

## **Governance of local care and public service provision**

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| <b>Dr. Eelco van Hout</b>       | TiasNimbas Business School Tilburg University and BMC, the Netherlands<br><a href="mailto:eelcovanhout@bmc.nl">eelcovanhout@bmc.nl</a>                            |
| <b>Dr. Kim Putters</b>          | Institute of Health Policy and Management, Erasmus University Rotterdam,<br>the Netherlands<br><a href="mailto:k.putters@erasmusmc.nl">k.putters@erasmusmc.nl</a> |
| <b>Dr. Mirjan Oude Vrielink</b> | Tilburg School of Politics and Administration, Tilburg University, the<br>Netherlands<br><a href="mailto:m.j.oudevrielink@uvt.nl">m.j.oudevrielink@uvt.nl</a>     |

### **1. Introduction**

The traditional role of government is one of unilateral, vertical governance. Governance is usually defined as the influencing of conduct to achieve goals. The government identifies the problems, sometimes in consultation with others, sets objectives and then deploys legal, financial and perhaps communicative instruments to guide the conduct of others in the desired direction.<sup>1</sup> In terms of the classical governance paradigm, governance means that the government formulates concrete, and where possible, quantitative objectives, which it then timetables, weighs up and prioritises. However, these principles are difficult to reconcile with often dynamic decision-making processes (Ten Heuvelhof, 1999: p. 75). In public administration and related disciplines, this realisation has led to a focus on developments whereby authorities give substance and direction to social matters in interaction with other parties – in other words, in a less unilateral, centralist way. As a consequence, the classical governance instruments have also come up for discussion, with particular attention being given to processes and coordination mechanisms in network approaches. More recently, this has also become a focus of ideas on governance in relation to public administration. In this context, governance refers to forms of governance that are a mix of the central and local, the hierarchical and horizontal, and of obligation and persuasion (Dorbeck-Jung and Oude Vrielink-Van Heffen, 2007).

The move from *government* to *governance* reflects a shift away from two pretensions implicit in the classical governance paradigm. Firstly, it is no longer the government that defines public interests. De Bruijn (1999: p. 56) describes this as the recognition by the government ‘that a range of definitions of reality are possible. The way in which other social actors define reality can be richer than that of the government’. The second pretension to be abandoned is that ‘the government has a monopoly on power: in modern society, power is fragmented, there is no power centre, but rather a large number of power centres that are constantly in

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<sup>1</sup> Our definition of a policy instrument is based on that of Van den Heuvel (1998, p. 21): an instrument employed by a policy actor to achieve a particular governance output (goods or services) or a desired governance effect (on the target group).

motion' (De Bruijn, 1999: p. 56). In this paper, we will explore the implications of this for local authorities. The Social Support Act (*Wet Maatschappelijke Ondersteuning/WMO*) has allocated them a governance role in a field traditionally the domain of private organisations providing social services. Although we are aware of the multiple ways of interpreting the WMO and the implications this has for implementation and results, we will focus here on relinquishing the pretension that the government holds a monopoly on power. Our particular interest is the question of how local authorities that are not hierarchically superior interpret their governance role, the extent to which they can and do fall back on traditional coordination mechanisms, the position that municipalities occupy within care and service provision networks, and the implications of this combination of role and position for care and service provision. The specific questions we ask are (1) how does the introduction of the WMO alter the composition of public, private and professional stakeholders in care and service provision networks? (2) what influence does that have in practice on interaction between stakeholders? and (3) what does that mean for local care to clients?

## **2. Composition and interaction in care and service provision**

The government has a constitutional responsibility for the distribution, affordability, solidarity and quality of health care. However, it cannot fulfil these obligations autonomously because the actual care and service provision is to a large extent privately organised. Care institutions were originally set up as private foundations and associations with a public objective; as a result, they are not hierarchically subordinate to the government. Care and service provision is to a significant degree funded from collective resources, which are largely collected through insurance premiums managed by private insurers. The actual provision of care is in the hands of professionals who operate independently or under contract. In other words, a system exists that can be described as a network of mutually dependent actors. A new player – local government – has been added to the cast list of actors in the field of local care and service provision. The question now arising is how municipalities can and do interpret their role and what this means for their *interaction* with other stakeholders in care provision. To answer this question, we will first examine more closely the features of interaction in local care and service provision and the aims of the WMO.

