



Elder Care in The Netherlands

*Interviews with Dr. Daan Dohmen, Dr. Hans Becker,
Roland de Wolf, Jos de Blok, Gertje van Roessel*



Based on Gustav Klimt, Tree of Life, Stoclet Frieze, Lebensbaum, 1905

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Introduction Elder Care Netherlands

As part of my studies of good practice in elder care, I decided to spend a couple of weeks in the Netherlands. Many healthcare professionals in Sweden regard the Netherlands as a country that promotes innovation. I wanted to explore the innovative mindset that healthcare professionals in Sweden seem to associate with the Netherlands, learn about the Dutch healthcare system, and visit a few internationally recognized elder care groups.

I was amazed by what I saw in the Netherlands. I will try to communicate some of the strongest elements of the organizations that I visited, and of the Dutch elder care system at large. I think it is safe to say that we all are looking for inspiring examples that can help us shape the future of our elder care systems. In my view, some of the Dutch organizations that I visited already embody what I would like to see in all elder care organizations in the future, such as personal freedom, a focus on wellness and wellbeing, and an environment that feels just like home.

Background

There are almost seventeen million Dutch citizens, and sixteen percent of the population is sixty five or older. This number is slightly lower than the European average, with comparable figures in Germany and Italy at around twenty one percent. The population over the age of eighty in the Netherlands is expected to increase to around ten percent by 2050. As such, the Netherlands, like Sweden and many other countries, will have to think carefully about how to care for its aging population. The Dutch healthcare and elder care systems provide universal coverage through healthcare insurance. All Dutch citizens are required by the Health Insurance Act to pay for private health insurance. The cost for private insurance ranges from one hundred and thirty to one hundred and ninety US dollars per month. The insurance companies must accept every applicant who applies for insurance. Companies also contribute toward healthcare insurance for their employees. There is a parallel insurance system for long term care, including nursing homes and exceptional medical expenses such as extended hospital stays.

The Netherlands spend about fifteen percent of gross national product on healthcare, including elder care. Elder care comprises around eighteen percent of total healthcare costs. There have been a number of recent reforms to the payment system. Among them, elder care is now the responsibility of local municipalities instead of the central government.

In the Netherlands, life expectancy is eighty three years for women and seventy nine years for men, resulting in an average life expectancy of eighty one years. The Dutch elder care system has traditionally been ranked as one of the best in the world by international researchers and academics. The system is based on the principle of solidarity and universal coverage. However, there are concerns about the increasing cost of long term and chronic care as the population ages. The Netherlands are looking abroad for inspiration.

Lifestyle and Wellbeing Matter

I visited a number of different care homes, homecare organizations, academic institutions, and eHealth providers, as well as the University Medical Center in Groningen. Throughout my time in the Netherlands, I noticed that innovative groups all shared fundamental ideas upon which they centered the delivery of care. The organizations I visited focused on wellbeing, wellness, and lifestyle choices. They focused less on the medical aspects of chronic and long term care. These groups did not consider themselves to be part of the curative branch of the healthcare system. These healthcare professionals wanted to focus on patients' individual capabilities, freedom, autonomy, and wellness.

For example, the care homes wanted to provide a nice home environment, with home cooked meals, small groups, interior design choices, and a personalized care routine. The care homes focused on providing tasty food, the freedom to go to bed and wake up at will, and an exterior environment that feels just like the environment in any city neighborhood. The homecare organizations strove to provide assistance, but only when individuals could not manage on their own. The nurses look first at a person's capability to care for him or herself. Next, the nurses look to the neighborhood and what help neighbors might provide. Then the nurses reach out to relatives to see if they can be of assistance. As a final step, the nurses provide care.

The nurses and assistant nurses in the organizations I visited were able to help individuals not only with the medical aspects of homecare, but also with personal hygiene and cleaning the house. Their goal is that the person who receives the care is happy and satisfied. As we all know, satisfaction and wellness can come from many different sources, not only by following a medical care routine rigorously. Satisfaction and wellness are also about how you feel in your home. For example, whether the flowers are watered or the garbage is taken out.

This boils down to is a different view of the role of nursing. Many times today, the most experienced and most senior nurses are promoted to managerial positions. The most experienced rarely see patients. The senior nurses manage assistant nurses and younger nurses. Some assistant nurses prefer to handle the more technical and medical aspects of homecare, such as treating wounds and distributing medication. Some nurses prefer to do this work to bathing patients, cleaning the house, and talking to relatives. In a way, the Dutch approach resembles what the district nurses did in the 1980s, when they assumed a holistic view of nursing.

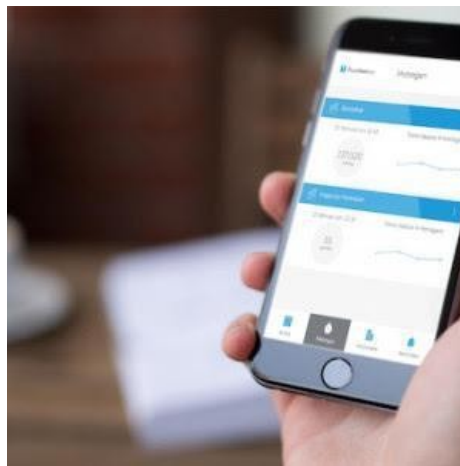
The researchers and academics I met all considered autonomy and freedom to be critical elements of the elder care system. Throughout my conversations, the researchers focused on vitality, a word that they associated with the state of remaining alert and active, despite the bodily weakness that comes later in life. Vitality is not in inevitable opposition to aging, but accompanies aging when individuals alter their expectations and lead active lives based on their physical and mental capabilities. Many aspects of elder care could benefit from more freedom, personal autonomy, and a focus on wellness and vitality.

Innovative Organizations: FocusCura and Dementia Village at de Hogeweyk



Learning to use the videoconferencing app on a tablet.

I visited FocusCura, an eHealth provider currently headquartered in the city of Utrecht. I met with Dr. Daan Dohmen, the founder and chief operating officer of FocusCura. Dr. Dohmen is a trained elder care nurse who completed his doctoral thesis on the adoption of technology among the elderly. He has built an eHealth technology company that currently provides two main software applications in elder care.



An app to monitor your healthcare at home.

The first is a video conferencing application that works with a tablet. The application allows individuals to Skype with their homecare providers, the doctors in the hospital, the general practitioner, any other healthcare provider, and relatives. The second application is a health monitoring device that helps patients manage illnesses such as chronic obstructive pulmonary disease, heart failure, and diabetes from their home. The application helps individuals collect their own health data and share it automatically with their providers. Both of these products have been rigorously evaluated and have received a standardized European product certification. The software applications are classified as medical products.

Throughout my discussion with Dr. Dohmen, I was surprised to learn about the many different facets of technology adoption and the way that FocusCura has chosen to introduce technology into elder care. The company focuses on providing services to the elderly, but at the core of this work is personal autonomy and freedom. Many other organizations provide standardized homecare with little room to choose what kind of services and what kind of assistance you want. With the help of the applications, individuals can choose with whom they want to videoconference and what type of care they want. For example, individuals can choose whether they want an in person visit with the doctor or a digital visit. Individuals pay the same price through their insurance policy for videoconferencing as they would for an in person visit to the doctor. Many choose to receive blended care, a combination of digital and in person care.

This application provides freedom for individuals who receive homecare. This is a flexible model: If you want to see your nursing provider, you can do so. If, for some reason, you do not want to see a doctor on a particular day, you can choose not to. Individuals can also add neighbors or relatives as videoconferencing contacts so they can videoconference with other people who matter to them. The Dutch insurance system reimburses videoconferencing, which is far from common in every country.



Dementia Village at de Hogeweyk.

I was also able to visit the famous Dementia Village at de Hogeweyk, in Weesp, about half an hour southeast of Amsterdam. This care home is constructed as a small, self contained village. Individuals who have been diagnosed with a later stage of dementia can live relatively normal lives here. The care home consists of smaller houses with six individuals in each house, a street with a shop, an activity center, a theater, and a grocery store. The village also includes restaurants, a bar, and many different gardens that surround the smaller houses. Inside the village, individuals are free to walk around. Staff dress in normal clothing. At the front end, the village is just a normal village. At the back end, de Hogeweyk is a nursing home with nurses and other healthcare professionals who deliver professionalized care.

I liked the atmosphere in the village. I sat down for a cup of coffee in the restaurant. I looked into the bar and I saw the theater. The village attracts many volunteers from the city of Weesp. Many companies rent the theater for meetings and functions. Sometimes the village is full of people, just like a normal village. Other times, the village is quiet. This variation instills some normalcy into the everyday lives of the individuals who live there.



Supermarket in de Hogeweyk (Photo: Hans Erkelens)

Residents can stroll down the street and go into the grocery store to pick up whatever they like. There is no need to handle cash. At times, the lack of cash can be confusing, but it also simplifies matters for the residents. Each house has its own unique lifestyle. The lifestyle of the house can be city living, traditional living, or Indonesian living, for example. The small scale allows individualized care. Each nurse knows the residents quite well.

The nurse brings the residents to the grocery store to pick up ingredients for dinner. Later on, the nurse involves the residents in cooking. Such a simple activity also ensures that life in the dementia care home still contains strong elements of normalcy. Residents walk outside and engage in activity when they go to the grocery store. Families testify that individuals who live in the village need less medical care and consume fewer medications.

The focus on activities is strong in the village. Each resident can sign up for one free activity, such as joining the classical music group. Many residents pay for additional activities. This approach cuts to the core of what de Hogeweyk is all about: maintaining your physical and mental strength by engaging in the normal everyday activities that you have enjoyed throughout your life. The managers of de Hogeweyk report that activities can reduce the need for rehabilitation services and prevent a range of medical illnesses, such as fall injuries. I was encouraged to see the amount of freedom, flexibility, and normalcy that the residents in the village could enjoy every day.

It is, of course, difficult to describe all of the impressions that I gathered while I was traveling around the Netherlands. I hope that I have been able to communicate some of the core principles and approaches that these groups have taken. Many elder care providers around the world work hard to provide person centered, individualized services. Far too often, resources are scarce, care needs are high, and staff turnover burdens care organizations. It is not easy to provide high quality elder care at an affordable price. I hope to communicate that achieving high quality and affordable elder care is possible, and that some of the organizations in the Netherlands are doing just that. It will be my objective in the coming years to inspire others to look toward these innovative examples. I aim to help policymakers, practitioners, and community groups be inspired by these ideas and ultimately improve the quality of elder care. I hope that this research is the first step in that direction.

Background FocusCura

FocusCura is an international eHealth provider. It provides five products which improve the quality of life for seniors and chronically ill. The eHealth solutions of FocusCura give the elderly the opportunity to live independently in their homes. Internationally two interesting eHealth applications are provided by FocusCura on a large scale. The first application, cContact works with a tablet. It provides video conferencing. The application helps people to maintain their care network and have contact with them, such as their homecare providers, doctors, general practitioner, specialists, and relatives. The second application, cVitals, is a health monitoring service. It helps patients manage illnesses such as chronic obstructive pulmonary disease, heart failure, and diabetes from their home. Patients collect their own health data. The data is shared with their providers automatically. Both products have been evaluated and cVitals has received a European CE mark. The CE mark is a standardized product certification for medical products.

