REVIEW ARTICLE

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A Holistic Care Approach: The Adaptability of the Buurtzorg Model to the Turkish Health Care System

Ufuk Burak KARCIOĞLU [1]

[1]İstinye University, Faculty of Health Sciences, Department of Health Management, İstanbul, Türkiye.

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ABSTRACT

This study aims to analyse the core principles and practical outcomes of the Buurtzorg model, which originated in the Netherlands, and to evaluate its transferability to Turkey in the context of rapid population ageing, shifts toward nuclear family structures, and fragmented home health service delivery. This study is designed as a conceptual review. The theoretical foundations of the model are examined through the lenses of bureaucratic theory, integrated care frameworks, and community health perspectives. Empirical findings from the international literature are synthesised with particular attention to care-hour utilisation, hospital admission rates, patient and staff satisfaction, and cost efficiency indicators. These findings are comparatively interpreted within the structural and regulatory context of Turkey's home healthcare system. In light of Turkey's demographic transition and increasing chronic disease burden, there is a growing need for community-based, autonomy-driven home care models. Carefully designed pilot implementations that respect Turkey's regulatory and cultural context may improve equity, efficiency, and dignified ageing in place, enabling the development of a resilient and context-sensitive community care model.

Keywords: Buurtzorg model, Home care, Nursing

Bütünsel Bakım Yaklaşımı: Buurtzorg Modelinin Türk Sağlık Sistemi'ne Uyarlanabilirliği

ÖZET

Bu çalışmanın amacı, Buurtzorg modeli olarak bilinen Hollanda kökenli evde bakım yaklaşımının temel ilkelerini ve uygulama sonuçlarını incelemek; modelin kendi kendini yöneten hemşire ekipleri, profesyonel özerklik, bütüncül birey odaklı bakım ve topluluk ağı entegrasyonu gibi yapısal özelliklerini analiz etmek ve Türkiye'nin hızla yaşlanan nüfusu, çekirdek aile yapısının yaygınlaşması ve parçalı evde sağlık hizmeti sunumu bağlamında uyarlanabilirliğini değerlendirmektir. Bu çalışma kavramsal bir derleme niteliğindedir. Modelin kuramsal temelleri bürokrasi teorisi, bütünleşik bakım yaklaşımları ve topluluk sağlığı perspektifleri çerçevesinde analiz edilmiştir. Uluslararası literatürde yer alan ampirik bulgular; bakım süresi kullanımı, hastane yatış oranları, hasta ve çalışan memnuniyeti ile maliyet verimliliği göstergeleri açısından incelenmiş, elde edilen veriler Türkiye'nin mevcut evde sağlık hizmetleri yapısı ile karşılaştırmalı olarak değerlendirilmiştir. İncelenen literatür, modelin daha düşük bakım saati kullanımı, hastane yatışlarında azalma, yüksek hasta ve çalışan memnuniyeti ile maliyet etkinliği sağladığını göstermektedir. Küçük ve otonom hemşire ekipleri aracılığıyla sağlanan süreklilik, birey merkezli bakım planlamasını güçlendirmekte; toplumsal ağların bilinçli aktivasyonu ise bakımın sürdürülebilirliğini artırmaktadır. Türkiye bağlamında ise birinci basamak hizmetlerine entegre mahalle temelli otonom ekipler, primer hemşire sürekliliği ve dijital bürokrasi azaltımı gibi yerel uyarlamaların uygulanabilir olduğu değerlendirilmektedir. Türkiye'nin demografik dönüşümü ve artan kronik hastalık yükü dikkate alındığında, topluluk temelli ve profesyonel özerkliğe dayalı evde bakım modellerine ihtiyaç artmaktadır. Hukuki ve kültürel gerçeklikler gözetilerek geliştirilecek pilot uygulamalar, eşitlik, verimlilik ve yerinde onurlu yaşlanmayı destekleyebilir; Türkiye'nin kendi dirençli ve sürdürülebilir topluluk bakım modelini geliştirmesine katkı sağlayabilir.

Anahtar Kelimeler: Buurtzorg modeli, evde bakım, hemşirelik

Sorumlu Yazar: Ufuk Burak KARCIOĞLU, İstinye University, Faculty of Health Sciences, Department of Health Management, İstanbul, Türkiye.