### **2.1 Interdependencies and multiplicity in local care and service provision**

The past two decades have seen a move away from the State in the field of care and service provision: there is a trend toward greater market orientation, combined with a shift from the state to society. The care and service provision sectors feature a wide range of actors, often with conflicting interests, objectives, wishes and requirements. The recognition on the part of society and government that the welfare and well-being of patients and clients requires more than just medical care has created an integrated approach to care, which also encompasses domestic help, personal contacts, housing, income security, medical aids, moral support, attention, love and intimacy. Recent developments in care legislation and regulations in the

Netherlands have reinforced this broader interpretation, with parties other than the traditional stakeholders being offered a place in the care system. For example, we see care being provided by commercial organisations, as well as by family, friends or neighbours, and by publicly funded institutions. Ideally, they work together to arrange a tailor-made package of care and service provision, but in practice, high expectations can all too frequently not be realised. The high expectations of each of the actors involved (government, citizens, social organisations) are not matched by opportunities for satisfying these expectations. Care and service provision needs to be increasingly customised, while at the same time providers have to position themselves as (social) entrepreneurs (Putters, 2001; 2005). This leads to hybridisation towards a more market-oriented environment within a field strongly dominated by the government and the social administration. On the other hand, we also see the WMO assigning more responsibilities and tasks to local government, thereby creating further hybridisation towards the public domain. Thus the operations of organisations in the fields of care, service provision and housing are subject to many different forces: social needs, political wishes, financial and economic restrictions and possibilities, altruistic motives about helping people, and the drive to make a profit (Van Hout, 2005). Government legislation serves to strengthen the intensity of these forces.

## **2.2 The 2007 Social Support Act (WMO)**

On 1 January 2007 the Social Support Act came into force in all municipalities in the Netherlands. Under the Act, the municipalities are now responsible for setting up social support. The introduction of the WMO should provide an opportunity to improve service provision to citizens and clients. The WMO is the result of broader policy, emphasising individual responsibility in health care, on both the insurance side and the care provision side. Within this concept, a new basic health insurance scheme has been established for the entire population. As part of this reform, the WMO introduces a new scheme for all Dutch citizens covering care and support in cases of protracted illness, disability or geriatric illness. The Act also covers the area of well-being or welfare policy.

### **Participation**

The aim of the Social Support Act is the participation of all citizens in all facets of society, with or without the assistance of friends, family or acquaintances, with coherent policy in the field of social support and related areas. Municipalities are now responsible for developing a cohesive policy on social support, housing and welfare, and related matters. The WMO puts an end to various rules and regulations for the handicapped and elderly. It encompasses the Services for the Disabled Act (WVG), the Social Welfare Act and parts of the Exceptional Medical Expenses Act (AWBZ). The Ministry of Health, Welfare and Sport defines the financial and legal framework in which each municipality can develop its own policy, based on the composition and demands of its inhabitants.

## **2.3 Network composition and interaction under the Social Support Act (WMO)**

The move outlined above – away from the state and towards the market and the shift from the state to society – also characterises the WMO. It implies a different division of roles between the individual, civil society (such as voluntary work, care provided by family and friends) and the government. The Balkenende II Cabinet has this to say: ‘By definition, the government – both central and local – cannot make civil society, as it is after all a society of and by citizens. It is primarily the citizens themselves and their organisations that make up this civil society. For the Cabinet, the limited makeability of society is no licence to stand by and watch. Much can be achieved by supporting good initiatives. But the Cabinet, once again, places greater emphasis on personal responsibility, as set out in the Outline Agreement.’ The Cabinet hopes to achieve these substantive principles by following three paths:

- Personal responsibility: do what you can to help yourself. Where possible, individuals are expected to take responsibility for themselves and for the people in their immediate environment. This opens up for discussion a number of care and support issues which have developed over time and which have gone largely unquestioned. A greater call is being made on an individual’s own resources and on assistance from the immediate environment. As a result, some matters (such as domestic help) have disappeared from the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten/AWBZ*). Only if the immediate environment is unable to offer a solution can the citizen make an appeal for professional care.
- Support: do locally what can be done locally. Support is needed for people who are unable to solve certain problems either themselves or with the help of others. This involves ‘close to home’ matters like domestic help, modifications to the home, transport options, and social support, and covers housing, welfare and light forms of care. The municipalities are the key actors here and are granted considerable freedom to shape policy in the areas of housing, welfare and care. They are the central point of contact for people requesting assistance.
- Care: insure what must be insured. The Exceptional Medical Expenses Act has been returned to its original core task – namely, providing more intensive, long-term care. These are matters which incur large financial risks for individuals and which cannot be insured privately. In any event, the Act applies to people with severe physical or mental handicaps, as well as to elderly people with dementia and chronic psychiatric patients. These groups require sufficient, good-quality provisions, including institutional care where necessary.

### **3. Towards a new division of roles**

#### **3.1 Reassessing the relationship between the State and municipalities**

The WMO constitutes the pivotal point in the move away from intensive forms of care towards lighter forms of support, and goes hand in hand with considerable decentralisation. This choice has been prompted by the view that local government can come up with provisions closer to the citizen, and can consequently respond better to real care needs and to

the cooperation chain that this requires. We can also expect efficiency benefits because local arrangements entail relatively less bureaucracy. This governance philosophy has practical consequences for the division of roles between the State and local authorities. In this era of governance, the classical form of central governance by means of legislation and regulation is being partially replaced or supplemented by forms of governance in which government policy is determined and implemented through cooperation, self-governance, and/or competition, etc. As legislator, the State confines itself to determining the size of the playing field and setting the rules of play. For example, the WMO outlines the fields in which municipalities should pursue policy, how the funding should be arranged, who should be involved in the realisation of that policy and how performance should be made manifest. The municipality operates within these preconditions. The intention is to give municipalities considerable policy discretion under the WMO; on the playing field, they may organise matters as they see fit. The central government remains at a distance, but retains responsibility for the WMO system as a whole, and is hence accountable for the social outcomes of the Act if they are below par. In such an event, the State remains the arbiter.

### **3.2 The governance role of municipalities**

The decision by the legislator to allow municipalities themselves to decide on the division of roles within the confines of a legal framework means that the WMO provides enabling legislation. The Act's point of departure is that municipalities are ideally placed to channel developments at the local level, and to pursue an integrated policy taking proper account of local circumstances and the wishes of citizens. The municipality should promote coherence amongst those provisions that are important to citizens and should offer individual, customised solutions. Here governance means taking the initiative and making parties accountable. Of course, key players always remain dependent on the team that they have gathered around them. In practice, municipalities have to rely on their cooperation partners (e.g. care homes and housing corporations), which means that they decide on their role within an existing institutional force field. The WMO only stipulates that the role should be a governance role. Municipalities decide for themselves just what this means for the different policy areas covered by the WMO, such as local youth policy, the field of housing, welfare and care, local health policy, social relief, and the care and treatment of drug addicts, to name just a few.

The aim of the WMO is for citizens to 'participate'; they should be able, either independently or with the support of their social environment, to participate in society. By means of individual provisions, the municipality provides a safety net for citizens who, in spite of their own capacities and support from others, lack the resources to cope independently and to participate. What this means concretely for the governance role depends on the municipal vision of social support. Each municipality outlines within a four-year policy plan its vision of social support and the objectives that it hopes to achieve in the nine performance fields mentioned in the WMO. As an extension of this, the municipality sets out in the policy plan how it intends to interpret its governance role. If municipalities view it as their job to involve

vulnerable citizens in society and to activate and equip them to take control of their own lives, they see themselves as having a strong leadership role (cf. RMO (*Raad voor Maatschappelijke Ontwikkeling/Council for Social Development*), 2006). In that case, the governance role closely resembles the classical governance relationship in which the municipal government formulates policy objectives and leaves their implementation to municipal and/or private organisations. Legal instruments play a key role in such a relationship. The other extreme is a municipal vision based on self-governance by individual citizens or their networks; it is they who determine the nature of service provision and care. Here the governance role of the local authorities is to facilitate or establish contacts, and is designed, for instance, to ensure sufficient coherence within and between policy fields, to promote cooperation between organisations implementing policy, and to encourage high-quality services that are tailored to demand. To this end, the local authorities can utilise instruments such as entering into contracts or making grants to providers, making performance agreements and entering into covenants.