In the following interview, Dr. Daan Dohmen, the founder and chief executive officer of FocusCura, describes the many facets of technology that FocusCura has introduced into elder care. The philosophy of the company focuses on independent living. The applications allow people to choose the type of care they want, when they need it. For example, they can choose to receive an in person visit with the doctor or a digital visit via video conferencing. This is called 'blended care' and many choose to receive this blended care, a combination of digital and in person care rather than only personal care. Insurance providers reimburse patients equally for all options and interesting results are realized with blended care such as lowering admission rates and increasing efficiency of the care personnel.

About Dr. Daan Dohmen



Dr. Daan Dohmen is the founder and chief executive officer of FocusCura. Dr. Dohmen started as an assistant elder care giver in a nursery home. He completed his education at the University of Twente. His doctoral thesis examined implementation of modern technologies in homecare settings. FocusCura operates currently in several countries and is the first Dutch Apple Mobility Partner allowing the company to leverage Apple's expertise and global reach to get its innovative e-health solutions into the hands of more patients and care givers. Dr. Dohmen hopes to expand his applications and offer them to more interested countries in the future.

Interview

Sofia Widén (SW): Hello, Dr. Dohmen. Please tell me, does FocusCura have any facilities in Singapore?

Daan Dohmen (DD): No. We are currently active in the Netherlands, Belgium, Sweden and Denmark. We have some leads in the United States and United Kingdom as well. It may be too early to start there. We want to find interesting markets. We also want to find markets suitable for eHealth or telehealth. We need a government that allows and reimburses care on a distance, like via video, monitoring or similar technology. Such reimbursements are not available in all countries. I worked as an assistant elder care nurse. That is how I started here. Opposite to here, there is a nursing home. That is where I started wanting to become a doctor. In the Netherlands, we have a lottery system. My number was not chosen. Only people whose numbers are chosen are allowed to attend medical school. Grades are not considered. I think the system is different now. You apply for admission. When I went to university, this was not possible.

SW: Where did you go to school?

DD: I went to the University of Twente. I was the first student to earn a master's degree in technical medicines. The degree program combines medical technology, the basics of medicine, and the basics of administration or economics of healthcare. I completed my doctorate on eHealth implementation methods. I focused on eHealth as part of homecare for the elderly.

I asked myself, "How can we use modern technology to help elderly stay at home and remain independent as long as possible?" We found some solutions, including the personal alarm among others. We discovered that one factor that helps elderly to stay at home is whether they are connected with their environment. Do they have children living far away? Are they mobile? Do they have nurses or doctors from homecare or hospital care? We started with two applications that we run internationally. One of them is VideoCare. The other one is Home Health Monitoring. I want to create a system of blended care. Some of the contact and communication will be physical. Some of it will be virtual.

In many countries, elder care all runs much like a machine, a factory. We use the same process for everyone. For example, you indicate you need help taking your medicine. We send someone to give it to you. If you do not want someone to come to your house, you need to go to the doctor. FocusCura provides alternative methods of care. The average age of our client is about seventy nine. When we execute our model, the average age will be over eighty. About one hundred and thirty thousand people use our solutions daily in the Netherlands. VideoCare and Home Health Monitoring allow them to do some tasks themselves. Nurses and doctors then have more time for patients who need more attention.

I will tell you a story about Mr. and Mrs. Morette. Mr. Morette was seventy nine years old. He had no health problems. He lived at home. His wife, Mrs. Morette, was eighty three years old. She had diabetes and Parkinson's disease. Mr. Morette was able to help her with most tasks. Their life was normal. They did everything they wanted. Occasionally, the nurse would visit. They did not need special treatment until Mrs. Morette broke her hip. She went to a rehabilitation facility. After she came home, someone came to their house every two hours. These people cleaned, dressed her wounds, or gave her insulin. These services were all reimbursed. The Morettes did not need to pay for them. The problem was they had no privacy. They were exhausted because they had to get up and open the door so often. Also, Mr. Morette could not go out. He had to stay at home to ensure everything went

well. We changed their situation with free applications. Mrs. Morette needs to take a lot of medications. Now she can take them herself. We gave her a medication application.

SW: What philosophy do you teach the nurses?

DD: Our philosophy has two parts. One part addresses the connection we make between the call center, the person's nurse or doctor, and the person at home. This connection enables you to take your medications yourself. The nurse does not need to come to your house. She can spend her time helping another patient. For example, if a nurse has ten minutes, she used to spend five minutes with one patient and five minutes with another. If one person can take his medicine himself, the nurse can spend ten minutes at the house of the patient who needs physical attention. This is what patients want. They do not like nurses coming to their homes only to give them a pill and leave. The other part of our philosophy ensures that each patient has her own district nurse. We make this possible with VideoCare. It is available on an iPad.

SW: Is VideoCare developed for Swedish, Dutch, Danish and English?

DD: Yes. We go to other countries, as well. You download the application. Some people have the iPad installed at their house. We install it and teach them to use it. We work together with the Elderly Bond, which is a membership for elderly delivering all kind of services, like the AARP social welfare organization in the US. They have three hundred thousand members. We train older volunteers. The volunteers help other elderly to use the iPad. The application is simple. You see, it is one large button. It is user friendly, especially for the elderly. We also have a version for younger people. It is more complex. The elderly need a simple user interface. I will demonstrate. The first time I open the application, I am invited by my homecare staff to connect with them. The application connects me to my district nursing team. It holds all my relevant contacts. One care centre is responsible for me at any time. I have access to help with psychological or social problems. I can connect with my general practitioner or a physiotherapist. I have access to a pharmacist, as well. I can get my medications. I have contact with the pharmacist through a private video chat. I can add personal contacts. I can invite my relatives who live far away. The application holds all my contacts in one place. The green dot shows me they are available. A red dot means they are not available. I can chat with them through video. I also can have a group video chat.

SW: Do you provide contact with doctors, as well?

DD: No, we only offer the technology and help them implement it. They, the homecare organization or hospital provides the care itself.

SW: Do I understand correctly? You can offer the general practitioner this application on his tablet?

DD: Yes. He can also download it himself. Once he is in the system, you can connect with him. We build the network around the patient. The network enables all relevant medical professionals to be involved in the patient's care. You can see who is treating a patient. You can see when they are available. For example, the nurse will make an appointment to visit on Monday. She can see you virtually through VideoCare on Wednesday or Thursday. This is a blended care model. Mrs. Morette has a daily ten minute video chat with her own nurse. They talk about how she is doing. The nurse asks if she has any problems, including if she is sleeping well. Then she will take her own insulin. The nurse checks that she has taken it. The nurse can decide whether it is necessary to visit the house or whether the virtual contact is sufficient.

SW: Is the patient reimbursed by the insurer for the nurse's call?

DD: Yes. In the Netherlands, insurers offer the same reimbursement whether a medical professional visits you or speaks with you through video conference.

SW: Does this give medical professionals an incentive to use the video conference?

DD: Yes. We have about ninety thousand video visits like this every month. I will give you an example. Peter Marksman is a district nurse in the eastern part of the Netherlands. He helped one of his patients to dress, to wash, and to shower. One day the woman said to him, "Peter, you come here all the time. I want to do this myself. I am not confident that I can do it. Can I try?" Mr. Marksman said, "We will put an iPad in the bathroom. I will be in the living room. We will initiate the video connection. If something happens, I will be there in one minute." They did this for a few weeks. Mr. Marksman said, "I will sit in my office. We will do everything exactly the same." After three months, she could shower herself. She does not need anyone to come into her home. That is the blended version of elder care. She is happy she can do tasks herself. Most people who can take care of themselves want to

do so. They also need to know that if something happens, they can receive physical care.

In TioHundra, a nurse might drive for an hour to the house of the patient. Once there, the nurse may need to return to get information from the call center. Sometimes only the doctor is privy to a patient's information. With this service, a doctor can have more contact with a patient without going to the patient's house. This service allows a doctor to include family in a patient's care. For example, the family of a woman in TioHundra lived in Norrtälje. If a relative lives in Stockholm and the doctor wants to have the relative involved in conversation, he can set up a group call. He can speak with everyone without having to travel. Sometimes, doctors tell me they receive only five Euros to visit a patient. To drive costs more than that. The iPad also allows you to connect an extra device so the doctor can examine the eye or the ear. You can bring the specialist from Stockholm directly into the home of the patient.

SW: Do you provide this service with the use of Apple products?

DD: Yes. We are the first Apple Mobility Partner in the Netherlands.

SW: What academic partners do you have here?

DD: We work with the academic center in Utrecht. I am copromoting some doctoral students on this topic together with the university.

SW: What is your core product internationally?

DD: In the Netherlands we have five products, which are called cAlarm, cKey, cMed, cContact and cVitals. Internationally we started with the VideoCare application and the home monitoring application. A patient might have heart failure, chronic obstructive pulmonary disease, Parkinson's disease, hypertension, or gestational diabetes, for example. They get a prescription from the doctor. They download the application and might receive measurement devices like a blood pressure monitor, scale or glucose meter for instance. The application is preloaded with the actions you need to take. Today I had to take my blood pressure, my pulse, my weight, and my glucose. I need to fill out a questionnaire on chronic obstructive pulmonary disease. Then I receive a reading. I might need to take my blood pressure again or check my weight. We have devices you can connect to the iPad, including the Omron blood pressure meter. It is a validated program we developed together with doctors.

SW: Is it a Bluetooth scale?

DD: Yes. We have different versions available. You can add it manually if a patient has their own blood pressure meter. The information goes to the server. We developed algorithms that define the risk of the patient. If there is an increased risk, we notify the doctor. A yellow alarm means something is going on, but the patient is not at risk yet. An example is a reading that shows heart patient's weight is going up. A red alarm automatically notifies the doctor or the medical care center. They must react immediately.

Patients have access to their own information. They can set a goal together with their doctor. They have access to validated information on their disease. They can have information on sporting, heart failure, movies, or hay fever. We personalize the patient's information and have it ready for him.

SW: Which applications have been verified, tested, and implemented for the home healthcare monitor?

DD: Heart failure, chronic obstructive pulmonary disease, cardiovascular risk management, hypertension and amyotrophic lateral sclerosis.

SW: All of these have been evaluated rigorously with your academic partners, tested, and tried?

DD: Yes. This application is officially a medical device. It is regulated as a medical device throughout Europe. You create risk profiles based on received data. This classifies it as a Medical Device class one so therefore we have the CE mark. Also we are audited every six months on behalf of our quality and privacy according to ISO 9001 and ISO 27001. [ISO 9001 is a standard for quality management system. ISO 27001 is an information security standard.] They ensure everything is done correctly. The audit includes documentation and clinical trials.

SW: Does the healthcare inspector audit you?

DD: The healthcare inspectors can audit us. We had one audit us this year.

SW: How do you define and measure the outcomes and the successes of the applications? What indicators do you look for?

DD: We look for the quality of care. We look at a patient's quality of life and whether it is improving. We look at whether people who use this application become more independent by doing so. Our last measurement showed sixty nine percent of users reported they are more independent with this

application. Forty four percent of users reported they have fewer healthcare issues. Users appreciate someone watching over them. Eighty eight percent of users report that they would recommend this service to other patients.