E-mail: burakkarci23@gmail.com

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1. INTRODUCTION

The escalating burden of chronic diseases, population ageing, and the imperative for sustainable health systems have propelled home-based care to the forefront of global health policy debates (World Health Organization [WHO], 2020; Organisation for Economic Co-operation and Development [OECD], 2023). In high-income settings, innovative models that shift care from institutional to community environments have demonstrated capacity to improve outcomes while containing costs and enhancing patient autonomy. Among these, the Buurtzorg Nederland model stands out as a transformative exemplar of district nursing. Founded in 2006 by a group of experienced nurses frustrated with bureaucratic constraints, Buurtzorg organises care through small, self-managing teams (typically 8–12 nurses) that operate with near-complete professional autonomy, delivering holistic, neighbourhood-based support with minimal administrative oversight (Grey et al., 2015; Commonwealth Fund, 2015).

The model's defining features professional self-governance, relationship-based continuity, and integration of medical, social, and preventive dimensions have generated compelling evidence of impact. Independent evaluations document that Buurtzorg achieves substantially lower per-patient care hours (approximately 40% of budgeted time versus 70% in conventional organisations), faster restoration of patient independence, one-third fewer unplanned hospital admissions, reduced emergency department use, and markedly higher patient and staff satisfaction scores (often exceeding 9/10 in national benchmarks) (Ernst & Young, 2009, as cited in Commonwealth Fund, 2015; Monsen & de Blok, 2018; van der Lans & van der Zwaan, 2024). These outcomes are not merely incremental; they reflect a fundamental reorientation of care delivery away from task fragmentation and hierarchical control toward trust-based, value-driven practice (Nandram, 2015; Beadle & Sinnicks, 2025). The model's replicability has been tested in several European contexts, reinforcing its relevance beyond the Dutch welfare state (Hegedüs et al., 2022).

Turkey confronts a comparable convergence of demographic and structural pressures. The proportion of the population aged 65 years and older reached 10.2% in 2024 and is projected to exceed 20% by mid-century, driven by declining fertility and increasing life expectancy (Tuik, 2023). Concurrently, rapid urbanisation, rising female labour-force participation, and the progressive nuclearisation of families are eroding the traditional informal caregiving role historically provided by extended kinship networks (OECD, 2023; Mergen et al., 2013). Formal home health services, coordinated through the Ministry of Health's Home Health Services Programme and supplemented by private providers and municipal initiatives, deliver targeted

nursing, physiotherapy, and medical support to approximately 1.2 million beneficiaries annually (Ministry of Health of Türkiye, 2024). Yet the system remains characterised by marked fragmentation, heavy administrative burden, limited continuity of care, and constrained professional discretion for nurses features that compromise responsiveness, equity, and efficiency in the face of rising demand (GOLTC, 2025; Atun et al., 2013).

This conceptual review interrogates the transferability of the Buurtzorg model to the Turkish context. By synthesising evidence from high-impact international sources including systematic analyses in The Lancet family journals, OECD health system reviews, WHO nursing workforce reports, and peer-reviewed studies on organisational innovation it constructs a tripartite theoretical framework centred on (a) professional autonomy versus bureaucratic control, (b) holistic person-centred integration, and (c) network-embedded community health delivery. The analysis then maps these principles onto Turkey's current home-care landscape, identifying structural misalignments and proposing evidence-informed adaptations that respect cultural, legal, and institutional realities.

The objective is not to advocate wholesale transplantation of a Dutch model but to extract generative lessons that can inform a more adaptive, equitable, and sustainable evolution of Turkey's home-care ecosystem. In an era when health systems worldwide are compelled to reconcile fiscal restraint with rising expectations of dignity and personalised care, the Buurtzorg experience offers a compelling case that empowering professionals, integrating services, and embedding care in social networks can simultaneously enhance clinical outcomes, staff well-being, and system efficiency (WHO, 2020; OECD, 2023). This review contributes to that discourse by bridging global innovation with local reform imperatives in a middle-income setting undergoing rapid epidemiological and demographic transition.

2. MATERIALS AND METHODS

This conceptual review follows a structured literature synthesis approach inspired by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for scoping and narrative reviews, adapted for conceptual and transferability-focused work rather than a full meta-analysis. The process aimed to identify, appraise, and integrate high-quality sources on the Buurtzorg model, its theoretical underpinnings (professional autonomy, ethical organization, simplification, practical wisdom), empirical outcomes, and relevance to integrated home care, while contextualizing transferability to systems like Turkey's.

Search Strategy and Sources Literature was purposively selected from key international databases (PubMed, Google Scholar, Scopus) and targeted repositories (WHO IRIS, OECD iLibrary) using combinations of terms such as "Buurtzorg", "self-managing nursing teams", "home care Netherlands", "professional autonomy nursing", "holistic integrated care", "community-based nursing", and "long-term care innovation". No strict date restriction was applied, but priority was given to publications from 2015 onward to capture recent evaluations and adaptations. Grey literature from authoritative bodies specifically the WHO State of the World's Nursing 2020 report (WHO, 2020) and relevant OECD Health at a Glance series and long-term care reports (OECD, 2023; OECD, 2025) were included for global policy context on nursing workforce, community care, and integrated models.

