Chapter 5
Breakthrough: Strengthening Mutual Caring and Sharing

How can we live together with shared responsibilities, support, and risks?
The starting point for making and keeping healthcare universally affordable, and accessible is mutual care and sharing. This concerns the readiness to pay and care for each other when this is necessary. It relates to sharing the risks and fulfilling the corresponding rights and obligations in terms of behavior and responsible use of shared scarce resources. This concerns financial means but also creating and maintaining a society in which people take care of other people who need attention, help and support. Four examples of brilliant business models who show the way are the following:

- ***Algemeen Ziekenfonds Amsterdam: This concerns a general insurance fund which was initiated in 1846 by doctors who wanted to take good care of their patients for a fixed membership fee which provided themselves with a decent living as well.***
- ***Dhan foundation: This is a mutual microfinance organization in India which facilitates and stimulates groups of people to take care of themselves and each other.***
- ***Courtyard houses: Which go back to the moyen-âge and illustrate how groups of people with a shared background can live apart together in social communities after retirement.***
- ***Liebenau Foundation: Which started a living concept in Germany where people from different generations share what they can offer in a community given their own age and abilities.***

Finding ways to keep proper care affordable and accessible is becoming increasingly difficult due to rising healthcare costs. This is placing pressure on mutual caring and sharing between people. The question how groups of people can provide and share care mutually is therefore of even greater importance. They can divide the cost of care or help one another in kind without payment.

You only realize what you are missing once it has gone. In countries where (practically) everyone has access to good care, a system of care provision and mutual

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cost sharing via collective resources and/or healthcare insurance is perceived as perfectly normal. The historical perspective in the West and the current perspective in developing countries are sources of inspiration in this respect. They offer an insight into how mutual caring and sharing of costs and risks can be organized if this is not yet a given situation. Moreover, they clarify the role of enlightened self-interest, and how the motives of the various parties concerned can be aligned. We can use these insights to examine how we can create self-financing and self-reinforcing business models that keep healthcare widely accessible in a financial context. During the organization of this mutual caring and sharing, agreements must be made about which risks will or will not be shared between groups of people that differ in terms of income, age, health, and lifestyle, and about the conditions under which this will occur.

Mutual caring and sharing is not only about money, it is also about attitude and behavior. Formal and moral rules and responsibilities are required to maintain the system and keep it operational and affordable. The "sharing economy" in which people give what they have in abundance in exchange for matters which are scarce for themselves is renewed by social media and the Internet, but it is also as old as the civilization.[1] This includes topics such as the classic problem of "common fields." If grazing land is shared, how do you prevent every villager from allowing more and more cows to graze there, resulting in overgrazing and lower yields?[2] The risk of an individual allowing an unnecessary operation to be performed or swallowing medication just because it is free is not as great within healthcare—yet another reason why medicines should remain loathsome. There is less reticence in relation to aids, physiotherapy, and home care because these are often also pleasant. This imposes the moral duty on all parties involved to avoid abusing the system as a free rider and therefore treat healthcare sparingly as a shared scarse commodity. People also have a personal responsibility to ensure they do not fall ill, be self supportive in their recovery and look after themselves so that they stay as healthy as possible. Chapter 6 also takes a detailed look at ways to encourage and organize prevention and self-management.

Whereas mutual caring and sharing in healthcare relates primarily to sharing costs, daily living assistance more often revolves around caring for each other. Besides sharing financial risks in order to pay for care, mutual caring and sharing can therefore also be expressed in a nonmonetary form via informal care provided by family members, friends and neighbors. The daily living assistance that is provided can be more nursing in nature. It can also entail helping out with household chores or giving personal attention. This usually concerns people who care for children, people who are physically or mentally handicapped or elderly people in need of additional care. Housing for the elderly is an example of a major, topical theme with which this can be made concrete. Few people dream about ending up in a care home where they are dependent upon professional nurses. People often want to stay at home as long as they possibly can or, in any event, within an environment that

[1] Kemperman, Geelhoed en Hoog (2015).

[2] See for instance: Hardin (1968) and Axelrod (1984).

is as familiar to them as possible. From a social and societal perspective, it is ideal if you can grow very old independently in as healthy a manner possible with assistance from family members. This is increasingly becoming a great challenge. The cost of care and living assistance explodes the moment people leave their home, which also poses a major financial problem for society and the parties involved. The starting point is the situation in which people actually do not require professional care yet, but develop a need for communality and informal care provided by family and friends as a safety net. Due to the combination of an ageing population and technological progress, people are growing increasingly older and developing more and more chronic illnesses. The number of people with dementia is also on the rise, and this condition makes it difficult to live safely and independently.

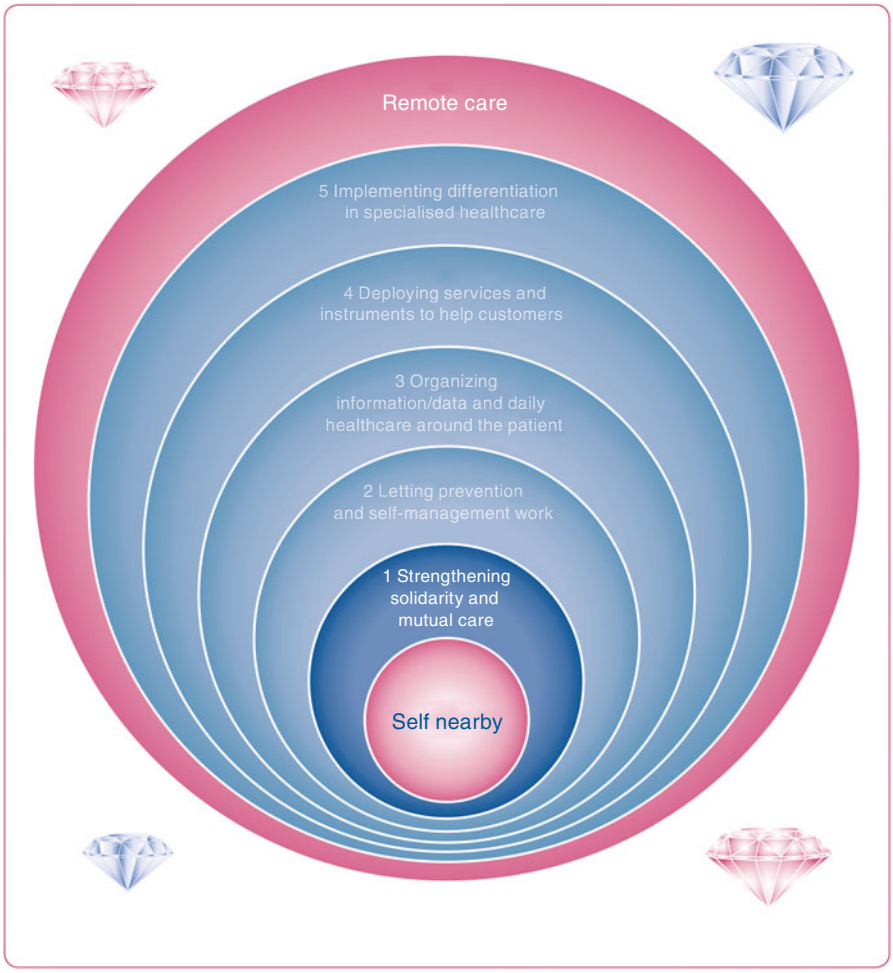

Figure 5.0.1 Breakthrough Strengthening mutual caring and sharing

Business Models Like Algemeen Ziekenfonds Amsterdam (A.Z.A.) To understand the value of mutual caring and sharing and how this can be structured, we can take a look into the past at the archetype put in place by the first healthcare insurers. This chapter examines the Algemeen Ziekenfonds Amsterdam (A.Z.A.) in the Netherlands. Via Z.A.O., Agis and Zilveren Kruis, it is a key player in the establishment of Achmea (the largest healthcare insurer in Europe and the largest general insurer in the Netherlands) as it exists today. A.Z.A. has been selected for several reasons. It was founded in 1946 and became operational in 1847 at a time when ordinary working people had no access to adequate healthcare. Consequently, it truly did make a difference in peoples' lives. A.Z.A. was the greatest example for subsequent health insurance funds that insured Dutch citizens below a fixed income threshold. The aim of these funds was to provide everyone in the Netherlands with access to proper care, which is still a fundamental principle of the Dutch healthcare system. A.Z.A. was established by doctors and provided an example for managed care and financing based on a fixed payment for a particular population. It was not the only health insurance fund of its time. The Netherlands alone had a wide range of regional health insurers in the nineteenth century. In addition to compulsory health insurance funds, there were more nonprofit philanthropic funds established primarily by notable citizens, commercial operational funds, and mutual compulsory health insurance schemes in which people organized themselves as a group. It also concerns insurance funds which have a background within a specific group or professional such as the mutualities in Belgium. Members of organizations such as "Onafhankelijke Ziekenfondsen and the Nationaal Verbond van Socialistische Mutualiteiten" have roots which have similarities with Dutch health insurance corporations. In the nineteenth and twentieth century, the rest of Europe also saw the emergence of a range of different systems for financing healthcare. This often involves government financing. Market leaders such as Medibank in Australia and VHI in Ireland were once originated by government and later on transformed into independent organizations. Depending on the country concerned, public healthcare is a complete system that hardly requires the involvement of an insurer or one that involves an elementary basis provided by the government where many people take out additional insurance with a private health insurer. Since the background, setting and reimbursement systems differ widely between countries, most insurance activities as well as the healthcare providers are still national in nature. Compared to other industries it is not very concentrated across borders. The more international health insurance companies often have found a specific strategy for internationalization such as via expats like BUPA, via general insurances such as AXA, or via services such as prevention which are less country and reimbursement specific such as Healthways and Discovery. Cooperation on a national level in the USA is supported by America's Health Insurance Plan's (AHIP's) which has 1300 members. Activities between countries are supported with joint organizations such as Eurapco for insurers with a mutual background in Europe. This includes the insurers Achmea from the Netherlands, Reale Group from Italy, Localtapiola from Finland, Gothaer from Germany, Covea and La Mobilière from France, Caser from Spain, and Länsförsäkringar from Sweden. The leading international platform

for cooperation in health insurances is the International Federation of Health Plans (IFHP) with members such as AXA, Medibank, BUPA, VHI, Discovery, Helsana, Sanitas, Blue Cross & Blue Shield, Kaiser Permanente, AHIP, UPMC and Achmea. The current Dutch system like in most countries has its very own characteristics. It operates via health insurers but is also highly regulated at the same time. It uses market dynamics while controlling the downsides by mandatory enrollment, laws against selection and pooling of risks of the people with higher expected health costs via an equalization fund. It is relatively unique in an international context and the history of A.Z.A. plays a key role in this.

Business Models Like DHAN The search for ways to foster mutual caring and sharing risks is still relevant today. Microfinancing and insurance in developing countries are the contemporary version of the health insurers established in the West in the nineteenth and twentieth century. Faced with similar challenges, they offer solutions that are essentially very similar to those of the first insurers in the West. These solutions fully take into account the own culture, traditions, and problems in developing countries. Mutual health insurance is often the Holy Grail at the end of the journey: it is difficult to obtain and requires other matters to be taken care of first. This frequently involves sharing damage-related risks such as fire, flooding, and crop failure. It often only arises after people have acquired possessions to lose and protect. Money is usually spread over time in the period before people start to insure themselves: borrow now what you will repay later or save money now that you want to spend later. The cornerstone is the community, the mutual group itself. Microfinancing and insurance are often combined with collective activities, such as the joint purchasing of seeds or equipment, or sharing information about the weather, prices, or organizing community healthcare. DHAN in India is an example that we have selected here. This foundation also extends beyond (care) insurance. It is also about lending money to one another and joint activities such as water management and hospital construction. DHAN is an impressive example of an organizational model which realized a large size while keeping the human dimension in sight. It has developed into an organization with over one million members and still has only a very small central organization. The members are primarily groups that multiply organically on the basis of shared values relating to self-employment and rules pertaining to the organizational setup. The number of micro-bankers and insurers in general has increased significantly over the past few decades. The most famous initiator with a Nobel Prize-winning business model is Grameen Bank in Bangladesh. Another renowned leader from the 1980s is Bank Rakyat in Indonesia, which has become a stock exchange-listed company. Both Grameen Bank and Bank Rakyat developed into organizations with more than a million members even though they still had a manual administrative system. Examples of other micro-insurers and in particular micro bankers are Banco Solidario in Ecuador, Equity Bank in Kenya, SKS and SEWA Bank in India, BRAC in Bangladesh, and Compartamos and Fin Comun in Mexico. These successful examples have prompted other commercial financial institutions to venture into this market. They often do so out of social responsibility, but also due to a business perspective geared to creating market share

and expanding it in the future. Examples include Credifé, part of Banco Pinchincha from Ecuador, Banco SOL in Bolivia, Sagebank in Haiti, ICICI Bank in India, Banco Bradesco and Banco Real in Brazil, and Banco Caja Social from Colombia. Micro-bankers and insurers have also emerged from other sectors. The starting point often is to lend money to people so that they can buy the supplied product. Banco Aztecan in Mexico does this for electronics and household equipment and CEMEX does likewise for construction material. SELCO in India lends money for the acquisition of solar panels.[3] Mobile telephony providers such as G-Cash constitute a fascinating, rapidly emerging group within financial services in developing countries. Section 8.3 takes a closer look at the M-PESA case which shows what instruments this can provide to enlarge access to healthcare.[4]

Business Models Like Courtyard Houses In the quest for new forms and formulas enabling people to live at home for as long as they can and in as healthy a manner as possible, one can look—in addition to professional care homes—at mutual solutions that have been implemented within society according to a small scale approach. As is the case with healthcare insurance, this search can be initiated by drawing inspiration from the past. Centuries ago in the Netherlands, for example, a surprisingly simple combination was conceived whereby accommodation, care and pensions were provided via courtyard houses. These were structured according to a small scale approach within the own group and established by means of a bequest. A one-off payment entitled elderly people to live in a courtyard house until their death. The additional alms they received took the form of a weekly supply of food and drink. A combination was therefore found between private altruism and personal contributions and responsibility that has continued for centuries. This case examines the establishment of these courtyard houses, of which there were hundreds. The majority of the courtyard houses were originated by private individuals and usually contain 12 to 15 small appartments. There were also larger courtyards houses. The majority of these originated from guest houses, leper houses, plague houses and lunatic asylums, which existed in most European countries from the middle ages on. If we examine the versions of courtyard houses in existence today, we can look at the very same ones. Most of them are still in use, occupied partly by senior citizens on the basis of a similar formula, but usually with a regular monthly rent. They are often inhabited by students since senior citizens desire greater comfort and privacy nowadays. Luxury residential care homes, are becoming more popular. These target wealthy senior citizens who want to swap their large, high-maintenance private homes for a flat that offers living assistance facilities and comfort. Remarkably, realizing this independently as a group of

[3] For more background information and examples, see for instance: Collins, Morduch, Rutherford, and Ruthven (2009), Rhyne (2009), and Preker, Lindner, Chernichovsky, and Schellekens (2013). The cases of Rakyat, SKS, Grameen and G-Cash are also included in Kemperman, Geelhoed en Hoog (2015).

[4] For more background information and examples, see for instance: Collins, Morduch, Rutherford, and Ruthven (2009), Rhyne (2009), and Preker, Lindner, Chernichovsky, and Schellekens (2013).

seniors appears to to be a difficult task and promising ideas often do not come to fruition.

Business Models Like Stiftung Liebenau We also see examples nowadays of local communities that have organized mutual care completely differently, in which living assistance is integrated perfectly naturally within the day-to-day lives of a group of people with strong ties. The German foundation Stiftung Liebenau is an inspirational, modern-day example of such an approach, in addition to the Dutch historical courtyard houses. This foundation provides residential communities where the very elderly can live together with people who have just retired as well as families with children. The concept works since these groups participate in the community in accordance with their individual abilities and needs. Liebenau is additionally unique thanks to the creation of a formula that can be reproduced quickly. The foundation approaches a municipality and asks it to assist with the acquisition of a specific plot of land intended for the establishment of the new residential community. Once the project has been completed, the building and the guaranteed rental agreements are sold to investors and the money can then be reinvested in the following residential community. This allows the capital to be reused again while investors enjoy a solid and safe return on their investment. The communities created in this manner can best be compared to a small neighborhood, a street or a large building where people have strong social ties and are ready to help each other. Unusually normal, in other words. It is therefore also similar to a wide range of social residential solutions. As a business model, it is comparable with capital providers and real estate developers who truly engage in vertical integration. They do not merely construct a building, but are also intensively involved in its purpose and utilization. This is very common in modern large infrastructural projects. This sort of social-design and programming is used less in the construction of affordable homes with living-assistance facilities for senior citizens, especially if this involves nonfinancial solutions supported via new forms of financing. This truly is a challenge as a senior if you need to take the specific situation into account. Often (some) pension money and savings and occasionally some equity in an existing house exist, but you are not sure how much time you still have left to live and the full extent of the living assistance that you will require. Additionally you can not purchase care or living assistance using the bricks of your existing home. A inspirational example with another perspective is provided by Argoz, a land developer that moved into finance in El Salvador. Argoz purchases plots of land, builds roads and facilities upon these and also constructs homes especially for low-income groups. These people can also obtain loans to finance their new homes if required. The company offers new residents a way out of the slums, an opportunity that never existed before. At the same time, it is a highly cost-effective approach for Argoz.[5] It is therefore not only valuable but also scalable for all parties concerned, just like Stiftung Liebenau.

[5] Rhyne (2009).

5.1 Algemeen Ziekenfonds Amsterdam (A.Z.A.)

"Doctors for the little man"

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Prelude[6] *The Dutch Minister of Home Affairs requests in a letter from 24 August 1842 that the Provincial Committee for Medical Control and Prevention in the province of Noord-Holland notify him about "the objections raised about illness funds and to provide him with measures that could yield improvements."*[7] *The local Committee in Amsterdam subsequently publishes a report in December 1842 detailing the situation in the Netherlands concerning these small private insurance funds for illness.*

The Committee's conclusion is as follows: "We are therefore of the opinion that, if illness funds cannot be kept out altogether, their number should be decreased, as should the number of members, to the extent that not too much care be placed in the hands of a single practitioner, or to avoid the appointment of more than one practitioner from the circle of associated members; that a practitioner should not be allowed to accept a larger number of patients than he can care for properly; that

[6] This article is largely based on Leclerq (1947) and passages from that research have been incorporated into the article (adapted or not). A number of literal quotations have been given an endnote in the text.

[7] Leclerq (1947), p. 16.

henceforth no new illness fund may be founded before authorization has been granted following a thorough investigation by the proper authorities whereby the number of members has been established as well; and that—in order to rule out any abuse—financial management should be placed under the supervision of a notary public or another authoritative type of surveillance; and, if it were possible to achieve this, that only the representatives from what we usually call the lower classes of society are admitted to the illness fund, with the exclusion of those who can rely on their financial resources to ensure proper medical care. As a result of all of this, which is crucial, the number of illness funds members could be suitably reduced while in addition—which is equally important—the medical profession (with too many practitioners owing to the multiplication and extension of illness funds) would regain its traditional esteem and, moreover, an associated benefit would be that abuse, so rife in pharmacy, would be eliminated rather effectively as well."[8]

The report is filed and the Dutch Minister of Home Affairs leaves matters as they are. This does not suffice though for some doctors and surgeons in Amsterdam, who want to create an alternative for the small illness funds. On 24 October 1846, in the Oude Wapen van Amsterdam, a building situated on the corner of Kloveniersburgwal and Rusland, they therefore decide to establish the Algemeen Ziekenfonds van Amsterdam. These doctors introduce principles such as the welfare threshold and the freedom to choose a doctor (among the many doctors exclusively affiliated to A.Z.A.). A.Z.A. provides the cornerstone for the health-insurance system that followed later and that lies at the heart of Achmea's current health-insurance activities. Achmea is now the largest health insurer in Europe in terms of premiums and, partly thanks to its strong position within healthcare, the fifth largest insurer in Europe for non-life including health, and the market leader for insurance in the Netherlands.[9]

Introduction The French Revolution at the end of the eighteenth century gave people many things: freedom, equality and fraternity to be precise. The Netherlands was also "liberated" by the French in 1795. However, the rigid organization of professions within guilds in the Netherlands at that time is entirely contrary to the concept of "freedom" embodied by the French Revolution. If terms and conditions must be complied with before a person may exercise a particular occupation, this is not exactly indicative of freedom. The Constitution of 1798, which is the Netherlands' first, therefore also abolishes all guilds, including guild funds. Members deposited fixed sums of money into these guild-administered funds periodically. In the event of illness, they were used to offset any loss of income and cover the costs of medical assistance later on. This mutual care for one another in accordance with strict rules observed by people with a similar craft, including prohibitions and penalties, dissappeares when guilds are abolished. A replacement is not forthcoming. The working population is therefore left to its fate and has to endure poor conditions. The lower and lower middle class have no access to medical care. What happens next?