### **3.3 Shifting roles in a pluralistic environment: a framework for empirical research**

A theoretical framework is important if we wish to study empirically the consequences of the new, larger role of local government in care and service provision for both the composition of network stakeholders and for their interaction. The previous sections led us to conclude that there are two relevant shifts, both empirical and theoretical. Firstly, the shift from care to service provision, which points to the importance of network development and the expansion of care to service provision and housing. Secondly, the shift from government to governance in order to manage these networks, which points to a different relationship between government and social actors and to an increasing need to be able to change roles in different public and private environments. This gives us a framework of four variables for an empirical study:

- *The governance role of municipalities.* The WMO assigns local authorities a governance role, but how do they interpret this, and do they do so in the same way? Do they themselves take the initiative in interpreting their role, or does this follow on from their place in the network? These questions are relevant, given that local government is entering into an existing network of care and service providers in a new policy area.
- *Environment and network management.* In our introduction, we defined governance as the influencing of conduct to achieve goals. According to Ten Heuvelhof (1999: p. 72), conduct is embedded in decision-making processes; it precedes decision-making and sets it in motion. The implementation of the WMO has many of the characteristics of complex decision-making processes, as Ten Heuvelhof explains. They include the following: because of the large number of actors involved in the process, there are many perceptions of the problems and solutions, decision-making processes do not develop in a straight line from problem to solution, actors enter the arena in changing alliances, and the different combinations of forces make the process outcome highly unpredictable. Given the fact that it is a new policy area and the extent to which it is interwoven with other policy

processes, we are faced with the question of what the entry of local government means for network composition and interaction.

- *Process management.* Earlier we commented that the move from government to governance has led to a focus on processes. To be more precise, there has been a shift from central governance in matters of substance to coordination between stakeholders who stand in a relationship of relative equality to one another. This means that although the legislation has appointed local government as ‘director’, it cannot fall back on hierarchical coordination mechanisms. What are then the implications of this for interaction in networks that are dynamic and capricious in nature? What are the ordering mechanisms and does local government play a role here?
- *The carry-over into results.* The outcome of complex decision-making processes is uncertain and often temporary. It is the result of an unpredictable process of pushing and pulling. What is important here are the interests and objectives of the stakeholders who are entering into (temporary) alliances with one another. This is where network composition and interaction come together: it is the interests and objectives of stakeholders – who find each other and who push interactions within the network in a particular direction – that determine the emphasis within care and service provision.

In the preparations for and initial experiences with the WMO, we have looked for clear evidence of a role shift towards the market, government or social administration. In the following sections, we present three case studies that are moving towards these three types.

## **4. Case study: Alblasserwaard Vijfherenlanden**

### **4.1 Introduction**

The Alblasserwaard Vijfherenlanden case study involves a regional partnership between smaller municipalities seeking – through a joint arrangement – to develop and implement the tasks outlined in the WMO. The councils of these municipalities are involved in policy development and political decision-making, after which public institutions enter into further implementation agreements in consultation with social and market stakeholders. Citizens and clients are involved locally, per municipality, through roundtable meetings, WMO platforms and other consultation procedures. The institutional and political partnership in the Alblasserwaard Vijfherenlanden region has given rise to a powerful public actor that has taken considerable initiative. In this section we explain how the role of this new public actor evolved and what this means for the private and professional environment and for the processes between policy formulation and implementation.