Inclusion and Selection Sources were included if they: (1) directly described or evaluated the Buurtzorg model (core features, outcomes, organizational design); (2) provided theoretical framing relevant to its pillars (bureaucratic theory vs. autonomy, ethical/virtuous organization, practical wisdom, simplification/integration); or (3) offered comparative insights into home care or long-term care systems applicable to middle-income contexts like Turkey. Exclusion criteria encompassed non-English sources without accessible abstracts, purely clinical nursing studies unrelated to organizational innovation, and low-evidence opinion pieces.

The selection process is visualized in a simplified PRISMA-style flow diagram in Figure 1 (adapted for conceptual review; no formal meta-analysis conducted):

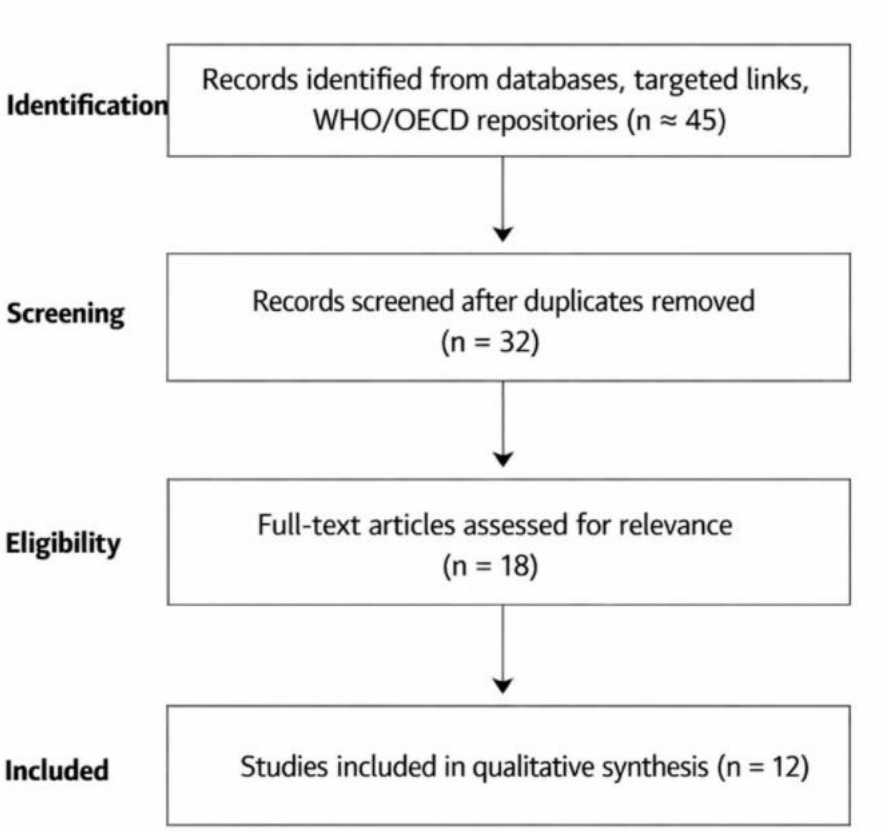

Figure 1. PRISMA Flow Diagram

3. LITERATURE REVIEW

3.1. Conceptual Framework

The Buurtzorg model is underpinned by three interlocking conceptual pillars that challenge conventional paradigms in health service delivery: professional autonomy supplanting bureaucratic control, holistic integration of care, and embedded community networking. These elements collectively enable a shift from fragmented, protocol-driven interventions to adaptive, value-oriented practice. This framework draws on established theories while grounding them in empirical evidence from the model's implementation.

Bureaucratic Theory versus Professional Autonomy

Max Weber's foundational theory of bureaucracy describes organisations structured around rational-legal authority, hierarchical chains of command, specialised roles, and standardised rules to maximise efficiency and predictability (Weber, 1947/2019). In long-term and home

care, this manifests as centralised planning, performance targets, detailed task allocation, and extensive administrative oversight mechanisms intended to ensure consistency but frequently resulting in rigidity, professional disempowerment, and reduced responsiveness to individual patient contexts (OECD, 2023).

Buurtzorg explicitly inverts this logic by vesting near-complete decision-making authority in self-managing teams of nurses. Teams of 10–12 highly qualified professionals (predominantly baccalaureate-level) assume full responsibility for the care of 50–60 patients in a defined neighbourhood, determining care plans, scheduling, resource allocation, and even team recruitment and conflict resolution without managerial intervention (Commonwealth Fund, 2015; Grey et al., 2015). Administrative support is minimal: a bespoke digital platform (BuurtzorgWeb) handles documentation, billing, and performance transparency using standardised taxonomies such as the Omaha System, while a small central office and regional coaches provide facilitative rather than directive guidance (Nandram, 2015).