[8] Idem.

[9] Duffhues (ed.), Korsten and Vonk (2011), p. 67.

Entrepreneurs jump in to fill this gap and continue on a commercial basis, and new guild funds are established. People try to make arrangements amongst themselves. But it is all too small-scale to really bear the associated risks, completely dependent on a single (commercial) administrator, and riddled with mismanagement. The power wield by the administrator meant that medical care is often of insufficient quality due to the excessive burden and underpayment endured by healthcare practitioners. Doctors and pharmacists in Amsterdam can no longer bear to witness the lack of proper healthcare. What can they do about this?

On 15 March 1846, the home of Dr. M. Busch Geertsema hosts a meeting attended by doctors and surgeons with no affiliation to the sickness funds. They come together to discuss a proposal on "the creation of a general health-insurance fund from the corps of doctors themselves." The founders deem this necessary in the interest of doctors as well people in need of care in order to combat misuse, lack of care and the degradation of the medical profession. The health insurance fund will involve "participants" (the doctors) and "members" (the insured). A draft regulation and an explanatory memorandum are drawn up to attract doctors and pharmacists to this initiative. The response is very positive and over 80 doctors indicate in writing that they are willing to participate. A similar number provide a verbal commitment to this end. And so on 24 October 1846, the decision is taken to establish the *Algemeen Ziekenfonds te Amsterdam* (A.Z.A.). On 1 December, the General Board was chosen from among the participants, heralding the first time in The Netherlands that a health insurance fund is managed by doctors. It is a precursor to integrated managed care, with the insurer and healthcare practitioners working together as a single organization as is internationally visible in various countries. Doctors seize the opportunity to turn criticism into action and prove that it really can be done better. The health insurance fund becomes operational on 1 April 1847 and members are now able to register. Just a few months after its establishment, A.Z.A. is already the second largest health insurance fund in Amsterdam.

As is customary in managed care, doctors provide the treatment they deem to be medically necessary without any further limitations. This is substantially more than what existing illness funds are offering. Of course this appeals completely to people who are unhealthy and very care-dependent. That much appeal was extremely dangerous. The fledgling health insurance fund immediately suffers a substantial financial deficit and has to take drastic survival measures in its first year. To ensure A.Z.A. remains financially sound, the premium is increased, members are asked to pay an additional contribution and new participants are charged an admission fee. Measures are also taken to limit the prescription of treatments, lower medicine prices and reduce doctors' fees. Even more startling, participating doctors are asked to help tackle the deficit by making a voluntary deposit. However, a form of profit sharing for doctors is introduced so that they can also benefit when things go well in the future. The roller-coaster ride continues. All the measures implemented to deal with the deficit make A.Z.A. much less appealing to the insured, and 40 % of its members leave at the start of the second year. These drastic measures are justified, however. Financial results improve and grow steadily, along with membership, after the second year.

Table 5.1 Financial results A.Z.A. 1847–1852

Period	Balance	Members
1-4-1847 to 1-4-1848	Deficit USD 6363 (EUR 5408)	9205
01/04/1848 to 01/04/1849	Deficit USD 1451 (EUR 1233)	5712
1-4-1849 to 31-12-1849	Positive balance USD 669 (EUR 569)	6132
1850	Positive balance USD 2181 (EUR 1853)	6907
1851	Positive balance USD 3403 (EUR 2892)	8959
1852	Positive balance USD 2411 (EUR 2049)	11,644

The difficult start-up phase imediately provides doctors and "their" members with important lessons and experience. Even when losses are made, members receive the care promised to them. Doctors prove they are willing to make personal sacrifices when the situation becomes tense and require the adoption of such measures. This fosters mutual trust in the healthcare fund and shows that members' and participants' interests are equally represented by the General Board.

5.1.1 The Cornerstone: "The Little Man and the Doctor"

Let us return to the situation that existed prior to the establishment of the healthcare fund. At that moment poor relief is provided to people who have the least money. Wealthy citizens are in the position to pay for the care they desire out of their own pockets. Highly expensive specialist treatments do not exist yet. Very few arrangements are in place for the working class and if something has been organized with an illness fund, it can be nullified due to mismanagement by the administrators. "Insuring the little man (the lower and lower middle classes) with medical assistance" forms the essence of the creation of A.Z.A. It is not only about offering insurance, but also about ensuring that good medical care is provided at all times.

The higher goal of A.Z.A is to "Insure the interests of the less fortunate class in times of illness in the most effective way."[10] Members have to be able to rely on their health insurance. Doctors establish A.Z.A. to combat the misuse of the existing smaller illness funds by their administrators. Administrators want priority treatment for themselves and their dependents, and decide who is and is not entitled to join an illness fund. In addition, doctors believe that these individuals are trying to benefit financially from the illness fund. Many administrators own a pub or wine house and like organizing illness fund meetings within their own establishments, where members spent their hard-earned money on drinks. Members of A.Z.A. board do not receive any remuneration in order to avoid conflicts of the interest. In addition to the medical board, a supervisory board comprising prominent citizens of Amsterdam is

[10] Leclerq (1947), p. 142.

tasked with managing the fund's finances independently. During the establishment of the fund, wealthy citizens are asked to assist with the creation of a reserve fund, which they duly do. Amsterdam is therefore closely connected to A.Z.A., which inspires profound trust among all concerned.

A.Z.A. promises to "Provide medical assistance that is as comprehensive as possible to the little man for a moderate weekly contribution, and ensure that those providing this assistance are properly remunerated."[11] In addition to members, it is therefore also about the own interests of participating doctors. The interests of both groups has to be represented and remain in harmony. Both groups have to be willing to compromise when circumstances require them to do so. But upon the establishment of the health insurance fund, it is stated during the participants' meeting held on 30 June 1848, when financial deficits emerge, that "the first knocks would have to be weathered not by members but by participating doctors."[12] This also stems from the birth certificate of A.Z.A., which features an audacious goal for the new health insurance fund: "What needs to be done to vigorously combat increasing pauperism and support the needy."[13] Solidarity between doctors and members as well as within each of the groups plays a pivotal role in the establishment of A.Z.A. This means that all resources and care have to be handled frugally. There is no room for wastage, in any form whatsoever. Participants and members alike have to be able to rely on A.Z.A. all the time, and this reliability inspire the trust of both participants and members. All of this require the professionalism of participating doctors, but also provides the scope to do so. This addresses a major reason behind the establishment of A.Z.A.; participants want to provide members with professional care and avoid being exploited by the administrator(s) of an illness fund.

A.Z.A. is unique in relation to the other sickness funds in that members are free to choose the doctor they want. They can therefore personally choose the A.Z.A.-affiliated doctor they desire. These affiliated doctors can independently decide which treatment to provide and are financially independent from individual patients. As a result, the quality of care A.Z.A. offered is higher than that of other illness funds. Doctors also have more time to devote to members because the number of members per doctor is limited. A.Z.A. additionally demonstrates that it practises what it preaches since the supervisory board reduced the fees of participating doctors when the organization experienced financial deficits. The extremely rapid growth in members and participants reveal that members and participants truly view A.Z.A. as a reliable insurer that defends the interests of the little man. This is not temporary either, given that A.Z.A. is still around today. It no longer exists independently, but first became Z.A.O. via a merger and then Agis and then, via another merger, part of Achmea.

[11] Idem, p. 29.

[12] Idem, p. 20.

[13] Idem. 18.

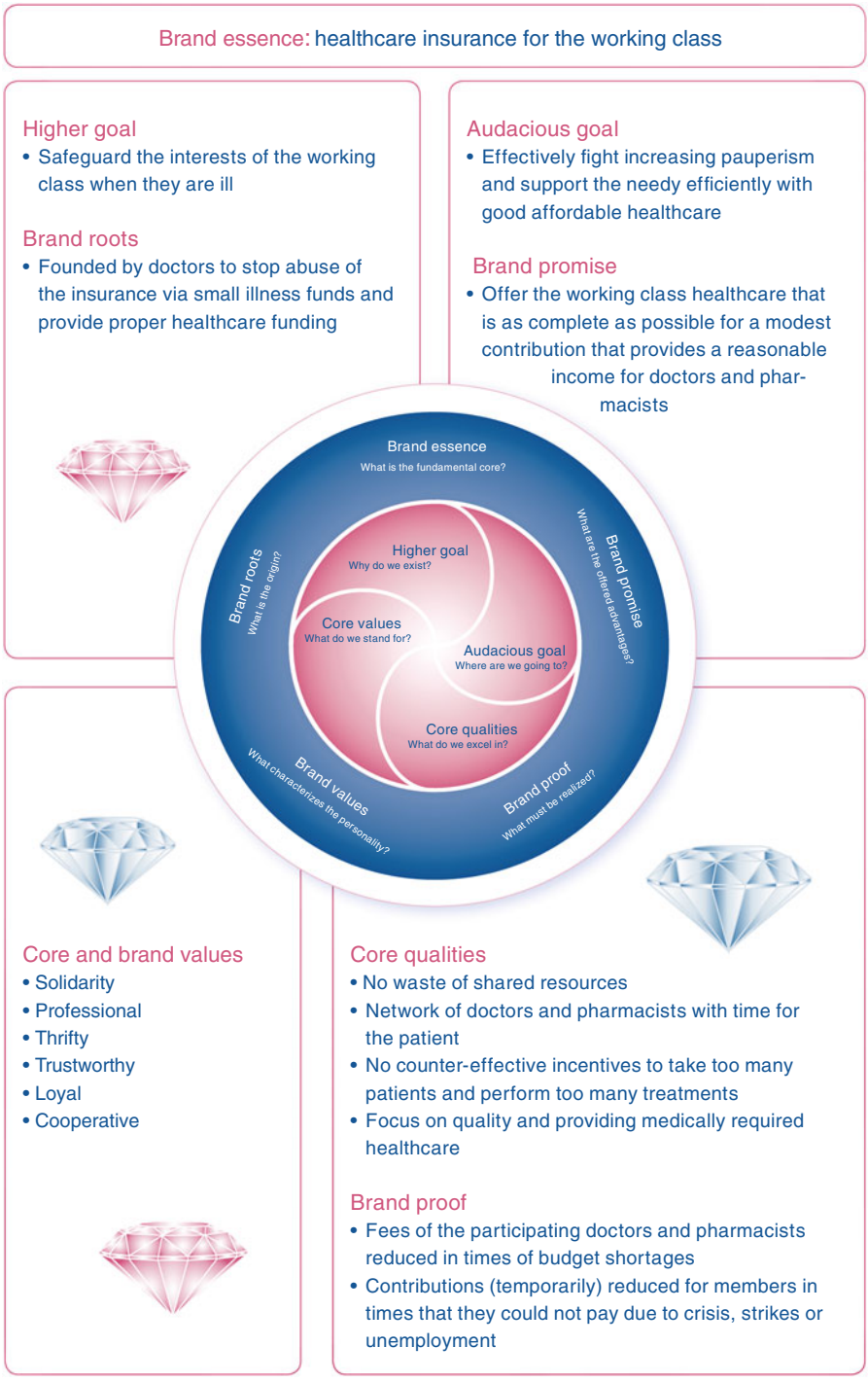


Figure 5.1.1 Vision and Positioning of A.Z.A.

5.1.2 The Business Model: Solidarity-Based Exclusivity

Market Segments: Market Leader in Amsterdam with Doctors at the Helm From its third year onwards, A.Z.A. grows rapidly and quickly becomes the largest illness fund in Amsterdam. The services offered to its members are considerably better than those of its competitors, thanks to its deeply rooted and solid position within the corps of doctors in Amsterdam, which appeal to people. This position is very different to that of the competition, which is more fragmented. In 1842, Amsterdam has 71 illness funds with 52,771 members. Medical care is entrusted to 33 doctors and surgeons. Membership of the illness funds ranges from 30 to 900 insured, which means they are too small to bear the risk of very high claims. Moreover, the agreed care does not always materialize. An illness fund often also has to share the one doctor it has. Doctors affiliate themselves to multiple illness funds in order to earn a decent income, which is limited primarily because they have to pay a fee to the illness fund to be an appointed fund doctor. The target group of A.Z.A. is: "the little man who lives in Amsterdam, belongs to the working class, is not supported by the poor relief board and does not have the means to bear illness-related costs." In particular, the craftsman who works on a daily or weekly wage, the servant class, and those "whose social condition corresponds to the aforementioned."[14] In other words, people below the income threshold of the lower middle class. This is not only a noble choice. More wealthy private individuals including the higher middle class pay doctors directly for the care they receive, which yields more than subscriptions. This free market is reserved for doctors due to the income threshold. The little man knows that with A.Z.A. he is assured of care that will remain available, affordable and be provided by doctors without any direct financial interests. That is valuable!

Customer Value: Access to Good, Affordable Care with a Free Choice of A.Z.A. Doctors Unlike existing illness funds, A.Z.A. provides its members with a source of confidence for the future through the manner in which it operates. It guarantees access to proper care and medication. Members are free to choose one of its affiliated doctors, surgeons, or pharmacists. This is very different to other illness funds, which have one affiliated doctor and pharmacist. A.Z.A. also works with a fixed subscription fee, with care provided in kind and without any additional payment. This is also different to many competing illness funds with a so-called fee-for-service system that require members to pay an additional amount directly to the doctor and surgeon during each visit.[15] People can become an A.Z.A. member by registering and taking a test to determine their physical and financial condition. The risk of A.Z.A. collapsing is considered minimal as its size allowed large payment peaks to be accommodated without any problems. That is reinforced via the financial management of the supervisory board, which reduces fees in times of shortages. The risk that members will receive poor care quality is low since doctors are jointly

[14] Idem. 30.

[15] Duffhues (ed.), Korsten and Vonk (2011), p. 62.

responsible for the quality standard. For members, there is also the value of a temporary contribution reduction if they temporarily have no money to pay the full contribution.

A special added value that participants offer customers are the ex gratia payments financed from the *rijksdaalder* fund, which is fed with admission fees from participants and fines imposed on those who arrive at board meetings too late or fail to turn up. Participants' solidarity with members is far-reaching.

Delivery: "A.Z.A. Must Shine Gently Thanks to Its Virtues" A.Z.A. pursues a conservative policy in relation to its members, which can be characterized as very robust and fatherly. The organization experiences rapid and organic growth upon its establishment, but does not focus solely on expanding its membership. Positioning and branding itself has never been one of A.Z.A.'s strongest points. The board discusses the pros and cons of "propaganda" at length, but that also speaks volumes about the organization's ambivalent attitude. As advertising by doctors is considered inappropriate, advertising by a health insurance fund administrated by doctors is viewed in a similar light. However, "propaganda books" are produced regularly that focus the public's attention on the benefits offered by the organization in an "appropriate manner." In 1882, advertisements are placed in (weekly) newspapers. In 1894, a wall calendar is handed out to members (and continued to be distributed until 1942). In 1883, bills and posters are placed in gatehouses, in 1898 at public soup kitchens, public baths, coffee houses, and establishments near the population register, in 1899 at stations, in 1903 at the homes of collectors, shops, and factories, and in 1910 on steam ferries.[16] In 1910 advertisements start being printed on the back of tram tickets. Some board members think things are going too far when banknotes are also proposed: "Advertising may not degenerate into the shouting of a market seller. The purpose is not to deprive members of other funds, but rather to proclaim all the good provided by A.Z.A. It is not impossible that conferences in the trams about health insurance funds will have the opposite effect that was envisaged. A.Z.A. must shine gently thanks to its virtues and avoid imposing itself."[17]

The most important contact with members is established directly via a doctor. In addition, health insurance collectors visit members to collect their weekly contribution. A committee assess whether new members belong to the working class or were equivalent on the basis of their income, and therefore whether they fall below the income threshold. Another committee is also charged with verifying the health of new members. A.Z.A. has favorable conditions for accepting people with chronic illnesses. Those with a lingering illness can be accepted, subject to a higher contribution if necessary. Members can submit requests and objections both orally and in writing. Initially, new members have to appear before the committee in person for a physical and financial assessment. Direct consultation and contact with

[16] Leclerq (1947), p. 39.

[17] Idem. 39.

administrators is minimal. In addition to normal care provided by an institution, A.Z.A. offers several additional services such as prevention by offering free inoculations against infectious diseases like chickenpox.

Operation: Care in Kind with Exclusivity All doctors, surgeons and pharmacists can participate. An important restriction is that participating doctors and pharmacists can not promote the existence of other illness funds in any way. A.Z.A. itself has no direct contact with other illness funds and also demands exclusivity from its participants (the doctors). During the first few decades this concerns funds other than those to which they were already affiliated. In 1880 all cooperation with other illness funds is prohibited. Doctors can then perform their day-to-day work independently and personally decide which treatment they wish to provide. However, instructions about treatment are issued, prescribing behavior is evaluated, and everything is done to limit administrative costs. The financial remuneration of participating doctors is organized in a way that helps eliminate incorrect financial incentives but also simplifies administration. An essential element of A.Z.A. is to avoid the development of a financial relationship between participating doctors and insured members. The remuneration is independent of performance or the number of treatments. The fee for participants compromises the subscription money for each registered member. Doctors therefore have very little administration to take care of. The history of A.Z.A. states the following in this regard: "Doctors are simply not administrators, nor should they become that. Their task is to cure sick people, not to fill in forms. Every system that burdens a doctor with administrative work is based on an incorrect division of labor and therefore wrong."[18] The supervisory board detemines and revises the remuneration of each doctor, if required. The fee is in fact the closing entry of the budget. A type of profit-sharing scheme also exists: any positive result from the health insurance fund is divided among participants according to a predetermined ratio (3/9 for doctors, 2/9 for surgeons, and 3/9 for pharmacists) and the reserve fund (1/9). However, a limit is imposed on the size of the reserve fund for each member. This means that careful prescribing behavior among participants and treatments on an overarching level also offers all participants a financial advantage. Such an approach also helps ensure meticulous financial management in that all commitments to members are fulfilled first.

In addition to participating doctors who work exclusively for A.Z.A., honorary participants (professors, and doctors and pharmacists with a large private practice and an established name) are also affiliated to the organization and work for free. Up until 1915, specialists assist A.Z.A. members free of charge (in the interest of science) and are therefore also honorary members. They receive "fire and light" at no cost and a subsidy for the purchase of their instruments. After 1915, specialists also receive a fee for each member, which is to the detriment of the fees of other participants. Agreements are made with other healthcare practitioners such as male and female midwives, dentists, suppliers of trusses and leeches, and enema providers. Detailed instructions are also drawn up for them.

[18] Idem. 57.

