

# COMMISSIONING OF SOCIAL CARE SERVICES

Municipal commissioning approaches for social care services  
– evidence from a countrywide live experiment



Niels Uenk



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## **Commissioning of Social Care Services**

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– evidence from a countrywide live experiment

## **Gemeentelijk opdrachtgeverschap in het sociaal domein:**

inzichten uit een landelijk live experiment  
(met een samenvatting in het Nederlands)

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# Part I

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## **Dutch municipal commissioning practices – Introducing the object and context of the studies in this thesis**

This thesis is divided in three parts. In the first part I introduce the object of study of the research – commissioning social care services – and describe the studies presented: the scientific disciplines in which commissioning of social care services is studied, the research questions addressed, and why answering these questions is relevant. To understand the context in which municipalities commission care, part I of this thesis also discusses the history of social care regulations in the Netherlands (Chapter 2), and the EU public procurement rules that apply to outsourcing social care services (Chapter 3). Commissioning social care services in the Netherlands is the responsibility of municipalities, but only since 2015 for the vast majority of social care services. I conducted empirical research on the municipal commissioning of social care services in a time of reform, from 2015 to 2018; these empirical studies are discussed in part II. Finally, in part III I present my research findings on the effects of these commissioning approaches on the outsourced social care services.



# Chapter 1

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Introduction

As with many western nations, in the past two decades the Netherlands has increasingly struggled to maintain a sustainable social care system that adequately meets changing contemporary societal and individual demands, as well as a sustained growth in public expenditure. There is consensus among scholars and practitioners that in a welfare state context, the manner in which social care services are coordinated is crucial to address this problem. Many scholars point to outsourcing social care services as (part of) the solution for capacity, cost, and quality problems: see for example Evans, Hills, & Orme (2012). However, extant research with respect to coordination of social care services seems stuck in overly simplistic comparisons, such as ‘in-house versus outsourced provision’ and ‘introducing competition’. Extant scientific research in the public management context that addresses the coordination of social care services generally fails to acknowledge there is more granularity in grand concepts such as ‘outsourcing’ or ‘competition’. This granularity exists to a larger degree in purchasing and supply management (PSM) literature, for example with respect to buying professional services. However, a translation of these concepts and theories to the context of public procurement of care services is both necessary and underdeveloped. The context of public procurement of social care services may also provide ample opportunities to test PSM theories, study their concepts, and in general extend this body of knowledge. I argue that these opportunities have not been fully exploited to date, and in doing so I aim to contribute to the understanding of the public procurement – or more accurately the ‘commissioning’ of social care services. Furthermore, I aim to both contribute to existing public management oriented literature, and to advance the scientific knowledge in purchasing and supply management literature with respect to buying services. A detailed comprehensive analysis of commissioning approaches of social care services is currently lacking, although I argue this may provide much more insight in the adequate responses to the challenges mentioned. By combining insights from multiple research disciplines (PSM, public management, law studies, and economics), and introducing new concepts such as commissioning models, I seek to contribute to developing adequate approaches for the challenges that many developed countries face.

In short, developing a better understanding of the public commissioning of social care services is the focal point of this research. With this thesis I intend to provide a more detailed and comprehensive analysis of different aspects of commissioning social care services, which I consider necessary to develop adequate responses to the growing demands of social care systems, both in the Netherlands and in other countries. In this current chapter I introduce the research topic and elaborate on

its scope and my approach. This chapter also provides an overview of the research objectives and their relevance, a description of the research questions, and an overview of the different methodologies that have been applied in the consecutive chapters. The final sections of this chapter discuss the structure of the thesis as a whole and introduce the terminology that is utilized throughout the thesis.

## **1.1 Origin and relevance of studying commissioning of social care services**

1

Promoting the social inclusion and active participation of every citizen in our society, supporting those who need it, and generally taking care of each other, is – in my opinion – fundamental to an inclusive, developed, open society. Providing this support is of course not a matter that should be left to public authorities only. However, in many modern welfare states – and especially those embracing a social-democratic welfare regime (Esping-Andersen, 1990) – the government plays a pivotal role in establishing the public services necessary to ensure every citizen has access to health care and social security. In light of an increasingly aging population, upholding financially sustainable and high quality health and social care services for all citizens is one of the major challenges developed nations face. In times of financial crisis – such as the global financial crisis of 2008 - and consequent austerity, governments face pressure to reduce their expenditure in general. Paradoxically, the costs of health and social care services are rising across all developed countries due to specific demands that aging societies require, especially long term health and social care services (OECD Indicators, 2015). Furthermore, individuals become more demanding with respect to social care services. Those entitled to social care services expect to be informed, to be involved in decisions concerning their care - known as shared decision-making; see for example Légaré et al. (2014), to receive care tailored to their individual preference, and to have a choice in treatment and care provider.

These pressures call for the formulation of new approaches to organizing social care services that simultaneously reduce increasing costs while maintaining (or improving) the quality of care services. Many governments choose to outsource the provision of social care services by contracting external care providers. By breaking down government monopolies (if still extant), providing clients (the recipients of social care services) with freedom of choice among care providers, and introducing competitive market pressures, governments aim to establish a system of social

care services fit to meet contemporary demands.

## 1.2 The primary research objective

Gaining a better understanding of how social care services can be commissioned, and consequently how different approaches to commissioning social care services may support (or hinder) governments to achieve the goals referenced before is paramount. To this end, this research aims to define and empirically study different legal instruments, commissioning models, and public procurement procedures for outsourcing social care services. I empirically study the implementation of these procurement practices, their theoretical advantages and disadvantages, and how they may affect clients (users of care), municipalities, and care providers. I aim to make academic contributions by observing and defining commissioning models and public procurement procedures for outsourcing social care services, studying these through theoretical lenses of agency theory, service triads, and perspectives on competition and relational contracting, by building testable propositions based on theory with respect to these commissioning practices, and finally testing the impact of commissioning models on the perceived quality and effectiveness of social care services. In doing so, this research also aims to contribute to achieving a financially sustainable social care system, and ultimately to help build a society that is inclusive to those in need of social care and support.

### *Striving for high quality, affordable, effective, and innovative social care services*

Throughout this thesis the concepts of quality, effectiveness, and innovation of social care services are referenced as goals that public bodies (in effect Dutch municipalities in the context of my research) aspire when commissioning social care services. These goals are common for public procurement of goods, services, and works in general; Directive 2014/24/EU frequently mentions quality, efficiency, and innovation as prime targets for contracting authorities in the award of public contracts. For instance, recital 47 reads:

*'(...) Buying innovative products, works and services plays a key role in improving the efficiency and quality of public services while addressing major societal challenges. It contributes to achieving best value for public money as well as wider economic, environmental and societal benefits in terms of generating new ideas, translating them into innovative products and services and thus promoting sustainable economic growth.'* (Directive 2014/24/EU; recital 47).

Specifically with respect to social care services, Article 76 section 2 of the same Directive stipulates:

*'Member States shall ensure that contracting authorities may take into account the need to ensure quality, continuity, accessibility, affordability, availability and comprehensiveness of the services, the specific needs of different categories of users, including disadvantaged and vulnerable groups, the involvement and empowerment of users and innovation. (...)' (Directive 2014/24/EU; Art.76 section 2).*

Interestingly, it can be argued that continuity, accessibility, availability, and comprehensiveness of services – mentioned here next to quality – are in fact essential elements of service quality itself.

It does not fall within the scope of this thesis to define the concepts of service quality, efficiency, or innovation; nor to analyze these concepts extensively. There is an extensive body of literature that discusses service quality in general and the quality of health and social care services specifically. A variety of studies, quality models, and institutes distinguish (partly overlapping) quality factors such as safety, effectiveness, patient-centeredness, timeliness, efficiency, equity, continuity, influence, personal relation, care giver competence and personal manners, care giver professionalism and skills, uncertainty reduction, reliability, and other derived or related aspects (Edebalk, Samuelsson, & Ingvad, 1995; Lee, Delene, Bunda, & Kim, 2000; USA Institute of Medicine, 2006).

The generic manner in which the concepts of quality, effectiveness, and innovation are used throughout Directive 2014/24/EU also suffices for this thesis. Clearly, without discussing each antecedent of social service quality, 'service quality' represents a range of dimensions that accumulate in the client's – and other stakeholders' – experience. It is self-evident that quality relates to the monetary value of a service, for which the commissioner pays. In other words, a municipality that commissions high quality, effective social care services in effect aims to achieve good value-for-money, commissioning social care services that deliver desired outcomes.

An exception to the generic definition of service quality and effectiveness that suffices for the main part of this thesis is made in Chapter 11. In this penultimate chapter I set out to *measure* quality and effectiveness of social care services to statistically analyze the impact that commissioning models and reimbursement meth-

ods applied by commissioning municipalities have on service outcomes, in terms of quality and effectiveness. For this I must more precisely define each concept along with the variables I measure as proxy for quality and effectiveness. Thus, in Chapter 11 I build on extant literature concerning the measurement of social care service quality. The perception of quality by care users ('clients') is considered to be an appropriate measurement of social care quality (Bergman, Johansson, Lundberg, & Spagnolo, 2016). I furthermore draw on the law governing social care in the Netherlands since 2015 to define effectiveness of social care services in terms of goal realization. The *Wet maatschappelijke ondersteuning 2015* (Social Support Act 2015, referred to as the 'Wmo 2015') aims to facilitate self-reliance for people who need support, and measures effectiveness as the extent to which a service achieves an improvement in self-reliance. This is comprehensively explained in Chapter 11.

Achieving high quality social care services in an environment characterized by increasing demand, while simultaneously stabilizing or reducing expenditure, calls for innovation in service provision. In this research, innovation entails new approaches to service provision, for example by incorporating advanced technology, improved choice among care providers, and better coordination and integration of care services.

The emphasis of this research is on building a much more granular overview of the different ways in which public organizations (can) outsource services such as social care. I discuss the municipal choices in commissioning models, reimbursement methods, and procurement procedures that I observe empirically in the scholarly contexts of public management, purchasing and supply management, and economics. Here I contribute to theory by studying service triads in a health and social care context, by taking an agency theory perspective on care service reimbursement methods, constructing testable propositions on their expected effects, and introducing a new perspective on competition in public contracting of services. In addition, I discuss the legal context of public procurement, public law, and healthcare laws directly related to commissioning social care by governments. This discussion is necessary to understand the legal room for manoeuvre for municipalities when outsourcing social care services. I apply insights from literature on public management, public procurement law, and health economics within research grounded in public procurement, purchasing, and supply management. Section 1.4 elaborates on this interdisciplinary research approach.

### 1.3 Social care services within the scope of this research

Since 2015, municipalities in the Netherlands are responsible for social care services for both youth and adults. Social services for Dutch citizens below the age of 18 years old are regulated under the *Jeugdwet* (Youth Act, introduced in 2015), and adult social care services are regulated under the *Wmo 2015*; the latter serves as the focus of this research. Particular attention is paid to the types of social care services that were decentralized to municipalities in 2015, which I explain in detail in Chapter 2. This decentralization concerned the provision of the social care services personal assistance, day care, respite care, and sheltered housing. Simple household assistance services such as cleaning, grocery shopping, and laundry, had already been decentralized in 2007 with the introduction of the first *Wet Maatschappelijke Ondersteuning* (Social Support Act). However, home care services of a more medical nature – for instance those that require physical contact between the caregiver and the client – were not decentralized. These ‘nursing care’ services include administering medication or assisting a client to take medication, helping with personal hygiene, taking care of wounds, and assisting with putting on clothes.

Since 2015, municipalities decide individually or in collaboration with other municipalities to provide the services of personal assistance, day care, and respite care either in-house or contracted out. In the latter (and most probable in the Dutch context) scenario, municipalities must determine, *amongst others*, the service specifications, reimbursement method, procurement strategy, contract type, procurement procedure, and contract management activities. This allows for comparative empirical research on the services that were decentralized in 2015. For this reason, the scope of this research includes contracts for personal assistance, day care (for adults), and respite care. I furthermore study the household assistance services that were decentralized in 2007 in Chapter 10 by conducting a country comparison between the Netherlands and Finland, since these services are most similar to the home care services provided in Finland.

While sheltered housing was also included in the scope of the *Wmo 2015*, municipalities had less freedom to arrange these services. A limited number of municipalities (*‘centrumgemeenten’*) became responsible for the coordination of these services for their own citizens and those of the surrounding municipalities. Municipalities were forced into procurement collaborations for sheltered housing, and I therefore expect to find less variation in the commissioning of these services. For

these reasons, sheltered housing has not been subjected to any empirical studies in this thesis. Section 1.5 discusses in more detail the uniqueness of this period of reform in the Netherlands, in the contexts of both management and legal empirical studies.

## **1.4 The relevance of multi-disciplinary research for a well-drafted commissioning of social care services**

Studying the commissioning of social care services, its legal context, and the effects on service quality and effectiveness truly embodies multi-disciplinary research. Procurement, or more commonly purchasing and supply management (PSM), is in itself multi-disciplinary (Wynstra, Suurmond, & Nullmeier, 2018). Lamming (1994) recognized as early as 1994, when the PSM discipline was still emerging (concerning purchasing): 'Its researchers and educators come from a wide spread of disciplines: operations management, economics, law, political science, engineering, marketing, psychology and accountancy, to name but a few'. For public buyers this certainly holds true, as public buyers – more than their private counterparts – deal with public management and procurement law in addition to the purchasing and supply management discipline. Finally, as the object of study concerns the procurement of social care services, this research also touches on the disciplines of health care and health economics.

Taking such a multi-disciplinary approach adds depth to this research, because the insights provided from one discipline may offer new viewpoints on others. Let me give two examples. In public management literature, the debate on whether public services are better off provided 'in-house' by a public authority or contracted out to a market now spans over half a century. Proponents of market provision argue that competitive market forces lead to efficiency, increased quality, and innovation. Public management researchers also participating in this debate have studied the presence of competition in the market and effects of outsourcing on quality and price of public services, see for example Bergman et. al. (2016); Bergman, Jordahl, & Lundberg (2018); Enthoven (Enthoven, 1993); Lamothe & Lamothe (2009); and Lamothe (2015). However, public management has only recently, and very gradually, started paying attention to the fact that 'outsourcing' can be conducted in (many) more ways than one; and that the manners in which public bodies commission public services can to a large extent influence the (successful) outcome of the outsourced provision. Adding a PSM perspective can thus complement the

discipline of public management. The complexities of buying services, and the consequent managerial implications including the appropriate relational approach to procurement, type of contract, and monitoring activities, have received much attention in the literature on PSM. It can thus be said that combining the perspectives from the two disciplines of public management and purchasing and supply management adds granularity to the debate on in-house versus outsourced provision of public services. A multi-disciplinary approach may provide new insights for proponents of both sides of this discussion.

Another interesting example of multi-disciplinary research adding depth is where the regulatory discipline (public procurement law, public law, health care law) meets the management and economics disciplines that concern service buying. Public authorities cannot simply commission public services, including social care services, according to management and economic principles without careful consideration of the laws governing public management, public procurement, and health services. Tensions may arise if public authorities perceive the laws as limiting their discretion to commission social care services according to what they consider optimal from a (public) management perspective, without taking into account the importance of the aims and principles safeguarded by public procurement law. These tensions are often perceived and discussed with respect to, for example, competitive public tendering of health and social care services (Uenk, 2017). However, some of these tensions may actually be grounded in a misunderstanding of regulations. EU public procurement law is not intended to promote competition as a goal in itself, but rather seeks to abolish discrimination between economic operators in the EU member states on the single EU market. The emphasis on competition and pure market-orientation found in the Treaty of Rome has even been replaced in the Lisbon Treaty in Art. 3(3) of the Treaty on European Union (TEU) by the broader concept of the highly competitive social market economy (Manunza, 2018). In fact municipalities have much wider discretion than 'just' competitive tendering over public contracts for social care (Uenk, 2017). While this thesis is not primarily grounded in law, I do pay attention throughout the different studies conducted to the relevant tensions that arise in practice due to the different goals any single discipline aims to achieve or safeguard. Chapters 3 and 10 discuss examples of these tensions in much more detail, alongside their potential solutions.

## **1.5 A unique research setting and design**

### **1.5.1 A countrywide live experiment**

This thesis presents the findings of extensive empirical studies on the municipal procurement of social care services in the Netherlands. The studies focus on the procurement of social care services as a consequence of the 2015 reform of social care services in the Netherlands. In 2015, many types of social care services were decentralized to municipalities. Each of the (then) 393 municipalities in the Netherlands became responsible for organizing social care with the introduction of the Wmo 2015. Chapter 2 discusses the coordination of social care services in the Netherlands, elaborating on social care service coordination in the Netherlands prior to and after the 2015 reform. Here I highlight how the 2015 reform provided a unique environment in which to study municipal procurement of social care services.

With the introduction of the Wmo 2015, each of the Dutch municipalities (393 in total at that time) in existence became responsible for the provision of social care services for both adults and youth, although the latter falls outside the scope of this thesis. Providing these social care services are an important new responsibility for municipalities from at least two perspectives. First, these services aim to support the most vulnerable people to participate in and be part of society. Supporting citizens in need in order to encourage and maintain self-reliance and active participation are fundamental aspects of inclusive, open societies. For a municipality, supporting their vulnerable citizens in the best possible way is therefore a marked departure from maintaining street-lights, roads, or distributing passports. Second, the decentralization of different types of social care services also has a significant financial impact on municipalities. Together with youth care, the expenditure on social care services for adults represents approximately 50 % of the total municipal procurement budget (Rijksoverheid, 2014; Weert, Boneschansker, Geurts, & Lopulalan, 2016). Contracts for social care services typically comprise of a number of different types of care, and their value transcends the relevant EU public procurement threshold for social services, even for small municipalities outsourcing by themselves (i.e. not in collaboration with other municipalities). This emphasizes how the municipal organization of social care services is a matter of great societal and financial importance.

Besides its societal relevance, the 2015 reform of social care services in the Netherlands is fascinating from a research perspective. The decentralization of social care services where:

- *at exactly the same point in time;*
- *the same services;*
- *with high societal and monetary importance;*
- were decentralized to 393 individual municipalities with:
  - *the same context of extensive legal discretion; and*
  - *with the same background information and experience*

can be considered a live experiment. There are ‘manipulations’ with respect to commissioning models (see Chapters 4 and 5), procurement procedures used (see Chapters 6 and 7), and care service reimbursement methods applied (see Chapters 8 and 9). The municipalities that maintain the commissioning practices from before the decentralization may act as control group. Within both legal and management disciplines, these conditions very rarely (or perhaps never) apply. Experiments in purchasing and supply management are useful to help explain the decisions occurring in practice as compared to theoretical predictions (Eckerd, 2016). While the application of experiments in PSM in itself is already rare, most experimental studies are laboratory-based or scenario-based (Eckerd, 2016). However, the context of this research mostly resembles a field experiment (Chatterji, Findley, Jensen, Meier, & Nielson, 2016), which is even less common. From the twelve studies highlighted by Eckerd (2016), only one is a field experiment (in which only two organizations are compared). While Eckerd does not intend to provide an exhaustive list, her overview illustrates the rarity of these studies in a PSM context.

As mentioned above, the context of ‘extensive legal discretion’ is crucial here. For common public contracts above EU threshold value, EU public procurement law prescribes the use of one of a limited number of legal procurement procedures. Here the context of social services within the scope of the Wmo 2015 is particularly interesting. The Wmo 2015 provides municipalities with extensive discretion to coordinate these services; there are no regulations that require a certain manner of commissioning care providers, and even outsourcing itself is not mandatory. When municipalities do outsource, the EU and national public procurement law only applies when contracting authorities choose a public (concession) contract over other types of outsourcing. Public procurement regulation provides much more discretion to governments that award contracts for social services rather than other supplies and services. Chapter 3 discusses the relevant EU and national public procurement rules on awarding social care services in more detail.

To summarize: at the same point in time and under the same circumstances, 393 Dutch municipalities gained new responsibilities that hold substantial societal and financial impact. These municipalities have the same context, no prior experience with social care services yet enjoy significant discretion in how to organize them, and the manner in which municipalities choose to coordinate – typically outsource – these services directly affects their citizens. In principle, there could have been 393 different, parallel approaches to coordination of social care services. This context effectively amounts to a live experiment, this allows for the empirical study of municipal approaches to the organization of social care and the comparison of the outcomes of these approaches.

### **1.5.2 Studying the facts concerning the entire population**

Such a unique research context also allowed a unique research approach. The chapters of this thesis that address the municipal approaches to commissioning social care services are based on the systematic analysis of the tender documents and contracts used in municipal procurements between 2014 and 2018. Documentation analysis of actual procurement tenders for almost all Dutch municipalities is fundamental to the empirical analyses undertaken. Rather than gathering the perceptions of municipal buyers on their approaches to procurement of social care services from surveys, the empirical studies on municipal commissioning models (see Chapters 4, 5, and 11), public procurement procedures (see Chapters 6 and 7), and reimbursement methods (see Chapters 8, 9, and 11) are based on the analysis of facts. Whilst collecting empirical data through interviews is a common research method considered reliable for purchasing and supply management research, I argue for the analysis in this research the document analysis yields the most reliable results. For example, for certain public procurement procedures and reimbursement methods for social care services there are many synonyms: carefully studying in procurement documents exactly how the procurement procedure is executed or how care services are reimbursed results in the most reliable analysis. Each procurement document was systematically assessed with respect to the mentioned models, procedures, and methods used, and I discussed my findings at length with my supervisors and – where relevant – co-authors, to ensure rigorous analyses.

Besides the measurement method, another strength of this research is the scope of the data collection. I have not settled for collecting a representative sample of the municipalities for collecting procurement data. Rather, the intention has been to be

as comprehensive as possible, aiming to collect procurement data for all Dutch municipalities. The analyses in the chapters mentioned above evaluate the procurements of more than 95% of all Dutch municipalities over a four-year time period.

## 1.6 Research questions and methodology

As discussed, this research connects different disciplines, each contributing its own methodological rules and practices. A variety of methods are applied in the studies that are discussed in this thesis, and each chapter aims to answer specific research questions, some of which build on those addressed in previous chapters. This section first introduces the main research question of this dissertation. The next section elaborates on the methodology generally used throughout the thesis and the way in which the thesis has been theoretically framed.

### 1.6.1 The main research question

This research presents the findings of studies conducted on the municipal commissioning of social care services in the Netherlands in a period of extensive reform. With the introduction of the reform, the central government emphasized (the assumption) that municipalities were more capable of organizing locally tailored social care services that better fit local citizen needs while maintaining high quality services against lower costs and fostering innovation in care provision. The aim of this research is to study how municipalities outsource social care services in order to achieve these goals, and which mechanisms (such as competition, incentives, building relations) they employ in the process. Another goal of this research is to identify the impact of these commissioning approaches on the (perceived) quality and effectiveness of social care services.

The main research question of this thesis is defined as:

*How did Dutch municipalities use their legal discretion in outsourcing social care services with respect to procedural, relational, competitive, and financial incentive antecedents (together 'commissioning') to accomplish the 2015 reform goals, and what was the consequent impact of these outsourcing practices on the quality and effectiveness of social care services?*

To answer this research question, I used different methods to study multiple aspects of municipal commissioning of social care services in the time period between 2015 and 2018. The following section discusses the methods used in this thesis in general. The section thereafter discusses the separate chapters of this thesis, that each focuses on a relevant aspect of the main research question.

### **1.6.2 Methodology: multi-disciplinarity, literature, theory, and empirical studies**

To answer the main research question I conducted multi-disciplinary research that combines perspectives of empirical legal studies, literature on the disciplines of public management and purchasing and supply management, and empirical studies of municipal commissioning practices and their impact. The aim of the empirical legal study (see Chapters 3 and 10) was to analyze the ‘real world’ effects of regulation on public procurement of social care services. The literature studies undertaken throughout the thesis are grounded in both public management literature and purchasing and supply management literature. Public management literature discusses concepts of in-house provision or outsourcing of public and social care services and competitive mechanisms and their effects, which provides a basis for discussing commissioning models (see Chapter 4). Purchasing and supply management literature (including public procurement management) addresses the management problems and phenomena in outsourcing relations, contracts, and incentives that are relevant when discussing the details of commissioning choices. I make conceptual and theoretical contributions by discussing empirical findings of municipal commissioning choices (see Chapters 4 to 9) and statistically testing hypotheses (Chapter 11).

The coming together of multiple disciplines also prompted a conscious choice on research and writing conventions, which differ between disciplines. Most chapters in this thesis are grounded in literature on PSM or public management with the exception of Chapter 3 and partly Chapter 10, which are partly or completely grounded in legal discipline (EU and national public procurement law, administrative law, and the Dutch Wmo 2015), and where methodology and details such as citing sources is typically managed differently from management science. I chose to adhere to the methods and approaches commonly used in management science for methodology and writing conventions; for example, I use the APA referencing style rather than working with footnotes. With my background rooted in public

procurement and purchasing and supply management, the inclusion of chapters primarily grounded in legal discipline risked the incorrect interpretation of regulations. However, the legal background of my supervisor Elisabetta Manunza guarantees a correct interpretation.

### *Theoretical grounding in purchasing and supply management*

In the chapters of this thesis that present the findings of empirical research I mainly use two theories: agency theory (or principal-agent theory) and the theory on the dynamics of service triads as introduced by Li and Choi (2009). I introduce these theories here in general, and they are revisited and applied in specific research contexts throughout the thesis. In these sections I stick to the general terminology used in management literature, for example using 'buyer' rather than 'municipality' for the organization that buys services and 'end-customer' rather than 'client' for the user of services.

### *Agency theory*

While agency theory originates from the 1960s and early 1970s, it is Katherine Eisenhardt who first most comprehensively discussed and described agency theory in her seminal work 'Agency Theory: An Assessment and Review' (Eisenhardt, 1989). The first two sections of this paragraph are completely based on this seminal work. Agency theory is concerned with an agency relationship in which one party (the principal) delegates work to another (the agent) who then performs that work. Agency theory is concerned with resolving two problems that can occur in agency relationships. The first is the problem that arises when (1) the goals of the principal and agent conflict ('goal incongruence'), and (2) it is difficult or expensive to verify what the agent is actually doing. The problem here is that the principal cannot verify that the agent has behaved appropriately; there is an *information-asymmetry*. The second is the problem of risk sharing that arises when the principal and agent adopt different attitudes toward risk. The principal and the agent may then prefer different actions because of their risk preferences.

Agency theory typically focuses on identifying the most efficient contract that governs the relationship between the principal and the agent. It builds on assumptions concerning people, organizations, information, and contracting. Agency theory assumes people act out of self-interest, make decisions with bounded rationality, and are risk averse. With respect to organizations, agency theory assumes the existence of (at least partial) goal conflict among its members, and considers information as a commodity that can be purchased. The contracting problems agency theory

addresses are:

- *moral hazard*: the lack of effort on the part of the agent;
- *adverse selection*: the misrepresentation of ability by the agent (falsely claiming an ability) that the principal cannot verify up front; and
- *risk sharing*: how risks are shared between principal and agent.

Based on the theory and its assumptions, Eisenhardt (1989) makes propositions on the appropriate type of contract both in general and under specific circumstances. For example, when using an outcome-based contract the agent is more likely to behave in the interest of the principal. However, if there is outcome-uncertainty – meaning the outcomes are only partly a function of the agents’ behaviors – behavior-based contracts may be more appropriate (entire section: Eisenhardt (1989)).

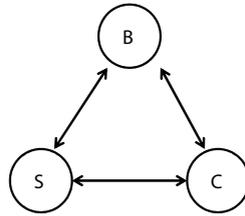
Agency theory has been used by many scholars to address and study contracts between buyers and suppliers, for example to study supplier opportunism, e.g. Zsidisin & Ellram (2003) and the appropriate contract types for buying services, e.g. Tate, Ellram, Bals, Hartmann, & van der Valk (2010), and address principal monitoring activities, e.g. van der Valk & van Iwaarden (2011). The latter two studies refer to a service triad context – just like the context of this thesis – where agency theory is especially appropriate, since some of the principal-agent problems can be more prominent (Li & Choi, 2009). The following paragraph introduces the theory concerning service triads, and revisits agency theory from a service triad perspective.

#### *Service triads and its dynamics*

Buying and classifying services has received much scholarly attention in the last decades (Axelsson & Wynstra, 2002; Van Der Valk & Axelsson, 2015; Wynstra, Axelsson, & Van Der Valk, 2006). Service buying is associated with problems in effectively organizing the transactions and relations involved in sourcing services (Van Der Valk & Van Iwaarden, 2011). Related to the intangible nature of services, managing the quality of procured services and the contractors that deliver these services is one of the issues highlighted in literature (Axelsson & Wynstra, 2002).

In the past decade increasing attention has been paid to buying services in a triad constellation. When a buyer (B) contracts a supplier (S) to provide services to the end-customer of the buyer (C), this is known as a service triad (Li & Choi, 2009). Figure 1.1 depicts the service triad with the connections between the three actors in the triad. A service triad typically occurs when an organization outsources the

service delivery for the organization's end-customers to a third party.

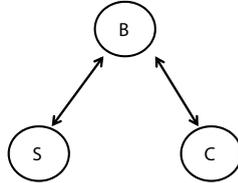


**Figure 1.1** – The service triad consisting of a Buyer, Supplier, and Customer

Managing the quality of service delivery becomes even more problematic in a service triad: the performance of the buying organization towards its end-customers depends on the quality of service delivery by the supplier. The buyer does not directly experience the quality of service delivery. Therefore, the buyer must take measures to ensure the service delivery and behavior of the supplier are appropriate (Van Der Valk & Van Iwaarden, 2011). The problems addressed in agency theory (see the previous section) are magnified in a service triad. It is therefore not surprising that various studies use agency theory as theoretical lens for studying service triads: see for example Li & Choi (2009), Tate et al. (2010), Valk & Iwaarden (2011), and Zhang, Lawrence, & Anderson (2015).

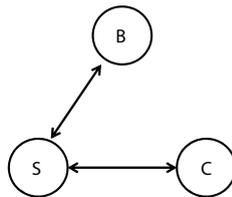
An important observation, first introduced and theorized by Li & Choi in their seminal work, is that the connections between the three actors in the service triad are not static but rather change over time (Li & Choi, 2009). Li & Choi (2009) describe three stages of the service triad: in the *initial stage* there are typically only connections between the end-customer and the buyer and between the buyer and the supplier respectively. The connection is prompted when the buyer contracts the supplier. The end-customer connects to the service buyer – for example because the end-customer buys a product from the service buyer, or because the service buyer is a municipality and is by law required to arrange services for its citizens (the end-customers). However, when the supplier is not yet providing services to the end-customer, these two actors are not yet connected. Li & Choi use the concept of the structural hole (Burt, 1992) to explain the lack of the connection between supplier and end-customer, and to stress that the buyer is the only connection holding the triad together. In fact, the buyer assumes a bridge position associated with an *information benefit* and a *control benefit* (Burt, 2000a, 2000b). Contrary to the information asymmetry discussed in agency problems where the agent holds an information benefit, a buyer in the bridge position has more information than the

supplier. The bridge can negotiate and exploit information to its advantage (Burt, 2000b). Figure 1.2 shows the three actors in the service triad in the initial stage.



**Figure 1.2** – The initial stage of a service triad (Li & Choi, 2009)

This initial state of the service triad with the buyer in the bridge position changes when the supplier starts providing services to the end-customer. A connection is formed between the supplier and the end-customer, closing the service triad as shown in Figure 1.1. The structural hole disappears, reducing the leverage of the bridge position for the buyer. Li & Choi (2009) describe this second stage as one of bridge decay. The buyer in this stage no longer enjoys the full benefits associated with acting as the bridge between the supplier and end-customer. However, the stage of bridge decay is not necessarily the final stage. Whereas the supplier is in frequent contact with the end-customer (providing services), the buyer may lose the connection with the end-customer. There may simply be no reason for the end-customer and buyer to maintain a connection. Li & Choi (2009) define this as a state of 'bridge transfer', which occurs in the transformed stage of the service triad. In fact, the bridge position transfers from the buyer to the supplier; this is reflected in Figure 1.3, below. The supplier is now in the bridge position and enjoys its associated benefits.



**Figure 1.3** – The transformed stage of a service triad (Li & Choi, 2009)

As I already mentioned in the discussion of agency theory, the information-asymmetry in regular dyadic buyer-supplier relationships is already problematic for the buyer. This is magnified in a service triad in the transformed stage of bridge de-

cay, and even further during bridge transfer. The buyer is therefore recommended to maintain a strong position in the service triad and to avoid the state of bridge transfer (Li & Choi, 2009; Peng, Lin, Martinez, & Yu, 2010).

This section has introduced two important theories, used as theoretical lenses through which to assess the studies presented in Chapters 8, 9, 10, and 11. In those chapters I translate the general theories to the context of municipal procurements of social care services.

## 1.7 Terminology

This section introduces and defines key terminology that is used throughout the thesis. While the findings presented are relevant for procurement of services in general and the procurement of social care services in many contexts and economies, the terminology is defined with the context of the Netherlands and other EU member states in mind. The terminology is not ordered alphabetically, but instead by context and subject.

### *Public services*

A public service is a service organized by a government (or an official body) for the benefit of the citizens living within its jurisdiction, and which is (usually) subject to regulation. These public services can be provided in various ways: directly by the government itself (in-house provision) or outsourced to an external organization through a formal mutual agreement, such as a public contract. In many developed countries social care services are public services. While this research specifically concerns social care services, extant research on public services in general is also relevant.

### *Social care services*

I define a social care service as a service aimed at supporting individuals with needs arising from illness, disability, old age, or poverty to participate in society and improve their self-reliance. Social care services include household assistance; personal assistance; respite care; and general, vocational, and educational daytime activities. In this research nursing care services are excluded from the scope of empirical studies, because in the Netherlands nursing care is not a municipal responsibility. Nursing care is often defined as home care when it is provided for in the home of the recipient and integrated with other types of social care mentioned

above; in these cases it is difficult to separate the social and medical components of the service. However, in the Netherlands the medical components of home care, such as taking care of wounds and administering medication, are not the responsibility of municipalities and are therefore not included in this research. In many modern welfare states, especially those embracing a social-democratic welfare regime (Esping-Andersen, 1990), social care services are to a certain extent publicly financed (e.g. tax-based, or through compulsory insurance), although social care systems differ greatly per country.

Throughout this research I refer to 'social care' or 'social care services'; terms that other research refers to as comprising or falling within the scope of 'Long Term Care' (LTC), 'home care', or 'public social services'.

#### *Client*

A client is defined as a person receiving social care services. In other research, scholars use a variety of terms for the recipients of (social) care services, including 'user', 'recipient', 'beneficiary', or 'patient' (usually in curative health care). I deliberately do not use 'patient' as this implies an illness requiring medical treatment, whereas clients that receive social care typically do not perceive themselves as 'patients' with an illness.

#### *In-house provision*

Governments are not required to outsource the provision of social care services to external organizations; they can provide these services directly within their own organization. This is referred to as *in-house provision* of social care. It is the opposite of *outsourcing* the provision of social care services to one or multiple external organizations.

#### *Outsourcing*

Outsourcing is the opposite of *in-house provision*. A government outsources the provision of social care services by contracting one or multiple external organizations to provide social care services. Outsourcing is also referred to as 'externalization', although this may imply that services were outsourced prior to being provided in-house. There exist various legal instruments that facilitate the outsourcing of social care services to external organizations. For instance, a government can use a subsidy, public contract, authorization scheme (see '*open house model*', below), or concession contract. Each of these instruments brings advantages and disadvantages and a specific set of rules governing their use. External organizations con-

tracted by a government for the provision of social care services are referred to as *care providers* (see below).

### *Commissioning*

I use ‘commissioning’ as an umbrella term to cover fundamental and strategic outsourcing decisions as well as operational outsourcing activities (in effect captured in the procurement procedure). Commissioning services entails making fundamental choices about the coordination and organization of outsourced services. These include, for example, the scope of outsourced contracts, how risks are divided between the supplier and public buyer; the legal instrument used for outsourcing, the number of care providers to contract, and which incentives to use in the contract. Only after such commissioning choices are made can a public buyer proceed to draft the public procurement procedure – which I consider to be the more operational part of public procurement. This understanding of commissioning is consistent with that of Murray (2009), who defines commissioning as the more strategic aspect of outsourcing compared to procurement or purchasing. A more strategic approach to outsourcing is also known as ‘strategic purchasing’ (Klasa, Greer, & van Ginneken, 2018). In Dutch, commissioning translates to *opdrachtgeverschap*, which best fits the context of outsourcing care services by public authorities; therefore I adopt commissioning rather than strategic purchasing. Whereas in this research I refer to commissioning as a process or activity (i.e. the municipality commissions social care services), commissioning entails *both* making the more fundamental (strategic) choices discussed above, as well as the consequent more administrative process of procurement (or purchasing).

### *Commissioning model*

A commissioning model in this research concerns the manner in which a public buyer – in this case a municipality – shapes the outsourcing relationship(s) with its suppliers. A commissioning model is reflected in a specific combination of the strategic choices made with respect to outsourcing (i.e. aspects mentioned under ‘*commissioning*’, above), such as contract scope, implicit or explicit risk allocation, and incentives for care providers. These are typically stipulated in the contract, not in the manner in which a contract is concluded (the procurement procedure).

### *Open house model*

In the CJEU *Falk* judgment (CJEU, 2 June 2016, Case C-410/14, *Falk*) the court ruled that

*‘a contract scheme through which a public entity intends to acquire goods on the*

*market by contracting throughout the period of validity of that scheme with any economic operator who undertakes to provide the goods concerned in accordance with predetermined conditions, without choosing between the interested operators and, allows them to accede to that scheme throughout its validity, does not constitute a public contract within the meaning of that directive’.*

In the CJEU *Tirkkonen* judgment (CJEU, 1 March 2018, Case C-9/17, *Maria Tirkkonen*) the CJEU further clarified that allowing access to economic operators throughout the validity of the contract scheme is not required. From a legal perspective this open (licensing) scheme is similar to a permit system (Manunza & Meershoek, 2018). The Dutch and German translations of the *Falk* judgment refer to the contract scheme as an ‘open house model’, and in the Netherlands in particular this is the name by which the scheme has become known. I therefore choose to refer to an open house model for the contract scheme described above.

#### *Care provider*

In this research I define care providers as organizations external to a municipality that can be contracted by a municipality for the provision of social care services. Care providers can be private, specialized, for-profit or not-for-profit organizations that employ professional care givers. However, other types of organizations such as public organizations, social enterprises, or even organized citizens initiatives may be contracted for the provision of social care services and therefore qualify as care providers within the scope of this research. Care providers can also be contracted by individual clients who receive a personal budget (in Dutch a ‘*persoonsgebonden budget*’ or ‘PGB’), which is a form of direct payment, or ‘cash-for-care’; an established right in the Netherlands for eligible citizens. Although these personal budgets can also be used to finance informal social care, the definition of a care provider used in this research is limited to *external professional* organizations that can be contracted by a municipality. Although municipalities often conclude contracts with privately owned and operated organizations for the provision of social care services, it is not within the scope of this research to verify whether the contracted organizations are in fact private or external public organizations (in effect by how the organization is financed and managed). Where this is relevant, I explicitly mention *external* care providers rather than private care providers.

#### *Competition*

Competition refers to a contest among actors to obtain a scarce entitlement or right. In purchasing and supply management, public procurement, and public manage-

ment literature, the concept of competition usually signifies a procedure initiated by the buyer to award a (government) contract to one or more providers based on award criteria. In this classic approach, organizations competing for the contract each submit a competitive proposal specifying their price and quality aspects for provision of the contract, and the contracting body awards the contract based on (1) the best price-to-quality ratio; (2) the lowest cost based on cost-effectiveness, such as life-cycle costing; or (3) the lowest price (Art. 67 Directive 2014/24/EU).

In this research I argue that this definition of competition is too narrow. There are two flaws: first, that competition does not necessarily have to include price; and second, that competition does not necessarily have to concern *exclusively* winning a contract – consider for example the award of a framework agreement. In this research I adopt a different, broader approach to competition. First, competition can be based on quality alone when the municipality sets fixed prices for social care services. Furthermore, competition is possible among *contracted* care providers – where care providers compete over individual clients. In order to accommodate this extension of the definition of competition, I distinguish between *ex ante competition* and *ex post competition*.

Ex ante competition is competition over winning scarce municipal social care contracts. This occurs when a municipality organizes a competitive *procurement procedure* and it awards one or a limited number of social care service contracts. To this end, the municipality ranks care provider proposals based on clear quality – and possibly price – criteria, and awards the contract(s) to the care provider(s) with the best proposal(s). Ex ante competition is therefore institutionalized; it is based on clear and testable criteria.

Ex post competition is competition over individual clients among care providers in a municipal framework agreement or open house model for social care services. Municipalities that contract multiple care providers for the same social care services often allow clients to choose their care provider from a list of contracted providers, and these care providers may distinguish themselves based on quality and client satisfaction of existing clients. Municipalities can apply both ex ante and ex post competition, for example by contracting a limited number of care providers in a framework agreement and then allowing clients free choice among these contracted care providers. Ex post competition is generally not institutionalized, but rather left to the individual choice of clients where the motives for their choices remain unknown.

### *Procurement procedure*

In this research a procurement procedure is the process through which an organization (in this case; public) selects one or multiple suppliers with whom to conclude a contract (or subsidy, concession) for the provision of goods, services, or works. In the context of this research, municipalities organize a procurement procedure in order to award contracts to external care providers for the provision of social care. A procurement procedure can be a competitive procedure: then the procedure aims to award a limited number of contracts to care providers, and the selection is made on the basis of award criteria. A procurement procedure leading to the award of a (framework) contract with every care provider that meets the quality criteria is not a competitive procurement procedure.

The procurement procedure is comprised of different elements and types of criteria that may include:

- the national or European publication of the contract;
- the invitation of care providers to participate in the procurement procedure;
- a description of the context and subject matter of the contract;
- the (administrative) rules care providers need to adhere to when tendering for the contract;
- the content of care provider tenders required in order to be eligible for contract award;
- criteria with respect to suitability, selection, and award of the contract;
- exclusion grounds governing access to the procedure (e.g. not being convicted of fraud);
- elements of negotiation; and
- further administrative rules provisions, for example governing question and answer protocols, completeness of care provider tenders for the contract, and the time-frame for various parts of the procurement procedure.

Municipalities typically describe the procurement procedure in the procurement documentation they use to publish the contract or invite specific care providers to participate in the procedure. A procurement procedure does not necessarily comprise of all the aforementioned elements; this depends on the nature of the procedure.

While the definition of 'procurement procedure' used in this research is inspired by the concept of public procurement procedures in public procurement law, the definition I use is wider. This relates to the special position held by social and other

specific services in Directive 2014/24/EU, which allows the use of procurement procedures other than those stipulated in Directive 2014/24/EU in Arts. 27 up to and including Art. 32. Governments have more discretion to design a procurement procedure to award social service contracts (compared to common services), and may design their own procurement procedure as long as it will not conflict with the general provisions of the Treaty on the Functioning of the EU (TFEU), the fundamental principles of public procurement law (such as Art. 18 of Directive 2014/24/EU), and the Arts. 74 up to and including 76 of Directive 2014/24/EU that govern the award of contracts for social services valued over the threshold for these services and the relevant case law of the CJEU.

#### *Legal procurement procedure versus custom procurement procedure*

To further clarify this distinction, I distinguish in this research between *legal procurement procedures* and *custom procurement procedures*. *Legal procurement procedures* are defined in the Public Procurement Directive 2014/24/EU in Arts. 27 up to and including Art. 32 and in the *Aanbestedingswet 2012* (Dutch Public Procurement Act 2012), which implements Directive 2014/24/EU. Legal procurement procedures (i.e. public procurement law) prescribe the basic elements and process steps a public contracting body is required to include in its procedure. The aim is to ensure full and fair competition based on objective criteria and compliance with the principles of transparency, non-discrimination (equal treatment), and proportionality. For public contracts and concessions for common goods, services, and works the public procurement regulations require governments and public bodies to use a legal procurement procedure when the contract is valued above the threshold specified in Directive 2014/24/EU, and adherence to the other mandatory requirements.

However, for social services, including social care services, a light regime exists in the Public Procurement Directive 2014/24/EU (Art. 74), its predecessor Directive 2004/18/EC (see Art. 21), and the *Aanbestedingswet 2012* (Art. 2.38 and 2.39 Dutch Public Procurement Act 2012). Note that social care contracts are subject to EU regulations and CJEU case law concerning internal market provisions and cross-border interest, which may imply other mandatory requirements; Chapter 3 discusses the exact public procurement regulations relevant to social care services. At this point it is relevant that municipalities have more legal room for manoeuvre with respect to designing their procurement procedure for social care service contracts, since in this context the use of one of the legal procurement procedures is not mandatory. I define *custom procurement procedures* as procurement proce-

dures ‘made up’ by municipalities (or their advisors), consisting of different combinations of the elements mentioned under the definition of procurement procedures.

Manunza and Berends (2012) make a comparable distinction between ‘public procurement procedures’ (termed in this research as ‘legal procurement procedures’) and other ‘competitive procedures/competitive tendering’. I deviate from their definitions because the custom procurement procedures discussed in this thesis are not necessarily competitive in nature. The legal procurement procedures and custom procurement procedures can both be competitive in nature, in effect leading to the award of a limited number of contracts based on award criteria; or not competitive in nature, in effect leading to the award of an unlimited number of contracts on the basis of minimum quality and suitability requirements alone.

#### *Municipal collaboration*

Municipal collaboration in this research refers to municipalities that jointly procure social care services by contracting external care providers. Municipalities collaborating together outsource social care through one procurement procedure, although collaboration among municipalities for the procurement of adult social care services in the Netherlands is voluntary, not required by law. A collaborative procurement procedure may result in individual contracts between each of the collaborating municipalities for the care providers that are contracted. In other countries, a collaboration among municipalities for social care provision may signify that one municipality with in-house social care provision also provides social care for another municipality.

#### *Service triad*

In a service triad there are three actors: a buyer, a (service) supplier, and an end-customer receiving the services (Li & Choi, 2009). In a ‘regular’ dyadic buyer-supplier relationship, the buyer is also the end-customer of the goods or services that they buy. In a service triad the buyer contracts a supplier to deliver services to a third party (the end-customer who is separate from the buyer). A municipality that contracts care providers to provide social care services to its citizens is an example of a typical service triad. Service triads do not fall exclusively in the domain of social care services; for instance, an original equipment manufacturer that outsources repair-services for IT products for its end-customers to a local IT-repair shop is also an example of a service triad. The Dutch (national) Railways that contract a cleaning organization for cleaning the interior of trains (at the benefit of the travelers –

who are customers of the Dutch Railways organization) is another example. Buying services in a service triad is associated with additional challenges for the buyer because the buying organization does not experience service quality and supplier performance first hand. This challenges for example the monitoring of supplier performance (Li & Choi, 2009; Van Der Valk & Van Iwaarden, 2011), which may cause quality issues (Van Iwaarden & Van Der Valk, 2013). Also, information with respect to end-customer values, wishes, and demands are not directly experienced by the buying organization, and the buyer may even run the risk that the contracted service provider takes over part of the buyer's business (Rossetti & Choi, 2008).

### *Social community team*

Dutch municipalities are responsible for scrutinizing citizens who apply for social care services. A municipality is required to assess the situation of the citizen, both in terms of limitations and possibilities for informal support, before making a formal decision on the assignment of social care services. Many Dutch municipalities organize this 'gateway' to social care in social community teams (*sociaal wijkteam* or *sociaal team*). These teams, consisting either of generalists, specialists, or a combination of both, are the point of contact for citizens who request social care services. Municipalities organize social community teams through a wide variety of methods. For example, the teams' responsibilities may vary from only making care assessments, to also monitoring care provider performance, to client case management; along with providing light forms of social care services themselves. As such, social community teams vary in their composition with respect to the types of expertise present in the teams. Finally, the manner in which teams are constituted differs between (1) in-house organization (i.e. team members are municipal employees) and outsourcing the teams. When a municipality opts for outsourcing, the teams may either be outsourced to a welfare organization (not contracted for the provision of social care services), or to care providers that are also contracted to provide social care services.

## **1.8 Overview of the chapters in this thesis**

This section provides an overview of the contents of each of the following chapters, the research questions addressed, and the methodology applied.

### *Chapter 2 – Regulations for social care services in the Netherlands*

The object of study in this research is the commissioning of social care services,

which I study in the context of the Netherlands during a period of reform. Chapter 2 first introduces the specific social care services studied in this research. It then elaborates on the context of the studies in the consecutive chapters by discussing the manner in which these social care services were regulated both prior to the 2015 reform under the *Algemene Wet Bijzondere Ziektekosten* (Exceptional Medical Expenses Act) or 'AWBZ' and after.

### *Chapter 3 – EU and Dutch legal systems governing the commissioning of social care service provision*

As Dutch municipalities are subject to both national public procurement regulation and EU law, Chapter 3 addresses the research question: which rules govern the procurement of social care services in the Netherlands? In particular, Chapter 3 discusses the specific rules that applied to the procurement of public contracts for social care services in the years 2015 to 2018. To provide a better understanding of these specific rules as compared to 'regular' services contracts, this chapter also briefly discusses earlier EU directives on public procurement with respect to social services. Chapter 3 furthermore discusses relevant EU case law on open contracting schemes and briefly introduces Dutch public case law that impacts the municipal procurement of social care services. It is thus based on a study of the relevant legal sources: EU directives, the *Aanbestedingswet 2012* (Dutch Public Procurement Act 2012), documents from – or used by – the European Commission in relation to the development of subsequent EU directives on public procurement, and relevant CJEU and national case law.

### *Chapter 4 - Commissioning models for public procurement of social care services*

A central part of this thesis is an extensive analysis of how municipalities outsource social care services. However, the question 'how do Dutch municipalities outsource social care services?' is too broad, and is therefore divided into multiple complementary perspectives on outsourcing: a 'commissioning' perspective and a 'procedural' perspective. The commissioning perspective is first discussed in Chapters 4 and 5 and entails choices in – or with respect to – the contract(s) commissioned for social care, e.g. the scope of activities a municipality outsources and the reimbursement method applied. Chapter 4 aims to answer research questions on which commissioning models can be distinguished in Dutch municipal commissioning of social care services, what elements these models consist of, and their advantages and risks. To answer these questions, I reviewed literature on the fundamental aspects of outsourcing (versus in-house provision) of social services. Building on this literature as a starting point, I then empirically studied the Dutch commissioning

practices from the first years of their responsibility for specific types of social care services (personal assistance, day care, respite care). For this empirical analysis, the procurement documents used by Dutch municipalities for outsourcing social care services were collected and analyzed. Documents on the contracts enacted from 2015 to 2018 were collected on as many Dutch municipalities as possible.

*Chapter 5 – Dutch municipality choices for commissioning models – four years of empirical evidence*

This chapter builds on the defined commissioning models in Chapter 4. Chapter 5 answers the research question which commissioning models were adopted by Dutch municipalities – and how often – for 2015 to 2018 contracts for social care services. Furthermore the chapter presents an interpretation of these choices within the context of the social care reform in the Netherlands. The research questions are answered through the same empirical study of procurement documents used in Chapter 4.

*Chapter 6 – Public procurement procedures for social care service procurement*

Whereas Chapters 4 and 5 focus on the commissioning models, Chapters 6 and 7 discuss the procurement procedures used by Dutch municipalities to conclude contracts for social care services. Chapter 6 first discusses literature on the public management and procurement of social care services that centers around using competition as an instrument to achieve efficiency and improve service quality, and more relational aspects of (public) procurement. Against this body of literature, I introduce a competition-relation framework to interpret the procurement procedures used by municipalities for social care services. This chapter aims to answer the following questions: *which procurement procedures were used by Dutch municipalities for outsourcing social care services in the advent of the 2015 reform of social care services; and how do these procedures qualify both in terms of competitive and relational aspects.* I further distinguish between ‘legal procurement procedures’ – the procedures defined in the EU public procurement Directive 2014/24/EU – and ‘custom procurement procedures’ – constructed by municipalities or their advisors within the context of the light regime for social care services in Directive 2014/24/EU (see Section 1.7 ‘Terminology’ and Chapter 3 for a more detailed discussion). Similar to Chapter 4, Chapter 6 is based on an empirical study on the procurement procedures of Dutch municipalities, using the actual procurement documents for almost all Dutch municipalities for 2015 and the years up to 2018.

*Chapter 7 – Public procurement procedures for social care services: municipal choices between 2015 and 2018*

Chapter 7 builds on the findings of Chapter 6 and illustrates to what extent each of the identified procurement procedures were used for the 2015, 2016, 2017, and 2018 municipal contracts for social care. In this chapter I position each of the procedures in the competition-relation framework. The findings of the empirical study of the municipal procurement documents for social care services are presented, demonstrating to what extent each of the identified procurement procedures were used by the municipalities year by year. A longitudinal study design also allowed me to highlight the trends in municipal choices, identifying whether municipalities stuck to their procedure used for the first (2015) contract in subsequent years, or whether municipalities used a different procedure in subsequent years.

*Chapter 8 – A service triad approach to social care procurement: managing challenges in social care service triads*

The procurement of services where the buyer is not the recipient of the service is known in purchasing and supply management literature as a service triad. In the past decade there has been a growing interest in service triad literature, although it is mainly conceptual and theoretical research that has been published. Chapter 8 presents an empirical study on social care services from a service triad perspective. However, buying services in a service triad constellation is associated with additional challenges for the buyer. This chapter therefore addresses the research questions *which challenges are associated with buying services in a service triad in literature; which management mechanisms for coping with these challenges are identified in the literature; and which management mechanisms are applied in practice by Dutch municipalities in the public procurement of social care services?* This Chapter then presents the findings of a literature review on service triads with respect to (1) the challenges, and (2) the management mechanisms used to cope with these challenges. I empirically studied the extent to which, and how, the management mechanisms were applied by municipalities in the social care services triad. The dataset of municipal procurement documents for 2015 contracts for social care services – addressed in the previous chapters – was used for the analysis.

*Chapter 9 – Supplier opportunism in social care services – a service triad perspective on different reimbursement methods*

The way in which a commissioner pays for social care services inhibits economic incentives that may influence the behavior of care providers. Chapter 8 discussed the risk of care provider opportunism (behavior beneficial to the care provider, but

possibly unbeneficial to the municipality, the client, or society in general) and how the reimbursement method applied by the commissioner (here the municipality) can reduce or magnify these risks. Building on this, Chapter 9 elaborates on the reimbursement methods implemented by Dutch municipalities for commissioning social care services and the related risks in the Dutch context. Using agency theory as my theoretical framework, I employ inductive reasoning to formulate testable propositions regarding the risks for supplier opportunism, the manner in which care providers may act opportunistically, and factors that may influence the likelihood of occurrence of care provider opportunism.

#### *Chapter 10 – Home care procurement: comparing the Netherlands with Finland*

Whereas every previous chapter has focused on the procurement of social care services within the context of the Netherlands, Chapter 10 presents a comparison between Finland and the Netherlands of municipal procurement practices, since in both countries municipalities are responsible for arranging social care services. This study aims to (1) compare the relevant regulations for municipal procurement of social care services, (2) identify how these regulations affect municipal purchasing practices of home care services, and (3) identify and compare the municipal procurement practices in the Netherlands and Finland. In this Chapter I study home care services, also known in the Netherlands as ‘household assistance’ (*huishoudelijke hulp* or *huishoudelijke verzorging*), which are a different type of social services compared to previous chapters. The reasons for studying a different type of service are twofold. First, this type of service corresponds more closely to the Finnish social care services under municipal responsibility, allowing for a more reliable comparison. Second, using the procurement of different services, decentralized in the Netherlands in 2008, extends the data set used for various parts of this thesis. Chapter 10 therefore combines an analysis of the legal frameworks for the public procurement of social care services with an empirical study of the procurement practices in both countries for home care services. Relevant aspects of social care procurement such as procurement procedures, award criteria, and reimbursement methods used by municipalities are identified from the actual procurement documents for the 2018 contracts.

#### *Chapter 11 – The impact of commissioning practices on social care quality and effectiveness: a client perspective*

This final chapter of the thesis seeks to identify whether the anticipated effects of commissioning approaches on the quality of social care services actually occur. The previous chapters extensively and systematically *describe, arrange, and reflect*

upon the different commissioning and procurement approaches that Dutch municipalities have used for outsourcing social care services. Chapter 11 builds upon the empirical studies with respect to both commissioning models and reimbursement methods and tests whether these have an effect on the quality and effectiveness of services, as perceived by clients. Chapter 11 addresses two research questions: (1) *do commissioning models for social care services that allow clients free care provider choice, that feature ex post competition, no volume caps, and municipal coordination of care result in better client satisfaction and perceived self-reliance?;* and (2) *do more outcome-oriented reimbursement methods for social care services lead to better client self-reliance compared to traditional fee-for-service reimbursement?* To answer these questions, I utilize a difference-in-difference analysis, combining the empirical data on municipal commissioning models and reimbursement methods with extensive longitudinal survey data on client perceptions of the social care services received. Client perceptions with respect to satisfaction and effectiveness are compared between pre-reform (2014) and post-reform (2015, 2016, and 2017) using matched-cases, and effects of municipal procurement practices on the observed differences are tested using statistical analyses (F-test and contrast tests).

*Chapter 12 – Epilogue: research findings in perspective*

This final chapter reflects upon the findings and relevance of the studies presented throughout the thesis, adopting a somewhat broader perspective. It discusses recent developments in legislation, arguing additional research is necessary especially in light of these developments. Consequently, I make suggestions for further research.

Table 1.1 summarizes for each chapter the body of literature in which the analysis is grounded, the theoretical perspective, the applied methodology, and the data incorporated.

**Table 1.1** – overview of the literature, theories, methodology, and data sets per chapter

Chapter	Literature and theory	Methodology	Data set
2	Public management Health care management Dutch social support act (Wmo 2015)	Context analysis	
3	EU and national public procurement law and case-law, Wmo 2015	Analysis of legal framework	EU and national rules 2004 - 2018
4 & 5	Public management Agency theory, service Triads	Empirical procurement document analysis	2015 - 2018 Dutch municipal contracts for personal assistance, day care and respite care services
6 & 7	Public Procurement Public management	Empirical procurement document analysis	2015 - 2018 Dutch municipal contracts for personal assistance, day care and respite care services
8	Purchasing and supply management (PSM) Agency theory, service triads	Literature review Empirical procurement document analysis	2015 Dutch municipal contracts for personal assistance, day care and respite care services
9	PSM Health care economics Agency theory, service triads	Literature review inductive reasoning to postulate testable propositions	2015 Dutch municipal contracts for personal assistance, day care and respite care services
10	PSM Public management	Analysis of legal framework Empirical document analysis Country comparison	Dutch municipal home care services ( <i>huishoudelijke hulp</i> ) contracts for 2018 Finnish 2018 municipal home care services contracts for 2018
11	PSM Agency theory, service triads	Difference-in-difference statistical analysis of client perceptions; building on previous empirical research with respect to procurement	2015 - 2017 Dutch municipal contracts for personal assistance, day care and respite care Survey data client perceptions of social care services in 2014, 2015, 2016, and 2017
12	The chapters of this thesis, national public procurement law and case-law, Wmo 2015, national and European reports on health care expenditure, non- scientific journals	Context analysis	



# Chapter 2

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**Regulations for social care services in the  
Netherlands**

This thesis consists of studies conducted on various aspects of the procurement of social care services by municipalities in the Netherlands. In this research I weave together different perspectives – purchasing and supply management, public management, and public procurement law – on the commissioning of social care services. This means each study is considered in the context of several bodies of literature, and extant research on buying services in service triads, public procurement, the outsourcing or in-house provision of public services, and (the commissioning of) social care services is examined. Each chapter in this thesis is carefully positioned in its corresponding scientific context through a discussion of this literature. The main object of the study is the municipal procurement of social care services in the advent of the 2015 reform of social care in the Netherlands, and in the consecutive years that follow.

This chapter introduces the subject matter of the thesis in more detail. I provide an overview of the context and history of the coordination of social care services in the Netherlands. Section 2.1 starts by providing a definition and description of social care services, followed by an overview of the history of the coordination of these services in the Netherlands. By describing this historic context, Chapter 2 provides insight into the circumstances under which Dutch municipalities became responsible for arranging social care services. Furthermore, this chapter extensively discusses the context of the different studies examined in the subsequent chapters of this thesis. To avoid redundancy I refer back to this chapter rather than repeating these discussions in later chapters.

## **2.1 What is a social care service?**

A social care service is a service aimed at supporting individuals with needs arising from illness, disability, old age, or poverty to participate in society and improve their self-reliance. Social care services include household assistance, personal assistance, respite care, general day-time activities ('day care') and vocational and educational day-time activities. When these services are provided in the homes of clients, social care is commonly referred to as home care. In its most simple form, home care includes services aimed at supporting individuals in need – generally arising from old age – with activities such as cleaning, grocery shopping, preparing food, and doing laundry ('household assistance'). Home care may also include assistance with personal care, such as putting on clothes, managing personal hygiene (taking a shower, bath, or washing), assistance with (or administration of) medica-

tion, and possible care for wounds.

Individuals may depend on social care services for a number of reasons. People most commonly rely on social care services when their age or physical and/or mental deterioration leads to a growing dependence on others for daily activities. Other reasons for a dependence on social care include physical or mental disability (innate or developed as a consequence of trauma), a low IQ, or mental disorder.

The extent to which people in need of support have access to government-arranged 'formal' social care services differs across countries, cultures, and politics. In *welfare states* – where governments play a key role in the protection and promotion of the economic and social wellbeing of its citizens – the state provides for public services, such as education and health care, financed by taxes. The extent to which the more 'social' types of care are included in government provisions differs per country. However, a discussion concerning the reasons for this – relating to different socio-economic systems and different types of welfare states (social-democratic welfare state, Christian-democratic welfare state, and Liberal model (Esping-Andersen, 1990)) – is beyond the scope of this research. The 2015 health statistics of the Organization for Economic Co-operation and Development (OECD) demonstrate the wide variety in government expenditure on long term health and social care (even) within the OECD countries (OECD, 2016). In western countries a trend has developed to promote the provision of care at home rather than institutional-based care; see for example Wysocki et al. (2015). In 2013, the OECD reported on this trend in the context of long term care between 2000 and 2011 in twelve OECD countries; the results showed that the share of home care increased in ten out of twelve countries (OECD Indicators, 2015). For example, in Sweden, there has been a consistent trend since 1990 of more people receiving help in their own home, rather than living in nursing homes (Bergman et al., 2018). While empirical evidence is still scarce, the assumption is that home care is more efficient than institution-based care (Guo, Konetzka, & Manning, 2015).

## 2.2 Public services versus social services

Studying the coordination and public procurement of social care services can – and should – be addressed from different research perspectives. Besides the bodies of literature on management science (in effect the literature on buying services and service triads) and health economics, consideration of the public management per-

spective cannot be omitted in research on the coordination of publicly financed social care services. In public management literature significant attention is paid to the efficient and effective coordination of public services, with strong advocates on both sides of the debate on in-house provision versus outsourcing social care services to external care providers. There are many studies on this subject, each differing in the scope of services discussed. The more general studies focus on public services in general: services financed and either provided or outsourced by public authorities, including waste collection, management and cleaning of public spaces, and social services. Studies also focus on social services, which besides social care services include services aimed at supporting vulnerable citizens with needs concerning housing, employment, and debt relief. Finally, there are studies that specifically address social care services. Chapter 4 includes a discussion of the literature on the in-house provision versus outsourcing the provision of public services in general, and social care services specifically. While this thesis focuses specifically on social care services, considerations in studies on public services in general are also relevant.

## **2.3 The evolution of social care services coordination in the Netherlands since 1968: a brief overview**

Until 2015, social care services in the Netherlands were regulated under the *Algemene Wet Bijzondere Ziektekosten* (the Exceptional Medical Expenses Act), or 'AWBZ'. This section provides a brief overview of the history of the AWBZ, including its problems. The discussion then moves to the regulation for social care services now in effect, the Wmo 2015, in more detail.

### **2.3.1 The AWBZ: a universal mandatory social health insurance scheme until 2015**

The Netherlands introduced the AWBZ, a universal mandatory social health insurance scheme, in 1968. Prior to this, the financing of long-term care facilities was highly fragmented and increasingly unable to provide access to adequate care for lower income groups. Initially, the AWBZ primarily covered nursing home care, institutionalized care for the mentally handicapped, and hospital admissions lasting more than a year (Asselt, Van Bovenberg, Gradus, & Klink, 2010). In due course, however, coverage was expanded by including home health care, e.g. for rehabilita-

tion at home after hospital admission and care for elderly people with impairments (in 1980); ambulatory mental health care (in 1982); family care, e.g. home help in case of frailty, psychosocial problems, or after childbirth (in 1989); and residential care for the elderly (in 1997) (Schut & van den Berg, 2010).

The AWBZ constituted a mandatory insurance scheme for long-term care for the entire Dutch population. Every citizen from the age of 15 upwards paid an income related contribution to finance the AWBZ through a general fund, and the AWBZ was administered by health care insurers that in practice delegated responsibilities to the largest regional health care insurer. The Netherlands was divided into 32 regions, and for each region one health care insurer – through a distinct ‘regional care office’ – administered the AWBZ on behalf of the health care insurers, including the contracting care providers. All expenses for the AWBZ were paid from the general fund, and the health care insurers were not at risk for the AWBZ-expenditure. Those who appealed to AWBZ-financed social or health care were scrutinized to determine whether they really required care, what type of care was appropriate, and in what amount. The single national organization ‘*Centraal Orgaan Indicatiestelling*’ (Centre for Needs Assessment, or ‘CIZ’) was tasked to make these assessments. Access to AWBZ care was solely based on a person’s health and not dependent on income or wealth.

### 2.3.2 How was social care commissioned under the AWBZ?

While the 32 care offices contracted social care service providers independently, they were required to follow strict national specifications, policies, and regulations. There was no variation in product specifications, tariff thresholds, quality criteria, procurement process, contract types and length, or monitoring and accountability procedures. Care offices contracted a selection of care providers concluding contracts with an annual budget, and care providers had to account for the use of the budget. The contract specified a range of different care services, which varied in the nature of the service itself, the nature and severity of the client’s needs, the nature of the client’s handicap (e.g. somatic, psychogeriatric, et cetera), and possible additional requirements such as permanent stand-by or on-call duty. At the point in time where the AWBZ social care services were decentralized, there were over two hundred different social care services specified that corresponded to the decentralized types of care. These services were referred to as ‘NZA-codes’, after the *Nederlandse Zorgautoriteit* (Dutch Care-authority, or ‘NZA’), which defined and

managed this set of social care services.