This design aligns with contemporary critiques of excessive bureaucracy in health care, which link hierarchical control to diminished intrinsic motivation, higher burnout, and suboptimal outcomes (Beadle & Sinnicks, 2025; WHO, 2020). By contrast, Buurtzorg's emphasis on "practical wisdom" and trust-based autonomy fosters professional accountability, ethical deliberation, and adaptive expertise (Nandram & Bindlish, 2022). Evaluations demonstrate tangible benefits: nurse absenteeism and turnover rates are up to two-thirds lower than sector averages, staff satisfaction consistently ranks among the highest in the Netherlands, and teams achieve greater productivity through self-regulation (Commonwealth Fund, 2015; van der Lans & van der Zwaan, 2024). Conceptually, the model reframes health management from control-oriented efficiency to commitment-oriented professionalism, positing that empowered expertise not procedural compliance drives superior clinical, relational, and economic value. Figure 2 presents a dynamic systems representation of the Buurtzorg model, illustrating how professional autonomy, holistic care, and community network integration interact synergistically to produce value-based outcomes at patient, workforce, and system levels

Figure 2. Interaction of Core Pillars in the Buurtzorg Model

3.2. Holistic Care and Service Integration

Conventional home care often fragments services into discrete, task-specific packages (e.g., wound dressing, medication administration, personal hygiene), delivered by different cadres at different times, leading to discontinuity, duplication, and failure to address interconnected needs (Valentijn et al., 2013). Buurtzorg adopts a holistic, person-centred orientation that assesses and responds to the patient's full biopsychosocial and environmental context. Nurses act as "health coaches," co-creating care plans that prioritise self-management, prevention, and quality of life over mere task completion (Commonwealth Fund, 2015; Monsen & de Blok, 2018).

This approach mirrors established person-centred care frameworks, which emphasise lived experience, relational continuity, and integration across domains to reduce silos and enhance outcomes (Entwistle & Watt, 2013). Buurtzorg nurses deliver both skilled nursing and supportive activities (e.g., assistance with daily living), enabling comprehensive interventions within a single visit and fostering trust-based relationships. Evidence indicates that this integration accelerates patient independence: average care duration is shorter (e.g., 5.5 months versus 7.5 months industry average), patients regain autonomy faster, and unnecessary hospitalisations decline (Grey et al., 2015; OECD, 2023). Cost analyses show Buurtzorg uses

approximately 40% of authorised hours (versus 70% in traditional models), with case-mix-adjusted home-care expenses in the lower percentiles despite higher per-hour nursing wages (KPMG, 2015, as cited in Commonwealth Fund, 2015).

Visionarily, holistic integration positions health systems as enablers of sustained wellbeing rather than episodic treatment providers. It aligns with WHO's call for comprehensive community-based services that address multimorbidity and social determinants holistically (WHO, 2022), offering a pathway to value-based care that simultaneously improves quality and efficiency.

3.3. Network and Community-Based Health Systems

Health outcomes are profoundly shaped by social determinants and informal supports; isolated clinical interventions often fail to sustain gains when patients return to unsupportive environments (Marmot et al., 2008). Buurtzorg embeds care within neighbourhood ecosystems, with nurses proactively cultivating networks that include families, friends, general practitioners, therapists, volunteers, and local organisations. The "onion model" begins with the patient and radiates outward, mobilising informal and formal resources to build resilience and prevent crises (Commonwealth Fund, 2015).

This network-oriented strategy draws on community health management theories that view health as co-produced through relational capital and social infrastructure (Beadle & Sinnicks, 2025). Teams maintain a physical presence in the neighbourhood often with a local Office to facilitate introductions, build trust, and integrate community assets. Evaluations highlight how this reduces isolation, enhances preventive capacity, and leverages informal supports for long-term independence (Monsieurs et al., 2015; van der Lans & van der Zwaan, 2024). WHO frameworks endorse similar approaches for equity and sustainability in ageing societies (WHO, 2022).

In this pillar, nurses function as connectors within dynamic social webs, reimagining home care as a collaborative, place-based endeavour. By strengthening community ties, the model amplifies impact beyond individual episodes, contributing to broader population health and social cohesion.

These three pillars autonomy over bureaucracy, holistic integration, and networked embedding interact synergistically in Buurtzorg, producing outcomes that exceed traditional metrics. The framework provides a robust lens for assessing transferability to contexts such as Turkey, where bureaucratic legacies and fragmented delivery constrain responsiveness.