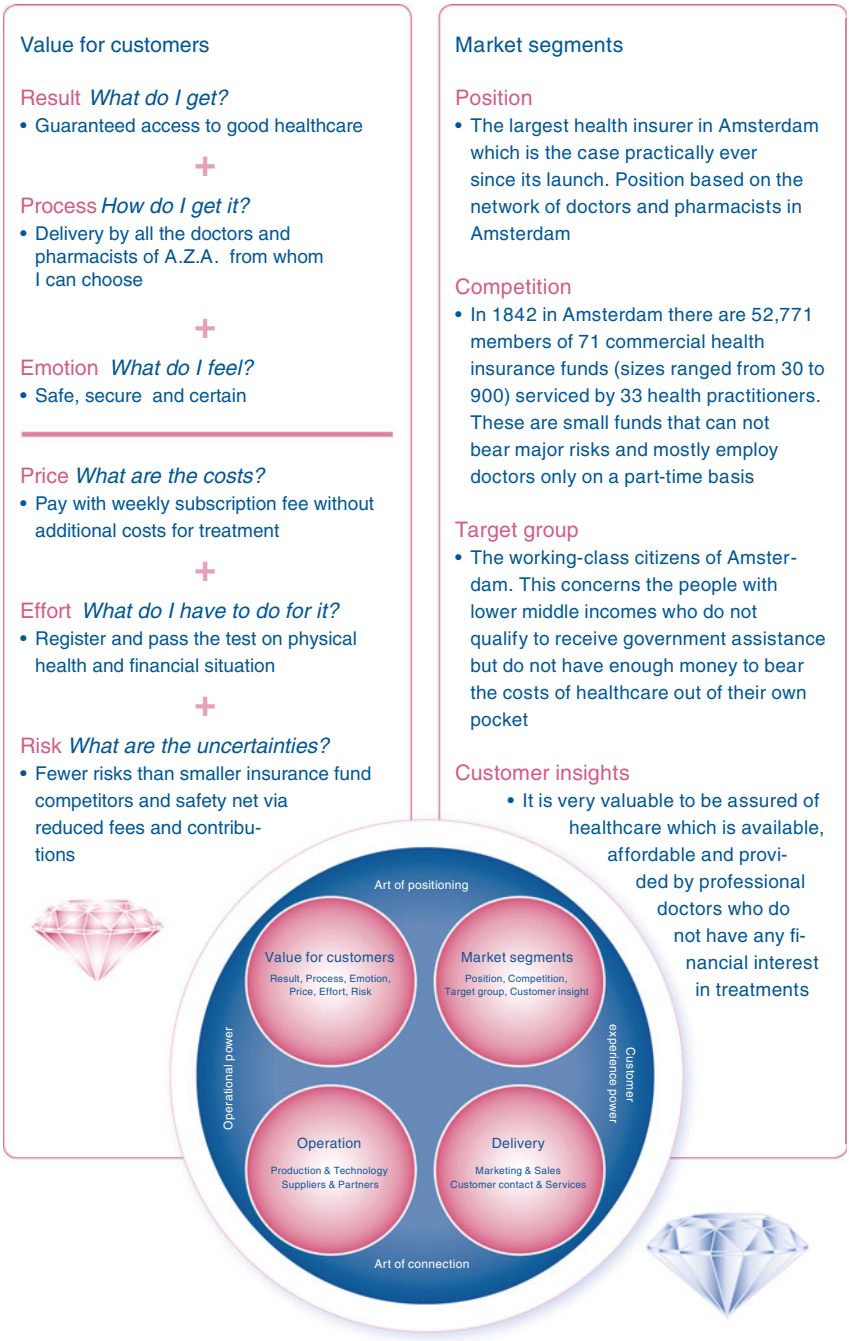


Figure 5.1.2 Value for customers and Market segments of A.Z.A.

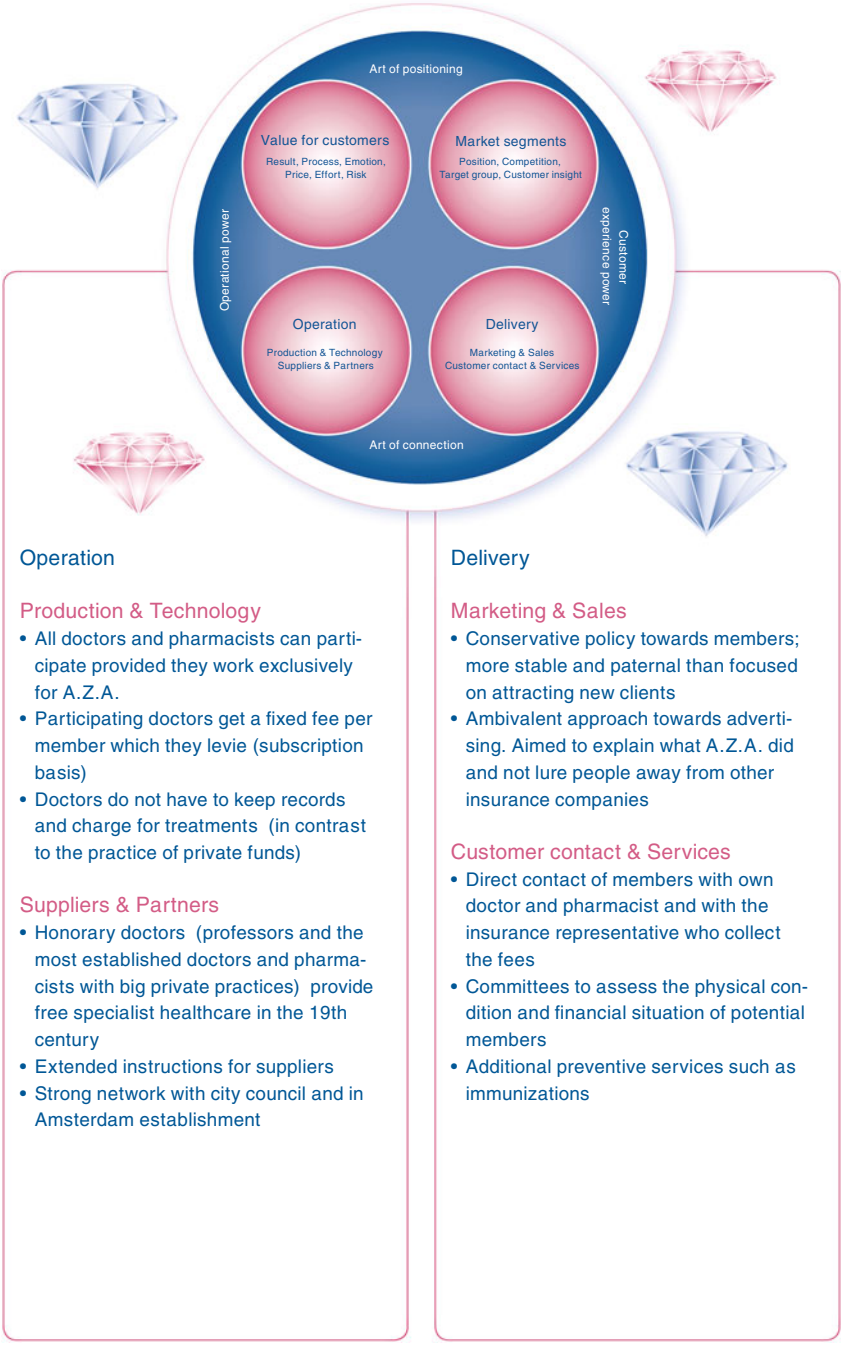


Figure 5.1.3 Operation and Delivery of A.Z.A.

5.1.3 *The Result: "The Little Man, the Doctor and the City Taken Care of"*

The confidence in the future provided to members is also paid out in the value offered by these members. It translates into faith and an increase in the number of members, and a greater loyalty towards A.Z.A.

The future with A.Z.A. is also considerably sunnier compared with existing illness funds for doctors. A reasonable existence was guaranteed, with a good fixed fee and the opportunity to share additional profits. Doctors and pharmacists affiliated to A.Z.A. can practice their profession independently and enjoy a large degree of freedom. They do not have to worry about being overloaded thanks to the maximum number of patients. Participating doctors merely have to worry about their patients' health. The fact that they are not required to keep records reinforces this and made their work even more appealing.

A.Z.A. does not have any regular shareholders. Due to the profit-sharing structure, for example, doctors themselves are actually the owners for the most part. In addition, participating doctors have a seat on the medical board while prominent citizens of Amsterdam are on the supervisory board. Both boards are not paid and the results that participants receive takes the form of respect and a contribution to society. The medical board can improve care and the medical rank in Amsterdam. The supervisory board is able to ensure care remains accessible by keeping the illness fund in good financial health.

The situation in Europe and especially in The Netherlands and Amsterdam in the first half of the in the nineteenth century in terms of wealth distribution, poverty and social issues bares many similarities with poorer developing countries nowadays. The value of A.Z.A. in such a society is encapsulated in the preceding sentence. It fulfills the need created by illness and its consequences for the large group of the working class. This group is not supported by the poor relief board and can not bear healthcare costs itself. The organization guarantees the health of the large middle group of Amsterdam's population. Besides offering regular care, it also prevents the spread of infectious diseases by administering free vaccinations. A.Z.A. also focuses specifically on providing care to people suffering from chronic illnesses who are not covered by other illness funds. In this way, it can ensure better health for a large section of Amsterdam's population.

It is not the first and only health insurance fund to be established in the mid-nineteenth century in the Netherlands. The approach and principles used by A.Z.A. serve most clearly as the example in the creation of numerous sickness funds across the Netherlands. Links exist, for example, with the establishment of the *Nutsziekenfonds* in The Hague in 1848, and with the *Afdeelings Ziekenfonds Rotterdam* founded in 1858 (which is now also part of Achmea via *Zilveren Kruis*). The government asks the A.Z.A. board for advice on several occasions. It also received frequent requests to provide information and advice throughout the Netherlands, the former colony of the Dutch East Indies and internationally.

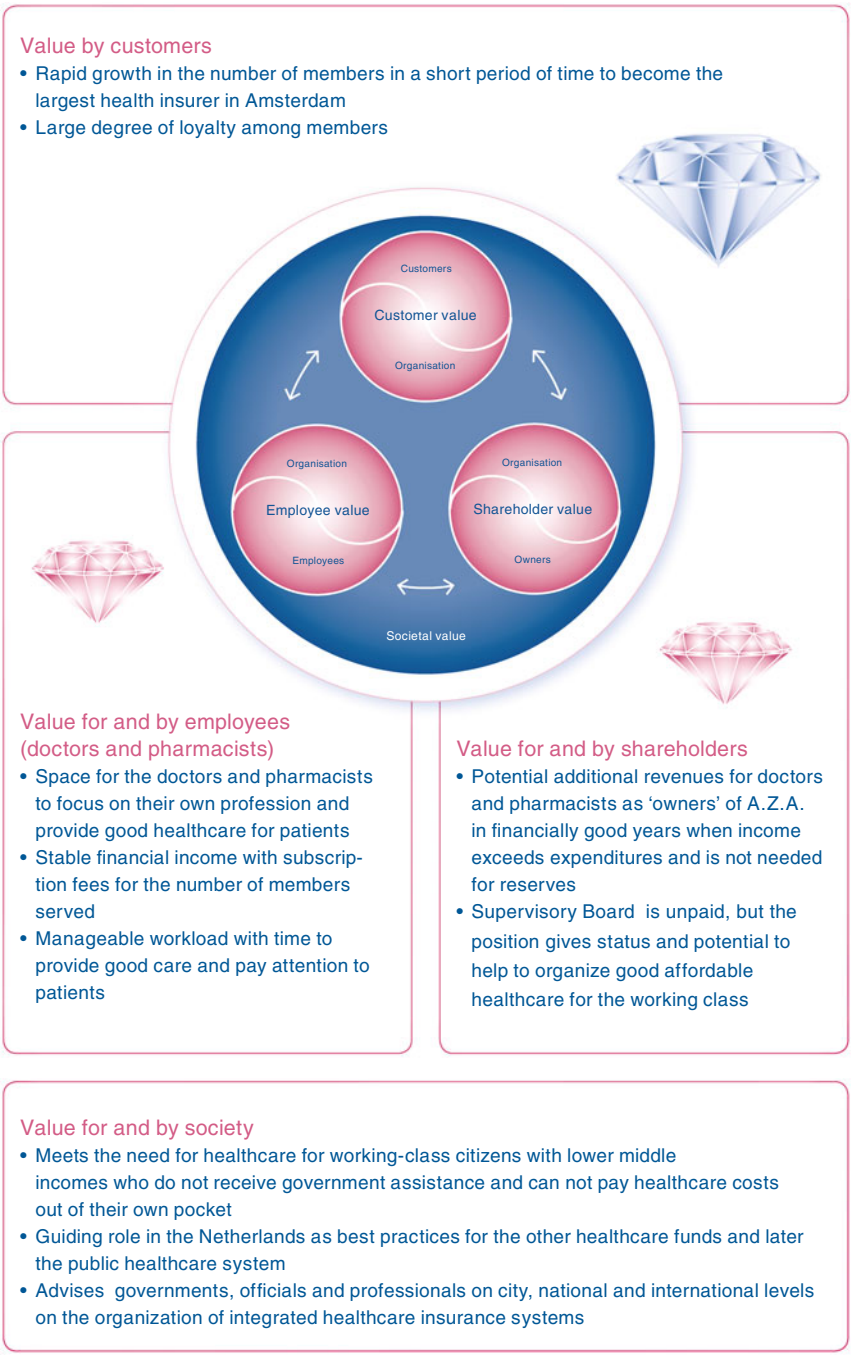


Figure 5.1.4 Value for and by stakeholders of A.Z.A.

5.1.4 The Brilliant Lessons of A.Z.A.

Someone has always lived in your future… What can we learn from A.Z.A. in the perspective of our era? The business model of A.Z.A. had its greatest innovative strength during the time of its establishment, the impact of which is still visible today. It brought major benefits for the development of the doctor and pharmacist ranks and the health of Amsterdam's population. The example it provided was followed elsewhere in the Netherlands and laid the cornerstone for the subsequent health insurance system untill 2006. Its principal elements are still apparent in the current basic health insurance system that everyone in the Netherlands can rely on nowadays to receive the best available care.

The level of care provided in 1846 was inadequate or unaffordable for most of the population, which in turn had a negative impact on society. It was everyone for himself. An initiative such as A.Z.A. succeeded in realigning the interests of citizens, patients, and caregivers on the basis of mutual caring and sharing. Principles, responsibilities, and remuneration mechanisms were used, and clear to everyone concerned. The challenge to ensure more shared interests is topical again at this moment. This is the case in developing countries, where it is currently being set up for the twenty-first century. However, this also applies to prosperous countries where existing systems must renew and innovate themselves again. That is where we must halt the spiral of rising healthcare costs, increasing contributions, restrictions on health insurance cover where there is a medical need and dwindling confidence in whether the agreed care can be provided. Assuming joint responsibility for care and healthcare costs is the only way to achieve this. If this fails to happen, only the wealthy will have access to high-quality care, and the "little man" will be back to where he started.

Important inspirational lessons provided by A.Z.A. include:

- A common higher goal to overcome social "injustice" for the insured and healthcare providers at the same time can be a powerful source of inspiration and an incentive to break through an existing system. The challenge is to recognize everyone's own interests without opposing them, and bring these into line.
- Constructions such as fixed population payments and separation of the direct relationship between decisions taken by doctors regarding treatment and financial remuneration may result in cost-efficient measures, proper patient care, intrinsic professional motivation for the healthcare practitioner, and reduced administrative costs.
- A shared responsibility and objective of a group of healthcare practitioners with an insurer to offer good, affordable, and accessible care to a group of people can help realize this.
- Instruments that reinforce mutual caring and sharing in good and bad times, such as reductions in subscription fees during periods of economic adversity and profit sharing during periods of prosperity will help the system to be more flexible and robust when setbacks occur, and boost mutual loyalty and confidence between everyone concerned.

- It is useful to have a good knowledge of the source and original context in order to understand and reuse principles. The income threshold in the Netherlands was introduced, as in most countries, when wealthy people could still pay all medical treatments in cash. It also served to protect this lucrative market for doctors. The concept of "free choice of doctor" is now often used as a counterpart to "managed care," but it actually originates partly from the Netherlands. Back then, it entailed choosing a doctor who had affiliated himself exclusively to an integrated care system, with all accompanying rights and obligations.

5.2 DHAN[19]

"Be the change you wish to see in the world"

Tom Buijtendorp & Jeroen Kemperman[20] @: Jeroen.Kemperman@achmea.nl, Phone: 0031 651222099

Prelude *Sitting in the sweltering heat in a circle with women dressed in colorful robes, primary case author Tom Buijtendorp seems very far removed from his day-to-day life in Europe. As a visitor, a dot is also painted on his forehead—the eye of Shiva. A priest is busy performing incomprehensible rituals. Nothing here reminds*

[19] This case is described based on the personal experiences and contacts of Tom Buijtendorp, supplemented by the experience of Annette Houtekamer. Generic public information can be found on the website and in the Annual Report (DHAN Foundation 2013A, 2013B).

[20] As in all cases in this book, this brilliant business model was defined by the case authors, including a member of the book's editorial team. The primary case author, Tom, has a large personal involvement in DHAN. It is worth noting here that he is the mental owner of this case, with Jeroen providing a contribution.

you of Europe. Nevertheless, this self-help group of 15 people has managed to make their care costs affordable to the poorest people, and has demonstrated that the poor can save. They are realizing a dream with the local development organization DHAN. A dream that is now being lived by over four million people, a number that is increasing rapidly. After the ritual has finished, a visit is paid to a restored temple with a water basin. This would appear to be a pointless tourist trip for the friend visiting from the West who knows more about insurance, But delve deeper into the case and you will discover the essence of DHAN's philosophy. It is the key to the sustainable development realized here in a remarkable manner. DHAN has received numerous awards, including one for the best development organization in India, a country that is home to nearly a fifth of the world's population.

As a Western outsider, Tom had the privilege of putting the vision and strategy down on paper together with the management team of DHAN and helping them come up with ideas about their following step. During the annual Foundation Day it was an exceptional experience to see and feel how so many from the "bottom of the pyramid" assume responsibility for their own future. It was unique to witness that the essence of mutual sharing and caring is experienced here, on the basis of enlightened self-interest. The actual purpose of the visit was to convey knowledge, but it became increasingly clear that the opposite would occur here: a wealth of essential insights could be acquired.

Introduction The social challenge facing India is enormous, including within the domain of health and care. The economy is developing rapidly, especially in knowledge-intensive sectors. At the same time India is a very poor country. According to estimates, some 500 million people in India suffer from malnutrition while 300 million live on less than one dollar a day. This translates into more than a quarter of the poorest people in the world. India lags in healthcare way behind surrounding countries in Southeast Asia and the world. The government is unable to provide care at a socially acceptable minimum level.[21] The care system is mostly private and does not provide any safety net for the majority of the population.

DHAN initiates and encourages communities to engage in self-help activities, such as micro-insurance, micro-credit, and small-scale irrigation. It therefore ensures, for example, that groups of people share risks, can lend small amounts from each other and jointly manage water used for agriculture. The organization helps people care for one another, something which begins right from the bottom. By tackling poverty, DHAN ensures that people remain healthy or healthier and can protect themselves against loss of income should they fall ill nevertheless. Steps are also being taken now to build hospitals and provide healthcare insurance. This sequence is common: within micro-insurance, medical expenses are often seen as the most difficult and important piece of the puzzle.

The first projects started in 1990 and laid the foundation for DHAN, which was established on 2 October 1997. An important source of inspiration was Mahatma Gandhi (1869–1948), the man who achieved what appeared impossible with his

[21] Hsiao, Medina, Ly and Dukhan (2013).

peaceful revolution: he drove the seemingly invincible British Empire from his country without an army. "Be the change you wish to see in the world," Gandhi said. And he heeded his own advice. When a mother asked him to tell her son to stop eating so much sugar, he refused. Gandhi asked her to come back 2 weeks later, even though she had made a long journey to see him. Two weeks later he gave her some advice, prompting the mother to ask him why she had needed to wait so long. "Two weeks ago I myself was still eating too much sugar, madam," was his reply. He could only give advice about what he personally did and was prepared to adapt his lifestyle in order to help a single boy. He understood the power of example, the essence of its impact.

