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Title: Introducing Self-Organization to Finnish Home Care Teams: Expectations and Outcomes

Year: 2023

Version: Publisher pdf

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Please cite the original version:

Jantunen, S., Mäkelä, T., Ruotsalainen, S., & Sinervo, T. (2023). Introducing Self-Organization to Finnish Home Care Teams: Expectations and Outcomes. *Scandinavian Journal of Public Administration*, 27(3), 57–72. <https://doi.org/10.58235/sjpa.v27i3.14161>



Introducing Self-Organization to Finnish Home Care Teams: Expectations and Outcomes

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Scandinavian Journal of
Public Administration
Vol. 27 No. 3 (2023),
p. 57 – 72

DOI:
[10.58235/sjpa.v27i3.14161](https://doi.org/10.58235/sjpa.v27i3.14161)

Keywords:

older people care;
home care;
self-organization;
teamwork;
Finland;
management

Abstract

The purpose of this paper is to understand better what kinds of expectations Finnish home care workers have about self-organizing teams and what kinds of outcomes Finnish early adopters have experienced after self-organizing principles have been introduced to their organization. To this end, we share results from two research projects that have coached Finnish home care and assisted living teams towards self-organizing team practices. We will identify expectations about self-organization by interviewing and gathering information from home care workers who will soon be coached toward self-organizing practices. We will then evaluate outcomes of self-organization by comparing personnel survey results between teams working in home care and assisted living facilities that have and have not been coached towards self-organizing work practices. Our findings reveal that, although management and team members perceive their current organizational environment differently, both parties share the will to evolve towards self-organizing work practices. The early results of coaching home care teams towards self-organization suggest that achieving change is likely to be a slow process.

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Introduction

Finland has, in recent years, systematically moved care activities for older people from institutions to their homes (Ministry of Social Affairs and Health, 2012). Consequently, public home care organizations providing care for older people have needed to serve an ever-increasing number of customers with more challenging conditions than before (Mielikäinen & Kuronen, 2019). The increasing workload has not been adequately matched with the increase in home care workers (Alastalo et al., 2017). Instead, the management of home care organizations has often sought to optimize the utilization of existing resources with Enterprise Resource Planning systems (ERP) and detailed work processes. Unfortunately, managing organizations in such a linear and authoritative way seem to have deteriorated working conditions in many home care organizations (Rantanen, 2018; Vehko et al., 2018). Strong critique has also emerged relating to the quality of care and well-being of workers in assisted living facilities with 24-hour assistance. Recent studies have reported fundamental challenges in Finnish home care organizations and assisted living facilities, including time pressures,

role conflict, working alone, interruptions, poor team morale, and problems in leadership (Kröger et al., 2018; Ruotsalainen et al., 2020; Vehko et al., 2018).

The Dutch home care provider Buurtzorg has raised widespread interest with its innovative use of self-organizing teams. By empowering caregivers to be responsible for their own work processes and the organization of their work, Buurtzorg seems to have achieved positive results regarding the effectiveness and satisfaction of clients and workers (Monsen & de Blok, 2013). Despite the scarce scientific evidence of the Buurtzorg model, there is some evidence of the positive outcomes of self-organized teamwork in health and social care (Maurits et al., 2015; de Groot et al., 2018). Such success suggests that self-organization could effectively alleviate severe problems in Finnish public home care organizations and assisted living facilities with 24-hour assistance. Implementing self-organizing team practices in existing home care organizations with long traditions may not, however, be straightforward. Lalani et al. (2019) reported positive outcomes in implementing the Buurtzorg model in London but also noted several barriers, such as different legislation and organizational culture.

Recently, several initiatives have been made to introduce self-organizing team practices to Finnish home care organizations and assisted living facilities. In this paper, we will share experiences from two of such initiatives. In one research project, we coached Finnish home care teams towards self-organizing practices and measured the outcomes regarding work satisfaction and well-being of workers in both home care and assisted living facilities. In another project, we collaborated with Buurtzorg and started coaching the home care teams of a non-profit organization in Finland in the spring of 2020.

The purpose of this paper is to understand better what kinds of expectations Finnish home care workers have about self-organizing teams and what kinds of outcomes Finnish early adopters have experienced after self-organizing principles have been introduced to their organization. We intend to answer these questions with mixed methods. We will identify expectations about self-organization by gathering information and interviewing home care workers who will soon be coached toward self-organizing practices. We will then evaluate outcomes of self-organization by comparing personnel survey results between teams working in home care and assisted living facilities that have and have not been coached towards self-organizing work practices.

Evolution of Home Care Organizations in Finland

Management practices in home care, their effect on working conditions, and the emergence of self-organizing organizations can all be viewed as evolutionary steps of organizational thinking. The evolution of public organizations is typically closely connected with the economic and political situation of the welfare state. How home care is currently organized in Finland has its roots in the economic depression of the early 1990s. The unfavorable economic situation of that time made it apparent that modernization of the public sector is inevitable and that the public sector needs to be able to offer more value for the money (Lähdesmäki, 2003).