Clients who were entitled to AWBZ social care received social care services in kind from one of the regionally contracted care providers. Clients could also opt for a personal budget (a form of direct payment). Clients that opted for a personal care budget received payment for social care services on their own bank account and had to purchase social care with that budget. The personal care budget was set at approximately 75% of the costs of care in kind and could be spent on informal care, which was expected to be less costly (Schut & van den Berg, 2010).

### **2.3.3 AWBZ problems: accessibility versus affordability of social care**

The enactment and gradual expansion of the AWBZ paved the way for a strong growth of long-term care facilities and of public expenditure on long-term care (Asselt et al., 2010). As a consequence, the percentage of GDP spent on long-term services covered by AWBZ increased from 0.8 percent in 1968 to 4.5 percent in 2008 (Asselt et al., 2010). The growing expenditure between the introduction of the AWBZ until the end of the millennium has been attributed mostly to the expanding coverage of the AWBZ. Although cost-containment policies introduced to prevent growing use of social care were quite successful, they led to long waiting lists. This policy was effectively ended in 1999, when a court ruled that AWBZ insured people were entitled to timely access to home health care. Consequently lifting the cost containment policies led to a dramatic growth in expenditure: over 10% growth annually between 2000 and 2004 (Schut & van den Berg, 2010). In addition, in 2008 the expenditure was projected to grow to 6,4% of GDP by 2020, in absence of policy measures (SER, 2008). Clearly the AWBZ system was no longer financially sustainable now that the cost containment policies of the past were no longer accepted. Furthermore, the AWBZ was characterized by highly bureaucratic administrative processes, hindering clients to receive individually tailored care, leading to high overhead costs and ill-informed clients (Rolden & Waal, 2012). By 2008, the first major policy change was introduced when the *Wet Maatschappelijke Ondersteuning* (Social Support Actor, or 'Wmo'), came into force, making municipalities responsible for 'household assistance' or 'domiciliary care'. It is this law that was revised in 2015, extending its coverage.

### **2.3.4 The Wmo 2015: towards a more tailor-made and affordable coordination of social care services**

With the introduction of the Wmo 2015, the former Wmo was extended to cover personal assistance, day care, respite care, and sheltered housing as additional forms of social care. Moving away from the central standardized AWBZ system, from 2015 onwards each of the (then) 393 Dutch municipalities became individually responsible for arranging social care services for their citizens. While the Wmo 2015 does allow for in-house provision, the most obvious choice for municipalities was to contract-out care providers. Social care services under the AWBZ, including household assistance already decentralized to municipalities in 2007, were already entirely executed by external care providers; municipalities were therefore not expected to provide for decentralized social care services in-house.

Under the Wmo 2015, municipalities must organize social care and support for their citizens who are not sufficiently self-reliant or capable of participating in society due to impairment, and who cannot find sufficient informal support (Wmo 2015, Art. 1.2.1). The Wmo 2015 defines the conditions and basic rights concerning the provision of social care services for citizens in need, without prescribing a detailed system of services or contracting regulations. This provides ample discretion for municipalities to organize social care services in a manner they see fit. Decentralizing social care services combined with wide legal discretion in how to coordinate it according to local policies leads to a situation where citizens with the same impairment and needs may receive different provision of social care depending on the municipality in which they live. This could give rise to a tension between the principles of the reform (local tailor-made care and wide discretion afforded to municipalities) and the principle of equal treatment of all citizens. Although the fundamental rights of Dutch citizens have, over the past years, been clarified in administrative case law, a discussion of these cases falls outside the scope of this thesis, except where they directly affect municipal commissioning of social care. I explain this in more detail in Section 3.7.

As the former cost-containment policy of capacity-regulation and subsequent waiting lists were no longer viable, the Wmo 2015 is based on different principles in order to suppress the rising expenditure. Compared to both the AWBZ and the former Wmo, the Wmo 2015 more strongly emphasizes the citizen's own responsibility and their opportunities to arrange for support from family, friends, and their social network (Wmo 2015 Art. 1.2.1). An individual is only eligible to receive formal

social care services under the Wmo 2015 when family and friends cannot (comprehensively) provide sufficient informal support (*'mantelzorg'*). Although in this sense the Wmo 2015 acts more like a safety net for social inclusion compared to the AWBZ, municipalities cannot force families to provide informal care.

Although the introduction of the Wmo 2015 has been promoted by the legislator by stressing opportunities for more integrated care provision and care services tailored to individual needs, the Wmo 2015 was also primarily intended to cut costs. With decentralization came heavy budget cuts, which ranged from 12% to 32%, dependent on the type of care (Rijksoverheid, 2014). Municipalities therefore had an urgency to transform social care service provision. Simply copying the pre-2015 method of commissioning social care would not have been a viable option in the long run, since the goals of organizing social care services tailored to the individuals needs of citizens would not be met. Furthermore, against the backdrop of severe budget cuts, municipalities would quickly exceed their budgets.

### **2.3.5 Commissioning social care under the Wmo 2015**

The former central standardized AWBZ system was abandoned, providing municipalities the opportunity to design their own systems of service specifications, payment structures, and commissioning approaches towards social care services. As mentioned before, neither the Wmo 2015 nor EU directives generally require municipalities to outsource social care services to external care providers. However, it was not expected that municipalities would organize social care services in-house, as they did not do so for the most basic social care services decentralized in 2007. However, the Wmo 2015 does include some very basic requirements in relation to contracting care providers in case municipalities opt to do so. For example, it requires municipalities to award contracts on the basis of the most economically advantageous tender (MEAT) and not on lowest price alone (Wmo 2015 Art. 2.6.4 Section 2). It also includes requirements with respect to quality of care, and that municipalities should pay a 'fair price' to providers of social care services (Wmo 2015 Art. 2.6.6). Aside from these generic requirements, under the Wmo 2015 municipalities are free to commission social care services as they see fit. Nevertheless, when municipalities opt to outsource social care services by means of a public contract, both the European Directive on public procurement and the national public procurement law, and relevant case law apply. These are discussed in further detail in Chapter 3.

The decentralization of social care services, formerly part of the AWBZ, coincided with the decentralization of all types of youth care. While for youth care, municipalities were required to form collaborations for procurement of youth care services, the same was not required for adult social care services. Sheltered housing was the only exception; 43 municipalities were appointed to contract care providers for their surrounding municipalities.

## **2.4 Conclusion**

To summarize and conclude, the Netherlands have a history of a broad formalized social care system. Facing a steady rise in expenditure and a need for better coordination, integration, and independent tailoring, social care services were decentralized to municipalities. With the introduction of the Wmo in 2007 home support services for adults were decentralized, and later the extended Wmo 2015 brought additional social care services under municipal responsibility. The decentralization aimed for a 'transformation' in social care by emphasizing informal support where possible, promoting more tailored social care where necessary, and (assumed to be a consequence) achieving cost savings. Municipalities were therefore afforded ample room for manoeuvre to organize and outsource these services to allow for a local, individualized approach. This is the context for the research presented in this thesis.



# Chapter 3

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**EU and Dutch legal systems governing the commissioning of social care service provision**

This research studies the municipal procurement practices for outsourcing social care services, including commissioning models (see Chapters 4 and 5) and the public procurement procedures used for contracting out services (see Chapters 6 and 7). To fully understand the legal room for manoeuvre for Dutch municipalities for commissioning social care services, an analysis of the legal system governing the commissioning of social care services is crucial. This chapter provides an analysis of the EU and Dutch legal systems governing the commissioning of social care service provision. This chapter addresses the following research question: *which rules govern the procurement of social care services in the Netherlands?*

In the European Union, public authorities are bound by primary EU law (general principles and fundamental provisions as laid down in the TFEU, internal market and competition provisions derived from the TFEU, and case law from the CJEU; secondary EU law (directives on public procurement and competition regulation); and national rules governing public procurement when contracting out works, supplies, and services. Public authorities in the Netherlands are also bound by the Public Procurement Act (*Aanbestedingswet 2012*), the Dutch Civil Code (*Burgerlijk Wetboek*), administrative law (*Algemene wet bestuursrecht*), the Guide on the Principle of Proportionality (*Gids Proportionaliteit*), and national case law.

The EU directives on public procurement aim to abolish all existing forms of direct and indirect discrimination in order to achieve the fulfillment of a single EU market for public procurement. However, social services are considered to relate strongly to the different contexts and cultural traditions of individual EU member states, and 'by their very nature to have a limited cross-border dimension' (recital 114 Directive 2014/24/EU; and CJEU, 13 November 2007, *An Post*, par. 25). Social (and other specific) services have therefore traditionally held a special position in the EU directives on public procurement, subject to lighter regimes. This special position has developed in subsequent directives. The same holds for national public procurement law (Manunza, 2010, 2015; Manunza & Berends, 2012; Pennings & Manunza, 2015).

This chapter discusses this development of the rules for public procurement of social care services for Dutch municipalities. The aim is to provide a clear overview of the legal contexts in which municipalities operate when outsourcing social care services, and to provide insights into the background and development of these rules. Together with Chapter 2, which illustrates the backgrounds, history, and context of the Dutch social care system, the main goal of this chapter is to provide the

insights necessary to better understand the context behind municipal choices for commissioning social care (discussed in Chapters 4 and 5) and municipal choices in procurement procedures (Chapters 6 and 7). This chapter is descriptive in nature, as this suits the main goal. Finally, if by discussing the rules on public procurement of social care services I happen to ‘crack the myth’ that there is only one way for municipalities to tender these services EU-wide, I consider this a bonus. Especially since this one-sided and simplistic image is all too often used by politicians to blame everything that is wrong with social care services on the fact that municipalities must follow EU procurement rules when outsourcing these services.

The chapter is built up as follows: the first paragraphs discuss the history of the position of social services in subsequent EU public procurement directives up until Directive 2014/24/EU, which came into force when writing this thesis. I then discuss national public procurement rules in the Netherlands and legal requirements for outsourcing social care services that originate from the Wmo 2015. Finally I discuss selected EU case law concerning open contracting schemes and national administrative case law on the use of outcome-based contracts, due to their impact on outsourcing social care services in the Netherlands. Only relevant EU and national case law published prior to 1 January 2019 is included.

## **3.1 Social services and the EU regulation on public procurement: a historical overview of a regulation in motion.**

This section elaborates on the introduction and overview of the development of the position of social services in different EU public procurement directives, starting with the first public procurement Directive 92/50/EEC.

### **3.1.1 Introducing a light regime for social services in Directive 92/50/EEC**

The special position of social services originates from Council Directive 92/50/EEC on the coordination of procedures for the award of public service contracts. This Directive distinguished two groups of services, identified in Annexes I A and I B. The 20<sup>th</sup> recital clarified the distinction: ‘the full application of the directive must be limited to contracts for those services where its provisions will enable

the full potential for increased cross-frontier trade to be realized'. The recital also clarified that the limitation of full application concerns a 'transitional period' and was intended to be temporary. It furthermore stated that the contracts for Annex I B services not yet subject to the full application of the Directive must be monitored for a certain period before deciding on extension of the application. Since the Annex I B services in Directive 92/50/EEC included social care services, contracts for social care services were not subject to the full extent of the Directive – only Articles 14 and 16 were applicable. Article 14 concerned the use of technical specifications and EU standards, and Article 16 required public authorities to inform the Office for Official Publication of the European Communities of the results of the award procedure when a public contract has been awarded. This in fact allowed the monitoring of the award of Annex I B services, as announced in the preamble of the Directive. Article 43 of consequently stated:

*“Not later than three years after the time-limit for compliance with this Directive, the [EU] Commission, acting in close cooperation with the Committees referred to in Article 40(1) and (2), shall review the [manner] in which this Directive has operated, including the effects of the application of the Directive to procurement of the services listed in Annex I A and the provisions concerning technical standards. It shall evaluate, in particular, the prospects for the full application of the Directive to procurement of the other services listed in Annex I B, [...]”.*

### **3.1.2 Continuation of the light regime for social services in Directive 2004/18/EC**

The intention of the EU legislator concerning the Annex I B services was clearly to monitor the award of public contracts for these services with the intention to reconsider their position in the Directive. The aim was to evaluate whether I B services should either be brought under the full application of the Directive (lifting the distinction between two categories of services), or whether they should be maintained as a separate category of special services but to extend the scope of the directives for these services. Despite this intention and the monitoring that followed, the only difference with respect to I B services in Directive 2004/18/EC was a renumbering of the annex that lists the services to 'II A' and 'II B'. Even the recital that discusses the distinction between service categories is copied word for word from the previous Directive and reproduced as the 19<sup>th</sup> recital of Directive 2014/18/EC. Interestingly, while at this point in time the legislator already collect-

ed the mandatory contract award notices for ‘B-services’ for over a decade (which can be considered monitoring the award of these services), the recital again reads ‘whereas the mechanism for such monitoring needs to be defined’.

### 3.1.3 CJEU in the *An Post* case: enlarging the public procurement obligations

The limited rules on the award of II B service contracts often caused confusion or uncertainty for public buyers and economic operators, for example with respect to transparency requirements and the possibility of direct award of contracts. In 2007, the CJEU delivered its ruling in *An Post* (CJEU, 13 November 2007, case C-507/03, *An Post*), a case that concerned the provision of the payment of social welfare benefits (a II B service), and shed light on the requirements for the award of contracts for these services under EU law. The Irish government had entered into a contract, without organizing a competitive tendering process, with the Irish postal service (*An Post*) for the payment of social welfare benefits to its citizens. The question at hand was whether the direct award of this contract without prior publication and consequent competitive tendering process infringed Articles 43 EC and 49 EC, as well as the general principles of transparency, equality, and non-discrimination (paragraph 14). The CJEU confirmed that the legislator granted a special position to II B services:

*‘based (...) on the assumption that contracts for such services are not, in the light of their specific nature, of cross-border interest such as to justify their award being subject to the conclusion of a tendering procedure intended to enable undertakings from other Member States to examine the contract notice and submit a tender. For that reason, Directive 92/50 merely imposes a requirement of publicity after the fact for that category of services.’* (*An Post*, par. 25).

Despite the special position II B services hold, the CJEU clarified in par. 26 of *An Post*, by referring to case *HI* par. 42 (CJEU, 18 June 2002, C-92/00, *HI*), that the award of public contracts, including those for II B services, remains subject to the fundamental rules of Community law, in particular to the principles laid down in the Treaty on the right of establishment and the freedom to provide services (art. 43 and 49 EC). The CJEU clarified that the inclusion of a service in Annex II B does not preclude application of the principles deriving from Arts. 43 and 49 EC in the event that a contract for such a service is ‘nevertheless (...) of certain cross-bor-

der interest' (*An Post*, par. 29). If this is the case and the contract is awarded in a non-transparent manner, this results in different treatment of undertakings that are located in other member states, mainly to the detriment of these undertakings, amounting to 'indirect discrimination on the basis of nationality, prohibited under Articles 43 EC and 49 EC (*Coname*, par. 19 and case-law cited)', as clarified in *An Post* par 31. Following CJEU rulings in subsequent cases, where a certain cross-border interest for II B services exists, the public body concerned must ensure sufficient transparency in order to guarantee that undertakings in member states other than that of the public body have access to appropriate information regarding the contract. This concerns cases where a certain cross-border interest was present, for example given by the economic value of the contract or the location where services must be performed: see *Coname* par. 21 (CJEU, 21 July 2005, C-231/03, *Coname*), *Telaustria* par. 60 – 62 (CJEU, 7 December 2000, C-324/98, *Telaustria*), and *Coditel* par. 25 (CJEU, 13 November 2008, C-324/07, *Coditel*). Ensuring sufficient transparency does not 'necessarily imply an obligation to launch an invitation to tender' (*Coditel*, par. 25), but does 'ensure a degree of advertising sufficient to enable the services market to be opened up to competition and impartiality of procurement procedures to be reviewed' (*Telaustria*, par. 62) (Manunza, 2006).

### **3.1.4 A new perspective on social and other special services – towards the major 2014 EU public procurement reform**

While the monitoring of B services did not lead to any apparent reconsideration by the EU Commission of the exemptions in Directive 2004/18/EC, the distinction between A and B services remained on the agenda, and in 2011 the EU Commission published its evaluation report 'Impact and Effectiveness of EU Public Procurement Legislation'. This report aimed to identify possible improvements in existing legislation and policy, and served as an important input for the preparation of the EU Commission's proposals for review of the directives (SEC(2011) 853 final, p. ii).

The evaluation report concluded that in 2009, only 20% of the total public expenditure on goods and services was covered by EU directives (SEC(2001) p. 27). Contributing to this low coverage was the fact that of the high public expenditure for health, social services, and education – which constituted 5% of GDP spent by governments – only a marginal amount is subject to EU wide publication. This is partly due to the manner in which health care, education, and social services are financed (in kind to citizens, through institutions that do not consider themselves public

contracting bodies). However, this is also directly related to the light regime for social services provided for under Annex II B. The evaluation report evidenced the actual direct and indirect cross-border procurement for both A and B services. While (as expected) on average a higher share of A services were contracted cross-border compared to B-services, the difference was marginal. A share of 2.8% of A services was contracted cross-border directly, and 16.2% were contracted cross-border indirectly, through affiliates. The shares for B services were 2.4% direct and 14.6% indirect cross-border contracted. More interestingly, several categories of B services had exceptionally high shares of cross-border procurement: legal services (21% direct cross-border), water transport services (9% direct cross-border), rail transport services (53% indirect cross-border), and hotel and restaurant services (39% indirect cross-border). These categories of B services actually had a much higher share of direct or indirect cross-border procurement compared to A services (although the B services included in this analysis may be subject to self-selection bias). The B services awarded without publication were not included in the analysis, and the percentages of cross-border contracting for B services would have been lower if these contracts had been included. Still, the EU Commission concluded that the findings justified a revision of the Directive with respect to the A and B services.

The EU Commission published their proposal for the revised public procurement directive (COM(2011) 896 final, Brussel) in 2011. The findings of the evaluation with respect to services had a direct impact on the proposed new directive. The 10<sup>th</sup> recital in the preamble refers to the evaluation report directly, mentioning that its findings justify a review of the exclusion of certain services from the full application of the directive. The proposal for the revised directive extended the full application to a number of services that already demonstrated a high share of cross-border trade. As the evaluation only reported very low cross-border trade for health, social, and educational services, the proposal maintained a special regime for them. In particular, acknowledging the special characteristics of social services and the fact that they exhibited a very limited cross border trade, the proposal explicitly characterized regular procedures as inappropriate for the award of these contracts. Instead, the EU Commission proposed a new regime aimed at social services contracts with a higher threshold of € 500.000, imposing only the respect of basic principles of transparency and equal treatment (proposal p.10). In the proposal, this special regime applied only to health, social, educational, social benefits, unions, and religious services; all of which were exempt from full application. All other former II B services were brought within the scope of the full application by the proposal. The higher threshold value itself was not arbitrary; the proposal

informed that a quantitative analysis of the values of contracts demonstrated that contracts for the relevant services below the value of € 500.000 typically have no cross-border interest. The next section discusses the final, new Directive 2014/24/EU, in which the fundamental aspects of proposal COM(2011) 896 are clearly visible, yet where a number of striking deviations from the proposal emerge.

### **3.2 Giving and taking freedom from member states: new legal provisions**

In line with the initial proposal, Directive 2014/24/EU abandoned the distinction between A and B services and introduced 'social and other specific services' listed in Annex XIV. While they are still exempt from most of the detailed provisions, Directive 2014/24/EU broke the 'tradition' with respect to the treatment of social and other specific services. According to Article 75, contracting authorities are to publish a contract or prior information notice for social and other specific services with a value equal to or exceeding the threshold specified in Article 4 sub (d), which is set at € 750.000. In addition, they must also publish a contract award notice. Public authorities are of course required to respect the basic principles of transparency (now detailed in the mandatory publication for contracts above the threshold) and equal treatment. The Directive 2014/24/EU does not formulate a detailed procedure for the award of social care services. However, according to Article 76, 'member states shall put in place national rules for the award of contracts (for social and other specific services) in order to ensure contracting authorities comply with the principles of transparency and equal treatment of economic operators'. These rules are subject to the rules of Directive 2014/24/EU Chapter 1 concerning the award of contracts for social and other specific services, which require that transparency for contracts above the threshold (art. 4 sub d) is respected.

To summarize, regardless of the (possibly more restrictive) national rules that member states shall put in place, the new 'minimum' regime is that (1) social service contracts above the threshold value must be published, and (2) these contracts are to be awarded complying to the principles of transparency and equal treatment of economic operators. The first condition implies that contracting authorities are obliged to publish contracts, in advance (*ex ante*), for social care services that exceed the threshold so that every interested economic operator can express their interest. The second condition implies that every economic operator that has expressed their interest is to be treated equally by municipalities. As a consequence,

the direct award of such contracts without publication or competitive procurement is no longer permitted. The legislator has acknowledged the specific nature of social and other Annex XIV services by setting a much higher threshold for contracts: valued at or in excess of € 750.000. In essence, the legislator has made the assumption that, while considering the specific cultural or social aspects of Annex XIV service contracts, cross-border interest shall be assumed when the contract value is sufficiently high (and at least equal to the threshold).

Two interesting observations can be made when comparing the final text of Directive 2014/24 to the initial proposal of 2011. The first observation concerns the value of the threshold associated with the procedure for social and other specific services. In the 2011 proposal, the threshold for the special regime for social, health, and educational services was set at € 500.000, based on a quantitative analysis of cross-border interest for the relevant services. Directive 2014/24/EU defined a substantially higher threshold of € 750.000 for the new rules on transparency (in effect Art. 75) and the requirement for member states to put in place national rules that ensure contracting authorities comply with the principles of transparency and equal treatment of economic operators (Art. 76). The second observation relates to the scope of services subject to full application of the Directive. The proposal extended full application of the Directive to most of the former II B services, some of which actually demonstrated high shares of cross-border trade. However, in the final text of the Directive, many of these services ended up in Annex XIV (social and other specific services – subject to the light regime), despite their high cross-border trade. However, the result of simultaneously increasing the threshold and bringing additional services with higher demonstrated cross-border trade under the special regime is highly paradoxical. It would have made more sense to lower the threshold when bringing other services under the light regime, rather than raising it. Consequently, while ‘abolishing the distinction between A and B services’ was one of the most prominent anticipated differences between Directives 2004/18 and 2014/24, the distinction has in fact remained as it was. B services have been placed in the new Annex XIV, and these services remain subject to a light regime; only a selection of former B-services have now moved to become ‘regular’ services.

To conclude these first sections, the EU legislator has consistently provided for a special position for social services in EU public procurement regulations. The motivations behind this special position are focused on the highly country-specific and cultural dimensions of social (care) services and the (consequent) very limited

cross-border interest for these services. While the aim of the EU Commission has been to monitor these services and possibly – eventually – also bring social services under the full scope of Directive 2014/24, EU member states are still afforded extensive discretion in how they award social service contracts.

### **3.3 Implementation of Directive 2014/24 in the Dutch *Aanbestedingswet* 2012 (*herziening* 2016): a missed opportunity**

The EU regulations on public procurement are implemented in national public procurement law. In the Netherlands, this is the *Aanbestedingswet* 2012 (Public Procurement Act 2012). The *Aanbestedingswet* 2012 was last revised with the implementation of directive 2014/24/EU, in 2016. With respect to social services, the *Aanbestedingswet* 2012 did not deviate from Directive 2004/18/EC. This changed with the revised *Aanbestedingswet* 2012 in the year 2016 following the implementation of Directive 2014/24/EU. Arts. 74 and 75 of the Directive were implemented in the *Aanbestedingswet* 2012 (*herziening* 2016) in paragraph 2.2.1.8 under articles 2.38 and 2.39. The following rules apply for the award of public contracts for social services (*Aanbestedingswet* 2012 Art. 2.39 Sec. 1):

Contracting authorities shall:

- a) make known their intention to award a public contract (for social or other specific services) by means of a contract notice or prior information notice;
- b) verify whether tenders meet the required technical specifications, requirements, and norms;
- c) draw up an official report of the award of the contract;
- d) conclude the contract; and
- e) publish the contract award notice.

When applying this procedure for the award of public contracts for social and other specific services, only paragraphs 2.3.1.2 (communication and information), 2.3.2.1 (prior information notice), 2.3.2.2 (contract notice), 2.3.3.1 (technical specifications), and 2.3.8.9 (reporting and publication) are applicable (Art. 2.39 Sec. 2). Finally, the contracting authority that includes grounds for exclusion and the fulfilment of the selection criteria in the procedure for social and other specific services requires the economic operator to use the standardized format (*Uniforme*

*Eigenverklaring Aanbesteden*, or 'UEA') to provide this information.

While these requirements correspond to the basic provisions in Articles 74 and 75 of Directive 2014/24/EU, the Dutch legislator ignored article 76 section 1 that requires member states to put in place national rules for awarding social service contracts, subject to the other articles in the corresponding chapter of the Directive. Manunza identifies this and other areas where the Dutch central government lacks a more specific regulation, suggesting that more specific regulations would have been more efficient and legitimate (Manunza, 2012, 2017). In line with Manunza, I argue this is a missed opportunity for the Dutch government to provide more guidance to municipalities for the procurement of social care services and to enforce specific policies. An anticipated effect of decentralization for care providers was the increase in the administrative burden resulting from being contracted by individual municipalities rather than regional care offices. More specific national rules that standardized (elements of) the procurement procedures for social care contracts might, for example, have reduced the administrative burden of municipal contracting for care providers. As there are no further specific national rules concerning the award of contracts for social (care) services, in the remainder of the thesis I refer only to EU Directives 2004/18 and 2014/24 when relevant.

### **3.4 Procurement regulations during the social care reform period**

The previous sections discussed the relevant directives that regulate the public procurement of social care services within the period of this longitudinal research. I study municipal procurement of social care services in the period between 2014 and 2018, which coincides with two subsequent EU directives on public procurement. During the first years of the social care reform in the Netherlands, Directive 2004/18 was in force until it was replaced by Directive 2014/24 on 18 April 2016. Each municipality that chose to outsource social care services in the advent of the 2015 reform contracted services at that time subject to Directive 2004/18. The municipalities that contracted these social care services again throughout 2016 and 2017 were then subject to Directive 2014/24, which included the new light regime for social services. This research will therefore demonstrate the impact of Directive 2014/24 on the municipal procurement of social care. This impact is anticipated due to the changes in rules for social service contracts valued above the threshold. Typical contracts for social services within the scope of this research

are valued beyond the € 750.000 threshold, even for small municipalities in the Netherlands.

### **3.5 The Wmo 2015 provisions on commissioning: ensuring best quality for a ‘realistic price’**

To complete the legal framework for the municipal procurement of social care services, I consider the relevant provisions in the Wmo 2015, relating to contracting care providers for provision of social care. The Wmo 2015 regulates the rights of citizens to social inclusion and participation in society and the responsibilities of municipalities to support citizens in need (Art. 1.2.1). It is necessary to clarify that the Wmo 2015 does not require municipalities to contract care providers for the provision of social care services. The Wmo 2015 does, however, contain certain provisions that impact the procurement of social care services, although these provisions apply only when municipalities decide to outsource social care services by contracting third parties for their execution. The Wmo 2015 requires municipalities that contract care providers to periodically evaluate their policy plan with respect to social support. In this policy plan, special attention should be paid to client choice among care providers, taking into account their religion, belief, and cultural background (Wmo 2015 Art. 2.1.2 section 4c). Furthermore, the municipality must establish which performance indicators are used towards care providers (Art. 2.1.2 section 6).

When the municipality tenders the provision of social care services, the municipality shall award the contract based on the most economically advantageous tender (MEAT), and the municipality announces in the publication of the tender which award criteria it will use – where at least quality is one of the criteria (Art. 2.6.4 section 2). Art. 2.6.4 section 3 further clarifies that the municipality is not allowed to award contracts for social care services on the basis of lowest price. When the municipality awards a public contract for the provision of social services, the municipality is required to take into account how the contracted care provider will ensure continuity of care to the recipients of care (Art. 2.6.5 section 2). Related, Art. 2.6.5 section 3 further requires the municipality to guarantee that contracted care providers deliberate with previous contracted care providers concerning taking over personnel, and that the contracted care provider(s) ‘put in maximum effort’ to accomplish the transfer of personnel and continuation of existing client-caregiver relationships. Finally, the municipality is required to establish rules to ensure a

sound relationship between the price for a service and the requirements on the quality of the service when contracting care providers (Art. 2.6.6). The municipality must consider the expertise and terms of employment of the professional care givers when determining the ‘realistic price’. This requirement is elaborated further in additional rules with the introduction of the ‘*Algemene Maatregel van Bestuur (AMvB) reële prijs Wmo*’ (Decree realistic price Wmo), or in full: ‘*Besluit van 10 februari 2017, houdende regels ter waarborging van een goede verhouding tussen de prijs voor de levering van een voorziening en de eisen die worden gesteld aan de kwaliteit van de voorziening en de continuïteit in de hulpverlening tussen de cliënt en de hulpverlener*’ (Decree on rules to safeguard a sound relationship between the price and the requirements with regard to quality and continuity of a care service).

To summarize and conclude the previous sections: Dutch national public procurement rules do not set additional rules for the award of social care service contracts, and the Wmo 2015 requirements for outsourcing care services are minimal. Subsequent chapters of this thesis will evidence that on the one hand the implementation of directive 2014/24/EU in national rules, and on the other hand recent EU case law on open contracting schemes, had a prominent impact on the municipal procurement of social care services in the 2015-2018 period used in this research to empirically study municipal procurement practices: see Chapters 4, 5, 6, and 7. The next sections therefore discuss the relevant CJEU case law on open contracting schemes.

## **3.6 EU public procurement rules versus open contracting schemes (‘open house model’)**

### **3.6.1 Commissioning social services outside the scope of the public procurement directive**

Public contracts and concession contracts for social services are subject only to a light regime under the EU directives, as discussed in the previous paragraphs. There are, however, circumstances where the provision of public services are in general not subject to Directive 2014/24/EU at all. For example, non-economic social services of general interest (SSGI) do not fall within the scope of this Directive (recital 6). A discussion on SSGI falls outside the scope of this research project. There are, however, other forms of outsourcing outside the scope of the public pro-

curement Directive. According to recital 114:

*'Member States and public authorities remain free to provide those [in effect social] services themselves or to organize social services in a way that does not entail the conclusion of public contracts, for example through the mere financing of such services or by granting licenses or authorizations to all economic operators meeting the conditions established beforehand by the contracting authority, without any limits or quotas, provided that such a system ensures sufficient advertising and complies with the principles of transparency and non-discrimination.'*

These two examples in the recitals are not referenced here arbitrarily. Governments of EU countries have made use of such 'legal instruments' or means of financing social care. Finland has established a law governing a voucher system for home care, according to the system described in recital 114 (Finnish national Act (569/2009), see Chapter 10 for more details). In the Netherlands, prior to the implementation of Directive 2014/24, different municipalities had introduced similar systems that share many similarities to a licensing scheme that enables care providers to provide social care. Until 2016, before Directive 2014/24/EU was implemented in Dutch legislation, these systems were typically defined by municipalities as public contracts procured under national legislation and the light regime of the EU.

### 3.6.2 CJEU case law on open contracting schemes

Strong debates accompanied the introduction of Directive 2014/24 on whether – and exactly how – such open contracting schemes were compliant with the new rules. Note that the recital 114 refers to 'organizing services in such a way that *does not entail conclusion of a public contract*' when referring to granting licenses or authorizations. Two CJEU cases have since clarified the position of open contracting schemes (this definition is taken from the *Falk* case), vis-à-vis the EU public procurement Directive: *Falk* (CJEU, 2 June 2016, Case C-410/14, *Falk*) and *Tirkkonen* (CJEU, 1 March 2018, Case C-9/17, *Maria Tirkkonen*). In *Falk*, DAK – a statutory health insurance fund – published a notice concerning an 'authorization procedure' for the conclusion of rebate *contracts* for a medicine. That procedure provided for the authorization of all interested undertakings that met the authorization criteria, and for the conclusion with each of those undertakings of identical contracts whose terms were fixed and non-negotiable. Furthermore, any other undertaking fulfilling those criteria also had the opportunity to accede to the same terms to the

rebate contract scheme during the contract period. Dr. Falk Pharma (Falk) protested against this procedure, stating the authorization procedure was incompatible with public procurement law. Falk argued that public procurement regulations require contracting authorities to place a tender on the market and award contracts exclusively – which was not the case with the authorization procedure of DAK. The CJEU again stressed in *Falk* that the public procurement regulations primarily aim to protect the interests of economic operators in a member state that wishes to offer goods or services to contracting authorities in another member state (Falk, par. 35). Essentially, the risk of member states favoring national economic operators – which the Directive seeks to preclude – is closely tied to the selection that the contracting authority intends to make from the admissible tenders, and to the exclusivity that results from awarding the contract (par. 36). Summarizing in paragraph 42 of the *Falk* case, the CJEU clarifies that the authorization procedure of DAK does not constitute a *public contract* within the meaning of the Directive. In this situation there is no need to control the actions of the contracting authority to prevent it from awarding a contract in favor of national operators (Falk, par. 37). The Dutch translation (as well as the German) coined the term ‘open house model’ for these open contract schemes, and while this term is not generally used in other member states, ‘open house model’ became the common definition for this system in the Netherlands. I therefore use this term throughout this thesis.

While in *Falk* the authorization procedure remained accessible to economic operators throughout its existence, in *Tirkkonen* (CJEU, 1 March 2018, Case C-9/17, Maria Tirkkonen) an authorization procedure to conclude contracts for farm advisory services was disputed that was only open to economic operators before the start date of the contracts. The system of contracts and the authorization procedure are otherwise fundamentally similar to DAK: Maaseutuvirasto, the Agency for Rural Affairs in Finland (‘the Agency’), published a contract notice and launched a tender to conclude contracts for advisory services. The attached draft framework agreement specified the conditions for service provision. The advisory services were offered to farmers who have entered into an agreement, and these individual farmers are free to contact a contracted advisor of their choice. Applicants who wished to be admitted under this scheme were to demonstrate that they were qualified. Again, in *Tirkkonen*, the CJEU ruled that the contracting authority does not make a selection among economic operators (Tirkkonen, par. 33). The CJEU concluded, in line with the *Falk* judgment, ‘*in the present case, the decisive factor is that the contracting authority has not referred to any award criteria for the purpose of comparing and classifying admissible tenders. In the absence of that factor (...), a farm advisory*

*scheme, (...), cannot constitute a public contract within the meaning of Article 1(2) (a) of Directive 2004/18'* (Tirkkonen, par. 35). In light of the foregoing, in absence of this decisive factor of making a comparison between the economic operators and consequent exclusive award of public contracts, the award of contracts is not subject to the EU Directive on public procurement. However, contracting authorities remain bound by the TEU and TFEU, and must respect the principles of the Treaty (as it is stressed in Directive 2004/18 recital 2) when concluding contracts under the described open contract scheme (open house model). In addition, Dutch municipalities contracting services in an open house model are still bound by the general principles of good administration (*de algemene beginselen van behoorlijk bestuur*) as interpreted in national courts. Nevertheless, the question by which national rules and principles contracting authorities are bound when awarding a contract under the open contract scheme is not included in the scope of this research. See for more information Bouwman (2016).

While both *Falk* and *Tirkkonen* are recent cases, Chapters 6 and 7 will demonstrate how these cases have already had an impact on Dutch municipal procurement practices. In the final paragraph of this chapter I briefly discuss very recent Dutch administrative case law that I expect to have an even stronger impact on municipal procurement practices for social care contracts.

### **3.7 Dutch administrative case law: new tensions for the commissioning of social care services**

This section discusses recent case law arising from the application of the Dutch General Administrative Law Act (*Algemene wet bestuursrecht* (Awb)). At first sight, this does not seem to fit the scope of the chapter, which focuses on the public procurement rules that bind municipalities when outsourcing social care services. However, recent cases from the Central Appeals Court for Public Service and Social Security Matters (*Centrale Raad van Beroep*; hereafter CRvB), the highest Dutch appeals court for public service and social security matters, have such an impact on the public procurement of social care services that I choose to briefly discuss these cases here. They concern municipalities that have contracted social care services according to an outcome-based contract, specifying the care services that are no longer under a fee-for-service reimbursement (paying for the delivered hours of, for example, household assistance), but are 'paying for outcomes'. In general procurement terminology, paying for outcomes is known as performance based

contracting (*prestatie-inkoop* or *prestatie-contracten*; hereafter PBC). PBC is also closely related to functional specifications (*functioneel specificeren*) as opposed to technical specifications. PBC can assist with the efficient utilization of public resources (Ambaw & Telgen, 2017). Functional requirements are known to foster innovation, and '*should be used as widely as possible*' (Directive 2014/24/EU, recital 74). For social care services, specifying the outcome rather than the 'inputs' (hours of social care) enables care providers to find new, innovative ways to achieve the desired outcomes (Robbe, Telgen, & Uenk, 2016). See Chapter 9 for a more elaborate discussion on different payment structures, such as outcome-based reimbursement.

When a municipality concludes an outcome-based contract for social care, the municipality buys the desired end-results rather than hours of care services. For example, Dutch municipalities use outcome-based contracts for household support services, where the desired end-results are defined as 'a clean and livable house', usually further detailed in relation to different areas and aspects of the house. Clearly, the EU Directive on public procurement supports the use of functional and performance requirements (see recital 74 cited above). Although the Wmo 2015 does not prescribe any kind of reimbursement method when municipalities outsource social care, it does in fact require municipalities to agree on outcome (performance) criteria with care providers (Wmo 2015 Art. 2.1.2 section 6 and Art. 2.5.3).

However, two cases from the CRvB, case relate to the use of functional requirements and outcome-based contracts for social care services: (CRvB, 18 May 2016, 14/6239, municipality of Rotterdam, henceforth *case Rotterdam*) and (CRvB, 8 October 2018, 18/4138 WMO15-VV, 18/3980 WMO15, municipality of Steenbergen, henceforth *case Steenbergen*). The cases of *Rotterdam* and *Steenbergen* address the manner in which municipalities formally decide on, and document, a client's entitlement to social care services. To evaluate these cases, I discuss input-based versus outcome-based care entitlement decisions.

The idea of using functional specifications in contracts is to allow care providers room for innovative approaches to provide social care services. Both the contract between the municipality and care provider and the formal decision from the municipality to the client must be outcome-based, and defined in terms of end-results in order for the incentive and room for manoeuvre for innovation to occur. Traditional municipal decisions on social care were input-based, which means they

described the amount of hours of social care to which a client was entitled. In contrast, an outcome-based formal municipal decision on social care for a client does not clarify to the client how many hours of social care services that client is entitled to. Rather, the decision specifies the end-results that must be achieved, e.g. 'a clean and livable house'. This may cause a problem for the client: the specification of the desired (and contracted) outcomes may be incomplete and lack sufficient details. Consequently, the client does not know whether the social care services in the municipal decision are sufficient and adequate. The client is furthermore at risk, because the care provider might not be providing sufficient and adequate services. For example, what exactly constitutes 'clean and livable'? A particular problem arises with outcome-based decisions: in general, it does not make sense to appeal a decision that entitles a client to a 'clean and livable house', because there is nothing wrong per se with that. However, the current Awb does not provide for legal protection within administrative law that includes the external (usually private) care provider that provides care service to a client who submits a complaint.

This problem lies at the heart of both cases. In the *Rotterdam* case, the CRvB ruled that neither the municipal policy rules (*beleidsregels*) nor the formal care entitlement decision (*toekenningsbesluit*) provide sufficient insight for the client to identify *how* the indicated end-results ('a clean and livable house and clean and wearable clothes') will be achieved. '(...) *The client is not sufficiently informed exactly what care services will be offered (...)*' (*Rotterdam*, par. 4.6). The CRvB ruled that the client is entitled to know in sufficient detail what care services will be offered, and declared the Rotterdam system invalid. In the *Rotterdam* case the CRvB did not explicitly demand that the entitlement decision specifies the number of hours of social care services; one interpretation was that the outcome-based decision simply had to be much more concrete and detailed. However, this interpretation was dismissed in the 2018 *Steenbergen* case. The municipality of Steenbergen included in its formal entitlement decision of household support services a very detailed overview of activities and end-results, including an attached plan that specified the cleaning activities required in each area of the house, the frequency of these activities, and by whom they will be executed. Despite this degree of detail, the CRvB ruled that '*in fact the client (...)* does not know how many hours of support he can count on' (*Steenbergen*, par. 4.11), and that '*there is no insight (...)* how many time is necessary to achieve a clean and livable house. (...) *This means the municipality has not provided insight that (...)* a clean and livable house can be achieved (...)' (*Steenbergen*, par 4.12).

The consequence of these cases seems to be that municipalities are required to include a specification of the social care services in terms of *input* (hours or other time-units), and that outcome-based entitlement decisions are prohibited. When a client's entitlement decision specifies the number of hours of social care services, consequently there is no added value in using an outcome-based contract in outsourced social services. The benefit of outcome-based contracts is to allow an extended scope of actions for a care provider, and input-based entitlement-decisions eliminate this extended scope.

Note that some of the details in the two cases have been left out in this discussion, since a detailed discussion of these cases is outside the scope of this research.

In later chapters in this thesis I make a case for using outcome-based contracting to achieve the goals of the decentralizations in the Netherlands, and I evidence that outcome-based contracting has in fact been introduced by many municipalities since 2015 in the procurement of social care services. Therefore, in my opinion these CRvB rulings create tension between the goals of the Wmo 2015, as these rulings seriously affect the municipal discretion to organize social care services efficiently and effectively, and will negatively impact the potential to innovate in the provision of social care services in the Netherlands. If there is no intervention from the Dutch legislator on this matter, it is highly likely that municipal outcome-based contracting of social care services will disappear altogether.

### 3.8 Conclusion

Municipalities have a wide room for manoeuvre when it comes to the public procurement of social services. Social services have a special position in the EU public procurement Directive, which is discussed in Section 3.2. A standing procurement practice for social care services in the Netherlands is to use an open contracting scheme. CJEU case law that deals with schemes that closely resemble such open schemes seems to provide new legal grounds, although a 'scope creep' lures with regards to defining a system as an open house model. When a municipality defines a contracting scheme as 'open house model' while implicitly or explicitly raking and selecting care providers to conclude contracts with, of course this system does may not actually meet the criteria of an open house system.

Finally, I have pointed out that it is not EU public procurement law, but rather Dutch

administrative law that at this stage seems to be the most restrictive towards Dutch municipalities – at least to those municipalities that aim to achieve, in part, the goals of transforming social care services through the use of functional requirements and outcome-based contracting.





# Part II

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## Dutch municipal procurement practice – an inventarization

Public authorities responsible for the arrangement of social care services face a number of choices when aiming for availability of high quality social care at acceptable costs. A fundamental choice regards whether to in- or outsource: does the public authority provide these services in-house or outsource them to external organizations. There is no EU regulation with respect to this ‘make-or-buy’ decision, meaning EU member states have discretion to decide on self-provision or outsourcing (Janssen, 2018). Many countries have moved – or are moving – towards at least partially outsourcing social care services to external organizations (Bergman et al., 2018; Taponen, 2017; Wysocki et al., 2015). This introduces the possibility for citizens to choose a care provider rather than the compulsory use of government-provided care.

Public authorities that opt for outsourcing social care services must also make choices with respect to the public *contract* with care providers and the public procurement procedure used to award the contract(s) to care providers. Public authorities also enjoy ample discretion in these choices. The following chapters discuss the choices with respect to public procurement procedures. I first present a framework for studying public procurement procedures for social (care) services before presenting the findings of an extensive longitudinal study on Dutch municipal social care procurement, focusing on the procurement procedures applied.



# Chapter 4

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**Commissioning models for public procurement  
of social care services**

## 4.1 Introduction: towards a granular overview of outsourcing approaches

A fundamental question that continually occupies governments is how best to coordinate public services in general and social services specifically. The first fundamental decision for public authorities to make, is whether to organize public (social) services in-house, or whether to outsource these services: contracting care providers for the provision of certain public (social care) services. In searching for a more efficient and innovative provision of social services and accommodating the desire for freedom of choice in care providers, public authorities often opt to outsource public services. By introducing competition the public authorities aim for the competitive forces to encourage quality while driving down costs (Randall & Williams, 2009). This transition fits the New Public Management (NPM) paradigm in which 'contract based competitive provision' is considered a mechanism superior to in-house provision ('bureaucracy') for organizing the delivery of public services (Hood, 1995). Competition lies at the center of debating the merits of privatization (S. Lamothe, 2015), where privatization concerns outsourcing services that were previously provided for in-house. There is, however, a debate over the extent to which these competitive market forces are present in public – and especially social – services. The move to externalization of public services has faced many critiques; for instance, some consider markets for public services in general inappropriate and even counter-productive (J. Stewart & Walsh, 1992). This argument is made even more strongly for social services, which generally concern vulnerable users and ambiguous outcomes (Wistow & Hardy, 1999). Acknowledging these critiques, others still maintain the position that the market has a major potential role in supplementing – or even sometimes replacing – the role of public sector's in-house provision of such services (Bovaird, 2006; Savas, 2002). An interesting observation at this point is that the focus in the debate on competition is on 'ex ante' competition: competition over a contract in the form of competitive procurement procedures with one or a few care providers 'winning' a contract, where price is one of the award criteria.

It is important to highlight two issues here. First, when a government opts for a competitive procurement procedure for contracting social care services, more than just one 'modus' of ex ante competition is available. A competitive procurement procedure may result in the award of one contract to the care provider with the best proposal, or in the award of multiple contracts to the best rated care providers. The more contracts awarded in parallel, the weaker the emphasis on ex ante

competition. Second, *ex ante* competitive tendering is not the only way to introduce competition – in framework agreements and open house systems (as introduced earlier in the Terminology section and Chapter 3) the ‘competitive arena’ is moved to the phase that occurs after contract closure. The element of competition may then impact service quality. Price is not – or to a lesser extent – at play in this competitive mechanism. Individual clients choose their care provider, and a client that is not satisfied with its current care provider may also switch to a different one. For ‘*ex post*’ competition a market should of course remain, in effect comprised of multiple competing organizations that may provide services.

Although markets for social services are often considered weak (S. Lamothe, 2015) – for example demonstrated by the relatively low number of bidders counted on social service tenders – the involvement of the market seems to have gained more traction compared to those arguing for continued or reinstated in-house provision. The debate amongst scholars has moved away from the question on *whether* social services should be outsourced, towards the question on *which* outsourcing relationships best serve public goals. Therefore, the more prominent question is *how* to contract for public – and specifically social care – services. Buyer-supplier relationships may be prone to supplier opportunism as a consequence of moral hazard and information asymmetry (Eisenhardt, 1989). Having a collaborative buyer-supplier relationship, rather than an adversarial relationship, is known to reduce supplier opportunism (Li & Choi, 2009; Nätti, Pekkarinen, Hartikka, & Holappa, 2014). It is increasingly recognized that these buyer-supplier (market) relationships are socially constructed through the procurement process, and they are not simply a product of market conditions (Bovaird, 2006). Indeed, traditional, bureaucratic arms-length competitive tendering has long been known to hinder the development of collaborative relationships and trust (Steane & Walker, 2000). While trust takes time to grow between the government and its suppliers, governments cannot guarantee long-term relationships, and in a next competitive tender a new supplier may win the contract, leaving the government to incur ‘trust costs’ (Boyne, 1998). Governments often adopt an administrative approach with extensively detailed specifications and the use of penalties for the supplier, which according to Davis & Walker (1997) are contract features commonly found in a ‘low trust world’. Here an interesting paradox arises: while the merits of outsourcing, as opposed to in-house provision, pivot around *ex ante* (price) competition, competitive tendering is associated with adversarial buyer-supplier relationships, exacerbating the disadvantages of outsourcing.

Considering the involvement of the market is gaining popularity in general, and specifically in the Netherlands social care services are in fact completely outsourced by municipalities to external care providers, the focus in this and the following chapters is on the outsourced provision of social care services. This chapter also acknowledges that there is not one method of outsourcing (or 'commissioning') social care services. In fact, both in terms of competitive and relational mechanisms, municipalities may *commission* social care services in very different ways. In this research I use the term commissioning to cover the more fundamental strategic outsourcing decisions. Commissioning services entails making fundamental choices in the coordination and organization of outsourced services. These include, for instance, choices with respect to the scope of outsourced contracts, how risks are divided between a public buyer and supplier, the legal instrument used for outsourcing, the number of care providers to contract, and which incentives to use in the contract. Only after such commissioning choices are made can a public buyer proceed to draft the public procurement procedure, which I consider to be the more administrative aspect of commissioning. This positioning of commissioning is in line with others who define commissioning as the more strategic aspect of outsourcing compared to procurement or purchasing (see for example Murray (2009) in this respect). Commissioning in this sense is also often referred to as strategic purchasing (Klasa et al., 2018). Similar to Murray (2009) I refer to commissioning as a process or activity (i.e. the municipality commissions social care services), whereby commissioning entails *both* making the more fundamental (strategic) choices discussed above, as well as the consequent more administrative process of procurement (or purchasing). This chapter extensively discusses *commissioning models*: the emphasis in these models is on the combination of strategic choices with respect to outsourcing (i.e. aspects mentioned above such as contract scope, implicit or explicit risk allocation, incentives for care providers) and not so much on the procurement process of concluding contracts.

It is the purpose of this chapter to consider the different ways in which municipalities commission social care services. With 393 Dutch municipalities each commissioning social care services at the same time, there is the risk of discussing 393 different commissioning models, as each is slightly different. However, there is no purpose in describing different commissioning approaches that are fundamentally similar yet different in unimportant details. There is purpose, however, in discussing models for commissioning social care services that differ in the fundamental mechanisms of market coordination and provision of social care services.

This leads to the following research questions:

1. Which different models of commissioning social care services can be distinguished in Dutch municipal social care service outsourcing?
2. What are the fundamental elements of each commissioning model, and how are they used in each of these models?
3. What are the theoretical advantages and risks of each of the models in light of relevant extant literature?

The remainder of this chapter is structured as follows: the next section (4.2) discusses the relevant literature on coordination (make-or-buy) of social care services, agency theory, and service triad theory. Section 4.3 consequently discusses four different models of commissioning social care services. I briefly describe each model in general and discuss in more detail the position of contracts within each model. I also discuss these models in the context of relevant academic literature, which for some required inductive reasoning to substantiate expected advantages and disadvantages of each model. Finally, section 4.4 provides a brief discussion on the findings of this chapter.

## 4.2 Scientific debate on insourcing versus outsourcing social care

The question on how best to coordinate the provision of public services in general, and public social services specifically, has been a topic of scholarly interest for decades, which can be traced back to organizational theory. Ouchi (1980) takes a transaction cost approach, and proposes the best coordination mechanism for organizations in general depends on transaction costs arising from goal incongruence and task ambiguity. Ouchi considers markets (outsourcing) the best coordination mechanism when goal incongruence is high and performance ambiguity is low. Bureaucracy (in-house provision) is preferred when both goal incongruence and performance ambiguity are moderately high. Clans – an organic association resembling a kin network that relies on socialization as coordinating mechanism – is deemed appropriate where there is low goal incongruence and high performance ambiguity (Ouchi, 1980). Note that in this research I use ‘outsourcing’ and ‘market provision’ interchangeably, where the *market* may constitute both public and private external organizations (care providers). In this section and those that follow I use market provision when it better represents or paraphrases the cited literature.

For public organizations responsible for public services the coordination question can typically be reduced to two options: in-house provision or involvement of the market, i.e. outsourcing to external organizations. Long have governments relied on in-house provision of public (social) services, although this practice started to turn when public authorities decided to search for more cost efficiency and innovation in service provision. The traditions and labor practice within the bureaucracies are generally considered barriers to new services and innovation (Maddock & Morgan, 1998), which finds support in economic theory as the state basically operates a monopoly when opting solely for in-house provision. An additional argument with respect to the provision of social services is the lack of provider choice in a state monopoly, which in addition to competition is deemed important for good performance (Savas, 2002). Aiming for more cost-effective provision, many public organizations in the eighties opened up the market for public service provision; by 1990 contracting for public services was considered a common prescription to improve government efficiency (Dehoog, 1990).

#### **4.2.1 New Public Management, managerialism, privatization, and its critique**

This externalization movement was encouraged by the NPM paradigm making its introduction, which a number of OECD countries moved towards over the course of the 1980s (Hood, 1995). In NPM literature it is assumed that contract-based competitive provision is a superior mechanism to in-house provision for organizing the delivery of public services (Hood, 1995). It therefore comes as no surprise that the privatization movement gained traction among public authorities in the 1980s and 1990s. In the area of health care procurement, this movement occurred in a number of countries including the United States of America, the United Kingdom, Canada, and New Zealand under the flag of ‘managed competition’ (M. Lamothe & Lamothe, 2009; Light, 2001; Randall & Williams, 2009). Alain Enthoven, the founder of managed competition, describes the system as a ‘purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles’ (Enthoven, 1993). Managed competition involves structuring and adjusting the market to overcome attempts by insurers to avoid price competition. While managed competition is purely focused on health care services, the general outsourcing paradigms put competition at the center of debating the merits of privatization and market provision (S. Lamothe, 2015). However, together with its growing popularity the critique surrounding the privat-

ization movement also grew – and sustained. Some scholars argue that outsourcing is inappropriate in the context of public services, and that market provision may even be counter-productive (J. Stewart & Walsh, 1992). This critique is especially visible when dealing with provision of social services. Some argue that social care – differing from other goods and services – is an inappropriate context in which to introduce market relationships, as users are vulnerable and outcomes are difficult to define or measure (Wistow & Hardy, 1999). Others argue that markets for social services tend to be weak in terms of competition, e.g. Girth, Hefetz, Johnston, & Warner (2012) and Lamothe (2015). This latter argument of course depends on the specific social services under consideration and the time that has been granted to a market to develop itself. It could be argued that the problems associated with contracting social services are short-term and transitional, and more a symptom of early development of markets and the inexperience of (purchasing) practitioners (Kirkpatrick, Kitchener, & Whipp, 2001). Other studies simply quantitatively demonstrate that there is in fact a market for social services through the analysis of market response to contract publications (in effect the number of proposals received per tender, (Savas, 2002)), from analysis of the Herfindahl index of market concentration in social care markets (Eijkel, Kattenberg, & Torre, 2018) or through empirically studying the effects of contracting social care services (Bergman et al., 2016). Interestingly, research on competition and its expected or observed merits focuses almost exclusively on ‘ex ante’ competition over contracts, and even more specifically on *price* competition. While this is a common and traditional explanation of competition, I argue it is too narrow because it overlooks the potential mechanism of ex post competition – competition over individual clients in a framework agreement or open contracting scheme, such as an open house model. While ex post competition does not directly result in lower prices, it may induce high quality of services and stimulate innovation.

#### **4.2.2 Different approaches for outsourcing social care: commissioning models**

The debate amongst scholars on in-house provision versus outsourcing social care services is ongoing. For instance, a recent study has found competition, while deemed weak in social service markets, is even overestimated (S. Lamothe, 2015). In contrast, Bergman, Jordahl, and Lundberg (2018) find that the introduction of free choice and free entry in home care has increased perceived quality without affecting cost, as a result of new choice opportunities. Despite this ongoing lack of

consensus among scholars, public authorities demonstrate far less ambiguity with respect to in-house or market provision of social services. In practice, at least the partial introduction of market provision by public authorities continues to thrive, while at the same time a movement of insourcing social services by public authorities has not been observed. As Bovaird (2006) summarizes on public services in general: ‘in spite of many critiques of the move to externalization of services, by the late 1990s there was a much greater understanding than ever before that the market had a major potential role in supplementing – even sometimes replacing – the role of public sector in-house provision’ for public services. The more prominent question now seems concern how to contract public (social) services, and which market (i.e. public authority-care provider) relations best serve the public interest.

The question ‘how to contract’ social care services is considerably broad. Contracting social care services consists of many aspects that range from fundamental choices (which services to outsource or provide for in-house, what type of contract to use, and how selective should the procurement be) to choices concerning the details of contracting care providers. Consecutive chapters in this thesis discuss in detail the municipal approaches with respect to aspects such as the public procurement procedure used for contracting social care services, reimbursement methods used in social care service contracts, and other management mechanisms that municipalities use for social care service procurement. The most fundamental choices, defined here together as the *commissioning model* (see Section 4.1), underlie these other aspects. In this research a commissioning model comprises of a combination of choices that determine the responsibilities, incentives, opportunities, and risks for contracted care providers in the provision of social care services. Each model can be expected to have its own impact on the quality and cost efficiency of social care services in the long run. Since municipalities are the only commissioners for the types of social care services included under the scope of the Wmo 2015, the municipal choice for a commissioning model also impacts the local market structure of social care service providers.

The commissioning model encompasses the division of activities and responsibilities concerning social support for citizens between municipalities and external care providers. It defines the scope of individual care provider contracts, the resulting competitive mechanisms in the provision of social care services, and the dynamics in the municipality-client-care provider service triad. I discuss the implications of these social care commissioning models from the perspectives of agency theory and the specific dynamics of service triads. I furthermore present scientific

literature that discusses each observed commissioning model. As extant literature on specific commissioning models is scarce, I also refer to relevant government commissioned reports and working papers from scholars or research institutes.

### **4.2.3 An agency theory perspective on outsourcing social care in service triads: avoiding bridge transfer**

Service buying is associated with problems in efficiently organizing sourcing transactions and relations (Van Der Valk & Van Iwaarden, 2011). Managing the quality of procured services and the contractors that deliver those services are amongst the issues highlighted in existing literature (Axelsson & Wynstra, 2002). Problems associated with service procurement are exacerbated in service triads where the buyer contracts a supplier to deliver services directly to the buyer's end-customer. The quality of the care services depends on the performance of the service supplier, yet the buyer in a service triad does not experience service quality first hand. The buyer in a service triad needs to take measures in order to ensure the services delivered and behaviour of the supplier are appropriate (Van Der Valk & Van Iwaarden, 2011). Furthermore, where interactions between end-customers and buyers in service triads are minimal in frequency and intensity, acknowledging end-customer needs and satisfaction becomes difficult for the buyer. These problems are also prevalent in social care service triads where a municipality commissions social care services by contracting care providers to provide social care to their citizens.

Agency theory provides the basis for building a deeper understanding of these problems and appropriate ways of dealing with them in terms of contractual arrangements. The following overview is based entirely on the seminal work of Eisenhardt (1989). Agency theory is concerned with resolving two problems that can occur in agency relationships (for example a buyer-supplier relationship). The first is the agency problem that arises when (a) the desires or goals of the principal and agent conflict, and (b) it is difficult or expensive for the principal to verify what the agent is actually doing. The problem here is that the principal cannot verify that the agent has behaved appropriately. The second is the problem of risk sharing that arises when the principal and agent have different attitudes toward risk. The problem here is that the principal and the agent may then prefer different actions due to their different risk preferences. Underlying agency theory are specific assumptions about human nature (self-interest, bounded rationality, and risk aversion), infor-

mation (considered a commodity that can be purchased), and organizations (goal conflict among members) (Eisenhardt, 1989). Agency theory thus hypothesizes the appropriate use of different types of contracts and monitoring practices under different circumstances. For example, using outcome-based contracts increases the likelihood of the agent behaving in the interest of the principal; however, outcome-based contracts are not appropriate in situations with high outcome uncertainty or where outcomes cannot be (efficiently) measured. Eisenhardt discusses ten different of such testable propositions (Eisenhardt, 1989).

#### *4.2.3.1 Bridges, structural holes, bridge decay and bridge transfer*

The literature on service triads often takes an agency theory perspective, translating original propositions to a specific service triad context. For example, a service triad with two departments within the buying firm, which contracts a supplier of marketing services (Tate et al., 2010). This discussion on commissioning models in social care procurement demands the careful consideration of the seminal paper of Li & Choi (2009). This paper initially introduced the notion of service triads as an object of study and in particular addressed the dynamic nature of the relations between the three actors in a service triad. In a service triad outsourcing context, the buyer starts of in a bridge position, in effect connecting the other two actors in the triad. In this initial stage as defined by Li & Choi (2009), there is not yet a relationship between the service supplier and end-customer; a situation referred to as a 'structural hole' (Burt, 1992). The bridge position brings information and power advantages. However, the buyer in a service triad will, by nature, not remain in the bridge position. When the service supplier commences service provision to the end-customer, this fills the structural hole; a process Li & Choi define as 'bridge decay' (Li & Choi, 2009). Bridge decay reduces the benefits for the actor in the bridge position, which at the early stage is typically the buyer. Bridge decay itself cannot be prevented in a service triad. However, if the buyer does not act, the bridge position may actually *transfer* to the service supplier, reaching the stage of bridge transfer. In this stage the supplier now benefits from the advantages of being in the bridge position, potentially at the cost of the buyer. For example, a supplier may act opportunistically at the cost of the buyer, taking advantage of the information-asymmetry. The buyer should therefore prevent bridge transfer by maintaining a connection with the end-customer; maintaining a permanent stage of bridge decay (Li & Choi, 2009).

#### *4.2.3.2 Agency Theory, bridges, and structural holes in commissioning of social care services*

The above discussion of agency theory and the dynamics of service triad structures have used generic terms from purchasing and supply literature (i.e. buyer, supplier, end-customer). In the context of social care service triads, the municipality is the buyer, the care provider is the (service) supplier, and clients entitled to formal social care services are the end-customers. There is goal incongruence between municipalities and care providers; while there are certain common goals such as the establishment of a strong social support network for citizens, (especially) the financial aims of municipality and external care providers are opposing. Certainly, municipalities that contract external care providers for provision of social care services will experience bridge decay – and possibly bridge transfer – after contracting social care services. Once a care provider starts provision of care services for an individual client, the care provider has regular, intensive periods of contact with the client while the municipality is out of the client’s sight. If the municipality fails to maintain a connection to the client (through monitoring client satisfaction) and fails to somehow monitor care provider performance, higher risks of care provider opportunistic behavior can be expected. In short, these theories are applicable to the context of this research, and it is relevant to verify, through inductive reasoning, how municipalities may face the consequences of goal incongruence, care provider opportunism, or otherwise undesirable behavior from care providers in different commissioning models.

### **4.3 Commissioning models for social care services**

The subsequent sections describe each of the commissioning models encountered in Dutch municipal social care procurement in the advent of the 2015 reform of social care services in the Netherlands. While this research is the first to comprehensively describe these models, their identification and categorization builds on years of collaborative efforts from myself and Jan Telgen, which has resulted in short publications in popular Dutch journals: Telgen, Uenk, & Lohmann (2014), and Uenk (2016), and the subsequent use of the models in government-commissioned report: Heuzels, Uenk, & Kanne (2016). Each model is primarily described on the basis of my own empirical observations, which are then supplemented with general discussions of the model in literature where available.

### 4.3.1 The 'AWBZ-model': maintaining the status quo

The AWBZ-model is named after the AWBZ Act (*Algemene Wet Bijzondere Ziektekosten*, or General Act on Special Health Care Costs), which until 2015 regulated social care services in the Netherlands (Chapter 2 discusses the AWBZ and the manner in which social care services were commissioned until the end of 2014). The AWBZ-model closely resembles the former approach to contracting social care services. In the AWBZ-model the municipality contracts a limited number of care providers and establishes with each care provider an annual fixed budget. In the AWBZ-model, municipalities typically only contract the incumbent care providers, although this is not a necessity. Municipalities typically use a negotiated procedure without prior publication and invite only the incumbent care providers for contract negotiations. Alternatively, municipalities can launch an invited competitive procedure in which only proposals from the invited care providers are permitted. While care providers that participate in the procurement procedure may be required to submit a proposal specifying quality and prices for different social care services, there is no actual competition over contracts; each of the invited (usually incumbent) care providers is contracted.

#### 4.3.1.1 Fixed budget contracts

The AWBZ-model is characterized by the use of contracts with annual budget allocations. As described above, the municipality contracts a limited number of care providers and agrees upon an annual budget with each one. Care providers need to account for the use of the budget. Therefore the contract specifies a range of different care services that vary in the nature of the service itself, the nature and severity of the client's needs, the nature of the client's handicap (e.g. somatic, psychogeriatric, et cetera), and possible additional requirements such as permanent stand-by or on-call duty. While the former AWBZ system had over two hundred different social care services (referred to as 'NZa-codes' after the *Nederlandse Zorgautoriteit*, the Dutch Care authority that defined and managed this set of social care services), the municipalities adopting the AWBZ-model typically contract significantly less; up to fifty services. The other services are not included in the scope of the Wmo 2015 or were rarely used. For each of these services the municipality agrees with each of the care providers upon a tariff on a fee-for-service reimbursement basis. The tariffs are negotiated in the procurement procedure or follow from the formal care provider proposal.

Care providers account for the spending of their budget by invoicing municipalities

the amount of services provided to clients against their associated agreed tariff. The clients' care entitlements determine the services that the care provider should provide on a weekly basis. The care entitlement decision of a client in the AWBZ-model is specified in terms of time unit inputs per week; for example, a client is entitled to four hours of specialized personal assistance for people with psychogeriatric impediments. Under a fee-for-service reimbursement of social care services, the fixed budget contract is actually an annual maximum production agreement; the care provider can provide social care services up to the agreed budget.

As the decentralization of social care also brought strong budget cuts, municipalities could not completely mirror the 2014 contracts of incumbent care providers with the exact same conditions. To reduce social care expenditure, municipalities generally aimed to lower the service tariffs and reduce budgets as compared to the 2014 contracts.

#### *4.3.1.2 Reform in copy-paste style: easy, but missing opportunities*

Compared to other models, the AWBZ-model for contracting municipal social care has several advantages for municipalities. First, the model is a continuation of existing policy and practice, and for clients already receiving social care little or nothing changes. Clients can keep their current care provider – and more importantly their current caregiver(s) – and the exact same care service entitlement. Such continuity of care is generally considered an important quality across different types of health care, such as primary care and mental health care, although continuity may have different definitions in different types of care (Adeoye, Brutus, & Sarfraz, 2014). Continuity of care has several dimensions: informational, management, and relational continuity (Haggerty et al., 2003). In social care, the relational continuity in particular is emphasized as clients build up a relationship of trust with their caregiver. Maintaining the same caregiver minimizes tension and anxiety that existing clients may feel with the approach of the social care reform. This relational continuity may be lost when incumbent care providers are not contracted as a consequence of system reform and the municipal choice for commissioning model. For many municipalities, continuity of care was one of the motives for their choice of commissioning model, which is either the AWBZ-model or other models in which each of the incumbent care providers is contracted.

