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Tackling the problem of regulatory pressure in Dutch elderly care: the need for recoupling to establish functional rules

Abstract

Regulatory pressure is widely recognized as a problem in healthcare. At first sight the solution seems simple: discard rules and give caregivers more resources to provide personalized care. Based on qualitative research in four elderly care organizations in the Netherlands, this paper shows that regulatory pressure is a persistent problem that cannot be solved on an individual level, as it results from a disconnect between the work of different actors in the healthcare system. Drawing on concepts from Organization Studies, the paper shows that the work of caregivers, healthcare managers and external actors is often decoupled. Caregivers experience regulatory pressure when the origin and function of rules are unclear. The studied care organizations are experimenting with rules, reconsidering and creating functional rules. They do so by stimulating reflection among actors in the healthcare system, thereby recoupling their work. The findings suggest that recoupling can be achieved by creating comfort zones, focusing on stimulating debate between stakeholders on the functionality and origin of rules and aligning ideas about good quality care, the role different actors can play and the rules that are needed to accommodate this.

Keywords: decoupling, elderly care, personalized care, recoupling, regulatory pressure

1. Introduction

Regulatory pressure is widely recognized as a problem in healthcare. Professionals, politicians and scholars alike claim that having to spend so much time on administrative tasks impedes the healthcare professionals' ability to give high-quality care to their patients [1-4]. Moreover, scholars argue that many rules fail to recognize that healthcare provision requires flexibility; professionals need discretionary space to attune their care to individual patients [5-7]. With the increasing emphasis on personalized care, this flexibility has become all the more relevant [8].

There is a wide variety of formal and informal rules in healthcare. These rules are designed by regulators, payers, professional bodies, healthcare organizations and professionals, and clients and their relatives. Many rules have important functions, e.g., ensuring good quality care and public accountability and research has shown that rules and procedures contribute to job satisfaction among nurses [9]. However, rules can turn into regulatory pressure. This is the case when rules are perceived to *'entail a compliance burden but do not achieve the functional objectives of the organization' [10]* 737-738]. The multitude of rules in healthcare can lead to conflicting demands and clashes in professional roles, which has a negative influence on job satisfaction [9]. For example, being confronted by an extensive set of specific rules is likely to conflict with incorporating a patient's needs and preferences.

From a psychological perspective, solutions to the experience of regulatory pressure should be sought in matching individual job demands (e.g., quantitative workload) and resources (e.g., control, self-efficacy beliefs) [11]. Discarding non-functional rules and providing professionals with the discretionary space needed to provide personalized care seems to solve the conflict. However, discarding rules is hard to achieve in practice. Regulatory pressure is a very persistent problem [12].

This persistence can be explained by looking at regulatory pressure from a governance perspective. From this perspective, differentiating between functional and non-functional rules might not be that easy. One actor (e.g., a healthcare professional) might find a specific rule non-functional, while another (e.g., a regulatory body) perceives the same rule as crucial to fulfilling its task. So regulatory pressure is not just a problem for individuals, it results from a disconnection between the work of different actors in the healthcare system. Therefore, solutions to the problem of regulatory pressure should not only be sought in the realm of individual demands and resources, but also in the realm of (dis)connections between the actors involved.

The concepts of decoupling and recoupling, drawn from Organization Studies, can shed new light on the problem of regulatory pressure, as well as on directions for policy development and improvement [13]. The literature points to the problem of means-end decoupling, which means living by the rules becomes an end in itself, even if it goes against the functional objectives of the organization [14]. Thus, decoupling contributes to the problem of regulatory pressure. To combat regulatory pressure caused by means-end decoupling, it is important to recouple the work of different actors, bringing their worlds together and reconsidering means and ends [13, 15]. In this paper, we contribute to the literature on regulatory pressure in healthcare by focusing on processes of decoupling and recoupling between different actors. We argue that more functional rules can be created through recoupling [10, 16].

Our qualitative research is based on a multiple case study of four elderly care organizations in the Netherlands. Dutch elderly care provides an excellent case as regulatory pressure is widely reported and is said to prohibit the provision of personalized care [17]. Also, several experiments are taking place that aim to tackle the problem of regulatory pressure by establishing more functional rules.

