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Result-oriented purchasing of individual support

Individual support in order to develop and stabilise clients

Submitted by:	XXX XXX
1st Supervisor:	XXX
2nd Supervisor:	XXX
Practical Supervisor:	XXX

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Please enjoy reading this thesis.

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Abstract

In 2015, the tasks of municipalities regarding the Social Support Act (Wmo) were expanded and municipalities became responsible for implementing the Youth Act (Jw), which is a decentralisation of healthcare in the Netherlands. Due to this decentralisation more customised solutions at individual client level are provided because these are aimed within the Wmo and Jw. Therefore, more client-oriented care is required. Furthermore, due to the declining budget, municipalities need to save costs. Social Domain Achterhoek, which is a collaboration of eight Achterhoek municipalities, has subsequently investigated how more client-oriented work can be combined with cost savings. They have drawn up a vision that concludes that result-oriented purchasing could realise this because result-oriented purchasing provides the greatest incentive to innovate, which in turn can contribute to the promotion of client-oriented solutions. However, it is necessary to have a clear understanding of how result-oriented purchasing should be organised in practice.

Municipalities in the 'Achterhoek' purchase customised facilities Wmo and Jw jointly, and integrally. The support is divided into Packages. Package 1 focused on individual support, in which setting goals at client level is not as abstract as in other Packages. Package 1 involves complex cases.

The aim of the study is to advice Social Domain Achterhoek on how result-oriented purchasing should be organised for individual support. The following research question has been prepared for this: *how should result-oriented purchasing be organised for individual support?* Result-oriented purchasing concerns the entire health purchasing model and therefore not only funding. A healthcare purchasing model includes, among other things, a purchasing procedure, funding method, contract form and paying method.

To be able to answer the research question, it was first determined which healthcare purchasing models are possible with result-oriented purchasing based on a literature review. Subsequently, the requirements and wishes of stakeholders (the municipality, clients and healthcare providers) regarding the healthcare purchasing model were determined based on semi-structured interviews. Then, the weights and preferences of the stakeholders were determined. The weights and preferences of stakeholders are discussed based on the literature and logic. Based on the weights, preferences and a discussion of these, it was determined which healthcare purchasing model fits best to result-oriented purchasing of individual support in the Social Domain Achterhoek, how this should be implemented in practice, and who the buyer and specifier are.

The interviews mainly showed that certainty and quality are the spearheads of healthcare providers, that promoting quality and stimulating innovation are the spearheads of the municipality, and that customised care and quality are the spearheads of clients. In addition, the municipality and healthcare providers prefer to apply only result steering and not to apply result funding, while based on the interviews with clients, result funding might be the best option. The healthcare purchasing model with a dialogue-oriented purchasing procedure, a framework agreement with interim entry and fixed payment per period in combination with 'voting with the feet', fits best to the municipalities in the Achterhoek for individual support. The healthcare purchasing model includes production funding in the first instance, and population funding in the future. A trade-off is made between a healthcare purchasing model that fits best with result-oriented purchasing and a model that is best suited for individual support. Well-established demand-oriented access, focusing on the client's abilities, and continuous consultation between stakeholders should be the focus of this model, because at individual support, it is difficult to determine and measure results.

Based on the choice for the healthcare purchasing model, in which the population is not reflected clear, it is recommended to map out the population apportion of Package 1. Afterwards, a pilot should be conducted, and the model should only be implemented if the pilot is successful. The pilot could first be conducted for a specific client group in a specific neighbourhood, and after that in one of the eight municipalities. Furthermore, it is recommended, to train front employees in order to get more specialistic knowledge for a well-established access, and to do further research to demand-oriented clarification models in which results can be defined and measured. In order to save costs, it is also recommended to do further research to the possibilities to focus more on help from the client's environment, focus more on prevention, and more frequent use of general facilities. Another recommendation is that result steering should be applied, which is benchmarking the achieved results at healthcare providers by, for example, grouping clients with similar abilities/disabilities of similar healthcare providers, and measuring the differences in those groups. Further research should also be done to the benchmark possibilities for contract managers. Furthermore, it is recommended to do further research to regional differences, to determine differences between the Wmo and Jw by using the same method as in this study, and to provide insight into the differences between large and small healthcare providers because all these differences are not included in this study.

Index of contents

Index of abbreviations

Abbr.	Abbreviation
ADL	General Daily Activities (‘algemene dagelijkse levensverrichtingen’)
AMvB	General Administrative Order (‘Algemene Maatregel van Bestuur’)
AO Youth	Administrative Organisation Youth
AO Wmo	Administrative Organisation Wmo
AWBZ	General law on special medical expenses (‘Algemene Wet Bijzondere Ziektekosten’)
BVP	Best Value Procurement
CAK	Central Administration Office (‘Centraal Administratie Kantoor’)
CLM	Contract & Supplier Management
DAS	Dynamic purchasing system (‘Dynamisch Aankoop Systeem’)
FTE	Full-time equivalent
GP	General Practitioner
Jw	Youth Act (‘jeugdwet’)
MCDA	Multicriteria-Decision-Analysis
MOSD	Management Consultation Social Domain (‘managementoverleg sociaal domein’)
N/A	Not Applicable
PGB	Personal Budget (‘persoonsgebonden budget’)
POHO	Portfolio Holder Consultation (‘portefeuillehouders overleg’)
PPA	Public Purchasing Act (‘aanbestedingswet’)
P*Q	Product-based funding (price * quantity/volume)
PoR	Program of Requirements
SAS	Social and Other Specific Services
VBHC	Value-based healthcare
VNG	Association of Dutch Municipalities (‘Vereniging van Nederlandse Gemeenten’)
VWS	Ministry of Health, Welfare and Sport (‘ministerie van Volksgezondheid, Welzijn en Sport’)
Wlz	Long-term Care Act (‘wet langdurige zorg’)
Wmo	Social Support Act (‘wet maatschappelijke ondersteuning’)
ZRM	Self-reliance matrix (‘zelfredzaamheidmatrix’)
Zvw	Health Insurance Act (‘zorgverzekeringswet)

Index of tables main text

Index of figures main text

1. Social Domain Achterhoek

1.1 Social domain Achterhoek

Since 1 January 2018, the municipalities in the Achterhoek have a new vision on the regional social domain. The core theme is cooperation. Members of Social Domain Achterhoek are the municipalities: Aalten, Berkelland, Bronckhorst, Doetinchem, Montferland, Oost Gelre, Oude Ijsselstreek and Winterswijk. All municipalities in region Achterhoek have agreed to the 'new' vision. This vision is a follow-up to the vision that focused on the transition. The transition includes the transfer of tasks and responsibilities from the central government and provinces to municipalities, also called decentralisation. The 'new' vision focuses on the transformation. The transformation is the phase in which the intended substantive effects of the transition is realised. The municipalities aim to achieve more participation, vitality and self-reliance from the resident in the coming years. Correspondingly, less bureaucracy, smart combinations to achieve real results determined by the municipality in consultation with the client, a more limited role of the municipalities, and a reduction in the use of public money (1).

The new vision describes the new required division of roles between citizens, social institutions, and the government. For example, the role of citizens is to control their care and support themselves where possible. The municipalities will focus on the shift towards prevention and innovation in the range of support. Another role for municipalities will be to connect and integrate the various domains (care, work, education, etc.). To achieve all of this, the municipalities will work together in a more structured way, for example, in the area of purchasing. To respond flexibly to society's changing demands, more effective assistance and reduction in costs are ensured (1).

1.2 Research scope

Within Social Domain Achterhoek, a project group has been put together to provide advice with regard to the elaboration of the purchasing vision of 2021. This project group is investigating whether it is possible to purchase healthcare in another way, rather than the open-house procedure. This investigation will be centered around the possibility of purchasing healthcare in a result-oriented way. The project group investigates all Packages, which differ in forms of care, whereas this research investigates only one Package. This Package is further explained in the following chapters. The project group consists of purchasers, contract managers, policy officers, executive staff, a project secretary, and the project manager.

2. Introduction

In Section 2.1 the healthcare system of the Netherlands will be described. In Section 2.2 the changing role of municipalities will be described, followed by a description of purchasing in the social domain and the relation to decentralisation and integral cooperation in Section 2.3. The aim of the study will be stated in Section 2.4, followed by the research focus in Section 2.5. In Section 2.6 a reading guide will be provided.

2.1 The healthcare system in the Netherlands

In the Netherlands, care is purchased by various parties, with the following Acts in force (2):

- Health Insurance Act (Zvw)
- Long-Term Care Act (Wlz)
- Social Support Act (Wmo)
- Youth Act (Jw)

The Wmo and Jw have a different basis than the Wlz and the former General Law on special medical expenses (AWBZ) when it comes to the role of the client. This will be further explained in Sections 3.1.1 and 3.3. The focus of this thesis is the purchase of Wmo and Jw healthcare by Dutch municipalities (2).

2.2 The changing role of municipalities

Municipalities spend most of their money on purchasing goods, works and services in the social domain (55%). Between 1990 and 2007, municipalities spent only about 25% - 40% of their money on the social domain (3)[1].

Municipalities are principal in the social domain. According to Telgen, Uenk & Lohman (4) there are five models that are applied in practice for the fulfillment of tasks as a principal: 'AWBZ'-model, auction model, population-based funding, director model and district teams (4). However, it is important that the client is central to each of these models. It is established in the Wmo and Jw that the role of the client should be central (5-7).

Healthcare in the social domain partly concerns a new group of clients for municipalities. In contrast to already existing contracts, such as domestic help and aids, social healthcare addresses more difficult cases. Municipalities did not have much knowledge about, or experience with, those cases. In addition, new care products are developed which are customised for individual clients. Furthermore, clients do not get rights per disability, but municipalities have the duty to compensate for it. All these aspects complicate the functioning of the Wmo and Jw[1]. However, these aspects are the basis of the current Wmo and Jw and will be explained in Section 3.

The healthcare providers who are not familiar with commercial processes, need to sell their products to municipalities. The number of municipalities is higher than the number of healthcare offices, with which they had to deal in the past. Healthcare providers did not have a lot of knowledge of selling activities, and their own cost structure and price. Besides, large contracts are at stake, the total turnover of healthcare providers decreased greatly (25%) and healthcare providers must compete in order to continue. In general, new products must be developed in a new position, while both municipalities and healthcare providers do not have a lot of knowledge and experience about new services. These aspects also complicate the functioning of the Wmo and Jw[1].

[1] Telgen J. 2018-2019 Lecture 10 Wmo purchasing (social support purchasing) 2019; unreferenced lecture.

The budget will shrink with 15-20% in the coming years and municipalities and healthcare providers must cut costs. Uncertainty about the budget will continue because, among other things, the distribution models determining available budgets for municipalities are still under discussion. This makes it unclear how much each municipality will receive for the various tasks (Wmo, Jw) year on year (7-9)[2].

The new healthcare Acts are still in motion. Jurisprudence that clarifies the preconditions and obligations for municipalities in the implementation of Acts is created on the Wmo and the Jw. This influences the possibilities for municipalities, also in contracting[2]. Proceedings also arise in other areas with a direct influence on purchasing decisions, for example the mandate of the so-called kitchen table conversation on healthcare providers (10)[2]. Regarding the transformation of the above-mentioned social issues, municipalities aim to continue and further improve the transformation of healthcare. For example by creating more integrated forms of healthcare, focusing more on prevention or putting more emphasis on general provisions. Technological developments must also be taken into account[2].

As a result of the changing role of municipalities, healthcare, which is part of the social domain, is more and more being purchased decentral[2]. Due to the decentralisation of care, the total purchases of the municipality per inhabitant per year have increased from €1.000,- to €2000,- (3, 4, 11). According to Uenk (12) almost all municipalities (93%) have started a regional cooperation in Wmo purchasing in order to save costs in the purchasing process by sharing knowledge of healthcare and purchasing, and ensuring standardisation at local level. Especially among small municipalities cooperation is seen as a necessity, because of their lack of knowledge and limited administrative capacity for independent tendering. Downsides of cooperating purchasing include the decision-making process becoming more complex and the declining of individual influence of the 'Board of Mayor and Aldermen'. Democratic accountability is also under pressure: municipal councils typically have less influence (12).

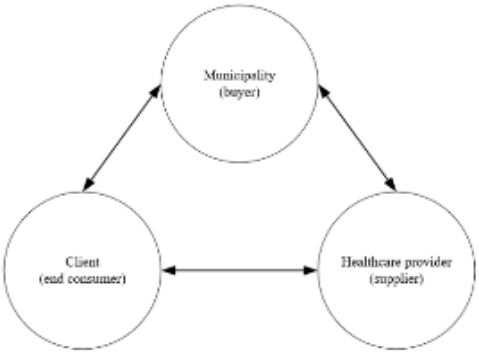
2.3 Purchasing in the social domain

The municipalities purchase the care, which is part of the Wmo and Jw, at healthcare providers and healthcare providers provide care to the client (2). In this case, the relation between these three stakeholders is called a service triad in which the buyer (municipality) contracts the supplier (healthcare provider) to deliver services directly to the buyers' end customer (client) (13, 14). In Figure 1 the service triad for the Wmo and Jw is shown schematically.

As described by Li & Choi (14), the service triad consists of three phases. In the initial phase, there is no direct relationship between the end consumer and the supplier, because support has not yet been delivered. The buyer then holds the bridge position. When a relationship develops between the end consumer and the supplier, Figure 1 applies. Then, there is can be bridge decay. The bridge position is slowly shifting from the buyer to the supplier. The bridge position has been completely transferred in the final phase (14).

[2] Telgen J. 2018-2019 Lecture 10 Wmo purchasing (social support purchasing) 2019; unreferenced lecture.

Figure 1: service triad social domain (13, 14)



In order to purchase healthcare in the social domain, municipalities use different healthcare purchasing models. These healthcare purchasing models differ in type of principle model, procedure, type of funding method, type of contract form and type of paying method, which is overall defined as a *healthcare purchasing model*. The differences between these models will be further explained in the theoretical framework (10, 12, 15-21)[3].

Decentralisation of care within the context of the Wmo and the Jw aims to provide more customised solutions at the individual client level. Result-oriented purchasing contracts are structured as follows. The healthcare provider is free to decide on how to treat, in consultation with the inhabitant, as long as results are reached. Result-oriented purchasing has advantages and disadvantages compared to non-result-oriented purchasing (22). According to Uenk and Telgen (22) one of the advantages is that the focus is not on the service specifications for healthcare providers, but on what it delivers (22). According to Robbe (22) a disadvantage of result-oriented purchasing is that achieving results is always uncertain in the social domain. It is necessary to purchase something else than results if the causal relationship between the intervention and the result cannot be demonstrated (22).

Municipalities in the 'Achterhoek' purchase customised facilities (Wmo) and individual youth activities (Jw) jointly, and integrally apply the so-called open-house model under the name: Social Domain Achterhoek ('Sociaal Domein Achterhoek'). Social domain Achterhoek uses open-house purchasing until 2021. In 2021 they aim to switch to result-oriented purchasing of healthcare. With this, Social Domain Achterhoek aims to work more client-oriented and save costs.

Purchasing is done integrally per form of care (23). A purchasing document has been drawn up, which contains information regarding the purchase of healthcare for nine different Packages (forms of care). These Packages vary widely: from the individual level to protected living, dyslexia, and paediatrics. If a healthcare provider can offer all forms of care, that is also allowed (5). Based on the current discussion about the central role of the client in healthcare, the focus in this thesis is on Package 1: individual support. According to Social Domain Achterhoek[4] within this Package, the most progress can be achieved with result-oriented purchasing considering advantages, disadvantages, healthcare expenses, social developments and legislation. It is most difficult to establish result agreements within Package 1, since setting goals is not as abstract as it is in other Packages[4]. Package 1 will be further explained in Section 3.4. This thesis assumes that the current format of Packages will be maintained.

[3] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

[4] Project-leader. Introductory meeting. In: Meijer A, editor. 2019; unreferenced meeting.

2.4 The aim of the study

The decision to switch to result-oriented purchasing in 2021 has already been made. This general decision also applies for Package 1: individual support. For Social Domain Achterhoek, however, it is unclear how result-oriented purchasing should be organised in practice. The aim of the study is to advice Social Domain Achterhoek on how result-oriented purchasing should be organised for individual support.

The main research question is: *how should result-oriented purchasing be organised for individual support?*

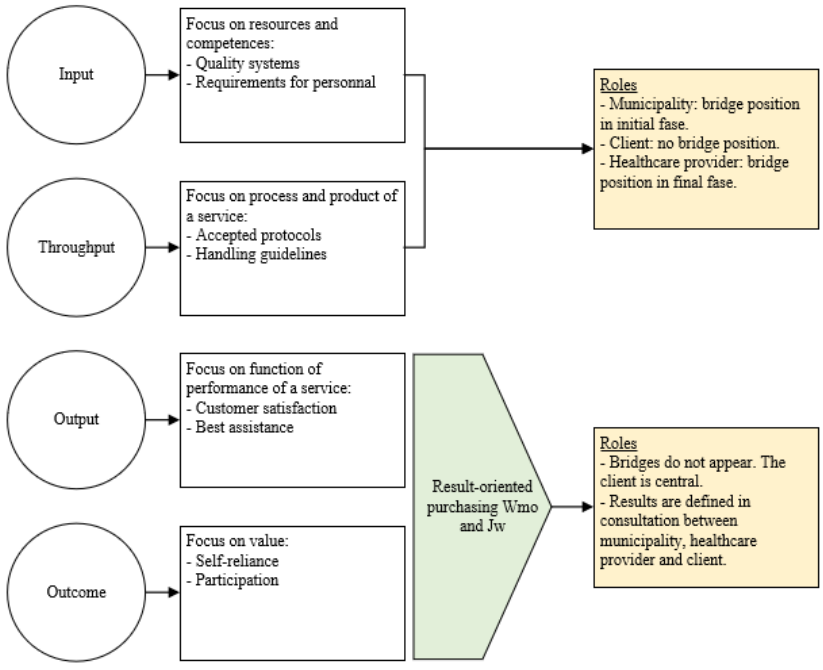
To be able to answer this main research question the following subquestions have been set-up.

1. *Which result-oriented healthcare purchasing models are possible for individual support?*
2. *What are the requirements and wishes of Social Domain Achterhoek, healthcare providers and clients when purchasing care for individual support?*
3. *Which healthcare purchasing model fits best to the municipalities in the Achterhoek for individual support?*
4. *How should the chosen healthcare purchasing model be applied in practice?*

2.5 Focus research question

The following scheme (Figure 2) clarifies the focus of result-oriented purchasing of individual support in this thesis. The relationship with the roles from the service triad from Section 2.3 is also mentioned.

Figure 2: focus of result-oriented purchasing & changing roles (14, 20, 22)



According to Uenk (20), result-oriented purchasing is a purchasing methodology that provides healthcare and support purchased on the basis of agreements about how to reach results and outcomes, in contrast to the commitment and actions of healthcare and support. A contract exists based on the results to be achieved. The municipality and the client determine the results to be achieved, and the healthcare provider determines the approach and commitment (20).

2.6 Reading guide

In Sections 1 and 2 an introduction to Social Domain Achterhoek and the subject of this thesis is provided. In Section 3, the context of the thesis will be described. This includes Acts and regulations concerning Wmo and Jw, and general information about Package 1: individual support. Followed by Section 4, in which, based on a literature review, various principle models, purchasing procedures, funding methods, contract forms, paying methods (healthcare purchasing method), and result-oriented purchasing will be outlined. Criteria will be determind at the end of Section 4. In Section 5 the methods will be discussed. In Section 6 the findings of this study will be described, followed by a discussion of these findings. Section 7 discusses limitations and options for further research. Finally, the conclusions and recommendations will be presented in Section 8. These conclusions and recommendations are also the advice to the project group.

3. Context

In Section 3.1 general information about the Wmo and legal aspects in relation to the Wmo will be provided. In Section 3.2 general information regarding the Jw and legal aspects in relation to the Jw will be provided. Furthermore, in Section 3.3 the prosumer model en the relation of the prosumer model to this thesis will be described. Finally, in Section 3.4 an overview of Package 1: individual support will be provided, which is the focus of the research question.

3.1 Wmo

3.1.1 General information Wmo

The Wmo is based on the principle of customisation, an individual approach, and participation in the society. This is in contrast to the Wlz, which is intended for the most vulnerable people, such as the elderly with advanced dementia, severely mentally or physically impaired people and people with long-term psychiatric disorders. Municipalities enter into conversations with the client about the request of support. Based on these conversations, municipalities have to provide appropriate support and have to determine a way of organising this support. In addition to individual customised services, municipalities have to set up general facilities. The purpose of these facilities is that people, regardless of their limitation, can participate in society. Municipalities support people who experience difficulty with participating in society, who are not self-reliant, or need a protected living environment or (temporary) shelter. Municipalities distinguish general facilities and customised facilities. General facilities, for example, meal service, shopping service or activities in a community centre, are meant for all citizens who apply for this service, while customised facilities are tailored to one person. In 2016, around 6.2% (approximately 1,054,000 people) of all Dutch people used Wmo-customised facilities. Of these 6.2%, around 25.1% (approximately 265,000 people) used support at home (24). In 2015, municipalities spent € 12.7 billion on Wmo and Jw. Of this, € 5.6 billion was spent on Wmo. A total of € 4 billion has been spent on general provisions and Personal Budgets (PGBs) in the field of Wmo and Jw, which cannot be attributed to either policy area (25). When looking at municipalities, there is no obligation to join for the majority of purchasing partnerships (17). Many healthcare providers are active in the Wmo market. In general, these are healthcare providers who aim to provide a wide range of support, so there is little specialization. Because there is little specialisation in the Wmo market, new healthcare providers can easily join. That is the reason many smaller healthcare providers are active in the Wmo market[5].

In Appendix 1, Figure 1 a detailed scheme of obtaining support from the Wmo is provided (2, 10). If it concerns a customised facility in ‘natura’, the facility is made available by the municipality or carried out by the municipality. If it concerns PGB, the support is bought by the citizens themselves (2). Within legal frameworks, municipalities have the freedom to determine the rate of the PGB themselves. A distinction is made between a PGB rate for support provided for formal care (by professional healthcare providers) and a PGB rate for support provided for informal care (by the social network of the client). Informal care is often used when it concerns non-plannable care, whereby the intensity and time of the requested care is unpredictable (26). When it comes to customised facilities, sometimes citizens have to pay a co-payment (2). On 1 January 2019, the subscription fee was introduced. People who use the Wmo will pay 17.50 euros per four weeks. Many people who rely on the Social Support Act were confronted with a ‘stacking’ of their own payments. They often depend on income and use. With the introduction of the subscription fee, support is becoming cheaper for many groups. According to the government, municipalities and implementers also save

[5] Project-leader. Wmo & Jw markets. In: Meijer A, editor. 2019; unreferenced meeting.

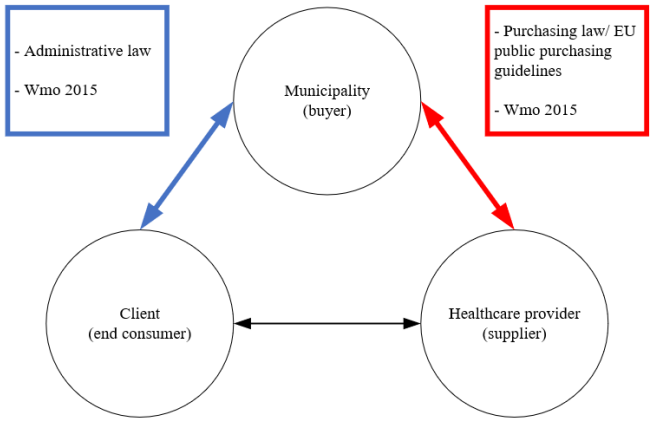
implementation costs and reduce administrative burdens (27, 28). Municipalities receive money from the government through the municipal fund and are allowed to spend this money on the implementation of the Act. The support 'in natura' is financed by the municipality who pays the healthcare provider who provided the support, and the support in PGB-form is financed through the social insurance bank (2, 27, 28). In Appendix I, Figure 2 a detailed schema of financing the customised Wmo is shown.

The quality is guaranteed according to a basis Quality Act. Agreements are made between municipalities, healthcare providers and clients. Clients can object to the decision made by the municipality, and indicate complaints about the healthcare provider and municipality. In addition, clients receive independent counseling with regards to the support and advice they are entitled to. Finally, the municipal council ensures that the municipal Board of Mayor and Aldermen performs the Wmo tasks properly (2).

3.1.2 Legal aspects Wmo

In Figure 3 the legal relationships between the municipality, the healthcare provider and the client are shown.

Figure 3: legal relationships Wmo (20)



3.1.2.1 Relation municipality/ client

Within the Wmo, the municipality is responsible for the availability, quality and continuity of social support. In the former Wmo (before 2015), the obligation to compensate was central, while in the Wmo 2015 self-reliance is central. The client is obliged to arrange as much as possible their selves (29).