The AWBZ-model is also an easy model for municipalities to adopt, as the municipality can simply copy the existing contracts and the procurement approach formerly used under the AWBZ regime. Finally, establishing budgets with the care

providers should ensure firm expenditure control for the municipality, although I will revisit this theoretical advantage to argue how this may work out differently in practice.

There are also, however, serious drawbacks with the AWBZ-model. First of all, fee-for-service reimbursement of social and health care services is associated with a perverse incentive to over-produce care services. Fee-for-service reimbursement rewards volume (Miller, 2009), and it is now widely recognized as perhaps the single biggest obstacle to improving health care delivery (Porter & Kaplan, 2016). Incentives for efficient, effective, and innovative provision of care services are lacking in fee-for-service reimbursement. The fee-for-service reimbursement facilitates supplier induced demand (SID): the overconsumption of medical services that is generated by the economic interests of providers (Sørensen & Grytten, 1999). The fact that SID is not just a theoretical supply-concept is evidenced by van Noort, Schotanus, van de Klundert and Telgen (2017), who demonstrate how supply factors explain 17 to 23 percent of variation in the number of home care clients per inhabitant in the Netherlands. Higher competition levels and the availability of complementary services predict higher utilization of home care. The budget allocation should in theory limit the extent of supplier induced demand; however, if budgets are too tight, care providers often respond by maintaining a waiting list for care services. Waiting lists for social care services are considered undesirable – under the AWBZ even considered illegal (Schut & van den Berg, 2010) – as it means people in need cannot access social care and support in a timely manner. Waiting lists therefore become a means for care providers to put pressure on municipalities (local politicians) to provide for additional budget. Furthermore, maintaining the former AWBZ approach to commissioning social care services while the goals of the reform are to promote more tailored care, better integration of different types of social care services, and reduce expenditure does not seem a sensible approach for the long term.

### **4.3.2 All eggs in one basket: population-based commissioning**

In the model of population-based commissioning, a municipality contracts one main contractor per district of the municipality for certain types of social care. A more generalized version of this commissioning model for health and social care is discussed in literature as the ‘prime contractor’, ‘prime provider’, or ‘lead provider’ model: Billings & De Weger (2015), and various government commissioned

reports and working papers: see for example O'Flynn et al. (2014) and Addicott (2014). The number of districts – and therefore the number of distinct main contractors – varies between one and four in the municipalities that apply this model in the context of social care in the Netherlands. A 'one-district' municipality thus contracts one care provider for certain types of social care for the entire municipal population. This main contractor is responsible for all social care service provisions of the agreed upon type within its district. In this model, the municipality relies on the services of one organization – in a proverbial sense, 'putting all eggs in one basket'. Given the procurement approach utilized until 2014, reflected in the AWBZ-model, the market of social care services is generally far less concentrated at the moment a municipality introduces population-based commissioning. Throughout 2014 there were no regions or municipalities with external care providers with sufficient capacity to independently provide all social care services for entire districts or municipalities. As a consequence, organizational and market adjustment is necessary, which may take shape in different ways:

1. The main contractor is in an alliance or other type of formal collaboration between several existing (usually incumbent) social care providers;
2. The main contractor takes over the personnel of other social care providers who therefore disappear from the local market;
3. The main contractor sub-contracts other care providers to meet the required capacity and quality criteria; or
4. A combination of these.

#### *4.3.2.1 Lump sum budget contracts*

The main contractor is financed through condition-adjusted capitation (Miller, 2009): the care provider receives one lump sum budget per annum that is based on characteristics of the population for which the care provider is responsible. While the budget may be determined by estimating the expected number of clients within the population and their cumulative social care service demand, payment does not depend on actual delivery of social care as is the case with fee-for-service reimbursement. Rather, the contract between the municipality and the main contracted care provider specifies quality criteria, procedures, protocols, and desired performance outcomes. Municipalities use performance outcomes related to social care provision such as the minimum level of client satisfaction, average time between intake and start of social care service provision, and the absence of waiting lists. Outcomes relating to aspects other than client service provision may also be specified, for example a sufficient level of sub-contractor satisfaction (where the main

contractor works with sub-contractors).

#### *4.3.2.2 Integrated contracts: coordination and provision of care*

Within the population-based commissioning model there is variation in the scope of contracts. I distinguish between variation in *horizontal* and *vertical* scope of the contract. Horizontal scope variation refers to the different types of social care services included in the scope of the contract for the main contractor. The main contractor may be responsible only for one type of care (for example home care, ambulatory personal assistance, or day care services), and the municipality may have a main contractor for each type of social service. More often, the contract is more *horizontally integrated* to some extent and includes different types of social care services such as all ambulatory adult care (household assistance, personal assistance), adult day care, and respite care. Horizontally integrated contracts may even include adult social care services, youth care services, debt relief services, and other municipal public services that relate to social care.

Vertical integration refers to the integration of additional responsibilities and activities other than the provision of social care services. One common additional responsibility is the provision of services for which no formal municipal care entitlement is required: these types of services are less specialized and openly accessible to municipal citizens. Municipalities organize these generic provisions as an easily accessible service, expecting also a preventive effect on more specialized expensive types of care. The contract for main contractors may be vertically integrated with these generic provisions. Another important additional responsibility that can be vertically integrated in population-based commissioning contracts is the organization of the 'gateway' function to social care. Rather than having a separate municipal – or third party – organization assess citizens' entitlements to social care, this function can be included in the scope of the main contractor's contract. The main contractor is then responsible for scrutinizing citizens who request social care and organizing access to, as well as provision of, individual social care services to municipal citizens. Both horizontal and vertical integration have theoretical advantages and drawbacks, which is discussed in the next paragraph.

#### *4.3.2.3 Creating a local monopolist: opportunities for innovation as well as opportunism*

Advantages of the population-based commissioning model center around the opportunities for integrated (holistic) social care provision, cost control, reduced coordination efforts for the commissioner, and incentives for prevention rather than

medicalization – see for example Billings and de Weger (2015), who describe this model more generally as the ‘prime contractor’ or ‘prime provider’ model. The scope of the contract in a population-based commissioning approach allows the main contractor to coordinate different types of social care services that may be necessary for one client or for different members in one family. While the main contractor may still need to involve other care providers based on their capacity and specialization, here it is the care provider acting as the main contractor that coordinates the necessary care services for the client or family, rather than the municipality or a third party, such as the welfare organization contracted for ‘case management’ in other municipalities. While in the AWBZ-model existing clients benefit from the relational continuity of care (not being forced to switch care providers), this coordination argument for a population-based commissioning model translates to ‘management continuity’. Management continuity is the consistent and coherent approach to the management of a health condition that is responsive to a patient’s changing needs (Haggerty et al., 2003). Proponents of this model argue that the main contractor is in a better position to achieve collaboration among different care providers (O’Flynn et al., 2014). As a consequence, more integrated delivery of social care services and better collaboration among care providers may lead to financial benefits, and the main contractor may benefit from economies of scale (O’Flynn et al., 2014).

Another advantage of the population-based commissioning model is the incentive for the main contractor to strive for early signalling and even prevention rather than medicalization. In situations such as problematic debts or issues associated with depression or mental stability, early signalling and treatment is considered most effective. If these problems build up over time (for instance, debts increasing, depression worsening, mental stability further deteriorating), more care – and more specialized care – may be necessary for a longer period of time. Formal social care in some cases may even be prevented through the support of formal care givers or other activities. In the population-based commissioning model the main contractor has both the opportunity to build a local infrastructure to accommodate the prevention of formal social care, and early signalling to accommodate efficient provision. The contract scope allows the main contractor to invest in building a local network with, for example, existing informal initiatives, schools, churches, and sport clubs. Through such a network, more informal caregivers (volunteers) may be mobilized, which may prevent a part of the clients to apply for formal care services, and/or support these clients with less formal support. In this model, there is a strong incentive for prevention and early signalling of problems. Formal social

care services tend to be more expensive compared to informal support, and the prevention of formal social care is therefore likely to be less expensive than the provision of social care services. The provision of more – and more specialized – social care services obviously leads to more costs.

Finally, the municipality has an advantage in buyer-supplier relationship management: with only one contractor, the municipality can focus on contract management and build a collaborative partnership relationship with the main contractor. Furthermore, efforts and costs shift from the municipality to the main contractor as the latter becomes responsible for organizing and coordinating the supply chain (O’Flynn et al., 2014). Contract management can also be managed at different levels by both the municipality and main contractor. The municipality may participate in main care provider initiatives, share information, and collaborate with the main supplier to achieve better social care services and the goals of the Wmo 2015. Expenditure control is also streamlined: with only one – or a few – main contractor care provider(s) with a fixed budget, maintaining insight into expenditure requires less coordination for the municipality.

While this model has strong potential advantages, it is equally associated with strong disadvantages. First, its advantages are theoretical: they are anticipated by proponents, although not yet evidenced. While the population-based commissioning model of the four models I introduce here is the most often referenced in other research, there is no evidence that demonstrates its effectiveness (Billings & De Weger, 2015). Its disadvantages, however, are less ambiguous. When contracting main contractors, a municipality in fact creates an oligopoly – or even a monopoly – position for the main contractors. These markets do not function well, as competition is absent. Furthermore, it creates a vendor lock-in or a ‘hostage situation’ for the municipality; the municipality becomes over-reliant on this one main contractor. This presents challenges if the main contractor fails, or chooses to exit the contract (O’Flynn et al., 2014), and it becomes much more difficult to contract a different care provider. Even if the municipality decides to contract a new main contractor after the initial contract period, this would involve substantial transaction costs.

Another issue is the vulnerability of the care providers that are not contracted as main contractor in relation to the main contractor, since they are forced into sub-contractor positions vis-à-vis their competitor(s). While the municipality is held publicly accountable for their commissioning approach – and exploitation of

care providers would not be publicly accepted – the conditions under which care providers are subcontracted are far less visible to both the municipality and the public in general. O’Flynn et al. (2014) refer to this risk as the ‘squeezing out of smaller providers’ and the subsequent loss of social capital (O’Flynn et al., 2014). The combination of these effects can be expected to have a disruptive impact on the local market of care providers. Many of the care providers that are not contracted as main contractor will likely diminish in size or disappear altogether (hence the loss of social capital). When the main contractor(s) are independent care providers – rather than formalized collaborations, alliances, or cooperations of multiple independent care providers – they often take over a substantial amount of personnel of their competitors. In short, the municipality creates their own monopolists that carry substantial bargaining power. This undermines the theoretical advantages of cost control and collaboration – the municipality may have no alternatives when the main contractor does not perform or operate as expected. For example, if the main contractor demands more budget, the municipality may be forced to concede, even if this means going against contractual agreements. These problems related to the functioning of the market may go beyond being undesirable – they may even be legally problematic. Under competition law, forcing care providers to form alliances and ‘divide’ the market or simply banishing competition altogether are problematic – although a rigorous analysis of this commissioning model from a competition law perspective is outside the scope of this research.

Finally, additional risks and disadvantages present themselves when the main contractor is an alliance of multiple (possibly incumbent) care providers. For instance, there is a high failure rate of organisations in alliances largely due to the fact that competition between partner care providers jeopardises their alliance. The attributes of individual firms, partnerships, or networks of alliance relationships can also hamper alliance performance (Augustine & Cooper, 2009).

One consequence of externalizing the coordination is a lack of transparency and the deterioration of the municipality’s information position. While having information on clients, their social care needs, and the performance of (sub-contracted) care providers is critical for the municipality as the commissioner, in the population-based commissioning model the municipality positions itself further away from its citizens. In terms of service triad dynamics as described by Li and Choi (2009), a municipality actively positions the main care provider firmly in the bridge position with the associated benefits for the care provider and risks for the municipality. From the perspective of the service triad theory of bridges and struc-

tural holes, the Dutch municipal implementation of population-based commissioning puts the municipality in a very weak structural position. Related to this is the risk of 'hollowing out the government' (O'Flynn et al., 2014) – as policy makers are further removed from direct service delivery, there is a danger that they start to lose touch with critical issues that impact not only future policy decisions but also the actual structure of service delivery systems. One specific risk concerns people who require social support or counseling but who do not request support, or even actively avoid care themselves. These people may cause an inconvenience to their environment (or even a security threat), but they do not acknowledge they may need treatment. While society as a whole may be better off when people in such a situation receive the support they need, it may not be in the financial interest of the main contractor to actively pursue those who avoid care (in Dutch: *'zorgmijders'*).

Another fundamental disadvantage is the absence of the client's freedom to choose their care provider. The Wmo 2015 requires that clients can choose their care providers, so contracting one main care provider per district is problematic from this perspective. Furthermore, when moving towards this model for the first time, many client-caregiver relations are typically broken. The relational continuity of social care, as discussed by Haggerty et al. (2003), depends on the incumbent care provider that wins the competitive procurement tender for the integrated social care contracts. In terms of relational continuity, the best-case scenario is that an alliance of incumbent care providers wins the competitive procurement procedure – meaning a substantial number of existing clients can keep their current caregiver(s). In the worst-case scenario, (a combination of) care providers new to the municipal population win the contract, and most or all clients lose their existing caregiver.

Finally, the consequences relating to the local care services market disruption are difficult to overcome. Organizations may disappear swiftly, but new markets generally take considerably more to establish themselves when a municipality decides to abandon the population-based commissioning model and switch to one of the alternatives.

Both advantages and disadvantages may be exacerbated in more integrated forms of population-based commissioning. In horizontal integrated population-based commissioning, the advantages of integration, collaboration, and control span across a wide range of social care services on which more families and individuals rely for social care. With respect to vertical integration, the inclusion of the gateway to social care deserves particularly careful consideration. This integration

has a clear benefit: it is not necessary for citizens to first explain their needs and personal circumstances to a case manager of the municipal social community team, only to then repeat this conversation with the selected care provider of choice when the provision of social care service starts. There is, however, also a serious drawback: the care provider in a population-based commissioning contract has a financial incentive to provide less services and support less clients. The care provider receives a fixed annual budget, regardless of how many clients and services it provides. Fewer clients and less extensive care entitlements lead to higher financial margins for the main contractor. There is no independent assessment of a client's needs or objective matching of care services, which increases the risk of skimping; reduction of the amount of services, and dumping; refusing social care or pushing clients towards other financiers, terms Ellis (1998) introduced and discussed.

#### 4.3.3 Catalogue model: a basket for each egg

The catalogue model centers around a catalogue of different social care services for which the municipality contracts care providers. This catalogue of services may resemble the old set of NZa-codes, although in general municipalities in the catalogue model have reduced the number of different services even further compared to municipalities in the AWBZ-model. A more fundamental difference between the AWBZ-model and catalogue model is the latter's absence of contracts with a fixed budget allocation. The catalogue model is characterized by the use of standardized framework agreements with a wide variety of care providers. The municipality contracts care providers for the services in the catalogue, with standardized terms and conditions, and allows clients freedom to choose a contracted care provider. As the framework agreements do not include budget agreements, the care provider relies completely on individual clients choosing (or staying with) their organization. In fact, the municipality may even contract every service in the catalogue in an entirely different way. For example, the municipality may contract some services using an 'open house' system (open contracting scheme) and for others through a public framework contract. Similarly, the municipality may use different types of procurement procedures per service listed in the catalogue (procurement procedures are discussed in Chapters 6 and 7).

In the catalogue model, it is not required that each contracted care provider is capable of delivering every service in the catalogue. Care providers can be contracted for every service or a subset of their services, which lowers the threshold for small-

er or specialized care providers to be contracted. In contrast to population-based commissioning, the catalogue model provides ‘a basket for each egg’.

#### *4.3.3.1 Open or framework contracts: no budgets, just standardized requirements and conditions*

As already mentioned, in the catalogue model municipalities define a catalogue of social care services. Municipalities then contract care providers for these services using framework agreements that regulate their provision but do not guarantee any budget or production. Care providers rely on the individual client’s choice for providing services and having revenue, although incumbent care providers with an established client base have some degree of certainty. Many clients of social care services – such as elderly people – tend to rely permanently on social care services and are thus unlikely to switch care providers unless they are not satisfied with their current provider.

There is no necessity for municipalities to limit the number of different care providers in catalogue- model framework agreements. Although they may use a variety of public procurement procedures for contracting care providers under the catalogue model (see Chapter 6), Dutch municipalities commonly rely on ex post competition rather than ex ante competitive procurement procedures. In absence of ex ante competition, municipalities contract each of the *interested* care providers that meet their standardized quality and suitability criteria. This results in framework agreements with a few dozen contracted care providers across different social care services in smaller municipalities contracting on their own, to over two hundred contracted care providers in the biggest municipalities or municipal procurement collaborations.

With respect to reimbursement of social care services there are two different municipal approaches in the catalogue model. The first option is that municipalities contract social care services in the catalogue with a fee-for-service reimbursement. For each service the municipality sets a standardized tariff, which corresponds to, for example, one hour of ambulatory personal assistance, partial day of supported day-time activities (four hours), or one full day (24 hours) of respite care. The formal care entitlement of a given client specifies one or multiple services and the duration per period, for example ‘two hours of household assistance per week’. The second option is that municipalities contract social care services in the catalogue with an outcome-based bundled payment, where each service is associated with certain outcomes. These outcomes are either specified up front (generic) in

the contract, or by the case manager, tailored to the needs of the individual client upon formalizing the care entitlement. These outcomes are specified at individual or family level: 'the client opens and reads their mail', 'the client is able to cope with their disability', 'the client pays their bills timely', 'the client has of a clean house and clean clothes', et cetera. The care entitlement of a client thus does not specify the production of services, but rather the relevant outcomes that a care provider needs to accomplish permanently (for instance, the client can cope with his disability and is mentally stable) or periodically (e.g. the client has a clean house; every week the house is cleaned).

Prior to 2015, contracted care providers were accustomed to the contracts with budget-allocations, providing financial certainty throughout the contract duration. This certainty is replaced by continuous competition throughout the contract over each new client in the catalogue model. It is mostly the incumbent 'status quo' care providers that are affected by this and thus prefer the AWBZ- or population-based commissioning models (assuming these providers are contracted). In contrast, new care providers or care providers that were not directly contracted under the AWBZ now have much more opportunities for 'business' in these municipalities, and may therefore flourish under the catalogue model.

#### *4.3.3.2 Case management and care entitlement: in-house or outsourced?*

A fundamental element in the catalogue model is the role of case managers (1) in the assessment of citizens entitlements to social care, and (2) throughout the provision of social care services by a care provider. In the catalogue model municipalities use case managers who are independent from the contracted care providers. Upon a citizen's request for social care services, the case manager assesses the citizen's need for support and discusses with the citizen opportunities for informal care and support. If there is a need for formal social care services, the case manager assigns the appropriate services from the catalogue and constructs a 'care plan' together with the client, specifying how the client will be supported. The citizen (becoming a client) can then choose which care provider will provide social care services from the list of providers contracted for the specific allocated service(s). Note that in this model the municipality assumes the role of specifying the care plan from the care provider, who made such plans under the AWBZ.

When a care provider starts providing care services, a case manager conducts oversight by monitoring both the situation of the client and the performance of the care provider. Client case management was formerly the responsibility of care

providers, although case management typically did not extend beyond the services provided by individual care providers (which in fact has had dramatic consequences for clients with multiple care providers, each only taking responsibility for their own activities). Clearly, case managers play a pivotal role in the catalogue model. Often these case managers are organized in social community teams. Most Dutch municipalities have incorporated these social community teams, while their formal organization, composition of team members and specialties, and responsibilities differ from one municipality to another. In the catalogue model, case managers are organized in one of three ways:

1. Case managers are municipal employees (in-house provision);
2. Case managers are contracted from organizations that are not contracted for social care service provision, for example from local welfare organizations;
3. Case managers are contracted from organizations that are also contracted for provision of social care services incorporated in the catalogue.

There is great variety in not only the organization of social community teams, but also in their respective responsibilities and capacities. Besides completing the assessment for care entitlement, there may be limited capacity for actual case management, and this is sometimes even outsourced to the care provider (as it was under the AWBZ). In the latter situation this means there is no independent case manager who can objectively monitor and appraise care provider performance. If case management is assumed by the municipality, this shifts part of the responsibility from the care provider to the municipality.

There are general advantages and disadvantages associated with this model, some of which are moderated by the way municipalities reimburse care services and organize client case management (i.e. social community teams).

#### *4.3.3.3 Ultimate free choice of care providers for clients and maintaining a strong position in the service triad*

To some extent the catalogue model is the antithesis to the population-based commissioning model, implying that some of the advantages of the population-based commissioning model become the disadvantages of the catalogue model (and vice-versa). First, the catalogue model provides clients with optimal choice over care providers. As each interested care provider that meets quality criteria and accepts the terms and agreements for care provision is contracted, an extensive list develops. Choice, next to competition, is considered important for good performance of social service provision (Savas, 2002). In addition, Bergman, Jordahl,

and Lundberg empirically evidence the importance of choice in municipal commissioned home care in Sweden, where they find that the introduction of free choice and free entry in home care increased perceived quality by about one quarter of a standard deviation, without affecting costs (Bergman et al., 2018). New choice opportunities are established as the underlying mechanism associated with the increase in perceived quality.

Another advantage with the catalogue-model is the absence of vendor lock-in. If a care provider does not abide the contractual agreements there is no lock-in situation; there are sufficient alternative care providers in the framework agreement. As a consequence, the risk of care providers abusing a power position is minimized in the catalogue model. There is no mandatory sub-contractorship where care providers are forced into a vulnerable position vis-à-vis their competitor, risking being 'squeezed out' by the main contractor (O'Flynn et al., 2014). Ex post competition in relation to free client choice among contracted care providers generates an incentive for sufficient quality and performance.

In the catalogue model, new care providers are given the opportunity to provide social care services beside the incumbent care providers by highlighting their innovative methods to prove themselves, the success of which is determined by the 'wisdom of the crowd' (individual client choices). The catalogue model therefore is not as disruptive for the local market of social care services. Incumbent care providers lose their comfortable position of the certainty of annual budget-allocations and are in fact forced to compete in framework agreements. This affects market conditions and may have an impact on the relative sizes of incumbent care providers. However, in the catalogue model this is a gradual process rather than a sudden disruption, as it is unlikely that entire groups of clients switch care providers at the same time.

In the catalogue model, the municipality maintains the coordination of the commissioning and contract management of all care providers. If in addition case management and care entitlement is not externalized but provided for in-house (or by a third party), the municipality in effect maintains a pivotal position in the social care service triads between care providers and clients. The municipal case manager is in the perfect position to independently monitor care provider performance. Considering service triad theory and the importance for buyers of maintaining a strong position in the triad, this is a major advantage of the catalogue model over other models, especially population-based commissioning. The municipality main-

tains a position close to clients, providing case management and monitoring care provider performance, or commissions these activities to a third party without stakes to keep information from the municipality. This means the municipality effectively maintains a stage of bridge decay, but prevents bridge transfer, in line with the strategy suggested by Li and Choi (2009) and evidenced to be beneficial (Peng et al., 2010).

Finally, the catalogue-model allows for relational continuity of care, discussed earlier as an advantage also present in the AWBZ-model where municipalities contract incumbent care providers. This is also done in the catalogue model so long as the incumbent care providers meet minimum quality requirements.

However, certain disadvantages are also linked to the catalogue model. Most prominent is the fact that municipalities in the catalogue model may have a substantial number of contracted care providers. Taking into consideration each framework agreement for the different types of social care and adding up all the contracted care providers makes it very likely that smaller municipalities may have dozens of care providers per framework agreement. Municipal collaborations and bigger municipalities may have to deal with several hundred contracted care providers. The management of these contracts on care provider organization level demands considerable efforts in terms of administrative management, relational management, and performance measurement. Of course, not every single one of the several hundred contracts requires the same contract management attention – here the ‘pareto principle’ applies. This implies that approximately 20% of the care providers are responsible for 80% of the clients, whereby the smaller group of care providers demands the greatest contract management attention.

The adequate functioning of the catalogue model depends to a great extent on the quality of the case managers who assess clients, decide on social care entitlements, perform client case management throughout the provision of social care services, and monitor care provider performance and the outcomes of social care services. Case managers hold a pivotal position towards each of the actors in the service triad. If a case manager makes an inadequate judgment of the needs of a person requesting social care, the client may receive inadequate social care services and possibly end up with the wrong care provider. For instance, the client might receive either more care services than necessary (at the cost of the municipality) or not enough care services (at the cost of the client and the care provider). ‘Inadequate’ may also refer to the client being unable to receive the appropriate type of care

services from a care provider with adequate competences, at the expense of the client and possibly even causing safety risks for the professional care giver. This reliance on case managers, specifically on their quality and competence, is a risk factor associated with the catalogue model.

Furthermore, in the catalogue model it is virtually impossible to make production agreements or maximize budgets for care providers. Keeping expenditure under control requires mechanisms other than budget agreements with care providers. Capping total expenditure on social care in the catalogue model requires controlling access to care, as cumulative client care entitlements (the type and magnitude of social care services) determine expenditure. Again the pivotal position of case managers – generally positioned in social community teams – responsible for client access to social care becomes apparent. These case managers hold the key to municipal social care expenditure, advising clients on their most suitable care provider and monitoring care provider performance. This means the catalogue model is only as strong and efficient as the quality of the case managers – the system relies heavily on their performance.

Besides these general advantages and disadvantages, the reimbursement methods and organization of case management in social community teams can be expected to have a moderating effect. The disadvantages of fee-for-service reimbursement discussed under the AWBZ-model apply equally to the catalogue model, and one criticism in particular is that this practice still upholds the undesirable incentive of rewarding volume rather than value. Although the choice of care providers for clients is extended, the fundamental incentive for volume remains unchanged compared to the AWBZ-model. The question is whether the catalogue model with fee-for-service reimbursement sufficiently contributes to achieving the goals of innovation and reduced expenditure, which relies to a great extent on the organization of access to care – the social community teams. The case manager responsible for the assessment of formal social care needs on the one hand and client case management throughout care provision on the other is the only (substantial) key to achieve innovation and reduce the need for social care services.

In contrast, when municipalities adopt outcome-based bundled payment of care services, this introduces incentives for the efficient and innovative provision of social care services. Therefore, an additional advantage of the catalogue model when applying outcome-based bundled payment is the opportunity to make case managers responsible for monitoring care provider performance. Case managers then

monitor if indeed the care provider achieves the intended outcome (for example, a clean house). This also depends, of course, on the organization of case management. When social community teams are organized independently from the care providers contracted for provision of social care services, this minimizes the risk of opportunistic behavior, for example in the form of supplier induced demand (for instance inflated care entitlements. When care providers are contracted both for case management (i.e. in social community teams) and the provision of social care services, this increases the risk of care provider opportunistic behavior. Care providers in the position of case managers can inflate client care entitlements, influence the client choice of care provider(s) for social care services (referring clients to their own organization), and possibly even mask under-performance in social care provision. This is not necessarily borne out of opportunism; professional caregivers may also act out of intrinsic motivation when allocating professional social care easier (in effect to more clients) and in higher volumes than municipal case managers would. Recently, the Dutch Centre of Economic Policy Analysis (*Centraal Plan Bureau*, 'CPB') published a study on the effects of social community teams on the number of clients who have been assigned professional social care services in the Netherlands since the decentralization in 2015. The CPB found that in municipalities with professional care providers in their social community teams the number of citizens who were assigned professional social care between 2015 and 2017 grew twice as much (59% increase of clients who were assigned professional care), compared to municipalities where professional care providers were not involved in the social community team (29% increase of clients in professional care) (Eijkkel, Gerritsen, & Vermeulen, 2019). Indeed, professional care providers in social community teams allocate professional social care much easier, either out of opportunism or intrinsic motivation (or a combination).

#### **4.3.4 Client auction model: a platform approach to match demand and supply**

In the *client auction model* or henceforth *auction model* the municipality organizes an auction for every (new) client entitled to social care services; care providers must therefore submit a proposal and 'bid' for every client. This model consists of several stages between the contracting and provision of social care.

First, the municipality sets up an electronic marketplace, to which only invited or admitted care providers are granted access by the municipality to participate in

auctions. The municipality only admits care providers that meet its suitability and quality criteria and which accept the terms and agreements of service provision and the auction system. The procedure municipalities use to allow access to the electronic market place closely resembles the procurement procedure leading to framework agreements in the catalogue model. In both the catalogue and auction model the procedure aims to verify suitability for service provision. This leads to a (framework) agreement that specifies the conditions for care service provision without actually providing a guarantee for production. This kind of procedure is therefore characterized as an admission procedure; a successful proposal allows access to the framework agreement or electronic marketplace and the *possibility* of being selected for the provision of social care. In reality, care providers must complete another step before being selected to provide social care services to clients.

In the auction model municipalities use case managers who are independent from the contracted care providers similar to the catalogue model. However, the process of care entitlement and client selection of a care provider differs markedly between the catalogue and auction model. In the latter, upon a citizen's request for social care services, the case manager assesses the citizen's needs and discusses opportunities for informal care and support. If there is a need for formal (professional) social care, the case manager in the auction model writes an anonymous description of the client's impairment, social support needs, and relevant aspects of their situation. This *case description* is then submitted for auction in the electronic marketplace, where admitted care providers can see the client description. What follows is a *sealed-bid auction*, in (public) management literature better known as a tender, for the client. The care providers must submit a proposal for the provision of social care to this client, based on the anonymous description. In the proposal the care provider must describe the care plan (the type of social care services and activities), what goals and results to work towards, as well as the price. Multiple care providers submit proposals for one client, such that the client – together with the municipal case manager – can select the proposal that best fits their preferences. The client decides together with the case manager, where the latter should ensure a cost-effective proposal is selected. In fact, there is a competition with a formal 'tender' for each client.

In a variant of the auction model described above, the municipality uses standardized services, and the anonymous case description tendered in the auction model includes the client's entitlement to social care on a fee-for-service basis. The case description then features the anonymous description of the client, their

situation, and the care entitlement; for example, ‘four hours of household assistance and home care per week’. Care providers do not have to propose a care plan; they simply propose their price (per hour) to provide the services listed in the case description. The process to solicit the lowest bid for the care services of each client is effectively an electronic reverse auction, or ‘e-reverse auction’: see Teich, Wallenius, & Wallenius (1999) and De Boer, Harink, & Heijboer (2002) for a more extensive discussion on e-reverse auctions. One e-reverse auction occurs per client, where over a period of several days care providers underbid on price. The final (i.e. lowest) price offered by care providers, combined with other factors such as client preferences or disfavor for a care provider and average client satisfaction of the care provider, determine who ‘wins’ the client. It is thus not guaranteed that the care provider with the lowest price offer always wins the client, although the additional contributing factors are hidden from care providers that participate in the auction. The municipality can decide how much weight to place on each factor (price, client preference, et cetera) that determine the winner, which is comparable to any MEAT procurement procedure where a public authority awards a contract on the basis of price and quality criteria. The auction model has been used in the Netherlands for outsourcing maternity care (Jansen, van Mierlo, & Vendrik, 2008), and is sometimes referred to as a ‘dynamic assignment model’ because it primarily centers around the assignment of a client to a care provider. It also resembles the basic principles of platform services such as Uber (for taxi services) and Airbnb (hotel services), bringing together supply and demand for (in this case social care) services through an internet- and IT-based platform service.

#### *4.3.4.1 A contract to provide access to the social care service platform*

The framework agreement between the municipality and care provider in the client auction model regulates the conditions for admission to the electronic marketplace and participation in client auctions. Similar to the catalogue model, the framework agreement does not guarantee any production. In any of the two variants – auctions based on care approach and price proposals or on price proposals alone – the care provider only actually provides care to the clients it has won through the auctions. In the first variant, the care provider delivers the services according to the proposed care plan and associated price. The proposed care plan and price are in fact an additional contract in itself. In the second variant, once an auction is won the care provider is bound to provide the services in the care entitlement against standardized terms and conditions in the framework agreement and the price proposed in the auction. Here, the initial framework agreement is more complete than in the first variant, as it specifies the social care services for which care providers

offer the prices in the auction in detail.

There is debate over which services are most appropriate for the client auction model. On the one hand it can be argued this model is suited for standardized, relatively simple services, such as household assistance and maternity care. There is little variety between the services offered by care providers, unambiguous quality standards can be imposed, and price will be an important factor in deciding the winner of the auction. On the other hand it can be argued this model is best suited for complex situations that concern clients with multiple problems, where tailor-made plans developed by care providers will actually make a difference. In these cases, the client actually has a choice among differentiated approaches to social care and support.

#### *4.3.4.2 'Auctioning your grandmother': how political rhetoric reduces an innovation*

While the two variants of the client auction model share many similarities, the second variant has quite a different set of advantages and disadvantages. These are therefore discussed separately. I first discuss the first variant of the auction model, where a care provider proposes both a customized care plan for social care service provision and the corresponding price.

The auction model guarantees social care services tailored to the individual needs and situation of the client. Additionally, clients are involved in the selection of the care provider of their preference. The basis for making this choice extends beyond characteristics of the care provider itself (as in other models), as there is a choice in the care provider approach for their specific situation. Tailored care was one of the goals of the decentralization, and client choice is required by the Wmo 2015, which in social care is associated with an improvement in perceived quality (Bergman et al., 2018). In this model the choice extends beyond that of the care provider; the client is also entitled to choose a care plan. Furthermore, the auction system operates to ensure cost-efficiency of care provider proposals. It allows participation of a wide range of care providers, and smaller or specialized care providers can focus their participation in auctions on clients that fit their specialization, which leads to a better client-care provider fit. Larger care providers that offer a wider range of services may participate in more client auctions.

Besides these advantages of the auction model, there are also severe drawbacks. Care providers are required to propose care plans to provide social care services

without actually meeting their clients. This is a weakness in the model; the care provider proposals for social care provision can only be as good as the case description submitted for auction. Especially in more complex situations or more specialized types of care, the question is whether the case manager can make a sufficiently complete and accurate assessment and description. If the case description is incorrect, incomplete, or inaccurate after the award of the client to the auction winner, the care provider and municipality must engage in debate to clarify the details. The winning proposal may need to be amended, or, in the worst case, the client is put up for auction again. This disadvantage is neutralized in the second variant, in which the client case description includes care service entitlements. Another serious drawback is that for every client multiple care providers are writing proposals with care plans, while only one care provider can win the client, which results in a heavy administrative burden for care providers.

Another disadvantage of auctions relates to their associated negative impact on buyer-supplier relationships (Jap, 2002, 2003). The use of auctions increases the belief that the buyer acts opportunistically with both new and current suppliers (Jap, 2003). Maintaining a trusting and collaborative relationship with suppliers is argued to reduce the risk of supplier opportunism, and maintaining trust is especially important in service triads (Gunawardane, 2012; Li & Choi, 2009; Nätti et al., 2014). From this perspective, opting for the auction model seems an unwise choice. However, Jap (2003) demonstrates how the negative impact is more visible with open-bid auctions (the second variant of the auction model, discussed below) compared to closed-bid auctions. Finally, the concept of auctioning the social care services of individual clients has faced considerable critique in Dutch media and politics. While it is argued that this critique has grossly oversimplified the situation and seems to be aimed at political gain rather than an objective discussion of the model (Telgen & Uenk, 2014), local politicians may of course be sensitive to such negative media attention.

In the variant in which standardized services are specified up front in the initial framework agreement, the outsourcing system becomes more like the catalogue model, while the price is set by a typical e-reverse auction. There is less emphasis and reliance on the correctness of the case description; the care entitlement is provided by the municipality in this variant. However, the auction system becomes much more price focused. While competitive procurement procedures for social care services are already perceived as being a 'race to the bottom' (with negative connotations), the e-reverse auction over social care service prices in fact fits the

definition of the ‘race to the bottom’ on price. This model has suffered considerable negative publicity in Dutch media (Berends, 2014; Heijne, 2014) and has also been met with criticism from members of the Dutch parliament. Furthermore, as already mentioned above, e-reverse auctions are associated with a negative impact on buyer-supplier relations (Jap, 2003). Using e-reverse auctions increases a supplier’s belief that the buyer acts opportunistically (Jap, 2003). From the point of view of the buyer-supplier relationship, it appears the latter variant of the client auction with an open-bid auction on price alone is the worst model and may have detrimental effects on buyer-supplier relationships.

## 4.4 Discussion and conclusion

### 4.4.1 Different economic and management mechanisms to achieve reform goals

In Dutch social care, there is no discussion on whether to involve the market in the provision of social care services. There is, however, variation in the commissioning models that municipalities apply. In this chapter I discuss four different commissioning models and a number of variants within these models. Each commissioning model has distinct mechanisms with respect to competition, client assignment to a care provider, coordination of care provision, expenditure control, and fostering collaboration among care providers. The commissioning models differ in the mechanisms to achieve the goals of the social care reform in the Netherlands – organizing for more tailored, integrated, and high quality social care services while reducing expenditure on social care. The AWBZ-model emphasizes continuity of care and seems appropriate only for a transitional period. Population-based commissioning emphasizes the role of the care provider, aiming for a main-contractor to invest in the prevention of formalized social care and achieve integration of care and collaboration among professionals, at the cost of client choice. The catalogue model centers around the municipal case-manager to consider opportunities for informal care and achieve integrated care and collaboration among professionals, as well as freedom for clients to choose their care provider. Outcome-based contracts may further support innovation and cost-efficiency in the catalogue model. The client auction model emphasizes a trade-off between tailored care, client choice, and cost-efficiency, where different configurations of this model may put more emphasis on price (i.e. the e-reverse auction with open bids on price) or on

tailored care and client choice in the variant with a closed-bid auction, where the client is involved in making the choice for a care provider.

In the discussion and conclusion that follow, I elaborate on two dimensions where these commissioning models are fundamentally different: the core subject matter of a contract under the different commissioning models, and the scope of activities and responsibilities that a municipality outsources. Table 4.1 shows how the core elements and activities of social care commissioning discussed in this chapter are managed in the different commissioning models. I chose to distinguish the two versions of the catalogue model based on the reimbursement method applied, and expect the reimbursement method in this model to strongly influence the effects of the model on, for example, the quality of care services, innovation in service provision, and municipal expenditure for care services.

**Table 4.1** - Key elements of the four commissioning models

<b>Model</b>	<b>Competition</b>	<b>Client choice</b>	<b>Core subject of the contract</b>	<b>Client case management</b>
<b>AWBZ</b>	Ex ante (strong), limited ex post (among contracted providers)	Limited choice (among contracted providers)	Fixed annual budget	In-house, outsourced to a third party, or part of care provider contract
<b>Population-based commissioning</b>	Ex ante	No client choice	Support the population for a fixed budget	Main contractor care provider.
<b>Catalogue model – fee for service</b>	Ex post	Extensive free choice	Hours of care services ( <i>fee-for-service contract</i> )	In-house or outsourced to a third party
<b>Catalogue model – outcome based reimbursement</b>	Ex post	Extensive free choice	Client outcomes ( <i>outcome-based contract</i> )	In-house or outsourced to a third party
<b>Client auction model</b>	Ex post	Client choice is part of the auction award	The individual proposal for clients	In-house, outsourced to a third party, or part of care provider contract

#### 4.4.2 The core subject of the contract: inputs or outcomes

One of the fundamental differences between the commissioning models is the essential subject matter of the contract. Although in every model the municipality

outsources social care services, the core clause of the contracts – what the municipality essentially pays the care provider for – differs. In the AWBZ-model, a municipality concludes a contract on an annual budget with corresponding terms and conditions on how to deplete that budget (in effect the different services with their fees). In the population-based commissioning model, the contract concerns the support provided for a certain population against a fixed lump sum budget. The contract in the catalogue model concerns either the ‘input’ of hours of care services (a fee-for-service contract) or achieving (a) certain outcome(s) for a client (an outcome-based contract). Finally, in the client auction model, the contract concerns a proposal from the care provider for the individual client. In the variant where the client auction model is reduced only to the reverse auction for the price of the social care services, the contract concerns the provision of hours of care services, similar to the catalogue model. In the AWBZ-model and the population-based commissioning model there is little uncertainty for the contracted care providers; at the start of the year they know their budget. In both the catalogue model and the client auction model care providers have much more uncertainty with respect to their income, because the care providers rely on the individual client choices.

#### **4.4.3 The scope of outsourced services: a continuum between two extremes**

Related to the essential subject of the contract is the scope of the responsibilities that a municipality outsources. The scope can be considered a continuum between two extremes: (1) full in-house provision, and (2) full outsourcing of all activities. When considering commissioning models, the complete in-house provision is not a ‘commissioning’ model, as commissioning implicitly means at least some activities or services are outsourced. Similarly, at the other end of the spectrum, there is one responsibility that a municipality cannot outsource: the formal municipal decision on a client’s social care service entitlement must be extended to that client by the municipality itself. Within these practical boundaries a municipality can lie at either end of the scale or somewhere in between. At one extreme there are municipalities with the baseline approach of ‘empowering’ professional care providers as early and as extensively as possible. These municipalities opt for the population-based commissioning model and outsource (1) the provision of social care services; (2) the organization of client access to social care, including scrutinizing clients (the municipality only formalizes the care entitlement); (3) client case management, including, if relevant, the coordination of multiple care provid-

ers around a client and their family; and (4) any additional activities to support clients and the community that may have a preventive effect on the volume of formal social care service. At the opposite extreme there are municipalities with the baseline approach to 'be in optimal control and have optimal information' in the domain of social care services. These municipalities opt for the catalogue model with municipal case managers, outsourcing only the provision of social care services. In these municipalities the care providers no longer have a role in the access to, and coordination of social care services, which reduces their scope of activities. The AWBZ-model and the client auction model are positioned somewhere on the continuum between the two extremes, depending on the manner in which client access to care and case management are organized.

As mentioned under the discussion of the catalogue model, municipalities that maintain both access to care (in effect determining client care entitlements) and client case management require sufficient capacity and competences to do so, as much relies on the quality of the case managers. However, from the perspective of agency theory in a service triad context, these municipalities maintain a much stronger position in the social care service triad vis-à-vis the care provider. This prevents the stage of 'bridge transfer' (Li & Choi, 2009). This in turn makes these municipalities less prone to care provider opportunism and reduces the possibility for care providers to take advantage of the information asymmetry. Therefore, from this perspective municipalities are better off organizing client case management before and during service provision in-house. The CPB report (referred to in Section 4.3.3) supports this conclusion, as combining social community teams with professional care providers led to two-fold increase in new clients in formal social care, compared to social community teams operating without professional care providers (Eijkkel et al., 2019).

#### **4.4.4 The advantages and disadvantages in each model from a service triad theory perspective**

In Section 4.2.3 the literature on service triads and agency theory is discussed. In this literature it is observed that (1) maintaining collaborative relationships with suppliers is important, and that it is important for a buyer to maintain a strong position in the service triad (Li & Choi, 2009). The buyer is advised to monitor the behavior or outcome of the supplier and the service provided (van der Valk & van Iwaarden, 2011). From agency theory it follows that buyers should align its own

goals with the goals of the suppliers (Eisenhardt, 1989). Finally, I have identified that the different commissioning models may either maintain the current market structure, or disrupt this structure to some extent (often either at the cost or benefit of especially smaller care providers). Table 4.2 summarizes for each commissioning model how it can be expected to impact these 'mechanisms' proposed in economic, service triad, and agency theory. For each model and each aspect, the table signifies whether the commissioning model strongly supports (++), or supports (+) the proposed mechanism, whether the model is neutral (0) towards, conflicts (-) or strongly conflicts (--) with the proposed mechanism. The judgments in the table are the result of repeated reflections and discussions with practitioners and scholars in the field of social care commissioning.

**Table 4.2 - Aspects from service triad and economic theory in each commissioning model**

Collaborative relationship	Incentives - costs	Incentives - quality	Maintain a strong position in the triad	Monitoring (behavior or outcome)	Market structure development
AWBZ-model	- (fee-for-service in combination with fixed budgets is not an incentive to be efficient)	+ /- (there is no incentive to 'underproduce, but also there is no incentive to innovate)	- Coordination left to care providers, difficult to maintain a strong position	+ /- (a limited number of care providers to monitor, but municipality not ideally positioned)	- (exploitation of smaller providers)
Population-based commissioning	+ /- (opportunities for efficiency, but also for opportunistic behavior)	+ /- (opportunities for innovation and improving quality, but also for skimming and dumping)	-- (Municipality positioned at great distance from clients)	-- (the municipality is not positioned for effective monitoring)	-- (creates monopoly)
Catalogue model - fee-for-service	0/- (neutral, since municipal social care gateway determines entitlement, but fee-for-service has perverse incentive to maximize volume)	0/- (no dumping, no skimming, but also no incentive for innovation or putting value at the core)	++ (municipality ideally positioned in the service triad)	++ (municipality ideally positioned for monitoring service quality and impact)	0/+ (through definition of interventions and choices by clients)
Catalogue model - outcome based reimbursement	0/+ (neutral, since municipal social care gateway determines entitlement, but outcome-based payment has incentive for efficient provision)	+ /- (no dumping, there is an incentive for innovation, but also a risk for skimming)	++ (municipality ideally positioned in the service triad)	++ (municipality ideally positioned for monitoring service quality and impact)	0/+ (through definition of interventions and choices by clients)
Client auction model	+ (auction provides incentive for good price to quality ratio)	+ (auction provides incentive for good quality to price ratio)	0 (depends on positioning of municipality)	0/+ (there is a concrete care plan to monitor, but further depends on positioning of municipality)	0 (through choices by clients)

#### 4.4.5 Conclusion

To conclude, each model has its own merits and inhibits different mechanisms to achieve good quality care. This chapter contributes to the literature on procurement of social care services by explicitly discussing the different commissioning models, and their advantages and disadvantages, encountered in Dutch municipal procurement of social care services. In my frequent encounters with municipal decision makers concerning social care commissioning, I find these decision makers are often not aware of each of the existing models. Furthermore, they are often not aware of all potential risks of their model of choice when assuming a new model. The definition of these commissioning models and the discussion of their advantages and disadvantages therefore may help municipalities to make better-informed choices in commissioning social care, and to improve their implementation of a specific commissioning model.

Further research into the effectiveness of these models in achieving appropriate social care outcomes, improved collaboration, satisfied clients, and cost effectiveness is required to evidence which of the mechanisms is the most effective. Even then, municipalities need to take into account the fact that the risks of certain models – in particular the population-based commissioning model – may only materialize years into the future.



# Chapter 5

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**Dutch municipality choices for commissioning  
models – four years of empirical evidence**

## 5.1 Introduction

The previous chapter discussed models for commissioning social care services by public authorities. This chapter presents the findings of an empirical study into the application of these commissioning models by Dutch municipalities in the advent of the 2015 decentralization of social care services and the subsequent years of 2016, 2017, and 2018.

Chapter 4 discusses the advantages and disadvantages of every model in general and how these models relate to the intentions and goals of the Dutch decentralizations. From these observations and discussions, it follows that each model clearly has its own merits and . Studying the actual application of these models in the first year of the decentralization (2015) demonstrates which models municipalities have deemed fit for the procurement of social care services. Even more interesting is the longitudinal study of the municipal choices for a commissioning model. This provides insight into the extent to which municipalities have only temporarily adopted a model, only to implement a different model in one of the subsequent years that follow.

Therefore, in this chapter I first analyze how – and how often – Dutch municipalities have adopted each of the commissioning models (introduced in Chapter 4) in 2015, the first year of the reform. This chapter provides descriptive statistics for the applied commissioning model in 2015 for nearly every municipality in the Netherlands. I then present the findings of a longitudinal analysis of the commissioning models in the years 2016, 2017, and 2018 for municipalities that concluded new social care contracts or made considerable changes to their existing contracts. Finally, this chapter provides a discussion and interpretation of the municipal choices in the subsequent years that I analyzed.

## 5.2 Empirical methodology

In order to determine the municipal use of each commissioning model between 2015 and 2018, I collected the official procurement documents that were used for commissioning the decentralized social care services. The procurement documents used for this research include official tender documents (requests for proposals), concept contracts, prior information notices, and any formal attachments published by the municipality as part of the procurement procedure to conclude

contracts with care providers for the decentralized social care services. Many of the municipalities publish these official procurement documents on specific European and national public contract databases such as [www.ted.europe.eu](http://www.ted.europe.eu), [www.tendered.nl](http://www.tendered.nl), [www.negometrix.nl](http://www.negometrix.nl), [www.aanbestedingskalender.nl](http://www.aanbestedingskalender.nl). I searched these internet databases by combining different search terms, including the municipality name and references to the Wmo 2015 and common Dutch terms for social care services (for instance, personal assistance: '*begeleiding*'; day care: '*dagbesteding*'; respite care: '*kortdurend verblijf*'). Not every municipality published their contracts on these tender-databases (given the light regime in the public procurement rules for social services; see Chapter 3). A similar search on Google revealed that many municipalities published formal tender documents on their municipal website or on a separate website created specifically for the municipal procurement procedure to conclude new social care contracts. Finally, municipalities that were still missing in the procurement database were contacted directly through contact information available on their website with a request to receive their tender documents.

Based on a thorough analysis of the collected procurement documents, each municipality's approach to commissioning was analyzed on a wide range of aspects, including on fundamental aspects of the commissioning models as discussed in Chapter 4. The procurement documents were all rated by the same researcher – assuring optimal consistency. There were discussions with other expert researchers on the classification criteria of the commissioning models (this chapter), and aspects such as the classification of procurement procedures (Chapter 6) and reimbursement methods (Chapter 9), and procurement approaches that could not be unambiguously classified directly were discussed with these expert researchers as well, to ensure a rigorous classification approach. This analysis led to a classification of the commissioning model(s) used by each of the municipalities in the database.

From 2016 to 2018 the search for new procurement documents for social care services was repeated, save for one difference. For the 2015 social care contracts, some municipalities used contract clauses that allowed for modifications in the contract without the need to launch a completely new procurement procedure. When these clauses are invoked, the subsequent amended contract may in fact result in a different commissioning model or a different variant. For example, a municipality might change the reimbursement method for services under the catalogue model from 'fee-for-service' to 'outcome-based'. Such changes to existing contracts are identi-

fied separately from the municipalities that launched an entirely new procurement procedure (see Table 5.2), although the resulting new commissioning model is included in the statistics.

Collecting procurement documents for 2016 onwards posed an additional challenge. Unlike for 2015, where every municipality had to conclude new contracts, it was not certain whether a municipality actually procured again or whether existing contracts were continued for another year. As much available evidence as possible was examined to identify whether a municipality has continued their existing contracts (with or without changes), or whether the municipality has launched a new procurement procedure. In addition, for the analyses of the years 2016, 2017, and 2018 I consulted information from the last known contract with respect to the nominal contract duration, change clauses, and possible extensions to determine whether or not the municipality was likely to launch a new procurement. Table 5.2 in the findings section reflects the different possible scenarios. This methodology results in a limitation of this research: despite rigorous search-activities, it is possible that municipalities are wrongfully classified as *not* having concluded new contracts.

## **5.3 Dutch municipal commissioning of social care services in 2015: the first year of the reform**

### **5.3.1 Setting the stage for a live experiment with 393 municipality 'lab rats'**

Following the 2015 decentralization, Dutch municipalities became responsible for the following adult social care services: personal assistance (including both ambulatory personal assistance services and day care services), respite care, and sheltered housing. With day care services, a client spends a period of three to four hours at the premises of the care provider, undertaking educative, labor, or leisure activities. These types of social care services were previously managed through the AWBZ, and external care providers were contracted by regional care offices, organized by the health care insurance agencies. This chapter focuses on the municipal commissioning of these new types of care, with the exclusion of sheltered housing. The social care type sheltered housing is regulated differently than other types of care under the Wmo 2015; rather than making each of the 393 municipalities indi-

vidually responsible for sheltered housing, 43 municipalities were appointed with regional responsibility to commission sheltered housing. It therefore has been left out the scope of this research.

Throughout 2014 the municipalities of the Netherlands contracted care providers and decided on their commissioning model. Since most municipalities collaborated for the procurement of social care services, deciding on a commissioning model required the municipalities to reach a consensus. Furthermore, the decentralized social care services were completely new to the municipalities, and there was no clear and concise overview of the various models to choose between. Chapter 2 presented a comprehensive discussion of the social care system in the Netherlands before 2015 and discussed in more detail the reform that was introduced with the Wmo 2015.

### 5.3.2 Descriptive statistics: a revolution in commissioning social care

Table 5.1 provides the descriptive statistics of Dutch municipal choices for commissioning models for social care services. The catalogue model is further broken down into the two variants described in Chapter 4; a variant where municipalities pay for social care services through fee-for-service reimbursement, and a variant with outcome-based bundled payments. While from a contracting perspective the two variants of the catalogue model are similar, the reimbursement methods have such a fundamental impact on the incentives and freedom of action of professional care providers that they can be considered different models.

**Table 5.1** – Commissioning models in Dutch municipal social care commissioning - 2015

Commissioning model	Number (%) of tenders in 2015	Number (%) of municipalities in 2015
AWBZ-model	19 tenders (23%)	108 municipalities (28%)
Population-based commissioning model	5 tenders (6%)	15 municipalities (4%)
Catalogue model / fee-for-service	31 tenders (37%)	142 municipalities (37%)
Catalogue model / outcome-based	27 tenders (32%)	104 municipalities (27%)
Client auction model	2 tenders (2%)	11 municipalities (3%)
Total	84 tenders	380 municipalities

### 5.3.3 The 'copy-paste' AWBZ-model: continuity before innovation

In light of the goals of the decentralization of social care services, it is remarkable that over one quarter of the municipalities basically copied the AWBZ-model, the former approach to contracting social care services. The goals of the decentralization were to reduce expenditure and achieve social care that is better tailored to individual client needs and circumstances. Better tailored care requires improved collaboration among professional care providers, informal caregivers, and other organizations (e.g. churches or community centers) in order to achieve a better coordinated and more integrated provision of care. Achieving these goals requires change and innovation in professional social care service provision. Maintaining former procurement practices that allow only incumbent care providers and sticking to the same service definitions, fixed annual budgets, and fee-for-service reimbursement does not seem like a recipe for such change and innovation.

Considering the context under which municipalities in the Netherlands have had to choose and create their commissioning models, explanations can be found for why so many maintained the AWBZ-model. First, in the advent of the 2015 reform municipalities were under a lot of pressure to contract social care services, although critical information necessary to make procurement choices was made available to the municipalities relatively late. Municipalities were expected to finish the procurement procedures for social care services on 1 October 2014 to allow care providers and municipalities three months for contract implementation. This was agreed between the Dutch Ministry of Health, Welfare, and Sport (*Ministerie van VWS*) responsible for the decentralization of social care, and the Association of Dutch Municipalities (VNG) that represents Dutch municipalities in negotiations and discussions on a national level. At the same time, the Wmo 2015, which regulates the precise municipal responsibilities, was finally accepted only on 9 July 2014. The final information regarding the municipal budget for social care – the '*September circulaire 2014*' – was published on 16 September 2014. Data regarding clients and their current care entitlements was shared through different sources during the summer of 2014, but the information proved inaccurate for many municipalities. Two organizations, CAK and Vektis, each provided information on the number of unique clients and further details of their care entitlements in 2014. Some municipalities found an average difference of 30% in the number of unique existing social care clients indicated by the two formal sources CAK and Vektis (Van Den Elsen, 2014).

Second, in relation to the first argument, the social care services were new to the municipality. Municipal buyers and policy makers still were getting to know the types of social care services, their users, the disabilities and disorders these clients cope with, and the market of care providers for which they became responsible. There was a knowledge gap, and municipalities were afforded little time to fill this gap. Adopting a different approach to commissioning services and a market with which the buyer is unfamiliar is difficult and involves much more risk than simply copying the contracts used by the previous commissioner.

A third explanation for adopting the AWBZ-model can be found in the transitional arrangement (*'overgangsrecht'*) to which municipalities were bound in the first year of the Wmo 2015. The transition arrangement aimed to encourage continuity of care for existing clients in the first year of the decentralization. To ensure a gradual transition for existing individual clients under the AWBZ to the Wmo 2015, existing clients kept their rights with regard to enforcing the entitlement to care from their AWBZ-indication (Wmo 2015 Art 8.3 sub 1). The transitional arrangement ended for individual clients at the end date of their AWBZ-indication, but no later than 1 January 2016. For this period, municipalities were required to provide for social care services 'under similar circumstances'. The transitional arrangement aimed to secure continuity of the provision of social care services to clients. However, providing 'relational continuity' – in effect contracting the same care providers – was not mandatory for municipalities. Forcing municipalities by law to contract existing care providers would have granted these care providers too much leverage in contract negotiations. The municipalities were nevertheless expected to make an effort to contract incumbent care providers as much as possible; see for example page 7 of the 'guide for interpretation and implementation of the transitional arrangement' (TransitieBureau Wmo, 2014). Many municipalities interpreted the transitional arrangement as a requirement to contract the existing care providers of the clients within their municipal population. Maintaining the same contracts and social care services was a logical step for many municipalities, ensuring compliance with the transitional arrangement. This was another reason for municipalities to adopt the AWBZ-model.

Considering the circumstances discussed above, developing a commissioning strategy that includes a new structure of services, contracts, reimbursement methods, and procurement procedure (et cetera) is challenging. From this perspective, copying the former commissioning model and simply re-negotiating budgets and tariffs with incumbent care providers seems a sensible – albeit temporary – strategy. In

light of the context illustrated above, the choice to adopt the AWBZ-model (at least temporarily) makes more sense. Adopting the AWBZ-model furthermore ensures municipalities measure up to the requirements of the transitional arrangement for clients under the Wmo 2015 without any doubt, facilitating relational continuity.

### **5.3.4 Population-based commissioning: the rise of a local external social care monopoly**

Compared to the AWBZ model, the population-based commissioning model is the most fundamentally different in terms of contract scope, completeness of the contract, and selectivity of care providers. In 2015, only 4% of municipalities directly introduced this model. There are some differences in the organizations contracted as main contractor: in two tenders a consortium of incumbent care providers won the competitive procurement procedure and became the sole contracted care provider in the municipality. In the other tenders, one organization became main contractor either for the whole municipality or for a dedicated district. One municipality defined four districts, and contracted three different care providers as main contractor: one care provider per district, where one care provider won two districts.

As discussed in Chapter 4, the population-based commissioning model facilitates great opportunities, but also brings with it serious disadvantages and risks. The low number of municipalities opting for this model in 2015 first of all may relate to the disadvantages and risks discussed in Chapter 4: the risks associated with vendor lock-in, the vulnerability of sub-contractors, the devastating impact on the local care provider market, and the deteriorating information position of the municipality as buyer in the social care service triad. Furthermore, the model lacks freedom of choice for care providers, to which clients are entitled under the Wmo 2015.

In addition, especially for 2015 the population-based model is problematic in relation to the transitional arrangement discussed in the previous section. Although it was not a legally binding requirement to contract incumbent care providers, municipalities were expected to do so as much as possible. In the population-based commissioning model, municipalities by definition do not contract many of the 2014-incumbent care providers unless they form a consortium. Depending on the organizations that win the contract, ranging from consortia of incumbent care

providers to a nonincumbent independent organization, more or less clients have had to leave their care provider (organization) and actual caregiver(s) as a consequence of the care provider not being contracted.

### **5.3.5 The catalogue model: the majorities' choice**

Despite arguments in favor of adopting the AWBZ-model, the majority of municipalities recognized that simply copying the former commissioning model in light of the intentions and goals of the decentralization was not suitable.

Most municipalities adopted one of two variants of the catalogue model: either contracting services on a fee-for-service basis or with outcome-based bundled payments. Municipalities opting for the catalogue model with fee-for-service reimbursement typically define new, broader social care services compared to the numerous NZa codes existing under the AWBZ. Under the catalogue model, municipalities generally define between six and twelve services, abandoning more than 200 NZa codes that previously existed. The most prominent changes in terms of contracts for care providers is the absence of a guaranteed budget and a much wider contracted care provider base. One of the fundamental tenets of the catalogue model is freedom of choice of care provider for clients. Besides offering freedom of choice of care providers to new clients, the catalogue model also allows relational continuity for existing clients. Incumbent care providers were typically always contracted, meaning clients were never forced to choose a new care provider. Finally, in the catalogue model with fee-for-service reimbursement, municipalities allowed for using the old NZa codes and their corresponding tariffs as a basis for determining the standard tariffs for their new services. As discussed in Chapter 4, it can be questioned whether the 'fee-for-service' catalogue model differs sufficiently from the AWBZ-model to attain the goals of the decentralization. Additionally, some municipalities actually contract the same care providers that provide social care services for the responsibility of care assessments and case management too. These municipalities introduce new and additional ways for care providers to act opportunistically. It allows inflating care entitlements (granting more services than the client actually needs) and influencing clients to choose their own organizations as care provider.

Just over a quarter of municipalities have adopted the catalogue model with outcome-based bundled payment for social care services. Here, the method of con-

tracting and subsequent organization of access to care and client case management resembles the fee-for-service catalogue model. The difference lies in specification and payment of social care services. Rather than 'pay by the hour' services, here the municipality defines outcomes for the care provider to accomplish and pays for the outcomes through bundled payment. The bundled payment in the Dutch municipal catalogue model is a fixed price per period, usually four weeks, and the care provider is paid for achieving and maintaining the specified results. The level of specificity of the social care service outcomes differs among municipal contracts. The most complete contracts specify in detail the required outcomes across a range of aspects such as managing the household, self-care, mental wellbeing, managing finances, and social skills. Every aspect is broken down into more detailed outcomes that the care provider must accomplish for and with the client. The least complete contracts simply specify the type of service or broad type of outcome required (for instance 'living self-reliantly', 'participation in society'), and leave the more detailed specification of outcomes to be defined by the municipal case managers responsible for the social care service entitlement of individual clients.

The catalogue model with outcome-based bundled payment is markedly different compared to the AWBZ-model, as here the reward for volume has been partially removed. At the level of individual clients, a care provider now has an incentive to achieve outcomes as efficiently as possible. The care provider is not bound by the provision of hours of social care, allowing for alternative ways to achieve the outcomes. This way the bundled payment facilitates innovation. The main challenge for municipalities is to establish whether the desired outcomes have been achieved. As discussed in Chapter 4, social community teams may be in the ideal position to monitor the agreed outcomes. Still, the difficulties of monitoring outcomes – and attributing outcomes to care providers (related to outcome uncertainty) – must be overcome. A risk in the outcome-based bundled payments therefore is underperformance of the care provider that may go unnoticed – or which at least may lead to discussions over the performance of the care providers. Furthermore, the incentive for volume in this model is still present as care providers are rewarded for supporting more clients. This stresses the importance of organizing access to social care independently from the care providers that financially benefit from each additional client.

### 5.3.6 The client auction model: suffering from political rhetoric

The client auction model was a rather ‘exotic’ commissioning model, supported by a software supplier, Stipter, that developed and sold the software infrastructure that supports e-reverse auctions. The commissioning model had already been used by a few dozens of municipalities for procuring household assistance: the one type of social care service that was already decentralized in 2007 to Dutch municipalities. Furthermore, health insurance agencies were also already using the model for contracting maternity care (Jansen et al., 2008). Throughout 2014, municipal interest in this commissioning model grew, as did its opposition both in media and politics (Telgen & Uenk, 2014). Finally, only two municipal collaborations adopted the client auction model.

Municipalities adopting the client auction model organized a procurement procedure for contracting care providers in a similar fashion to the catalogue model. The municipalities contracted providers through a framework agreement that allowed access to the electronic marketplace. Municipalities then verified whether care providers met the quality and suitability requirements, ensuring only trusted care providers can participate in the client auctions. Auctions typically commenced for new clients and clients up for re-assessment – at the start of 2015, clients already receiving social care under the AWBZ remained with their care provider, provided these care providers were contracted. This model therefore fit the requirements of the transition arrangement.

The requirement that clients choose their care providers is met comfortably in the variant of the auction model, where clients choose on the basis of the tailored care plans proposed by care providers in the auction system – provided there are multiple proposals to choose from. However, this aspect differs under the variant of the client auction model with an open-bid auction on price alone. The client’s preference for a care provider is then only one of the parameters that determines which care provider wins the auction. In this variant of the auction model, clients may indicate both a care provider they prefer and care providers they disapprove of. The municipality decides on the relative weights given to a client’s preference and disapproval of care providers, as well as the auction price of each participating care provider, and other factors. A disapproval will likely be afforded significant weight to avoid clients being matched to a care provider they dislike, unless there is no other option. However, price should matter significantly for this model to exhibit sufficiently strong incentives for low price proposals. While I found no empirical

evidence for this, it can be reasonably expected that clients are not always matched to the care provider of their choice. Furthermore, in both variants of the model the possible choice of care providers is limited to the care providers that actually participate in the auction. Assuming not every contracted care provider will participate in every client auction, the level of choice is reduced compared to other models, such as the catalogue model.

## **5.4 Dutch municipal commissioning of social care services in 2016, 2017, and 2018 – continuing the revolution in social care commissioning**

### **5.4.1 Municipal commissioning year by year**

While for the year 2015 every Dutch municipality had to conclude new social care service contracts, this was not the case for the consecutive years that followed. Municipalities that have concluded contracts with a duration of multiple years do not have to launch a new tender in 2016. Municipalities that have included options to extend the contract can either choose to do so or launch a new tender.

Chapter 6 discusses the public procurement procedures and includes only the municipalities that actually launched a new public procurement procedure for the 2016, 2017, and 2018 contracts. The selection of municipal contracts included in the analysis of this chapter differs slightly, because over half of all Dutch municipalities (215 out of 393) included options to modify any part of the contract in the 2015 social care service contracts. While not launching a new social care procurement procedure, these municipalities may for example change the reimbursement procedure or abandon the use of fixed budgets. In other words, these municipalities may change their commissioning model through invoking the contractual change option. For the 2016 contracts, 44 municipalities made changes in current contracts; for the 2017 contracts, 110 municipalities made changes; and for the 2018 contracts, 31 municipalities made changes. These changes are usually implemented at the start of the new year, although there are exceptions. Table 5.2 provides an overview of the numbers of municipalities that launched a new tender, chose not to tender, and modified existing contracts for the years 2015 to 2018. Furthermore, Table 5.2 also illustrates how many procuring and contract-modifying municipalities are included in this study.

**Table 5.2** - Commissioning municipalities 2015 – 2018 in total – and share included in this analysis

	2015	2016	2017	2018
Total number of municipalities	393	390	388	380
Number of procuring municipalities (% of total number of municipalities)	393 (100%)	88 (23%)	126 (32%)	37(10%)
Number of municipalities not procuring	0 (0%)	247	209	299
Number of municipalities uncertain of procuring	0 (0%)	55	53	44
Number of municipalities changing existing contracts (% of total number of municipalities)	0 (0%)	44 (11%)	70 (18%)	31 (8%)
Procuring municipalities included in this study (percentage of procuring municipalities)	382 (97%)	56 (64%)	110 (87%)	37 (100%)
Municipalities changing contracts included in this study (percentage of modifying municipalities)	382 (97%)	44 (100%)	70 (100%)	31 (100%)
Total number of municipalities included in analysis (% of municipalities procuring or changing contracts)	382 (97%)	100 (76%)	180 (92%)	68 (100%)

The tables below show the municipal choices of commissioning models year by year between 2015 and 2018, including only those municipalities that have concluded new contracts or made changes in existing contracts. Table 5.3 shows the separate municipal tenders, which generally correspond to multiple collaborating municipalities. Table 5.4 illustrates the breakdown into individual municipalities.