The paper answers the following research questions: *(1) How do different actors in Dutch elderly care experience regulatory pressure? (2) How do initiatives aimed at tackling the problem of regulatory pressure contribute to recoupling? (3) What lessons about developing more functional rules can be learned from these initiatives?*

2. Institutional context of elderly care in the Netherlands

The Netherlands are known for their generous long-term care system and for having a relatively high percentage of the elderly population institutionalized [18]. However, in recent years, much has changed in Dutch long-term care. With the introduction of the Long-term Care Act (*Wet Langdurige Zorg* [WLZ] in Dutch) in 2015, institutionalized care for elderly became available only to those with the greatest care needs [19, 20]. Government policy to promote 'aging in place' led to the closure of many residential care homes. As a result, Dutch institutionalized long-term care provision mainly consists of nursing homes. The fact that clients in nursing homes need permanent care and supervision makes the issues of personalized care (what are the wishes of individuals approaching the final stage of their life?) and regulatory pressure (how much time do nurses spend on administrative tasks compared to care-related tasks?) even more relevant than before.

Elderly care organizations have to relate to multiple external actors, each with their own sets of rules, e.g., various funders including regional care offices that direct nursing home care

under the WLZ, whose offices determine the severity of residents' needs (*zorgzwaartepakketten*). Home care is financed by the Social Support Act (*Wet Maatschappelijke Ondersteuning* [WMO]) which is directed by municipalities. In addition, people in need of care can apply for a personal budget to finance their own care. The Health and Youth Care Inspectorate supervises the quality of care provided in elderly care organizations. The Dutch Healthcare Authority supervises whether elderly care organizations and healthcare insurers comply with the financial rules.

3. Methods: Multiple case study

Our qualitative research is focused on understanding the respondents' beliefs, experiences and actions with regard to rules and regulatory pressure. By including multiple perspectives, we tried to develop a holistic view on the problem of regulatory pressure [21].

We conducted a multiple case study based on four elderly care organizations in the Netherlands that were organizing experiments on reducing regulatory pressure. The four organizations were selected based on their attempts to change and discard rules in order to provide more personalized care. They were involved in relevant projects that belonged to the Dignity & Pride (*Waardigheid & Trots*) national quality program for improvement of elderly care. Box 1 presents brief descriptions of the four organizations and their projects.

Qualitative research, consisting of interviews, observations and document analysis, enabled us to reveal daily regulatory practices and problems in elderly care. We conducted interviews (n=28) in the four organizations, with a broad variety of actors involved in the experiment (managers, team leaders, professional caregivers, directors). We asked whether and if so how the respondents experienced regulatory pressure, what their involvement was in experiments on limiting regulatory pressure, and what they thought/felt about it.

Observations gave us the opportunity to see rules and regulatory pressure in vivo in the daily care practices of the professional caregivers, and how they coped with regulatory pressure. We tried to find moments and meetings where we could experience the experiments in action. During the observations, we talked with professional caregivers and other relevant actors to find out more about their work on regulatory pressure.

We obtained permission from the management of each organization to conduct a case study and obtained verbal consent from all respondents at the start of interviews and observations. All data are anonymized. Box 2 contains specific details of the respondents and observations.

Besides interviews and observations, we conducted document analysis. These documents provided information about the context of regulatory pressure and the attempts to diminish this problem. We included policy documents that gave insight into the experiments and analyzed quality reports to gain more insight into organizations' policies. As the projects were embedded in the organizations' own broader policy, and influenced by national elderly care policies, we studied documents on these broader policies as well.

Alongside the case studies we conducted a round of interviews (N=11) with key informants in the national debate on regulatory pressure in elderly care. Interview topics included: the respondents views on the problem of regulatory pressure, how they perceived the link between rules and personalized care, their experiences with initiatives aimed at limiting regulatory pressure and how they related to other actors in the field with regard to regulatory pressure. In addition, we conducted observations at national conferences on elderly care and attended three national 'Breaking the rules' sessions (*schrapsessies*). Interviews and observations were aimed at exploring the meaning of regulatory pressure in the broader policy context of elderly care. Zooming in and out of both practices and policy [22], we compared the experiences and ideas of different actors in the healthcare system.

