The Buurtzorg Nederland (home care provider) model

Observations for the United Kingdom (UK)
Purpose of this briefing

This briefing considers the successes of the Buurtzorg community care programme while also identifying some of the challenges which this model has encountered and which would need to be addressed if the UK were ever to adopt a similar system approach.

The findings contained in this briefing have been informed by a number of leading nurse stakeholders in the Netherlands with whom the RCN has formal contact.

An introduction to Buurtzorg

What is it?

Founded in the Netherlands in 2006, Buurtzorg is a unique district nursing system which has garnered international acclaim for being entirely nurse-led and cost effective. The latter point has sparked particular interest in the UK where a key challenge is meeting the needs of an ageing population increasingly susceptible to co-morbidity and complex long-term conditions.

Buurtzorg was set-up by Jos de Blok (himself a former nurse) who envisaged a reformed district nursing system in the Netherlands. Prior to Buurtzorg, home care services in the Netherlands were fragmented with patients being cared for by multiple practitioners and providers.

Ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce who were unable to properly care for patients with co-morbidities, leading to a decline in patient health and satisfaction.

Buurtzorg’s answer to this problem was to give its district nurses far greater control over patient care – a factor which it attributes as key for its rapid growth. In 2011, Buurtzorg employed nearly 4,000 district nurses and nurse assistants across 380 teams. By 2013, this had risen to 6,500 nurses (an increase of 62.5 per cent) across 580 teams.¹

How does it work?

Nurses lead the assessment, planning and coordination of patient care with one another. The model consists of small self-managing teams of a maximum of 12 professionals (comprising both nurses and other allied health professionals). These teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients.²

The composition of these teams in terms of specialty and level of practice varies according to the needs of each catchment area.

In the Netherlands, integrated care has been cited as easier to deliver because district nurses tend to be well known in the small neighbourhood/community they work in. This has helped them to build good working relationships and strong dialogue with GPs, home doctors, police, paramedics and social care providers.

What services does Buurtzorg provide?

The Buurtzorg model comprises six key services. These are:³

1. Holistic assessment of the client’s needs which includes medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment

2. Map networks of informal care and assess ways to involve these carers in the client’s treatment plan

3. Identify any other formal carers and help to co-ordinate care between providers

4. Care delivery

5. Support the client in his/her social environment


The aim of this approach is to engage three key national health priorities:

- Health promotion,
- Management of conditions, and
- Disease prevention.

---

³ Ibid
Buurtzorg cares for patients who are terminally ill, suffer from long-term conditions, dementia or require home care following major surgery. Most of the nurses who join Buurtzorg are trained at a ‘generalist’ level – similar but not directly equivalent to a UK Registered Nurse in Adult Care. This allows them to deliver treatments from wound care and diabetes monitoring to IV infusion therapy and end-of-life care. Importantly, unlike in the UK, there is no formal district nursing qualification in the Netherlands.

Buurtzorg’s successes

Buurtzorg has achieved some notable breakthroughs, particularly in the following three areas (each of which is explored in more detail in this paper).

- Higher levels of patient satisfaction
- Significant reductions in the cost of care provision, and
- The development of a self-management structure for nurses.

Importantly, it’s not just nurses who have noted the positive impacts of Buurtzorg. While better patient outcomes are the most notable of its successes, Buurtzorg has also drawn attention from politicians and other health workers as a money-saving model.

On higher levels of patient satisfaction:

- Buurtzorg has delivered improved quality of patient care through 24/7 access to a district nursing team via phone or a home visit service. Results have shown a correlated decrease in unplanned care and hospital admissions, as well as better patient satisfaction when compared to other home care providers in the Netherlands.

- In 2009, the Netherlands Institute for Health Services Research (NIVEL) found that Buurtzorg had the highest satisfaction rates among patients in the country.

- As of June 2014, the University of Minnesota is finalising a design for a Buurtzorg pilot model with funding being provided both by the university and by state/federal health authorities as part of the Affordable Health Care roll-out. Buurtzorg’s patient satisfaction rates were a key incentive for this project being undertaken.