Result-oriented purchasing also includes result-oriented indication. With result-oriented purchasing, the whole of principle models, purchasing procedures, funding methods, payment methods and contract forms is meant, while result-oriented indication is only aimed at guidance. The guidance depends on the chosen healthcare purchasing model. The entire purchasing process is included in this thesis, but guidance can perhaps play a key role (30, 31). Municipalities must ensure that result-oriented indication does not infringe the principle of legal certainty ('rechtszekerheidsbeginsel'). This is part of the administrative law. It is mandatory to provide a time indication (30, 31)[6]. According to Telgen[7], the Dutch institutes Ministry of Health, Welfare and Sport (VWS) and Association of Dutch Municipalities (VNG) are in the

[6] Policy-officers-municipality. Result-oriented purchasing in the social domain. In: Meijer A, editor. 2019; unreferenced interview.

[7] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

process of amending the Act, making result-oriented indication without a time component possible. He expects that if the principle of legal certainty can be met in another way, the judges will approve it[7].

With regard to result-oriented purchasing, various municipalities have been approached by administrative courts since 2014. These judgments of administrative courts only concerned the relationship between the municipality and the client: they focussed on the care that was made available to the client, not on the contract (22).

Jurisprudence focuses on the protection of citizens' rights. In recent years there has been a great deal of jurisprudence on result-oriented purchasing for domestic help. For example, the municipality must carefully examine the client's situation before making a decision regarding the allocation of the customised facility. In addition, the award decision ('toekenningsbesluit') must provide the client with sufficient insight into his rights and the decision to allocate a customised facility must be based on a clear benchmark (20).

3.1.2.2 Relation municipality/ healthcare provider

In the relationship between the municipality and the healthcare provider the 'European guideline 2014/24 EU' and the 'Public Purchasing Act (PPA) 2012' apply. Transparency, equal treatment, objectivity and proportionality are the principles in the PPA (20, 22, 29, 32). These principles protect healthcare providers against discrimination, unequal treatment, a lack of transparency and a lack of proportionality (20, 22, 29). The PPA has no objection to result-oriented purchasing. Functional specifying is encouraged in the guidelines. From the Wmo, there is also no objection to result-oriented purchasing. The application of outcome criteria to healthcare providers is even required (20, 22, 29).

3.2 Jw

3.2.1 General information Jw

The support, help and care to the youth (up to 18 years old, with possible extension up to 23 years old) and their families has been decentralised since 2015. The municipalities are responsible. The Jw concerns support, help and care for the youth and their families in a wide arrange of occurring problems. This includes difficulties growing up, problems in the upbringing, psychological problems and disorders. Customised facilities which are based on youth who need continuous care are not included in the Jw. The aid form varies from general prevention to specialised care. The purpose of the Jw is that children can grow up in a safe and healthy way, become independent and, to their own ability, become an active member of society. The municipalities are also responsible for child protection measures, juvenile rehabilitation, domestic violence and child abuse. Because the municipality is responsible for all these tasks, it is possible to provide help to youth and their parents integrally (2). The number of youth receiving youth care has been increasing since 2015. In that year, 380,000 youth up to the age of 23 received youth care. In 2017, there were nearly 420,000. In 2018 that number climbed to 428,000, which is 10% of the youth in the Netherlands (33). In 2015, municipalities spent 12.7 billion euros on Wmo and Jw. Of this amount, 3.1 billion euros was allocated to Jw, which is less than what was allocated to Wmo, but there were also less people who received support from the Jw (25). For the purchase of Jw, all municipalities started a purchasing cooperation in 2015: there were 42 youth assistance regions nationwide. Municipalities concluded regional transition arrangements and there was a duty to join one of the regions for each municipality, which is necessary because the municipality still has too little expertise in the field of youth care. Youth care is not only purchased regionally, but also supra-regionally and at municipal level (17). Little healthcare providers are active in the Jw market. In general,

these are healthcare providers who aim to provide specialised support. Because there is specialisation in the Jw market, it is difficult for new healthcare providers to join. That is why there are mostly large healthcare providers active in the Jw market[8].

Municipalities serve to provide youth care to youth who need it timely and appropriately. They can fill in the implementation in practice themselves. In this way, municipalities have the opportunity to provide customised facilities and to organise the best youth care for their specific environment and specific youth (2).

Youth obtain support according to the Jw in the same way as for the Wmo (Appendix 1, Figure 1).The same applies for the financing of the Jw (Appendix 1, Figure 2). The difference is that the parents usually execute the application and financing for the child. Besides, if the child has a PGB and parents are youth worker themselves, they may get some money from the PGB (2).

In terms of quality, the same applies to Jw as in Wmo. Municipalities can make demands on quality when purchasing youth care and check whether the declarations from the youth aid providers match the agreements. They also check if the claimed care ('gedeclareerde zorg') is delivered actually and efficiently. Furthermore, the youth and their parents can influence the quality of youth care via the client council, or submit a compliant to the Inspection for Healthcare or the Youth Care Inspectorate.

Generally, the government is responsible for ensuring the healthcare system function properly. The Jw contains quality requirements for youth care providers, implementers of child protection measures, and for the advice and reporting points for domestic violence and child abuse. The Inspectorate of the government supervises compliance with quality requirements (2).

3.2.2 legal aspects Jw

3.1.2.1 Relation municipality/ client

In the relationship between the municipality and the client, the same interpretation of the legislation applies as with the Wmo[9].

3.1.2.2 Relation municipality/ healthcare provider

In the relationship between the municipality and the healthcare provider, the same interpretation of the legislation applies as with the Wmo. The Jw has no objection to result-oriented purchasing. The application of outcome criteria to healthcare providers is even required[9].

3.3 The client as prosumer

As mentioned in Section 2.1, the Wmo and Jw have a different basis than the Wlz and the former AWBZ when it comes to the role of the client (2). In the Wmo and Jw, municipalities sometimes provide the support themselves, whereas in other instances healthcare providers are required (2, 29, 34). It is assumed that in all models discussed in this thesis, the director model will be applied.

[8] Project-leader. Wmo & Jw markets. In: Meijer A, editor. 2019; unreferenced meeting.

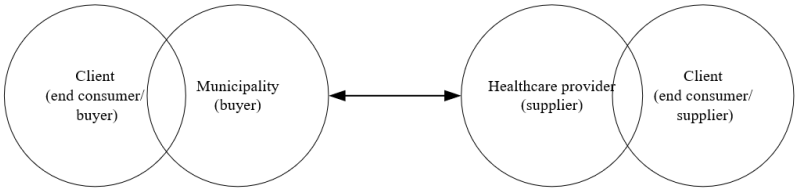
[9] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

As mentioned in Section 2.3, decentralisation of care within the context of the Wmo and the Jw aims to provide more customised solutions at the individual client level (22)[10]. Clients partly become their own healthcare provider. This promotes the delivery of sensible and economical care (‘zinnige en zuinige zorg’). On the one hand, because unrest with regard to the care provided is prevented, and caregivers and care staff are relieved. On the other hand, because care is becoming more affordable because customised care is provided[10]. A distinction must be made between self-employed clients (independent) and clients who are dependent on their environment[11]. In this thesis it is assumed that independent clients are articulate, able to stand up for themselves and fairly independent, while dependent clients are not. The independent client become a prosumer, while the dependent client do not or only partly become a prosumer.

Despite the distinction between independent clients and dependent clients, in practice every client could be a prosumer according to Van Dijk[11]. Independent clients are prosumers themselves, while dependent clients in their prosumer role are supported by family members and, where necessary, client support staff[11]. In the Achterhoek, for example, there is a care cooperation in Mariënvelde (35)[11]. In comparison with the Netherlands as a whole, the Achterhoek is the place where the prosumer model can function well, because the Achterhoek is smaller and more manageable than most other regions. The networks are shorter and there is a high degree of willingness to experiment. This is less so the case in a densely populated area such as large cities, unless that densely populated area is then split into zones or neighbourhoods. In addition, there are often greater cultural differences in densely populated areas[10].

The prosumer model is not taken into account in the triangular model from Figure 3. Theoretically, the service triad of the prosumer model should look differently[10]. In Figure 4 the service triad of the prosumer model is shown. Intermediaries such as the Central Administration Office (CAK) are not taken into account. The legal relationships are still the same as in Figure 3, because the relationships are fixed. With result-oriented purchasing, there is a discussion about who is the end consumer, who is the buyer and who is the specifier. The client is the end consumer. Who the buyer and specifier are will be part of the results of this study.

Figure 4: service triad prosumer model [10]



3.4 Package 1: individual support

Social Domain Achterhoek created nine Packages to purchase healthcare jointly and integrally. The support in Package 1 is aimed on learning, practicing and perpetuating skills and behaviour. Package 1 consists of the domains of individual guidance, personal care and individual youth treatment. Per domain, requirements are included for employees who offer support in the domain in question. In Appendix II a detailed overview of the current situation in Package 1 is provided.

[10] Montfort Gv. 2018-2019 Lecture 7 Client takes the lead. 2018; unreferenced lecture.

[11] Dijk Ov. Prosumer model & citizens initiatives. In: Meijer A, editor. 2019; unreferenced interview.

4. Theoretical framework

In Section 4.1 result-oriented purchasing will be explained. In Section 4.2 principle models will be described. Which principle model is applied in a municipality arises from the mission and vision of the municipality (4, 15).

In Section 4.3 purchasing models will be described. The purchasing model influences the distance between the municipality and the market, the number of parties to be contracted, the possibility to steer on price and quality, and the possibility to make use of competition between suppliers. The purchasing model should be in line with the mission and vision of the municipality, therefore it is also in line with the applied principle model (36).

In Section 4.4 funding methods will be described, which determines the incentives for among other things innovation and quality improvement, and degree of flexibility for providers (17). In the decision whether or not to switch to result-oriented purchasing, it is important to include whether they also want to implement result-oriented purchasing in the funding.

In Section 4.5 the challenges of results-oriented purchasing will be stated, in which challenges regarding the paying method will be included in Section 4.5.3.

In Section 4.6 several contract forms will be described.

For principle models, purchasing models, funding methods, paying methods and contract forms, it must be determined whether these can be applied for result-oriented purchasing or not. The principle model, purchasing model, funding method, paying method and contract form are overall defined as *healthcare purchasing model*.

4.1 Result-oriented purchasing

In Section 4.1.1 will be described what result-oriented purchasing generally entails. Subsequently, Section 4.1.2 describes what result-oriented purchasing entails in Package 1: individual support. This is the focus of this thesis.

4.1.1 What is result-oriented purchasing?

Result-oriented purchasing is a purchasing methodology that provides healthcare and support purchased on the basis of agreements about how to reach results and outcomes, in contrast to the commitment and actions of healthcare and support. Properties are a contract that exists on the results to be achieved (20).

When it comes to result-oriented purchasing, it is actually about result-oriented funding, the method of specification, and the division of roles of the client, municipality and healthcare provider. With result funding, an amount is granted based on an agreed result or a reward is provided for an achieved result. The complete purchasing model consists of a principle model, a procedure, funding method, contract form, and a paying method. In this thesis it is assumed that a director model is applied, so the choice for the 'model' type is eliminated.

4.1.2 Result-oriented purchasing Package 1: individual support

In order to determine which *healthcare purchasing model* is suitable for result-oriented purchasing in Package 1: individual support, and whether result-oriented purchasing is suitable for Package 1 at all, it is necessary to know 'what' is purchased in Package 1. The starting point for defining results is the Act. The purpose of the Wmo is to promote self-reliance and participation. These objectives must be translated into concrete results. When it comes to the

funding method, Social Domain Achterhoek currently applies production funding (P * Q), but aims to switch to result funding. Then the product "individual guidance" could for example be replaced by "achieving self-reliance in the field of finance and administration". Each result area can be assigned to a client as an customised facility. The funding methods are further explained in Section 4.4 (37).

The P*Q model is an integrated model in which the volume risk is for the municipality in case of the Wmo and Jw, because there is no resale obligation ('doorleverplicht'). This is why the indication is so important for the municipalities, so that they keep control on the volume. Because only budget agreements are made, healthcare providers cannot compensate a low price with more volume, which means that the price is relatively high. Another possibility is a model in which separate agreements are made about price and volume (P & Q). In the P&Q-model the volume risk is for the municipality too in case of the Wmo and Jw. Because separate agreements are made about the volume, healthcare providers can compensate a low price with more volume, which means that the price relatively low. Furthermore, a model can be applied in which only price negotiations take place (P-model). In the P-model the volume risk is for the municipality too, because the volumes are not fixed. The prices are relatively low, because healthcare providers can compensate a low price with more volume. The P-model is interesting for healthcare providers to grow, and for municipalities it offers the opportunity to create more competition between healthcare providers, because of the relative low price[12].

In Appendix III, Table 1 an overview of the result-areas based on the current activities in Package 1: individual support, is provided. In Social Domain Achterhoek, this overview is used in the current open-house procedure with production funding (P*Q). The overview is based on the self-reliance matrix (ZRM), but therefore shows similarities with the Positive Health Spin. Both models are applicable in order to determine results (37). The overview has been adapted to concrete results in the context of this thesis. The application manager has supplied data in which all selected goals since 2016 in the processing system are mentioned. The overview has been compared with this data to prevent missing goals, also called results. The overview is divided into two groups of clients: independent clients and dependent clients (prosumer or not, as mentioned in Section 3.3). However, it is also possible that a dependent client is not dependent on all result areas or that an independent client is not independent on all result areas. The results in Appendix III, Table 1 apply for both the Wmo and Jw.

4.2 Principal role municipality

In Section 4.2.1 possible principle models will be described.

4.2.1 Possible principal models

According to Telgen, Uenk & Lohman (4), there are five models that are applied in practice when the municipality is the principal (4):

- 'AWBZ'-model
- Auction model
- Population-based funding
- Director model
- District teams

[12] Montfort Gv. 2018-2019 Lecture 9 Business economic aspects in health care. 2019; unreferenced lecture.

For all models the service triad as shown in Figure 1 can be different. The service triad from Figure 1 is the basis for this thesis because the legal relationships are fixed anyway. Only the perspectives of the three parties differ (4, 14).

When applying the 'AWBZ'-model the municipality has taken over the role of the care office and uses the same products, method of identification and funding method as in the old 'AWBZ' (4).

In the auction model, the municipality conducts a kitchen table conversation with the client with a support question and the municipality describes the problem situation. The anonymised problem situation is placed on a private website where qualified healthcare providers can 'bid' with a care plan and associated price. The municipality then chooses, in consultation with the client, which plan best suits the wishes and which healthcare provider wins the auction (4).

With population-based funding, a municipality is divided into a number of neighbourhoods. The municipality selects one or more healthcare providers per district that receive the entire budget for that district and then must arrange everything. A large healthcare provider (provider with a lot of staff and many clients) is typically chosen as the main contractor because it can deliver support to many clients and is well able to coordinate collaboration with smaller healthcare providers (4).

In the director model, a director conducts the kitchen table conversation with the client on behalf of the municipality to chart the client's need for care. In consultation with the client, the director draws up a support plan, in which self-reliance, the social network, and general facilities are the most important. The municipality has framework contracts with healthcare providers for each intervention. Mostly, the client can choose from the available healthcare providers. The director remains involved and maintains an overview during the implementation of the care (4). In the director model, a distinction is made between result-oriented and product-based (P*Q)[13]. Obtaining support from the Wmo and Jw as described in Appendix 1, Figure 1, is based on the director model.

However, according to Telgen[13], district teams is not a goal in itself, it can be applied alongside the other models[13]. When handling district teams, municipalities set up multidisciplinary district teams with employees from the municipality and from providers of general facilities. The district team conducts the kitchen table conversations and draws up support plans. Moreover, the district team carries out as much as possible itself. Where professional support is needed, the team refers clients to healthcare providers (4)[13]. Social Domain Achterhoek uses an intermediate form of both the director model and district teams (23). However, the focus of this thesis is on the director model. In Appendix IV, Table 1 an overview of the advantages and disadvantages of both the result-oriented form and the performance-oriented form of the director model for the different stakeholders is provided.

4.3 Purchasing procedures

In Section 4.3.1 possible purchasing procedures in the Dutch social domain will be described. Subsequently, in Section 4.3.2 will be described how the advantages and disadvantages of the various purchasing procedures have been processed. Finally, in Section 4.3.3 criteria have been drawn up on the basis of the advantages and disadvantages.

[13] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

4.3.1 Possible purchasing procedures

Individual support from the Wmo and Jw is outsourced by municipalities. Depending on the conditions under which the municipality wants to put the service on the market, there are three main options for applying this outsourcing (38):

1. Subsidisation
2. Open-house procedure
3. Government contract

4.3.1.1 Subsidisation

Subsidisation is often used for activities in the public interest. Strictly speaking, subsidising is not a form of purchasing. Nevertheless subsidisation is mentioned because it is not excluded that subsidies cannot be applied in the Wmo and Jw (12, 16, 21). There are three types of subsidies, which are explained in the *'Informatiekaart Inkoopmodellen'* (36) of the Dutch Government:

- *policy-driven contract financing*, whereby the municipality finances one or more healthcare providers on the basis of a contribution to common objectives;
- a *subsidy tender*, where the subsidy is based on award criteria and the healthcare providers compete with each other;
- and the *traditional subsidy* based on an implementation agreement, whereby the subsidy is based on activities to be carried out (36).

According to Robbe[14] subsidies cannot be applied in result-oriented purchasing, because it is only allowed to finance activities and that cannot be linked to an obligation to achieve a result[14]. Therefore, subsidisation is ultimately excluded in this thesis.

4.3.1.2 Open-house procedure

The open-house procedure does not have limitations under the Purchasing Act. It is a system of agreements whereby the municipality intends to purchase services. During the term of the system, the municipality concludes an agreement with every healthcare provider who qualifies and commits himself to the conditions. This agreement does not offer a turnover guarantee, because the client chooses the healthcare provider himself. There are no limitations to for example intermediate entry or changes. This means that an enforceable contract can still be concluded without applying the Purchasing Act (15, 21). The municipality establishes agreements with every healthcare provider who can deliver goods or services at standard conditions and rates. Before committing to the agreement, the municipality checks whether these healthcare providers are qualified according to quality requirements (17, 39).

4.3.1.3 Government contract

A government contract does have limitations under the Purchasing Act and involves a written agreement for pecuniary interest. This means that the buyer pays a competitive fee for a service, work or delivery. The healthcare provider provides the service and is then entitled to the agreed fee (17). In this thesis, a government contract with a value above European thresholds is assumed, because of the value of the care needed (38, 40, 41). There are some formal procedures and some form retaining procedures. In addition to the regular European tendering procedures (formal procedures), support from the Wmo and Jw may also be based on a simplified, largely

[14] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

self-designed procedures (form retaining procedures) (38). In some procedures, several parties are contracted and in some procedures, only one party is contracted. The number of healthcare providers influences the degree of competition between providers (42).

However, there is an enlightened regime for social and other specific services (SAS) in the PPA 2012 and the European Public Purchasing Directive ("Europese aanbestedingsrichtlijn"): the use of 'standard' legally defined tendering procedures is not mandatory. Therefore, there a number of specific procedures, which are mentioned later in this section (38).

According to Telgen[15], the municipal care purchasing monitor (17) describes the most recent common classification of purchasing procedures in the Dutch social domain. That is why it is used as a benchmark (17, 38).

There are various names for the procedures. For this reason, the procedures in this thesis are "functionally" determined. It is not about the name used for the procedure, but about the properties and characteristics of the procedure itself. In Table 1 an overview of common purchasing procedures in the Dutch social domain, which are also included in this thesis, is provided. The various purchasing procedures are explained under Table 1.

In theory, the order of choices in Table 1 should be used to choose purchasing procedures. In some cases contracts have to be put out to tender, which means that in those cases subsidising and the open-house procedure are no longer options (38, 43, 44). If tendering is required and therefore a government contract applies, it must be determined whether or not the contract falls above the European threshold (38, 40, 41). Then, a suitable procedure must be found (38).

[15] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

Table 1: purchasing procedures

Choice 1	**Choice 2**	**Choice 3**	**Choice 4**	**Choice 5**
Subsidy (12, 16, 21)	Policy-driven contract financing (36)	Not taken into account in this thesis.		
	Subsidy tender (36)			
	Traditional subsidy (36)			
Open-house procedure (15, 17, 21, 39)	Only one choice: every healthcare provider that meets the requirements will receive a contract.			
Government contract (17) *	Under European threshold (38, 40, 41)	Not taken into account in this thesis.		
	Above European Threshold (38, 40, 41)	Form retaining procedure (38)	Contract multiple healthcare providers (12, 16, 17, 21, 41, 42)	Procedure in accordance with 'Zeeuws' model (12, 16, 17, 21)
				Dialogue oriented administrative purchasing (17, 21, 41)
			Contract usually only one healthcare provider (12, 17, 21, 42)	Best Value Procurement (BVP) (12, 17, 21)
			Contract multiple healthcare providers/ contract usually only one healthcare provider (42)	Other form retaining procedures in line with the enlightened regime
		Formal procedure (38)	Contract multiple healthcare providers (12, 16, 17, 41, 42, 45)	Classical European public purchasing (12, 16, 17, 21)
				Dynamic purchasing system (DAS) (17, 41, 45)
			Contract multiple healthcare providers/ contract usually only one healthcare provider (42)	Other formal procedures in line with the enlightened regime

*Only procedures that are permitted above the European threshold and procedures that have been applied in recent years in the Dutch social domain are included (38).

'Zeeuws' model (government contract – form retaining – multiple providers)
In the *'Zeeuws' model* municipalities determine all conditions themselves with standard rates. Every healthcare provider that meets the eligibility criteria is admitted to the framework agreement with these conditions (12, 16, 17, 21).

Dialogue-oriented purchasing (government contract – form retaining – multiple providers)
Dialogue-oriented purchasing leads to the same type of agreement as with the 'Zeeuws' model. However, the rules of the game for the dialogue sessions are agreed upon in a separate agreement. During implementation, there is also room for dialogue, room for early accession and withdrawal, and changes to the agreement are laid down in a contract. The contract must then be republished within the framework of the Purchasing Act (17, 21).

BVP (government contract – form retaining – one provider)
At *BVP* in this thesis, it is assumed only one provider is contracted. The municipality describes the wishes and goals. The assignment is functionally specified by the municipality and the municipality asks healthcare providers to demonstrate their expertise by questioning the expected risks and opportunities. The municipality tests the "quality" award criterion partly on the basis of interviews with key officials of the healthcare providers. The municipality chooses the best healthcare provider and then, in consultation with the healthcare provider, concretises the assignment. The municipality describes the desired results and the healthcare providers describe how they will execute the assignment. This is a form retaining procedure because the details of the assignment are largely determined by the healthcare provider. Only the outcome is determined in advance by the municipality. BVP can also be used under a formal procedure, but the application of BVP will then be more restricted to fixed assignments (12, 17, 21).

Classical European public purchasing (government contract – formal – multiple providers)
The agreement does not guarantee turnover. Clients choose their healthcare provider themselves (21). In traditional *classical European public purchasing*, the municipality publishes a Program of Requirements (PoR) and award system and calls on healthcare providers to submit bids. The municipality only awards one or a limited number of contracts, namely only to healthcare providers that offer the best quality and price (12, 16, 17, 21). The municipality usually uses this procedure to award an entire assignment to one party (17).

DAS (government contract – formal – multiple providers)
At *DAS* the municipality goes through digital procedures to conclude continuous agreements for current purchases. The agreement has standard conditions, requirements and rates for all parties. Within the agreement, the municipality awards individual assignments (care for individual clients). Municipalities organise dialogue sessions with healthcare providers in the procedures. Therefore, this procedure looks like dialogue-oriented purchasing (17, 45).

Other form retaining procedures in line with the enlightened regime
In addition to the European formal procedures, other simplified SAS procedures can also be applied to SAS services, as mentioned earlier. For support from the Wmo and Jw, general rules for the organisation of a SAS procedure must be followed. The included retaining procedures that are applied in the Netherlands are mentioned in Table 1 (17, 38).

Other formal procedures in line with the enlightened regime
In addition to *classical European public purchasing* and *DAS*, there are other more formal European purchasing procedures such as *communication with negotiation, competitive dialogue, innovation partnership* and the *restricted procedure (17, 38)*. These are not included in this thesis, because they are not used by any municipality for the purchase of Wmo customised facilities and individual Jw facilities (17).

4.3.2 Summarising advantages and disadvantages of purchasing procedures
In Table 1, Appendix V an overview of the advantages and disadvantages of the purchasing procedures for the different stakeholders is provided. Every advantage and disadvantage has its own colour and designation, also called 'topic', in Table 2, Appendix V. The order of the advantages and disadvantages in Table 1, Appendix V and Table 2, Appendix V is exactly the same. The same applies to the corresponding references. The advantages and disadvantages of the various purchasing procedures will be reflected in the determination of the criteria in Section 4.3.3.

4.3.3 Criteria purchasing procedures
In Table 3, Appendix V all topics from Table 2, Appendix V are grouped into a few criteria. These criteria have been drawn up to be able to assess which purchasing procedure fits best to result-oriented purchasing of individual support. In Table 2 on the next page an overview of what the final criteria for the assessment of purchasing procedures entail, is provided. The criteria are assessed through a multi-criteria analysis. In Section 5.4.1 will be explained what this multi-criteria analysis entails and how this multi-criteria analysis will be performed.