All interviews were transcribed verbatim and extensive reports were made of the observations. We used a combination of inductive and deductive analysis of these transcripts and observation reports. Based on our literature study, regulatory pressure, rules, personalized care, decoupling and recoupling were used as sensitizing concepts that offered a heuristic for inductive analysis of the empirical findings. The first three authors coded material using these sensitizing concepts. The reports were thematically analyzed to provide context to the attempts to diminish the problem of regulatory pressure. After the individual analyses, we discussed our codes together and mutually agreed on the four themes described in the results section. To validate our results, we presented our findings at the elderly care organizations we studied and also at a national elderly care conference. We used the responses to these presentations to fine-tune our analysis.

4. Results: problems, practices and persistence

This section first describes how our respondents perceive the problem of regulatory pressure. Second, we show that the persistence of the problem of regulatory pressure is connected to the problem of distributed or unknown origins of rules. Third, we present the results of attempts at (1) tackling the problem of regulatory pressure and (2) creating more functional rules through

the process of recoupling. The section concludes by showing that despite some success, the danger of a regulatory reflex that creates new dysfunctional rules is never far away.

4.1 Regulatory pressure: the problem of non-functional rules

Describing the problem of regulatory pressure, professional caregivers across organizations gave examples of rules they saw as non-functional in providing good care to their residents. These rules include accreditation systems, following (sometimes conflicting) protocols, filling in detailed care plans and daily registrations such as the temperature of the refrigerator, what residents have eaten and how often residents used the bathroom.

Complying with rules that standardize care costs time, and professional caregivers already feel pressed for time. There is the danger that strictly following these rules stops them from reflecting on what they are doing, thus limiting the situatedness of their work that is needed to provide personalized care. Certain registrations are not regarded as problematic but their standardized use does cause problems. A care professional provides an example:

> *You know, I find standard rules for everyone difficult. That you need to fill in a form to report an MDO [multi-disciplinary meeting] and then a fall-risk form and one of those medication forms as well. Then I think: why do it? Why all the red tape? And for someone who poops perfectly well every day, why do I need to keep a poop list for all residents as a rule? I understand if someone is on morphine, then you have to keep the list, but I wonder if it has to be done for everyone. (professional organization 2)*

Importantly, many respondents, not only professional caregivers but also managers, point out that the focus of many rules, e.g., on safety or freedom restriction, can conflict with residents' wishes. Consequently, these rules restrict the possibility of providing personalized care. One respondent gave the following example:

> *We once had a woman with psychogeriatric problems. She couldn't walk properly, but she wanted to walk all the time. We gave her a chair on wheels which she could shift by using her feet. A hip belt stopped her from getting up and falling out of the chair. She could move all over the place in her chair. But the Inspectorate [Health and Youth Care Inspectorate] told us that it was against the rules. Belts restrict freedom and are so they're not allowed. (quality manager organization 1)*

Professional caregivers try to find balanced solutions to such dilemmas but rules can stand in the way. Sometimes they have to work around certain rules to make personalized care

possible. In other cases this requires professional caregivers to discuss what good quality care should entail with the care team and the resident's family.

4.2 Persistent regulatory pressure: the problem of distributed origins of rules

External actors are often pointed at as the source of the problem of regulatory pressure. This is not always justified however, as many rules have an internal origin [4]. Also in our study we noticed that there is often a lack of clarity about the origin of rules. Many respondents recognize that it is often felt that rules come from external actors, e.g. the Health and Youth Care Inspectorate or the insurer, and therefore they have to follow them, whereas in fact rules frequently originate from elderly care organizations or care workers themselves.

> *During a discussion on regulatory pressure, two young care workers say they are really struggling with keeping residents' records. '[When a resident arrives] it takes a lot of time but afterwards you have to work on it constantly as well.' They give all kinds of examples of what they report on. Joining the discussion, others suggest that they do not have to report everything. The young care workers think this is strange: 'That's not possible because it's important to record [things]. We just* ***have*** *to do it. 'Says who?' asks a more experienced care worker. They don't know 'But there's probably legislation behind it,' the young workers reply. When another care worker says this is not the case, they respond with disbelief. (observations Dignity & Pride conference, 4-7-2017)*

The unclarity about the origin of rules adds to the problematic persistence of regulatory pressure. The fact that many rules are 'homemade' means that, in practice, elderly care organizations and professional caregivers often have more room to maneuver than they think they have. When the origin of a rule is unclear and attributed to external actors, the rule is perceived as a given. Such rules diminish the sense of ownership among caregivers; outsiders determine what 'good care' entails; they do not.

