less generous and became stricter, co-payment especially for higher income groups have been raised. In 2007, it was decided that local instead of central government should decide about household help in order to increase the connection between recipients and organisations as well as to increase the quality of care*. (Plaisier et al. 2017).*

Next to that, cash-for-care programmes, which aim to increase service flexibility and completion have been promoted. (Genet et al). In addition, home care in the Netherlands is often integrated with other types of services. However, this can be a problem, for personal budget holders in the Netherlands and in some cases a too many professionals are involved, also the service coordination is poor due to different jurisdictions and budgets. Consequently, integration and quality are higher and more successful in the Netherlands, when nurses from different disciplines working together in one organisation.

1.2 Elderly care in China

Mostly elderly care in China is provided by family. The reason for that can be found in Confucianism where filial piety (Chinese: 孝, xiào) is a key value of the Chinese culture. Xiào which means something like being "obedient" to ancestors and parents, to be respectful and to care for them and even to make personal sacrifices to be able to perform necessary duties to support someone's parents and ancestors. The government supports this cultural norm by enacting legal norms for elderly care as well. Various Chinese laws and policies, including the Elderly Right and Protection (PRC) law from 1996, try to keep the family - especially the children- as the main provider of elderly care. Family and government turn to nursing homes, or other institutions for last resort, as next to the feeling of guilt children would feel for giving their parents away, there is a lack of affordable care institutions. Moreover, the existing institutions are rarely affordable for many families due to their financial situations. There also concerns a high concern about the quality of care and qualification of nurses.

Due to the One-Child Policy (OCP), a single child (1) has to provide and support not only his, or her parents (2), but for four grandparents (4) as well (4-2-1). In consideration of the aging population the need of change in elderly care provision in China becomes obvious: "by 2040 there will be 400 million Chinese at least 60 years old. This figure would represent 26 percent of the total population" (Zhang & Goza, 2005:152). In combination with the One-Child-Policy (OCP), there is an entire generation of young people with a smaller number; "China's total fertility rate dropped from about 7.5 in 1963 to 1.7 in 2003" (Zhang & Goza, 2005:152).

Since 1990, there has been a series of governmental policies which promote the development of new social service programmes. In 2005, a new policy which promoting the development of community based volunteer service in response to the new situation of the high average age, was established. This programme should increase the local government inputs and strengthen the communities' role in service provision and delivery. The committees, or grass root organisations do not really provide high quality care in the medical aspect. The committees can be understood as day care centres or community kitchen with a combination of a vertical and horizontal structure and are primarily provided by small state business service providers

and/or volunteers instead of professionals. This is the reason why the quality of medical aspects within those committees is not always high. Nevertheless, the committees provide structure and input into the community in many different forms like English lessons, computer lessons, or community celebrations. Next to that, those committees extend community services to meet local needs and promote greater cooperation of services. They also improve the community services by building more harmonious and both elderly and environmentally friendly modern communities.

This is the reason for China opening its market for foreign companies to provide health care. Since 2014, two Buurtzorg pilots are in the city of Shanghai. Fundamental, is that both the provision of elderly care, as well as the civil society organisation, differs between Chinese and Dutch contexts, resulting in difficulties during the implementation of Western models into Eastern societies. Financial resources, people's attitude on the issues of tradition and family obligation, government positions, the rural-urban gap and regional disparities are only some factors which have to be considered. Providing elderly care in the Netherlands is very different from providing care in China.

1.3 Elderly care by Buurtzorg

In 2006, Jos de Blok, a former nurse, founded, the highly successful model *Buurtzorg* in the Netherlands, which means *neighbourhood care* in English. Buurtzorg provides community health care; and the idea of Buurtzorg is in process of being replicated and implemented in many different countries. Buurtzorg is already established into the health care sector of Belgium and Japan. It is in process being established in Germany, Thailand, Australia, and the United States of America. Buurtzorg received international attention because of its great success in the Netherlands. Now this model is planned to be implemented to China. (Buurtzorg Nederland)

The context of how elderly care is provided in the Netherlands and China is very different and highly important for this study. Buurtzorg's maxim "humanity over bureaucracy" is achieved by self-directed, autonomously working community nurse teams; their scope of practice, which is cooperation with other local community health care providers and general practitioners, is relationship-based, and simplifies billing (Kreitzer et al. 2015). Buurtzorg has been developed to counter existing problems in the Dutch health care system, which are low quality of health care, lack of transparency, high costs of care, and growing dissatisfaction among, both patients and caregivers within the healthcare systems. Buurtzorg builds upon the observation, which local communities seem to be a very important factor of achieving high quality of care. Home care within communities can include formal, as well as informal community partners and

creates a network around the client. Each nursing team is building an informal network consisting of family members, friends, and neighbours who are included into the caregiving processes. The main task of home care by Buurtzorg is to advise and assist patients in gaining, or retaining their independency by a qualified and well-documented care schedule. Next to that, a formal network which consist of doctors, specialists, pharmacies, hospitals and especially local respectively community organisations is established. (Buurtzorg Nederland, Buurtzorg Deutschland, Buurtzorg USA, Buurtzorg Asia)

1.4 Relevancy of this study

In China, elderly care, is imposed by law and traditionally provided by family, in particular by children not by institutions or community nurses. That might be the greatest difference between the care provision and system. That is why the case study of Buurtzorg is so interesting, since the pilots in China are still in development process and findings about them will be pioneering work and can give appealing findings about implementing elderly care models to Eastern contexts. Further, it is interesting to see, how community health care will be introduced to the Chinese society and market. The relevance of solving problems due to a demographic change indicates the social relevance of this study. A *copy-paste-approach* of the Buurtzorg model into China is not possible. A policy mimicking, or policy learning is more presumably (van Gerven & Weiguo). Therefore, this study will focus on the phenomenon of Buurtzorg and their mechanisms of formal network building in China and the Netherlands. The aim is to compare the Dutch network of Buurtzorg with the Chinese Buurtzorg network and how those networks influence the quality of home care. Since there is a gap in research about network movements in the home care from one sector to another, this study will try to fill that gap with new findings.

1.5 Research question

The research aim is to find out what type of network the Buurtzorg network is in China and in the Netherlands, by comparing and investigating key characteristic of networks in both contexts. The outcome as the efficiency of the networks is measured as the quality of care. This comparison of the formal networks of Buurtzorg will be guided by the following research question:

"How does the inclusion of civil society organisations into the Buurtzorg network influence the implementation of high quality home care by Buurtzorg in China and the Netherlands?"

The purpose of this question is to identify the members of Buurtzorgs informal network in both countries, their amount, the decision making process and their working process. To answer the explanatory main question, the following three sub questions will guide the process:

(a) How are civil society organisations included in the network of Buurtzorg to provide high quality *home care in the Netherlands?*

The aim of this question is to investigate the network of the original Buurtzorg organisation. The second question aims to do the same as the first sub question only within the Chinese context:

(b) *How is civil society included in the network of Buurtzorg in China to provide high quality* home care?

The last sub question which will help to answer the main research question is:

(c) *To what extent do civil society networks have a differentiated influence on the provision of high quality home care by Buurtzorg in China and the Netherlands?*

The results of the first and second research question will be compared in the process of answering the third sub- question. When all sub questions are answered, their results will lead to answer of the main research question.

1.6 Outline of the study

Following the introduction, the theory and conceptualization will provide a theoretical framework for the case study. Here hypothesis/assumed relationships, which will draw a connection between theory and variables, will be introduced. Following the research design, the case selection and sampling, the operationalization, data collection, and the data analysis will be introduced. In the analysis chapter the hypotheses will be tested; this section is divided into three parts, (a) into the analysis of the Buurtzorg network in the Netherlands, (b) about the Buurtzorg network in China and (c) into a comparison of both networks. The last chapter of this thesis will be the conclusion of this case study and will provide an outline about limitations and further research recommendations.

2. Theory

2.1 Conceptualisation of the term network

To address the research question, the term network and social capital needs to be defined, and further the two most important theories for this study - the network governance and the social capital theory - will be explained in the following section. For this study effectiveness is defined as a positive network outcome, which is in this particular case high quality health care.

Provan and Kenis (2008) define networks as "groups of three or more legally autonomous organisations that work together to achieve not only their own goals, but also a collective goal" (Provan & Kenis 2008). Often in the care sector such goals could not be achieved effectively by one organisation only. "In health and human services, agencies can and do join networks to lower operating cost and gain competitive a*dvantage" (Provan & Sebastian 1998).* Social capital, which has been addressed by many author like Burt (2001), Coleman (1998), Putman(1993), and White (1990), "refers to feature of social organisation, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated action" (Putman 1993 in Burt 2001). Following theories by Provan and Kenis,(2001, 2005, 2008) Putman (1993), O`Toole (1997) and Burt (2001) , it is assumed that the cooperation within the network, the share of information and the quality of care (efficiency) are the most important mechanisms or indicators for this study about networks. Conceptualizations and hypotheses about possible network structures, will be provided in the following.

Many authors conceptualize networks differently. To investigate the type of network the definition of Provan and Kenis (2008) will be used. The authors have three core criteria to decide between network types: structure (1), amount of members (2) and decision-making process (3). Moreover, this study will use key elements by Burt (2001) which are share of information (4), closure of the network (5) and brokerage (6). With those criteria, it can be decided on the network type as well as the efficiency of the network, which will indicate the quality of the network. It has to be considered, that all three authors, have a background Western universities and networks, however, the networks shapes are not expected to vary in a great deal to non-Western organisational models.

2.2 Hypothesis 1 and 2: The network type

To answer the main question of this study the network in which Buurtzorg and other partners collaborate is in needs to be investigated. The term network needs to be defined closer since there are several types of networks: the participant-governed networks, the lead-organisation-governed network and the network administrative organisation (Provan & Kenis 2008).

The first type of network is the participant governed network. The participant-governed network is governed by the network members; each member makes a commitment to the goal(s) of the

network. The founding of this network is easy, and the participation in achieving the goals is very high. The number of members in the participant-governed network is the ideal type low, ideally, since the involvement and commitment of all actors is highly important. Hence, no distinctive formal administrative entity is necessary to give guidelines how to achieve the goal(s). Instead this network is managed by all members. Problems can occur, if meetings are only frequently and without a key-organisation always a compromise - a consensus must be found. Sometimes that can take a long time in cases where the opinions vary drastically. Moreover, there is no contact organisation or contact person; often this network type has no "face". In the best case, this network has a high participation of all members, in the worst case, there is a high level of inefficiency and the organisation's block each other.