In the multicriteria-analysis, only the advantages and disadvantages of the purchasing procedures in relation to result-oriented purchasing in contrast to not result-oriented purchasing were taken into account. On the one hand, it meant that some purchasing procedures are not applicable at all to result-oriented purchasing. On the other hand it meant that some topics did not apply in the decision to apply result-oriented purchasing or not.

According to Robbe[16] and Telgen[17], almost all purchasing procedures could be applied to result-oriented purchasing in theory, because this is about how the end result is worked towards[16] [17]. The purchasing procedure subsidisation is not applicable for result-oriented purchasing, because it is only allowed to finance activities, which cannot be linked to an obligation to achieve a result[16].

Price, quality, innovation, and volume are performance aspects. Performance aspects are important in the execution of determined results. Freedom of choice is important because it influences the performance aspects. The Purchasing Act has no direct link with the decision to apply result-oriented purchasing or not, but it is essential for Social Domain Achterhoek. Social Domain Achterhoek applies the open-house procedure in the current situation, where no Purchasing Act is enforced. The other criteria in purchasing procedures from Table 3, Appendix V are not important in the decision to apply result-oriented purchasing or not, or are closely

[16] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

[17] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

related to one of the other criteria. Besides, for all stakeholders (municipalities, clients and healthcare providers) some of the included criteria were not applicable (N/A).

For municipalities, all criteria are applicable because of the director role of the municipalities. For clients, only the criterion freedom of choice/diversity of providers is applicable. The quality, innovation, and volume are not fixed in a certain procedure, and the client has nothing to do with the Purchasing Act. The price is known whether it is fixed or not, but in this thesis financing from the Wmo and Jw is assumed, so the client is not directly concerned with the price.

The performance criteria price, quality, innovation and volume are applicable for healthcare providers. The Purchasing Act applies between municipalities and healthcare providers. The quantity of providers is important for healthcare providers because it reflects the degree of competition and the barriers to entry. In Tables 3 up to and including 5 overviews for the perspectives of the municipality, client and healthcare provider of the included criteria for purchasing procedures are shown.

Table 2: explanation criteria purchasing procedures

	Criterion	**Meaning**
1	Price control	Indicates to what extent the stakeholder in question has influence on the price
2	Quality control	Indicates to what extent the stakeholder in question has influence on the quality
3	Innovation control	Indicates to what extent the stakeholder in question has influence on stimulation of innovation
4	Freedom of choice/quantity of provider	Indicates the extent to which there is diversity of providers (many / few)
5	Purchasing Act in force?	Indicates whether the Purchasing Act is in force (difference with open-house)
6	Volume control	Indicates to what extent the stakeholder in question has influence on the volume

Table 3: purchasing procedures criteria (view of municipalities)

	Price control	**Quality control**	**Innovation control**	**Freedom of choice/quantity of providers**	**Purchasing Act in force?**	**Volume control**
Open-house	*Limited price control*, standard rates, but diversity in the offer (21, 39)	*Limited quality control*: only basic quality requirements (15, 39)	*Reasonable innovation control*, through involvement in realisation (16, 39)	*Large diversity of providers* (differentiation between providers). Every provider that meets requirements must be included (15, 39)	*No* (17, 21)	*Limited volume control*, no competition, but diversity in the offer. Besides, no agreements about the volume (21, 39)
'Zeeuws' model	*High price control* through unilateral pricing (16)	*Limited quality control*: only basic quality requirements (36)	*Limited innovation control*: no fixed agreements. Only incentives at providers through freedom of choice (16)	*Large diversity of providers* (less differentiation between providers). Every provider that meets the requirements is contracted (12, 16, 21)	*Yes* (17, 21)	*Volume is uncertain*: no agreements about the volume (16)
Dialogue-oriented purchasing	*Reasonable price control* through dialogue sessions and a bandwidth for price (16)	*High quality control* through dialogue sessions and long term contracts (16)	*High innovation control* through dialogue sessions and long term contracts (16)	*Reasonable diversity of providers*, because providers that meet the requirements are contracted. However, an agreement must first be reached on the content of the contract (16)	*Yes* (17, 21)	*Volume is uncertain*: no agreements about the volume (16)
BVP	*Limited price control*: may only specify a bandwidth, but select usually one provider (12, 16)	*High quality control*: maximum number of providers/ one provider based on the best quality (12, 16)	*Limited innovation control*: limited incentive at providers, because the municipality determines services unilateral (12, 16)	*Usually no diversity of providers*, because only one provider is selected (21)	*Yes* (17, 21)	*Limited volume control*, because the provider determines the execution. Only selection of one provider (12, 21)
Classical European public purchasing	*Limited price control*: may only specify a bandwidth, but select usually one provider (16)	*High quality control*: maximum number of providers selected based on the price/quality (16)	*Limited innovation control*: limited incentive at providers, because the municipality determines services unilateral (16)	*Limited diversity of providers*: only providers with the best price/quality combination are selected (16, 21)	*Yes* (17, 21)	*Limited volume control*, because the provider determines the execution. Only selection of a few providers (12, 16, 17, 21)
DAS	*Reasonable price control* possible through dialogue sessions and setting price as a criterion in the DAS (36, 45)	*Continuous quality control* due to the dynamic nature and dialogue sessions (17, 36)	*Continuous innovation control* due to the dynamic nature and dialogue sessions (17, 36)	*Limited diversity of providers*: award to one provider, but choices in the DAS (17, 45)	*Yes* (17, 21)	*Volume is certain*, because individual contracts are awarded (17, 45)

Table 4: purchasing procedures criteria (view of clients)

	Price control	Quality control	Innovation control	Freedom of choice/quantity of providers	Purchasing Act in force?	Volume control
Open-house	N/A	N/A	N/A	*Large diversity of providers* (15, 16, 21, 39)	N/A	N/A
'Zeeuws' model	N/A	N/A	N/A	*Large diversity of providers* (12, 16, 21)	N/A	N/A
Dialogue-oriented purchasing	N/A	N/A	N/A	*Reasonable diversity of providers* (16)	N/A	N/A
BVP	N/A	N/A	N/A	*Usually no diversity of providers* (21)	N/A	N/A
Classical European public purchasing	N/A	N/A	N/A	*Limited diversity of providers* (16, 21)	N/A	N/A
DAS	N/A	N/A	N/A	*Limited diversity of providers* (17, 45)	N/A	N/A

Table 5: purchasing procedures criteria (view of healthcare providers)

	Price control	**Quality control**	**Innovation control**	**Freedom of choice/quantity of providers**	**Purchasing Act in force?**	**Volume control**
Open-house	*Limited price influence* through diversity in the offer & *no price competition* because it is not allowed (21, 39)	*Reasonable quality influence*, because only basic quality requirements are fixed (16, 21, 39)	*Reasonable innovation influence*: possibility through involvement in realisation (16, 39)	*Low entry barriers & large diversity of providers* (15, 16, 21, 39)	*No* (17, 21)	*Volume is uncertain:* no agreements about the volume and competition about getting the client (21, 39)
'Zeeuws' model	*No price influence & no price competition*: unilateral pricing by the municipality (12, 16, 21)	*Reasonable quality influence*, because only basic quality requirements are fixed (36)	*Limited innovation influence*, because it is not taken into account in the price, but there is an incentive through the freedom of choice (16)	*Low entry barriers & large diversity of providers* (12, 16, 21)	*Yes* (17, 21)	*Volume is uncertain*: no agreements about the volume (16)
Dialogue-oriented purchasing	*Reasonable price influence & price competition*: dialogue sessions, price within a bandwidth (16)	*High quality influence* through dialogue sessions and long term contracts (16)	*High innovation influence* through dialogue sessions and long term contracts (16)	*Normal entry barriers & reasonable diversity of providers* (16)	*Yes* (17, 21)	*Volume is uncertain*: no agreements about the volume (16)
BVP	*Reasonable price influence & price competition*: offer a price within a certain bandwidth (12, 16)	*Difficult quality influence & quality competition*: maximum number of providers/ one provider based on the best quality (12, 16)	*Low innovation influence & little innovation competition*: municipality determines services unilateral (12, 16)	*Usually no diversity of providers* (21)	*Yes* (17, 21)	*Reasonable volume influence*, because the provider determines the execution (12, 21)
Classical European public purchasing	*Reasonable price influence & price competition*: offer a price within a certain bandwidth (16)	*Difficult quality influence & quality competition*: maximum number of providers/ a few providers selected based on the best price/quality (16)	*Low innovation influence & little innovation competition*: municipality determines services unilateral (16)	*Limited diversity of providers* (16, 21)	*Yes* (17, 21)	*Reasonable volume influence*, because the provider determines the execution (12, 16, 17, 21)
DAS	*Limited price influence & little price competition*: possible to set price as a criterion in the DAS (16, 17)	*Reasonable quality influence & quality competition*: dialogue sessions and dynamic system (17, 36)	*Reasonable innovation influence & innovation competition*: dialogue sessions and dynamic system (17, 36)	*Low entry barriers & limited diversity of providers* (16, 17, 21, 45)	*Yes* (17, 21)	*Volume is certain*, because individual contracts are awarded (17, 45)

4.4 Funding methods

In Section 4.4.1 possible funding methods in the Dutch social domain will be described. Subsequently, in Section 4.4.2 will be described how the advantages and disadvantages of the various funding methods have been processed. Finally, in Section 4.4.3 criteria have been drawn up on the basis of the advantages and disadvantages.

4.4.1 Possible funding methods

Common funding methodologies in the Dutch social domain are: production funding, population funding, function funding, result funding and personal funding (12, 15, 16, 18, 21). However, according to Telgen[18], the municipal care purchasing monitor (17) describes the most recent common classification of funding methods. That is why it is used as a benchmark. The municipal care purchasing monitor describes three only three methods:

- Production funding
- Population funding
- Result funding

4.4.1.1 Production funding

Production funding is the most traditional way of funding and is effort-oriented (16, 20). The fee is determined by multiplying the price (P) of support by the number of hours (Q) the support has been delivered (P*Q). Agreements made about the description of the products and about the rates have been established for the duration of the contract. During that period, there is basically no reason for providers to improve quality or to innovate. After all, what the healthcare provider has to deliver is precisely described in the contract. Expenditure is in principle not maximised with production funding, which is a financial risk for the municipality. It is possible to accurately estimate the total realisation volumes in advance so that the expenditure is ultimately reasonably predictable. Production funding is very much in line with the traditional tendering procedure, but a form of production funding is possible with every purchasing model. In practice, most municipalities use this form of funding for most of the new tasks (16). This funding method was also used in the old AWBZ (12, 17).

4.4.1.2 Population funding

In the case of *population funding*, the financial compensation for providers is determined on the basis of demographic characteristics. The reimbursement is usually made available in the form of a lump sum amount per month or per year and is therefore maximised. Healthcare providers must provide all clients with the necessary care and support (16, 17). Population funding is usually deployed in places where multiple healthcare providers are jointly responsible for social support in a municipality or neighbourhood (12, 15, 16). Population funding is also deployed in places where large parts of the care and support are provided by one healthcare provider or one partnership of healthcare providers (16).

4.4.1.3 Result funding

For *Result funding*, which is output/outcome-oriented, the financial compensation for healthcare providers is determined on the basis of results achieved (12, 16, 17, 20). A simple example is household help. The result is "a clean house". So no hours of household help are purchased, but a number of clean houses. Funding can also be used for more complex forms of care and support. For this, for example, the different domains of the ZRM can be used. The financing is then determined on the basis of the client's position in the various areas of life in

[18] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

the ZRM. The healthcare provider determines in consultation with the client what the most suitable support is. How the healthcare provider achieves the result is therefore basically a matter between the healthcare provider and the client, although the municipality may not completely be independent. Various court rulings have reminded municipalities of their duty to investigate each individual situation and to give substance to outcome agreements with healthcare providers (16).

4.4.2 Summarising advantages and disadvantages of funding methods

In Table 1, Appendix VI an overview of the advantages and disadvantages of funding methods for the different stakeholders is provided. Every advantage and disadvantage has its own colour and designation, also called 'topic', in Table 2, Appendix VI. The order of the advantages and disadvantages in Table 1, Appendix VI and Table 2, Appendix VI is exactly the same. This also applies to the corresponding references. The advantages and disadvantages of the various funding methods will be reflected in the determination of the criteria in Section 4.4.3.

4.4.3 Criteria funding methods

In Table 3, Appendix VI all topics from Table 2, Appendix VI are grouped into a few criteria. These criteria have been drawn up to be able to assess which funding method fits best to result-oriented purchasing of individual support. In Table 6 on the next page an overview of what the final criteria for the assessment of purchasing procedures entail, is provided. The criteria are assessed through a multi-criteria analysis. In Section 5.4.1 is explained what this multi-criteria analysis entails and how this multi-criteria analysis is performed.

In the multicriteria-analysis, only the advantages and disadvantages of funding methods in relation to result-oriented purchasing or not result-oriented purchasing were taken into account. Result-based funding was included in the analysis, because on the basis of the research question '*how should result-oriented purchasing be organised for individual support*?' it must be indicated how result-oriented purchasing should be organised. However, production funding and population funding were not dropped, because the possibility to only steer on results instead of to fund on results was also present.

Customised care was included, because the client should be central, which should not be forgotten in the decision to apply result-oriented purchasing or not. Quality, financial security, and innovation were included because those are performance aspects that are important in the execution of the determined results. Freedom of choice is important because it influences the performance aspects, but there is no difference in freedom of choice between the funding methods. For this reason, freedom of choice was therefore still not included. Determining function was included because there is an essential difference in determining performances and determining results in the decision to apply result-oriented purchasing or not. The other merged topics in funding methods from Table 3, Appendix VI are not important in the decision to apply result-oriented purchasing or not, or are closely related to one of the other criteria. For some stakeholders (clients and healthcare providers) some of the included criteria were not applicable (N/A).

For municipalities, all criteria are applicable because of the director role of the municipalities. For clients, only the degree of customised care and quality are applicable. This thesis assumes financing from the Wmo and Jw, so the client is not directly concerned with financial security. In this thesis, the determining function applies to the municipality and the healthcare provider. The municipality has to decide whether healthcare providers and clients have to be involved. For healthcare providers, only quality was not applicable. The quality depends on among others

the freedom of choice. When a customer is dissatisfied with the quality and it is not known whether the client can switch to another healthcare provider, measuring quality gives an unreliable picture. In Tables 7 up to and including 9 overviews for the perspectives of the municipality, client and healthcare provider of the included criteria for funding methods are shown.

Table 6: explanation criteria funding methods

	Criterion	**Meaning**
1	Customised care control	Indicates to what extent the stakeholder in question has influence on the customised care
2	Quality control	Indicates to what extent the stakeholder in question has influence on the quality
3	Financial security	Financial security in terms of volume, costs and rates/prices
4	Innovation control	Indicates to what extent the stakeholder in question has influence on stimulation of innovation
5	Determining function	Indicates on which the stakeholder has influence: performances, results or both.

Table 6 only applies to the municipality and the healthcare provider. For the client, it applies that for customised care, quality and innovation it is not about control. It is about the degree of customised care, quality or innovation presence.

For the client, the concept of quality is described as follows:
"Ultimately, it is the match between the client's need for support and the support that the healthcare provider provides that determines the quality of the support (16)."

Table 7: funding methods criteria (view of municipalities)

	Customised care control	**Quality control**	**Financial security**	**Innovation control**	**Determining function**
Production	*Low customised care control*: fixed products and rates = no stimulation for customised care at providers (16, 20)	*Low quality control*: fixed products and rates = no stimulation for improving quality at providers (16, 20)	*Limited financial security* through uncertain volume and no maximised expenses. However, the volume is fairly good to estimate (16)	*Limited innovation control*: fixed products and rates = no stimulation for innovation at providers (16, 20)	*May determine performances* (16)
Population	*Reasonable customised care control*: efficiently and required care, because the financial compensation does not depend on the volume actually delivered (15, 16)	*Reasonable quality control*: few incentives for improving quality, because of fixed contracts without interim adaptation. However, possibility of quality improvement, because the services are not tightly framed (15, 16).	*High financial security* through cost-reducing deployment & maximised expenses (budget ceiling) (16)	*Reasonable innovation control*: stimulation of innovation and prevention through long-term relationship. Low investment-risks. Fixed contract with a fixed compensation (15, 16).	*May determine results* (16)
Result	*High customised care control*: providers have the responsibility to do what is necessary to achieve the result (20)	*High quality control*: possibility to steer on quality. Providers are asked to do what is necessary to achieve the result and what is best for the client. The service is not described in advance (15, 16)	*Reasonable financial security* through cost-reducing deployment & financial compensation is determined on the basis of results achieved (15, 16, 20)	*High innovation control*: within result agreements, providers have the possibility and incentive to make smart combinations of different forms of support (12, 15, 16, 20)	*May determine results* (16)

Table 8: funding methods criteria (view of clients)

	Customised care	**Quality**	**Financial security**	**Innovation**	**Determining function**
Production	Certainty about performances, but due to the fixed rates and volumes in contracts *no certainty that it is actually customised care* (16)	*No quality guarantee*, because suppliers are not encouraged to improve quality through the fixed contracts (16)	N/A	N/A	N/A
Population	*Reasonable customised care*: efficiently and required care, which is reasonably customised, because services are not tightly famed in advance and cost-reducing deployment (16)	*Reasonable quality*: opportunity to improve quality, because services are not tightly framed in advance. However, no incentives because of the fixed contract without interim adaptation (15, 16).	N/A	N/A	N/A
Result	*High customised care*: providers have the responsibility to do what is necessary to achieve the result (20)	*High quality*: providers are asked to do what is necessary to achieve the result and what is best for the client. The service is not described in advance. This contributes to quality according to the described quality concept on the former page (15, 16)	N/A	N/A	N/A

Table 9: funding methods criteria (view of healthcare providers)

	Customised care control	**Quality control**	**Financial security**	**Innovation control**	**Determining function**
Production	*Low customised care control*: obstruction of space to provide customised care, because of the fixed contract (fixed performances) (16, 20)	N/A	*Reasonable financial security* through no maximised expenses. However, there is no turnover guarantee (16)	*Limited innovation control*, because of the fixed contract (fixed performances) (16)	*May not determine performances* (16)
Population	*High customised care control*: possibility to adjust care to customer needs, because services are not tightly framed in advance (16)	N/A	*Reasonable financial security* through maximised expenses (budget ceiling). Reimbursement does not depend on the volume of customers. However, customers could be selected in advance (15, 16)	*High innovation control*: stimulation of innovation and prevention through long-term relationships. Low investment risks. Fixed contract with a fixed compensation (15, 16).	*May not determine performances* (16)
Result	*High customised care control*: no obstruction of space to provide customised care. Have the responsibility to do what is necessary to achieve the result (16, 20)	N/A	*Low financial security* through cost-reducing deployment & financial compensation is determined on the basis of results achieved (15, 16, 20)	*High innovation control*: within result agreements, providers have the possibility and incentive to make smart combinations of different forms of support (12, 15, 16, 20)	*May not determine the results* (16)

4.5 Challenges result-oriented purchasing

Since result-oriented purchasing is the starting point in this thesis, the challenges of result-oriented purchasing based on literature (especially result funding) are stated in this section. Result funding has three challenges (20):

- How should results be defined? (Section 4.5.1)
- How to measure whether results have been achieved? (Section 4.5.2)
- Which paying method must be applied? (Section 4.5.3)

4.5.1 How should results be defined?

In Section 4.5.1.1 the characteristics of the type of result-oriented funding will be explained. Subsequently, in Section 4.5.1.2 the choice for the type of result-oriented funding will be stated. This choice is part of the informal analysis, which will be described in Section 5.4.2.

4.5.1.1 summarising characteristics type of result-oriented funding

In Table 10 is stated in which ways results could be defined.

Table 10: defining results[19] (20)

Level		Description
Client level	1	Predefined results per living domain (for example ZRM) or result area
	2	Client profiles without predefined results
Population level	3	Objectives at population level

With result-based funding on client level, reimbursement is linked to certain results. Results are for example ‘a clean and liveable house’, ‘daily structure’ or ‘financial independency’ instead of the use of care. This reimbursement is often a fixed amount per period or trajectory. A real performance-related fee is rarely or never used. Result-oriented funding at the population level is in principle also result-oriented at the level of a population. A healthcare provider receives a reimbursement per period to provide support to all residents of a neighbourhood, district or municipality. The municipality does not pay the healthcare provider (often as the main contractor) for the deployment of care but makes result agreements. Sometimes with a result-related payment (17).

According to Robbe[19], population funding can be applied to result-oriented purchasing if results are linked to the number of well-defined performances, but the results are not binding. That is different from population funding where the result is binding and therefore becomes a form of result funding[19].

4.5.1.2 choice: type of result-oriented funding

Result-based funding can be applied at client level or at population level. In the informal analysis, only choice ‘fixed amount per’ should be included. Based on the literature research in Section 4.5.1.1 two other possible criteria are ‘performance-related agreements’ and ‘performance-related reimbursement’, but these criteria are the same for both client level and population level. The criterion in Table 11 is only applicable for municipalities and healthcare providers. The criterion is not applicable for clients, because clients have, as mentioned earlier, no direct link to the financing in the Wmo and Jw.

[19] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

Table 11: type of result-oriented funding choices (view of municipalities and healthcare providers)

	Fixed amount per
Client level	Client
Population level	Population (neighbourhood, district or municipality)

4.5.2 How to measure whether results have been achieved?

It is difficult to define a result, because it is not specific. As a result, providers can get rid of it with a minimal amount of care. If hours are registered, there must be extensive reports on the details of those hours. If results are indicated, it is still necessary for the municipality to check how that result was achieved. In theory, result-oriented indication can therefore be at the expense of the client[20]. According to Telgen and Robbe[21], that does not have to be the case[20] [21].

There are instruments available to measure results. For example the ZRM. However, results cannot be captured in hard numerical data. Therefore, a concrete result definition must always be taken as a starting point. In addition, directors are needed who are independent of the healthcare provider to monitor the healthcare provider. However, this requires a lot from the directors.

Another alternative is to use the 'high trust, high penalty' approach (20), which starts from a relationship of trust that is punished more heavily the greater the trust is harmed (46). The aim is not a numerical score, but a yes / no answer, which has to be assessed by a director or by the client (20).

4.5.3 Which paying method must be applied?

In Section 4.5.3.1 the characteristics of the possible paying methods will be explained. Subsequently, in Section 4.5.3.2 the choice for paying method will be stated. This choice is part of the informal analysis, which will be described in Section 5.4.2.

4.5.3.1 summarising characteristics paying methods

There are various ways of paying results. These ways are stated in Table 12.

Table 12: tariff structures result-oriented purchasing (20)

Paying method	**Definition**	**Characteristics**
Everything or nothing	Pay with success	Assumes a finite trajectory, which is not always the case.
		Leads to discussions about outcome and external factors.
Reward/penalty	Depending on the extent to which results have been. achieved	Very numerical performance measurement required.
		Difficult / impossible at individual client level.
Voting with the feet	The client gives his preference by being able to change of healthcare provider	Does not steer with individual reimbursement per client, but with freedom of choice of healthcare provider and inflow/outflow of clients.

[20] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

[21] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

When applying the all or nothing method, different intermediate forms can be used. The methods differ in the way the healthcare provider is stimulated and cannot all be applied in every situation. According to Cashin, et al. (47), possible intermediate forms are (47):

- Capitation
- Case-based
- Fee-for-service
- Global budget
- Line-item budget
- Per diem

According to Noort (48), the aforementioned intermediate forms differ in the degree of financial risk for the healthcare provider and the degree of payer savings. For example, capitation has the highest financial risk, but also the highest potential payer savings. Fee-for-service, on the other hand, has the lowest financial risk, but also the lowest payer savings. The optimum balance between the degree of financial risk for the healthcare provider and the degree of payer savings is achieved by applying shared savings (48), according to Noort. The reason for this is that healthcare providers are encouraged to deinstitutionalise, which saves money. This saved money can be used for, for instance, better care and for reducing the costs for the individual consumer (49, 50).

Shared savings is the division of healthcare change costs ('zorgkostenombuiging') between the health insurer and the healthcare provider (50). In the case of the Wmo and Jw, this is the municipality instead of the health insurer.

In short, more payment methods can be applied, but in this thesis, only the payments methods in Table 12 are taken into account.

4.5.3.2 choice: paying method

A choice in paying method had to be included in the advice. For this reason, to the municipalities and healthcare providers should be asked which paying method they prefer based on the four questions below:

1. Would you like to see a gradual payment or a payment after achieving the result?
2. Do you think is it possible to steer with giving clients the ability to change healthcare providers in the meantime?
3. Do you think that a reward/penalty arrangement is possible at individual level and do you have access to information about the extent to which a result has been achieved?
4. Do you think that there will be discussions about the result and external factors if an everything or nothing arrangement is chosen?

4.6 Contract forms

Section 4.6.1 briefly discusses the contract forms that occur with purchase agreements in the social domain. In Section 4.6.2 criteria have been defined on the basis of characteristics of the contract forms that occur with purchase agreements in the social domain. This is part of the multicriteria-analysis which will be described in Section 5.4.1.

