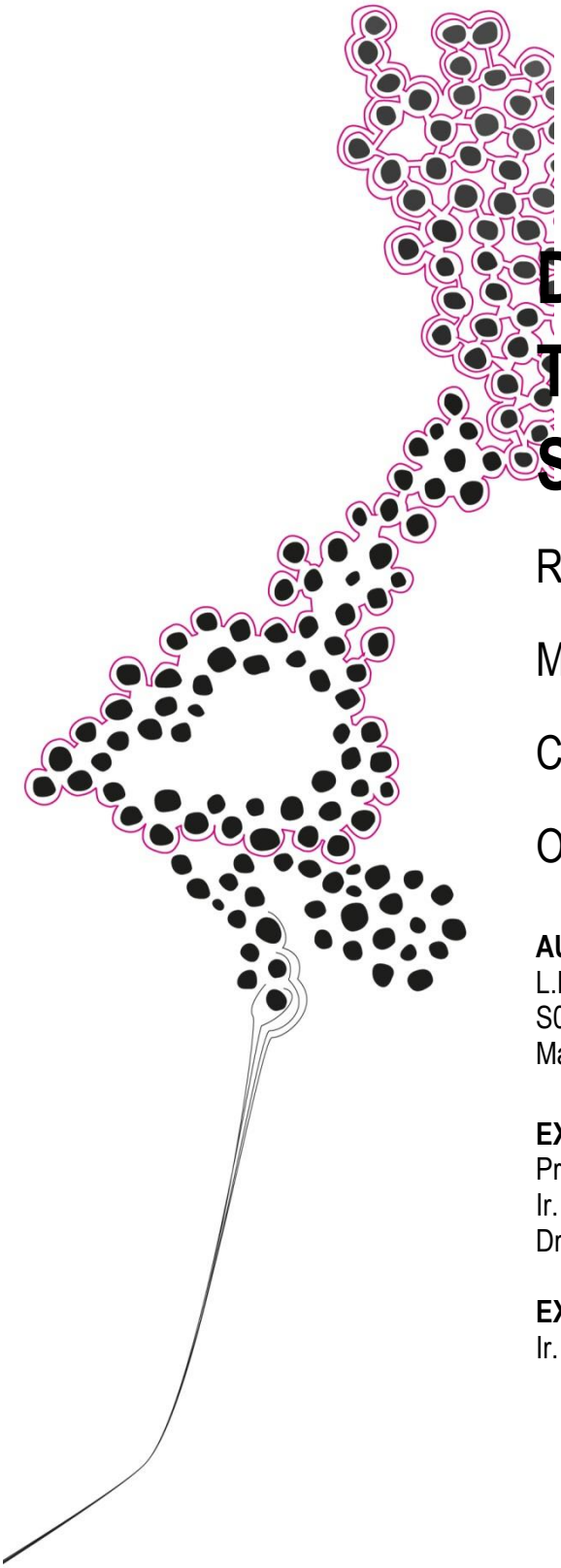
MASTER THESIS



# DECENTRALISATIONS IN THE DUTCH SOCIAL CARE SECTOR

## RESEARCHING APPROACHES OF MUNICIPAL COMMISSIONING OF SOCIAL CARE ON PATIENT PERCEIVED QUALITY OF CARE AND SELF-RELIANCE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## Summary

Social care, youth care and job participation have become part of the tasks and responsibilities of Dutch municipalities since January 1st 2015. The municipalities have been given a lot of freedom to implement the transition to their own situation and preference. One of the tasks is the commissioning of social care providers, for which a multitude of approaches are used. Yet, it remains unclear if the different approaches lead to different and/or the desired results. The goal of this thesis is to provide empirical evidence for the effects the different municipal approaches towards commissioning care have. The main research question is the following:

*"Does the approach of municipal commissioning of care influence quality of care and self-reliance of clients after the Dutch social domain decentralizations of 2015?"*

Municipal commissioning of care is conceptualized into three components: five commissioning archetypes, three financing- and contract types. Each of these approaches have mechanisms that potentially influences behaviour of care providers. Principal-agent- and service-triad theories form the background of these incentives. Outcome variables consist of client perceived assessments of quality of care and self-reliance. Data on client perceived quality of care is collected in three separate studies by I&O Research and data regarding municipal commissioning, contracting and financing of social care is gathered by the PPRC in 2014. Subsequently a quantitative analysis is conducted in order to see whether or not the choice for a certain commissioning approach affects the client perceived quality of care and self-reliance.

Analysing the effect on quality of care, on first hand it appears that influence of the commissioning approach is very small. The same pattern is visible when looking at financing and contract types. However, when looking at the assessment of quality of care over time the commissioning effect surfaces. The AWBZ-model performs as expected. In this model the provision of care and social services hardly changed. It is no surprise that this model does not show a large difference in perceived quality of care or self-reliance. The new, more innovative approaches were structurally graded lower by especially relatives of clients. The lower assessment of these new approaches may perhaps be explained by reluctance towards changes in care provision by both groups. Looking at self-reliance Wijkgericht Contracteren and the corresponding financing and contracting models outperform the others. This was not expected based on service-triad theory and the models incentives. It appears that some of the approaches other than the old AWBZ-model, pave the way for the care providers to assess the care needed by clients and to implement other ways of providing care besides professional care, still resulting in decent performances.

It is advised that, in order to further research the effects of municipal commissioning of care on quality of care and self-reliance, this research is repeated in upcoming years. The main limitation this research was the method of data collection. Data was collected by questionnaires that were used for other research intentions. Moreover, due to the fixed method of data collection several archetypes are under-represented in the sample. Adding weights to the respondents was not sufficient to counter the lack in observations of some of the models.. In future research it is therefore advised to critically assess the questionnaire that is sent to the respondents and make sure it is more suitable for clients and relatives who receive care and social services that are commissioned by Dutch municipalities.

## Preface

Exactly one year and a month ago I stepped into the office of Prof. Dr. Telgen looking for a master thesis assignment to conclude the master Health Sciences at the University of Twente. During the course of Healthcare Purchasing the process of public procurement and procuring health- and/or social care triggered my attention, mostly due to the contemporary nature and societal impacts of the topics discussed. I was immediately filled with enthusiasm when Prof. Dr. Telgen offered me the opportunity to do research in this field of study, whilst writing the thesis you are reading now, in collaboration with I&O Research.

Right now I'm in the process of finishing my thesis and wrapping up the final comments before handing in my work to the examination committee. Looking back, the past year has been one in which I've learned and discovered a lot and made, in my opinion, quite a few steps in my personal development. Of course, this wouldn't have been possible without the efforts and support of several people. First and foremost I would like to thank the Public Procurement Research Center and I&O Research for giving me the opportunity of writing a thesis on this very interesting subject. Most notably to Niels Uenk of PPRC, for providing me with good comments and guidance throughout the process of writing this thesis, and Rachel Beerepoot of I&O Research for getting me acquainted with I&O Research and helping me out whenever I had questions about the concepts in the questionnaires used for data collection. Second, I would like to thank Prof. Dr. Jan Telgen for offering me this subject and my co-workers at I&O Research for helping me out with SPSS-syntax-troubles whenever I had difficulties with the data analysis process.

I hope you enjoy reading this thesis.

Best regards,

Leon Heuzels

Student Master Health Sciences

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# Inhoud

# 1. Introduction

## 1.1. Background

Over the past two years, the Dutch care sector has undergone a lot of developments regarding the financing, commissioning and provision of social care. Most notably, the home care, personal care, youth care, care for the elderly, long-term care and job participation[1], have become part of the tasks and responsibilities of Dutch municipalities. Among these tasks and responsibilities are the financing and procuring of social care providers to deliver the care needed, also known as and referred to here as commissioning of social care. Before this transition, the aforementioned care sectors were mostly financed and commissioned by Dutch health offices (Dutch: *Zorgkantoren*). This decentralization of the procurement, financing and provision of social care impacts the personal environment of many care receivers and their loved ones and the stakes involved, both financial and societal, are huge. Both advocates and opponents of these developments stress the (presumed) impacts the decentralisations of social care to Dutch municipalities might have.

Figures that illustrate the enormity of the decentralisation processes are provided in letters to the Dutch parliament by the Dutch Minister of Internal Affairs. Ronald Plasterk (2013) writes to the Dutch parliament that in 2015 a total of €17,7 billion euro's is reserved for municipalities to spend on the social domain, €12,8 billion of which is reserved for the social domain clusters 'Social Support' (Dutch: *Maatschappelijke ondersteuning, Wmo*) and 'Youth' (Dutch: *Jeugdwet*). In their overall report on the transitions in the Dutch social domain the SCP (2016, p. 59) estimates that 620.000 people – out of a population of roughly 17 million - in the Netherlands receive care that is regulated by the Social Support Act (Dutch: *Wmo*). It is no surprise that ever since the decentralisations were publicly announced in 2013 they have been under the microscope of public attention and have had high news coverage ever since (SCP, 2016, p.11).

The rationale behind the decentralization of social care is that the municipalities stand closer to clients who need care and the municipalities can subsequently deliver better tailored care (Dutch: *maatwerk*), more effective, with less bureaucracy and above all: at lower cost (Rijksoverheid, 2015). Noort & Schotanus (2015) write that it is thought that municipalities are better able to create local networks of long-term care services and social services like domestic cleaning, social work, social housing and job participation. Moreover, stressing the responsibility of the task that has been given to the municipalities even more: the Dutch central government (Dutch: *Rijksoverheid*) has cut social domain budgets for municipalities – and plans to cut them even more in the upcoming years. In 2015, when the decentralisations were implemented, the budgets for different types of care were cut varying from 11 to 32 percent (Ministerie BZK, 2014). The Dutch association for municipalities (Dutch: *VNG*) writes that for 2017 a budget cut of €400 million for the social domain budget is planned (VNG, 2016).

In order to achieve this new methods and steps of procurement are necessary (Bouman et al., 2011) that should aid in achieving the goals of the decentralisations. The central government has given the municipalities a lot of freedom to implement

[1] Dutch: Wmo, Jeugdwet, Participatiewet (2015).

the decentralisation to their own liking and situation (PPRC, 2016). This includes for example the type of procurement procedures to select suppliers, types of contract, scope of the contracts and number of suppliers contracted. This implies that municipalities are able to apply new methods, for example using concepts of Performance Based Contracting (Selviaridis & Wynstra, 2015) or budgets based on population (Noort & Schotanus, 2015). However, up until now, no studies have been conducted to see what approach fares best and performs better than other approaches. This study is a first attempt to provide empirical evidence regarding the performance of several, very different, municipal approaches.

## 1.2. Research goal

The freedom given to implement decentralization policies to the situation of each municipality and their preferences has led to many different approaches for procurement, financing and contracting of care by municipalities. Studies already showed that municipalities address the decentralisation issue in many different ways (van Eijkel, van Ommen, & Uenk, 2015). Some municipalities opted for the possibility to commission social care in a collaboration of municipalities, others decided to commission care themselves. This process of municipal commissioning started late 2013 and early 2014 when municipalities had to select and negotiate with suppliers to provide social care as of January 1st, 2015 (PPRC, 2016). Yet, it is still unclear if the different approaches lead to (different) effects and moreover: Which approaches achieve the most desired results of the decentralisations? The desired results being: (1) care close to the client, (2) tailored care and (3) improving client self-reliance (Rijksoverheid, 2015).

A lot has been written and said, both in politics and the media about (expected) effects of decentralizing the commissioning of social services to lower-level government bodies like municipalities. Yet, up until now no empirical studies have been conducted to analyse the different methods used for commissioning care and whether or not these have different results as a consequence. The goal of this thesis is to provide the first quantitative empirical evidence of the effects the different municipal approaches towards commissioning care have after January 1st 2015. This goal consists of two steps. First, to see whether the different approaches of commissioning social care lead to different effects and second, if different effects are observed, which approach performs best. Effects that are sought after are e.g. quality of care, client self-reliance and other effects related to the goals of the decentralisations. Several key questions that subsequently need to be answered are: Which new ways of commissioning social services are being implemented by Dutch municipalities? What outcome variables are to be used?

## 1.3. Research outline

Chapter Two provides a background and problem analysis based on scientific literature. Chapter Three presents the concepts and variables used in this research: Both approaches used by Dutch municipalities to commission social services as well as outcome variables used to measure performances. Using theory presented in chapter Two, expected behaviour and results are presented. Chapter Four provides methodology on data collection and –analysis. Chapter Five presents the results of the analysis. The final chapter, Chapter Six, draws up the conclusions derived from the analysis to answer the research questions, evaluates the theory-based expections and presents several recommendations for future research.

# 2. Research Problem

Before presenting the research questions, analysing the problem clarifies and maps the current situation of the developments after decentralisations in the Dutch social domain.

## 2.1. Problem analysis

First step in the problem analysis is sketching the overall process of social care purchasing and -commissioning, assigning the stakeholders in this process and determining what mechanisms affect and tie these groups together.

### 2.1.1. Market mechanisms

The health- and social care market in general differs from the traditional market structures of supply and demand. Whereas in a traditional market economy the demand-side is both customer and financer and the supplier is producer and seller of good or services, in care markets this process is more complex (Lapré & van Montfort, 2001). Due to the high cost and (relative) low accessibility of supply and demand in health- and social care, a third market is added to the traditional economic model: the financing market, thus creating a service triad. In this three-market-model (Lapré & van Montfort, 2001) a third actor, the financer, is intertwined in the relation between supply (the healthcare provider) and demand (the patient). In order to make sure the client receives healthcare the financer has to purchase healthcare from the healthcare providers, which is then provided to the client. The figure below shows a graphical representation of the three-market-model, based on the model of Lapré and van Montfort (2001).

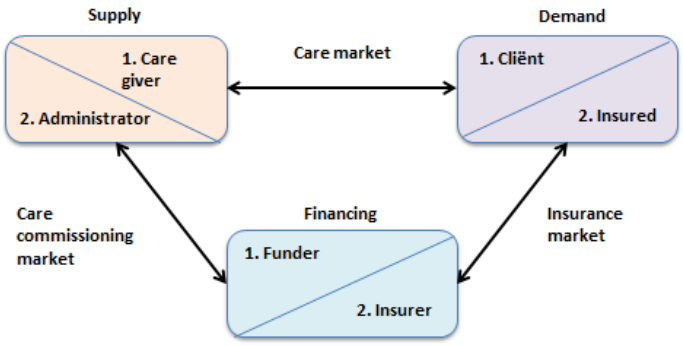


**Figure 2.1: Three-market-model in health- and social care markets (Lapré & van Montfort, 2001).**

The abovementioned implies that the financer charges the care provider with the task of providing care of which the client is end-customer. This commissioning of services can be described as a buyer/supplier/end-customer service triad within a supply network and contains mechanisms that predict the behaviour of an actor in this network (Choi & Dooley, 2009). These mechanisms are explained by two distinct features of this triadic relationship. First, the buyer does not directly experience the service delivered with respect to quality, performance and needs fulfilment. Second, information from the relation between the supplier and the end-customer is not directly visible to the buyer. The structure of these relations can be fitted in a principal-agent-relationship (Eisenhardt, 1989) and subsequently face problems, e.g. regarding agent incentives, monitoring and quality control (Mooney & Ryan, 1993).

In addition to the above: As mentioned before, because municipalities are free to choose their own method of commissioning care (PPRC, 2016), different municipalities employ different methods to ensure needed care is commissioned from care providers (van Eijkel, van Ommen & Uenk, 2015). The choice the municipality makes regarding overall method of procuring, the financing and contracting (thus: commissioning) of social services has consequences for the interests of all involved parties. It is expected that the different commissioning processes face largely similar, but also several distinct problems connected to service-triad-theory and principal-agent theory.

### 2.1.2. Agency theory

Agency theory is concerned with resolving two problems that occur in agency relationships. The first is that the goals of the principal and the agent conflict. The second problem is that it is difficult or expensive for the principal to verify what the agent is actually doing (Eisenhardt, 1989). The agent, as executor of the principal's orders, has an information advantage over the principal and therefore the principle has to monitor the agent in order to make sure the agent does not act based on self-interest. Moreover, due to the information gap, the agent may change behaviour after the transaction has taken place. This is the 'moral hazard' in the relationship. These are the main characteristics of the theory (Mooney & Ryan, 1993, p. 126). In the case of a health- and social care related system, the relation between principal (buyer of services) and agent (provider of services) is plagued by incentive problems (Fuloria & Zenios, 2001).