DHAN's approach is characterized by a similar, far-reaching consistency that emanates from within. Inspired by Gandhi's patience and unrelenting efforts, DHAN wants to expel poverty from India, and even throughout the world. Its dream, as a mental leader, is to serve as an example itself and ensure it is emulated elsewhere in India, and preferably also outside the country given that poverty does not stop at borders. Over one million families are now members of DHAN, with an average of four to five members per family. The organization is throwing a pebble into the pond of poverty in the hope that the ripples will spread out and reach other poor people. Around 4.5 million people appear to be nothing but a drop in an ocean of 500 million undernourished people. But a ripple can make a great deal possible. This vision gives DHAN the calm to work with great consistency amidst overwhelming poverty on its own organization, which is now active in twelve different states.

In the spirit of Gandhi, DHAN is also fighting against the caste system and the extreme differences that exist between social classes in India. The organization works for the benefit of all poor people without making any distinction. Staff at all levels of the organization use only their first names because their surname would betray their own caste. This helps build religious bridges. While most staff and customers are Hindu a poem penned by the Catholic Mother Teresa (1910–1997) is sung with great conviction during the morning ceremony held on the rooftop terrace of DHAN's headquarters in Madurai. Staff do so simply because its message appeals to them, just as Gandhi was partly inspired by Jesus' Sermon on the Mount. This is consistent with a devoted organization.

Although India is already an old democracy, the central government of this vast country is geographically far away from its poor population. In the spirit of Gandhi once again, DHAN advocates the reinforcement of local democracy through local governments that have already existed for centuries. It is a crucial element in the dream of empowering the poor to help them escape poverty. The empowerment of women is playing a pivotal role in this. Coercion is being rejected: freedom of choice is a high priority for DHAN.

5.2.1 The Cornerstone: Empowering the Poor to Help Themselves

Many brilliant business models build with a consistent focus inspired by the past applied to the present and developed into the future. This also applies to DHAN to a large degree. It translates this focus to local communities and the people within them.

The forces needed to attain DHAN's higher goal are therefore released: empower the poor to help themselves grow out of poverty through cooperation and mutual caring and sharing.

Respect for local history and the connection with contemporary culture is one of the distinctive elements of such an approach. This helps prevent the not-invented-here syndrome that corrodes the sustainability of much development work. As the word says, the traditional development being on a 'mission' from the West focused more on sending than receiving. The moment traditional aid stops, the attained result often vanishes and the community relapses back into its former state of poverty. DHAN, on the contrary, succeeds in making participating self-help groups self-sufficient and self-financing within 5 to 15 years. They then remain a member of the "family" to which they can turn in times of need, but they save themselves. In line with the higher goal, self-help is the brand essence of DHAN: becoming a member of the DHAN organization entails an important step towards self-help. For many, this is a crucial step in life.

The past is a powerful source of inspiration. Many centuries ago, the management of water reservoirs occurred via local cooperation. This system is still applicable to almost two-thirds of small farmers in India. During short, intense rainy seasons, increasingly scarce water is stored in collective reservoirs, some of which are located at temples. This old Vayalagam approach comprises a system of local cooperation, which is cherished as an early seed of local participatory democracy. Many water reservoirs fell into disuse during the British occupation and local cooperation made way for large overarching structures. DHAN encourages local communities to use old reservoirs again and rekindle the accompanying cooperation. The same applies to traditional saving systems. An example is the Kalanjiam system used in a particular region, involving the storage of rice in a traditional pot. DHAN has introduced a savings program and used the old name of Kalanjiam deliberately. Anyone visiting the communities will still find a Kalanjiam pot, which symbolizes the anchoring in the past. It is reminiscent of the first automobiles at the end of the 19th century that deliberately resembled horse-drawn carriages so that people would recognize them as means of transport and not be afraid to use them.

Building on old traditions and local cultural practices is essential. Doing so helps avoid the not-invented-here syndrome where possible and an aversion to innovation. New programs quickly feel "familiar" as a result. They can therefore also be maintained during the phase when local communities need to continue on their own. This is also deliberately linked to reinforcement of the local community as the basis for the required cooperation and mutual caring and sharing. By restoring old temples with reservoirs, for example, DHAN is consciously helping foster local pride and self-confidence. Traditional festivals are also supported. In DHAN's vision, development partially involves rediscovering what already existed and building upon this. The past and the local culture are important roots for DHAN because they contribute significantly to credibility. DHAN also attaches importance to strengthening the local community with a view to the future. When one looks at the West and prosperous city dwellers in India, the belief arises that greater prosperity will increase the tendency towards individualism. This could eventually undermine the solidarity that has been fostered.

The higher goal is to fight poverty, on the basis of self-help, throughout India and even the rest of the world. The audacious goal focuses on fighting poverty on the basis of self-help for members of the own local level. It is the belief that the maximum limit comprises approximately 395 federations compared with the 300 or so at the moment. Each federation consists of different clusters that in turn contain various self-help groups to which families belong. A federation unites some 15,000 family members on average. That means that the approximately 4.5 million people at present could possible reach a maximum of 7.5 million in the future. By the time such a number is attained, DHAN wants to have developed itself into a widely respected model that others copy on a large scale (with the foundation's support where needed). The brand promise focuses primarily on this potential group, with the prospect of members developing and escaping poverty on their own within a maximum of 15 years. And they will do so while retaining their self-respect and in close cooperation with their immediate surroundings.

DHAN's values have been formulated from a social perspective. Unlike the values that exist within numerous organizations, here it is truly about moral objectives: deep-rooted convictions that indicate what members expect of the ideal society, and what they themselves would therefore like to be in order to contribute to this. In line with the inspiration provided by Gandhi, DHAN therefore wants to be the change it considers necessary, and create this within society. It is about a fair community focused on these values. The core values mentioned in the annual report include: "poverty-free with self-respect", "gender equality", "respect for diversity", "participatory democracy", "freedom of choice", and a "mutually supportive society". These guiding values are deeply embedded within the organization and confirmed annually during the Foundation Day in October, for example. Those permitted to participate on stage can experience the passion of members.

DHAN has to realize a series of core qualities in order to demonstrate brand proof. These core qualities are: the ability to empathize with local tradition and culture, the ability to be self-sufficient (instead of offering help), and the ability to cooperate well with multiple stakeholders.

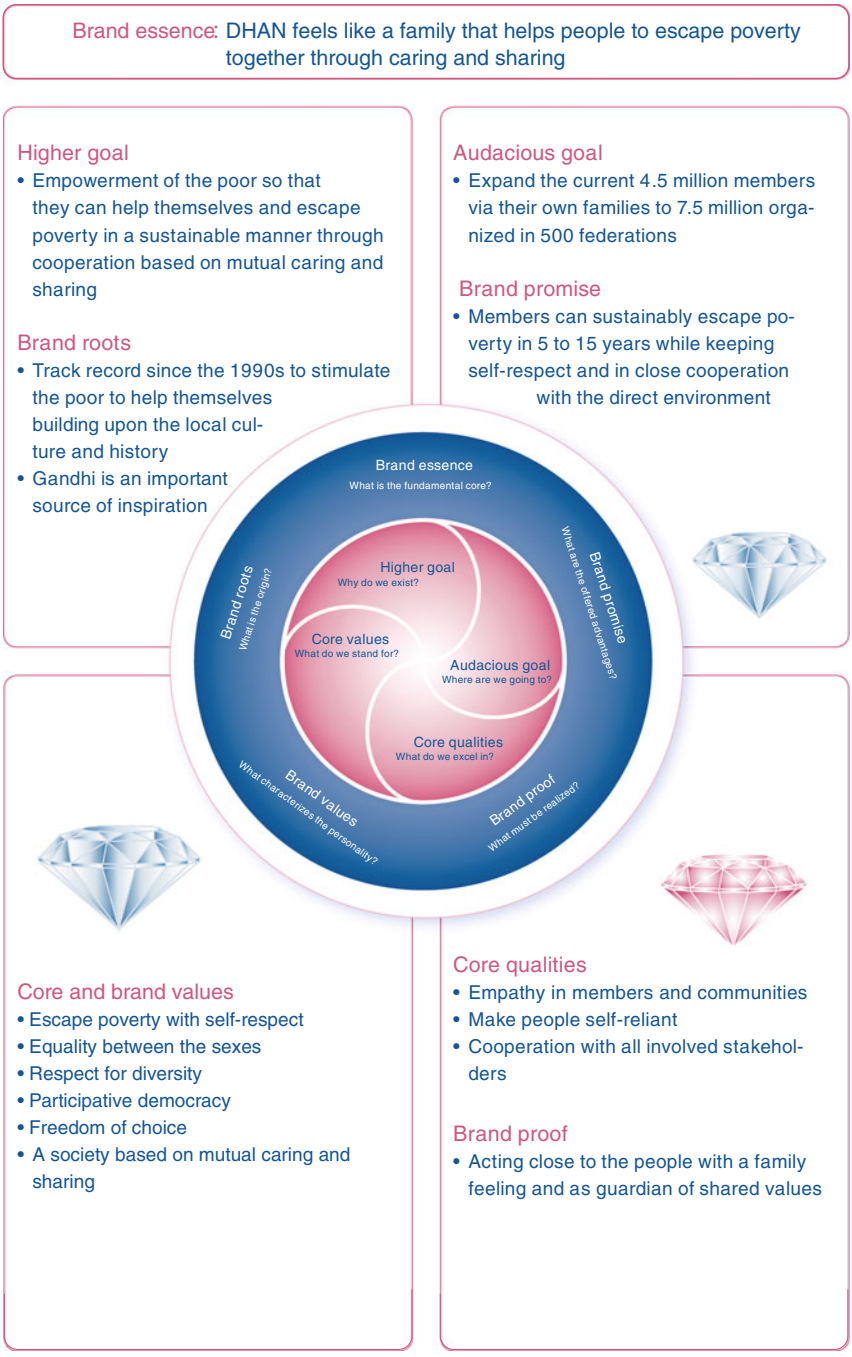


Figure 5.2.1 Vision and Positioning of DHAN

5.2.2 The Business Model: Self-Management

DHAN is focusing on self-management and empowering the poor to help themselves grow out of poverty permanently through cooperation and mutual caring and sharing. This is being achieved in three ways, namely:

(a) By stimulating scalable cost efficiency and sustainable innovations such as micro-insurance, micro-credits, and small-scale irrigation;
(b) By developing support institutions required for that purpose, such as consultative structures and hospitals;
(c) By training thousands of development staff using its own educational institute, namely the TATA-DHAN Academy, for example.

Market Segments: The Poor in Various Development Situations DHAN distinguishes between four target groups according to their development potential: countryside, tribal, coast and urban.[22] The largest group (76 %) comprises poor farmers from the countryside. In practice, they can be self-sufficient within 10 years on average. Tribal members (8 %) living in remote areas require far longer in practice than farmers in order to become self-sufficient. People on the coast (7 %) are mostly fishermen. DHAN has only started working with this group recently following the tsunami in 2004 and does not have any empirical figures yet. Poor city dwellers in the slums (9 %) become self-sufficient within 10 years on average.

A hundred thousand members from the initial period can now consider themselves independent. A large-scale survey conducted by DHAN to investigate the needs of new members revealed that 90 % of respondents live below the poverty line and almost half are illiterate. They spend most of their income (over half) on food and almost a fifth on clothing, education, and healthcare. A member has an average loan of INR 8521 (USD 137 or EUR 116). A third have a loan for agricultural purposes, with an average value of INR 10,783 rupees (USD 173 or EUR 147). Around a third take out housing loans while approximately one in ten do so to develop their own business. Money is also loaned to pay education and repay old debts. Healthcare can cause a substantial financial deficit and has a double-pronged effect since this often goes hand in hand with a loss of income. A crucial customer insight was "*poor people can save*": the realization that the poor want to and can help themselves, and will take advantage of temporary assistance if this is linked to their own traditions and culture.

Customer Value: Lasting Prosperity The result for customers is the opportunity to escape poverty permanently as part of a strong social community. The retention of self-esteem plays an important, emotional role in this. The process occurs largely within the own community and under its own steam where possible, with ample

[22] DHAN Foundation (2013A).

scope for the human dimension. The organization is based on simplicity and low costs. Thanks to the system of social control and small-scale practice, the cost for members in the form of interest and insurance premiums is as low as possible. Members must make an effort though. The risk is limited and can be covered by insurances such as a credit insurance. All in all, DHAN fulfills a huge need as the farming population has very few opportunities to take out loans or insurance (and lacks knowledge in areas such as water management).

A series of products has been developed over the years. Apart from physical ones, such as water reservoirs and water pumps for water management, services such as the provision of credit and insurance also exist. Savings are made and then lent to other members under the motto "the poor can save." Thanks to the resulting buffer, three times as much money can be lent compared to the amount that is saved. The interest rate is also less than half of what commercial providers ask. To ensure that the money is paid back later, strict social controls on the expenditure of the loaned money are enforced within the self-help group. Preferably, this money is used productively to boost agricultural production by purchasing better-quality seeds or a storage barn so that the borrower can produce more and repay the loan from the proceeds. There is therefore a collective interest in ensuring that the money is spent wisely. This is important. The global credit crisis which started in 2008 has been attributed to the fact that this relationship between lenders and borrowers had disappeared completely and along with it the means to curb reckless spending.

As prosperity increases, so too does the need to insure the acquired prosperity. That is the reason why mutual insurances have been introduced to cover the risk of death and also insure livestock, crops and income. It usually begins with simple products to familiarize members with insurance and frequently culminates in relatively complex products such as health insurances. The challenge is to ensure available care: where necessary, DHAN builds hospitals together with the community to this end, such as in Madurai and Theni. Prevention programs focusing on better sanitation and drinking water are also implemented. Specific programs have been launched after it transpired that many members of the target group suffer from an iron deficiency. Insurances are covered by paid contributions and backed up by reinsurance for larger claims.

Delivery: In the Own Circle The most striking aspect of DHAN's operation is that everything is organized in a highly decentralized way. The organization is not led by a large central holding company. The umbrella federation is small and barely automated. From a Western perspective, it seems a miracle that this functions effectively. Shared values and ideals and intelligent organizational principles containing considerable wealth and wisdom are used as primarily management mechanisms. The self-help groups comprising between 15 and 25 families form the base or "foundation of the organization." These families are members and themselves constitute the operation of DHAN. The term "self-help" dovetails with the cooperative principle upon which the model is based. In the century-old brilliant business model the German cooperative bank Raiffeisen, the guiding motto was "helping people help themselves" and there was also an awareness that the groups should not become

too large in order to ensure they could continue to steer and correct themselves.[23] In India, the same principle forms the core of self-help groups that work on the basis of consensus. The human dimension is important. Based on experience, a group size ranging between 15 to 25 families is ideal for self-management. Anything above that will make the group too large and prevent members from getting to know one another and meeting up.

Operation: Simplicity Whereby Members Are the Organization Members themselves lie at the heart of the operation. Broader partnerships that focus on organizing education, sharing knowledge and spreading greater risks also exist. The next level comprises regional clusters of around 20–30 self-help groups that collectively form a kind of large family with 150 and 500 members. The level thereafter consists of federations in which 100–200 self-help groups work together, totaling around 3000–4000 families on average.

The basic principle of the model is that self-help groups manage themselves where possible. DHAN assists in their establishment and development, and provides the values and setup principles. The self-help groups take many decisions themselves, preferably on a consensus basis. On this level there is a strong awareness that resources are scarce. Although self-help groups can provide a warm family feeling, participation is based on enlightened self-interest. You help the other in order to be helped yourself later on, if required. Savings are regarded as a joint possession. The same goes for collected contributions. The self-help group system is evidently perfectly capable of keeping payments under control with very limited resources. Considerable focus is placed on accident prevention since this is in everyone's interest, and an assessment is made to see how damage, once inflicted, can be limited where possible.

Simplicity, self-motivation and cost management play a pivotal operational role in the ability to offer scalable, cost-effective and sustainable innovations. In view of the limited resources, as little as possible must be lost to complex administrative processes. In the countryside especially, mobile technology is used extensively to transmit data to coordination centers. Additional coordination is kept to a minimum because much of the work and control is organized within the self-help groups. DHAN goes beyond the primary process and the products. As already indicated, the foundation also assists by creating supporting bodies such as consultative structures and by building the required infrastructure. It also disseminates its knowledge by training thousands of development staff via its own educational institute, the DHAN Academy. The bargaining power of over four million members is used in relation to suppliers to make attractive agreements for these members. Furthermore, DHAN works together with universities, financial institutions, governments, professional networks and donors.

[23] Case description: Geelhoed and Geelhoed: "Raiffeissen: Hilfe zur Selbsthilfe," in: Kemperman, Geelhoed, and Op 't Hoog (2013).

Value for customers

Result *What do I get?*
- Support to escape poverty using own strengths

+

Process *How do I get it?*
- Primarily offered nearby via self-help group with DHAN organization as back-up

+

Emotion *What do I feel?*
- Strong sense of own culture, roots and responsibility as part of DHAN family

Price *What are the costs?*
- Interest and premiums kept low thanks to efficient approach, self-service and self-control

+

Effort *What do I have to do for it?*
- Providing self-support and taking responsibility within own direct environment

+

Risk *What are the uncertainties?*
- Risks are reduced because it is shared with acquaintances and the danger of a return to poverty is reduced via insurance

Market segments

Position
- Organizing 1 million families with 4 to 5 family members, totaling 4.5 million people spread out over 12 Indian states, 66 districts and 12,404 villages

Competition
- Local providers of single offerings, such as usurers for loans who demand extremely high interest rates, and limited solutions with own group, such as lending directly from each other

Target group
- All the poor, no matter what caste or religion. Spread over 4 groups: primarily rural (74%), tribes, on the coast and in the cities

Customer insights
- The poor are capable of saving money and escaping poverty in other ways. Building upon tradition and culture prevents the not-invented-here syndrome and helps to make the impact sustainable

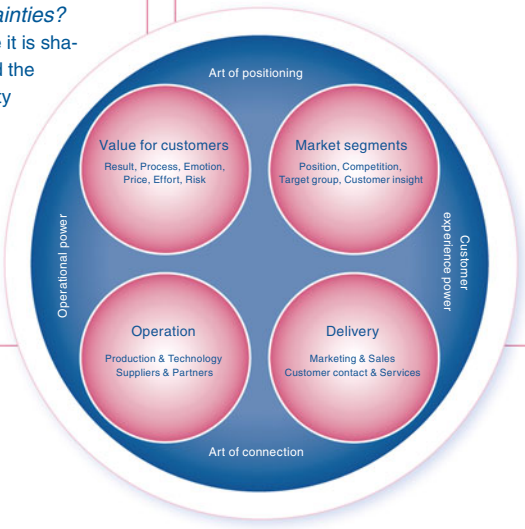
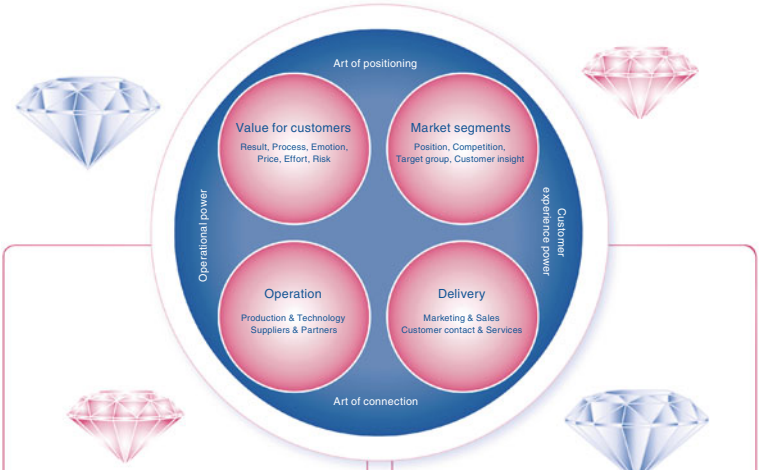


Figure 5.2.2 Value for customers and Market segments of DHAN



Operation

Production & Technology

- Products such as micro-insurance, micro-credits and small-scale water management and irrigation projects
- Simplicity, self-service, thrift and lean administrative processes are key
- Innovations to make products accessible and scalable on the basis of locally available technology and infrastructure
- Support for setting up institutions, such as consultative structure, but also for building hospitals

Suppliers & Partners

- Shared procurement scale and power to save money on products, such as reinsurance, and for water management and irrigation
- Cooperation with universities, financial institutes, governments and donors who want to connect to the purpose and family feeling of DHAN

Delivery

Marketing & Sales

- No money spent on marketing
- Sales and diffusion via the grapevine spreading out from DAHN, via federations and clusters towards self-help groups in own neighborhood

Customer contact & Services

- Direct contact primarily via own self-help group
- Technical advice on matters such as water management
- Education of thousands of development workers via own DHAN Academy, amongst others

Figure 5.2.3 Operation and Delivery of DHAN

5.2.3 The Result: The Value of Sustainable Poverty Reduction

The emphasis placed on self-management and self-help means that the customer is not sitting idly by in the passenger seat, but is actually at the helm of the operation. In other words, customers are also active suppliers and create value for themselves and other customers. This attracts new (groups of) customers in turn. The table below outlines the organization's growth in terms of the number of federations, clusters, self-help groups, and families:

Talk to a DHAN staff member and you will immediately notice the immense passion and satisfaction on all levels. It is abundantly clear that an awareness of doing meaningful work for society is motivating, but the intrinsic motivation of staff is also significant. The contact with members—mostly direct—makes the work very gratifying. Staff receive only a third of the salary they could earn elsewhere in India. Although the financial rewards are deliberately lower than average, staff are nevertheless attracted to the foundation by other benefits. They opt for DHAN because of the immense satisfaction derived from helping people help themselves. The moral relationship for staff is stronger than the financial relationship with the organization. Considerable importance is attached to nurturing this relationship. That is why you can meet someone at DHAN who used to earn a handsome salary as a marketing manager of a large group, but now finds much more enjoyment in fighting poverty. DHAN refers to such members of staff as "social entrepreneurs".