The participant-governance network has the following shape:

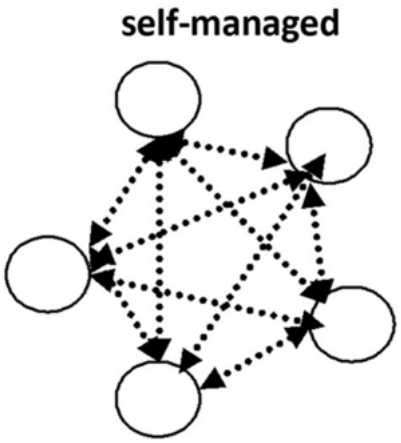

Figure 1: Structure of a participant-governance network (Provan & Kenis, 2007)

In ta participant-governance network all participants share information with everyone elseas well as receiving them from every member. The decentralized structure of the network becomes obvious. The equality of all members is highly important in this network; there is no key player, who has more power than other members. The participant-governed network is common in health and human services.

The the lead-organisation-governed networks are also common in health and human services. Within this network, there is one core organisation – a key player, which manages the network by decision-making, and providing of some administration for the other network actors. This network has a centralized and asymmetrical power structure. The size of the network can vary;

many actors can be involved. By having a strong leader in the network, tasks and goals can be achieved with a great deal of efficiency. However, having a strong leader can also lead to disadvantages: the domination by the lead organisation or member can have a negative influence on the network; the other members might not be as committed to the goal(s) and to the network. If the lead organisation does not dominate but instead guides the other members, the outcome is highly effective. (Provan & Kenis 2008).
The lead organisation looks as follows:

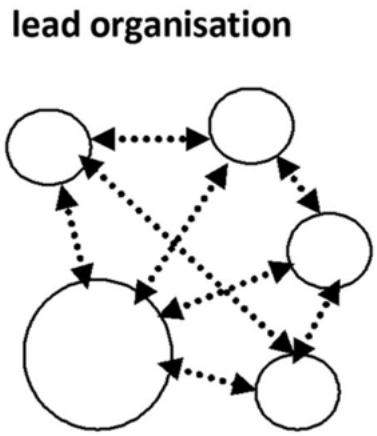

Figure 2: Figure 1: Structure of a lead organisation network (Provan & Kenis, 2007)

The structure of a lead lead organisation is depicted in illustration 2: The big circle, which is the lead organisation, is connected to all the other members of the network. In comparison to the graphic of the participant-governed network the leading member is the only one who is connected to everyone while the others are only connected to some other members. One lead organisation is connected to all members, and the other members are sometime connecting with each other only through that lead organisation (indirectly connect),

The third type of network is the administrative organisation network. The network administrative organisation has a distinct administrative entity, which governs and manages the network. This organisation does not provide services of any other kind to the network. A Network administrative organisation is usually operating in networks with a higher number of members. The decision-making process is mixed. That means, there can be more than one administrative entity in the network. The advantages of such a network are efficiency of day-to-day management, due to key members not one party has all the power, the involvement of the members is strategic and overall very sustainable. Problems can occur in form of high operation costs. Sometimes the administration entity is built up to be too complex, and can be perceived as burdensome, due to the hierarchies and bureaucracy

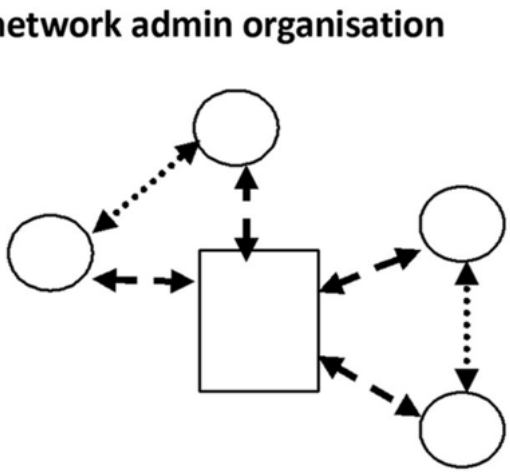

Figure 3: Figure 1: Structure of a network administrative network (Provan & Kenis, 2007)

The network administration organisation (figure 3), shown in the figure as a square, differs from all the other members in the network. This entity which consist of one or many organisations has a direct connection to every network member. The members of the network, are not necessarily connected to each other directly. Within this network, sub-networks that are connected to the administration organisation are possible.

To sum up, the participant, as well as the lead organisation network are most common networks in health care (Provan & Kenis). Key characteristics, which are necessary to differ between the networks are: structure, amount of members and decision making process. The table below by Kenis and Provan summarizes the key characteristics, the structure, amount of members and decision-making process of all three network types. All can be in their ideal form very efficient and in the worst care highly inefficient.

Design Characteristics	Self-Governance	Lead Organization	Network Administrative Organization
Structure	No administrative entity, participation in network management by all members	Administrative entity (and network manager) is a major network member/service provider	Distinct administrative entity set up to manage the network (not a "service provider")—manager is hired
Optimal number of members	Few	Many	Many
Decision making	Decentralized	Centralized	Mixed
Advantages	Participation, commitment by members, ease of forming	Efficiency, clear network direction	Efficiency of day-to-day management, strategic involvement by key members, sustainable
Problems	Inefficient—frequent meetings, difficulty reaching consensus, no network "face"	Domination by lead organization, lack of commitment by members	Perception of hierarchy, cost of operation, complex administration

Table 1: Alternative forms of network governacne - the management design (Milward & Provan, 2005)

In the case of Buurtzorg, it is important to examine in which network Buurtzorg and its partners operates in. This is done by researching the structure, the amount of members and the decision-making process. According to the characteristic of the network governance (Kenis &Provan 2008) the self-governance and lead organisation are the most likely network types for Buurtzorg and its cooperation. Since, it is known that Buurtzorg provides high quality care that means works very efficient, has a clear direction throughout the entire care process and works efficiently together with other partners; the lead organisation is, consequently, assumed to be the network type in which Buurtzorg operates in the Netherlands. The core organisation in the lead organisation takes centralised decision to give the network a clear goal and direction. That means, other network members help to achieve a particular goal and, or guidelines set by this core organisation. In the case of health care, that would be the provision of high quality care according to the indicators and values of the care organisation. In the case of Buurtzorg that is high quality of care, "humanity over bureaucracy" and to gain the independency of its client. Consequently, if Buurtzorg does provide high quality home care in the Netherlands, the network of Buurtzorg must be efficient. ***Hypothesis 1. The higher the degree of Buurtzorg being the key player in the network performing centralised decision-making, the higher will be the quality of home care (efficiency).***

Since it is known, that the government in China has a great influence in providing care by community committees, neighbourhood committees and other institutions with not professionally trained personnel, the consequence is the assumption that care in China is provided by a network administrative government. From 1990 on, a series of government policies have promoted and increased local government inputs towards social service programs by strengthening the role of communities in service provision and delivery (Xu & Chow 2011); those committees provide structure and input to community services.
Hypothesis 2. The higher the involvement of community committees in China, the more less Buurtzorg is the key player to controlling resources and information within the network.

2.3 Hypothesis 3: Control of information

As described above, the network type is assumed to be highly important to achieve high quality care. However, the lead organisation needs to have access to information, as well as the other organisation in the network. The share of information is required for an effective working network. Also "[c]entrality is frequently used to assess power in networks based on the control of resources and information" (Provan et al 2005). However, even if there is a high-quality

sharing of information, it will take time. Burt (2001) argues, that the flow and access of information within a closed network is higher between direct connected partners. The closure of a network leads to more trust. This is because the level of risk of collaboration decreases with a higher flow of information and “without a high degree of trustworthiness among the members of the group, the institution could not exist” (Coleman 1988, 1990 in Burt 2001).

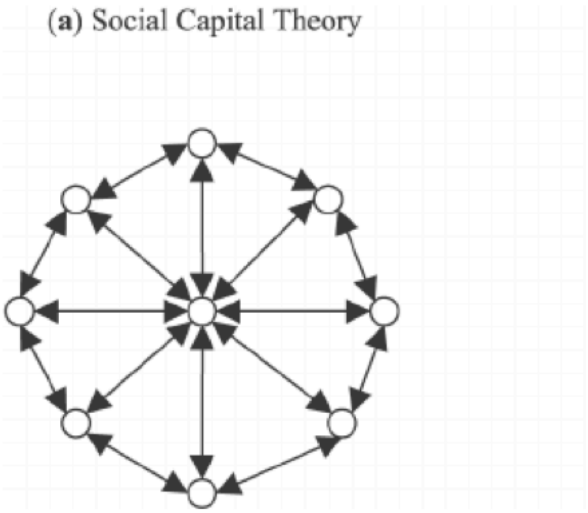

Figure 4: Social Capital Theory (Burt, 2001)

The circle in the middle of figure 4 represents is the individual, or member of a closed network. This party is connected to all others involved. The other members are connected to some other, but not to all other members directly. The middle party has contact and an information flow with all other members. The degree of trust is greater between the members with a direct connection (drawn arrows), then between members without direct arrows respectively direct ties. The member in the middle gain and shares information with all network members. It is expected that Buurtzorg has a great control over the information flow in the network.

Hypothesis 3. The higher Buurtzorgs control of information is in a closed network is, the higher is the efficiency and as such the quality of care.