Incentive problems between the principal and the agent may have consequences for the second mechanisms in the triadic relationship: the relation between the client and the care provider, in other words: the provision of actual care. If the care provider acts in its own interest and monitoring by the municipality is lacking, this may have consequences for the quality and/or amount of care delivered to clients (van Eijkel, van Ommen, & Uenk, 2015). Van Eijkel, van Ommen & Uenk (2015) emphasize that when faced with specialized, complex care, it becomes more difficult for municipalities to monitor quality of services delivered. One of the risks is overproduction, also known as upcoding or supply-induced demand (van de Ven, Schut, & Rutten, 1994), of services delivered. This implies that because the agent acts based on self-interest, he provides more (or more expensive) care than necessary (NZa, 2014, p. 5). For example, when the care provider is also responsible for indicating the amount of care needed and indicates more care than necessary for the benefit of the organization. Subsequently the municipality pays for care of which the added value is unclear and/or deemed unnecessary. Another, more visible risk to the client, is that of underproduction, or delivering the minimal needed care. For example when a care provider gets paid-per-client and henceforth tries to treat as many clients as possible in the time available to maximize profit, putting the quality of care in second place (van Eijkel, van Ommen, & Uenk, 2015).

### 2.1.3. Service triads

In this context this implies that providers of social services may act more in their own organizational interest, rather than in the societal interest of the municipality, which is also assumed by Li & Choi (2009) in their supply network theory. When also taking into account the announced budget cuts for social care provision, if the care providers opt to act in their own organizational interest, the social interest may move to the background even further.

Li & Choi's (2009) theory connect the relationships in the health- and social care markets and principal-agent-theory in a triadic service network. In different stages of the network, the actors are connected by one "bridge" that is in the centre of the triad buyer/supplier/end-customer. Preferred position in the network is the bridge, since the bridge is the connecting node between the two other actors, who are not in direct contact. Subsequently, the bridge benefits from an information advantage over the others in the network. This information advantage is best illustrated by a "structural hole" or lack of information between the initial buyer and the buyer's customer (Li & Choi, 2009, p. 30). Figure two below illustrates this information gap.

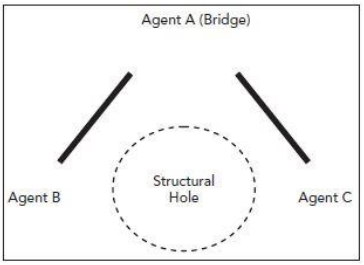


**Figure 2.2.: The information gap between agents in a network (Li & Choi, 2009, p. 30).**

This information advantage may have consequences for the performance and/or behaviour of the bridge (Forder, 1997, p. 519). The incentive problems of the agent are applicable to the bridge position. The theory of Li & Choi (2009) is applicable to the delivery of social services in Dutch municipalities. In early stages of commissioning social services the buyer (the municipality) is the bridge between the supplier (care provider) and the end-customer (client), when the municipality commissions services from the care provider with the intention to maximize benefits for the client. After the care provider is commissioned to actually provide services, the bridge position of the buyer decays and in some cases will transfer to the care provider who has to ensure care is delivered to the client (Li & Choi, 2009). Due to these events the initial bridge, the municipality, has to monitor the new bridge does not abuse the information advantage it has, since the municipality has only limited contact with the client and has no information on the full extent of the quality of services and care the care provider delivers.

This is the core of Li & Choi's (2009) theory, namely that the bridge has the upper hand in the network due to the position where it is in contact with all other participants in the network. In this position the bridge has an information advantage which can be used to serve the organizations best interests. After a supplier is selected, the supplier's relation with the buyer's client intensifies and the care provider subsequently gain more influence. This process of bridge decay (seen from the municipality's point of view) leads to an outcome where the supplier has the upper hand in the network: the bridge transfer. The municipality in the role of buyer isn't able to maintain the bridge position, because the care provider is in direct contact with the end-customer and not the municipality themselves. Li & Choi (2009) therefore propose that the buyer accepts the loss of the bridge position and deals with the bridge decay and subsequent information gap as much as possible. They suggest filling in the structural hole completely, creating a permanent state of bridge decay (Li & Choi, 2009, p. 34). Below two figures show a schematic view of the different stages of the triadic relationship between the municipality, care provider and client, and the desired state for municipalities after commissioning care.

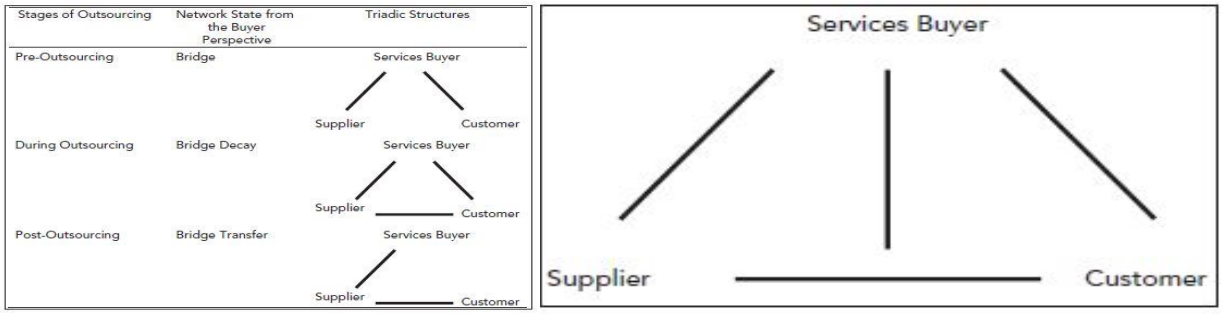


**Figure 2.3.: Li & Choi (2009) on outsourcing stages and network consequenses (left) and the desired state of permanent bridge decay (right).**

## 2.2. Research Questions

Summarizing and taking the research goal into account: before achieving the main goals of the decentralization: better tailored care, improved quality of care and more client self-reliance, municipalities face several principal-agent and monitoring issues with care providers when commissioning care to them. The municipality has in this respect a high degree of social responsibility, since they need to purchase (in theory) the most efficient care possible for the people (Smith et al., 1997, p. 57) and people expect of the municipality that they take care of their needs, despite that the municipalities have less means to achieve these goals due to the budget cuts.

De Boer et al. (2016) emphasize that commissioning strategies and approaches are a vital tool for municipalities to steer the transition of the social domain in the right direction. But how can municipalities approach care providers in such a way that the correct incentives are given to achieve desired results? In the theoretical framework below, the different approaches towards commissioning of care of Dutch municipalities are presented.

In order to quantify the performance of these approaches, several steps are necessary to structure the research. First, we determine outcome variables in order to measure the performance and effects when comparing them to the commissioning approaches. The next chapter presents these concepts in a theoretical framework, to provide for a basis for the actual data collection and data analysis. Summarizing the above in research questions the main research question of this thesis is:

*"Does the approach of municipal commissioning of care influence quality of care and self-reliance of clients after the Dutch social domain decentralizations of 2015?"*

In order to further structure the answering of the main research question the following sub-questions are presented below.

1. How can quality of care and client self-reliance be conceptualized and measured?
2. What effect does commissioning care by municipalities have on the quality of care delivered?
3. What effect does commissioning care by municipalities have on client self-reliance?
4. Which approaches of commissioning care by municipalities attain the goals of the decentralizations the best, based on the studied outcomes?

# 3. Theoretical Framework

This theoretical framework elaborates on the used models of municipal commissioning of care and which outcomes are used to measure quality of care and client self-reliance.

## 3.1. Structuring commissioning of care

First the general structure of municipal commissioning of social care is explained, e.g. the policy options for the municipalities after the decentralizations of 2015. This results in presenting five distinct commissioning archetypes which describe the way in which a municipality commissions, contracts and finances care for clients.

### 3.1.1. Municipal instruments for commissioning care

In their report for the Central Planning Agency (Dutch: *CPB*) van Eijkel, van Ommen & Uenk (2015) describe several roles the municipality can adopt in the process. Each of these roles involves an attitude towards commissioning care. Uenk (2016a) mentions several attitudes exist because of the high degree of freedom to implement an own style of ensuring the proper care is provided. Dutch municipalities have a number of instruments when commissioning care, these options involve contracting, monitoring and steering incentives for care providers. Van Eijkel, van Ommen & Uenk (2015) and Uenk (2016b) analysed the steering options municipalities have regarding procuring social services. Out of these instruments determining the *procurement market*, the *financing process*, *contracting process* and *contracting scope* are vital in municipal commissioning of social care (Uenk, 2016a).

### 3.1.2. Approaches towards commissioning care

A first distinction can be made between the municipality that likes to keep close contact with the client and the municipality that let third parties do the *coordination* (Dutch: *Regie*) of care (Telgen, Uenk, & Lohmann, 2014). These third parties are mostly second line care providers. The *financing* of social service provision follows a spectrum where on the one side healthcare is financed by amount of input (fee-for-service) and on the opposite municipalities may use performance-based contracting. In other words: a provider attains predetermined goals in order to receive payment. Along the spectrum there are two other options in between the two above: financing based on results achieved for individual clients and a budget per client, not taking results into account (Uenk, 2016a, p. 15). Third is the *number of contractors*. Municipalities may opt for either one main contractor or several contractors who compete each other for the commission. Another step in the contracting procedure is determining *the scope of the contract*. Either the municipality settles with a small scope: a contract that solely issues the provider deliver care of an individual client, where the municipality takes up most responsibility. The second option is the possibility of a ‘framework agreement’: where more responsibilities within the care provision lie with the care provider, e.g. indicating the care needed and setting up a plan for care provision (Uenk, 2016a, p. 15).

Note that of the spectrums and options mentioned above, one might rule out the other, as was mentioned before. For example it is impossible that financing based on population and/or outcome is realizable with an unlimited amount of contractors (Uenk, 2016a). Figure 3 below shows the abovementioned options a municipality has when purchasing social services in Dutch based on the figure in Uenk (2016a).

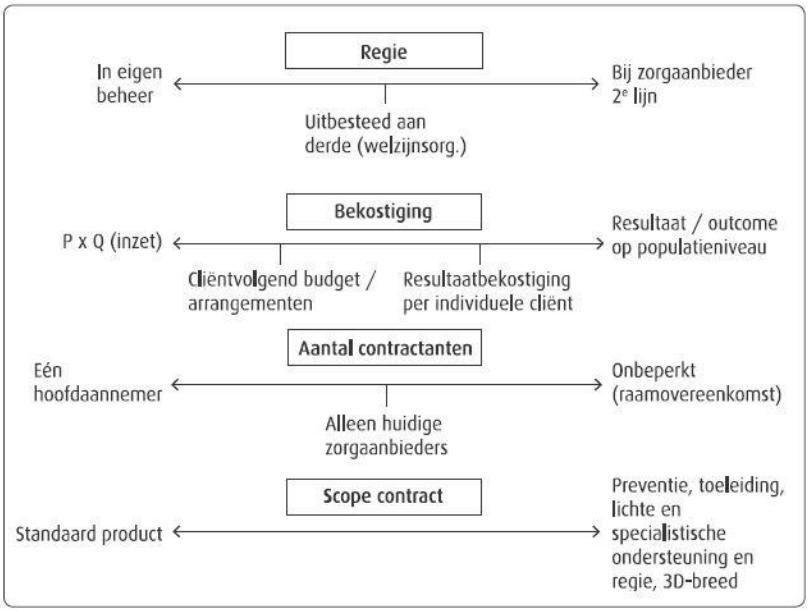


**Figure 3.1.: Municipal steering options for outsourcing healthcare services (Uenk, 2016a).**

### 3.1.3. Archetypes

Mixtures of the available options have been conceptualized in to five different archetypes of commissioning care. The archetypes determine in general the attitude of a municipality towards the role of principal in social care provision: how the principal designs the market in which social care providers compete. Uenk (2016a, p. 17) emphasizes that a certain archetype determines for a large part the other choices that have to be made regarding financing and contracting processes, and the contract scope. Moreover, although not always the case, when choosing for certain financing processes, this choice determines the contracting process that follows, and vice versa. The archetypes are: (1) AWBZ; (2) Veilingmodel; (3) Wijkgericht Contracteren; (4) Regisseursmodel and (5) Gronings model, based on Telgen, Uenk & Lohmann (2014) and Uenk (2016a). Advantages and disadvantages are discussed for clients, municipalities, larger- and smaller care providers.

#### *3.1.3.1. AWBZ-model*

In this archetype the municipalities stick with the same structure of care provision as before the decentralizations (the former AWBZ-structures). Almost no incentives are given to innovate the care provision. This implies fee-for-service financing with fixed budget, a small contracting scope and responsibility mostly with the municipality. Containing cost is done by e.g. cutting hourly tariffs. Although there are some short-term advantages, namely a certain degree of stability and familiarity for the municipality, care provider and client (Telgen, Uenk, & Lohmann, 2014) and the possibility to learn from municipalities who do innovate, in the long term this archetype is not feasible. Due to announced budget cuts of up to 40 percent for some social services in the next years municipalities have to implement new strategies, missing out on experience and knowledge gained when implementing new strategies in an earlier phase. Stable performance in the initial phase after the decentralizations may result in a huge set-back after budget cuts are implemented and the AWBZ-model does not suffice anymore.

#### *3.1.3.2. Veilingmodel*

In this archetype the municipality takes up the role of 'regisseur' and is subsequently responsible for indicating the care needed, whilst in dialogue with the client. After the situation is analysed, the care for an individual client is offered, anonymously, at an (online) market place where care providers place bids and offers in order to receive the contract. The main focus and advantage is that every client receives personalized care for the lowest possible cost. Possible pitfalls are a change of plans after a care provider has been assigned a client and the amount of administrative work for (especially) larger care providers due to the fact that care providers have to tender individual clients. Smaller care providers however, have the possibility to try and contract the clients they specialize in, although they would have to make a plan without seeing the client, leaving the possibility that an indication is incorrect.

#### *3.1.3.3. Wijkgericht Contracteren*

In this archetype a population (town/city) is divided in to several segments (e.g. neighbourhoods) and subsequently a municipality appoints a care provider to take up the provision of social services in that particular area. Financing and contracting is based on performance and a lot of responsibility lies with the care provider. Normally a larger care provider is contracted by the municipality, due to the large administration burden and scope of the contract. The larger care provider then has the possibility to subcontract smaller care providers when specific expertise is needed. Advantages of this model are the influence of the experienced professional organization on the care process and compared to other models little work for the municipality. This however also has a downside, due to the lesser influence on the care process; the municipality has to make sure to monitor the process correctly. Because of performance based financing the care provider has the incentive to provide the minimal care required by strictly looking at care needed in order to save costs. On the other hand: care providers are motivated to stimulate self-reliance and informal caregiving, both goals of the transitions, by being given a fixed budget per population.

#### *3.1.3.4. Regisseursmodel*

In the Regisseursmodel a third party indicates the amount of social care needed on behalf of the municipality. After the amount of care needed is determined, the 'director' (Dutch: *regisseur*) is able to pick (along with the client) from a number of tailored care packages, procured by the municipality from several care providers using framework agreements. The director stays in close contact with the client and monitors the care provision. In this archetype extra attention needs to be paid to the contracting and financing of commissioned services, since the municipality is free to choose for either input- or performance based financing and contracting. Advantages of this archetype include the amount of influence a municipality has on social service provision through the 'regisseurs'. Also, the personal preferences of the client are taken into account. Attention is needed from all parties for the role of the regisseur, who is a major node in the service provision triade. It is important to ensure the independency of the regisseur (Uenk, 2016a), in order to exclude negative incentives that might lead to e.g. procuring too much healthcare.

#### *3.1.3.5. Gronings model*

The final archetype taken into account in this thesis is the 'Gronings model'. This archetype, like the AWBZ-archetype, also takes historic structures into account. In this model only currently employed care providers are contracted. Budgets are fixed and readjusted if necessary, based on the number of clients a care provider serves. If a

care provider cares for fewer clients they have to return budget, whereas in the case a care provider cares for more patients they receive more budget. In any case the total budget reserved by the municipality remains the same. The municipality gives room for the providers to innovate and provides incentives to downscale social care provision, knowing that the budget is fixed. This structure however also gives the care providers an incentive to maximize the number of clients while in the meantime delivering the minimal required care to the clients. Moreover, the municipalities is limited in the possibilities to steer care provision and only including current care providers limits innovation and is possibly incompatible with procurement legislation.

Summarizing the above, the archetype chosen by a municipality determines for a large part how they fill in the role as principal in the care process. Below, several *financing and contracting methods* are discussed, being two of the most vital instruments when commissioning care (Uenk, 2016a). Advantages, disadvantages and incentives compliant to the archetypes also suggest that there is a possible connection with outcomes like quality of care and amount of self-reliance of clients.