### **4.2 Role definition: the municipality as *director***

The local authorities in the Alblasserwaard Vijfherenlanden region have taken the lead in developing local care and service provision. As a rule, they have taken on the role of director, which means taking the lead in organising the adequate provision of care and services. In that

capacity, they determine the division of roles between the different stakeholders. In the Alblasserwaard region, municipalities work in partnership in a WMO pilot scheme, with seven municipalities taking the initiative for the ‘Bleskensgraaf Pact’, a regional arrangement for care and service provision. This involves smaller municipalities working in partnership to generate enough resources to set up a WMO office. In both the WMO pilot study and the Pact, the municipalities face the issue of what to organise locally and regionally. For example, the smaller municipalities in the region would like to have local front offices (e.g. Internet as a solution). The municipalities are also up against the almost classical political and administrative barriers to intermunicipal cooperation (a neutral arbiter was called in to eliminate suspicion about each other’s intentions).

#### **4.3 Environment and network management**

Because the cooperating municipalities in the Alblasserwaard case study see themselves as playing a key governance role, they have won ground from the care and service providers who were active in this area before the WMO took effect. These providers see the municipalities as a single, large government block which has taken power upon itself. The power of the municipalities lies in their control of procurement, which is reflected in the care providers’ fear that, as a result of the WMO, local care and service provision will become part of a political, administrative game involving sluggish decision-making processes. The care providers were also afraid that the municipalities would make procurement decisions solely on the basis of price, and would not prioritise the quality of care and service provision (e.g. by economising). Strangely enough, the municipalities owe the powerful position that they have managed to acquire to uncertainty in the new policy area. Because care organisations have more experience in the area of care, the municipalities were worried that they would abuse their position. Therefore, in a Pavlovian response, the municipalities took upon themselves the governance arrangements with which they were so familiar. This simply heightened the care providers’ suspicion of municipalities. Their misgivings were further reinforced by the fact that the cooperating municipalities had to try to bring all municipal councils and official organisations into line; as a result, care providers were long left in the dark about just what the municipalities wanted. For one large regional provider, the Rivas Zorggroep, this was sufficient cause to step out of the consultations set up by the local government to keep all parties around the table. The provider felt that the consultations had produced too few concrete actions and objectives, and that the municipalities had allowed them little influence. The dominance of the local authorities led to considerable mistrust. Since then, there has been greater clarity about the municipalities’ objectives and about how they wish to realise them together with the providers. The contracting-out process, which has now taken place, appeared to allow plenty of scope to local and regional providers. The result has been a gradual increase in mutual trust.

#### **4.4 Process management**

In processes involving a growing local authority role in care and service provision, we see municipalities taking the initiative upon themselves, particularly on the basis of their statutory

powers and their means of exercising power. This entails setting out tasks, responsibilities and powers in guidelines, protocols and by-laws. The same happens in the area of quality, personal budgets, and other elements of the WMO. In the Alblasserwaard case study, local authorities took the initiative and did not involve care providers and housing corporations until a later stage. The result was a degree of mistrust because not all parties from outside the public sector felt involved. Also illustrative of the Alblasserwaard case study is the important role played by related instruments: independent chairmanships, declarations of intent, steering and focus groups, etc. Such instruments are vital for building support and keeping developments on track. The multiplicity of actors and interests was rendered manageable by means of a comprehensive project structure involving representatives of all kinds of organisations.

#### **4.5 Result**

Preparations for and the implementation of the WMO had varying results for care and service provision networks and their outcomes. A stronger public actor has emerged which is seeking new relationships with social actors and which is having to rebuild trust. Cooperation between municipalities has also produced a strong desire for uniformity, so that equivalent provisions can be delivered throughout the region. Cost control has been a key principle for municipalities when it comes to contracting-out, leaving providers with the strong impression that price takes priority over quality. However, cooperation has ensured that the WMO office is operating very well in all participating municipalities, and efficiency benefits appear to have been achieved with regard to operational management.

