



Innovations in Home care: How to learn from mistakes

Fall of the dinosaurs and rise of the mavericks: an
analysis by business model logic.

Steven de Waal en Peter van Felius

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Center On Strategies For Public And Civil Entrepreneurs

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Historical sketch: Mergers and Managerial Centralization

- ▶ **Homecare:** 15 years ago the Dutch system had separate private non-profit organizations for *home nursing* (mostly associations) and for *care related house hold help* (mostly foundations);
- ▶ A wave of mergers started, initiated by the field, later government backed. All of these activities ended in bigger organizations. Mostly in separate home care organizations, some combined with intramural care.
- ▶ In the first ten years this was first a local, than a regional process, the last 5 years some national mergers were added.
- ▶ **Primary care** in Holland is mostly organized in small firms of independent professional practitioners. Only in areas with bigger primary care organizations (e.g. with professionals on the payroll) there was a combination with homecare.

So the really dominant trend was: **up scaling and mergers within the care domain, mostly in separate home care organizations.** And, amazingly, predominantly the centralized divisional model was chosen, although 2 models were studied and actively promoted.

Our history in this field

Steven de Waal:

- '91 Study for the ministry about the benefits of merging the two disciplines into homecare organizations. Two models were promoted: centralized divisional and decentralized in neighbourhood teams.
(1992: against earlier agreements, the prognosed (!) efficiency gain was used by government for budgetcuts);
- '07 Chairman of a jury on best practices in health care giving the award to 'Buurtzorg' (NeighbourhoodCare) (www.kmbv.nl)
- '08: Study on 'Professional entrepreneurship in primary care' (in Dutch)
(www.publicspace.eu)

Before / After: As a management consultant and conference lecturer involved in many strategic studies and actual mergers in home care;

Peter van Felius:

- '07-'09 Part of the team that supports, promotes and controls a national innovation program in care (26 radical experiments). (S. de Waal is part of the Think Tank that formulates a transition agenda for this program.)
- '08 Developed a method of Public Business Case Analysis in care.
Building a roadmap for the development of primary care.
- '05 Consulted on marketing and endgroup analysis in homecare.

Policy Context: Two steering models in care

The Dutch health care system now knows three semi-separate domains of collective insurance with different steering models. The care domain works in two of these systems:

AWBZ: Collective insurance for long term care/uninsurable diseases with:

- separate organizations for objective indication of necessary and refundable care;
- some emphasis on competition and output steering in contracting by regional bureaus, managed at arm's length by private insurance companies (!);

WMO (since 2006): Social support services, taxbased financed and contracted through local government with:

- very different systems and regulations, especially in tendering/auctions;
- private provision
- very low tariffs (at first)
- rather drastic shift in the mix of indicated care (more help, less care)

Actual strategic overview (2008/2009)

- ▶ Some of the biggest conglomerates in homecare are now on or over the brink of collapse, some are just saved by others;
- ▶ Primary care organizations aim at hiring their own home care personnel;
- ▶ House hold help is sold to cleaning companies, further operating as (commercial) private providers within the public funded home care;
- ▶ ‘Buurtzorg’ attracts a lot of (political, professional) positive attention. It is the first home care organization (since 1991) that:
 - focuses' on nursing (although diversification is pending);
 - is professionally steered;
 - is organized in decentralized teams, scaled down to neighborhoods' and general practitioners

Our Research Questions

- ▶ Why was in 15 years only one organizational model chosen, in an environment full of increasing competition, strategic thinking and private autonomy?
- ▶ Why did the dinosaurs fail?
- ▶ What explains the recent rise of a different model, “Buurtzorg”?
- ▶ What can we learn from this about innovation in health care (at least in the Netherlands)?

The 2 models of the 1991-study

▶ Basic building blocks:

- Most efficient merged operational unit* on 6.200 inhabitants and app. 20 fte' s;
- One fte of operational management (diverse professional models!) on 40.000 hours of mixed* home care;
- Optimal scale for integrated home care organization on 400.000 inhabitants and 20-25 mio EURO
- Normative cost per hour average 18 EURO (range of 10 - 33,-) (past price level).

One designed model is integrated divisional with larger geographic units ('rayon's') above the operational level, the other a 'chain' - model of small neighborhood teams ('care' shops) with some provincial support. The second model was analyzed as the most efficient and the closest to primary care, but also as the more complex to manage and implement.