3.4. Core Features and Evidence of the Buurtzorg Model

Buurtzorg Nederland has evolved from a small entrepreneurial experiment into one of the most rigorously evaluated and widely discussed innovations in community nursing. Its operational model rests on a deliberately minimalist yet highly intentional architecture that maximises professional capability while minimising structural impediments. This section delineates the model's defining operational features and synthesises the accumulated evidence base, drawing predominantly from independent evaluations, peer-reviewed analyses, and international health system reviews.

At the organisational core are autonomous teams comprising 8–12 qualified nurses (predominantly registered nurses with baccalaureate or higher qualifications) responsible for the complete care trajectory of 50–60 patients within a clearly defined geographic neighbourhood. Teams possess full authority over clinical decision-making, care planning, rostering, budgeting within allocated resources, recruitment of new members, performance appraisal, and conflict resolution (Grey et al., 2015; Commonwealth Fund, 2015). No middle managers or team leaders exist in the conventional sense; instead, teams are supported by a small number of regional coaches who provide facilitative, non-directive guidance on request.

Administrative burden is radically reduced through a purpose-built digital platform (BuurtzorgWeb) that integrates standardised assessment and documentation using the Omaha System taxonomy, automated billing, rostering, and transparent performance dashboards visible to all team members and regulators (Nandram, 2015). Central office staff numbers remain exceptionally lowapproximately 45 employees for an organisation serving over 70 000 patients annually yielding an overhead ratio far below sector norms (van der Lans & van der Zwaan, 2024).

Care is delivered in a continuous, relationship-oriented manner rather than through task fragmentation. Each patient is assigned a primary nurse who acts as the main point of contact, supported by a small group of colleagues to ensure 24/7 availability without compromising continuity. Visits combine skilled nursing (wound care, medication management, palliative support) with supportive activities (personal hygiene, household assistance, companionship), enabling nurses to address multiple needs in single encounters and build deep relational trust (Monsen & de Blok, 2018).

Preventive and promotive dimensions are integral: nurses proactively identify risks (e.g., social isolation, declining mobility), mobilise informal supports, and coach patients and families toward self-management. Care plans are co-created with patients and families, explicitly prioritising quality of life, dignity, and autonomy over maximal service volume (Commonwealth Fund, 2015).

Buurtzorg deliberately locates teams within the communities they serve, often maintaining small neighbourhood offices that function as visible, accessible hubs. Nurses invest time in forging and maintaining networks with general practitioners, allied health professionals, social workers, volunteers, informal carers, and community organisations. This relational infrastructure enables early intervention, seamless referrals, shared care planning, and mobilisation of non-clinical resources to prevent escalation of needs (Monsieurs et al., 2015; Beadle & Sinnicks, 2025).

Multiple independent evaluations, employing diverse methodologies and comparator groups while controlling for case-mix differences, have consistently demonstrated Buurtzorg's superior performance across clinical, economic, experiential, and workforce domains. Key findings from high-profile studies, including those commissioned by the Dutch Ministry of Health, Welfare, and Sport, are summarised in Table 1.

Table 1. Comparative Performance Indicators: Buurtzorg Versus Traditional Dutch Home-Care Providers

Domain	Indicator	Buurtzorg Performance	Comparator (Traditional Providers)	Key Sources (APA 7)
Efficiency & Cost	Care hours utilised per patient (as % of authorised)	~40%	~70%	KPMG Plexus (2015, as cited in Grey et al., 2015); Ernst & Young (2009, as cited in Commonwealth Fund, 2015)
Efficiency & Cost	Overhead costs	~8%	~25%	Grey et al. (2015)
Efficiency & Cost	Aggregate annual savings to Dutch health system (estimated)	€300–500 million	-	Derived from KPMG Plexus (2015) and related analyses
Clinical Outcomes	Unplanned/emergency hospital admissions	One-third fewer (≈33% reduction)	Baseline	Grey et al. (2015); van der Lans & van der Zwaan (2024)
Clinical Outcomes	Length of hospital stay when admitted	Shorter	Baseline	Grey et al. (2015)
Clinical Outcomes	Time to regain patient autonomy	Faster	Baseline	Grey et al. (2015)
Clinical Outcomes	Average care episode duration	~5.5 months	~7.5 months	Grey et al. (2015)
Patient Experience	Satisfaction scores (national benchmarks)	9.1/10 (or 30% above average)	National/sector average	Commonwealth Fund (2015); Monsen & de Blok (2018); Centre for Public Impact (n.d.)
Workforce Outcomes	Nurse absenteeism and turnover rates	Two-thirds lower	Sector average	OECD (2023); WHO (2020); (Martela & Nandram,2025)
Workforce Outcomes	Staff job satisfaction and sense of purpose	Exceptionally high (multiple "Best Employer" awards)	Sector average	OECD (2023)
System-Level Effects	Overall home-care expenditure growth	Lower growth trajectory	Regions with traditional models	OECD (2023)