The modernization of the public sector in Finland has been influenced by New Public Management (NPM) (Yliaska, 2010). Although there is no unified understanding of the NPM reform model (Schedler & Proeller, 2005), the general objective of NPM has been to transfer market principles and business-management techniques from the private into the public sector (Siltala, 2013; Yliaska, 2010) to increase efficiency, productivity, and cost-awareness (Diefenbach, 2009).

Despite many well-meant attempts, NPM has been criticized for generating more of the issues it claims to fight, resulting in increased bureaucracy and less time for frontline staff to perform those tasks that directly serve citizens and the community (Diefenbach, 2009). For example, although NPM has been stated to pursue organizational flexibility with decentralization and less hierarchy, initiatives based on NPM have often led to centralization, hardened structures (between the center and the periphery), and more hierarchy instead (Diefenbach, 2009).

In the context of home care organizations, NPM has been reported to jeopardize individual nursing care with detailed goal management, time constraints, lack of resources, reporting

requirements, performance measurements, fragmentation of services, centralization of power, and decentralization of responsibility (Strandås et al., 2019). As nurses have been forced to focus more on biomedical and clinical procedures rather than paying attention to basic needs, patient-nurse ratios and stress have increased, job satisfaction has decreased, and time for conversation and guidance of patients has diminished (Strandås et al., 2019). These reported findings resemble closely the findings from Finnish home care organizations. In the earlier days, home care in Finland focused on helping clients to live in their homes, and the service package was tailored for each client according to their needs. In the quest for increasing cost-efficiency, offered services were standardized, shifting the focus from individualized care towards fulfilling tasks. ERP systems were introduced to orchestrate task implementation in a cost-efficient manner.

Attempting to schedule work efficiently with ERP systems seems to have created problems on a practical level, mainly because ERPs cannot know all the subtle details involved in the work to be done. One problem is the unpredictability of daily care visits. When visits are tightly scheduled, surprises can easily make the schedules undoable, creating additional work to resolve the new situation. This problem is often made worse by assigning the main user ERP responsibilities to higher levels in the hierarchy and situating the main users away from the home care teams. Consequently, caretakers have few opportunities to change their schedules when the old ones become undoable. As a result, workers feel that the work schedules are not as reasonable as they could be, and because of that, workers feel that they are always in a hurry, spending too much time driving from one place to another and spending too little time with the clients (Jantunen et al., 2020). In stress research, this assembly line experience significantly increases stress and harms workers' health (Karasek & Theorell, 1990). When an employee has high levels of demands (time pressure) and very little autonomy, stress levels are high, and possibilities to learn and develop at work are very low. Furthermore, when nurses have fewer opportunities to make independent decisions and are continuously forced to downgrade professional values and ethics, the nursing profession is challenged (Strandås et al., 2019).

Another problem in orchestrating work with ERP systems is that task scheduling does not typically value care continuity. The challenge of scheduling work seems to be simplified with the belief that any of the nurses can implement a particular care-related task equally well. However, the time of a familiar nurse may be more effectively used. They can assess the client's condition better than unfamiliar nurses and adjust care activities beyond the agreed task definitions.

The consequences of optimizing home care resources with ERP systems are already well known. The idea of seeking efficiency has been found to devalue qualitative values, resulting in additional work and a decline in efficiency and effectiveness on the ground where the real work takes place (Diefenbach, 2009). Furthermore, management of public organizations has been reported to often suffer from a "widespread lack of knowledge and often a total lack of understanding (or ignorance) of the work and problems of frontline staff," leading to "widespread demoralization of those working in public services, and a deep resentment and suspicion of the way they are being treated" (Diefenbach, 2009). Consequently, it has been argued that NPM seems to be less about empowerment and more about the infantilization of employees (Diefenbach, 2009).

Perceived challenges of home care services increase the pressure to adopt a new management paradigm to deal more adequately with current circumstances. The reliance on hierarchy, detailed processes, and control mechanisms no longer provides adequate support for organizations facing environments with high levels of volatility, uncertainty, complexity, and ambiguity (Bennet & Lemoine, 2014). Current issues in Finnish home care are not likely to be solved with the same organizational logic that created them in the first place. Adoption of a new organizational paradigm is needed.