4.6.1 Summarising characteristics contract forms

The type of contract influences the extent to which an agreement offers certainty in terms of revenue for healthcare providers. According to Robbe[22], the contract form has no direct link to the decision to apply result-oriented purchasing or not[22]. Nevertheless, the contract form has been included in the analysis, because this is part of the practical implementation. The main research question asks for a specific product. The contract form mainly relates to the certainty that the municipalities and the healthcare providers can derive from it. The following contract forms are distinguished (12, 17):

- Fixed budget
- Budget ceiling
- Framework agreement with interim entry
- Framework agreement without interim entry

When applying a *fixed budget*, the healthcare provider receives a fixed budget which is not related to the actually delivered support. This contract forms offers the most certainty for the healthcare provider.

When allying a *budget ceiling*, a healthcare provider has certainty that they may use care till the budget ceiling is reached.

Furthermore, a *framework agreement without interim entry* offers no turnover guarantee, because every individual client chooses the healthcare provider by himself. The agreement is only open for entry at the time of outsourcing. Interim entry is not allowed for new healthcare providers (17).

On the other hand, within a *framework agreement with interim entry*, interim entry is allowed. This contract form offers no turnover guarantee (12, 17).

It is important that the principle model, the purchasing procedure, the funding method, the paying method, and the contract form are consistent with each other (12). If results-oriented purchasing is assumed, Telgen[23] recommends a contract without a budget guarantee. This way, healthcare providers are stimulated to actually deliver the right care[23]. Besides, Robbe[22] states that regardless of whether or not there will be purchased in a result-oriented way, a contract with an interim entry is the best option. In this way, not all parties can join just like that, but non-contracted parties can be deployed if they provide the care that a particular client needs[22].

[22] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

[23] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

4.6.2 Criteria contract forms

In the multicriteria-analysis, only the certainty of each contract form should be included. In Table 13 an overview of the included criteria for the contract form is shown.

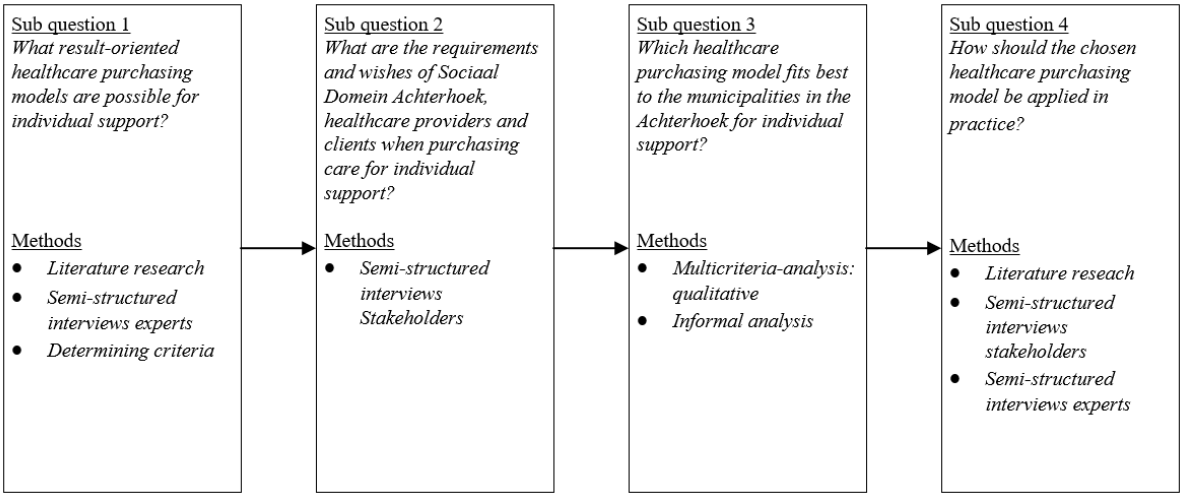
Table 13: contract forms criteria (view of the municipality and healthcare providers) (12, 17)

	Certainty Municipality	**Certainty Client**	**Certainty Healthcare provider**
Fixed budget	Great	N/A	Great
Budget ceiling	Certainty that the provider may use care	N/A	Certainty that they may use care
Framework agreement without interim entry	No certainty for one provider & only open at the time of outsourcing	N/A	No certainty & only open at the time of outsourcing
Framework agreement with interim entry	No certainty for one provider & always open	N/A	No certainty & always open

5. Methods

In order to answer the research question '*how should result-oriented purchasing be organised for individual support*?', a qualitative research was conducted. In Figure 5 an overview of the performed research steps is shown. In Sections 5.1 up to and including 5.5, the performed research steps were elucidated. Four sub questions were answered.

Figure 5: research steps



5.1 Qualitative research

A qualitative research was conducted because the different purchasing methods, purchasing procedures, funding methods and contract forms do not have objective properties. What is an advantage for one stakeholder can be perceived as a disadvantage by the other stakeholder. A characteristic can also be an advantage for, for example, one healthcare provider and a disadvantage for the other healthcare provider, while they belong to the same stakeholder group. This is qualitative, because no hard numerical data is available about the requirements and wishes of stakeholders. In order to determine which result-oriented purchasing procedure fits the best to the municipalities in the Achterhoek for individual support, a multi-criteria analysis (MCDA) in combination with an informal analysis, which will be described later in this section, was conducted. To determine which purchasing methods and funding methods would be preferred for all stakeholders a multi-criteria analysis was conducted. To determine which contract forms and paying methods would be preferred by all stakeholders an informal analysis was conducted (51, 52).

A MCDA is a scientific evaluation method to make a rational choice between various alternatives, based on various relevant criteria. These criteria differ in terms of weighting. One criterion can be considered more important than the other. A MCDA consists of a problem analysis, standardisation, weighting and scoring (51, 52). There are various MCDA techniques. In this thesis no precise numerical data are available. Some criteria do not naturally lend themselves to numerical measurement (52).

An informal analysis based on qualitative data is based on unilateral choices, which means that weights are not important (52, 53). The choice is then based on filling in rubrics or finding out the choice with the help of a question (53).

The expectation is that independent clients as described in Section 3.3 can determine and monitor results themselves, and that dependent clients cannot. That is why both client groups were examined separately. This means that throughout the analysis a distinction was made between these two client groups. That does not mean that there was actually a difference.

5.2 Data collection

5.2.1 Literature

For the literature research, both scientific and non-scientific articles were searched for in the search engines Google, Google Scholar, Scopus, Web of Science and the University library. Terms that were searched for were among others: healthcare purchasing, municipalities, social domain, open-house purchasing, result-oriented purchasing, value-based healthcare, healthcare purchasing procedures, purchasing procedures, Wmo, Jw, Participation Act, individual counselling, individual development, stabilisation, integral purchasing and joint purchasing. The vast majority of the articles were written by experts. In addition, various government documents were consulted. Inclusion and exclusion criteria concerning the literature research are shown in Table 14.

Table 14: inclusion & exclusion criteria

Inclusion criteria	**Exclusion criteria**
Articles written after 31th of December 2007	Articles written before 1th of January 2008
Published articles	-
Published reports	-
Official government documents	-
Both Dutch and English articles	-

5.2.2 Semi-structured interviews

In order to determine the purchasing procedure, funding method and contract form, interview questions were established based on the criteria in Section 4. For purchasing procedures, funding methods and contract forms, each criterion was discussed with the stakeholders, but the questions were asked to each stakeholder group in a different context for clarity. In order to determine the paying method, interview questions were established based on the established choices in Section 4.5.3.2. When applying result-oriented funding, the type of result-oriented funding was determined based on the established choices in Section 4.5.1.2. In Appendix VII a more specific overview of the topics of the interview questions is shown.

The interviews were semi-structured so that follow-up questions could be asked to obtain more information if necessary. Two experts, one mayor, and two policy officers were interviewed. Furthermore, two healthcare employees, two contract managers, and one healthcare manager were interviewed, from a total of three different healthcare providers. Two contract managers of Social Domain Achterhoek were interviewed: one regional contract manager and one local contract manager. One client council and the project leader, who took on the role of the client, were interviewed. Furthermore, one municipal back office employee, who are involved in the implementation of the Wmo and Jw, was interviewed.

Purchasing in the Social Domain is a subject to change. During the interviews, notes were made and, where possible, the interviews were recorded and partly transcribed. The detailed interviews can be requested at the supervisors or the student.

As mentioned on the former page, semi-structured interviews with in total 11 respondents, were executed. Those respondents are linked to the respondent letters ‘A’ to ‘K’. For example, 'respondent A' refers to the regional contract manager of the municipality. Appendix VIII contains an overview of which respondent is linked to which respondent letter. The corresponding references will not be included in footnotes, as was done with the interviews with experts, but only fully written out in Appendix VIII. However, these references are not included in the bibliography. In the current text of Section 6, the statements/opinions of stakeholders on which the results and discussion are based, will only be linked to the corresponding respondent letter.

5.3 Study population/stakeholders

Within the project group, a stakeholder analysis was executed. This stakeholder analysis served as the starting point for this thesis and was not doublechecked. However, not all healthcare providers were included in the analysis. Besides, not all intern stakeholders were included. Only the intern stakeholders who were involved in the project group were included. In Table 15 an overview of the stakeholders is provided.

Table 15: list of stakeholders

Stakeholders		**Function groups**
Healthcare providers (external)	Healthcare provider 1	Contract manager
		Healthcare employee
	Healthcare provider 2	Contract manager
		Healthcare employee
	Healthcare provider 3	Healthcare manager
Clients (external)	Wmo client council	Member 1: client
		Member 2: formal Wmo consultant
	Client perspective	Project leader
Municipalities (internal)	Board	-
	Administrative Organisation (AO) Youth	Policy officer
	AO Wmo	Policy officer
	Management Consultation Social Domain (MOSD)	-
	Portfolio Holder Consultation (POHO)	-
	Contract & Supplier Management (CLM)	Purchasers & contract managers
	Financials	-
	Purchasing group local purchasers	Purchaser
	Task group ‘messaging and billing’	Contract manager/member back office
	Consultants	-

In consultation with three contract managers of Social Domain Achterhoek and data based on the highest turnover in Package 1, three healthcare providers were included. These healthcare providers were anonymised. Healthcare providers 1 and 3 are active in four of the nine Packages. Healthcare provider 2 is only active in Package 1. All healthcare providers focus on both Wmo and Jw. However, healthcare provider 2 focuses on family issues, which means they

mainly focus on the Jw. The contract managers provided insight into the requirements and wishes with regard to the healthcare purchasing model. The interviews with healthcare workers provided insight into practice and also the possibility of result-oriented funding/indication.

There is no Jw client council, but the Wmo client council also examines the Jw. Concerning the intern stakeholders, the AO Youth, AO Wmo, CLM, purchasing group 'local purchasers', and the task group are represented in the project group. The project group also informs and consults the board, MOSD and POHO. The student has ensured that the results of the research do not unnecessarily deviate from the interests of the internal stakeholders through involvement in the project group.

5.3 Research progress

Three contract managers were asked for the semi-structured interviews and three healthcare employees were asked for the semi-structured interviews. For one healthcare provider, only the healthcare manager was interviewed. He had reasonable knowledge about contract management and his own experience with clients, but no specific knowledge about contract management.

Notes were made during the interviews. All interviews were recorded with permission from the interviewees, but the majority of the recordings had to be deleted immediately after processing. The elaboration of the interviews was anonymised.

Finally, a number of purchasing documents from other municipalities were studied.

5.4 Analysis

5.4.1 Multi-criteria analysis

This section refers to Sections 4.3.3, 4.4.3 and 4.6.2. A multi-criteria analysis consists of problem analysis, standardisation, weighting, and scoring (51, 52). First of all, a problem analysis was conducted on the basis of the literature in Section 4, which in this thesis involves: examining the advantages and disadvantages of the various purchasing procedures, funding methods, payment methods, and contract forms. No standardisation was carried out, because the data obtained from the interviews did not extend to this, and therefore a multi-criteria analysis based on arguments and logic was chosen. The weighting and scoring part was conducted based on arguments and logic. This also means that the results are based on the interpretation of statements made in the interviews with stakeholders and not on statements which are literally made by those stakeholders. No numerical scoring part was conducted. That means the preferences were only ranked in categories and were not numerically elucidated.

In weighting importance and defining preferences, a distinction is made between independent clients and dependent clients regarding the prosumer model, because in the other parts of the analysis there were no differences.

5.4.2 Informal analysis

This section refers to choices in 4.5.1.2 and 4.5.3.2. The informal analysis was done twice: for independent clients and for dependent clients regarding the prosumer model. Rubrics are applied for the informal analysis. With rubrics, transparency was created through the assessment of a criterion. Judgements were based on the rubrics which were applied to the stakeholders. That does not mean that the stakeholders were actually entered a rubric. In some cases, the student completed the rubrics based on the interviews, such as for the payment method (53).

5.4.3 Determining buyer and specifier

As mentioned in Section 3.3, it was not predefined which party is buyer and which is specifier when it comes to result-oriented purchasing. After determining the best fitting healthcare purchasing model, it was determined who is specifier and who is the buyer.

5.5 Validity & reliability

For the sake of validity, the interview questions were prepared on the basis of the literature. This concerns literature that was selected for relevance to the research question (Section 4). In addition, only the most recent literature was consulted for this study.

The interview questions have been checked by the teaching counsellors before they were used. It was examined whether the questions were understandable. In addition, the first interviews with regard to establishing requirements and wishes were conducted with internal stakeholders who also provided feedback on the questions. Based on the feedback, the questions were adjusted again, so that it was understandable for the external stakeholders. To increase repeatability, stakeholder-specific questions were used and there was no preference for purchasing procedure, funding method, contract form or paying method mentioned in the questions. The results of the interviews were anonymised. This makes the research valid.

To be able to test the answers of respondents and also to elaborate on the research, as mentioned before, 11 semi-structured interviews were conducted. Reliability can be guaranteed because no internally involved employees were present during the interviews, so there is a good chance that objective answers have been given. The interviews were recorded and drawn up. Afterwards, the detailed interviews were submitted to the interviewees for verification.

6. Results & discussion of results

In this section, the results and the discussion of the results will be presented in seven sub sections. The first five sub sections (Sections 6.1 up to and including 6.5) contain the results of investigating requirements and wishes of stakeholders regarding respectively purchasing procedures, funding methods, contract forms, paying methods and the type of result-oriented purchasing, followed by an interpretation of these results in a discussion part and choosing respectively a purchasing procedure, funding method, contract form, paying method and type of result-oriented purchasing.

Sections 6.1 up to and including 6.3 are part of the multi-criteria analysis, and Sections 6.4 and 6.5 are part of the informal analysis. The criteria with regard to purchasing procedures, funding methods and contract forms are defined in Sections 4.3.3, 4.4.3 and 4.6.2. The choices with regard to paying methods and the type of result-oriented purchasing are defined in Sections 4.5.3.2 and 4.5.1.2. Unless stated otherwise, there are no differences between independent clients and the dependent clients when it comes to weighting and scoring the criteria, and to determine the choices.

In the multi-criteria analysis, the weights are based on arguments and logic. The various stakeholders generally did not indicate a clear order in importance. Some criteria are equally important for the stakeholders. Therefore, the importance (weight) is divided into three categories:

- High: very important
- Medium: fairly important
- Low: (almost) not important

When determining both weights and preferences, the statements of stakeholders were logically interpreted during the interviews. This means weights and preferences are (usually) not literal statements from stakeholders. The weights and preferences of the municipality, clients and healthcare providers are based on respectively three, two and six semi-structured interviews. Unless stated otherwise, there are no differences in opinion of stakeholders who belong to the same stakeholder group. The same applies to the choices in the informal analysis. As mentioned in Section 5.4.2, in the current text, the respondent letters refer to 11 unreferenced semi-structured interviews in Appendix VIII.

For the municipality and healthcare providers, the interviews with contract managers are mainly decisive: two contract managers at the municipality, and two contract managers and one healthcare manager at healthcare providers. The interviews with healthcare employees were mainly used to determine the extent to which results-oriented purchasing is feasible in practice.

In the first part of Section 6.6 will be specified who is buyer and who is specifier, based on the above-mentioned interviews with stakeholders, two interviews with experts, one interview with policy officers, one interview with the mayor, and the literature review. The specification of buyer and specifier will be discussed in the second part of Section 6.6.

Finally, in Section 6.7 will be summarised which healthcare purchasing model fits best to Package 1: individual support, followed by a discussion and practical implementation advice of the chosen healthcare purchasing model.

6.1 Purchasing procedures

The results below are part of the multi-criteria analysis, followed by a discussion of these results. All stakeholder groups were questioned regarding the determination of the purchasing procedure.

6.1.1 Results purchasing procedures

6.1.1.1 Results: weights purchasing procedures

In Table 16 an overview of weights of the different stakeholders regarding purchasing procedures is provided.

Table 16: weights regarding purchasing procedures

Weights purchasing procedures					
Municipality		**Clients**		**Healthcare providers**	
Price control	High	Professionality	High	Price control	High
Quality control	High	Quality	High	Quality control	High
Innovation control	Medium	Freedom of choice/ quantity of providers	Medium	Innovation control	High
Freedom of choice/ quantity of providers	Medium			Freedom of choice/ quantity of providers	Low
Purchasing Act	Low			Purchasing Act	Medium
Volume control	High			Volume control	High
				Description PoR	Medium

According to the municipality, volume control is most important because the high costs are mainly attributable to the number of hours or the number of clients (Respondent A). Quality control is also very important because clients should receive good quality care, so that goals/results can be achieved (Respondents A-C). Furthermore, the municipality states that price control and quality control must be in balance with each other (Respondents A, B). According to one contract manager innovation control is important in the context of the transformation concept (Respondent B). Although, the other contract manager states that innovation is less influenceable than volume, price and quality (Respondent A). The diversity of healthcare providers is important, but in practice clients often seek advice from the municipality, which relies mainly on experience (Respondents B, C). The Purchasing Act is not important in this context according to the municipality. It is about finding a suitable procedure (Respondents A, B).

For clients, in addition to the criterium freedom of choice/quantity of providers, two additional criteria (professionality & quality) have been added based on the interview with the client council. According to the client council, clients are likely to get high-quality care which is delivered professionally, rather than worrying about choosing a healthcare provider (Respondent D). The project leader, who had assumed the role a client in this interview, did not specifically mention this additional criteria (Respondent E).

For healthcare providers, in addition to the criteria as defined in Section 4.3.3, one criterion (clear description Program of requirements (PoR)) has been added based on the interview with one of the interviewed contract managers, because a clear description of the PoR is necessary in order to prevent misunderstandings about the content of the support (Respondent F). The other contract manager and the healthcare manager did not mention this specifically (Respondents G, H). Healthcare providers are likely to have control over price and volume in

order to innovate and deliver quality. A healthcare provider can distinguish itself on quality and innovation, which are a major cause of whether or not a result is achieved (Respondents F-H). Furthermore, healthcare providers state that the Purchasing Act is only important in the sense that municipalities must use as much one-sided healthcare purchasing system (procedure, funding method, contract form and paying method) as possible (Respondents F, G). According to one contract manager, the number of healthcare providers is not important, because a satisfied referrer ensures the influx of clients (Respondent F). The other contract manager and healthcare manager state that the number of healthcare providers is fairly important because it influences making agreements and promoting quality and innovation (Respondents G, H).

6.1.1.2 Results: preferences purchasing procedures

The municipality prefers price control because the price affects costs (Respondents A, B). However, limited price control is sufficient, because price is not the main cause of the high costs, according to the regional contract manager of the municipality (Respondent A). The municipality must be sure that the quality of the support provided is satisfactory, so preference is given to the highest possible quality control (Respondents A-C). Although according to the municipality, innovation control is important (Respondents A, B), reasonable innovation control is sufficient. The provider itself must have space to innovate, but this must be in line with the vision of the municipality (Respondent A). Furthermore, freedom of choice is preferred by the municipality, but the freedom of choice does not have to be infinite. Limited freedom of choice still means freedom of choice for the client to some extent. The municipality does not have preferences regarding the choice for applying the Purchasing Act or not, because without the application of the Purchasing Act, it is likely that the requirements of the Purchasing Act will still be met, without being checked for that (Respondents A, B). A high degree of volume control is preferred by one contract manager because it is the main cause of the high costs (Respondent A). The other contract manager indicated that it is about achieving the goal/result, regardless of the amount of care (Respondent B).

The client council prefers a reasonable number of healthcare providers, so that clients do not have to worry too much about making a choice, and still get professional and high-quality support (Respondent D). The project leader, who has assumed the position of the client in the interview, prefers a wide variety of healthcare providers, so that clients have the option of choosing from many healthcare providers. The municipality must then advise the client, so that the client in fact only has to choose from a few care healthcare providers (Respondent E).

Almost all healthcare providers want to have a major impact on quality and innovation, because a healthcare provider can and must distinguish itself on these aspects (Respondents F-H). One contract manager and the healthcare manager state that to reach this major impact, a realistic price (‘reële prijs’) is required (Respondents F, H). The other contract manager states that quality and innovation should be taken into account in setting the price (Respondent G). Furthermore, high volume control is preferred, because during the intake it is not immediately clear what the final result should be (Respondents F-K). Not applying the Purchasing Act, which is only possible with the open-house procedure, is slightly preferred by one contract manager and the healthcare manager, because it is raising overhead costs (Respondents G, H). However, a clear procedure would solve this. It might be helpful to set one-sided purchasing, which means applying only one purchasing procedure (Respondent F). A clear description of the PoR is necessary in order to prevent misunderstandings about the content of the support (Respondent F). Reasonable diversity of providers is preferred by two of the three healthcare providers, because that makes it easier to make mutual agreements. In addition, large healthcare providers should not be given free space. By giving small innovative healthcare providers the

opportunity to enter, large healthcare providers are encouraged to innovate and improve quality (Respondents G, H).

6.1.2 Discussion purchasing procedures

6.1.2.1 Discussion: weights and preferences purchasing procedure

Although municipalities regard volume as a major cause of the high costs in the Wmo and Jw (Respondents A, B), there are also various other causes. A study executed by the municipality of Berg en Dal emphasizes that the high costs are caused in the access of the support. According to the municipality of Berg en Dal, the municipality can steer its own referral behaviour by, for example, setting a financial framework within which a neighbourhood team is able to work with their referrals. This indirectly also influences the volume. However, it might be better to focus on what the client can still do and what the possibilities are for help from within the client's environment. Furthermore, prevention is seen as an important way to limit access to more demanding care and services, which is more expensive (54). According to a study conducted by the municipality of De Bilt, another reason for the high costs is that a relatively large number of customised facilities is deployed, while some clients can also be taken care of with general facilities. By accommodating more support needs within the general facilities, the pressure on the customised services can decrease (55). In short, the municipality can focus on high volume control, but it should not be so decisive taking into account the above arguments. To save costs, the focus should be on what the client can still do, help from the client's environment, prevention and more frequent use of general facilities.

Price is also not the main cause of the high costs, as mentioned above. However, the municipality must comply with the 'AMvB (‘Algemene Maatregel van Bestuur’) Reële prijs Wmo 2015', which ensures a good price/quality ratio (56). Therefore, the statement of the municipality that the price and quality must be in balance with each other is well-founded (Respondent A, B), and the statement of the contract manager of healthcare provider 2 that quality should be taken into account in setting the price is also well-founded (Respondent G).

As mentioned in Section 4.1.2, in case of the Wmo and Jw, the volume risk is always for the municipality regardless of the type of negotiation model (P*Q-model, P&Q-model, P-model). Due to the absence of the resale obligation (‘doorleverplicht’), the volume risk in the P*Q-model is for the municipality. The municipality must therefore find other ways to limit the volume risk. The most obvious solution is to sharpen the indication[24]. However, the question is how the municipality can sharpen an indication without compromising the quality of the support. As mentioned above, starting from the strength of the client instead of the weakness, deploying the client’s environment, prevention, and deploying more customised facilities, are helpful to save costs instead of sharpening the indication. Another way for the municipality to limit the volume risk is to set a budget ceiling or to steer towards the number of hours needed to achieve results through discussions with healthcare providers. The disadvantage of a budget ceiling is that every healthcare provider, regardless of whether it has used the volume justified or unjustified, has no obligation to continue to provide support because of the lack of the resale obligation.

The municipality and healthcare providers prefer high quality control (Respondents A-C, F-H). Since good quality support is also laid down in the Wmo and Jw, as stated in Section 3, these preferences are well-founded (2). This is also in line with the client, who prefers high quality care (Respondents D, E). According to Beltman, Sok & Van der Veer (57) municipalities are

[24] Montfort Gv. 2018-2019 Lecture 9 Business economic aspects in health care. 2019; unreferenced lecture.

fully responsible for the quality of social support and for monitoring it (57). The VNG has drawn up a basic set of quality requirements. However, this is a fairly global tool, which means that municipalities often set additional quality requirements. If this set is expanded on the basis of experience, it might be easier for both healthcare providers and municipalities to benchmark the quality and get in quality control (58, 59).