We also look at efficiency levels. We look at the number of hospital readmissions. There are thirty percent fewer hospital admissions related to chronic obstructive pulmonary disease and heart failure, for example. There are close to thirty percent fewer regular hospital visits. This is a significant improvement. I think it can be even higher. We work with an older group. Thirty four percent of our people are over seventy. Thirty four percent are over eighty.

Being an Apple Mobility Partner helps us make the applications scale further. We want them to be easy to use. We want to develop a way to scale to other countries easily. For example, in Sweden we work closely with Atea. [Atea is a supplier of IT infrastructure.] We want to connect our services within their infra system so they can scale quickly. [An infra system is a system of infrastructure.] We have a list in our value chain proposition of what we need to scale easily.

DD: In addition to providing medical monitoring, we play bingo with elderly through VideoCare every Wednesday. We have many elderly who connect through this activity. They have a bingo card. They play together. They learn to meet each other. They see each other on the screen. This is an example of how we connect medical care, healthcare, and wellness in eldercare. I believe in this ecosystem. We do not introduce a medical device only. We encourage them to use it. It gives them confidence to use it for their healthcare.

SW: What role does psychology and incentive play in using this device?

DD: I earned my doctoral degree in behavioral sciences. I realized that you cannot only look at the medical side of healthcare. Our study results show that the patients do not care about medical statistics. What matters to them is that someone looks after them.

One man who uses our service will illustrate the point I want to make. His life changed when he suffered from an illness and had to stay in the hospital for some time. He had been an active man. Now, he cannot live as he used to. Once he got an exacerbation and was hospitalized for a few days. "They gave me medicine and I was there for a few days and I went home and everything changed. My whole life was changed. I was a very active man

doing training police dogs, doing the volunteer for fireman.” He said “I was so anxious of getting this again that I was not able to do anything. My wife was asking me three times a day if everything is going well. The children were calling me and I was sitting on the couch and my life was actually controlled by the chronic obstructive pulmonary disease.”

Initially, we thought users would stop using the application. They would not want to send in their measurements. But people continue to use it. Why? They feel safer now. Relatives can call patients. The application gives users certain benefits that they otherwise lack. It gives people freedom to live rather than focus on medical statistics. People want to be independent. They do not want to be dependent on the healthcare system.

SW: I think this is where many companies might go wrong in the early stages of introducing the application.

DD: They focus on the need for more variables, more data.

SW: Instead, you explain that the nurse in the hospital needs this information. The nurse in the homecare organization would work better with it. The relative would feel safer with their elderly family member using the application then not.

DD: We have learned many lessons along the way. The size of operations matters. We started with one hundred to three hundred patients. It is a different matter to serve over one hundred twenty thousand patients in the Netherlands. We need a different organization. We make processes simple and clean.

SW: Did you spend much time on the user interface design?

DD: Yes. People of a certain age need devices that are easy to use. Many have never used computers. We built a simple application for doctors, as well. It works like a car dashboard. It shows when the doctor is available. He has actions he can take. There are blue, red, and yellow flags. He can also receive messages. It also shows detailed information about a patient. It signals the alarms, as well. I can see trend lines. I can start a video call. I can start a chat conversation. The nurses can send messages to the doctors who work on a later shift. For instance, a triage nurse might have a particular concern about a patient. She might want the doctor to become involved. She can set a notification. The doctor will see it on his dashboard.

SW: Does this device connect with electronic records?

DD: Yes. We have two systems. One system makes all electronic records available. There also is a dashboard used only to monitor a patient's current status. We do not require the complete electronic medical record for monitoring. The doctor can choose which system to use. He can set up a video call and see relevant information through the same device.

SW: Is this how you filter the information before it is integrated into the system?

DD: Yes. We only present information in our dashboard that is relevant. We do not want the doctor to have to review several years of a patient's blood pressure readings. He only wants to see this information when it is relevant to him or her, not all the time.

We see a great deal of scientific research. We have a patient put all his data into the system. Perhaps nothing changes. We are interested in more than the application. We also want to change the process. We want to make it more effective and consumer friendly.

SW: Once the patient provides all his data, how does it help him directly? Can he see the data?

DD: Yes. They get feedback from their readings. They can see if their reading was a good one. When something does not look right, they can have a chat or a video call with the doctor or the nurse.

SW: It is instantaneous feedback.

DD: Yes. It is important to the patient to be able to do this, but they also want to feel that there is someone looking over their shoulder saying everything is okay.

SW: The security, the safety, the feedback,

DD: Those are the most important aspects of this service.

SW: How do you provide services to countries that are far away, including India, China or the United States?

DD: At the moment we don't provide these services in these countries.

SW: Where are the key challenges for FocusCura or your applications? What are the future opportunities?

DD: My doctoral dissertation was on the implementation of eHealth. I built a scientifically validated five stage model on how to implement eHealth in homecare. Unfortunately, it is only in Dutch. I need to translate it but in short it means that all the technology will change over time so that is not the real thing. The real thing is embedded the technology in the processes of the care organization and make sure that human services are applied whenever needed. Technology, also eHealth, is not a goal in itself. It is there to make the healthcare system better and to provide patients with certainty, contacts when needed, better care and independency. That's my mission. To realize this in a large scale for all elderly and chronically ill who need it.

We have not publicized our work because we want to have the system perfect before making it available. Opportunities are in scaling to other countries and scaling to other patient groups. On the medical side, there are opportunities to create more validated monitoring programs. We now have programs for heart failure, chronic obstructive pulmonary disease, hypertension and amyotrophic lateral sclerosis. We want to add more. We work with a doctor at Karolinska on a special disease contracted by lung patients, not chronic obstructive pulmonary disease.

SW: Perhaps programs for diabetes.

DD: Diabetes and obesity would be relevant.

SW: Thank you for taking the time to explain your VideoCare program. I look forward to seeing it adopted.

DD: Thank you, Sofia.

Background Humanitas Foundation

The Humanitas Foundation is a long established not for profit organization in the Netherlands. The organization is based in Rotterdam. The Humanitas Foundation is internationally known for Apartments for Life. Apartments for Life is an innovative elder care housing model that started in the 1990s. Staff regards apartment occupants as residents. They do not regard apartment occupants as patients. There are now more than fifteen Apartments for Life complexes in Rotterdam today. The apartments house thousands of elderly residents.

The core care philosophy of the Apartments for Life model has four tenets. The first is to “be your own boss.” This attitude empowers the residents to make decisions for themselves. Residents are encouraged to rely on themselves. They are not forced to rely on others. The second tenet is “use it or lose it.” The elderly lose their life skills if they do not use them regularly. Once lost, physical or mental abilities are difficult to regain. The staff at the Apartments for Life encourage residents to use their abilities, to build on their strengths, to learn new skills, and to take up new hobbies.

The third tenet of the Apartments for Life model is the “extended family approach.” This approach eliminates the divide between the residents and the care providers. This concept combines the knowledge and expertise of both groups. Each resident has something to offer that can benefit others. Examples include the work experience of residents, their professional skills, and personal experiences. The goal is to improve the self-esteem and self-worth of residents. The residents feel useful and appreciated. These feelings contribute to their happiness. The fourth tenet is the Yes Culture. The Yes Culture means that the staff agrees to any new idea, proposal, or request the residents make. The staff explore possibilities to find a workable solution to any challenge that arises.

The Apartments for Life model focuses on social interactions and human happiness. The model has inspired organizations around the world. The Apartments for Life complex includes a zoo, internet café, a remembrance museum, and more than sixteen restaurants. The Apartments for Life concept provides its residents with healthcare and a normal life.

About Dr. Hans Becker



Dr. Hans Becker is chairman of the Managing Board of the Humanitas Foundation. He was a professor at the Erasmus School of Economics in Rotterdam for twenty five years before joining Humanitas in 1992. Dr. Becker's "Apartments for Life" model and philosophy based on human happiness have revolutionized the social and commercial perception of nursing homes.

Interview

Sofia Widén (SW): Hello, Dr. Becker. Please tell me about your background.

Dr. Hans Becker (HB): I am an economist. I was a professor in the economics department at Erasmus University for twenty five years. I decided to change my career direction. I completed a dissertation in the care sector. I am now a professor of humanizing cure and care. Humanizing care focuses on the social dimension of care. This care model includes human interactions and happiness. This concept does not rely on just the medical and technical aspects of care.

Humanitas had twelve elder care homes in 1995. My father was eighty five years old. He said to me, "I am worried about the current state of elder care. Chronic illnesses cannot be cured, yet most elder homes focus only on the medical part. What can you do? How can you improve care?" He was skeptical about change. I realized we had to transform the core business of elder care. We had to focus on happiness. Diseases including Parkinson's and Alzheimer's have no cure. We cannot cure or prevent all illnesses or avoid death. Instead, we can empower people with a sense of happiness. This focus improves the quality of life for the elderly. That is the goal of the elder care homes at Humanitas.

SW: How did you transform the traditional elder care home model?



HB: People like to make their own decisions. They want to be in control of their lives. Nursing and elder homes do not permit that. You are given coffee only at 10 am. You cannot have it at 9:30 am. You are not allowed to drink every day. You are no longer in charge of your own life. You live in a room in an institute. The institute model is not humane. My first innovation was to make the elder care institution different from a hospital.

I named the Humanitas elder care apartments “Apartments for Life.” I wanted these apartments to provide a sense of normalcy. The Apartments for Life offer a shelter for the elderly. There, you can go to eat, to sit in the internet café, to change money, or to visit the supermarket. Anyone from outside the complex can visit. These apartments do not provide only medical and daily care. They also include restaurants, museums, and recreational activities.

I also introduced diversity in the apartments. The apartments are not just for those who are ill. We mix young and old, healthy and ill, rich and poor, homosexual and heterosexual. Forty percent of our staff are not Dutch. We have staff from forty one countries, including Morocco, Turkey, and Pakistan. The mixture of different people resembles regular life.

Finally, I wanted the residents to be in control of their own lives.

SW: Please explain.

HB: We have autonomy over daily decisions. The elderly should have autonomy as well. They do not have any in most nursing and elder care homes. The nurse or staff in charge determines which activity a patient can do. Meals and activities happen at fixed times. To drink or to eat beef is not allowed.

Autonomy gives the elderly a sense of power. Residents who have the mental capacity are entitled to make their own choices. Real autonomy comes from doing what they want even if the nurse and doctors do not agree. The elderly at Humanitas are free to live with minimum rules and restrictions. This goal is part of our core philosophy.

SW: Could you describe the philosophy behind Humanitas in more detail?

HB: We have four parts to our core philosophy: be your own boss, use it or lose it, the extended family approach, and the “Yes Culture.”

I just explained the first part of our philosophy. The second part, “use it or lose it,” encourages the residents to help themselves. The staff in most nursing and elder care homes assist you with simple tasks. They help you to bathe, to cook, to clean, and to eat. They assist with these tasks because it is faster. To help an elderly man put on a shirt is faster than to let him do it himself. There is too much care in the Netherlands.

People perceive the elderly as helpless. They think the elderly need assistance in every activity. People do not use their strengths when they receive too much care. You will forget how to walk if you sit in a chair all day. You have to exercise your legs. Too much care is worse than not enough care. Residents will forget how to do daily tasks by themselves if you always assist them. The functions that define personal independence are taken over by others. The elderly lose their self worth. They become miserable.