The Kothur community and its 2500 members are a typical example of the positive impact of DHAN. Both agricultural productivity and area of used ground increased. For each family, this translated into an average income increase of USD 57 (EUR 45) in relation to a minimum of USD 353 (EUR 300) annually. Food safety improved for almost two-thirds of participants. Some 100,000 members crossed over the poverty line on a sustainable basis. Almost one million insurance policies have been taken out. This includes a health insurance system linked to own hospitals which provides cover to over 120,000 poor families.

Table 5.2 Growth of DHAN in federations, clusters, self-help groups, and families

DHAN	2010	2011	2012	2015
Federations	260	283	303	395
Clusters	1648	1432	1728	2090
Self-help groups	33,039	37,071	45,525	55,000
Families	810,185	923,865	1,047,924	1,353,500

Table 5.3 Number of staff in 2012

DHAN in figures	2012	2015
Professionals	331	312
Program staff	430	415
"People functionaries"	2261	2140

DHAN's work in India has been acknowledged with a series of social awards. These include the Best NGO Award for 2008–2009 and the India NGO Award in the category Large NGOs in 2010. The 2011 Jindal Award was awarded to the foundation in February 2012 for its substantial contribution to the reduction of poverty in the countryside, along with the international AGMUND Award for pioneering projects that help ensure food security for the poor. And in spring 2013, the Times of India Social Impact Award 2012 was given in the NGOs category. The awards represent an important public recognition of DHAN's work in India. The model can be of social relevance outside India as well, providing it can be applied there successfully and in accordance with local culture. The establishment of DHAN International marked the first step towards this objective.

DHAN faces challenges at the same time. The examples of other brilliant business models reveal that success over time can also prove to be a pitfall. If people overestimate their abilities, there is a risk that too many new activities are undertaken even though the original task has not been completed yet. Although the tale of DHAN has been very inspirational for others up until now, the challenge ahead is still considerable. Nevertheless, what it has achieved so far can be an important source of inspiration, including for breakthroughs in healthcare within more prosperous countries.

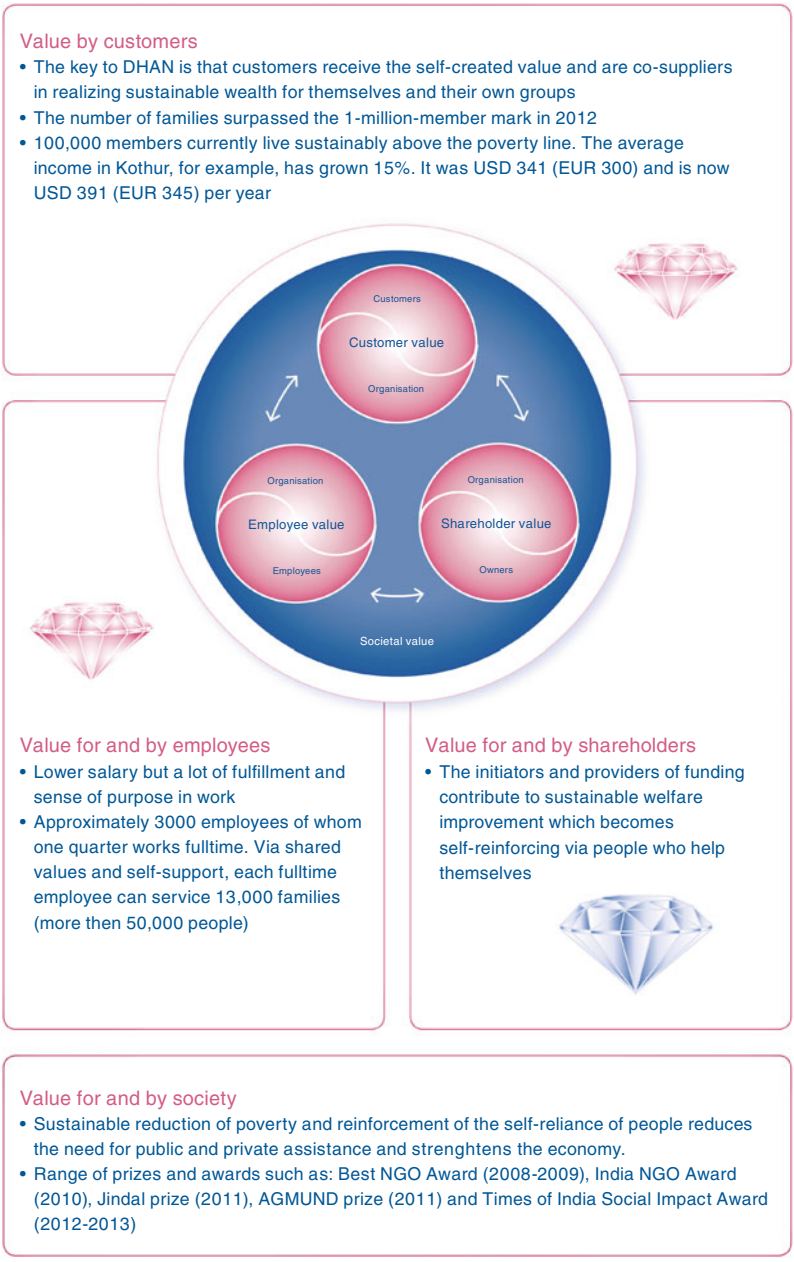


Figure 5.2.4 Value for and by stakeholders of DHAN

5.2.4 The Brilliant Lessons of DHAN

Some key insights that may also be relevant for healthcare in prosperous and still-developing countries are listed below:

- The local scale is and remains crucial in healthcare, particularly in the provision of living assistance and non-specialized care. Shared values and intelligent setup principles can help limit the bureaucracy, which can be a major factor in cost management and complexity reduction. The power of small organizational units is that people know each other, can trust each other and therefore want to help each other.
- The power of self-correction and self-management within a defined group can be tremendous and contribute to the joint control of expenditure. People are evidently capable of self-management to a large extent when stimulated by social pressure, and in a manner that feels "familiar."
- A connection with one's own culture and traditions is crucial for ensuring that the effects of development are sustainable. DHAN builds upon the old and familiar so that people do not immediately adopt a reticent attitude. This does not involve permanent assistance but rather a collaboration focusing on the development of self-reliance.
- Countries such as India have a huge shortage in available care. Prosperous countries, on the other hand, have an extensive selection and sometimes even a surplus. This provides other puzzles and therefore cannot be translated directly. However, the underlying mechanisms for mutual caring and sharing are human and therefore global in nature. Insurers with a cooperative background and any other interest groups can develop a profound bargaining power on the behalf of members, for example. And since everything comes together in one place, new technologies such as the Internet can clarify the overall cost of care for someone, which helps restore the transparancy and trust. An own-risk element with a certain maximum can increase cost awareness, without posing a great risk to the customer.
- An inspirational exemplary role such as that of Gandhi for DAHN allows a relatively small activity to be scaled up to a large activity with much greater effect. Anyone with sufficient patience to free a country as large as India from a superpower can successfully motivate poor people to attain prosperity and possibly also inspire solutions for healthcare issues in other countries.

5.3 Courtyard Houses[24]

Security and good care assured
for the rest of your life as a pensioner

Jeroen Kemperman & Ida Kemperman-Wilke @: Jeroen.Kemperman@achmea.nl, Phone: 0031 651222099

Prelude[25] *Christoffel van Brants passes away on 5 November 1732 in his home at Keizersgracht 317 in Amsterdam. He can look back on an impressive life. He has helped Russia to learn from the Netherlands (and vice versa). Christoffel is in close contact with Tsar Peter the Great for much of his life. During his visit to the Netherlands to learn how to turn Russia into a comparably modern country, the Tsar resides in Christoffel's home on the Keizersgracht and in his countryside home on the Amstel river. Christoffel assists him by recruiting specialists in the Netherlands and dispatching them to Russia. As one of the key traders between these two countries, he also plays a pivotal role in the war the Tsar is waging against Sweden over the passage through the Sound. Peter the Great also does a great deal for Christoffel.*

[24] Jeroen Kemperman wants to thank Wouter Schouten for his support by reviewing this case about courtyard houses. Wouter was Alliance Manager at Zilveren Kruis Achmea and is currently working at the insurer CZ. During his MBA studies, he became inspired by new business models and value propositions. In that regard he has a special interest in segments relating to domestic care and seniors.

[25] An extensive description of the life of Christoffel van Brants and the Brants Rus courtyard house is found in Donga (2008).

The highlight comes in 1717 when Christoffel becomes a noble and is appointed a member of the Russian Royal Council and resident minister and ambassador to the Tsar in Amsterdam. Trade with Russia turns Christoffel into an immensely wealthy man. Before his death, he chooses an office where the executor of his will spends a year and a half making an inventory of his possessions and arranging the inheritance. At the time of his death he has no direct heirs other than two distant nieces. On 29 October, a week before he passes away, he amends his will once again. The nieces receive around USD 106,000 (EUR 90,000), a pittance when one considers the millions he leaves behind. Christoffel is seemingly more concerned with ensuring that his name lives on. Two small boys called Christoffel receive part of the inheritance on the condition that they adopt the surname "Van Brants." But Christoffel's greatest and most enduring claim to fame is the Van Brants-Rus courtyard house, which is founded thanks to his bequest. Compared with other Amsterdam courtyard houses, this one is spaciously designed. The Van Brants-Rus courtyard house is intended to accommodate 48 women over the age of 50 and of the Lutheran faith for the remainder of their lives. The plans includes 21 double rooms and 6 single rooms. Christoffel does his utmost to organize all of this in detail before he passes away. He finds a site at Nieuwe Keizersgracht 28–44 and construction work commences. Regulations are drawn up for the governors (recruited from the ruling class of merchants), the "house father" and "house mother"; and residents. The part of the inheritance that Christoffel sets aside for his nieces' bequest is used as an additional reserve for his courtyard house. His legacy is therefore assured for eternity, and so too is his courtyard house! The Van Brants-Rus courtyard house still exists to this very day.

Introduction Members of the baby-boomer generation that emerged after the Second World War in many Western countries are gradually reaching an age that necessitates a degree of rest and care. For a long time society was expected to take care of this on their behalf, but the ageing population is complicating this task. At the same time, baby-boomers are one of the first generations to have mostly generated capital thanks to their own home and a pension. The financial crisis that started in 2008 has had some effect, but this has often not been profound in nature. The puzzle—and brain teaser—now is how to ensure this baby-boomer generation can enjoy a good retirement in a fine home that provides care and nursing where required. While many senior citizens have plans to start a large home-care villa, they often fail in realizing them. How can you implement appealing initiatives in practice while simultaneously retaining the human dimension? Will society pay for the desired living assistance? Is it possible to finance this entirely or partially from the equity of elderly people or family members? In that case, how will their personal income suffice up until the end of their lives? Although these questions are topical and urgent in nature, they are not at all new. The past returns in a different form. What can we learn from this?

Since the Middle Ages, North-Western European countries such as Sweden, Norway, Denmark, Germany, and the Netherlands provide a small yet interesting experiment in social welfare and mutual care and living assistance. The elderly and

the poor in the Netherlands enjoy better benefits than in most other Western countries in the aforementioned period. Judging from the "tweets" they post in their diaries, tourists like the Swede Bengt Ferrner and the Englishman Harry Peckham are amazed when they visited the country in 1759 and 1772, respectively.[26] The affordability/non-affordability and sustainability/non-sustainability of social welfare provisions in the Netherlands often feature on the Dutch agenda since the country's "Golden Age" in the seventeenth century. City administrators have devoted themselves to assisting poor and elderly people unable to care for themselves. In doing this, the focus in that and our own time is often placed on economies of scale, ambitious plans for new buildings and stricter government control over care.[27] The idea that these measures will resolve problems and make care affordable do not always materialize. Do other solutions exist?

Let us look at a small-scale, private alternative for elderly healthcare that emerged in the Netherlands from the fifteenth century onwards, namely "*courtyard houses*." The name relates to the fact that these houses are built around courtyards. They are established thanks to an inheritance. Elderly people go there and continue living there until they pass away. New residents are required to pay a one-off sum upon arrival. In exchange for this, they receive fixed supplies of food and drink in addition of accommodation. The amount due depends on the assets of the courtyard house. People can pay less if these assets are still sizeable, which means it is at least partly a type of charity. If the reserves are depleted, the establishment has to cover its costs. Market competition thus plays a distinct role. The courtyard houses formula is multiplied extensively during the five centuries that follow up until the second half of the twenteeth century. The buildings still exist today, but are to a large extend no longer used as houses for seniors. They do not always comply with modern Dutch requirements for facilities (such as own toilet and shower facilities) and the number of square meters for living space. Students are often housed there nowadays and one-off purchases are no longer common. Housing concepts such as courtyard houses seem to be solutions and at least offer inspiration for resolutions to the social problems of today. Can this type of housing teach us something? Where does it conflict with the automatisms and value judgments of our time? Do courtyard houses, free of the dust of centuries, offer a fresh perspective on the current issues with housing, care and pension arrangements for senior citizens?

5.3.1 The Cornerstone: Acts of Mercy

A courtyard house essentially is originated to provide people with a place where they will receive shelter and care during old age. The higher goal is linked to Biblical acts of mercy.[28] The real roots of and inspiration for courtyard houses lie in the

[26] Kernkamp (1910) and Peckham (1772).

[27] Medema (2010).

[28] Matthew (first century A.D.).

Christian ethics of Europe. These do not always serve as the source of connection, but the requirement that the weak must be cared for does really help. That is why guest houses are established throughout Europe during the Middle Ages. They emerge in countries such as Britain, Germany, France, Spain, and Italy, along permanent travel and trade routes in cities as well as monasteries. As the name suggests, "guest houses" are meant to temporarily accommodate passers-by such as travelers and vagrants as guests. Over time this also extends to poor and sick people. Greater focus was therefore placed on the local population and guest houses also become almshouses for example houses where lepers receive care. When guest houses run out of funds and/or people who have some form of income wanted to live there, these institutions also start taking in people who pay a deposit.[29] In exchange they receive their own room or home along with a guarantee that they can remain there until they pass away. They also receive a periodic gift in the form of a payment in cash and/or in kind.[30] Several guest houses and almshouses specialize later on. This trend is also visible across Europe. The guesthouses turn into homes for elderly men and women, hospitals or orphanages, but sometimes also into houses where people can live until their death after paying a one-off purchase sum. This is, for example, how the leper houses in Schiedam and Amsterdam, transformed during the seventeenth century.[31]

In the Netherlands the system of a one-off purchase sum for life-time living inspires the development of courtyard houses. These are established from the fifteenth century onwards by private persons. This is usually executed for and by the own religious community. These establishments often change accordingly when the prevailing religion makes way for another during the Reformation. Some Catholic establishments became Protestant, for example.[32] This embedding within the own ecclesiastical group is in keeping with Dutch tradition. While significant consideration and tolerance is given to different beliefs, each group looks after itself in particular. This solidarity within the own circle is an important way to live alongside one another, organize effective social welfare facilities and keep them affordable at the same time. This phenomenon is reflected hundreds of years later in the Netherlands through the Poor Law of 1854, which assumes that the State will only be deployed once all other safety nets have been missed. Mutual caring and sharing within the group is still firmly embedded within the Netherlands in the civil society organizations of pension funds, housing organizations, purchasing corporations such as banks and insurers, and sales corporations in the agricultural sector. This is also visible in other countries with a "Rhineland" tradition such as Germany, Belgium, and France. But that is a different story. What about the Dutch courtyard houses?

[29] Kam (1998).

[30] Spaans (2002).

[31] Van Essen (2012).

[32] Driessen (1948).

Going back in time the Dutch courtyard houses make a simple and fundamental promise to residents to provide them with protection and care for the rest of their lives. A moment occurs when an individual resident passes away and makes way for a new resident. But since people do not die simultaneously, the courtyard house has to continue existing in order to keep that promise to all residents. An individual courtyard house is also not focused on expanding, but on still existing tomorrow, the day after tomorrow and the following day, etc. It aims to be there for eternity. This is also appealing to founders since a courtyard house allows wealthy people to continue helping others after their own death. It also offers them a unique opportunity to live on after their death because the establishment can be named after them. Although individual courtyard houses do not have any growth-related ambitions, the concept is multiplied extensively and hundreds of similar courtyard houses appear.

The values of courtyard houses can be summed up as compassion, mutual caring and sharing, and security. Biblical charity is organized on the basis of solidarity, which applies to the establishment of courtyard houses but also to the subsequent form of habitation whereby residents assist one another. A feeling of mutual caring and sharing exists between residents because they put their personal money into a collective pot. This provides residents with mental and physical security.

The courtyard house has to excel in several core qualities in order to give substance to the promises and values. They are organized according to the human dimension in a small scale with usually 10 to 20 appartments. They form communities of people who live together until their death. This requires a sound balance between taking other people into account and reinforcing mutual assistance, but also respecting each other's privacy.[33] Moreover, the courtyard house would outlive its residents. They have to treat the courtyard house as good stewards and bequeath it to following generations. The governors and administrators also have to handle assets prudently. The resident house fathers and/or mothers have to look after the courtyard house carefully and keep the calm. Residents are expected to conform to the establishment and not vice versa. They remain guests, after all. In exchange, the courtyard house has to fulfill the promises weekly by means of gifts. The right to exist in the long term stems from always being there for new residents year in year out, and century after century.

[33] Leene (1997).