Despite its success in the Netherlands, international replication of the Buurtzorg model has yielded mixed results. In the United Kingdom, pilot implementations faced structural barriers

due to the separation between health and social care systems, limiting integration capacity (Hegedüs et al., 2022). Similarly, in the United States, fragmented multi-payer systems and reimbursement constraints have hindered scalability. In Japan, strong hierarchical professional norms and rigid role definitions have restricted the adoption of self-managing teams. These experiences indicate that contextual misalignment particularly in governance, financing, and professional culture can significantly limit the transferability of the model. Therefore, adaptation rather than direct transplantation is essential.

3.5. Limited Professional Autonomy and Continuity of Care

Nurses in Turkey's home health teams operate within a tightly regulated, hierarchical framework. Clinical decisions require physician approval for many interventions, care plans are standardised rather than individualised, and team composition is centrally determined with limited input from frontline staff. Professional discretion is further constrained by performance targets focused on volume (number of visits) rather than outcomes or patient experience.

Continuity is compromised by high caseloads (often 150–200 patients per team), frequent rotation of personnel, and lack of dedicated primary-nurse assignment. Patient and family feedback frequently highlights poor relational continuity, limited involvement in decision-making, and a sense that care is "procedural" rather than person-centred (qualitative studies cited in Atun et al., 2013; recent Turkish Public Health Association reports).

In summary, Turkey's home-care system delivers essential volume but struggles with the hallmarks of high-performing models: integration, autonomy, relational depth, and prevention-oriented flexibility. These gaps are amplified by demographic pressures and declining informal support networks, creating an urgent imperative for structural innovation. The next section draws lessons from Buurtzorg's evidence base to propose targeted, culturally attuned adaptations that could enhance responsiveness, equity, and sustainability within Turkey's existing institutional architecture.

3.6. Lessons and Adaptation Recommendations for Turkey

The Buurtzorg model's accumulated evidence showing concurrent gains in clinical effectiveness, patient and family satisfaction, nurse well-being, and overall system efficiency provides a rich source of transferable principles for Turkey's home health services. Rather than proposing a direct replication of the Dutch organisational structure, the following recommendations extract core mechanisms and adapt them to Turkey's regulatory environment (Social Security Institution reimbursement rules, Ministry of Health protocols), cultural

reliance on family and community solidarity, robust primary-care network through Family Medicine Centres, and ongoing digital health infrastructure (e-Nabız and e-Pulse platforms). The proposed adaptations are designed to begin with controlled pilots in selected provinces, allowing iterative refinement before broader scaling. A critical consideration in the Turkish context is the integration of such teams within the existing Family Medicine system. While Family Health Centres provide a strong primary care infrastructure, current legal frameworks limit nurses' authority in clinical decision-making, including prescribing rights and independent care planning. Under existing regulations, physicians retain primary responsibility for diagnosis and treatment decisions, which may constrain the full implementation of autonomous nursing teams.

A central lesson from Buurtzorg lies in the power of self-managing teams that hold genuine decision-making authority. In Turkey this could translate into reconfiguring selected home health teams initially 10–20 pilot units in high-demand metropolitan regions such as Istanbul, Ankara, and Izmir into small, geographically anchored groups of 8–12 experienced nurses. These teams would receive substantially expanded operational discretion over care planning, visit scheduling, resource allocation within predefined budget envelopes, and even recruitment of new colleagues, while preserving mandatory physician authorisation for high-risk clinical decisions in line with existing legislation. Centralised team assignment would give way to localised recruitment processes and self-selection, supported by regional facilitators whose role mirrors Buurtzorg coaches: offering training in collaborative decision-making, reflective practice, and conflict resolution rather than issuing directives. Anchoring these autonomous teams within or in close proximity to existing Family Health Centres would naturally strengthen integration with primary-care physicians, shorten referral pathways, and facilitate shared care planning. Early Turkish experiments with greater frontline discretion in primary-care performance incentives have already shown positive associations with staff motivation and service continuity, suggesting that such decentralisation could yield similar benefits in the home-care domain.