2.4 Hypothesis 4: The effect of broker position on redundancy of information

While the closure of a network decreases the risk of cooperation, brokerage within a network increases the value of cooperation (Burt, 2001). Within structural holes in a network, weaker connections between groups of a network are defined. This groups are likely more focusing on themselves and their activities. “Structural holes are an opportunity for broker the flow of information (Kreitzer et al. 2015) and control the projects that bring together people from opposite sides of the hole (Burt 2001). To find out, to which extent Buurtzorg, or other

community committees are brokers within a network, the network betweenness can be used as an “index that measure(s) the extent to which a person brokers indirect connections between all other people in a network” (Burt 2001). Furthermore, brokers within a network help to reduce overlapping information. Being in a broker position in a network, gives this member, not only benefits resulting from the information asymmetry, but also more control over the network e.g. by knowing which not connected participant should meet at which point of time, thus creating creating strategic values. Due to diverse contacts the volume of information is higher and the redundancy lower. Figure 5 illustrates an open network. The party in the middle is the only member, which is connected to many other members. The figure makes it more obvious, that this member has the most ties, and mot connections. This position is the broker position, from which information can be filtered and shared. Further, the openness of this network becomes obvious in the graphic below:

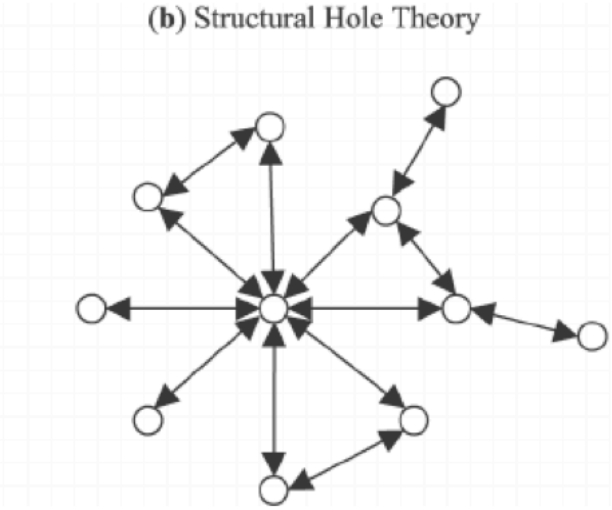

Figure 5: Structural Hole Theory (Burt, 2001)

Since Buurtzorg in the Netherlands is characterised to foster high trust it can be assumed that: ***Hypothesis 4: The higher the level of trust in the Buurtzorg models and the more Buurtzorg is in a broker position the lower is the redundancy of information.***

The theory suggests that the participant and the lead organisation network are the most common forms of networks in the health sector. The lead organisation network has a great deal of brokerage due to its central position. Quality is measured to be the outcome of the networks, since Buurtzorg provides in the Dutch context high quality home care, the network

Buurtzorg operates in must be effective. So a perfect example of the ideal types illustrated by the network governance theory.

3. Methodology

3.1 The Research Design

China has a different political and cultural context than the Netherlands. It is assumed that this case study will present new finding and deflate gaps for further research by answering the research question. It is not intended to point out what is not working with the Buurtzorg model in China but why the model changed. The reason for choosing one case of implementing of elderly care is because of Buurtzorgs unique and modern model. By comparing only one case, the insights will be deeper. The units of analysis in this study are the same as the units of observation: Buurtzorg on the network level in China and the Netherland and Buurtzorg on the organisational level in the Netherlands and China. This research is conducted as a case study (Dooley, 2010). In addition, the qualitative data, which will be collected consist of existing literature especially about networks, their mechanisms and changing contexts, as well as policy documents and interviews with both Chinese as well as Dutch professionals.

3.2 Case selection and sampling

The cases of Buurtzorg and its civil society organisation networks in the context of implementation of Western models into the Eastern context and mechanism of elderly community care, has been selected primarily due to its exigency and novelty. Shanghai is an interesting selection as place to establish Buurtzorg models, since it is one of the largest and developed cities in China. Also, one of the greatest community committee networks is in Shanghai. Consequently, the involvement of organisations and volunteers is higher than in other parts of China.

The interviews with both Dutch and Chinese English speaking personnel with adequate knowledge about the pilots and or networking of the Buurtzorg model in general. They will be conducted in the Netherlands, with nurse's from Buurtzorg, nurse coaches and members of local municipality professionals. They will be the basis to draw conclusion about the organisational network in which Buurtzorg Nederland operates in the Netherlands. Interviews with people, who have knowledge about the Chinese civil society and about how elderly care in China is provided as well as Chinese nurses, Chinese nurse coaches and other people who accompany the pilot in China, will provide the comparison to the Dutch model and help to confirm, or dissent with the main hypothesis.

3.4 Data collection methodology

Data has been collected in this study via semi-structured interviews. During most of the interviews, which were sometimes held face-to-face and sometimes via Skype video calls, two researchers were present. For each interview, there was a list of questions and topics which should be address in the interviews. However, it was the goal to turn each interview in a fluent conversation. That is the reason why not every question was addressed as they were written down before. Moreover, more or less question or themes were addressed according to the knowledge of the participant, which varied. Semi–structured interviews allowed more questions to be asked if more knowledge about a specific situation was needed. All in all, the interviews as such, as well as the questions, were structured with consideration of Hammers and Wildvsky (1993) guide for conducting open-ended, semi-structured interviews.

The following aspects were addressed in the interviews: the inclusion of mantelzorg (informal network) of Buurtzorg into their care giving process, bureaucratic steering and the involvement of the local government in the care giving process, the autonomy of nurses, the policy entrepreneur ship the collaboration of (formal network) Buurtzorg with other civil society organisation and the quality of care. The interview questions are shown in the appendix. Towards all respondents of this study, it was agreed to only to use the interviews anonymously, no specific organisation names (except from Buurtzorg) will be mentioned, nor any individual names in any publications.

3.5 Analysis of the Data

To analyse the data, all interviews were recorded and transcribed. Conclusions will be drawn by comparing the existing networks, with the conditions from the theories. Further conclusions will be drawn by interviews with Chinese and Dutch Buurtzorg professional, who are involved in the actual current implementation process in Shanghai. Since every single one out of the four researchers only needs a part of each interview, each researcher will only analyse the answers of his, or her own questions which are on average 15 questions (see appendix). After that first division, all answers will be sub-organised into categories: cooperation with civil organisations, decision-making process, access and sharing of information and quality of home care. Since, only 10 interviews have been held, the use of a categorisation software like ATLAS.ti is not necessary to further visualizes the data. Another reason is that the data is not that complex that a coding would ease the work. Not all answers are the same, coding would only make too many categories which would have the same gist. After categorising the results, they will be set into accordance with the four hypotheses as well as with the sub questions and the main research question in the discussion. The previous mentioned categories are enough of a categorisation.

3.6 Validity of the data collection

During the interviews, as well as during the discussion, possible validity threats should be considered. Possible threats towards the study may be the participants themselves. Since more than half of the respondents work in any way for Buurtzorg questions have to be addressed more carefully to gain information. Some of the Buurtzorg nurses' answers were provided to us from Buurtzorg professionals in higher positions, thus negative or critical answers about Buurtzorg are less likely to occur. Next to that, the information about the Buurtzorg pilots was limited, due to language barrier, since none in the researcher speaks Mandarin.

To gain more validity for this case study firstly, the interviews were recorded and transcribed. The average time of the interviews is 43,47 minutes; the transcription process took on average of 3 hours and 35 min per interview and are 7 pages long. Secondly, the transcriptions were sent to the participants, so that they could check them, or make recommendations for changes. Thirdly, questions for which the answers were already known, or given in another interview were asked to generalise the results/information.

Analysis

3.1 Buurtzorg in the Dutch context

3.1.1 Civil society in the Dutch context

4. Civil Society

Civil Society, often also called the third sector, in the western context is defined as a place between state and economy and, or market and the community. It is a place where the private initiative of friends, family and associations matter. "It is the idea that good government performance as well as economic development is a product of 'civic community', i.e. the network of trust, reciprocity, and habits of co-operation that arise in the association micro-spheres of civil society" (Mouritsen 2004:1). The World Bank defines civil society as a "wide array of non-governmental and not-for-profit organisations that have a presence in public life, (…). Civil Society Organisations (CSOs) therefore refer to a wide of array of organisations: community groups, non-governmental organisations (NGOs), labour unions, indigenous groups, charitable organisations, faith-based organisations, professional associations, and foundations" (World Bank, 2013).

Here, the many different organisations which can be civil society organisation become obvious. According to this definition, Buurtzorg as a non-profit making organisation is a civil society actor. Buurtzorg expresses the interest of remodelling the health care based on ethical values for instance “humanity over bureaucracy”.

Civil Society organisations (CSO) may diverge, they are free to work, provide goods, operate, criticise, build communities and demonstrate without governmental intervention, even if actions are not in immediately with the leading party. Moreover, this is one of the reasons why civil society is called third sector, next to economy and politics. If those organisations, like they are in the Netherlands, are based on democratic values, they can be used as an instrument of checks and balances for politics and the economy. The phenomenon of the civil society is understood very naturally in the Western context and especially in established democracies. Nevertheless, this does not mean that in non-democratic countries like China the phenomenon does not exist.

Civil Society in the Netherlands, matches the criteria as stated before in the chapter about Civil Society. The Dutch civil society is well-developed and modern. The involvement of the Dutch in civil society organisations is great; “55% of the Dutch belonging to a civil society organisation ranks the Dutch society as one of the highest in the European context” (Czułno:231). Their involvement of the voluntary activities is also high. Around “15% of the total Dutch workforce is in the not-profit sector, which is also the highest proportion in Europe” (Salamon in Czułno 2013: 232). Civil Organisations have as the third sector a great influence on the political and economical sphere. Buurtzorg was founded to counter existing problems in health care, since the nurses did not believe that the government as an administrative entity which does not provided care itself can change them top down.

4. 1.2 Cooperation in the network in the Netherlands

In order to decide which network type Buurtzorg builds together with its partners the following aspects need to be answered: structure, number of members, and decision making.
From literature reviews it is known that Buurtzorg has a special position within the Netherlands in delivering care. Buurtzorg – with its self governing, autonomous nursing teams - is not a normal form of community health care. Buurtzorg works together in close collaboration with doctors and other health care professionals. Hereby, physicians are the main partner in the Netherlands, combining of functions between care teams and physicians are highly important to achieve high quality care. The reason for that is the high knowledge general practitioner or other doctors have about the kind of care which is needed for the patient. Furthermore, Buurtzorg nurses are generalists and often have an additional specialisations. The nursing

team provides many different medical services and besides many other support services like bathing, or dressing which usually are provided by other organisations from other health care services. This is a first hint that due to a great deal of knowledge and expertise of Buurtzorg nursing teams, it is not likely that they will be highly dependent form other network members, since they are perfectly able to provide most of the caring tasked themselves.