**Table 5.3** - Commissioning models applied by Dutch municipalities 2015-2018 contracts (tenders)

<i>Tenders</i>	2015	2016	2017	2018
AWBZ-model	19 (23%)	1 (4%)	2 (5%)	0 (0%)
Population-based commissioning model	5 (6%)	1 (4%)	2 (5%)	1 (4%)
Catalogue model / fee-for-service	31 (37%)	14 (61%)	19 (48%)	11 (48%)
Catalogue model / outcome-based	27 (32%)	6 (26%)	16 (40%)	11 (48%)
Client auction model	2 (2%)	1 (4%)	1 (3%)	0 (0%)
Total	84 (100%)	23 (100%)	40 (100%)	23 (100%)

**Table 5.4** - Commissioning models applied by Dutch municipalities 2015-2018 contracts (municipalities)

<i>Municipalities</i>	2015	2016	2017	2018
AWBZ-model	108 (28%)	7 (7%)	9 (5%)	0 (0%)
Population-based commissioning model	15 (4%)	1 (1%)	2 (1%)	1 (1%)
Catalogue model / fee-for-service	142 (37%)	61 (61%)	102 (57%)	38 (56%)
Catalogue model / outcome-based	104 (27%)	26 (26%)	62 (34%)	29 (43%)
Client auction model	11 (3%)	5 (5%)	5 (3%)	0 (0%)
Total	380 (100%)	100 (100%)	180 (100%)	68 (100%)

The tables clearly evidence certain trends in municipal commissioning in the Netherlands since 2015. I discuss the most notable trends in Section 5.5.

### 5.4.2 Consolidated statistics of commissioning models per 2015 and 2018

Tables 5.3 and 5.4 illustrate the municipal choices for commissioning models in new tenders and the number of municipalities that have modified existing contracts year by year. In these tables it is not visible whether municipalities simply commission according to their current commissioning model or whether their new social care tender or the changes made in the contract imply their choice for a different commissioning model. Table 5.5 therefore provides the consolidated descriptive statistics for the municipal social care contracts for two points in time: 1 January 2015 and 1 January 2018.

The descriptive statistics in Table 5.5 confirm the findings with respect to the AWBZ-model and the catalogue model. Three years after the social care reform in the Netherlands, only 1% of municipalities still commissioned according to the AWBZ-model. The catalogue model has become the new status quo, where fee-for-service reimbursement still is the dominant municipal choice. The number of municipalities that have adopted outcome-based reimbursement within the catalogue model has risen each consecutive year since 2015.

**Table 5.5** – Commissioning models in 2015 and 2018 consolidated

<i>Municipalities</i>	2015	2018
AWBZ-model	108 (28%)	2 (1%)
Population-based commissioning model	15 (4%)	8 (2%)
Catalogue model / fee-for-service	142 (37%)	194 (57%)
Catalogue model / outcome-based	104 (27%)	133 (39%)
Client auction model	11 (3%)	6 (2%)
Total municipalities in analysis	382	343

Table 5.5 also illustrates that in total, the number of municipalities opting for population-based commissioning has declined since 2015. While a handful of municipalities adopted the population-based commissioning model in the years that followed, more municipalities abandoned it. The total share of the population-based commissioning model remains rather insignificant, as do the AWBZ-model and client auction model. However, in contrast to the latter two models that seem to have completely lost the interest of municipalities, the population-based commissioning model remains the center of many municipalities' attention, which is discussed further in the next section.

## 5.5 Interpretation of the trends in social care commissioning

This section provides an interpretation of the trends in municipal commissioning of social care services evidenced in the previous section. The interpretation discusses each commissioning model with respect to its share; either growing or declining.

### 5.5.1 The fall of the AWBZ-model

Perhaps most notable is the decline in the number of municipalities that contract according to the AWBZ-model in the years after 2015. As discussed, there are a number of reasons why municipalities opted for this model in 2015, although it does not seem to fit the goals of the social care reform. The motives for choosing this model in the transition period relate to facilitating a smooth transfer of responsibilities to the municipality. For the municipality, current care providers,

and existing clients, the AWBZ model allowed for optimal continuity and minimal change. The share of municipalities opting for this model in subsequent years has substantially decreased, and for 2018 contracts not a single municipality opted for this model. Chapter 4 has extensively discussed the disadvantages of the AWBZ-model (see Section 4.3.1.2). The disadvantages can be summarized as a lack of change compared to the pre-2015 regime of social care in the Netherlands, while the goal of the reform was in fact to achieve certain changes. This lack of change and overall ‘misfit’ with the social care reform goals are the likely explanations for why municipalities did not choose this model in consecutive procurements. Over the course of just three years, the model has almost completely disappeared.

### **5.5.2 The paradox of population-based commissioning: much debated but rarely adopted**

The population-based commissioning model received much attention from municipalities from the start of the decentralization. The (few) municipalities that have adopted this model have been referred to as an example of ‘*commissioning for innovation and partnership*’ on municipal platforms for sharing knowledge on commissioning of social care services among Dutch municipalities (‘*depilotstarter.vng.nl*’). Early in 2016 the NDSO, a network association representing the 50 largest Dutch municipalities, commissioned a study on the application of population-based commissioning for social care services (KPMG, HHM, & NDSO, 2016). This study illustrated the widespread municipal interest in this commissioning model. However, the findings of this research do not reflect this municipal interest. Among the new or modified social care contracts for the years 2016 to 2018, only four tenders have been launched that were in accordance with the population-based model. Another interesting observation is the fact that these four tenders correspond to four municipalities in total; every municipality that opted for this model did so independently. The municipalities typically left their existing procurement collaboration to commission a main contractor by themselves.

Possible factors contributing to this paradox between municipal interest and the actual adoption by municipalities of this the model are the following: first, the population-based commissioning model is fundamentally different from other models from different perspectives. In other models the municipality coordinates the contracts with each of the care providers (whether a few dozen or a few hundred). The municipality manages – or at least oversees – the care entitlement to citizens

as a separate process from social care service provision. Both the relations with subcontracted care providers and the process of care entitlement are out of sight for the municipality in the population-based commissioning model. A consequence is that the previous social care infrastructure (e.g. service specifications, tariffs, and terms and conditions) offers little to no guidance to draft the new contract. This makes population-based commissioning additionally complex in comparison to other models. Furthermore, in this model there is only one contracted care provider, meaning that there is a lot at stake to contract the right one. Second, many existing clients may lose their current caregiver (see Section 5.3.4). Third, as discussed in Chapter 4 Section 4.3.2, the model is associated with many risks for the municipality and clients. Fourth, while adopting the population-based commissioning model is complex, municipalities may recognize that once adopted it may be even harder to choose a different commissioning model in the future due to the vendor lock-in problem. To summarize, while the model perhaps has the strongest *theoretical* benefits in terms of expenditure control, allowing for innovations in care provision, collaboration among care providers, and integrated care provision, these benefits come at the cost of serious disadvantages. This results in higher risks – what if the benefits do not materialize, but the disadvantages are certain to occur? Governments – municipalities included – are known to be risk averse in relation to public procurement (Knight et al., 2007). The gap between theoretical advantages and certainty of the disadvantages of the population-based commissioning model may keep municipalities from implementing this model, despite its ongoing attention.

### 5.5.3 The catalogue model: the popular choice

The catalogue model has become the most popular commissioning model in the years following 2015, with most municipalities abandoning the AWBZ-model in its favor and hardly any municipalities switching once they have opted for the catalogue model. While fee-for-service reimbursement of social care services within this model remains the most common, a growing share of municipalities has adopted the variant with outcome-based reimbursement for services acquired under the catalogue model. Every year a number of municipalities introduce outcome-based bundled payments, and tables 5.3 and 5.4 evidence that the relative share of tendering municipalities that adopted the catalogue model with outcome-based payment grows every year – 26% of tenders in 2016, 40% of tenders in 2017, and 46% of tenders in 2018. There are hardly any municipalities that have abandoned the

outcome-based payment between 2016 and 2018, leading to a growing share of municipalities in this commissioning model. The popularity of the catalogue model may reflect that most municipalities, while they choose to outsource these services, still have the basic attitude of being in optimal control. Furthermore, in terms of commissioning care providers, the model is not complex or risky compared to population-based commissioning. The catalogue of services allows for a more incremental development of new services and approaches, that can be added to the catalogue over the course of time.

The growing popularity of the catalogue model in the subsequent years following 2015 has further decreased the certainty of clients and volume of services for care providers. Between 2015 and 2018, 95% of the contracts that used to involve a fixed budget for care providers no longer provided this certainty to providers of social care services. However, the framework agreements used in the catalogue model that do not contain agreed budgets also require a different mechanism to control expenditure for social care services for municipalities. Whereas until 2015 expenditure control was managed by agreeing upon fixed budgets for each contracted care provider, municipalities have now abandoned fixed budgets, except for those still operating the AWBZ-model and the population-based commissioning model. The municipalities operating the catalogue model rely on the scrutiny of local community teams in charge of social care entitlement to citizens. These organizations responsible for the formal assessment of a citizen's needs, the availability of options for informal care, and residual need for formal care hold the key to the municipal expenditure in the catalogue model. An outreaching local community team may find citizens in need of social care who might not have requested social care services on their own initiative. A generous local community team may be less strict in the scrutiny of citizens and entitle more clients to a higher volume of social care. While ensuring a high standard of social care to the municipal citizens, generous and outreaching local community teams may cause an increase in social care service expenditure. Keeping control over the local community teams is therefore pivotal for achieving the financial goals of the social care reform. Critical assessment of a citizen's needs, making a holistic assessment of the situation of the citizen, and only granting formal social care that is truly indispensable is considered an effective means to achieve the desired cost savings. Furthermore, the municipalities opting for outcome-based bundled payment often mention in the procurement documents that this is aimed to provide full professional discretion to (only) do what is necessary to achieve the social care outcomes, leading to innovation and (further) cost reductions.

### **5.5.4 Extinction looms for the client auction model**

The client auction model remains ‘exotic’, with only a handful of municipalities opting for it in subsequent years. The client auction model has never seriously gained traction, perhaps as a result of the negative media coverage discussed in Chapter 4 (see Section 4.3.4). Closer analysis reveals that the municipalities that commissioned according to this model in 2016 and 2017 had in fact already adopted it, meaning that after 2015 no municipalities newly adopted this model.

## **5.6 Conclusions and discussion**

The different commissioning models discussed in Chapter 4 each inhibit different competitive mechanisms and incentives for tailored social care, better collaboration among care providers, cost-efficiency, and – in general – innovative approaches to providing social care services. The developments in the Dutch municipal choices for social care commissioning in the years after the 2015 reform demonstrate that municipalities prefer *ex post* competition; in effect continuous competition over clients between a wide variety of care providers. The catalogue model allows extensive freedom of choice to clients with respect to their care provider, which indeed is one of the motives often referenced in the procurement documents.

The previous sections have already discussed interpretations of the findings of this chapter. I briefly revisit three aspects here: (1) a municipality’s basic attitude towards outsourcing social care services, (2) each commissioning model’s fit with the goals of the social care reform in the Netherlands, and (3) a municipality’s appetite for risk in relation to commissioning social care services. I discuss each aspect here, starting with the first. In Section 4.4.3 I introduced the idea of a scale, where at one end municipalities maintain as much control as possible over the organization of social care services except for outsourcing service provision. These municipalities organize client access to social care and case management in-house to keep a firm grip and maintain access to important information with respect to client needs, perception of quality, and care provider performance. At the other end of the scale municipalities opt for maximum involvement and room for manoeuvre for professional care providers, arguing that a municipality should not tell professional care providers how to do their jobs. While the previous section has evidenced the population-based commissioning model may count on wide municipal interest, the vast majority of municipalities opts for a position with firm grip and

optimal information vis-à-vis the care providers.

With respect to the second aspect, concerning each commissioning model's fit with the goals of the social care reform: achieving more tailored care, more integrated care provision and collaboration among care providers, and a cost-reduction. Where I argued the AWBZ-model is a poor fit with these goals (see Section 5.3.3), the other models each have their own mechanisms to potentially achieve the goals of the reform. This likely explains why the AWBZ model has almost completely disappeared over the course of 2015 to 2018.

The third aspect highlighted here is the risk appetite of municipalities levelled against the risk profile of the different commissioning models: governments – municipalities included – are known to be risk averse in relation to public procurement (Knight et al., 2007). While Chapters 4 and 5 do not provide an exhaustive analysis of every risk in each commissioning model it has become apparent that implementing the catalogue-model and client-auction model impose less extensive changes to the clients, the care providers, and in general the organization of social care services. The population-based commissioning model imposes much stronger changes, and is associated with more risk. Again, this may contribute to the findings that – despite wide interest – only a hand full of municipalities have so far opted for this latter model.

Although discussing motives for municipalities to adopt a certain commissioning model is relevant for the interpretation of the findings in this chapter, this does not yet provide insight in the actual impact of the model on the quality of social care, the costs of social care, or the effectiveness of social care services in attaining the desired outcome (i.e. improved self-reliance and social inclusion). Chapter 11 provides an empirical study into the effects of commissioning models on client perceived quality and effectiveness of social care services, and in doing so answers these questions.





# Chapter 6

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**Public procurement procedures for social care  
service procurement**

## 6.1 Competition or no competition: that's the question

This chapter discusses public procurement procedures used for contracting social care services. The *procurement procedure* here entails the process through which a (public) organization selects one or multiple suppliers for the provision of goods, services, or works to conclude a contract (or subsidy, concession) with. The procurement procedures used for contracting public services in general, and social services specifically, are a relevant object of study. The procurement procedure involves a relational dimension: how buyer and supplier interact in the process of concluding a contract, which impacts trust (Bovaird, 2006; Davis & Walker, 1997), which in turn is known to impact supplier performance in service (triad) contracts (Gunawardane, 2012; Karatzas, Johnson, & Bastl, 2016; Li & Choi, 2009). The procurement procedure *may* involve competition (this chapter will evidence procurement procedures that are not competitive in nature), which is often considered the primary advantage of outsourcing public services (S. Lamothe, 2015). Governments expect competitive forces to improve quality and reduce costs of public (social care) services (Randall & Williams, 2009). There is an apparent tension between traditional public procurement practices of administrative tendering of public contracts (in effect competitive procurement procedures) on the one hand, and establishing supplier relations characterized as trusting collaborations or partnerships (Erridge & Greer, 2002; Erridge & Nondi, 1994; Steane & Walker, 2000) on the other. As municipalities have wider discretion to design public procurement procedures for social care contracts (see Chapter 3 and further details in this chapter), studying the public procurement procedures used for social care contracts will shed light on the manner in which public buyers deal with this tension between a competitive and relational approach to contracting in a context with less administrative and procedural rules. This section first discusses these aspects of competition, competitive procurement procedures, and their perceived problems in more detail in the context of social care service contracts. This more elaborate discussion is used to introduce the research questions at the end of this section.

### 6.1.1 Public contracts and undistorted competition

Having identified that Dutch municipalities without exception opt for market provision of social care services (see Chapters 4 and 5), in this chapter I shift the attention to the process of concluding contracts: the public procurement procedure. Commonly, public authorities rely on competitive pressures to ensure efficient

delivery of contracted services and supplies. The Treaty of Rome established the single European market and created a set of rules to ensure competition among the EU member states was not distorted (European Commission, 2014). Competition is considered a vital element in EU economies and is associated with reduced prices, improved quality, more choice for consumers, and innovation in goods and services (European Commission, 2014).

Although Chapter 4 introduces the concept of ex post competition – being competition beyond the point in time where a public authority has concluded public contracts with suppliers – the emphasis in both literature and regulations typically falls on ex ante competition. Ex ante competition is the competition between economic operators over winning an exclusive contract. The exclusive award of public contracts requires a competitive procurement procedure through which the contracting authority determines the supplier that ‘wins’ the contract. Within EU member states, competitive public procurement is governed by EU directives and national public procurement law. These directives aim to abolish all existing forms of direct and indirect discrimination in order to achieve the fulfilment of a single EU market, allowing every economic operator within the EU equal opportunities to win the public contract. The regulations build on principles of objectivity, non-discrimination, transparency, and proportionality for awarding public contracts. As discussed, the regulations focus on the process of concluding contracts, assuming competition to be ‘ex ante’ competition over contracts. Directive 2014/24/EU prescribes different public procurement procedures, which depending on certain conditions (i.e. contract value, market conditions, etc.) may be used for the exclusive award of a public contract.

### **6.1.2 Problems with traditional competitive tenders: in search of a more relational approach**

Competitive public tendering and EU public procurement regulations have struggled with compliance issues, especially among local governments (de Boer & Telgen, 1998; Martin, Hartley, & Cox, 1999; Roel van Weert, Zwanepol, & Idzenga, 2015). Public competitive tenders are often bureaucratic in nature, and the tedious bureaucratic procedures involved may lead to frustration both at the side of local governments and suppliers (Erridge & Greer, 2002). Administrative competitive public procurement procedures may in turn affect the relationship between public buyer and its suppliers, resulting in the erosion of trust (Boyne, 1998). An under-

standing is growing that (public) buyers benefit from collaborative and trusting relationships with their suppliers (Gunawardane, 2012; Karatzas et al., 2016; Li & Choi, 2009; Nätti et al., 2014). Furthermore, it is recognized that these buyer-supplier relationships are socially constructed in the procurement process (Bovaird, 2006). Establishing a trusting and collaborative relationship therefore calls for a different, more relational approach to public procurement. However, these relational approaches and the use of long-lasting contracts are often considered to conflict with public procurement regulations.

### **6.1.3 In-house or outsourced provision of social care services: the academic debate continues**

The debate over *market* versus *government in-house* provision of social care services also circles around competition. Advocates of contracting external care providers (within this debate considered 'private') argue that competition will improve quality, reduce costs, foster innovation, and increase client choice (S. Lamothe, 2015; Randall & Williams, 2009). Scholars not in favor of contracting out social services argue that there may not be a market for social care (S. Lamothe, 2015), or that the delivery of care services to frail, elderly citizens is not a suitable context in which to introduce competition (Kirkpatrick et al., 2001; J. Stewart & Walsh, 1992; Wistow & Hardy, 1999). As the benefits of market provision are attributed to competition, generally assumed to be achieved through competitive tendering, it can be expected that municipalities use competitive procurement procedures when commissioning social care services. However, the disadvantages of traditional bureaucratic competitive tendering (discussed in the previous section) also weigh heavy on the procurement of social care services. Contracting external care providers for to provide social care services is a politically sensitive subject, as it concerns services delivered to the most vulnerable citizens in our society. Fears over quality and safety are felt more strongly in this context compared to other services such as cleaning office spaces. Furthermore, procurement of services in itself is considered additionally complex compared to procurement of supplies, for example with respect to defining and measuring service quality (Jackson, Neidell, & Lunsford, 1995). With social care services, it is not the buyer that experiences service quality, but the client. This is known as a service triad (Li & Choi, 2009), and it is not exclusively the domain of health and social care – the outsourcing of IT support to a third party or of cleaning services can lead to the same triadic service relations. The clients may experience the negative consequences of suboptimal procurement, in this

context insufficient quality of care services. Consequently, the public procurement of social care requires municipalities to find a balance between competitive forces and building trusting collaborative relationships with contracted care providers. These two elements of relations and competition come together in the public procurement procedure used for contracting care providers, which is the first reason why studying these procedures is relevant and interesting.

#### **6.1.4 The light regime social services in public procurement law: an opportunity for new procurement approaches**

Interestingly, contracts for social services are subject only to a light regime under the EU directives on public procurement (for an overview see Chapter 3). Public authorities need to comply with the principles of equal treatment, transparency, and proportionality when awarding contracts for social (care) services. However, the more detailed provisions that apply to contracts for common services and supplies do not apply to contracts for social services. This means municipalities that buy social care services have much more freedom to organize the procurement process. The light regime offers more discretion to municipalities, for example by allowing a more relational approach to public procurement of social care services. This is the second reason why studying public procurement procedures in the context of social care is very interesting. There is not only an emphatic need for a balanced approach to procurement; municipalities also have the discretion to tailor the procurement procedure to needs that arise from this context. The 2015 reform of social care services in the Netherlands adds to an already highly interesting context for this study, because the municipalities had to contract social care services simultaneously and under the same conditions.

To summarize, I identify on the one hand the dimension of competition that acts as the key driver of the benefits of market provision of public social care services, and on the other the dimension of relational contracting – the desire and need to build trusting and collaborative relationships with suppliers – that starts in the procurement process. While these two dimensions are not entirely mutually exclusive, a certain tension exists between them. In order to exclusively select the best supplier(s), a public authority must objectively and transparently rank each alternative supplier's proposal; a process leaning more towards an arm's length bureaucratic approach. In contrast, establishing collaborative and trusting relationships may be better achieved through intense dialogue, shaping a contract and detailed terms

together between buyer and supplier, and allowing for negotiations on the basis of a more equal relationship (Bovaird, 2006; Erridge & Nondi, 1994; Rowlinson & Cheung, 2004). Besides identifying the public procurement procedures used for contracting social care in itself, it is therefore also very interesting to identify how these procedures are positioned in a competition-relation framework.

This leads to the following research questions:

1. Which public procurement procedures have Dutch municipalities applied in the advent of the 2015 reform of social care services in the Netherlands?
2. How do the different procedures qualify in terms of competition (are these procedures aimed at achieving ex ante competition, ex post competition, or both?)
3. How do the different procedures qualify in terms of the relational approach?

At this stage it is appropriate to introduce more detailed terminology with respect to procurement procedures. In this research a *procurement procedure* entails the process through which a (public) organization selects one or multiple suppliers for the provision of goods, services, or works with which to conclude a contract (or subsidy, concession). In the context of this research, municipalities organize a procurement procedure in order to award contracts for social care to external care providers. I furthermore distinguish between *legal procurement procedures* and *custom procurement procedures*. *Legal procurement procedures* are defined in Directive 2014/24/EU in Art. 27 up to and including Art. 32 on public procurement, and in the *Aanbestedingswet 2012* (Dutch Public Procurement Act 2012). As discussed in Chapter 3, EU public bodies such as municipalities have more discretion with respect to procurement procedures for contracting social care services. A municipality may deviate from using a legal procurement procedure for social care contracts, and use a *custom procurement procedure* within the confines of the light regime of Directive 2014/24/EU. A custom procurement procedure is defined here as a procedure – other than a legal procurement procedure – designed by a municipality. This chapter discusses both the legal and custom procurement procedures municipalities used for outsourcing social care services within the scope of this research. Note that a careful legal analysis of the procurement procedures encountered in the empirical analysis is outside the scope of this research. I did not verify whether every legal and custom procedure complies with the EU and national procurement law. Section 6.2 synthesizes the relevant literature with respect to public procurement of public social services with a focus on competitive

and relational contracting. Section 6.3 discusses the methodology applied in this research. Section 6.4 discusses the findings of this research, followed by a discussion of conclusions in Section 6.5.

## **6.2 The scientific debate on competition and relational contracting for social care contracts**

### **6.2.5 Competition versus relational contracting: a public management perspective**

Competition is at the center of debating the merits of outsourcing public social services (S. Lamothe, 2015). By introducing competition, public authorities aim for the competitive forces to encourage quality while driving down costs (Randall & Williams, 2009). The mechanism to invoke competition is generally – implicitly or explicitly – considered to revolve around gaining exclusive rights to deliver services, in effect winning a public contract over other interested providers. In the introduction of this chapter I refer to the disadvantages of more traditional competitive procurement procedures. Recognition grew that markets for social services need to be more effectively ‘managed’ in order to encourage greater collaboration and joint working between purchasers and providers; a process which requires the development of networks and relational contracts (Kirkpatrick et al., 2001). These networks and relational contracts are expected to minimize transaction costs by reducing the potential for opportunism through interdependent relationships based on trust, loyalty, and reciprocity (Lowndes & Skelcher, 1998). Implementing the partnership approach to procurement has proved to be a difficult task, as the operating framework and culture of public authorities have hindered the development of inter-organizational relationships and trust (Erridge & Greer, 2000). In recognizing that market relationships are socially constructed in the procurement process rather than being a product of market conditions (Bovaird, 2006), it became apparent that there the was a need for an approach different from traditional competitive tendering, which was associated with creating adversarial relationships (Bovaird, 2006). Partnerships have the potential to build social capital by establishing networks and developing long-term relationships with private sector suppliers by moving public procurement away from traditional arm’s length competitive tendering procedures (Steane & Walker, 2000). In contrast to an administrative approach and market governance mechanisms, in the relational contracting

literature relational mechanisms are considered a more efficient contracting governance mechanism (Dyer & Singh, 1998; Macaulay, 1963). Relational contracting aims to establish collaborative relationships and build social capital among the buyer and supplier. It is based on, and strives towards, a recognition of mutual benefits and win-win scenarios through more cooperative relationships between the buyer and supplier, embracing various approaches such as partnering, alliancing, joint venturing, and other collaborative working arrangements. Relationship contracts are usually long-term, develop and change over time, and involve substantial relations between the parties (Rowlinson & Cheung, 2004). Although there is no one strict approach to relational contracting, perhaps the most common characteristic with respect to the procurement process is that contracts are constituted through buyer-supplier negotiations rather than bureaucratic tendering of over-specified cast-in-stone contracts. See in this respect the work of Erridge & Nondi (1994).

### **6.2.6 A new perspective on procurement procedures for social care: the competition - relation framework**

To identify how Dutch municipal procurement procedures qualify with respect to both competitive and relational characteristics, I position the observed procedures within a framework composed of competition characteristics as one dimension, and relational characteristics as the other. Below I further elaborate how the competitive and relational characteristics in the framework are classified. I deviate from earlier comparative frameworks between ‘competition’, ‘mixed’, and ‘partnership’ approaches to public procurement (Erridge & Nondi, 1994). Erridge & Nondi (1994) discuss a partnership versus competition approach, including in this comparison in total of seven characteristics: supplier selection, length of the contract, number of suppliers, contractual relations, communication with suppliers, negotiation, and joint activities with suppliers. As the research in this chapter focuses on public procurement procedures, I do not include characteristics that relate to the contents of the contract (length of the contract, joint activities with suppliers) or choices I discussed in chapters concerning the commissioning model (i.e. the number of suppliers). I do however revisit the framework developed by Erridge & Nondi in the discussion in Chapter 7.

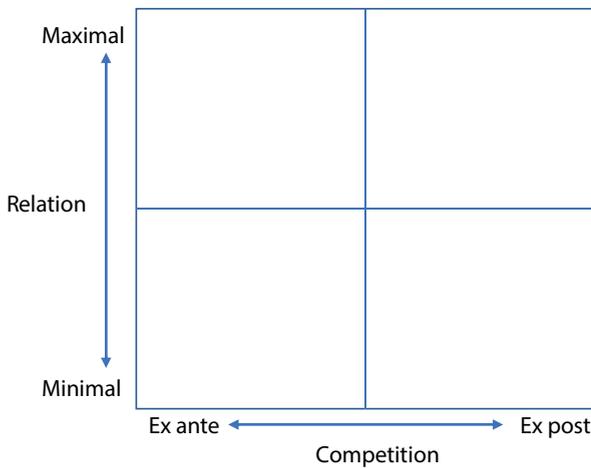
Extant research on competition often paints a one-sided image of competitive forces in the form of price competition in relation to contractual exclusivity. This ‘ex ante’ competitive mechanism is studied by measuring the strength of market

forces, for example through analyzing the number of tenders in a competitive procurement procedure (Eijkel et al., 2018; Savas, 2002) and the quality of such competitive tenders (S. Lamothe, 2015). Ex post competition has received very little scholarly attention in this debate, although I nevertheless argue that its impact on service quality is potentially extensive. Municipalities that contract care providers in framework agreements with standardized terms and agreements typically allow clients free choice of care providers, as well as the opportunity to turn to a different care provider in case they are not satisfied. For services with sufficient competing care providers, and users that are capable of comparing alternative care providers, such ex post competition can strongly incentivize service quality. Ex post competition then is a different mechanism that can be used in addition to, or as an alternative to ex ante competition over contracts. Ex post competition does not cater for reduced expenditure, although I will discuss municipalities have alternative means for this. In the competition-relation framework, pure ex ante competition over a contract is at one end of the spectrum, and ex post competition is positioned at the other.

In public procurement in general, and in social service procurement specifically, the recognition has dawned that investing in the buyer-supplier relationship has its merits for the public buyer. Buyer-supplier relationships with a trusting and collaborative character are found to be less prone to supplier opportunism (Hartmann & Herb, 2014; Li & Choi, 2009; Nätti et al., 2014). Collaborative relationships between the commissioning municipality and social service providers are therefore expected to foster good quality of services and to avoid other opportunistic behavior such as supplier induced demand (Sørensen & Grytten, 1999). While traditionally public procurement has favored arms-length competitive procedures – known to hinder the establishment of a trusting and collaborative relationship – relational contracting is on the rise in public procurement. As this relational dimension in buyer-supplier relationships is of such importance in the broader discussion on the optimal coordination of social services, it is the second dimension of public procurement procedures elaborated here further.

Combining both competition and relational characteristics creates a competition-relation framework for public procurement procedures. With respect to competition, the framework distinguishes ex ante and ex post competition. With respect to the relational characteristics, the framework distinguishes between minimum to maximum attention and focus on the buyer-supplier relationship in public procurement procedures. Traditional, bureaucratic arm's length competi-

tive procedures enacted without consultation or negotiation with care providers are positioned at the one end of the spectrum – with minimal attention given to building collaborative buyer-supplier relationships. On the other hand, procedures with extensive consultation and negotiation between municipality and care providers, with formalized influence of care providers in the process of drawing up the final contract, are considered to draw maximal attention to building collaborative and trusting buyer-supplier relationships. The combinations of these two dimensions form the competition-relation framework depicted in Figure 6.1, within which different procurement procedures can be positioned. In this research I analyzed the public procurement procedures used by Dutch municipalities in the advent of the 2015 reform of social care services in the Netherlands and following years. To do so, I position each of the identified types of procedures in the competition-relation framework. The next section discusses the research methodology.



**Figure 6.1** - Competition-relation framework

### 6.3 Empirical methodology

In 2015, Dutch municipalities became responsible for a range of social services for adults with a disability (cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these), including all forms of personal assistance, respite care, and certain types of residential care. Residential care is not financed by the central government to each individual municipality: rather, 43 '*centrumgemeenten*' (municipalities in the center of a region) are funded for these services

and mandatory collaborations were formed (Kamerstukken II 2013/14, 33841, nr. 3, 2014). However, for *personal assistance services* 393 municipalities each received their own individual funds and no collaboration was imposed. I chose the procurement of *personal assistance* as the object of this study for a number of reasons. First, these social care services are among those subject to the 2015 reform; each of the 393 municipalities are obliged, as of 2015, to organize these services, and each municipality has effectively outsourced these services. Second, I chose these services because of the far stretching discretion municipalities have for organizing and outsourcing them. Municipal procurement is not bound by strict regulations, nor is collaboration with other municipalities imposed. Third, personal assistance is a common type of social care service for which there are typically many (potential) suppliers, and the recipients of these services are relatively self-reliant and empowered to choose among contracted care providers. These conditions are important in a study on the competitive nature of procurement procedures. Both *ex ante* competitive procedures and *ex post* competition in framework agreements rely on market forces – in effect the presence of different contracted care providers – to compete with each other. Both municipalities organizing competitive procurement procedures and citizens having a choice among contracted care providers are in fact competitive mechanisms important for good performance (Savas, 2002).

### 6.3.1 Retrieving the 2015 procurement documents

To study municipal procurement procedures for the procurement of personal assistance, I systematically searched, gathered, and analyzed the official relevant procurement documents used by Dutch municipalities. The aim was to collect public procurement documents for as many municipalities as possible – in other words, to be as complete as possible. For searching and gathering these procurement documents, I consulted multiple sources. I started by searching the official public tender database of the European Union (tender electronic daily – or TED – database; ted.europe.eu) and the national public tender database of the Netherlands (Tenderned.nl) using terms that refer to the *Wet Maatschappelijke Ondersteuning 2015* alone and various additional references to ‘social service’, ‘personal assistance’, and related synonyms. Search terms included ‘Wmo’, ‘Wmo 2015’, ‘WMO maatwerk\*’ (*Wmo provision*), ‘WMO begeleiding’ (*Wmo personal assistance*), ‘maatschappelijke ondersteuning’ (*social support*), et cetera. Search results were scrutinized for relevance to ensure that the resulting tenders actually included the specific services in scope of the research. For relevant tenders, the procurement documents such as official

statements of requirements, prior information notices, policy documents, draft (framework) contracts, side letters, appendices, question and answer sheets, and any other official documents that could be relevant were collected. After these initial search activities, the municipalities were identified for which no procurement documents had been retrieved yet. As the publication of social service contracts was not mandatory under EU Directive 2004/18/EG (see Chapter 3), two additional rounds of searching were necessary. In the second search round, I broadened the search database and used Google search, now using more targeted search terms such as 'inkoop Wmo Amsterdam' (*procurement Wmo Amsterdam*) or 'aanbesteding Wmo Amsterdam' (*tender Wmo Amsterdam*) to find the missing municipalities. Through these searches, procurements published on dedicated municipal webpages were retrieved. After two rounds of searching these public data sources I retrieved the procurement documents for the services within scope of this research for approximately 75% of the 393 Dutch municipalities. To further complement the data, individual municipalities were contacted directly through contact information on the municipal websites, requesting the procurement documents used. This third round of searching secured the total retrieval of procurement documents for 382 out of the 393 Dutch municipalities that existed on 1 January 2015.

### **6.3.2 A systematic analysis of 382 procurements**

For 2015 contracts of personal assistance, the majority of the 382 municipalities voluntarily collaborated with other municipalities in a total of 86 different procurement procedures. For each of the 86 procurement procedures I analyzed the procurement documents to determine how municipalities managed the dimensions of competition and dialogue. Besides analyzing and categorizing every tender with respect to these dimensions, the different types of social service procurement procedures were determined. Before Directive 2014/24/EU was formally implemented in the Dutch Public Procurement Act on 18 April 2016, social (care) services were included in Annex 2B of Directive 2004/18/EC, and subjected only to a light regime. Contracts for social care services were not subject to mandatory ex ante publicity (unless these contracts were of certain cross-border interest), and the Dutch legislator did not implement specific national rules for the award of social care contracts in the national *Aanbestedingswet* 2012 (Public Procurement Act 2012). As a consequence, municipalities contracting social care services could deviate from public procurement procedures defined in EU and national legislation. This allowed municipalities to combine elements of the *legal procurement proce-*

dures in tailored *custom procurement procedures*, or to create completely new procedures. A categorization of public procurement procedures therefore could not be solely based on an exhaustive set of procedures defined in legislation. In the analysis of procurement documents, I identify 'custom' procurement procedures. Similar custom procedures that share their characteristics with respect to competition and dialogue are grouped. This led to a categorization relevant for answering the research questions in this study.

### 6.3.3 Collection of the 2016, 2017, and 2018 procurements

The 2015 reform of social care services forced a simultaneous procurement of 393 municipalities. From a research perspective this was convenient: it is certain that every municipality had contracts starting on 1 January 2015. Every municipality must have organized a procurement throughout the year leading up to the reform. By gathering and analyzing the procurement and contracts of 97% of all municipalities, I created an accurate picture of the first round of municipal social care service procurements with respect to the services addressed in this research. The aim to also study the social care service procurement longitudinally – in effect studying the second and where relevant third and fourth round of social service procurements between 2016 and 2018 – was more complicated. The municipal discretion to organize local social care services and the light regime of rules consequently gave rise to a high degree of variation in organization and procurement procedures. For example, the duration of the 2015 municipal contracts for social care services vary in duration from 6 months to 10 years. And a substantial number of contracts did not specify an exact duration at all. These contracts had an undefined duration that could in theory be indefinite. Municipalities with these contracts used clauses to allow for changing the contract terms and conditions and even dissolving the contract at any point in time.

For the consecutive years after 2015 (2016, 2017, and 2018), I annually searched which municipalities procured *personal assistance* services year by year. For these years, the aim was to establish whether these municipalities have procured the social services in scope of this research and how they have procured social services. This longitudinal search and analysis allowed me to build a complete overview of municipal procurement over a four-year period.

## **6.4 Findings: procurement procedures for social care services**

This section discusses the different procurement procedures encountered in the analysis of municipal procurement of social services between 2015 and 2018. Chapter 7 provides descriptive statistics with respect to frequencies of the different procedures and the trends encountered in the longitudinal study. Furthermore, Chapter 7 also discusses the positions of each of the procedures in the competition-relation framework.

### **6.4.1 Discretion for custom procurement procedures**

During the 2015 decentralization of social care in the Netherlands, municipalities had ample room to initiate public procurement procedures for awarding social care contracts tailored to their own needs. As a consequence, several custom procurement procedures that combine elements of different legal procurement procedures became popular among municipalities. Directive 2014/24/EU abandoned the annexes 2A and 2B, but maintained a different – light – regime for social and other specific services. The Directive requires member states to implement a procedure specifically for social and other specific services. The Dutch government chose not to implement the procedure for social and other specific services Directive 2014/24/EU calls for. Therefore, from April 2016 onwards, only the rules stipulated in Directive 2014/24/EU with respect to the procedure for social and other specific services applied to the municipal procurement of social care services. This led to a prolonged situation of municipalities using many of the custom procurement procedures alongside municipalities using a legal public procurement procedure, i.e. one laid down in Directive 2014/24/EU. These custom procurement procedures became very popular amongst Dutch municipalities for outsourcing social care services. The absence of a formalized definition of these procedures created the opportunity for a wide range of different procedures and variations. Such extensive variation was indeed observed with respect to both terminology and the actual procedural activities and elements used by different municipalities. However, by accepting minor variations in procedural steps and the variation in terminology used (as is common in the application of legal procurement procedures too), it was possible to identify three classes of custom procurement procedures used by Dutch municipalities for outsourcing social care services: (1) an open competitive negotiated procedure, (2) an open non-competitive procedure,

and (3) a dialogue-based procedure. Furthermore, two legal procurement procedures are observed: (1) the negotiated procedure without prior publication, and (2) the open competitive procedure. I describe each of these five procedures in the context of social care contracts in the following sections.

#### **6.4.2 Negotiations with hand-picked care providers only: the negotiated procedure without prior publication**

Directive 2004/18/EC did not require the publication of contracts for social care services, and municipalities used this discretion to apply the negotiated procedure without prior publication. In public contracts with a value below EU and potential national thresholds, the negotiated procedure without prior publication is typically used by contracting bodies to request a limited number of tenders. The public body invites a limited number of economic operators to tender in competition and awards the contract to the economic operator with best tender. In this study, I found municipalities have taken a different approach, yet using this same procedure. Municipalities applying this procedure typically involved only the incumbent care providers for social services under the existing (2014) contract. During the first municipal procurement – throughout the year 2014 – this concerned care providers contracted under the AWBZ. Under the AWBZ, the Netherlands was divided in 32 regions with respect to social care procurement. In each region, the health insurance company with highest market share was responsible to contract care providers for social care services. Through ‘regional care offices’ typically up to two or three dozens of care providers were contracted against standard quality criteria and for standard services, but with variation in fees for services. Rather than inviting or negotiating with these care providers in competition, municipalities negotiated a contract with each of these care providers. From its implementation this procedure is not ‘ex ante’ competitive for the invited (typically incumbent) care providers. The individual contracts with care providers built on a standard set of services and conditions, and any negotiations with individual care providers generally concerned the tariffs within the fee-for-service contract, and production agreements (i.e. the annual budget). There is no competition over contracts and no opportunity for new care providers to enter into contracts under the negotiated procedure without prior publication. There is limited ex post competition over individual clients as production agreements are typically part of the contracts procured through this procedure. These production agreements – based on the clients in care at the start of 2015 – determined the annual budget, although in situations

of great client mobility (clients switching to a different care provider) some municipalities arranged, to some extent, for contract clauses to redistribute budgets accordingly. The negotiated procedure without prior publication in fact closely resembles the 'negotiation model' proposed by Dehoog as one of two alternative contracting models for the 'competition model' (Dehoog, 1990).

The implementation of the negotiated procedure without prior publication is characterized by the absence of 'ex ante' competition and by only very limited 'ex post' competition. There is no competition over contracts; incumbent care providers are invited to bilateral negotiations, which generally result in the award of a contract to each of these care providers. Similarly, competition over individual clients is either very limited or non-existent. A handful of municipalities that contracted care providers deviated from this approach; they either introduced ex ante or ex post competition. With ex ante competition, the few hand-selected care providers compete over contracts with population-based budgets. The care providers that win a contract become the main contractor for part of the municipal population. When introducing ex post competition within the framework of this procedure, every hand-selected care provider is contracted without making production or budget agreements. Here, the contracted care providers do have to compete over individual clients.

### **6.4.3 Ex ante competition with the open competitive procedure**

The open competitive procedure is a common public procurement procedure in general public procurement. For social care services, municipalities publish the tender that specifies exclusion grounds, suitability criteria, conditions and service specifications, and information with respect to the tender procedure itself. Furthermore, in the open competitive procedure municipalities also publish their award criterion. The Wmo 2015 requires municipalities to award contracts on the basis of the Most Economically Advantageous Tender (MEAT), rather than lowest price. The open competitive procedure – as the name implies – involves ex ante competition; in other words, in this procedure there is a certain degree of competition over contracts. However, for the 2015 social care services procurement it was exceptional for municipalities to award only one contract. The competitive element in this procedure more commonly materializes in one of two ways. The most common is that municipalities award a limited amount of contracts, in effect awarding to the care providers with the most economically advantageous tenders. These tenders are

evaluated with respect to quality and price; provisions in the Wmo 2015 require that contracts are not awarded on lowest price alone. For example, municipalities that award a limited number of contracts rank offers in terms of price-to-quality ratio and award contracts only to the best care providers, until total capacity requirements are fulfilled. Alternatively, municipalities award contracts to every care provider that meets suitability and quality criteria, and allow higher production (a higher budget) to care providers with better offers. Whether competition is over contracts or better contract conditions, there is an incentive for care providers to submit competitive – in effect low price and high quality – tenders. Out of all procedures encountered, the open competitive procedure (as it is implemented by Dutch municipalities for the 2015 social service procurement) best resembles the traditional bureaucratic competitive tendering. The service specifications and planning of all steps of the procedure are cast in stone before the publication of the contract, and the procedure is not designed to incorporate input from care providers into the service specifications, quality criteria, or contract terms.

#### **6.4.4 Negotiating a new social care monopolist: the open competitive negotiated procedure**

Some Dutch municipalities implemented an entirely new way of coordinating the outsourced provision of social services by contracting one or a few main contractors for social services for the entire municipality. These contracts have a wide scope, and main contractors need sub-contractors to fulfil capacity requirements. The contracts therefore not only deal with the provision of social services, but also the required coordination activities between main and sub-contractors, and coordination between municipality and main contractor. Municipalities here typically opt for a customized procedure based on the open competitive procedure, according to a purchasing methodology known in the Netherlands and the USA as 'best value procurement' (BVP). According to the BVP principles, the buyer should refrain from specifying details in order to prevent a negative influence on the quality of the delivered services (Kashiwagi, 2011). Essential in the BVP method is that the buyer does not specify the contract extensively or in detail. The buyer specifies the objectives that a supplier must achieve rather than using detailed technical specifications. The procurement procedure then starts with functional requirements or 'performance requirements' rather than specifying the route by which it should be achieved (Georghiou, Edler, Uyarra, & Yeow, 2014). Subsequently, the BVP procurement procedure follows two phases: (1) the selection of the best supplier(s) based

on an initial offer to proceed with in phase 2, and (2) negotiations over the final (more detailed) contract.

I define municipal social care procurements according to these principles as ‘open competitive negotiated procedures’, which are also divided in two phases. In phase 1, care providers are invited to submit an initial offer based on a functional specification of the contract. The municipality evaluates the offers according to the award criteria (MEAT) and preliminarily awards the contract to the care provider with the best evaluated offer. However, the municipality and care provider then enter into negotiations (phase 2) to work out the details of the contract and make it more complete. Only if the municipality and the (preliminarily) awarded care provider agree on all the details, is the contract award finalized. If the negotiation phase does not result in mutual agreement over the contract details, the municipality revokes the preliminary award, and repeats the negotiation with the second-best care provider from phase 1. This procedure has elements of the competitive procedure with negotiation (Directive 2014/24/EU, Art. 29) and is characterized by strong ex ante competition; the strongest among the procedures discussed in this research.

#### **6.4.5 Towards ex post competition with a qualification procedure: the open non-competitive procedure**

The open non-competitive procedure is another ‘custom’ public procurement procedure used for social services in the Netherlands. In the Netherlands, this procedure is also known as the ‘Zeeuws’ model. To a certain extent, it resembles the open competitive procedure. The municipality publishes the contract including exclusion grounds, suitability criteria, conditions, and service specifications. A distinguishing feature of the open non-competitive procedure is the absence of award criteria to determine the best care provider offer(s). With the open non-competitive procedure, municipalities in fact award framework agreements with standardized terms and conditions. Every suitable and qualifying care provider that submits a tender for providing social services against the conditions and terms offered by the municipality is awarded a framework agreement. The procedure is characterized by a low level of administrative efforts; the care provider does not have to elaborate specify their services or their way of working. Municipalities typically require only a minimum of evidencing documents in the tender. A signed note confirming unconditional acceptance of terms and conditions, a copy of the organization’s

quality plan or certificate, and proof of formal registration at the Dutch chamber of commerce generally suffices. The open non-competitive procedure completely lacks *ex ante* competition: the municipality awards framework agreements to any interested qualifying care provider. The framework agreement, however, does not yet guarantee any business, since within the framework agreement there is *ex post* competition over clients. New clients choose their care provider from the providers in the framework agreement, and clients are allowed to switch to different care providers if they are not satisfied. Municipalities may organize market consultations in preparation of the open non-competitive procedure; however, once the contract is published, the terms, conditions, and service prices are cast in stone. There is one variant of the procedure, which concerns service prices: while using this open non-competitive procedure, some municipalities require care providers to submit a price offer for the services. The municipal tender documents typically state maximum prices (per minute, hour, or day, depending on the type of service) under which care providers must stay when offering prices. Interestingly, here incentives for care providers to offer the lowest possible prices completely lack. As long as the prices offered are below the municipal maximum, care providers are awarded framework agreements when meeting all other the suitability and quality criteria. Finally, there is no reference to any '*ex post*' advantage for care providers with the lowest prices.

#### **6.4.6 A relational approach to *ex post* competition: plenary negotiations in the dialogue-based procedure**

The dialogue-based procedure is the third type of custom procurement procedures that originated in the Netherlands when social services were subject to the light regime of Directive 2004/18/EC. This procedure is known in the Netherlands as *Bestuurlijk Aanbesteden*. The procedure was developed by T. Robbe, who wrote many essays and short articles on it; see for example the 2011 essay that discusses this procedure (Robbe, 2011). The dialogue-based procedure is characterized by the municipality organizing repetitive plenary negotiations to draw up a standardized framework agreement together with interested care providers. The municipality publishes this negotiation procedure and invites interested care providers for plenary negotiation sessions. The plenary negotiations bring the most important care providers together at the negotiation table with the commissioning municipalities; other interested care providers are kept informed – and may provide feedback – through an internet platform. The negotiations lead to a standardized

framework agreement that is awarded to each of the interested and qualifying care providers; this type of standardized contract is actually very similar to the contract type procured using the open non-competitive procedure. Care providers that respond to the publication of the procedure first formally join the procurement network by signing a formal process contract that specifies communication, negotiation, and decision rules for the negotiation sessions. The municipality and all care providers that have signed the process agreement make up this procurement network. The process contract furthermore specifies the exclusion grounds and suitability criteria applying both to access to the negotiation table and to the actual final framework agreement for service provision. This initial process contract can be seen as a formalized social contract as defined by John (1984): a micro-level agreement that is purposely designed within an individual exchange relationship. It does not regulate the terms and agreements for the provision of social services, rather it formalizes the intentions of entering into a partnership between municipalities and care providers in the procurement network. The plenary negotiation sessions are iterative; in multiple sessions different parts of the contract are negotiated, with opportunities to revisit earlier discussion points when contract formulation is not yet satisfactory for different stakeholders. For practical reasons selection of care providers is necessary for the actual negotiation table, and care providers not invited to the negotiation table are kept informed of progress through publication of the resulting intermediate draft contracts. These care providers are allowed to provide feedback and suggestions for alteration through e-mail, which are then discussed in the next physical negotiation.

The end result of the procedure is a standardized framework agreement that is also open to care providers who did not participate in the negotiation sessions. These care providers must first join the procurement network by requesting access to the process contract. The process contract typically regulates that the framework agreement remains open throughout the contract duration for new care providers as long as they meet suitability and quality requirements. The dialogue-based procedure should be considered a form of 'relational contracting'. This is reflected in the level of involvement of care providers in drawing up the framework agreement. Additionally, municipalities using this dialogue-based procedure opt for an unusually long contract duration both for the process contract and service framework agreement. Until 2014, care providers were contracted on an annual basis. Since 2015, the contracts of over one quarter of municipalities using the dialogue-based procedure have an indefinite duration. Another 30 percent of these agreements have a duration between four and ten years, not counting the options to extend the

contract. The municipalities with indefinitely lasting contracts include clauses in the contract to make alterations to the contract, to dissolve or remit the contract altogether, and for care providers to withdraw from the contract. However, a long duration is considered a sign of investment in the procurement network and an indication of the intention to build long lasting relationships between commissioners and care providers.

## 6.5 Conclusion

The observed public procurement procedures illustrate how buying social care services is of a very different nature compared to common services and supplies. First of all, the legal procurement procedures defined in Directive 2014/24/EU and the *Aanbestedingswet 2012* are implemented in an atypical fashion. Municipalities use the open competitive procedure to award multiple contracts in parallel to the care providers with the most economically advantageous tenders. Second, and more prominently highlighting the contrast between social services and common service contracts, I described custom procurement procedures. Municipalities used their discretion provided by the light regime in the public procurement laws for social care services to devise custom procurement procedures. Custom procedures such as the dialogue-based procedure and the open competitive negotiated procedure demonstrate a relational approach to contracting, making use of negotiations and defining terms and conditions together with care providers. Furthermore, while municipal contracts for social care services are well over the EU threshold value that applies to common services, it is observed that municipalities used the light legal regime to apply the negotiated procedure without prior publication for social care contracts – at least in 2015. The open, non-competitive procedure does not reflect the emphasized relational approach. However, this custom procedure again is atypical, as here *ex ante* competition is non-existent.

The diversity in the procurement procedures, both in terms of competitiveness and relational approaches and used by different municipalities at the same point in time for the same social care services, demonstrates that municipalities feel the need for non-traditional procurement procedures. Some municipalities opt for competition over clients, rather than contracts, and for negotiation rather than administration. Chapter 7 provides more details of the analysis of public procurement procedures leading to contracts for 2015, and the consecutive years to follow until 2018.



# Chapter 7

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**Public procurement procedures for social care services: municipal choices between 2015 and 2018**

## 7.1 An overview of the procedures used from 2015 to 2018

Chapter 6 discussed the public procurement procedures used by Dutch municipalities to contract care providers for the social care service of personal assistance between 2015 and 2018. Chapter 6 also introduced the competition-relation framework. This chapter presents the findings of the empirical analysis of each of the studied municipal procurement procedures used to contract the social care service of personal assistance in 2015, 2016, 2017, and 2018, and positions the different procedures described in Chapter 6 within the competition-relation framework. Finally, this chapter also identifies and discusses municipal choices and trends based on the findings of the longitudinal empirical study.

### 7.1.1 The 2015 municipal procurement procedures for social care services: dialogue above all else

For each the 382 municipalities in this research I analyzed their procurement procedures based on publication notices and procurement documents. These 382 municipalities collaborate in their social service procurement, meaning that in total I analyzed 86 different procurement procedures for the social service of personal assistance. Collaboration in this context refers to multiple municipalities jointly procuring services through the same procurement procedure. Table 7.1 illustrates both the frequency of procedures encountered and the number of associated (collaborating) municipalities.

**Table 7.1** - public procurement procedures used for 2015 social service procurement

Public Procurement Procedure	Number (%) of procedures in 2015	Number (%) of municipalities in 2015
Negotiated procedure without prior publication	12 procedures (14%)	68 municipalities (18%)
Open competitive procedure	7 procedures (8%)	29 municipalities (8%)
Open competitive negotiated procedure	2 procedures (2%)	10 municipalities (3%)
Open non-competitive procedure	17 procedures (20%)	65 municipalities (17%)
Dialogue-based procedure	48 procedures (56%)	210 municipalities (55%)
Total	86 procedures	382 municipalities

Interestingly, more than three quarters of Dutch municipalities procure social services using a custom public procurement procedure and not one of the procedures specified in EU or national public procurement law. In terms of the two dimensions of the competition and relational approach, two interesting observations can be made. First, the majority of municipalities (72 percent) used a procedure without ex ante competition (in effect the open non-competitive procedure or the dialogue-based procedure). To some extent, the other municipalities create ex-ante competition over contracts, with only 2 percent opting for the most strong ex-ante competition by contracting a main contractor. Second, with respect to the relational approach, the majority of municipalities (76 percent) opted for a procedure with some degree of negotiation. More than half of the municipalities contracted care providers through the dialogue-based or open competitive negotiated procedure, both of which strongly emphasize the collaborative nature of the municipal care provider relationships by taking a relational, rather than a bureaucratic ‘take it or leave it’ approach.

### **7.1.2 The 2016 to 2018 procedures for social care: exit competitive tendering**

Each of the 393 municipalities had to contract social care services for 2015, meaning that obtaining the procurement documents for the 2015 personal assistance contracts for 382 municipalities amounts to 97 % of all municipalities for 2015. For the years 2016 to 2018 this is different, and for each consecutive year there are three options:

1. the municipality procured social care services again (the contract ended and the municipality did not extend the contract);
2. the municipality did not procure social services again, as there still was an ‘active’ contract;
3. the municipality did not procure social services again, but effectuated changes in the contract if the contract permitted this. These municipalities are considered not to procure services, as there is no public procurement procedure organized.

For each consecutive year after 2015 and for each municipality in the Netherlands, I searched for (1) evidence the municipality launched a new procurement procedure for the social care service of personal assistance, and (2) the corresponding

procurement documents. Only municipalities that launched a new procurement procedure are included in the findings presented in this chapter, except for the tables and figures representing the consolidated situation as of 2018. The municipalities that made changes in existing contracts (option 3 mentioned above) are not included in these year by year statistics in this chapter. Table 7.2 shows the procurement procedures included in this study, listed against the total number of (procuring) municipalities per year.

**Table 7.2** - municipal procurement of personal assistance

	2015	2016	2017	2018
Total number of Dutch municipalities	393	390	388	380
Number of procuring municipalities (% of total number of municipalities)	393 (100%)	88 (23%)	126 (32%)	37(10%)
Number of municipalities not procuring	0	247	209	299
Number of municipalities for which no information was found	0	55	53	44
Procuring municipalities included in this study (percentage of procuring municipalities)	382 (97%)	68 (77%)	110 (87%)	37 (100%)

In total, 139 different procurement procedures were analyzed, reflecting the procurements of personal assistance social care services of a total of 597 municipalities throughout the four-year research period (where clearly some municipalities are included several times with different procurements). With between 393 (2015) and 380 (2018) municipalities in total, each municipality on average procured these social care services 1,5 times between 2015 and 2018. Tables 7.3 and 7.4 show the number of municipalities and the percentages for each of the procurement procedures throughout the four years. Table 7.3 is based on the number of procurement procedures; Table 7.4 is based on the number of participating municipalities in these procurement procedures.

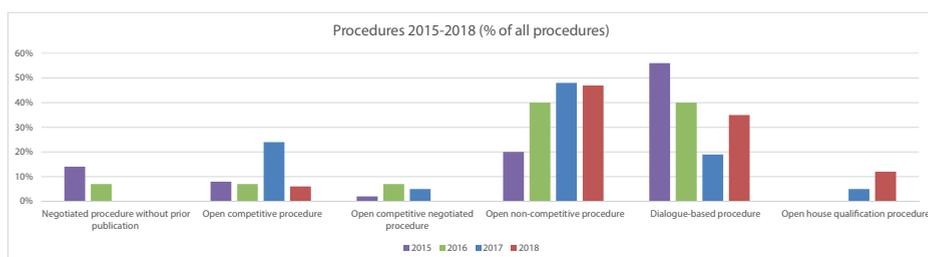
**Table 7.3** - Dutch municipal social service procedures for personal assistance 2015 – 2018

Public Procurement Procedure	2015	2016	2017	2018
Negotiated procedure without prior publication	12 (14%)	1 (7%)	0 (0%)	0 (0%)
Open competitive procedure	7 (8%)	1 (7%)	5 (24%)	1 (6%)
Open competitive negotiated procedure	2 (2%)	1 (7%)	1 (5%)	0 (0%)
Open non-competitive procedure	17 (20%)	6 (40%)	10 (48%)	8 (47%)
Dialogue-based procedure	48 (56%)	6 (40%)	4 (19%)	6 (35%)
Open house qualification procedure	-	-	1 (5%)	2 (12%)
Total	86	15	21	17

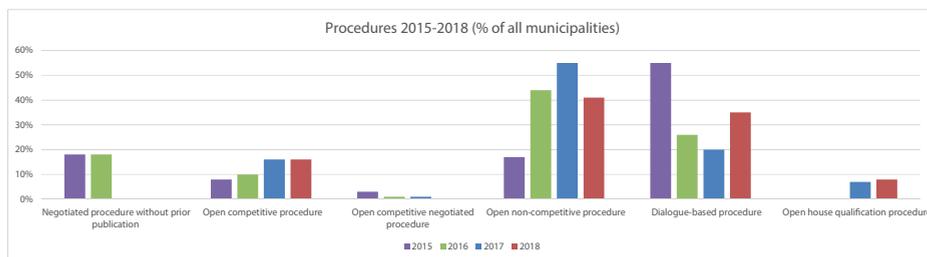
**Table 7.4** - Dutch municipal social service procedures for personal assistance 2015 – 2018 (municipalities)

Public Procurement Procedure	2015	2016	2017	2018
Negotiated procedure without prior publication	68 (18%)	12 (18%)	0 (0%)	0 (0%)
Open competitive procedure	29 (8%)	7 (10%)	18 (16%)	6 (16%)
Open competitive negotiated procedure	10 (3%)	1 (1%)	1 (1%)	0 (0%)
Open non-competitive procedure	65 (17%)	30 (44%)	61 (55%)	15 (41%)
Dialogue-based procedure	210 (55%)	18 (26%)	22 (20%)	13 (35%)
Open house qualification procedure	-	-	8 (7%)	3 (8%)
Total	382	68	110	37

Tables 7.3 and 7.4 are visually represented in Figures 7.1 and 7.2 below.

**Figure 7.1** - Procurement procedures used for social care (% of all procedures year by year) 2015 – 2018

**Figure 7.2** – Procurement procedures used for social care (% of procuring municipalities year by year) 2015 – 2018



The longitudinal study highlighted some interesting findings. In the first year that municipalities were responsible for personal assistance, more than half of the municipalities used the dialogue-based procedure. In the consecutive years following 2015, less municipalities opted for this procedure, giving the impression that the dialogue-based procedure had become less popular amongst Dutch municipalities. Closer analysis revealed that municipalities using the dialogue-based procedure for 2015 contracts generally had not yet started a new procurement due to long contract durations. This means the total number of contracts procured (consolidated year by year) using the dialogue-based procedure has actually slightly increased. The 2018 analysis of contracts revealed that in fact 46 percent of all 2015 contracts were still valid at the start of 2018 (going into their fourth year), and of these long-lasting contracts 87 percent were procured using the dialogue-based procedure.

Another interesting observation is that municipalities ceased to use the negotiated procedure without prior publication from 2017 contracts onwards. This coincided with the implementation of Directive 2014/24/EU in Dutch law in the year leading up to 2017. Under Directive 2014/24/EU, prior publication is required for social service contracts valued over € 750.000; procedures without prior publication are therefore problematic. The contract value of personal assistance services typically transcends this threshold even for small municipalities that buy these services alone (i.e. outside procurement collaborations with other municipalities that require the municipalities to add up individual contract values). It comes as no surprise that municipalities stopped using this procedure for 2017 contracts onwards.

### 7.1.3 Introduction of the open house qualification procedure

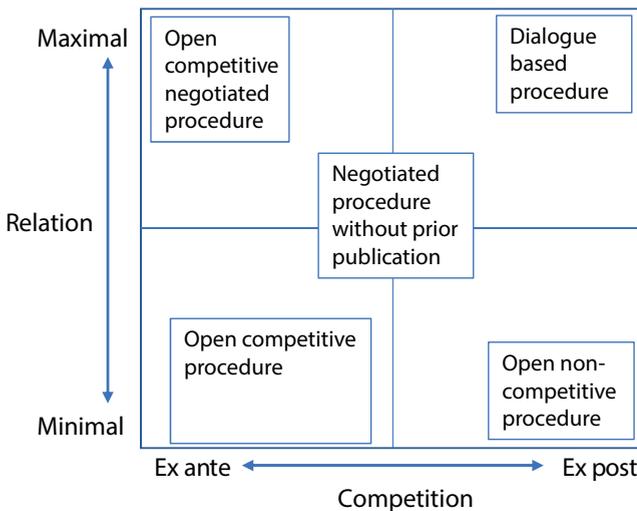
Besides the trends that are evident in the municipal procurement of social care services with respect to the procedures used, in 2017 a new procedure appeared: the *open house qualification procedure*. This new procedure relates to developments in public procurement case law. In 2016, the Court of Justice of the EU (CJEU) concluded in *Falk* (CJEU, C-410/14) that standardized public contracts are not subject to the EU Directive on public procurement, in case the government concludes standardized contracts with every interested organization that meets predefined standard quality criteria. When using such an *open contracting scheme* the procuring government does not compare the economic operators, nor does it consequently award exclusive contracts to only a limited number of economic operators. The German and Dutch translations of *Falk* refer to this open contracting scheme as an ‘open house model’, which has become the common term in the Netherlands (see Section 1.7 on Terminology and Section 3.6.2 for a more extensive description of the open house model and related CJEU case law). At first glance, both the dialogue-based procedure and the open non-competitive procedure present in the Dutch social service procurement practice meet the characteristics of an open contracting scheme. Both are characterized by their use of standardized contracts and the absence of a comparison and subsequent selection of care providers. Municipalities impose criteria with respect to quality and suitability, and each care provider that meets these criteria is admitted to a framework agreement. While this system of open contracts was in use in municipal procurements of social services even before the 2015 decentralization, as of the 2016 *Falk* case it has now obtained a more explicit legal basis in EU public procurement case law. Since this system became known in the Netherlands as an ‘open house model’, municipalities started using this terminology from 2017 onwards for contracting social care services. To clearly distinguish the open contracting scheme from a public contract subject to EU and national public procurement law, municipalities avoided using references to previously used public procurement procedures (such as dialogue-based procedures or the open non-competitive procedure). While the procedures to contract care providers for an open house model are actually similar to either the dialogue-based or open non-competitive procedure, municipalities referred to them as an ‘admission’ or ‘qualification’ procedure to the social care service open house model. Determining whether a contract concluded through a dialogue-based procedure (defined as such) is in fact an open contract scheme according to the criteria established in *Falk* (CJEU, C-410/14) and *Tirkkonen* (CJEU, C-9/17) would require further detailed legal analysis. For example, in the dialogue-based procedure the

criteria stipulated in the contract are negotiated as part of the custom procurement procedure, while in *Falk* there were ‘predetermined conditions’ (*Falk*, Para. 42). This detailed legal analysis falls outside the scope of this thesis, and I discuss these procedures separately.

## 7.2 Procedures positioned in the competition-relation framework

Figure 7.3 illustrates the competition-relation framework introduced in Chapter 6 and positions in the framework the five identified procedures used by Dutch municipalities to procure social care services. The open house qualification procedure is not positioned in this framework separately because it completely overlaps either with the dialogue-based procedure or the open non-competitive procedure, as explained in the previous section.

**Figure 7.3** - Public procurement procedures for Dutch social care contracts positioned in the competition-relation framework



Each area of the framework is represented by a procedure that I identified in this empirical study of Dutch municipal procurement procedures for social care services. While each of the municipalities concluded social care service contracts in exactly the same context and circumstances, the municipalities take very different

approaches. The approaches characterized by ex post competition are dominant. It can be concluded that Dutch municipalities followed different strategies towards achieving the same goals. I reflect on these strategies here.

The approach in the left-bottom quadrant focuses on ex ante competition and little or no negotiations. This approach reflects the traditional public procurement approach of competitive tendering without specific attention or effort towards building collaborative and trusting relationships. Numerous researchers have pointed out the disadvantages of this competition approach, including the adversarial relationships it breeds and its risks of care provider opportunism (Bovaird, 2006; Davis & Walker, 1997; Dehoog, 1990; Erridge & Nondi, 1994). There has been a sustained interest in ‘relational contracting’ for more than two decades, which emphasizes the importance of building trust and aiming for long-term partnerships and mutually rewarding relationships: see for example Bovaird (2006), Davis & Walker (1997), Dehoog (1990), and Erridge & Greer (2002). Relational contracting – or a *partnership model* – is often offset against the *competition model*, sometimes distinguishing a third ‘intermediate’ approach (Dehoog, 1990; Erridge & Nondi, 1994; Parker & Hartley, 1997). Interestingly, in extant research the competition approach is typically characterized by elements of the procurement procedure, while the partnership approach combines both aspects of the procurement procedure (i.e. based on negotiations, starting with only a rough specification, and having frequent communication with possible suppliers) as well as the resulting contract (i.e. the length of the contract, number of suppliers, joint activities, reimbursement or remuneration method, and risk sharing); see for example the approaches of Dehoog (1990) and Erridge & Nondi (1994).