### 3.1.2. Financing options and contract types

Besides the commissioning archetype, effects of financing and contracting options as a vital part of municipal commissioning are also taken into account. Besides new archetypes, in recent years new views regarding financing and contract types have emerged.

Over the course of the past decades the focus within healthcare shifted more and more towards the attainment of results rather than the volume of care. This is in line with the trend towards performance based contracting both in manufacturing and service industries in both the public and private sectors (Selviaridis & Wynstra, 2015). With costs for healthcare (as well as for social care) rising, the question 'is the care delivered of any added value?' became more relevant. Paying for quality instead of paying for volume is the new creed (Ikkersheim & Kuperus, 2014). Besides a focus towards results and quality of care delivered, simultaneously more attention is aimed towards transparency in health- and social care in general, in other words: the possibility to choose care yourself and have information on the quality of care delivered (Hayen et al., 2013). This free choice is more reflected in 'framework agreements', where municipalities commission several care providers, the clients' free choice determining the care providers budget (Uenk, 2016a).

The trend mentioned above has also been seen at the municipal level for social care after the decentralisations. Uenk (2016a, p. 17) describes a pattern where the focus at the municipal level regarding the purchasing and contracting of social services shifts towards result-based provision of care. This is also mentioned by Porter & Kaplan (2016). They argue that payment and contracting models in health- (and social) care influences care delivery and –innovation by stating: "we need a better way to pay for health care, […], for achieving better health outcomes at lower costs. The move towards 'value-based-reimbursement' is accelerating, which is an encouraging trend (Porter & Kaplan, 2016, p. 89)." Uenk (2016a) presents an overview of the main financing options and available contract types, which can be found below.

**Table 3.1.: Financing options for municipalities (Uenk, 2016a.)**

| **Financing** | |
|---|---|
| **Input** | Input financing is the type of financing also used in the AWBZ. Care is financed by a fixed price per hour of care given. It is also known as the fee-for-service style of financing. This type of financing provides fewer incentives for care providers to come up with more efficient and/or effective ways of giving care. It does however provide more certainty for all parties. |
| **Population** | When financing based on a population a main contractor is given a budget based on the number of clients and/or the size of the population in a given area. This type of financing is always used in combination with Wijkgericht Contracteren. |
| **Result** | Result (or: performance) based financing demands a certain result to be achieved by care providers before being granted the budget. Results have to be achieved, regardless of input. Payments are usually completed on a monthly basis. The thought behind result based financing is that care providers are motivated to come up with new, more efficient and/or effective ways of providing care. |

**Table 3.2.: Contract types for municipalities (Uenk, 2016a).**

| **Contract types** | |
|---|---|
| **Contract w/ guaranteed budget** | For each care provider a fixed yearly budget is agreed upon. Although it is expected from the care provider to answer for the budget, the provider is guaranteed of the revenue for that certain year. This form of contracting was used in the former AWBZ before the decentralisations. |
| **'Framework agreements' without guarantee(s)** | A framework agreement without a guarantee of income determines the conditions to deliver care needed, but they do not guarantee income for the care provider. This type of contract is signed simultaneously with several care providers, the free choice of clients and subsequent indication determines ultimately the height of the budget received by the care provider. |
| **Main contractor** | When municipalities opt for contracting a main contracting, they usually assign one main contractor for a certain neighborhood or area. This form of contracting is chosen automatically when a municipality chooses for Wijkgericht Contracteren. The contract consists of a fixed budget, alongside several bonuses or budget cuts, depending on results. |

## 3.2. Outcome variables

The second part of this theoretical framework focuses on conceptualizing outcomes that are capable of measuring effects in quality of care and client self-reliance. First important outcomes are defined, followed by how to measure these outcomes.

### 3.2.1. Patient-reported Outcome Measure (PROM)

The goal of this research is to measure whether or not the different commissioning approaches Dutch municipalities use have effect on quality of care and self-reliance of clients. Important question that follows is how to measure these outcomes? The answer lies with patient-reported outcome measures.

Eijkenaar & Schut (2015) made the definition of quality in healthcare one of their main goals in their report on result-based financing in Dutch healthcare. They define adequate results in (health)care in five points and provide for a clear overview and definition of concepts that are also mentioned in other contemporary reports and articles (Eijkenaar & Schut, 2015, pp. 5-8). For this research and social care the first point Eijkeneaar and Schut (2015) mention is most relevant, being: 'good quality of healthcare'. They state that good quality of (health-)care besides good technical quality also the patient satisfaction is relevant as a measure of good quality in care. Patients are more and more considered to possess important experiential knowledge on health and health care, a source of information that is relevant for improving quality of care (Wiering, de Boer, & Delnoij, 2017).

Patient satisfaction is subjective, and can be measured using patient-reported outcome measures (PROM) (Hunter, et al., 2015). PROM's add the perspective of the patient (in this case: client) to an evaluation of health care processes. Marshall, Haywood & Fitzpatrick (2005) state that PROM's aim to capture patients' perspectives of health, illness and the effects of (health) care interventions in a reliable, valid, acceptable and feasible way. Hunter et al. (2015) continue stating that this is merely a role at the individual level; an alternative role for PROMs is in providing aggregated evidence of the performance and quality of services. Although mainly focused on healthcare situations, like surgeries, treatments and hospital evaluations, the aggregated evidence implied by Hunter et al. (2015) suggests that PROMs can also be used to evaluate quality of care at a larger level. In addition to the patient or client reported outcomes, Shilling et al. (2016) state that informal care givers, whether they are spouse, family member or friend, are pivotal to the overall outcome of a patient's treatment and thus may be viewed as 'second-order patients' in their own right. This implies that the reported outcomes by relatives are also valuable in assessing e.g. quality of care.

Summarizing the above, in order to assess quality of care PROMs are deemed a valuable source of information, even on an aggregated level as is the case in this research. Given the goal of this research and the different approaches used by a wide variety of municipalities when commissioning social care PROMs given by clients across the Netherlands are a valuable source to measure (client-reported) quality of social care and client self-reliance. These PROMs on quality of care and self-reliance can subsequently be used to assess whether or not the different approaches have effect and if an effect is noticed, which approach leads to more desirable results.

## 3.3. Expected outcomes

Combining the archetypes, financing options and contract types for municipalities (Uenk, 2016a) with agent-theory and service-triad-theory by Li & Choi (2009); model incentives lead to several outcome expectations.

*(1) AWBZ*

In 2015 many municipalities stuck with the AWBZ-model to buy more time to adapt to the decentralisations (NJI, 2016b). The AWBZ-model distinguishes itself from the other models by providing no incentives for care providers to innovate care provision. Budget cuts are implemented by cutting hours and/or hourly tariffs. The status quo is maintained with regards to the situation in 2014, with the exception of announced budget cuts (Uenk, 2016a). There are two outcome possibilities for quality of care and client self-reliance: (1) the client does not notice change, therefore effects in the AWBZ-model are minimal and (2) the client notices a drop in quantity and quality of care, due to budget cuts.

*(2) Veilingmodel*

Main advantage over the other models is that when using the Veilingmodel, the client should always receive tailored care because care providers make a bid for individual clients. Care is adjusted to the needs of the client and therefore should lead to a higher (perceived) quality of care. A pitfall of the model, mentioned earlier, is that the change of an incorrect client indication is present, because care providers need to make an anonymous bid. Another potential problem is the amount of monitoring the municipality as principal will have to do. Because this model is characterized by the larger amount of smaller care providers that have the possibility to bid on a individual client, the municipality is intertwined in a lot of service-triads with different care providers. Monitoring all of these service-triads may prove to be difficult for the principal, with the risk of care providers abusing the information advantage they have over the municipality, with all due effects on quality of care.

*(3) Wijkgericht Contracteren*

In the Wijkgericht Contracteren model one main care provider is contracted and made responsible for an entire neighbourhood or designated area. This archetype is in practice the closest to the service-triad theory mentioned in Li & Choi (2009), where a buyer (the municipality) order a supplier to deliver services to the end-customer. This model subsequently has to cope with incentive problems. Because the care provider is given full responsibility and a fixed budget for a population, they receive the incentive to deliver the minimal amount of care. Every penny spent extra on care implies more financial burden for the care provider. The care provider is more likely to encourage clients to look for alternative sources of care, e.g. informal care by relatives, neighbours or friends. Expected is that both quantity and quality of care drop, whilst perceived self-reliance may increase.

*(4) Regisseursmodel*

The Regisseursmodel is a model that is more or less a framework in which each municipality that opts for this approach does not directly choose one subsequent financing model or contract type, like in e.g. the Wijkgericht Contracteren model. Because of the variety of options that are left, expected outcomes are hard to define. With regards to the service-triad of Li & Choi (2009), the Regisseursmodel is the model in which the municipality, with the ‘director’ (Dutch: *Regisseur*) as a central

actor in the care provision, fills in the state of permanent bridge decay the best. According to Li & Choi (2009) quality of care is more likely to be preserved when the buyer positions himself in this state of permanent bridge decay, a mechanism in which monitoring of the care provider is possible. This is an advantage compared to e.g. the Wijkgericht Contracteren model.

*(5) Gronings model*

The Gronings model resembles the AWBZ-model, where only care providers contracted in 2014 and before are invited to compete for a contract in 2015. Budgets are fixed and readjusted according to the number of clients a care provider has. This gives the incentive to maximize the number of clients, whilst minimizing the quantity of care per client. Also, by only contracting a limited number of care providers and not including others, Uenk (2016a) suggests there is a limited incentive to innovate care provision by care providers, since they have a high degree of certainty to win the contract.

Based on the theory and characteristics of the archetypes, these expectations were tested. The next chapter gives more details about the methods used to measure the approaches towards commissioning social care by Dutch municipalities and how potential effects were analysed.

# 4. Research Methodology

This chapter focuses on the methods used to operationalize the concepts mentioned in the previous chapters. Collecting data, analysis of the data and subsequently deriving valid and reliable results regarding municipal commissioning of social care after the decentralisations.

## 4.1. General overview of methods

This research is mainly explorative, no previous quantitative analysis is made to analyse the effects of procurement of social care by municipalities on client satisfaction and self-reliance in the Netherlands. The data collected in order to conduct this this research consists of two sets of data that have been previously collected in 2014 and 2015. The first dataset consists of longitudinal data regarding client perceived quality of care and client perceived self-reliance, made available by I&O Research. The second dataset is data regarding municipal commissioning of care in 2014 collected from 381 Dutch municipalities by the Public Procurement Research Centre (PPRC).

## 4.2. Data collection

### 4.2.1. I&O Research data

The first dataset consists of outcome data, collected by I&O Research. I&O Research conducted a three-year longitudinal research to measure the level of content of clients (or relatives and friends of clients) regarding care they received or services provided to them. Other goals of the research were to measure the level of self-reliance, the amount of care received and the respondent's opinion towards the decentralisations. The first study (Dutch: *Nulmeting*) was conducted before the decentralisations; in December 2014. The two follow-up questionnaires (Dutch: *Éénmeting* & t*weemeting*) were conducted in May 2015 and December 2015.

**Table 4.1.: Data collection of outcome variables by I&O Research**

| | When? | Total N |
|---|---|---|
| **First study** | December 2014 | N = 9.055 |
| **Second study** | Juni 2015 | N = 7.051 |
| **Third study** | December 2015 | N = 6.923 |

The first questionnaire resulted in 9.055 responses (I&O Research, 2014), the first follow-up had 7.051 respondents (I&O Research, 2015) and the second follow-up 6.923 respondents. In order to make the sample representative for the whole Dutch population a weight was added to the results, according to age, sex and region (I&O Research, 2014). Respondents were contacted via the I&O Research panel. The I&O Research panel consists of participants who are randomly selected, without financial compensation for filling in the questionnaire. Socially desirable and/or biased answers are thus expected to be minimal.

The first step in the questionnaires was asking respondents to fill in if they had experiences with one or more of sixteen situations, either as a client or as a relative, friend or neighbour, that are common in the social domain in the Netherlands. The situations ranged from 'light' care, e.g. helping with the housekeeping to 'intensive' care, like psychiatric care and care for elderly with Alzheimer-disease. For a full overview of the sixteen situations, see appendix A. Subsequent questions focused on

the perceived satisfaction about care received, amount of self-reliance and related topics like informal care and thoughts on the decentralisation. Respondents were asked to grade the care they received on a scale ranging from 1 to 10, with 1 being the worst and 10 the best. The additional topics make it possible to do some additional, related, analyses on the effects of municipal commissioning of care. Examples are the amount of care provided and client's perception towards the decentralizations. The full questionnaire for the second follow-up study is added in appendix B.

### 4.2.2. PPRC data

The second dataset consists of data collected by PPRC from 381 Dutch municipalities regarding the municipal attitude towards commissioning care and social services. This data was collected in the light of a larger research revolving around the public procurement in the social domain by Dutch municipalities. Data was collected by analysing procurement- and tender documents and contracts of Dutch municipalities. Around 70 percent of these procurement contracts were provided by online published tenders, via either Tenderned or the official websites of municipalities. The other 30 percent is collected through personal contact with municipalities. The dataset provides information of each municipality on their archetype of commissioning social care, the method of contracting and financing and whether or not the municipalities participate in collaborations with other municipalities. An important note is that the collected commissioning data on social care commissioning does not include commissioning data on social cleaning services. This is also included in the Social Care Act, but has been since 2007 and was commissioned before the decentralisations of 2015.

**Table 4.2.: Overview of data collected by PPRC**

| ARCHETYPE | FINANCING | CONTRACT TYPE | TARIFFING | LENGHT OF CONTRACT | OPTION TO PROLONG |
|---|---|---|---|---|---|
| AWBZ-model | Input | Contract w/ guaranteed budget | (Still) unknown | Undetermined | Undetermined |
| Veilingmodel | Population | 'Framework agreements' without guarantee(s) | Pre-determined tariff | 1 year | 1 year |
| Wijkgericht contracteren | Result based | Main contractor | Maximum tariff | 2 - 3 years | 2 - 3 years |
| Regisseursmodel | | Mixed | Based on offer care provider | 4 - 6 years | 4 - 6 years |
| Groningsmodel | | Unknown | Offer by municipality based on offers care providers | More than 7 years | More than 7 years |

Table 4.2 shows that more data on the commissioning of care by municipalities was collected. This research focuses on the first three columns in the table: (1) archetype, (2) financing and (3) contract type. The other three characteristics of commissioning of care were not included in the research, the link between these characteristics and effects on perceived quality of care and self-reliance is considered to be too indirect to presume a causal relation.

These two datasets were combined in one SPSS-file and suffice in providing data to conduct a quantitative analysis in order to see whether or not the choice for a certain approach of commissioning of social care affects the client perceived quality of care and self-reliance. The next sub-chapter goes into more detail about the analysis of the data collected.

## 4.3. Statistical Analysis Plan

The first step in analysing whether the archetypes influence client satisfaction is comparing means using cross tables. Although it is of no statistical value, the cross tables are used to indicate whether or not a difference may exists between styles of procurement. Grades between 1 and 10 (with 10 being the best score) provided by clients and relatives regarding satisfaction with the care received and perceived self-reliance are the main outcome variables used. Also the amount of care received in comparison with previous years (in percentages) and the amount of informal care given or received is used to indicate the behaviour of the care providers and possible related effects on client perception.

These results are subsequently analysed using three statistical methods. Not only are the results and performances of the procurement styles of December 2015 compared, the longitudinal development – from December 2014 to December 2015 - is also used to analyse archetype performance. It is both interesting to see whether or not there is a difference between the performances of the archetypes in December 2015 as well as to see whether there is a change in archetype perception over time. The three statistical tests applied are ANOVA, dependent and independent T-Tests and a Difference in Difference-analysis. For all methods an alpha of 5 percent is used ($\alpha$ = 0,05)

### 4.3.1. ANOVA

For the comparison of results between two or more groups one-way ANOVA is used. ANOVA compares the variance between groups and determines whether or not there is a difference between the groups. This method is however not able to state which of the tested models differs significantly from another, it states solely whether or not there is a difference between all of the models tested (Moore & McCabe, 2005, p. 523). ANOVA is used to test the results between the models of procurement, financing and contracting in December 2015.