The new slogan of Humanitas is, "You should not care for people." This is a strange slogan for a care organization. The idea is that people care for themselves. You should assist only where necessary.

SW: How does this concept work?

HB: Our concept sounds simple. However, the elderly cannot do everything themselves. They cannot all cook for themselves. They cannot all clean their apartments without help. The elderly would become exhausted. They would not pursue other activities that make them happy. They would not have time to relax. They would not have energy to play cards with their friends. They would be tired from cooking meals. To determine which activities they should do themselves and which the nurses should help with is difficult. We need to determine who should make these decisions. People have different perspectives on how much care is necessary. A manager should determine the level of care each resident needs. These managers must combine care, perseverance, creativity, and empathy in their decisions.

We should provide for the basics needs of the elderly. We should support those who need help to bathe, to clean, and to prepare food. The elderly also need to stay active. They should have a daily plan. Doing some tasks by themselves improves the self esteem of the elderly. They have a sense of control. The residents also are encouraged to try new activities. They are given opportunities to learn new skills. We avoid any sense of limitations.

We also train our staff in the "Yes Culture." This approach allows our residents to pursue different ideas.

SW: What is the Yes Culture?

HB: A Yes Culture means to say "Yes" to any request our residents make. This Yes Culture starts a dialogue. Staff members and clients start to look for solutions. For example, a lady requests to keep five cats with her at the facility. Five cats is difficult to accommodate. However, staff are not allowed to say "No." We have a conversation. We ask her, "How old are your cats? How long have you had them?" One of her cats was twenty four years old. We agreed it should stay with the woman's daughter. One of the younger cats stayed with the woman. There were other residents in the facility who could and wanted to care for the cats. The rest of the cats were given to these residents. Now everybody is happy. That is the Yes Culture.

We do not have this Yes Culture in our society. We make recommendations to the government. If the government likes our plan, they approve it. If not, they reject it. The government does not allow for discussions. A Yes Culture starts a dialogue. Dialogues help implement ideas. They help us innovate. They help us adapt to the changing needs and values of the people.

Some people assume the Yes Culture misleads residents. I understand that not everything is possible. For example, you cannot build a swimming pool here even if the residents want one. There is no space. There is not enough money. You start with “Yes” to have a dialogue. The residents are aware of the Yes Culture. They feel empowered to make requests. The approach allows the residents to decide how to live their lives.

SW: Can you tell us about the fourth tenet of your core philosophy?

HB: The fourth tenet is the extended family approach. This approach views everyone in the facility as one big family. Each resident has their competencies, expertise, and experiences. We bridge the gap between the residents and care professionals. This connection allows everyone to share their experiences and knowledge. Shared knowledge can lead to improvements in care. We do not assume that care professionals know everything about a patient’s care requirements. A resident might have lived with an infection for years. Care professionals should listen to what a resident knows about his condition. The extended family approach acknowledges the residents’ experiences. This recognition improves the residents’ feelings of self worth, self esteem, and happiness.

SW: Please describe the biggest challenge the elderly face.

HB: Human beings are like other animals. They like to move in a herd or group. If your group is gone, you are not happy. The biggest challenge the elderly face is not the trembling hand. Their biggest challenge is loneliness. Loneliness spreads like a cancer. Groups disappear. The family is gone once you are ninety nine years old. You do not play hockey or soccer anymore. You may no longer be a member of the local country club. We need to encourage the elderly to form new groups.

SW: How do you encourage the elderly to interact and form new groups?

HB: We recognize the strong link between food and social interaction. A traditional nursing home focuses on the necessary intake of carbohydrates, vitamins, and minerals. The elderly eat their meals for sustenance. They do not eat because they like the food. What can you discuss if you do not walk well, see well, hear well, and smell well? People have trouble once they lose their physical and mental capabilities. They cannot interact with their environment. People can always talk about food, even if their bodies are weak. I built sixteen restaurants. The residents come and talk with each other over a delicious meal. We also provide simple meals for people who cannot pay much. Even a poorer person can have lamb chops on his birthday.

The slogan of the care homes was, “The bucket filled with ice and peas is as important as the nurse.” Another one was, “The small duck is as important as the doctor.” Enjoyment of food is as important as medical attention. People tend to place more importance on the nurse than a tasty meal. The tasty meal and the nurse are equally important. They each foster well-being and happiness.

SW: What else did you introduce in Humanitas?

HB: I wanted to focus on wellness and happiness. Happiness is a broad term. The concept is too abstract. I asked myself what freedom and happiness mean. I enjoy a glass of wine at the bar every day. My clients should have that same option. That realization was my first concrete step toward defining freedom and happiness. That is why I started the restaurant.

Then I focused on art. I allocated money to buy abstract art. The residents did not like it. We bought more traditional paintings. We started to make the paintings ourselves. We now have five art studios.

I also started a zoo. It has small belly pigs, a few goats, and rabbits. The zoo attracts children to the care homes. The zoo encourages them to visit their grandparents. Visits from family make the residents happy. I introduced the internet corner for the children, grandchildren, and grandparents. I started the remembrance museum. The past works as a conversation piece.

SW: Which time periods does the remembrance museum cover?

HB: We start in the 1930s. The 1970s is the last period we cover. We should venture into the 1980s. The museum encourages a resident’s friends to visit. All the attractions bring more visitors to our residents.

In the care homes, the residents complain about health issues. One quarter of the complaints are not related to medical matters. The complaints are a cry for attention. People are lonely. Visits from the nurse or the doctor are expensive. We want to attract the family to visit. Visitors make the atmosphere happy. Seeing friends and family improves the residents' health and happiness without pills and injections.

SW: Do you see the requests for medications and visits to the nurse decrease?

HB: Yes. We also want to show medical professionals that too many pills poison people. Some medication is necessary. Some have side effects. We improve the residents' happiness without the introduction of medicinal complications.

SW: Please tell me about the volunteers at Humanitas. What role do they play?

HB: The volunteers are a part of the extended family approach. We have a mix of volunteers. They are different ages. They have different backgrounds. One of our volunteers is eighty five years old. Volunteers assist the residents with various tasks. They help with grocery shopping, socialization, and basic care. We use everyone's experiences to improve the happiness of our residents. We create a strong sense of community among the employees and volunteers. They support one other, provide feedback to one other, and create improvements to enhance working practices.

SW: Is there anything you would like to change or improve at Humanitas?

HB: I would like to have more swimming pools. Swimming is good for older people. I would like to add more remembrance museums, more restaurants, fewer nurses, and less care. Access to extra benefits is good as long as we do not overdo it.

SW: Would you consider introducing new technologies?

HB: We use some technology. However, I think the benefits of technology are overestimated. Happiness does not come from technology. Many older people do not know how to use it. Technology is important. Technology is not the most effective path to happiness.

SW: Is Humanitas in other countries?

HB: Yes.

SW: What factors should we consider if we want to introduce Humanitas in Sweden?

HB: You must have the money. You also must look at the context. You must insert the model in a way that suits Sweden. You can use our model anywhere. For example, our concept is popular in China. Our website has received half a million hits on the internet from China. One of my books was translated into Chinese. This country is interested more in my extended family philosophy. There are unique possibilities to modify the model. We can adapt it to different contexts.

SW: Where does China use the Humanitas model?

HB: China does not have the Humanitas model. They know about my model. They are making their own. I was invited to Beijing and Shanghai to speak about my model.

SW: Is there any interest in Humanitas from the United States or Latin America?

HB: I visited a university in Boston. Also I went to Tokyo. I have been to many places.

SW: What are the strengths and weaknesses in the Dutch elder care system?

HB: The core weakness is the elderly homes and the nursing homes. The nursing homes expect patients to be old and frail. They do not expect people to be active. They expect patients to need extensive care. These facilities function as if they are hospitals. They become housing for people with handicaps. This is the wrong approach. Elderly homes are not meant only for ill people. People must be sixty five years old to enter a nursing home. Many people arrive healthy.

SW: Let me be sure I understand. Do you suggest we treat a care home as a home rather than a care institution?

HB: Yes. It should not be a hotel. It should be your own apartment. That apartment should have the care you need. In the Netherlands, you live in your own house until you need help completing tasks. Then they send you to a service apartment. They send you to a nursing home or to an elderly home when you need more help. The care takers in nursing homes have a patronizing attitude. You cannot do anything yourself. There are too many nursing homes.

SW: How do you feel about the Dutch elder care system?

HB: I am worried. I feel sad. This approach is ineffective and expensive. After twenty years, the Netherlands now is changing their system. Their new approach is similar to mine.

SW: Are the politicians aware of the elder care situation?

HB: The politicians focus on technical and medical services. They think elderly care requires medicine. Their concept does not include a social component. The elderly should look for the solution in social media, activities, and conversation pieces. Apartments for Life show people the importance of a focus on human happiness.

SW: Where did the inspiration for the Apartments for Life originate?

HB: I saw that the elder care sector was full of misery when I began my career. Elder care was not beautiful or compassionate. I wanted to make elder care homes like a normal home. I did not like the patronizing attitude of the care providers.

Older people are not helpless animals. They should be allowed to do things themselves. There is too much care. Care looks comforting and helpful. In reality, it patronizes the elderly.

SW: Can you live in the Apartments for Life if you have severe dementia or an advanced disease?

HB: Yes. Initially, the Apartments for Life employed some traditional nurses. They were similar to those in elderly homes. I changed the model gradually. I made the model more social. I saw the morale of people with Alzheimer's improve. However, patients with dementia cannot socialize all the time. We decided to shelter Alzheimer's patients in groups of eight. We have a cook for each group.

SW: Do I understand that Alzheimer's patients live in separate apartments within the complex?

HB: Yes.

SW: Thank you for showing me around. I enjoyed learning about your approach and your philosophies.

HB: Thank you, Sofia.



In Picture: Outside the Apartments for Life

About Roland De Wolf



Roland De Wolf is chairman of the board of directors at the Saffier de Residentie Group. Since the 1990s, Mr. De Wolf has been focused on improving quality of life options in the Netherlands for elders and particularly the most vulnerable people, such as dementia care and brain damaged patients. The Saffier Residentie Group currently has eight homes where residents can live independent lives in the presence of trained elder care staff, as well as a medical rehabilitation center.

Interview

Sofia Widén (SW): How did you find your way into elder care?

Roland De Wolf (RD): After high school I started studying information technology. I am a very mathematical person, so I thought I had to go into information technology. I hated the work, so I started to study economics at Erasmus in Rotterdam. I first started working in healthcare when I took a job taking care of some disabled people. I realized I was not meant for economics. I had to do something in healthcare. I studied psychiatric nursing, then common healthcare and children's nursing. I also studied management. When I was twenty nine years old I wanted to work as an interim manager in care centers in the Netherlands. Then I was asked to be the director of a care company here.

SW: Which care company was this?

RD: It was a very small house for elderly people. The Maison Gaspard de Coligny. It is connected to the church, the Wallonian Church, a French language church of the Huguenots, which is connected with the Kingdom of the Netherlands. My wife thought it would be good to work there because it was close to where we lived. I went there and it was half French speaking! I am a mathematics type, as you know, so languages are not my thing. Luckily, I had taken some French, so I managed it.