The way in which municipalities purchase care enables them to steer towards transformation objectives such as integrated organisation of support and innovation (17). Transformation is also a spearhead in the vision document of Social Domain Achterhoek, as stated in Section 1.1 (1). The result that innovation control is important therefore corresponds to the national and regional concept. Innovation is necessary for both municipalities and healthcare providers in connection with the changing role of municipalities as described in Section 2.2. However, the innovation is taking off very slowly. The municipalities that have actually set up an 'innovation wallet' in the Wmo and Jw budget usually spend only 3%-10% of the total budget on innovation. Innovation appears to be more stimulable through the funding method (17, 60).

Although the municipality would like to contract a more limited number of healthcare providers based on the idea that with limited freedom of choice there is still freedom of choice (Respondents A, B), this is not easy to set up in Package 1: individual support. Package 1, as stated in Section 3.4, is characterised by the great diversity of care issues (23). A sharp reduction in the number of healthcare providers creates the risk of an increase in the number of PGB holders and an increase in the number of subcontractors. In that case, it is not necessarily easier for the municipality to establish agreements with healthcare providers about results to be achieved, quality and innovation. The client council also prefer a more limited, which is a reasonable number of healthcare providers in the first instance (Respondent D). However, they do not seem to have taken into account that they would like to retain the current healthcare provider. Considering the preferences of the municipality and clients (Respondents A-E), the focus seems to lie more on establishing better agreements with healthcare providers than on limiting the number of healthcare providers. Furthermore, giving clear advice about the choice of possible healthcare providers by the municipality would fit better to the preferences. This is also in line with the preference of healthcare providers that competition is needed to stimulate innovation and improve quality (Respondents G, H). Part of establishing better agreements may be that the PoR must be clear. Therefore, this ties in with the idea of healthcare provider 1 that discussions about the content of the support must be prevented (Respondent A).

Not applying the Purchasing Act, which is only possible with the open-house procedure, is slightly preferred by one contract manager and the healthcare manager, because it is raising overhead costs (Respondents G, H). However, the relationship between the Purchasing Act and the rising overhead costs seems to be partially unjustified. A SAS procedure (form retaining) in which the Purchasing Act is in force, as described in Section 4.3.1.3, can largely be set up freely (38). When setting up, limiting the administrative burden for healthcare providers can also be taken into account. Therefore, it is questionable whether the inclusion of the Purchasing Act as a criterion is correct because the Act must always be met if applicable.

6.1.2.2 Discussion: the chosen purchasing procedure

Considering, the weights, preferences and discussion of these, the **dialogue-oriented purchasing procedure** fits best to Social Domain Achterhoek for Package 1: individual support.

In the dialogue-oriented procedure *the municipality has reasonable price control* through dialogue sessions and a bandwidth for price, which is sufficient because the municipality has to deal with the 'AMvB Reële prijs Wmo 2015' and price is not the main cause of the high costs. Healthcare providers want price control to a certain extent in order to be able to deliver quality and to be able to innovate. Full price freedom of choice might create a large price competition, which may not be an incentive for promoting quality and innovation because quality and innovation are not always taken into account in the price according to healthcare providers. *Reasonable price influence for healthcare providers with a little price comp*etition is therefore sufficient.

Although a limited diversity of providers is preferred by the municipality and clients, as discussed, Package 1 is not suitable to have a limited diversity of providers. The dialogue sessions can be used to establish better agreements with healthcare providers. That is why dialogue-oriented purchasing with a *reasonable diversity of providers* seems to be acceptable for both stakeholder groups. However, it is more difficult to establish result agreements with a larger number of providers unless a few products and services are defined in advance. This predefined product and services provide guidance for the negotiation, but goes against the idea that when results become steering, healthcare providers must be able to do what is needed for the client without being recalled on based on predefined performances. When it comes to result agreements, a limited number of providers would be better suited. Therefore, Package 1 should actually be divided into groups based on, for example, clinical picture or abilities of the client, but for now, a reasonable number of providers seems to fit best in Package 1. Based on the interviews with two contract managers from healthcare providers, is it assumed that most healthcare providers will agree to a reasonable number of providers, so that large healthcare providers do have competition in order to improve quality and innovation.

The dialogue sessions and long-term contracts provide *high quality and innovation control for both the municipality and healthcare providers.* Although reasonable innovation control was sufficient for the municipality, high innovation control fits well with the transformation concept. *High quality is also desired by clients*.

The *volume is an uncertain factor* for the municipalities in every procedure. However, as discussed, the volume should not be so decisive in the choice as the municipality itself indicates. Due to the absence of the resale obligation, municipalities focus on sharpening the indication but the focus should be on other solutions to save costs. Therefore, taking the strength of the client as starting point instead of the weakness, deploying the client's environment, prevention, and deploying more customised facilities, are essential. Besides, the municipality can steer towards the number of hours needed to achieve the results through discussions with healthcare provider. So dialogue-oriented purchasing with an uncertain volume seems to be acceptable.

The *Purchasing Act is in force* in the dialogue-oriented procedure. The municipality has expressed no preference for this. The healthcare providers indicated that they did not consider this criterion to be very important and, in addition, preferred only slightly for a procedure where there is no Purchasing Act in force because the Purchasing Act is raising overhead costs. However, even though the Purchasing Act is in force, a SAS procedure could take into account

the limiting of administrative burdens for healthcare providers. For this reason, providers will also agree to a procedure in which the Purchasing Act is in force when taking into account the limiting of administrative burdens.

In the open-house procedure and the 'Zeeuws'-model, there is a large diversity of providers, which fits less well with result-oriented purchasing because it is more difficult to establish agreements with many healthcare providers. Furthermore, in the open-house procedure, the municipality has limited price control because of the standard rates, and there is no price competition which gives hardly any incentive for quality improvement and innovation. Little competition on price should be realised. In both the open-house procedure and the 'Zeeuws'-model, there are only basic quality requirements while high quality control/ high quality is preferred by all stakeholder groups. BVP and classical European public purchasing seem to fit based on the reasonable price influence & price competition for healthcare providers. Furthermore, based on the high quality control for the municipality through the selection of healthcare providers on the best price/quality, BVP and classical European public purchasing fit also to result-oriented purchasing. However, only one or a few healthcare providers are selected, which does not fit well with a variety of care issues in Package 1. Another important reason why the dialogue-oriented procedure fits result-oriented purchasing better than BVP or classical European public purchasing is that the dialogue sessions can be used to establish good agreements on quality, innovation and volume. DAS fits less well to result-oriented purchasing in Package 1 because there is a more limited diversity of providers. At DAS the individual assignment is awarded to one healthcare provider while at dialogue-oriented purchasing, every healthcare provider that meet the requirements is contracted taking into account the freedom of choice. However, based on continuous quality and innovation control, DAS may be an option.

6.2 Funding methods

The results below are part of the multi-criteria analysis, followed by a discussion of these results. All stakeholder groups were questioned regarding the determination of the funding method.

6.2.1 Results funding methods

6.2.1.1 Results: weights funding methods

In Table 17 an overview of weights of the different stakeholders regarding purchasing procedures is provided.

Table 17: weights regarding funding methods

Weights funding methods					
Municipality		**Clients**		**Healthcare providers**	
Customised care control	High	Customised care (independent client)	Medium	Customised care control	High
Quality control	High	Customised care (dependent client)	High	Quality control	High
Financial security	High	Quality (independent client)	High	Financial security	High
Innovation control	Medium	Quality (dependent client)	Low	Innovation control	High
Determining function	High			Determining function	High
				Administrative burden	Medium
				Responsibility professional	High

According to the municipality, financial security is required to maintain quality and innovation. Both contract managers state that financial security, quality control and customised care control are equally important (Respondent A, B). Customised care is important and according to one contract manager, innovation can contribute to customised care. Both customised care and innovation can contribute to reducing costs. Therefore, customised care control is more important than innovation control (Respondent A). According to one contract manager, changes in the determining function (result management) are related to quality. To manage results, the quality must be good. Otherwise, results will not be achieved (Respondent A). Furthermore, to be able to provide customised care, it is important that results are clearly defined, which also makes the determining function important (Respondents A, B).

According to the client council, quality can only be measured after a certain period. Independent clients are able to assess quality. Dependent clients are not able to assess quality. The client council states that because independent clients are able to assess the quality, this weighs more heavily than customised care, while dependent clients, on the other hand, judge a lot more on whether he/she believes the care is suitable (customised care) (Respondent D). However, the project leader, who has assumed the position of the client in the interview, states that the one (quality) does not exclude the other (customised care) (Respondent E).

For healthcare providers, in addition to the criteria as defined in Section 4.4.3, three criteria (administrative burden, quality and responsibility of professional) have been added based on the interview with the contract manager of healthcare provider 1 (Respondent F). Both the other contract manager and the healthcare manager mentioned the importance of good quality care and that they are subjected to administrative burden under the Purchasing Act and the application of different purchasing systems in different regions (Respondents G, H). In the interviews with healthcare employees, it appeared that the role of the professional is important to find out the original problem of the client, which is often unclear in the first instance (Respondents I-K). The administrative burden is slightly important because some healthcare providers have to deal with different funding methods in different regions (Respondent F, G). The responsibility of the professional is related to the determining function. The healthcare provider is the professional who can best determine what the result should be and how that result can best be achieved (in consultation with the client) (Respondent F, G, I-K). According to the healthcare provider, financial security is needed to be able to innovate, deliver quality and deliver customised care. Ultimately it is about appropriate (customised) support (Respondents F-H).

6.2.1.2 Results: preferences funding methods

Both contract managers of the municipality prefer financial security because they relate financial security to quality and innovation possibilities (Respondent A, B). Although good quality is required to manage results, healthcare providers do have the most influence on quality. Reasonable quality control seems to be sufficient for the municipality (Respondent A). In case of dependent clients in Package 1, a long-term relationship when it comes to innovation is preferred, because then it may involve more specialistic care. In case of independent clients, the incentive for innovation among healthcare providers should be sufficient, because it may involve less specialistic care (Respondent A). Customised care is preferred by both contract managers because the client should be central and it might save costs (Respondents A, B). By working more demand-oriented instead of supply-oriented, new concepts of support (innovation) may arise that fit better with the client (customised care) (Respondent A). Not applying result funding is preferred by both contract managers. It is difficult to define the result precisely and to determine to what extent the result has been achieved. Discussions with

healthcare providers will arise when the result becomes decisive in funding (Respondents A-C). Steering based on results is a possibility. This can be based on a relationship of trust or by benchmarking result data (Respondent A).

According to the client council, the dependent client is more likely to judge a lot more on whether he/she believes the care is suitable (customised care). Therefore, the dependent client will be less focused on results, while the independent client is more likely to actually achieve results. Regarding quality, the independent client attaches more value to quality advancement, because they simply think about it faster (Respondent D). According to the project leader, who has assumed the position of the client in the interview, the fact that the client wants a voice in the implementation of care is an important factor. Because a client is involved in the implementation of care when working with results, both quality and customised care are promoted (Respondent E).

According to the contract managers of healthcare providers, no obstruction of space to provide customised care is highly preferred because ultimately it is about appropriate (customised) support, which means high customised care control. High innovation control, high quality control and high customised care control is preferred by healthcare providers, but financial security is required for that (Respondents F-H). High innovation control is preferred because innovations can lead to customised care (Respondents G, H). A long-term relationship is preferred because it is necessary to be able to determine which support is needed to achieve results. That means that the professional also bears a great responsibility, and the result and the way to achieve that result must also be determined in consultation (Respondents F-H). Besides, implementing innovations can take a long time, which means that the investment risks are relatively high in short-term relationships according to one contract manager (Respondent G). According to two contract managers, a low administrative burden is preferred because some healthcare providers have to deal with different funding methods in different regions (Respondents F, G). Result-oriented funding is not preferred by healthcare providers, because it is not always easy to estimate what the result should be in advance. Results should only be decisive if the result is determined in consultation and may be adjusted in the meantime. In addition, healthcare providers confirm that money is not the right incentive for achieving the result (Respondents F-K). Two healthcare providers indicate that the incentive is to 'help' the client (Respondents G, H, K). The contract manager of the other healthcare provider indicates that a satisfied referrer is the incentive for achieving the result, because otherwise the healthcare provider will not be assigned clients (Respondent F). Therefore, steering on results is more desirable than funding on results according to healthcare providers (Respondents F-H).

6.2.2 Discussion funding methods

6.2.2.1 Discussion: weights and preferences funding method

According to a study carried out by the Public Procurement Research Centre (17), healthcare providers can rely less on budget certainty (17, 61). Therefore, it is well-founded that healthcare providers prefer more financial security through funding methods (Respondents A, B, F-H). Although both healthcare providers and the municipality state that financial security is required to deliver quality and innovation (Respondents A, B, F-H), based on the literature in Section 4.4.2 and 4.4.3, there also appear funding methods with low/limited financial security for healthcare providers and reasonable financial security for the municipality, and the possibility of high quality control and high innovation control (12, 15, 16, 20). Healthcare providers also state that financial security is required for the provision of customised care (Respondents A, B, F-H). That statement is contradictory with the literature from Sections 4.4.2 and 4.4.3 in which healthcare providers implement, for example, production funding, in which reasonable financial

security but low customised care control, applies (16, 20). As stated in Sections 4.4.2 and 4.4.3, there is reasonable financial security because expenses are not maximised while there is no turnover guarantee. There is low customised care control because the performances are fixed (16, 20). In short, there does not seem to be a direct link between financial security and having quality control, innovation control, and customised care control, although both the municipality and healthcare providers stated there is a direct link (Respondents A, B, F-H).

The municipality's statement that reasonable innovation control and quality control are sufficient is well-founded (Respondents A, B), because based on the literature in Sections 4.4.2 and 4.4.3, the incentives for quality improvement and innovation are in most cases set at healthcare providers (15, 16, 20). Furthermore, the statements of the municipality and healthcare providers that innovation stimulates customised care (Respondents A, B, F-H), which, according to the municipality, both reduce costs might be true (Respondents A, B). However, this is only the case if the innovations are actually implemented because the tight budget currently limits innovation in the social domain (62).

Long-term contracts are among other things interesting for achieving transformation objectives, for the mutual relationship, and for care continuity (63). Therefore, the statement by healthcare providers that long-term contracts are preferred for innovation is well-founded, and the statement by healthcare providers that long-term contracts are necessary to discuss the content of care in order to achieve results is also well-founded (Respondents F-H). For the municipality, the distinction of independent clients and dependent clients regarding long-term contracts and innovation is not absolutely correct, because it does not necessarily have to be the case that a dependent client receives more specialist care than an independent client. Therefore, a long-term relationship regarding innovation for both clients groups seems to be sufficient for the municipality. In the literature as stated in Sections 4.4.2 and 4.4.3, a long-term relationship is linked to innovation (12, 15, 16, 20), while that is not sufficient. A long-term relationship facilitates the making of agreements better in general, so that better quality agreements and results agreements can also be made. Therefore, a long-term relationship should not be linked to the funding method, but can, in fact, be applied to every contract.

The responsibility of the professional is emphasised when it comes to result-oriented purchasing. Results could be defined by a consultant of the municipality, but determining how the result should be achieved should be done by a professional. However, a study conducted by the ‘Sociaal en Cultureel Planbureau’ concludes that the Wmo consultants do not always have sufficient specialist knowledge (64). Therefore, the statement of healthcare providers that the role of the professional is important, is well-founded (Respondents F, G, I-K). The healthcare professional is expected to have more specialist knowledge than a Wmo consultant. The most optimal situation seems to be that the result and the way to achieve that result (performances), should be determined in consultation between the municipality, client and healthcare provider. This is contradictory to the literature of Section 4.4.3, in which the municipality and healthcare provider are not able to have influence on both performances and results (16). For the healthcare provider, it is important that if the results are steering or decisive in funding, the performances are not fixed in advance. In this way, the healthcare provider has the space to do what is best for the client.

Although a low administrative burden is preferred by healthcare providers (Respondents F, G), it seems that healthcare providers conclude that this burden arises because municipalities use different healthcare purchasing models. This idea is not entirely justified. If every municipality uses the same intensive model, the administrative burden is still high. Therefore, on the one

hand, Social Domain Achterhoek will have to apply only one healthcare purchasing model. On the other hand, Social Domain Achterhoek should apply a healthcare purchasing model with little administrative burden. Although it is questionable whether it is possible to apply only one healthcare purchasing model is package 1 individual support, in which there is a large diversity of care issues. As stated in the literature of Sections 4.4.2 and 4.4.3, when it comes to funding, the administrative burden with product funding is relatively higher than with population funding and result funding because not every hour has to be registered (12, 16, 17, 20). Even though no hours have to be delivered to the municipality, it is likely that healthcare providers will continue to register hours internally for, among other things, the payment of employees. However, the intensity of discussions about the level of the indication will decrease, so that healthcare employees can spend this time on direct care.

According to the literature in Sections 4.4.2 and 4.4.3, customised care and quality are two different characteristics (15, 16, 20). Care can be of high quality, but still not fit with the situation of a certain client (15, 16, 20). Therefore, customised care and quality were investigated as two separate criteria. However, is it questionable to make this distinction for clients, because for most clients it is impossible to notice the difference between quality and customised care. Therefore, the statement of the project leader that a client wants to be involved in the implementation of care, whereby both quality and customised care are promoted, seems to be right (Respondent E). One of the members of the client council was a client, who does notice the difference between customised care and quality (Respondent D). She was clearly an independent client, but it cannot be determined on the basis of one client whether the vast majority of clients can or cannot notice the difference between those two criteria.

What is striking is that both the interviewees of the municipality and the healthcare providers are against result funding (Respondents F-K), while the purchasing vision 2021 of Social Domain Achterhoek had already concluded that funding should be focused on results (65). The biggest disadvantage that both the interviewees of the municipality and of healthcare providers argue with regard to result-oriented funding, is the lack of causal relationship between the result and the service (Respondents F-K). According to Tim Robbe (22) [25], as also stated in Section 2.3, that would mean that funding for results is not possible, while Jan Telgen and Niels Uenk (22) argue that results should be funded if the causal relationship is not clear. Agreements about results then give clients more certainty, as long as it can be monitored (22). However, when monitoring results, problem arises in Package 1. Some results, such as results for clients with dyslexia, can be well defined and monitored, while results for clients with, for example, non-congenital brain injury are much more difficult to define and monitor. This is mainly because the situation of these clients is constantly changing, especially in the beginning.

6.2.2.2 Discussion: the chosen funding method

Considering, weights, preferences and discussion of these, population funding fits best to Social Domain Achterhoek for Package 1: individual support. However, Social Domain Achterhoek currently appears unable to determine a population budget because of the diversity of care issues in Package 1. If the population in Package 1 has been made fully transparent, the population can be subdivided into groups. These groups can, for example, be made based on clinical pictures. However, what the client still is able to do should be central and not what the client is unable to do, so 'abilities of the client' might be a better apportion. A population budget can then be determined for each group, which will be linked to one main contractor per group. Then,

[25] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

that main contractor becomes responsible for a certain group of clients. It can happen that the main contractor has to hire subcontractors to be able to offer the right care. However, the main contractor still remain responsible for the client when subcontractor structures arise. Before applying population funding, Social Domain Achterhoek should execute a pilot with one or more defined illnesses or care products, for example, 'dyslexia'. For the time being, the other products are still financed through production funding, while results are already steering through benchmarking. If the pilots prove to be successful and the population in Package 1 has been fully mapped out, it may be possible to switch to population funding. **In short, while mapping out the population of Package 1 and conducting some pilots for population funding, results should only be steering and production funding will still be applied**.

The statements made by healthcare providers and the municipality, and the literature regarding the relationship between financial security, innovation control and quality control, are contradictory. Financial security is not included as decisively as is preferred by both parties. Although high financial security is preferred by both stakeholders, reasonable and limited financial security should also be accepted. With regards to production funding the municipality has only limited financial security because the volume is uncertain and expenses are not maximised, while for healthcare provider the fact that there are no maximised expenses results in reasonable financial security. With result funding the municipality has reasonable financial security because financial compensation is based on the achieved results, while the fact that the healthcare provider only gets paid when achieving results, result in low financial security. However, it might be possible that the healthcare provider will focus too much on achieving results, while the cause of the problem has not been addressed. This is a disadvantage for the municipality, but an advantage for the healthcare provider. Therefore, healthcare providers do not need to have low financial security at result funding. With *population funding, the municipality has high financial security because the reimbursement is fixed and maximised. The healthcare provider has reasonable financial security because the reimbursement is fixed, but the expenses are maximised*. Both result funding and population funding might fit to the preferences regarding financial security of the municipality and healthcare providers regarding the funding method.

The municipality, healthcare providers and clients prefer high quality control/high quality. The starting point from the discussion that most clients do not notice the difference between quality and customised care is assumed, which means that the difference in result between the independent client and the dependent client is cancelled on this point. When it comes to production funding there is low quality control for the municipality and healthcare providers, and no quality guarantee for the client because healthcare providers are not encouraged to improve quality through the fixed contracts (fixed products & fixed rates). Therefore, production funding does not fit to the preferences of the stakeholders regarding quality. At results funding, healthcare providers are asked to do what is necessary to achieve the results and what is best for the client. The service is not described in advance, which means there is almost unlimited space to improve quality when necessary as long as the result will be achieved. Therefore, at result funding, there is high quality control for the municipality and healthcare providers, and high quality for clients. At population funding, there is a fixed compensation which is not dependent on the volume and quality improvements (no interim adaptation). However, there is space for quality improvement because the services it selves are not tightly framed. *Therefore, population funding provides healthcare providers high quality control and provides clients with a reasonable quality*. For clients, on the basis of weights and preferences, result funding is more suitable. For the municipality reasonable quality control is sufficient.

Although, population funding provides the *municipality only reasonable quality control*. The municipality already has high quality control by applying a dialogue-oriented procedure.

All stakeholder groups prefer high customised care control/high customised care. With regards to production funding, there is only low customised care control for the municipality and healthcare providers, and no certainty there is actually customised care. Regarding the customised care control, the same reasoning applies as with the above-mentioned quality aspect. Therefore, production funding does not fit to the preferences of the stakeholders regarding customised care. With population funding, the municipality has *reasonable customised care control*, because the financial compensation does not depend on the volume. *Clients gets reasonable customised care*, because services are not tightly framed in advance, but there is no responsibility that everything needed to achieve the goal is implemented. Only the *healthcare provider actually has high customised care control*. When it comes to result funding, in contrast to population funding, there is the responsibility that everything needed to achieve the goal/result is implemented, which results in high customised care control/high customised care. Result funding might have been better suited on the basis of the criteria quality control and customised care control, but not all forms of support in Package 1 are suitable for result-oriented funding in terms of among other things the lack of causal relationship.

With regards to innovation control, both population funding and result funding are suitable for the municipality and healthcare providers. Reasonable innovation control is sufficient for the municipality. Population funding provides *municipalities reasonable innovation control* and provides *healthcare providers with high innovation control* through fixed contracts with a fixed compensation. Innovation and also prevention can lead to more efficient support, which reduces costs while the compensation still is the same. However, healthcare providers have more influence on innovation than the municipality. With result funding the incentive to make smart combinations of different forms of support and to innovate is even better because of the responsibility to provide the best support in order to achieve the result. However, as mentioned above, not all forms of support in Package 1 are suitable for result-oriented funding. Regarding innovation, production funding is not suitable for the municipality and healthcare providers because of the fact through the fixed rates and products, there is no incentive for innovation.

For the municipality and healthcare providers, it is necessary to be able to determine which support is needed to achieve results. That means that the professional also bears a great responsibility, and *the result and the way to achieve that result (performances), should be determined in consultation between the municipality, client and healthcare provider.* This can be the case with both population funding and result funding. Production funding is not suitable because, at production funding, performances are fixed in advance which may limit the possibilities to do what is best for the client.

Although a unilateral healthcare purchasing model is assumed, so also only one funding method for Package 1, this seems to be impossible to implement in Package 1 because of the diversity of care issues/diversity of the population. Furthermore, a funding method with a low administrative burden is preferred, which means population funding or result funding is most suitable because of the fact no hours have to be registered. In this way, the *administrative burden for healthcare providers might be limited*.

6.3 Contract forms

The results below are part of the multi-criteria analysis, followed by a discussion of these results. Only the municipality and healthcare providers were questioned regarding the determination of the contract form.

6.3.1 Results contract forms

6.3.1.1 Results: weights contract forms

In Table 18 an overview of weights of the different stakeholders regarding contract forms is provided. There is only one criterion.

Table 18: weights regarding contract forms

Weights contract forms			
Municipality		**Healthcare providers**	
Certainty	High	Certainty	High

According to healthcare providers, certainty is important because it indicates whether a contract provides certainty in terms of turnover. The survival of healthcare providers is largely dependent on turnover (Respondents F-H). For the municipalities, it is about both financial certainty and certainty with regard to healthcare providers. This certainty with regard to healthcare providers includes quality, innovation and the achievement of goals/results (Respondents A, B).