### 4.3.2. T-Test

The second and third statistical methods are both T-Tests to test the differences over time. A T-Test is a method to compare the means of results, in this case the client perceived quality of care and self-reliance over time. Both independent sample T-Tests and paired sample T-Tests are performed (Moore & McCabe, 2005). The reason two difference tests are used is because of the nature of the clients who participated in the I&O Research studies. Clients had the opportunity to participate in all three studies, but not all respondents did. The results of clients who participated in both the first and third questionnaire (*Dutch: 0- en 2-meting*) are paired, since the results are from the same group, yet on two different moments in time. The results of people who did not participate in all studies are independent from one another; hence the independent T-Test had to be used.

### 4.3.3. Difference in Differences-analysis

The former two statistical methods test for statistical significance at one moment in time for all models combined (ANOVA) or over time for a single model (T-Test). The third statistical test used combines these two features. A Difference in Differences-analysis (abbreviated: 'DiD-analysis') is a quasi-experimental design that makes use of longitudinal data from treatment and control groups to obtain an appropriate counterfactual to estimate a causal effect (Columbia University, 2017). Abadie (2003) writes that it is one of the most popular tools to evaluate the effects of public

interventions on relevant outcome variables. This test is used to assess whether or not the difference over time between the five archetypes is statistically significant. The figure below shows a schematic overview of the DiD-analysis.

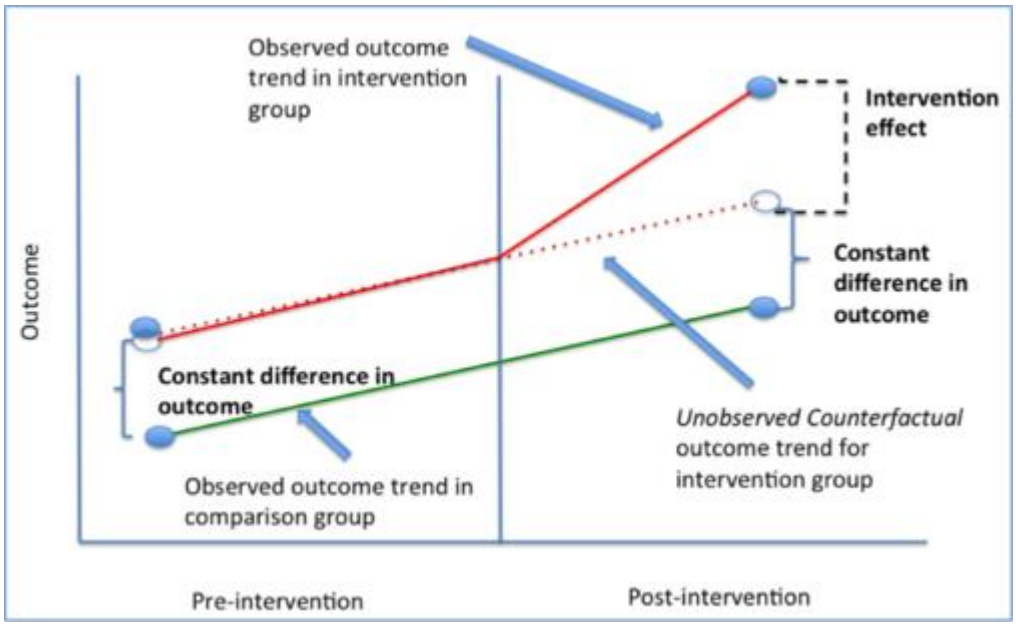


**Figure 4.1: Overview of Difference in Differences-analysis (Columbia University, 2017).**

The intervention effect seen in figure 4.1 can be estimated using a regression model. The coefficients are the time trend (T), difference between two groups pre-intervention (S) and difference in changes over time (T · S), modelled in the following formula.

$$Y = \beta_0 + \beta_1 T + \beta_2 S + \beta_3 (T \cdot S) + \varepsilon$$

Drawback of the DiD-analysis is that this type of analysis only allows tests between an experimental group and a single control group. In order to perform this test, the AWBZ-model functions as the control group, whilst the other four archetypes are used as experimental groups. The rationale behind this is that four separate tests are performed which compare results between the new, innovative commissioning approaches and the traditional approach (AWBZ-model) towards commissioning of social care. Only commissioning archetypes are tested using the DiD-analysis, financing and contracting options are not.

For each test all grades given (for quality of care and self-reliance) were combined in a single outcome variable. Subsequently, three dummy variables were constructed. The first dummy took the time trend in to account, where a positive score implied a grade given after intervention. A positive score for the second dummy determines that the grade was given to a non-traditional commissioning approach. The third dummy is an interaction between the first two.

### 4.3.4. Possible confounders

The previous chapter concluded with several expected outcomes. Although results may point in the direction that one model performs better than another, may also be explained by the fact that clients and their relatives are hesitant to change. This may also explain a difference in score between e.g. the AWBZ-model, a model that had the main characteristic that it does implement new ideas and changes, and other more innovative models. Another limitation that has to be taken in to account on forehand is the sample sizes within models that are not used very often. Most of the Dutch municipalities opted for either the AWBZ-model or the regisseursmodel. These models are subsequently represented the most often in the sample. Models like the veilingmodel and the Gronings model are used far less often. This has some consequences for the interpretation of the results, if issues on the validity and reliability of the results are probable this is mentioned in the text. Further discussions are presented in the final, concluding chapter.

Below the results of the analysis are presented. First the effects on client satisfaction and amount of care are discussed, followed by the client' self-reliance and effects on the amount of informal care by relatives and friends or neighbours.

# 5. Results

This chapter presents the results derived from the analyses of the combined datasets. First, the effects of the archetypes, models of financing and contracting on the (perceived) amount and quality of care received are presented. Second, the effects on self-reliance of clients are shown.

## 5.1. Model effects on perceived quality of care

### 5.1.1. Average scores by clients and relatives

Both clients and their relatives were given the opportunity to assess the quality for the care they have received. Respondents were asked to grade the care if they reported that they had experiences with one of the sixteen situations in the social domain, either 1) themselves or within their own household or if 2) relatives, neighbours and other acquaintances had experiences with social care. The first group is referred to as clients and the second group as relatives.

In overall, clients grade care given to them better than their relatives. Table 5.1 below shows the average grades given, ranging from 0 (being the worst) to 10 (being the best).

**Table 5.1: Average grades given to quality of care by clients and relatives (I&O Research, 2016)**

| | First study | Second study | Third study |
|---|---|---|---|
| | Dec 2014 | Jun 2015 | Dec 2015 |
| Average grades for quality of care by clients | 7,7 | 7,3 | 7,4 |
| N | 1.301 | 621 | 800 |
| | | | |
| Average grades for quality of care given to relatives | 7,2 | 7,0 | 7,0 |
| N | 2.191 | 1.269 | 1.581 |

In 2014 – before the decentralization – both groups rated care received better, clients score on average a 7,7 and relatives a 7,2 out of 10. Six months later, in June 2015, the satisfaction decreased by almost half a point (0,4) for the client group and 0,2 for relatives. Another six months later the decrease in satisfaction is made up slightly for clients and remained stable for relatives.

### 5.1.2. Commissioning Archetypes

Table 5.2 below shows the grades for each commissioning archetype. First thing that is remarkable is that differences between scores are greater in December 2014 compared to December 2015. In December 2014 grades differed between 7,6 for the Wijkgericht Contracteren model and a 8,5 for the Veilingmodel. This is remarkable because in 2014 all clients received care regulated by the former AWBZ bill. Prior to the analysis, the opposite situation was more or less expected: Due to the implementation of different models with different incentives the results in 2015 were expected to differ more from one another compared to the previous year. This is not the case, the archetypes score either a 7,4 or 7,5 on average. This is reflected in the ANOVA result: a p-value of 0,99 implies there is not a sign of difference between the models.

**Table 5.2: Perceived quality of care by clients per archetype**

| | AWBZ-model | | Veilingmodel | | Wijkgericht contracteren | | Regisseursmodel | | Gronings model | | ANOVA Sig. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Study** | N | Grade | N | Grade | N | Grade | N | Grade | N | Grade | |
| **0 (dec '14)** | 239 | 7.7 | 67 | 8.5 | 68 | 7.6 | 896 | 7.8 | 31 | 7.8 | |
| **1 (juni '15)** | 120 | 7.4 | 31 | 7,3 | 27 | 8,1 | 425 | 7.3 | 18 | 7.1 | 0,21 |
| **2 (dec '15)** | 155 | 7.5 | 31 | 7.4 | 52 | 7.4 | 542 | 7.5[2] | 20 | 7.4 | 0,99 |
| **Difference** | | **-0.2** | | **-1.1**[3] | | **-0.2** | | **-0.3** | | **-0.4** | |

When looking at each model separately over time, some effects - possibly caused by the models - are noticeable. Satisfaction with care received is only by 0,2 point lower with the AWBZ-model and Wijkgericht Contracteren-model, whilst being more than 1 point lower for the Veilingmodel. The difference between grades in the Regisseursmodel is statistically significant, based on T-Test results[4]. The other results are not statistically significant, most likely due to the low number of observations for some of the models. Looking at the DiD-analysis, only the AWBZ – Veilingmodel test resulted in statistical significance. This implies that the introduction of the Veilingmodel lead to a statistically significant worse effect, compared to the traditional approach of commissioning care. Although most of the results are not statistically significant, the results provide for an indication that the chosen commissioning archetype may influence perceived quality of care. However, results may also be explained by confounding variables, e.g. a reluctance of clients towards a change in care provision, which may also lead to lower scores on perceived quality of care.

Relatives of clients grade quality of care (given to the clients) lower than the clients themselves. Also, there is more differentiation between models as well as within the models over 2015. Most notable is the score for the Regisseursmodel in in December 2015. The average score dropped 0,3 points, which is statistically significant[5], based on T-Test results. In overall, the ANOVA showed there is a statistical significance between commissioning archetypes in December 2015. This implies there is a difference in perceived quality. Over time, the Gronings model shows the most decline in perceived quality, although the low number of observations is reason to question the reliability of the result, which is also not statistically significant, based on T-Test results.

**Table 5.3: Perceived quality of care by relatives per archetype**

| | AWBZ-model | | Veilingmodel | | Wijkgericht contracteren | | Regisseursmodel | | Gronings model | | ANOVA Sig. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Study** | N | Grade | N | Grade | N | Grade | N | Grade | N | Grade | |
| **0 (dec '14)** | 397 | 7.1 | 116 | 7.1 | 121 | 7,0 | 1512 | 7.2 | 45 | 7.1 | |
| **1 (juni '15)** | 235 | 7,0 | 70 | 7.0 | 71 | 6,8 | 868 | 7.0 | 25 | 6.6 | 0,26 |
| **2 (dec '15)** | 295 | 7,1 | 79 | 7.1 | 102 | 7.1 | 1076 | 6.9 | 29 | 6.5 | 0,03 |
| **Difference** | | **0** | | **0** | | **+0.1** | | **-0.3**[6] | | **-0.6** | |

[2] Difference is statistically significant when comparing means of December 2014 and December 2015, based on T-Test results. See footnote 4.
[3] Statistically significant difference compared to AWBZ-model, based on DiD-analysis ($p < 0,04$).
[4] Independent T-Test sig. = $p = 0,004$ & Dependent T-Test sig. = $p < 0,001$
[5] Independent T-Test sig. = $p = 0,011$ & Dependent T-Test sig. = $p = 0,042$
[6] Difference is statistically significant when comparing means of December 2014 and December 2015, based on T-Test results. See footnote 4.

### 5.1.3. Financing

Below, table 5.4 presents the results of perceived quality of care for each type of financing: Input, population and performance based financing. The second model, population based financing, shows the same results as the Wijkgericht Contracteren archetype. This is because when a municipality opts for the Wijkgericht Contracteren archetype, they automatically choose population based financing.

The results lead to two insights: (1) Input based financing results in better perceived quality of care, both in December '14 as well as in December '15, but (2) performance based financing' scores better when looking at the trend between 2014 and 2015. This indicates that financing based on performance of care providers attains a higher perceived quality of care, possibly due to care providers reacting positively on the incentives inherent to the financing type. For example: in a performance based financing method, care providers are given the incentive to critically assess the (human) resources they spend on clients, instead of providing fixed budgets and resources and simply cutting these by e.g. 25 percent. Overproduction in performance based contracting is minimized, thus providing extra care and resources to needy clients, enhancing the quality of care. This possibly explains the difference between input- and performance based financing.

**Table 5.4: Perceived quality of care by clients per financing model**

| | **Input** | | **Populatie** | | **Resultaat** | | **ANOVA Sig.** |
|---|---|---|---|---|---|---|---|
| **Study** | N | Grade | N | Grade | N | Grade | |
| **0 (dec '14)** | 918 | 7.9 | 68 | 7.6 | 315 | 7.5 | |
| **1 (juni '15)** | 423 | 7.3 | 27 | 8.1 | 171 | 7.2 | 0,09 |
| **2 (dec '15)** | 556 | 7.5 | 52 | 7.4 | 198 | 7.4 | 0,59 |
| **Difference** | | **-0.4** | | **-0.2** | | **-0.1** | |

Whereas there is little difference between input and performance based financing when asking clients, relatives are more negative towards the financing model based on results and performance by the care provider. ANOVA shows that the difference between the groups in December '15 is statistically significant (p = 0,01), indicating that input based financing is better appreciated than performance based financing by relatives of clients. A possible explanation is that, in contrast to clients, relatives only see a drop in quantity of care (e.g. number of hours per week care) for their loved ones, assessing the actual quality of social care less, thus assessing quantity as quality.

**Table 5.5: Perceived quality of care by relatives per financing model**

| | **Input** | | **Populatie** | | **Resultaat** | | **ANOVA sig.** |
|---|---|---|---|---|---|---|---|
| **Study** | N | Grade | N | Grade | N | Grade | |
| **0 (dec '14)** | 1629 | 7.1 | 126 | 7.0 | 557 | 7.3 | |
| **1 (juni '15)** | 1160 | 7.1 | 101 | 6,8 | 403 | 6.9 | 0,06 |
| **2 (dec '15)** | 1141 | 7.0 | 106 | 7.1 | 415 | 6.8 | 0,01 |
| **Difference** | | **-0.1** | | **+0.1** | | **-0.4** | |

### 5.1.4. Contract type

Although the methodology chapter speaks of more contracting models than those shown in table 5.5, only the contract with guaranteed budget, the framework agreement contracts and contracts with one main contractor are taken into account in the analysis. The other contracting models did not provide sufficient numbers of

respondents for a reliable analysis. Framework contracts perform the best on average, despite a statistically significant drop in perceived quality of almost half a point. The results between groups in December 2015 are not statistically significant.

**Table 5.5: Perceived quality of care by clients per contracting model**

| | Contract met budgetgarantie | | Raamcontract | | Hoofdaannemer | | ANOVA Sig. |
|---|---|---|---|---|---|---|---|
| **Study** | N | Grade | N | Grade | N | Grade | |
| **0 (dec '14)** | 259 | 7.5 | 977 | 7.9 | 47 | 7.2 | |
| **1 (juni '15)** | 122 | 7.2 | 474 | 7.4 | 18 | 7.8 | 0,08 |
| **2 (dec '15)** | 167 | 7.4 | 585 | 7.5 | 37 | 7.2 | 0,37 |
| **Difference** | | **-0.1** | | **-0.4**[7][8] | | **0** | |

When analysing the grades given by relatives, little differences were observed, both between models and over time. Table 5.6 shows the results of this analysis. The statistical significant ANOVA is presumably caused by the large difference in number of respondents between the models.

**Table 5.6: Perceived quality of care by relatives per contracting model**

| | Contract met budgetgarantie | | Raamcontract | | Hoofdaannemer | | ANOVA sig. |
|---|---|---|---|---|---|---|---|
| **Study** | N | Grade | N | Grade | N | Grade | |
| **0 (dec '14)** | 397 | 7.0 | 1659 | 7.2 | 88 | 7.0 | |
| **1 (juni '15)** | 239 | 6.8 | 961 | 7.1 | 50 | 6.5 | 0,05 |
| **2 (dec '15)** | 279 | 6,9 | 1201 | 7.0 | 73 | 6,9 | 0,01 |
| **Difference** | | **-0.1** | | **-0.2** | | **-0.1** | |

## 5.2. Effect on client self-reliance

### 5.2.1. Average scores

The second goal of the decentralizations in the Dutch social domain is increasing client self-reliance. Clients ought to live longer at home and received tailored care if necessary. Care receivers should be less reliant on (professional) care providers and need to look in their own social network to provide for care needed. Like with the quality of care, clients were asked to grade their perceived amount of self-reliance. In contrast to the quality of care, the perceived self-reliance did increase after one year. After a small drop from a 7,4 in December '14 to a 7,2 in June '15, the perceived self-reliance peaked at 7,5 out of 10 in December '15. Below the scores for every archetype and financing model are shown. A relation with contracting model is left aside, the theoretical relation between contracts and perceived self-reliance is too indirect to produce reliable results.