The approach in the left-top quadrant of the competition-relation framework best fits the partnership model from for example Dehoog (1990) and Erridge & Nondi (1994). However, Dutch municipalities demonstrated a completely different approach to relational contracting, which is positioned in the top-right quadrant of the competition-relation framework. Municipalities using this approach invest in trusting relationships with care providers by entering into negotiations with care providers over the contract terms and conditions (similar to the partnership approach), but without committing to one care provider as main contractor. This allowed clients complete freedom of choice and prevented the risks associated with contracting a main contractor (see Chapter 4). Municipalities using the procurement procedure positioned in the bottom-right quadrant of the framework rely on ex post competitive forces without entering into negotiations. The procedure(s)

in the bottom-right quadrant should not be considered relational contracting, and these procedures even further emphasize the role of ex post competition. Finally, the procurement procedure that was used before the decentralization (the negotiated procedure without prior publication) is positioned in the center of the competition-relation framework. This procedure has some relational characteristics (i.e. completing a contract through negotiations, although leaving only limited room for change in the contract) but minimizes competitive forces. Generally there was no ex ante competition; every invited care provider is contracted as long as an agreement is reached on the price and budget. There is also limited ex post competition, as there is some degree of choice for new clients, although it is restricted to contracted care providers and their budgets. The question remains as to which strategy is most effective – this is a topic for further research.

Note that the qualification and positioning of the different observed procedures is based on the observations of these procedures in this research. The dialogue-based procedure as discussed in this research fits the top-right quadrant as its negotiations are typically not aimed to ‘squeeze out suppliers’, but to reach consensus with the relevant actors in the local social care network. This does not imply that every negotiation procedure is always aimed at – nor results in – better buyer-supplier relations. Similarly, not every open competitive procurement procedure necessarily fits the ‘arms length bureaucratic’ qualification, nor does it necessarily lead to suboptimal relationships with the supplier. The procedures for social care procurement as observed and classified in this research are positioned according to criteria based on the competition and relational contracting literature referenced in Chapter 6.

**Figure 7.4** – Use of procedures by Dutch municipalities in 2015 and consolidated as per 2018

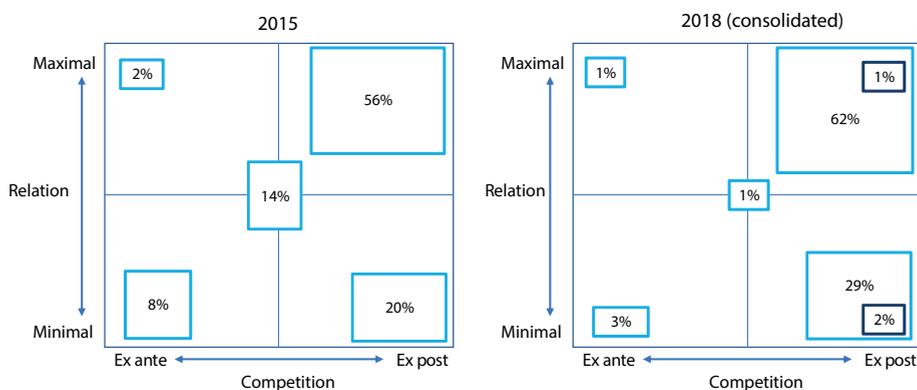


Figure 7.4 shows the percentages of municipalities that used each of the discussed public procurement procedures within the competition-relation framework. The left-hand side reflects the situation for the 2015 contracts. The right-hand side is a consolidated overview of the contracts that are in place at the start of 2018. The figure on the right-hand side includes dark blue squares that represent the *open house qualification procedure*. As discussed before, this procedure is similar to either the *dialogue-based procedure* or the *open non-competitive procedure* in terms of procedural steps. Only the legal basis differs in the open house qualification procedure. Note that the percentages in the right-hand side do not correspond to the last column of Table 7.4. The figures in Table 7.4 only include the municipalities that concluded new contracts as of 1 January 2018. The right-hand side of Figure 7.4 provides a consolidated overview of all the contracts in our database that are in effect at the start of 2018. This includes municipal contracts from 2015, 2016, and 2017 that are still in effect and new contracts starting in 2018.

Figure 7.4 shows a clear growth in procedures characterized by ex post competition. The overall number of municipalities with a contract procured by means of a competitive procedure (the left side of the framework) – already a minority in 2015 – has further declined. With respect to the relational approach in the public procurement of social services, it becomes evident that municipalities that opt for the dialogue-based procedure tend to stick with this choice in subsequent years. While at the start of 2018 slightly more municipalities had contracts procured by means of the dialogue-based procedure, more municipalities abandoning com-

petitive procedures opt for the open non-competitive procedure. The use of this procedure has grown from 20 percent in 2015 to 29 percent, mostly at the cost of the open competitive procedure and the negotiated procedure without prior publication. Table 7.5 illustrates which procedures were used for the contracts in place in 2015 and 2018 with respect to the 325 municipalities for which both the 2015 and 2018 procedures are known in this research. This is a consolidated overview that includes municipalities that did not start a new procurement procedure after 2015. The percentages are relative to the 2015 frequency for the corresponding procedure.

**Table 7.5-** Municipal procurement procedures for social care in 2015 and 2018

Public Procurement Procedure 2015	2015 <i>freq.</i>	Public Procurement Procedure 2018					
		Negotiated procedure without prior publication	Open competitive procedure	Open competitive negotiated procedure	Open non-competitive procedure	Dialogue-based procedure	Open house qualification procedure
Negotiated procedure without prior publication	47	4 (9%)	8 (17%)	0 (0%)	20 (43%)	15 (32%)	0 (0%)
Open competitive procedure	25	0 (0%)	1 (4%)	2 (8%)	11 (44%)	11 (44%)	0 (0%)
Open competitive negotiated procedure	10	0 (0%)	0 (0%)	3 (30%)	7 (70%)	0 (0%)	0 (0%)
Open non-competitive procedure	53	0 (0%)	0 (0%)	0 (0%)	43 (81%)	2 (4%)	8 (15%)
Dialogue-based procedure	190	0 (0%)	0 (0%)	0 (0%)	9 (5%)	179 (94%)	2 (1%)
Open house qualification procedure	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	325						

Table 7.5 shows that from the 47 municipalities using the negotiated procedure without prior publication in 2015, only four still procure contracts using the same procedure in 2018. In total, 75 percent of these municipalities adopted an *ex post* procedure in the years after 2015, and most opted for the open non-competitive procedure. Without discussing every cell in detail, some general conclusions can be drawn:

- Most municipalities that changed procurement procedures chose a procedure emphasizing *ex post* competition (the open non-competitive procedure or the dialogue-based procedure). Only a few municipalities adopted a procedure with *ex ante* competition after 2015.

- No municipality that already used an ex post procedure changed to an ex ante competitive procedure. The only changes from municipalities with the open non-competitive procedure or dialogue-based procedure in 2015 are to other ex post procedures (including the open house qualification procedure).

Furthermore, it should be noted that municipalities that adopted the open house qualification procedure in the years after 2015 simply copied their previous procedure and only changed the terminology they used. The use of the dialogue-based procedure and the open non-competitive procedure is very stable, with only a few municipalities switching to another procedure.

### 7.3 Conclusion and discussion

In 2015 the majority of Dutch municipalities procured the social service of personal assistance using a custom non-competitive procurement procedure. They used the discretion that EU and national public procurement law allows for the procurement of social services, which in effect does not oblige them to use one of the competitive legal public procurement procedures. While 393 municipalities, collaboratively procuring in over 90 procedures (86 of which are incorporated in the analysis in this study), had almost full discretion to devise their own procurement procedures, only five archetypal public procurement procedures are prevalent (this ignores minor variations in each of these procedures). Over 75 percent of municipalities opted for two of these procedures, evidencing strong mimetic behavior. While in these two procedures ex ante competition – traditionally the strongest argument for market provision of public services – is absent, this does not mean competitive forces lack altogether. There is ex post competition as clients of social care services have free choice among contracted care providers, and are also allowed to change care providers after services have started. This ex post competition pressures care providers to provide sufficient quality services. The longitudinal study evidenced that the municipal preference for ex post competition – already substantial in 2015 – only grew in the years after 2015. Including the new open house qualification procedure, in 2018 as many as 94 percent of Dutch municipalities procured social care services without using a traditional (ex-ante) competitive procedure. However, this popularity should not be explained by the introduction of the open house case law; this has merely provided a clearer legal foundation of procurement methods that were already developed and widely used.

The popularity of ex post competition for public social care service contracts is relevant for public procurement in general. The principles and legal foundation of this public procurement approach are relevant and applicable to public contracts for other services and commodities. Further research may shed light on the conditions under which ex post competition offers sufficient incentives to ensure high quality products or services. With respect to the open house qualification procedure, further research should clarify exactly how these open contracting schemes can be used outside the scope of the EU public procurement Directive in contexts other than social care services (and the contexts of the two CJEU cases). Interesting questions that could be asked include: who should make the final decision for a provider / supplier within the open contracting scheme? Should this always be a 'third party' (the client in case of social care services)? What services and commodities lend themselves for such an open contracting scheme?

Also, interesting to note is the fact that ex post competition does not ensure reduced expenditure through the procurement procedure. Municipalities need to ensure costs are kept at a reasonable level through other additional mechanisms. Municipalities controlling access to social services may establish more rigorous gate-keeping systems and client scrutiny to reduce expenditure. Furthermore, municipalities opting for ex post competition in framework agreements set prices (or price caps) for services themselves. This provides a key for setting competitive prices, although if the price offered is too low care providers may either refuse contracts or accept the contract and provide services below cost price. Neither option is sustainable in the long run. Municipalities that set prices too low face societal pressures, because associations that represent market segments of care providers tend to name and shame municipalities that do not pay fair prices. Additionally, the Wmo 2015 was recently extended with more explicit provisions requiring municipalities to 'pay a fair price' for social services obtained from the market (*AMvB Reële Prijs Wmo*; See Section 3.5).

The preference of Dutch municipalities for ex post competition resulted in a transition for care providers who were more familiar with contracts with annual guaranteed budgets. Under the ex post competition procedures they rely on the choice of individual clients for production and income, which results in much more uncertainty for care providers. Before the reform, contracted care providers knew at the start of the year how they would cover their fixed costs and pay for their personnel. Under ex post procedures, new care providers (previously not contracted for these types of social care) have equal opportunities for a contract – which may lead

to lower market concentration. This typically hurts the incumbent care providers, whereas it actually offers opportunities to new care providers who have nothing to lose.

In terms of the relational approach, many municipalities used relational contracting approaches with extensive negotiation and dialogue, and additionally opted for long-lasting contracts. This also sharply contrasts with the pre-2015 annual contracts used for these social care services. Just over a quarter of municipalities opted for minimal negotiation and care provider influence or involvement. This does not mean these municipalities organized extensive administrative procurement procedures that required considerable paper-work from care providers. The open non-competitive procedure (which is the most used procedure within the 'minimal negotiation' side of the framework) is characterized by how it minimizes bureaucracy in the procedure – another striking difference compared to pre-2015 procedures. These municipal choices were only strengthened in the subsequent years that followed 2015.

The fact that at least some municipalities are represented in each segment of the competition-relation framework illustrates there is more granularity in public procurement procedures for social service procurement than represented in extant literature. This research evidences there is another relational contracting approach possible other than the typical partnership approach, where a public buyer negotiates with one main provider (Dehoog, 1990; Erridge & Nondi, 1994), and which necessitates legal entities such as a public-private partnership (Bovaird, 2006). While there are municipalities represented in every quadrant of the competition-relation framework for social care service contracts, the low – and declining – number of Dutch municipalities contracting social care services through non-relational competitive procurement procedures confirms municipalities prefer relational contracting over traditional competitive tendering, ex post competition over ex ante competition, and in general to minimize the administration and bureaucracy associated with the procurement procedure. Whether this preference is completely rational (procurement procedures are chosen after careful consideration of all options) or influenced mostly by mimetic pressures (copying from other municipalities) or the preference of the consultant hired to support the commissioning process remains to be studied.



# Chapter 8

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**A service triad approach to social care  
procurement: managing challenges in social  
care service triads**

## Preface

This chapter is based on the paper *Managing challenges in social care service triads – Exploring public procurement practices of Dutch municipalities* published in the *Journal of Purchasing and Supply Management* in 2018: (Uenk & Telgen, 2018). This paper was co-authored by prof. dr. Jan Telgen, and I therefore choose to maintain the writing in plural form ('we' instead of 'I'). This study positions the empirical research on social care service procurement by Dutch municipalities in the literature on service triads, and discusses the challenges arising in a service triad context and how Dutch municipalities have dealt with these challenges within procurement procedures and contracts for social care services. The original published paper is only modified in this thesis to fit the structure of the thesis, to maintain consistency in the terminology used, and to prevent redundancy in the discussion of the context and methodology.

## Abstract

Buying services in a triad constellation is associated with challenges related to quality control, performance monitoring, and a deteriorating information position for the buyer. There is growing attention for service triads in Supply Chain Management (SCM) literature. However, these studies are mainly theoretical. The studies suggest to manage the identified challenges by monitoring supplier performance, maintaining a strong position in the service triad, developing collaborative trusting relationships, using outcome-based contracts, and aligning incentives between buyer and suppliers. Empirical studies on service triads and management mechanisms are rare, especially in a public procurement context. We studied the application of management mechanisms in a public procurement context where 393 Dutch municipalities each had to contract social care service providers at the same time. This context allowed us to study which of the management mechanisms proposed in literature are actually employed in a public procurement context, and whether other mechanisms are applied that are not addressed in the literature. We found municipalities deviate from traditional bureaucratic procurement procedures and apply a relational approach to the procurement procedure, including establishing social contracts, to cope with buyer challenges in service triads. Furthermore we identified municipalities apply ex post competition to drive up service quality through tendering framework agreements and allowing clients to choose their care provider of choice. This mechanism of ex post competition through the

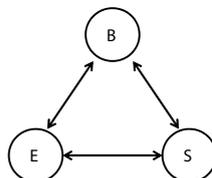
use of framework agreements has not been suggested in service triad literature before, and may be an effective mechanism in other service triads to address service quality and customer needs fulfilment issues.

*Key words: service triads; management mechanisms; social care; public procurement; social services*

## 8.1 Buying services in a service triad: a new object of study

Service buying and classification of services has received much scholarly attention in the last decades (Axelsson & Wynstra, 2002; Van Der Valk & Axelsson, 2015; Wynstra et al., 2006). Service buying is associated with problems in effectively organizing the transactions and relations involved in sourcing services (Van Der Valk & Van Iwaarden, 2011). Managing the quality of procured services and the contractors that deliver the services is amongst the issues highlighted (Axelsson & Wynstra, 2002). More recent is the attention to triads in the field of Supply Chain Management (SCM) (Wu, Choi, & Rungtusanatham, 2010). Studies on triads have focused on theory building and conceptualizing triadic relations in SCM (Li & Choi, 2009; Vedel, Holma, & Havila, 2016; Wu et al., 2010). There seem to be two motives for the growing interest in triads. For some scholars the interest in triads emerged out of the intention to study networks rather than dyads. Choi and Wu (2009) argue studying networks starts with studying triads, because a triad is the smallest unit of analysis that constitutes a network. Others consider triads as distinctive objects worth studying (Wynstra, Spring, & Schoenherr, 2015). Especially service triads have received much attention in the literature in the last decade. In service triads, the buyer (B) contracts a supplier (S) to deliver services directly to the buyer's end customer (E). Figure 1 shows the basic service triad. A service triad typically occurs when an organization (out)sources to a third party the service delivery to its end customers.

**Figure 8.1** – The service triad consisting of Buyer, Supplier, and End Customer



Managing the quality of service delivery becomes even more problematic in a service triad: the performance of the buying organization towards its end customers depends on the quality of service delivery by the supplier. The buyer does not directly experience the quality of service delivery. Therefore, the buyer needs to take measures to ensure the service delivery and behavior of the supplier are appropriate (Van Der Valk & Van Iwaarden, 2011). Also, information from the end-customer with respect to its needs and satisfaction is not directly visible to the buyer. Service triads are associated with challenges in (amongst others) service quality control (Van Iwaarden & Van Der Valk, 2013), monitoring (Van Der Valk & Van Iwaarden, 2011), service provider identity and brand recognition (Wynstra et al., 2015). Conceptual and theory-building studies address these issues from the perspectives of structural dimensions of service triads (Li & Choi, 2009) and social capital; collaborative relationships and trust among buyer and supplier (Hartmann & Herb, 2014, 2015; Holma, 2012; Karatzas et al., 2016). Empirical studies on service triads, while emerging, are still rare. We studied the application of management mechanisms applied by hundreds of similar buyers in service triads in practice. We aimed to fill two gaps in the literature with this extensive empirical study: on the one hand, we studied the extent to which the proposed management mechanisms in literature are used in practice. On the other hand, we aimed to identify other management mechanisms not yet discussed in the literature on service triads, extending the scientific discussion on managing service quality and customer needs fulfilment, countering supplier opportunism, and other buyer challenges in service triads.

We studied service triads in a municipal (local government) public procurement context. We have not found any service triad studies where the buyer is a (local) government, yet we argue this is a very relevant context to study service triads. Public procurement faces additional challenges over private sector purchasing because of additional demands. Five categories of additional demands for public procurement compared to private sector procurement can be distinguished: external demands (transparency, integrity, accountability), internal demands (e.g. serving many – sometimes conflicting – goals simultaneously, political goals), demands originating from the context (e.g. budget driven procurement, cultural setting), demands on the process (the strict legal framework), and demands originating from the multiple roles the public organization has (e.g. reciprocity in supplier-buyer relations – suppliers are also citizens of the buying government) (Knight et al., 2007). The challenges of buying services in service triads may, therefore, be exacerbated in a public procurement context. For example, buyers in service triads should strive

for building collaborative relationships and trust with suppliers to reduce opportunism and improve service quality (Gunawardane, 2012; Li & Choi, 2009; Nätti et al., 2014). However, the operating framework and culture of the public sector may in fact hinder the development of interorganizational relationships and trust (Erridge & Greer, 2002). The traditional bureaucratic competitive procurement procedures used for public contracts are known to stand between building social capital in partnerships and developing long-term relationships between public buyers and private sector suppliers (Steane & Walker, 2000). The pressure on municipalities to save money whilst ensuring sufficient quality of social care services exemplifies the exacerbated challenges of service buying in this context. Demonstrating how public buyers deal with challenges in outsourcing services in service triads is relevant in general. This increases our understanding of the 'management mechanisms' proposed in conceptual and theory-building research.

Besides the relevance for understanding service triads in general, we contribute to the understanding of (out)sourcing social care services. For many OECD countries public expenditure on health and long term care services are a matter of great concern in view of aging populations and increasing constraints on public budgets (Schut & van den Berg, 2010). The 2015 OECD health statistics demonstrated long term care (including social care) public expenditure averaged 1.7 percent of the GDP in eleven OECD countries in 2013, while in some countries this is actually up to three times the average (OECD, 2016). More alarming, the average annual growth rate of long-term care expenditure for 22 OECD countries between 2005 and 2013 was 4.0 percent (OECD, 2016). To address the issue of steadily rising social care expenditure, many countries outsource social and home care services (M. Lamothe & Lamothe, 2009). By introducing competition (the *market mechanism*), governments aim for competitive forces to encourage quality while driving down costs (Randall & Williams, 2009). Research on public procurement of social care services has focused on the buyer-supplier dyad, addressing collaboration issues (Grudinschi, Sintonen, & Hallikas, 2014) and reimbursement methods in relation to integrated care (Olivier van Noort & Schotanus, 2015). Studies addressing the introduction of 'managed competition' in the provision of social care services have focused on the introduction of competition and effects on quality of care and efficiency in general (M. Lamothe & Lamothe, 2009; Lesemann & Martin, 1993). These studies lack a more detailed analysis that a service triad perspective on buying social care services allows.

In this paper we address the following research questions:

1. Which challenges are associated with buying services in a service triad in the literature?
2. Which management mechanisms for coping with challenges in service triads are identified in extant literature on service triads?
3. Which management mechanisms are applied in practice in the public procurement of social care services?

The original published paper on which this chapter is based proceeds to discuss the context of the empirical study. This section is omitted here to avoid redundancy: the context of this study is extensively discussed in Chapter 2. Next, we first review the literature to identify challenges and management mechanisms for coping with these challenges in service triads in Section 8.3. Section 8.4 discusses the methodology for studying municipal social care procurement, followed by the findings of our research in Section 8.5 and a discussion of these findings in the perspective of extant literature in Section 8.6. Finally, Section 8.7 presents our conclusions.

## **8.2 Buyer challenges in service triads**

Studies focusing on triads in SCM emerged in different triad contexts. Multiple studies focus on the triad between a buyer and two upstream suppliers, analyzing for example co-opetition and how a buyer can increase cooperation or collaboration between two upstream suppliers to its benefit (Wu et al., 2010). Others study dyad-to-triad transformation and the relationship characteristics within a triad, for example differentiated versus undifferentiated relations (Portier, Pardo, & Salle, 2014), and triads with two actors from the same (buying) organization, for example the buyer and internal customer, versus the supplier (Andersson-Cederholm & Gyimóthy, 2010; Tate et al., 2010). Our study builds on service triad literature with a buyer, supplier, and end-customer as triad. In their seminal work Li and Choi (2009) are the first to address specific issues in service triads, focusing on shifting relationship structures over time, incorporating the ‘structural hole’ concept from Social Network Theory (Burt, 1992). Li and Choi (2009) emphasize the advantages of being in a bridge position as a buyer between customer and supplier, which may transfer to a bridge position for the supplier between customer and buyer. Other studies consider service triads from a more traditional supply chain perspective and focus on the managerial issues that arise in service triads, such as appropriate

contract types in service triads (Van Der Valk & Van Iwaarden, 2011) and managing supplier performance (Van Der Valk & Van Iwaarden, 2011; Van Iwaarden & Van Der Valk, 2013). Many studies take Agency Theory as a theoretical lens to study problems that may occur in service triads due to goal incongruence between principals and agents stemming from assumptions on human nature (self-interest, bounded rationality, risk aversion), information asymmetry, and organizations (Eisenhardt, 1989). Practical settings relate to a marketing context (Tate et al., 2010) and professional security services and technical facility services (Van Der Valk & Van Iwaarden, 2011; Van Iwaarden & Van Der Valk, 2013). With growing maturity of service triad literature, the concept is studied in more specific contexts: corporate travel purchasing (Andersson-Cederholm & Gyimóthy, 2010; Holma, 2012), health care (Gunawardane, 2012), IT/ITES outsourcing (Niranjan & Metri, 2008), commercial vehicle manufacturing (Karatzas et al., 2016) and vehicle maintenance (Hedvall, Dubois, & Lind, 2016). There are no studies yet that specifically address public procurement of services in service triads, while the additional demands public buyers face make this a relevant context.

Municipal procurement studies often relate to the additional external, internal, context, process, and roles demands identified by Knight et al. (2007). Multiple studies address the typically low or at least deficient municipal compliance to public procurement regulations (de Boer & Telgen, 1998; Martin et al., 1999). Associated with poor compliance to regulations is the lack of a professional approach towards the purchasing function (de Boer & Telgen, 1998). Ochrana and Pavel (2013) also find a rather low level of competence of (procurement) administrators in Czech Republic local governments (Ochrana & Pavel, 2013), an example of context demands. Other studies focus on the procurement procedures (related to external and process demands) and their effect on procurement outcome. Arai (2013) finds the introduction of competitive bidding leads to a decrease in the average winning bid and hence the price paid. Despite the low skills of workers at the contracting entities, using open procedures still has a positive effect on supply side competition (Ochrana & Pavel, 2013). Other performance-aspects of municipal procurement studied are the time performance in the execution of public works (Guccio, Pignataro, & Rizzo, 2014) and mitigation of contractual hazards in procurement procedures (Waara, 2008). More recent is the attention to green and sustainable (local) public procurement in relation to external and internal demands, e.g. (Preuss, 2007) and (Gelderman, Semeijn, & Bouma, 2015). Table 8.1 presents the studies on municipal public procurement categorized according to the five demands.

**Table 8.1** – Public procurement demands and related studies

Demand Type	Municipal procurement studies related to demand type
External	(de Boer & Telgen, 1998; Gelderman et al., 2015; Martin et al., 1999; Preuss, 2007)
Internal	(Gelderman et al., 2015; Preuss, 2007)
Context	(Ochрана & Pavel, 2013)
Process	(Arai, 2013; de Boer & Telgen, 1998; Martin et al., 1999; Waara, 2008)
Roles	-

As a starting point for our study in service triad public buyer practices, we identified the challenges and issues of buying in service triads discussed in the literature. Furthermore, we provide an overview of the identified management mechanisms to cope with these issues that are proposed and studied. We group the studies around the management mechanisms proposed in the literature. Various studies refer to the actors in the triad differently depending on the context of their study. The buyer is also referred to as principal, the supplier as service-integrator or subcontractor, and customers in some studies are departments (other than procurement) within a firm. The roles vis-à-vis each other of these actors remain similar, and for clarity we refer to buyer, supplier, and customer within the literature review section. In subsequent sections of this article, we refer to buyers as municipalities, suppliers as care providers, and customers as clients – as this is appropriate for the social care service context.

### 8.2.1 Obtaining or maintaining a strong position in the triad

Li and Choi (2009) argue the positions of each actor in a service triad are not constant, but change over the course of the stages of sourcing and service provision. First the buyer is in a bridge position and there is a structural hole (no linkage) between the end-customer and supplier. After the contract is in place, service provision by the supplier starts and this creates a link between the end-customer and supplier: the stage of bridge decay. Subsequently the bridge position may transfer completely to the supplier, in case the buyer does not actively maintain a link with the end-customer (Li & Choi, 2009). The bridge position is associated with advantages: power and information. A supplier in the bridge position may act opportunistically without the buyer knowing. This emphasizes the lack of control over service quality, which is already prominent in service buying in dyadic buyer-supplier relations (Van Der Valk & Van Iwaarden, 2011). Buyers should there-

fore continuously monitor supplier performance, maintain close communication with its customers, and strive for a collaborative rather than an adversarial type of relationship with the supplier to minimize the risk of opportunistic behavior (Li & Choi, 2009). A 2010 case study in an avionics maintenance context confirms the benefits of being in the bridge position, demonstrating a (buying) firm in the bridge position perceives a higher cooperative performance (Peng et al., 2010). When a firm plays a peripheral role and the supplier is in the bridge position, high levels of coordination combined with high levels of trust result in higher levels of perceived cooperative performance (Peng et al., 2010). Gunawardane (2012) confirms the risks of bridge decay and bridge transfer; and demonstrates buyers have to establish management policies and practices to re-establish information flow and control of supplier performance. Firms may achieve a structurally powerful network position in the service triad through (developing) various power sources: improving capabilities, mitigating suppliers actions - for example through contracts, which we discuss separately - and building strong mutually dependent customer relationships (Finne, Turunen, & Eloranta, 2015).

### **8.2.2 Buyer-supplier relationship types: strive for collaboration**

The relation between buyer and supplier receives attention in many studies as well, arguing the buyer should strive for a collaborative rather than an adversarial relationship (Gunawardane, 2012; Li & Choi, 2009; Nätti et al., 2014; Wuyts, Rindfleisch, & Citrin, 2015). Karatzas et al. (2016) also support this, but go beyond the typical classification of 'adversarial versus collaborative' relationships and identify configurations of both more detailed relationship dimensions (information exchange, operational linkages, cooperative norms, and formalization) and exogenous factors. This study in a manufacturing setting adds granularity to the 'strive for a collaborative relation' mantra by distinguishing various dimensions of a collaborative relation. Furthermore, the study evidences that certain relational dimensions play an important role in one configuration of relational and exogenous dimensions, while having no significant effect in other configurations (Karatzas et al., 2016). Close relational ties also moderate the relation between a strong customer-focus of the supplier and customer needs fulfilment, where close relational ties have a positive effect (Wuyts et al., 2015). Various other studies relating to this theme discuss the positive effect of trust between a buyer and a supplier in service triads on supplier performance (Finne et al., 2015; Gunawardane, 2012; Hedvall et al., 2016; Holma, 2010, 2012). In a longitudinal study Holma (2012) elaborates

on the aspect of trust, demonstrating the importance of interpersonal interaction between firms. Having dedicated contact representatives who have the knowledge of processes and services is found to be valuable, because the bonds between these individuals provide channels for information exchange (Holma, 2012). Hartmann and Herb (2014) study the wider concept of social capital, distinguishing three types: structural, relational, and cognitive social capital. These elements refer respectively to the configuration and the nature of linkages between triad actors, and the shared goals, visions, and values among the actors. Hartmann and Herb suggest social capital reduces opportunism (Hartmann & Herb, 2014, 2015). Social contracts closely relate to the topic of relationships and trust. John (1984) defines a *social contract* as a micro-level agreement that is purposely designed within an individual exchange relationship. A social contract is not necessarily legally binding, although it may build on legally binding documents (John, 1984). Van Der Valk and Van Iwaarden (2011) propose that the buyer is to establish micro-level social agreements with the supplier when service outcomes are not measurable. Gunawardane (2012) evidences supplier performance is superior when the buyer is able to create a social contract environment.

### **8.2.3 Monitoring in service triads**

The possible configurations of a service triad depend on linkages between the three actors. As discussed, maintaining a bridge position as buyer or preventing the supplier to accomplish this is important to avoid opportunistic behavior and to keep control over service quality. For a buyer, this means keeping communications with its customers and monitoring supplier performance (Li & Choi, 2009). Monitoring can help buyers to deal with an agent's opportunism; it is an activity that is an integral part of an organizations' current relationship management strategies (Heide, Wathne, & Rokkan, 2007). In various contexts studies confirm the need for monitoring supplier performance in service triads (Tate et al., 2010; Zhang et al., 2015). Monitoring can be aimed at either supplier output or supplier behavior. However, monitoring the behavior of a supplier at a reasonable cost and establishing a link between that behavior and certain outcomes is difficult in professional service settings (Sharma, 1997). Monitoring is associated with negative effects on supplier behavior, although social contracts moderate this effect (Heide et al., 2007). The appropriate type of monitoring furthermore relates to the contract in place. Van Der Valk and Van Iwaarden (2011) propose the type of monitoring should be similar to the type of contract: an outcome-based contract should be accompanied

with monitoring outcomes and behavior-based contracts should be accompanied with monitoring supplier behavior. Gunawardane (2012) confirms supplier performance in terms of customer satisfaction and quality of service is superior when the contract requires the supplier to regularly report on its performance.

### **8.2.4 Using incentives for service providers**

Another approach to counter opportunistic behavior and increase control over service quality is through aligning the goals of buyer and supplier by setting the right incentives. Studies on a franchisor-franchisee-customer triad (Zhang et al., 2015) and the aerospace industry and its aftermarket for replacement parts (Rossetti & Choi, 2008) proposed or demonstrated that buyers should put in place incentives to reduce free-riding, opportunistic behavior, and Supply Chain Disintermediation (SCD). SCD involves suppliers entering its buyer's aftermarket, which may seriously affect the buyer's market share and revenues. Incentives do not always have a positive outcome from the perspective of the buyer: they may lead suppliers to maximize short-term profit rather than optimize the long-term relationship (De Vries, Schepers, Van Weele, & Van Der Valk, 2014).

### **8.2.5 Contracts: behavior- or outcome-based**

Grounded in Agency Theory, one of the most often studied or mentioned management mechanism in service triad studies is the appropriate contract type. Based on the classification of Ouchi (1979) a principal should apply behavior-based contracts where outcome is difficult to measure and behavior (the transformation process) is measurable. Outcome-based contracts should be used when the principal is able to measure outcome and not the behavior. Eisenhardt (1989) proposed that when the contract between the Principal and Agent is outcome-based, the Agent is more likely to behave in the interests of the Principal. In complex service purchases in service triads a hybrid contract type that combines elements of both behavior-based and outcome-based contracts may be most appropriate to reduce conflict (Tate et al., 2010). Van Der Valk and Van Iwaarden (2011) proposed the use of outcome-based contracts in service triads, with behavioral elements in case the exchange has an important social character. In an empirical study in a health care context Gunawardane (2012) evidences outcome-based contracts lead to superior supplier performance. Besides the contract type, the level of specification is

important as it positively impacts knowledge-sharing by the supplier (De Vries et al., 2014). De Vries et al. (2014) argue unarticulated expectations leave suppliers guessing for desired performance levels, resulting in disappointing service performance.

### **8.2.6 Other management mechanisms**

In a 2013 case study Van Iwaarden and Van der Valk (2013) proposed ways to increase buyer control over service delivery in service triads, and thereby managing service quality. Standardization of processes, separating high- and low-contact services, fail-safing, the use of poka-yokes, contracts, and service level agreements (SLA's) each increase buyer control over service delivery in a service triad (Van Iwaarden & Van Der Valk, 2013). In relation to perceived service quality, specifying SLA's in contracts is important, but Niranjana and Metri (2008) argued other factors, such as physical and human elements that are not captured in SLA's, may significantly impact client satisfaction as well. While failure of front end service providers leads to greater shareholder losses than failures due to the buyer firm, the productivity of the buyer-firm employees moderates the greater financial penalty (Modi, Wiles, & Mishra, 2015). Wuyts, Rindfleisch, and Citrin (2015) studied the customer focus of suppliers in service triads, and found a strong customer focus of the supplier leads to better customer needs fulfilment. However, the study indicated the relation between customer focus and customer needs fulfilment is moderated by relational, firm, and customer characteristics. Customer-focused suppliers achieve higher levels of customer needs fulfilment when the buyer also has a strong customer focus and when buyer and supplier share close relational ties (Wuyts et al., 2015). Furthermore, risk-sharing between buyer and supplier is associated with superior supplier performance (Gunawardane, 2012).

Throughout the reviewed literature, the challenges of buying in service triads that are most often discussed are service quality and customer needs fulfilment, information control, and supplier opportunism and goal incongruence. The most commonly studied management mechanisms are relationship development, contracts, social contracts, monitoring, and incentives. We studied which of these management mechanisms are applied, and how these are applied in a public procurement context where 393 municipalities in parallel buy social care services. We also determined if other mechanisms are applied that are not yet discussed in extant service triad literature.

## 8.3 Methodology

This chapter is based on the same empirical study of municipal social care contracts discussed as Chapters 4, 5, 6, and 7. The same methodology applied to this study with respect to searching and collecting procurement documents for the municipal procurement of the 2015 contracts for the social care service personal assistance. Chapters 5 (Section 5.2) and 6 (Section 6.3) discuss the methodology used for the collection and analysis of municipal procurement documents in detail. For this study, this methodology section only discusses the additional methodology used for the analysis of management mechanisms identified in service triad literature.

We analyzed how, and to what extent, Dutch municipalities applied management mechanisms to cope with the service triad challenges using this data set. Using the actual procurement documents allows us to analyze the actual procurement procedures followed and contract types applied by municipalities, rather than the perceived choices. This very rich and extensive data set offers us very detailed, factual information on almost every municipal social care service tender for the 2015 contracts. However, there are limitations to using this data set. By reading and analyzing the procurement documents and contracts we can only include the information that has been explicitly written down. We argue this suffices with respect to the management mechanisms of contract type and incentives, monitoring and the public procurement procedure. While the mechanism of relationship management may be reflected or discussed in procurement documents, it can inherently not be comprehensively captured in documentation alone. From the procurement documentation we analyzed certain factors that relate to relationship development. First, we distinguished between a traditional bureaucratic competitive procurement procedure and more relational approaches where the municipalities emphasize buyer-supplier dialogue and make use of negotiations. Second, we considered whether or not there is explicit evidence that municipalities established social contracts. Table 8.2 shows how we conceptualized and analyzed the each management mechanism.

**Table 8.2** - Conceptualization of management mechanisms included in the empirical research

Management mechanism	Dimensions studied related to the management mechanism
Maintaining a strong position in the triad	The monitoring activities that the municipality announces in the procurement documents
Relationship development, trust and social contracts	Type of procurement procedure (traditional bureaucratic competitive procedure versus a relational approach) Explicit use of social contracts
Contract type and incentives	The type of contract applied, reflected in the reimbursement method Expenditure control in contracts
Monitoring	The monitoring activities that the municipality announces in the procurement documents
Market Mechanism	Characteristics of the procurement procedure (ex ante or ex post competition)

## 8.4 Findings: management mechanisms in municipal commissioning of social care

The challenges associated with buying services in a service triad in a public procurement context are similar if not exacerbated because of the additional internal, external, process, and contextual demands public buyers face. We report for each of the five management mechanisms how, and to which extent municipalities in the Netherlands have applied the mechanism in the procurement of the 2015 social care service contracts.

### 8.4.1 Maintaining a strong position in triad

In the social care service triad, maintaining a strong position in the triad implies preventing bridge transfer to care providers when service provision to individual clients starts. One way to accomplish the suggested permanent state of bridge decay (Li & Choi, 2009) is to monitor the performance of the care provider. We discuss this in Section 8.3. Here we discuss one other aspect: the organization and responsibilities of social community teams. Social community teams act on behalf of the municipality as gateway to social care. A citizen in need of social care makes a request known to the social community team. After assessment, the social community team decides on the entitlement of social care services. Besides this responsibil-

ity, social community teams in some municipalities have additional responsibilities for monitoring care provider performance, performing client case management, and sometimes providing light types of social care services themselves. Among municipalities in the Netherlands there is a wide variety of formal organizational structuring of the social community teams, ranging from in-house management by municipalities to purely outsourced teams operated by care providers. We argue social community teams can be ideally positioned to monitor care provider behavior and performance, and to remain in communication with clients. We also argue that for this reason social community teams should not be outsourced to the same care providers that are contracted for provision of social care services to clients: then the benefits of having social community teams monitor care providers are lost. We do not have empirical information on the organizational forms of social community teams in the data set used for this study.

#### **8.4.2 Relationship development, trust, and social contracts**

With respect to developing relationships it is relevant to note that in the context of our study municipalities were buying social care services for the first time. This means there was no prior buyer-supplier relationship before the social care tenders that led to the 2015 contracts. For this reason we focused our analysis of relationship development (building social capital) on the characteristics of the procurement procedure applied by municipalities. Bureaucratic, arm's length competitive procurement procedures have been known to hinder development of collaborative relationships and trust (Steane & Walker, 2000). Social care service contracts are subject to a light regime with respect to public procurement law both on EU and national level. This allowed municipalities to deviate from traditional competitive tendering. We found municipalities have in fact to a great extent made use of their discretion. The majority of municipalities applied a procurement procedure other than the traditional bureaucratic competitive procedure. We found a range of different procedures have been applied. With respect to the extent these procedures foster or hinder building relationships and trust, we distinguish three categories of procedures. The first category is the traditional bureaucratic arm's length competitive procedure discussed before. The second category procedure is non-competitive: Chapters 6 and 7 discuss this procedure (the open non-competitive procedure) more extensively. In this procedure every care provider meeting minimum quality criteria and accepting the terms and conditions for providing social care services is awarded a framework agreement. Procedures in this cate-

gory are much less bureaucratic: care providers are not required to write lengthy proposals or attach many evidencing references and proofs of suitability. Municipalities using a procedure in this category minimize administration by only requiring care providers to declare they meet quality requirements, and requesting only a minimum of supporting evidence (e.g. a formal registration at the chamber of commerce and a common quality certification). We argue the non-competitive and non-bureaucratic nature of this type of procurement procedure causes less frustration in relationship development. We therefore distinguish these procedures from traditional arm's length competitive procedures. Still, within these non-competitive and non-bureaucratic procedures municipalities make little effort to actually develop relationships with suppliers. The third category of procedures we distinguish is a dialogue-based procedure (see Chapter 6) and is characterized by municipalities explicitly organizing repetitive dialogues between municipality and care providers as an essential part of the procurement procedure. In plenary dialogue sessions, municipalities and care providers collaborate to draw up the contract terms and conditions for social care service provision. Care providers together with municipal buyers and policy makers formulate contract terms with respect to performance indicators, reimbursement methods, quality criteria, and any other clause and paragraph in the contract during the procurement procedure. The municipalities aim to reach consensus on the mentioned aspects, not just to pay lip service to care providers. The resulting framework agreement between municipalities and care providers is the product of this collaborative approach to social care service procurement – which has been referred to by municipalities as dialogue-based procurement or relational contracting. Table 8.3 illustrates that in fact the majority of Dutch municipalities apply a procurement procedure where the care providers are invited to negotiate and develop the contract together with municipalities, which we expect to reflect in improved relationships and trust between these municipalities and the contracted care providers.

**Table 8.3** – Procurement procedure categories in 2015 Dutch social care tenders

Characteristics of procurement procedure	Number (%) of tenders – Number of municipalities
Traditional bureaucratic competitive procedure	7 tenders (8%) – 29 municipalities (8%)
Non-traditional, non-competitive, non-bureaucratic procedure	29 tenders (34%) – 133 municipalities (35%)
Non-traditional, non-competitive, non-bureaucratic dialogue-based / relational procedure	50 tenders (58%) – 220 municipalities (58%)

Within the third category of procurement procedures, almost all municipalities actually established an underlying contract formalizing ‘rules of engagement’ between municipality and care providers that apply both to the contracting (dialogue) phase and to the execution of the contract once awarded. Considering the definition and purpose of social contracts as defined by Heide et al. (2007), these additional contracts fit the definition of social contracts albeit they are made explicit and legally binding. Out of the 86 tenders in our database, 48 tenders apply such a formalized social contract. All of these formalized social contracts are part of a tailored ‘dialogue-based’ procurement procedure that became popular amongst Dutch municipalities for contracting social care services.

### 8.4.3 Contract types and incentives: a range of approaches observed

In social care service contracts, the contract type relates to the way care providers are financed (the reimbursement method), and to the incentives corresponding to the reimbursement method. Therefore we choose not to separate incentives and contract types in the analysis. Behavior-based contracting in health and social care in general corresponds to ‘fee-for-service’ reimbursement: the care provider is paid to perform an activity: providing a treatment or an hour of counseling. Outcome-based contracts in social care take on different forms, categorized per reimbursement method such as bundled payment, pay-for-performance, and population-based (capitation) reimbursement. Up until 2015 social care services discussed in this research have been exclusively contracted using behavior-based ‘fee-for-service’ contracts. Contracts prior to 2015 distinguished up to 200 different services codes each associated with providing a specific type of social care to a client, relating to a certain type of disability (e.g. dementia, physical deterioration, psychological or psychiatric disorder) and describing the specific type of activities associated with the service code. These specified services codes each correspond-

ed with a tariff against a certain period of time: one hour, four hours (day part), or a day. Individual clients that were eligible for receiving social care were assigned an entitlement specifying the service code(s) and the amount of hours, day parts, or days per week. Care providers were contracted on the basis of an annual budget. A care provider was allowed to provide social care services to clients on a fee-for-service basis, charging the delivered volume of care services delivered against the associated tariff until reaching the agreed maximum annual budget.

Starting 2015, municipalities were free to specify their own services, tariff structure, contract type, and reimbursement method. This is reflected in the 86 social care service tenders, as a third of the municipalities have chosen a different contract type. Rather than behavior-based contracts that operate a fee-for-service reimbursement method, 121 municipalities collaborating in 34 tenders applied outcome-based contracts. These contracts do not require care providers to account for the volume of care services provided (fee-for-service). Rather, these contracts define outcomes in terms of desired results on individual client level (for example: 'the client should open and read his mail, pay his bills, and make a conversation with strangers') or on population level (for example '75 percent of people above 70 years can still live in their own home with support of formal and informal caregivers'). From the 34 procurements that applied outcome-based contracts, 29 measured and reimbursed desired outcomes on individual client level and 5 measured and reimbursed outcomes on population level. In the five procurements where municipalities contract the outcomes on population level, the municipalities contract a main contractor - in some cases a consortium of care providers - that assumes the responsibility for arranging social care services for (part of) the population of the municipality. Finally, the majority of municipalities (68 percent) still apply behavior-based contracts similar to the contracts that were used before the decentralization. Table 8.4 illustrates the application of the different contract types of the 2015 municipal social care service contracts.

**Table 8.4** – Contract types in 2015 Dutch social care contracts

Contract type	Number (%) of tenders – Number of municipalities <i>Breakdown details</i>
Behavior-based	52 tenders (60%) – 261 municipalities (68%)
Outcome-based	34 tenders (40%) – 121 municipalities (32%)
<i>Individual outcomes</i>	<i>29 tenders – 106 municipalities</i>
<i>Population outcomes</i>	<i>5 tenders – 15 municipalities</i>

Related to the contract type and reimbursement method is the method used by municipalities to control expenditure. Before 2015, social care contracts allocated a fixed annual budget to care providers, with the fee-for-service structure to account for the way the budget was spent. This system is associated with perverse incentives. First of all, while certain clients may actually not need the full extent of their hourly social care entitlement every week of the year, there is a strong incentive for care suppliers to ‘produce’ up to the exact entitlements of individual clients. In case at the end of the year a care provider has not provided enough hours of care to fully account for his annual budget, the care provider will not be paid the complete budget and consequently the budget for the next year is reduced. In case the care provider takes on too many clients and provides more care services – the care provider budget will be used up before the end of the year. A common response of care providers in this situation is to try to renegotiate their budget, leveraging the need for continuity of care for vulnerable clients and the possible emerging waiting lists when the financier is not willing to increase the budget.

Most municipalities recognized the perverse incentives in the old system and adopted new ways to control expenditure. Only 11 out of 86 contracts provide for annual fixed budgets. Three other systems were introduced in 2015, each with different incentives, both positive and perverse:

- Fee-for-service based framework contracts without guaranteed maximum budgets.
- Outcome-based framework contracts without guaranteed maximum budgets.
- A population-based budget contract with one main contractor (or a consortium of care providers as main contractor) to arrange all social care services for a certain population.

Table 8.5 provides a breakdown of municipal choices for each type of expenditure control.

**Table 8.5** – Methods for expenditure control in 2015 Dutch social care contracts

Expenditure control method	Number (%) of tenders – Number of municipalities
Fixed annual budget	11 tenders (13%) – 70 municipalities (18%)
Fee-for-service framework agreement	40 tenders (47%) – 186 municipalities (49%)
Outcome-based framework agreements	28 tenders (33%) – 107 municipalities (28%)
Population-based fixed budget	5 tenders (6%) – 15 municipalities (4%)
Combination of methods	2 tenders (2%) – 4 municipalities (1%)

Framework agreements without guaranteed production became most popular. In total 80 percent of the municipalities contracted using framework agreements.

#### 8.4.4 Monitoring: a challenge in (social care) service triads

All Dutch municipalities monitor client experience and satisfaction, typically through surveys. Other monitoring activities depend on the type of contract in place. For behavior-based contracts municipalities monitor the volume of care services provided, based on the invoices of care providers. Municipalities also verify the care provider does not invoice more services per client than the individual client's entitlements. Of course, a care provider may invoice more hours than actually provided to the clients, but clients know their entitlement and would notice this. Additionally, care providers with significant turnover are subject to an annual audit by an external accountant, reducing the probability of fraud. Municipalities operating outcome-based contracts typically did not apply behavior-based monitoring. This would be counterproductive: in outcome-based contracts it is up to the care provider to achieve the desired outcome. Municipalities with outcome-based contracts are expected to focus on monitoring outcomes. Although not all procurement documents in our database for the outcome-based contracts explicitly defined the monitoring procedures that the municipality applies, the tenders that do mention their monitoring methods indeed referred to monitoring outcomes. Besides client experience and satisfaction, municipalities monitor the extent to which desired results (the outcomes) are achieved: for example the level of goal attainment for individual clients, and reasons for ending social care service delivery.

In general, monitoring supplier behavior and outcome is more challenging in service triads. Additional challenges relate to the contract type applied. Monitoring the delivered volume of social care services based on invoices in behavior-based

contracts is easy, but provides limited insight. It is possible that the clients could have also been supported and cared for sufficiently with less hours of care, meaning that the municipality is actually paying too much. In outcome-based contracts, objectively monitoring the outcome and establishing whether a sufficient level of self-reliance has been achieved by the care provider is challenging and potentially time consuming. Some municipalities chose to have the care provider report on outcomes as well. Of course, this leaves ample room for opportunistic behavior. Other municipalities have the social community teams monitor social care outcomes. Representatives from the social community team check up on clients periodically to verify whether the desired outcome (for example improved self-reliance) is achieved. We argue social community teams, when operating independent from the care providers that provide the social care services, may strengthen the municipality's position in the service triad and prevent bridge transfer.

#### **8.4.5 A new perspective on competition: ex post**

Market mechanisms – the elements of competition included ex ante and ex post of contract closure – have not been studied in extant service triad literature. Peng et al. (2010) mention simultaneous competition and cooperation in triads as management mechanism and suggest this is an interesting area for future research. We study the use of this mechanism for two additional reasons. First, ex ante competition is at the heart of the public procurement regulations that apply to 'regular' public contracts. Second, in the light of the strong budget cuts in the context of our study, we expected municipalities to drive costs down using competitive tendering. We analyzed competitive elements both in the tender phase (ex ante) and in the contract execution phase (ex post). Ex ante competition typically takes form in a competitive procurement procedure with multiple suppliers competing for a limited number of contracts. Price and quality criteria are weighed and scored, and the buyer awards a contract to one or multiple suppliers with best ranked offer(s). Or alternatively, multiple suppliers are awarded a contract, but the suppliers with better offers (lower price, higher quality of combination of both) are rewarded by receiving beneficial contracts: for example a higher annual budget and a higher volume of clients. Besides competition over contracts, a different market mechanism is the manner in which social care service tariffs are determined: through care provider offers in the tender procedure, or by the municipality setting standardized tariffs.

Ex post competition in social care contracts can be introduced by awarding framework agreements without any guaranteed volume of turnover. Individual clients choose their care provider and this determines the contract value for care providers. Care providers then compete over individual clients. Especially when clients are allowed to switch to a different care provider, this may provide a strong incentive for the care provider to provide services of good quality. We identified (1) the extent to which the procurement procedure involved ‘ex ante’ competitive elements (for example a request for proposal-procedure with price offerings), and (2) whether methods were applied to introduce ex post competition in service provision.

Interestingly, despite social care budgets for 2015 have been cut on average by 11 percent (Rijksoverheid, 2014) leading up to budget cuts averaging 32 percent in 2016, the majority of social care service procurements are not ‘ex ante’ competitive in nature. Only in 7 out of 86 tenders there was competition over contracts based on price and quality. In the other tenders there was no competition over contracts, but the method to determine tariffs varied: see the breakdown in Table 8.6. Contrary to ex ante competition, the vast majority of municipalities procured contract types allowing ex post competition. Not surprising, the few municipalities that chose a competitive procurement procedure do not have ex post competition. In a few social care tenders, both ex ante and ex post competition were absent, so there is no competitive mechanism at all.

**Table 8.6** – Market mechanism in 2015 Dutch social care service tenders and contracts

Market mechanism	Number (%) of tenders – Number of municipalities
Ex ante competition (competitive procedure)	7 tenders (8%) – 15 municipalities (4%)
No ex ante competition, but offer tariffs	22 tenders (26%) – 121 municipalities (31%)
No ex ante competition, standardized tariffs	52 tenders (60%) – 222 municipalities (58%)
No ex ante competition, tariffs unknown	5 tenders (6%) – 24 municipalities (7%)
Ex post competition over every client	68 tenders (79%) – 293 municipalities (77%)
No ex post competition	15 tenders (17%) – 76 municipalities (20%)
Multiple types of contracts or unclear	3 tenders (3%) – 13 municipalities (3%)

## 8.5 Discussion: a service triad perspective on commissioning social care

There has been much academic attention to the quality and affordability of social care services, for example in relation to the way social care services are reimbursed. Issues relating to availability and quality of health care in general have been attributed to fee-for-service payments, where the volume rather than the value of care services is rewarded (Porter & Kaplan, 2016). An issue relating to care quality and care provider opportunism in health care services in general is the risk of Supplier-Induced Demand: the overconsumption of medical services generated by the economic self-interest of care providers (Sørensen & Grytten, 1999), which results from moral hazard and the information asymmetry typical for outsourced services, and more strongly present in service triads with a supplier in the bridge position. An analysis of these problems from a service triad perspective still lacks. We argue the knife cuts both ways in our study: findings concerning how public buyers deal with these issues offer new perspectives on the extant SCM service triad literature. At the same time, applying the service triad literature in this context increases our understanding of how public buyers can manage buying social care services more effectively. We discuss our findings here for each of the identified mechanisms.

### 8.5.1 Maintaining a strong position in the triad: a role for social community teams

In social care service procurement the risk of bridge decay, where the buyer loses its bridge position, and bridge transfer, where the care provider assumes the bridge position, is clearly present. A municipal citizen in need of social care makes a request to the organization responsible for assessing eligibility for social care services, including the type and volume of social care services. Municipalities organize this 'gateway to care' in social community teams: local organizations staffed either with municipal employees, by the local welfare organization, by external care providers, or a combination of these. The final decision with respect to the formal care entitlement is made by the municipality and the municipality at this stage is in the bridge position. In situations where a client needs to renew an existing entitlement to social care services, the client already has a relation with a care provider. Then there already is a 'connected triad' and there is no structural hole between client and care provider. The municipal position in the triad in both cases (new or existing client) deteriorates the moment social care service provision

starts or presumes. From that moment on, the care provider is in regular contact with the client while the role of the municipality diminishes. In case the municipality does not take action by remaining in contact with the client, bridge transfer occurs. The best possible situation – which according to Li and Choi (2009) municipalities should strive for – is to aim for a state of permanent bridge decay by filling the structural hole. This means the municipality should stay in contact with the client and monitor care provider behavior or performance – depending on the type of contract applied (Van Der Valk & Van Iwaarden, 2011). We argue the organization of social community teams may facilitate the municipality to maintain a state of bridge decay – when social community teams are organized independent of care providers, and these teams or the municipality monitors care provider behavior or performance. When social community teams are managed by the same care providers who also provide care social services, of course municipalities are not even in the bridge position in the first place.

### **8.5.2 Relationship development, trust and social contracts: evidence of relational contracting practices**

Having a collaborative and trusting relationship between buyer and supplier in a service triad has been proposed and demonstrated to reduce supplier opportunism (Hartmann & Herb, 2014, 2015) and improve the perceived service quality by end-customers (Gunawardane, 2012). Customer-focused service providers more effectively fulfil end-customer needs when service provider and buying organization share close relational ties (Wuyts et al., 2015). These observations give rise to the question how buyers may accomplish these close relational ties with service providers. This is even more interesting in a context where public buyers had no previous contractual relationship with suppliers. Developing a collaborative relationship and trust is known to be difficult in public procurement. The operating framework and culture of the public sector may hinder the development of inter-organizational relationships and trust (Erridge & Greer, 2002). Traditional bureaucratic competitive tendering stands between building social capital in partnerships and developing long-term relationships between public buyers and private sector suppliers (Steane & Walker, 2000). For common services and commodities, public buyers have to adhere to strict regulations for competitive procurement procedures. Erridge and Greer (2002) demonstrated these regulations have restricted the development of closer supply relations and social capital as public buyers set out rigid bureaucratic procedures. Social care service contracts are to a great extent

exempt from these strict rules for competitive tendering. Our findings demonstrate municipal buyers used their discretion for using custom procurement procedures, as most municipalities take a much more relational approach to social care service procurement. Two hurdles for building collaborative relationships are removed by municipalities with the absence of ex ante competition for contracts, and the reduced level of bureaucracy and administration in procurement procedures. In addition, the majority of municipalities explicitly start collaborating with care providers early to draw up the contract.

Another dimension of relationship development is the establishment of social contracts. John (1984) defines a social contract as a micro-level agreement that is purposely designed within an individual exchange relationship. A social contract is not necessarily legally binding, although it may build on legally binding documents (Heide et al., 2007; John, 1984). We know the municipalities in our study had no prior buyer-supplier relationship for the social care services they are contracting. Therefore no prior implicit or explicit social contracts will exist. We found that explicit social contracts were established by municipalities and care providers in more than half of the social care service tenders in our study. Each of these tenders categorizes as a dialogue-based procedure. These municipalities were putting explicit efforts in building collaborative relationships and trust by both entering in a dialogue with care providers about contract clauses, and establishing explicit social contracts describing expectations and 'rules of engagement' both during the dialogue-based procurement procedure and execution of the social care contract. Summarizing, the majority of municipal buyers demonstrated a relation contracting approach characterized by the absence of ex ante competition, low levels of bureaucracy and administration, care provider dialogue and negotiation in drawing up contracts, and establishing formalized social contracts. The extent to which municipal buyers used this relation contracting approach evidences the public buyers identified the need for building collaborative and trusting buyer-supplier relations in service triads.

### **8.5.3 Contract type and incentives: introducing outcome-based contracting in social care in the Netherlands**

Behavior-based contracting of health and social care services relates to 'fee-for-service' reimbursement: a care provider is paid to perform certain activities such as a treatment, or providing an hour of counselling. Outcome-based contracts for

social care services may take on different forms, distinguished by the reimbursement method applied. The social care service contracts in our data set applied outcome-based bundled payment or population-based (capitation) payment. There is much attention in health economics with respect to disadvantages of traditional reimbursement methods. Porter and Kaplan (2016) mention fee-for-service reimbursement is now widely recognized as perhaps the single biggest obstacle to improving health care delivery (Porter & Kaplan, 2016). In the Dutch health care system financial incentives to suppliers for improving quality and effectiveness of health care often completely lack (Kleef, Schut, & Ven, 2014). The contract types and associated incentives of the applied reimbursement method directly relate to the main challenge for the organization of social care: reducing or stabilizing expenditure while maintaining or improving quality and availability of care services. We find the majority of municipalities still procured behavior-based contracts, although a third of the municipalities procured an outcome-based contract. The disadvantages of behavior-based (fee-for-service) contracts were discussed extensively. However, using outcome-based contracts in a service triad – and in a social care context particularly has its own difficulties. Depending on the exact type of care, objectively and clearly specifying the required outcome may be very difficult. Social care is often not intended to cure a client, but rather to help disabled people to cope with their disability both mentally and physically in order to achieve improved self-reliance. However, goals such as ‘self-reliance’ and ‘participation in society’ are global concepts lacking a precise definition and measurement scale. The extent to which a care provider is responsible by contract to support a client with improving his self-reliance becomes difficult to pinpoint in the absence of a precise definition. A related problem is that the level of self-reliance that can be achieved by a client differs per individual. Actually realizing (or maintaining) that level of self-reliance can only be influenced by the care provider to a certain extent, and depends on external factors as well. The client itself contributes to the service outcome as well. In situations with high outcome uncertainty (or low performance attributability), performance-based contracts (in effect outcome-based contracts with payment at least partially dependent to supplier performance) are argued to be less effective (Nullmeier, Wynstra, & van Raaij, 2016). Hybrid contract types that combine elements of both behavior-based and outcome-based contracts – proposed for complex service purchases (Tate et al., 2010) – may in fact be most appropriate in the social care service context.

Regarding incentives we also studied the mechanism to control expenditure by means of the contract. The two most commonly used types of contracts in our study

were fee-for-service framework agreements and outcome-based framework agreements. Again, both types have certain risks. In fee-for-service framework agreements the care provider benefits from exaggerating the extent to which support is necessary: the client receives more support, the care provider can provide optimal care and has a higher turnover. Care provider opportunism in this situation leads to supplier induced demand and a higher level of expenditure as a consequence (Sørensen & Grytten, 1999). Of course the client receiving care may object to receiving more care than necessary. However, the relation between client and care provider will quickly become much stronger compared to the relation between client and municipality, in effect bridge decay and bridge transfer (Li & Choi, 2009). This may reduce the probability that clients will report the situation of supplier-induced demand to the municipality. Hence, the municipality has to take measures to prevent care provider opportunism. In outcome-based framework agreements the care provider benefits from achieving the required outcome with the least amount of efforts. The care provider may reduce social care quality to the level that is just acceptable, before resulting in too many complaints from clients. Here, the municipality should directly monitor the realized outcomes to prevent inadequate performance of the care provider. If contracting a population-based fixed budget, the challenges from outcome-based framework agreements are similar but magnified: typically in this reimbursement system the buyer is less involved with individual clients, as performance indicators will typically focus on a population rather than on an the individual client. The contracted care provider may even refuse social care against people's request, increase waiting time before starting social care service provision, or try to push clients to types of social care with different financers such as health insurers; 'dumping': see Ellis (1998). Chapter 9 discusses these incentives and related risks related to the reimbursement methods in more detail.

#### **8.5.4 Monitoring: the focus on outcomes**

The contract alone is not sufficient for successful service procurement; the contract management activities that take place after the contract becomes effective are equally important (Van Der Valk & Van Iwaarden, 2011). In social care service triads, monitoring the behavior of care providers is very difficult: this is in line with the findings of Sharma (1997). The social care service is often provided at the clients' home. Actually monitoring the service when it is provided is not only very time consuming, it may even violate the privacy of the client. When municipalities use behavior-based contracts with fee-for-service reimbursement, they monitor

the volume of care services that is invoiced. This production is compared to the entitlement of the clients, making sure no more hours of care services are reimbursed than the clients are entitled to. However, it is not visible to the municipality whether the client over time can actually manage with less social care services, or no social care at all. This becomes apparent only when the client's entitlement is formally re-evaluated by the municipality. Outcome monitoring therefore is much more appropriate in this context, where typically the client satisfaction is measured, together with indicators concerning the extent to which the clients' goals have been achieved, and the reason why care provision has been terminated. The data we used for this study offers only limited and rather superficial insights in the monitoring practices, limiting our findings in this respect. Given the importance of monitoring in public sector service triads in general, we call for more research on monitoring practices in (public sector) service triads.

### **8.5.5 Competition: ex ante versus ex post - competition after contract award as new management mechanism**

Interestingly, no service triad studies to date have paid attention to the differentiation between ex ante and ex post competition in relation to service quality control and supplier opportunism. Peng et al. (2010) mention simultaneous competition and cooperation in triads as management mechanism and suggest this is an area for future research. By studying elements of competition we extend the discussion of management mechanisms in service triads. Our findings are surprising especially in the context of public procurement of social care services. Realizing substantial cost savings on social care services was one of the major motives for the Dutch system reform. A typical government response is to introduce some degree of competitive market forces in public funded care systems (Gross & Harrison, 2001; Light, 2001; Randall & Williams, 2009). Governments assume competitive forces encourage quality while driving costs down (Randall & Williams, 2009). Also, competitive procurement is at the core of public procurement rules. Surprisingly we found only a minority of municipalities used ex ante market mechanisms in their social care service procurement. Four out of five municipalities procured framework agreements, awarding every qualifying care provider a contract. Municipalities may have had different motives for this choice. The Wmo 2015 (*Social Support Act 2015*) requires municipalities to offer their citizens some degree of choice in care providers. Furthermore, despite severe budget cuts, competition on price in health care procurement is often faced with critique. Although it is in line with pol-

icy goals to realize more efficient social care service delivery, in public debate too much focus on price is considered perverse as it triggers a 'race to the bottom' that is considered to have a negative effect on the quality of social care and employment in the care provider market. These are to a large extent political arguments, but in public procurement with additional demands (Knight et al., 2007) these cannot be ignored. Finally, using a competitive procurement procedure is known to hinder the establishment of a collaborative relationship between buyer and supplier, while as we have discussed before this is even more important for the buyer in a service triad. These findings lead to interesting new insights in managing service triad issues such as service quality control, customer satisfaction, and supplier opportunism. Besides the other management mechanisms discussed, putting in place ex post competition introduces a strong incentive for care providers to maintain or improve their social care service quality, in case clients are free to choose their care provider and may switch if they are not satisfied with their current care provider.

## 8.6 Conclusion and implications

The literature on service triads proposes buyers to focus on building or maintaining collaborative relationships and trust in the buyer-supplier dyad, enforcing behavior through contracts, incentives, and SLA's, possibly using social contracts, and finally monitoring supplier behavior and/or service outcomes. Although the 86 social care service tenders studied in this research show a wide variety of approaches and choices with respect to the management mechanisms discussed, there are some 'dominant choices'. The majority of municipalities still applied a behavior-based (fee-for-service) contract and behavior monitoring, although approximately a third of the municipalities introduced outcome-based contracts and monitoring. Competition on price and quality to award contracts was rare and ex post competition for individual clients was the norm. A majority of Dutch municipalities aimed to build collaborative relationships through 'dialogue-based' procurement procedures, establishing formalized social contracts and choosing ex post competition over ex ante competitive procurement procedures. Reflecting on the additional demands a public buyer faces as discussed in the literature review, we see clear evidence of context demands in terms of risk-averse buying behavior. Many municipalities mimicked the pre-2015 procurement approach and furthermore avoid competitive contracting, which often is a source of conflict. External demands of transparency and accountability are visible too. For example, many social care service tenders were published on national or European level even though

social care service contracts were exempt from this transparency requirement under the EU public procurement law applicable in 2014. The light regime social care services were subject to meant that process demands were much less strict. This gave room to the wide variety of procurement procedures we observed, with elements that are not common in other public procurement procedures. The most prominent example is the high degree of involvement and input of care providers throughout the procurement procedure in drawing up the contract.

### **8.6.1 Theoretical contributions**

We contribute to existing literature and service triad theory in the following manners. First, our findings extend earlier studies discussing the need for a collaborative and trusting buyer-supplier relationship in service triads by evidencing how municipalities as public buyers may initiate or build collaborative relationships and trust from the very early stage of contracting. Earlier studies discuss in this perspective relationship configurations (Karatzas et al., 2016), interpersonal interaction (Holma, 2012), and interconnectedness between the buyer-supplier dyad and buyer-customer dyads (Hartmann & Herb, 2015). An extensive study whether buyers indeed aim for collaborative relations when buying in service triads, and how to achieve these relationships lacked, and our study fills this gap. Arm's length administrative and competitive procurement procedures are known to hinder collaborative relationships (Steane & Walker, 2000). Our study evidences municipal buyers to a great extent applied dialogue-based procurement procedures without ex ante competition. Care providers were in fact invited to plenary discussions on the content of the contracts before signing. When contracts had been drafted, municipalities awarded every (interested) care provider that met the minimum quality criteria the framework contract. Furthermore, earlier research proposes buyers to establish social contracts with suppliers in the service triad (Van Der Valk & Van Iwaarden, 2011). In this respect our study contributes by demonstrating how public buyers established social contracts in a formal manner, in a context where no prior buyer-supplier relationship existed between the municipality and the care providers. We further contribute by identifying and addressing the use of framework agreements and ex post competition in the light of service triad challenges. There have not been studies addressing this aspect in service triads. When discussing service triads from an Agency Theory perspective, studies typically conclude buyers need to monitor performance and put in place the right type of contracts (Tate et al., 2010; Van Der Valk & Van Iwaarden, 2011). The procurement practices

evidenced in this chapter suggest that enabling clients (end customers) to choose their care provider (service supplier) and facilitating to switch care providers may offer a completely different but strong mechanism to avoid supplier opportunism and improve or maintain service quality levels. Generally: when end-customers have the opportunity to switch to a different service provider, using a framework agreement may in fact reduce the need for other, more costly management mechanisms. This is very relevant outside the context of public procurement and social care services, and is an interesting area for further research.