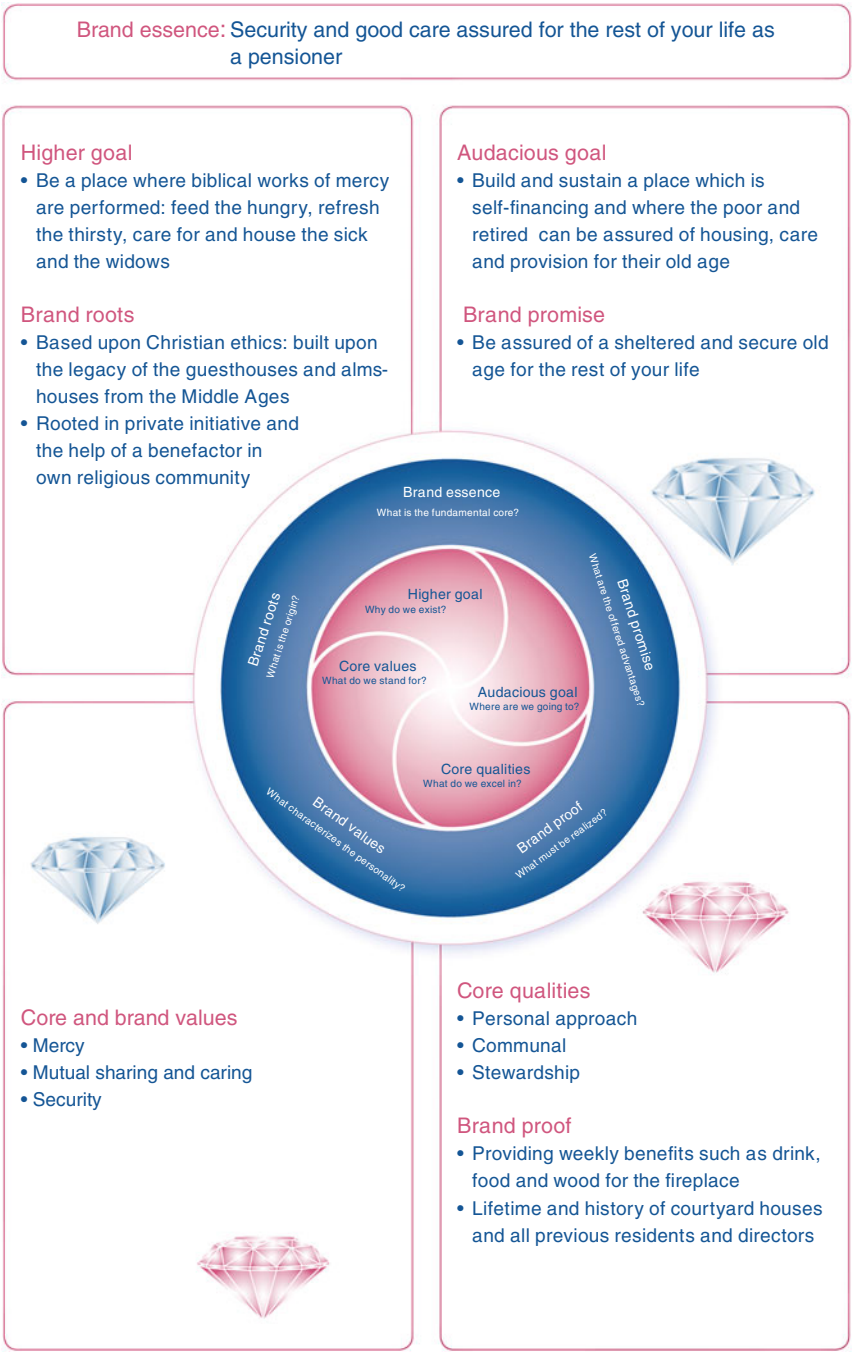


Figure 5.3.1 Vision and Positioning of Courtyard houses

5.3.2 The Business Model: Self-Sufficient Within the Own Group

Market Segments: Focused on the Middle Class Within the Community What position do the courtyard houses occupy? Let us go back in time. They are always deeply rooted in the specific local religious community and often affiliated to a church via a foundation. These establishments are found primarily in several Dutch cities, the majority of which were in Amsterdam, but also in Leiden, Groningen, Haarlem, and Utrecht. It is a supply market: over the centuries almost all of them have a greater demand from people wishing to live there than the supply of available rooms or homes. Minimal competition is required to attract residents. The main alternative for potential residents is to remain at home and live independently. That is what the very wealthy do: allow themselves to be served and cared for within their own homes. The somewhat romantic notion today that elderly people are often taken in by their children is something that never occurs that much in the Netherlands at in that time. It is certainly not common in cities. When no other option exist, a place might be available in an almshouse or in an old men's and women's house, but these are much larger and offers less privacy and inferior food and drink. This is the last alternative for the poor. Courtyard houses are intended for middle-class groups such as craftsmen and domestic servants.[34] They can pay the deposit for such an establishment from their savings or via a contribution from a grateful employer. They also comply with the requirement that gifts be supplemented with own income and means of support where necessary. The target group for each establishment is specified in statutes. Apart from the religious community, there is often also a provision that priority would be given to family members or acquaintances of the founder if they will face difficulty. Many of these courtyard house are intended exclusively for women. They live longer than men, after all, especially at a time when the mortality rate among military personnel and seafarers is exceptionally high.[35] Women also have the benefit of being more inclined to live together in harmony and less susceptible to drunkenness. From the sixteenth until the nineteenth century, people have to learn how to live together in close proximity without engaging in public fights, parties and/or sexual encounters. Back then, that is more often a challenge outside in cities and factories than is the case today where people are more accustomed to living and working in close proximity to each other.[36] Fighting and drunkenness are also reasons for being evicted from courtyard houses, something that most certainly did occur.[37] Establishments in which couples could live also exist, but these face a specific problem. As spouses do not die at the same time, a courtyard house eventually

[34] There are, of course, exceptions. For instance, the "Grand Dame" Henriette Amelie van Haren de Nerha from 1804 to 1818 in the Deutsenhofe at Prinsengracht, Amsterdam. See Van Eeghen (1967).

[35] The mortality risks of soldiers and seamen in the Dutch East India Company (VOC) are listed, for instance, in the similarly named case in Kemperman, Geelhoed, and Op 't Hoog (2013).

[36] Mastenbroek (1993).

[37] Donga (2008).

houses couples as well as single people. The establishments usually have a minimum age of around 50–60 to ensure that residents no longer have children still living with them, which potentially could result in insufficient accommodation space.

The reason why people want to live in courtyard houses is very simple. You have no inkling of what will happen in the future or what age you will reach. That underlines the importance of having the certainty and security that you will receive care and shelter during your old age, preferably in a separate physical and social world where you feel at home and protected.

Customer Value: "I Entrust Myself to the Good Care and Community of the Courtyard House" In concrete terms, the gifts entail an own home and vital necessities. Residents live together with other group members who can help each other when necessary. Gifts and house rules are provided and arranged by the resident house father and/or mother in the interest of compassion, mutual caring and sharing, and security. In principle, a one-off purchase sum has to be paid in order to live in a courtyard house. As noted the amount depends on the own assets of the relevant courtyard house at that moment. Future residents do not all pay the same amount. Some courtyard houses have start-up capital from their founder and initially require no payment whatsoever while others offer free places for poor people. Prospective residents are often also required to bequeath all or part of their possessions to the courtyard house upon their death. The proceeds were then used to renovate the home for the next occupant. Prospective residents are placed on a waiting list, have to observe the house rules and also help residents as much as they can. They are usually expected to look after themselves and also take care of their own cooking and cleaning. From a social perspective, they also run the risk that fellow residents will dislike them. However, the likelihood of this is mitigated given that they generally belong to the same group in terms of class and religion. From a financial perspective, they may only benefited from the investment for a short period if they pass away soon, but can also profit more if they reach a ripe old age. From a modern-day perspective and in line with twenty-first-century morals, the loss of independence is a striking aspect of a courtyard house: the resident is a passer-by and subject to the establishment's rules, and therefore has to adapt. It is an agreement based on acquiescence and trust.

Delivery: Recruitment Within the Own Network, Living Together Independently Within the Courtyard House Larger elderly houses where people can buy a life time place for a one-off purchase sum, occasionally place advertisements to attract potential residents. For smaller, private courtyard houses, however, it is primarily a supply-side market. The amount of capital of each establishment varies, but each one starts in principle with a private "subsidy" in the form of immovable property. If a landlord wants to launch a chain of courtyard houses to earn money, he will have to request a larger contribution. That can also explain why the demand is always greater than the supply. Prospective residents are tipped off through word-of-mouth advertising and proposed and selected on the basis of references and favors. The initiative lies with prospective residents, but also within their environment. An example of this is when someone has to find a good place for an elderly member of staff or a family member who no longer has anyone else to lean on. The size of the

courtyard house and the life expectancy of existing residents constitutes the physical limits. The real limitation lies in the shortage of space. A place on the waiting list after a ballot is not yet enough to guarantee the availability of a home before your death.

The governors of the courtyard house are mostly prominent representatives of the involved church community. They are actively involved in the selection of new residents but then have little contact with existing residents thereafter. Day-to-day care is taken care of mostly by the resident house father or mother who report to these governors. The amount of contact outside the establishment differs from resident to resident and also depends on residents themselves. There is of course also mutual contact. The manner in which this occurs depends logically on the group dynamic and therefore varies from establishment to establishment and over the course of time. Evidently, most establishments do not intend to forge a single, very tightly knit community. They are not communal living groups like those from the 1970s in the US and Europe. Instead, they focus more on treating one another with decency and friendliness while maintaining a certain distance. With people living in such close proximity to one another, this appears to be the right recipe for maintaining privacy and avoiding explosive and complex group processes.[38]

Operation: the Organization of Psychological, Financial and Physical Security The heart of the courtyard house is its physical location and the building. Remarkably, the design itself is a direct reflection of the calm, protection and security that the establishment provides. What aspects do the various designs share? Just like a monastery, the courtyard house is litterally oriented inwards. Front doors and many windows do not face the street but the courtyard instead, as the name already indicates. The human dimension is retained in the social design but also in the size of the physical design. Private courtyard houses usually comprise around 10–20 cottages or rooms. They often have 12 homes with a single occupant or a couple, which is an easily manageable number of people. The number 12 is also a number of significance in the Bible and is also often referred to when describing the number of rooms.

The organization and much of the work in the establishment is carried out by house fathers and/or mothers who also live there. They fulfill the role of intermediaries to the governors, gatekeepers of the establishment, guardians of house rules and coordinators of maintenance and service facilities. Practical tasks such as domestic work for the communal area, chores and gardening also fall under their responsibility. The assistance provided by the house father and/or mother and the mutual aid between residents involves primarily informal care. Residents have to personally call in and pay for medical and personal care that is really intensive. Bear in mind that medical care up until the twentieth century is much more limited, with considerably fewer people in need of intensive care as a chronic patient.

The governor's primary task, in addition to the selection of new residents, is to ensure continuity and financial solidity in particular. The contribution paid by new residents has to be calculated properly. If everyone grows much older than antici-

[38] Leene (1997).

pated, available funds will be used up quicker (the "long-life risk"). And if everyone dies earlier than anticipated, the requested contribution will have been too great (the short-life risk). The excess contribution of people who die younger has to cover the additional costs of people who grow older. Maintaining financial equilibrium is essential, in other words.[39] This is fairly precise and requires high-level calculations. The Dutch leading politician Johan de Witt writes about this in 1671 in a book about The Worth of Life Annuities Compared to Redemption Bonds.[40] Besides a leading politician, he is therefore also a "leading actuary" and his book is still considered one of the milestones in modern pension and life insurances. Due to the uncertainty at the moment of death, the courtyard house requires equity capital as a "solvent" buffer. This equity has to be invested, managed and protected with care. Excess equity provides additional scope for greater charity. The contribution requested from residents decreases and gifts can be increased. When the available equity is too little, the establishment will not be able to fulfill the obligations undertaken in relation to residents and can go into liquidation, in the worst case scenario. In a nutshell and on an elementary level, these are the same issues that still occur today in the proper and orderly management of pensions and life insurance. The phenomenon of life annuities described by Johan de Witt which forms the basis for courtyard houses is still a wonderful, old-school life insurance construction. "Immediate annuities": a one-off sum of money is invested in return for a sum of money that you receive in monthly installments until your death. It is also not very different to the issues prevalent within healthcare and non-life insurance since here it is not clear either beforehand how much will have to be reimbursed. Reserves are intended as a solvent buffer for getting by in times when the outflow of money exceeds the inflow, and also when it is the other way round. Sailing too close to the wind with equity and solvency and returning everything immediately and in full to the customer is tempting in the short term and makes you popular. In the long term, it inevitably leads to a financial crisis in bad times.

Besides suppliers of the day-to-day needs of the courtyard house and its residents, suppliers and partners of a more strategic nature also exist. As indicated, the church community plays a key role. Furthermore this includes, of course, the builders and architects who help construct, maintain and renovate the establishment. Finally, there are the politicians and civil servants, who have a considerably less active role in day-to-day care because it is based on a private initiative. They can be either a help or a hindrance. That is also evident during the twenty-first century within courtyard houses that still exist today in the form of residential communities. This does not appear to dovetail with current regulations and permits. Over the past few decades many such establishments have had to comply with Dutch regulations pertaining to individual residential units for each room, all of which prove to be somewhat puzzling. It sometimes even results in changing the focus to housing students in one household as the only way to comply with regulations.[41]

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[39] Schmitz (1965).

[40] For the real scientist in this field, it is interesting to know further that the first scientific mortality tables were compiled in 1693 by the Englishman Edmond Halley. See Halley (1693).

[41] Donga (2008).

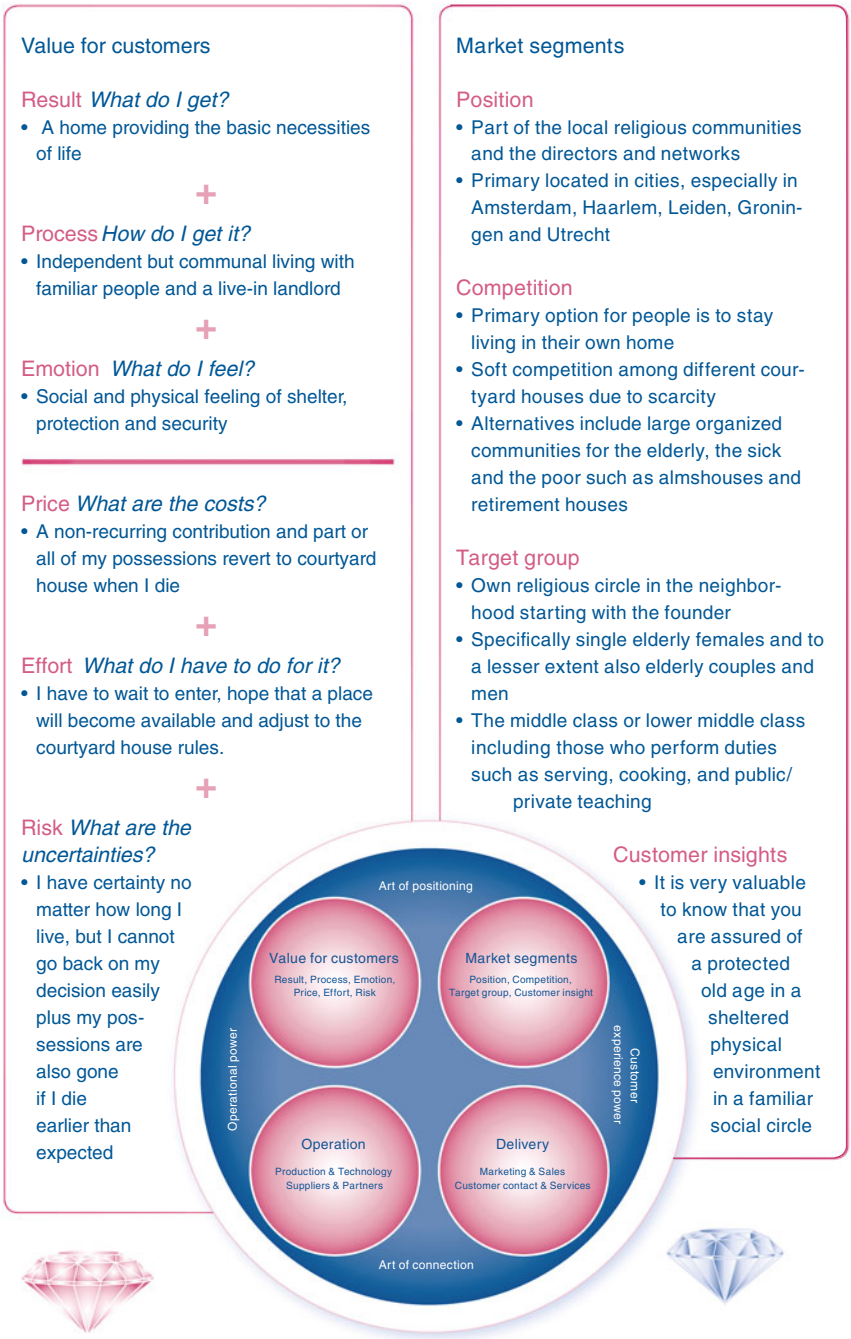
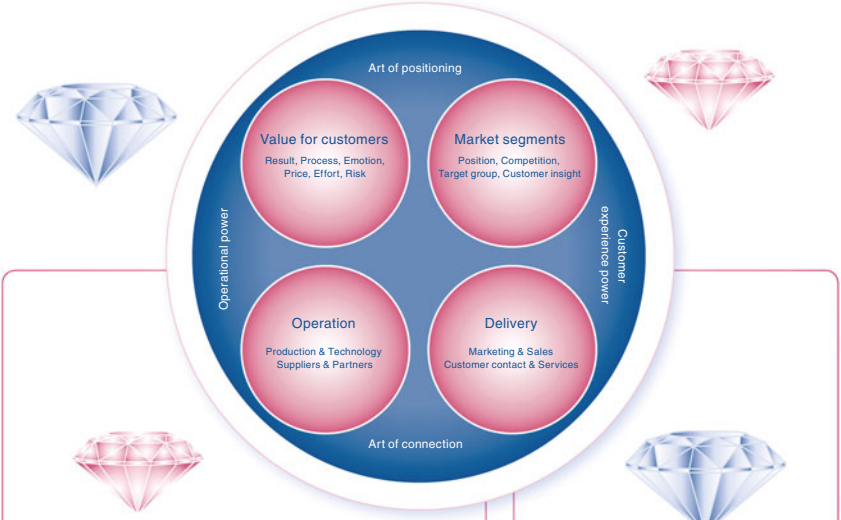


Figure 5.3.2 Value for customers and Market segments of Courtyard houses



Operation

Production & Technology

- Physical materialization of shelter and safety in architecture of courtyard built around a garden with frontdoors towards enclosed inner space and not out onto open street
- Personal approach of 10 to 20 homes (often 12 or 13) among a courtyard
- Daily coordination of supplies, maintenance and abiding by the rules of the live-in landlord with the courtyard house directors residing off-site
- Expertise with and knowledge of actuarial mortality tables concerning life expectancy and solvency management to protect the continuity and pay expenditures such as the living supplies, maintenance and wages for the landlord

Suppliers & Partners

- Primary suppliers to build and maintain the courtyard house such as architects, constructors and craftsman
- Partners such as churches and religious communities that often also provide the directors and own the courtyard house
- Governments that create a context, limits building permits but for instance also give tax advantages and exemptions

Delivery

Marketing & Sales

- New residents are recruited via the grapevine in own network.
- It is a privilege if you are allowed to enter through own network or initiator's circle of surviving relatives of courtyard directors

Customer contact & Services

- Mutual contacts between residents who can help each other and keep each other company within the boundaries of everyone's privacy
- Support, care and basic living supplies via live-in landlord (housemother, housefather or housecouple)

Figure 5.3.3 Operation and Delivery of Courtyard houses

5.3.3 *The Result: Altruism and Self-Financing Complement One Another*

Courtyard houses often start with substantial capital but the returns are not sufficient to remain self-financing. Nevertheless, they often manage to operate for centuries. Although they no longer function as courtyard houses nowadays, there are still some 200 establishments in the Netherlands where people live together. Of the 51 courtyard houses founded in Amsterdam over the centuries, only seven have disappeared completely. Particularly striking is the number of centuries during which they function as a courtyard house. The social design and revenue model evidently succeeds in striking a balance between value creation for and by stakeholders that works effectively and is resistant. How is that achieved?