Another pivotal insight concerns the shift from task-oriented fragmentation to holistic, relationship-based care that prioritises quality of life and self-reliance. Turkey could move away from predominantly discrete interventions by encouraging pilot teams to adopt a primary-nurse model in which one nurse assumes ongoing responsibility as the main point of contact for each patient and family, supported by a small group of colleagues to ensure round-the-clock availability without sacrificing relational continuity. Care planning would evolve toward co-

creation with patients and families, explicitly incorporating biopsychosocial needs, preventive strategies, and goals related to dignity and independence rather than focusing solely on volume of visits. Nurses would be empowered to combine skilled clinical tasks with supportive activities in single encounters whenever clinically appropriate, reducing the number of separate professional visits and building deeper trust. Training curricula, potentially developed in partnership with nursing faculties and the Ministry of Health, could emphasise practical wisdom, motivational interviewing, and shared decision-making skills already recognised as high-value in international person-centred care frameworks. Such an approach aligns closely with Turkey's cultural context, where families remain deeply involved in caregiving, and could leverage that strength by formally including family members in care-plan discussions and goal-setting sessions.

The third major lesson emerges from Buurtzorg's deliberate embedding of care within neighbourhood social networks. In Turkey, nurses in pilot teams could be encouraged and resourced to systematically map and activate informal supports surrounding each patient, beginning with extended family but extending to neighbours, local mosques or community associations, volunteers, and municipal social services. This would involve structured yet flexible time allocation for relationship-building activities home visits that include family education, coordination meetings with general practitioners, and proactive linkage to community resources such as day centres or meal-delivery programmes. The existing e-Nabız platform offers a ready foundation for secure information sharing among providers, while future enhancements could incorporate simple shared care-plan templates and alerts for social-risk factors. By positioning nurses as connectors rather than sole providers, the model could amplify the preventive impact of care, reduce social isolation (a growing concern among urban elderly populations), and ease pressure on formal services through better mobilisation of informal networks precisely the dynamic that has contributed to Buurtzorg's ability to shorten care episodes and prevent crises.

Finally, meaningful bureaucracy reduction remains essential to realising these gains. Pilot teams could be supported by accelerated rollout of fully digital workflows already under development in Turkey's health information systems: automated authorisation for routine interventions, real-time rostering and billing integration, and simplified outcome documentation using standardised yet flexible taxonomies. Transferring administrative tasks to centralised support units or AI-assisted tools would free nurses to spend more time in direct patient contact, mirroring Buurtzorg's dramatic reduction in overhead. Initial cost-modelling

exercises, informed by OECD health-system comparisons, suggest that productivity improvements from reduced paperwork and higher nurse utilisation could offset higher per-hour compensation for more autonomous, skilled practitioners.

Taken together, these adaptations autonomous neighbourhood teams, holistic relationship-based practice, intentional network activation, and digital bureaucracy reduction offer a coherent pathway toward a more responsive, equitable, and sustainable home-care system in Turkey. Beginning with well-evaluated pilots in diverse settings (urban, peri-urban, and selected rural districts) would generate local evidence, surface implementation barriers, and build stakeholder buy-in among nurses, physicians, families, and policy makers. If successful, such reforms could position Turkey as a regional leader in innovative community-based long-term care, reconciling fiscal sustainability with the growing societal expectation of dignified ageing in place.

From a policy perspective, limited regulatory adjustments could facilitate implementation. These may include expanding nurses' authority in care planning within defined protocols, introducing limited prescribing rights for chronic care management, and formally recognising nurse-led care coordination roles. Such changes would not eliminate physician oversight but would enable more flexible and responsive service delivery aligned with international best practices.

4.DISCUSSION

The Buurtzorg model, through its emphasis on professional autonomy, holistic integration, and community-embedded networks, presents a compelling counter-narrative to the bureaucratic, fragmented approaches that characterise many home-care systems worldwide. In Turkey, where demographic ageing accelerates alongside the erosion of traditional family-based care, the model's principles hold significant promise for addressing persistent inefficiencies: service fragmentation across providers, excessive administrative burdens on frontline staff, limited nurse discretion, and suboptimal continuity and prevention. Adapting these elements could enhance responsiveness, reduce unnecessary hospitalisations, improve workforce retention amid growing specialist shortages, and align care more closely with cultural values of relational solidarity and dignity in ageing.

International experience with Buurtzorg-inspired adaptations, however, underscores that transferability is neither straightforward nor guaranteed. Attempts in countries such as the United States, United Kingdom, Denmark, Sweden, Japan, and India have encountered

substantial hurdles, including misaligned payment structures (e.g., multiple payers with conflicting rules in the US), rigid health-social care divides (as in the UK's "Berlin Wall" between NHS and local authorities), cultural mismatches in hierarchical expectations (evident in Indian pilots), and policy environments that resist decentralisation of authority. Many adaptations have required selective adoption of core elements rather than faithful replication, with mixed sustainability outcomes when economic viability or organisational support proved insufficient. These lessons are directly relevant to Turkey: the country's centralised reimbursement framework under the Social Security Institution, hierarchical traditions in public-sector management, and ongoing digital-health investments offer both constraints and opportunities. Wholesale adoption risks failure; targeted, iterative pilots that preserve regulatory safeguards (e.g., physician oversight for complex cases) while progressively increasing team-level discretion appear more feasible.

