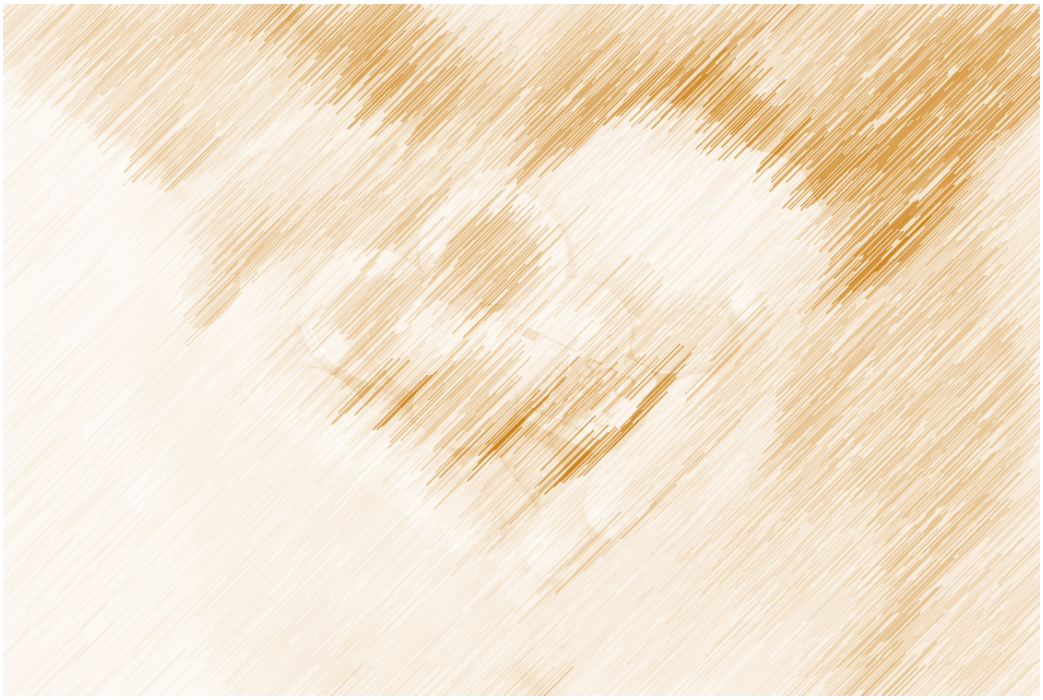
DECENTRALIZATION OF DUTCH SOCIAL CARE:

HOW THE OUTSOURCING OF SOCIAL CARE SERVICES BY MUNICIPALITIES AFFECTS THEIR POSSIBILITIES TO HANDLE THE RISKS POSED BY CONCEIVABLY ILL-INTENTIONED CARE PROVIDERS



By: Martijn IJzerman

Master Public Administration
Specialty: Sustainability

University of Twente:
First Supervisor: Dr. P.J. Klok
Second Supervisor: Prof. Dr. Ariana Need

Date: 8th February, 2022

ABSTRACT

Dutch municipalities have been responsible for social care services since 2015. The central government has only prescribed basic obligations and rules to municipalities, which led to the rise of different methods of organizing social care. It has become the norm to outsource social care to external providers, but over the past years there have been reports of ill-intentioned care providers who use public funds for their own good. The purpose of this study is to look at how the different approaches of outsourcing social care, taken by municipalities, influences their possibilities to handle risks that conceivably ill-intentioned care providers could pose.

Agency theory and social service triad form the theoretical background of this study. Regarding the gap in knowledge, risks in social service triad change when care providers are ill-intentioned. It is more difficult for municipalities to have a strong information position if there are numerous care provider and when client works together with the care provider.

Two forms of outsourcing are common in the Netherlands: Public procurement and open house. With public procurement, municipalities can be selective and have an exclusive contract with its care providers, whereas in open house there can be no selection of care providers if criteria are met, often leading to numerous care providers.

Four cases (32 municipalities) are compared by their (pre-)selection and monitoring phase, to see what the different approaches and possibilities to handle their risks are. Data is collected by having four interviews with experts on outsourcing social care services. Three cases use a form of open house, with the aim of giving the client freedom of choice and therefore settle for fewer selection and quality criteria options at the (pre-)selection stage. OZJT/Samen14, uses a barrier model where a risk indication is given to care providers. Zorgregio Midden-IJssel/ Oost-Veluwe uses a relational approach, in which there are multiple plenary negotiation sessions and a quality commission. Inkoop SDCG uses semi-open house, in which the window of registration is closed after the initial purchasing round. One case uses public procurement: Municipality of Utrecht, in which a partnership is built with its care providers. The importance of a long-term partnership between municipality and few care providers is a primary reason for being selective in their care providers.

Municipalities have different motivations for organizing their care in a particular way. If the choice is made for freedom of choice of the client, it is recommended to screen and monitor well. Public procurement seems the better option to handle their risks posed by ill-intentioned care providers, as a municipality can be selective in their care providers and strive for long-term relationships.

TABLE OF CONTENTS

1. INTRODUCTION

1.1 Background information

Since the introduction of the WMO regulations in 2015, municipalities' responsibilities in social care have expanded. Decentralization was implemented to provide better customization for clients' needs, less bureaucracy and to enable clients to live independently if possible (Rijksoverheid, 2015). This is done through two services, so-called care in kind (ZiN) or a personal budget (PGB). When providing ZiN, the support is provided by a care provider with whom the municipality has a contract or subsidy scheme. If a PGB is offered to a client, they can purchase care themselves (Ministerie van Volksgezondheid, Welzijn en Sport, 2021).

Over the past few years there have been reports of ill-intentioned care providers in the Dutch social care sector (Torre & Heijkoop, 2020). Care providers who willingly use public funding for their own good, declaring services without given the appropriate care to clients. Explicit figures are unavailable, but the costs are estimated at millions (VNG, n.d.). Some municipalities struggle with this illegitimate use of public funds (Informatie Knooppunt Zorgfraude, 2020). This research explores how municipalities organize their social care services and what effects is has for handling their risks posed by conceivably ill-intentioned care providers.

In the Netherlands, municipalities opt for complete outsourcing of social care services (Uenk & Taponen, 2020). The WMO 2015 regulations describe basic obligations and rights for this form of outsourcing of social care services, without giving a detailed procedure of services or contracting regulations (Fenger et al., 2016). Therefore, the regulations give freedom to municipalities in organizing social care services that fits their criteria. The implementation freedom led to different methods to outsourcing by municipalities (Pianoo, 2018).

Each approach to social care by municipalities can be divided in three phases (Li & Choi, 2009): The pre-selection phase (selecting an outsourcing method), selection phase (selecting and contracting care providers) and monitoring phase (monitoring care provider's behavior). Moreover, there are three methods to involve external parties (Pianoo, 2018), namely: Public procurement (tendering), subsidy (outsourcing is subsidized) and open house (open admission procedure for all interested providers). The methods are characterized in terms of possible quality requirements and selection mechanisms.

Due to decentralization municipalities are responsible in the role as financier, gatekeeper and enforcer. From a theoretical perspective, municipalities are part of a social service triad (Uenk & Telgen, 2019), in which the municipalities (Buyer) purchase care from

social care providers (Supplier) for the benefit of the client (End customer). This creates a distance between the municipality and the client receiving care. These social service triads face similar issues and risks as dyadic contractual service relations, such as opportunism, information asymmetry and goal incongruence (Uenk & Taponen, 2020). However, these challenges are inflated in social service triads as the buyer does not experience the service itself (Uenk & Telgen, 2019). This adds an additional challenge in monitoring and quality control in which the buyer needs to take measures to guarantee the service delivery and behavior of the supplier are appropriate (Van Iwaarden & Van Der Valk, 2013). Outsourcing social care services seems to have encouraged competitiveness in the market at the cost of increased risks both for the responsible government and the client (Rodrigues & Glendinning, 2015).

Typically, studies examine a dyadic contractual relationship between a private buyer and an individual supplier. Studies in which the buyer is a public body rather than a private organization are scarce (Uenk & Telgen, 2019). Moreover, these studies focus on the risks assuming care providers operate in good faith. As far as known, scholars have not addressed the risks involved in social service triads involving conceivably ill-intentioned care providers.

In recent years there has been research on ill-intentioned care providers in social care (Torre & Heijkoop, 2020), in which is mentioned that opportunities arise due to the selection procedures, quality requirements and monitoring of social care providers by municipalities. This goal of this research is to examine how the organization of social care by municipalities affects their possibilities to handle the risks posed by conceivably ill-intentioned care providers.

1.2 Research questions

To summarize: Dutch municipalities have been responsible for organizing social care since 2015 and outsource social care services to external care providers (Uenk & Taponen, 2020). Municipalities have the freedom to organize social care in their own way. The chosen method of outsourcing care is characterized by the possible quality criteria and selection options for municipalities (Pianoo, 2018). The outsourcing of social care is divided in three phases (Li & Choi, 2009): The pre-selection phase is the type of outsourcing method used. The selection phase consists of selecting and contracting care providers. The monitoring phase is how the municipality monitors the care provider's behavior. There are signs that there are opportunities for ill-intentioned care providers arise due to the selection procedures, quality requirements and monitoring by municipalities (Torre & Heijkoop, 2020).

Moreover, the municipality, care provider and client are part of a social service triad, which brings additional risks to outsourcing (Van Iwaarden & Van Der Valk, 2013). Studies

on these risks of outsourcing social care services are scarce and as far as known no research has been performed on the risks posed by ill-intentioned care providers.

The goal of this research is to examine how the options of organizing social care services by municipalities influences their possibilities to handle risks that potentially ill-intentioned care providers could pose. This raises the main research question:

- *'In what way does the outsourcing method of social care services by Dutch municipalities affect their possibilities to handle the risks posed by conceivably ill-intentioned care providers?'*

The first sub question explores the regulation WMO 2015 and how this gives freedom to municipalities to organize social care services and looks at the characteristics between the outsourcing methods.

1. 'What are the characteristics of the methods used by which Dutch municipalities organize their social care services?'

The second sub question explores scientific findings on the interactions between actors in social care and how these interactions change when incorporating risks posed by conceivably ill-intentioned care providers.

2. 'In what way could conceivably ill-intentioned care providers influence the dynamics and risks between the actors in the social service triad?'

The third sub question comes in play by analyzing and comparing the methods of municipalities and partnerships.

3. 'In what way do Dutch municipalities organize their social care services (pre-)selection and monitoring phase?

1.3 Societal and scientific relevance

By performing this research there is a scientific and societal benefit. The societal benefit revolves around the fact have been various reports addressing ill-intentioned care provider cases since 2015, with also media paying attention (Ark et al., n.d.). Moreover, on a societal level there are clients who are victimized and do not receive the care needed. This research attempts to contribute to by making municipalities aware that their options to deal with conceivably ill-intentioned care providers changes based on their outsourcing method.

This research attempts to contribute to the scientific literature by gaining knowledge on the risks of outsourcing social care services by municipalities. The current body of outsourcing literature predominately focuses on a dyadic relation between buyer and supplier. Less literature scrutinizes the relation in a triad: (public) buyer, supplier and end-customer and the provision of social care: social service triad. Furthermore, risks described in current literature do not include ill-intentioned actors. This research contributes to the literature by filling the gap incorporating risks posed by conceivably ill-intentioned actors into the social service triad.

1.4 Outline of the research

This research consists of desk and field research, studying the methods used by Dutch municipalities for outsourcing social care and how this affects their way to handle the risks posed by conceivably ill-intentioned care providers. The first part of the research sets out the background information by analyzing reports. This gives the needed context and understanding of the legal framework regarding social care in the Netherlands. By analyzing recent reports from government agencies and various researches, the first sub question is answered. Afterwards, scientific literature is used to find what scholars have been studying regarding the dynamics between actors in social care in relation to social care. The gap in knowledge and therefore the second sub question is answered by combining various theoretical implications found in public administration and criminology regarding outsourcing of social care and risks posed by conceivably ill-intentioned care providers. The third sub question consists of the organization of social care by four Dutch municipalities, analyzed by combining desk research with interviews.

1.5 Reading guide

The next chapter presents general background information on social care in the Netherlands. It describes the WMO 2015 act and shows what choices municipalities make in their procurement procedure. Subsequently, the theoretical framework reveals concepts and the gap in knowledge by performing a literature review regarding characteristics and dynamics between municipality, care provider and client, so called social service triads. The theoretical framework concludes by answering the second sub question, analyzing the change of implications given in research regarding social service triads risks when combined with subversive crime. The conceptual framework depicts the variables found in literature and in the first part of the study and their possible interaction. Then, the methodology explains how the variables are operationalized and measured. It explains the case selection, and how data is gathered and analyzed. The validity

and reliability of this research is also explained. Afterwards, the social care procurement practices of four cases are studied and compared. Then, the conclusion gives answer to the research question. Lastly, there is a discussion of the research.