Let us travel back in time to find out. The contribution which new residents pay, the gifts they receive and the degree of self-motivation among residents differ among courtyard houses. This provides scope to make adjustments over time during financially difficult periods and to do something extra if people have little money or unexpectedly reach a very old age. People are keen to live in one of these establishments, as evidenced by the long waiting lists. When the requested contribution or self-motivation is somewhat higher, or the gifts lightly less, vacancies hardly rise. At the same time, governors do not abuse this system. From a purely commercial perspective, places could have been auctioned off or sold to people on the waiting list for the highest bid. But that is not the case. Such an approach does not correspond to the original goals of compassion and would not have been tolerated within the own circle to which administrators and residents belonged.

The founder's name is immortalized in exchange for his or her inheritance. Governors acting on behalf of the church or foundation usually receive no financial compensation, although they are able to enjoy fine dinners. It revolves primarily around social status. In addition, favors can be granted within the own immediate surroundings or religious community.

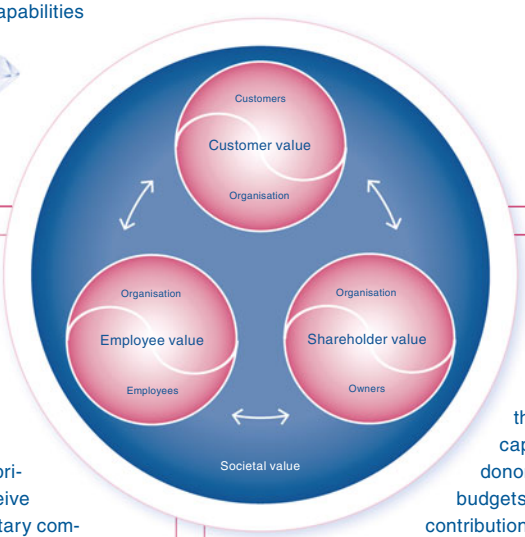
Staff does not enjoy the comprehensive conditions of employment and working hours we are accustomed to in many North-Western European countries nowadays. In this respect, it is more akin to developing countries and countries with a more flexible labor market, such as the USA. Supervisors at the courtyard house do not head off to work and return home at the end of the day. Instead, it is more like working from home. The name "house father" or "house mother" is therefore more appropriate than "staff member." As the head of the "family," these individuals have a relatively large degree of freedom and responsibility to manage day-to-day affairs in the establishment. They receive a small salary in return, but the reward is mainly nonmonetary in nature because they live in the courtyard house alongside residents and receive gifts in the form of food and drinks. This give them certainty as well as the feeling they are doing something beneficial that matter to others.

The courtyard houses are based on private initiative and governance within the own social circuit. From a public perspective, this is beneficial in that they do not depend on common collective facilities. Over the centuries, this sort of approaches makes it possible to finance and implement the high-quality social system in the Netherlands. This offers additional calm and stability in society.

And today? Can we learn something from courtyard houses with regard to living and caring for ageing people in the twenty-first century?

Value by customers

- The one-off contributions and assets of residents make it self-financing. They are set at and used to keep the funds on a level which is sufficient to pay for the day-to-day expenses such as living supplies, maintenance and wages.
- Residents have duties to help each other and participate in the overall tasks within the courtyard house, so that they contribute in kind to the community within their own physical capabilities



Value for and by employees

- Live-in landlords primarily receive non-monetary compensation, since they can also live and use living supplies in the courtyard house.
- Landlords are offered long-term certainty in that the necessities of life are provided for and residents can play a valuable and respected role within their own group

Value for and by shareholders

- Founder provides the initial starting capital and potential donors create surplus budgets. Their merciful contribution results in respect, ensures that their name will live on after their death and contributes to their salvation
- Directors receive respect, strengthen their reputation and have a position in which they can grant people the privilege to be allowed to live in the courtyard house.
- The official owner (often the church and/or a foundation within own network) gets an additional instrument to do good works and strengthen their own group

Value for and by society

- Solutions within the own group limit the demands on public funding and over the centuries have been an important instrument in the provision of communal arrangements with high standards for good care for those who truly need it
- Good solutions for living, care and old age strengthen and maintain social peace and stability
- Still offers an inspiring example of a self-financing social solution with a personal approach to communal living and access to care and provisions for seniors

Figure 5.3.4 Value for and by stakeholders of Courtyard houses

5.3.4 The Brilliant Lessons of Courtyard Houses

It is becoming increasingly clear that care and human attention for all senior citizens in countries cannot be fully provided collectively in countries with a significantly large ageing population. Types of housing are being sought in which people can continue living at home longer and look after themselves and each other more. The old system of living in courtyard houses offers several surprising and inspiring elements in this day and age. It also seems to conflict with a number of points relating to Western standards, values and automatisms. That gives rise to questions and puzzles that can serve an educational purpose:

- Elderly people can live together facilitated by a house father/mother. How can they do this and what is the appropriate human dimension to this end? As indicated, many old courtyard houses only had 12 rooms or cottages and therefore rarely 25 residents. This size ensured everything remained transparent for both the residents and the organization. Does this constitute the human dimension that healthcare is seeking? Primary coordination and everyday matters at these establishments were entrusted to a house father and/or house mother. These individuals also lived on the premises and always acted as a point of contact for residents. This was a formula that demanded flexibility in terms of hours and tasks. When viewed from a modern perspective, however, it was a totally transparent system: no handovers, schedules or management layers.
- Common background creates community. Another aspect was the common background with respect to the environment and religion, which ensured that the environment felt familiar to residents. This is a philosophy that is still embraced today and valued within different forms of care, but it is sometimes also critized since it conflicts with the ideal to treat everyone equal.
- A good balance between privacy and communality. Many people are not accustomed to living in close proximity to one another. It results in too much intrusiveness among residents and gives rise to complex social processes. On the other hand, too much privacy can lead to loneliness. The courtyard house appears to be a type of accommodation that can ensure privacy and communality due to the social as well as the physical design. The question this also gives rise to is how democratic and how proactive you make the residential community. New, more luxurious residential concepts are often created by people including active senior citizens who are still in the prime of their lives. Often they also assume that older senior citizens are highly active and wish to remain in control. This is a wonderful perspective but perhaps not suitable for everyone, and neither until the end of someone's life. Courtyard house*s* are based more on the concept of a protected environment that provides shelter and care for you and not on fulfilling all different needs for proactive individual consumers.[42]

[42] Differentiation in target groups and a comparison between communes and courtyard houses are elaborated on in Leene (1997) and by Veltman (1995).

- The one-off purchase sum. Can we learn something from the simple and elegant revenue model used by courtyard houses? Are they an example when it comes to contributing one's own assets in exchange for a guarantee of care if this is required? Even after several years of economic crisis, equity in homes and the pensions of many senior citizens in western countries evidently provide an adequate source for the payment of care if it cannot be financed through collective resources. Macroeconomists also see that very clearly, but how to translate that into everyday reality on a micro level still poses a conundrum. Part of the problem is that you cannot exactly take your home along brick by brick in order to pay for care if needed. You also have no idea how long it will take before "you'll eventually have eaten up your home." The old principle of the one-off purchase sum with fixed gifts or annuities until you die seems a logical part of the solution.
- Continuity is ensured because the institution is larger and outlives individual residents. Many people nowadays consider selling their home and starting a private home-care villa with a group of acquaintances. This has not yet resulted in a large number of establishments as they often come up against problem of practical organization, legal snags and pitfalls, and the entry-exit strategy. What happens, for example to the home care villa you share when people leave, or die? How do you find and select a new resident? How do you jointly divide and/or purchase care and domestic help? What is the best mix for housing senior citizens who are old and those who are not as old? In short: the organization of such a type of housing is already so complex that it often only remains in the planning stage. If you are not careful, collective aspirations lead to conflict before even a single brick has been laid or purchased. The advantage of courtyard houses is that the organizational aspect is taken care of and the applicable rules are not open to debate.
- Self-contributing. What can people do for themselves and for each other? The courtyard houses have a tiered system. Residents are, in principle, self-sufficient, self-motivated, and self-contributing. In addition, mutual neighborly assistance is provided within the court courtyard house community. If residents differ in terms of age and dependency, they can organize much of the normal human care and attention amongst themselves. House fathers and/or house mothers do lend a helping hand, but are not total healthcare practitioners.

The courtyard house model which originated from the sixteenth century is somewhat rusty five centuries later. But below the surface lies a wonderful, refreshing and inspiring concept for the issues we face today. It is high time to discuss the business model of courtyard houses 3.0!

5.4 Stiftung Liebenau

Lebensräume für Jung und Alt

Rick Kasper, Tim Widdershoven, Sanne Boevé & Jeroen Geelhoed @: J. Geelhoed@samhoud.com, Phone: 0031 622408791

Stiftung Liebenau

Prelude *It is around 10 o'clock on a Thursday morning and we are driving on the premises of Stiftung Liebenau. We immediately notice the hustle and bustle around us; mothers are pushing prams, elderly men are strolling along the street with the aid of their walking sticks, and a young woman wearing tracksuit bottoms is pushing an elderly lady around in a wheelchair. The moment we enter the reception area, with charming children's paintings adorning the walls, we notice the informal nature of the establishment. The receptionist, who looks incredibly relaxed, shows us the way and we soon arrive at Wohnanlage Meckenbeuren, a residential community where young and elderly people alike live together in the same apartment complex. The foyer is filled with photos of elderly people pushing prams, children playing, elderly people cooking to an accompanying recipe and cheerful children's drawings. Convivial, almost cozy, are the words that spring to our mind. A large board on the wall is covered with photos of elderly and young people, colored prints of large and small hands and the text "Wir Stärken uns Gegenseitig" (together we strengthen one another). "Yes!" exclaims an elderly lady enthusiastically when asked if she really does feel more fit and vital because she is surrounded by so many young people. And that is precisely what Stiftung Liebenau wishes to achieve with its Lebensräume projects.*

Introduction Let us return to the nineteenth century to obtain a better picture of the foundation. Adolf Aich was a vicar in the chapel of St. John in Tettnang. He decided to establish a hospital that could provide care for the "incurable" since almost no-one was interested in assisting handicapped and chronically ill people. In 1866, he therefore founded the "St.-Johann-Verein" together with a socially engaged citizen in Tettnag. The aim of this association was to create an independent hospital using voluntary contributions. He visited twenty dioceses and regions to collect donations. In 1870, Aich purchased Schlösschen Liebenau himself and established a nursing home for disabled and poor people. He called it the *Pfleg- und Bewahranstalt*

Liebenau (Liebenau Hospital and Custodial Institution), and his establishment soon garnered an excellent reputation in the region. In 1873, the association was officially founded Stiftung Liebenau. In 1893, the foundation purchased Schlösschen Liebenau from Aich and by the end of the nineteenth century it housed up to 400 people.

Adolf Aich could probably never have imagined where all of this would ultimately lead to. Today Stiftung Liebenau and its subsidiaries have more than 6400 employees. The foundation is active in over 100 locations spread across five different countries, namely Germany, Austria, Italy, Switzerland, and Bulgaria. All of them account for an annual turnover of USD 294 million (EUR 250 million). The foundation no longer focuses solely on people with a disability but also trains and educates children and young people with learning difficulties. It also provides assistance and support to parents of children with a chronic illness or disability. The foundation also runs several businesses that offer employment to people with disabilities. Finally, elderly care is also provided now in various ways. The most striking are the Lebensräume (Living area) projects, which make elderly people part of close-knit community. Fellow residents assist the elderly with activities they themselves can no longer carry out. Professional care is only provided when assistance from the community is no longer sufficient. The Lebensräume projects are remarkable and brilliant due to the collaborative structure between the municipality, the foundation, healthcare practitioners and property developers, but this will be discussed later in greater detail. We will first take a closer look at Stiftung Liebenau as a whole in order to obtain a good overall impression. A notable aspect of the foundation's activities is that it gives people opportunities to participate fully in society. Often, however, people need to take action themselves. They have to be active if they wish to benefit from the foundation.

5.4.1 The Cornerstone: Value for Every Individual

The idea that everyone should be able to participate in society and play an active role is reflected in the foundation's brand essence: "Creating conditions for a dignified life." The foundation helps people to help themselves. A fine example of this is the help offered to disabled people. The foundation creates the conditions that enable people to participate in society as fully as they personally wish to and can. The foundation offers educational and employment opportunities so that these people can live independently later on. They must, however, seize these opportunities.

The organization's higher goal can be described as: striving to allow every individual to lead a dignified life from birth until death. It focuses on value for the individual as well as society. His or her gender, nationality or religion play no role in this. It is also irrelevant whether the individual has physical, mental or emotional limitations. This conviction originates from the organization's Christian roots. All its activities revolve around giving a dignified life to people who would otherwise not be able to participate or fully participate in society. Ever since the foundation's very first day, it has endeavored to offer a dignified life to the disabled, chronically ill, and poor.

The foundation's audacious goal is twofold. Firstly, to make people believe that God is present in our world through the work of the organization. Secondly, to create an inclusive society where people think less about themselves and take better care of one another. The audacious goal is expressed in the brand promise to offer every individual a dignified life and help every human being to participate in society as fully as possible. Finally, the facilities of Liebenau provide safe and dignified shelter to those in need of long-term support.

Everything is done according to the Christian conviction that people must look after each other. That is why care is one of the foundation's core values. It permeates throughout all of the foundation's activities, ranging from providing education to children and young people with learning difficulties to offering employment to people with disabilities. The other core values of brotherly love and solidarity are also clearly evident in the organization's numerous activities. These values are reflected in the huge number of volunteers active within the organization. This is also apparent from the success of the Lebensräume projects, which appeal to brotherly love and solidarity among residents. The fourth core value, independence, can be derived directly from the brand essence. Independence plays a major role in the organization. Within a Lebensraum project, for example, professionals will only mediate and assist if people in the community cannot resolve something themselves.

The core values of care, brotherly love, solidarity, and independence are also the brand values used to realize the brand promise. These values are expressed externally and reflected in the foundation's activities. The foundation's social workplaces exemplify this, and also serve as brand proof. These workplaces employ disabled people to give them a useful purpose in society. The manner in which care for the elderly is provided in community projects, which permit older people to retain their dignity, also proves how the foundation has kept its promises since the outset. An event from the Second World War is indicative of the foundation's fight to fulfill its promises regardless of peoples' origins. The Nazi regime systematically murdered people with a disability during the war. Some 1500 Stiftung Liebenau residents perished in the gas chambers of the Grafeneck Euthanasia Centre during this atrocious period. Liebenau managed to save 150 people from this horror.

The foundation can fulfill promises because of its community-focused approach. It therefore knows how to create the right preconditions that almost automatically give rise to self-help and neighborly assistance. Residents are also allowed to assume responsibility within projects. Other core qualities of the foundation include its independence from the state and the degree of autonomy stemming from this. The organization is therefore free of any political influence. This independence is achieved because the financing of day-to-day operations originates primarily from entitlements to statutory subsidies and payments from private insurance funds. These are neither political- nor government-dependent. Donations and occasionally proceeds from wills are used to finance new projects. Ultimately, the evidence is provided by the success of the foundation and its projects. The number of projects has grown significantly and hence the number of employees and turnover too.

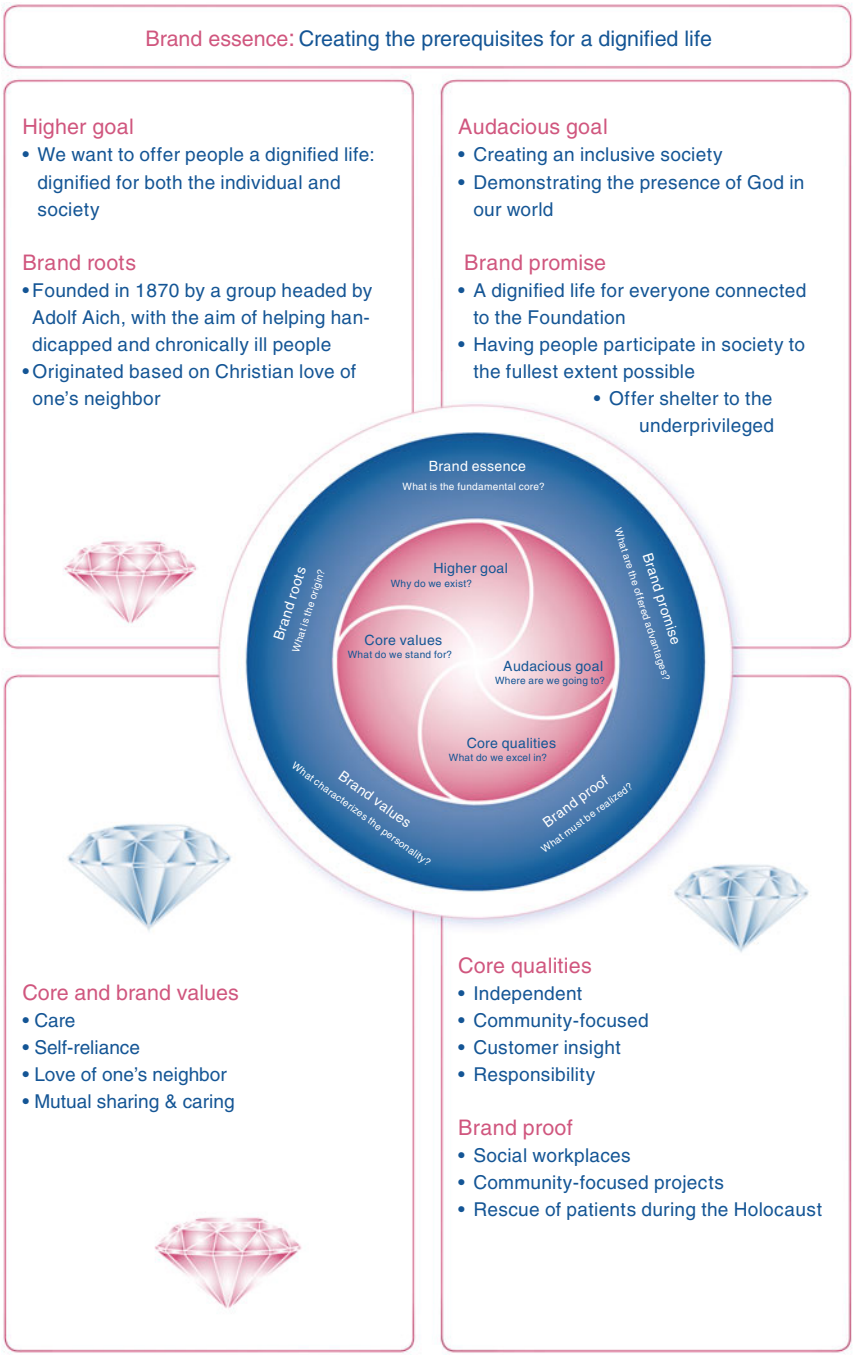


Figure 5.4.1 Vision and Positioning of Stiftung Liebenau

5.4.2 The Business Model: Lebensräume für Jung und Alt

Stiftung Liebenau has numerous subsidiaries and participating interests. This business case focuses on the *Lebensräume für Jung und Alt* (Living Area for Young and Old), in other words projects set up and run by two daughter foundations called Liebenau Leben im Alter and St. Anna Hilfe. The development of these projects commenced around 20 years ago. In the early 1990s, the first residential community based on the *Lebensräume für Jung und Alt* concept started operating in the municipality of Vogt.

Gerhard Schiele, the director of *St. Anna Hilfe für ältere Menschen,*[43] believes that if you want to ensure that elderly people remain active, you must not offer them care they do not require. In view of the increasingly ageing population, he believed that the various age generations could help each other to continue supporting the elderly in the long term.[44] He therefore came up with the idea to initiate a housing project where elderly and young people could live together and help each other. The municipality of Vogt was very enthusiastic. In the opinion of Gerhard Schiele, the project's success hinged on a central location for the housing community nearby shops and medical and cultural facilities. Thanks to the close collaboration with the municipality, the building land for the project was provided for free. Southern Germany currently has 26 Lebensräume projects.