I started there with two projects in mind. One was to look at what happens to old people who do not live in nursing homes or service homes. The main

problem is you are afraid to fall down, to break your hip. If you break your hip, that puts you in a nursing home. Many people also fear dementia. The worst fear of all is being allowed to die from neglect. We had to address the fears of elders and their families. I thought, "How do we resolve the fear?"

We started with what we call service packages. It means we offer services to people who live independently. For a small amount of money you receive several things. First, you can use the resources in the house. Second, there is a coordinator who knows you. Not a phone number, but a person who has visited you. She sends you a birthday card every year. You know who she is. She understands your situation. That is very important. You can reach her seven days a week, twenty four hours a day. If something happens, you call. The third thing is insurance. If something happens and you cannot stay at home anymore, we have rooms here in this house. These rooms are always available. We guarantee that you will have a place in this house. That was the essence of the packages.

I always want to see if our projects are working, so we conducted an investigation with two universities, one in Utrecht and one in Amsterdam. We studied three hundred people who used our packages and three hundred people who did not. The results were remarkable. Over three years, the people who had the packages visited the doctor much less, almost thirty percent less, than the other group. They used less medicine. They even broke their hips less frequently. That was amazing. The system is all over the Netherlands now. It works.

The second thing I did was to make a difference in the way we subsidized care. In the Netherlands, care is subsidized as a total package, or it was at that time. You come in, you pay a variable amount of money to the government based on your income, and we receive an invariable amount of money as a care organization. It does not matter if you require a lot of care or not. The money is the same. I thought we needed a change. First, and this is very important, if something happens to you and you are unable to stay in your own home, where do you go: another house or a hospital with nursing care? There is a difference.

Fredrik Knoeff (FK): You do not necessarily know who is taking you in and giving you a bed.

RD: It makes a big difference. What we did in this nursing home is we changed the system. We had to obtain permission from the government because our program did not fit into the law. So people started to pay rent and service costs. They had the choice of three packages at that time. That

was 1993.

Next we said, "Your apartment is your apartment. Service is service. We have three levels of care packages. If you need help with this or that, you get fifty points to spend on extra services. Or one hundred points. Or one fifty. If you have medication and you have fifty points to spend, do you want us to bring it to you? Do you want us to clean your room? Do you want to call us?" The elders together with their families chose what they wanted for those points. If the care increased, it cost a little more.

We investigated the results over three years in this case as well. The results were equally impressive. The most important conclusion was that costs went down. If people are in charge of their own budget they spend less.

That was in the 1990s. Then we had a lot of mergers and finally became the Saffier Residentie Group. That was about nine years ago I think.

FK: How many organizations merged?

RD: The Saffier de Residentie Group now has ten locations. Eighty percent is nursing care, elderly care. We have some people with brain damage, young people suffering brain damage, and people with Korsakoff Syndrome. We are number one in Korsakoff Syndrome treatment in the Hague. We do a lot of dementia as well. In fact, that is what we do most. We also do "intramural care," as they call it now. I do not like the term.

SW: What does it mean?

RD: We have intramural and extramural care. Intramural is if you live in a care home. Extramural is if you live in your own house and we bring the care to you. There is a rift between the two in the Netherlands. The main question is always the same: How do you want to live? If you want to live somewhere else, you want to move to your own place, not to my institution where I take you on my grounds and my unit, where I am the doctor and you are my patient in my room. "And don't worry," I say to the family, "I will keep her alive."

SW: Do you view the care home as a work place or a home?

RD: Exactly. That is an important distinction. So we made a change and we built houses with apartments. People rent an apartment. They have a high need for care, so normally those people would go to a nursing home. Here they rent an apartment and get subsidized extramural care. They use their insurance for the doctor, just like everyone else. That is something I need to

explain a little bit. If you live in a nursing home in the Netherlands, your doctor is not your home doctor. It is the doctor of the institution, a specialist in elder care. So you only use your insurance if you go to the hospital or something. The rest—the doctor, the medicine, your materials, treatment, physio, all the therapies—is all included in the nursing home package. It is the doctor and treatment stream of the institution where you are taken. What we did here is make the treatment extramural: you keep your own doctor. If there is a need for an elder care specialist, you can consult him. You use your insurance like everybody else. That is what we did in this house.

Quality of life for elderly people must not be confused with quantity of life. The older you get, the more risk there is. In Europe, we typically restrict your activities to alleviate that risk. If there is a risk of falling down and breaking your hip, you are given a walker. We do not question the quality of a life spent behind this walker. Quality of life brings risks. When we are young we accept risks. If you want to bungee jump, you know there is a risk. There is a risk every time you get in an airplane, but we do it.

What is the meaning of quality of life? If you go to an institution, what we typically do is take away those things that have quality for you. Homes usually take your big books, your pet, your social circle. We believe we should look at maintaining quality of life, and learn to accept some risks.

SW: How do you do that here?

RD: We have one group of twelve people in apartments upstairs. There are no treatment areas there, only the house. We have a group of dementia patients. We have a group for somatic diseases. We have a group of mentally disabled people, young people from eighteen to twenty five and a group of forty and older. We have a group of people with brain damage, also younger. They all live together. They have their own houses. The houses are next to each other. Theoretically those houses are theirs, whereas the elderly residents can walk through the houses and floors to visit one another's apartments.

The house is full of information technology. It is not a problem for there to be only one night watchman. If someone leaves, there is a camera. You will see on your iPhone who is walking out of his apartment. We can even switch on the television in the room if we want. It has almost never happened. The doors are not locked. Anybody can walk away if they want, but nobody walks away. It has only happened once in the last eight years, when a person was lost.

So what we see is that if we put those people in normal houses with some security, their own houses, then they start to act differently. Families act differently. If you bring your mother to an apartment here, we say, "This is the apartment. You can rent it. It's yours." Then you start to put the bed in, the things in, what you want. We do not decorate your room. It is your house.

In the 2000s, the Netherlands started creating packages for living in a nursing home or an assisted living home. Now the lower service packages are not available anymore. You can only go to a nursing home or assisted living home if you have a certain level of care needs. We had ten packages. Now we have six. I think that was a good decision. People need to stay at home longer.

Do not build institutions. Never do it. Make homes for people who need care. Also, if you want the market to invest in homes for elderly or disabled people then you must not subsidize it. That is the main thing. If the government subsidizes, then the market is uninterested.

SW: So what kind of subsidies would you take away in the Netherlands?

RD: I would take away two things: One thing is medical treatment in a special law for disabled or old people with comorbidity. I would take it away and replace it with the normal insurance packages. That will give you the opportunity to take only what you need. There is already a plan prepared for that. It will happen. Maybe not next year, because we have elections, but it will happen.

The second thing is living space. By law, institutional living is now paid for with a certain amount of money. The institutions in the Netherlands are very expensive. Their booking value is very high compared to their commercial value. So for instance, a room of thirty square meters in an assisted living home costs twelve hundred euros a month. That is not a social rent. Here in this building we maintain a social rent. Everybody can rent an apartment here because I do not build any treatment areas, physio areas, or offices.

My message is this: Never build institutions to be lived in. If you intend to treat there, like in hospitals or residential care centers, then just make sure the doctors are good because people want to go home as soon as possible. If people go somewhere to live for the rest of their lives, then it must be designed for living. It must be your apartment, your house where you feel safe.

SW: You can stay there until you pass away.

RD: Yes.

SW: What kind of nurses and caregivers do you employ?

RD: That is a challenge too. When we started here the employees thought, "Okay we have two teams. One team takes care of the wellbeing of the house, housekeeping and things. They are in the house. The care comes like homecare to take care of you."

SW: Was that outsourced?

RD: No. That was also a team of us from our company. Anyway, that was the system. It went wrong. After about six or eight months, the quality of care went down. Those people are welfare workers. They are very good at making you happy, but they do not notice if you have a fever or if something is going wrong with your health. You must understand that the people who live with us are elderly. It is not for nothing that they would have gone to a nursing home. So this is not good.

We decided the medical care team should be in charge in these houses. We put the medical care in charge, the nurses and the doctors. Within three months all the doors were opened. They made their own nursing office downstairs. They made a nursing home out of it. People started to complain. That was not the solution either.

FK: That is against your philosophy.

RD: Completely. Nursing people are used to efficiency. "We must be faster. We can run through the halls. We keep all the doors open." So it was a nursing home. That was wrong. We made a competencies profile for ideal employees, then we started testing people on these competencies. About one third, almost half of the people we had could not work here. They were intramural persons, persons who need to work in an institution. They are good people, but not appropriate for this situation. We took them out, put them in other places, and put new people in.

SW: What were the competencies?

RD: There is a nice example I can give you. There is a lady who is ninety two. She is in a wheelchair. One morning she was downstairs and she said to one of the care people, "I would like to have cake with my coffee." So the care person says to her, "Okay, there is the kitchen. We can bake a cake if

you want.” The lady says, “Bake a cake? I am ninety two. You think I am going to bake a cake?” The employee says the right thing. She says, “Okay, then there is no cake.” That is it exactly. Everybody else would say, “Okay, I will bake a cake for you. You are ninety two. Stay there.” No. She says no cake, I’m sorry. Then the lady says, “Okay, I will help you.” She starts to bake the cake together with the employee. In the afternoon there was cake with tea with the other residents. The lady’s daughter was there. She complained to her daughter that she had pain in her arm because she had to make the cake, but the compliments of the other residents made her day.

Quality of life is connected with such worries. If I cannot complain about anything anymore because everything is okay and everything is nice and I am lying on my back in Hawaii on the beach, that might be nice for one week, maybe two. But then . . .

SW: You are bored.

RD: Exactly. You start to understand that complaining, having worries, is part of quality of life. When you take all the worries from someone’s life there is no reason to live anymore. If you are older and you are depending on other people for care it is already difficult. To be unnecessary for society is one thing. Being unnecessary for your children or your family, or even worse being a problem for them, imagine how that feels.

SW: I think a lot of this is driven by fear of the media. In Sweden, if you have an incident, even if it is one person in ten years getting lost or spending two hours walking on the road, then the homes have a big media scandal on their hands.

RD: Us too. If one of the residents from this house runs in front of a train, you know what it will say in the newspapers: “Mr. De Wolf does not take care of his people.”

SW: How do you communicate this to policy makers and the public?

RD: I give a lot of speeches about my vision for quality of life. Everybody my age says, “Absolutely, you are right.” But if it is your mother who lives in my house and falls down the stairs and breaks her hip or something, how do you feel?

SW: You are scared. You are angry.

RD: So what happens? Who is to blame? “My mother, why did you not put her in a chair? Why did you not lock the door to keep her from running

away? Why?" That is the discussion about risk and quality of life that we need to have. We need a big attitude change toward accepting risks.

SW: Do you think we talk about this enough?

RD: No, not enough. I am trying. The Ministry has a program called Dignity and Pride. We are one of the members of that program. Our goal is to show that we can make this cultural change. It is a change of mind about disabled people and elderly people.

There is another important fact that we must keep in mind: in ten years, more than fifty percent of the people in the Netherlands will not be working anymore because of their age. That does not mean that this group has no economic potential. If you have your pension, you can do whatever. That is why there are so many older volunteers. There are many more possibilities for them. That improves life quality. If I say to one of the people here, "You have to bake a cake every week for the other elders," that gives some meaning to that person's life.

SW: So people need expectations.