### **8.6.2 Managerial implications**

Our study offers a number of insights to buyers in service triads in general, and buying social care services specifically. With respect to power positions in the service triad: municipalities clearly start off in a bridge position for new clients requesting social care. However, we see that, once social care service provision starts, the municipality loses its bridge position. The risk of care providers acting opportunistically, and the consequences for clients and municipality depend on the type of contract. In behavior-based contracts there is an incentive for the care provider to manipulate demand causing over-expenditure from municipalities. In outcome-based contracts there is a contrary incentive for the care provider to minimize quality and volume of service delivery, where mostly the client may suffer the consequences. Both types of contracts have other advantages and disadvantages and the choice of contract type should not rely completely on the incentives we point out here. Rather, the implication for buyers is to be aware of the risks of their contract of choice. Different types of monitoring are necessary to reduce the risks: in behavior-based contracts the behavior of the service provider should be monitored. Monitoring behavior in a professional service environment is known to be complex and time-consuming (Sharma, 1997). Therefore municipalities should on the one hand control the gateway to social care services such that they have control over the social care entitlements, and on the other hand monitor the production through management information. Monitoring outcomes if outcome-based contracts are applied may also be time-consuming, but it is critical to prevent inadequate service provision. Monitoring behavior, in effect the volume of social care services provided, does not make sense in outcome-based contracts, as Van Der Valk and Iwaarden (2011) propose the monitoring type should correspond to the contract type. Besides monitoring attainment of the outcome (for example self-reliance of the client), a survey measuring client experiences and satisfaction can be

used as a monitoring instrument. However, we argue using framework agreements with ex post competition over clients can be a powerful mechanism to counter care provider opportunism and improve service quality. By allowing clients to choose their own care provider and switch to a different one if they are not satisfied, clients themselves are enabled to act when confronted with poor care provider performance. This mechanism may alleviate the need for time-consuming monitoring activities although we argue some level of monitoring remains necessary.

Furthermore, buyers in service triads should invest in their relationship with suppliers and build trust. For municipalities buying social care services, the light regime in the public procurement rules for social care service contracts allows other than the traditional bureaucratic competitive procedures known to hinder social capital development. Municipalities can use their discretion to negotiate contracts, involve care providers in drawing up contract specifications and performance indicators, and to establish consensus on both formal and social contracts throughout the procurement procedure. Municipality-care provider relations may further benefit from choosing ex post competition in a framework agreement, rather than a competitive procurement procedure. Finally, we identify a practice of using explicit social contracts – which may further improve the relationship between municipalities and care providers.

### **8.6.3 Limitations**

Some limitations arise from the context of this study. The context of social care services lends itself for contracting multiple care providers, and relying on ex post competitive forces to drive up or maintain a sufficient level of service quality. Although we argue this mechanism may be very effective in other public and private service triads, contracting multiple suppliers in a framework agreement will not be effective and efficient for every outsourced service. Also, the relation between the buyer and end-customer in social care service triads differs from a private context: the relation is not managed through a contract. For example in the Netherlands the entitlement to social care is tax-funded. Clients cannot choose their buying organization (rather than moving to another municipality), and have no contractual relation with the municipality as buyer. Their rights and entitlements to social care services are regulated under national public law. This of course differs from private service triads, where the end-customer may switch to a different product or service supplier.





# Chapter 9

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**Supplier opportunism in social care services –  
a service triad perspective on different  
reimbursement methods**

## Preface

This chapter is based on a book chapter entitled ‘Supplier opportunism in social care services – a service triad perspective on different reimbursement methods’ in the book *The Art of Public Procurement – the Liber Amicorum* put together for prof. dr. Jan Telgen in honor of his valedictory lecture held at the University of Twente on 26 May 2018 (Uenk, 2018).

### 9.1 Rewarding value or volume?

In recent years Jan Telgen has been an advocate for performance-based or outcome based contracting and applying ‘functional specifications’ in (public) procurement in general, and in public commissioning of long-term social care specifically. Performance-based contracting (PBC) is widely accepted as a useful tool. It is believed that the use of PBC can assist the efficient utilization of public resources (Ambaw & Telgen, 2017). In the context of social care services, improving service quality against lower costs through the procurement of these services calls for new approaches to buying and financing social care services (Telgen & Uenk, 2015). For social care services, functional specifications put the intended effects of social care, such as improved or endured self-reliance of elderly people, at the center of a contract. Specifying the outcome rather than the inputs means care providers may find new, innovative ways to achieve the desired outcome (Robbe et al., 2016). There is an incentive to innovate and provide social care services as efficiently as possible when the outcome is reimbursed, rather than the volume of performed interventions or the inputs. It is these incentives that fuel the interest of public care commissioners into alternative ways of commissioning – and paying for – social care services.

To address the issue of steadily rising social care expenditure, many countries outsource social care services (M. Lamothe & Lamothe, 2009). By introducing competition, governments aim for competitive forces to encourage quality while driving down costs (Randall & Williams, 2009). However, competitive tendering aiming for the lowest price for services is, at least in the Netherlands, considered undesirable. Although it is in line with policy goals to realize more efficient care service delivery, in public debate too much focus on price is considered perverse as it triggers a ‘race to the bottom’ that is associated with negative effects on service quality and employment in the social care service sector (Kamerstukken II 2013/14,

23235, 116, p.1, 2014). Dutch care commissioners – municipalities – therefore direct attention to building in the right incentives in the way social care services are commissioned. In this respect, there is much attention – both from scholars and practitioners – to the reimbursement methods for services in general, and for health and social care services specifically. Different reimbursement methods each offer certain incentives for the care provider with respect to service quality and demand. These incentives either align the goals of the public care commissioner and the external care provider, or they can in fact cause goal incongruence between the commissioner and the care provider. A typical example is fee-for-service reimbursement, where care providers are paid per performed procedure or other types of inputs. There is a financial incentive for care providers to increase the volume of performed procedures; this is known as supplier induced demand (Sørensen & Grytten, 1999). This is of course a perverse incentive from a societal perspective, and fee-for-service payment is now widely recognized as perhaps the single biggest obstacle to improving health care delivery (Porter & Kaplan, 2016). This is a widespread problem. In the Dutch health care system financial incentives to suppliers for quality and effectiveness are often inadequate (Kleef et al., 2014), although Dutch health care commissioners have experimented with different reimbursement methods; for example, integral population-based budgets for social and nursery care (Olivier van Noort & Schotanus, 2015).

However, the matter of efficient and effective procurement or commissioning of services in general, and health care services in particular, is known to be complex. Service buying is associated with problems in effectively organizing the transactions and relations involved in sourcing services (Van Der Valk & Van Iwaarden, 2011). Managing the quality of procured services and the contractors that deliver the services is amongst the issues highlighted (Axelsson & Wynstra, 2002). Health and social care service procurement is additionally complex compared to regular buyer-supplier dyadic relationships in two ways. First, in a privatized health care system, health and social care typically are commissioned by a government or health insurer, delivered by an external care provider, and received by a client. The additional complexity stems from the service buyer not directly witnessing or experiencing the service delivery himself. This constellation is known as a service triad (see Chapter 8 for an extensive discussion and literature review on service triads). Emerging research in the purchasing and supply management literature on service triads finds that the challenges for service buyers in dyadic relations with suppliers are exacerbated in a service triad. The buyer does not experience service quality directly and needs to take measures. Extant research has focused

on the changing relationships over time among actors in the service triad (Li & Choi, 2009), monitoring (Van Der Valk & Van Iwaarden, 2011), contract types (Tate et al., 2010), and the influence of social capital among service triad actors (Hartmann & Herb, 2014, 2015). A second factor complicating social care services commissioning arises if public bodies such as central or local governments commission the care services. Compared to private buyers, public buyers face additional demands (Knight et al., 2007), for instance: public buyers in the European Union must adhere to public procurement law (process demands); citizens expect exemplary behavior and transparency of public buyers (external demands); and governments serve many different political goals, some of which may conflict (internal demands) (Knight et al., 2007).

Despite the two topics, health and social care service reimbursement methods on the one hand and buying services in service triads on the other, both receive much scholarly attention, although there exists an interesting gap in the literature from both an academic and practical perspective. There has been limited attention to studying reimbursement methods in health and social care services from the perspective of service triads. The aim of this study is to fill this gap by studying social care reimbursement methods from a service triad perspective. Insights from more recent service triad literature in the context of business services shed new light on managing the issues of service quality and expenditure control associated with commissioning social care services. This research does not aim to answer the question which reimbursement method works best for buying social care services. Rather, for different reimbursement methods observed, the research in this chapter defines propositions regarding the most appropriate measures public commissioners should take in order to control service quality and expenditure on social care services.

This research focuses on reimbursement methods applied in the Netherlands for social care services. Following the 2015 social care reform in the Netherlands, 393 municipalities became responsible for commissioning social care services. Aiming to achieve the goals of better quality of long-term care at lower costs, Dutch municipalities adopted a range of different reimbursement methods when commissioning social care services. Each of these methods brings both incentives for the care providers and (consequently) risks for the municipality (as public buyer). However, knowledge is lacking in this context on how to address the undesirable effects of perverse incentives present in both traditional activity-based and new outcome-based reimbursement methods. Therefore, it is relevant to identify the

measures proposed in literature for municipalities to control service quality and social care expenditure. It is the central proposition of this paper that these measures depend on the specific reimbursement method applied by the municipality in social care service contracts, and that potential risks are moderated by the way that municipalities organize the access for citizens to social care services (the ‘gateway’ to care, often organized by social community teams): see van Eijkel, Gerritsen, & Vermeulen (2019).

The research questions this paper addresses are twofold:

1. Which reimbursement methods do Dutch municipalities use in contracting social care services?
2. Based on agency theory, what are appropriate measures municipalities should take to control service quality and care expenditure in each of these reimbursement methods?

To answer these questions, I review the literature on service triads, and from the literature perspective I reflect on reimbursement methods observed in Dutch municipal commissioning of social care services. I use inductive reasoning to present a series of theory driven, testable propositions regarding agency relationships in social care services service triads (Tate et al., 2010). The research design closely resembles a study that adopted an agency theory approach to buying in service triads in general by Tate et al. (2010). This study specifically applies this methodology to the context of social care services and the different reimbursement methods empirically observed in Dutch municipal social care service commissioning. Contrary to Tate et al., I not only incorporate agency theory, but I extend by using the propositions on the dynamics of structural dimensions in service triads – grounded in social network theory – as discussed in the seminal work of Li and Choi (2009).

The chapter is organized as follows: first, I briefly discuss those aspects of the context of this study that have not yet been discussed in sufficient detail in previous chapters. Section 9.3 then addresses the different reimbursement methods Dutch municipalities have adopted for commissioning social care services from 2015 onwards. Section 9.4 synthesizes the literature on service triads and discusses how findings may impact in the Dutch municipal social care services setting. Based on the findings and observations, this section presents testable propositions with respect to effective management of social care services commissioning under various reimbursement methods. Section 9.5 adds a discussion of the findings and pre-

sents limitations of this study.

## **9.2 Context: the pivotal position of social community teams**

Again, an extensive discussion of the context of this study – included in the original thesis chapter on which this chapter is based – is omitted here to avoid redundancy. This research is performed in the same context as discussed in Chapter 2. I do highlight one aspect that is particularly relevant for the research discussed in this chapter, which is the municipal organization of access to social care. Almost all Dutch municipalities have implemented social community teams (SCTs) as the first point of contact for clients in need of social care services (Oude Vrielink, van der Kolk, & Klok, 2014). Although these SCTs vary in terms of organizational structure and the scope of their responsibilities, they in general are responsible for the assessment of social care entitlements of citizens of the municipality. The different organizational structures of SCTs are relevant for the municipal control over service quality and expenditure, as SCTs hold a pivotal role and position in the municipality-client relation. SCTs across municipalities vary in dimensions such as their formal legal entity, whether or not SCTs also provide light types of social care services themselves, and how the staffing is organized. In this respect, municipalities either (1) hire SCT employees directly, meaning the SCT staff then consists of municipal officials; (2) hire or mandate local welfare organizations as external SCT organizations; or (3) hire (employees from) the care providers that are also contracted to deliver social care services. The third option is especially relevant as SCT employees work for care providers who have a stake in the decisions on social care eligibility and the extent of citizens' entitlement to social care. This point is revisited in Section 9.4.

## **9.3 Reimbursement methods for social care services**

Aiming to achieve the goals of better quality of long-term care at lower costs, Dutch municipalities adopted a range of different reimbursement methods when buying social care. As indicated above, each of these methods brings certain incentives for the care provider and (consequent) risks for the public buyer. Earlier chapters in this thesis presented empirical research in which the reimbursement methods used by Dutch municipalities were determined and discussed. This chapter builds

on this prior research and the resulting overview of reimbursement methods (see for more details Chapter 8, particularly Section 8.5.3), where I concluded that the majority of municipalities at the start of 2015 still adopted traditional fee-for-service payment for care services, either with or without annual budget thresholds. About one in three municipalities have adopted new reimbursement methods, three of which were identified in this prior analysis: (1) fee-for-service payment, (2) outcome-based bundled payment, and (3) population-based budgets. Each of these reimbursement methods is discussed in more detail below.

### **9.3.1 Fee-for-service payment: paying for (and rewarding) volume**

Fee-for-service is a reimbursement method where individual services are paid for separately. Fee-for-service is a widely adopted reimbursement method in health care, for example in primary care where a professional is paid a fixed amount per person that visits the general practitioner. Dutch municipalities using the fee-for-service reimbursement method for social care services generally define between 6 and 30 different social care services including individual and group guidance (and) counselling. The services are specified in more detail, ranging in the nature and severity of handicap of target clients and detailed requirements, such as optional 24/7 availability for unstable clients. These specifications also relate to the required education and experience level of the professional caregiver. Municipalities that define a limited number of different services typically have broader service specifications, while municipalities with more services distinguish (for example) different client groups based on handicap or handicap types. Under fee-for-service reimbursement, municipalities establish service fees for each of the services. These fees may be standard across all care providers or individually established for each contracted care provider. In the latter case, fees are based on individual offerings by care providers in a public tender, or the result of municipality-care provider negotiations. Depending on the type of service, the fees correspond to an hour of individual guidance counselling, a period of 3 or 4 hours of group guidance counseling at care provider premises, or one day of (temporary) stay and shelter. In these municipalities, a client requesting social care services is assessed by the designated municipal department, most often an employee of the SCT. The assessment results in a formal entitlement that in fee-for-service operating municipalities states the amount of services the client is entitled to, for instance four hours per week of individual guidance counseling and one day of group day-care.

### **9.3.2 Outcome-based bundled payment: a new focus on outcomes**

With bundled payments in health care, also known as ‘episode-of-care payments’ or ‘case rates’, the care provider is paid a single price for all of the services needed by a client or clients during an entire episode of care (Miller, 2009). A simple example in curative care would be to pay one fixed fee for the entire treatment of a client with a broken arm, instead of every individual part of the treatment. With bundled payments, the care provider is not obliged to deliver a predetermined volume of services. Rather, the care provider is paid to accomplish a desired outcome. Optionally, the payment is to a certain extent performance based, meaning the payment depends on the extent to which the desired outcome has been achieved. More than a quarter of Dutch municipalities contract social care services on the basis of outcome-based services with a form of bundled payment. These municipalities specify certain desired outcomes of social care services at the level of individual clients; for example, ‘the client has insights into their financial situation’, ‘the client has a clean house’, or ‘the client has social exchanges with the people around them’. Municipalities then pay a fixed weekly or monthly fee to care providers for achieving or maintaining this outcome. Different to fee-for-service reimbursement, with bundled payment the care provider is free to determine the services necessary to accomplish or maintain the desired outcome. The application of performance-based bundled payment is still very rare in the commissioning of Dutch social care services. Municipalities using bundled payments put the desired outcome at the center of their commissioning of social care services but still stick to fixed periodic fees rather than performance-based payments. The main advantage of bundled payment over fee-for-service is that within episodes of care, there is an incentive to achieve desired outcomes as efficiently as possible. Furthermore, the perverse incentive of fee-for-service (to maximize the volume of care services within one episode of care) does not present itself in bundled payments. Still, there is a financial incentive to increase the number of episodes of care.

### **9.3.3 Population-based budget payment: transferring risks to the care provider**

A third reimbursement method is the population-based budget, also known as ‘capitation’ or ‘lump sum payment’. With population-based budget payments, a care provider is responsible for the delivery of (health) care services for a certain population and receives a budget independent of the number of episodes of care

and the volume of services delivered within these episodes of care. The population not only consists of people currently in care or under treatment; demand for health care depends on circumstances in the population. This means there is more risk involved for the contracted care provider, and the population-based budget should be adjusted for the population case mix. Otherwise health care suppliers may end up bearing financial risks they cannot cope with, or it would act as an impediment to signing the contract with the purchaser (Frakt & Mayes, 2012). Research on the factors that need to be included in risk-adjusted population budgets for home care finds that both ‘demand side’ factors (e.g. population age, average income, etc.) and ‘supply side’ factors (e.g. the level of competition among care providers in a region) influence home care use and costs (O. van Noort et al., 2017). Dutch municipalities that apply a population-based budget for social care services generally contract one main contractor for the entire municipality, although that main contractor may be a consortium of multiple care providers. However, the consortium is one formal entity towards the municipality, taking on the responsibility of arranging social care services for every citizen of the municipality who is entitled to social care services. Only a few Dutch municipalities implemented population-based budgets for main contractors for social care services in 2015 and the years that followed. The main contractor care provider is typically held responsible for achieving output or outcome-based performance indicators on the population level, for example sufficiently high average client satisfaction. Within these municipalities there is some interesting variation in the scope of the contracts. Certain municipalities chose to exclude social community teams (functioning as gateways to social care) from the responsibility of the main contractor. These municipalities argue that access to social care should be organized independently from the provision of social care. Other municipalities included SCTs in the scope of the contract and population-based budget, arguing this allows the main contractor to organize a more integrated social care services system and provides an incentive to focus more on the prevention of (intensive forms of) social care services.

## **9.4 Testable propositions on social care reimbursement grounded in agency theory**

Despite the substantial scholarly attention paid to reimbursement methods in health and social care in general, a service triad perspective on the reimbursement methods of social care services is currently lacking. In this section the literature on buyer-supplier-end customer service triads is reviewed. Based on inductive

reasoning from extant literature, propositions are constructed with regards to the three reimbursement methods encountered for social care services. Many of the propositions for buyers in service triads that regard measures and management mechanisms (such as contracts and monitoring) in extant research are grounded in agency theory. Agency theory explicitly addresses the contractual arrangements under which the relationship between a principal and an agent operates most efficiently. It can be used to look at both the explicit (legal) and implicit (social) aspects of the contract (Eisenhardt, 1989). Agency theory is concerned with solving measurement and motivation problems when principals and agents have differing goals, and it is (economically or otherwise) infeasible for the principal to completely verify the agent's performance. Underlying agency theory are specific assumptions about human nature (self-interest, bounded rationality, risk aversion), information, and organizations (goal conflict among members) (Eisenhardt, 1989). In the agency theory perspective on buyer-supplier arrangements in general, contracts and monitoring are pivotal instruments for a buyer to influence supplier performance. In service triads, a third instrument becomes relevant: maintaining a strong position in the triad vis-à-vis the contracted service provider (agent) and the end-customer. I discuss these three instruments and implications for different reimbursement methods for social care services.

In their seminal work, Li and Choi (2009) are the first to address specific issues in service triads, focusing on shifting relationship structures over time and incorporating the 'structural hole' concept from social network theory (Burt, 1992). Li and Choi (2009) emphasize the benefits of being in a bridge position as a buyer between customer and supplier, which may transfer to a bridge position for the supplier between customer and buyer. The bridge position is associated with advantages. First there is an information benefit: actors in the bridge position can benefit from additional information over the two other actors (Burt, 1992, 2000b, 2002). Second there is a control advantage: the actor in the bridge position can negotiate and exploit information to its advantage (Burt, 2000b; Zaheer & Bell, 2005). Li and Choi (2009) argue the relationships among the actors in the triad are not static; in short, the buyer may start out in the bridge position, having a relation with its end-customer on the one hand and establishing a relation with an external service provider when outsourcing service delivery to end-customers on the other. In the initial stage there is a structural hole between end-customer and service provider, but of course here a relationship forms as soon as actual service delivery commences from service provider to the end-customer. The buyer is no longer in the bridge position – this process is known as bridge decay (Li & Choi, 2009). When

the buyer is no longer involved in the service delivery due to its outsourcing decision, the bridge position may actually transfer to the service provider. With bridge decay, the benefits of being in the bridge position for the buyer reduce. With bridge transfer, the benefits of being in the bridge position transfer to the service provider. Therefore the buyer should prevent bridge transfer by continuing to interact frequently with end-customers and monitor the service provider (Li & Choi, 2009). Other researchers find firms may achieve a structurally powerful network position in the triad through (developing) various power sources by improving capabilities and mitigating suppliers' actions – for example through contracts and building strong, mutually dependent customer relationships (Finne et al., 2015).

The shifting relationship structures over time are clearly present in the municipality-care provider-client social care services service triad. A citizen requesting social care first interacts with the municipal organization responsible for the assessment of care entitlements – typically the SCT. If the SCT assessment is positive – in other words the citizen is entitled to social care – the client then chooses the care provider to provide the care services. Even if there is a prior relationship between client and care provider, at this early stage the municipality – often through the SCT – interacts with the client. The municipality is either in the bridge position (there is not yet contact between client and care provider) or in a position of bridge decay (if there is a prior relationship between client and care provider, which is possible if there was a previous episode of social care provision). When care services commence, however, the care provider has frequent and often intensive interactions with the client, while the role of the municipality diminishes. If the municipality does not act, the care provider will take over the bridge position. In general, regardless of the reimbursement method for social care services, the municipality is advised to maintain interactions with clients and monitor the care provider's behavior or performance. From this perspective the organization of SCTs are pivotal. SCTs are the gateway for clients to social care and are responsible for making the assessments of clients' situations, desires, and needs for social care services. Most municipalities choose to either organize SCTs in house or contract organizations independently of the care providers contracted to provide the social care services. This allows for an assessment of social care service entitlements independent of care provider goals and desires. Interestingly, however, there are municipalities that contracted care providers for SCT positions as well as for provision of social care services. I argue this weakens the municipal position in the service triad vis-à-vis the contracted care provider, resulting in less control and an inferior information position right from the start of an episode of care. The first of the following

propositions is based on this observation.

**Proposition 1a:** If the municipality as buyer of social care services outsources SCTs as the gateway to social care services to the same organization(s) that are contracted to deliver social care services, there is a higher probability that these organizations show opportunistic behavior.

**Proposition 1b:** If the municipality as buyer of social care services outsources SCTs as the gateway to social care services to the same organization(s) that are contracted to deliver social care services, there is a higher probability that these organizations show behavior that focuses too much on the interests of individual clients and less on the broader interests of the municipality and the community it represents.

Care provider opportunism here translates to behavior in the self-interest of care providers at the cost of the municipality (and the community it represents) as buyer. Which behavior is in the self-interest of the care provider to a large extent depends on the reimbursement method in the contract between municipality and care provider. In a standard fee-for-service reimbursement method ('standard' meaning no additional measures were taken to counter the disadvantages of the reimbursement method), there is an economic interest for the care provider to lower the threshold to social care eligibility, meaning more citizens are assessed as eligible for receiving social care services. Additionally, there is a financial incentive to inflate social care services entitlements, meaning clients are entitled to more care services than necessary (over-provision). This is also known as 'creaming' (Ellis, 1998). Finally, there is a risk that the specific person assessing care entitlement (assessor) will influence the choice of the client with respect to which care provider to select for delivery of social care services. The assessor may act in the interest of his own organization and advise the client to choose their organization over others. Both entitling more citizens to social care and inflating their entitlements more than necessary directly negatively impacts municipal expenditure on social care services. This goes against the municipal – and societal – goals of achieving a financially sustainable social care services system. The third behavior (directing clients to their own organization to provide care out of economic interest) may result in suboptimal quality of care for the client, and of course leads to unfair competition at the disadvantage of care providers not represented in SCTs. These observations lead to the following propositions:

**Proposition 2a:** If an external care provider is responsible for the assessment of social care entitlement and is paid on a fee-for-service basis for delivery of the same social care, the care provider is more likely to entitle more clients to social care.

**Proposition 2b:** If an external care provider is responsible for the assessment of social care entitlement and is paid on a fee-for-service basis for delivery of the same social care, the care provider is more likely to entitle clients to a higher volume of social care services.

**Proposition 2c:** If an external care provider is responsible for the assessment of social care entitlement and is paid on a fee-for-service basis for delivery of the same social care, the care provider is more likely to influence clients to choose their own organization for social care service delivery.

In a standard outcome-based bundled reimbursement method, certain incentives are similar to fee-for-service payment: care providers financially benefit from receiving more clients. Furthermore, these services sometimes have the same specified desired outcomes, but various intensities in relation to the nature and severity of handicap or disability of the client. With more intensive services, care providers get paid a higher fee for achieving the same outcome, as achieving this outcome is more difficult in clients with more severe and complex handicaps. Therefore, care providers would financially benefit from more assessments of clients in more expensive service categories. This behavior would lead to higher municipal expenditure, as was the case in propositions 2a and 2b. These observations lead to the following propositions:

**Proposition 3a:** If an external care provider is responsible for the assessment of social care entitlement and is paid on an outcome-based bundled payment basis for delivery of the same social care services, the care provider is more likely to entitle more clients to social care.

**Proposition 3b:** If an external care provider is responsible for the assessment of social care entitlement and is paid on an outcome-based bundled payment basis for delivery of the same social care services, the care provider is more likely to entitle more clients to more intensive services, which have a higher fee for achieving the same outcome.

In a standard population-based budget payment, the financial incentives for a care

provider with regard to providing clients access to social care are very different compared to other reimbursement methods. Care providers contracted on the basis of population-based payment receive a fixed annual budget for providing social care services for an entire population. This reimbursement method controls the number of episodes of care as well as the cost of individual episodes (Miller, 2009). It therefore transfers the risk associated with the number of clients and required services from the municipality to the care provider. The more (new) clients within the population that are entitled to social services and the more services assigned per client, the more services the care provider must provide within the same fixed budget. Contrary to fee-for-service and outcome-based bundled payment, with population-based budget payment the care provider has a financial incentive to reduce the volume of services to provide ('skimping') and the number of clients entitled to social care ('dumping') – see Ellis (1998) for more details on skimping and dumping. In this situation, it is not the municipality but the citizens requesting social care services who suffer from this opportunistic behavior. These observations lead to the following propositions:

**Proposition 4a:** If an external care provider is responsible for the assessment of social care entitlement and is paid on a population-based budget basis for delivery of the same social care, the care provider is more likely to entitle less clients to social care.

**Proposition 4b:** If an external care provider is responsible for the assessment of social care entitlement and is paid on a population-based budget basis for delivery of the same social care, the care provider is more likely to entitle individual clients to less social care services.

The propositions discussed so far relate to incentives and related care provider behavior in the situation where these care providers decide over citizens' access to social care services. If municipalities organize access to social care services independently from care providers that are contracted for social care service provision, then care providers have no direct influence over care entitlements; rather, they have to 'fulfil' the services to which clients are entitled. In a standard fee-for-service reimbursement method, the entitlement specifies the type and volume of services. For social care services in the Netherlands, this volume of services is expressed in time units of care provided by the professional caregiver. Depending on the type of social care service, the volume is expressed in units of minutes, hours, day parts (four hour periods), or days of care per week to which the client is entitled. Care

providers are paid per provided service with a maximum of the weekly care entitlement. Care providers are not paid for care services provided in addition to the client's care entitlement. It is permitted to deliver less care services than the care entitlement, but only in agreement with the client and if providing more services does not support the goals of the individual client. However, if less services are provided then also less services are paid for in a fee-for-service reimbursement method. Care providers acting out of self-interest or out of routine behavior would not provide less services than the exact client entitlement, which causes inefficiency at the cost of the municipality. This observation leads to the following proposition:

**Proposition 5:** An external care provider that is paid on a fee-for-service basis for delivery of social care is more likely to provide the exact volume of services according to the entitlement of the clients.

In a standard outcome-based bundled reimbursement method, the incentive with respect to care service delivery in terms of input (i.e. the hours of professional care provided) is the opposite. The care provider receives a fixed periodic fee for achieving the outcome, regardless of the volume or nature of the services provided. There is an incentive to achieve the outcome with minimum effort and with economically efficient means. Within the limits of what is contractually allowed, the care provider may for example deploy lower skilled staff to reduce expenses. It can be argued that this is a positive incentive; it is in the best interest of municipalities and society as a whole to organize high quality social care services efficiently. With outcome-based bundled payments, it is expected that the definition of the required outcome influences care provider behavior. Desired outcomes of social care services can be either specified at a very global and generic level ('the client is better capable of participating in society', or 'the house of the client is clean') or broken down into very specific and detailed outcomes. The less specific outcomes are specified, the more room this leaves for different interpretation. If a care provider acts opportunistically, he would use ample room for interpretation of the desired outcome to lower the performance thresholds, in effect leading to underachievement. This effect has been observed in studies in a different context: a study on the level of knowledge sharing (one of the desired goals in that study) finds the level of specification positively impacted knowledge sharing (De Vries et al., 2014). De Vries et al. (2014) argued unarticulated expectations leave service partners guessing for desired performance levels, resulting in disappointing service performance. These observations lead to the following propositions:

**Proposition 6a:** An external care provider that is paid on an outcome-based bundled payment basis for delivery of social care services is more likely to try to achieve the desired outcome as efficiently as possible.

**Proposition 6b:** An external care provider that is paid on an outcome-based bundled payment basis for delivery of social care services is more likely to try to achieve the desired outcome with the lowest volume of care services necessary.

**Proposition 6c:** If an external care provider is paid on an outcome-based bundled payment basis for delivery of social care services, a low level of specificity and detail in the defined outcome is more likely to lead to a lower volume of services provided.

The same incentives and opportunities for opportunistic behavior exist in a standard population-based budget reimbursement method. Therefore, propositions 6a, 6b, and 6c are proposed for social care service contracts on a population-based budget basis, with an additional proposition about the possible prevention effects of population-based budget reimbursement methods. Note that proposition 7d is expected to demonstrate a stronger effect than proposition 6c; desired outcomes at a population level are almost by definition less detailed and specific compared to outcomes at the individual client level.

**Proposition 7a:** An external care provider that is paid on a population-based budget basis for delivery of social care services is more likely to try to achieve the desired outcome as efficiently as possible.

**Proposition 7b:** An external care provider that is paid on a population-based budget basis for delivery of social care services is more likely to try to achieve the desired outcome with the lowest volume of care services necessary.

**Proposition 7c:** An external care provider that is paid on a population-based budget basis for delivery of social care services is more likely to invest in the prevention of social care services.

**Proposition 7d:** If an external care provider is paid on a population-based budget basis for delivery of social care services, a low level of specificity and detail in the defined outcome leads to a lower volume of services provided.

As discussed previously, maintaining a bridge position (or preventing another actor from obtaining it) is important to avoid opportunistic behavior and keep control over service quality. For a buyer this means maintaining interactions with the end-customers and monitoring supplier performance (Li & Choi, 2009). Monitoring can help a principal deal with an agent's opportunism; it is an activity that is an integral part of an organization's current relationship management strategy (Heide et al., 2007). In various contexts, studies confirm the need for monitoring supplier performance in service triads (Tate et al., 2010; Zhang et al., 2015). Monitoring can be aimed at either supplier output or supplier behavior; however, monitoring the behavior of a supplier at a reasonable cost and establishing a link between that behavior and certain outcomes is difficult in professional service settings (Sharma, 1997). Monitoring is associated with negative effects on supplier behavior, although *social contracts* moderate this effect (Heide et al., 2007), where a social contract is a micro-level agreement that is purposely designed within an individual exchange relationship (John, 1984). The type of monitoring appropriate also relates to the contract in place. Van der Valk and Iwaarden (2011) propose the type of monitoring should be similar to the type of contract: an outcome-based contract should be accompanied with outcome-based monitoring, and behavior-based contracts should be accompanied with behavior-based monitoring. Based on the classification of Ouchi (1979), a principal should apply behavior based contracts where output is difficult to measure and behavior (the transformation process) is measurable, and outcome-based contracts should be used when the principal is able to measure outcome but not the behavior. The contract type for social care services strongly relates to the reimbursement method: fee-for-service contracts focus on the activities that will accomplish a desired result and qualify as behavior-based contracts. Outcome-based bundled payment and population-based budget payment both define the desired results, outcome (not the behavior to accomplish the outcome), and quality as outcome-based contracts. The proposition by Van der Valk and Iwaarden (2011) to match monitoring and contract type similarly applies in a social care services service triad. However, the previous propositions illustrate how care provider opportunism may have different consequences under the different reimbursement methods. Monitoring activities in each of the reimbursement methods should focus on the specific corresponding risks. These observations lead to the following propositions:

**Proposition 8a:** If an external care provider is reimbursed on a fee-for-service basis for delivery of social care services, municipal monitoring of care provider behavior reduces 'creaming' – the occurrence of over-provision or supplier-induced

demand.

**Proposition 8b:** If an external care provider is reimbursed through an outcome-based bundled payment or a population-based budget for delivery of social care services, municipal monitoring of service outcomes reduces ‘skimming’ – the occurrence of under-provision or provision of inferior quality services.

Health care commissioners generally monitor performance concerning clients receiving health and social care services or treatment. Furthermore, production volume monitoring activities (behavior monitoring) under fee-for-service reimbursement contracts is common ground. However, for health and social care services reimbursed with population-based budgets, this is not sufficient. Monitoring of the entire population, especially relevant when using population-based budgets and outsourcing the SCTs to care providers, is not common. This increases the risk of the refusal of social care services to eligible citizens under population-based budget contracts. If municipalities outsource access to social care to the same care provider that is contracted with a population-based budget, there is a risk of ‘dumping’ clients: the refusal to provide social care services to them. This occurrence will not be visible in the typical client satisfaction monitoring as this monitor focuses on clients alone. This leads to the final proposition:

**Proposition 8c:** If an external care provider is responsible for access to social care and remunerated through a population-based budget for delivery of social care, municipal monitoring aimed at the entire population, rather than on clients in care alone, reduces ‘dumping’ of clients by the contracted care provider.

## 9.5 Discussion and limitations

This chapter has taken a theoretical service triad perspective on the commissioning of social care services. Findings and propositions in extant literature on service triads are projected on the different reimbursement methods encountered in Dutch municipal commissioning of social care services. With regards to the appropriate reimbursement methods for health and social care services, there seems to be consensus among scholars that fee-for-service reimbursement is associated with both cost and quality problems (Miller, 2009; Porter & Kaplan, 2016; Robbe et al., 2016). However, the consensus with regards to identifying a more suitable payment method is lacking. Many scholars see outcome-based reimbursement meth-

ods (paying for outcomes and performance) as the way forward (Miller, 2009; Porter & Kaplan, 2016; Uenk & Telgen, 2016). However, health and social care services do not meet all of the necessary conditions associated with successful application of performance-based contracting, for example in terms of outcome uncertainty (Eisenhardt, 1989; Nullmeier et al., 2016; Ouchi, 1979) and intrinsic versus extrinsic motivation of employees in health care (Ryan & Werner, 2013). Empirical studies have reflected positive yet modest effects of outcome-based contracting in health and social care services on the quality and cost-efficiency of care (Ryan & Werner, 2013; Scott et al., 2011). This chapter on the one hand aims to contribute to the debate on reimbursement methods in social care services, and on the other to provide practical insights for social care services commissioners. To achieve these goals, through inductive reasoning based on extant service triad literature propositions were formulated concerning the social care service triad. More specifically, the propositions addressed both the desired effects and risks of care provider opportunism under different reimbursement methods. The propositions also highlighted the possible impact of outsourcing the SCT as the gateway to social care services to the care providers also contracted for social care service delivery. Finally, the propositions addressed the expected impact of monitoring when using reimbursement methods.

This study has a number of limitations. First, the propositions are based on inductive reasoning from service triad literature without underlying case studies, for example used by Tate et al. (2010). Furthermore, the assumptions underlying agency theory have been questioned in general (Eisenhardt, 1989). More specifically in the context of health and social care, care provider behavior may be more likely intrinsically motivated and thus less likely to respond to external incentives such as payment (Ryan & Werner, 2013). This may impact the reliability of propositions assuming care provider opportunism. In addition, the notion of a 'care provider' has been simplified and used as a one-dimensional agent throughout this study. However, care providers contracted by municipalities for social care services range from self-employed psychologists to organizations employing more than 10.000 professional caregivers with all kinds of routines, procedures, and levels of management. While in the larger organizations top management may (be forced to) respond to contract incentives (both positive and perverse), individual caregivers directly dealing with clients may be driven by intrinsic motivations. As such, the behavior of these caregivers may not always be in line with the financial incentives in contracts or top-management desires. Still, the decentralization of social care services in the Netherlands came with budget cuts up to 32 percent in the first

year alone. In this situation, care providers have to fight for survival, which is likely to increase competitive and opportunistic behavior. Additionally, new contract instruments such as open contracting schemes might attract new care providers that may prioritize making money over providing the best social care to clients.

Many OECD countries face the same problems as the Netherlands with maintaining a long-term financially sustainable health and social care system (OECD, 2016). It can be expected that external care providers in other developed countries will experience similar circumstances. Ignoring the possibility of care provider opportunism and opportunities to counter this behavior is therefore naïve. The propositions in this study support follow-up research to identify better ways to commission long term social care services.





# Chapter 10

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**Home care procurement:  
comparing the Netherlands with Finland**

## Preface

This chapter is based on the paper ‘Procurement practices for home care of Finnish and Dutch municipalities: a country comparison’ co-authored by dr. Suvi Tuulia Taponen, presented as a competitive paper at the 28<sup>th</sup> IPSERA Conference in Milan, 2019, where the paper was awarded the NIGP award for best paper on public procurement of the conference. Therefore, similar to Chapter 8, this chapter is written in the first-person plural form. Where relevant, the terminology and focus of the research has been adjusted to fit the thesis. It should also be noted that the type of social care services studied in this chapter is home care for the elderly, known in the Netherlands more specifically as household assistance (*huishoudelijke hulp*). This is a different social care service compared to the object of study in Chapters 4 to 8 and Chapter 11. This type of social care service compared best to the Finnish data, and using a different dataset has broadened the scope of this thesis.

## Abstract

We compare how Finland and the Netherlands organize home care services, both in legislation and in procurement practices. In both countries, municipalities are responsible for coordinating home care. We find Finnish municipalities rely to a great extent on in-house provision, and when contracting they use the lowest price competitive procedures. Dutch municipalities rely completely on outsourcing, awarding contracts on quality criteria. Both countries have open systems, where every qualifying care provider is permitted to provide care by relying on clients’ choices. From an agency theory and service triad perspective, Dutch municipalities and Finnish citizens are more at risk of care provider opportunism.

## 10.1 Misery loves company – the challenges in social care systems across countries

Many developed nations face the challenge of maintaining a financially sustainable, high quality social care system. Government budgets are increasingly under strain as the aging population and thus the costs of care continue to rise (Hanski, Lanne, Hämäläinen, & Jännes, 2016; Puthenparambil, Kröger, & Van Aerschot, 2017). Furthermore, citizens have become more demanding with respect to the individualization of public services. In short, governments face the challenge of meeting

higher demands for social care services with a lower budget. The decisions on care delivery methods and processes are becoming a major interest to governments (Hanski et al., 2016). These developments have resulted in increasing interest in the outsourcing of social care services as well as stricter access to public services (Puthenparambil et al., 2017).

A typical government response is to reform the organization of social care services by either centralizing or decentralizing and to move from in-house provision to outsourcing, expecting that competitive forces will increase both quality and efficiency (S. Lamothe, 2015; Randall & Williams, 2009). Enhancing client choice is a typical additional motivation for privatization and known to improve perceived quality of care (Bergman et al., 2016). However, within such grand reforms the devil is in the detail. Reforms introduced across Europe seem to have encouraged competitive markets at the cost of increased risks for both the municipality and the individual (Rodrigues & Glendinning, 2015). While these countries each have their own specific context, lessons can be learned from comparing the coordination of social care in different EU countries. This chapter discusses the findings of a comparison between the Netherlands and Finland. Including more different EU countries with different legislative, socio-economic, and historic contexts may provide even more insights, but this is outside the scope of this research, although a comparison of the Netherlands and Finland can pave the way for further research.

There are many ways to coordinate care within a decentralized system. For example, municipalities may gradually introduce outsourced (market) provision in parallel to in-house provision or rely completely on market provision. Yet purchasing social care services is not always a viable option due to uncompetitive or even non-existent markets (S. Lamothe, 2015; Puranam, Gulati, & Bhattacharya, 2013) or political opposition (Taponen, 2017). However, the absence of a market may be temporary, meaning a market may develop once a public body chooses to outsource public services. Problems with outsourcing social care services may be short-term and transitional – a symptom of early development of markets and inexperienced purchasers (Kirkpatrick et al., 2001). There are different (legal) instruments to outsource, ranging from the competitive tendering of public contracts to a voucher or ‘open house’ (licensing) system. Governments are increasingly introducing these outsourcing instruments to enable client choice (Rodrigues & Glendinning, 2015), such as a personal budget (in Dutch: *persoonsgebonden budget* or ‘PGB’) for financing home care services directly in the Netherlands, or the service voucher in Finland.

Indeed, different nations organize their long-term social care system in different manners (Theobald & Luppi, 2018). Comparing public expenditure on long-term health and social care amongst OECD countries also demonstrates a high variation in public expenditure, ranging from 0,0 to 4,3 % of a country's GDP (OECD, 2016). While EU member states each operate under the same EU legislative framework, member states themselves have their own rules and regulations that determine the playing field for municipalities when organizing social care services. In this study we compare the organization the delivery of home care services in a system that relies completely on outsourcing to external – most often private – care providers (the Netherlands) with a system in which outsourcing of social services is used to complement in-house provision (Finland). In both countries the elderly population is increasing, meaning the demand for services that support living independently is also increasing. The countries are similar in terms of their socio-economic standing, and both countries have tax-based funding for social and health services. Municipalities in the Netherlands and Finland are the providers or purchasers of home care for the elderly, and care can be organized in-house or by purchasing from external providers either completely or partially. Only the provision of the service can be delegated to an external care provider; the municipality remains responsible for financing, regulating, and monitoring the care services (Stolt & Winblad, 2009). These similarities enable a comparison between the two countries. We focus on home care for the elderly (hereafter: 'home care') for two reasons: the service contents are similar in both countries, and in Finland, where outsourcing is used less, several municipalities have outsourced a portion of delivered home care. Enabling life at home as long as possible is worth aspiring to for governments as it is more cost-efficient than institutionalized care, and most elderly people prefer to live at home (Hanski et al., 2016). There is a need to analyze the delivery methods of home care to enable the development of the most efficient delivery methods and regulation. And while there is abundant research that discusses in-house provision versus outsourcing in general, a more granular analysis of public procurement practices for social care services is lacking. In this research, we first identified the legal context for the procurement of social care in both Finland and the Netherlands, and subsequently analyzed municipal procurement practices in detail. We fill a gap in the literature by identifying the differences in discretion amongst municipal buyers of social care in different EU countries, and by analyzing in detail *how* municipalities have outsourced social care within the confounds of their discretion. With respect to this thesis, this chapter extends the research context beyond the Netherlands. It additionally focuses on home care for the elderly, which is a different social care service compared to the services studied in Chapters 4 to

8 and Chapter 11.

In this research we address the following research questions:

1. How do the differences in national regulations for procurement of home care reflect on the municipal purchasing practices of home care?
2. What are the procurement practices used and how do they differ between the Netherlands and Finland?

We take an agency theory and service triad perspective to analyze the contractual relations resulting from purchasing social care services. The analysis takes the perspective of the public organization responsible for the service delivery, i.e. a municipality. Service providers are different types of external parties, typically other public organizations (a neighboring municipality) or private organizations (Brown & Potoski, 2006). In the context of this study, purchasing or procurement is defined as buying services from an external care provider. Municipal collaboration in the form of outsourcing the provision to another municipality (which occurs in Finland, not in the Netherlands) is not considered purchasing in this research; we address this as a form of municipal collaboration. Note that in the other chapters of this thesis, *collaboration* among municipalities exclusively refers to municipalities that outsource social care services together (in effect in one procurement). When municipalities collaboratively purchase services from external (private) care providers we consider this as purchasing of services.

This chapter is organized as follows: the next section introduces the theoretical framework of service triads and agency theory in the context of coordinating and procuring social care services, and the subsequent sections discuss the methodology of this research, the findings of the analysis and comparison of the legal context in the Netherlands and Finland, and the findings and discussion of the empirical research on municipal procurement approaches of home care contracts. The chapter concludes with a discussion of our findings, a conclusion, and a call for further research.

## 10.2 Literature review: agency theory and service triads

### 10.2.1 Agency theory

Agency theory provides a theoretical lens that offers insight into how to effectively organize relations between the principal (here the purchaser of care services) and the agent (here the provider of care services) (Eisenhardt, 1989). Agency theory addresses under which contractual arrangements the relationship between a principal and an agent operates most efficiently (Eisenhardt, 1989). It acknowledges that the principal is primarily concerned with attracting the most capable agent and establishing control mechanisms that ensure efficient service delivery by the agent (Simonsen & Hill, 1998). The relationship between the purchaser and provider is furthermore characterized by two assumptions: 1) there is a misalignment of goals between a public principal (that seeks the best interests of the public) and an agent (that seeks profit maximization), and, 2) agents have more information on the service processes than the principals, which is generally referred to as 'information asymmetry' (O'Flynn & Alford, 2008; Van Slyke, 2007). These issues are generally resolved and managed within the contract, through which the principal and agent agree upon controls and incentives that are acceptable for both parties (Simonsen & Hill, 1998). The focus and purpose of the contract is therefore to act as a management tool, and the core idea of agency theory is to establish the most efficient control mechanisms between parties (Eisenhardt, 1989).

Contracts should align the goals of the principal and the agent, as goal congruence is required for contracts to be effective (Tate et al., 2010). In supply management literature, two types of contracts are distinguished: outcome-based contracts, which emphasize measurable results or contractual effectiveness (Eisenhardt, 1989; Zsdisin & Ellram, 2003), and behavior-based contracts, which focus on processes, tasks, and activities that will accomplish the desired result (Zsdisin & Ellram, 2003). Outcome-based contracts are more likely to lead the agent to behave in the interest of the principal (Eisenhardt, 1989), whereas behavior-based contracts are more appropriate when an agent's behavior can be readily monitored and measured at a reasonable cost (Eisenhardt, 1989). In contracting social care services such as home care, outcome-based contracts define (outcome) elements of the health and social situation of individual clients or of a population. Behavior-based contracts in this context define the activities and inputs of social care

services delivered to clients. These concepts of behavior and outcome in health and social care relate to payment – or reimbursement – methods. The typical reimbursement methods employed in public sector contracts are fixed price contracts and cost-reimbursement ‘fee-for-service’ (Kim & Brown, 2012; Mannion, Marini, & Street, 2008). The traditional reimbursement method for social care services is fee-for-service; the care provider is reimbursed according to realized provider costs and/or quantity of delivered service (Kim & Brown, 2012), for example the number hours of home care delivered to a client. This reimbursement method resembles a behavior-based contract. While it is the most commonly used method to pay for health and social care services, fee-for-service reimbursement rewards volume rather than quality or value of health care, and is recognized by some as the single biggest obstacle in improving health care (Porter & Kaplan, 2016). Reimbursement methods that focus on outcomes of social care can be categorized as outcome-based contracts. The service contract acts as an essential management tool in both mitigating the risks of contracting and in ensuring that the benefits from the relationship are gained. This can be done by specifying measures of service quality and specific levels of output quantity and quality (Kim & Brown, 2012; L. Tspouri et al., 2010). However, the unpredictability and the complexity of public organizations’ operating environments today generally exceed a purchaser’s ability to specify service contracts (Brown & Potoski, 2006).

### 10.2.2 Service triads

While principal-agent problems may arise in any dyadic buyer-supplier relationship, these problems are magnified when the principal is not the recipient of the purchased services. Purchasing services is associated with problems in effectively organizing the transactions and relations (Van Der Valk & Van Iwaarden, 2011). Managing the quality of purchased services and the agents that deliver those services is one of the highlighted issues (Axelsson & Wynstra, 2002). In service triads, the recipient of services is not the purchaser (as in dyadic procurement relations), rather there is a different end-customer. In service triads the purchaser therefore does not directly experience service quality. The purchaser needs to take measures in order to ensure the service provision is of appropriate quality and the agent behavior is appropriate (Van Der Valk & Van Iwaarden, 2011). Monitoring the behavior and performance of providers is not sufficient. The purchaser needs to maintain contact with its end-customers to identify their (changing) needs and satisfaction with provided services. Summarizing, the information asymmetry in service triads

is magnified compared to regular buyer-supplier relations.

Municipalities that outsource the delivery of social care services for their citizens to external care providers form this typical service triad constellation. Li and Choi (2009) made a paramount contribution to theorizing service triads by describing how the connections in the triad are not constant over time. Translated into the context of social care, this means that in the initial stage a municipality contracts a care provider and scrutinizes citizens requesting social care. At this point, the care provider and the client are not yet connected; there is a structural hole between them (Burt, 1992), and the municipality is in the bridge position (Li & Choi, 2009). The bridge position is associated with benefits as the actor in the bridge position enjoys a superior information position. However, once a care provider starts provision of care services, the bridge ‘decays’ and the municipality no longer enjoys the benefits of the bridge position. If the municipality does not actively maintain a connection with the clients of social care, the bridge position transfers to the care provider (the transferred stage) (Li & Choi, 2009). When the care provider is in the bridge position the information benefits are for the care provider, and the municipality is at risk of care provider opportunism and moral hazard. The municipality should therefore monitor care provider behavior and/or performance and maintain a connection to its citizens in care (Tate et al., 2010; Uenk & Telgen, 2018) – in short, maintain a strong position in the triad. To further counter the risks for a buyer in service triads, buyers should strive for collaborative and trusting relations with its suppliers (Li & Choi, 2009; Nätti et al., 2014), establish social contracts (Van Der Valk & Van Iwaarden, 2011), and align goals of municipality and care providers by using the appropriate contracts (Tate et al., 2010; Van Der Valk & Van Iwaarden, 2011) and incentives (Rossetti & Choi, 2008; Zhang et al., 2015). In contexts where end-customers may choose between different service providers – such as social care services – imposing ex post competition by contracting multiple providers in parallel may further reduce supplier opportunism; see Uenk & Telgen (2018), the paper that is the basis for Chapter 8 of this thesis.

### **10.3 Methodology for the country-comparison**

This country comparison combines an analysis of the relevant legal frameworks in the Netherlands and Finland with an empirical analysis of procurement practices for social care services. We chose to compare the Netherlands and Finland because of the similar societal and legal contexts. Both researchers individually identified

the relevant sections of their country's national legislation. We systematically analyzed relevant provisions of Dutch and Finnish laws with respect to coordination and procurement of social care (e.g. regulation on in-house provision, contracting external care providers, adopting a voucher system, and combinations of such); each author analyzing their respective country. Furthermore, we analyzed the additional rules and regulations on both national and EU level that apply when municipalities decide to contract care providers. The results of legal frameworks are presented in Table 10.2 in the next section.

### **10.3.1 Empirical data collection: analyzing commissioning at the source**

For the empirical analysis, data on municipal procurement practices of Dutch municipalities for home care were collected in two ways. First, through an internet search we collected as many of home care tenders and contracts that were in place at the start of 2018. We searched internet tender databases (e.g. [www.tenderned.nl](http://www.tenderned.nl)) and used Google to collect the tender documents and contracts used for contracting home care services. We used contracts valid on 1 January 2018. Through these internet searches, we collected the procurement information and home care contracts for 101 individual tenders, for a total of 245 Dutch municipalities (64 percent of the 380 municipalities in the Netherlands existing in 2018). Second, we obtained a dataset collected by a third party that complemented our initial dataset. The third party contacted the missing Dutch municipalities directly through e-mail to collect the most important information used in this study: the public procurement procedures and reimbursement methods used. This complementary data source covered another 110 municipalities. Combined, this study reflects the procurement practices of more than 90 percent of Dutch municipalities.

To analyze the procurement practices of Finnish municipalities, the municipalities that have purchased a part of the delivery of home care were first identified. This was done by analyzing a dataset (Tilastokeskus, 2017b, 2017a) including the purchasing percentage of home care concerning all 311 Finnish municipalities. After this analysis, the 146 municipalities that purchased more than 10 percent of home care for the elderly were contacted by e-mail. Additionally, internet searches were carried out to collect rulebooks for service vouchers that are publicly available. Out of the 146 municipalities that were contacted, we received documents from 76 municipalities for the analysis. Of these municipalities, 51 municipalities organized

their delivery of social and health care through a coalition (in effect contracting these services jointly).

### 10.3.2 Analysis of commissioning data

After the analysis of the legal systems, we analyzed the home care procurement documents from both Finnish and Dutch municipalities (each author for their respective country). Differences in the respective legal systems of the two countries may explain different municipal choices with respect to delivery methods and purchasing approaches. After the data analysis, the findings were discussed and analyzed between the researchers.

The following information was collected from each tender, contract, or – in the Finnish context – rulebook:

- Payment type: bundled payment, fee-for-service, payment-by-results, or population-based budget;
- Contract type and length: single contract, framework agreement, voucher or open house system;
- Award criterion: lowest price, Most Economically Advantageous Tender (MEAT), or no award criterion.

Observations of these three main themes were made individually by both researchers and listed in English, as the collected data was not translated from the domestic languages. The authors discussed the observations comprehensively to ensure their comparability, and after validating them analysis was carried out by both researchers based on observations of both countries. Table 10.1 introduces the countries selected for the comparison.

**Table 10.1** - Introduction of countries selected for comparison (Kuntaliitto, 2018)

	<b>The Netherlands</b>	<b>Finland</b>
Population	17.101.514	5.522.858
Population density	507 / km <sup>2</sup>	16,3 / km <sup>2</sup>
Total number of municipalities	380	311
Largest municipality	859.732 inhabitants	643.272 inhabitants
Smallest municipality	941 inhabitants	734 inhabitants

Our sample from Finland includes four bigger cities out of the total of 9 with more than 100.000 inhabitants in the country. The rest of the municipalities, which have purchased more than 10 percent of the delivery of home care, are small municipalities. The highest portion of home care purchased from markets in our sample from Finland is 23 percent.

## **10.4 Findings – comparing the legal frameworks**

This section provides a discussion of the legal systems of each country with respect to (1) public procurement, and (2) the coordination and procurement of social care services. This section first introduces the general public procurement regulations relevant to social services that apply in the Netherlands and Finland. Consequently, we discuss the legal aspects of coordination and procurement of home care in both countries. This section concludes with an overview of the most important aspects and their differences and similarities between the countries in Table 10.2.

### **10.4.3 Public procurement laws in the Netherlands and Finland**

The Netherlands and Finland are both subject to EU directives on public procurement, where for social services Directive 2014/24/EU applies. The rules that apply for public contracts for social care services are discussed in more detail in Chapter 3. This section provides a brief summary to improve readability of this chapter. The Directive recognizes the specific cultural and social aspects of social services such as home care, extending more discretion to member states to coordinate social service contracts compared to ‘regular’ service contracts. Because of the special position of social care services and the small percentage of expected cross border trade, there is a light regime for social services in this Directive. Directive 2014/24/EU requires contracting bodies in EU member states to publish contracts for social services EU-wide only when their value surpasses the threshold of € 750.000. For these contracts, contracting bodies are to use the procedure for social and other specific services. However, this procedure does not provide any detailed procedural requirements. Contracting bodies have ample discretion to design their own procurement procedures, although they must of course abide by the principles of equal treatment, non-discrimination, and transparency.

In both countries, municipalities are responsible for organizing the delivery of so-

cial care. When municipalities contract care providers, the services are delivered to clients ‘in kind’. The discretion afforded to municipalities for the coordination and commissioning of home care (including household assistance in the Netherlands) even extends to the task of scrutinizing citizens’ requesting home care services. The formal care entitlement following the scrutiny remains a formal municipal decision – this is the only responsibility that cannot be outsourced.

Certain government contracts are not subject to Directive 2014/24/EU. This applies when a public government does not exclusively award public contracts, but rather publishes an authorization scheme to conclude contracts with every supplier (in this case care provider) that meets suitability criteria and that accepts the terms and conditions of the contract; see Section 3.6.2 of this thesis. This manner of contracting, which has recently become known in the Netherlands as an ‘open house system’ is further extended and clarified by two Court of Justice of the EU (CJEU) rulings. The EU case law concerned contracts for medicine (*Falk*) and agricultural consulting services (*Tirkkonen*). In Finland this manner of contracting is known as the service voucher system, which is regulated in national legislation. In the next two sections we identify common procurement practices both in the Netherlands and Finland that relate to this open system.

#### **10.4.4 Commissioning home care in the Netherlands: complete outsourcing**

The Netherlands reformed its social care system in 2007 and 2015, decentralizing the coordination of social care, including home care, to Dutch municipalities. In 2007 the *Wet Maatschappelijke Ondersteuning* (‘Wmo’; Social Support Act) was introduced, and its scope was extended in 2015 (Wmo 2015). The history of the coordination of social care services is discussed in more detail in Chapter 2. Under the Wmo 2015, Dutch municipalities are individually responsible for organizing social support for their citizens. There is no prescribed delivery method for municipalities, which allows for in-house provision, outsourcing, or a combination of both. However, social care services were already outsourced before the 2007 reform, as the Dutch government adopted principles of (managed) competition and the purchaser-provider split in health care in the Netherlands in general. Municipal home care remained 100 percent outsourced since the decentralization. When a municipality outsources home care, alongside considerations from a quality and client choice perspective (see Table 10.2) the Wmo 2015 requires the municipality

to pay a fair price for home care services in relation to the quality requirements used in public tenders. Besides receiving care ‘in kind’ through a municipality-contracted care provider, Dutch citizens entitled to social care services may opt for a personal budget (*Persoonsgebonden budget* or PGB, also known as ‘direct payment’ or ‘cash-for-care’). With a personal budget the citizen buys social care services directly. We do not consider personal budgets as procurement, as the municipality is not the buyer of care in that situation. However, we will revisit the personal budget, because the Finnish ‘voucher’ instrument (see next section) shares a resemblance with it, which is also addressed in the findings section. Dutch municipalities may require an out-of-pocket contribution for the cost of their home care services. Municipalities determine the gross out-of-pocket contribution, which can be set at up to 100 percent of the costs of home care services. However, the wealth and income of a client determines the actual required out-of-pocket contribution. This means wealthy citizens may pay 100 percent of the costs of home care, while poor citizens pay no out-of-pocket expenses at all.

#### **10.4.5 Commissioning home care in Finland: supplementing in-house provision**

Municipalities may deliver care (1) in-house, (2) through contract(s) resulting from competitive tendering, or (3) by launching a service voucher alongside in-house production. Home care is delivered mainly in-house with supplementing external providers. If a municipality has decided to purchase social services, they have the option to organize a competitive tendering according to the procurement Directive 2014/24/EU or to implement a service voucher. Health and social services are primarily funded with municipal tax revenues; the funding is completed with grants from the central government as well as out-of-pocket-fees (Puthenparambil et al., 2017). There is an out-of-pocket fee for clients of home care, which exists regardless of whether the service provider is public or private.

#### **10.4.6 Service voucher in Finnish home care: the Finnish ‘open house’**

The service voucher is based on a national act (569/2009). The municipality sets, in a rulebook, the criteria for the care providers and the service that have to be met. The municipality must approve all providers that apply to become voucher provid-

ers and meet the standards set in the rulebook. By signing up, the contractors verify that they meet the criteria and agree to deliver the service as per the standards set. The municipality establishes the value of the voucher, which can depend on a client's income, or can be fixed as the same for all clients. In each case the provider can set the price of the service as they wish and the client must pay the difference. When using service vouchers, the municipality does not have a contract with the providers. The municipality has the right to unanimously alter the criteria in the rulebook, and if the provider does not accept, they must resign. The contract is between the consumer of the service and the provider, and the Consumer Protection Act (38/1978) is applied in case of contractual disagreements. The service voucher enables the clients to choose a provider from a list of approved providers. The voucher is typically used to meet the growing demand of home care services rather than to downsize in-house operations. A care manager carries out an estimation of needs and decides what kind of help and assistance the elderly will receive (Stolt & Winblad, 2009). Based on this estimation, a client may be offered a voucher or referred to publicly provided care. Municipalities may thus restrict the voucher's use. As a result, the proportion of services delivered through a service voucher has remained low (Puthenparambil et al., 2017).

#### **10.4.7 Comparing legal frameworks: an overview**

Table 10.2 summarizes the comparison of legislation on the delivery of social care in the Netherlands and Finland.

**Table 10.2** – Comparison of social care and procurement laws in the Netherlands and Finland

Legal framework	The Netherlands	Finland
<b>General</b>		
Responsible government body	Municipality (380 as of 2018)	Municipality (311 as of 2018)
Coalitions for outsourcing / organizing the service delivery	Collaboration is encouraged but not mandatory.	Mandatory for municipalities with less than 20.000 inhabitants.
Access to social care	The Wmo 2015 entitles citizens who need formal support to maintain self-reliance and participate in society to social care. Municipalities coordinate the access to home care. Access can be organized in different manners, but must involve scrutiny of citizens before making an official decision on care entitlement.	Each citizen has the right to receive home care if their capability to live independently, to maintain current level of functionality, or follow through with daily routines is lowered due to an illness or an equivalent reason causing a lowered ability to function. Municipalities makes formal decisions of care based on evaluating a client's situation and need for care. The client's opinion needs to be heard.
Out-of-pocket expenses	Municipalities have discretion to require an out-of-pocket contribution up to 100 % of the costs of home care. Actual out-of-pocket contribution depends on a client's income and wealth.	Maximum amount is set nationally at 35 % of the monthly cost for permanent care need.
Client choice	Choice <i>suggested</i> but not mandatory for outsourced services provided <i>in kind</i> through municipal contracted care providers. Free choice among care providers mandatory through the option of a personal budget (PGB).	Municipalities may offer an opportunity for client choice, although it is not enforced by law in the current system. There is an ongoing reform aiming to introduce patient choice to home care, among other services.
Quality criteria	Municipalities are required to set quality requirements to assure good quality home care and treat citizens in a respectful, non-discriminatory manner, but these requirements are not defined in detail.	Municipalities are held by law to general requirements to deliver good quality care and treat the citizens in a respectful, non-discriminatory manner.
<b>Procurement related</b>		
Procurement procedures	No set procedures, as long as public procurement principles are respected. Open publication of the contract is mandatory for contracts above the EU threshold for social services.	No set procedures, as long as public procurement principles are respected. Open publication of the contract is mandatory for contracts above the EU threshold for social services.

**Table 10.2** – (Continued)

<b>Legal framework</b>	<b>The Netherlands</b>	<b>Finland</b>
Award criterion	MEAT with quality criterion required: contract award based on lowest price alone is not allowed.	A contracting entity that applies the lowest price as the sole criterion for determining the best tender shall set out the justifications for doing so (section 115, 2, act 569/2009).
Threshold for EU publication of public social care contract	EU threshold: € 750.000 National law: € 750.000	EU threshold: € 750.000 National law: € 400.000 (in effect the lower threshold applies)
Client perspective in regulation	When municipalities choose to outsource, they are required to consider the context, preferences, and religious beliefs of citizens, as well as continuity of care for existing clients in the organization of home care (Wmo 2015, § 2.1.2)	The contracting entity may conduct a direct procurement in individual cases if arranging competitive tendering or if changing a service provider would be manifestly unreasonable or especially inappropriate, in order to secure same care or client relationship that is important for the client (§110, act 569/2009).
Alternatives to public tender	Open house model (following from CJEU case law) – still a form of government contract with suppliers Personal budget (PGB)	Voucher system (following from national law, using national discretion within EU directives)
Price mechanism	Municipalities may request quotes or set standard tariffs. They are required to pay fair prices considering the contract quality requirements and labor laws.	Prices are set based on tendering. If the service voucher is used, voucher value is calculated based on the costs of the municipality's service delivery.

Table 10.2 describes the main features of the legal frameworks of each country on organizing home care for the elderly. While there are many similarities, we identify four key differences with respect to municipal discretion for contracting social care. First, Dutch municipalities are not required to contract together with other municipalities (in coalitions), no matter their size. Finnish municipalities with less than 20.000 inhabitants are required to form or join a procurement coalition. Second, Dutch municipalities have less discretion with respect to the award criteria compared to Finnish municipalities. While in Finland the award of home care contracts based on lowest price is allowed if properly justified, Dutch municipalities are required to use quality criteria next to price in the award of home care contracts. Third, while in both countries there is no set procedure to contract home care, and the EU regulations for social services require publication of contracts valued above € 750.000, the relevant threshold in the Finnish national public pro-

curement law is lower at € 400.000. As a result, all contracts over this threshold are published at the EU level.

The fourth interesting difference relates to the Finnish voucher system, regulated by a distinct law as described in the previous section. The voucher system may be used to complement in-house service provision or (in theory) as the main method of service delivery. The municipality does not have a formal public contract with the care provider, rather the client using the voucher is in a formal consumer relationship with their care provider of choice. While the Netherlands lacks a law that defines a voucher system, municipalities have used their discretion, following from CJEU case law, to establish highly comparable open house systems that are not subject to Directive 2014/24/EU. Dutch open house systems and Finnish voucher systems differ in at least two relevant dimensions: (1) Dutch municipalities use open house systems for complete outsourcing, and (2) in such systems the care providers are formally contracted by a municipality in the Netherlands. This may strengthen the position of clients vis-à-vis the care provider.

## **10.5 Findings and discussion country comparison – procurement practices**

This section discusses the observed purchasing practices with respect to (1) production methods, (2) contract types and reimbursement clauses, and (3) public procurement procedures and award criteria. We reflect on the differences in the legal frameworks when this explains the different procurement practices observed in both countries.