6.3.1.1 Results: preferences contract forms

Strict quality control must be carried out at the front, so that only the healthcare providers that deliver good quality want to innovate are eligible for a contract. When applying result control or even result-funding, for the municipality, it is necessary to have insight into which providers are suitable and which are not. Establishing good result agreements is easier with a small number of well-known healthcare providers. This makes it easier to establish result agreements. Therefore, a framework agreement without interim entry is preferred by the municipality (Respondents A, B).

According to healthcare providers, interim entry is necessary because the support may change over time, which means that the content of the contract may not correspond with the support provided. Therefore, adjustments to content of the contract are necessary (Respondent F). In addition, interim entry is necessary to be able to provide expertise that a particular provider does not have and that is not contracted at the municipality. Otherwise subcontractor constructions will arise (Respondent G). However, not all healthcare providers should be able to get a contract because delivering high-quality care is a condition. Therefore, accession should be limited by for example strict quality requirements (Respondents F-H).

6.3.2 Discussion contract forms

6.3.2.1 Discussion: weights and preferences contract form

Both healthcare providers and the municipalities did not mention any preference for a budget ceiling (Respondents A, B, F-H). For the municipality, this opinion is well-founded (Respondents A, B). As stated in Section 4.1.2, the volume risk is always for the municipality because there is no resale obligation (‘doorleverplicht’) when allying a budget ceiling[26]. For healthcare providers, this opinion is also well-founded (Respondents F-H). As stated in Section

[26] Montfort Gv. 2018-2019 Lecture 9 Business economic aspects in health care. 2019; unreferenced lecture.

4.6.1, healthcare providers only have the certainty that they may use care till the budget ceiling is reached (17).

In the ideal situation, healthcare providers would like to see a fixed budget with interim entry, because it provides the most certainty and flexibility (Respondents F-H). As stated in the theory of Section 4.6.1, this contract form does offer the most certainty for healthcare providers, but the budget is not related to the actually delivered support (17). This means there is no financial incentive for healthcare providers to improve quality or to innovate. With a framework agreement, healthcare providers are stimulated to improve quality and to innovate because the freedom of choice of the client determines the turnover (66). As also stated in Section 4.6.1, a framework agreement offers no turnover guarantee (17). According to Uenk (66), stimulation of quality is possible when applying a fixed budget or budget ceiling in combination with result-oriented funding. Quality and innovation must then be monitored in order to prevent quality and innovation being cut back in reality (66). The above confirms the statements of Telgen[27] and Robbe[28] during the interviews regarding the contract form as stated in Section 4.6.1. Telgen[27] recommends a contract without budget guarantee in order to stimulate delivering the right care, and Robbe[28] recommends a framework agreement with interim entry because then not all healthcare providers can join just like that, but non-contracted parties can be deployed if they provide the care that a particular client needs[27] [28].

However, a framework agreement without interim entry is preferred by the municipality, the reason why they prefer no interim entry seems not right (Respondents A, B). It is not necessary making it easier to establish result agreements and execute strict quality control when applying a framework agreement without interim entry. Establishing good result agreements is also possible with new health providers who meet the strict quality requirements that have been set in advance, as long as the number of healthcare providers is limited. Therefore, interim entry should not be a decisive condition.

Healthcare providers prefer interim entry because the support may change over time, which means that the content of the contract may not correspond with the support provided (Respondent F). However, when the theory about funding methods of Sections 4.4.2 and 4.4.3 is taken into account, this statement seems only be justified in a situation where production funding is applied, because the content of the support is not fixed when applying population funding or result funding (12, 15-17, 20). Therefore, this statement should not be decisive.

6.3.2.2 Discussion: the chosen contract form

Considering, the weights, preferences and discussion of these, the **framework agreement with interim entry** fits best to Social Domain Achterhoek for Package 1: individual support.

A budget ceiling does not meet the preferences of both the municipality and healthcare providers. For the municipality, this is because the volume risk which arises because of the lack of the resale obligation. For healthcare providers, this is because they only have certainty till the budget ceiling is reached.

A fixed budget does not fit to the preferences of the municipality because there is no financial incentive for healthcare providers to improve quality or to innovate. Furthermore, the

[27] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

[28] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

population of Package 1 first have to be mapped out. Therefore, this contract form should not be chosen.

Healthcare providers prefer the framework agreement with interim entry. Although the municipality prefer a framework agreement without interim entry because they think then it is easier to establish result agreements, establishing good result agreements is also possible with new health providers who meet the strict quality requirements that have been set in advance, as long as the number of healthcare providers is limited. Besides, a framework agreement with interim entry simulates quality and innovation, which are both spearheads of those stakeholders, as mentioned in Section 6.1 and 6.2. Although a framework agreement with interim entry *does not provide the most certainty*, it still seems to be accepted by both stakeholder groups. A framework agreement with interim entry also seems to fit best to Package 1 due to the large diversity of care issues, regardless of whether or applying result-oriented purchasing.

It must be said that the interim entry cannot take place indefinitely because when the population of Package 1 is mapped out and some pilots for population funding are conducted, population funding with result steering might be chosen in the future, whereby the population should be divided among healthcare providers based on for example clinical picture or abilities of the client. In this way, it will be possible to make deliberate choices about allowing subcontractors under the responsibility of the main contractors.

6.4 Paying methods

The results below are part of the informal analyses, followed by a discussion of these results. Only the municipality and healthcare providers were questioned regarding the determination of the paying method.

6.4.1 Results paying methods

6.4.1.1 Results: choices paying methods

According to the municipality, with ‘voting with the feet’ can be steered on results, both in advance and interim because it is almost impossible to determine exactly to what extent a result has been achieved. Therefore, ‘voting with the feet’ works better than other specific measuring instruments, and is an option to apply in combination with another payment method (Respondents A, B). If the municipality only applies result steering and does not apply result-funding, one contract manager of the municipality opts for a fixed monthly (periodically) payment because there will always be discussions with healthcare providers about the extent a result has been achieved, which makes ‘everything or nothing’ and ‘reward/penalty’ not suitable (Respondent A). If the municipality opts for result-funding, the other contract manager opts for a payment after achieving the result, so there is an incentive to achieve the result. Then, a condition is that the result is clearly defined in consultation with the client and healthcare provider, so that no discussions arise about the result and to what extent the result has been achieved (Respondent B).

According to healthcare providers, voting with the feet does not have to be adjusted, because that is already happening in practice (Respondents F, H). However, voting with your feet involves risks. Care avoiders (clients) very quickly exclude a healthcare provider (Respondent G). According to one contract manager of healthcare providers, a reward/penalty system also does not have to be applied because especially the Wmo market is a competitive market. Therefore, a satisfied referrer (municipality or external) who recommends healthcare providers to clients on the basis of benchmark information, already gives the right incentive (Respondent F). The other contract manager and the healthcare manager emphasize that a reward/penalty

system works on the basis of the wrong incentive. Money to achieve the result must not be the incentive, but substantive good care in which the client is central must be the incentive. The same reasoning applies to an everything or nothing payment (Respondents G, H). Healthcare providers prefer not applying result-funding based on the preferences mentioned in Section 6.2. They prefer a fixed payment per period because according to healthcare providers, a reward/penalty system and a everything or nothing system are not suitable based on the above-mentioned arguments (Respondents F-H).

6.4.2 Discussion paying methods

6.4.2.1 Discussion: choices paying method

The statements of the municipality that it is almost impossible to determine exactly to what extent the result has been achieved, and that there will always be discussions with healthcare providers about to what extent the result has been achieved, is well-founded (Respondents A, B). Based on the theory in Section 4.5.3.1, these discussions arise typically when applying an 'everything or nothing' system, and it is almost impossible to apply a reward/penalty system at individual client level. However, a reward/penalty system might be an option when applying population funding or result funding at population level (20).

Although healthcare providers indicate that a reward/penalty system and an everything or nothing system work on the basis of the wrong incentive, namely money and achieving the final result instead of focusing on substantive care where the client is central, it is doubtful whether this is actually the case (Respondents G, H). Telgen and Uenk (22) state that results focus precisely on what ultimately matters: self-reliance and participation (22). Achieving a result with an appropriate payment method does not necessarily have to be based on a wrong incentive. Furthermore, as mentioned in Section 4.5.3.1, there are different intermediate forms between 'everything or nothing'. It is not inconceivable that shared savings such as those applied in Enschede by health insurer Menzis can also be applied in the social domain (49, 50). By accommodating more clients in general facilities, more budget will become available for clients who require customised facilities. This extra budget can be used for prevention and innovation, so that clients less often need intensive support, which in turn saves costs. With the current shortages in the Social Domain, it remains questionable whether the budget will actually be transferred, or whether as a result municipalities will reach a normal level in terms of costs. Furthermore, as mentioned in Section 2.2, the distribution models for the available budget to municipalities are still under discussion (7-9). However, it should be borne in mind that shared savings do not actually lead to savings for every type of care and for every care organisation. According to data from the US, organisations with higher costs are more likely to achieve actual savings (67, 68).

6.4.2.2 Discussion: the chosen paying method

Considering, the choices and discussion of these choices, a **fixed payment per period in combination with 'voting with the feet'** fits best to Social Domain Achterhoek for Package 1: individual support.

Both the municipality and healthcare providers prefer a fixed payment per period without applying result-funding because there will always be discussions about the extent a result has been achieved, which makes 'everything or nothing' and 'reward/penalty' not suitable. Furthermore, healthcare providers state that and a 'everything or nothing' system and reward/penalty system work on the basis of the wrong incentives. However, based on the discussion in the former section, the result should be based on self-reliance and participation, which makes their reasoning doubtful.

Voting with the feet is already happening in practice because the competitivity in especially the Wmo market, and there has already been chosen for a framework agreement with interim entry which makes this possible. Furthermore, 'voting with the feet' might be an effective way to steer on results without specific measuring. Although 'voting with the feet' do not have to be implemented in the payment method, is should be desirable to maintain in the entire healthcare purchasing model.

6.5 Type of result-oriented purchasing

The results below are part of the informal analyses, followed by a discussion of these results. Only the municipality and healthcare providers were questioned regarding the determination of the paying method.

6.5.1 Results type of result-oriented purchasing

6.5.1.1 Results: choices result-oriented purchasing

According to one contract manager of the municipality, is it easier to determine a result-oriented budget for a population than for one client. However, a result-oriented budget on client level is easier to monitor and therefore preferred (Respondent B). The other contract manager prefers not result-oriented funding on client level, nor result-oriented funding on population level. There are always clients with problems within the process that cannot be foreseen in advance. Organisational funding may be a solution because it is easier to monitor an organisational by means of achieved results (Respondents A, C).

When applying result-funding, for healthcare providers it depends on the type of client whether there should be funding on client level or population level. For dependent clients, which often involve complex cases, it is difficult to establish a budget at client level. According to healthcare providers, establishing a budget is easier with independent clients (Respondents F-K).

As mentioned earlier, both the municipality and healthcare providers prefer to only apply result steering and not apply result funding (Respondents A-C, F-H).

6.5.2 Discussion type of result-oriented purchasing

6.5.2.1 Discussion: choices type of result-oriented purchasing

The municipality mainly emphasizes the monitor options when it comes to funding (Respondents A-C). Because result funding has not been chosen, it must be ensured that the budgets for the selected funding method in Section 6.2.2.2 can be properly monitored by the municipality. While mapping out the population of Package 1 and conducting some pilots for population funding, results should only be steering and production funding will still be applied.

Although healthcare providers prefer mixed result-oriented funding in connection with the distinction between independent and dependent clients, they stated earlier that they would like to see a one-sided healthcare purchasing model because of limiting the administrative burden. By applying mixed result-oriented funding, no uniliteral healthcare purchasing model will be applied. However, as also discussed in Section 6.2.2.2, by applying an unilateral healthcare purchasing model, the administrative burden is not limited by definition (Respondents F-K). Furthermore, it seems to be impossible to even applying a one-sided healthcare purchasing model because of the diversity of care issues/diversity of the population in Package 1.

6.5.2.2 Discussion: the chosen type of result-oriented purchasing

Considering, the choices and discussion of these choices, **not applying a type of result-oriented purchasing** fits best to Social Domain Achterhoek for Package 1: individual support.

While mapping out the population of Package 1 and conducting some pilots for population funding, results should only be steering and production funding will still be applied. Therefore, this choice is no longer necessary.

6.6 Determining buyer and specifier

The results in this section are based on an overall view of the student considering literature, and requirements and wishes of all stakeholders, followed by an discussion of this overall view. This determines how results should be defined, how should be measured whether results are achieved, who is the buyer and who is the specifier.

6.6.1 Results determining buyer and specifier

In the most ideal situation, defining results and measuring results should be based on one model, so that there are as few discussions as possible about the results between healthcare providers, consultants and clients. This model should be based on the client's demand, so that the client is central, and self-reliance and participation are promoted.

The chosen funding method in Section 6.2.2.2 is:
While mapping out the population of Package 1 and conducting some pilots for population funding, results should only be steering and production funding will still be applied.

In the current situation, in which production funding will still be applied in combination with a dialogue-oriented procedure, the municipality should be the buyer because there will be a reasonable number of healthcare providers. Then, the municipality is the party with the overall view of the client. In a situation, in which population funding will be applied in combination with a dialogue-oriented procedure, the municipality should still be the buyer. The difference with the current situation is that the municipality only purchases from a limited number of main contractors, who are designated on the basis of a division into for example clinical picture or ‘abilities of the client’.

There is not one specifier. Results should be defined and measured by all stakeholders (municipality, client and healthcare provider). This is a condition for being able to apply result steering or result-funding as mentioned in Section 6.2.2.2. For dependent clients, a legal representative or client adviser can be engaged because these clients are assumed not being able to contribute in defining and measuring results. Independent clients are assumed being able to contribute in defining and measuring results by themselves.

6.6.2 Discussion determining buyer and specifier

6.6.2.1 Discussion: determining buyer and specifier

Although defining and measuring results should be based on one model, this might be impossible to apply in Package 1 because of the diversity of care issues/diversity of the population. There are different models that focus on the client's question, what is confirmed in a study by Movisie and ‘Vraagwijzer’ (69). Two well-known models are the ZRM and the Positive Health Spin from Machelt Huber. The ZRM is currently also used in Social Domain Achterhoek. The ZRM has been developed to map the functioning of people in all important domains of life and expresses this in a score of self-reliance of the person at that moment. The ZRM is a screening instrument that allows you to get an integral view of a client because all

important areas of performance are covered (70, 71). The Positive Health Spin instrument is based on the following definition of health: "the ability to adapt and to manage, in the light of the physical, emotional and social challenges of life". This broad definition has six dimensions (72-74). The Positive Health spin shows similarities in content with the ZRM. A model that is less well known in the Netherlands is the Esbjerg model. The Esbjerg model is a client-centric coordination model that has been developed based on the need for a common direction and a common language, and the need to create greater cohesion and sustainability in client-centric interventions. Here the client is also central (75).

Although, it is defined who is buyer, and the specification and measuring takes place in consultation, this specification and measuring will still be difficult. As mentioned in Section 4.5.2, it must be prevented that results are defined not clear. Healthcare providers can get rid of it with a minimal amount of care. Then, the client is not yet central. Good measuring with, for example, the above-mentioned models can prevent this[29] [30]. Another alternative is to use the 'high trust, high penalty' approach (20), which is mentioned in Section 4.5.2.

In Section 2.3, the service triad is described. The service triad of Figure 1 is based on a triangular relationship between the municipality, the healthcare provider and the client (13, 14). The starting point that the municipality has the bridge position in the initial phase, and that the healthcare provider has the bridge position in the final phase (13, 14), was only partly reflected in the interviews with healthcare employees. The healthcare employees all indicated that pre-set goals are often incomplete, so it seems there is no strong bridge position for the municipality. Therefore, healthcare providers play an essential role in finding out the actual problem and finding out what the client is still able to do, so it seems they do have a bridge position (Respondents I-K). It is essential that the municipality, the healthcare provider and the client jointly defining the result and measuring the result, which is also stated in Figure 2 of Section 2.5 (13, 14).

6.6.2.1 Discussion: chosen buyer and specifier

Considering, the results and discussion of determining buyer and specifier, a situation whereby:

- **One model to determine the clients demand if possible**
- **buyer: municipality**
- **specifier: all stakeholders in consultation,**

fits best to Social Domain Achterhoek for Package 1: individual support.

No specific model has been chosen yet because of the diversity of care issues in Package 1. When the population of Package 1 is mapped out, the population can be divided based on for example clinical picture. 'Abilities of the client' should be a better apportion because as stated before, the focus should be on what the client is still able to do instead of what the client is unable to do. After making a suitable apportion, a model in which the client demand is central should be chosen. If, based on the out mapping of the population of Package 1, it turns out to be impossible to use only one model to define and measure results, it is still possible to choose to apply multiple models. As long as the starting point of the model is that the client's question is central.

[29] Robbe T. Result-oriented purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

[30] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

When managing results it is important not to stick too much on the triangular relationship as shown in Figure 1 continuously. Stakeholders are in constant consultation with each other about the results to be achieved. Therefore, none of the stakeholders should have a bridge position during the purchasing process.

6.7 The chosen healthcare purchasing model

This section contains the chosen healthcare purchasing model, which is a summarising of the results from Sections 6.1 up to and including 6.5, followed by an discussion of the chosen healthcare purchasing model.

6.7.1 Results: the chosen healthcare purchasing model

In Figure 6 an overview of the chosen healthcare purchasing model is shown. The corresponding section numbers indicate where the choices are explained.

Figure 6: the chosen healthcare purchasing model

Healthcare purchasing model					
Principle model	Purchasing model	Funding method	Type of result-oriented purchasing	Payment method	Contract form
Director model (Section 4.2.1)	Dialogue-oriented purchasing (Section 6.1.2.2)	Now: mapping out the population & conducting pilots, while production funding is applied in the meantime. Future: population funding (Section 6.2.2.2)	No result-oriented type of funding (Section 6.5.2.2)	Fixed payment per period in combination with 'voting with the feet' (Section 6.4.2.2)	Framework agreement with interim entry (Section 6.3.2.2)

6.7.2 Discussion: the chosen healthcare purchasing model

6.7.2.1 Discussion: the chosen healthcare purchasing model

As described in the literature from Section 4.2.1, in the director model, the director draws up a support plan, in which self-reliance, the social network, and general facilities are the most important (4). That is why it is important that the municipality remains the buyer as stated in Section 6.6. The municipality has an overall view, and is more involved when handling general facilities (4). The healthcare provider is more involved when handling customised facilities, as stated in Sections 3.1.1 and 3.2.1 (24). Therefore, it is important that defining the result and measuring the result is done in consultation between the municipality, the healthcare provider and the client. This is also confirmed based on the literature of Section 4.5.2, which states that defining and measuring results requires a lot from a only director (20).

The dialogue-oriented procedure is not the procedure that is most suitable for result-oriented purchasing, as it involves contracting a reasonable number of suppliers. However, the room for dialogue does offer many opportunities for quality promotion and innovation. In addition, in most cases there is a long duration of contracts, so that providers have the certainty that they may provide care in an area for a long time. This also encourages healthcare providers to innovate. For the municipality, innovation and quality are the main priorities, while healthcare providers, in addition to quality, are more likely to prefer financial certainty. Although it is difficult to establish result agreements with many healthcare providers unless a few products and services are defined in advance, which but goes against the idea that when results become steering, healthcare providers must be able to do what is needed for the client without being recalled on based on predefined performances. Therefore, dialogue-oriented purchasing has been chosen. A limited number of providers is not suitable for Package 1 and result agreements can be made in the dialogue sessions.

Although population funding is more plausible for deployment in a Package where the care is provided by one healthcare provider or by one partnership of healthcare providers, population funding seems to be most suitable to result-oriented purchasing in specifically Package 1. However, Package 1 should be mapped out first and some pilots for population funding have to be conducted. In the meantime, production funding will still be applied. When the population is mapped out and the pilots are successful, population funding can be applied. Population funding gives the municipality high financial security because of the maximised expenses, and gives the healthcare provider reasonable financial security because the reimbursement is fixed, but expenses are maximised. In addition, population funding offers sufficient opportunities for quality promotion, innovation and customised care. Although result funding should be chosen based on purely the preferences of stakeholders, with the exception of financial certainty, population funding seems to be more suitable for Package 1. In addition, results are so difficult to define and measure, that defining and measuring should be determined in consultation between the municipality, client and healthcare provider.

Although a fixed payment per period in combination with 'voting with the feet' was chosen, a fixed payment per period does not provide a financial incentive at healthcare providers to achieve results, even though these results are only steering. However, a fixed payment per period fits best to population funding. The healthcare provider must then be stimulated to improve quality and to innovate by strict monitoring of the municipality. Besides, there are already incentive to improve quality and to innovate through the dialogue sessions. 'Voting with the feet' does not have to be implemented in practice because of the competitive Wmo market, and applying a framework agreement. Furthermore, 'voting with the feet' do provide a financial incentive to achieve results.

Although a framework agreement with interim entry fits best to result-oriented purchasing, it must be said that the interim entry cannot take place indefinitely because when the population of Package 1 is mapped out and some pilots for population funding are conducted, population funding with result steering might be chosen in the future, whereby the population should be divided among healthcare providers based on, for example, clinical picture or ability of the client. According to the literature in Section 4.3.1.3, a framework agreement also fits best to a dialogue-oriented purchasing procedure (17, 21).

In short, Package 1 is suitable for a large number of health providers and therefore also suitable for a framework agreement with interim entry to promote quality and innovation, but Package 1 is less suitable for making result agreements in connection with the diversity and complexity of the most care questions. That is why results should not be decisive, but should be steering in the market.

The chosen healthcare purchasing model is entirely based on Dutch models/combinations of models to save healthcare costs and to put the client first. However, there are also two very well-known American models that can also save healthcare costs: Triple-Aim and Value-Based-Healthcare (VBHC) (76, 77). Triple Aim is simultaneously improving the individual experience of care, improving the health of populations, and reducing costs of care for populations (77, 78). In the US it appears that organisations that apply Triple Aim mainly work on creating the right foundation for population management, managing services at scale for the population, and establishing a learning system to drive and sustain the work over time (78). Many partnerships are already active in the Netherlands that focus on, among other things, integrated care and disease prevention (79). This integrated care can also be seen in the social domain. VBHC is about realizing the best outcome for the patient at the lowest possible

healthcare costs, taking the entire care process as a starting point (76, 80). VBHC is disease-specific, while Triple Aim is people-oriented. In addition, VBHC is not focused on cooperation, but on competition, which is less suited to integrated collaborations between municipalities, and cooperation in defining and measuring results in consultation between the municipality, healthcare providers and client (76-78, 80). Furthermore, VBHC is more difficult to apply with more fragmented healthcare systems (80). Package 1: individual support is highly fragmented. In the Netherlands, VHBC is used by medical specialists to provide insight into what investments yield (81, 82).

6.7.2.2 Discussion: practical implementation advice healthcare purchasing model

The following points indicate on what should be paid attention to with the practical implementation of the healthcare purchasing model as shown in Figure 6.

Involve stakeholders in decision making

All stakeholders, as mentioned in Table 15, should be informed about the possible new healthcare purchasing model. Then, healthcare providers and clients can also prepare for the possible changes. The model should be determined in consultation with a representation of all stakeholder groups. The municipality's vote is ultimately decisive. As stated earlier, first performing a pilot is recommended. The pilot could be executed in a specific neighbourhood which gives a reflection of the entire population. Afterwards, a pilot could be executed in one of the eight municipalities of Social Domain Achterhoek. In which neighbourhood and municipality of Social Domain Achterhoek the pilot could be executed, also depends on the degree to what extent the involved stakeholders in that specific neighbourhood or municipality, are willing to improve and innovate.

Apply only one healthcare purchasing model if possible

By applying only one healthcare purchasing model throughout Package 1 and throughout Social Domain Achterhoek, it is easier to establish agreements for all stakeholder groups. However, this might be impossible when the population of Package 1 is mapped out in a further research, this remains the most preferred by stakeholders.

Focus on the abilities of the client instead of the disabilities

In order to determine which support is actually needed, it is better to start from what the client is still able to do. Not every client with similar abilities has to reach the same level. This might save costs. Client-oriented demand clarification, which will be mentioned later in this section, is essential to this.

Focus more on help from the client's environment

By focusing more on help from the client's environment, costs might be saved.

Focus more on prevention

By focusing more on prevention, expensive customised support might be decrease which might save costs.

More frequent use of general facilities

By using general facilities more frequently, costs might be saved.

Volume risk for the municipality

By focusing on the abilities of the client, focusing more on help form the client's environment, focusing more on prevention, and a more frequent use of general facilities, costs might be saved

Based on this costs savings, the focus of the municipality does not have to be so much on limiting the volume risk. Limiting the volume risk of the municipality might be possible by steering on the hours needed to achieve a result through discussions with healthcare providers.

Expand and tighten the basic set of quality requirements of the VNG
The basic set of quality requirements should be expanded, tightened and formalised in consultation between the municipality, healthcare providers and clients.