RD: Yes. It makes use of the potential you have. Do not be afraid. Do not find an excuse. Someone is ninety two or someone does not know everything . . . We have a project here with children. After school they come to the garden to grow vegetables and things together with our residents. The people with dementia in the electric wheelchairs have children saying, "Can we ride on your wheelchair?" "Yes, sure you can ride." That is quality of life, but it also brings risks that we must learn to accept.

SW: How can you show through research that you provide a higher quality of life?

RD: We did three years of investigations and research with a research institute. We investigated three things. One thing was what happens to residents who live here compared to people who live in a typical care institution. What we saw is that quality of life is higher based on what they feel. They have more worries. "To be here, I have to take care of my money." There was more complaining, but quality was higher. That was interesting.

SW: How do you measure quality?

RD: There are lists. Focus groups get together every three months to identify quality. We got together with groups from the other houses over three years. You need to measure quality over longer periods, otherwise you

do not obtain accurate values. Only forty two people live here, which is too few for evidence based proof.

Professionally, it turned out to be no more or less work than working in a nursing home. A resident is not washed better or treated better by a doctor here than in a nursing home. It is the same. For the employees who work here, the quality of work is no better or worse.

The most important outcome was that the cost and the number of employees we need is twenty percent less than in a nursing home. That was really remarkable. At only forty two residents, we thought it must be more expensive. It is twenty one percent less expensive than a normal nursing home. Why is that? We think volunteers and the families are willing to provide much more here. Expectations for what you get if you rent an apartment here are different than what you expect if you go to a nursing home.

SW: The patients' social surroundings.

RD: Yes. People are coming much more often, taking care, and supporting their relatives because they do not have the expectation that we will do it for them. In a nursing home you bring your mother and the home does everything.

SW: Do the family members like it here?

RD: Yes. It is a very popular house. It is always full. Everybody wants to live here. When you see it, you understand. Do you want to bring your mother here or to an institution? The costs are low. Your living can be subsidized if your income is inadequate, so everybody can live here. It is not just for people with money. That is also important.

SW: You are improving the quality of care and you are lowering costs while you do it.

RD: Yes. That was important. It is called a government resistant program. No matter what the government does, it will always be useful. It has value.

FK: Did you foresee that you would lower costs?

RD: No. We did not expect that. We thought it would be maybe a little bit more expensive than a normal nursing home, but with better quality. We increase quality of life. People are better off. The rest is equal to a nursing home. The staff is no better or worse, but the costs are much lower.

SW: I have heard this place described as a learning center. Can you explain that term?

RD: Of course. Basically, we learn from the mistakes we make or the things we did not think about. We write it all down and make a complete book from it. It becomes a toolbox containing three years of learning. What are the problems we are encountering? What have we changed? Do our changes work or not? That is what we call our learning evaluation. As a result, we are now making the same change in a classical nursing home and have thirty people from three different groups switched back to their home doctors: the Korsakoff Syndrome group, which is quite a heavy group, a group of younger brain damaged people, and a somatical group. Over the next three years, the whole institution will make this change. Here too, the whole change is followed and described by science.

SW: So the idea is to spread your concept.

RD: Exactly.

SW: What is your biggest challenge?

RD: To change people's attitudes about care. That is the biggest challenge. I spoke about it in Sweden one or two years ago. I tried to explain what I knew. The problem in Sweden is that everything is based on government, yet there are now commercial foundations. They see everything commercially. They see my company here as a commercial company. It isn't. It is subsidized. I explained that. They still do not believe it. They say, "No, you need profit."

FK: The Dutch system is special.

SW: You are a nonprofit.

RD: Nonprofit. Our profit is in quality of life, not money.

SW: You travel and give speeches, not only in the Netherlands but elsewhere.

RD: I try to. There is not much time for it now. Something else has happened, a mindset change in the United States. In the United States, you always have to be young, you always have to be beautiful. That is the culture. Luckily, there was recently a best selling book by Atul Gawande. Do you know the book?

SW: Yes. Being Mortal.

RD: It was great. In that book he describes the meaning of life exactly.

FK: There is another new book called Disrupt Aging. It is also contributing to the discussion of how to grow old and how we should view growing old as enriching instead of just a passing away.

RD: I think that is one of the challenges here. The other challenge is thinking about the countries who are far behind us and are now considering their elderly. If they start to build nursing homes, they are making the wrong decision. We should teach them what we have learned: Do not build institutions. Build homes where people can live with the problems they have.

SW: Is there a difference between individuals who suffer from dementia and those who suffer from a somatic disease?

RD: In fact there is not a difference. I will tell you why. With dementia you need to look at what you need. If you lose your ability to communicate or to live independently, then you need a secure area. You feel better if you are together with people who help you. My mother has dementia. She still lives at her home. I pick her up every day. She knows that. I come inside, she plays piano, and so it goes. It has worked for five years. She needs a steady, safe situation. That is her home, including her music room with the piano where she still plays everyday for at least four hours. It drastically improves her quality of life. But her short term memory is gone and she needs help too. Of course, there is a risk that she will fall or get lost, but going to a nursing home will take away her piano and musical life for the most part, which is so important to her. So I accept the risks. That applies to everybody. A safe situation is important, but always in relation to the quality of life and its risks. Let's not lock up the elderly in a hospital and keep them alive as long as possible to let them suffer forever. Focus on quality of life as experienced by the person and accept the risks.

FK: You should not feel locked up.

RD: Exactly.

SW: Thank you for your time.

Introduction

This is a summary of an interview with Jos de Blok, founder and chief operating officer of Buurtzorg, and the transcript of an interview with Gertje van Roessel, a nurse coach and international coordinator at Buurtzorg. The interviews highlight the Buurtzorg philosophy and working methods in homecare management. Buurtzorg methods are being replicated worldwide.

Buurtzorg Nederland is a not for profit homecare provider with a reputation for delivering high quality and affordable elder care services. Buurtzorg means “neighborhood care” in Dutch. Buurtzorg is centered on neighborhood resources, including family members and neighbors.

Buurtzorg was founded in Almelo, the Netherlands, in 2007, by a small team of nurses and has grown rapidly. As of October 2015, eight thousand nurses, organized as seven hundred teams, care for sixty five thousand patients. The organization is expanding into other countries, including Sweden, the United States, and Japan. Many other Dutch homecare organizations are adopting several aspects of the Buurtzorg care model.

Buurtzorg provides patient centered care. Buurtzorg focuses on the needs of patients and patients’ resources and networks. Buurtzorg also relies on professional staff, especially nurses. Buurtzorg nurses work in teams of ten to twelve nurses. Nurse teams are self governing. Each nurse is a manager. The lean model of the organization is one of the keys to its success. Overhead costs are around eight percent. In 2012, Buurtzorg ranked first among all homecare organizations in patient satisfaction in the national quality of care assessment.

Buurtzorg was also named the best Dutch employer in 2011, 2012, 2014, and 2015 by Effectory, a company that collects, analyzes, and uses feedback from employees and customers in the Netherlands.

Buurtzorg generates surplus income, which is used to fund innovation and expansion. One of the core principles of the care model is to unlock a person’s own abilities to care for him or herself. Care is considered a success when patients care for themselves and nurses are no longer needed.

About Jos de Blok



Jos de Blok is a trained nurse. He holds a degree in healthcare innovation and recently received a Master's in business administration. Mr. de Blok has a long history in community nursing, both delivering care and in management positions. From 2000 to 2003, he played an important role in the National Association of District Nurses. He led a movement by community health nurses to take responsibility for their own professional development. Mr. de Blok worked to create a clear vision of the role of nurses in primary care.

In 2007, he established Buurtzorg, together with his team of four professional nurses. In 2011, Mr. de Blok was named the most influential healthcare leader in the Netherlands. That same year, Buurtzorg received its first award as the best employer in the Netherlands by Effectory. Mr. de Blok has transformed home based healthcare in the Netherlands. Today, Buurtzorg has grown to nearly eight thousand nurses, with teams in the Netherlands, Sweden, Japan, and the United States.

The Buurtzorg Philosophy

In the words of Mr. de Blok, “the idea of neighborhood care is to mobilize existing resources to create ecological systems of self supporting environments. In these environments, professional care is the only care people need. The focus must be on sustaining these dynamic networks.”

Mr. de Blok described the core values of Buurtzorg: “What we try to do is quite simple. What is important in healthcare? When people suffer from a handicap, impairment, disease, or other healthcare problems, it should be easy to receive support.” He continues, “We

need competent doctors, nurses, and healthcare professionals. The initial idea of Buurtzorg was to focus on the quality of life and quality of health of people, and the cost per client. If you have some sort of norm for quality of life, then you can judge what is a reasonable cost per client.”

Mr. de Blok explained, “Quality of life can be complicated. I try to make it easy. Quality of life is what gives people satisfaction and empowers people to take care of themselves. Quality of life comes when people have enough social contacts and people in their environment. Buurtzorg helps people to achieve a high quality of life. We focus on interventions that empower people to take care of themselves.

Self care leads to fewer hours of inpatient care. We work with educated people who create dynamic networks in their neighborhood.”

Of his unique approach to his workforce, Mr. de Blok said, “We need to provide healthcare staff with enough freedom to do what they think helps people. We need to work together. The current problems in healthcare are nothing that one person can solve independently. I try to involve everyone, including patients and nurses. If several people in one neighborhood struggle with the same problems, we may develop collective programs to support these people. I think we started an important process that led to an international discussion on how we are doing this.”

According to Mr. de Blok, the important thing is to simplify the healthcare system. “Try to see the relationship between someone who needs something and someone who gives something. Healthcare happens in this process. I recommend that you read the book *Reinventing Organizations*, by Frederic Laloux. This book will help you to understand the simple healthcare process¹. Mr. Laloux writes from an organizational perspective. He believes that the current way of organizing leads to a lot of problems. Society needs grassroots thinking. The focus should be on the operations. *Reinventing Organizations* describes how this practice developed into a higher level of consciousness, organizing with different membranes of self management. The book is a best seller and sold all over the world. *Reinventing Organizations* is one of the best books on this topic.”

Mr. de Blok continued, “In my opinion, hospitals must shift their focus from service delivery to management. This shift in focus has proven

¹<http://www.reinventingorganizations.com/>

successful in healthcare organizations that have adopted my philosophy. I met with six chief executive officers. It is important that the chief executive officers have been nurses because they understand what healthcare is about. They have support from their staff. Other chief executives officers lack this credibility. The solution is to simplify healthcare organizations. If you are creative and connect social problems, then you can provide healthcare.”

Mr. de Blok explained the simplified organization of Buurtzorg: “We disconnected the financial part from the professional part. We do not get paid for everything we do. Instead, we created an organization where the revenue is enough to cover all necessary costs. We are structured differently compared to other healthcare organizations. Our organization is flat, with fewer levels of hierarchy and lower overhead costs. At Buurtzorg, the overhead costs are eight percent, compared to twenty five or thirty percent at the average healthcare organization. We only have well educated healthcare workers. Our staff members design their own care methods based on what they see in the community. Our staff members each have skills in different methods. As a result, we can spend more money on the education level of nurses. We can also spend more time on networks supported by internet and social media. We can provide healthcare to everyone, even to people without insurance or citizenship. We help people. Now, many refugees are coming to the Netherlands and Europe. We will help them as well.”