**Table 5.7: Average perceived self-reliance by clients per study (I&O Research, 2016)**

| | 0-meting | 1-meting | 2-meting |
|---|---|---|---|
| | Dec 2014 | Jun 2015 | Dec 2015 |
| **Self-reliance** | 7,4 | 7,2 | 7,5 |
| **N** | 2.283 | 1.183 | 1.416 |
| **% insufficient self-reliance (grade lower than 6)** | 29% | 29% | 24% |

[7] Difference is statistically significant when comparing means of December 2014 and December 2015, based on T-Test results. See footnote 8.
[8] Independent T-Test sig. = p < 0,001 & Dependent T-Test sig. = p = 0,01

### 5.2.2. Commissioning archetype

Looking at the perceived self-reliance, graded by clients, the differences between models are greater than the differences when looking at the perceived quality. The two most widely used models, AWBZ- and Regisseursmodel both score average: both 7,5 points out of 10. Especially the Wijkgericht Contracteren model scores above average, increasing the average score of the model from 7,3 in December '14 to a 8,2 in December '15. It is possible that giving more responsibility to several main contractors, combined with population based financing, paves the way for the care providers to assess the care needed by clients and to implement other ways of providing care besides professional care or that the care providers succeed in providing better tailored support. The Veilingmodel and Gronings model are the only models that have a lower average after a year of decentralizations. Comparing the differences of the new models and the traditional AWBZ-model between 2014 and 2015 - using the DiD-analysis - no statistically significant results were found.

**Table 5.8: Perceived self-reliance by clients per archetype**

| | AWBZ-model | | Veiling-model | | Wijkgericht contracteren | | Regisseurs-model | | Gronings model | | ANOVA Sig. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Meting** | N | Cijfer | N | Cijfer | N | Cijfer | N | Cijfer | N | Cijfer | |
| **0 (dec '14)** | 433 | 7.4 | 104 | 7.3 | 124 | 7.3 | 1566 | 7.6 | 56 | 7.6 | |
| **1 (juni '15)** | 225 | 6.9 | 55 | 6.4 | 58 | 8.0 | 818 | 7.3 | 27 | 7.4 | 0,02 |
| **2 (dec '15)** | 266 | 7.5 | 66 | 7.0 | 90 | 8.2 | 968 | 7.5 | 26 | 7.2 | 0,09 |
| **Verschil** | | **+0.1** | | **-0.3** | | **+0.9** | | **-0.1** | | **-0.4** | |

### 5.2.3. Financing model

The population based scores the same as Wijkgericht Contracteren, as expected. Looking at the other two financing models, result based financing scores a bit lower than the input financing model.

**Table 5.9: Perceived self-reliance by clients per financing model**

| | Input | | Populatie | | Resultaat | | SIG. |
|---|---|---|---|---|---|---|---|
| **Meting** | N | Cijfer | N | Cijfer | N | Cijfer | |
| **0 (dec '14)** | 1582 | 7.5 | 124 | 7.3 | 669 | 7.4 | |
| **1 (juni '15)** | 820 | 7.2 | 58 | 8.0 | 456 | 6.9 | 0,07 |
| **2 (dec '15)** | 964 | 7.5 | 90 | 8.2 | 442 | 7.3 | 0,05 |
| **Verschil** | | **0** | | **+0.9** | | **-0.1** | |

## 5.3. Other effects

### 5.3.1. Effects on quantity of care

Directly related to the archetypes of commissioning care are incentives care providers receive for delivering a certain quantity of services. Taking the announced budget cuts into account, (1) when using performance or result based financing or Wijkgericht Contracteren and population based financing one would expect a decrease in volume. Another example is the Gronings model: this model is rewarding care providers who take up the care for as many clients as possible, giving the incentive to provide less care per client, because production capacity remains the same. On the other hand, (2) when using input based financing or the AWBZ-model municipalities and care providers are more likely to decrease hourly tariffs instead of volume.

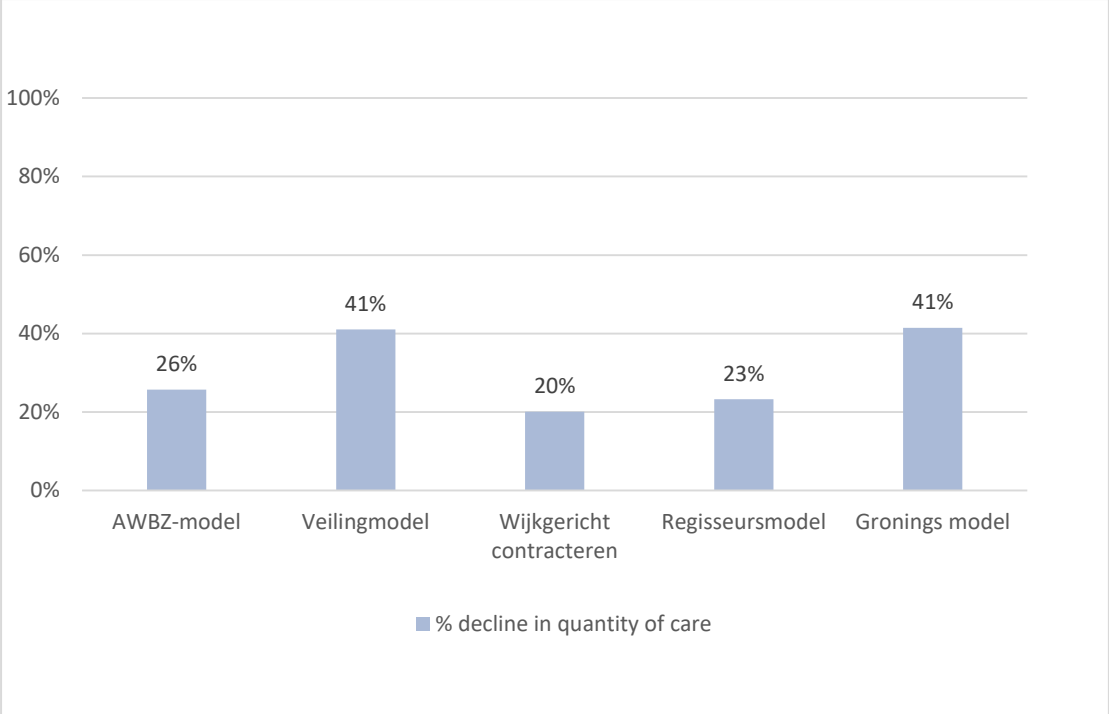


**Figure 5.1: % clients that indicate being given less care in December '15**

Figure 5.1 above shows the relative number of clients that indicate having received less care in 2015 compared to 2014. As expected, a lot of the clients in the Gronings model indicate that they have been given less care after the decentralisations. Up to four out of ten (41 percent) of the clients indicate so. Note that due to the low number of clients of the Gronings model present in the dataset, this statement has to be made with reservation. This is equal to the Veilingmodel and almost twice as high as the Wijkgericht Contracteren and Regisseursmodel. The AWBZ-model sits in between, with 26 percent of the clients stating they had a decrease in volume of care. In the Wijkgericht Contracten model it's also expected that there would be a decrease in volume, due to the incentives of the model, but this did not happen. According to agency theory a main contractor may be reluctant to increase the volume of care, since they have a fixed budget based on the population. This does not appear to be happening. Metaphorically, every penny that can be saved is welcome to the main care provider, either in quantity or in quality. Because neither quality nor quantity of social care in the Wijkgericht Contracteren model is underperforming (yet), the care providers do not seem to react to the negative incentives expected when taking the agency theory and service-triad theory (Li & Choi, 2009) into account.

### 5.3.2. Informal care

Closely connected to the volume of care and self-reliance, the use of informal care is also interesting to investigate. Due to the budget cuts in the social domain, clients and (informal) care givers and –providers are given the incentive to look for alternative solutions, one of them increasing the volume of informal care by relatives, friends and neighbours as a substitute of regular, professional social care.

In the I&O Research questionnaires two types of informal care are differentiated. First is intensive formal care, where a client is being cared for by relatives, friends or volunteer on a daily basis. Care received involves washing, cooking, cleaning et

cetera. The second form is non-intensive informal care. This is incidental informal care, for example doing the weekly groceries for a family member, neighbour or friend. Besides informal care received, attention is also paid to informal care givers, using the same dimensions of intensity.

The figure below shows the percentages of intensive and non-intensive informal care received. Looking at the different archetypes, besides the Veilingmodel there is not much difference between the situation in 2014 and 2015. The drop in use of informal care for the Veilingmodel is probably due to the low number of clients of this model that are present in this research.

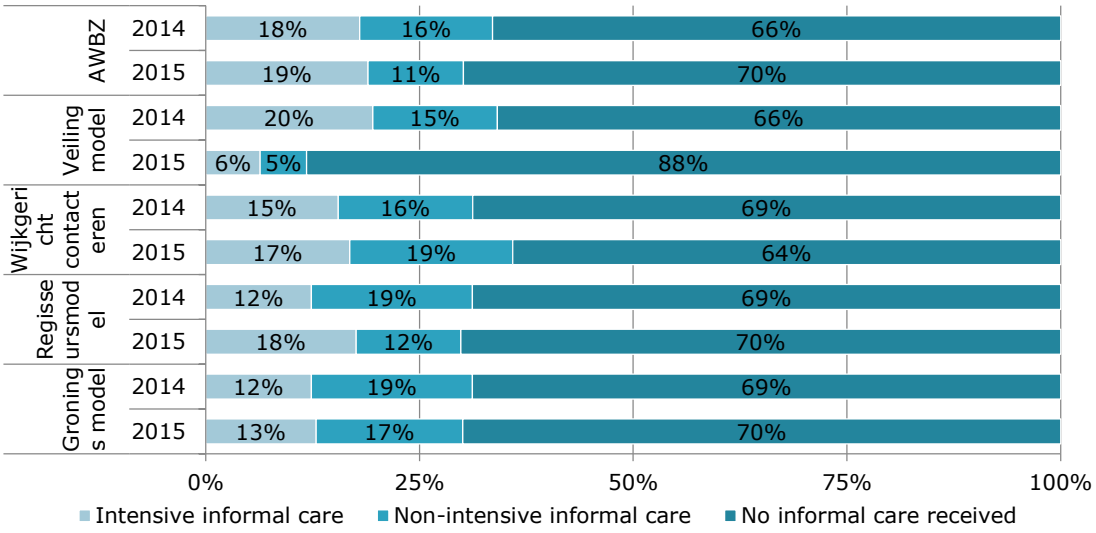


**Figure 5.2: % informal care received per archetype in 2014 and 2015**

More interesting are the developments when looking at the informal care givers. The relative amount of informal care given did not increase that much, but the amount of intensive informal care given did. Especially in the AWBZ model, the amount of informal care given is almost doubled in one year, from 16 percent in 2014 to 30 percent in 2015. There is also an increase noticeable in the Regisseursmodel (10 percent), Gronings model (10 percent) and Veilingmodel (6 percent).

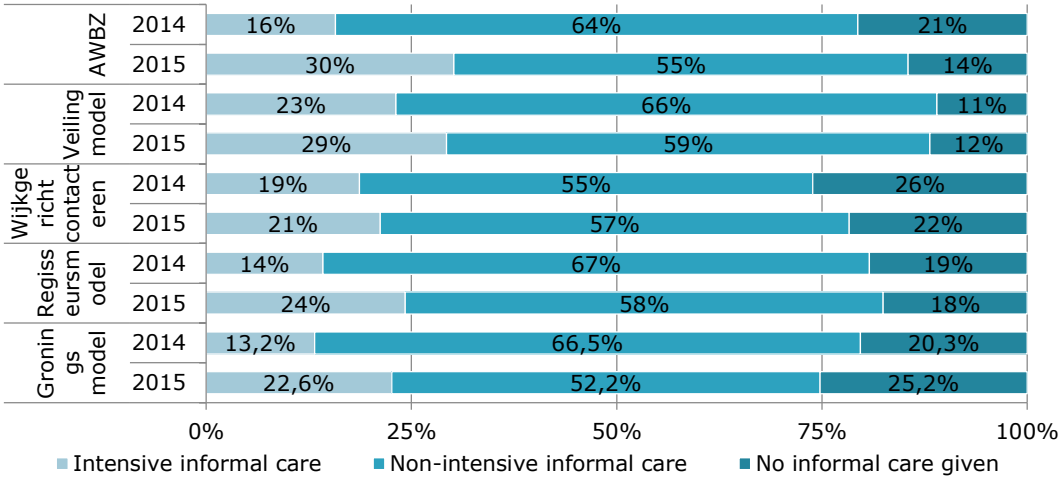


**Figure 5.3: % informal care given per archetype in 2014 and 2015**

# 6. Conclusions

This final chapter translates the results of the analysis into conclusions that answer the main research question, followed by several recommendations for future research. Provided alongside the conclusion and recommendations is a short discussion on how the results relate to the expectations based on the agent- and service-triad theory. The chapter ends with a short discussion of the limitations this research.

## 6.1. Main research question

The main research question that this research answers is the following:

*"Does the approach of municipal commissioning of care influence quality of care and self-reliance of clients after the Dutch social domain decentralizations of 2015?"*

Taking all results into account, it can be concluded that there is an indication that the chosen approach of municipal commissioning of care does affect quality of care and self-reliance. The commissioning archetypes, financing models and contract types all conceptualized into the overall picture of commissioning of care by Dutch municipalities all perform different, looking at the client reported quality of care, self-reliance, quantity of care and the use of informal care. However, not all differences found proved to be statistically significant. This implies that other, confounding, variables may also influence the perceived quality of care and self-reliance.

Expectations based on agent theory and service-triads were met in some cases, but in some cases the results were quite surprising. The conclusions presented below are interesting for further investigation in in future research, either to see if a trend is developing or to look for more evidence that support the indications found.

### 6.1.1. Effects on perceived quality of care

Regarding the perceived quality of care, it is remarkable that there is no difference between models after one year of decentralizations. However, taking each commissioning archetype separately, some of the results over time are worth mentioning. In this regard, the AWBZ-model and Gronings model perform according to expectations made before the data analysis.

The AWBZ-model is one of the archetypes that performed as expected. In this model the provision of care and social services is almost completely the same as the provision of care before the decentralizations. It's no surprise that this model does not show a large decrease in patient perceived quality of care or self-reliance. The expectation that in the clients' and relatives' perspectives only slight changes are noticeable in the actual care provision may illustrate the slight decrease. This is supported by the observation of the quality assessments of relatives, friends and neighbours. The new, more innovative approaches were structurally graded lower by relatives of clients. The lower assessment of these new approaches may perhaps be explained by reluctance towards changes in care provision by both groups, also illustrated by the overall lower perception of quality in June 2015 and a slightly better perception of quality in December 2015.

Out of the municipalities that did reform the commissioning of care and social services, the Gronings model also performs in line with the expectations. Both clients

and relatives grade their situation in this archetype lower in 2015, compared to 2014. The observation that the Gronings model has the highest percentage of clients that indicate their volume of care has decreased over 2015 may prove to be an explanation. The incentive within this archetype: maximizing the number of clients whilst minimizing the amount of care per client is reflected in the results. This seems to affect the perceived quality of care. However, note that due to the very limited number of observations in the Gronings model, the above is primarily an indication and no clear empirical evidence.

Another archetype where care provider incentives were prominent is Wijkgericht Contracteren. According to theory by Li & Choi (2009) this model faces several incentive problems, since the relationship between municipality and care provider resembles the service-triade-theory the most. With a municipality not acting upon the bridge transfer, the care provider may, theoretically, be able to fully exploit the information advantage. Uenk (2016a) stated that care providers within this archetype are more likely to minimize care provision per client. However, this was not observed in the data analysis. Moreover, the perceived quality by clients is at the same level as the AWBZ-archetype and perceived quality by relatives is higher after the decentralisations. The data analysis cannot provide evidence why expected results were not observed. No information of e.g. monitoring by municipalities was available. The observations do suggest that the service-triad-theory may not be fully applicable and/or explanatory when researching the approaches towards municipal commissioning of care.

### 6.1.2. Effects on perceived self-reliance

The main conclusion derived from the analysis on the effects of the archetypes and models on perceived self-reliance is that the archetype Wijkgericht Contracteren and the corresponding financing and contracting models outperform the others. Clients from municipalities who used the Wijkgericht Contracteren approach assessed the perceived amount of self-reliance by 0,9 point. Because the care providers are granted a fixed budget for a designated population under Wijkgericht Contracteren, the care providers are given the incentive to first look for care options in the social network of the client, since this is financially more appealing for the care provider. The five percent increase in use of informal care supports this conclusion.