### **5. Case study: Domare**

#### **5.1 Introduction**

The Domare Foundation was set up in Almere in 2001. Originally an initiative of the three housing providers (WVA, Groene Stad Almere and GoedeStede) and the care provider Zorggroep Almere (primary and secondary care) – hence the name ‘Domare’, a combination of *domus* (house) and ‘care’ – it was soon after joined by the welfare organisation ‘De Schoor’. The common objective of the five founding members of the Domare Foundation was to create the conditions necessary *‘(...) to support the inhabitants of Almere in such a way that they can continue to live independently for as long as possible and hence to enhance the quality of neighbourhood life’*. Despite the broad support for this objective, the organisations have not succeeded in reaching agreement. The attitudes and working methods of housing and care providers have proven a major stumbling block. With their technical and practical orientation, professionals in the housing sector have a long-term vision and interpret the objectives in terms of specification development and building materials. The care professionals, on the other hand, are focused less on products and more on the more abstract ‘caring’, which is founded on a short-term vision. These different professional visions

generate conflicts of values that stand in the way of concrete partnership in care and service provision.

### **5.2 Role definition: the municipality as *arbiter***

Domare's pro-active role in preparing for the WMO makes it an interesting case study in which to examine the role that remains for local authorities if social organisations take the initiative in developing an integrated vision of housing, care and welfare without involving the local government. We have seen that a common vision is not enough to ensure agreement on implementation. And it is here that the municipality gained a foothold when it was called in by the participating parties to play the role of arbiter. The local government was able to introduce a separation between policy and implementation, thereby allowing it to take up its governance role.

### **5.3 Environment and network management**

Cooperation between the Domare partners is ambivalent. Without one another they cannot realise their shared objective, but at the same time they operate from entirely different perspectives on care and service provision. This means that their mutual expectations need to be managed, and visions of quality and product definitions need to be made transparent. In addition, the closed nature of the networks should be taken into account. The openness of care networks is enshrined in law. Whereas medical care (or 'cure') is provided within a relatively closed network in the Netherlands, there is far greater scope for joining the non-medical care network. An unintended side effect of the greater opportunities for involving new stakeholders in local care and service provision is that interests have become more diversified. It has been shown that they cannot be 'organised away' by excluding some parties from care networks. In the Domare case study, for example, the exclusion of the Salvation Army remained a weakness in the implementation of local care provision.

### **5.4 Process management**

When civil society plays a greater role in local care and service provision, the dynamics are governed by the capriciousness of the interaction between social organisations. Separate from the question of whether municipalities should take the lead here, it is essential for this approach to incorporate the ongoing 'management' of trust. Domare, for example, came unstuck as the result of a mutual lack of trust and the erosion of relationships. In this type of care and service provision, process management revolves around constant references to shared responsibilities and interdependency on the one hand and to the added value of interaction on the other. A critical factor appears to be constant checks on commitment, and ongoing management of the involvement and interests of the participating parties.

### **5.5. Result**

The Domare case study shows that the quality of local care and service provision is largely determined by cooperation between care providers and their dialogue with clients. As the case study shows, mutual mistrust can have far-reaching negative consequences. A possible benefit

of stronger cooperation between social actors is that the social institutions themselves can 'presort' the range of services, thereby reducing their dependency on the local authorities or being at the mercy of the care market. The Domare case study sends municipalities the message that cooperation between social institutions cannot be achieved without a struggle.

## **6. Case study: Village service centres (*Dorpspunten*)**

### **6.1 Introduction**

Dorpspunt Moerdijk is an intermediary service that puts clients requesting care in contact with care providers. It is an example of self-governance by commercial parties, providing care in the broadest sense: intramural care and homecare as well as domestic help, help from family and friends, shopping and personal support. The concept is fleshed out by commercial providers in the areas of care (care providers, homecare organisations), employment (employment agencies), welfare and well-being (sports associations, volunteer organisations and private initiatives), food products (supermarkets) and financial products (banks). Their services are combined in a local, easily accessible intermediary service (called *Dorpspunten*, and housed in the empty premises of the former home-nursing service). They are staffed by an employee who receives the clients and refers them to the different providers (or requesters) of care and other services. The administrative structure is that of a clearinghouse (as it is called in other sectors); it is the key intermediary between parties, and is based on trust in the market forces of supply and demand, and in the broad range of care products and services, requests and providers. Dorpspunt Moerdijk functions in practice as a parallel public administration: a social administration. It functions as a strategic hub and manages the resulting pathways towards solutions. It does so by recognising and facilitating local and private initiatives. In this section we show how local care needs can be met without interference or intervention from local authorities, but instead through market principles.