2. APPROACHES TO SOCIAL CARE SERVICES

This chapter is concerned with the background information of social care and specifically WMO 2015 in the Netherlands. At first, an explanation on what social care in the Netherlands comprehends and the regulation of WMO 2015 is explored. Moreover, the choices municipalities have in their organization of social care is clarified and answering the first sub question: 'What are the characteristics of the methods used by which Dutch municipalities organize their social care services?'

2.1 Social care in the Netherlands

In the Netherlands social care services are intended for assisting individuals with who need care to participate in society and to increase their self-reliance (Ministerie van Algemene Zaken, 2021. Reasons for receiving such services are old age, disability, illness, or living in poverty. These services are mostly non-medical and range from simple tasks as cleaning, cooking shopping to light medical and nursing treatment: washing, getting dressed, giving medicines, day care or mental and psychiatric counseling. Five types of care are included in the classification of social care services (Wind & Uenk, 2020): domestic assistance, individual guidance and personal care, daytime activities, short term stay and protected housing. In the Netherlands these services are given via private social care providers. Typically, the municipality or a collective of municipalities outsources these tasks to the social care providers. The clients who fall under the social care receive this care from the social care providers and are therefore the end customers.

The situation described here, is the result of the WMO. Before 2015, regional offices managed by insurance agencies, contracted care providers through centrally prescribed procurement guides and standardization (VNG, 2014). Since the WMO 2015, all municipalities are responsible for providing social care to their citizens. All non-medical care (except nursing) is the responsibility of the municipalities. An important reason the central government gave the responsibilities to municipalities is the fact that, they are closer to citizens and therefore respond better to specific wishes and needs of their inhabitants. This should lead to: 'Appropriate support enabling people to carry out the general daily activities of life and to maintain a structured household (self-reliance)' (TK 2013/2014: 6). Moreover, the decentralization was

expected to lead to lower costs (Rijksoverheid, 2015). As an effect of the decentralization each municipality had to contract care providers. The municipalities have a great degree of freedom in organizing access to social care of their citizens and the procurement of the social care providers. For assessing the social care entitlements, often social community teams are implemented (Oude Vrielink, van der Kolk, & Klok, 2014). These social community teams are the gateway to social care services, for which the municipality contracts care providers. Similarly, there are no set rules in the public procurement procedure municipalities use in contracting providers, the type of contact, scope of contract, number of care providers, the way social care is reimbursed, the tariff structure, the choice of quality criteria, how care provider performance is monitored, et cetera (Uenk & Wind, 2020). Consequently, each municipality has made their own choices with respect to each of these dimensions.

Generally, to receive social care as a citizen, an application must be submitted. The citizen undergoes an assessment to determine the extent of the disability and which care needs to be arranged (Ministerie van Volksgezondheid, Welzijn en Sport, 2021b). The assessment results are then analyzed in which the citizen receives the appropriate social services: the type of service, the extent and quantity to which the service is performed. Social care sevices (WMO) is provided through general facilities, so-called persoonsgebonden budget (PGB) or Zorg in natura (ZiN) (Ministerie van Volksgezondheid, Welzijn en Sport, 2021a). If a PGB is provided to a client, they can purchase social care themselves. A client can use a PGB to purchase care provided by a professional care provider or by person from their own social network. The PGB is not further researched in this thesis. Municipalities have the choice to organize the service for ZiN themselves or use a contracted third party. In case the municipality chooses for outsourcing there are three different methods namely: government contract or public procurement, subsidy or open house (Pianoo, 2018). If a municipality decides on a public contract or open house there are different options for the selection of their care providers. Six options are distinguished in this research, based on handreiking aanbesteden (Pianoo, 2018): Negotiated procedure without prior publication, Open competitive procedure, Dynamic assignment model, Open non-competitive procedure, Dialogue based procedure and Open competitive negotiated procedure. More procurement options exist, but are currently unused (Wind & Uenk, 2020). After establishing the outsourcing method, municipalities choose in what way they want to organize their care. This includes the reimbursement method and contract form, but also the options the number of providers and municipal cooperation. Figure 1 shows a schematic overview of the process.

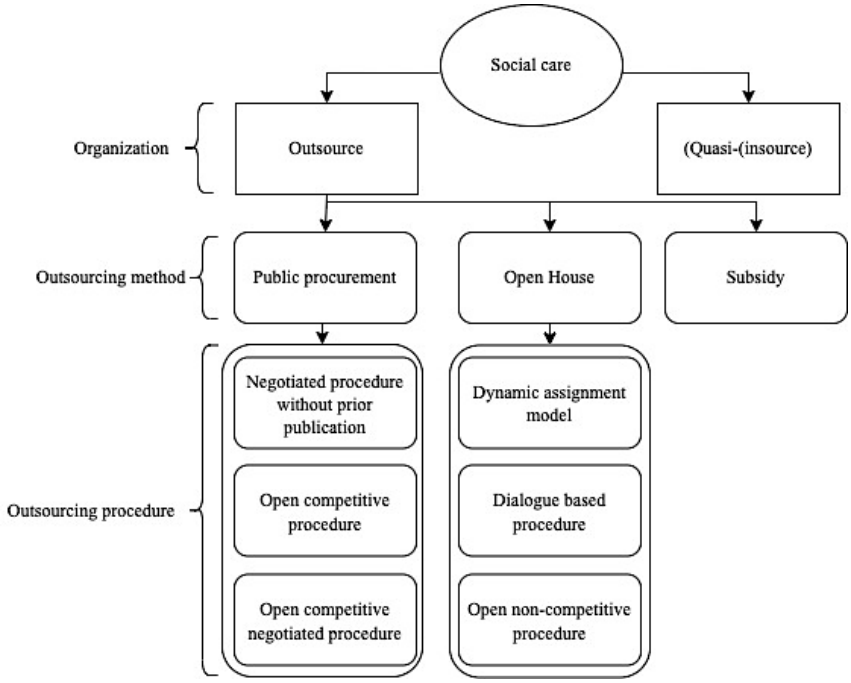


FIGURE 1 SCHEMATIC OVERVIEW SOCIAL CARE OPTIONS OF DUTCH MUNICIPALITIES, BASED ON HANDREIKING AANBESTEDEN (PIANOO, 2018).

2.2 Social service organization under social care under the WMO 2015

As mentioned in the last paragraph municipalities have several methods at their disposal to involve providers. As a municipality, the first choice is between carrying out the required activities themselves or outsourcing to providers. If they wish to carry out certain activities under own management, they can opt for insourcing. The services are in that case carried out from within the own municipal organization (insourcing) or by an affiliated public organization.

(Quasi-) inhouse provision

Dutch municipalities have several methods at their disposal in providing social care services. Municipalities can carry it out themselves or outsource their tasks. The WMO 2015 does not obstruct municipalities to perform the social care tasks themselves. Municipalities can hire employees to carry out the service. An example in this is municipalities deploy employees of social teams who judge access to the social care, avoiding conflicts of interest. Moreover, quasi-insourcing is possible by transferring the tasks to a separate legal entity, for example a foundation, where the municipality has full control over. In Finland, inhouse methods are popular (Uenk & Taponen, 2020). However, Dutch municipalities use other providers to perform tasks. In this case, there are three possible options for outsourcing.

Subsidy

A subsidy is when an administrative body provides financial resources to certain activities (Pianoo, 2018). Municipalities almost always provide subsidies in the social domain without a tendering procedure. Once the subsidy is in force, the municipality will provide every applicant who meets the conditions a subsidy. However, it is possible to use the subsidy method to include selection criteria for example, a ranking system. Also, when specifically selected care providers receive a subsidy there could be a case of unauthorized state aid. A disadvantage for the municipality is that there is no obligation agreement possible between the actors. If the recipient does not perform, the municipality can only reclaim the subsidy.

Public procurement

Public procurement takes place with a public contract is the form of a written agreement (Pianoo, 2018). This means that the contracting authority pays a fee for a service and can thus enforce performance of the service (Unlike a subsidy). The contractor provides the service and then has the right to the agreed compensation. European and national rules apply to the tender of public contracts: the European directive 2014/24/EU7, the Procurement Act 2012 with revisions as of April 2016.

This Act implemented rules and procedures for tendering for all public contracts by public or semi-public institutions in the Netherlands (Pianoo, 2018). This is based on four basic principles. First, there is the non-discrimination principle that states that no distinction should be made based on nationality. In addition, there is the principle of equal treatment of providers, who must give everyone the same way and give the same information. The third basic principle is transparency: providers must be able to gain insight into the tender and they must receive information about the tender from the incentives. The fourth principle is proportionality, whereby the requirements for the tender are in proportion to the activities and scope of the contract (Pianoo, 2020a).

Social care services are subject to an enlightened European and national regime tendering rule: not all rules apply to regular public contracts (Pianoo, 2018). The Procurement Act contains a special procedure assignments below €750,000: the procedure for social and other specific services (SAS procedure). This SAS procedure gives municipalities room for custom procurement procedures. In 2016 and 2018, the European Court of Justice delivered judgments that have consequences for the definition of the public contract. These judgments clarify that the government involved in the tendering of a public contract makes a choice from the tendering providers. The choice is made by choosing the provider that fits the tender criteria

best. According to Wind and Uenk (2020), municipalities often contract all care providers who fulfill the criteria their public procurement, which means the procedure is that of open house.

Open house method

The tendering procedures described above are all subject to the Public Procurement Act. Nevertheless, there is still a possibility to conclude enforceable contracts without the Public Procurement Act being applicable. Namely by setting up an Open House model. Open House is not a (legally prescribed) tendering procedure. It is a method of contracting that, under certain conditions, does not qualify as a public procurement within the meaning of tendering regulations. Municipalities can choose their own way of tending, even some used in public procurement, as long certain requirements are met (Pianoo, 2018). The municipality will conclude a framework agreement with each provider that qualifies and commits to the conditions. The municipality is still obliged to treat care providers in an equal, non-discriminatory manner and to publish the open house system. This often leads to many care providers having a contract. However, this contract does not offer a guarantee: the client ultimately chooses the care provider. Although, not all municipalities call their methods 'open house', they implicitly qualify as such. After all, the municipalities do not select care providers in the procurement procedure, and therefore do not comply with the core element of a public contract.

2.3 Outsourcing methods characteristics and their share in the Dutch situation

The table (1) below shows how each method's characteristics. Interesting here are the entry possibilities and exclusivity grounds involved around the open house method.

Characteristics	**Public procurement**	**Subsidy**	**Open house**
Freedom of choice for client	Depends on procurement procedure	Choice between interested providers	Choice between interested providers
Enforceability	Contractual agreement	Only reclaiming subsidy	Contractual agreement
Exclusivity and selectivity	Exclusive contract	No selection of care providers if criteria are met	No selection of care providers if criteria are met
Competition	Beforehand (Ex ante)	Afterwards (Post ante)	Afterwards (Post ante)

TABLE 1 SOCIAL CARE SERVICES OUTSOURCING METHODS AND THEIR CHARACTERISTICS

Outsourcing method	% of total	% of total corrected
(Quasi-) Inhouse	0%	0%
Public procurement	73%	8%
Subsidy	3%	3%
Open house	23%	87%
Unknown	0%	2%

TABLE 2 USE OF OUTSOURCING METHODS BY MUNICIPALTIES IN THE NETHERLANDS AS OF 2020 (UENK & WIND, 2020).

Table 2 gives an overview of which methods are used by Dutch municipalities. The first column is the percentage as given by the municipalities. However, as mentioned before, many municipalities use standard terms and conditions in their public contracts and all interested social care providers who meet the requirements are granted a framework agreement, effectively leading to open house. The second column is corrected to the percentage of municipalities being selective in their care providers. In this case, the percentage of open house increases to 87%.

2.4 Outsourcing procedure

The outsourcing methods subsidy, open house and public procurement have different outsourcing procedures to find and contract care providers. The outsourcing procedure includes the municipal activities and processes to award public contracts.

A subsidy often involves one-on-one contact between the municipality and a care provider. However, in open house and public procurement, outsourcing procedures (tendering) are used. When choosing for public procurement or open house, there are six different options for tendering. Uenk (2019) identified five tendering procedures by Dutch municipalities and their characteristics. According to Wind and Uenk (2020) a sixth procedure of dynamic assignment model is also seen. Two are public procurement (Open competitive negotiated procedure, open competitive procedure and four of which effectively lead to an open house structure (Negotiated procedure without prior publication, Open non-competitive procedure, Dialogue based procedure and Dynamic assignment model). Figure 2 shows a schematic overview of the procedures. On the x-axis competition refers to the way care providers compete which each other. Ex ante competition occurs during the procurement procedure, where care providers compete for a contract. Ex post competition occurs when competition takes place after the procurement procedure. Often municipalities offer framework contracts, where clients can choose from all contracted care providers This leads to competition between the care

providers after the procurement procedure called ex post. On the y-axis relation refers to how the procedure gives room building a trusting collaborative relationship between municipality and the care providers. With many contracted care providers, building a collaborative relationship with all seems unlikely, while contracting few care providers means a higher chance of building collaborative relationships.