In his book, *Reinventing Organizations*, Frederic Laloux (2014) has described how organizational thinking has evolved through seven distinct organizational models over time, where each consecutive model brings breakthroughs that address the challenges of previous models. Each of these organizational models has a home ground where it works best and its own distinctive drawbacks. Although there still exist a wide variety of different kinds of

organizations exemplifying most of these organizational models, we will summarize the four latest steps of organizational evolution. According to Laloux (2014), the *Conformist-Amber* model operates like the military, having clear hierarchies with formal rules and processes. This approach has helped organizations coordinate work efficiently in relatively stable and predictable situations but has faced challenges in dealing with changing environments. The next evolutionary step, the *Achievement-Orange* model, seeks to deal with changing environments, believing individuals should be free to challenge the rules and do what they consider most effective. This organizational model introduced three key breakthroughs: innovation, accountability, and meritocracy, giving birth to many of our current resource allocation, appraisal, and incentive systems. The drawback of organizations following this organizational model is that some feel their operations are soulless, where people are seen as resources to be optimized with the goal of maximizing profits. As an answer for such a drawback, the *Pluralistic-Green* model was built on the belief that there is more to life than just seeking success. This organizational model values harmony, equality, fairness, and consensus and introduced breakthroughs such as empowerment, value-driven cultures, and valuing multiple perspectives from diverse stakeholders. In this model, organizations operate like families, breaking down old organizational structures. Unfortunately, the desire for consensus has often led to inefficient decision-making. In the current final evolutionary step, the *Evolutionary-Teal* model attempts to solve such a challenge with three breakthroughs. By introducing *self-management*, Teal organizations are based on peer relationships rather than hierarchy or consensus. Instead of seeing people only through their professional roles, *wholeness* allows them to bring all they are to work. Finally, *evolutionary purpose* allows us to see organizations as soulful entities with aspirations, making it possible to align personal calling with the organizational purpose. In this way, Teal organizations are like living organisms, constantly evolving to fit into the broader ecosystem. When Laloux (2014) developed his view describing the evolution of organizational thinking, he studied Buurtzorg as one of the case organizations showing properties of the Evolutionary-Teal organization.

Due to a vague understanding of the nature of NPM and the simultaneous presence of many different organizational models in current working life, any reform put into practice may take different forms on a practical level. The end results are affected by the decision-makers' interpretations. Consequently, it may be possible that organizational decisions implemented in practice are influenced by the ideas originating from different organizational models. Inspired by the work of Laloux (2014), Emich Szabolc developed an evolutionary development map of organization, describing in more detail how the implementation of organizational models differs from each other on a practical level. In this paper, we have extracted the key organizational differences from Szabolc's (n.d.) visual presentation into Table 1 and used this as a framework for enquiring about the organizational practices of home care teams to estimate the underlying influence of different schools of organizational thinking on the home care teams' current way of organizing and their desired way of organizing.

Table 1. Differences of organizational models on a practical level. Adopted from Szabolc (n.d.)

Theme	Amber organization	Orange organization	Green organization	Teal organization
Leadership style	Gives proper instructions	Motivates by targets, accountability	Inspires and involves everyone—empowerment	Gives open space and participates situationally — self management
Decision-making	Leaders (not transparent)	Goals and strategy	Values	Evolutionary purpose
Personnel development	Instruction/ education	Training	Coaching/ networking	Open space, even beyond the organizational context
Conflict resolution	Being correct and compliant	Struggle for the most effective solution	Find a solution that considers everyone's needs	Perceive and use conflict as opportunity
Moderation skills	Keep order and document contents	Saving results — orientation	Pay attention to diversity of opinion and sentiment	Hold space
Organizational structure	Industrial, divisions, formal roles	Matrix	Network	Fractal/holarchy
Process	Standardized processes	Flexible processes with goal focus	Cross-organizational processes with culture focus	Free cross-disciplinary process networks
Flow of information, communication	Working groups, meetings	Meetings, strategic information	Informal and formal communication platforms, transparency	Free networking, peer consulting
Resource efficiency	Compliance with laws/sector obligations	Cost efficiency and material alternatives	Sustainable supply chain	Intelligent systems
Products and services	Copied/established product	Market-driven products/trending products	Meaningful, sustainable product	Ethical disruptive innovations
Stakeholder relationship	Hierarchical	Purposeful, strategic	Based on partnership	Co-creative
Vision and core values	Dogmas from above — long-term perspectives	Basic awareness, cultivated from both directions	Instruments of decision-making	Evolutionary purpose and values
Work climate	Experienced cooperation and coexistence	Pragmatic and results-driven	Friendly and community-oriented	Open and creative
Attitude during contact	Careful — rank is important	Strategic, benefit-oriented	Empathetic	Complete acceptance of others — wholeness
Inner motive, drive for manifestation	Generate security	Entrepreneurial thinking and acting — innovation	Inspiring people/meaning and harmony	Trust one's own intuition, authenticity
Consciousness of self	Repressed thoughts and feelings	Conscious thoughts, unconscious feelings	Conscious thoughts and feelings	Awareness of intelligence beyond thoughts and feelings (wholeness)

Material and Methods

The purpose of this study is to understand better what kinds of expectations Finnish home care workers have about self-organizing teams and what kinds of outcomes Finnish early adopters have experienced after self-organizing principles have been introduced to their organization. We use the term home care as in Finland, home help services and home nursing are merged into one entity.