### **6.2 Role definition: the municipality as *observer***

In the case study, the breadth of the care and service range, and especially local trust in the Dorpspunt service, ensure that inhabitants of rural areas do not ask the municipal government to solve local social problems (such as youth nuisance, mobility of the elderly, the range of shops, and leisure pursuits), but instead turn to the local service centre. Apart from – as a matter of course – taking care of the numerous preconditions for social order, the municipalities in this approach are no more than interested observers. Evidently, local care provision can be organised in a customised fashion based on market principles. In administrative practice in the Netherlands, this means that social organisations and commercial care providers are competing with one another for the customers' favours. There is far less necessity to follow democratic procedure because the best solution can be determined on a case-by-case basis. Generally binding decisions are also no longer required. It is also clear that legal frameworks can be adapted to the situation, thereby reducing the need to frame cooperative relationships in terms of administrative law. Legitimacy exists by the

grace of a win-win situation for the parties concerned, and will continue to do so for as long as this situation holds.

### **6.3 Environment and network management**

The Dorpspunt case study shows that interdependency can be included in a game of supply and demand, where the outcomes of interdependency are determined each time anew. In the governance approach that allows greater scope for market forces, governance of care and service provision means facilitating encounters between clients and providers. Network management of local care is therefore also about the routes by which ad hoc networks and temporary arrangements are created. This implies that situational relationships take the place of institutional ones. In Dorpspunt, alliances are always created around a specific product or service. However, unlike pure markets, there is no question of the ‘invisible hand’ of supply and demand. The personal element within care and service provision means that it is not only purely market considerations that play a role in supply and demand. For example, in the Dorpspunt case study we see that the inhabitants themselves wished to contribute to the revitalisation of their village.

### **6.4 Process management**

When market forces are given greater play, we observe that it is exchange and negotiation in particular that determine the services created. Critical to this process within public service provision is the constant organisation of the links with local customers. It needs to be an ongoing process in order to best respond to the wishes of individual citizens (called customers). This means that initiative rests with citizens and commercial providers in the marketplace and that the local authorities remain at a great distance, playing at most a facilitating role. Market relationships determine above all the course of the processes – in other words, demand governs the range of services provided in governance environments dominated by market forces. The key governance instruments are marketplace contracts, negotiation and financial incentives. It is a relatively open situation in which private, non-profit and commercial organisations can hook into the village service centres if desired. Added value is determined per situation. In this type of governance, process management aims to facilitate a reliable market with as broad as possible a range of services. The accessibility and added value of the local market above that of other markets or government services is a major issue. Accessibility, location, the personal approach, avoiding an emphasis on profit, and stressing the added value of markets for the local community (e.g. revitalising rural areas) – these are the subtle ways in which the market-led approach can contribute to a better understanding of governance.

### **6.5 Result**

In the Dorpspunt case study, the quality of care and service provision is determined in the marketplace interaction between clients and providers, with the end result benefiting from the broadest possible range of products. The strength of the Dorpspunt case study lies in the decentralisation of care and service provision, which is also its greatest risk. The Dorpspunt is

maintained by a limited number of commercial players with nothing to gain from competitors joining the service. As happens in the marketplace, the players are continuously steering a course between their immediate self-interest and their need to preserve the market in the longer term. Clients do so by selecting Dorpspunt above other routes, while service providers do so by offering clients a wider choice.

## 7. Conclusions

### 7.1 Mixed forms of governance

The case studies show that three categories of key players seem to have emerged in the field of local care and service provision. First of all, the *authorities* (in this case principally the municipalities). Secondly, *commercial players*, usually commercial service providers such as banks, insurance companies or other intermediaries such as food companies or private employment agencies. Finally, *social organisations* such as care institutions, housing corporations and welfare organisations. These categories differ from one another in numerous ways. The difference in governance mechanisms (central, professional and competition) is linked closely to the way in which contact occurs with individual citizens, patients, clients and customers. The players evolve in different environments, each with its own traditions (bureaucratic, religious, professional and market); they employ different instruments (rules and regulations, professional standards and price incentives); they perceive people in different ways (in terms of social, professional and individual responsibility); and they each have a different focus (public property, professionalism, profit).