### **10.5.1 Complete outsourcing versus outsourcing as supplementary to in-house provision**

The service production methods vary significantly between the two countries. In the Netherlands the provision of home care services is privatized, while in Finland services are mainly delivered by municipalities with external providers that only complement the delivery. Population density is a relevant factor that impacts the delivery method, as municipalities with low density do not attract private providers due to low possibilities to achieve economies of scale (Stolt & Winblad, 2009). As described in Table 10.2, there is a significant difference in the population den-

sity of the two countries. However, differences in production methods are not explained by this difference alone. In Finland, the decision to outsource or to introduce a service voucher is made by the municipality's elected council. In Nordic countries left-wing politicians typically strongly favor public provision of services, and right-wing politicians favor market-based solutions to deliver care (Stolt & Winblad, 2009). The majority of the municipality's council is therefore reflected in the emphasis on the use of external providers. In the Netherlands, a purchaser-provider split for social and health care existed long before municipalities assumed responsibility for home care. The general tendency in the Netherlands is to have a 'compact government' (see for example the 2012 government coalition agreement of the Netherlands (Rutte & Samson, 2012)). Central and local governments outsource services that can be provided by the market. Because of the 'compact government' policy and the history of outsourcing these services, when municipalities were made responsible for home care for the elderly in 2007, setting up in-house provision generally was not considered a viable option at the time of the reform.

Municipalities collaborate in home care provision in both countries. In Finland, collaboration is realized through municipalities belonging to coalitions. In a coalition (1) the biggest municipalities deliver services to all municipalities in the coalition, or (2) part of the delivery is purchased by the coalition on behalf of all municipalities. The bigger Finnish municipalities in our sample only collaborate in the delivery of home care when they are the 'leader' of a coalition, where (mostly) the smaller municipalities will reap the benefits of the collaboration (Schotanus, 2007). This indicates that economy of scale is a motivating factor for collaboration. If economies of scale are achieved individually, collaboration is not pursued. Lamothe (2015) and Puranam, Gulati, & Bhattacharya (2013) state that purchasing services is not always possible due to uncompetitive markets. The Finnish example indicates that delegating the responsibility to a bigger public organisation is another option for pursuing efficiency. Since there is no in-house provision in the Netherlands, municipal collaboration implies collaborative procurement. This type of collaboration is encouraged by the central government, as it limits transaction costs both for municipalities and care providers. For home care in 2018, we found 24 percent of Dutch municipalities had contracted home care providers individually. The remaining municipalities were in procurement collaborations ranging from two to thirteen members. With the collaboration size averaging 2,6 municipalities, these coalitions are typically smaller compared to the coalitions for other adult social care services (between 3,7 and 8,2 municipalities per collaboration) and youth care (between 7,4 and 10,3 municipalities per collaboration), according to statis-

tics from 2018 (Uenk, Wind, Telgen, & Bastiaanssen, 2018).

According to agency theory, the relationship between the service purchaser and the provider is characterized by information misalignment, which benefits the provider (Eisenhardt, 1989). Service triad theory states that the service provider may assume the bridge position in the triad, which is associated with the beneficial information position (even more than in dyadic principal-agent relations) if the service buyer does not prevent full bridge transfer (Li & Choi, 2009). Both theories build on the idea that the negative impacts of information asymmetry can be mitigated within the service contract and by interaction based on the contractual relation. Service triad theory in addition identifies the need for purchasers to maintain a connection to the end-user of services. Based on our sample on home care, the issue of information asymmetry relates only to a small number of Finnish municipalities: the three that have outsourced all social and health services. All other Finnish municipalities in our sample employ a hybrid model by maintaining parallel service operations in-house. Lower risks has been identified as a benefit of maintaining parallel service operations in-house (McNally & Griffin, 2004; Nordigården, Rehme, Brege, Chicksand, & Walker, 2014). However, this issue is more prominent in the Dutch context since all municipalities outsource all home care services. These municipalities are exposed to risks related to service quality and (other) opportunistic behavior. Quality issues relate to either incompetent or opportunistic care providers not delivering services according to agreed quality without the municipality knowing. Another risk is over-production of home care – not reducing the delivery of care even when clients in due course can manage fine with less services. We do not see evidence that the difference in the percentage of outsourcing home care between Finland (mostly the hybrid model) and the Netherlands (100 percent complete outsourcing) relates to differences in the procurement and social care legislation in both countries.

Besides these principal-agent issues, service delivery methods are relevant from the perspective of the client that receives care. The client has a different role depending on the service delivery method. The citizen is of course best protected against opportunism arising from agency problems when care is delivered in-house. When care is delivered through a procurement contract, agency problems may affect the client, and the municipality should take measures through the contract and monitoring (Tate et al., 2010; Van Der Valk & Van Iwaarden, 2011). The role of 'active citizen' is emphasized in context of the Finnish service voucher. When using the voucher, the client is required to choose the provider and to

form a contractual relationship with the provider. While this resembles the open house contracting model adopted by most Dutch municipalities, they remain the contractor of the care provider and citizens are protected under public law. Service quality and delivery issues that may arise are subsequently dealt with by municipal procurement professionals. Finnish citizens who receive care through a service voucher become the contractor of the care provider themselves, and their rights are protected under consumer law. This situation resembles Dutch citizens who opt for a personal budget rather than receiving care 'in kind'. Compared to the municipality-care provider dyad, there is a strong power imbalance in a dyad with an individual client and a care provider. In addition to the municipality monitoring the service delivery, the client is responsible for claiming damages in case there are severe quality issues. In situations of power imbalance, clients may find it difficult to speak up to their provider (Joseph-Williams, Edwards, & Elwyn, 2014). The emphasized role of the client is one of the reasons that service vouchers are granted only after the assessment of each client's case (Stolt & Winblad, 2009) and the capability to act the role of commissioner. Dutch municipalities may in fact only refuse a personal budget (and award care in kind instead) on the latter ground – a client's incapability to commission care.

Table 10.3 compares the different observed legal outsourcing instruments for home care services: a public contract, open house system, voucher system (FI), and personal budgets (NL). The instruments are compared with respect to different roles in the home care service triad: which service triad actor sets quality requirements, which actor verifies the care providers eligible to provide care, and which actors are the parties in the formal agreement. Although in this research we do not consider the Dutch personal budget as procurement, it is an outsourcing instrument as the services are not provided by the municipality. However, this is to some extent arbitrary, since the client is also in a consumer relationship with the care provider in the Finnish voucher system.

**Table 10.3** – Comparison of legal instruments for outsourced care provision Finland / Netherlands

	Outsourcing instruments			
	Public contract (NL and Finland)	Open house (Netherlands)	Voucher (Finland)	Personal budget ('PGB' – Netherlands)
<b>Quality requirements</b>	Set by municipality in the tender (as minimum quality criteria or award criteria)	Standardized quality requirements are set by municipality in the contract / rule thesis.		Client ('budget holder') must ensure sufficient quality; municipality may refuse to provide a personal budget when care does not meet professional standards
<b>Care providers are eligible to provide care...</b>	After a contract is awarded by the municipality on the basis of a tender.	After acceptance by the municipality to the open contracting scheme.		After selection by the client (budget holder). N.b.: the municipality may refuse or withdraw a personal budget if there are serious concerns over safety or effectiveness of the care provided.
<b>Contract parties</b>	Buyer: municipality Supplier: care provider		Buyer: client (budget holder) Supplier: care provider	

Table 10.3 is set up to visualize how the four legal outsourcing instruments in fact overlap with respect to how quality requirements are enforced in the contract, who selects eligible care providers, and which parties subsequently enter into contractual relations. The Dutch open house system and the Finnish voucher system are similar with respect to the first two dimensions, but different with respect to the contract parties – where the voucher system is similar to the Dutch personal budget instrument (PGB). This is an interesting finding for both the Dutch and Finnish municipalities. Evidently, across EU countries there are different contracting instruments used for outsourcing home care. From the perspective of the Netherlands, we can conclude that there is an alternative outsourcing instrument – the voucher system – that shares similarities with both the open house system and with the personal budget. More interestingly, this intermediate contracting system existed since 2009 with its basis in a national law, while the open house system in the Netherlands was only introduced after publication of the 2016 CJEU case law.

### 10.5.2 More outcome-based contracting in the Netherlands

In the Dutch data we found that 40 percent of the municipalities used outcome-based contracts. These contracts define the desired outcomes (e.g. 'provid-

ing a clean house for the client'), and reimburse these outcomes with a fixed fee per month – a form of outcome-based bundled payment (Uenk & Telgen, 2018). These contracts are aimed to increase efficiency and innovation in service delivery, and the majority of municipalities contracted on a fee-for-service basis (59 percent). A few Dutch municipalities contracted one main care provider and used population-based budget payment. The main care provider received an annual fixed lump sum budget and was responsible for the provision of home care to all clients in their respective region (which usually encompasses the entire municipality). In Finland, the majority of services is purchased on the basis of fee-for-service reimbursement. Only the three municipalities that outsourced all social services (home care being one) use a population-based budget. In Finland we observed no outcome-based payments.

From an agency theory perspective, the reimbursement method relates to goal alignment (a means to mitigate the risk of supplier opportunism). Outcome-based contracts aim to align the goals of the supplier and buyer through the contract incentives. Both with outcome-based bundled payment and population-based budget contracts, the care provider has an incentive to achieve the desired outcomes as efficiently as possible. Fee-for-service contracts reward volume of care service delivery, which misaligns the financial goals of the municipality and the care provider. In both Finland and the Netherlands, this risk is controlled through the process of the assessment and entitlement of citizens to social care. The municipality reviews a citizen's request and decides on the assignment of social care, including the volume, or in the Netherlands, the amount of the personal budget. Still, in this situation there is little incentive for the care provider to report inflated care assignments (i.e. situations where clients can do with less services in due time) – see Chapter 9 where this point is discussed extensively.

From a service triad perspective, the contract types identified in our empirical analysis also relate to the structural position of the municipality as principal in the social care service triad. The principal in a service triad is encouraged to prevent full bridge transfer (Li & Choi, 2009), meaning that in our context a municipality should prevent the complete loss of its connection with citizens that receive home care. When a care provider starts the delivery of home care, the information position of the municipality as compared to the care provider necessarily deteriorates, since it is not possible to observe the behavior of the care provider in an efficient manner (Sharma, 1997). By maintaining a relationship with the citizens in care, the municipality reinforces its (weak) information position and prevents care provid-

ers from assuming the bridge position associated with information benefits. From this perspective, the delivery model of total outsourcing to one main care provider – identified in a few municipalities in both Finland and the Netherlands – seems an unwise choice. More coordination is left to the main care provider to benefit optimally from this contracting approach. This consequently weakens the information position of the municipality.

### **10.5.3 Awarding contracts on quality in the Netherlands, and on price in Finland**

One means of attaining more balance in the social care service triad is through organizing ex post competitive pressures to award sufficient service quality (Uenk & Telgen, 2018). The Dutch data strongly evidenced the use of ex post competition, i.e. using framework agreements or open house systems similar to the Finnish voucher systems. In these framework agreements or open house systems, clients have free choice of their care provider, and switching is allowed. In Finland we observed less ex post competition, as service vouchers are not widely used. We find 99 percent of Dutch municipalities offered clients a choice among care providers: only 1 percent contracted one main care provider. Furthermore, a total of 85 percent of Dutch municipalities opted for an open house approach with an unlimited number of care providers, resembling the Finnish voucher system. Finland is more divided, with smaller municipalities also opting for strong ex ante competition (contracting one supplier per lot in a framework agreement), and other municipalities opting for the voucher system.

In both countries the municipalities are allowed to create their own procedures for provider selection as long as the principles of the public procurement Directive are respected. All the Finnish purchasing contracts in our sample were the result of an open competitive procedure. In previous literature the negotiated procedure is recommended over the open procedure when purchasing complex care deliveries (Chever & Moore, 2012; L. Tsipouri et al., 2010). The recommendation is based on the negotiated procedure enabling a dialogue with preselected service providers to adequately specify the service description (Chever & Moore, 2012). In all cases of outsourced service provision in Finland, the service description was the same as the services delivered in-house. In addition, home care is a clear and relatively simple care service compared to more complex care pathways. A dialogue was therefore not perceived necessary to describe the service content. In the Dutch

outsourcing practices, we identified that many municipalities did incorporate extensive dialogue with care providers aimed at adequately defining service descriptions and appropriate conditions and controls. We did not find evidence that the difference in procurement practices in the Netherlands (a high degree of dialogue and negotiation used in procurements) and Finland (only open competitive procedures) stems from differences in differing public procurement rules in the two countries.

As described in the legal comparison of the two countries, the award criteria used for home care contracts differ between the two countries. In the Netherlands, home care contracts are mostly awarded based on quality criteria. In Finland, the practice is the opposite; we observed lowest price weighing generally the most in the tender comparison, ranging from 70 to 100 percent. These differences are explained by the fact that in the Netherlands using quality criteria is mandatory by law, and in Finland the use of quality criteria is only encouraged, but exceptions are allowed. This is one difference in procurement practices that can be directly related to the difference in the national procurement rules for social care contracts. Interestingly, the Netherlands, similarly to Finland, supported a system in which quality is set in the mandatory criteria. Voucher (Finland) and open house (Netherlands) systems rely on ex ante validation of care providers according to quality and suitability criteria, without evaluating prices. In Finland the service providers can set the out-of-pocket fee on the level they see fit. However, the fact that end-users use the amount of out-of-pocket fee as a selection criterion in provider selection keeps the fees on a competitive level.

## 10.6 Conclusion

We set out to compare the Netherlands and Finland, two member-states of the EU, in terms of how these countries regulated and organized the delivery of home care for the elderly. We focused on three different perspectives: (1) the key differences in national regulation on purchasing social care, (2) how the national regulations reflected on the purchasing practices, and (3), the purchasing practices used. As discussed in the previous section, we identified many similarities but also clear differences between the countries. The nature of municipal collaborations, the specific voucher system, and the award criteria used by Finnish municipalities are different from the Netherlands, and these are explained by regulatory differences. The difference in the use of complete outsourcing versus hybrid outsourcing, and

the observed differences with respect to procurement procedures (negotiated procedures versus open competitive procedures) are not explained by differences in the procurement rules for social care services. In the following sections we address the observed procurement practices from the perspective of agency theory and service triads.

### **10.6.1 Percentage of privatized provisions of care is reflected in legislation and care delivery practices**

In neither Finland nor the Netherlands is outsourcing the provision of home care mandatory. The proportion of externally delivering home care is relatively low in Finland. To some extent is due to local politics and uncompetitive markets in parts of the country. In the Netherlands the situation is found to be the opposite – there is no in-house provision of home care due to national public policies and tradition. In the Dutch context we were able to identify variation in contract reimbursement methods from fee-for-service to outcome- and population-based payment. This might be due to a higher number of analyzed contracts. The position of the citizen differs between the countries, especially in relation to patient choice. In Finland the majority of municipalities maintain a public ‘back-up’ for privatized care. This may protect the citizen most effectively from provider opportunism, as identified in agency theory. In the Netherlands the agency-problems may affect the client, and municipalities should take measures through the contract and monitoring (Tate et al., 2010; Van Der Valk & Van Iwaarden, 2011; Van Iwaarden & Van Der Valk, 2013). To ensure sufficient legal certainty for clients in the Netherlands, municipalities are required to provide concrete and unambiguous care entitlements; this has been clarified by rulings of the Central Appeals Court for Public Service and Social Security Matters (see Section 3.7).

### **10.6.2 Discretion in award criteria explains differences**

We found that the Dutch national regulation leaves less discretion to municipalities in setting the award criteria compared to Finnish municipalities. Unlike Finnish municipalities, Dutch municipalities are required to apply the best price to quality ratio (also known as the most economically advantageous tender, or MEAT) as award criteria. In the Netherlands we observed a paradoxical situation: on the one hand reducing expenditure on home care has been a central government policy;

and on the other, tendering home care with too much focus on price is frowned upon in the public debate, arguing that in the context of social care it leads to a 'race to the bottom' at the expense of the quality of care and working conditions for caregivers. Multiple Finnish municipalities (or collaborations) that outsourced provision of home care used lowest price, or MEAT with 70 % weight on price, to award (a) contract(s). Within the current political climate in the Netherlands, such a procurement would face considerable critique.

### **10.6.3 Service vouchers long before the Dutch open house systems**

A Finnish municipality using the service voucher does not have a formal public contract with the care provider, rather the client using the voucher is in a formal consumer relationship with the care provider of choice. While the Netherlands lacks a law that defines a voucher system, municipalities have used their discretion – following from EU (case) law – to establish highly comparable open house systems that qualify as 'permit' systems and are not subject to many of the provisions of Directive 2014/24/EU. Dutch open house systems and Finnish voucher systems differ in at least two relevant dimensions: (1) Dutch municipalities use open house systems for total outsourcing, and (2) care providers are formally contracted by the municipality in the Netherlands. This may strengthen the position of clients vis-à-vis the care provider in the Netherlands, because the client's position is better supported by the municipality in the Dutch context when receiving care through an open contracting system (in effect the Finnish voucher system or the Dutch 'open house' model).

Agency theory addresses under which contractual arrangements outsourcing is most effective for the principal (Eisenhardt, 1989). Interestingly, scholars focus on the contents of the contract, discussing incentives relating to the contract type (in our context how care services are paid for). In service triad literature, additional attention is paid to buyer-supplier relationships and structural dimensions of the triad (Hartmann & Herb, 2014, 2015; Li & Choi, 2009). In earlier chapters in this thesis, the mechanism of ex post competition is discussed, which may help buyers cope with the risk of agent opportunism in service triads (see Chapters 4, 6, 7 and 8). In this study we also observe this mechanism in the Finnish context. By parallel sourcing (either external provision complementing municipal in-house provision of home care or contracting numerous external care providers in parallel) and allowing clients free choice of providers, competitive forces continue to exist after

contracts are concluded. Agents (care providers) acting opportunistically may suffer consequences, as the clients may switch to a new provider or to municipal provision if they are not satisfied. This mechanism may be a strong incentive against care provider opportunism.

The strength this incentive really depends on (1) the sourcing context, and (2) other contract incentives. For example, in the context of social care, a client may have built up a long lasting relationship with a care giver. Even if the care giver is forced to 'cut corners' and reduce the quality or volume of care, clients may not actually be prone to switch to a new provider. In a general service triad context, end-customer mobility will depend on the 'threshold' or lock-in that customers may perceive to switch to a different provider, which may relate to aspects such as social capital, efforts to build new relationships, uncertainty, and personal characteristics. With respect to other contract incentives, this relates to the actors that suffers from supplier opportunism. In a service triad, either the buyer, the end-customer, or both, may suffer from supplier opportunism. When only the buyer suffers from supplier opportunism, ex post competition is not an incentive against supplier opportunism. For example, in the context of home care – when services are reimbursed fee-for-service – opportunistic behavior leads to over-production, meaning clients are supported more than they really need. However, the client may actually appreciate these additional services, even though the municipality pays too much.

#### **10.6.4 More evidence of little cross-country learning in public procurement**

Perhaps the most interesting finding of our country comparison for the Dutch practice is the fact that there evidently exist 'intermediate' legal outsourcing instruments that combine elements of both the open house system and the Dutch personal budget (PGB) system. Although the Dutch personal budget system allows clients (who have sufficient capacity to manage their PGB) optimal freedom of choice in the selection of their care provider(s) and increases their autonomy, the personal budget is also associated with increased risk of fraud. In a 2017 study, 13.000 clients receiving a personal budget were visited by researchers. In 220 cases (1,7 percent) the researchers suspected fraud, leading to follow up criminal investigations (Poortvliet, Gerwen, & Bosch, 2018). While the reported percentage of *suspected* fraud is low, fraud with personal budgets receives much political attention. The Finnish voucher system potentially offers an interesting intermediate

solution between the open house and the personal budget systems, by reducing the risk of fraud while maintaining extensive client autonomy and freedom of choice among care providers.

The evidence of the Finnish voucher system – as an instrument comparable to the Dutch open house system – also reveals that (municipalities in) EU countries apparently do not learn directly from one-another. After the implementation of EU Directive 2014/24, Dutch municipalities struggled to find a proper legal basis for extant procurement practices using an open contracting scheme. While evidently Finland had already passed a law in 2009 for such an open contracting scheme, it was not until the publication of *Falk* in 2016 that Dutch municipalities picked up on the legal discretion EU law provides. This finding is in line with earlier research findings; researchers in search of cross-country learning in public procurement have failed to find evidence countries learn from each other (Nijboer, Senden, & Telgen, 2017). Fotaki (2007) similarly found evidence of little cross-country learning (with respect to introduction of choice elements in health care reforms in Sweden and the UK), but even noted limited learning from a country's own past experience.

### **10.6.5 Further research is needed**

Despite differences between the Dutch open house system and the Finnish voucher system, these systems undisputedly share many characteristics. As discussed, it is striking that municipalities in the Netherlands failed to identify the existence of open contracting schemes in other EU countries, while there was a clear need for clarity on the EU rules with respect to these schemes. More or less by chance, the CJEU *Falk* case (in 2016) and *Tirkkonen* case (in 2018) were published around this time, which clarified how such an open contracting scheme relates to EU directives on public procurement. In short, a comparison of the legal frameworks for procurement of social care services, and the consequent procurement practices among more EU countries than just the Netherlands and Finland, may provide more relevant insights into procurement practices that may be beneficial to other countries as well.

The benefits of a combination approach (public delivery of home care complemented with outsourcing – the 'Finnish approach') have been recognized as lower risk and presenting opportunities for continuous learning (McNally & Griffin, 2004; Nordigården et al., 2014). However, these so-called hybrid models have also

been criticized for being expensive; see for instance Mols (2010). Further research is necessary to evidence whether hybrid models are in fact more expensive than 'going Dutch' – which in this context implies total outsourcing.

In the Dutch model of total outsourcing we identified a range of outsourcing approaches, for example in terms of reimbursement methods. Based on agency theory, different reimbursement methods relating to contract types can be expected to have a different effect in terms of quality and efficiency of services and risks of provider opportunism. We call for further research to analyze the effects of using different reimbursement methods on the (client perceived) quality and the municipal expenditure on home care services.



# Part III

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## Dutch municipal procurement impact – empirical evidence

The first part of this thesis has provided a careful analysis of the context of the organization and commissioning of social services by public authorities, and the second part a detailed overview of municipal choices in the organization of their responsibilities for social care services. These choices include the commissioning model, competitive mechanisms, public procurement procedures, and relational approaches of municipalities towards social care providers. This third part of the thesis addresses the impact of these commissioning and procurement choices. Chapter 11 focuses on the impact of commissioning approaches on the perceived quality and effectiveness of social care services.



# Chapter 11

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**The impact of commissioning practices on  
social care quality and effectiveness:  
a client perspective**

## Abstract

Both the commissioning model and reimbursement method are expected to impact social care service quality. This chapter presents the findings of a study on the effects of these choices on the quality of social care services and their perceived effectiveness. Service quality in this study is measured through client satisfaction with care services. Effectiveness is measured by examining client perceptions of their self-reliance in relation to received social care services. Cost-effectiveness is not included in this analysis. Using a difference-in-difference design, differences in client satisfaction and self-reliance from before and after the 2015 reform of social care services in the Netherlands are analyzed with respect to different commissioning models and reimbursement methods applied by Dutch municipalities. I find that 'open' commissioning models with ex post competition between care providers associate with better client satisfaction. Commissioning models other than the pre-2014 AWBZ model (including open commissioning models) and outcome-based reimbursement methods do not result in better perceived self-reliance, although municipalities typically do adopt these models and methods to better achieve the goals of the Wmo 2015; i.e., to support citizens in need maintain their self-reliance. Furthermore, I find there is no correlation between improved client satisfaction and perceived improved self-reliance resulting from social care. Clients that become more self-reliant as a result of social care services are not more satisfied and vice versa. This calls for a reconsideration of the emphasis on client-satisfaction as the most important care provider performance indicator in both the Dutch context and literature on social care services.

## Acknowledgement

The research presented in this chapter builds on the master thesis research project of Leon Heuzels, supervised by Jan Telgen, Niels Uenk, and Fredo Schotanus, finalized in 2017: *'Decentralisations in the Dutch social care sector – Researching approaches of municipal commissioning of social care on patient perceived quality of care and self-reliance'* for the University of Twente (Heuzels, 2017). This original research also led to the publication of the report *'Gemeentelijk opdrachtgeverschap in de zorg: één jaar verder'* ('Municipal commissioning of health care: one year further') commissioned by the *Transitiecommissie Sociaal Domein* in September 2016 (Heuzels et al., 2016). This *Transitiecommissie* was installed for a period of three years to monitor the first years of the Dutch reforms of social care, and reported

directly to the House of Representatives of the Netherlands (*Tweede Kamer der Staten Generaal*).

This chapter builds on comparable data and a generally comparable methodology. However, there are a number of differences between the thesis project of Heuzels and the research presented in this chapter. First, this research is based on an extended data set. While the thesis of Heuzels only uses commissioning data of 2015 (from my own research, as discussed in Chapters 4 and 5) and client perceptions on the quality and effectiveness of care in 2014 and 2015, this research includes both types of data for 2016 and 2017 in addition to the same data. Second, the research presented in this chapter uses a different, more refined methodology for the difference-in-difference analysis compared to the 2016 report and 2017 thesis. Leon Heuzels – now employed as researcher with I&O Research (<https://ioresearch.nl/>) – also contributed to this research, although his role here is limited to (1) providing the data on client perceptions, and (2) explaining the research methodology of the client surveys. The data modelling, statistical analyses and interpretation of the findings are done by the author of this chapter.

*I extend my gratitude to I&O Research for allowing me to use their panel data on perceptions of social care service quality and effectiveness for this research. I also extend my gratitude to Leon Heuzels for providing me with the data sets, and discussing the research methodology. No remuneration was provided to I&O Research or Leon Heuzels for using their data set.*

## 11.1 Setting the stage for statistical analysis of commissioning practices

Previous chapters discuss a wide variation of mechanisms that municipalities use in the commissioning of social care services. These mechanisms – and choices between them – include competition in different forms (ex ante versus ex post; for my definition see Section 1.7 Terminology – Competition), client choice of a care provider (ranging from free choice to no choice at all), and outcome-based reimbursement with incentives for efficiency and effectiveness versus fee-for-service reimbursement (rewarding volume: (Porter & Kaplan, 2016)). In the first years after the reform, Dutch municipalities used these mechanisms in social care service procurement in search of high quality social care services at acceptable costs. Chapters 4 and 5 discuss commissioning models used by Dutch municipalities to

commission social care services in the advent of the 2015 reform of social care in the Netherlands, as well as the years after 2015. Chapters 8 and 9 discuss the reimbursement methods used by Dutch municipalities to pay for social care services.

Given the differences in competitive mechanisms and incentives in the different commissioning models and reimbursement methods, both commissioning models and reimbursement methods can be expected to have an impact on the quality and effectiveness of social care services. Studies have focused, for example, on client choice (one aspect of commissioning models: see Chapter 4), evidencing choice positively correlates to improved client satisfaction (Bergman et al., 2018). Fee-for-service (as well as diagnosis-related group reimbursement) models lack incentives for improving quality – providers are paid for the quantity of care that they deliver, not for the impact on the health status of their patients (Tai, Kalanithi, & Milstein, 2014). Chapter 9 discusses these arguments in more detail.

The Wmo 2015 was introduced to organize social care services more tailored to individual client needs, better integration between actors (i.e. both formal care providers and informal care givers) around a client, and to generally achieve a higher quality of social care. Furthermore, municipalities faced a budget cut when they became responsible for these social care services, meaning service provision needed to become more effective in the sense that improved quality should be achieved at reduced costs. The Wmo 2015 fits a trend among OECD countries that in response to cost pressures promote policies of deinstitutionalization and community-based care (Anderson & Hussey, 2000). Substitution of relatively inexpensive home based services for institutional care offers the prospect of considerable cost savings, as well as improved care (Johri, Beland, & Bergman, 2003). In the remainder of this chapter I refer to these goals as ‘the goals of the Wmo 2015’, and the introduction of the Wmo 2015 is referred to as ‘the reform’ (see Chapter 2 for a more elaborate discussion of the introduction of the Wmo 2015). I argue that these goals require a different approach to social care organization, and therefore also different approaches to commissioning. Simply copying the pre-2015 commissioning model (the AWBZ-model) and reimbursement method (fee-for-service reimbursement) seems an ineffective strategy for achieving an improvement in terms of quality and effectiveness.

Some municipalities opted for the AWBZ-model and fee-for-service reimbursement in the first years after the reform. However, four other commissioning models and two other types of reimbursement methods were introduced in the municipal

commissioning of social care services in the first years after the reform. The new commissioning models feature different approaches to competition; a fundamental attribute of outsourcing social care services, as competitive forces are associated with improving quality and efficiency of public (social) care services (Bunger, McBeath, Chuang, & Collins-Camargo, 2017; Enthoven, 1993; S. Lamothe, 2015; Light, 2001; Randall & Williams, 2009). A clear distinction can be made between traditional *ex ante* competition among care providers – a competition to win a public contract – and ‘*ex post*’ competition – where every qualifying care provider is contracted in a framework agreement (or open house system), and every client chooses among the contracted care providers. A municipality’s choice between *ex ante* versus *ex post* competition (or the combination of *ex ante* and *ex post* competition, for example awarding a limited number of framework agreements) is relevant in relation to continuity of care for existing clients of social care services. Continuity of care is generally considered an important quality across different types of health care such as primary care and mental health care, although continuity may have different definitions in different types of care (Adeoye et al., 2014). Continuity of care has several dimensions: informational, management, and relational (Haggerty et al., 2003). In social care, especially the relational continuity – a client maintaining the same caregiver – is emphasized, as clients build up a trusting relationship with their caregiver. Keeping the same caregiver minimizes tension and anxiety existing clients may feel in the advent of a social care reform.

The observed commissioning models also differ in contract scope and to mechanisms for achieving coordination and integrated care service delivery (Korda & Eldridge, 2012; Sampson, Schmidt, Gardner, & Van Orden, 2015), which in turn relates to management continuity of care. In certain models, coordination and client case management are explicitly outsourced to care providers, while in other models municipalities organize these responsibilities in-house. Another dimension of commissioning models is the mechanism to control expenditure. In certain models – similar to pre-reform commissioning – care providers are contracted on the basis of a fixed annual budget. Budget overruns are prohibited, hence their effective limitation of service ‘production’ volumes. If budgets are too tight, care providers generally respond by maintaining a waiting list for care services. Waiting lists for social care services are considered undesirable and are associated with a perceived deterioration of the quality of health and social care (Schut & van den Berg, 2010). In 1999, waiting lists for AWBZ-care were even successfully challenged before the courts in the Netherlands (see court case Rb. Utrecht, nr. KG 105038 KG ZA, 1999). From that point onwards waiting lists were even illegal (Schut & van den Berg,

2010), as it means people in need cannot access social care and support in a timely manner.

It is expected that the combinations of these attributes in commissioning models, especially (1) freedom of choice, (2) ex ante versus ex post competition, (3) the use or absence of annual budget caps, and (4) the organization of coordination and case management, impacts the perceived quality of care services. Note that freedom of choice and ex ante and ex post competition are related. The fewer care providers that are contracted, the stronger the ex ante competition becomes - and the fewer care providers clients may choose between. The AWBZ-model here is an intermediate model with ex ante competition and client choice to some extent. Table 11.1 summarizes these attributes for each of the commissioning models. As in many other studies in social and health care service context, this research measures service quality through client satisfaction: see for instance Laferriere (1993), Vuori (1991), and Wolf et al. (1998). However, there is debate on whether client satisfaction fully comprises service quality (Cleary & McNeil, 1988). Therefore, this research incorporates the perspective of the effectiveness of social care services, since public service effectiveness is considered a fundamental attribute of service quality (Sanderson, 1996). I define effectiveness in this perspective as the degree of goal-attainment. Since social care services primarily aim to support and improve the self-reliance of clients (so improved self-reliance is an important goal of social care), the perceived self-reliance of social care clients is used as a measure for service effectiveness. This leads to the first research question:

- 1. Do commissioning models for social care services that allow clients free care provider choice and that feature ex post competition, no volume caps, and municipal coordination of care result in better client satisfaction and perceived self-reliance?*

**Table 11.1** – Attributes of commissioning models in each model

Commissioning model	Client choice	Competition	Volume caps	Coordination	Reimbursement type
AWBZ	Limited	Ex ante and (limited) ex post	Yes	Outsourced	Fee-for-service
Population-based commissioning	No choice	Ex ante	Yes	Outsourced	Outcome-oriented
Catalogue model / fee-for-service	Free choice	Ex post	No	Municipal coordination	Fee-for-service
Catalogue model / outcome-based	Free choice	Ex post	No	Municipal coordination	Outcome-oriented
Client auction model	Free choice	Ex post	No	Municipal coordination	Outcome-oriented

The manner in which a financier pays for health and social care services (the ‘reimbursement method’) relates directly to the incentives for service quality and cost-efficiency and have a fundamental impact on achieving better care quality (Porter & Kaplan, 2016). Traditional reimbursement methods such as fee-for-service reimbursement reward volume instead of value (Porter & Kaplan, 2016) and are widely considered to be an important reason for rising costs in healthcare (Orszag & Ellis, 2007). Traditional reimbursement methods such as fee-for-service lack incentives for better and more cost-efficient care provision (Kleef et al., 2014; Porter & Kaplan, 2016; Vlaanderen et al., 2018). Reimbursement methods that focus more on outcomes may overcome these problems, as there are incentives for improving quality and cost-efficient achievement of the desired outcomes (Vlaanderen et al., 2018). At the same time, these methods shift certain risks to clients, and for example, the risk of underproduction (Eijkel & Uenk, 2016) also known as skimping. Many Dutch municipalities have adopted more outcome-oriented reimbursement methods, raising the interesting and paramount question as to whether the new commissioning models and reimbursement methods actually achieve better (higher *quality* and *more effective*) provision of social care. With respect to the reimbursement method used for social care services, service effectiveness (the degree to which self-reliance is improved by the service provision) is arguably a better attribute of service quality, compared to client satisfaction with the social care service. Depending on the performance indicators used in remuneration in outcome-oriented reimbursement methods, these reimbursement methods may be primarily aimed to reward cost-efficiency and effectiveness of service provision. For example, the client is made more self-reliant, but with less input from a professional caregiver, hence at lower costs. The result of this more effective provision of care may be that a caregiver spends less time at the client while achieving the

same or better outcomes. While care is then more effective (in the definition of this research), the client may perceive reduced satisfaction (some client groups being more prone to the duration of care services received, rather than to the outcomes achieved). Therefore, this research measures the impact of reimbursement methods on the quality of services by considering the effectiveness of social care services. Again, effectiveness is measured through perceived client self-reliance in relation to the social care services received. This leads to the second research question:

2. *Do more outcome-oriented reimbursement methods for social care services lead to better client self-reliance compared to traditional fee-for-service reimbursement?*

The contributions of this study are threefold. Firstly, the study demonstrates that commissioning models with freedom of choice for a care provider, ex post competition (rather than or in combination with ex ante competition), the absence of fixed annual budgets, and in-house coordination of care lead to improved client satisfaction; a proxy typically used for social care service quality. Second, the study evidences that more outcome-oriented reimbursement methods fail to achieve more effective social care service provision, possibly because they suffer from care provider opportunism in a context with strong budgets cuts. Third, this study demonstrates that client satisfaction *alone* may not be a suitable 'stand-alone' proxy for the quality of social care services. This is interesting, as in previous studies on social care client satisfaction is often used as measure for service quality (Bergman et al., 2018; Laferrriere, 1993; Vuori, 1991; Wolf et al., 1998). This study evidences, as suggested before by Cleary & McNeil (1988), that client satisfaction does not fully explain care service quality. Comparing differences over time in (1) client perceived self-reliance, and (2) client satisfaction with social care, no correlation is found between the differences in self-reliance in relation to social care services received (a proxy for the effectiveness of these services) and client satisfaction. Clients receiving ineffective care services (effectively those care services that did not result in an improvement of perceived self-reliance) are just as satisfied, and clients receiving effective care services (where perceived self-reliance improved) are just as unsatisfied.

This chapter is structured as follows. First, I briefly revisit the findings with respect to commissioning models and reimbursement methods. From this discussion I then draw hypotheses with respect to social care service quality and effectiveness (as defined above). Section 11.3 discusses the data and methods; Section 11.4 pre-

sents the findings of the statistical analyses; and finally Section 11.5 discusses the findings, presents the conclusions, and discusses limitations of this study.

### 11.1.1 Revisiting the commissioning models for social care

Similar to the positioning of Murray (2009), when this research refers to commissioning as a process or activity (for instance: *the municipality commissions social care services*), commissioning entails *both* making the more fundamental choices discussed above as well as the consequent more administrative procurement process. With respect to *commissioning models*, the emphasis lies on the combination of the strategic choices with respect to outsourcing (i.e. aspects such as competitive mechanisms applied, contract scope, implicit or explicit risk allocation, incentives for care providers, and the coordination of case management) and not so much on the procurement process of concluding contracts. Chapter 4 discusses four commissioning models, distinguishing two variants of the catalogue model. The AWBZ-model is named after the commissioning practices in the Netherlands up to the social care reform.

The AWBZ-model is characterized by the contracting of a limited number of care providers on the basis of fixed annual budgets. A care provider accounts for the use of the budget by administering the provided services on a fee-for-service basis. Services are charged per time unit (e.g. € 48 per hour of ‘personal assistance’), which means the contract budget limits, on an annual basis, the volume of services the care provider is reimbursed for. The AWBZ-model combines *ex ante* competition over contracts with limited *ex post* competition, as clients may choose between the limited number of contracted care providers (subject to their budget and volume cap). While access to care is typically taken over by municipalities, case management is generally outsourced to the care provider.

The population-based commissioning model, also known as the ‘prime contractor’ or ‘lead provider’ model (Addicott, 2014; Billings & De Weger, 2015; J. O’Flynn et al., 2014), is characterized by contracting one main contractor – with an annual fixed budget – that becomes responsible for certain social care services for an entire population (in this context: an entire municipality or geographical area of a municipality). The main contractor typically needs to subcontract or form a consortium with other care providers. The population-based commissioning model relies purely on *ex ante* competition; clients have no choice over their care provid-

er. The main contractor is responsible for organizing access to care and client case management.

In the catalogue model, the municipality concludes framework agreements with a wide range of care providers (any interested care provider meeting standardized quality requirements) for the provision of standardized services against standard terms and conditions. Municipal or third-party (i.e. a separate organization or care provider that is not contracted for provision of social care services) client case managers identify a citizen's needs for social care, decide on formal social care eligibility, and monitor the provision of social care by care providers. The eligible citizen has freedom of choice to select a care provider among the contracted providers. The services in the catalogue are either contracted on the basis of fee-for-service (similar to the AWBZ-model, except that the framework agreement has no fixed budget or volume cap), or on the basis of outcome-based bundled payment. Outcome-based bundled payment contracts specify services in terms of the required outcomes rather than the 'inputs', and a bundled payment (usually per period) is paid to the care provider for achieving these outcomes. Both versions of the catalogue model rely exclusively on ex post competition, offering clients complete freedom of choice for a care provider.

In the client auction model, a municipal or third-party case manager identifies a citizen's need for social care, including possible preferences and relevant contextual factors. An anonymous case description of the citizen is then placed on a restricted auction website. Care providers meeting the required quality criteria have access to this website and may bid for client cases with a care plan and associated price. Together with the case manager the client decides on the best offer, and the selected care provider delivers care according to the bid. Clearly the client auction model emphasizes ex post competition and client choice, although client choice is restricted to the care providers that actually bid for the client. Case management is either organized in-house, or made part of the individual care plan for the client.

Using longitudinal contract analysis, the commissioning model for almost all Dutch municipalities was retrieved from social care service contracts commissioned between 2015 to 2017. Table 11.2 shows for each commissioning model the number and share of municipalities using this model for personal assistance, day care services, and respite care services between 2015 and 2017. The 'N' referenced in the first row represents the number of municipalities included in the empirical study; the aim was to include as many municipalities as possible. For some municipali-

ties, procurement documents were found only in part, so the commissioning model could not be established unambiguously. For an even smaller set of municipalities, no procurement documents were retrieved at all.

**Table 11.2** – Municipal commissioning models for personal assistance in the years 2015-2017

Commissioning models	2015 (N=382)	2016 (N=389)	2017 (N=351)
AWBZ	107 (27%)	63 (16%)	29 (7%)
Population-based commissioning	15 (4%)	16 (4%)	8 (2%)
Catalogue model / fee-for-service	143 (36%)	162 (42%)	182 (47%)
Catalogue model / outcome-based	104 (26%)	120 (31%)	126 (32%)
Client auction model	11 (3%)	11 (3%)	6 (2%)
Unknown	13 (3%)	18 (5%)	37 (10%)
Total number of municipalities	393	390	388

### 11.1.2 Revisiting the reimbursement methods: paying for input, outcome, or a population

The reimbursement method determines what the financier pays for (for example an ‘input’ or an ‘output’) and also reflects the distribution of risk between financier and care provider (Miller, 2009). While more reimbursement methods exist (see for example Miller (2009) for a more granular discussion), Dutch municipalities use three main groups for social care services.

With fee-for-service reimbursement, a care provider is paid per performed procedure or other type of ‘input’. In a social care service context, the ‘inputs’ are typically specified in minutes, hours, or days of care service provision.

When paid on the basis of a population-based budget, also known as capitation or ‘lump sum payment’, a care provider receives a fixed periodic (typically annual) budget to provide care services for a certain population, independent of the number of ‘episodes of care’ and the volume of care services provided within these episodes. The population includes both the people that are currently in care and people who do not yet use care.

Outcome-based bundled payments specify certain outcomes at the level of an individual client (e.g. with support the client has insight into their personal financial

situation). A care provider is paid a (in this context, typically fixed) remuneration to achieve – or permanently maintain – these outcomes. The payment is per episode of care (e.g. per month or per year) but is independent of the volume of care services provided within these episodes of care.

Using the same methodology as discussed in the previous section, for over 95% of Dutch municipalities the reimbursement method used for commissioning the social care services of personal assistance, day care services, and respite care was analyzed. Table 11.3 reflects the reimbursement methods implemented for the years 2015, 2016, and 2017.

**Table 11.3** – Findings of reimbursement methods 2015-2017

Reimbursement methods	2015 (N=382)	2016 (N=389)	2017 (N=351)
Fee-for-service	261 (66%)	236 (61%)	217 (56%)
Population-based budget	15 (4%)	16 (4%)	8 (2%)
Outcome-based bundled payment	106 (28%)	122 (31%)	119 (31%)
Unknown	11 (3%)	16 (4%)	44 (11%)
Total number of municipalities	393	390	388

## 11.2 Hypotheses

### 11.2.1 Client satisfaction as measure for service quality

There is considerable extant research on client or patient satisfaction in relation to health care service quality, for example Aldana, Piechulek, & Al-Sabir (2001), Laferriere (1993), Vuori (1991), and Wolf et al. (1998). The literature concerning both ‘care’ and ‘cure’ (‘social’ and ‘medical’ health care services) overlaps here; therefore, in this discussion I use the terminology of both fields (e.g. ‘client’ versus ‘patient’ as the recipient of health and social care services). While there is no complete consensus among scholars with respect to using client satisfaction as the only indicator for the quality of health care services, scholars agree that client or patient satisfaction is at least an important attribute of health and social care quality. Pascoe (1983) finds that patient satisfaction can serve as an outcome measure of the quality of health care and provides a consumer perspective that can contribute to a complete, balanced evaluation of the structure, process, and outcome of (health care) services. Vuori (1988) concludes patient satisfaction is part and parcel of

quality health care, that patients are capable of assessing the quality of care, and that patient satisfaction can be measured. Some studies suggest that more personal care will result in better communication and more patient involvement, and therefore better quality of care (Cleary & McNeil, 1988). Cleary & McNeil (1988) at the same time call for further research to measure specific aspects of medical care and the ways in which patient reports can complement other sources of information about quality. Johansson, Oléni & Fridlund (2002) are more firm, and in a nursing-care context state ‘patient satisfaction is a significant indicator of the quality of care’. In social care, client satisfaction is a common – and sometimes the only – indicator for the quality of care services, both in academic research (e.g. (Lafferriere, 1993; Vuori, 1991; Wolf et al., 1998)) and in practice. For example, Dutch municipalities are required to report social care performance indicators to the national bureau of statistics (*Centraal Bureau Statistiek*, or CBS) for benchmarking purposes, and client satisfaction is one of the main required indicators. Other indicators for example relate to the accessibility of social care or timeliness of social care – the website [www.waarstaatjegemeente.nl](http://www.waarstaatjegemeente.nl) reports such performance indicators for every municipality in the Netherlands. Client satisfaction – or more generally, client experience – is used by municipalities to measure the impact of their policy on (the commissioning of) social care. Client perceptions of service quality are considered a suitable measure for care provider performance, since the quality of social (home) care perceived by the user will closely resemble a reasonable social measure of quality (Bergman et al., 2018).

Although there is sufficient support to only use client satisfaction as a proxy for service quality (Bergman et al., 2018), this research used a separate complementary indicator of perceived self-reliance in relation to receiving social care services. This latter indicator can be considered a measure of the *effectiveness* of social care services; after all, social care services aim to improve a client’s self-reliance. While it was not the main purpose of this research to address the appropriateness of client satisfaction as a proxy for social care service quality as such, using a complementary indicator of perceived improved or reduced self-reliability allowed for a critical reflection on the indicator of client satisfaction. Contrary to expectations, this research revealed a correlation between the improved or reduced self-reliance in relation to social care services received (service effectiveness), yet the corresponding difference in client satisfaction was not found. For a more detailed assessment see Section 11.4.3 and the subsequent discussion section.

### **11.2.2 Do ‘new’ commissioning models improve client satisfaction and care service effectiveness?**

Commissioning attributes discussed in Section 11.1.1 are known to impact the perceived quality of social care services. First, the introduction of free choice of care provider for a client increases the perceived quality of home care services (Bergman et al., 2018). Free choice of care providers does not only relate to new clients. In the Dutch social care reform context, municipalities started contracting social care services in 2015, and as demonstrated these municipalities had different options with respect to commissioning models. Some of these commissioning models are characterized by a strong emphasis on ex ante competition over a contract (i.e. the AWBZ model and Population-based commissioning), whereas other municipalities opted for commissioning models that emphasized ex post competition, in which framework agreements were awarded to every care provider that met the required municipal quality and suitability criteria (i.e. the catalogue model and client auction model). In models with ex ante competition, existing clients are at risk of losing their current caregiver, which likely leads to reduced satisfaction. The models that emphasize ex ante competition are also characterized by the use of fixed budgets, where both new and existing clients are at risk of reduced service provision or waiting lists, see Schut & van den Berg (2010) at the end of the year when their care provider risks a budget overrun. This too is expected to negatively impact client satisfaction. Finally, in the AWBZ and population-based commissioning models, the care providers are usually (AWBZ) or always (population-based) responsible for client case management. Under the other models, the municipality organizes client case management in-house or through a third-party independently of the care provider. Summarizing this reasoning, superior client satisfaction is expected in the commissioning models with freedom of choice for a care provider, ex post competition, the absence of fixed budgets, and independent client case management. I define these commissioning models (the catalogue model and the client auction model) in this respect as ‘open models’ for commissioning. The AWBZ-model and population-based commissioning model are here considered ‘closed models’.

*H1: Clients in municipalities with ‘open models’ for commissioning social care are significantly more satisfied with these services compared to clients in municipalities that have a ‘closed’ commissioning model.*

It is expected that client satisfaction and perceived service effectiveness are re-

lated. Vuori (1988) concludes that patients are capable of assessing the quality of care, and it is argued that the quality of care here includes its effectiveness. Despite an expected positive correlation between client satisfaction and service effectiveness, there is a different emphasis in both attributes. The social care service effectiveness may not be comprehensively captured in client satisfaction. For example, while a client may be unsatisfied because of a forced change in care provider (in effect, breaking relational continuity), this does not mean that the new care provider is less competent or less successful in achieving the desired outcome (in effect, improved self-reliance or its antecedents). Also, clients that receive less volume of social care services may perceive this as a deterioration of quality, while the services may actually be more effective in terms of achieved self-reliance. In relation to the goals of the social care reform in the Netherlands (more tailored care, better coordination and integrated delivery of social care, improved effectiveness and cost-efficiency), each of the 'new' commissioning models – the models municipalities adopted instead of the AWBZ-model – combines a different set of mechanisms to achieve these goals. Section 11.1.1 (and in even more detail, Chapters 4 and 5) discusses each of the new models and their implied mechanisms in detail. It is expected that these new commissioning models are better fitted to achieve the reform goals, reflected by achieving client self-reliance, compared to the AWBZ-commissioning model. In short, the new commissioning models are expected to result in better client self-reliance.

*H2: Clients in municipalities that implemented a new commissioning model perceive better self-reliance in relation to the social care services received, compared to clients in municipalities with the AWBZ-model.*

### **11.2.3 Do outcome-oriented reimbursement methods improve the quality and effectiveness of social care services?**

Traditional reimbursement methods, such as fee-for-service, reward volume rather than effectiveness (Porter & Kaplan, 2016). Fee-for-service reimbursement lacks incentives for better and more efficient care provision (Kleef et al., 2014; Porter & Kaplan, 2016). Reimbursement methods that focus more on outcomes may overcome these problems, as there are incentives for efficient and effective achievement of the desired outcomes (Vlaanderen et al., 2018). Outcome-oriented reimbursement methods such as outcome-based bundled payments and population-based budgets are expected to result in better quality of care services. Here,

service effectiveness, compared to client satisfaction, is arguably a better attribute of service quality. Outcome-oriented reimbursement methods primarily aim to reward cost-efficiency and effectiveness of service provision while maintaining a sufficient level of client satisfaction. As care services primarily aim to improve a client's self-reliance, this is used as the measure for service effectiveness.

*H3: Clients in municipalities that use outcome-oriented reimbursement methods for social care services perceive higher self-reliance in relation to care services received, compared to clients in municipalities that use fee-for-service reimbursement.*

Despite the optimistic expectation with respect to outcome-oriented reimbursement, there is risk for clients when a municipality adopts outcome-oriented reimbursement methods. Where budgets for social care services are reduced and care providers have to fight to survive, outcome-oriented reimbursement methods provide the environment for care provider opportunism. For example, with outcome-based bundled payment, a care provider has an incentive and opportunity to reduce the volume of services (skimping), and with population-based budget payment the care provider has a financial incentive and opportunity to 'skimp' as well as 'dump' – the latter referring to reducing the number of clients entitled to social care (Chapter 9 further elaborates on these risks). If indeed care providers have used the opportunities and incentives in outcome-oriented reimbursement methods to 'cut corners' rather than to become more effective, clients may actually perceive deteriorated self-reliance in these municipalities compared to fee-for-service municipalities.

## **11.3 Data and empirical statistical methods**

### **11.3.1 Commissioning data and repeated client satisfaction surveys**

In order to study the effect of the commissioning model and the reimbursement method adopted by municipalities, this chapter builds on the classifications and findings of empirical studies on municipal social care procurement discussed in Chapters 4, 5, 8 and 9. In this chapter I focus on the contracts in place for 2015, 2016, and 2017, combining municipal commissioning approaches with data on social care service quality and effectiveness, as perceived by clients. More precisely, I

study the change of client satisfaction and perceived self-reliance (as measurements for respectively service quality and service effectiveness) between the pre-reform and post-reform time period. The independent variables in this research are the municipal commissioning models and the municipal reimbursement method for the social care services of personal assistance, day care services, and respite care.

*Social care service quality and effectiveness: a panel survey*

In this study the impact of the different municipal commissioning models and reimbursement methods on the quality of social care services is measured through the perceptions of clients of the social care services they received. These perceptions of service quality are expected to closely resemble a reasonable social measure of quality (Bergman et al., 2018). The research in this chapter uses both the primary data on municipal commissioning, presented in earlier chapters of this thesis, and secondary data from a longitudinal research project of the Dutch research organization I&O Research. In a purchasing and supply chain management context, using secondary data has been shown to have several advantages, such as highly objective and less biased data, and requiring fewer resources compared to primary research (Calantone & Vickery, 2009). Using an ISO 26362 certified panel (over 45.000 panel members) with an appropriate regional and socio-demographic spread – representative for the Dutch population aged 18 to 89 – I&O Research has researched clients' perceptions of the quality and effectiveness of social care service they received. These surveys were conducted in December 2014 (Q0), June/July 2015 (Q1), December 2015 (Q2), December 2016 (Q3), and December 2017 (Q4). Respondents were unpaid and did not receive compensation for joining surveys.

At the time of the 2014 survey, social care services in the Netherlands were not yet reformed, which happened directly after on 1 January 2015. This allowed me to use the survey outcomes of the Q0 measurement as a baseline from which to compare outcomes (and consequent differences) in consecutive years. I used the differences in client scorings for satisfaction and perceived self-reliance between Q0 and one of the Q2, Q3, or Q4 measurements in a difference-in-difference analysis to determine the effects of commissioning models and reimbursement methods on social care quality (measured by client satisfaction) and effectiveness (measured by the perceived self-reliance). The Q1 measurement here was omitted. This measurement is dated only 6 months after the reform, which possibly left insufficient time for effects of commissioning to become visible in client perceptions of social care services. I used the consecutive December measurements of client perception of

quality and effectiveness, combining this data with the commissioning model and reimbursement method applied by the municipality throughout the corresponding year. This means the client perceptions concerned care received for a period of at least 11 months under the corresponding commissioning model and reimbursement method used by municipalities.

In this research, the responses of clients are used. As the panel is representative for the entire Dutch population aged between 18 and 89, not all panel members received social care. Table 11.4 shows per measurement how many respondents participated in the survey, the percentages of these participants that answered the questions as a client receiving social care services, and the source of the respective survey.

**Table 11.4** – Overview respondents in surveys on perceived quality and effectiveness of social care

Measurement	Total number of respondents	% of respondents received professional care ('client')	Source
Q0 - December '14	9.055	21% (1.902)	(I&O Research, 2015)
Q2 - December '15	6.923	18% (1.246)	(I&O Research, 2015)
Q3 - December '16	10.839	21% (2.276)	(I&O Research, 2016)
Q4 - December '17	10.542	19% (2.003)	(Beerepoot & Heuzels, 2018)

#### *Selection of appropriate respondents*

Not all clients of social care services received the types of social care services reflected in this chapter. Household assistance and sheltered housing services are excluded, while the survey respondents may have answered for these specific services. The survey cases were filtered on the basis of the survey question concerning the appropriate situations that apply to the respondent. The following situations are associated with the types of social care (personal assistance, day-care services, respite care) for which the contracts are used in the empirical analyses on municipal commissioning in this chapter.

The client receives the following types of social care and support:

1. Support with *organizing/managing* the household;
2. Support with finance and administration;
3. Being kept company, emotional support, and supervision;
4. Doing activities together;

5. Personal care;
6. Support with organizing and coordinating professional social care services.

Other categories (i.e. cleaning the house or transportation) do not correspond to the types of social care services addressed in the analyses of this chapter; clients that only indicated these situations were left out.

#### *Client perceptions of quality and effectiveness of social care*

I used the responses on the survey questions concerning (1) the satisfaction with the (quality of) social care services received, and (2) the survey question concerning the effectiveness of received social care services in terms of perceived self-reliance. In the survey, the respondents first indicate which of the situations mentioned above apply to them. The exact questions for which the responses are used in this research are the following:

- *How do you rate the support or care you received from the institution(s) relating to these situations?*
- *Can you indicate on a scale from 1 to 10 to what extent you can take care of yourself?*

The first question is used as measurement for service quality in this research; the second question is used for perceived self-reliance – and this is used as a measure to examine the effectiveness of care services. Both questions (satisfaction with services and effectiveness of services) are measured on a scale of 1-10. While the 2017 survey (Q4) was modified by adding some new questions, the questions used in this research remained equal to the corresponding questions in the earlier surveys. This allows a comparison of the answers between the four measurements. To identify the impact of the commissioning model and reimbursement of social care services, I used a difference-in-difference analysis.

### **11.3.2 Empirical strategy: difference-in-difference before and after the reform**

The empirical strategy here is described for the municipal commissioning model. The exact same research design was applied for the reimbursement method, but not described separately to keep the text concise. To test the effect of the municipal commissioning model on the quality and effectiveness of social care, this re-

search used a difference-in-difference design. I tested the differences in the survey scores for quality and effectiveness in the 'baseline' AWBZ-model between 2014 and the 2015, 2016, or 2017 score for 'matched case' panel data. I then compared the differences between the differences between the AWBZ baseline model and the other commissioning models in the consecutive years. I used matched panel data, meaning only the respondents that have participated in the 2014 survey and one of the 2015, 2016, or 2017 surveys are included in the analysis. For these mapped cases the difference between their 2014 score and the 2015, 2016, or 2017 score was calculated. If a respondent participated in multiple surveys between 2015 and 2017, the latest score is used. To demonstrate, Table 11.5 shows for five imaginary example respondents how these would be used in the analysis.

**Table 11.5** Example of calculated differences and survey selection

<b>Respondent</b>	<b>2014 score satisfaction</b>	<b>2015 score satisfaction</b>	<b>2016 score satisfaction</b>	<b>2017 score satisfaction</b>	<b>Year used</b>	<b>Delta Qx-Q0</b>
R1	8.0	7.0	-	-	2015	-1.0
R2	7.0	6.0	8.0	-	2016	1.0
R3	-	9.0	-	7.0	-	-
R4	6.0	-	6.0	5.0	2017	-1.0
R5	2.0	-	-	-	-	-

The survey responses are matched with longitudinal data on municipal commissioning. In 2014, every social care client received care under the AWBZ regime, and from 2015 onwards the commissioning model depended on the municipality where the client lived. For each client the commissioning model of their municipality was determined, which corresponds to the score used in the difference-in-difference analysis. The clients have received care under the indicated commissioning model in the year leading up to the latest survey score, which is used to calculate the delta. For the 2016 and 2017 surveys, the client may have received care under the new commissioning model and reimbursement method during a two- or three-year period, although the municipality may have opted for a new model and method after 2015. See Table 11.6 for an example of this step in the analysis.

**Table 11.6** Example of matching of commissioning models to respondents

Respondent	Year used	Delta	Municipality	Commissioning model in 'year used'
R1	2015	-1.0	Ede	AWBZ
R2	2016	1.0	Amsterdam	Catalogue model / fee-for-service
R3	-	-		
R4	2017	-1.0	Wageningen	Population-based commissioning
R5	-	-		

In the final step I compared the means of the differences of the AWBZ-model as baseline and the other commissioning models. The statistical analyses consisted of multiple univariate ANCOVAs as well as Bonferroni's contrast testing with Type III sum of squares (Ruxton & Beauchamp, 2008; Yates, 1934). Type III sum of squares are invariant with respect to cell frequencies (Vos, Scheffler, Schiele, & Horn, 2016), and, therefore, applicable to the unbalanced data used here, because the sizes of the groups (i.e. commissioning models and reimbursement methods) vary considerably, which can lead to biased findings when the analysis methods do not account for this. With respect to the group comparisons, the pre-coded contrast test 'simple' was selected in SPSS. This allows the contrasting of one focal group's mean (here the AWBZ-model resp. the fee-for-service reimbursement) to the means of the other groups (Schaap, van der Gaag, Gouma, & Jansen, 2009). The analyses used Bonferroni(-Dunn)-type simultaneous confidence intervals based on Student's T distribution across all dependent variables (Dunn, 1961). The Bonferroni adjustment is based on the premise that comparisons within a research design are pre-planned, requiring that the analyses are guided by underlying research questions and hypotheses (Ingersoll, 2010). Since all contrast procedures are concerned with a trade-off between risks of Type I and Type II errors (Cribbie, 2003; Sato, 1996), in this research the Bonferroni adjustment was chosen because it controls for Type I errors (false positives).

In the analysis, the difference between the 2014 survey response and the response in one of the surveys of 2015, 2016, or 2017 are compared to identify the change in satisfaction and perceived self-reliance among social care clients. The year of the second participation to the survey (so 2015, 2016, or 2017) may have had an effect on the survey outcomes. For example, throughout 2015 the reform created uncertainty with existing clients ('can I keep my current caregiver?', 'will I keep sufficient social care services?'), and this uncertainty was in fact reflected in a general – yet temporary – dip in confidence among clients, who feared whether social care ser-

vices were in the right hands with municipalities (I&O Research, 2015). Therefore, the year of the second participation in the survey was used as control variable. Furthermore, in the surveys the cases were weighed to establish a representative sample for the entire population of the Netherlands, considering a respondent's age, gender, education, and geographic region in the Netherlands. The cases are weighed using this compound weight factor. The analyses used a significance level of 0.05 (two-sided).

## 11.4 Findings

### 11.4.1 Clients are more satisfied in municipalities with an open commissioning model

#### *Commissioning model*

In total, 107 matched cases remained after selecting those respondents that participated in both the 2014 survey and at least one of the other surveys, who have received the appropriate care services in the years of survey participation, and who live in a municipality for which the commissioning model is determined from the contract analysis. The average difference in client satisfaction among all groups was -0.52, meaning that satisfaction dropped with half a point between 2014 and the consecutive survey in which these respondents participated.

First, general F-tests were applied to obtain an indication of whether the groups had significant different group means. Second, contrast tests using Bonferroni adjustments were applied to gain higher resolution information and test the specific hypotheses. The contrast tests determined the differences between the specific group means for the AWBZ model and the other models, and only indicated significant findings when the differences were significantly strong. Table 11.7 shows the mean values of the difference in client satisfaction for each of the groups (split between years of participation to the second survey). Clearly the population-based commissioning model (one respondent) and the client auction model (3 respondents) are not sufficiently represented for a reliable comparison with the AWBZ-model. This corresponds to the fact that these models were only very rarely used by municipalities in the Netherlands between 2015 and 2017. Therefore, the discussion of findings focuses on the AWBZ-model versus the two variants of the catalogue model.

**Table 11.7** Differences in client satisfaction per commissioning model and survey year

Commissioning model	Year of second measurement	Mean difference to 2014	N
AWBZ	2015	-0,111	9
	2016	-3,167	6
	2017	-1,000	3
	<i>Total</i>	<i>-1,278</i>	<i>18</i>
Population-based commissioning	2016	0,000	1
	<i>Total</i>	<i>0,000</i>	<i>1</i>
Catalogue model – Fee-for-service	2015	-0,250	24
	2016	0,071	14
	2017	-0,188	16
	<i>Total</i>	<i>-0,148</i>	<i>54</i>
Catalogue model – Outcome-based	2015	-0,600	10
	2016	1,000	2
	2017	-1,211	19
	<i>Total</i>	<i>-0,871</i>	<i>31</i>
Client auction model	2016	0,000	2
	2017	0,000	1
	<i>Total</i>	<i>0,000</i>	<i>3</i>
Total	2015	-0,302	43
	2016	-0,640	25
	2017	-0,744	39
	<i>Total</i>	<i>-0,542</i>	<i>107</i>

Table 11.7 evidences that the satisfaction of clients under the AWBZ-model has reduced the most, dropping 1,28 points compared to a difference of -0,15 and -0,87 for the catalogue model with ‘fee-for-service’ and ‘outcome-based’ contracts respectively. This means the satisfaction of clients has reduced in general since the social care reform in the Netherlands, but the decline is sharpest in municipalities that have maintained the old manner of commissioning with the AWBZ-model.

**Table 11.8** - ANCOVA for client satisfaction including the commissioning models and control variable for year of participation.

Source	SS	df	MS	F	p	Eta
Main Effects						
Comparison groups (1, 2, 3, 4, 5)	20,50	4	5,124	1,516	0,102	0,06
Covariates:						
Year of participation	3,16	2	1,582	0,468	0,314	0,01
Interaction groups * year of participation	40,05	5	8,01	2,37	0,023	0,111

Notes: SS = Sum of squares; df = degrees of freedom; MS = Mean square difference; F = F-value of the ANCOVA Analysis; p = significance level (two-sided); Eta = Partial Eta Squared

Table 11.8 presents the outcome of the ANCOVA analysis of the model. The main effect is not significant, which would reflect the commissioning models do not differ with respect to client satisfaction with their care services. Despite the general F-test not being significant, the contrast tests were pre-planned to a gain higher resolution analysis of the group differences.

**Table 11.9** - Contrast analysis client satisfaction versus commissioning models.

1 - AWBZ	2 - Population-based comm.	3 - Catalogue model / fee-for-service	4 - Catalogue model / outcome based	5 - Client auction model	2 vs. 1		3 vs. 1		4 vs. 1		5 vs. 1	
M	M	M	M	M	Diff.	p	Diff.	p	Diff.	p	Diff.	p
-1,278	0	-0,148	-0,871	0	1,278	0,179	1,13	<b>0,004</b>	0,407	<b>0,020</b>	1,278	0,056

Notes: Group 1 (AWBZ-model) is used as contrast group; M = Group mean of difference in client satisfaction; Diff. = Difference between groups; p = Significance level of difference (two-sided)

Contrary to the general F-test, the outcomes of the pre-planned contrast test (see Table 11.9) shows that both variants of the catalogue model do have significantly better client satisfaction scores compared to the AWBZ-model. The means of the population-based commissioning model and the client auction model are not omitted – they happen to be exactly equal to 0 (see Table 11.7). The difference of the client auction model vs. the AWBZ model is not sufficient at  $p = 0,05$ , but considering the very small number of observations this result is not deemed reliable. Hypothesis 1 that clients are increasingly satisfied with their social care services under open commissioning models is confirmed with respect to both versions of the catalogue model compared to the AWBZ-model. I do note the fact that the general F-test

does not support any differences between the groups, while the contrast test does. A possible explanation is that the ANCOVA is more robust against making Type I errors compared to Bonferroni's contrast analysis, which also protects against false positives but appears to be more sensitive to differences among groups.

### 11.4.2 Care services are not more effective in 'new' commissioning models

#### *Commissioning model*

To analyze the effect of the municipal commissioning model on the effectiveness of social care, a general F-test between the groups was conducted, followed by a contrast analysis between the groups, with AWBZ as the baseline model. For this analysis there are in total 111 valid cases, and Table 11.10 shows the difference scores for every commissioning model per year of participation to the second survey.