Market Segment: Competitors Are Partners The position that Lebensräume projects occupy in the market is a special one. The foundation aims to offer residents a dignified existence. The project focuses primarily on (vital) elderly people, but young people are also important even essential for its success. The know-how acquired over the years and the networks create an exceptionally unique position, or an *Alleinstellungsmerkmal* (unique selling point). The elderly care provided by Stiftung Liebenau also includes nursing homes. When an elderly person residing in one of the *Lebensräume* requires care and can no longer receive it in their home, this individual is entitled to stay at a stationary care facility in a nearby nursing home.

As its name suggests, the point of these communities is to allow young and old(er) people to live under the same roof. These can be elderly people in need of assistance, active and energetic senior citizens, old or young couples, single parents or young families. The aim is to create an age mix where children and young adults make up a third of residents and middle-aged or older people account for two-thirds. Residents must be able to identify with the social model and want to be part of a *Lebensräume* community. The *Gemeinwesenarbeiter* (GWA) or community worker and the residents' council verify this during the selection procedure for new residents. In line with the foundation's vision, they do not make any distinction between religion and income.

In the future, professionals will no longer be able to fully meet the growing demand for care. Director Gerhard Schiele is pursuing the idea that much of the demand for professional care can be avoided by optimizing the use of the community.

[43] See also http://www.stiftung-liebenau.de and http://www.st.anna-hilfe.de.

[44] http://www.zorgwelzijn.nl/Welzijnswerk/Nieuws/2007/5/Lebensraume-fur-Jung-und-Alt-Burenhulp-als-uitkomst-voor-de-vergrijzing-ZWZ011433W/.

People will remain more vital and independent if they help themselves and others. This will enable people to live without or with less professional help. At the same time, residential areas are made accessible to young people who would otherwise have difficulty finding a home. In return, these young help assist the elderly.

Customer Value: Self-Esteem, Satisfaction, and Vitality Although every *Lebensräume* project is different, the higher goal of Stiftung Liebenau is always the focal point. It will therefore always revolve around creating a valuable life for residents themselves and for society. Residents organize a wide range of activities in the Meckenbeuren and Amtzell establishments, for example. These include joint activities such as festivities, eating breakfast together, cooking together, and participating in courses.

The age structure ensures that young people and active senior citizens can always assist the elderly. Should an elderly resident require professional help, this is communicated and organized. If possible, this will take the form of extramural care so that elderly residents can continue living at home. This approach gives them a feeling of self-esteem, independence, and vitality. Residents feel like they belong to a community, but can also lead their own lives and retain their own identity. This is different to residential communes from the 1970s where people did everything together and their own identity was weakened.

The projects are not only interesting for elderly people in need of assistance, but also for young people and active senior citizens. First of all, they can live in a pleasant, central location. These projects also give them a feeling of satisfaction and responsibility thanks to the voluntary community care they provide to fellow residents. It is also wonderful for active senior citizens to live in a community with young people and children, and not only with other elderly people. This keeps them more in touch with the youth and ensures in turn that they remain more youthful. It is also interesting for young people—young families with children—because they can benefit too from a helpful community, such as babysitting for their children.

The costs for residents are limited to the purchase or rental price of the home and the normal cost of living. The purchase or rental price is just below the price of similar homes in the vicinity. Residents of Lebensräume projects can register if they are willing to offer basic support and assistance to neighbors and fellow residents. This help is voluntary.

Delivery: Together We Are Strong The building has shared rooms in which activities are organized. Residents can rent the rooms for a small fee to celebrate their birthday with family members, for example. The rooms and corridors in the building radiate communality and conviviality thanks to photos of residents and children's activities and works. One community worker (GWA) is employed to ensure that everything runs smoothly within the community. This individual often works part-time and is employed by the foundation, but never personally lives in the residential community. He or she acts as the first point of contact for residents, brings residents into contact with each other and encourages self-help and neighborly assistance. Residents do not provide actual care, such as physical nursing. Neighborly assistance can be offered in various ways, such as walking a fellow resident's dog, tending the garden or doing the laundry. Activities within the community that residents

organize themselves for free include childcare, grocery-shopping services, courses, morning gymnastics, group lunches, cooking together or book clubs. Everyone can contribute. In this way, elderly residents can keep an eye on their fellow senior citizens. A unique example is the roll-down shutter check. If desired, residents can ask their neighbors to knock on their door if their roll-down shutters are not opened by a specific time. In the event of an emergency, a spare key to the home is on hand so that the neighbor can enter the property and "save" the resident. Professional help is sought in situations where neighborly assistance no longer suffices. Cooperation with local healthcare practitioners plays a pivotal role in this respect. If possible, professional help is provided at the resident's home to allow him or her to continue living within the community. If the requisite care can no longer be provided in the resident's own home, he or she is entitled (with priority) to receive care in a Stiftung Liebenau home.

Operation: Working Together Municipalities usually approach Stiftung Liebenau to construct and run a residential community. In most cases they do so out of a desire to delay the demographic change somewhat or to alter the demographic structure.

Homes are sold to homeowners and investors during the construction phase. All of them are normally sold before construction work has been completed. Homeowners do not always personally occupy their home but view it as a capital investment. Stiftung Liebenau takes care of the rental process and guarantees rent returns. Investors enjoy a high degree of certainty and can therefore be assured of a safe investment. To finance the community project, Liebenau and the municipalities involved at the time set up a *Sozialfonds* (social fund). Proceeds from the sale of homes, contributions from resources paid by the municipalities concerned and gifts and donations flow in and out of this fund. A treaty of principles determines that resources from this fund are assigned directly and exclusively to residents from the relevant municipality. In the event of a deficit, which is realistic given the low(er) housing returns and interest on contributed resources nowadays, the municipality will step in. A community worker is the focal point of the Lebensräume concept. This is usually a professional woman with a background in social education, such as a social worker or a social pedagogue, who works part-time. Her salary is covered by the social fund.

A round-table meeting is held in the *Lebensräume* twice a year, during which residents are given the opportunity to express themselves and identify problems. The residents' council then addresses these problems in consultation with the community worker. The projects' success depends largely on the residents of the residential group, which is why the selection of new residents is so important. The residents' council, in cooperation with the community worker, looks at age first since the age structure must be maintained. This council also verifies whether the family or person in question has relatives of friends in the area, with a view to family reunions later on.

The most important partner in a *Lebensräume* project is the municipality. Municipalities are often the first to approach Stiftung Liebenau and they are responsible for the provision of public utilities and public services within the care area of their citizens. The involvement of the municipality and the community in a Lebensräume project is therefore considerable and also crucial to a project's success.

Value for customers

Result *What do I get?*
- I remain a part of society and I live a dignified life. I remain more active and with a higher vitality*
- A central location to live and an involved community with helpful co-residents**

+

Process *How do I get it?*
- I am selected to live here. I receive help from my neighbors and other co-residents when I ask for it

+

Emotion *What do I feel?*
- I feel responsible, more self-reliant, younger and safer*
- It is a good feeling to be part of a social community**

Price *What are the costs?*
- Accommodation in a community such as this one is slightly less expensive than the average rental prices

+

Effort *What do I have to do for it?*
- As part of the community, I am expected to make a contribution according to my ability

Risk *What are the uncertainties?*
- Residents should show involvement and actually offer to help out

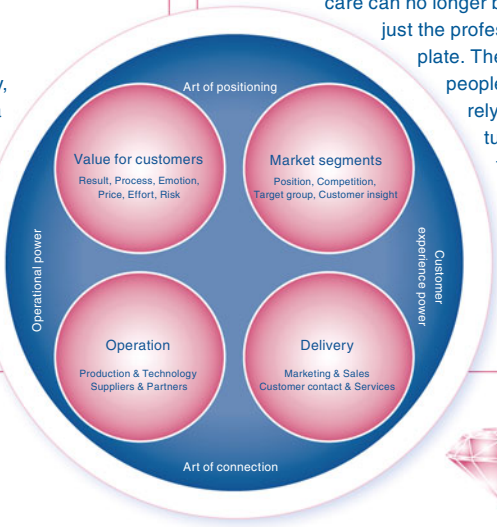
Market segments

Position
- Stiftung Liebenau has occupied a special position in the market with its 'Lebensräume' (Living Space) concept

Competition
- Traditional nursing homes are considered partners rather than competition. The elderly can divert to living in such homes when living in the community is really no longer possible
- Home care organizations are not seen as competition either. In the end, the people should be the priority

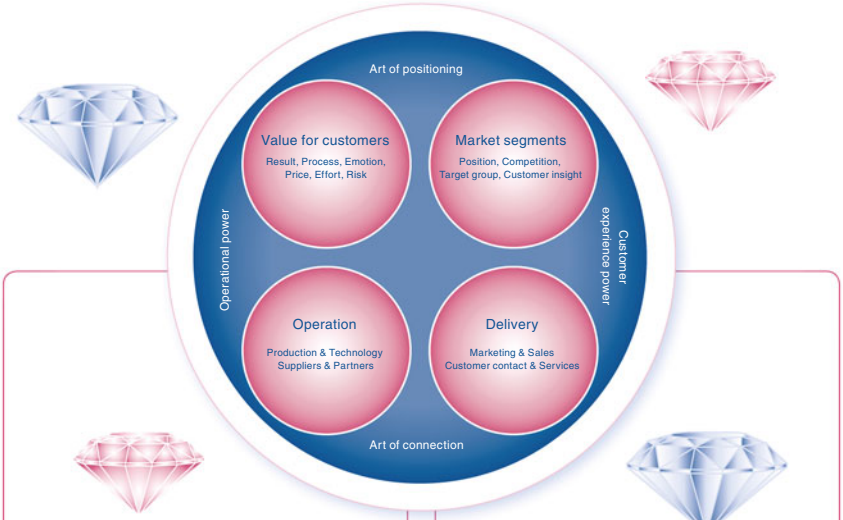
Target group
- All people that wish to live in a Lebensraum-community and that wish to contribute to it are seen as the target group. The aim is to create a mixed-age group. The selection is based on age, local contacts, urgency and the belief in the philosophy

Customer insights
- In the future, increasing demands for care can no longer be put on just the professionals' plate. Therefore, people should rely on mutual care to a much larger extent



*Specifically elderly **Specifically young

Figure 5.4.2 Value for customers and Market segments of Stiftung Liebenau



Operation

Production & Technology

- The community in the municipality takes the initiative to submit a plan to the Foundation and is responsible both for financing and building the residential unit. The Foundation takes a steering role in this (organizational philosophy).
- The Community Worker ('Gemeinwesenarbeiter(in)' or GWA) has a coordinating and organizing role, he or she is is approachable and mediates in case of conflicts
- Consultation and feedback originating from the community is gathered during-roundtable meetings.
- Decisions (e.g., selection of new residents) are made by the residents' council together with the Community Worker

Suppliers & Partners

- The Foundation collaborates, among others, with local construction companies, municipalities, associations, communities and healthcare institutions

Delivery

Marketing & Sales

- The Foundation engages in marketing activities, the municipality suggests potential clients and the projects are reinforced through word-of-mouth advertising

Customer contact & Services

- The building possesses several communal areas in which for instance the activities are organized.
- If a resident really needs extra care this can be provided by professional care instututions of Stiftung Liebenau or another provider.

Figure 5.4.3 Operation and Delivery of Stiftung Liebenau

5.4.3 The Result: A Positive Spiral

Stiftung Liebenau as a whole has achieved significant results. With respect to business models, this chapter focuses mainly on the *Lebensräume für Jung und Alt*. The results in this section are based on our visits to the two Lebensräume projects in Amtzell and Meckenbeuren.[45]

Customers—read: residents—are immensely satisfied, and a 76-year-old resident had the following to say about the residential community: "I adore watching children play. I love them and they love me. There are also so many activities here such as gymnastics for senior citizens, handicrafts, singing or drinking coffee. You never have to feel bored. Who would not want that?" Younger residents believe that the residential community is a fine place to raise their children. Elderly people provide additional supervision in the area and even babysit children sometimes. On the other hand, young people assist elderly residents with new technology by giving them computer lessons. The waiting lists that have developed reveal that this community is also interesting for young people. Numerically, value for the customer can be expressed in a satisfaction survey.[46] Approximately 90 % of respondents in both Amtzell and Meckenbeuren are satisfied with their state of health, their quality of life and the absence of barriers in the residential community. In addition, over 95 % of respondents are satisfied with the situation in their private life while more than 90 % are satisfied with the general situation in the residential group.

Amazingly, only one paid employee (a community worker) is active within a Lebensräume project. The number of hours this individual works during the week depends on the number of residents in the residential group. She manages the neighborly assistance and works closely with the residents' council. A community worker from one of the projects says: "I feel I can provide a useful contribution to society through this project, which really gives me a feeling of satisfaction." Community workers also have considerable freedom in how they fulfill the role. As long as they succeed in organizing and managing the project properly, the foundation is satisfied. These individuals can therefore really turn the residential community into a personal project for the relevant municipality.

In fact, a project always involves multiple partners. The first is Stiftung Liebenau, with its know-how. With the realization of each residential community, the foundation takes one step closer towards its goal of giving everyone a dignified life. The second partner is the municipality. It proposes the establishment of a Lebensräume project, looks for a location, and draws up a financing plan to this end. The municipality derives value because it fulfills the duty of care imposed upon it by the state.

[45] With thanks to the employees of Stiftung Liebenau and the residents of the *Lebensräume* projects that we spoke with.

[46] Befragung der "Lebensräume für Jung und Alt" zur Weiterentwicklung des Qualitätsmanagementsystems: March 2010.

The Mayor of Amtzell explains: “The project also creates a positive spiral for the municipality: quality of life is good, which keeps a working population in the municipality (something that is quite exceptional for a rural municipality). In fact, it actually attracts people. This is favorable for companies based in the municipality, and we the municipality therefore receive more revenue—and corporation tax, for example—that allows us to continue developing the rest of the municipality. In addition, the demand for professional care is decreasing thanks to the project.” Homeowners and investors the final partner. They make the municipality’s plan financially viable and receive a guaranteed rental income for their property.

Finally, a project also yields value for society. The professional care system is unburdened thanks to Lebensräume projects. Hospital admission is deferred because elderly people continue living on their own for a longer period of time. The projects also ensure integration between young people and elderly people within the project, but certainly also beyond. The neighborhood or town often actively cooperates with this community. Lebensräume projects are a step in the right direction, a step towards a more inclusive society.

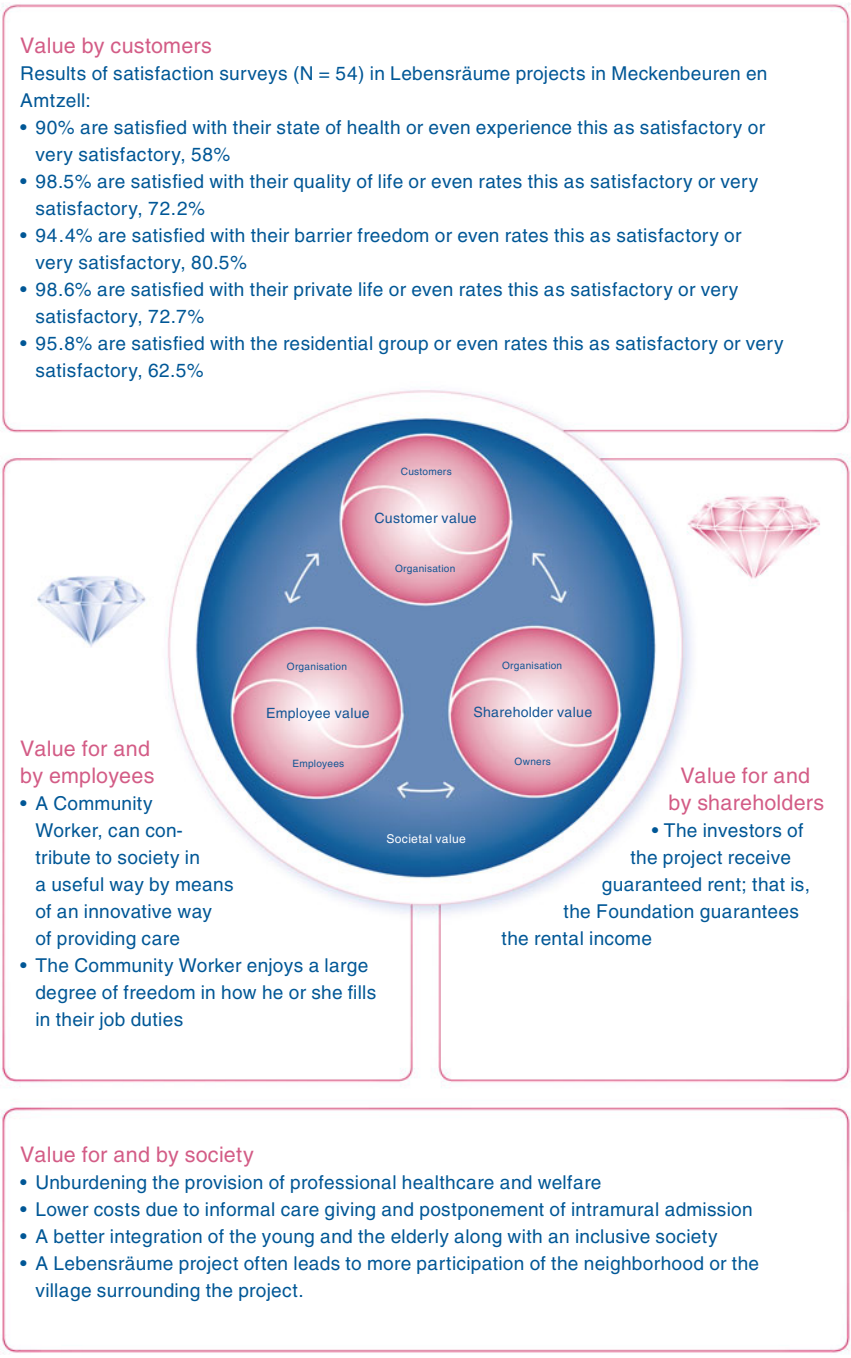


Figure 5.4.4 Value for and by stakeholders of Stiftung Liebandau

5.4.4 The Brilliant Lessons of Stiftung Liebenau

What lessons can we learn from the work of Stiftung Liebenau?

- Allow people to do a lot themselves. Much of the demand for care can be avoided by encouraging people to remain active and by organizing care and neighborly assistance within a social network. People continue to be more active and vital and require less care when less work is automatically taken off their hands. Simple support and assistance can be provided by neighbors or active elderly people in the neighborhood, who act on the basis of brotherly love and community spirit. A corresponding lesson is the fact that a company does not need to organize everything by itself in order to attain its higher goal. You can work towards this also by encouraging your fellow citizens (in this model your customers) to help you achieve your higher goal. As an organization, you must have the nerve and confidence then to give customers the power to decide. In Lebensräume projects, this takes the form of a residents' council.
- Facilitate connection; you can foster community spirit by creating the appropriate conditions. Mutual caring and sharing, and tolerance can emerge automatically because the inclusiveness that prevails within the community helps eliminate exclusiveness. Lebensräume projects are a step towards a more inclusive society. They often ensure a high level of involvement in the area or neighborhood around the residential community. In other words, it is a step towards a society in which people deviate from individualism and we as people start looking after each other more once again. This is a crucial step towards making care affordable.
- Allow people to help each other. Everyone, young and old alike, can make a contribution. Active senior citizens, for example, can still provide a very useful contribution to young people by babysitting their children or giving music lessons or tutoring, for example. The most elderly can also help by keeping a close eye on one another (roll-down shutters). This is extremely important for the retention of self-esteem.
- Work is carried out together with partners and each partner benefits. The unique partnership between the foundation, the municipality, and property investors makes Lebensräume projects a brilliant business Model. This is brought to live by elderly, middle-aged and young residents themselves. Benefits exists for all stakeholders. Stiftung Liebenau succeeds in connecting this effectively.