This study combines results from two research projects that have coached home care teams toward self-organizing team practices. In creating an understanding of the expectations about self-organizing teams, we estimated current and desired organizational practices in two case organizations participating in Project 1. We then enriched these findings by analyzing qualitative data originating from a third case organization participating in Project 2.

In creating an understanding of the outcomes of self-organizing principles, we conducted a comparative experiment in home care organizations participating in Project 1 between teams working in home care and assisted living facilities that have and have not been coached toward self-organizing work practices.

A summary of research activities, sampling procedures, gathered data, and method of analysis is presented in Table 2, followed by a more detailed description of both research projects.

Table 2. Summary of research activities

Research activity	Sampling procedure	Respondents	Method of analysis
Determination of current and desired organizational practices. (Case study of two organizations in Project 1)	Any available member from the two organizations participating in our coaching activities. In addition, any available team leader from the large city, regardless of their participation in the coaching activities.	Small town: - 3 managers - 7 team members Large city: - 7 team leaders - 17 team members (District 1) - 19 team members (District 2)	Visualized map of organizational decisions
Interviews to understand expectations from self-organization and commitment for the coaching activities. (Case study of one organization in Project 2)	Available persons from different levels of hierarchy that are to participate in the forthcoming coaching activities by Buurtzorg.	- 2 people from top management - 2 team leaders - 7 team members	Grounded theory, Gioia et al. (2013)
Survey of work practices for estimating effects of coaching towards self-organizing work practices. (Comparative study in Project 1)	Test group: - Teams that have been coached towards self-organizing work practices. Control group: - Teams that have not been coached towards self-organizing work practices.	Test group - Home care: 113 respondents from 15 teams. - Assisted living: 187 respondents from 15 teams. Control group: - Home care: 141 respondents from 17 teams. - Assisted living: 158 respondents from 16 teams	Chi-Square test

Project 1

Project 1 (2018–2020) coached home care teams from two locations. One of the locations was a large city in Southern Finland, with two of their districts participating in the coaching activities. The other location was a smaller town with more rural areas, where one of the teams was coached. In addition to our own coaching activities, we also studied home care and assisted living facilities (with 24-hour service) in a large city in Finland, where the coaching towards self-organizing team practices was done by other organizations or by the city's employees.

When starting to coach teams towards self-organizing team practices, it is essential to understand whether this is something teams want to accomplish. This is why we started work with each team in Project 1 by exploring the views of both home care workers and their superiors on how their organization is currently organized and how they wish they could organize their work in the future. To this end, we created a simplified version of Szabolc's (n.d.) evolutionary development map of organization that followed the original visual layout presented in Figure 1. When creating the map, we translated the information in Table 1 into Finnish. We placed information from each cell of Table 1 in its appropriate place on the map based on the theme and the organizational model. We then printed the map on A3-sized paper for each team member and team leader and asked them to mark on each axis what would best describe their organization today and how they would like the theme to be implemented in the future.

Figure 1. Visual layout of evolutionary development map of organization



In total, we received three responses from the management level and seven responses from home care team members from the small town. From the large city, we received 17 responses from home care workers from District 1, 19 responses from District 2, and seven responses from the management level.

Employees in all three organizations participated in a personnel survey after the coaching to explore the effects of self-organized teamwork. Participating in the coaching activities for improving self-organizing team practices also meant permission to start working in a self-organized way. In this article, we describe the differences between team autonomy in teams where self-organized teamwork had been launched and in teams without self-organized practices. If the development of self-organized teams is successful, there should be a difference in team autonomy, meaning the decision-making authority of teams. The results on worker well-being and quality of care are described elsewhere (Surakka et al., 2020; Ruotsalainen et al., 2022). Team autonomy was studied using a scale of 8 questions. Due to a lack of validated team autonomy scales, the scale was based on earlier studies of autonomous teamwork in care work

(especially that of the Buurtzorg model, Lalani et al., 2019), along with interviews of home care employees and supervisors. The internal consistency was rather good, with Cronbach's alpha being 0.81. The respondents were asked how autonomously their team was able to make decisions on eight factors: planning of client care, task distribution, working methods, professional development, scheduling of work shifts and hours, estimation of the need for substitutes, and recruitment of substitutes, recruitment of new employees, scheduling of vacation time. The differences between teams having and not having launched self-organized teamwork were analyzed using Chi-square tests.