Even when the origin of a rule is clear, it is not easy to discard or change it, as rules usually influence the work of different stakeholders. Our observations of 'Breaking the rules' sessions aimed at discarding rules showed that while one actor might want to discard a certain rule, this rule will be important for the policy of other actors and it regulates the relations between them. Changing a rule therefore involves changing a social and organizational network. For example, a respondent from the Dutch Healthcare Authority (NZa) – that regulates healthcare providers and healthcare insurers – explained that they changed certain rules for healthcare insurers with the intention of reducing regulatory pressure on both healthcare insurers and healthcare providers. However, providers adhere to the 'old' rules because the insurer's reimbursement

systems are still built on the old rules, as are their own reporting systems. This demonstrates that discarding a rule in one place will not necessarily reduce regulatory pressure in another.

4.3 Using recoupling instruments to create functional rules that stimulate reflexivity

In order to tackle the problem of regulatory pressure it seemed important to recouple the work of different actors. Reflecting on the origin and functionality of rules would create rules that support rather than hinder good quality care and fit healthcare practices better [13, 14]. We saw different instances of recoupling taking place in our case studies. For instance, the experiments with the 'Kafka button' (organization 3) and 'red button' (organization 1) gave staff the opportunity to report on rules they considered problematic. These are not physical buttons, but online platforms where staff members can fill in a form. Reports are followed by an inquiry into the rule by quality managers of the elderly care organizations and the findings are fed back to the caregivers who 'pushed the button'. Sometimes this means that a rule is discarded. However, the function of a rule could be discussed and it could be concluded that it does serve a purpose, or could do with an adjustment. For example, someone pushed a button to report the protocol for weighing residents. According to the rule, residents had to be weighed on a certain day every month. This was time-consuming and, besides, not all residents liked being weighed so often. Analysis revealed that the official rule behind the protocol was to weigh residents at regular intervals; they did not have to do so every month. As a result, the protocol was changed into weighing residents every three months. This new rule was also debated:

> *But now care workers ask why they have to weigh every three months…. Now they think it's nonsense. So we talked about it and made an infographic [showing] why it's an essential element of basic quality of care (quality manager organization 1).*

This quote shows that changing a rule *needs* a discussion of its functionality by managers and professional caregivers, thereby recoupling the work of these actors.

Other functional ways to ensure and account for quality of care were also sought. The quality instrument 'Images of Quality' (*Beelden van Kwaliteit*) that organization 1 experimented with is an example. Ethnographic observations of care are an important element of this instrument. Long, close observations by trained professionals of daily work on the wards are used as a source of reflection on quality of care. Different actors contribute to this reflection: care team members, managers, and other internal and external stakeholders such as members of the board, client representatives, healthcare insurers and policy makers of the municipality. In one case the observations led to a discussion on the implicit rule or norm of professional caregivers

that residents should be kept active; something should be happening in the living room all day. This functionality of the rule was debated during a reflection session.

> *It's hard to motivate people. We get lots of remarks on that. (…) Sometimes we ask too much [of them], any activity is too much, really. Doing the laundry or putting flowers in a vase is already quite something, or planting bulbs in a pot and feeding the birds. (…) They [the residents] want to sit at the table. They don't want to do anything else. (…) Is silence a bad thing? No, it's want people want. (observations team reflection on Images of Quality, 18-1-2018)*

External parties and internal actors from different layers of the elderly care organization took part in a panel that reflected on the observations made with the Images of Quality method. In the dialogue between the panelists and the observed professional caregivers, it became clear that members of the panel reflected on the observations from their own healthy, young perspective. They understood that their own perceptions could differ from the perceptions of a resident suffering from dementia. Reconsidering their values and discussing the implicit rule or norm of 'being active' together recoupled the managers and professional caregivers and the external and internal stakeholders. Clearly the implicit rule 'activating residents' was difficult to comply with, causing stress for professional caregivers. Discussing implicit rules relieves this regulatory burden. Caregivers also reconsidered their interpretation of 'active'. Brief chats could also activate the residents, not just cooking together or playing games.