4 Ibid
5 Ibid
On reducing the costs of care:

- By limiting managerial structure and bureaucracy, Buurtzorg’s nurses have greater autonomy to organise their own client visits and day-to-day nursing interventions. This has immediately reduced administrative costs and time spent on paperwork.

- A 40 per cent reduction in client costs when compared to other homecare organisations, indicating a potential national savings of €2 billion euros (£1.9 billion) per year\(^8\)

- A 50 per cent reduction in hours of care due to health promotion initiatives and promotion of self-care and patient independence\(^9\)

- Buurtzorg’s overhead costs are estimated at eight percent, compared to a competitor average of 25 per cent\(^10\)

- Despite being a not-for-profit organisation, Buurtzorg registered an 8 per cent profit margin in 2012\(^11\)

- In terms of staff efficiency, sickness rates for 2012 were three per cent, compared to a competitor average of seven per cent\(^12\)

On promoting self-management for nurses:

- Approximately 70 per cent per cent of Buurtzorg nurses are Registered Nurses (RNs) and are educated to a bachelor’s degree level, compared to only 10 per cent of nurses working in other Dutch home care organisations\(^13\)

- Buurtzorg has consistently been ranked as number one among all home care organisations according to a national quality of care assessment survey. In 2011 and 2012, Buurtzorg was named Dutch employer of the year\(^14\)

---


\(^9\) Ibid


\(^11\) Ibid

\(^12\) Ibid


- Registration of patients’ information, time registration and communication are supported by a web application called the ‘Buurtzorgweb’ which nurses are able to access directly in order to deliver better care and share information with each other.

- Buurtzorg prides itself on its non-hierarchical structure. There are no leaders within the teams and individuals work on the basis of consent. This is helped by the use of a tailored coaching system. How this works is that when a new team begins, a coach is appointed to help them to recruit new colleagues, learn to use the Buurtzorgweb, divide the different roles in the team and build their network with other caregivers, both on a formal and informal basis.

- Thanks to the Buurtzorgweb patient database and self supporting teams, no managers are needed and the back office function is comparatively small – only 20 employees for 3,300 nurses (as of 2011). The focus on simple, accessible IT systems has helped to reduce the bureaucratic workload and Buurtzorg’s back office function provides any assistance for what remains to be done in this area in order to minimise non-patient facing time by nurses.15 16

- Buurtzorg has grown rapidly. The below graph shows expansion in total team numbers up until 2010.17 The organisation’s ability to facilitate this rapid expansion evidences an integral structural foundation, as well as a strong recruitment appeal.

Observations on the Buurtzorg model and its applicability in the UK

Without a doubt, the Buurtzorg model has demonstrated considerable successes – especially in its demonstration of nursing capability and self-management in delivering better patient care. Areas which the UK should be focusing on for implementation include:

- **Fostering a strong entrepreneurial innovation among nurses, supporting them to present tangible solutions to many of the significant challenges facing district care in the UK.** This approach has enabled Buurtzorg to win the endorsement of key observers both within and outside of the Netherlands.

- **Bolstering district nursing services, including: increasing district nurses’ autonomy, allowing them to deliver patient-centred care, and by increasing funding for placements and training.** A 2013 report by the Royal College of Physicians concluded that, in their current state, health services for the elderly and vulnerable are variable, inconsistent and do not meet key needs. The report proposes that community-based health working, similar to that found in the Buurtzorg approach, should play a central role in future service deployment.\(^\text{18}\)

- **The Buurtzorg model works well in both urban and more sparsely populated areas – a factor which the UK can learn from.** According to the World Bank, the percentage of the national population located in towns or cities for the UK was 82 per cent in 2013, only slightly less than the Netherlands at 89 per cent.\(^\text{19}\) This indicates that large numbers of patients are easily accessible to well-organised catchment teams, although care does need to be taken to ensure that rural populations in the UK are also integrated into any such model.