All work units that had participated in the coaching activities participated in the survey and the control work units. Altogether 64 teams, including 600 employees, participated in the survey. We had 15 teams with 113 participants in the home care test group (teams with coaching) and 17 teams with 141 participants in the control group (teams without coaching). In assisted living and other services for older people, we had 15 teams and 187 participants in the test group and 16 teams and 158 participants in the control group. The majority of the respondents were practical nurses (60%) with vocational training, and 26% were registered nurses. The mean age of the respondents was 43.8 years old.

Project 2

The case organization in Project 2 is a small home service team inside a larger non-profit company providing services for the elderly. The company's management launched an organizational reform in 2019, which included plans for a development pilot to test the suitability of Buurtzorg's self-organizing operating model in the Finnish service system. As part of the pilot, coaching provided by Buurtzorg began in the fall of 2019 but was suspended in the spring of 2020 due to the COVID-19 pandemic. The coaching restarted through virtual meetings in the fall of 2020 and lasted until the fall of 2021.

In order to ensure favorable outcomes for the coaching activities, questions related to expectations of self-organization and commitment for the coaching activities were asked both to the team members and managers. To this end, two persons from top management, two team leaders, and seven team members were interviewed.

Expectations and Outcomes of Self-Organizing Teams

The current and desired organizational model of two home care districts in a large Finnish city in Project 1 are presented in Figure 2. Figure 3 shows similar results from a home care team in a small town in Southern Finland. These results were analyzed by combining all responses of a particular case organization into the same diagram and then visually estimating the average responses of managers and team members.

In both case organizations, the team members' views of the current situation largely resembled the *Achievement-Orange* organizational model (Laloux, 2014), which seeks effectiveness by giving goals, and some freedom in how to achieve them. Typical of this kind of organization is that most of the power is concentrated at headquarters, far away from the teams. However, the results show that in some themes, teams have considered their organization to resemble more of a *Pluralistic-Green* organization (Laloux, 2014), valuing harmony, equality, fairness, and consensus. One such theme is the attitude during client visits, in which all teams considered themselves more empathetic rather than benefit-oriented.

Figure 2. Current and desired organizational style of two home care districts of a large city in Finland

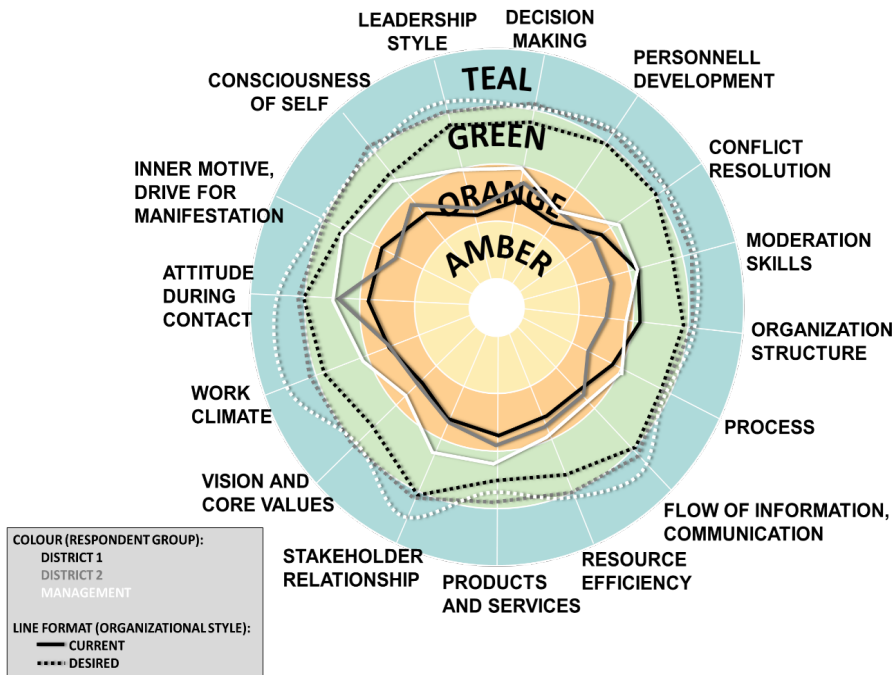
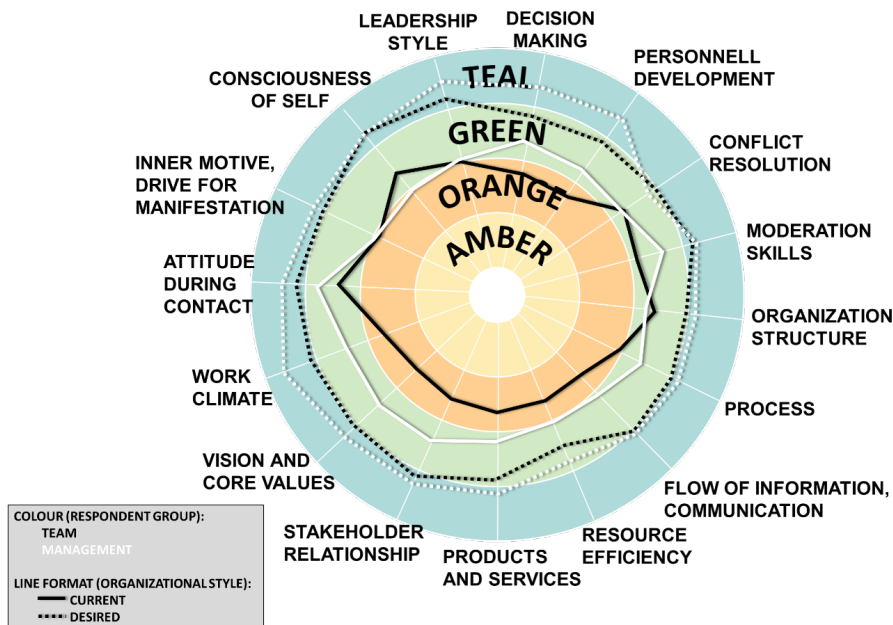