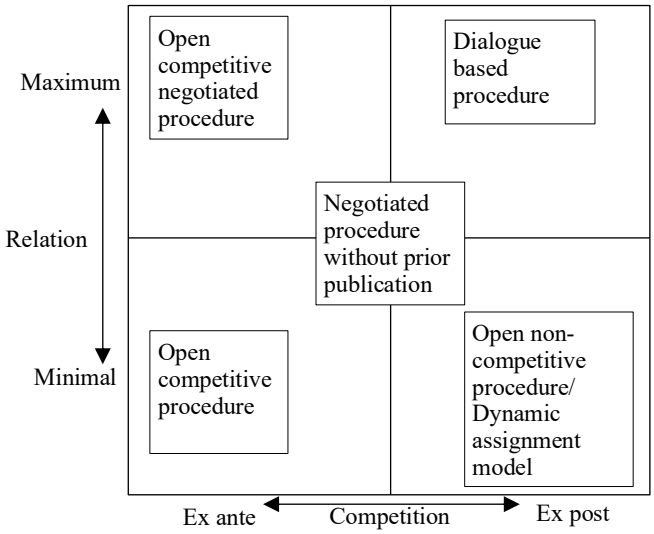


FIGURE 2 OUTSOURCING PROCEDURES BY DUTCH MUNICIPALITIES, BASED ON FRAMEWORK OF UENK (2019)

Negotiated procedure without prior publication

The negotiated procedure without prior publication is typically used in instances with a limited number of tenders. In this case the municipality invites a limited number of providers and grants the best tender(s) with contract. In this case there is limited ex post competition on contracts and care providers are not able to enter after the tendering.

Dynamic assignment model

The municipality goes through a completely digitally procedure to arrange framework contracts. The framework agreement has standard terms and conditions, requirements and rates for all parties. Within the framework agreement, the municipality awards individual assignments (the care for individual client). As framework contracts are granted, the dynamic assignment model leads to an open house structure.

Open competitive procedure

A commonly used procedure in the public procurement is the open competitive procedure. In here, municipalities publish their assignment with information on the specification of the

service, criteria and exclusion grounds. There are two ways in which municipalities use this procedure: The first is awarding a limited number of contracts to the providers with the best quality and price ratio, until the needs are fulfilled. The second is to grant every provider who meets the criteria a contract, but only give the best providers assignments.

Open competitive negotiated procedure

The open competitive negotiated procedure refers to municipalities granting interested parties a preliminary contract on an initial based offer and evaluating these on the award criteria. The best providers are then invited and both parties negotiate on the details of the contract. If there is no agreement in the negotiation phase, then the municipality revokes the preliminary award, and the second-best provider is invited.

Open non-competitive procedure

The open non-competitive procedure is also known as the 'Zeeuws' model. The municipality publishes certain criteria, such as the service specifications, conditions and minimal requirements. In the open non-competitive procedure, there is no ex-ante competition. Every care provider can get a framework agreement, if it meets the right criteria (Open house). The procedure has minimal administrative efforts: the care provider does not have to elaborately specify their services or their way of working. The requirement documents are also minimal: Accepting the terms and conditions, proof of formal registration and a quality plan suffice. However, a contract does not means having work. Clients choose which care providers they want and can switch. This results in ex post competition through clients.

Dialogue based procedure

The dialogue-based procedure is also called bestuurlijk aanbesteden (Before 2017). The dialogue-based procedure is characterized by the municipality having multiple negotiation sessions with interested care providers. Both municipality and care providers negotiate over the terms of the contract and results in a standardized framework agreement, that is obtainable by all interested and qualifying care provider (Open house). The care providers that join the process are then involved in a procurement network. This initial process contract can be seen as a formalized social contract as defined by John (1984): a micro-level agreement designed within an individual exchange relationship. It does not set the terms and agreements for the provision of social services but formalizes the intentions of entering a partnership between municipality and care providers in the procurement network. When finished other care

providers can get an agreement, by first joining the network. Typically, the framework agreement stays open for other to join and do not close. In dialogue-based agreements, contracts tent to have a longer term, sometimes being indefinite. A long term is considered a sign of investment in the procurement network and an indication of the intention of a lasting relationship.

Share of procurement procedures in 2020.

The table below shows what share each public procurement method had as of 2020, excluding subsidies.

Outsourcing method	Share
Negotiated procedure without prior publication	5%
Open competitive procedure	8%
Dynamic assignment model	5%
Open non-competitive procedure	25%
Dialogue based procedure	55%
Open competitive negotiated procedure	1%
Unknown	1%

TABLE 3 SHARE OF OUTSOURCING PROCEDURES IN 2020, ADAPTED FROM UENK & WIND (2020).

2.5 Contracting, number of providers and reimbursement forms

The contract form refers to the extent to which an agreement offers certainty for care providers. The framework agreement is used in 90% of the cases (Uenk & Taponen, 2020). Also, municipalities need to choose whether to work with few or numerous care providers. Moreover, municipalities have the choice to offer a fixed budget or have a budget ceiling. Both last two options are not used widely. Contract length varies between a one-year period to open-ended, averaging around four to five years. The way in which municipalities reimburse support largely determines the incentives and flexibility for social care providers. Two types of reimbursement can be distinguished: The first option is a fee-for-service reimbursement. There is a standardized tariff for each of the services and this tariff corresponds with, for example, one hour of service. Meaning providers are being reimbursed for their work (Uenk et al., 2018). The second option is an outcome-based model, in this model, each service corresponds with certain outcomes. These outcomes are mostly defined in advance in the contract. This model does not focus on the input delivered by providers, but on the outcomes that providers need to

achieve at the end of a certain period. The fee-for-service method is used in around 60% of the cases and reimbursement method around 40% (Uenk et al., 2018).

2.6 Municipal cooperation

Municipalities can purchase their social care themselves or work together with others. Around 90% of the municipalities work in cooperation with around three to four municipalities together. Moreover, there are small municipalities who procure alone and coalition of up to 13 municipalities (Uenk et al., 2018.)

2.7 Conclusion

This section explored the social care situation since 2015 and identified the choices that municipalities have in their social care provision under the WMO 2015. Therefore, answering sub question 1: 'What are the characteristics of the methods used by which Dutch municipalities organize their social care services?'

Dutch municipalities outsource their social care to private organizations and contract these care providers in various ways. Three outsourcing methods were identified being public procurement, subsidy and open house. The difference being freedom of choice for the client, the enforceability of the contract, the exclusivity and selectivity options and when the competition between providers takes place.

87% of outsourced social care services by Dutch municipalities qualifies under open house, in which possibilities for selection of care providers and the number of care providers in limited. All interested and qualifying care providers obtain a framework contract. There are six outsourcing procedures municipalities can select from when opting for public procurement and open house and the selected procedure implies whether the municipality can build strong relationships with providers and when competition between the care providers takes place (before of after contracting).

An overview of the choices that municipalities make in outsourcing social care services are found in figure 1.

3 THEORETICAL FRAMEWORK

The next chapter elaborates on the theory which is relevant on the topic of outsourcing social care services. The theoretical framework has two uses. The first being defining concept used in this research and second explaining the relation between these concepts. Moreover, there have been studies over the years examining dynamics between actors in the social care sector. This section provides an overview of the most important concepts, their relation and a theoretical discussion. This chapter discusses the perspective of principal and agent (3.1), the concept of social service triad (3.2), the risks involved regarding social service triad (3.3) and (3.4) Ill-intentioned risks in social service triads

3.1 Agency theory

In the buyer-supplier relationship, the client and the contractor may have partly conflicting interests. An understanding of these problems and appropriate ways of dealing with them in terms of contractual arrangements could be described by the agency theory (Eisenhardt, 1989). Agency theory deals with resolving two problems that could appear in agency relationships (for example a buyer-supplier relationship). The first agency problem occurs when the needs or ambitions of the principal and agent are conflicting, Also, it is challenging for the principal to verify how the agent is performing. The main problem is the principal, who is not able to confirm the agent has acted appropriately. Secondly, a problem of risk sharing occurs when the principal and agent both diverse attitudes toward risk. It could be that the principal and the agent favor diverse actions because risk preferences are different. Assumptions made in in agency theory are that of human nature (bounded rationality, self-interest, risk aversion), information (the commodity that can be purchased), and organizations.

This theory indicates a principal and agent have different risk preferences and different interests. The principal, in this case the municipalities, strives for quality, efficiency and the cheapest possible products. The agent, in this case the social care provider, wants certainty about the funding, to make profit, the volume of production and is somewhat more indifferent to the content of the services. This means that the provider may show an incentive for potential undesirable behavior, such as consciously offering more expensive or unauthorized forms of care and products. It may also be the case that providers do not refer to a cheaper alternative, offer lower quality care or deploy unqualified employees while receiving compensation as if qualified employees were being used. Agency theory often assumes there is only one agency and principal, whereas the relationship in this research consists of a triad.

3.2 Social service triads

The municipalities involved are part of a so-called social service triad. The municipalities purchase care from care providers for the benefit of its clients who need this care. This creates a distance between the buyer (municipality) and the client (citizen), whereby the challenge for municipalities lies in monitoring this process and checking the quality of the service provided by the care provider (Uenk & Telgen, 2018).

The literature on service triads often takes an agency theory perspective, translating to a specific service triad context. Studies on social service triads have their roots in supply chain management, in which triads are scrutinized in multiple contexts.

Managing the quality of purchased services and the suppliers delivering the services are among the highlighted issues in service buying in general (Axelsson & Wynstra, 2002). According to Van der Valk and Iwaarden (2011) these issues are magnified in service triads, where the receiver of the purchased service is not the buyer. The buyer contracts a supplier who then performs the service to the end customer. It is therefore necessary for the purchaser to take measures and ensure the service and behavior of the supplier is of adequate quality. Tate and van der Valk (2008) argue solely monitoring behavior and performance of providers is not enough. The purchaser must evaluate with its end-customers to identify their needs, as the information in social service triads is amplified, compared to regular buyer and supplier relations.

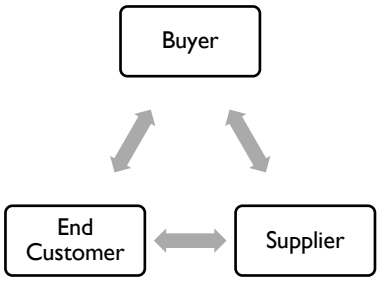


FIGURE 3 THE SERVICE TRIAD

Moreover, contribution on the literature on service triads are made by Li and Choi (2009), describing how the connections in the service triad are continues evolving. They define three stages of the service triad pointing at the connections between the three actors. The first stage encompasses the supplier and buyer having a contract, but the supplier does not offer services to the end-customer yet. The buyer is in a bridge position between the supplier and end customer. In this stage the so-called bridge position means having the superior information position, as the linking pin between the parties. In the second stage, the supplier starts to provide the service to the end customer and the information position of the buyer changes. This shifting of power position has direct effect on the contact between supplier and end customer,

which reduces the control and information of the buyer. The third stage is associated with a potential bridge transfer. In this case, the buyer loses the connection with its end customer and the supplier takes the position as linking pin, with the benefits to information and control as a result. When this happens, the buyer is not able to maintain in contact with the end-customer. This adds an additional challenge in monitoring and quality control in which the buyer needs to take measures to guarantee the service delivery and behavior of the supplier are appropriate (Van Iwaarden & Van Der Valk, 2013).

3.3 Buyer's risks in service triads

As mentioned before, there is a distance between the municipality, care provider and client as de municipality does not experience the service given by the care provider. There may be conflicting interests in the buyer-seller relationship. These opposing interests are thematized in the Agency Theory, according to Eisenhardt (1989), this rational choice theory starts from the assumption that the principal and the agent have different risk preferences and different interests. The principal, in this case the municipalities, strives for quality, efficiency and the cheapest possible products. The agent, in this case the social care provider, may show an urge to possibly undesirable behavior, such as fraud. An example of this is that the care provider can declare higher expenses for the delivered services. In the literature this behavior is often mentioned as opportunistic behavior of the agent. Buyers should therefore continuously monitor the provider's performance, provide close contact with its customers, and strive for a collaborative rather than an adversarial type of relationship with the supplier to minimize the risk of opportunistic behavior (Li & Choi, 2009). Brown and Potoski (2003) mention that effective contract management and continuous monitoring by purchasers should help prevent such opportunistic behavior among providers.

When looking at service triads, risks are magnified based on the relation between the actors described by Li and Choi (2009). Sengupta et al. (2018) catalogues different risks present in service triads. The risks that emerge from the structural and dynamic properties of the service triadic (Wynstra, Spring, & schoenherr, 2014) can be viewed because of the buyer's low control over the provider and limited insight into behavior of the provider and client and conflict of interests.