**Table 11.10** - Differences in perceived service effectiveness per commissioning model and survey year

Commissioning model	Year of second measurement	Mean difference to 2014	N
AWBZ	2015	-0,6667	3
	2016	-0,1667	6
	2017	0	3
	<i>Total</i>	<i>-0,25</i>	<i>12</i>
Population-based commissioning	2016	0	1
	<i>Total</i>	<i>0</i>	<i>1</i>
Catalogue model / fee-for-service	2015	-1,0833	24
	2016	-0,7778	18
	2017	1,3125	16
	<i>Total</i>	<i>-0,3276</i>	<i>58</i>
Catalogue model / outcome-based	2015	-1,0833	12
	2016	-1,8333	6
	2017	-2,5263	19
	<i>Total</i>	<i>-1,9459</i>	<i>37</i>
Client auction model	2016	9	2
	2017	6	1
	<i>Total</i>	<i>8</i>	<i>3</i>
<b>Total</b>	2015	-1,0513	39
	2016	-0,2424	33
	2017	-0,5385	39
	<i>Total</i>	<i>-0,6306</i>	<i>111</i>

Notable in Table 11.11 is the client auction model, for which there are just three observations across 2016 and 2017 in total. Each of these observations is however an almost optimal improvement in their self-reliance - going from a scores between 1 and 3 to scores of 9 or 10. The overall F-test (Table 11.11) revealed significant differences in the groups. However, while we hypothesize better results with respect to effectiveness in every one of the new commissioning models, the catalogue model with outcome-based contracts actually consistently showed the biggest decline in perceived effectiveness in every year. Furthermore, the extreme values of the client auction model may disturb the analysis.

**Table 11.11** - ANCOVA for perceived service effectiveness including the commissioning models and control variable for year of participation.

Source	SS	df	MS	F	p	Eta
Main Effects						
Comparison groups (1, 2, 3, 4, 5)	219,97	4	54,993	6,284	<b>0,000</b>	0,202
Covariates:						
Year of participation	1,98	2	0,99	0,113	0,447	0,002
Interaction groups * year of participation	74,27	5	14,853	1,697	0,071	0,079

*Notes: SS = Sum of squares, df = degrees of freedom, MS = Mean square difference, F = F-value of the ANCOVA Analysis; p = significance level (two-sided); Eta = Partial Eta Squared*

Contrast testing revealed that indeed the significant effect is that between the client auction model and the AWBZ-model. However, with only three observations this group cannot be considered representative for the population. Furthermore, the contrast analysis showed that the catalogue model with outcome-based contracts also significantly differs from the AWBZ-model, yet not in the direction that was hypothesized. Therefore, H2 is rejected.

**Table 11.12** - Contrast analysis perceived service effectiveness including the commissioning models and control variable for year of participation.

1 - AWBZ	2 - Population-based comm.	3 - Catalogue model / fee-for-service	4 - Catalogue model / outcome based	5 - Client auction model	2 vs. 1		3 vs. 1		4 vs. 1		5 vs. 1	
					Diff.	p	Diff.	p	Diff.	p	Diff.	p
M	M	M	M	M	0,25	0,349	-0,08	0,382	-1,6959	0,049	8,25	0,000

*Notes: Group 1 (fee-for-service) is used as contrast group; M = Group mean of difference in client satisfaction; Diff. = Difference between groups; p = Significance level of difference (two-sided)*

The analysis here revealed another interesting – and unexpected – finding. With respect to client *satisfaction* with care services (see Section 11.4.1), both variants of the catalogue model ranked significantly better than the AWBZ-model. Client satisfaction is considered a suitable proxy for quality in the context of social care (Bergman et al., 2018). However, the quality of a service clearly stretches beyond mere client satisfaction: I argue the primary aim of social care services is to achieve an effect in terms of improved self-reliance. After all, these are the fundamental goals of the Wmo 2015. Interestingly, Table 11.12 demonstrates that both versions of the catalogue-model ranked worse than the AWBZ-model with respect to perceived service effectiveness (although only group 4 - Catalogue model with outcome-based contracts differs significantly). So, while clients are more satisfied in the catalogue-model, they perceive care services to be less effective. This raises the question whether client satisfaction actually is a suitable proxy for service quality, which – besides in academic literature – is also common practice among municipalities. A follow-up analysis into the correlation between satisfaction and perceived effectiveness is discussed in Section 11.4.3.

#### *Reimbursement methods versus effectiveness of social care*

In total, 110 valid cases reported on average a decreased self-reliance of 0,5 points: see Table 11.13. Similar to the differences reported between commissioning models with respect to perceived effectiveness, the means of the fee-for-service reimbursement and outcome-based reimbursement are contrary to the hypothesis. Outcome-based bundled payment reimbursement was hypothesized to lead to better effectiveness compared to fee-for-service reimbursement. However, the difference reported by clients in fee-for-service municipalities before and after the reform is actually positive (+0,05), and the clients in outcome-based municipalities report a substantial decline (a mean of -1,58) in self-reliance. Again, population-based budget municipalities are only represented by two cases, and therefore not discussed further.

**Table 11.13** - Differences in perceived service effectiveness per reimbursement method and survey year

Reimbursement method	Year of second measurement	Mean difference to 2014	N
Fee-for-service	2015	-1	26
	2016	0,1154	26
	2017	1,35	20
	<i>Total</i>	<i>0,0556</i>	<i>72</i>
Population-based budget	2015	-2	1
	2016	0	1
	<i>Total</i>	<i>-1</i>	<i>2</i>
Outcome-based bundled payments	2015	-0,9231	13
	2016	-1,8333	6
	2017	-2	17
	<i>Total</i>	<i>-1,5833</i>	<i>36</i>
Total	2015	-1	40
	2016	-0,2424	33
	2017	-0,1892	37
	<i>Total</i>	<i>-0,5</i>	<i>110</i>

**Table 11.14** - ANCOVA for perceived service effectiveness including the reimbursement methods and control variable for year of participation

Source	SS	df	MS	F	p	Eta
Main Effects						
Comparison groups (1, 2, 3)	64,20	2	32,1	3,194	0,023	0,059
Covariates:						
Year of participation	9,92	2	4,96	0,494	0,306	0,01
Interaction groups * year of participation	53,78	3	17,926	1,784	0,078	0,05

**Table 11.15** - Contrast analysis perceived self-reliability versus reimbursement method

1 - Fee for service	2 - Population-based budget	3 - Outcome-based bundled payment	2 vs. 1		3 vs. 1	
M	M	M	Diff.	p	Diff.	p
<i>0,056</i>	<i>-1,000</i>	<i>-1,583</i>	<i>-1,06</i>	<i>0,278</i>	<i>-1,64</i>	<i>0,007</i>

Notes: Group 1 (fee-for-service) is used as contrast group; M = Group mean of difference in client satisfaction; Diff. = Difference between groups; p = Significance level of difference (two-sided)

The overall F-test revealed that there are statistically significant differences between the groups, yet opposite to how it was hypothesized. The contrast analysis – Table 11.15 – illustrated that indeed the outcome-based bundled payment method corresponded to significantly lower perceived self-reliance compared to fee-for-service payment. It was expected that more outcome-based reimbursement methods would lead to more effective service provision. H3 is therefore rejected.

A possible explanation relates to the risk of these more outcome-based reimbursement methods of under provision by care providers. As discussed in Section 11.2.3, outcome-based reimbursement on the one hand provides opportunities and incentives for more efficient and effective provision of health and social care services (Miller, 2009; Porter & Kaplan, 2016). On the other hand, stepping away from the unambiguous fee-for-service reimbursement method with clear entitlements in time units (e.g. hours) to social care services also opens the door for opportunistic care providers to underperform (skimp). Care providers are not required to provide care services in fixed time units and may therefore reduce their efforts, which will likely lead to reduced rather than improved effectiveness. Hypothesis 3 relating to the effect of outcome-based reimbursement was optimistic, assuming non-opportunistic care providers that would use the incentives, increased flexibility, and focus on outcomes to achieve required outcomes ('self-reliance') more effectively. The data and subsequent statistical analyses suggest this optimism was neither appropriate nor realistic. Rather, the findings suggest the actual response of care providers was to use the increased flexibility to reduce their efforts. It is possible that the strong budget cuts – creating a context in which every care provider has to fight for its survival – had a moderating effect on the care provider response to the introduction of outcome-based reimbursement of social care services.

#### **11.4.3 Client satisfaction unsuited as proxy for service quality in Dutch social care**

Comparing the findings of the group effects of commissioning models with respect to client satisfaction on the one hand and client perceived self-reliance on the other, revealed that clients are more satisfied when experiencing less self-reliance compared to the baseline model. This paradox undermines the common assumption (Bergman et al., 2018; Johansson et al., 2002) that client satisfaction with care services is a reliable proxy for social care service quality in general. This finding supports earlier calls for more research into the use of client satisfaction as an at-

tribute of health care quality (Cleary & McNeil, 1988). Of course, client satisfaction is important in the provision of social care services just as it is important in commercial service delivery. However, I argue the services provided with public funds on the basis of national legislation to support self-reliance for those in need should primarily be effective in attaining the goal of improved self-reliance.

To further analyze the relation between client satisfaction scores and client perceived self-reliance scores, I calculated the correlation between the satisfaction and self-reliance differences between the matched 2014 measurement and the post-reform measurement. Comparing the observed differences between pre- and post-reform satisfaction to the observed differences in pre- and post-reform self-reliance demonstrates whether clients of social care who perceived themselves more self-reliant also reported an improvement in satisfaction with the services. Not every respondent with a matched pre- and post-reform response for satisfaction also reported a matched response for self-reliance – in total 104 matched cases responded for both satisfaction and self-reliance. Figure 11.1 shows that a correlation between the difference in satisfaction and the difference in self-reliance is almost completely absent.

## **11.5 Discussion and conclusion**

This research makes three contributions. First, the research evidences that commissioning social care according to 'open models' such as the catalogue model leads to higher client satisfaction with social care compared to the AWBZ-model with limited choice. Second, the research finds outcome-based reimbursement does not lead to improved effectiveness of social care services – at least not in a context of strong budget cuts. Third, client satisfaction with social care services is found not to correlate with the effectiveness of social care services to achieve improved self-reliance. Therefore, based on this analysis, client satisfaction may not be suitable as a single measure for the quality of social care services as assumed in many studies on the quality of social care services. Each of the findings is discussed in more detail.



**Figure 11.1** - Scatter Plot, trend line and explained variance (R<sup>2</sup>) for difference in satisfaction versus difference in perceived self-reliance

Clients are more satisfied with their social care services when a municipality commissions according to the catalogue model, both with fee-for-service reimbursed services and outcome-based reimbursement, compared to the AWBZ-model. The catalogue model is characterized by free client choice for care providers, municipal or third-party client case management, and the absence of volume caps that may lead to waiting lists for social care services. Open commissioning models such as the catalogue model rely on ex post competition over clients as a mechanism to foster quality, while commissioning models such as the AWBZ-model rely on ex ante competition over contracts and only offer limited choice to clients. Note that they are different mechanisms that can also be implemented in parallel, and both to a greater or lesser extent. For example, there is ex post competition if a client can choose between as little as two care providers, but the ex post competitive pressure increases when there are more alternatives. Interestingly, Bergman et al. (2018) demonstrated that having a wider choice among care providers improves client satisfaction in a context where clients had no other choice than government provision before a reform. This research demonstrates that moving from a model with limited choice (the AWBZ-model) to a model with virtually free choice (the catalogue model) still increases satisfaction. However, I argue the cause of the difference between the catalogue model and AWBZ-model likely extends beyond the

dimension of extended choice of care providers in the catalogue model alone. In the context of this study, the municipalities that opted for the AWBZ-model typically contracted the incumbent care providers, meaning existing clients generally maintained their current care provider (see Sections 4.3.1 and 5.3.3). Furthermore, this study uses only the satisfaction scores of existing clients receiving social care in December 2014. As existing clients value relational continuity of care, i.e. maintaining their existing caregiver (see for example Haggerty et al. (2003)), I argue improved choice among care providers may have been – on average – much less important for the respondents in this research. The respondents in this research are biased ‘away’ from valuing improved choice compared to the general population. Still, the catalogue model is associated with higher client satisfaction, suggesting that besides improved freedom of choice, the absence of volume caps and the organization of case management (independently of the care provider contracted for social care services) contribute to improved client satisfaction. More importantly, the increased ex post competitive pressures may lead to better perceived social care services. This is an interesting finding, which offers a new perspective to studies that argue increased choice is the cause for better perceived social care services, e.g. Bergman et al. (2018). As existing clients may be less sensitive to increased choice among care providers, the positive effect of commissioning according to the catalogue model compared to the AWBZ-model may be even stronger for new clients.

While outcome-oriented reimbursement methods reward efficient and effective service provision and allow innovative approaches to support clients, they are also more prone to care provider opportunism compared to fee-for-service reimbursement. With fee-for-service reimbursed social care, the care provider is rewarded or the volume of services provided. With outcome-oriented reimbursement methods, such as the population-based budget and outcome-based bundled payment, there is an incentive to achieve the desired outcomes (e.g. self-reliant citizens) with minimal efforts. Opportunistic care providers may minimize their efforts at the expense of service effectiveness. The findings of this research evidenced the latter risk may have been dominant, as clients reported a substantial decline in self-reliance in municipalities with outcome-based bundled payment reimbursement – significantly different compared to fee-for-service reimbursement. It is expected that the context of the budget reductions that were introduced together with the social care reform had a moderating effect. The decentralization of social care came with budget cuts ranging from 12 to 32 percent, depending on the specific type of care (Rijksoverheid, 2014). Municipalities passed these budget cuts onto the care providers, reducing their annual budgets and – in situations both with or without

contracted budgets – reducing service tariffs. In this context care providers were fighting for survival, and they may have perceived the reduction of their effort as the only way out. Another possible explanation is that Dutch municipalities – introducing outcome-based reimbursement methods for the first time – did not implement adequate outcome-based contracts. Possibly the incentives to reduce quality outweighed the direct (in effect, monetary) or indirect (for example, reputational damage) penalties associated with bad performance.

Furthermore, I find that client satisfaction and perceived service satisfaction are uncorrelated. Clients reported either improved, similar, or reduced satisfaction regardless of whether their self-reliance was improved, stable, or reduced. One remark should be made. Many clients of social care services need support because of old age, or because they cope with a mental or physical handicap. Limitations related to old age or permanent handicaps cannot be cured, and clients may even have to accept that over time their limitations will worsen and their self-reliance will further reduce. In those cases, even the best possible social care services cannot turn the tide for these clients. This implies that a situation where a client is very satisfied with social care services despite a declining self-reliance is not necessarily inconsistent. However, only 44 percent of the respondents actually reported a decreased self-reliance; 20 percent of respondents reported no change and 36 percent of respondents reported an improved self-reliance, with even some scores of almost optimal improvements. In this situation, the lack of correlation between satisfaction and self-reliance at least suggests that client satisfaction alone is not a reliable proxy for the quality of social care services after all. This finding is in line with other studies that found client satisfaction to be much stronger predicted by care provider behavior (especially politeness and respect), rather than care provider competence (Aldana et al., 2001). This also implies that while open commissioning models – emphasizing ex post competition rather than ex ante – lead to improved client satisfaction, they are not more effective in improving a client's (perceived) self-reliance. This finding calls for a debate: an increasing emphasis on measuring client satisfaction in social (and health) care services fits the paradigm of patient-centered care with many advocates, e.g. Cleary & McNeil (1988), Kitson, Marshall, Basset, & Zeitz (2013), Richards, Coulter, & Wicks (2015), and Stewart (2001). At the same time, and at least in the context of this study, client satisfaction is not correlated to improved self-reliance. The question is whether municipalities prioritize satisfied citizens or self-reliant citizens, and whether municipalities commission care services using the commissioning model that is most adequate for their priorities. Perhaps in a political context where citizens vote for the munic-

ipal council every four years, policy makers are more prone to commission what is valued best by their citizens, rather than what *works* best.

#### *Limitations and suggestions for further research*

Despite the substantial number of participants in the overall survey used as secondary data, the total number of valid cases in some of the groups in the difference-in-difference analysis was not sufficient for a reliable analysis with respect to those specific groups. The number of participants that participated in the 2014 survey and (at least) one of the measurements after the reform and who received the appropriate types of social care during both measurements were sufficient for the overall analysis. However, the population-based commissioning model, the client auction model, and the population-based budget reimbursement are so rare among Dutch municipalities that only a handful of participants represented these municipalities in this research. The effects of some of the statistical analyses would have been stronger when more respondents would have participated. Related, the findings of the general F-test analyzing differences between commissioning models in client satisfaction (not resulting in significant difference) compared to the outcomes of the subsequent contrast analysis (finding significant differences) is a weakness of the study. Clearly, the evidence of the analysis would have been stronger if the general F-test would have also been significant. Still, the contrast analysis provides a more detailed and sensitive test, supported by the improved satisfaction of clients in the catalogue models. Further research should include more respondents within each group of commissioning models and reimbursement methods.

Using matched cases with responses pre-reform and post-reform is considered a strong aspect of this research design, as it is not sensitive to variation that would stem from using a difference-in-difference design with repeated cross-sections. In the latter, different groups of respondents would be used at the two different points in time, and the random variation between the two samples would need to be accounted for. Having said this, existing clients may be biased compared to new clients. As discussed, existing clients may value keeping their existing caregiver most and not care as much about a more extensive choice for a care provider compared to new clients. Further research should also involve new clients. The measurement of the constructs client-satisfaction and client self-reliance with only one item is another limitation of this study.

The context of this study is framed by strong budget cuts that likely influence the behavior of care providers. I suggest this context makes care providers more prone

towards opportunistic behavior. Further research into outcome-oriented reimbursement methods in a context where budgets are not – or to a lesser extent – under stress could provide further insight in the impact such reimbursement methods may have on quality and effectiveness.

Finally, while this study explores the impact of commissioning on the perceived quality and effectiveness of social care, the impact of different commissioning models on the costs of social care is not included in this study. Adding a cost-perspective would allow analysis of the trade-off between quality and costs. Including both the quality and costs of social care as dependents of municipal commissioning would provide an even more extensive and complete overview of the impact of commissioning.



# Chapter 12

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**Epilogue: a bird's eye view of the findings and a call for further research**

The previous ten chapters have sketched the context and history of social care service coordination and regulation in the Netherlands. They have discussed the relevant regulations at EU and national level and presented the findings of empirical research concerning commissioning models, procurement procedures, contracts, and reimbursement methods used for outsourcing social care services by municipalities in the Netherlands in the period between 2015 and 2018. In addition, Dutch and Finnish regulations and procurement practices were also compared. Finally, the effects of commissioning models and reimbursement methods on the perceived quality and self-reliance of Wmo clients were statistically tested. In this final reflective chapter, I ‘zoom out’ to consider the bigger picture, to put the main findings into perspective, and to look forward by calling for new follow-up research.

## **12.1 Research findings in perspective**

### **12.1.1 A country in need for a long term sustainable social care system**

This research focused on a very interesting phase in time with respect to the coordination of adult social care services in the Netherlands. At the turn of the millennium, the Netherlands increasingly struggled with rising expenditure in social care services. The cost containment mechanism that had proved relatively successful before the turn of the century – only scarcely allowing care providers to expand their capacity, resulting in long waiting lists for care services – was swept off the table with a 1999 court ruling that clarified that long waiting lists were illegal under the AWBZ (Rb. Utrecht, nr. KG 105038 KG ZA, 1999). Consequently, expenditure on social care services sharply rose in the years thereafter, and in 2009 the *Sustainability Report* of the European Commission reflected that the Netherlands already had very high public expenditure on long term social care compared to all other EU countries. The expenditure as a percentage of gross domestic product (GDP) in the Netherlands in 2010 was projected at 3,5 percent, while the EU average was 1,3 percent (European Commission, 2009). Even more alarming, the report estimated a further growth – by a staggering 4,6 percent – to 8,1 percent of Dutch GDP for 2060. If the Netherlands did not respond to this development, its social care system would not be financially sustainable in the long run. Chapter 2 more extensively discussed the context leading up to the reforms of social care in the Netherlands.

Against this backdrop, the Dutch government moved to decentralize home care for the elderly (*huishoudelijke hulp*) to municipalities in 2007 with the introduction of the *Wet Maatschappelijke Ondersteuning* (Wmo), inspired by the Scandinavian health care system (Magnussen & Martinussen, 2016). In 2015, municipal responsibilities substantially increased by dismantling the AWBZ, adding other adult social care services to the Wmo, as well as all youth care services (which are outside the scope of this thesis). This entire operation was estimated to double municipal procurement volume. At the same time, as discussed in Chapter 3, municipalities were afforded extensive discretion with respect to the manner in which they could outsource these services. The Wmo 2015 was designed as a framework act; intended to secure basic citizen rights to social care and support while leaving ample discretion to municipalities to organize social care. And within EU procurement law, social services held (and continue to hold) a special position based on the specific local character of such services and the expected low percentage of cross-border trade for social services (see Chapter 3).

### **12.1.2 A multitude of procurement approaches – a live experiment**

This research has demonstrated that the context described above provided fertile ground for growing a wide variety of outsourcing approaches for social care services. Before the reform, both adult social care services as well as youth care were already outsourced completely. Care providers were annually contracted on the basis of fixed budget contracts with a fee-for-service system of accounting for the budgets. Contrary to many other countries, and in line with the NPM-adage of outsourcing services, in the Netherlands the provision of social care was already completely outsourced to external providers, yet the AWBZ-model of commissioning was associated with inefficiencies and perverse incentives (see Sections 4.3.1 and 5.3.3). Since 2015, within a few years' time almost all municipalities abandoned the traditional commissioning approach that was used throughout the Netherlands under the AWBZ, introducing four new commissioning models (and many small variations within these models); see Chapters 4 and 5. In a similar fashion, municipalities used a variety of different procurement procedures for outsourcing social care services, and, borne in the legal discretion for social care services, *custom procurement procedures* became particularly popular (see Chapters 6 and 7). Municipalities introduced a range of new mechanisms to support the reform goals to achieve more tailored and integrated care while reducing (the growth of) public expenditure. Dutch municipalities introduced a variety of new reimburse-

ment methods (see Chapter 8 and 9), relational approaches to contracting care providers, and competitive mechanisms (see Chapters 4 to 9). The variation does not end here; many details of the hundreds of contracts I collected and analyzed for the empirical analyses presented in this thesis were only mentioned in passing or were not featured at all. For example, municipalities procure social care services alone or in procurement collaborations ranging from 2 to 20 different municipalities. Municipal social care contracts differ substantially with respect to dimensions such as the contract duration (one year to ten years and even undefined durations), tariffs per service, the number of different care services contracted (from three to thirty services within the same type of social care), and the quality criteria applied.

Despite the wide variety of different approaches, this research revealed that the overwhelming majority of municipalities adopted new competitive mechanisms in outsourcing. Contracts no longer guarantee annual turnover: in over 97 percent of Dutch municipalities, client choice dictated care provider revenues in 2018 (see Chapter 4). And while fee-for-service remains the dominant method to pay for social care services, as of 2018 41 percent of Dutch municipalities adopted outcome-based reimbursement (outcome-based bundled payment or population-based budgets). It is safe to say that from the perspective of professional care providers, within a few years' time the world had completely changed. Instead of managing fixed budgets, providers now have to compete for clients in an open ended (framework) contract or open house system. In many municipalities, other activities such as client case management and coordination of care between local care providers, which were formerly outsourced to the care providers, are now performed by the municipality or through a separate entity (for example the social community team). The former comfortable position of care providers – enjoying a position of certainty and control – has changed extensively in most municipalities.

The variation in procurement approaches by municipalities for outsourcing the same services at the same point in time, under the same rules and in the same context, provide for a very interesting research context. The situation can be considered a live experiment, facilitating the study of the effects of different commissioning models and procurement approaches on outcomes such as expenditure, and service quality. Chapter 11 presents such an empirical study of the effects of commissioning on the perceived quality and effectiveness of social care services. This study illustrated that procurement choices with respect to the competitive mechanism and the reimbursement method do in fact impact care provider behavior to some extent. More research is necessary to develop a deeper understanding

of the impact commissioning choices have in the short and long run with respect to care provider market development, client choice, expenditure, social care consumption, working conditions and employment rates in the social care sector, care service quality, and innovation of care services.

This research contributes to the body of knowledge concerning commissioning models among scholars as well as practitioners in the Netherlands and abroad. This adds depth to in-house versus outsourcing discussion, and adds detail to the NPM perspective of externalizing public services – see Hood (1995) – by acknowledging the different ways (social care) services can be outsourced, each commissioning model and procurement procedure with their own benefits and risks. In this research, the commissioning models, reimbursement methods, and procurement procedures have been systematically defined, categorized, and positioned within relevant theories. In addition, the research in Chapter 11 is a first step towards answering prominent questions such as ‘which commissioning model works best’ in relation to the goals of the social care reform. In Section 12.2 I suggest more research that is necessary for municipalities to make informed decisions based on facts and sound research.

### **12.1.3 How do municipalities choose their approach?**

The variety of commissioning models and procurement approaches on the one hand reflects different political views and public management approaches with respect to coordinating municipal responsibilities. Some municipalities believe that professionals of external care providers should be involved as early as possible, and that main contractor care providers – selected using a competitive procurement procedure – are better at coordinating the market than the municipality. Other municipalities believe that they should coordinate the market and organize client case management in-house. On the other hand, despite how these rational arguments are visible in the policy and procurement documents of some municipalities, it appears the majority of the Dutch municipalities did not make a completely rational decision with respect to commissioning model, procurement procedure, legal outsourcing instrument, and all of the other relevant dimensions discussed extensively throughout this thesis, based on complete knowledge of all available options. The paragraphs in the procurement documents explaining assumptions and policy goals of different municipalities were often difficult to distinguish from another – even though these municipalities often chose a different commissioning

model. I found substantial evidence in the contracts that some municipalities often mimicked approaches from others, for example by literally copying entire sections of contracts. Especially in the first round of outsourcing (2015), the commissioning model and procurement procedure used in a municipality seemed to be better predicted by the external consultant hired to advise on the process, rather than by the individual policies and political views of the municipality. In an early (unpublished) study on the relationship between the political party of responsible municipal alderman and the 2015 commissioning model for social care of the municipality, I found these two not to correlate at all. Of course, decision processes concerning the commissioning model and other procurement choices become more complex when the size of these collaborations grows and each individual municipality has a vote.

#### **12.1.4 More research is paramount for sound commissioning decisions**

As complex as these decision processes may be, having an overview of different potential models with their advantages and risks should be the starting point of a decision process. This introduces another problem: how can this knowledge be adequately dispersed from academic research into the world of practice? Unless we develop more insights into the impact of commissioning models – and which factors may influence these conditions – municipalities remain reliant on ‘best guesses’, their own experiences, and the experience of other municipalities (the approaches that are ‘trending’).

With respect to this latter source of information, a warning is in place. Some municipalities – especially the ones that have adopted more extreme commissioning models – promote their own approach to other Dutch municipalities as the panacea for all problems and challenges associated with the coordination of social services. On practitioner conferences, social media, events, and working visits these municipalities share their experiences, presenting their approach as (self-declared) ‘best practice’. The manner in which some municipalities present their commissioning model seems biased, and aimed more towards defending or finding support for their approach rather than to provide an objective representation of their experiences. In this perspective it is even more problematic that rigorous academic research with respect to the impact of commissioning choices on the relevant outcomes (quality and costs of social care services, market conditions and working

conditions in the social care sector; et cetera) is still rare.

It is of course advisable to study procurement practices in countries that have more experience with decentralized social care. However, scholars in search of cross-country learning in public procurement have failed to find evidence that countries learn from each other (Nijboer et al., 2017). Exemplary in this respect is the fact that Dutch municipalities struggled to find a sound legal basis for existing procurement practices (in effect, open contracting schemes) after the implementation of EU Directive 2014/24, while in Finland a national law was passed as early as 2009 that uses the national discretion provided for by EU law for such systems. Initiatives such as IRSPP (the International Study of Public Procurement – see [www.irspp.wordpress.com](http://www.irspp.wordpress.com)) that bring together scholars and practitioners in public procurement are highly important in this respect. And, as Fotaki (2007) evidences, countries even easily forget to learn from their own past experience. The Netherlands may be at risk here. As discussed in Chapter 2, the AWBZ system led to an unsustainable increase in expenditure – in part associated with the AWBZ-model. All but a handful of municipalities have in the past four years abandoned this model. However, municipal expenditure on social care is not decreasing as much as anticipated. While the increased volume of care provision and consequent expenditure in many municipalities may not primarily relate to their new procurement practices (e.g. rather their coordination of social care teams), municipalities must resist the urge to revert back to AWBZ procurement practices.

## **12.2 Call for further research (and knowledge dissemination)**

Further research into the commissioning of social care services is necessary to better understand how new commissioning models work out in practice. The government bodies responsible for commissioning social care in countries such as the Netherlands are in dire need of better and more comprehensive, objective insights into the workings of commissioning models, procurement procedures, and reimbursement methods in the social and health care sector. Rigorous research is necessary to develop these insights, which will help municipalities and public financiers of social care in general to adequately cope with increasing needs for social care services and to maintain a long-term sustainable social care system. Within the context of the Netherlands, I highlight two areas where further research is particularly necessary. These two areas are discussed in the next subsections:

- More insights are necessary into the dynamics and effects of new commissioning models and legal instruments, such as the open house model currently observed in the Netherlands on the quality of social care services and municipal expenditure on these services.
- The rules for municipalities for commissioning care are not static; examples are provided below. How can municipalities adequately deal with new rules and concrete interpretations of existing laws in case law?

### **12.2.1 Commissioning models versus the affordability of social care – a paramount part of the puzzle?**

For adult social care services, the commissioning models used by the majority of municipalities (the catalogue model with either fee-for-service or outcome-based bundled payment; see Chapter 5) and legal contracting instruments (the open house model; see Chapter 7) revolve around ex post competition. The same holds for youth care services, which were also decentralized in the Netherlands in 2015 (Uenk et al., 2018). As argued in Chapter 8, ex post competition resulting from outsourcing with framework agreements or open house systems may offer strong incentives against care provider opportunism. This may help avoid undesirable care provider behavior that leads to reduced service quality or inflated costs. However, contracting care providers so abundantly in an open-ended system (in effect, there are no budget agreements) may provide opportunities for supplier-induced demand. A recent study of Dutch social community teams (*sociale wijkteams*) responsible for citizen scrutiny studied the allocation of professional social care by these teams, distinguishing teams with and without personnel of the contracted care providers. While generally the social community teams were established to reduce the allocation of professional social care services, the study demonstrated that in fact the volume of social care grew. More striking still, the growth of municipalities with teams involving professional care givers was twice as high compared to municipalities with ‘in-house’ social care teams (Eijkel et al., 2019). This study did not include the type of contracts used by municipalities, nor the reimbursement method used for the corresponding types of social care services. More comprehensive quantitative models, including independent variables such as the commissioning model, reimbursement method, (relational) procurement approach, and dependent variables such as the quality and costs of social care services should be tested. Such analyses would provide insights into whether indeed open contracting schemes such as the open house model – when applied for complete outsourcing

(as opposed to complementing in-house provision such as in Finland; see Chapter 10) – lead to increased service volumes.

Another interesting area of further research is the extent to which ex post competition truly provides incentives for providing better quality social care services, for preventing care provider opportunism, and whether open contracting schemes affect the volume of care services and the related municipal expenditure. Do clients of home care indeed switch to a different care provider when the perceived service quality deteriorates? And how about clients of more specialized types of care or more complex types of impairments; is there a difference in client mobility? And does it matter whether clients actually switch in response to deteriorating care services, or is the risk of losing clients in itself an adequate incentive for care providers to maintain a sufficient level of quality? Some Dutch municipalities are considering to publish client satisfaction ratings of the contracted care providers on public websites to inform new clients when they decide on a care provider. What impact would such initiatives have on care provider behavior? How do clients in general decide on their care provider of choice? And are clients of all ages and social backgrounds capable of making rational and optimal choices? What information and support are necessary to accommodate their choices, and is this information and support adequately provided in the municipalities opting for an open house system? In short, there still is a lot to study with respect to current commissioning practices for Dutch social care services. This research is relevant to other countries with comparable challenges and social and economic systems.

### **12.2.2 Commissioning under ongoing developments in the legal framework**

Early on in the social care reform, clients, municipalities, and care providers faced initial problems caused by the transition. For example, some municipalities struggled to correctly manage citizen scrutiny at the expense of citizens in need of social care. Also, care providers were faced with much more administration in order to get contracted and to implement these contracts. Local small care providers formerly contracted by one regional care center (*Zorgkantor*) now had to simultaneously participate in a range of different municipal tenders, and larger regional or national operating care providers were contracting with up to 100 different municipal procurement collaborations. Each municipal procurement collaboration used their own new product codes, quality criteria, invoicing procedures, et cetera.

As a consequence, the administrative costs of care providers grew dramatically. Furthermore, a 2015 analysis of the tariffs used by municipalities for certain social care services revealed differences among municipalities of up to 100 percent for the same services (Koster, 2015). These are examples of issues that were repeatedly discussed in the Dutch House of Representatives, leading to proposed modifications of the Wmo 2015. Initially, the central government administration that introduced the Wmo 2015 was quite successful in blocking such modifications (through decrees), arguing these problems were a consequence of the transition, and only temporary in nature. Despite these efforts to block modifications to the rules early on, a first decree was passed in 2016, defining in detail the cost parameters municipalities must take into account when calculating a fair price to pay for social services (*the 'AMvB Reële Prijs Wmo'*, see Section 3.5 for details). This decree proved to have quite a dramatic effect on procurement practices for household support services – the service decentralized first in 2007. A recent case study revealed that municipality-care provider dialogues in recent tenders for these services are dominated by extremely detailed discussions over price components, e.g. whether the realistic percentage of overhead costs should be 14 or 16 percent (KPMG, 2018). At the start of 2019, an amendment of the Wmo 2015 was passed in the Senate of the Dutch Parliament (*'Wijziging van de Jeugdwet en de Wet maatschappelijke ondersteuning 2015 en de Zorgverzekeringswet in verband met het handhaven van de mogelijkheid om gemeenten in uitzonderingsgevallen tot samenwerking te verplichten en in verband met het verminderen van uitvoeringslasten'*, 34 857, 22-01-2019). This amendment of the Wmo 2015 (and other care-related acts) forces municipalities to further reduce the administrative burden for care providers. The amendment also grants the responsible ministry discretion to force municipalities to collaborate in the organization and procurement of social care services. Furthermore, citizens' appeals led to administrative case law; this is discussed in Section 3.7 with respect to outcome-based care entitlements.

These developments in legislation each decreased the legal room for manoeuvre for municipalities in coordination and outsourcing of social care services. Additional stricter rules with respect to calculating prices for services generated a stronger position for care providers vis-à-vis the municipalities. The fact that municipalities may now be forced to collaborate causes a tension with the principle of decentralization, reducing the individual discretion of municipalities. The CRvB case law discussed in Section 3.7 severely reduces possibilities for functional specification of social care contracts and working with outcome-based reimbursement methods, which many considered a key instrument to achieve a more efficient so-

cial care system. In this dynamic context, it is highly relevant to monitor and analyze how each of these developments impact on commissioning practices and the consequent effects on the provided services and expenditure. It is highly important to study whether these new amendments prove to be effective, and whether these new rules do not introduce new barriers for municipalities to achieve the goals of the reform.

### **12.2.3 Final conclusion**

Dutch municipalities have introduced substantial innovations in terms of how social care services are commissioned. Using ex post competition, outcome-based reimbursement methods, relational contracting procedures, and long-term contracts at this scale for complete outsourcing of the extensive scope of social care services to my knowledge is unprecedented both within the Netherlands and across the European Union. It is crucial to study the effects of these new commissioning approaches while appreciating that certain effects of the new commissioning models may take years to materialize. The Dutch reforms of adult and youth social care offer a unique context for studying purchasing problems, since, as noted before, the context can be considered a live experiment. It would be a waste not to use this opportunity.

With respect to the Netherlands, I have discussed in this chapter a recent trend towards less municipal discretion and more regulation from the central government, already initiated three years into the reform. The central government should of course act when it serves the public interest, to prevent accidents, or when the basic rights (e.g. social inclusion, social support, and equal treatment) of Dutch citizens are at stake. I argue it is equally important to keep recognizing that local discretion for municipalities to coordinate social care services is the foundation of the entire decentralization operation. It is perhaps a political reflex – certainly in times of elections – to call for new and additional regulations in response to incidents. However, limiting municipal discretion, for example with respect to adopting outcome-based reimbursement methods, may obstruct innovations necessary to achieve the long-term sustainable social care system of which the Netherlands, like so many other countries, is in dire need.



# Nederlandse samenvatting

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## 1. Inleiding

Dit onderzoek heeft tot doel om inzicht te verschaffen in de wijze waarop opdrachtgeverschap voor sociale zorgdiensten ingericht kan worden, en hoe deze inrichting van opdrachtgeverschap – bekeken vanuit een theoretisch kader, en empirisch geanalyseerd - kan bijdragen aan het bereiken van de doelstellingen van de opdrachtgever. Overheden, verantwoordelijk voor de organisatie van de gezondheidszorg voor haar inwoners, zoeken in tijden van vergrijzing naar een financieel toekomstbestendige inrichting van langdurige sociale zorg. In veel westerse landen besteedt de overheid sociale dienstverlening deels of geheel uit aan externe zorgaanbieders. Met deze sociale zorgdiensten ondersteunen zorgaanbieders inwoners om de nadelige gevolgen van ouderdom of een beperking te verminderen of weg te nemen. De inrichting van opdrachtgeverschap in het sociaal domein draagt stevig bij aan de mate waarin doelstellingen zoals een goede kwaliteit en beschikbaarheid van zorg tegen acceptabele kosten behaald worden. Gedegen inzicht in het opdrachtgeverschap in het sociaal domein (in dit onderzoek: modellen van opdrachtgeverschap) is onontbeerlijk om het sociaal domein toekomstbestendig in te richten.

Dit onderzoek is uitgevoerd in een unieke context: de decentralisatie van de Algemene Wet Bijzondere Ziektekosten (AWBZ) naar Nederlandse gemeenten in 2015 en de jaren daarna. Met de invoering van de Wet Maatschappelijke Ondersteuning 2015 (Wmo 2015) werden de destijds 393 Nederlandse gemeenten elk individueel verantwoordelijk voor sociale ondersteuning voor mensen met een ondersteuningsbehoefte. De gemeenten kregen ruime beleidsvrijheid, bijvoorbeeld ten aanzien van in- of uitbesteding van sociale zorgdiensten en de inrichting van opdrachtgeverschap. Deze context kan gezien worden als een 'live' experiment, waarin gemeentes vanuit dezelfde uitgangspositie verschillende keuzes maken in de inrichting van het opdrachtgeverschap in het sociaal domein. Dit onderzoek combineert (1) een juridisch perspectief, (2) een bestuurskundig perspectief, en (3) een bedrijfskundig 'inkooptechnisch' perspectief op de inkoop van sociale zorgdiensten. Diverse hoofdstukken in het onderzoek vertrekken vanuit agency theorie en dienstentriades als theoretisch kader. Het onderzoek brengt de modellen van opdrachtgeverschap en inkoopprocedures in beeld die door gemeentes zijn gehanteerd voor de uitbesteding van sociale zorgdiensten tussen 2015 en 2018, door het verzamelen en analyseren van gemeentelijk inkoopdocumenten. Het onderzoek levert zo een bijdrage aan de wetenschappelijke kennis over de mogelijkheden, kansen, risico's en effecten van opdrachtgeverschap van sociale zorgdiensten.

## 2. Regulering van sociale zorg in Nederland

Dit hoofdstuk brengt de recente ontwikkeling in kaart van de wijze waarop sociale zorgdiensten in Nederland zijn gereguleerd. Sociale zorgdiensten zijn diensten gericht op het ondersteunen van individuen met een ondersteuningsbehoefte die voortvloeit uit ziekte, beperking, handicap, ouderdom, om deel te nemen aan de maatschappij en zo zelfredzaam mogelijk te leven. Het gaat hier om zorgdiensten als begeleiding, dagbesteding, hulp bij het huishouden en respijtzorg. Deze sociale zorgdiensten werden vanaf 1968 gefinancierd vanuit de AWBZ, een algemene verzekering waar iedere inwoner van Nederland een beroep op kon doen. Onder de AWBZ werden sociale zorgdiensten ingekocht bij externe (private) zorgaanbieders. Zorgkantoren contracteerden op jaarlijkse basis enkele tientallen grote zorgaanbieders op basis van een stelsel van honderden gespecificeerde diensten (elk met een 'NZA-code'), en jaarlijks per zorgaanbieder vastgestelde budgetten. Onder de AWBZ werd zorg op basis van inzet vergoed: bijvoorbeeld een vergoeding per uur begeleiding.

Onder de AWBZ stegen de kosten van deze zorg zo snel dat dit op lange termijn niet duurzaam vol te houden was. Tevens waren er problemen met wachtlijsten en gebrekkige samenwerking tussen zorgaanbieders. Om deze problemen het hoofd te bieden werd dit zorgstelsel in Nederland stevig herzien. In 2007 werd de Wet Maatschappelijke Ondersteuning geïntroduceerd. De gemeente werd in Nederland verantwoordelijk voor de zorgvorm 'hulp bij het huishouden'. In 2015 werd de dekking van de Wmo uitgebreid met begeleiding, dagbesteding, respijtzorg en beschermd wonen. Uitgangspunten van de Wmo 2015 waren een lokale inrichting van het zorgstelsel, zorg op maat voor de cliënt en het uitgaan van de mogelijkheden van de inwoner in plaats van de beperking. De veronderstelling was dat deze zorg op deze wijze ook goedkoper wordt ingericht.

## 3. EU en Nederlandse wetgeving ten aanzien van opdrachtgeverschap voor sociale diensten

Hoofdstuk 3 analyseert de wetgeving ten aanzien van het inkopen van sociale zorgdiensten door Nederlandse gemeenten: de Europese en nationale aanbestedingsregels, de bepalingen ten aanzien van zorginkoop in de Wmo 2015, en bepalingen in de Algemene Wet Bestuursrecht (Awb) die uitwerking hebben op gemeentelijke zorginkoop. De Europese aanbestedingsregels beogen elke vorm van discriminatie

tussen ondernemers uit verschillende lidstaten te voorkomen, om zo de interne Europese markt te voltooien. Onder de Europese Richtlijnen voor overheidsopdrachten 92/50/EEG en 2004/18/EG bestond er echter een uitzonderingspositie voor overheidsopdrachten voor onder andere sociale diensten. Deze '2 B diensten' waren uitgezonderd van de gehele reikwijdte van de Richtlijn wegens het gering geachte grensoverschrijdende belang. Naast de fundamentele regels van het gemeenschapsrecht gold voor deze overheidsopdrachten enkel de verplichting om de gunningsbeslissing achteraf mee te delen aan de Europese Commissie. In EU Richtlijn 2014/24/EU introduceerde de Europese wetgever voor sociale en andere specifieke diensten een nieuw (nog steeds lichter) regime, met verplichte transparantie vooraf voor opdrachten die de (hogere) drempelwaarde van € 750.000 overschrijden. Voor de Nederlandse gemeentelijke zorginkoop is verder specifiek de jurisprudentie van het HvJ EU relevant, over een systeem dat kenmerken vertoont van een vergunningstelsel en dat 'open house' wordt genoemd. Dit open contracteringssysteem (open house) en de interpretatie daarvan door het Hof van Justitie van de EU in de zaken Falk (2016) en Tirkkonen (2018) is zeer relevant voor de Nederlandse situatie. De open contracteringssystemen in die zaken vertoont namelijk grote overeenkomsten met bestaande inkooppraktijken in het Nederlandse gemeentelijke sociale domein. Kort samengevat concludeerde de Europese rechter dat er geen sprake is van een aanbestedingsplichtige overheidsopdracht op grond van de richtlijn overheidsopdrachten 2014/24/EU wanneer een overheid – zonder rangschikking en selectiviteit – overeenkomsten sluit voor dienstverlening met alle kwalificerende aanbieders die aan de tevoren vastgestelde objectieve en niet-discriminerende voorwaarden voldoen. Wel benadrukte het Hof in lijn met zijn talloze jurisprudentie over gelijke rechten en vrij verkeer bij vergunningstelsels dat wanneer er sprake is van grensoverschrijdend belang ook deze systemen onder de werkingssfeer van het Verdrag tot werking van de EU vallen. Dan zijn de fundamentele beginselen en vrij-verkeer bepalingen onverkort van toepassing.

De Wmo 2015 zelf heeft slechts enkele bepalingen ten aanzien van het inkopen van ondersteuning, waarvan de belangrijkste twee: (1) de verplichting om kwaliteit mee te wegen in de gunning van opdrachten, en (2) de verplichting om reële tarieven voor diensten vast te stellen. Tenslotte volgt uit jurisprudentie van de Centrale Raad van Beroep (CRvB) dat een gemeentelijk toekenningsbesluit voor ondersteuning aan een cliënt de toegekende zorg niet alleen in termen van resultaten, maar ook in termen van inzet (bijvoorbeeld uren) moet specificeren. Gemeenten mogen sociale diensten niet zuiver resultaatgericht aan cliënten beschikken, waarmee resultaatgericht inkopen geen effect meer sorteert. Met name deze

CRvB-jurisprudentie blijkt innovatie-gericht inkopen van zorg in de weg te staan, en niet de 'verplichte aanbesteding' van sociale diensten. Er is zowel binnen de Richtlijn 2014/24/EU (licht regime) als daarbuiten (open house) veel beslissingsruimte voor overheden die zorg inkopen.

#### 4. Modellen van opdrachtgeverschap voor sociale diensten

Steeds meer wetenschappers richten zich niet langer op de vraag *of* sociale diensten moeten worden uitbesteed, maar *hoe* uitbesteding het beste kan worden vormgegeven. Dit onderzoek beschrijft een viertal archetype benaderingen voor uitbesteding van zorg: 'modellen van opdrachtgeverschap', elk met voor- en nadelen. Het AWBZ-model sluit aan bij de inkooppraktijk van vóór de decentralisatie. Een selectief aantal grote zorgaanbieders wordt jaarlijks een contract gegund met een vast budget. Zorgaanbieders moeten de uitnutting daarvan middels de productie van gestandaardiseerde diensten verantwoorden. Het model garandeert continuïteit van zorg en is eenvoudig in te voeren. Echter, het model houdt bestaande problemen (wachlijsten, beperkte samenwerking tussen zorgaanbieders, en perverse volume opdrijvende effecten) in stand. Het tweede model is de populatie-gerichte bekostiging, waarbij de gemeente één of enkele hoofdaanemers contracteert. De hoofdaannemer ontvangt een jaarlijks *lump sum* budget en wordt verantwoordelijk voor het bieden van ondersteuning aan alle hulpbehoevenden in een wijk of soms hele gemeente. De hoofdaannemer heeft maximale ruimte en een financiële prikkel om de ondersteuning zo efficiënt mogelijk in te richten. Echter, het model introduceert een oligopolie of zelfs monopolie op de lokale zorgmarkt. Er is sprake van *vendor-lock in*, kleinere zorgaanbieders verdwijnen of worden afhankelijk van de hoofdaannemer, en er is geen keuzevrijheid voor cliënten tussen zorgaanbieders en veel cliënten verliezen hun huidige zorgaanbieder.

In het catalogusmodel sluit de gemeente raamovereenkomsten voor standaard diensten met alle geïnteresseerde gekwalificeerde zorgaanbieders. Een inwoner met recht op ondersteuning kiest uit het aanbod de zorgaanbieder naar wens. De raamovereenkomsten bieden geen omzetgarantie: er ontstaat 'concurrentie op de markt'. De diensten in de catalogus kunnen vergoed worden op basis van inzet (tijdseenheden) of uitkomsten. Het catalogusmodel laat nieuwe (vernieuwende) zorgaanbieders toe, en huidige cliënten kunnen hun zorgaanbieder behouden. De gemeente houdt in dit model de toegang gescheiden van de leverende zorgaanbieders, wat onafhankelijke toewijzing en monitoring mogelijk maakt. Er kunnen

zeer veel zorgaanbieders gecontracteerd worden, wat contractmanagement complex kan maken. De gecontracteerde zorgaanbieders hebben geen productieplafond, dus de toegang tot zorg bepaalt het zorgvolume en daarmee de uitgaven. In het veilingmodel maakt de gemeente per cliënt een casus-beschrijving en plaatst deze op een besloten marktplaats die enkel toegankelijk is voor gekwalificeerde zorgaanbieders. Zorgaanbieders moeten op de cliënt 'bieden' met een voorgesteld ondersteuningsplan en een prijs. De cliënt kiest op basis van de plannen samen met de gemeente welke zorgaanbieder wint. In een variant op het model is de zorg-toewijzing al vastgelegd, en bepaalt de veiling enkel de prijs. Het model maakt maatwerk mogelijk, laat (mede) de client kiezen, en geeft kansen voor specialistische kleine zorgaanbieders. Echter, een mini-veiling per cliënt brengt hoge administratieve kosten met zich mee, en het model is gevoelig voor politieke discussie over wenselijkheid van een zorgveiling.

## **5. Gemeentelijke keuzes in opdrachtgeverschap: vier jaar aan empirisch bewijs**

Op basis van de analyse van de inkoopdocumenten van 382 gemeenten voor de Wmo-diensten begeleiding, dagbesteding en kortdurend verblijf voor de jaren 2015 tot en met 2018 is voor al deze gemeenten in kaart welke keuzes zij maakten ten aanzien van het model van opdrachtgeverschap. In 2015, het eerste jaar van de decentralisatie, hanteerde nog 28% het AWBZ model. Ruim 60% koos één van beide varianten van het catalogusmodel, en een kleine minderheid populatiebesteding (4%) en het veilingmodel (3%). In de opvolgende jaren 2016 tot en met 2018 heeft slechts een deel van de gemeenten opnieuw zorg ingekocht. Het AWBZ-model is in de nieuwe zorginkoop in vier jaar tijd 'uitgestorven', ten bate van het catalogusmodel – waarbij de variant met inzetbesteding dominant blijft, maar het aandeel van resultaatbesteding tot aan 2018 steeds verder groeit. Er zijn na 2015 geen gemeenten die het veilingmodel kiezen, en elk jaar zijn er enkele gemeenten die overstappen naar populatiebesteding.

## **6. Inkoopprocedures voor de inkoop van sociale zorgdiensten**

In de wetenschappelijke bestuurskundige en inkooptechnische literatuur concentreren de voordelen van het uitbesteden van zorg aan externe zorgaanbieders zich rond het element van competitie, wat veronderstelt tot hogere kwaliteit van zorg

tegen lagere kosten leidt. Tegelijkertijd wordt het ‘traditionele’ competitieve aanbesteden door overheden in verband gebracht met nadelige effecten: het zou bureaucratisch zijn en onder andere een goede relatie met leveranciers in de weg staan. Er is behoefte aan inkoopbenaderingen met meer aandacht voor de relatie met de leverancier. Opmerkelijk is de eenzijdige benadering van competitie: namelijk ‘ex ante’ competitie om een contract te winnen. Ik maak hier het onderscheid tussen competitie ex ante en ex post. Onder het laatste versta ik competitie op de markt tussen gecontracteerde zorgaanbieders. Ik bestudeer de gehanteerde inkoopprocedures in het sociaal domein vanuit deze twee perspectieven: de relationele benadering en de wijze waarop gemeentes competitie inrichten. De grotere beleidsruimte van gemeenten om inkoop van sociale diensten in te richten (zie Hoofdstuk 3) maakt dit een geschikte context om inkoopprocedures te onderzoeken. In het empirische onderzoek observeer ik procedures die variëren in alle genoemde opzichten: van ex ante tot ex post competitie, en van traditioneel bureaucratisch tot nadrukkelijk relationeel. Gemeenten passen de volgende procedures toe: (1) een onderhandse procedure, waarin enkel zittende aanbidders worden uitgenodigd tot indienen van een offerte, (2) een open competitieve aanbesteding met gunning op prijs en kwaliteit, (3) een competitieve procedure met onderhandelingselementen (conform de uitgangspunten van ‘best value procurement’ - BVP), (4) de ‘Zeeuws model’ procedure waarin alle kwalificerende aanbidders een standaard-overeenkomst tekenen, en (5) een dialooggerichte procedure (‘bestuurlijke aanbesteden’) waarin over standaard-overeenkomsten plenair met zorgaanbidders wordt onderhandeld. Gemeenten maken met name bij de laatstgenoemde procedures – die niet als zodanig in de aanbestedingsregels zijn vastgelegd - gebruik van de ruimte die de Richtlijn 2014/24/EU voor sociale diensten laat.

## **7. Gemeentelijke keuzes voor inkoopprocedures voor sociale diensten tussen 2015 en 2018**

In dit hoofdstuk onderzoek ik de door gemeenten gehanteerde inkoopprocedures voor sociale zorgdiensten door documentanalyse van de inkoopdocumenten van 382 gemeenten in 2015 tot en met 2018. Voor de jaren 2016 tot en met 2018 kopen veel minder gemeenten ondersteuning in, omdat contracten veelal doorlopen. Voor de contracten per 2015 hanteert een grote meerderheid van de gemeenten ex post competitie: de Zeeuws model procedure (17%) en dialooggerichte procedure (55%). De onderhandse procedure wordt door 18% van de gemeenten gehanteerd, en de overige competitieve procedures vormen een kleine minderheid. De statis-

tieken bevestigen tevens het beeld dat gemeenten gebruik maken van de ruimte die aanbestedingsregels laten voor meer relationele dialooggerichte procedures. Naast de dialooggerichte procedure vindt er ook dialoog en onderhandeling plaats binnen de inkoopprocedure bij een deel van de onderhandse procedures en de competitieve BVP procedures.

Na 2015 worden de effecten van ontwikkelingen in het wettelijke kader zichtbaar in de keuzes van gemeenten ten aanzien van de inkoopprocedures. In 2016 implementeert Nederland de Richtlijn 2014/24/EU in de Aanbestedingswet 2012, en is het niet langer toegestaan om een onderhandse procedure te gebruiken voor drempel-overstijgende sociale dienstencontracten. Deze procedure wordt dan ook niet meer waargenomen voor de 2017 en 2018 contracten. Er is een lichte procentuele stijging van gemeenten die een open (competitieve) procedure hanteren, maar de niet-competitieve procedures blijven de boventoon voeren. Vanaf 2017 introduceert een deel van de gemeenten de toelatingsprocedure voor een open house model, in aansluiting bij het open contracteringsmodel in het *Falk*-arrest. Overigens vullen de betreffende gemeenten deze procedure op dezelfde wijze in als één van de andere niet-competitieve procedures.

## **8. Een dienstentriade perspectief op de inkoop van sociale diensten: het beheersen van uitdagingen**

Er is recent veel aandacht in inkoopliteratuur voor het inkopen van diensten in dienstentriades, waarbij de inkoper niet de ontvanger is van de dienst. Ik onderzoek als een van de eersten dienstentriades in een (sociale) zorgcontext, en ik beschrijf in dit hoofdstuk vanuit het theoretisch perspectief de risico's en beheersmaatregelen in de sociale zorgdienstentriade. De inkoop van diensten in een triade wordt geassocieerd met uitdagingen ten aanzien van kwaliteitscontrole, prestatie monitoring, en een slechte informatiepositie voor de inkoper. Deze driehoeksrelatie is bovendien niet constant: de inkoper start in een brugpositie tussen leverancier en eindgebruiker – met het voordeel van controle en informatie over alle partijen – maar wanneer levering van de dienst start, verzwakt deze brugpositie, en loopt de inkoper het risico dat zelfs de leverancier de brugpositie overneemt (Li & Choi, 2009). Beheersmaatregelen voor inkopers die in de literatuur worden benoemd zijn: (1) het behouden van een stevige (brug)positie in de dienstentriade, (2) het monitoren van de prestaties van leveranciers, (3) het ontwikkelen van gezonde samenwerkingsrelaties met leveranciers, (4) het gebruik van uitkomst-georiën-

teerde contracten (prestatiecontracten), en (5) het in lijn brengen van de doelen (prikkel) van inkoper en leverancier in het contract. Uit mijn empirische onderzoek blijkt dat gemeenten veel gebruik maken van niet-traditionele inkoopprocedures met veel nadruk op de relationele aspecten, en hiervoor zelfs expliciete 'sociale contracten' afsluiten. Dit komt overeen met de beheersmaatregel van het ontwikkelen van gezonde samenwerkingsrelaties. Verder blijken gemeentes ex post competitie te organiseren door het parallel contracteren van vele zorgaanbieders in raamovereenkomsten. Er ontstaat competitie om cliënten, en dit kan een positieve prikkel geven aan het leveren van goede kwaliteit van zorg. Het organiseren van ex post competitie kan hiermee een effectieve beheersmaatregel zijn voor kwaliteitsrisico's bij het inkopen van diensten in een dienstentriade, maar is nog niet eerder in de literatuur beschreven.

## **9. Opportunistisch gedrag door leveranciers – een dienstentriade perspectief op verschillende bekostigingsmethodes**

Dit hoofdstuk gaat dieper in op het perspectief van dienstentriades, en brengt dit in verband met bekostigingsmethodes die gemeenten gebruiken om sociale diensten te vergoeden. Gemeentes vergoeden sociale diensten op één van drie manieren: (1) inspanningsgericht – een vergoeding per geleverd uur zorg, (2) resultaatgericht per individuele cliënt – een vergoeding per cliënt voor behalen van uitkomsten, of (3) populatiegebonden bekostiging – een vergoeding voor het ondersteunen van een bepaalde populatie. Elke bekostigingsmethodes heeft bepaalde financiële prikkels voor de zorgaanbieder. Een opportunistische zorgaanbieder die zijn winst wil maximaliseren, heeft in een sociale zorg-dienstentriade met elk van de genoemde bekostigingsmethodes andere prikkels. Hierin speelt bovendien de wijze waarop de toegang tot zorg wordt georganiseerd naar verwachting een modererende rol. Op basis van inductief redenen, vertrekkend vanuit een agency theorie-perspectief, presenteert Hoofdstuk 9 in totaal een twintigtal testbare proposities ten aanzien van de verschillende bekostigingsmethodes. Inspanningsgerichte bekostigingsmethodes kan leiden tot het opdrijven van het volume, en als zorgaanbieders ook de toegang tot zorg controleren is het effect naar verwachting groter. Individuele resultaatgerichte bekostiging kan juist leiden tot minimalisatie van de inzet, met potentiële kwaliteitsproblemen tot gevolg. Wel is er een prikkel om zoveel mogelijk cliënten te ondersteunen, waarbij dit risico groter wordt geacht als zorgaanbieders de toegang tot zorg controleren. Een opportunistische zorgaanbieder die met populatiebekostiging wordt vergoed, zal zowel het aantal cliënten dat ondersteund

moet worden – als de inzet per cliënt minimaliseren, waarbij de verantwoordelijkheid voor de toegang dus naar verwachting tot nog minder cliënten zal leiden.

## **10. De inkoop van thuiszorg: een vergelijking tussen Nederland en Finland**

In Hoofdstuk 10 maak ik – samen met Dr. Suvi Tuulia Taponen, een vergelijking tussen de inkoop van thuiszorg in Nederland en Finland. We vergelijken het juridische kader – de zorgwetten én aanbestedingswetgeving – ten aanzien van het uitbesteden van sociale diensten, en op basis van empirisch onderzoek vergelijken we de inkooppraktijken in beide landen. Zowel Finland als Nederland zijn lidstaat van de EU, en daarmee onderworpen aan de EU Richtlijn voor overheidsopdrachten, en in beide landen zijn gemeenten verantwoordelijk voor de inkoop van sociale diensten. Beide landen hebben Richtlijn 2014/24/EU geïmplementeerd in nationale regels, waarbij Finland gekozen heeft voor een lagere drempelwaarde van € 400.000 voor verplichte transparantie vooraf bij het aanbesteden van sociale diensten. Naast vele overeenkomsten valt op dat Finse gemeenten contracten voor sociale diensten wel op laagste prijs mogen gunnen, mits gemotiveerd – wat in Nederland niet is toegestaan. Verder blijkt Finland sinds 2009 al een wet te hebben voor een voucher-model, dat grote gelijkenis vertoont met het Nederlandse open house. Deze wet maakt gebruik van dezelfde discretie in de Richtlijn voor overheidsopdrachten, waar ook de open house systematiek op is gebaseerd. Waar deze ruimte door Nederlandse gemeenten pas ontdekt werd na publicatie van het *Falk*-arrest in 2016, was dit al zeven jaar eerder bekend in Finland.

Ook de vergelijking tussen de inkooppraktijken van thuiszorg (voor de Nederlandse context keek ik naar huishoudelijke hulp) levert enkele interessante verschillen op. Finse gemeenten besteden overwegend slechts een deel van de sociale diensten uit (zowel via een overheidsopdracht of als vouchersysteem) als aanvulling op de organisatie in eigen beheer. Slechts enkele kleinere gemeenten in het onderzoek kiezen voor volledige uitbesteding, en dan vaak aan de gemeentelijke dienst van een naburige grotere gemeente. Nederlandse gemeenten besteden huishoudelijke hulp volledig uit aan externe zorgaanbieders. Waar Nederlandse gemeenten huishoudelijke hulp op drie verschillende manieren bekostigen (inspanningsgericht, resultaatgericht voor individuele cliënten, en populatiegebonden bekostiging), worden in Finland enkel de eerst- en laatstgenoemde variant waargenomen. Anders dan in Nederland speelt de prijs als gunningscriterium in Finland in de meeste

gevallen een grote rol.

## **11. De invloed van opdrachtgeverschapsmodellen op de kwaliteit en effectiviteit van sociale ondersteuning: een cliëntenperspectief**

In dit onderzoek toets ik de effecten van gemeentelijke modellen van opdrachtgeverschap op de door cliënten ervaren kwaliteit en effectiviteit van sociale diensten. Voor dit onderzoek combineer ik de data over gemeentelijk opdrachtgeverschap voor sociale zorg met uitkomsten uit een longitudinale enquête onder inwoners in Nederland ten aanzien van de ervaringen met ontvangen sociale diensten, met peilingen in 2014, 2015, 2016 en 2017. Ik gebruik de metingen van respondenten die aan de 2014-enquête én een van de andere metingen deelnamen. Cliënten gaven een rapportcijfer voor tevredenheid met zorg (een indicator van kwaliteit van dienstverlening) en voor de ervaren zelfredzaamheid (een indicator voor effectiviteit van de dienstverlening). Ik hanteer een 'difference-in-difference' analyse: cliënten worden gegroepeerd naar het model van opdrachtgeverschap van hun gemeenten. Vervolgens wordt het verschil in de tevredenheid (en idem zelfredzaamheid) tussen de 2014-meting en de latere meting berekend. Tenslotte wordt bepaald of de verschillen (dus afname of toename in tevredenheid / zelfredzaamheid) tussen de groepen significant van elkaar verschillen. indicator van de kwaliteit van zorg). Op deze wijze worden drie hypothesen getoetst: of (1) de cliënttevredenheid en (2) de ervaren zelfredzaamheid hoger is wanneer de gemeente een 'open' opdrachtgeverschapsmodel (catalogusmodel of veilingmodel) hanteert, en (3) of cliënten een betere zelfredzaamheid ervaren in gemeenten die sociale diensten bekostigen met uitkomstgerichte bekostiging. Enkel de eerste hypothese wordt bevestigd: cliënten in gemeenten met 'open' model van opdrachtgeverschap zoals het catalogusmodel zijn significant tevredener over de ontvangen sociale ondersteuning dan cliënten in de 'gesloten' modellen zoals het AWBZ-model. Er is geen effect aangetoond tussen de modellen van opdrachtgeverschap en de ervaren zelfredzaamheid, of tussen bekostiging en zelfredzaamheid. Opvallend is dat de ontwikkeling in de cliënt-scores voor tevredenheid en zelfredzaamheid niet correleert. Tevredenheid is zowel in wetenschap als praktijk een veelgebruikte indicator voor kwaliteit, maar dit onderzoek laat zien dat aanvullende indicatoren voor kwaliteit van sociale zorg wenselijk zijn.

## **12. Epiloog: een helikopterperspectief op de bevindingen in dit onderzoek en oproep tot meer onderzoek**

Voor mij als onderzoeker was Nederland de afgelopen jaren een ‘proeftuin’, waarin gemeenten een grote diversiteit aan modellen van opdrachtgeverschap en andere aspecten van uitbesteding implementeerden. Deze context bood – en biedt nog steeds – de unieke mogelijkheid om de effecten van verschillende inrichtingskeuzes grondig te onderzoeken. Dit proefschrift beschrijft uitgebreid de verschillende modellen van opdrachtgeverschap, inkoopprocedures en bekostigingsmodellen die gemeenten voor uitbesteding van sociale zorgdiensten hebben gehanteerd in de eerste jaren na de decentralisatie van de AWBZ. Ik plaats deze modellen en procedures in de wetenschappelijke literatuur, duidt keuzes vanuit theoretische kaders, en ik toets wat de effecten van modellen zijn op de ervaren tevredenheid en zelfredzaamheid van zorggebruikers. Er is nog veel meer onderzoek nodig naar gemeentelijk opdrachtgeverschap: naast het kwaliteitsperspectief (tevredenheid en zelfredzaamheid) is bijvoorbeeld een wezenlijke vraag welke effecten de verschillende benaderingen hebben op de kosten van de zorg. Voor de Nederlandse gemeenten is daarnaast relevant hoe het juridische kader zich ontwikkelt. Dit kader is steeds in ontwikkeling, bijvoorbeeld met de implementatie van Richtlijn 2014/24/EU in de Aanbestedingswet 2012, wijzigingen in de Wmo 2015, en jurisprudentie op de Awb ten aanzien van resultaatgericht beschikken. De wijzigingen hebben één gemene deler: ze beperken – impliciet dan wel expliciet – de juridische ruimte voor gemeenten bij het inkopen van zorg. Met het inperken van de ruimte groeit het risico dat gemeenten in steeds mindere mate ook daadwerkelijk de doelstellingen van de decentralisatie kunnen realiseren.





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## Curriculum Vitae



Niels Uenk was born on 7 May 1982 in Ede, the Netherlands. He holds a bachelor's degree and a master's degree in Industrial Engineering and Management with a specialization in Production and Logistics Management, from the University of Twente.

After working as an implementation consultant for the private consulting company ORTEC between 2008 and 2013, he joined the Public

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From 2015 onwards, Niels has held the position of guest researcher both at the University of Twente and at Utrecht University, where he wrote his Ph.D. thesis on commissioning social care services. He has published his research internationally on many occasions, and regularly publishes in international and national journals. Since 2015 he has annually (co-)authored reports on the procurement of social care services by Dutch municipalities, commissioned by the central government of the Netherlands. These reports and his other research publications have led to parliamentary questions and debate in the Dutch House of Representatives on numerous occasions. He is a member of the PIANOo expert group on procurement of social care (*vakgroep sociaal domein*). Furthermore, Niels is a main lecturer of the NEVI course on municipal procurement of social care, and since 2016 he is treasurer of the International Purchasing and Supply Education and Research Organization (IPSERA).

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