* Current mix of care activities kept constant

Possible reasons for the lack of diversity in these mergers

- ▶ **External institutional pressure?** On merging and up scaling: yes, on the organizational model: no. Most pressure was on cost-efficiency and the second model was better in that aspect!
- ▶ **External work floor pressure?** The force to keep them decentralized was lacking: primary care due to its small scale was no strategic force. The separate indication put a bureaucratic boundary between client/general practitioner and home care. Centralization was not punished.
- ▶ **Power considerations?** Yes: first we merge within the domain we know, than we can, on an equal base, merge with other are(n)as.
- ▶ **Struggle between professionals and management? Struggle between cultures?** Yes: management had to conquer its position, many of them came from house hold help, the discipline with lower status, but a stronger managerial culture. Home nursing was less efficient and undermanaged. Mostly the full time separate managers model was chosen, not the combination with professional work (which fitted nursing more).
- ▶ **Isomorphism?** Yes: home care management was a small community with a lot of copy cat behavior.

Why did the Dinosaurs wither and (some) die?

► Management failures

- * Entrepreneurial freedom in health care meant the same for real estate without the competence;
- * Bad negotiators in the new tenders;
- * Managerialism A; not serving leadership or sound leadership of professionals, but bureaucratic and positional thinking; including euphoria and ‘big projects-disease’ ;
- * Managerialism B: not entrepreneurial or market oriented, but institutionally framed, focus on government and regulation instead of clients and professionals;
- * Peter’ s principle: organizations became too big for current management generation.

Fall of the Dinosaurs (2)

▶ **Government or Systems failures**

- * Wrong implementation of WMO
- * There was the myth of a market, but budget caps, regulations, union culture and public image didn't follow;
- * Wrong expectations in the public at large: house hold help is care, but the price was that of cleaning services

Mixed Failure

- * The introduction of the WMO changed the delicate strategic balance of the portfolio (mix of help and nursing, mix of local and national) of the big home care organizations. Their real market was health insurers, municipalities were then added with totally different scale, competences and attitude. The market became more local.

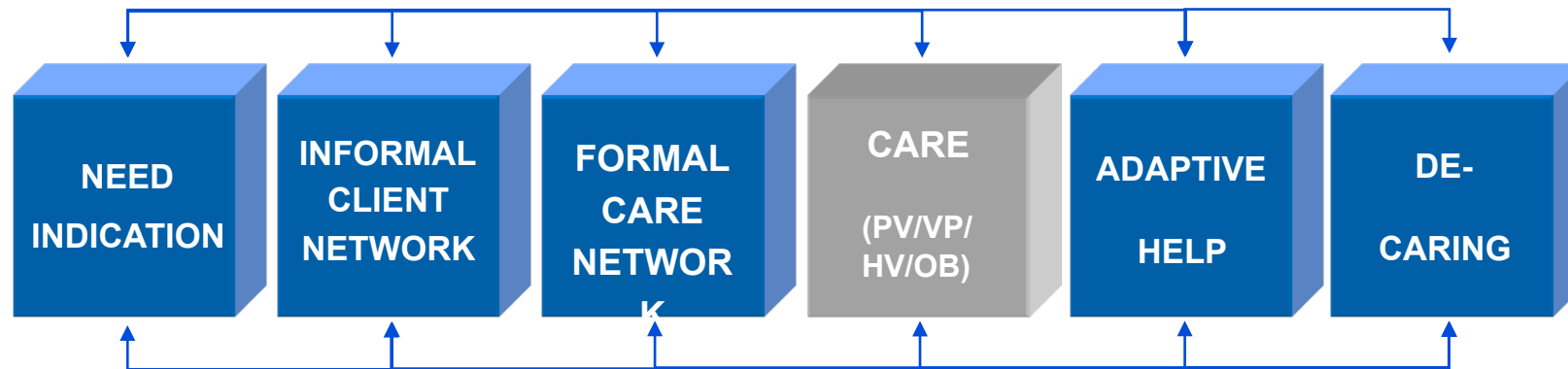
Root cause analysis: a cross sectoral viewpoint

- ▶ It seems that public sector organizations have little or no experience nor incentives to **reinvent themselves**. Old healthcare companies fall, while new rise. New service introduction and innovation is **mainly reserved for the new and young ones** in their own niche. And the dinosaurs? They fall and we wonder what the heck happened...
- ▶ We think **health care companies need to constantly rethink their value proposition**. From our cross sectoral studies we learned that the **private sector has the tools** and jargon readily available, like value added tools, business models, ‘triple P’ calculations, value market-insight tools etc.
- ▶ In this heavily regulated sector you have to actively make a difference between internal steering and external systems like financing, accountability, targets. **You** are the boundary between bureaucracy and clients/care; the Dutch private non profit construction should help in this;
- ▶ The private sector is better capable in thinking in **optimal scales, scopes & sources of diseconomies**. They are more able of measuring the impact of their *quantities* of services and *variety* of services on their business model.
- ▶ The **lack of public sector entrepreneurship** and focus on economic value is the **root cause of being unable** to (re)build businessmodels to **maximize public value**.