## 6.2. Discussion and future research

This research presents, for the first time, a quantitative study to measure the effects of the decentralisations in the Dutch social domain. As stated above, the results show that different approaches to municipal commissioning of care affect perceived outcomes by clients and relatives. Some of the observations are in line with expectations based on theory and others are not, the performance of the Wijkgericht Contracteren archetype being the best example of the latter. The latter implies that more research can be done to research these effects and moreover, what the causes are of the results observed in this research. It also implies that the theory used to make expectations and explain results, the agency- and service-triad-theories, are sufficient only to certain extent. More research with the use of new theories and constructs may provide to be useful in researching the social domain decentralisations.

In the case of the AWBZ-model it would be interesting to see how this model performs after several years with increasing budget cuts. 2015 was seen by many municipalities as a transition year, in which they could learn from other municipalities

who did use new approaches to commissioning care provision (Uenk, 2016b). The results observed indicate that clients and relatives did not notice many changes, subsequently assessing the quality of care received slightly lower. In the case municipalities shift away from the AWBZ-model in the upcoming years: Does perceived quality of care provision and self-reliance also drop, like they did in the municipalities who adopted new approaches in 2014/2015? This trend is likely to become more noticeable in the near future, in 2015 municipalities tended to stick with the AWBZ-archetype to buy more time to adapt to the decentralisation (NJI, 2016b). For 2016 and beyond it is expected that there will be a higher variety in archetypes and methods (Uenk, 2016b).

It is advised that, in order to further research the effects of the styles of municipal commissioning of care and social services on the set goals of the decentralizations, this research is repeated in coming years. After e.g. three years a more distinct trend in quality and volume of care and perceived self-reliance can be noticed. After only one year of studying the effects, many confounding variables may influence the results and conclusions presented in this research. Henceforth it is mentioned that the results are to certain extent only an indication of effects. This also corresponds with the limitations of this research and how to improve future research, mentioned in the next sub-chapter.

As mentioned before the Wijkgericht Contracteren archetype performs well compared to other archetypes and in the light of the incentives it has to cope with. Future research could focus on the specific network characteristics of the individual municipalities who chose the Wijkgericht Contracteren approach. The service-triade-theory may prove to be useful: How did these municipalities cope with bridge transfer and what characteristics ensured good results? Or is the service-triad theory not fully applicable when researching social care commissioning, if so: What other theories may prove to be useful in explaining the mechanisms of Wijkgericht Contracteren? Unfortunately, this was not possible to measure using the datasets of this research.

Regarding the Regisseursmodel, it is one of the largest models in the data analysis, but due to the nature of the Regisseursmodel, it is difficult to pinpoint the exact performance of this archetype. Uenk (2016a) states there are many approaches within this model, e.g. municipalities are free to choose financing methods and contract types, but the analysis did not make a distinction between these variants of the Regisseursmodel. A new construct for the Regisseursmodel in future research, e.g. Regisseursmodel A using input- based financing and Regisseursmodel B using performance based financing, could provide better understanding which approach works best.

As for the other two archetypes, the Veilingmodel and the Gronings model, observation and results presented in this research only provide for an indication and overall reliability regarding these models is low due to a limited number of observations. Future research could focus more on non-random sampling in order for these archetypes to be better represented in future research.

## 6.3. Limitations

The foremost limitation this research had to cope with that data was collected prior to the start of this research. The data used was not collected with this type of research

specifically in mind. I&O Research created the questionnaire for clients and relatives to report on several opinions revolving around the decentralizations in the social domain. It wasn't their direct intention to create a questionnaire that could be used for the analysis of commissioning of care by municipalities.

The questionnaire was not directly sent to clients and/or relatives but to a panel consisting of random members, who may not even receive care or get in contact with relatives who receive care or other social services. This lead to some of the respondents of the questionnaire not receiving the questions on perceived quality of care and self-reliance. This decreased the statistical power for some of the analyses that have been made. This is reflected in some of the archetypes being under-represented in the analysis, as has been mentioned above, most notably the Veilingmodel and Gronings model. These models are used by only a handful of municipalities, and because the sample for the questionnaire had a more general purpose than this specific research, some of the observations mentioned in the results are too low to properly derive conclusions from the results. Weighting was added to counter the under-representation of these groups, but still, because of this under-representation several of the conclusions made during the research have to be presented with a certain degree of caution. Because of the low statistical power of some of the samples there are some concerns revolving the reliability of the results.

Also, running statistical tests was in some cases problematic because not every respondent participated in all studies by I&O Research. Due to the aforementioned both the number of paired and independent observations was lower, making the results of the T-Tests performed prone to bias.

In future research it is therefore advised to critically assess the questionnaire that is sent to the respondents and make sure it is more suitable for clients and relatives who receive care and social services that are commissioned by Dutch municipalities. Furthermore the research sample should be designed to give a reliable representation of the different archetype populations. By implementing these changes to the research methods, the reliability and internal validity of the future research can be improved and trends and further effects can be investigated.

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# Appendix A: 16 situations in the social domain

| | **Met welke van onderstaande problemen of situaties heeft of had u zelf te maken?** | **Ikzelf** | **Gezin** (partner/ kind/ouder) | **Familie** (ouders, uitwonenden kinderen) | **Vrienden /Buren** | **NIET mee te maken** |
|---|---|---|---|---|---|---|
| 1 | Kan niet zelfstandig het huishouden organiseren | o | o | o | o | o |
| 2 | Kan het huis niet schoonhouden | o | o | o | o | o |
| 3 | Kan niet rondkomen / financiële problemen | o | o | o | o | o |
| 4 | Hulpmiddelen nodig (bijv. rollator, scootmobiel, krukken, aanvullend openbaar vervoer) | o | o | o | o | o |
| 5 | Kind met fysieke problemen/langdurige ziekte | o | o | o | o | o |
| 6 | Volwassene met fysieke problemen/langdurige ziekte | o | o | o | o | o |
| 7 | Kind met gedrags- of psychische problemen | o | o | o | o | o |
| 8 | Volwassene met gedrags- of psychische problemen | o | o | o | o | o |
| 9 | Kind met verstandelijke beperking | o | o | o | o | o |
| 10 | Volwassene met verstandelijke beperking | o | o | o | o | o |
| 11 | Moeite met de opvoeding van kind(eren). | o | o | o | o | o |
| 12 | Iemand met 'afstand tot de arbeidsmarkt' vanwege een beperking | o | o | o | o | o |
| 13 | Kind had problemen met politie, justitie, reclassering | o | o | o | o | o |
| 14 | Oudere kan niet (goed) zelfstandig wonen / (beginnende) dementie/ alzheimer | o | o | o | o | o |
| 15 | Oudere die in een verpleeg- of verzorgingshuis is (gaan) wonen | o | o | o | o | o |
| 16 | Eenzaam voelen | o | o | o | o | o |

# Appendix B: Questionnaire third study

## 2-meting onderzoek decentralisaties – I&O Research

**Doel onderzoek:**
monitoren wat de invloed is van de drie decentralisaties op:

- de kwaliteit van de voorzieningen en
- de zelfredzaamheid van burgers.

**Opzet**
Monitoren van kennis, houding, gedrag en waardering van de dienstverlening m.b.t. de taken die nu bij de gemeente komen (en ten dele al zijn).

- Onderzoek in eigen beheer
- Uitgevoerd in (online) I&O Research Panel
- Longitudinaal:
  - 0-meting in december 2014 (n=9.000) (publicatie: februari 2015)
  - 1-meting in mei 2015 (n= 7.000 à 9.000) (publicatie: juni 2015)
  - 2-meting in december 2015

**Opbouw vragenlijst:**

**A. Prevalentie belangrijkste situaties behorend bij 3D** (vraag 1)
- Situaties meegemaakt? Wie? (ikzelf, gezin, familie, vrienden/buren)

**B. Hoe is het voor mij en mijn gezin?** (Wat ontvang ik?) (vr 2 t/m 10b)
- Zelfredzaamheid (zelf)
- Krijgt hulp? Van wie?
  - Professioneel (wie/wat)
  - Omgeving (mantelzorg, wie, wat voor hulp?)
- Waardering prof. hulp
- Wel prof. hulp gezocht? Waarom niet geholpen?
- Belang hulp (omgeving en professioneel)
- Geluk, eenzaamheid, lichamelijke en geestelijke gezondheid

C. **Hoe is het voor mijn omgeving** (familie/vrienden/buren?) (Wat geef ik?) (vr 11 t/m 23)
- Zelfredzaamheid (ander)
- Geeft hulp? Aan wie?
  - Professioneel (wie/wat)
  - Omgeving
- Wel prof. hulp gezocht? Waarom niet geholpen?
- Mantelzorg
  - Aan wie
  - wat voor hulp
  - Hoe lang al? Hoeveel uur per week?
  - Hoe belastend?
  - Ondersteuning bij mantelzorg? Behoefte aan ondersteuning?
  - Dagbesteding?
- Waardering prof. hulp
- Belang hulp (omgeving en professioneel)
- Geluk, eenzaamheid, lichamelijke en geestelijke gezondheid

D. **Hoe is het voor professionals?** (vr 24, 25, 28)
- Werkzaam in domein 3D? (zelfde situaties als v1). Als wat?
- Verwachte gevolgen van 3D voor werk.

**E. Opiniërende vragen en bekendheid 3D** (vr 26, 27, 29, 30)
- Stellingen 3D, zelfredzaamheid en hulpbereidheid algemeen
- Bekendheid met 3D

- Vertrouwen in kwaliteit korte/lange termijn, voor mijzelf
- Ontwikkeling in de tijd (wordt het beter/slechter/gelijk)

## Vragenlijst landelijke onderzoek decentralisaties - I&O Research

**1-meting**
I&O Research
Mei 2015

**Inleiding**
Dit onderzoek gaat over situaties die u meemaakt in uw persoonlijk leven, zelf, met uw gezin, familie of vrienden en de hulp of ondersteuning die u daarbij wel of niet krijgt.

Het kan zijn dat u deze vragen eind vorig jaar ook hebt beantwoord. We hopen dat u ze opnieuw wilt beantwoorden voor uw situatie in de periode van 1 januari 2015 tot nu.

Het kost u tussen de 5 en 12 minuten om de vragenlijst in te vullen (afhankelijk van uw situatie).

**1. Met welke van onderstaande problemen of situaties had u zelf na 1 januari 2015 te maken?**

**Gold dat voor u zelf, iemand in uw gezin, iemand uit uw familie of iemand in uw naaste omgeving als privé persoon (dus niet beroepsmatig)?**

**We bedoelen situaties waar u zelf nauw bij betrokken was.**
*(U kunt per situatie één antwoord aanvinken, indien het voor meer mensen geldt, kies dan degene die het dichtst bij u staat)*

| | **Met welke van onderstaande problemen of situaties had u zelf sinds 1 januari te maken?** | **Ikzelf**<br><br>Ikzelf heb/had daar mee te maken | **Gezin**<br><br>Iemand in mijn gezin (partner/kind /ouder) heeft/had daar mee te maken<br><br>en ik was daar nauw bij betrokken | **Familie**<br><br>Iemand in de familie maar buiten mijn gezin (ouders, uitwonenden kinderen)<br><br>en ik was daar nauw bij betrokken | **Vrienden/ buren**<br><br>Vrienden of buren<br><br>en ik was daar nauw bij betrokken | **NIET mee te maken** |
|---|---|---|---|---|---|---|
| 1 | Kan niet zelfstandig het huishouden organiseren | ○ | ○ | ○ | ○ | ○ |
| 2 | Kan het huis niet schoonhouden | ○ | ○ | ○ | ○ | ○ |
| 3 | Kan niet rondkomen / financiële problemen | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | Hulpmiddelen nodig (bijv. rollator, scootmobiel, krukken, aanvullend openbaar vervoer) | ○ | ○ | ○ | ○ | ○ |
| 5 | Kind met fysieke problemen/langdurige ziekte | ○ | ○ | ○ | ○ | ○ |
| 6 | Volwassene met fysieke problemen/langdurige ziekte | ○ | ○ | ○ | ○ | ○ |
| 7 | Kind met gedrags- of psychische problemen | ○ | ○ | ○ | ○ | ○ |
| 8 | Volwassene met gedrags- of psychische problemen | ○ | ○ | ○ | ○ | ○ |
| 9 | Kind met verstandelijke beperking | ○ | ○ | ○ | ○ | ○ |
| 10 | Volwassene met verstandelijke beperking | ○ | ○ | ○ | ○ | ○ |
| 11 | Moeite met de opvoeding van kind(eren). | ○ | ○ | ○ | ○ | ○ |
| 12 | Iemand met 'afstand tot de arbeidsmarkt' vanwege een beperking | ○ | ○ | ○ | ○ | ○ |
| 13 | Kind had problemen met politie, justitie, reclassering | ○ | ○ | ○ | ○ | ○ |
| 14 | Oudere kan niet (goed) zelfstandig wonen / (beginnende) dementie/ alzheimer | ○ | ○ | ○ | ○ | ○ |
| 15 | Oudere die in een verpleeg- of verzorgingstehuis woonde of is gaan wonen | ○ | ○ | ○ | ○ | ○ |
| 16 | Eenzaam voelen | ○ | ○ | ○ | ○ | ○ |

***INDIEN 'ik zelf' en 'gezin' >> naar vraag 3***

***INDIEN familie, vrienden/buren >> naar vraag 11***

***INDIEN NERGENS mee te maken gehad >> naar vraag 10a***

## Zorg voor mijzelf/gezin

*Vraag 3 indien antwoord = 1 'ikzelf' of 'gezin'*
U of iemand in uw gezin had dus in de periode van 1 januari 2015 tot nu te maken met:
<situatie vraag 1>
<situatie vraag 1>
<situatie vraag 1>

**3. Heeft iemand in uw naaste omgeving u in de periode tussen 1 januari en nu verzorgd of geholpen bij deze situatie(s)?**

**Indien ja, welk soort zorg of hulp kreeg u?**
**(We bedoelen hier GEEN professionele hulp, dat volgt hierna)**
*Eén antwoord mogelijk*

1. Ja, intensief en langdurig verzorgd (door mantelzorger in hetzelfde huishouden)
2. Ja, intensief en langdurig verzorgd (door mantelzorger, niet in hetzelfde huishouden)
3. Ja, regelmatig geholpen of bezocht, maar niet verzorgd (door vrijwilliger)
4. Ja, af en toe geholpen of bezocht, maar niet verzorgd (door vrijwilliger)
5. Nee (niet of nauwelijks)

**Hulpscherm voor wat mantelzorg en vrijwilligerswerk is:**
Mantelzorg
Mantelzorgers zorgen onbetaald en langdurig voor een chronisch zieke, gehandicapte of hulpbehoevende partner, ouder, kind of ander familielid, vriend, buur of kennis. Een mantelzorger zorgt voor iemand in zijn of haar omgeving waar al een emotionele band mee bestaat.
Mantelzorgers zorgen soms 24 uur per dag, kunnen de zorg niet zomaar beëindigen en verrichten soms ook verpleegkundige handelingen.
Mantelzorg is *niet* de alledaagse zorg voor, bijvoorbeeld de zorg voor een gezond kind.

Vrijwilligerswerk
Vrijwilligers kiezen ervoor om te zorgen. Als zij met het vrijwilligerswerk starten, is er vaak (nog) geen of weinig emotionele band. Daarnaast zorgen zij voor een afgebakende tijd (bijvoorbeeld een dagdeel per week) en kunnen zij de zorg op eigen initiatief beëindigen.