When asking the respondent to name other organisations they work together with our first expectation of possible partners were confirmed. The first request was to give example of organisations Buurtzorg collaborates with. All respondent who work in the Netherlands, named the general doctor, physiotherapists, social workers in forms of civil society organisations and home care (cleaning) organisation. Respondent 6 named in particular named social workers form Buurdienst, which is another initiative of Buurtzorg; Buurdienst delivers all forms of domestic help to patients. Furthermore, respondent 5 and respondent 6 named the occupational therapist. The team of respondent 2 works together with the ergo therapist and respondents 5 team with hospitals and day care centres. Voluntaries who for example drink a coffee, or go to the market with a client, were named as possible partners by respondent 1, which can be from civil society organisations, NGOs, neighbours, or students. None of the nurses could name an average number of organisation they or their team work together with. However, all agree that the number of organisations they cooperate with depends on the clients' need and therefore varies. Further, respondent 4 said that the cooperation "(…) is all local. This is the intensive cooperation with the partners in hospitals and, our nearby hospital is 33 kilometres away; (…) some special nurses I know and they know me and once, or twice we see each other, but it is less intense, the cooperation, and communication as with the local colleagues and caregivers" (respondent 4 p4). This gives evidence to the expectations that Buurtzorg has strong ties to local organisations and weaker ones to bigger, non-local organisations. The relationship to the therapist is closer than the relationship to the hospital. The number of participants is a moderate number, not a great number, depending on the client 5 or more. However, this number could grow according to the needs of the patient. The greater the number, the less effective a participant governance network would work.

The next questions were about the cooperation as well. Respondent 5 and respondent 6 referred to the client as the main decision maker; ("the client is leading the nurse advises" [page 2 respondent 5), in similar words all respondents confirmed this statement. Respondent 4-6, as well as, respondent 1 confirmed that the Buurtzorg nursing team advises the client in this processes and is making suggestion of possible cooperation partners, "the nurse suggests some physiotherapist which they collaborate on nice way, or which understands the situation of the client very well, or opposite the way Buurtzorg works very well" (page 2 respondent 5). Respondent 6 even called Buurtzorg the "spider in the net" for two reasons: firstly, because of the advising guidance of Buurtzorg in the decision making process and secondly, because in

the experience of respondent 6 Buurtzorg also takes the lead in starting the communication process with other possible new partners. Respondent 1 confirmed that the nurse team taking the lead in the cooperation. They can oversee the situation and make the decision with respect to other professions. These answers validate our hypothesis. It becomes obvious, that Buurtzorg has a great deal of influence on the patient as well as on the selection of other network partners.

Next to that, respondent 1 said that often teams are already connected and part of the community as an individual; this is the case for especially smaller areas, or villages. In bigger cities, or communities Buurtzorg nursing team often start the communication process with other organisations by inviting them to team meetings, go to events or even present themselves at the local market. Respondent 4 also implied that sometimes other care organisations which provide services to the patient worked already with the client before Buurtzorg did. Decisions need to made in cooperation with each other and especially, as respondent 6 pointed out, with the client who is part of the cooperation and the network.

All respondent for the Dutch case agreed that contact and meetings between the network partners happen only if needed: “When it’s needed, that there is another change of plans then there is contact. And sometimes teams have regularly contact and meetings with doctors, or physiotherapists, but not everywhere, it depends on the team. Sometimes teams, doctors and physiotherapists have a really good relationship, very much clients which they see together and then sometimes they organise regular meetings” (respondent 5 page 1). Another hint, for more than few network members are the few meetings all participants have. Only few members would make a monthly or even weekly meeting very easy. However, that is not the case for Buurtzorg.

It can be concluded that the structure of the network of Buurtzorg is has no distinct administrative entity which manages the network as it would be the case by a network administrative organisation. However, one could argue that Buurtzorg together with the client manages the network as something like an administrative entity. But this entity is in its edeal form not a service provider itself, according to Provan and Kenis (2008) as a lead organization is is more likely.

As we know form the respondents’ decisions are made together with other partner. This is a strong indicator for the participant network structure. The fact of the advising and suggestion function as well as being the catalyst in the communication process is a strong indication of the lead organisation network structure. Buurtzorg seems to be a major network member and service provider.

Identifying the size of the network is highly difficult, since it depends on the needs of the patient. Buurtzorg nurses are generalist; it can conclude that the number of members, of cooperation

will be as few as possible for each patient, but in general there is no problem with a larger network still working efficiently.
The decision-making process of Buurtzorg is centralized to a certain degree. As respondent 6 answered, the nurses do the care schedule in their electronic system which is called Omaha. This care plan includes everything the patient needs. As respondent 1 said decisions are made by Buurtzorg in respect to expertise and professionalism of other organisation, indicates a great deal of influence in decision making in the network. That is why the participant network can be excluded: in this network, decisions are made decentralised. Decisions in the lead organisation network are made centralised, which is true for Buurtzorg to a certain degree.

As a first summary, and conclusion concerning the cooperation, it can be said that civil society organises are likely become a lead organisation network. In this case Buurtzorg is the central member of the network who makes key decisions and and give the network a clear direction, by setting the agenda of achieving high quality care according to their care schedule and by choosing partners they want to collaborate with. Further Buurtzorg give the network a clear direction, by still allowing partners to make their own decisions their field of expertise. All respondents agreed that cooperation with other partners increases the quality of home care: “I think the quality increases, yes definitely” (respondent 5 p2). Buurtzorg had the highest satisfaction rates among patients in the Netherlands according to the Netherlands Institute for Health Services Research (Nivel) in 2009. Here, it becomes obvious that the network Buurtzorg operates in, is very efficient. Efficiency is one of the advantages of a lead organisation network. All the organisations, do provide together high quality care, help the patients to gain their independence and lowering the bureaucratic burden. However, this are the goals and values of Buurtzorg, which are achieved by all. It is very likely the case, that every organisation has its own goal. All actors want to provide high quality in their field of expertise but do not necessarily care about how the others achieve their own goals. The goal consensus is moderately low. That could lead to low quality of care due to different goals or definition of what high quality is. Buurtzorg by taking the lead, combines all the different goals and definition into one definition- their own. Consequently, high quality of this network is measured by among other things by the independence of the patient and few administrative work for the patient. As the lead organisation Buurtzorg leads the other organisation to follow Buurtzorgs care plan and limits such different definitions or ways to achieve high quality care. This increases the level of trust towards Buurtzorg of the single network members, however the level of trust between the other members could be lower.

The self- governance network cannot be excluded with a certainty, since the autonomy of the nursing team and how they deal with it has an influence on their position in the network, but in

general decisions are rather more likely to be made by Buurtzorg and the patient then from other organisation making decisions which Buurtzorg has to follow, or even making consensus decisions. According to Kenis and Provan (2007), the self-government network entity does not provide services except from decision- making in the network.

In order to answer the first sub-question, it can be said that civil society organisations are included into a lead organisational network, in which Buurtzorg takes the lead and makes key decisions which results into high quality home care. This, also, a first validation for the first hypotheses. By making key decisions and having a central position within the network, the quality of home care is high.

4.1.3 The share of information in the network

To decide which position Buurtzorg has in its networks, the following questions, which are essential in the social capital theory, need to be answered: Who has the most information in the network? How information is shared, e.g. tools, meetings and how are meetings held? How is the trust in the network and the closure of the network? All nurses, in the Netherlands were telling, that a new web based tool is being designed, with which information sharing will be facilitated. However, this tool is not available at this point of time because of concerns of privacy laws and other legal obligations. Nevertheless, it can be expected that the information sharing process will be drastically improved as soon as this tool is applicable. To date, information in the Netherlands is shared per phone, paper and pen (respondent 4 p.2); “they (Buurtzorg nurses) can write down their questions for the physiotherapist. The physiotherapist can write the answers in the same book. It is with the client. The client can see it, what the questions are and what the answers are. That is the most common way of communication, or by telephone” (respondent 5 p.1).

The folders, in which all information is included, are with the client, and not - as one might expect - with the Buurtzorg nurses. Here it becomes obvious, that every medical partner has access to this information when visiting the clients house. This is an indicator for a closed network. The amount of contact by phone depends on the nursing team, however respondent 1 said that Buurtzorg nurses “quite often use the phone” (respondent 1 p 2). The sharing of information “with the volunteers, they will (…) meet face to face” (respondent 1 p. 2). It is expected that volunteers only get minimal information and consequently are excluded from the decision-making process: “formally, the volunteers will not decide, or play a role, but the volunteers, as they quite often spend more time with the clients, so they quite often have more information, so the information of the volunteers and their arguments and ideas will be used by our professionals to make a well-considered decision” (respondent 1 p1). Respondent 1

stated that the volunteers sometimes have more information, which they share with the nurses, than the team itself.

When a patient comes back from a stay in hospital, “hospitals can give some paperwork and they can be deposited in a secret environment and we have access to that environment” (respondent 5 p1-2). Here, according to respondent 5, Buurtzorg is the only actor who has access to this information in the safe environment and shares that information with other partners involved in medical treatments. Contradictory, respondent 5 says that “physiotherapists and other colleagues home care organisations make use of the same environment” (respondent 5).

Information sharing is always connected to trust. Trust is difficult to measure and to find out about in with interview questions, so it is possible that interpretation of the answers might be differently interpreted by someone else. All respondents answered, that they do like to cooperate with others and all agreed that the quality of home care increases due to cooperation. It can be assumed, that they feel good and comfortable working together with their partners. Further, it can be concluded that only sometimes there is a small till no level of mistrust between the partners. Only respondent 4 did elaborate on the issue of trust a little bit concrete: “There is a really great deal of trust between the different care givers in the local society, but what makes it difficult, is the laws about privacy, so patients are guaranteed that their information is shared only with (…) with people they know” (respondent 4 p3). Moreover, the nurse said “all the professionals have their own administration, electronic administration they not always compatible with each other and they don’t want 100% transparency. They want to share something and not all” (respondent 4 p3). Here, it becomes obvious that the partners might only share information which are essential for the health of the patient, but keep other information to themselves. As Buurtzorg makes the care plan, and only shares specific professional information, it can be concluded that Buurtzorg nurses do only share all the information necessary to follow the care plan with the other network members as well. The end result was what was expected before.