Our study shows that recoupling does not only need to take place within elderly care organizations but also between these organizations and external parties. For elderly care organizations to provide personalized care, they need discretionary space [23]. Several attempts to this effect have been made in Dutch elderly care. For example, the Inspectorate has changed its regulatory practices by including observations of care provision conducted by inspectors. The results of these observation are subsequently included in the conversations with healthcare directors about the quality of care they provide [24]. During these conversations elderly care organizations can explain why they choose not to follow certain rules. The emphasis is put on reflecting and learning instead of controlling certain aspects of care. At the same time respondents note that traditional accountability is still needed for certain aspects of care. Respondents across the organizations mention medication safety as an example of a clear rule that must be applied. Multi-faceted care thus requires a differentiation of rules and regulations.

Organization 4's personal budget, introduced as a way to offer personalized care, is a nice example of the need to recouple activities between different actors. The organization had to negotiate with all kinds of external parties, such as the Ministry of Health, Welfare and Sport,

regulators and healthcare insurers, to be allowed to replace the imposed rules that they felt were non-functional with the alternative financing structure of personal budgets. Working with personal budgets would not only change the financing structure but also supervision and other organizational aspects. The way the organization would register the care plan for residents would deviate from the Inspectorate's norms for example. Their negotiations succeeded. They were given 'exotic' status by the Ministry of Health, Welfare and Sport which permitted them to create their own set of new rules:

> *Being 'exotic' helped a lot, and [two civil servants] were strong diplomatic forces. You need them in the ministry and independent governing bodies [such as regulators] (....) otherwise I would've had to go to [the regulator] and say: 'hello!' And they would've been like: 'who are you and why are you here?' (project leader organization 4)*

This example shows that creating new rules and setting aside old ones can be done by an elderly care organization. However, this requires work from different actors within and outside that organization to create a context in which there is room to experiment.

4.4 The regulatory reflex and the danger of creating new non-functional rules

Respondents are positive about instances when they could make space for reflection and set aside or change rules that stop them from providing good quality care. This is especially the case when they can link their efforts to external organizations, such as regulators or payers, to which they have to account for their actions. However, our results show that this is not easy to achieve and the danger of re-regulation that hampers work practices is never far away.

In the first place our findings show that tools like the Kafka button or the personalized budget are in danger of being accompanied by a new set of detailed rules. In the case of the Kafka button (organization 3) rules were set for what can (or not) be reported with the button, and in the case of the personalized budget records (organization 4) new rules required reporting activities considered examples of normal personal interaction. Care teams also use the regulatory space created for them to make their own rules. Again these can turn out to be not functional in the provision of person-centered care:

> *Next week, on December 18th, is the Christmas dinner. Residents can invite someone to that. Then yesterday a care worker came to me and told me that they'd decided to tell the residents that no relatives would be allowed to stay for dinner on Christmas day: it would be just for staff and residents. So I said: Why did you decide that?' They felt that informal carers were already deciding everything, including Christmas dinner. So I tried to get them to reason from [the residents'] perspective: 'Okay, you're home*

alone, your partner is institutionalized and you can't see them on Christmas day. How would you feel?' Then we have a chat: 'Why does someone want to be here at Christmas? Isn't it a compliment to you that they want to be here? What can that someone do for you on the day? Can they help with the dinner? Can they lighten the workload?' Last night I got an email saying that it had been a nice chat and 'Now we think about it differently.' (team coach organization 1)

New rules are created for various reasons: they can create order, provide a sense of control, and grant certain power [9, 25]. Several respondents note that policymakers are also prone to falling into the trap of re-regulation. Where a new risk is identified, the regulatory logic is to come up with new rules for all organizations and clients. One respondent identifies this logic as working in relation to the extra money that the Ministry of Health, Welfare and Sport attributes to elderly care:

The danger is building an entire machine for control, to check if we are spending the [money] properly. (policy advisor branch organization)

However, it is important to note that not only policymakers or regulators create new rules; *all* actors in elderly care tend to do so.