Risks in service triads according to Sengupta et al. (2018) include: dependency on the service provider, information asymmetry, conflict of interest, mismanagement of customer intelligence, incompetence, opportunism, reducing quality (shirking), misuse or breach of information and bypassing the buyer. Important for this research are service triads with a public

buyer. In here there is political risk and market risk meaning there is inadequate capacity and capability in the market for a certain type of service. Financial risks affect the municipality, while service quality risks directly influence the client receiving social care. When the care provider adopts the bridge, position mentioned by Li and Choi (2009), the care provider benefits of the information position. As a result, the public body is at risk of care provider ill-intentioned behavior. Scholars recommend the public body monitoring the care provider's behavior and performance and maintain strong connection with their clients and therefore in the triad, through social community teams (Tate et al., 2010; Uenk & Telgen, 2018). Moreover, Nätti et al (2014), mentions buyers should counter risks by striving for collaboration and trusting relations with their suppliers, establish social contracts (Van Der Valk & Van Iwaarden, 2011) and generate appropriate contracts that align with the goals of the public body and care providers.

To further counter the risks for a buyer in service triads, buyers can collaborate and build trusting relations with its suppliers (Li & Choi, 2009), establish social contracts (Van Der Valk & Van Iwaarden, 2011), align goals of public body and care providers by using the appropriate contracts (Tate et al., 2010; Van Der Valk & Van Iwaarden, 2011) and use appropriate incentives (Rossetti & Choi, 2008). In contexts where end-customers can choose between different service providers, imposing ex post competition by contracting multiple providers in parallel may also reduce supplier opportunism (Uenk and Telgen, 2018).

In the literature it is observed that maintaining collaborative relationships with suppliers is a key component, as is maintaining a strong position in the service triad (Li & Choi, 2009). For the buyer it is recommended to monitor the behavior or outcome of the supplier and the service provided (van der Valk & Van Iwaarden, 2011).

3.4 Ill-intentioned risks in social service triads

The gap in scientific knowledge occurs when the care provider and/or client are ill-intentioned actors. As mentioned before the risks for municipalities in social service triads stated in literature changes when incorporating ill-intentioned actors. Cressey (1950) mentions these actors making use of the opportunity arising from weak control systems and a low chance of being caught. While some risks may be similar, others are increasing. The risks in service triads mentioned by Sengupta et al. (2018) include dependency on the care provider and client bypassing. The care provider has direct connection with the client weakening the position of the municipality. This could lead to providers actively seeking and recruiting clients (Torre & Heijkoop, 2020). The care providers make use of the information asymmetry and have a

conflict of interest, increasing opportunism and make use of their information position spreading disinformation. The relatively effortless way new care providers can be established, and no competence register for care providers' employees (Torre & Heijkoop, 2020) results in an increased risk of incompetent employees and therefore reduced service quality (shirking) for clients. Moreover, the financial risk for the municipality increases, as the goal of ill-intentioned care provider is to disturb the integrity of economic life and institutions for financial gain (Spapens, 2019).

The mentioned counters to risks in social service triads as mentioned by the literature also changes. In the first phase of the procedure, municipalities decide on their way of outsourcing: public procurement, open house or subsidy. This changes in what way municipalities have a saying in which care providers are getting a contract. Moreover, it changes how the municipality can build a relationship with its care providers and how competition takes place. The mentioned counter by Nätti et al (2014) of collaboration and trusting relations with the providers and establish social contracts (Van Der Valk & Van Iwaarden, 2011) depends on the procurement and contracting method chosen by the municipality. In the open house method, all willing care providers who meet the criteria are granted a contract. This requires municipalities to use the best criteria possible to withhold ill-intentioned care providers.

In the second phase of contracting these care providers are granted a contract, the information position of the municipality changes. Especially in an open house structure establishing social contracts and trusting relationships is time consuming. Municipalities are unlikely to get to know all their contracted care providers well, which leads to a potential bridge transfer and worse information position for the municipality in the third phase (Li & Choi, 2009). Ill-intentioned care providers are often part of a network, consisting of care providers and clients (Torre & Heijkoop, 2020). Moreover, the mentioned ex post competition (Uenk & Telgen, 2018) by contracting multiple care providers, does not necessary lead to less opportunism by ill-intentioned care providers.

In the third, monitoring phase, the care provider's behavior and maintaining a strong connection with the clients (Tate et al., 2010; Uenk & Telgen, 2018) changes when the care provider and potential clients work together. The counter of a strong connection with their clients and therefore in the triad (Tate et al., 2010; Uenk & Telgen, 2018) is difficult when the clients are deliberately cooperating with the criminals. The incentive for clients to alarm the municipality on misbehaving of the care providers and therefore an essential part of monitoring decreases.

The risks mentioned by existing literature changes somewhat when incorporating ill-intentioned care providers in social service triads.

3.5 Conceptualizing the variables

This segment focuses on the importance of the different variables of the research. The conceptual framework shows an overview of the definitions needed to answer the research questions. The first column are the dimensions each municipality deals with that have influence on the possibilities for municipalities to handle their risks posed by conceivably ill-intentioned care providers. The dimensions are based of the phases described by Li and Choi (2009). The second column shows the factors in each dimension. These dimensions are based on chapter two and three.

Dimensions influencing the possibilities for municipalities to handle their risks posed by conceivably ill-intentioned care providers	Factors influencing the possibilities for municipalities to handle their risks posed by conceivably ill-intentioned care providers
First phase: Pre-selection	
1.1 Choice of social care organization by municipality	Municipal collaboration
	Public procurement
	Subsidy
	Open house
Second phase: Selection phase	
2.1 Ability to control selection and deny entry of care providers	Barriers such as quality criteria
	Type of contract such as framework agreement
	Gathering of information of care providers Information sharing between public bodies Difficulties in privacy legislation
	Way of contact: Digital or face to face
2.2 How competition takes place	Competition before contracting (Ex ante)
	Competition after contracting (Ex post)
2.3 The extent in which a municipality can build a relationship with the care providers	Influence having many contracts on relationship

	Influence having many contracts on relationship
Third phase: Monitoring stage	
3.1 Social service triad: Distance between municipality/care provider/client	Influence of social community teams Way of monitoring the care providers Channels for checking clients' satisfaction

FIGURE 3 CONCEPTUALIZATION OF OUTSOURCING SOCIAL CARE SERVICES BY MUNICIPALITIES TO HANDLE RISKS POSED BY CONCEIVABLY ILL-CONCEIVED CARE PROVIDERS.

4 METHODOLOGY

The first section (4.1) discusses the design of the research. The second section (4.2) shows the case and respondent selection. The fourth section (4.3) elaborates on what data will be collected and analyzed. The last section (4.4) elaborates on the validity and reliability of the research.

4.1 Research design

This study is of a qualitative design, in which desk and field research is combined to answer the research question. Firstly, chapter five focuses on the organization of social care in the Netherlands by comparing four municipalities, a comparative case study. It therefore answers the third sub question: 'In what way do Dutch municipalities organize their social care services (pre-)selection and monitoring phase? Semi-structured interviews with a topic list are used to gather clarification on these questions. Interviews are a good way to collect data in exploratory research. The researcher can obtain a lot of information through qualitative interviews about a particular subject (Boeije, 2005).

4.2 Case and respondent selection

Four semi-structured interviews were conducted to gather information from experts on the organization of social care. Four cases have been studied, with a total of 32 municipalities. For the selection of the cases a most-different system design is used. Each of the four cases has a way of outsourcing social care: Public procurement and open house. Subsidy is excluded because there is no contractual agreement in which municipality can steer the provider. To identify candidates for the research, the yearly inventory of municipal social care procurement by the Public Procurement Research Center (PPRC) was used (Ministerie van Volksgezondheid, Welzijn en Sport, 2021b). From here four areas were selected that differentiated in their organization of social care services: OZJT/Samen14: (Twente region), Zorgregio Midden-IJssel/Oost-Veluwe, Municipality of Utrecht and Inkoop sociaal domein Centraal Gelderland. The respondents were contacted by e-mail with the request of interviewing an expert on the purchasing practices of the municipality in relation with social care services. Appendix 2 shows the respondents and interview protocol. Four interviews have been held, with each municipality represented by one expert in purchasing of social care and in the case of Utrecht two experts. Table 4 shows the social care organization per case. From the six procurement methods mentioned in table 3, the open competitive negotiated procedure is not included in the cases.

TABLE 4 CHARACHTERISTICS OF SOCIAL CARE SERVICES BY EACH CASE

Cases	Social care service	Outsourcing method	Outsourcing procedure
OZJT/Samen14	Domestic assistance	Open house	Open competitive procedure
	Personal care	Open house	Dynamic assignment model
	Daytime activities	Open house	Dynamic assignment model
	Short term stay	Open house	Dynamic assignment model
	Protected housing	Subsidy	Subsidy
Zorgregio Midden-IJssel/Oost-Veluwe	Domestic assistance	Open house	Dialogue-based procedure
	Personal care,	Open house	Dialogue-based procedure
	Daytime activities	Open house	Dialogue-based procedure
	Short term stay	Open house	Dialogue-based procedure
	Protected housing	Open house	Dialogue-based procedure
Inkoop sociaal domein Centraal Gelderland	Domestic assistance	Open house	Open non-competitive procedure
	Personal care	Open house	Open non-competitive procedure
	Daytime activities	Open house	Open non-competitive procedure
	Short term stay	Open house	Open non-competitive procedure
	Protected housing	Open house	Open non-competitive procedure
Municipality of Utrecht	Domestic assistance	Public procurement	Open competitive negotiated procedure
	Personal care	Public procurement	Open competitive negotiated procedure
	Daytime activities	Public procurement	Open competitive negotiated procedure
	Short term stay	Public procurement	Open competitive negotiated procedure
	Protected housing	Public procurement	Open competitive negotiated procedure

4.3 Data collection and analysis

To investigate the context of this research and therefore answering the first and second sub question an analysis of policy documents and research reports was used. The policy and

research documents were found via internet by searching on the Dutch term zorgfraude and filtering on research reports published on government websites between 2020 and 2021. These reports were collected through January to March 2021. The aim of these reports was to get a clear understanding of the organization of social care by municipalities in the Netherlands and in which way social care fraud takes place. The research data was written down, summarized and associated with each other (Boeije, 2005).

The literature review revolved around desk research analyzing scientific papers on social care organization and risks involved. As, the theoretical framework suggested that risks in social care services changes when incorporating ill-intentioned care providers, various experts on social care services from municipalities were interviewed to find out how these municipality organize their social care services and how this way of organizing may facilitate or make it more difficult for conceivably ill-intentioned organizations. The topic list and related questions are attached in appendix 2.

Before the interviews could be conducted, permission had to be obtained from the Ethics Committee of the Faculty of BMS of the University of Twente. For any investigation where individuals are included, permission must be given by this committee. In this way, it can be verified whether obtaining, analyzing and storing the data of the respondents in an ethical manner. Only after the Ethics Committee had approved interviews were conducted. Since this study also included individuals, permission had to be requested in this case as well and was granted by the Ethics Commission request number: 210776. The interviews were finally transcribed and coded. The data retrieved through the document analysis and the interviews were also analyzed.

4.4 Validity and reliability of the research

To assess the research, it was evaluated by the validity and reliability. According to Babbie (2013), the validity can be determined by construct validity and content validity. The construct validity and content validity were covered by using indicators and measurements based on relevant earlier research on social care. Moreover, the reliability refers to the way in which the research could be repeated, given the proper measurements.

A possibility in measuring is when actors are asked questions that could be socially undesirable and therefore give a socially accepted answer. Therefore, information was gathered in a non-obstructive way.

To minimize the threats of internal validity, a mixed-method or triangulation approach was used. Both content analysis and interview data sources were used to confirm suggested

findings. The second factor is the external validity, which refers to the generalizations of the conclusions of this research and in which way they are useable in other situations. For this research, the findings are related to the situation to Dutch municipalities. Therefore, is only applicable to Dutch municipalities.

The reliability of the research suggests in what way the quality of the measurement method is adequate when the same data would be collected, and repeated research shows the same phenomena. For this, the same measurements must be used. In interviews, respondents were asked questions they certainly know the answer to and answers are coded. Also, there were certain checks, where questions were asked twice, but differently formulated.

5 SOCIAL CARE SERVICES MUNICIPALITIES

This chapter contains the characteristics of social care services between the four municipalities and answers sub question 3: 'In what way do Dutch municipalities organize their social care services (pre-)selection and monitoring phase? At first, the four municipalities are discussed individually, following a comparison between all four municipalities in the last section.

5.1 Twente Region

In the Twente region the organization for care and youth assistance is organized by OZJT/Samen14, which facilitates the purchasing, contract management, monitoring, and expertise of social and youth care for fourteen municipalities. For twelve of these municipalities, namely: Borne, Dinkelland, Enschede, Haaksbergen, Hellendoorn, Hengelo, Losser, Oldenzaal, Rijssen-Holten, Tubbergen, Twenterand en Wierden all social care services are performed by OZJT/Samen14. For the last two Hof van Twente and Almelo some care services are organized by themselves. The goal of this collaboration is better economies of scale and a healthier partnership with care providers. OZJT/Samen14 developed the barrier model which goal is to halt conceivably ill-intentioned care providers.

