Chapter 44
We Have Just One World but Live in Different Parts:
A Comparative Study of OCD in Healthcare in the Netherlands and Honduras

Gerard Brekelmans
Erasmus MC Academy, The Netherlands

Marcel J. M. H. Boonen
Elisabeth-TweeSteden Ziekenhuis, The Netherlands

Nancy Y. Jaspers
Humanya, Belgium

ABSTRACT

This chapter describes the differences and similarities between two case histories in the Netherlands and Honduras. Both are situated in the healthcare sector. The organizational change and development in both cases are major but the process and effects differ. The Dutch case describes an organizational change, combining the Toyota production system with a human care program, inspired by the theory of presence. The Honduras case is part of a large optimization and improvement process of one of the main governmental health institutes. Both cases show how people are involved and/or committed to organizational change: Is this built on trust or rather on control? Organizational culture in both cases differs and this is illustrated in the development of the process and the lessons learnt. More attention to the team from the start of the organizational change and trust instead of control is recommended.

INTRODUCTION

Healthcare is a global issue with one goal: to build a better, healthier future for people all over the world. The World Health Organization (WHO) works through offices in more than 150 countries and their staff closely collaborate with governments and other partners to ensure the highest attainable level of

DOI: 10.4018/978-1-5225-6155-2.ch044

health for all people (WHO, 2018). Over time, healthcare has undergone various developments. In this chapter we identify and describe the similarities and differences between two organizational change and development (OCD) initiatives undertaken in the healthcare sector: one in Honduras and the other in the Netherlands. The main goal of healthcare in both countries is to provide quality of care for all their citizens, but the structure and resources are different. Not only the structure and resources, but also the approaches to OCD differ from each other. Based on a comparison of the two cases, we will explore approaches to OCD in healthcare and come to some insights and lessons learned regarding evidence-based change agency practice.

As mentioned by Hamlin and Davies (2001), change agents require more knowledge and understanding about current OCD-related theory and research to become truly effective. The consultants involved in the two compared case histories reflect critically on this need for more knowledge and understanding to inform and shape their consultancy practice. Both offer their insight into the specific organizational contexts of the respective OCD initiatives and their 'participatory' role within the change process.

Our comparison of the two case histories looks at them from three perspectives: the interventions, the approaches and processes, and the overall lessons that can be learned from both cases.

REFLECTION ON THE INTERVENTIONS

Background and Context

Both countries differ greatly in culture and structure. What they have in common is that in both countries many women work within the healthcare sector, and that the retention of well-trained staff is a priority. In the Netherlands, healthcare is based on "everything that can be done must be done". However, this kind of care and cure approach encounters ethical and economic boundaries. How far can you go in care and cure? In the Netherlands a broad public debate has started about the boundaries of health care. In Honduras these issues are not a priority since the focus there is still more on getting the basic structures in order; and there is much room for improvement in providing access to healthcare services.

Another difference between the Netherlands and Honduras is that in Honduras the hospital infrastructure and health centers are still deficient: services are not of the required quality and coverage. Maintenance is scarce, and this has led to the constant deterioration of both infrastructure and equipment. This is not the case in the Netherlands where the challenges focus more on the identification of barriers and waste, on collaboration between healthcare service organizations, and on defining the boundaries of the growing amount of resources, medical possibilities, and technological innovation.

In addition, in the Netherlands there exists a tendency towards deregulation and giving back professional discretionary space to the workers in the field. The government's interference in the Netherlands is decreasing, and this process is still going on. Hence Dutch healthcare is no longer not-for-profit but is moving towards a market-orientated sector. At the same time, regulations, healthcare insurance, and accreditation bodies still have a big regulating impact on healthcare. In Honduras there is also a wish to decentralize services, but at the same time the healthcare sector is strongly regulated and fragmented. This leads to problems of coordination and articulation between institutions and service units which results in duplication of activities, efforts and resources. In fact, the healthcare sector in Honduras is still largely regulated and coordinated from the top and out to the work field.