Mr. de Blok spoke about the big picture and his plans for Buurtzorg: “It is our responsibility to contribute to better healthcare. In the Netherlands, Buurtzorg reaches fifteen to twenty percent of the population. Soon, we will reach fifty percent. It is just a matter of time. We do not need to set targets. We expand to nearby villages, cities, and neighborhoods where Buurtzorg is present. We are continuously expanding in the Netherlands as well as abroad. We want to provide the best homecare support. Thank you for taking the time to understand our care.”

About Gertje van Roessel



Gertje van Roessel is a nurse coach and international coordinator at Buurtzorg. After receiving her Bachelor's degree in nursing, in 1983, from the University of Nijmegen, she began her career as a nurse for a psychiatric hospital in the Netherlands. Ms. van Roessel also completed two postgraduate degrees, the first in healthcare innovation and the second in healthcare management. She later worked as a community nurse in the northwest region of the Netherlands and as a care manager for different private organizations. Ms. van Roessel joined Buurtzorg in 2007.

Interview

Sofia Widen (SW): Tell me about your professional background.

Gertje van Roessel (GR): In the 1980s, I wanted to become a district nurse. A district nurse is a nurse with specialist training, while a community nurse works at a patient's home instead of at the hospital. It was difficult in those days. It is hard to imagine that today because of the shortage of district nurses in the Netherlands. Instead, I started to work as a community nurse for about seven years. When I think back to my time as a community nurse of the 1980s, I realize that the district nurses at Buurtzorg work in a similar way today.

SW: Do the district nurses at Buurtzorg work similarly to the community nurses in the 1980s?

GR: My work as a community nurse was simple. We had our autonomy. We worked in the small neighborhoods. We had our colleagues. The management team was located far away. The management team left us alone without a lot of rules and regulations. Instead, we arranged our work for ourselves. Families, doctors, everybody knew us in the village. We involved and maintained close contact with the whole neighborhood.

Afterwards, I saw changes over the years. More organizations with community nurses merged and became bigger. The frontline people lost contact with the organization and struggled with the new administrative work. Nurses spent less time on what they were trained to do. We needed to think more carefully about the needs of patients. I saw increasing fragmentation of nurses' responsibilities. Early in my job, I saw assistant nurses replacing experienced nurses. The assistant nurses took care of intakes, assessments, and official partners. The experienced nurses did the planning. The nurses with more education spent less time with the clients. The management team thought the experienced and highly educated nurses were better at desk work and coordinating the assistant nurses. The less educated assistant nurses did all the work with the patients.

When assistant nurses were brought in to replace the experienced nurses, patients suffered. No one was responsible for the whole care chain. The assistant nurses were not educated to see the whole care system and needs of a patient.

This setup was very expensive for society.

SW: What did you do after working as a community nurse?

GR: I worked as care manager. In the Netherlands, there are many ways of describing managers in healthcare. I was a head nurse, team leader, and manager. All those words describe the managerial role. The organization I worked for had 150 employees, when I started. When I left after twenty two years, the same organization that had grown to twenty three thousand people. All care organizations moved, merged, and became large entities. I think this growth was typical for that period in the Netherlands.

SW: Were these private organizations or public?

GR: Those were private not for profit organizations paid for by the government.

SW: Did you work with Jos de Blok during that period?

GR: Yes. We worked together, but I was unaware of it at that time. Mr. de Blok worked at the psychiatric hospital, twenty five years ago. Afterwards, he worked at a large homecare organization in the east of the Netherlands. This organization was different than the one I worked at, but the two organizations were often in contact and exchanging knowledge. We met each other a few times. In 2007, he founded Buurtzorg and asked me to come over and work as a nurse coach. This was an exciting offer, which I accepted.

SW: Who came up with the philosophy of nurse coaches?

GR: Mr. de Blok came up with his own model. In this model, self organizing teams replace management. Mr. de Blok invented the role of nurse coaches. This important role supported and assisted the self organizing teams. At the start of Buurtzorg, all of these teams had a nurse coach.

SW: What is the role of a nurse coach at Buurtzorg?

GR: The nurse coaches assist and support the teams. Nurse coaches advise the teams in their making decisions processes. The role of a nurse coach depends on the needs of the team. If the team is new, the nurse coach plays a more active support role than for more mature teams. Many times, the teams ask their nurse coach for advice.

SW: How many nurse coaches does Buurtzorg have today?

GR: Today, around fifteen nurse coaches work at Buurtzorg. Every nurse coach handles a region in the Netherlands that contains around fifty teams. As a result, nurse coaches travel a lot. I started to work as a nurse coach in Amsterdam and the surrounding region.

SW: What are some of the most rewarding and hard parts of coaching?

GR: The rewarding part is that it is amazing to be able to visit the teams to see how they work. It is beautiful to see what the teams are doing and how they stay in contact with the patients and the whole network around the patients and to hear the patient view on the care process. The professionals in the teams are great at arranging the whole care process and taking care of their patients. They find solutions that I think managers and policymakers would never have found. At Buurtzorg, we

give the freedom, the space, and the trust that the teams need. We do this without saying, “Well, you are on your own.”

It is rewarding to be a part of the teams’ care process and help them to find their way. The best working style for one team might be different from that of another team. These differences are sometimes also what makes my job difficult. To work as a nurse coach limits your ability to help teams in their decision making process. You cannot decide for the teams. When I see the teams struggle, I want to help them. I want to make the right decision for them, but it is not up to me to decide. These situations are sometimes difficult.

I see Buurtzorg as a whole team, from the back office to the nurse coaches. As a team, we all try to support the self organizing teams so that can give the right care to their clients. As a result, the clients are able to live life as autonomously as possible.

SW: What are some of the characteristics that can help a nurse coach in his or her role?

GR: To be curious, friendly, and interested in people. It is also important to be able to look and listen to a team and to refocus on a care process without judging. The ability to stay in contact with and build up a relationship with the teams is also important. This team relationship is very important within Buurtzorg.

One of the first books that Mr. de Blok wrote about our model concerned building up relationships and then providing care. Before the teams care for a new client, they have a coffee together with the patient. Coffee is important in the Netherlands. Coffee is an important way to socialize and stay in contact with people. To drink coffee together builds trust in the team-client relationship. The coffee time shows the patients that we take time for them and that the team is there for them. The team and client have time to connect with each other. To build up relationships are what the teams do with their client and families. This relationship building is the same that a nurse coach is doing with his or her team.

SW: Do you train other nurse coaches?

GR: We train new nurse coaches on the job. We had two new colleagues in the last six months. We trained these new nurse coaches on the job. The new nurse coaches join the more experienced nurse coaches at work. We discuss different situations and how we help the new nurse coaches to find their own ways. The best working style for one nurse coach might be

different than for another nurse coach. Just as I talked about before, when we help the teams find their ways. It is important to find your own way because, as a nurse coach, your work has to fit with you. There is no one way to how we work at Buurtzorg.

SW: Do you also receive training by external organizations?

GR: Yes. The organization we cooperate with is called the Institute for Cooperation Affairs². They train all of our teams and coaches at Buurtzorg.

SW: What kind of training does the institute offer?

GR: The Institute for Cooperation Affairs trains us on how to communicate, how to work together, how to work in a self organizing team, and how to arrange and structure meetings. We use solution driven interaction methods. These methods are important when making decisions based on consensus. This is a process that the teams use to reach decisions. These decisions relate to the care that they give. The institute trains all teams and nurse coaches at Buurtzorg in this method.

SW: If you have a self organizing team of six to twelve nurses and a nurse quits, who hires the new nurse?

GR: The team. It is also up to the team to decide how to design the recruitment and interview process. I used to be responsible for fifty seven teams. I saw fifty seven different ways of recruiting, planning, and arranging interviews. Some teams invite a potential nurse to come over for tea or lunch. Others invite them to join a nurse and visit the clients before their interview. The recruitment process has to fit with the team. The teams can also ask their nurse coach for advice or to join an interview session. The nurse coaches only advise and train their teams.

The nurse coaches never decide on a new colleague for the team.

SW: Do you usually hire younger nurses or rather more experienced nurses?

GR: We prefer a mix, but we seldom have the luxury of hiring whomever we want. We often advise the teams to make a recruitment profile for a new team member. The team composition and experience is important to define before identifying a new profile.

SW: Do the nurses work alone at a patient home or do they work in pairs?

GR: Our nurses always work alone, except during special or complex occasions. The nurses feel like part of a team. The clients also say that a team is taking care of them.

SW: Does a nurse have access to an in house doctor that he or she can consult over the telephone?

GR: Yes, but they are not in house doctors.

In this neighborhood, for example, there is a team just around the corner. When the nurses start to work in a new neighborhood, they must first contact all of the general practitioners in the area. These nurses make sure to visit all the doctors, by introducing themselves and explaining how Buurtzorg works. This introduction is very important, since the general practitioners often provide care for the clients. The nurses also give the doctors their phone numbers. The doctors can then call the nurse in case one of their patients needs homecare. Once the nurse is responsible for the homecare of a patient, the nurse contacts the general practitioner when needed.

SW: I think Buurtzorg has succeeded well in care coordination with doctors.

GR: Yes. What we see in Buurtzorg is that the nurses connect with the doctors when necessary. When the nurses visit their clients, they only call the doctor if it is urgent. The doctors know our nurses. The doctors know that the Buurtzorg nurses will only call them for important reasons.

SW: Do you share patient records with the general practitioner?

GR: Yes. We share information, but not electronically. We are still waiting to adopt digital information sharing.

SW: Is it the same for the emergency hospital? If one of your clients has an urgent visit to the hospital, do you know what is happening at the hospital? When the patient then returns back home, how does that communication work?

GR: Yesterday, for example, I had a meeting with a community nurse. She told me that the day before, she visited her clients. During her visit, she noticed that something was wrong with the patient. She ran all the tests on the patient and then called the doctor. The nurse and doctor talked and had a good discussion. The doctor then called the hospital to discuss the case with the doctor at the hospital. Five minutes later, the doctor phoned the nurse back and said that he had already sent an ambulance.

The nurse then informed the patient and the family about the situation. The nurse also prepared all the necessary patient information. She called the pharmacist and asked for the patient's list of medications. The patient then went to the hospital, while the nurse kept in contact with the family. The next day, the nurse visited the hospital to exchange information with the hospital staff. The nurse kept the family informed. She also stayed in contact with the hospital because the client would soon come home again and shift to her responsibility.

I think this coordination is a key strength of Buurtzorg. This strength turns into a weakness in many other care systems that we looked at. It is wrong saying that hospital care is the responsibility of the hospital and home is our responsibility. It is also important that the nurses feel the freedom to maintain contact. In other organizations, the nurses know that this contact is important. However, they are dependent on the set budget. The budget limits the nurses. They are only able to only do things that are chargeable. You are not allowed to visit the hospital to exchange information or to gather information about a potential client.

A hospital might call the nurse regarding a potential client that might go home and will need care. At Buurtzorg, the nurses visit the client at the hospital if it is necessary to meet with the potential client and his family. The nurses can then prepare what is needed before the patient goes home. This process keeps the family relaxed when the patient comes home. The preparations also give the nurse a good picture of the client's needs. The nurses have time to explore the whole situation, to know what is needed, and to prepare this once the client comes home. Nurses in other organizations can only make these preparations after the patient responsibility has shifted from the hospital to the homecare organization.