All in all, the sharing of information does fit into the social capital theory, however, the client (that is where all the information is) is in the middle, and Buurtzorg. Buurtzorg in the Netherlands, does provide the care plan etc., however, is not the “key sharer” of information in the network; most information is easily accessible to all members. An open network can be excluded as a result. From the social capital theory it is known that the flow and access of information within a closed network are higher between direct connected partner (Burt 2001). As shown above the Buurtzorg network in the Netherlands is a closed network. Non-network members have no access to any medical detail or information about the client.

Trust can be measured next to the share of information with the strength of the ties. Further, Burt (2001) says that the closure of a network leads to more trust as well.

As for the ties within the Buurtzorg network, they are expected to be many and to be strong. After the interviews it becomes obvious, that this is not the case. Within the Buurtzorg network, there are strong as well as weak ties. A very strong tie is towards the client, every respondent referred back to the client and its needs. As mentioned above, the folder with all information is an indicator of a high level of trust and strong ties to all parties which can read and contribute to the folder. Moreover, depending on the size of the community in smaller rather than in bigger cities actors are well-known as well as their overall positive or negative performance and reliability. That kind of pressure, general values and norm, guide all actors to perform the best they can. Due this reliance a higher level of trust in the network is probable. Further, respondent 6 said that Buurtzorg prefers seeking new cooperation partner organisations, which are structured in a similar way to Buurtzorg: with independent and self-autonomous teams.

It can be concluded that Buurtzorg operates with a closed network, and has few, but strong ties. Since the network is closed, as well as information are easily accessible for other network members that the degree of trust is high within this network.

4.1.4 The Quality of care

As mentioned before, all respondents agreed that cooperation increases the quality of care (respondent 1, 4,5,6) e.g. “working together increases quality, so it makes it bigger, better! So it is important that I know what is the status of a patient, what are goals and what are goals who can be reached and therefore I need information. And I get my information 80% from the patient, but not always know the patient enough to give me the correct information so I like it when a general practitioner, or the doctor, or the doctor in the hospital can give me certainty about what is going… What are the diagnoses and what future perspectives are. And the possibilities for me as a nurse because (…) I want to make goals who are reachable” (respondent 4 p.3). Information sharing and trust leads to set reachable goals for the client, and the nursing team including all other partners. Moreover, respondent 4 named another reason why quality increases due to cooperation with other partners: “that is where I see increasing quality by sharing and working together. (…) It is necessary to give feedback or to get feedback from colleague caregiver to increase quality. (…) There is a mostly open communication between the caregivers, you can correct or discuss things, you see as incorrect and make the best of it and try to increase quality” (respondent 4 p 4). Further, due to long-time cooperation the quality increases because all parties know what to expect from each other, here the high level of trust become obvious again. Respondent 4 said (..) I find it a great asset to know people and to build relations for longer periods of time. (…) I work here now for a lot of years, but I see, that if you work longer than four, or five years with a colleagues a general practitioner's you know what you can expect and you know where he is good at (…) It

is not only one way and so you can make the best of it and I find that a great asset" (respondent 4 p.4).

The high quality of home care by Buurtzorg can be explained by cooperation with other local partner in a closed network, with few members. Those are connected by strong ties with each other; other non-local partners are included by weaker ties with Buurtzorg, the client and other members (in some cases not directly connected to other members). The share of information between the strong connected network members is great, the cooperation of the members is not only limited to one patient; it can work for other patients with similar need as well. Because of long-term cooperation, closure and equal share the level of trust between the different health and domestic care organisation in the network is great.

According to the information from the interview , the network looks as in figure 6:

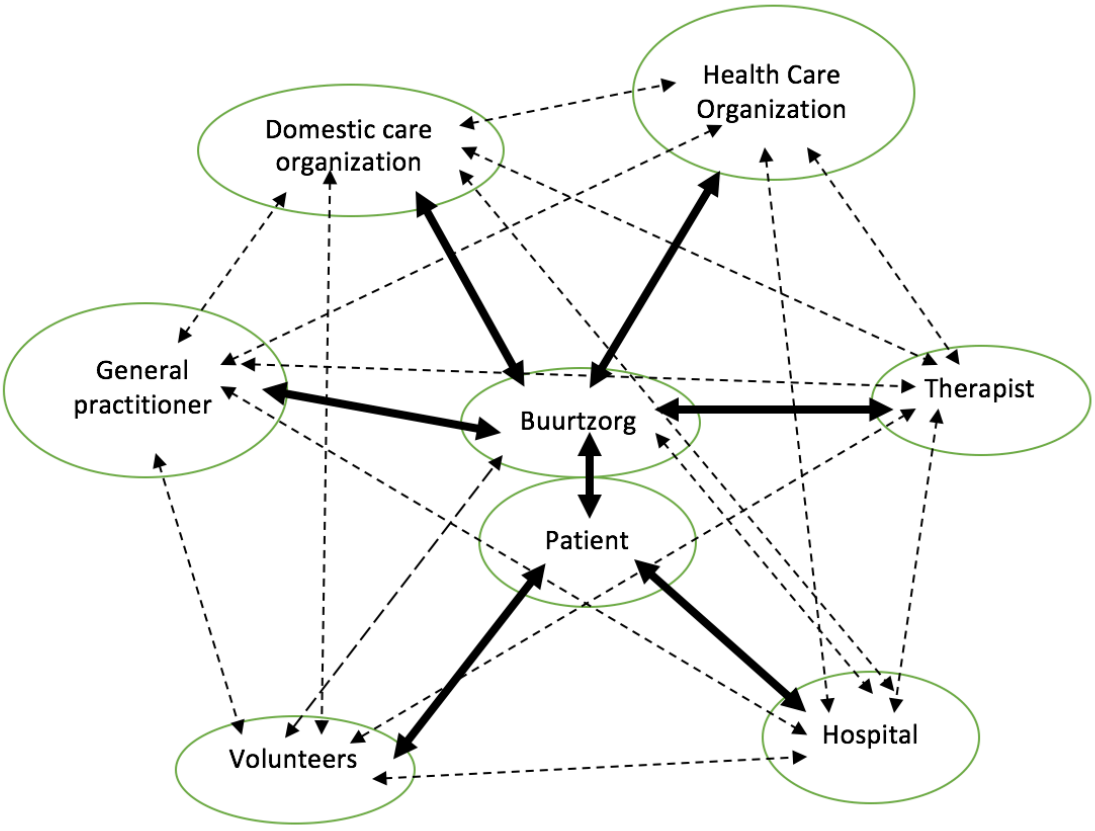

Figure 6: The network of Buurztorg in the Netherlands (Source: Own figure)

The dashed lines show the weaker ties respectively the indirect ties. The continuous lines represent the strong, direct ties. Members connected with a direct tie have a great deal of trust for each other, the level of trust between the others is relatively low. Here, the shape of the Buurtzorg network becomes obvious if compared to the diagrams from Kenis and Provan. The

network shape looks more like the lead organisation network than like the participant network. The reason for that is, that the different members are all directly connected to Buurtzorg and the patient; however, they only have indirect connections to each other by sharing information in a folder which is with the client and by the care plan, worked out by Buurtzorg nurses. To answer for the first sub question which was: "*How are civil society organisations included in the network of Buurtzorg to provide high quality home care in the Netherlands?",* it can be concluded that civil society organisations are included in a lead organisation network. The amount of members of the formal network, is as small as possible, since cooperation with other civil society organisation are only made if necessary for the need of the patient. Buurtzorg takes the lead to a certain degree in this network, firstly by advising and promoting possible cooperation to the client, secondly by working out the care schedule for the patients and setting the goals which have to be reached by all members; Thirdly, by the close connection of Buurtzorg nurses to their patients. The folder with all information and Buurtzorg being maybe the only actor who has access to the "safe environment" after a hospital stay, indicates that Buurtzorg has a broker position in the network and being next to the patient is the most important key player in the network. As far as that, the first hypotheses is also true. The reason for that is, in the Dutch model Buurtzorg does have control of information, to a certain degree more than other members.

4.2 Buurtzorg in the Chinese Context

4.2.1 The Civil Society in the China

As mentioned in the introduction, China is in the process of a social change. At the moment over three million civil society organisation at all level exists in China. Those civil service organisations have a great influence promoting public good governance. Nevertheless, an important question remains over whether, or not a real civil society exists in China: "a few scholars argue that civil society, as it is understood in the west, does not exist in today's China" (Keping 2009). Civil society organisations share the following features: they are non-profit orientated, non-governmental, independent and voluntary. CSO in China do share those definitions to a certain degree, however they do have their own special characteristics. Heberer (2008) makes a distinction between the Chinese civil societies and their Western counterparts. He argues that the "term used for civil society are *shimin shehui*, referring to the urban sphere only, and *gogmin shehui*, which means ´society of public people´ and focuses upon the responsibility of citizen in terms of public good and good behaviour" Heberer 2008: pages. Taking this definition into account there is a strict distinction between social and political aspects which does not exist in the Western definition of civil society, where civil society can be confrontational and a challenge to the Chinese state, or government. Nevertheless, social

associations such as trade unions and social organisations like commerce association, which have a high degree of administration as well as consumer association, academic association and civilian-run non-enterprise organisation can be found in the Chinese context of civil society.

Within the Chinese context, the one-party-state has the power to control or even ban associations, or organisations, which attempt to act in a confrontational manner toward the government. Many active, or former party members, are part of civil society organisations which give the party control about activities of these organisation to a certain degree. Nevertheless "society infiltrates the part-state via social associations and thus initiates processes of change" (Heberer 2009: 41). It becomes obvious that civil society in China has a special character which can be seen as a dual character. Heberer (2008) argues, that in a state like China with a so quickly changing society, that is still in the process of creating new rules of social behaviour, of institution building, it is naturally that the state has a high degree of control and subsequently monitor and restricts over the activities of their citizens. Therefore, an autonomous civil society is still in the building process. According to this, reforms for this developing society, which on the one hand, should help to prevent CSOs from becoming opponents towards the government and on the other hand to promote cooperation between the organisation and the government (Keping 2009.) Heberer (2009) defines the civil society in the Chinese context as "the emergence of a public sphere beyond the party state (…) in which the Chinese state plays a particular role in activating structures of a latent civil society in a top-down manner." Yu Keping (2009: 7) defines China's civil society as a typical case of a civil society led by the government. The most captious organisations are often established, led and sometimes even funded by the government which makes those NGOs (or GONGOs) in some cases dependent. Civil society is supported by the party-state to solve major political and social problems like the elderly care situation.