Although we only examined three cases, it is nevertheless clear that these different approaches result in different outcomes, with the most influential role being played by one of the categories of players:

1. A greater role for local authorities. Municipalities take care and service provision upon themselves. Traditionally, this tended to be done by parties outside the public sector, often foundations and associations. However, the WMO has given municipalities a new responsibility in this area. They can take on the implementation themselves (which was previously done privately), but they can also play a governance role, as in the Alblasserwaard Vijfherenlanden case study.
2. A greater role for third sector actors. Third Sector organisations such as care institutions, housing corporations, etc. take service provision and governance upon themselves, for example by setting up joint foundations and offering services to municipalities, as in the Domare case study.
3. A greater role for market forces. To a large extent, commercial market players take the provision of products and services upon themselves. Local authorities are strongly oriented to the marketplace, to comparing products and services and to contracting-out. Alongside traditional care partners, a key role is also played by project developers, banks, handyman

services and cleaning companies. The provisions may be located in commercial service centres, as in the Dorpspunten case study.

In diagrammatic terms, these trends toward hybridisation may be represented as follows:

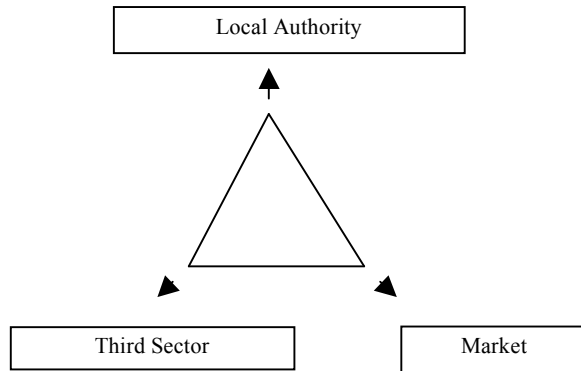


Figure 1. Dynamics in local care and service provision: forces

## 7.2 Towards new patterns of interaction

We observed in our empirical study that local authorities and social organisations deal in varying ways with the different rationales and values that play a part in care and service provision. As Van Hout (2007) correctly states, many forces are directed at the leaders of care and welfare institutions, but the same is also true of public administrators. Economic effectiveness and cost control continue to play a role, in addition to the interests of care, as well as family and professional interests. Just how all these interests and values are weighed up varies, as does the degree to which organisations or administrators are placed under pressure by these forces. It has to do with environmental factors, such as legislation, market structure and local policy. It also has to do with vision and culture. These are the factors which have a major impact on the nature of the interaction between all parties and which drive the result.

When local authorities take the lead, the municipality's role is mainly that of *coordinator/director*. The risk here is once again that too many rules will be imposed in a top-down fashion on the implementing organisations. This time the rules originate from the local government and not just from the national government. But there are opportunities too: this trend creates the potential for a high degree of continuity of care and service provision, with the security of products and services deriving partly from the political legitimacy of decisions taken under the auspices of the WMO. In such situations, the municipality is co-manager of care and service provision. The particular risk is that a shortage of money or manpower will generate a lack of trust among both the local authorities and citizens. This could also generate friction and place considerable pressure on cooperation. Moreover, it has been shown that professionals from different sectors find it difficult to see beyond their own field and to arrive at shared definitions of, say, quality of service provision. With well-functioning social

organisations, on the other hand, there is a chance that services are linked effectively, and that good communication occurs between the different sectors. In market-oriented situations, it is a question of contracts and exchange, with the municipality being one of the *contract parties*. Here, there is a risk that the politicians and administrators will have limited influence on public provisions. Democratic oversight is curbed, but local politicians remain accountable to citizens for the quality and availability of facilities and services. The opportunities here lie in flexibility, the broadest possible product range, responding to needs, and the temporary nature of cooperative partnerships and arrangements. The task for follow-up research is to identify within each interaction pattern the key factors behind the choice of a particular type of interaction.

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