SW: You work with neighbors, family members, and other people who are close to the individuals at home. You call this the person's network. The nurses know the neighborhood. What are examples of those resources that you unlock around the person at home?

GR: At Buurtzorg, we work on self management for all our clients. We also look at neighborhood resources. We empower our clients. We believe that autonomy is important. We are not there to take over and paralyze the regular routines of the client and her family. From the beginning of our engagement with a new client, it is clear for us how we will work. If the client's children are away, we call the children and ask the client to invite one of them to our next visit. It is important for the children to visit their

parent at home to see what they can do and to understand how they are involved. We then explain to the children what we are doing, what we will be doing, and how we would like to stay in contact with them. It is important to build a relationship with the family during those first weeks. At Buurtzorg, we take time and effort to get to know the client, which people are important in his or her life, and who might be supportive.

SW: Do you talk to neighbors?

GR: Yes, if necessary. We ask the client for permission first. We ask if they are close with their neighbors, with someone at church, or with people from a club. Sometimes, the nurse also looks in the street or in the neighborhood for someone who can provide care. The nurses must be creative. The longer a team handles a neighborhood, the more they build up this network of neighborhood care. The team knows how their clients live and who cooks for them every week. One person might cook some extra food and bring it over to the client or even drive the client to the hospital. This is how the team maintains contact in an organic way.

SW: At a patient home, the assistant nurse might shower the patient, while the nurse looks at a bed sore. A physical therapist might train the muscles of the patient, while a dementia nurse cares for her medications. Do the nurses at Buurtzorg do all that?

GR: Yes. Our nurses do most of it, but they are not physical therapists. I think it works differently in the Netherlands than in other countries, where nurses are also trained in physical therapy. At Buurtzorg, nurses are not trained in physical therapy. Instead, all of our nurses are generalists. In fact, all people that work for Buurtzorg are generalists. In our teams, there will always be someone responsible for the morning visit and showering as well as taking care of the wound. There might also be someone in the team more trained or more experienced in dementia, for example. This person might then be the one responsible for a client with dementia. This responsibility does not prevent the other nurses from visiting the client with dementia. Instead, the responsible nurse might be the one to train the colleagues regarding the situation.

SW: Is it always the same nurse that visits a client?

GR: No. The only exception might be if a client needs advice once a week or once every two weeks. However, most of our clients need more regular care. For visits three times a week, every day, or twice a day, different nurses will come to the client's home. The number of different nurses visiting corresponds to the size of the team, which is, at most, twelve

people. The maximum number is usually around seven for clients that need care twice a day.

SW: If the nurses do all these different tasks, they must be humble. Have they ever refused to do a specific task, for example, shower a patient?

GR: I do not think it is humility. What we see is a part of nursing. To shower a client is equally important as a complex technique. The nurses are aware of this, so for me, it is not about humility.

SW: Is that attitude something you see all over your country? Do nurses with that attitude exist all over the Netherlands or is it unique for Buurtzorg?

GR: I think it is a fundamental attitude of every nurse. However, this attitude has disappeared throughout the years. Today, the whole care system with its organizations direct the Bachelor nurses and district nurses to a position in which they only perform technical tasks. The organizations view these nurses as too highly educated and expensive to do the more simple tasks. These nurses end up at the office. It is important to take a holistic approach. At Buurtzorg, we look at the whole client and the client's well being. I think it helps the nurses to go back to the fundamental way of looking at their profession.

SW: Does the educational system also contribute to this wrong attitude?

GR: Maybe. It might be helpful if the educational system changes. Today, the Bachelor nursing education almost neglects the real fundamental care. Instead, nursing education is more about managing or other parts.

SW: You talk about the autonomy and the professionalism of the nurses. You also mentioned the continuity of care, with only seven people visiting a patient. This fundamental care increases the quality of care, but it also impacts costs. At Buurtzorg, you managed to lower or at least maintain the costs. How is that?

GR: What we have seen is that we are less expensive. We are less expensive since we take time to build relationships. It takes time to build up a relationship in the beginning of a client's care process. We spend more time, but we also save more money in this client situation. As a result, we know how to work on self management for the client. We also know how to reduce time, costs, and keep the care level low. That is an important factor to lower the costs.

We also have our small teams with highly educated nurses. These nurses work together and keep each other updated. These small teams prevent unnecessary client visits. In other organizations and teams, I know that unnecessary client visits happen quite often. These teams rarely contact each other to exchange information. The teams detach their own nurses from situations and keep them uninformed. The nurses become strangers to their own clients. The nurses only receive their schedule for the evening and make sure to do their own tasks. If their task is to change the bandage, they do the task without looking at the wound.

In these teams, there is no communication, no interaction, and no helping each other. In the long run, this way of working is more expensive than the way we are able to work now at Buurtzorg. We are well informed and know each other. At Buurtzorg, we know that our nurses react if they see something is wrong with the client. In the example I gave earlier, with the nurse who visited its client, as she entered the house, she noticed there was something going wrong with the client. This nurse knew her client and reacted appropriately to the situation.

Our small teams also lead to fewer unplanned readmissions, which makes the Buurtzorg model less expensive. Our more highly educated nurses know what is going on in their teams. This information helps them to contact the general practitioner at an earlier stage. If the nurses note that something is wrong with the patient, they can intervene and see what is needed. The nurses can then ask a general practitioner to come over or do whatever is needed. If they instead wait to intervene, the client will most likely turn into an unplanned readmission.

SW: Can you tell us about your upcoming work as an international coordinator for Buurtzorg?

GR: Yes. About one year ago, Mr. de Blok asked me to think about joining as international coordinator at Buurtzorg. I was a nurse coach from Amsterdam that liked to host international guests. My job helped the international arm of Buurtzorg to grow organically. People from abroad stayed in Amsterdam and wanted to visit Buurtzorg. As a nurse coach responsible for this area, I enjoyed hosting international visitors and telling them about Buurtzorg. That is how I grew into the position as an international coordinator. I combined my role as nurse coach and international coordinator. I recently decided to go full time with the international arm of Buurtzorg. This was a big decision for me. As a nurse coach, I love to meet the teams, to be together with them, and to hear

about their experience and processes. On the other hand, globalization is moving so fast that it is amazing. I want to be part of that global move. I am happy about my decision to go full time in the international work.

It is Mr. de Blok who is on the frontline of our international work. International organizations and governments invite Mr. de Blok as a speaker to explain why and how he started Buurtzorg. He is a visionary who enjoys traveling. He works on the frontline of Buurtzorg. Once he spreads the philosophy of Buurtzorg, I step in to coordinate and follow up, as much as possible. I can see that we are entering a new stage. We have invested for years. We worked hard to explain who we are, what we did, and what we are still doing. Now, we must take a concrete step. Some countries want to start projects or have already started projects with Buurtzorg. We must think about building up social platforms, franchising, joint ventures, and trainings. We had to make a training program for these new projects. This next step for Buurtzorg is exciting. It will be interesting to meet new people from other cultures and see how we can help each other without copying too much. I think it will work.

SW: Was the strategy of Buurtzorg from the start to expand internationally?

GR: No. People wanted us to expand. I think that is how Buurtzorg works. We do not have global strategies or structured plans for the next five years. I think our future will come naturally. All the interest from abroad surprised us. Buurtzorg grew through the many publications and writings about our model and philosophy.

SW: Please talk a little bit about the global expansion. Where is Buurtzorg present right now?

GR: We have invested in the United States, where we work with a small team in the city of Stillwater, Minnesota. We also have two teams in Sweden. A Swedish couple that used to live in the Netherlands started the two Swedish teams under the name Grannvård³. The wife used to work with Buurtzorg in the Netherlands. She had an idea and asked us if she could start a team in Sweden. That is a great example of how we work in Buurtzorg. People feel the freedom to contribute new ideas and to see how it works. That is how Grannvård started in Sweden.

SW: Did Buurtzorg also invest in Grannvård? What other investments have you made?

³An interview with the founders of Grannvård is soon to be published on ACCESS Health.

GR: Yes. Buurtzorg invested in Grannvård, but I see Grannvård as the investment of the founders. The wife invested her time. To start two teams in another country requires twenty four hours, seven days a week. We also invested in Japan. Its start is another example of a successful information exchange between a Japanese professor, Satoko Hotta, and Mr. de Blok. After a few years working with a Japanese organization, we started the Orange Cross Foundation in Tokyo⁴. We started this project for a year. Forty five organizations signed up for the project. Every organization worked on a transition plan. We tried to help by going through the transition plan and providing training on how our model works. Last night, I got an email from one of the team members in this project. He was very proud to announce the launch of his first Buurtzorg team in Japan. This is great news.

SW: How many teams are there now in Japan?

GR: This was the first team to start. We have forty five organizations in the project. The next step is for the organizations to ask for a license at the Orange Cross Foundation. Then we will continue to train and advise them. Last week, we had a group of thirty people visiting us at Buurtzorg for a week of training about our model and experience.

SW: Where do you have that training? What type of training do you offer?

GR: This time, our Japanese visitors stayed in a small Dutch city for a week. We created a training program for their visit. The aim of the program was to share the experience and practice the daily work of Buurtzorg. We have many teams in the host city. The program also included three days of joint team activities. The care group from Japan received more practical training since they were more informed than other guests. After the first few days of joint team activities, the group from Japan understood our concept. They understood the client center, the freedom for our nurses, the trust in our teams, and the relationship building.

SW: How does the training of practical experience work? Do you have someone in Japan who trains them as well?

GR: Yes. The Japanese professor, Ms. Hotta, is adapting the Buurtzorg model to the Japanese context. She does a great job and is important to the whole project.

⁴<http://orange-cross.org/>

SW: How do you think she bridges your model? What are the critical elements of the model that she translates into the Japanese context?

GR: She is well informed about the whole Buurtzorg model. Sometimes, when Mr. de Blok and I hear her talk, we say she knows better than us about how the model works. That is important. She is also a clever lady. She is knowledgeable about the Japanese context and healthcare system. In Japan, she is a leader on aging. She can translate our model into their situation. This bridge helps the healthcare organizations to apply the Buurtzorg theory with its fundamentals in Japan.

SW: Do you work in any other country in Asia?

GR: Yes. We are exploring opportunities in Singapore and South Korea. We are close to receiving a grant in South Korea. We are in contact with both the government and organizations interested in starting teams with us. In China, we have a small first team located in Shanghai.

SW: Does Mr. de Blok travel much?

GR: Yes. He travels in Asia and through Europe. He travels around to network. Mr. de Blok does an amazing job. He is great at building up a whole network. He looks for the right people to collaborate with in the different countries. The network helps him find models to start up.

SW: Are you the person who maintains contact with everyone in the Netherlands?

GR: Yes. I work in collaboration with Mr. de Blok. I follow up his work and help him with what he needs. I also prepare the training sessions we talked about. I am the one who keeps in contact with everyone. I also think about potential contacts for Buurtzorg. That is my role for now. The international arm is new for us. We are exploring my role step by step see what is needed. We do this in close contact with Mr. de Blok. It is important to know what he thinks is right, where he wants to go, and what he needs help with.

SW: Thank you so much, Gertje, for sharing your experiences at Buurtzorg.

GR: Thank you, Sofia!