Even if the Chinese civil society does not completely fit to the Western definition of civil society there is no doubt that there is some kind of civil society in China and furthermore a type of civil society which is still emerging. Moreover, the 'Regulations Concerning Registration and Administration of Social Organisations' complicate the foundation of NGOs. Organisations in China need the help of a patron institution "which has to apply for the admission and takes over the formal patronage as well as a monitoring function*" (Jobert & Kohler-Koch, 2008:93) That* does not mean, that the organisation has to represent government interest: as long as those organisations do not approach sensitive political issues they are accepted, or even supported by the government since often they address issues like sport, health, recreation, culture, or scientific-technical and environmental issues. Other institutional barriers are next to the supervisory body (*Jobert & Kohler-Koch, 2008*)

"Among primary-level rural and neighbourhood CSOs, those with the greatest influence and prestige are "villagers' committees, neighbourhood committees and some community organisations, such as retirees' associations. Especially due to the emerge of of opportunities for citizen to participate in political and social affairs, voluntary involvement in public and societal issues are increasing. The government highly encourages social engagement like taking care of weaker groups in the community as well as supporting voluntary work with disabled and elderly people. In comparison to western societies where the number of voluntary is around 35 to 40 per cent of the entire population the percentage in the Chinese context lay only around three per cent of all urban population. *(Ribao 2006).* The people who do work on a voluntary basis in community committees are up to 80 per cent part public servants, or members of the Communist Party or the Communist Youth League (*Sequa 2005:15).* Through professional supervisory bodies the government can recommend leader, attend meetings take part in activities, examine and approve annual work and finances as well as dispatching staff to associations to work in important position and plying employees. This has a great influence on the autonomy of those organisations. Nevertheless, the linkages between social organisations and the government, which would be a detriment in the western context, can be an advantage in the Chinese context. CSOs help the state in an informal way to solve problems. Those half-autonomous organisations are subject to the supervision and control of the state, but on the other hand are independent concerning many elements as long as those are not challenging the government, both sides gain something. Through villages and urban neighbourhood communities the government influences social rules and standards. "Since 2000, it has set up voluntary associations in urban communities and stipulated that students have to perform "voluntary" social work" (Heberer 2009, p.53).

Summarized, the government in China decides which kind of participation and organisation is good, or bad. Nevertheless, the change in many fields cannot be ignored. In China, there is, exists, even if only slowly emerging, a public sphere as well as basic structure of a civil society. Consequently, the provision of Buurtzorg in China together with civil society organisations would should be working.

4.2.2 Cooperation in the network

Regarding sub question two "How are civil society organisations included in the network of Buurtzorg in China to provide high quality home care?", the network type Buurtzorg builds together with its partners, in China, the following aspects need to be answered: structure, number of members, and decision making.

Alike with the Dutch respondents, the first question asked, was about the cooperation between Buurtzorg and other civil. Respondent 1 stated that Buurtzorg in China is always in need of

cooperation. The reasons for that, is that Buurtzorg is the great unknown on the Chinese market further, community nurses and home care as provided by Buurtzorg does not exists in China (respondent 3). Finding cooperation is a difficult process since there is a lack of service culture in health care as well as the organisations providing health care are either facility driven such nursing homes, or not highly qualified like community committees. The preferred cooperation partners are according to respondent 3 Public-Private-Partnership (PPP) those with day care centres, mini nursing homes as hospitals, or nursing homes, medical nurse station or home visitation nurse stations. However, respondent 1 made clear, that at this point of time Buurtzorg as very few collaborations. Moreover, the respondent said, that "there are quite a lot of volunteering organisations, but because this entire idea of care at home is not really established, yet the involvement is still rather low" (respondent 3 p 3). Further, respondent 3 said that the local organisations have more capabilities and already established networks than Buurtzorg has. Organisations with which Buurtzorg can establish networks are often "either newly founded companies with hardly any experiences in elderly care or in a better case in one city we have hospital companies and we have nursing home authorities as partners, so I would rather call them business-driven relationships" (respondent 3 p3). Nevertheless, Buurtzorg has cooperation with day care centres. "Day care centres are a sort of kindergarten for elderly, where they come during the day and they have activities there and they get food, also showering facilities and bathing facilities etc. some rehab facilities (…) (respondent 3 p4). But "they lack experience, they work with us, so we do the home nursing and provide the home care services in partnership with them." (respondent 3 p 4) Further, Buurtzorg is at this point of time still looking for cooperation, "they are looking, still looking for cooperation. Especially with (…) Chinese companies and if you look, you have to think about like nursing homes in a practically community, or area, where there is a nursing home and we can deliver in that area for example the home care and then that nursing homes can provide, provide and apply maybe the medical licence, so that would also be, in that part of cooperation you have to look. And they have some corporations like that" (respondent 1 p. 9), Moreover, respondent 1 thinks Buurtzorg can be successful in China is to (…) "work together (…) with Chinese companies and organisations and then slowly go up in that community and the local government and to work on with them further on the programme. But you need the government as well" (respondent 1 p. 9f). This shows, that Buurtzorg has a different position in China. Buurtzorg needs to actively look for cooperation and make itself dependent to a certain degree. Respondent 2 said, that working together with the government in China can be very difficult. There is not one but three ministries involved in the process; "ministry of people's health and family planning (...), ministry of civil affairs (...) and ministry of human resources and security and this minister is in charge of all the money. So, if the first two decide, there is other care necessary, they need the permission of the last ministry and they cannot provide any services

to the elderly people. So in China, due to the political structure to strive a long-term care insurance it is much more difficult than in the Netherlands" (respondent 2 p.1) Further, respondent 2 stated that the organisation Buurtzorg works together with are managed by different ministries. This is very complex situation in China! Buurtzorg is highly dependent from three different governments, who do not seem to have on gaol nor communicate very well.

It becomes obvious that elderly care, as motioned in the context before is something different for China and the government is not familiar with home care. Buurtzorgs' network partners are differently educated in providing care. Buurtzorg does not have a medical license at this point of time. That means Buurtzorg is not allowed to give any medical treatment, only domestic care (respondent 1-3). Consequently, the cooperation with nursing homes are a necessity to fulfil all the needs of one patient. Buurtzorg is dependent from other partners to provide medical care.

Respondent 1 and 3 both stated that the government is very much involved in the cooperation making process of Buurtzorg as well as in selection patient for Buurtzorg. "it is not like (...) an elderly people who needs care who is searching for a homecare organisation and goes to Buurtzorg. (...) Most of the time it is like, there is a project from the governments and now we the common health care we want to do something for the elderly of 90 and above. In a certain area they look for all the people who are 90 and above. Then they say, okay you do the intake and provide the care, but you only have a hundred hour a week. So the whole process and delivering care is totally different" (respondent 1). The client was not mentioned as a special partner of the cooperation, nor in having power in the decision-making process of choosing cooperation. Further, respondent 1 said "in China, unfortunately, it's all about money. (…) I mean in Shanghai we also have cooperation for the quality of care and the services, but in the end of the day it is also about money" (respondent 3 page 4). Respondent 2 agreed that cooperation in China is not the result of actors wanting to achieve the goal or to provide service in a non-profit making way, however, it is "about money and business. So most of them haven't any experience or expertise in this field. But when they smelled the money they start their business. So it is actually very difficult for us to find a very good partner with a good motivation. But because of the license some organisations have very good government relationship or they know some very important persons in the government who can give them the medical license very easily." This is a striking finding; it seems that the medical license Buurtzorg which applies for three years now is given to non-professional organisations and companies if they have a good relationship to the government. Party membership, friendship and money could be driving factors in achieving favours. Here, the power of the government becomes obvious, as well as Buurtzorg not being a key player with strong ties. There is no shared goal of the members, further the size of the network can be enormous since it is an open network.

Summarized it can be concluded that Buurtzorg has only few partners in the network. Further, only a limited choice of choosing those partners, as well as a limited choice of the patient in choosing care organisation is possible. Further, the great need to find cooperation partners to gain access to the market and next to that, Buurtzorg does have a necessity to work together with nursing homes, medical nursing stations, or home visiting nurse stations since this are the organisation with a medical license.
The participant network is highly implausible since there is no commitment to one goal, nor are the network members equal. Since three ministries are the steering organisations in the network, which provide, license and resources the government functions as the network administrative organisation in the network which does guides the process, however has a very complex, one could say, even too complex administration which it provides to the network.

4.2.3 The share of information

When asking questions about the share of information, respondent 1,2 and 3 told about the same new online IT device, which will be used in the future. The communication until now in China between Buurtzorg nurses and other partners works with pen and paper. However, the nurses do not write down more than measurable facts. Respondent 1 said that nurses in China fear if they "write too much, then the doctor or if something happens, we get maybe sued by someone who said yes you did that there is no law that covered/covers the nurses (...) But China is always: no, not we don't write to too much, (…) it can make the things worse, if we write them too much. (respondent 1 page 7f). Here, it becomes obvious that the information written down in the folder, which stays with the client, are not very detailed and no questions are asked in it. Further respondent 3 that "only internal communication with a little formal exchange with other organisations in regular meetings with our partners. And in internally, I would say, it's basically 'We chat' which combines WhatsApp with Facebook, a very popular social platform and everybody is using it" (respondent 3 p 4). It is not known if every nurse is in a group chat with all other health care professionals, but it is not very likely. "'We chat' plays such an important role", stated respondent 3 (respondent 3 p4). It is easy to use and does not require any special training. Further, it is unlikely that doctors are part of this 'Wechat' chat groups, moreover, group chats make looking up of information difficult.

All in all, it can be concluded that the share of information is less detailed with other civil society organisations and with the client as well. This is another hit for against a participant network and towards Buurtzorg being a member in a network where it does not make key decision, nor sharing key positions or is a broker position. Further, respondent 3 that when the government gives a list with clients to Buurtzorg, Buurtzorg makes the assessment, developments of care

plan and performs this care, and the government monitors the provided care by interviews with the clients and Buurtzorg needs to do a lot of documentation. The government gathers all the information of whom to provide home care to. Here it becomes obvious that the government knows that it does not have enough knowledge about home care at this point of time however is eager to gain more knowledge. Further, the government gives a list with clients to Buurtzorg. That indicates that the local government has a great knowledge about the situation in its own community, from which Buurtzorg is only in process, at this point of time, of becoming a part of. This is another hint, to expect the government to be in a key position which has a great deal of power and centrality in the decision-making process.