5. Discussion

It is important to recognize the multi-faceted nature of regulatory pressure. Rules can be formal and informal and have many origins. They stem from external parties such as regulators as well as from elderly care organizations, professional caregivers and family members. Rules turn into regulatory pressure when their function or origin is not clear or is felt to conflict with healthcare practices and especially the value to deliver patient-centered care. Adding to the complexity of the problem is the finding that many rules link the work of different actors within and between organizations in the healthcare system [26, 27]. This is why discarding rules is extremely difficult and why proposals that focus on matching individual job demands and job-related resources [11] are not enough to solve the problem of regulatory pressure.

In this paper we drew on the concepts of decoupling and recoupling from Organization Studies. This enabled us to look at the problem of regulatory pressure in healthcare in a new way and come up with alternative solutions. The insights obtained from our multiple qualitative case study are highly relevant because the debate on regulatory pressure is not only prominent in Dutch elderly care but also in other sectors and in other countries [3, 4, 28].

In the cases we studied, we saw instances of means-end decoupling, e.g., related to accreditation systems, filling in detailed care plans and daily registrations. In such cases, the set rules are perceived as having no or only a weak relationship with the core task of the organization [14]. Working in accordance with procedures in these cases becomes an end in itself [13]. Decoupling can happen in different places: between management and professional caregivers, between professional caregivers and family members and/or residents and between external organizations such as regulators and elderly care organizations. The examples of combating regulatory pressure in our case studies show the importance of recoupling ideas on quality of care and the activities of different actors. This requires reflection on the values that underlie the means and ends. To solve the problem of regulatory pressure, the discussion needs to move beyond doing away with rules or giving professionals more autonomy. Instead, it requires a search for functional rules [16]. This way the risk of discarding too many (functional) rules and the subsequent risk of re-regulation can be prevented.

This search for functional rules can be accommodated by creating safe spaces or 'comfort zones' [29] where reflection on quality of care and the rules needed to guide care practices can be established. Discussions in these comfort zones requires establishing the origin and function of rules and debating them with all the actors connected to these rules. The discussion we observed between panel members and professional caregivers about the Images of Quality method can be considered an example on how to create a comfort zone. Similarly, the discussions we observed on the red or Kafka buttons and the national 'Breaking the rules' sessions (schrapsessies) are also good examples. The added value of such sessions is that they stimulate debate on and align ideas about good quality care and the role different actors can play in accommodating this. A possible downside of these discussions is that they take time, when professional caregivers report that they are already pressed for time. However, the results show that instances of recoupling are valued positively in healthcare practice as professional caregivers feel heard and supported. Even if a rule cannot be abolished or changed, discussing its functionality for different actors is valuable for mutual understanding as the dysfunctionality of a rule is not a character of a rule itself but of the way it is embedded in relations between actors and understood by practitioners. As setting functional rules reduces regulatory pressure – either by discarding rules or giving them new meaning – it is likely to save time and spare frustration in the future.

A final result we would like to point to is the prevalent reflex of all actors to create new rules that turn out to be not functional to providing good quality care. Although all actors in the system agree on the problem of regulatory pressure, they often create new rules that cause new problems. This bureaucratic tendency has been described in healthcare before and is also identified as a general societal paradox [25, 30]. Policymakers, healthcare managers and

professional caregivers alike should be aware of this tendency if they truly want to do something about the problem of regulatory pressure.

Our study has some limitations. First, the scope focused closely on the provision of care, whereas regulatory pressure is also felt elsewhere in healthcare, e.g., in management and financial departments. Second, our study was limited in time. While our exploratory study offers important insight into the subject of regulatory pressure and the need for recoupling, longitudinal studies into coupling processes in other places in healthcare (and elsewhere) are recommended for future research as they will offer insight into the dynamics of these processes. Finally, our study was limited in scope as it focused on a small number of case studies. By also conducting interviews with key informants on the national level and by focusing on common mechanisms between cases we have minimized the impact of this limitation.