Figure 3. Current and desired organizational style of a home care team in a small town in Finland



In both case organizations, team leaders perceived the current situation to resemble more of a *Pluralistic-Green* organizational model (Laloux, 2014) that emphasizes empowering frontline employees. Both team leaders and members consistently wanted to evolve toward the *Evolutionary-Teal* organizational model (Laloux, 2014). This finding suggested that organizing coaching related to self-organization was worth pursuing.

The interviews from Project 2 also revealed differences in the viewpoints of home care workers on different organizational levels. The analysis of these interviews followed the

qualitative analysis methodology suggested by Gioia et al. (2013), where the analysis begins by identifying salient quotations from the interviews and then proceeds toward the emergence of themes by identifying similarities among the quotations. In this paper, the viewpoints of top management, team superiors, and team members were analyzed separately and summarized in Table 3.

Table 3. Emerged themes and quotations from two top managers, two team superiors, and seven team members

Role in organization	Emerg ed theme	Original quotation
Top management	Cost efficiency	“Buurtzorg has interestingly succeeded in simultaneously achieving business performance and quality.”
	Work efficiency	“If we continue to develop home care services within our current organizational model, we will soon reach our limits. We must renew work, our organizational model, management, and leadership towards self-organizing practices.”
	Image	“We need to adapt Buurtzorg’s work practices to suit the Finnish service system better.” “A well-functioning, self-organized home care service model can serve as an example to other actors in the field.”
Team leader	Increasing effectiveness	“By reforming work management and work processes, it is possible to work smarter.” “The objective is to develop work practices so that teams can work effectively together.”
	New kind of work culture	“Managing home care services is currently very fragmented work. Some of the problems wouldn’t need the involvement of a superior. Rather, teams could resolve the problems themselves. This would save supervisor resources and allow time to be allocated to more important tasks.”
Team member	Customer work	“Quality of customer work would be improved if you could plan the work yourself to respond better to the needs of each customer.”
	Participation	“It would be nice if team members’ improvement suggestions could be considered better.” “We need better opportunities to influence the planning of jobs and tasks.”
	Management and leadership	“We need better opportunities to influence work time and free time scheduling.” “Team objectives should be aligned better with their capabilities.”

According to the interviews (Table 3), top management’s interest in adopting a self-organizing team model was related to cost efficiency, work efficiency, and the organization's reputation. Top management was interested in self-organization because Buurtzorg seems to have succeeded in achieving cost efficiency while simultaneously achieving good service quality results. Top management anticipated that their current organizational model would likely reach its limits and that a new organizational model needs to be adopted to overcome current challenges. They also believed that if Buurtzorg’s organizational model is successfully adjusted to the Finnish environment, their organization could serve as a positive example to other home care organizations.

Team leaders’ expectations about Buurtzorg were related to finding more innovative ways of accomplishing the objectives. Team leaders believed that teams could improve their work by following Buurtzorg’s principles, such as: helping workers to spend at least 60% of their time directly with clients, limiting the number of people in each team, and encouraging team members to use their own judgment for developing links with other services, volunteers, and family who can offer solutions to support the client’s independence (Sheldon, 2017). Team leaders believed that if team members were allowed to take on more responsibility, their time could be spent on more critical tasks.

Team members believed that by adopting self-organizing work practices, they would have a better opportunity to influence how work is to be done, which is likely to increase the quality of offered services and work satisfaction.

Outcomes of Coaching Toward Self-Organizing Teamwork

When analyzing the coaching outcomes, the quantitative data analysis showed that, in both the test group and control group of home care and assisted living, the teams had fairly large autonomy in planning their own work and the distribution of tasks. Still, in other factors, autonomy was markedly lower. In most situations, teams felt they were fairly autonomous, but the actual decision required the supervisor's approval. In assisted living, the teams were clearly more autonomous than in home care. For example, in home care, only 25% of respondents experienced that the teams are autonomous concerning working methods (Table 4), whereas, in assisted living, 36–51% felt this way (Table 5).