4.2.4 The quality of care

Since many of the network partners are newly established, as well as Buurtzorg only has been in China, for two years, patient satisfaction and quality of care cannot be measured now. However, the day care centres in Shanghai, which do not give medical treatment more the social treatment are very good in operating (…), so it is very high quality" (respondent 3 p4). The quality of care in China is on a different level. Respondent 1said that the education of the nurses "is also different. It is used to have a lot of theoretic teaching and working models, not a lot of practical teaching (…) If you look at…, for a foreign company is very difficult to establish something here in China, so you always have to look for cooperation. If you want to be successful within a Chinese organisation. And when you are successful it is still quite difficult to get all the finance, for what you do and suitable profit of it" (respondent 1 p1). The nurses are not practically trained. However, the European brand of Buurtzorg has some influence in China. In some cases, other organisations "find us (Buurtzorg) because we are the only foreign company, and a trusted brand and concept" (respondent 3 p4). The success of Buurtzorg in Europe and especially in the Netherlands helps Buurtzorg to gain trust from other health care organisation. Respondent 1 said, that Buurtzorg invites other organisation to presentations, which results sometimes in cooperation seeking of those who were invited. The positive reputation of Buurtzorg helps to gain trust in the Chinese context. However, respondent 1 said that "in China, unfortunately, it's all about money. It's very sad to say. (…) I mean in Shanghai, we also have cooperation, for the quality of care and the services, but in the end of the day it is also about money. That's a typical situation in China" (respondent 3 p. 4). Respondent 2 said that Buurtzorg is "a lot behind with some other Chinese organisations. Also, they have no experiences in this field but they get the medical license and the location of the government. So what we can do now is to cooperate with this kind of company" (respondent 2 p2). Medical licences are not given due to quality or experience. It can be concluded, that the quality of care is low due to the lack of experience Chinese organisation have in the community nursing

sector. Further, if Buurtzorg cooperates with those partners it cannot be said that the quality of care will increase due to the lack of information share and the non-commitment to the goal, which should be a high quality but actual is on money on side the of many partners. Further, if there is no commitment to a goal, according to Kenis and Provan, the network is ineffective if the network administrative organisation fails to provide the administration for the day-to-day business.

All in all, it is highly difficult to measure trust in this network. On the one hand, there is the reputation of Buurtzorg Nederland which opens some doors in concerning cooperation. However, since home care is a new concept, for China and the home care quality is not high, respondent 1 said, that Buurtzorg nurses do not have a medical license to provide medical treatment (respondent 1) and are dependent on nurses from nursing homes to do provide medical treatment, which limits the scope of the Buurtzorg nurses and their key position in providing care. In China, unfortunately, it's all about money. Its very sad to say. I mean the Joint ventures anyhow. I mean in Shanghai we also have cooperation, for the quality of care and the services, but in the end of the day it is also about money. That's a typical situation in China" (respondent 3). Neither do the Community committees provide health care. Respondent 9 stated, that elderly do not usually go to the doctors if there are ill, but directly to the hospital (respondent 9). Buurtzorgs connection to the hospital is rather indirect than direct. Further, expert I said that nurse in China "the nurse to go to hospital after they graduate (…) education institution who do the nurse training in China, it is very different what we do here. They are like producing a standard product, so a group of nurses they stand together, one teacher says: Okay the first step, you measure the blood, second step is (…). So, 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. Respondent 1 and 3 mentioned that as well, nurses are not creative in home care, when they do not work in a team like in the hospital with all the tools which are offered in a hospital, but cannot be found in the home of a client. It can be concluded, that assumptions about the quality of home care are not reliable at this point of time. Nevertheless, it can be said, that the quality of home care is very different and lower than expected.

The network of Buurtzorg in the Chinese looks like as depicted in figure 7.

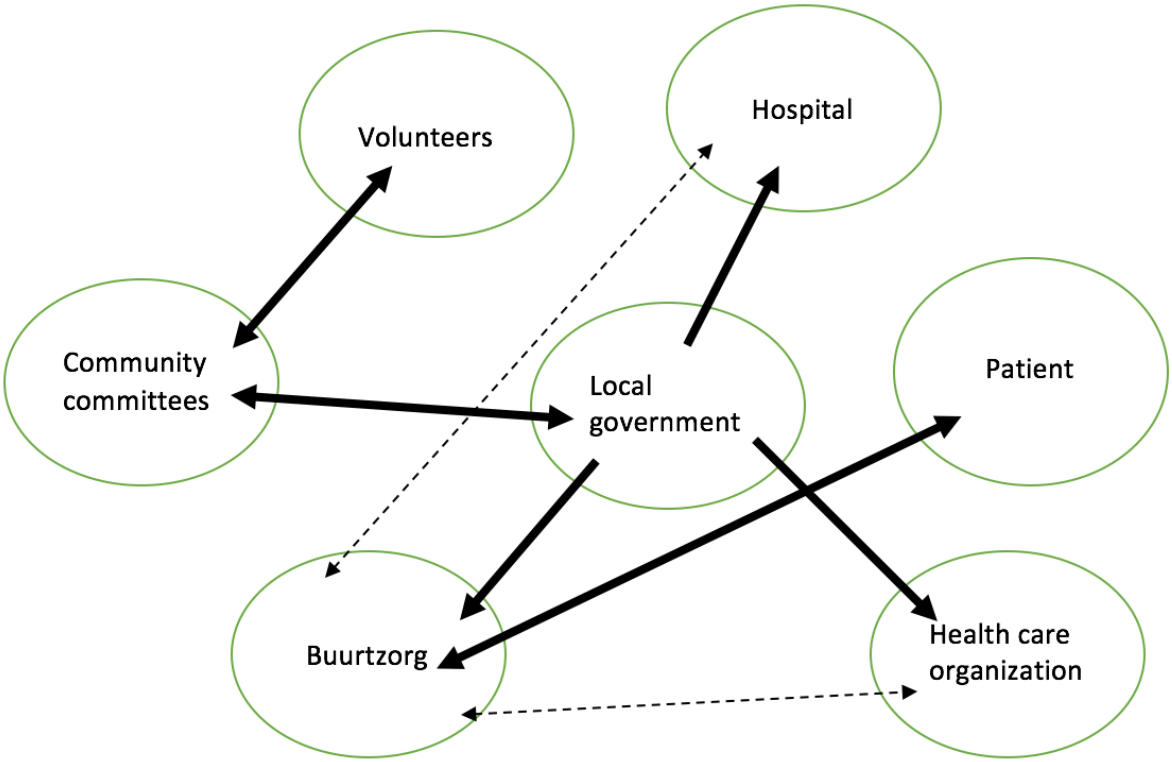

Figure 7: The Network of Buurztorg in China

The local government is the main actor in the network. It sets the legal framework, limitations, opportunities, cooperation suggestion and client projects, for Buurtzorg. Further, as stated in the context the other society organisations are closely connected to the government as well. The community committee is very closely connected to the government. Till now Buurtzorg has no a direct connection to the community committees (respondent 3) however, they will address that in future.

In figure 7, it becomes obvious that the local government has a central position in the network. Further, the government can have many more actors which are not drawn into this diagram. The local government does not provide service in the classical way, which is why the network administrative organisation is the most logical. Since it can be concluded that the quality of care provided by Buurtzorg is lower than in the Netherlands, the hypothesis one and two (How is civil society included in the network of Buurtzorg in China to provide high quality home care? And the higher the degree of Buurtzorg being the key player which takes centralized decision in the network the higher will be the quality of home care?) are true. The civil society is not deeply included into the network of Buurtzorg in China, nor is it a key player, who takes centralised decisions. The quality of quality home care is not high.

To answer the second research sub question (How is civil society included in the network of Buurtzorg in China to provide high quality home care?) it can be said that the civil society is in

not greatly included into the network of Buurtzorg. Further, the network in which Buurtzorg operates is not the network of Buurtzorg, but the one of the local government. The deal of trust between the actors which are not connected directly is low, and Buurtzorg does not have a broker position in the network as it had in the Netherlands. The second hypothesis, the higher the involvement of community committees in China, the lower, the less likely is the probability of Buurtzorg being the key player, to control resources and information within the network, is proven to be correct.

4.3 Comparison between the Dutch Buurtzorg model and the Chinese Buurtzorg model

To answer the third sub research question which is: "to what extent do civil society networks have a differentiated influence on the provision of high quality home care by Buurtzorg in China and the Netherlands?" The previous analysis of Buurtzorg in the Netherlands and of Buurtzorg in China will be compared.
The main finding will be summarized in table 2, which will be explained in the following.

	Buurtzorg Nederland	Buurtzorg China
Network type	Lead organisation network	Network Administrative organisation
Amount of network members	Only as many as needed	Few
Amount of organisations involved in total	Only as many as needed	Many
Most important network member	Patient, therapists	Local government, nursing homes
Position in the network	Key player	Dependent member
Symmetry	Asymmetric	Asymmetric
Involvement in Decision- making	High	Low
Share of information	Buurtzorg has a broker position	No broker position; dependent form other members
Quality of care	High	Very different standard

Table 2: Comparison of the Buurtzorg network in the Netherlands and China

The drastically different positions and task in Buurtzorg's the networks with other civil society organisation is obvious. Buurtzorg Nederland is the key network member in a lead organisation

network. Buurtzorg, has a great deal of trust, information and power in this network. The network in China is, as expected, very different. It becomes obvious that the context has a great effect on the network and its members. The fact that China has a Leoban culture (respondent 3) makes the nurses more compliable with authorities' even, insecure without direct instructions. A consequence of that could be a lower quality of care, when nurses only share standard information which can be easily be measured, but do not share what they expected or why they did a particular measurement. However, the self-dependency of the nurses is not only the result of a different professional education, but of tradition and culture as such. Firstly, respondent 1 mentioned that the profession as a nurse is not highly well-respected in China. Secondly, the nurses are not insured, which leads to great consequences like accustom. The independence of the nurses is limited by tradition – stigma, laws and the fear to make mistakes, and to step out of the standardise procedure. As mentioned in the context section of civil society in China before, the government is highly involved on all levels, for Buurtzorg the government is a highly important partner. On the one hand, the local government provides Buurtzorg with projects and funding. On the other hand, by setting the projects and the time frame, for caring, for one patient, the individuality nursing teams have in the Netherlands to decide how much time a patient need, which leads to high quality home care is prevent by to strict and flexible project demands (respondent 1).