6. Conclusions

Regulatory pressure is widely considered a problem in healthcare. It is argued that professionals need more regulatory space to provide good care. This need is exacerbated by the aim of providing personalized care. Regulatory pressure consists of rules that present professionals with a compliance burden but do not contribute to the goal of providing good quality care. In this article on Dutch elderly care, we drew on the concepts of decoupling and recoupling from Organization Studies, shedding new light on the problem of regulatory pressure by analyzing it as a problem of decoupling. From this analysis follows that policy makers, healthcare managers and professionals who want to tackle the problem of regulatory pressure should focus on creating opportunities for recoupling between all stakeholders. This can be done by creating comfort zones that stimulate debate on the functionality and origin of rules and align ideas about good quality care, the role different actors can play and the rules that are needed to accommodate this.

Organization 1 long-term care	Operates in several municipalities in the middle of the Netherlands. Provides both intramural care (15 locations) and home care. In nursing home locations, much attention is paid to creating a ‘like home’ atmosphere. Attempts to create functional rules and work on quality of care in new ways include introducing a red button that gives employees the opportunity to report unnecessary rules and ‘Images of Quality’, an instrument that does not quantify quality but focuses on observation and reflection.
Organization 2 long-term care	Operates in several municipalities in the middle of the Netherlands. Provides intramural care (13 locations), rehabilitation care and home care. It has tried to diminish regulation in the past, but was called to order by the Healthcare Inspectorate, which identified safety problems in several nursing home locations and demanded the organization re-introduce rules for e.g. medication safety. Professionals are happy with this stricter regime.
Organization 3 long-term care	Operates in several municipalities in the south of the Netherlands. Provides intramural care (10 locations), rehabilitation care and home care. In the nursing home locations, much attention is paid to giving residents more control. On-site experiments include opening internal doors to give residents more freedom to go from one ward or floor to another. The organization also tried to tackle the problem of regulatory pressure by introducing the Kafka button (comparable to the red button in organization 1).
Organization 4 long-term care	Operates in the north-west of the Netherlands. Provides intramural care (2 locations) and home care. Introduced the personalized budget in order to attune care to the wishes of clients. The agreed upon care is registered in the resident’s personal record. Agreements with the Ministry of Health, Welfare and Sport, the Healthcare Inspectorate and healthcare insurers have made this possible. Agreements include not having to comply with rules felt to be made redundant by the new personalized system (e.g. filling in care plans).

Box 1. Case studies

	Interviews	**Observations**
Organization 1	N=6 - 1 director - 2 quality officers - 2 middle managers - 1 team manager	16 hours - Meeting of Images of Quality - Care provision on the wards
Organization 2	N=7 - 1 director - 1 quality officer - 1 caregiver - 1 middle managers - 1 team manager	12 hours - Care provision on the wards
Organization 3	N=10 - 1 director - 3 middle managers - 3 quality officers - 1 facility manager & 1 financial manager (interviewed together) - 1 team manager - 1 client representative	18 hours - Meeting on Kafka button - Symposium informal care - Care provision on the wards
Organization 4	N=5 - 1 director - 1 project leader - 1 team manager - 1 caregiver - 1 care organizer	28 hours - Meetings of care providers and clients about personal budget - Training session on personal budget - Meetings with care organizations and insurer on personal budget
Key informants and national meetings	N=11 - 1 member Quality Council National Health Care Institute (ZIN) - 1 project leader administrative pressure Dutch Healthcare Authority (NZa) - 1 project leader, Administrative Pressure Ministry of Health, Welfare and Sport - 1 project leader Radical Innovation in Nursing Care - 1 director think tank '(Ont)regel de Zorg' - 1 director and advisor, Dutch national association of residential and home care organizations (ActiZ) - the Inspector-General Health Care Inspectorate - 2 healthcare purchasers from insurance company (interviewed together) - 1 director and 1 quality manager of an innovative nursing home (interviewed together) - 1 professor of Geriatric Medicine - 1 care entrepreneur, innovative small-scale care home	32 hours - Symposium, Dignity & Pride - Meeting, Radical Innovation in Nursing Care - Breaking the rules sessions
Total	**N=28**	**106 hours**

Table 1. Interviews and observations

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