The analysis also showed that coaching did not substantially affect the autonomy and possibilities of the team to influence their work. There was only one significant difference between the test and control groups. The teams that had launched the self-organizing work practices could consider by themselves whether they need substitutes (in case of sick leave, for instance) and could have more influence over the recruitment of substitutes.

Table 4. Team autonomy, home care

		n	Autonomously %	Fairly autonomously, but approval of the supervisor is required, %	Some autonomy %	No autonomy at all, %	χ^2	df	p
Planning of client care	Test group	110	54.5	27.3	16.4	1.8	0.91	3	ns.
	Control group	138	55.1	25.4	18.8	0.7			
Task distribution	Test group	112	29.5	8.9	42.9	18.8	2.51	3	ns.
	Control group	140	28.6	9.3	50.0	12.1			
Working methods	Test group	113	24.8	35.4	34.5	5.3	3.17	3	ns.
	Control group	140	25.0	28.6	43.6	2.9			
Professional development	Test group	110	10.0	69.1	20.0	0.9	4.29	3	ns.
	Control group	141	9.9	61.0	24.1	5.0			
Planning of work shifts and hours	Test group	111	8.1	56.8	32.4	2.7	4.81	3	ns.
	Control group	140	7.1	45.7	45.7	1.4			
Estimation of the need for substitutes and recruitment of substitutes	Test group	112	4.5	25.0	25.9	44.6	8.16	3	< .05
	Control group	139	2.2	13.7	38.1	46.0			
Recruitment of new employees	Test group	112	4.5	14.3	40.2	41.1	6.23	3	ns.
	Control group	137	1.5	13.9	29.9	54.7			
Scheduling of vacation time	Test group	111	3.6	72.1	21.6	2.7	7.34	3	ns.
	Control group	141	1.4	61.0	36.2	1.4			

In assisted living, the test group and control group differed clearly from each other. In the test group, teams could distribute the tasks more autonomously and plan work shifts, working methods, and vacations rather autonomously. They also could influence recruitment and consider whether they needed substitutes or not. Autonomy had increased, especially regarding planning work shifts and hours, choosing working methods, and task distribution.

Table 5. Team autonomy assisted living (with 24-hour service)

		n	Autonomously, %	Fairly autonomously, but approval of the supervisor is required, %	Some autonomy, %	No autonomy at all, %	χ^2	df	p
Planning of client care	Test group	186	71.0	16.1	11.8	1.1	2.35	3	ns.
	Control group	155	65.2	22.6	11.0	1.3			
Task distribution	Test group	185	67.6	18.4	13.5	0.5	12.02	3	< .01
	Control group	156	51.3	26.3	18.6	3.8			
Working methods	Test group	185	51.4	29.7	16.8	2.2	10.51	3	< .05
	Control group	158	36.1	32.3	29.1	2.5			
Planning of work shifts and hours	Test group	187	25.1	57.2	16.0	1.6	32.03	3	<.001
	Control group	157	5.1	59.9	33.1	1.9			
Scheduling of vacation time	Test group	187	13.9	70.6	15.0	0.5	14.11	3	< .01
	Control group	157	3.8	70.1	25.5	0.6			
Professional development	Test group	186	11.8	74.2	13.4	0.5	1.85	3	ns.
	Control group	158	8.2	74.1	17.1	0.6			
Estimation of the need for substitutes and recruitment of substitutes	Test group	186	11.8	29.0	30.1	29.0	28.45	3	<.001
	Control group	158	2.5	14.6	52.5	30.4			
Recruitment of new employees	Test group	185	9.7	32.4	39.5	18.4	37.17	3	<.001
	Control group	157	4.5	13.4	36.3	45.9			

Discussion

Although our method in Project 1 for estimating case organizations' current and desired way of organizing cannot be considered precise, the results nevertheless show similarities among the case organizations. Team members perceived that their work in home care is currently organized mainly according to the *Achievement-Orange* organizational model (Laloux, 2014) that seeks effectiveness by giving goals and some freedom in how to achieve them. Team leaders seem to view the current situation of home care slightly differently. Their perception resembled more of the *Pluralistic-Green* organizational model (Laloux, 2014) that seeks to empower frontline employees.

Findings from Project 2 show a similar kind of evidence. While team leaders' expectations of self-organizing team practices were related to increasing efficiency and public image, team members hoped to have their voices heard more and increase their opportunity to influence how

home care work is conducted. In this way, team members believe they will be able to increase the quality of their work. Common to team leaders and members was that they all seemed to want to evolve towards self-organizing practices. This finding suggests that there are fertile grounds in Finnish home care to continue with coaching toward self-organization.