Pre-selection phase

OZJT/Samen14 has full responsibility for the organization for twelve of these municipalities, with Almelo and Hof van Twente organizing domestic assistance themselves. OZJT/Samen14 uses an open competitive procedure for the organization of domestic assistance. For personal care, daytime activities and short term stay the dynamic assignment model is used and protected housing is facilitated by subsidy. Both open competitive procedure and the dynamic assignment model are effectively an open house method, as qualifying care providers are granted a framework agreement. Domestic housing uses a subsidy method as this is specialized care with a small number of care providers. The focus in this section is on domestic assistance, personal care and daytime activities. A key factor for municipal collaboration is the central coordination of social care providers, as it is common for care providers to be active in more than one municipality. *'So that collaboration is on the Twente scale. This is necessary because supervision is organized at the municipalities, so locally, only the care providers sometimes work regionally, sometimes nationally'(L12).* Moreover, municipalities have insufficient time and employees to manage the social care provision own their own.

Selection phase

The open competitive procedure and dynamic assignment model are characterized by their restriction of denying care providers: an open house method. Care providers register digitally on published tenders via Negomatrix and all who adhere to the quality requirements are granted a preliminary contract. At this moment, around four hundred care providers are contracted and therefore having close relationship with each care provider seems unlikely.

To keep grip in the social service triad and counter the risks involved by open house, OZJT/Samen14 developed a barrier model. In the Twente region providers can register every six months and are examined on a set quality requirements. Based on the answers given during the registration, a risk assessment is made. OZJT/Samen14 uses a traffic light model to assess the risk of care providers: red meaning increased risk, orange slight risk and green means no risk. OZJT/Samen14 set stricter requirements during the last years. As shown in appendix 1, the assessment consists of twelve question concerning risk indications. Care providers are asked, among other things, financial questions on the ratio of their labor expenses to turnover and net margins before taxes. Moreover, the executive's relevant healthcare education and experiences are asked. Each of these twelve questions holds a weighting factor and ultimately gives the care provider a result. If an organization scores more than five, the result of the traffic light is red, and more investigation and monitoring is needed. OZJT/Samen14 uses multiple sources to assess a care provider such as publicly available information (news articles, websites) and official documents such as financial statements and personal data of the employees.

The open house method for most of the social care services was selected, as choice of care provider for the client is of importance, which results in ex post competition. *'The hunch is that the client has the freedom to choose who they take as a care provider. So, you can kind of see that competition happens after contracts are signed.'(L74).*

Monitoring phase

Municipalities are unlikely to get to know all their contracted care providers well in an open house method, which leads to a potential bridge transfer and worse information position for the municipality in the monitoring phase (Li and Choi, 2009). As displayed in the selection phase, the Twente region also uses the barrier model in the monitoring phase. The results of the question (red, orange, green) illustrate in a proactive way how monitoring takes place. Care providers who score poorly are monitored more frequently. Moreover, larger care providers are monitored periodically as these are of importance for the region due to their specialism and number of clients.

The literature shows that scholars recommend monitoring the care provider's behavior and performance through social community teams and maintaining a strong connection with clients. In the Twente region, most investigation into a care provider are through signals from the social community teams. When signals of ill-intentioned behavior appear through for example social community teams or the municipal website, action is taken in a reactive manner. Clients, care providers or citizens can report through neighborhood coaches, their care provider, the municipal front office, or send an email to OZJT/Samen14. However, there is no direct way of reporting incidents through the OZJT/Samen14 website.

When signals of fraudulent behavior occur a small investigation is started in which the care provider is asked for more information (personal qualifications, quality system, client files) and some follow-up question, in which the issue is solved. When a small investigation leads to a larger investigation or a more extensive investigation is needed, there will be desk research, to find out how large the issue is. The care provider will be asked information and multiple internal and external sources are consulted to get a picture of the care provider. This can be detailed information: working hours, statements of good conduct, care description, client's information. There will be conversations with care providers' representatives and the organization is visited. If severe issues, for example social care fraud are discovered, the contract will be terminated, and criminal prosecution takes place.

Conceivably ill-intentioned care providers

The literature showed concerning conceivably ill-intentioned care providers showed that certain measures against opportunism such as ex post competition (Having multiple care providers (Uenk & Telgen, 2018) or maintaining close relationship with clients could have different outcomes when incorporating subversive crime. This seems especially true in the case of an open house method. Contact between municipality and care provider are mostly indirect via a digital manner and clients could work together with ill-intentioned care providers, in which the care provider uses ghost care.

The Twente region therefore monitors certain factors regarding conceivably ill-intentioned care providers. One indicator is a high redemption rate, when a care providers declares more than forecasted. A second indicator is that the care provider's organizational structure is ambiguous and has certain connections with other (private) companies. A third indicator is that of a high profit rate of more than 10%. For the Twente region a rapid growth in the number of clients is an indicator that the care provider and client could be working together is. A rapid growth of clients is an indicator as the care provider would also need the personnel to adhere to the demand. Additionally, indicators are having multiple clients with a

homogenous cultural background or with high indications and care budgets. The Twente region is working on a project in which the goal is to prevent these care providers getting a contract and what indicators to look for.

On a regional level the Twente region works with the RIEC to prevent ill-intentioned care providers. Moreover, signals of ill-intentioned care providers are shared with the IKZ.

Conclusion

In conclusion the OZJT/Samen14 organizes the social care for most municipalities in the Twente region. Three forms of tendering have been identified: open competitive procedure, dynamic assignment model and subsidy. Both the open competitive procedure and dynamic assignment model result in an open housing structure which is characterized by the number of care providers, around 400 and the restrictions on denying care providers entry.

To maintain a strong position in the social care triad and stop ill-intentioned care providers from getting a contract the barrier model is used in the selection and monitoring phase. OZJT/Samen14 does not have the personnel to check each new care providers thoroughly, due to the number of care providers and therefore uses the barrier model. In the selection phase, care providers receive a color based on their risk, which is acquired by their registration documents and organization characteristics. It is of importance to articulate that not all information can be obtained in the selection phase. After the care provider receive a contract, OZJT/Samen14 keeps track in the monitoring phase in a proactive and reactive manner. The barrier model result and size of the care provider matters in the frequency they are checked. Most reactive action is taken by signals of fraud through social community teams and could lead to contract termination and criminal prosecution. When it comes to conceivably ill-intentioned care providers, the Twente region keeps track on certain factors: vague organization structure, high redemption rate, high profits, rapid growth and characteristics of the clients. Moreover, on a regional level the Twente region works with the RIEC and IKZ on a regional and national level.

5.2 Zorgregio Midden-IJssel/Oost-Veluwe

The zorgregio Midden-IJssel/Oost-Veluwe is a collaboration of the municipalities of Apeldoorn, Brummen, Epe, Hattem, Heerde, Lochem, Voorst en Zutphen. The collaboration is responsible for the purchasing, monitoring, account management and contract management of social and youth care of the eight municipalities. The collaboration for social care services stems from the mandatory youth care regions formed in 2015 (VNG, 2017).

Pre-selection phase

Zorgregio Midden-IJssel/Oost-Veluwe uses a dialogue-based procedure in their organization of social care. The dialogue-based procedure or Bestuurlijk aanbesteden is characterized by having negotiation sessions with interested care providers which results in a framework agreement and the care providers being part of procurement network. The framework agreement is obtainable by all qualifying care provider and typically the window of registering does not close.

For Zorgregio Midden-IJssel/Oost-Veluwe the dialogue-bases procedure is used in all their social and youth care services. Plenary consultation sessions, both physically and digitally, with interested large, medium-sized and smaller care providers are organized to settle on (framework) agreements. The open house method resulted in over 500 care providers, with the primary reasoning being the freedom of choice for the client. Zorgregio Midden-IJssel/Oost-Veluwe is looking into having less care providers as there is a national trend to have few contracted care providers. For instance, entering a strategic partnership with a group of providers and change the care provision that allows to have a few care providers. *'On the contrary, there are developments to fewer providers, even though we have quite a lot of providers. We have over 550 care providers.'* (L177).

Selection phase

As mentioned before, due to the open house method, interested care providers can register and receive a preliminary contract if quality criteria are met. To keep the registration process in check, each new care provider is considered by a quality commission of Zorgregio Midden-IJssel/Oost-Veluwe. This commission consists of persons from multiple backgrounds such as: legal, supervision and enforcement and social community teams. The commission inspects the characteristics of the care provider and assesses delivered information. There are checks on location of the organization, employees having the right qualifications and if the administrator has other businesses. Quality requirements for care providers are separated in administrative requirements: having a quality certification system, must be affiliated with a professional association, certificate of conduct (vog). Moreover, the care provider must provide an organogram of the organization. The second set of requirements are financial: having no negative results in the last three years, present annual reports and an auditor's report. It occurs that care providers refuse to deliver certain information are denied granted a contract. Based on the information the quality commission evaluates the care provider and if admitted decides the amount of monitoring is needed. The client decides what care provider to engage with and therefore competition between care providers takes place after the procurement phase. Due to

the number of care providers, Zorgregio Midden-IJssel/Oost-Veluwe cannot have a close relationship with each care provider.

Monitoring phase

The monitoring of social care is organized on a regional level since 1st January 2019. Zorgregio Midden-IJssel/Oost-Veluwe and the GGD monitor the quality and legitimacy of the care providers in a proactive, reactive and thematic (checking one criteria) manner. The quality commission decides the extent of monitoring needed for the care provider. The assessment framework is a tool used in monitoring care providers. Certain checks on the effectiveness, efficiency, client orientation, safety and expertise of staff are checked. The way in which quality criteria are tested consists of:

Conversations with clients, management, employees	Check certification and read most recent audit report
Employee file research (vog, education)	Observations
Document analysis (regulations	Conversations with loved ones, counselors, collaborating organizations, volunteers etc.
View intranet, registration system incident reports	View website

Research is being conducted by several regional supervisors. In 2020, Zorgregio Midden-IJssel/Oost-Veluwe examined around 40 care providers. Where shortcomings have been identified and safety is not an issue, the care provider is given the opportunity to make an improvement plan. Where serious shortcomings are found and client safety is at stake, the supervisor discusses this with the municipality(ies) involved and can immediately act. Around 60% of the monitoring is proactive and 40% is reactive in response to a signal.

Care providers are obliged to report calamities and incidents to the municipality. In Zorgregio Midden-IJssel/Oost-Veluwe the GGD is issued with the task to assess incoming reports and contacts relevant providers and instances. Firstly, the care provider is instructed to a self-examination around the issue and has eight weeks to report back to the GGD. The GGD assesses whether the issue is sufficient examined. In exceptional cases, the GGD carries out the investigation into the issue itself. Moreover, sometimes signals arise that question the quality of the care provider. These signals can come from various channels, such as the website of the GGD or the social community teams. Often one signal about a provider does not lead to an investigation, as investigation is labor-intensive. If there are multiple signals action is taken

and there will be a multidisciplinary consideration in whether to investigate. When conducting a signal-driven investigation, it is assessed whether the care provider is in accordance with the (quality) requirements set in the legal and contract frameworks.

Conceivably ill-intentioned care providers

As Zorgregio Midden-IJssel/Oost-Veluwe has many care providers, there is a higher chance of conceivably ill-intentioned care providers. To counter this Zorgregio Midden-IJssel/Oost-Veluwe participates monthly in the local case consultation on undermining and subversive crime in of the municipality Apeldoorn. The RIEC and police are included discussing cases. In the last year, Zorgregio Midden-IJssel/Oost-Veluwe sought corporation on a regional and national level with actors, such as: RIEC, the VNG (association of all Dutch municipalities), the IKZ and Nza (Dutch care authority).

Conclusion

Zorgregio Midden-IJssel/Oost-Veluwe uses the dialogue-based procedure in the organization of social care services. This procedure is characterized by a framework agreement formed in sessions with multiple care provider. The framework agreement is obtainable by all interested care providers who meet the quality criteria and therefore Zorgregio Midden-IJssel/Oost-Veluwe select what care providers to admit and deny bases of other conditions. Newly registered care providers are evaluated by multidisciplinary quality commission. Furthermore, the open house method results in over 500 care providers in which the client has the freedom of choice. The number of care providers influence the way monitoring takes place: The quality commission decides the extent of monitoring needed for the care provider bases on their delivered information. Zorgregio Midden-IJssel/Oost-Veluwe uses the assessment framework to monitor care provider and checks the effectiveness, efficiency, client orientation, safety and expertise of staff. Moreover, reactive action is taken bases on signals from various channels, such as the website of the GGD or the social community teams. Lastly, there is a monthly consultation in which multiple agencies are gathered discussing cases of conceviably ill-intentioned care providers.