Business model logic: where public value arises

- ▶ a business model describes the **value** an organization offers to various customers and portrays the capabilities and partners required for creating, marketing, and delivering this value;
- ▶ Breakthrough, game-changing healthcare innovations are all underpinned by a **radical new businessmodel**, outperforming the dinosaur's model by creating more and new types of value.
- ▶ To draw **lessons from the past**, we need to analyze these models, look **where most public value is created** and learn healthcare organizations to **continuous revitalize** them.
- ▶ We think if **government stimulates optimizing public value by outcome steering**, the healthy economic value (return on investment) for services will follow.
- ▶ We need a systematic steering of public service organizations towards public value.

Rise of the mavericks: Building Blocks of Buurtzorg homecare



CONTINUOUS PROCESS: INTERACTIVE <> RECOMBINE <> ITERATION <> TAILOR MADE

 Ms. Jansen 				
 Mr. De Vries 				

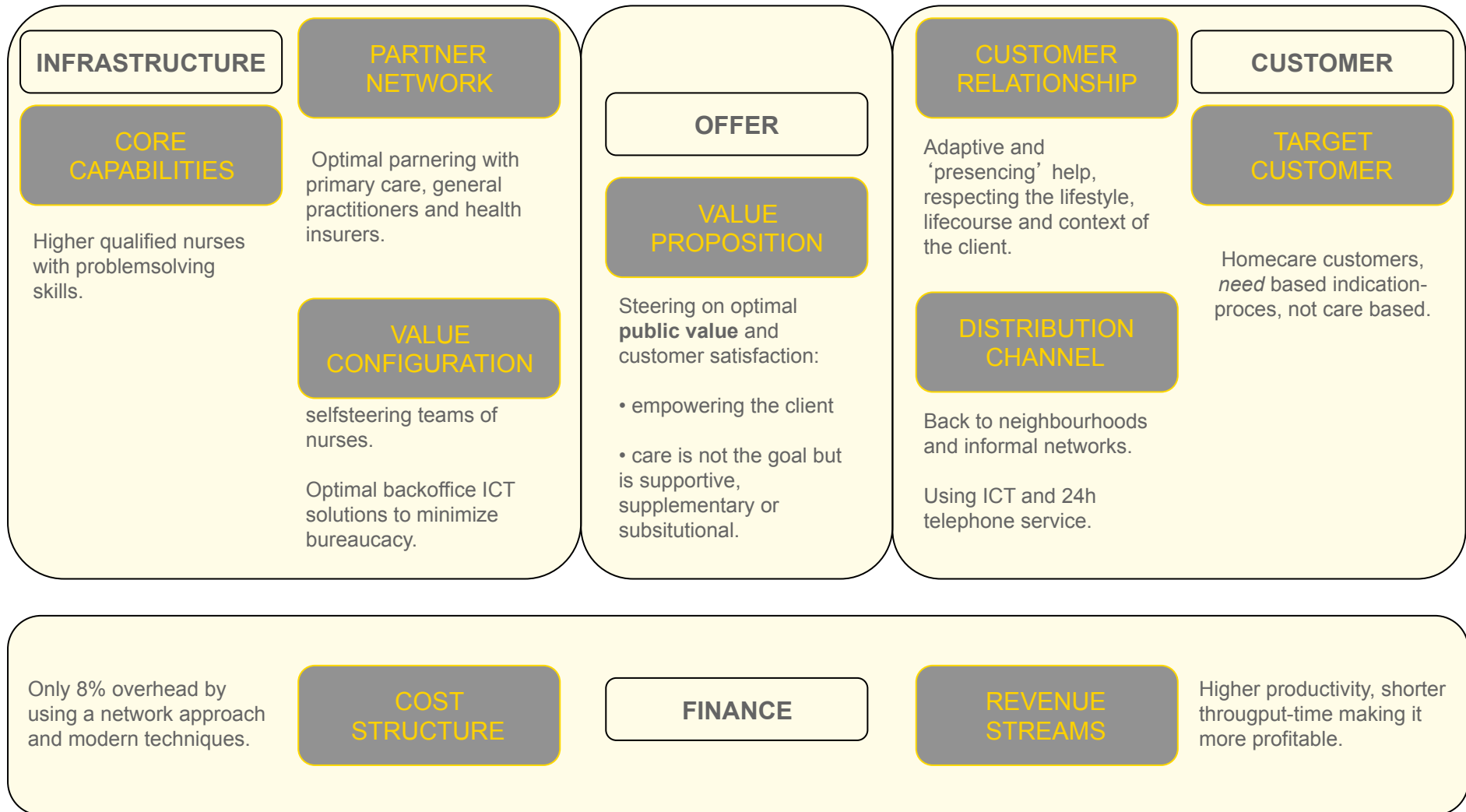
Resulting in:

- Less hours per client per year, shorter throughput time, reduction of unplanned (crisis) care
- Higher productivity, less overhead, lower omission and turnover of labour

So: a combination of public value and economic value!