Potential benefits in the Turkish context are substantial. Autonomous neighborhood teams could alleviate nurse burnout and turnover by restoring professional agency. In addition, holistic, primary-nurse-led care could shorten care episodes, accelerate patient independence, and reduce overall system costs through fewer acute exacerbations. These outcomes have been consistently observed in the Dutch setting. Embedding nurses within family and community networks aligns seamlessly with Turkey's familialistic welfare tradition, potentially amplifying informal supports and reducing social isolation among the urban elderly. Digital bureaucracy reduction, building on e-Nabız and e-Pulse, could free substantial frontline time, mirroring Buurtzorg's overhead efficiencies (8% versus sector averages of 25%). Such changes would complement recent Ministry of Health preventive initiatives (e.g., on chronic diseases) and ongoing reforms aimed at quality enhancement in the "Healthy Turkey Century" programme.

Nevertheless, risks and barriers demand careful consideration. Increased autonomy could initially generate coordination challenges or inconsistencies if training and facilitative coaching are inadequate. Cultural resistance to diminished hierarchical control both from physicians and nurses accustomed to top-down structures may slow uptake. Fragmented governance across the Ministry of Health, Ministry of Family and Social Services, municipalities, and private providers could complicate integration, as could reimbursement rules that prioritise volume over outcomes. Workforce implications are double-edged: while higher job satisfaction is likely, scaling autonomous teams requires sufficient numbers of experienced, well-trained nurses a challenge given reported specialist exits from public hospitals. Finally, equity concerns

arise if pilots concentrate in metropolitan areas, potentially widening urban-rural disparities unless rural adaptations (e.g., smaller teams with tele-support) are prioritised.

Economic implications in Turkey may differ from the Dutch context due to comparatively lower labour costs. While Buurtzorg achieves cost savings through reduced care hours despite higher nurse salaries, in Turkey the financial impact may stem less from wage differentials and more from efficiency gains such as reduced hospitalisations, shorter care episodes, and decreased administrative overhead. Therefore, the economic value proposition may shift from direct labour cost savings to system-level efficiency and resource optimisation.

These complexities highlight the need for rigorous, multi-site pilot evaluation, incorporating process and outcome measures (patient independence, hospitalisation rates, staff retention, cost per episode, satisfaction) and qualitative insights into cultural fit and implementation barriers. Such evidence would inform phased scaling, policy adjustments (e.g., outcome-based reimbursement pilots), and cross-sectoral collaboration. Future research should also explore hybrid models that blend Buurtzorg principles with Turkey's strengths strong primary-care infrastructure and family involvement while addressing gaps in long-term-care financing and workforce capacity.

This study has several limitations. First, the proposed model is based on conceptual adaptation rather than empirical pilot data within Turkey. Second, potential professional resistance particularly within physician-centred hierarchical structures may pose significant implementation challenges. The transition toward increased nursing autonomy may be met with institutional and cultural barriers, requiring gradual change management strategies. Third, regional disparities in workforce capacity and infrastructure may limit scalability across different settings.

5. CONCLUSION

Turkey stands at a critical juncture in its home-care trajectory. Rapid population ageing, shifting family structures, and persistent systemic fragmentation create an imperative for innovation that balances fiscal sustainability with expectations of personalised, dignified support. The Buurtzorg model, while rooted in a specific Dutch context, illuminates a viable pathway: one that trusts professional expertise over procedural control, integrates care around the whole person rather than isolated tasks, and embeds services within community and family networks to foster resilience and prevention.

The adaptations proposed starting with autonomous, neighbourhood-anchored pilot teams, primary-nurse continuity, intentional social-network activation, and accelerated digital simplification offer a coherent, evidence-informed response tailored to Turkey's institutional and cultural realities. If implemented thoughtfully, with robust evaluation and stakeholder engagement, these reforms could yield transformative gains: higher-quality care, empowered professionals, reduced acute-service reliance, and a more equitable long-term-care ecosystem.

Ultimately, the question is not whether Buurtzorg can be transplanted intact, but whether Turkey can harness its generative principles to evolve its own distinctive model of community-based care. Success would position the country as a regional exemplar in reconciling demographic pressures with human-centred health delivery, ensuring that ageing in place remains not merely feasible but fulfilling. The time for such visionary, pragmatic reform is now.

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