5.3 Inkoop sociaal domein Centraal Gelderland

Inkoop social domein Centraal Gelderland (inkoop SDCG) provides the organization of social care for eleven municipalities: Arnhem, Doesburg, Duiven, Lingewaard, Overbetuwe, Renkum, Rheden, Rozendaal, Wageningen, Westervoort and Zevenaar. The Inkoop SDCG is part of the MGR SDCG, an overarching collaboration in the social domain which goal is having an effective and efficient cooperation.

Pre-selection phase

The open non-competitive procedure for social care has been selected in the area. From the theory it seems that this method of procurement, also known as the 'Zeeuws' model, is characterized by its open house method. Each care provider gets a framework agreement if it meets the criteria and the procedure has minimal administrative efforts.

The Inkoop SDCG selected the open non-competitive for all social care services to give the client the freedom of choice in getting a care provider. Typically, the open house method leads to having many care providers. Inkoop SDCG has initial purchasing rounds, without possibility to register between these rounds, resulting in a manageable number of care providers. Although, Inkoop SDCG lowered their number of care providers from 900, the number of care providers is still around 400. The window for new registrations is closed, unless the collaborating municipalities decide to open the admission procedure. *'Eventually, you will get a network of care providers.'(L528)*. Therefore, the method of Inkoop SDCG can be labelled as semi-open house.

Selection phase

The selection phase is clarified based on the purchasing round from 2020 (Inkoop SDCG, 2019a). First, care providers are checked by contract management on the completeness of registration: Chamber of Commerce registration and if the Uniform Europees Aanbestedingsdocument (UEA) is filled in correctly. Moreover, certain validity checks are done based on risk indicators: Organization structure, location and addresses of care provider, foreign or domestic care provider and googling on the name of the organization and director. If successful, the care provider is granted a preliminary contract and can provide service to clients.

Afterwards, the care provider offers supporting documents that are checked by contract management on the quality requirements. These quality requirements involve the provider's quality system, procedures and protocols, searching the website. Furthermore, the qualifications and certificate of conduct (vog) of personal is checked. Additionally, there are checks on the financial situation such as the insurance, an auditor's report and annual statements.

Lastly, there is a verification call between the quality commission and care provider. The commission consists of three members: a relation manager, a policy officer of a municipality and a social care councilor. The quality commission assesses the quality system certification and there is discussion about the plan of action, the quality requirements and how the care provider plans to succeed. Furthermore, the quality commission pays attention to

suspicious aspects: the building in which the care takes place, conflict of interests, vague answers, or having incorrect experiences with other municipalities. If the conclusion of the quality commission is positive the care provider is granted a definitive contract and the monitoring starts.

Monitoring phase

Monitoring on quality and legitimacy of care providers and their services takes place in a reactive and proactive way (Inkoop SDCG, 2019b). Reactive action is bases on signals or calamities and proactive based on a so-called quick scan and trimester discussions. According to respondent 3 the monitoring process is in development when it comes to monitoring the legitimacy of care providers.

Clients, care providers, citizens or others can report quality or legitimacy signals through de website or contacting Inkoop SDCG, their municipality or via the social community teams. These signals are registered in a database called Vendorlink. At first, signals will be discussed with the care provider and typically the local councilor resolves the situation. If the situation is alarming a relation manager of Inkoop SDCG handles the situation and legitimacy, quality or calamity enforcers are informed. A task of the quality commission is to follow trends and developments in the area.

Proactive ways of monitoring are the trimester discussions and quick scan. The trimester discussions are yearly conversation with a care provider and the municipality, local counselor, contract manager and a relation manager. Topics are the financial results, quality situation and overall situation of the company. The quick scan, which is performed by the quality manager, is performed once every three years at one third of the contracted and the newly contracted care providers. After three years all care providers are scanned once. The aim of this quick scan is to estimate whether a full quality investigation is necessary. The quick scan contains a check if a trimester discussion took place, the number of signals and calamities, a visit to the care provider, conversation with an employee and a check on certain documents. Moreover, Inkoop SDCG experiments with other ways of monitoring. For example, the barrier model from the Twente region to use risk indicator to give each care provider a color and an app for clients in which they can give feedback or report issues.

Conceivably ill-intentioned care providers

Inkoop SDCG is part of Samen Weerbaar to be more resilient to ill-intentioned care providers in social care. This collaboration between the province Gelderland, the municipalities, police, Public Prosecution Service, RIEC Oost-Nederland work together on a strategic approach in battling undermining activities. Together a handboek aanpak zorgfraude has been developed

with guidelines and a checklist to prevent, control and repress social care fraud (Samen Weerbaar, 2021).

Conclusion

Inkoop SDCG uses the open non-competitive procedure in their social care services. The framework agreement is obtainable by all interested care providers who meet the quality criteria and thus a few selection possibilities for the Inkoop SDCG. To limit the number of care providers the window of registering is closed after the purchasing rounds and opened on initiative of a municipality's needs. In the selection phase care providers are checked on their completeness of registration and granted a preliminary contract and can provide service. Afterwards, supporting documents and requirements are checked and a verification call between quality commission and care provider results in a definitive contract. The monitoring of care providers takes a reactive approach through signals registered in a database. The proactive approach of monitoring consists of a trimester conversation and a quick scan in which the care provider is scrutinized whether full investigations is needed. Moreover, Inkoop SDCG experiments with multiple other ways of monitoring. Lastly, to be more resilient, there is a regional collaboration called Samen Weerbaar, which developed a manual on the approach to prevent ill-intentioned behavior by care providers.

5.4 Municipality of Utrecht

Utrecht acts as municipality individually in the provisioning of social care service. Contracts for personal care, daytime activities, short term stay and protected housing started in 2020, with domestic assistance contracts starting in 2022. The procurement process is a variant of the open competitive negotiated procedure characterized by having limited care providers with maximum relationship and minimum post competition.

Pre-selection phase

In the pre-selection phase, the municipality of Utrecht decided on having a limited number of care providers as an open house method results in the municipality not having the lead after contracting a care provider. '*Then we as a municipality, when you have the contract in place, are no longer in the lead, because the client chooses and we have no say in that.'(L384).* There was a form of open house in the past, as the municipality realized there few care providers active. Moreover, in the selection phase there is room for contribution of residents and their families. The involvement of residents is in the selection phase is unusual and based on the Utrecht care model (Gemeente Utrecht, 2018). This model has the ambition to organize social care in which the self-reliance of the residents and clients is central. For the tendering procedure personal responsibility and room for decisions by professionals is key. The municipality sees care providers as partners and therefore offers long term contracts of initial three years, plus three times a two-year extension with a of total nine years.

Selection phase

The municipality has tried to make the tendering process as accessible as possible for the providers (Vindplaats Inkoop Sociaal Domein, 2020). There are multiple information sessions in which the tendering process is clarified and questions from care providers are answered. Depending on the social care services registering is possible via Tenderned or email. The municipality set award criteria with each having a weighting factor. The care provider provides a motivation paper on each of the award criteria that is then assessed by the municipality. For instance, personal care has the following three award criteria:

Award criteria	Weighting factor
Quality of service	40%
Collaboration	30%
Organization and personnel	30%

In the assessment procedure the municipality checks if the Uniform Europees Aanbestedingsdocument is filled in correctly and there are no grounds of exclusion. As the municipality of Utrecht uses an official procurement method the law Bibob applies in which the municipality can check whether the care provider has had fraudulent behavior in that past. Moreover, official documents (Financial, personnel certifications) and references are asked.

Afterwards, the municipality assesses the registration on the award criteria and comes with a score based on a predetermined point scale. For the award criteria quality of service, the advice of clients was included. After assessing the award criteria, the municipality invites tenderers for an interview in which the registration is further clarified. Based on all available information, the procurement commission comes with an overall assessment and ranking of the care providers. The entries with the highest total score are granted the contract. This results in around fifty of care providers instead of hundreds.

Monitoring phase

The guiding principles of the Utrecht model are used in the monitoring of quality and legitimacy (Gemeente Utrecht, 2019). From the clients and citizens there are various measuring methods, such as: client or citizens experience survey and information from the iWmo, an information standard that provides insight into the data flows between municipalities and care providers. Utrecht makes use of a data-driven control set up. Information is made available from various sources such as the iWmo, the (quarterly) reports of the neighborhood teams, complaint registrations, waiting list registrations and results of surveys.

Complaints of clients are via the following channels:

- Verbally with the neighborhood team
- Digitally via the website
- By telephone with the social community team or at the municipal WMO counter.
- In writing, via a notification form made available for this purpose, to the neighborhood team.

Conceivably ill-intentioned care providers

At the municipality of Utrecht, they are mainly concerned with undermining. There is a central, cross-domain approach, in collaboration with various local, regional and national authorities If fraud is suspected, Utrecht works with the blue sector. Such as the Ministry, Public Prosecution Service, the police.

Conclusion

Utrecht acts individually in their organization of social care service. The procurement method is characterized by the selective nature, having limited care providers and a maximum relationship with the care providers. In the selection phase care providers and municipality have contact and clients are involved in the selection procedure. Moreover, the monitoring phase is characterized by the partnership between municipality and care provider.

5.5 Comparison

The goal of this section was to answer the sub question: 'In what way do Dutch municipalities organize their social care services (pre-)selection and monitoring phase?

The four cases each have a distinctive way of organizing their social care and their approach on preventing ill-intentioned care providers. The procurement procedure results into what way and extent municipalities can take measures to handle their risks posed by conceivably ill-intentioned care providers. Three cases are characterized by their open house method: Having limited selection options as all registering care providers who meet the criteria are allowed a framework agreement and the competition taking place after the contracting phase (Ex post). These cases are all three a collaboration between municipalities, namely: OZJT/Samen14, Zorgregio Midden-IJssel/Oost-Veluwe and Inkoop SDCG.

The following figure shows an overview of the cases' relation with care providers and when competition takes place.

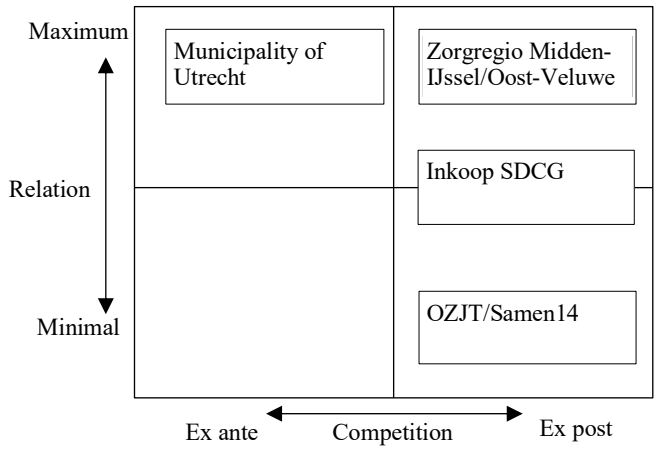


FIGURE 4 OUTSOURCING PROCEDURES OF THE FOUR CASES REGARDING THE RELATION AND COMPETITION

The collaborations have their differences in the (pre-)selection and monitoring phase to keep a strong position in the social service triad. Starting with OZJT/Samen14 the barrier model prevents fraudulent care providers from being awarded a contract. Care providers who submit a tender for providing social care services do this digitally, where a risk indication is made by the commissioner, bases on delivered and obtainable information.

Contrary to the minimal relation approach of the Twente region, Zorgregio Midden-IJssel/Oost-Veluwe uses a relational approach, with multiple plenary negotiation sessions. Interested care providers and commissioners come up with a framework agreement and form a network. In the selection phase a quality commission that assesses each care provider before granting a definitive contract.

Similarly, Inkoop SDCG uses a quality commission before granting contracts. In this area, there is a semi-open house method. Interested care providers can register in the initial purchasing stage, but the window of registration is then closed, resulting in less care providers. Inkoop SDCG can therefore build a relationship with these care providers in the monitoring phase.

From the examined cases, the municipality of Utrecht acts exclusively as an individual municipality in the organization of social care services. The organization is in contrast with open house: There is an exclusive contract with few selected care providers that have competition before contracting (Ex ante). Moreover, clients and citizens are involved in the selection procedure and contracted care providers are seen as partners by building trusting relationships. In this way, the municipality has a good information position and therefore strong ties in the social service triad (Li & Choi, 2009).

In conclusion, each case has a different approach to organizing social care. The methods chosen restricts municipalities in certain ways and therefore there are different methods in the (pre-)selection and monitoring phases. The cases using open house must take more measures in monitoring care providers behavior to keep a strong information position in the social service triad. In contrary, when having few providers, it is simpler to build a relationship with the care providers and therefore less monitoring is needed, at the cost of reduced freedom of choice for the client. Municipalities have different motivations for organizing their care in a particular way. If the choice is made for freedom of choice of the client, it is recommended to screen and monitor well. The main goal of municipalities is not always to mitigate risks, but public procurement seems the better option to handle their risks posed by ill-intentioned care providers, as a municipality can be selective in their care providers.