Steer on results
Results should become steering based on benchmarking, and not accountable based on paying for results which relates to the funding method. The difference between steering on results and funding on results should be defined, and shared with all stakeholders.
'*Steering on results is benchmarking the actual number of achieved results among healthcare institutions*.'
'*Result funding is paying healthcare institutions on whether or not, one or more results are achieved*.'
When results are steering, performances should not be determined in advance. Furthermore, as already mentioned, the municipality can also steer on the hours needed to achieve a result through discussions with healthcare providers in order to limit the volume risk, but this is contradictory to the assumption that performances should not be determined in advance when results are steering.

Define and measure results in consultation
Agreements should be made with healthcare providers and clients to define and measure results at least at the start of the process, at the end of the process and every six months.

Demand clarification (client-oriented)
Set up a model in which demand clarification is central, so that results can be determined and measured based on this. The current format of Package 1 should not be leading, although the results of this study are based on that. First, the population of package 1 has to be mapped out. There might be needed more demand clarification models based on the population of Package 1.

Changes in work at the back office of the municipality
All employees at the back office of the municipality should be prepared for possible changes. This is expected to take three quarters of a year.

Changes in work at the front office of the municipality
Because results are steered, consultants and neighbourhood coaches should be trained to define and measure these results. More specialist knowledge may be necessary. By focusing on the client's abilities instead of disabilities, costs might be saved. Cost savings seem to be possible through well-established demand-oriented access rather than by funding on results. Well-established demand-oriented access is crucial for a good indication of results.

Setting up dialogue sessions
In addition to the regular purchasing agreement, the dialogue-focused procedure requires dialogue sessions to be held with healthcare providers to determine implementation requirements. It is advised to develop tools for this and to make Full-time equivalent (FTE) available.

Steer on contract management
In order to be able to steer on results and setting up dialogue-sessions contract management, become more important. Therefore, handles must be set up for contract managers with regard to steering on results and conducting dialogue sessions.

Registration and declaration system
With population funding, no hours are declared, while with production funding that is the case. When the population of Package 1 is mapped out and the pilots for population funding are successful, the declaration system should be set for population funding.

7. Discussion (validity, limitations & further research)

In this section, first the validity of the research design will be discussed, followed by the limitations of this study. Finally, recommendations will be done for further research.

7.1 Validity research design

On some points the validity of this study has limitations. The Wmo client council was interviewed to determine the requirements and wishes of clients. It is assumed that it has the Wmo council has same views as the Jw client council, but there was no Jw client council to interview. Furthermore, only one of the municipality's two contract managers interviewed is involved in all municipalities of the Achterhoek Social Domain, while in fact it concerns eight municipalities. Dependent and independent clients were not actually interviewed separated, while a distinction was made there. Selection bias may have occurred at the above three points.

In addition, there may be some underfitting. The social domain is constantly changing. In addition, the opinions of experts on the social domain also differ considerably. The same applies to purchasing procedures, funding methods, contract forms, and payment methods that are applicable in the social domain. The social domain, and particular Package 1: individual support, is actually too fragmented to apply a model that meets all requirements and wishes.

Healthcare providers say that money is not an incentive to achieve results, but there is a possibility that, based on what they decide, money is an incentive to achieve results. As it is a qualitative study, of which the results are largely based on interviews, it is accepted not to carry out any observations in healthcare practice. The results are based on interviews with a select number of stakeholders per stakeholder group.

7.2 Limitations & further research

There are several limitations in this study. This study does not engage with regional differences within Social Domain Achterhoek. Discussions in the project group revealed that there are considerably large regional differences in access, in particular. However, the starting point of the assignment is a regional vision and issue, which makes it permissible to conduct the research regionally. Further research could usefully explore the regional differences.

The reader should bear in mind that the study is only based on the difference between dependent and independent clients in the current Package 1: individual support. Not all clients can be included in these two groups. Although it is clearly described what a dependent client and what an independent client is, there will always be clients who do not fall into neither of those groups. Furthermore, there are other formats to divide clients into groups. More client groups can be used, such as applied the IJsselland region (83). A distinction can also be made between single and multiple questions, homogeneous and heterogeneous questions, segments (high, medium, low), clinical picture and abilities of clients (83, 84). Further research should be undertaken to explore the apportion of population in Package 1: individual support.

When results become steering, contract management becomes much more important. This study does not investigate how results can be benchmarked by contract managers if they become steering. One option might be to group clients with similar abilities/disabilities of similar healthcare providers, and measure the differences in those groups. Further research to the possibilities for contract management, could be helpful.

In this study no specific demand clarification models in which the abilities of the client are central instead of the disabilities, are compared except for the ZRM, the Positive Health Spin,

and the Esbjerg model as described in Section 6.6.2 (70-75). That is because further research to explore the apportion of the population of Package 1: individual support, has to be executed first. The demand clarification model should be based on the population of Package 1. So after exploring the population of package 1, further research in order to find a suitable demand clarification model should be undertaken.

In any case, the result remains difficult to define and measure, even if this is done in consultation between the municipality, the healthcare provider and the client. A client can make it appear as if a result has been achieved when the healthcare provider and municipality check this, but can show other behaviour when he/she is alone. Who checks this? A legal representative or client supporter can fulfil this role, but that costs extra money, while the available budget is already reduced as discussed in Section 2.2 (7-9)[31]. The existence of legal representatives and client advisors with dependent clients has not been taken into account. These can play a major role in determining and measuring results.

This study does not fully engage with the differences between functional specification and technical specification. While drawing conclusions, this has been kept in mind because result-oriented purchasing has a functional basis, but no specific differences are mentioned between functional and technical specification (85).

No distinction has been made between large and small care providers. Based on the literature in Section 4 (12, 16, 17, 21, 41, 45), the differences between large and small care providers are small, but these differences have not been mentioned anywhere. Further research is needed to provide insight into the differences between large and small healthcare providers.

Wmo and Jw are integrally purchased by Social Domain Achterhoek. No research has been done into whether these forms of care should be purchased integral. In some municipalities, Jw and Wmo are not purchased integrally (17). In addition, no distinction is made between Wmo and Jw, while Jw deals with much more complex problems in many cases. It is beyond the scope of this study to examine the degree of integrality, and the differences between Jw and Wmo. Further research to the degree of integrality between Jw and Wmo, and the differences between Jw and Wmo regarding complexity of support, could be useful.

The definition of customised care and quality is different in different articles. For example, the publication of Movisie '*Inkoop en bekostiging als kwaliteitsinstrumenten*' (16) seems to put quality and customised care in one, while Uenk (20) defines customised care as doing what is needed (16, 20). It is beyond the scope of this study to extensively examine what definitions there are in the literature, compare them and then come to one clear definition.

No quantitative data such as rates and volumes, or historically, has been studied. Although this is a qualitative study, these data could have provided insight into among other things the differences with other Packages than Package 1, or differences with other municipalities.

[31] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

8. Conclusions & recommendations

This section contains the conclusions of this study, followed by recommendations to Social Domain Achterhoek.

8.1 Conclusions

The aim of this study was to advice Social Domain Achterhoek on how result-oriented purchasing should be organised for individual support. With this, Social Domain Achterhoek aimed to work more client-oriented and save costs. A qualitative research in combination with a literature research was conducted in order to answer the main research question:

How should result-oriented purchasing be organised for individual support?

The following sub question were answered in order to answer the main research question:

1. *Which result-oriented healthcare purchasing models are possible for individual support?*
2. *What are the requirements and wishes of Social Domain Achterhoek, healthcare providers and clients when purchasing care for individual support?*
3. *Which healthcare purchasing model fits best to the municipalities in the Achterhoek for individual support?*
4. *How should the chosen healthcare purchasing model be applied in practice?*

A healthcare purchasing model consists of a purchasing procedure, funding method, contract form and paying method. Three SAS procedures and two formal European procedures have been included. With regard to funding methods, a distinction is made between production funding, population funding and result funding. With regard to contract forms a distinction is made between a fixed budget, budget ceiling, and framework agreements with and without interim entry possibilities. For the payment methods, a distinction is made between gradual payments, payments in advance, payments afterwards and payments in the form of reward/penalty.

Customised care and quality are important to the municipality, healthcare providers and clients. Municipalities and healthcare providers also place a high value on innovation. The spearheads of the municipality are primarily the improvement of quality and the stimulation of innovation, while the spearheads of healthcare providers are primarily focused on quality promotion and certainty. The spearheads of clients relate to customised care and quality. All stakeholder groups prefer a limited number of healthcare providers.

The healthcare purchasing model with a **dialogue-oriented purchasing procedure, a framework agreement with interim entry and fixed payment per period**, fits best to the municipalities in the Achterhoek for individual support (Package 1). **The healthcare purchasing model includes production funding in the first instance, and population funding in the future**. In this model the results are not decisive, the results are merely used for steering. A trade-off is made between a healthcare purchasing model that fits best with result-oriented purchasing and a model that is best suited for individual support in Package 1.

The focus in determining and measuring results should be on well-established demand-oriented access, focusing on the client's abilities, and consultation between the municipalities, clients and healthcare providers, rather than a situation in which results are decisive.

In short, result-oriented purchasing for individual support (Package 1) should be organised by steering on results in the chosen healthcare purchasing model, whereby improved access, focusing on the client's ability and continuous consultation between municipalities, clients and healthcare providers in order to work more client-oriented and to save costs, are spearheads.

8.2 Recommendations

Based on the research conducted, the following recommendations are made to Social Domain Achterhoek:

1. This study has shown that the population in Package 1: individual support is reasonable divers and complex in most cases. The results of this study are based on the full population in Package 1: individual support, which excludes certain outcomes. Therefore, it is recommend to do further research to the population apportion in Package 1, and to align the demand-oriented model of recommendation 3 accordingly.

2. It is shown that the healthcare purchasing model which includes a dialogue-oriented purchasing procedure, production funding in the first instance, population funding in the future, a framework agreement with interim entry and a fixed payment per period, fits best to result-oriented purchasing in Package 1: individual support for the municipalities in the Achterhoek. It is recommended to conduct a pilot and the model should only be implemented if the pilot is successful. The pilot could be executed in a specific neighbourhood which gives a reflection of the entire population. Afterwards, a pilot could be executed in one of the eight municipalities of Social Domain Achterhoek. In which neighbourhood and municipality of Social Domain Achterhoek the pilot could be executed, depends next to the population apportion on the degree to what extent the involved stakeholders in that specific neighbourhood or municipality, are willing to improve quality and to innovate.

3. It is also shown that improved access and focusing on abilities of the client contribute to more client-oriented working and saving costs. Therefore, more specialistic knowledge at front-employees of the municipalities is necessary, and a demand-oriented model should be used to define and measure results. It is recommended to train front-employees in order to get specialistic knowledge about, for example, clinical pictures and abilities of clients, and to do further research to demand-oriented result models, which fit to individual support.

4. This study has also shown that focusing more on help from the client's environment, focusing more on prevention, and a more frequent use of general facilities might save costs. Therefore, it is recommend to do further research to the possibilities to focus more on help from the client's environment, focus more on prevention, and a more frequent use of general facilities.

5. It is shown that a situation in which results are decisive with regard to funding is currently not applicable in Package 1: individual support. Therefore, it is recommend to apply result steering, which is benchmarking the achieved results at healthcare providers by for example grouping clients with similar abilities/disabilities of similar healthcare providers, and measure the differences in those groups. Further research should be done to the benchmark possibilities for contract managers.

6. A limitation of this study is that the regional differences are not included. These differences can be significant. Therefore, it is recommended to determine the regional differences using the same method as in this study.

7. Another limitation of this study is that the differences between Wmo and Jw are not included, while healthcare providers stated that the Jw involves more complex cases. Therefore, it is recommended to determine the differences between Wmo and Jw by using the same method as in this study.

8. Also a limitation of this study is that no distinction has been made between large and small healthcare providers, while there are differences. Therefore, it is recommended to provide inside into the differences between large and small healthcare providers.

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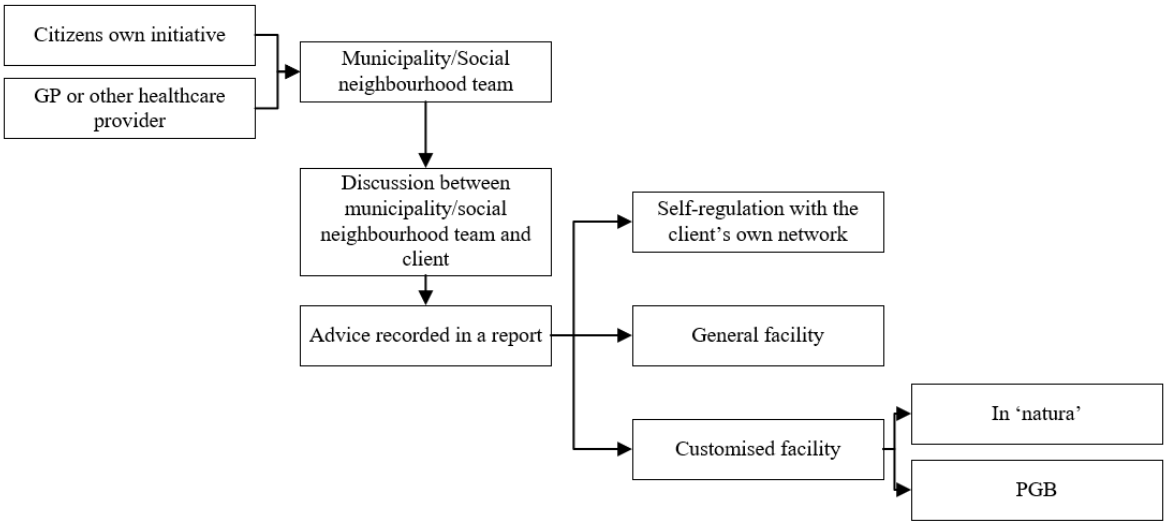
Appendices

Appendix I Obtaining support & financing Wmo/Jw

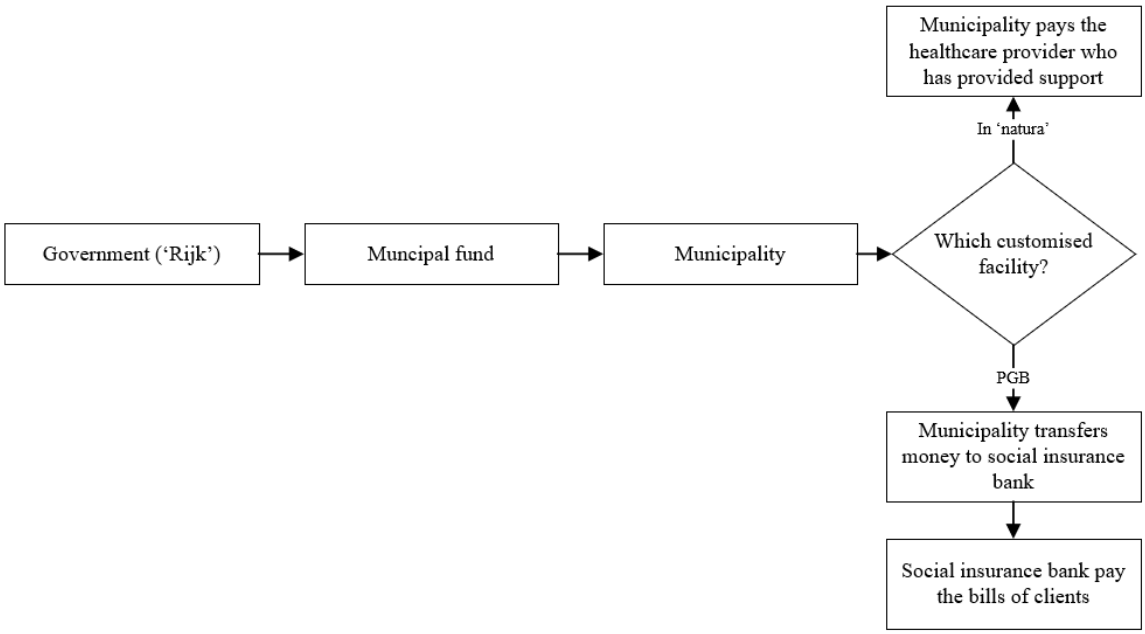
The following Figure 1 shows how citizens ultimately obtain support from the Wmo.

Figure 1: obtaining support from the Wmo/Jw (2, 10)



The financing of the customised Wmo support is shown schematically in the following Figure 2.

Figure 2: financing Wmo/Jw (2, 27, 28)



Appendix II Package 1: individual support

Table 1: overview Package 1 current situation (23)

Domain	Definition	Forms	Sub forms	Code	Tariff per hour 2019
Individual guidance	Definition Focused on increasing or maintaining self-reliance and participation in society. Client Free access support such as informal care or homework supervision is NOT part of individual supervision.	Focused on development	Development	Wmo: 02A06	€45,50
				Jw: 45A08	€51,00
			Development +	Wmo: 02A11	€76,20
				Jw: 45A09	€76,20
		Focused on stabilization	Stabilise and help	Wmo: 02A07	€40,80
			Stabilise and take over	Wmo: 02A08	€61,20
			Stabilise and take over +	Wmo: 02A12	€76,20
Personal care	Definition Focuses on ADL, personal hygiene and basic physical care to solve a lack of self-reliance in this area by learning or taking over tasks. In this way, the client is self-reliant in society for as long as possible. Client Applies for both youth and adults. This only applies to personal care that is not covered by the Zvw (medical purpose) or the Wlz.	Personal care	Development	Wmo: 03A04	€45,60
				Jw: 40A03	€45,60
			Stabilise	Wmo: 03A03	€40,80
				Jw: 40A04	€40,80
Individual youth treatment	Definition Aimed at improving parenting or growing-up problems, psychological problems and disorders. Client The client is learnable, the support is short-term and will change to a lighter form of support such as guidance if possible. Treatment only applies to the Jw, not to the Wmo. Adult treatment is part of the Zvw. The perpetuation of skills and behaviour is part of supervision, not treatment.	Individual youth treatment	Development	Jw: 45A66	€91,80
			Development +	Jw: 45A68	€106,80

Appendix III Result-areas Package 1: individual support

Table 1: overview Package 1 current situation (23, 70, 71)

	ZRM domain		Goals/results independent client	Goals/results dependent client
1	Finances	A	Sufficient income to provide for living	Sufficient income to provide for living
		B	Debts are known and can be solved by the client	Learn to ask for help in resolving debts
		C	Manage administration and finances	Learn to ask for help with administration and finances
2	Daily activities / time allocation / training	A	Having paid work, volunteer work and / or attending training	Learn to ask help in having paid work, volunteer work and / or attending training
		B	Having enough enjoyable or useful activities	Learn to ask help in having enjoyable or useful activities
		C	Children of compulsory education are seldom absent and have sufficient opportunity to do homework	Learn to ask help in reaching that children of compulsory education are seldom absent and have sufficient opportunity to do homework
		D	Know how to network for paid work or volunteer work	Learn to ask help in knowing how to network for paid work or volunteer work
3	Housing	A	Having a house to live in	Learn to ask help in finding a house to live in
		B	Have a safe environment	Learn to ask help in creating a safe environment
		C	Being able to run a household independently	Learn to ask help in running a household
		D	Access to information and technology aimed at independent living, aging and running a household	Learn to ask for information and technology aimed at independent living, aging and running a household
4	Domestic relationships / social network	A	Have a safe environment	Learn to ask help in creating a safe environment
		B	Feel safe and live together	Learn to ask help in creating a safe feeling and living together
		C	Have a social network to fall back on	Learn to ask help in creating a social network to fall back on
5	Mental health / social-emotional support	A	Good mental health	Learn to ask help in creating a good mental health
		B	Access to information about good mental health	Learn to ask for information about good mental health
		C	Growing-up ‘healthy’	Learn to ask for help in growing-up ‘healthy’
		D	Parent plays an exemplary role	Learn to ask help in playing an exemplary role
6	Physical health / ADL / physical care	A	Having a healthy lifestyle	Learn ask help in creating a healthy lifestyle
		B	Perform ADL independently	Learn ask help in performing ADL independently
		C	There is no physical abuse or neglect	Learn to ask help in avoiding/solving physical abuse or neglect
		D	Have access to advice about physical abuse, neglect or personal hygiene and basic physical care	Learn to ask for advice about physical abuse, neglect or personal hygiene and basis physical care
7	Addiction	A	Not having an addiction or having a addiction which does not cause nuisance, problems and danger to the person and the environment	Learn to ask help to avoid/solve an addiction
		B	Access to information and advice focused on the prevention/solvation of an addiction	Learn to ask help for information and advice focused on the prevention of an addiction
8	Justice	A	Feel safe	Learn to ask help in feeling safe
		B	Be safe	Learn to ask help in being safe
		C	Have access to information and advice focused on the prevention/solvation of crime	Learn to ask for information and advice focused on the prevention/solvation of crime

Appendix IV Purchasing models

Table 1: advantages & disadvantages principal role municipality per model (4, 15)[32]

Model		Municipality	Client	Healthcare provider
Director model - Result-oriented	+	Involvement via directors in the surveillance of quality, budget and overconsumption. Integral approach with other care domains possible. Involvement in implementation	Involvement in drawing up care plan. Freedom of choice in selection healthcare provider.	Ability to deliver healthcare faster without time component (with reservation). Chance to distinguish on quality.
	-	Nobody monitors the directors. Risk of lower amount of care delivered by healthcare providers: dissatisfied clients .	No legal certainty without time component (with reservation). Risk of lower amount of care delivered by healthcare providers: dissatisfied clients .	Framework agreements offer no certainty for turnover. Dependent of the director.
Director model - P*Q	+	Involvement via directors in the surveillance of quality, budget and overconsumption. Integral approach with other care domains possible. Involvement in implementation	Involvement in drawing up care plan. Freedom of choice in selection healthcare provider. Legal certainty.	Chance to distinguish on quality.
	-	Nobody monitors the directors. Financial risk: unlimited amount of care delivered by healthcare providers.	-	Framework agreements offer no certainty for turnover. Dependent of the director. No ability to deliver healthcare faster without time component (with reservation).

[32] Telgen J. Purchasing in the Social Domain. In: Meijer A, editor. 2019; unreferenced interview.

Appendix V Purchasing procedures

Table 1: advantages & disadvantages purchasing procedures

Procedure		Municipality	Client	Healthcare provider
Subsidization	+	No open end: expenses not higher than predetermined. Easy to manage costs (16). No Purchasing Act in force: enforceable contracts without publication of changes (17, 21).		No performance obligation (16). Gets time to phase out activities at the end of the subsidy relationship (16). Only one or a limited number of providers selected (16). No Purchasing Act in force: less administrative hassle (17, 21).
	-	Only permitted for Purchasing Activities, not for goods and services (16, 21). No performance obligation: difficult to manage on price, volume, quality and innovation (16). A subsidy relationship may not simply be terminated at the end of the subsidisation (16). Limited possibility to manage freedom of choice (16). Limited diversity of providers: worse price and quality (21).	Limited freedom of choice (16).	Only one or a limited number of providers selected (16). Only permitted for Purchasing Activities, not for goods and services (16, 21). No Purchasing Act in force: less equality (17, 21).
Open-house	+	A purchasing relationship may simply be terminated at the end of the contract (16). All stakeholders are involved in realisation: greater support (12, 16, 21, 39). Possibility of innovation through large involvement of stakeholders (16, 39). Contract changes always possible (21). Diversity of providers: stimulation quality by healthcare providers (21). No Purchasing Act in force: enforceable contracts without publication of changes (17, 21).	Great freedom of choice results in customised care (16, 21, 39).	Influence on quality, because only the basic quality requirements are fixed (16, 21, 39). Possibility of innovation through large involvement (16, 39). Contract changes always possible (16, 21). No price competition, because competition is not allowed: possibility to differentiate on quality and innovation. (21, 39). Interim entry and exit possible (16, 21). Low entry barriers: small healthcare providers can easily join (16, 21). No possibility to be excluded if they meet the requirements (15, 17). No Purchasing Act in force: less administrative hassle (17, 21)
	-	Open end: expenses might be higher than predetermined. Difficult to manage costs (16). All stakeholders are involved in realisation: more difficult decision-making (12, 16, 21, 39). Limited possibility to steer towards cost control: the real price is assumed (15, 16, 39).		Gets no time to phase out activities at the end of the purchasing relationship (16). No price competition, because competition is not allowed: not all healthcare providers can distinguish themselves on quality and innovation (21, 39). Interim entry and exit possible (16, 21)

		No possibility to exclude healthcare providers that meet the requirements (15, 39). No price pressure and volume pressure, because all providers must be treated equally. They can distinguish themselves on quality (21, 39). Only the basic quality requirements are fixed (15, 39).		Low entry barriers: risk of losing clients to other healthcare providers (16, 21). No turnover guarantee (21). No Purchasing Act in force: less equality (17, 21). Limited influence on price, because of the fixed rates. Although there is diversity in the offer (16, 21, 39).
Government contract - Form retaining procedure - Multiple healthcare providers - In accordance with 'Zeeuws' model	+	A purchasing relationship may simply be terminated at the end of the contract (16). Control over price and performance requirements: described by the municipality (12, 16, 21). Great freedom of choice for clients has a positive influence on quality and innovation (16). Great influence on cost control through unilateral pricing (16). Open entry possible to improve quality and to increase freedom of choice (16).	Great freedom of choice results in customised care (16).	All providers that meet the requirements (performance and price) are contracted for the same rate: no competition on price (12, 16, 21). No possibility to be excluded based on objective criteria (only minimum quality requirements) (36). Low entry barriers: small healthcare providers can easily join (12, 16, 17, 21). Purchasing Act in force: more equality (17, 21).
	-	Open end: expenses might be higher than predetermined. Difficult to manage costs (16). The volume is uncertain: no agreements about the volume (16). Purchasing Act in force: mandatory new publication of the contract in the event of changes (17, 21). Limited possibility to select providers based on objective criteria (only basic quality requirements) (36).	No control over price and performance requirements (16, 21).	Gets no time to phase out activities at the end of the purchasing relationship (16). No control over price and performance requirements: described by the municipality (16, 21). All providers that meet the requirements (performance and price) are contracted for the same rate: no competition on price (12, 16, 21). No turnover guarantee (21). Low entry barriers: risk of losing clients to other healthcare providers (12, 16, 17, 21). Purchasing Act in force: more administrative hassle (17, 21)
Government contract - Form retaining procedure -	+	A purchasing relationship may simply be terminated at the end of the contract (16). All stakeholders are involved in realisation: greater support (12, 16, 21). Possibility of innovation and improving quality through large involvement of stakeholders (16). Contract changes possible in consultation (16, 21).	Influence on price and quality via client councils (16). Reasonable freedom of choice results in customised care. However, agreement must be reached on the content of the contract. (16).	Influence on quality through involvement in realisation (16, 21). Influence on price through involvement in realisation, but within a bandwidth set by the municipality (16, 21). Possibility of innovation and improving quality through large involvement (16). Contract changes possible in consultation (16, 21). Interim entry and exit possible (16, 21).