*Indien vraag 3 = 1 t/m 4*
**4. Van wie ontving u deze hulp of zorg?**
**(We bedoelen hier GEEN professionele hulp, dat volgt hierna)**
*Meerdere antwoorden mogelijk*

1. Van mijn kind(eren)
2. Van mijn partner
3. Van mijn ouder(s) / schoonouders
4. Van een broer of zus
5. Van buren
6. Van vrienden/kennissen

*Indien vraag 3 = 1 t/m 4*

**5. Wat voor hulp of zorg ontving u?**
**(We bedoelen hier <u>GEEN professionele</u> hulp, dat volgt hierna)**

1 Huishoudelijke hulp, zoals schoonmaken, de was doen en boodschappen doen
2 Hulp bij organiseren van huishouden
3 Begeleiding bij het regelen van financiële zaken en administratie
4 Vervoer, begeleiding bij het bezoeken van familie, artsen, winkels enzovoorts
5 Gezelschap, emotionele steun en toezicht
6 Samen dingen ondernemen
7 Persoonlijke verzorging bij aan- uitkleden, wassen, toiletgang, e.d.
8 Verpleegkundige hulp, zoals het klaarzetten en toedienen van medicijnen en wondverzorging
9 Hulp bij het organiseren van professionele zorg
10 Anders, namelijk:

*Indien vraag 3 = 1 t/m 4*
**6. Hoe belangrijk is deze hulp of zorg van uw naasten voor u?**
**(We bedoelen hier <u>GEEN professionele</u> hulp, dat volgt hierna)**

1 Essentieel, ik kan niet zonder
2 Heel belangrijk
3 Tamelijk belangrijk
4 Niet zo belangrijk maar prettig
5 Ik kan er makkelijk zonder

*Vraag 7 indien antwoord = 1 'ikzelf' of 'gezin'.*
**7. Heeft u voor deze situatie(s) <u>in 2015</u> professionele hulp of zorg gekregen van één of meer van onderstaande instanties? Zo ja, van welke?** (meerdere antwoorden mogelijk)

U of iemand in uw gezin had dus in de periode van 1 januari 2015 tot nu te maken met:
<situatie vraag 1>
<situatie vraag 1>
<situatie vraag 1>

1 Nee, geen hulp of zorg gekregen
2 Instelling voor verstandelijk beperkten
3 Bureau Halt
4 Bureau Jeugdzorg
5 CAD (Consultatiebureau alcohol & drugs)
6 Centrum voor Jeugd en Gezin (CJG)
7 Consultatiebureau (ouders en kinderen)
8 Dagbesteding / dagopvang
9 Eigen Kracht organisatie
10 Gemeente
11 Gespecialiseerde hulp bij opvoeding
12 GGD/GG&GD (Gemeentelijke Gezondheids- en Geneeskundige dienst)
13 GGZ-instelling (Geestelijke Gezondheids- en verslavingszorg)

14 Huisarts
15 Huishoudelijke hulp
16 Jeugdarts
17 Jeugdhulpinstelling
18 Kinderbescherming (Raad voor de Kinderbescherming))
19 Maatschappelijk werk
20 Mantelzorgondersteuning
21 MEE
22 Ouderenzorginstelling
23 Orthopedagogische hulp
24 Politie/ wijkregisseur/wijkagent
25 Pleegzorgorganisatie
26 Psycholoog
27 Psychiatrische instelling
28 Reclassering / Jeugdreclassering
29 Schuldhulpverlening
30 School/Onderwijsinstelling
31 Schoolarts, schoolmaatschappelijk werk
32 Thuiszorg / Buurtzorg
33 UWV
34 Verzorgingstehuis / verpleegtehuis
35 Welzijnsstichting/organisatie
36 Wijkteam / Buurtteam / Sociaal wijkteam
37 WMO-Loket bij gemeente (Wet maatschappelijke ondersteuning)
38 Woningcorporatie/woningbouwvereniging
39 Zorgkantoor
40 Zorg- en adviesteams (ZAT)
41 Ziekenhuis
42 Anders, namelijk…

*Indien vraag 7 = niet 1*
**8a. Hoe belangrijk is deze hulp of zorg van deze organisaties voor u?**

1 Essentieel, ik kan niet zonder
2 Heel belangrijk
3 Tamelijk belangrijk
4 Niet zo belangrijk maar prettig
5 Ik kan er makkelijk zonder

**8b. Hoe beoordeelt u de hulp of zorg die u <u>in 2015</u> kreeg van alle organisaties en instellingen in verband met deze situaties?**
*(Waarbij een 1 heel slecht is en een 10 heel goed)*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Als vraag 8b < 6*
**8c. Waarom geeft u dit cijfer? (meerdere antwoorden mogelijk)**
*Random aanbieden*

1. Ik werd niet geholpen
2. Te veel doorverwijzingen
3. Duurde te lang voor ik geholpen werd/word
4. Er werd niet goed naar me geluisterd, probleem werd niet begrepen
5. Te veel organisaties die niet goed samenwerken
6. Privacy niet gewaarborgd
7. Ik moest steeds weer mijn verhaal vertellen
8. Ik moest steeds weer dezelfde gegevens geven
9. Te duur
10. Anders, namelijk:_____

U had dus zelf in de periode van 1 januari 2015 tot nu te maken met:
<situatie vraag 1>
<situatie vraag 1>
<situatie vraag 1>

*Indien vraag 7 is niet 36 (wijkteam/buurtteam)*
**8d. Heeft u bij de hulp die u kreeg ook contact gehad met het sociale wijkteam van uw gemeente?**

**Info:**
In een Sociaal Wijkteam werken professionals van verschillende zorg- en welzijnsorganisaties samen zoals de wijkverpleegkundige, opbouwwerker, maatschappelijk werker, WMO-consulent en ouderenadviseur. Samen met bewoners in de wijk zoekt het Sociaal Wijkteam naar praktische oplossingen voor vragen en problemen rond ziekte en beperking, zelfstandig wonen en voorzieningen.
Het sociale wijkteam wordt ook wel genoemd:

- Wijkteam
- Buurtteam
- Jeugdteam

1. Ja
2. Nee
3. Weet niet

*Indien vraag 8d = 1 óf V7= Wijkteam / Buurtteam / Sociaal wijkteam (36)*
**8e. Hoe beoordeelt u de hulp die u van het (sociale) wijkteam/buurtteam heeft gekregen?**
(Waarbij een 1 heel slecht is en een 10 heel goed)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Indien vraag 8e < 6*
**8f. Waarom geeft u dit cijfer? (meerdere antwoorden mogelijk)**
*Random aanbieden*

1. Ik werd niet geholpen
2. Ik werd niet goed doorverwezen
3. Het duurde lang voor ik geholpen werd
4. Er werd niet goed naar me geluisterd, probleem werd niet begrepen

5. Te weinig specialistische kennis in het team
6. Te veel organisaties die niet goed samenwerken
7. Mijn privacy werd niet gewaarborgd
8. Ik moest steeds weer mijn verhaal vertellen
9. Ik moest steeds weer dezelfde gegevens geven
10. Te duur
11. Zorgdossier is kwijtgeraakt
12. Te veel formulieren
13. Anders, namelijk:_____

*Indien vraag 8d = 1 óf V7= Wijkteam / Buurtteam / Sociaal wijkteam (36)*
**8g. Kunt u in uw eigen woorden omschrijven hoe de hulp van het (sociale) wijkteam/buurtteam verliep?**

< Open >

**8h. Heeft u een zogenaamd 'Keukentafelgesprek' gehad met uw gemeente?**

1. Ja
2. Nee
3. Weet niet

**Info:**
Een keukentafelgesprek is een gesprek dat burgers die een hulpvraag hebben samen met de gemeente voeren om in aanmerking te komen voor ondersteuning vanuit de gemeente. Tijdens het keukentafelgesprek komt de specifieke situatie van de burger aan bod: hoe ziet zijn leven eruit, wat is precies zijn vraag, wat wil hij daarmee bereiken? Met een keukentafelgesprek wordt bepaald wat iemand nodig heeft, wat kan hij zelf of wat zijn omgeving kan doen, en wat de gemeente zou kunnen doen?

Het keukentafelgesprek vindt meestal persoonlijk (face-to-face) plaats, maar het kan ook telefonisch, schriftelijk of online.
*Indien vraag 8h = 1*
**8i. Hoe vond het 'keukentafelgesprek' plaats?**

1. persoonlijk (face-to-face), bij de gemeente
2. persoonlijk (face-to-face), bij mij thuis
3. persoonlijk (face-to-face), bij het (sociale) wijkteam
4. telefonisch
5. schriftelijk
6. online
7. anders, namelijk: _____
8. weet niet

*Indien vraag 8h = 1*
**8j. Kreeg u naar aanleiding van het 'keukentafelgesprek' hulp of zorg van uw gemeente?**

1. Ja
2. Nee
3. Weet niet

*Indien vraag 8h = 1*
**8k. Hoe beoordeelt u het 'keukentafelgesprek'?**
(Waarbij een 1 heel slecht is en een 10 heel goed)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Indien vraag 8k = 1 < 6*
**8l. Waarom geeft u dit cijfer? (meerdere antwoorden mogelijk)**
*Random aanbieden*

1. Ik werd niet geholpen
2. Ik werd niet goed doorverwezen
3. Het duurde lang voor ik geholpen werd
4. Er werd niet goed naar me geluisterd, probleem werd niet begrepen
5. Te weinig specialistische kennis
6. Te veel organisaties die niet goed samenwerken
7. Mijn privacy werd niet gewaarborgd
8. Ik moest steeds weer mijn verhaal vertellen
9. Ik moest steeds weer dezelfde gegevens geven
10. Te duur
11. Zorgdossier is kwijtgeraakt
12. Te veel formulieren
13. Anders, namelijk:_____

*Indien vraag 8h = 1*
**8m. Kunt u in uw eigen woorden omschrijven hoe het 'keukentafelgesprek' verliep?**

< Open >

**9a. Kreeg u (ook) vóór 1 januari 2015 professionele hulp?**

1. Ja
2. Nee

*Indien vraag 9a = 1 én vraag 7 = niet 1*
**9b. Krijgt u sinds 1 januari dit jaar:**

1. Meer professionele hulp
2. Even veel professionele hulp
3. Minder professionele hulp
4. Weet niet

10a. Kunt u op een schaal van 1 tot 10 aangeven of u of uw gezinslid volledig voor zichzelf kan zorgen (10) of volledig afhankelijk is / bent van de hulp van de overheid of van instellingen (1) in verband met deze situatie(s)? U kunt natuurlijk ook een positie tussen 1 en 10 kiezen.

| Ik of mijn gezinslid is / ben volledig afhankelijk van hulp van instellingen/overheid | | | | | | | | | Ik of mijn gezinslid kan volledig voor me / zichzelf zorgen / helemaal niet afhankelijk van instellingen/overheid | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Vraag 10b voorleggen aan de personen die in vraag 1 hebben aangegeven zelf of iemand in het gezin iets heeft.*

En waarbij vraag 7 ≠1

| 10b. | Hieronder volgen enkele vragen over het effect op uw leven of het leven van uw gezinslid van de ondersteuning | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Helemaal mee eens | Mee eens | Neutraal | Niet mee eens | Helemaal niet mee eens | Geen mening/niet van toepassing |
| Door de ondersteuning die ik krijg, kan ik de dingen die ik wil doen, beter doen | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ik kan mij beter redden door de ondersteuning die ik krijg | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**11.** Hoe schat u uw gezondheid op dit moment in?

| | **uitstekend** | **goed** | **matig** | **slecht** | **wil ik liever niet zeggen** |
|---|---|---|---|---|---|
| Mijn lichamelijke gezondheid | | | | | |
| Mijn geestelijke gezondheid | | | | | |

**Indien bij vraag 1 bij 12 ik zelf of iemand in mijn gezin is aangeklikt**

**V11a Wat voor arbeidsbeperking heeft u of de persoon met een arbeidsbeperking in uw gezin? (meerdere antwoorden mogelijk)**

- **Lichamelijke beperking**
- **Verstandelijke beperking**
- **Psychische beperking**
- **Zintuigelijke beperking**
- **Anders, namelijk:……**
- **Niet van toepassing**

**V11b Heeft u/de persoon met een arbeidsbeperking een baan?**

- **Ja**
- **Nee**
- **Weet niet**

**Indien v11b is ja**
**V11c. Waar werkt u/ de persoon met een arbeidsbeperking**

- **Bij een sw-bedrijf**
- **Bij een reguliere werkgever**
- **Anders, namelijk:……**

**V11d. Heeft u/ de persoon met een arbeidsbeperking begeleiding gekregen vanuit de gemeente en/of het UWV bij het vinden van een baan?**

- **Ja, vanuit de gemeente**
- **Ja, vanuit het UWV**
- **Ja, vanuit anders nl……..**
- **Nee**
- **Weet niet**

**Indien v11d is ja**
**V11e. Hoe tevreden bent u over de begeleiding die u/ de persoon met een arbeidsbeperking heeft gekregen?**

- **Zeer ontevreden**
- **Ontevreden**
- **Niet tevreden en niet ontevreden**
- **Tevreden**
- **Zeer tevreden**
- **Geen mening**

*V11f alleen voorleggen bij V11e=tevreden of ontevreden*
**V11f Kunt u dit toelichten (open vraag)**

**Indien v11b is nee of weet niet**

**V11g Krijgt u/de persoon met een arbeidsbeperking begeleiding vanuit de gemeente en/of het UWV bij het vinden van een baan?**

- **Ja, vanuit de gemeente**
- **Ja, vanuit het UWV**
- **Ja, vanuit anders nl……..**
- **Nee**
- **Weet niet**

**Indien v11g is ja**
**V11h. Hoe tevreden bent u over de begeleiding die u/de persoon met een arbeidsbeperking krijgt vanuit de gemeente en/of het UWV**

- **Zeer ontevreden**
- **Ontevreden**
- **Niet tevreden en niet ontevreden**
- **Tevreden**

- **Zeer tevreden**
- **Geen mening**

*V11i alleen voorleggen bij V11h=tevreden of ontevreden*

**V11i Kunt u dit toelichten (open vraag)**

## Zorg voor de ander

*Vraag 12a indien vraag 1 = 1, 2 of 3*
**12a.**
U had dus in de periode van 1 januari 2015 tot nu te maken met de volgende situaties voor iemand uit uw gezin, familie, vrienden of buren:
<situatie vraag 1>
<situatie vraag 1>
<situatie vraag 1>

**Heeft u deze persoon (of personen) in de periode van 1 januari 2015 tot nu verzorgd en/of geholpen?**

1. Ja, intensief en langdurig verzorgd (als mantelzorger in hetzelfde huishouden)
2. Ja, intensief en langdurig verzorgd (als mantelzorger, niet in hetzelfde huishouden)
3. Ja, regelmatig geholpen of bezocht, maar niet verzorgd (als vrijwilliger)
4. Ja, af en toe geholpen of bezocht, maar niet verzorgd (als vrijwilliger)
5. Nee (niet of nauwelijks)

*Vraag 17 indien vraag 1 = **2,** 3 of 4) en vraag 12a = 1 t/m 4.*

**17.**
U was dus betrokken bij iemand uit uw gezin, familie, vrienden of buren die te maken had met de volgende situaties:
<situatie vraag 1>
<situatie vraag 1>
<situatie vraag 1>

**Heeft degene die u hielp in deze situatie(s) in de periode van 1 januari 2015 tot nu professionele hulp of zorg gekregen van één of meer van onderstaande instanties?** (meerdere antwoorden mogelijk)

1 Nee, geen hulp of zorg gekregen
2 Instelling voor verstandelijk beperkten
3 Bureau Halt
4 Bureau Jeugdzorg
5 CAD (Consultatiebureau alcohol & drugs)
6 Centrum voor Jeugd en Gezin (CJG)

7 Consultatiebureau (ouders en kinderen)
8 Dagbesteding / dagopvang
9 Eigen Kracht organisatie
10 Gemeente
11 Gespecialiseerde hulp bij opvoeding
12 GGD/GG&GD (Gemeentelijke Gezondheids- en Geneeskundige dienst)
13 GGZ-instelling (Geestelijke Gezondheids- en verslavingszorg)
14 Huisarts
15 Huishoudelijke hulp
16 Jeugdarts
17 Jeugdhulpinstelling
18 Kinderbescherming (Raad voor de Kinderbescherming))
19 Maatschappelijk werk
20 Mantelzorgondersteuning
21 MEE
22 Ouderenzorginstelling
23 Orthopedagogische hulp
24 Politie/ wijkregisseur/wijkagent
25 Pleegzorgorganisatie
26 Psycholoog
27 Psychiatrische instelling
28 Reclassering / Jeugdreclassering
29 Schuldhulpverlening
30 School/Onderwijsinstelling
31 Schoolarts, schoolmaatschappelijk werk
32 Thuiszorg / Buurtzorg
33 UWV
34 Verzorgingstehuis / verpleegtehuis
35 Welzijnsstichting/organisatie
36 Wijkteam / Buurtteam / Sociaal wijkteam
37 WMO-Loket bij gemeente (Wet maatschappelijke ondersteuning)
38 Woningcorporatie/woningbouwvereniging
39 Zorgkantoor
40 Zorg- en adviesteams (ZAT)
41 Ziekenhuis
42 Anders, namelijk….