6 CONCLUSION

In the conclusion the research question (6.1) is answered.

6.1 Research question

This research sat out to answer the question: 'In what way does the outsourcing method of social care services by Dutch municipalities affect their possibilities to handle the risks posed by conceivably ill-intentioned care providers?' This section answers the question based on the results of the previous chapters.

For this study, a literature review has been performed and interviews were conducted, to identify how municipalities formalize their social care services to handle their risks posed by conceivably ill-intentioned care providers. Results of the combined desk and field research show that each municipality has their own design in outsourcing social care services and use different arguments for selecting these social care services. Therefore, it is not possible to give an unambiguous answer to the research question.

What emerges from the results is outsourcing social care services encompasses three phases, the pre-selection, selection and monitoring phase. The outsourcing method results in how selective a municipality can be in contracting care providers, the intimacy of the relationship and when competition between care providers takes place. Three out of the four cases (OZJT/Samen14, Zorgregio Midden-IJssel/Oost-Veluwe, Inkoop SDCG) opted for open house as method and are characterized by having numerous care providers. The three cases mentioned that the client's freedom of choice of care provider as a key argument for ex post competition and therefore settle for fewer selection and quality criteria options at the (pre-)selection stage.

As these cases have many contracted care providers, monitoring is intensive. The three cases have a different method to screen and filter out conceivably ill-intentioned care providers. OZJT/Samen14 developed its barrier model, giving a risk classification to each care provider. Zorgregio Midden-IJssel/Oost-Veluwe makes use of relational approach, using a quality commission and having a dialogue with care providers. Similarly, Inkoop SDCG uses a quality commission, but rarely opens the window for new registrations. On the other hand, the municipality of Utrecht opted for public procurement and ex ante competition. The importance of a long-term partnership between municipality and few care providers is a primary reason for being selective in their care providers.

7 DISCUSSION

This chapter contains the discussion on the results of the research (7.1), the recommendations are given (7.2), the scientific and practical implications (7.3) and possible future research (7.4). Furthermore, the limitations of the research are discussed (7.5).

7.1 Discussion of results

As the research progressed it became clear that there is no one size fits all approach to the organization of social care services. The social domain is a dynamic environment and as the social care services are subject to enlightened European and national regime tendering rules, trends and regulations change frequently. Moreover, municipalities make their own assessment on how they organize their social care services. Preventing conceivably ill-intentioned care providers does not always carry the same weight at municipalities in the consideration of social care services, as some municipalities prioritize other factors such as client's freedom of choice. Besides, theory suggests that imposing ex post competition by contracting multiple providers in parallel may reduce supplier opportunism in ordinary situations (Uenk & Telgen, 2018). In the past six years, municipalities focussed on the continuity of social care and conceivably ill-intentioned care providers seemed to be relatively small issue.

However, in the last few years there has been more attention for the actors in social care and municipalities are more aware of the subject. Criminals make use of the possibilities offered by the government and other established institutions.

Indirect contact in the selection and monitoring phase, results in a complicated information position for municipalities. Around two third of the municipalities are now connected to the IKZ and RIEC. The sharing of ill-intentioned behaviour signals and a joint approach, on a regional and national level, leads to a better information position for the municipality.

Regarding the gap in knowledge, risks in social service triad change when care providers are ill-intentioned. It is more difficult for municipalities to have a strong information position. There is an increased risk of dependency on the care provider and client bypassing, as ill-intentioned care providers have a direct connection with the client. The incentive for clients to alarm the municipality on misbehaving of the care providers and therefore an essential part of monitoring decreases. Moreover, an open house method results in many care providers, making it harder to establish social contracts and trusting relationships. Additionally,

the mentioned ex post competition by contracting multiple care providers, does not necessary lead to less opportunism by ill-intentioned care providers. Municipalities have different motivations for organizing their care in a particular way. If the choice is made to have open house there is more freedom of choice of the client, but the municipality has to screen and monitor well. If a municipality strives for a more long-term relationship, public procurement would be the better option Public procurement seems the better option to handle their risks posed by ill-intentioned care providers, as a municipality can be selective in their care providers.

7.2 Recommendations

Bases on this research a few recommendations are given. The recommendations are based on best practices of the examined cases.

1. Limit the number of contracts by setting strict admission requirements

In the research we find that most Dutch municipalities use an open house method in their outsourcing of social care services. The open house method is characterized by an unlimited number of providers to be contracted. This means that a municipality can only limit the number of providers with minimum requirements and grounds for exclusion. Every provider that registers and meets the conditions will be contracted. In this way, the municipality increases the freedom of choice for clients. When working with an open house method, it is difficult to get a grip on the number of contracted parties. The examined cases see this as the main disadvantage of working with open house. Unfortunately, it is not possible to manage on an exact number of contracts because then there is a selection of providers. Although it is not possible to steer on an exact number of providers, there are ways for municipalities to limit the number of contracted parties. For instance, Midden IJssel Oost Veluwe uses a quality commission that has a look at each submission before allowing a contract. The number of contracted providers will vary by municipality, as demand also varies. However, by setting stricter admission requirements, risks associated with open house can be mitigated.

2. Limit registration window in open house

In addition, as seen by Inkoop sociaal domein Centraal Gelderland, a municipality can decide to open the registration window only to a limited period. Parties are only contracted in the first tendering. Registration will then only be opened if there is a demand for it from the municipality. The advantage is reducing the risks by allowing to keep a grip on the number of care providers and ensures that monitoring of care providers is manageable.

3. Use data to make a risk analysis of care providers

In the research it became clear that OZJT/Samen14 uses data to make a risk classification. It is considered difficult to get a grip on the number of care providers in open house. Because it is difficult to enter a relationship with every care provider in the monitoring phase. Data can be used to monitor care providers. Providers who meet the requirements are ranked based on their risk. By means of a classification, the municipality knows which providers pose more risk and which may need to be examined more closely.

4. Monitor clients and care providers through social community teams and client's signals.

Both from the literature and interviews it became clear that professionals in social community teams are key. Their role as gatekeepers is important as they are in direct contact with the client. Social community teams could also be responsible for screening and monitoring care providers and detect signals of ill-intentioned behavior. These social community teams should not be connected to the care provider. Moreover, clients who want to report, need a clear way to do so. In the research it became clear that not all municipalities have a clear way for clients to report. This can be done by facilitating a phone number of website where clients can report signals of ill-intentioned behavior.

7.3 Scientific and practical implications

The research report enables public procurement professionals and policymakers in the social domain to make a better assessment in their procurement strategy. Furthermore, an overview can be found of four outsourcing methods and how they can be utilized to handle the risks posed by ill-intentioned care providers.

Furthermore, this research supported some findings of other research. Uenk and Telgen (2018) mentioned having a strong position in the triad. This can be done by building and maintaining a relationship with the care providers and monitoring the behavior of the providers. This is supported by this study because the various cases show that municipalities are actively monitoring care providers to stop ill-intentioned behavior. However, the municipality's position differs in which method is chosen to outsource. If strict admission and selection options, with a small number of providers is possible, it is easier to build a relationship and monitor these care providers.

Consequently, this study presents new insights that have not been previously discussed in the literature and contradicts the findings of some other research. Uenk and Taponen (2020) mentioned care providers acting opportunistically may suffer consequences, as the clients may switch to a new provider if they are not satisfied. However, this research showed that ill-

intentioned providers can collaborate with clients and therefore opportunistic behavior is not stopped.

7.4 Future research

This study looked at the Dutch situation when it comes to social care services. However, the literature review revealed that other countries organize their social services differently: For example, Finland, where social services are also organized in-house (Uenk and Taponen (2020). In this way, less use is made of external providers, which may lead to less ill-intentioned care providers. In addition, there are other options that municipalities have for their outsourcing of social care, which are not included in this study, but are interesting for follow-up research: subsidy, negotiated procedure without prior publication and open competitive procedure. These three forms are currently hardly used in the Netherlands but will probably give different results depending on the selected form.

Furthermore, follow-up research into personal budget fraud (pgb) and Youth care could be done. Personal budget was not considered in this study, because municipalities do not have a contract with the care provider. The care provider, often a family member, has a contract with the client. Nevertheless, signals of fraud also surface in various investigations and news reports. On the other hand, youth care was not included as this form of care is elaborate and therefore did not fit in the scope of the research.

Another interesting follow-up study would be the relationship between the selected outsourcing method at a municipality and the number of social fraud cases in that municipality. An assumption is that the more providers you have, the greater the chance of fraudulent providers, but an investigation into this would be valuable.

7.5 Limitations

By performing this research, several limitations transpired. The main limitation of this research is caused by the number of municipalities included in this research. Four cases have been studied, with a total of 32 municipalities. Moreover, the cases had a limited set of participants, with each case having one interview. Therefore, the generalizability of the results is limited. However, each case represents an alternative way of organizing social care and the participants had sufficient knowledge to answer the interview questions.

Another limitation was that the research studied did not include the personal budget (pgb), youth care and subsidy. By looking at these municipal responsibilities the research would give a more complete picture of social care. However, the scope of the research had to

be smaller due to available time and capacity. Therefore, it is recommended to include these in future research.

In the literature review, certain factors or indicators could have been overlooked. Through using multiple search terms and reading thoroughly, this was kept at a minimum.

5. REFERENCES

Ark, E., Eikelenboom, S., Jong, F., Appels, D., Spanjers, J., Linden, A., & Verbon, H. (n.d.). *Zorgcowboys*. Follow the Money - Platform voor onderzoeksjournalistiek. Retrieved 20 April 2021, from https://www.ftm.nl/dossier/zorgcowboys

Axelsson, B., Wynstra, F., 2002. *Buying Business Services*. Wiley, Chichester.

Babbie, E. R. (2013). *The practice of social research*.

Boeije, H. (2005). *Analyseren in kwalitatief onderzoek. Denken en doen*. Amsterdam: Boom onderwijs.

Brown, T. L., & Potoski, M. (2003). *Contract-Management Capacity in Municipal and County Governments. Public Administration Review, 63(2), 153–164.* doi:10.1111/1540-6210.00276

Cressey, D.R. (1950). The criminal violation of financial trust, *American Sociological Review*, 15 (6): 738-743.

Eisenhardt, K. M. (1989). Agency Theory: An Assessment and Review. *Academy of Management Review*, *14*(1), 57–74. https://doi.org/10.5465/amr.1989.4279003

Fenger, H.J.M, Chin-A-Fat, N, Frankowski, A, & van der Torre, E.J. (2016). Naar rechtmatige zorg in het gemeentelijke domein. http://hdl.handle.net/1765/79833

Gemeente Utrecht. (2018). *Strategie contracteren Aanvullende Zorg Wmo vanaf 2020*. https://zorgprofessionals.utrecht.nl/fileadmin/uploads/documenten/zz-zorgprofessionals/hulp-en-ondersteuning-Wmo/2018-10-inkoopstrategie-Wmo.pdf

Gemeente Utrecht. (2019). *Kwaliteit en toezicht Wmo*. https://www.utrecht.nl/fileadmin/uploads/documenten/bestuur-en-organisatie/beleid/2019-04-wmo-kwaliteit-en-toezicht.pdf

Informatie Knooppunt Zorgfraude (IKZ. (2020, June). *Signalen fraude in de zorg 2019*. https://www.ikz.nl/documenten/publicaties/2020/06/18/rapport-signalen-zorgfraude-2019

Informatie Knooppunt Zorgfraude. (2019, July). *Strafrechtelijke antecedenten bij vermoedens van zorgfraude*. https://www.ikz.nl/documenten/publicaties/2019/07/04/rapport-strafrechtelijke-antecedenten-bij-vermoedens-van-zorgfraude

Informatie Knooppunt Zorgfraude. (2020). *Verwevenheid zorg & criminaliteit'*. https://www.ikz.nl/binaries/informatieknooppuntzorgfraude/documenten/rapporten/2021/01/14/criminaliteit-en-zorg/Rapport+Verwevenheid+criminaliteit+en+zorg.pdf

Inkoop SDCG. (2019a). *Algemeen Inkoopdocument* https://www.inkoopsdcg.nl/home+inkoop/download+documenten+website/handlerdownloadfiles.ashx?idnv=1467461

Inkoop SDCG. (2019b). *"Zicht op kwaliteit" Jeugdwet en Wmo 2015: Integrale aanpak kwaliteit, toezicht en handhaving*.

https://www.inkoopsdcg.nl/home+inkoop/download+documenten+website/handlerdownloadfiles.ashx?idnv=1502081

Li, Mei & Choi, Thomasy. (2009). Triads in Services Outsourcing: Bridge, Bridge Decay and Bridge Transfer. *Journal of Supply Chain Management*, *45*(3), 27–39. https://doi.org/10.1111/j.1745-493x.2009.03169.x

Ministerie van Algemene Zaken. (2021, December 24). *Wet maatschappelijke ondersteuning (Wmo)*. Zorg en ondersteuning thuis | Rijksoverheid.nl. Retrieved January 4, 2022, from https://www.rijksoverheid.nl/onderwerpen/zorg-en-ondersteuning-thuis/wmo-2015

Ministerie van Volksgezondheid, Welzijn en Sport. (2021a, 29 January). *3e voortgangsrapportage Rechtmatige zorg 2018–2021*. Rapport Rijksoverheid.nl. https://www.rijksoverheid.nl/documenten/rapporten/2021/01/29/3e-voortgangsrapportage-rechtmatige-zorg-2018-2021-aanpak-van-fouten-en-fraude

Ministerie van Volksgezondheid, Welzijn en Sport. (2021b, 16 March). *Database gemeentelijke zorginkoop 2021 en bijbehorende legenda*. Publicatie | Vindplaats Inkoop Sociaal Domein. https://www.inkoopsociaaldomein.nl/publicaties/rapporten/2021/03/16/database-gemeentelijke-zorginkoop-2021-en-legenda

Ministerie van Volksgezondheid, Welzijn en Sport. (2020c, 17 February). *Over het IKZ*. Informatie Knooppunt Zorgfraude. https://www.ikz.nl/onderwerpen/over-het-ikz

Nederlandse Zorgautoriteit (2013). *Onderzoek zorgfraude – Tussenrapport*. Den Haag: NZa.