Business model of Buurtzorg:

Better and cheaper care, optimal public value



Conclusions for innovation in health care

On a management level:

- ▶ Never pick only one model in a competitive market;
- ▶ Build-in the right incentives for business model innovation > stimulate intrapreneurship and renewal form within (falling dinosaurs are costly); be flexible; keep options open; bring in new management from different backgrounds; manage the culture clash;
- ▶ Analyze your market structure more carefully before making choices: rethink (de)centralization, cost-structures economies of scope/scale and the governance-model;
- ▶ Learn 2 Learn: Learn the sector cross-sectoral lessons, tools and instruments;
- ▶ Steer on value-optimization and (where possible on) the social return on investment
- ▶ Always (re-)consider the interfaces of regulation and product descriptions: what is homecare, primary care, nursing, household care etc.

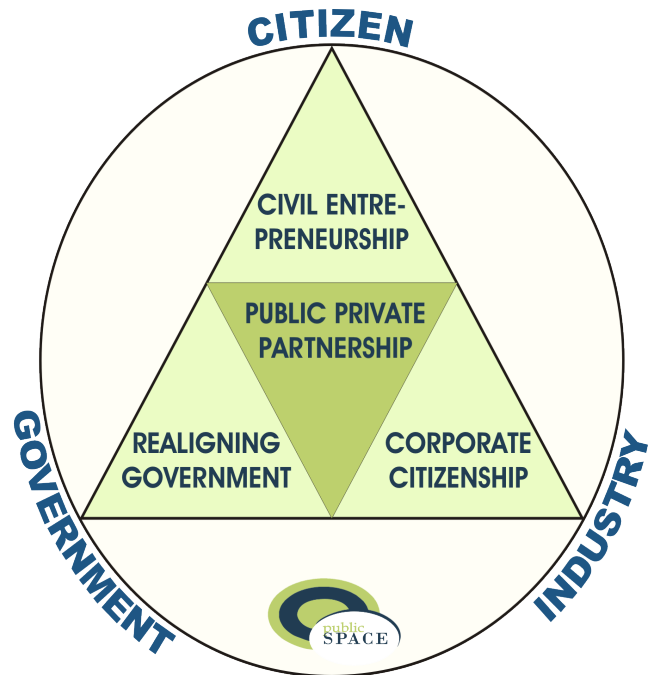
Conclusions for innovation in health care

On a national level:

- ▶ Don't underestimate the power of existing cultures; bureaucracy and procedural management enforce each other; they are partners; the entrepreneurial and innovative forces are few; outsiders with a different attitude are necessary on all levels;
- ▶ Make an explicit distinction between tasks and domains where experiment is tolerated (with risks and how to manage them) and where there is not; this insight should come from outside politics;
- ▶ There is some trendiness in innovation: 'Buurtzorg' would 15 years ago be seen as defensive and conservative!
- ▶ The best fertile ground for entrepreneurs is steady tariffs with some slack. Special supportive programs have only temporarily effect and can swing things on (but then again the innovation will have to land in the current system)

About The Public SPACE Foundation

The Public SPACE Foundation is the international knowledge and learning centre for **Strategies for Public And Civil Entrepreneurs**. As an independent, nonpartisan ThinkTank we focus on complex and strategic interactions between government, civil organizations and industry for public purposes. On a non-profit base we develop and provide realistic, tailored innovative strategic solutions to all sectors contributing to the public domain. The results of our work are communicated to public and private decision-makers and to the general public by books, articles, debates, lectures and an interactive website. Public SPACE was founded in 2000 by Steven de Waal and has, in its short existence, built a reputation in developing and communicating leading edge strategies for and between established organizations for public purposes.



The ThinkTank

Our ThinkTank consists of prominent executives, academics, opinion leaders and decision makers operating in strategic frontiers of public/private corporations. They have backgrounds in all domains of public interest and in a broad range of organizations.

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Our Mission

Our mission is to research and design innovative and sustainable strategies for the production of public services and collective goods. We want to contribute to **'Winning strategies for the common good'** characterized by an open non-ideological inquiry, an active international outlook for best practices and an interdisciplinary approach.

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