*Als vraag 17 is niet 1*

**18. Hoe beoordeelt u de hulp of zorg die deze persoon kreeg van alle organisaties en instellingen in verband met deze situatie(s)?**
*(Waarbij een 1 heel slecht is en een 10 heel goed)*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Als vraag 18 < 6*
**19. Waarom geeft u dit cijfer? (meerdere antwoorden mogelijk)**
*Random aanbieden*

1. Ik / hij / zij werd niet geholpen
2. Te veel doorverwijzingen
3. Duurde te lang voor ik / hij / zij geholpen werd/word
4. Er werd niet goed naar me geluisterd, probleem werd niet begrepen
5. Te veel organisaties die niet goed samenwerken
6. Privacy niet gewaarborgd
7. Ik / hij / zij moest steeds weer mijn verhaal vertellen
8. Ik / hij / zij moest steeds weer dezelfde gegevens geven
9. Te duur
10. Anders, namelijk:

*Indien vraag 17 is niet 36 (wijkteam/buurtteam)*
**20a. Heeft degene die u hielp ook contact gehad met het sociale wijkteam van zijn/haar gemeente?**

**Info:**
In een Sociaal Wijkteam werken professionals van verschillende zorg- en welzijnsorganisaties samen zoals de wijkverpleegkundige, opbouwwerker, maatschappelijk werker, WMO-consulent en ouderenadviseur. Samen met bewoners in de wijk zoekt het Sociaal Wijkteam naar praktische oplossingen voor vragen en problemen rond ziekte en beperking, zelfstandig wonen en voorzieningen.
Het sociale wijkteam wordt ook wel genoemd:

- Wijkteam
- Buurtteam
- Jeugdteam

1. Ja
2. Nee
3. Weet niet

*Indien vraag 20a = 1 óf V17= Wijkteam / Buurtteam / Sociaal wijkteam (36)*
**20b. Hoe beoordeelt u de hulp die degene die u hielp van het (sociale) wijkteam/buurtteam heeft gekregen?**
(Waarbij een 1 heel slecht is en een 10 heel goed)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Indien vraag 20b < 6*
**20c. Waarom geeft u dit cijfer? (meerdere antwoorden mogelijk)**
*Random aanbieden*

1. Hij/zij werd niet geholpen
2. Hij/zij werd niet goed doorverwezen
3. Het duurde lang voor hij/zij geholpen werd
4. Er werd niet goed naar hem/haar geluisterd, probleem werd niet begrepen

5. Te weinig specialistische kennis in het team
6. Te veel organisaties die niet goed samenwerken
7. Privacy werd niet gewaarborgd
8. Hij/zij moest steeds weer mijn verhaal vertellen
9. Hij/zij moest steeds weer dezelfde gegevens geven
10. Te duur
11. Zorgdossier is kwijtgeraakt
12. Te veel formulieren
13. Anders, namelijk:_____

*Indien vraag 20a = 1*
**20d. Kunt u in uw eigen woorden omschrijven hoe de hulp van het (sociale) wijkteam/buurtteam verliep?**

< Open >

**20e. Heeft degene die u hielp een zogenaamd 'Keukentafelgesprek' gehad met uw gemeente?**

1. Ja
2. Nee
3. Weet niet

**Info:**
Een keukentafelgesprek is een gesprek dat burgers die een hulpvraag hebben samen met de gemeente voeren om in aanmerking te komen voor ondersteuning vanuit de gemeente. Tijdens het keukentafelgesprek komt de specifieke situatie van de burger aan bod: hoe ziet zijn leven eruit, wat is precies zijn vraag, wat wil hij daarmee bereiken? Met een keukentafelgesprek wordt bepaald wat iemand nodig heeft, wat kan hij zelf of wat zijn omgeving kan doen, en wat de gemeente zou kunnen doen?

Het keukentafelgesprek vindt meestal persoonlijk (face-to-face) plaats, maar het kan ook telefonisch, schriftelijk of online.

*Indien vraag 20e = 1*
**20f. Hoe vond het 'keukentafelgesprek' plaats?**

1. persoonlijk (face-to-face), bij de gemeente
2. persoonlijk (face-to-face), bij hem/haar thuis
3. persoonlijk (face-to-face), bij het (sociale) wijkteam
4. telefonisch
5. schriftelijk
6. online
7. anders, namelijk: _____

*Indien vraag 20e = 1*
**20g. Kreeg u naar aanleiding van het keukentafelgesprek hulp of zorg van uw gemeente?**

1. Ja
2. Nee

*Indien vraag 20e = 1*
**20h. Hoe beoordeelt u het keukentafelgesprek?**

(Waarbij een 1 heel slecht is en een 10 heel goed)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Indien vraag 20h = < 6*
**20i. Waarom geeft u dit cijfer? (meerdere antwoorden mogelijk)**
*Random aanbieden*

1. Hij/zij werd niet geholpen
2. Hij/zij werd niet goed doorverwezen
3. Het duurde lang voor hij/zij geholpen werd
4. Er werd niet goed naar hem/haar geluisterd, probleem werd niet begrepen
5. Te weinig specialistische kennis
6. Te veel organisaties die niet goed samenwerken
7. Privacy werd niet gewaarborgd
8. Hij/zij moest steeds weer mijn verhaal vertellen
9. Hij/zij moest steeds weer dezelfde gegevens geven
10. Te duur
11. Zorgdossier is kwijtgeraakt
12. Te veel formulieren
13. Anders, namelijk:_____

*Indien vraag 20e = 1*
**20j. Kunt u in uw eigen woorden omschrijven hoe het 'keukentafelgesprek' verliep?**

< Open >

*als vraag 1 is situatie voor 'mijzelf' of 'gezin' en als vraag 7 = 1 (geen professionele hulp gekregen)*
**21a. U had dus te maken met de volgende situatie(s) voor uzelf of iemand uit uw gezin en u heeft geen professionele hulp gekregen.:**
**-**
**-**

**Heeft u wel hulp <u>gezocht</u> bij een professionele organisatie, een hulpverlener of de overheid? (tussen 1 januari en nu)**

1. jawel
2. nee

*als vraag 1 is situatie voor 'familie, vrienden of buren en als vraag '17 = 1 (geen professionele hulp gekregen)*
**21b. U had dus te maken met de volgende situatie(s) voor iemand uit uw naaste omgeving en deze persoon heeft geen professionele hulp gekregen.**
**-**
**-**

**Heeft deze persoon wel hulp <u>gezocht</u> bij een professionele organisatie, een hulpverlener of de overheid? (tussen 1 januari en nu)**

1. jawel
2. nee

*Indien vraag 21= 1*

**22. Waarom heeft u / deze persoon geen hulp gekregen van deze organisaties?**

*Meerdere antwoorden mogelijk*

1. Ik / hij / zij had (toch) geen hulp nodig
2. Ik / hij / zij kwam er niet uit, wist niet waar ik moest zijn
3. Ik / hij / zij kreeg genoeg hulp van mijn naasten (familie, vrienden, kennissen)
4. De organisatie / overheid vond dat ik/we geen hulp nodig had(den)
5. De organisatie / overheid kon me/ons niet helpen
6. Ik werd steeds doorverwezen, maar kreeg geen hulp
7. Te hoge kosten
8. Ik / hij / zij had geen vertrouwen in hulpverlener(s)
9. Weet ik niet
10. Anders,
    namelijk:_____

*Indien vraag 21= 2*

**23. Wat weerhield u of deze persoon ervan om hulp te zoeken bij een professionele organisatie, hulpverlener of overheid?**

*Meerdere antwoorden mogelijk*

1. Ik / hij / zij had (toch) geen hulp nodig
2. Ik / hij / zij kwam er niet uit, wist niet waar ik moet zijn
3. Ik / hij / zij krijg genoeg hulp van mijn naasten (familie, vrienden, kennissen)
4. De organisatie / overheid wilde me/ons niet helpen (vindt dat ik het zelf moet oplossen)
5. De organisatie / overheid kan me/ons niet helpen
6. Ik / hij / zij verwacht dat we worden doorverwezen, maar geen hulp krijgen
7. De instellingen zijn te ver weg
8. Te hoge kosten
9. Ik / hij / zij heb (heeft) geen vertrouwen in hulpverlener(s)
10. Schaamte
11. Weet ik niet
12. Anders,
    namelijk:_____

*Allen*

## Algemeen zelfredzaamheid en decentralisaties

**24. Kunt u voor de volgende uitspraken aangeven in hoeverre u het er mee eens of oneens bent?**

| ***Random aanbieden*** | Helemaal mee eens | Beetje mee eens | Neutraal | Beetje mee oneens | Helemaal mee oneen | Weet niet | Niet van toepassing |
|---|---|---|---|---|---|---|---|

| | | | | | s | | |
|---|---|---|---|---|---|---|---|
| We moeten toe naar een samenleving waarin mensen elkaar meer gaan helpen | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ik ben bereid om een deel van de hulp en ondersteuning die ik nu krijg van de overheid zelf te gaan betalen | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Het is realistisch om meer zorg van familieleden te vragen voor hun zorgbehoevende naaste | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| In mijn situatie is het niet mogelijk nog meer te doen voor mijn naasten. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Als ik jeugdzorg nodig heb weet ik goed waar ik moet zijn | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Decentralisaties**
Sinds 1 januari 2015 is er veel veranderd in de zorg. Sommige taken die eerst bij de Rijksoverheid of bij de provincie lagen, zijn nu de taak van de gemeenten. Het gaat om de jeugdzorg, zorg voor langdurig zieken of ouderen en de zorg voor mensen met een 'afstand tot de arbeidsmarkt', zoals mensen die werken bij een sociale werkplaats.

Deze hele operatie wordt wel 'de 3 grote decentralisaties' genoemd.

**26. Bent u ervan op de hoogte dat er taken naar de gemeenten zijn gegaan en welke taken dat zijn?**

1. ja, ik ben hiervan op de hoogte en weet vrij goed welke taken naar de gemeente zijn gegaan
2. Ik weet wel dat hier iets is veranderd, maar ik weet niet precies welke taken naar de gemeente zijn gegaan
3. nee, ik weet hier (bijna) niets van

*Indien vraag 26 = 1 of 2*
**27a. Heeft u zelf iets gemerkt van deze veranderingen in de zorg? ('aan den lijve')**

1. Ja
2. Nee

*Indien vraag 27a = 1*
**27b. Wat heeft u gemerkt van de veranderingen?**

< open >

**28. Kunt u voor de volgende uitspraken aangeven in hoeverre u het er mee eens of oneens bent?**

| ***Random aanbieden*** | Helemaal mee eens | Beetje mee eens | Neutraal | Beetje mee oneens | Helemaal mee oneens | Weet niet | Niet van toepassing |
|---|---|---|---|---|---|---|---|
| Als ik jeugdzorg nodig heb weet ik goed waar ik moet zijn | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Als ik ouderenzorg nodig heb weet ik goed waar ik moet zijn | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mijn gemeente heeft mij goed geïnformeerd over de veranderingen in de zorg | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mijn gemeente heeft mij goed geïnformeerd over hoe en waar ik een beroep kan doen op de zorg | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**28b Bent u in staat om:,**

| | Nee, helemaal niet | Een beetje | Grotendeels | Ja, helemaal |
|---|---|---|---|---|
| Het leven te leiden zoals u dat wilt | | | | |
| Regelmatig mensen te ontmoeten | | | | |
| Leuke dingen te doen ter ontspanning en recreatie | | | | |
| Activiteiten te ondernemen zoals werken, leren, anderen helpen | | | | |

*Allen*

**29.**

Het idee van de overdracht van de taken op het gebied van jeugd-, ouderenzorg, langdurige zorg en werk is dat gemeenten dichter bij de burgers staan en de ondersteuning beter en goedkoper vorm kunnen geven. Verwacht wordt ook dat daardoor de samenwerking tussen de instellingen zal verbeteren.

**29a. Verwacht u dat de gemeente de taken op het gebied van de <u>JEUGDZORG</u> op termijn beter of minder goed kan uitvoeren?**

1. De gemeente zal deze taken op termijn <u>beter</u> uitvoeren
2. De gemeente zal deze taken op termijn <u>minder goed</u> uitvoeren
3. Het zal weinig verschil maken
4. weet ik niet

**29b. Verwacht u dat de gemeente de taken op het gebied van de OUDERENZORG op termijn beter of minder goed kan uitvoeren?**

1. De gemeente zal deze taken op termijn beter uitvoeren
2. De gemeente zal deze taken op termijn minder goed uitvoeren
3. Het zal weinig verschil maken
4. weet ik niet

**29c. Verwacht u dat de gemeente de taken op het gebied van WERK EN INKOMEN op termijn beter of minder goed kan uitvoeren?**

1. De gemeente zal deze taken op termijn beter uitvoeren
2. De gemeente zal deze taken op termijn minder goed uitvoeren
3. Het zal weinig verschil maken
4. weet ik niet

*Indien situaties van toepassing bij vraag 1 (voor mijzelf of gezin)*
**30a. Vindt u dat de manier waarop uw gemeente deze taken uitvoert voor uzelf op dit moment (2015) een verbetering, een verslechtering of geen van beide betekenen?**

1. Verbetering voor mij
2. Verslechtering voor mij
3. Geen van beide
4. weet ik niet

*Indien situaties van toepassing bij vraag 1 (voor mijzelf of gezin)*
**30b. Vindt u dat de manier waarop uw gemeente deze taken uitvoert voor uzelf op langere termijn (2015) een verbetering, een verslechtering of geen van beide betekent?**

1. Verbetering voor mij
2. Verslechtering voor mij
3. Geen van beide
4. weet ik niet

*Indien vraag 1 = 'ikzelf' of 'gezin' of 'familie'*

**30c. Kunt u voor de volgende uitspraken aangeven in hoeverre u het er mee eens of oneens bent?**

| | Helemaal mee eens | Meer mee eens dan oneens | Meer mee oneens dan eens | Helemaal mee oneens | Weet niet | Niet van toepassing |
|---|---|---|---|---|---|---|
| Ik ben al met al tevreden over de hulp en zorg die ik krijg **van mijn omgeving** (familie, vrienden, etc.) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ik ben al met al tevreden over de hulp en zorg die ik krijg **van professionele instellingen en de overheid** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ik heb er **vertrouwen** in dat de hulp en zorg van professionele instellingen en de overheid door de decentralisaties (vanaf 1 januari 2015) op termijn beter zal zijn dan daarvóór | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Het is **begrijpelijk** dat de overheid **bezuinigt** op de zorg. Op deze manier blijft de zorg betaalbaar. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| De jeugdzorg is nu dichtbij de cliënten georganiseerd | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| De ouderenzorg is nu dichtbij de cliënten georganiseerd | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Achtergrondkenmerken

Tot slot nog twee achtergrondvragen.

**31. Welke situatie is op u van toepassing?**

- ☐ ik woon alleen
- ☐ ik woon met partner en 1 of meer thuiswonende kinderen
- ☐ ik woon met partner zonder thuiswonende kinderen
- ☐ ik woon met 1 of meer kinderen, maar zonder partner
- ☐ ik woon in bij ouder(s), verzorger(s) / bij broer(s) of zuster(s) / bij andere familie
- ☐ ik woon in een verzorgingstehuis/verpleeghuis
- ☐ andere woonsituatie

**ANDERE ACHTERGRONDKENMERKEN >> VIA PORTAL**

**Q2 : Q2 :** **Single coded**

Als er vandaag verkiezingen voor de Tweede Kamer zouden worden gehouden, op welke partij zou u dan stemmen?

1 ○ VVD
2 ○ PvdA
3 ○ PVV
4 ○ SP
5 ○ CDA
6 ○ D66
7 ○ ChristenUnie
8 ○ GroenLinks
9 ○ SGP
10 ○ PvdD (Partij voor de Dieren)
11 ○ 50 Plus
12 ○ Piratenpartij
13 ○ DENK
14 ○ VNL (Voor Nederland)
15 ○ Andere partij, namelijk:
16 ○ Ik zou niet gaan stemmen
17 ○ Geen stemrecht
18 ○ Blanco/ongeldig
19 ○ Wil niet zeggen
20 ○ Weet niet

**33. Dit waren alle vragen. Hartelijk dank voor uw medewerking.**
**Heeft u nog opmerkingen over de vragenlijst?**
**< open >**

**34. Hoe prettig vond u het om deze vragenlijst in te vullen?**
**Kunt u de vragenlijst beoordelen met een cijfer van 1 tot en met 10?**
*(Waarbij een 1 is helemaal niet prettig en een 10 heel prettig)*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | weet niet |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

.