Multiple healthcare providers - Dialogue-oriented purchasing		Longer term of contracts: innovation stimulation (16). Provides handles to increase client freedom of choice (16). The rates are set in consultation with the healthcare providers, but within a bandwidth set by the municipality (16).		Longer term of contracts: more certainty to innovate (16). Little competition on price (16). Normal entry barriers: small healthcare providers can easily join (16, 21). No possibility to be excluded if they meet the requirements (15). Purchasing Act in force: more equality (17, 21).
	-	Open end: expenses might be higher than predetermined. Difficult to manage costs (16). All stakeholders are involved in realisation: more difficult decision-making (12, 16, 21). Limited possibility to steer towards cost control: the real price is assumed (15, 16). No possibility to exclude healthcare providers that meet the requirements (15). The volume is uncertain: no agreements about the volume (16). Purchasing Act in force: mandatory new publication of the contract in the event of changes (17, 21).		Gets no time to phase out activities at the end of the purchasing relationship (16). Little competition on price (16). Normal entry barriers: risk of losing clients to other healthcare providers (16, 21). No turnover guarantee (21). Purchasing Act in force: more administrative hassle (17, 21)
Government contract - Form retaining procedure - Usually one healthcare provider - BVP	+	A purchasing relationship may simply be terminated at the end of the contract (16). Possibility to determine unilateral criteria and services (12, 16, 21). Possibility of cost control through price competition (12, 16). Possibility to determine minimum and maximum number of healthcare providers (in this thesis only one): quality control (12, 16). Possibility to select one provider based on the intended execution of the assignment (12, 21). May only specify a bandwidth for the price, but chooses on provider (12, 16).	Involved in determining quality criteria for selection and award; assessment is based on submitted documents (12, 16).	Possibility to offer a price by itself within a certain bandwidth (12, 16). Difficult to distinguish itself from others based on quality criteria (12, 16). Competition based on price (12, 16). Turnover guarantee, because only one provider (21). Purchasing Act in force: more equality (17, 21).
	-	Open end: expenses might be higher than predetermined. Difficult to manage costs (16). Determining services unilaterally by the municipality, so little incentive for innovation among healthcare providers (12, 16).	Criteria en services will be determined unilateral by the municipality (12, 16, 21). Usually no freedom of choice (21).	Gets no time to phase out activities at the end of the purchasing relationship (16). Criteria en services will be determined unilateral by the municipality (12, 16, 21).

		Purchasing Act in force: mandatory new publication of the contract in the event of changes (17, 21). Limited volume control possible, because the healthcare provider determines the execution (only in selection of the healthcare providers) (12, 21).		Difficult to distinguish yourself from others based on quality criteria (12, 16). Determining services unilaterally by the municipality, so little possibilities for innovation among healthcare providers (12, 16). Competition based on price (12, 16). No interim entry and exit possible (12, 16). Only one healthcare provider is contracted (21). Large possibility to be excluded based on the intended execution of the assignment (12, 21). Purchasing Act in force: more administrative hassle (17, 21)
Government contract - Formal procedure - Multiple healthcare providers - Classical European public purchasing	+	A purchasing relationship may simply be terminated at the end of the contract (16). Possibility to determine unilateral criteria and services (16, 21). Possibility of cost control through price competition: municipality chooses best price/quality combinations (16). Possibility to determine minimum and maximum number of healthcare providers: quality control (16). Possibility to select providers based on a program of requirements (12, 16, 17, 21). May only specify a bandwidth for the price, but chooses a few providers (16).	Involved in determining quality criteria for selection and award; assessment is based on submitted documents (16).	Possibility to offer a price by itself, within a certain bandwith (16). Difficult to distinguish itself from others based on quality criteria (16). Competition based on price (16). Purchasing Act in force: more equality (17, 21).
	-	Open end: expenses might be higher than predetermined. Difficult to manage costs (16). Determining services unilaterally by the municipality, so little incentive for innovation among healthcare providers (16). Purchasing Act in force: mandatory new publication of the contract in the event of changes (17, 21). Limited volume control possible, because the healthcare provider determines the execution (only in selection of the healthcare providers) (12, 16, 17, 21).	Criteria en services will be determined unilateral by the municipality (16, 21). Limited freedom of choice, only providers with the best price/quality combination are selected (16, 21).	Gets no time to phase out activities at the end of the purchasing relationship (16). Criteria en services will be determined unilateral by the municipality (16, 21). Difficult to distinguish yourself from others based on quality criteria (16). Determining services unilaterally by the municipality, so little possibilities for innovation among healthcare providers (16). Competition based on price (16). No interim entry and exit possible (16). Possibility to be excluded based on not meeting the program of requirements (12, 16, 17, 21). Limited turnover guarantee, because of the price competition (16). Purchasing Act in force: more administrative hassle (17, 21)

Government contract - Formal procedure - Multiple healthcare providers - Dynamic purchasing system	+	A purchasing relationship may simply be terminated at the end of the contract (16). Promotes freedom of choice: number of providers cannot be limited by applying selection criteria (16, 17, 45). Continuous quality control possible due to dynamic nature and dialogue sessions (17, 36). Continuous innovation control possible due to dynamic nature and dialogue sessions (17, 36). Certain volume, because individual contracts are awarded (17, 45). Price control possible by setting price as criterion in the DAS (36, 45).	Limited freedom of choice, because the municipality awards individual contracts to one provider, but the municipality can choose from all providers that are admitted to the DAS, thereby promoting customised care (17, 45).	Quality influence through dialogue sessions (17). Innovation influence through dialogue sessions (17). Interim entry and exit possible (16, 21, 45). No possibility to be excluded in the DAS if they meet the requirements (15, 45). Innovation competition through continuous innovation control (36). Purchasing Act in force: more equality (17, 21). Little competition on price when price is set as a criterion in the DAS (16, 17). Low entry barriers in DAS: only grounds for exclusion, suitability requirements and award criteria. No selection criteria. : risk of losing clients to other healthcare providers (16, 17, 21). Quality competition through continuous quality control (36).
	-	Open end: expenses might be higher than predetermined. Difficult to manage costs (16). Diversity of providers: because the municipality awards individual contracts to one provider, but the municipality can choose from all providers that are admitted to the DAS (17, 45). No possibility to exclude healthcare providers that meet the requirements (grounds for exclusion, suitability requirements and award criteria) (15, 45). Purchasing Act in force: mandatory new publication of the contract in the event of changes (17, 21).		Gets no time to phase out activities at the end of the purchasing relationship (16). Little competition on price when price is set as a criterion in the DAS (16, 17). Low entry barriers in DAS: only grounds for exclusion, suitability requirements and award criteria. No selection criteria: small healthcare providers can easily join (16, 17, 21). No turnover guarantee (17, 21). Quality competition through continuous quality control (36). Purchasing Act in force: more administrative hassle (17, 21) Innovation competition through continuous innovation control (36). Limited price influence when price is set as criterion in the DAS (36, 45)

Table 2: highlights advantages & disadvantages purchasing procedures

Procedure		Municipality	Client	Healthcare provider
Subsidization	+	Degree of open end Application Purchasing Act		Degree of price control Degree of quality control Degree of innovation control Degree of transition activities end relation Quantity of providers Application Purchasing Act
	-	Degree of application possibilities Degree of price control Degree of volume control Degree of quality control Degree of innovation control Termination possibility end relation Degree of freedom of choice control Quantity of providers	Freedom of choice	Quantity of providers Degree of application possibilities Application Purchasing Act
Open-house	+	Termination possibility end relation Involvement realisation Degree of innovation control Possibility contract changes Quantity of providers Application Purchasing Act	Freedom of choice Degree of customised care	Degree of quality control Degree of innovation control Possibility contract changes Possibility interim entry and exitexit Degree of price competition Degree of entry barriers Certainty to be included Application Purchasing Act
	-	Degree of open end Involvement realisation Degree of cost control Certainty to be included Degree of price control Degree of volume control Degree of quality control		Degree of transition activities end relation Degree of price competition Degree of entry barriers Degree of turnover guarantee Application Purchasing Act Degree of price control
Government contract - Form retaining procedure -	+	Termination possibility end relation Degree of price control Degree of quality control Degree of innovation control Degree of freedom of choice control Degree of cost control	Freedom of choice Degree of customised care	Degree of price competition Certainty to be included Degree of entry barriers Application Purchasing Act

Multiple healthcare providers - In accordance with 'Zeeuws' model				
	-	Degree of open end Degree of volume control Application Purchasing Act Certainty to be included	Degree of price control Degree of quality control Degree of innovation control	Degree of transition activities end relation Degree of price control Degree of quality control Degree of innovation control Degree of price competition Degree of turnover guarantee Degree of entry barriers Application Purchasing Act
Government contract - Form retaining procedure - Multiple healthcare providers - Dialogue-oriented purchasing	+	Termination possibility end relation Involvement realisation Degree of quality control Degree of innovation control Possibility contract changes Contract duration Degree of freedom of choice control Degree of price control	Degree of price control Degree of quality control Degree of innovation control Freedom of choice Degree of customised care	Degree of price control Degree of quality control Degree of innovation control Possibility contract changes Possibility interim entry and exit Contract duration Degree of price competition Degree of entry barriers Certainty to be included Application Purchasing Act
	-	Degree of open end Involvement realisation Degree of cost control Certainty to be included Degree of volume control Application Purchasing Act		Degree of transition activities end relation Degree of price competition Degree of entry barriers Degree of turnover guarantee Application Purchasing Act
Government contract - Form retaining procedure - One healthcare provider - BVP	+	Termination possibility end relation Degree of price control Degree of quality control Degree of innovation control Degree of cost control Degree of freedom of choice control Certainty to be included Degree of price control	Degree of quality control	Degree of price control Degree of quality competition Degree of price competition Degree of turnover guarantee Application Purchasing Act
	-	Degree of open end	Degree of price control	Degree of transition activities end relation

		Degree of innovation control Application Purchasing Act Degree of volume control	Degree of quality control Degree of innovation control Freedom of choice	Degree of price control Degree of quality control Degree of innovation control Degree of quality competition Degree of price competition Possibility interim entry and exit Quantity of providers Certainty to be included Application Purchasing Act
Government contract - Formal procedure - Multiple healthcare providers - Classical European public purchasing	+	Termination possibility end relation Degree of price control Degree of quality control Degree of innovation control Degree of cost control Degree of freedom of choice control Certainty to be included Degree of price control	Degree of quality control	Degree of price control Degree of quality competition Degree of price competition Application Purchasing Act
	-	Degree of open end Degree of innovation control Application Purchasing Act Degree of volume control	Degree of price control Degree of quality control Degree of innovation control Freedom of choice	Degree of transition activities end relation Degree of price control Degree of quality control Degree of innovation control Degree of quality competition Degree of price competition Possibility interim entry and exit Certainty to be included Degree of turnover guarantee Application Purchasing Act
Government contract - Formal procedure - Multiple healthcare providers - Dynamic purchasing system	+	Termination possibility end relation Degree of freedom of choice control Quantity of providers Degree of quality control Degree of innovation control Degree of volume control Degree of price control	Freedom of choice Degree of customised care	Degree of quality control Degree of innovation control Possibility interim entry and exit Certainty to be included Degree of innovation competition Application Purchasing Act Degree of price competition Degree of entry barriers Degree of quality competition
	-	Degree of open end		Degree of transition activities end relation

		Quantity of providers Certainty to be included Application Purchasing Act		Degree of price competition Degree of entry barriers Degree of turnover guarantee Degree of quality competition Application Purchasing Act Degree of innovation competition Degree of price control

Table 3: merged topics purchasing procedures

	Abbr. Criterion	**Criterion**	**Topic**
1	Open end	Degree of open end	Degree of open end
2	Contract possibilities	Contract possibilities	Degree of application possibilities
			Involvement realisation
			Possibility contract changes
			Contract duration
3	Price	Degree of price control	Degree of price control
			Degree of price competition
			Degree of turnover guarantee
			Degree of cost control
4	Quality	Degree of quality control	Degree of quality control
			Degree of quality competition
5	Innovation	Degree of innovation control	Degree of innovation control
			Degree of innovation competition
6	End relation	Termination of relation and activities at the end of the relation	Termination possibility end relation
			Degree of transition activities end relation
7	Freedom of choice	Freedom of choice	Freedom of choice
			Degree of freedom of choice control
			Degree of customised care control
		Quantity of providers	Quantity of providers
			Certainty to be included
			Degree of entry barriers
8	Purchasing Act	Application Purchasing Act	Application Purchasing Act
9	Volume control	Degree of volume control	Degree of volume control
			Degree of turnover guarantee
10	Interim entry & Exit	Possibility interim entry and exit	Possibility interim entry and exit

Appendix VI Funding methods

Table 1: advantages & disadvantages funding methods

Funding		Municipality	Client	Healthcare provider
Production	+	Fixed products and tariffs during the term of the contract: certainty (16). May determine performances (16).	Freedom of choice (16).	No financial risk: expenses are not maximised (16).
	-	No control on quality, innovation and increasing freedom of choice for clients, because what is stated in contracts is binding for the duration of the contract (16). Fixed products and rates during the term of the contract: no incentive for healthcare providers to improve quality, to innovate, to deliver customised care or to increase the freedom of choice. Additional agreements are needed to create an incentive for quality improvement and innovation among healthcare providers. Another possibility is to make a distinction in the access of the support. (16, 20). The volume is uncertain, but fairly good to estimate (16). Financial risk: expenses are not maximised (16). An incentive for overproduction for healthcare providers, because providers do not get paid for quality but for volume (16, 20). Selection in advance: expensive clients are excluded (15).	No influence on determining performances (16). Only certainty about the number of hours and the interpretation of the hours (performances), but the provider is not encouraged to determine whether it is actually customised care. Besides, what is stated in the contracts is binding for the duration of the contract (16). No incentives to improve quality among providers. No agreements have been made about this in the contract by the municipality. Only hours and rates are fixed (16). Selection in advance: expensive clients are excluded (15).	No control on quality, innovation and increasing freedom of choice for clients (16). No turnover guarantee (12, 16). No influence on determining performances (16). An incentive for overproduction for healthcare providers, because providers do not get paid for quality but for volume (16, 20). Obstruction of space to provide customised care, because what is stated in contracts is binding for the duration of the contract (16, 20).
Population	+	Low financial risk: the budget ceiling ensures that the municipality has full control over the expenditures (expenses are maximised) (16). Long-term relationships with healthcare providers: to stimulate innovation and prevention, investment risks are limited (16). Healthcare providers are encouraged to work efficiently and only provide the required care: cost-reducing deployment (16). May determine results (16).	Receive customised care, because services are not tightly framed in advance. (16). Healthcare providers are encouraged to work efficiently and only provide the required care: cost-reducing deployment (16). Healthcare providers do have the opportunity to improve quality, because services are not tightly framed in advance. However, that is not an incentive (15, 16)	Possibility to adjust care to customer needs, because the services have not been determined in advance, strictly (16). Long-term relationships with healthcare providers: limited investing risks with innovation and prevention (16).
	-	Few incentives to improve quality among healthcare providers, because agreements are made about commitment and quality but this	Selection in advance: expensive clients are excluded (15).	No competition, because the reimbursement does not depend on the volume of customers (16).

		is not adjusted during the term of the contract: there is no mutual competition and the financial compensation for the providers does not depend on the volume actually delivered or the valuation of clients (16). However, healthcare providers do have the opportunity to improve quality, because services are not tightly framed in advance (15, 16). Risk of underproduction, because the financial compensation does not depend on the volume actually delivered (15). Selection in advance: expensive clients are excluded (15).	Low freedom of choice, because it is usually used in areas where the care is provided by one or a few healthcare providers (16).	Financial risk: maximised expenses by the municipality (16). May not determine results (16).
Result	+	May determine the result (16). Possibility to manage quality and innovation, because they ask healthcare providers to do what is necessary to achieve the result (15, 16). Innovation possible, because providers have the space to use new forms within the result agreements or to make combinations of different forms of support (16). Space and incentive for innovation in care organisations: possible within the result agreements (12, 20). Space and incentive for smart and efficient work: possible within the result agreement. Cost-reducing deployment per client (15, 20). Financial compensation is determined on the basis of results achieved (16). Customised care based on results, healthcare providers have the possibility to do what is necessary to achieve the result (20).	Has influence on both the result to be achieved and the content of the support (16). The municipality manages quality, because they ask healthcare providers to do what is necessary to achieve the result (15, 16). Customised care based on results, healthcare providers have the possibility to do what is necessary to achieve the result (20).	No obstruction of space to provide customised care :may determine how the result can be achieved with the most appropriate customised care (16, 20). Innovation possible, because providers have the space to use new forms within the result agreements or to make combinations of different forms of support (16). Space and incentive for innovation in care organisations: possible within the result agreement (12, 20). Space and incentive for smart and efficient work: possible within the result agreement. Cost-reducing deployment per client (15, 20). No financial risk: in most cases a fixed compensation (17).
	-	May not determine how the result can be achieved with the most appropriate support, but the municipality remains responsible (16). Selection in advance: expensive clients are excluded (15).	Selection in advance: expensive clients are excluded (15)	May not determine the result (16). Financial compensation is determined on the basis of results achieved (16).

Table 2: highlights advantages & disadvantages funding methods

Funding		Municipality	Client	Healthcare provider
Production	+	Degree of certainty in terms of products Degree of certainty in terms of tariffs Degree of determining performances	Freedom of choice	Degree of financial risk
	-	Degree of quality control Degree of innovation control Degree of customised care control Degree of freedom of choice control Degree of volume control Degree of financial risk Possibility on overproduction	Degree of determining performances Degree of customised care Quality level Freedom of choice	Degree of innovation control Degree of quality control Degree of freedom of choice control Degree of turnover guarantee Degree of determining performances Possibility on overproduction Degree of customised care control
Population	+	Degree of financial risk Degree of innovation control Degree of customised care control Degree of cost control Degree of determining performances Degree of determining results	Degree of customised care Quality level Cost level	Degree of customised care control Degree of innovation control
	-	Degree of quality control Possibility on underproduction Degree of freedom of choice control	Freedom of choice	Degree of volume competition Degree of financial risk Degree of determining performances Degree of determining results
Result	+	Degree of determining results Degree of quality control Degree of innovation control Degree of cost control Degree of financial risk Degree of customised care control	Degree of result control Quality level Degree of customised care	Degree of customised care control Degree of determining results Degree of innovation control Degree of cost control
	-	Degree of determining results Degree of freedom of choice control	Freedom of choice	Degree of determining results Degree of financial risk

Table 3: merged topics funding methods

	Abbr. Criterion	Criterion	Topic
1	Quality	Degree of quality control	Degree of quality control
2	Freedom of choice	Freedom of choice	Degree of freedom of choice control
			Freedom of choice
3	Financial security	Financial security in terms of volume, costs and rates/prices	Degree of volume control
			Degree of financial risk
			Degree of cost control
			Degree of turnover guarantee
			Degree of volume competition
			Cost level
			Degree of certainty in terms of products
			Degree in certainty in terms of tariffs
			Possibility of overproduction
			Possibility of underproduction
4	Innovation	Degree of innovation control	Degree of innovation control
5	Determining function	Degree of determining performances and results	Degree of determining performances
			Degree of determining results
6	Customised care	Degree of customised care control	Degree of customised care control

Appendix VII Interview overview

In Table 1 an overview of the interview topics regarding the requirements and wishes of stakeholders is provided. In Table 2 an overview of the interview topics regarding remaining functions is provided.

Table 1: interview topics stakeholders

		Municipalities - 2 contractmanagers	Municipalities - 1 front employee	Client council Wmo	Healthcare provider 1 - contractmanager	Healthcare provider 1 - front employee	Healthcare provider 2 - contractmanager	Healthcare provider 2 - front employee	Healthcare provider 3 - care manager
Purchasing procedures	Price control	x	x		x	x	x	x	x
	Quality control	x	x		x	x	x	x	x
	Innovation control	x	x		x	x	x	x	x
	Freedom of choice/diversity of providers	x	x	x	x	x	x	x	x
	Purchasing Act in force?	x	x		x	x	x	x	x
	Volume control	x	x		x	x	x	x	x
Funding methods	Customised care control	x	x	x	x	x	x	x	x
	Quality control	x	x	x					
	Financial Security	x	x		x	x	x	x	x
	Innovation control	x	x		x	x	x	x	x
	Determining function	x	x		x	x	x	x	x
Contract forms	Certainty	x	x		x	x	x	x	x
Type of result-oriented funding	Fixed amount per	x	x		x	x	x	x	x
Paying method	See section 5.2.2.5	x	x	x	x	x	x	x	x

Table 2: interview topics remaining functions

	Jan Telgen (also represents Niels Uenk)	Tim Robbe	Mayor Oude Ijsselstreek	Teamcoach	Policy officer Social Domain
Purchasing methods Social Domain	x	x			
Purchasing procedures Social Domain	x	x			
Funding methods Social Domain	x	x			
Contract forms Social Domain	x	x			
Result-oriented purchasing	x	x		x	x
Prosumer role client	x	x	x		

Appendix VIII Unreferenced respondent/stakeholder interviews

In Table 1 an overview of the unreferenced respondent/stakeholder interview is provided.

Table 1: unreferenced respondent/stakeholder interviews

Respondent letter	Respondent	Reference
A	Regional contract manager	Regional-contract-manager-municipality. What are the requirements and wishes of Social Domain Achterhoek when purchasing care for individual support? In: Meijer A, editor. 2019; unreferenced interview.
B	Contract manager municipality	Contract-manager-municipality. What are the requirements and wishes of Social Domain Achterhoek when purchasing care for individual support? In: Meijer A, editor. 2019; unreferenced interview.
C	Back office employee municipality	Backoffice-employee-municipality. What are the requirements and wishes of Social Domain Achterhoek when purchasing care for individual support? (municipality). In: Meijer A, editor. 2019; unreferenced interview.
D	Client council	Client-council. What are the requirements and wishes of clients when purchasing care for individual support? In: Meijer A, editor. 2019; unreferenced interview.
E	Project leader in client perspective	Project-leader. What are the requirements and wishes of clients when purchasing care for individual support? In: Meijer A, editor. 2019; unreferenced interview.
F	Contract manager healthcare provider 1	Contract-manager. What are the requirements and wishes of healthcare providers when purchasing care for individual support? (healthcare provider 1). In: Meijer A, editor. 2019; unreferenced interview.
G	Contract manager healthcare provider 2	Contract-manager. What are the requirements and wishes of healthcare providers when purchasing care for individual support? (healthcare provider 2). In: Meijer A, editor. 2019; unreferenced interview.
H	Healthcare manager healthcare provider 3	Healthcare-manager. What are the requirements and wishes of healthcare providers when purchasing care for individual support? (healthcare provider 3). In: Meijer A, editor. 2019; unreferenced interview.
I	Healthcare employee Wmo healthcare provider 1	Care-employee-Wmo. What are the requirements and wishes of healthcare providers when purchasing care for individual support? (healthcare provider 1). In: Meijer A, editor. 2019; unreferenced interview.
J	Healthcare employee Jw healthcare provider 1	Care-employee-Jw. What are the requirements and wishes of healthcare providers when purchasing care for individual support? (healthcare provider 1). In: Meijer A, editor. 2019; unreferenced interview.
K	Healthcare employee Wmo/Jw healthcare provider 2	Care-employee-Jw/Wmo. What are the requirements and wishes of healthcare providers when purchasing care for individual support? (healthcare provider 2). In: Meijer A, editor. 2019; unreferenced interview.