The civil society in the Netherlands is highly developed and in cooperation with Buurtzorg achieves high quality home care. The civil society in China is still in development, that means has to develop accordingly. Social movements or civil initiatives concerning the need of elderly care did not come from bottom up but from top down. The government at the top, wants to find a solution for the elderly care problem due to demographic change, but has little knowledge, and does not provide Buurtzorg with services the way Buurtzorg nurses need it.

Buurtzorg in the Netherlands has already established partnerships in the communities, Buurtzorg in China only exist from two years they are still in process of gaining trust. "It is important for the Dutch elderly care models to gain the acceptance and trust in the society (...) the people have to get used to it. This might take a while and be one of the biggest challenges for Dutch models in China (respondent 8 p.1).

When looking for new partnerships in the Netherlands, respondent 2, that Buurtzorg is looking for organisations that work in similar way – independently and self-autonomous. Those partners are in China hard to find. At this point of time, Buurtzorg does not have a choice of many cooperation possibilities in China. Further, due to not having a medical license in China makes cooperation with actors who have a licence essential. A successful cooperation, with for instance nursing homes, increases the overall quality of home care for the patient essential. Until now Buurtzorg in China has a highly-depended position and must earn trust, a medical license, better cooperation and promote itself to change that. For both contexts it can be said

that cooperation increases high quality – for the Chinese, and for the Dutch context, if the license and already established facilities which results in a higher level of trust are considered. Nurses in the Netherlands are more self-independent and trained to notice not only medical facts, but secondary aspects which can turn out to be important. The nurses in the Netherlands, provide a broader scope of care to their patient. That is the reason why only few cooperation partners are possible within the network, or Buurtzorg Nederland. In China more actors need to be involved for one patient. Since the quality of care and patient satisfaction has not been measured at this point of time, it can only be presumed that too many actors participating in a network around one client the result will be not highly qualitative, maybe even take the conditions of the Dutch health care sector with problems in efficiency, and quality which was the case before Buurtzorg was developed. This will be highly dependent on the government, how quickly they learn how to administrate their network to achieve high quality home care, since everything is still in process.

All in all, the quality of home care is highly dependent on the lead respectively administrative organisation in the network. The difference of the network and the context highly influence the quality of home care. The extent of civil society organisation in networks with Buurtzorg in providing high quality is great. It can be concluded that in both cases the cooperation with other organisations in a network is essential to provide high quality home care. The greatest difference is that the network in the Netherlands is efficient and the network in China is less efficient. Since high quality is measured in efficiency the problem becomes obvious.

5. Conclusion

In this study, it was aimed to find an answer to the question whether the inclusion of civil society organisation increases quality of home care for the elderly in the case of Buurtzorg. To address this question, the formal network of Buurtzorg in the Netherlands and China were studied. It was expected that Buurtzorg in the Netherland operates within a lead government network, where it would have a central, broker position and Buurtzorg in China, to operate in a network, led by the government and having a broker position within this network.

Due to demographic change elderly care becomes more and more promoted by the governments in many countries, the government in China is eager to let experienced foreign companies teach how to provide high quality home care. Since this process only started recently the Chinese government as well as Chinese Civil Society Organisation are still in process of understanding and learning about it.

The four hypotheses (H1. The higher the degree of Buurtzorg being the key player in the network performing centralised decision-making, the higher will be the quality of home care (efficiency).

H2. The higher the involvement of community committees in China, the more less Buurtzorg is the key player to controlling resources and information within the network.
H3. The higher Buurtzorgs control of information is in a closed network is, the higher is the efficiency and as such the quality of care.
H4, the higher the level of trust in the Buurtzorg models and the more Buurtzorg is in a broker position the lower is the redundancy of information.) are proven to be right for their own context. However, it cannot be concluded that H1, H3 and H4 would be right in the Chinese context. It can only be said that since the opposite of the independent clause of the hypothesis is the case in China, (low degree of being key player, low control of information, low level trust), consequently the outcome is no high quality.

Based on the analyses, several conclusions can be drawn. In the first place, evidence was provided that context matters. Models, like Buurtzorg who are highly successful in one context, are not necessarily successful in another context. Often models need to change to a certain degree, or completely to adapt to a different context. The Buurtzorg model which is a lead organisational network in the Netherlands changed to an administrative organisational network in the Chinese context. The positon of the leader of the original model change to a dependent member of the network in the Chinese case. It is known, that Buurtzorg is still in the process and a lot of thing can change concerning Buurtzorgs position in the network, however the change from Buurtzorg Nederland to Buurtzorg Shanghai is a very drastic change.

In the second place, the inclusion of civil society organisations in the Buurtzorg network increases the quality of care for the patient. Buurtzorg nurses are all educated generalist and some do have a specialization. If non of the nurses is specialised enough or in the field needed, the cooperation with other specialised professional, such as therapist increases the quality of care. In the third place, the data indicates evidence for Buurtzorg operation in a lead organisation network in the Netherland. This network is highly efficient and has a clear vision of achieving previous set goals, with a high quality. In China, however, the goals of the different members are not the same. The goals of the government are to learn how the provision of home care is done efficiently, but without changing their own administration to much. Buurtzorgs, as a non-profit organisation, is to provide high quality care as independent, self-autonomous and without too much administrative burdens. For many of the other actor's money is the main goal. So every member is committed to achieve care however, high quality care is not the main priority. Fourthly at the end of this analysis the question has to be asked if home care is the right kind of elderly care for China. Respondent 2 reported that in the organisation and the government "are now doing their best to get more and more clients into the institutional care but actually we want them to stay at home. So it's not so easy" (Respondent 2 p4). It could be the case that elderly care as such in China will process firstly into institutional care before it might lead to home care. However, it cannot be said that the

differences in quality are due to the differences of networks. Here only differences in the efficiency of the networks become obvious. Nevertheless, a network administrative network could provide high quality care in China if the key player(s) learn how to provide structure into the network and make it more efficient.

5.1 Strengths and limitations of this study

The concept of high quality of care could not be answered perfectly within this study. At this point of time there have been no measurements, or any other evolutions of the quality of care in China. It was found out, that the model of Buurtzorg as well as the network changes drastically by implantation into the Chinese sector. However, it cannot be said that the quality provided by Buurtzorg in China is lower, it can only be said that the efficiency and as such the quality of the network in total is lower in providing care. A different measurement, that researches the quality of every member of the network and the total quality of the network as a different measurement would be more efficient to measure the Chinese case. Having clear indications of how to measure high quality in both contexts would have raised the credibility of the study. For future research those indications would be helpful to properly test the hypothesis. Further, language issues limited the amount of responses from the Chinese Buurtzorg case due to little comprehension of Mandarin of the research team. Having an interpreter within a future research team would be the key asset towards more information from Chinese professionals. Not being able to interview one person with four researchers is another limitation of the design and, not always all researchers were satisfied with the outcome of interviews.

Strengths of this study are that, even considering the limitations, this is a pioneer study concerning the inclusion of civil society organisations into the network of Buurtzorg in China. This study successfully presents the involved actors in the care provisioning as well as their existing or lacking relationships to Buurtzorg. The need for home care in China as well as the successes and difficulties of implementing a foreign model into the Chinese health care sector can be beneficial not only for Buurtzorg professionals, foreign companies but also for Chinese entrepreneurs and health care providers.

5.2 Further research

Many recommendations for further research can be drawn from this study.
These are, for instance, to study the case of Buurtzorg for a longer period of time in China and to document the different steps of the process of implementation. Further, a comparison of Buurtzorg in China with Buurtzorg in Japan would allow one to see if the model of Buurtzorg

has to change for the Eastern context in general or if China is unique case. A study of legal obligations in the Chinese healthcare sector with which a foreign company need to comply would be useful.

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Appendix

List of Appendices

Appendix A: Interview questions

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Appendix A: Interview Questions

Can you tell us about the **cooperation another civic society partner**? (please name an example of an organization that you have worked with if possible)

1. How do this cooperation between Buurtzorg and these partners *usually* come in about? Are they based on old friendships among care providers, preferred by the clients, advised by the local government, due to economic rationales, etc. can tell us examples?

a. With how many partners do you (Buurtzorg) work together with? (maybe average?)

b. *in your experience*, who takes the lead in this cooperation? Who starts the communication? Civic society partner? Buurtzorg? Client /family? Other professional (who?) and how does it happen?

c. how are the decisions made in this cooperation? In there a clear leader (if so who) or are the decisions taken together with (all) partners? Can name examples?

d. Is there a lot or little support from the local government or community committee to foster this cooperation? Can you us a bit more of this support?

e. How are voluntary helpers (NGO's, families, community) involved in the activities in the Buurtzorg?

2. Do you think Buurtzorg has a central role position in providing home care in the Dutch/Chinese context when other civic organizations are included?

the next questions are about the sharing of information between you and other partners in delivering care

3. How are information (concerning the patient) shared between Buurtzorg professionals, community Committees and voluntary workers?

a. What kind of tools are used in this information sharing? How quickly is information shared? (time) and how easy it is to use (without much training)?

b. To what extent are persons using these tools at ease? Is much training preferred/offered?

c. How and to what extent are non-Buurtzorg professionals (other civil service organization professionals) included within the decision making process of client decisions (new clients, treatments, etc)?

the next questions are about quality of care

4. What is considered as an indication of high quality of care?

5. Who decides on this? Does Buurtzorg use any indicators, if so what?

6. in your view, how does collaboration with several partners influence the quality of care?

7. What does Buurtzorg do to secure high quality home care when working with other many actors involved? Are there any strategies? For example, if voluntaries are included in service provision, how do you secure high quality home care?

8. What is done to professionalise NGO partners for examples, are there other attempts to secure the quality of care giving?

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