The results from projects 1 and 2 align with our analysis of the coaching activities' outcomes, revealing only minor advances toward self-organization in home care. Despite the common expectation of implementing self-management in home care, the teams' autonomy and the possibilities to influence their work did not develop positively (or the change was small). In contrast, in assisted living, the change was evident. In assisted living, the teams' autonomy was at a higher level and also in control teams compared to home care. As described earlier, managers' and employees' understanding of team autonomy differs. If managers see that the autonomy of the teams is already at a high level while employees do not, the circumstances to develop team autonomy are weak. One explanation for such a difference between assisted living and home care could be that home care uses ERP. This may have inadvertently inhibited the organization's evolution towards self-organizing team practices. Managers may give autonomy, but the ERP system makes decisions on all important things. It is also possible that in hierarchical municipal organizations, the management structure prevents fundamental changes in decision authority. The Lalani et al. (2019) study's barriers were similar. It is also possible that organizations are trying to pick cherries from new organizational models but only partially implement them. For example, employees are supposed to make decisions together, but the management style remains the same.

In assisted living, however, the changes were rather promising and showed that team autonomy in care work is possible. Team autonomy increased markedly in almost all fields through coaching. All assisted living facilities in this project were municipal organizations, similar to home care organizations. Why was it possible to increase team autonomy in assisted living but not in home care? In assisted living, employees in the team work together all the time, whereas the core work in home care is mostly done alone. In assisted living, similar to institutional care, there is a long tradition of developing different team models where employees make decisions without a manager. Secondly, in assisted living, the managers' responsibility is often larger than one work unit, perhaps two or four work units. This means teams must make many decisions as the managers are not present. Thirdly, ERP systems are used less in assisted living, and the tasks are divided into teams.

Our experiences coaching home care teams in the public sector and at a company suggest that the key challenge is transforming a hierarchical organizational culture into a culture that supports self-organization. Changing the mindset of stakeholders from one organizational paradigm to another can take a long time, which can be seen in the survey results. In organizations with strong hierarchical traditions, creating enabling conditions for change requires a significant contribution and commitment from the organization's management and supervisors. Therefore, in hierarchical organizations, the focus of development is initially on the leadership of the organizations. Particular attention should be paid to changes in management, conditions for building trust, the transparency of decisions, and the development of open communication and information when creating a team-friendly atmosphere and a process of cultural change.

Limitations

As the study was cross-sectional, we could not obtain information from the teams before coaching nor eliminate the possible effects of the selection of the test teams.

Conclusions

In this study, we wanted to understand better what kinds of expectations Finnish home care workers have about self-organizing teams and what kinds of outcomes Finnish early adopters have experienced after self-organizing principles have been introduced to their organization. To this end, we identified expectations about self-organization from home care workers that would soon be coached towards self-organizing practices and evaluated outcomes of self-organization

by comparing personnel survey results between teams in home care and assisted living facilities that have and have not been coached towards self-organizing work practices.

Our study revealed that employees and supervisors of our case organizations welcome the self-organizing team practices, but partly for different reasons. With self-organization, team leaders seemed to hope to increase efficiency and public image. In contrast, team members wanted better opportunities to influence how home care work is conducted.

Early experiences of introducing principles of self-organizing team practices revealed that implementing self-organized teamwork is difficult and time-consuming in the presence of a strong existing organizational culture and that the differences in the organizations may affect the pace of development towards self-organizing team practices. In assisted living facilities, teams were given more decision-making authority than in home care, which seemed to accelerate the change.

Implementing self-organizing teamwork practices requires changes in organizational culture and management style. There may also be ICT systems, such as ERP systems, which are based on the old organizational culture and effectively prevent self-organizing. In the future, it would be interesting to understand better the role of ICT systems and the different ways to use ICT systems when developing organizations towards self-organizing team practices.

Our study increases understanding of introducing self-organizing team practices into teams with a strong existing organizational culture. However, further research focusing on this topic is needed. Although the work practices of Buurtzorg have been reported to result in several positive outcomes, it is not clearly understood which elements of the Buurtzorg model or combination of them is the most influential factor (self-organization, including the neighborhood, ICT system). Most of the studies on self-organizing teams are case studies and qualitative studies. Without denying the value of qualitative research in providing a richer picture of the functioning of self-organized teams and their possible problem, we still have minimal evidence of the benefits of self-organized teams on care quality and staff well-being. In the future, longitudinal studies with a large sample of organizations and mixed-method studies are needed.

Acknowledgments

The authors want to thank the home care workers who participated in the study.

Disclosure statement

Project 1 was funded by the Finnish Work Environment Fund. Project 2 was funded by Keski-Suomen Kehittämisrahasto.

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