**Challenges**

Invariably, any effort to "lift" the Buurtzorg model and assume that it would immediately work in the UK is problematic. This is not to dismiss the importance of learning lessons from Buurtzorg’s successes, but it must be remembered that systems such as Buurtzorg have developed over time. Consequently, these models are suited to the unique nursing landscape, long-term care needs and funding systems of the host country. In the case of Buurtzorg, some of the challenges which the UK would need to consider are:

- **Buurtzorg’s stringently non-hierarchical approach can sometimes be counter-productive from an operational perspective.** For example, once a team has completed its coaching stage,

---


it will not receive any additional support unless it requests this directly. Consequently, it is arguable that having a managerial position – even if this were elected from within each team – could help to identify key support needs, as well as helping to resolve disputes among staff which, at the present time, rely either on internal resolution, or on an intervention by Buurtzorg’s founder, Jos de Blok. It is also important to note that self-directing teams need to be mindful of equality and diversity issues in the absence of a more centralised policy approach, and that their composition should reflect the communities which they serve.

- **Concerns have been raised that Buurtzorg’s 24/7 care commitment could lead to work patterns which infringe on the EU Working Times Directive.** This has been cited in cases where a patient requires a visit or is in distress late at night and the responding team has already worked a full day attending patients.

- **There has also been concern around new legislation in the Netherlands which requires that insurance companies only pay for care hours worked.** Payments do not include any time spent by the nurse in planning care interventions or travel time to the patient’s home, which can be difficult for more remote catchment areas.

- From a professional perspective, the Buurtzorgweb function has been a key innovation, enabling nurses to access and update patient information quickly and equitably (i.e. there are no systems of restricted access according to seniority for example). Again, this is a very positive development which has reduced bureaucracy and improved patient care. **However, it has been noted that Buurtzorg teams often maintain paper records and documentation at the patient’s home, raising issues around data security.**

- **It has also been noted that significant disparities in service provision can occur, especially depending on the time of day.** Night-time services for example tend to perform less well which indicates a significant patient risk, as many of Buurtzorg’s patients are elderly or terminally ill and are therefore likely to need good night time care.

- Buurtzorg’s focus on reducing hours of care (about 50 per cent compared to other providers)\(^{20}\) has raised concern that too little time may be given to patients. Given that Buurtzorg’s patient population is often frail with multiple conditions including dementia, there may be a risk that this approach limits critical patient-facing time.

- Finally, it is also notable that until recently **Buurtzorg provided only very limited financing or logistical support for continued professional development (CPD). CPD is not a regulatory requirement for nurses in the Netherlands – unlike in the UK.** As a result, the UK would need to seriously consider the implications of revalidation and how the Nursing & Midwifery’s fitness to practise requirements can be met within a 24/7 service.

---

View of the RCN

The RCN welcomes the remarkable success of the Buurtzorg model. Its demonstration of nursing capability and self-management in delivering ever better patient care is a great boost to the profession’s morale, both in the UK and internationally. The RCN hopes that by learning from Buurtzorg’s approach, the critical process of nurse-led innovation for patients – which was so important in forging Buurtzorg in the first place – can be strengthened in the UK.

However, the RCN also recognises that no model which seeks to address the incredible complexity of ‘joined-up’ community care, especially in times of tightened financial budgets and changing patient needs is ever going to be perfect.

In addition, while the challenges of care provision (especially for older people) across countries may be similar in terms of broad-brush description, they are rarely completely identical. Consequently, lifting the Buurtzorg model as it is without considering the significant differences between the UK and the Netherlands in terms of funding structures, demographics and patient needs etc. will invariably present challenges.

The King’s Fund in its analysis of Buurtzorg has reached a similar conclusion. While extolling the model’s virtues, it recognises that Buurtzorg’s approach ‘may not be right for all health systems but it highlights the potential benefits of taking a fresh look at professional roles.’\(^{21}\) It is the view of the RCN that this ‘fresh look’ can only achieve meaningful results if the central plank of the Buurtzorg model – its emphasis on nurses as self-managing agents of change – is maintained throughout.

Royal College of Nursing
Policy & International
March 2015

\(^{21}\) Ibid.