Oude Vrielink, M., van der Kolk, H., Klok, P.J., 2014. De vormgeving van sociale (wijk) teams. Den Haag: Platform 31.

Pianoo. (2018). *Handreiking aanbesteden WMO 2015*. https://www.pianoo.nl/sites/default/files/documents/documents/handreiking-aanbesteden-wmo2015-jeugdwet-tg-januari2018.pdf

Public Procurement Research Centre. (2016). *Gemeentelijk opdrachtgeverschap in de zorg: één jaar verder*. https://vng.nl/files/vng/20160902_gemeentelijk_opdrachtgeverschap_in_de_zorg.pdf

Ministerie van Justitie en Veiligheid. (2021, 3 March). *Ondermijnende criminaliteit*. Ondermijning Rijksoverheid.nl. https://www.rijksoverheid.nl/onderwerpen/ondermijning/ondermijnende-criminaliteit

Ministerie van Volksgezondheid, Welzijn en Sport. (2021a, June 16). Wat is het verschil tussen een persoonsgebonden budget (pgb) en zorg in natura? Rijksoverheid.nl. Retrieved October 31, 2021, from https://www.rijksoverheid.nl/onderwerpen/persoonsgebonden-budget-pgb/vraag-en-antwoord/verschil-pgb-zorg-natura

Ministerie van Volksgezondheid, Welzijn en Sport. (2021b, October 25). *Hoe krijg ik ondersteuning van de gemeente vanuit de Wmo?* Rijksoverheid.nl. Retrieved January 4, 2022,

from https://www.rijksoverheid.nl/onderwerpen/zorg-en-ondersteuning-thuis/vraag-en-antwoord/ondersteuning-gemeente-wmo-2015-aanvragen

Rijksoverheid. (2015). Decentralisatie van overheidstaken naar gemeenten. Retrieved 10 December 2021, From https://www.rijksoverheid.nl/onderwerpen/gemeenten/inhoud/decentralisatievan-overheidstaken-naar-gemeenten

Rijksoverheid (n.d.) Ondermijning. Retrieved 12 April, from https://www.rijksoverheid.nl/onderwerpen/ondermijning/ondermijnende-criminaliteit

Rodrigues, R., and Glendinning, C. (2015) Choice, Competition and Care – Developments in English Social Care and the Impacts on Providers and Older Users of Home Care Services. *Social Policy & Administration*, 49: 649– 664. doi: 10.1111/spol.12099.

Rossetti, C. L., & Choi, T. Y. (2008). Supply Management Under High Goal Incongruence: An Empirical Examination of Disintermediation in the Aerospace Supply Chain. *Decision Sciences*, *39*(3), 507–540. https://doi.org/10.1111/j.1540-5915.2008.00201.x

Sengupta, S., Niranjan, T. T., Krishnamoorthy, M., & van der Valk, W. (2018). A client-centric risk-based taxonomy of service triads. *The Service Industries Journal*, 1–23. https://doi.org/10.1080/02642069.2018.1504923

Spapens, A. (2019). Bestuurlijke aanpak van ondermijning: ervaringen in Nederland en het buitenland. *Tijdschrift voor Bijzonder Strafrecht en Handhaving*, 2019(2), 85-92. https://doi.org/10.5553/TBSenH/229567002019005002002

Tate, W. L., & van der Valk, W. (2008). Managing the performance of outsourced customer contact centers. Journal of Purchasing and Supply Management, 14(3), 160–169. https://doi.org/10.1016/j.pursup.2008.04.002

Uenk, N. (2019). *Commissioning of Social Care Services (PhD thesis).* Retrieved from https://dspace.library.uu.nl/bitstream/handle/1874/383180/136727-uenk_com.pdf

Uenk, N., & Taponen, S. (2020). Risk allocation in service triads – The case of Dutch and Finnish home care procurement. *Journal of Purchasing and Supply Management*, *26*(4), 100647. https://doi.org/10.1016/j.pursup.2020.100647

Uenk, N., & Telgen, J. (2019). Managing challenges in social care service triads – Exploring public procurement practices of Dutch municipalities. *Journal of Purchasing and Supply Management*, *25*(1), 5–17. https://doi.org/10.1016/j.pursup.2018.08.001

Samen Weerbaar. (2021). *Handboek zorgfraude*. https://docplayer.nl/214662714-Nulmeting-zorg-in-natura-en-pgb-aan-de-hand-van-risico-indicatoren-fraudeproof-check.html#show_full_text

Steen, M., van der, Schram, J., Chin-A-Fat, A., & Scherpenisse, J. (2016). Ondermijning Ondermijnd. Nederlandse School voor Openbaar Bestuur.

Tops, P., & Schilders, H. (2016). Naar een meervoudige aanpak van ondermijning. Het Tijdschrift voor de Politie, 78 (7), 12 – 15

Van der Valk, W., & van Iwaarden, J. (2011). Monitoring in service triads consisting of buyers, subcontractors and end customers. *Journal of Purchasing and Supply Management*, *17*(3), 198–206. https://doi.org/10.1016/j.pursup.2011.05.002

Van Iwaarden, J., & Van der Valk, W. (2013). Controlling outsourced service delivery: managing service quality in business service triads. *Total Quality Management & Business Excellence*, *24*(9–10), 1046–1061. https://doi.org/10.1080/14783363.2013.776766

Vindplaats Inkoop Sociaal Domein. (2020, 2 October). Praktijkverhaal: zeven zorgvormen en zeven aanbestedingen tegelijk. Retrieved 25 October 2021, from https://www.inkoopsociaaldomein.nl/actueel/nieuws/2020/10/02/praktijkverhaal-gemeente-utrecht-zeven-verschillende-zorgvormen-en-zeven-aanbestedingen-tegelijk

VNG. (n.d.). *Dossier Aanpak Zorgfraude*. Received 1 December 2021, from https://vng.nl/artikelen/dossier-aanpak-zorgfraude

VNG. (2014). *Handreiking invulling en uitvoering van het Overgangsrecht AWBZ – Wmo 2015*. https://vng.nl/sites/default/files/publicaties/2015/201412-handreiking-overgangsrecht-awbz-wmo2015_0.pdf

VNG. Kaart van 42 jeugdregio's. (2017). Retrieved 14 October 2021, from https://vng.nl/publicaties/kaart-van-42-jeugdregios

VNG Naleving, Van de Torre, E., & Heijkoop, M. (2020). *Een wereld te winnen*. Https://vng.nl/kennisbank-naleving/een-wereld-te-winnen-over-zorgfraude-wmo-2015-en-jeugdwet-onderzoek

Wind, M., Uenk, N., & Telgen, J. (2020). *Monitor gemeentelijk zorginkoop 2019. Stand van Zaken inkoop diensten in het kader van Wmo 2015 en Jeugdwet.* Ministerie Van Volksgezondheid, Welzijn en Sport.

Wind, M., Uenk, N. (2020). Monitor gemeentelijke zorginkoop 2020. Stand van zaken inkoop diensten in het kader van Wmo 2015 en Jeugdwet. Ministerie Van Volksgezondheid, Welzijn en Sport.

Wynstra, F., Spring, M., & Schoenherr, T. (2014). Service triads: A research agenda for buyer-supplier-customer triads in business services. *Journal of Operations Management*, *35*(1), 1–20. https://doi.org/10.1016/j.jom.2014.10.002

Zorgregiomijov. (2021). *Toetsingskader kwaliteit*. https://www.zorgregiomijov.nl/images/Documenten/Toezicht/Jaarverslag_regionaal_toezicht_2020.pdf

6. APPENDICES

Appendix 1 Risk indicator questions

	premonitoringsvragen	wegingsfactor	antwoord	
1	Hebben eigenaar, bestuurders en/ of commissarissen van inschrijver eigen vermogen in de onderneming?	1	Ja	
2	Is eigenaar, bestuurders en/ of commissaris jonger dan 25 jaar?	1	Ja	
3	Hebben eigenaar, bestuurders en/ of commissarissen van inschrijver onroerend goed in privé bezit dat wordt verhuurd aan cliënten van inschrijver?	1	Ja	
4	Zijn eigenaar, bestuurders en/ of commissarissen als bestuurder betrokken bij rechtspersonen die onroerend goed verhuren aan cliënten van inschrijver?	1	Ja	
5	Hoe is hoog is het aandeel loonkosten van de totale omzet (in % van de totale omzet) in het laatste afgesloten boekjaar? *Toelichting: Deel hiervoor de loonkosten door de bedrijfsopbrengsten. Bereken hierbij de loonkosten als alle personeelskosten (inclusief werkgeverslasten) en inhuur personeel als alle kosten verband houdend met de inhuur van personeel. De omzet is de gerealiseerde omzet over het gehele jaar.*	3	50	%
6	Hoe hoog is de netto marge (in %) voor belastingen in het laatste afgesloten boekjaar ? *Toelichting: Bereken hierbij de netto marge, door de netto winst te delen door de bedrijfsopbrengsten. De netto winst is de winst na aftrek van alle bedrijfskosten en voor het betalen van de belasting.*	2	45	%
7	Staat inschrijver ingeschreven als ZZP'er? Zo ja, heeft inschrijver in het laatste afgesloten boekjaar een bedrijfsopbrengst gehad hoger dan € 121.000,-?	3	Nee	
8	Heeft inschrijver een BV met alleen de bestuurder als werknemer? Zo ja, heeft inschrijver in het laatste afgesloten boekjaar een bedrijfsopbrengst gehad hoger dan € 121.000,-?	3	Ja	
9	Staat/staan of heeft/hebben eigena(a)r(en), bestuurder(s) en/ of commissaris(sen) van inschrijver de afgelopen twee (2) jaar ingeschreven gestaan bij de Kamer van Koophandel in een of meerdere van de volgende sectoren (SBI-codes)? *35 Productie en distributie van en handel in elektriciteit, aardgas, stoom en gekoelde lucht* *38 Afvalinzameling en -behandeling; voorbereiding tot recycling* *43 Gespecialiseerde werkzaamheden in de bouw* *45 Handel in en reparatie van auto's, motorfietsen en aanhangers* *47 Detailhandel (niet in auto's)* *49 Vervoer over land* *53 Post en koeriers* *55 Logiesverstrekking* *56 Eet- en drinkgelegenheden* *64 Financiële instellingen (geen verzekeringen en pensioenfondsen)* *66 Overige financiële dienstverlening* *68 Verhuur van en handel in onroerend goed* *69 Rechtskundige dienstverlening, accountancy, belastingadvisering en administratie* *77 Verhuur en lease van auto's, consumentenartikelen, machines en overige roerende goederen* *78 Arbeidsbemiddeling, uitzendbureaus en personeelsbeheer* *80 Beveiliging en opsporing* *82 Overige zakelijke dienstverlening* *92 Loterijen en kansspelen* *96 Wellness en overige dienstverlening; uitvaartbranche*	1	Nee	
10	Hebben eigenaar, bestuurders en/ of commissarissen van inschrijver een relevante opleiding in zorg- en welzijn?	1	Ja	

FIGURE 5 OZJT/SAMEN14 (2020). INVULEXCEL BIJ EIS 2.7.1 VERSIE SEPTEMBER 2020 [EXCEL]. NEGOMATRIX. HTTPS://PLATFORM.NEGOMETRIX.COM/PUBLISHEDTENDERS.ASPX?TENDERID=87613&COMPANYID=6520

Appendix 2 Interviewees and interview protocol

Case	**Function of interviewee**
OZJT/Samen14	
Zorgregio Midden-IJssel/Oost-Veluwe	
Inkoop sociaal domein Centraal Gelderland	
Municipality of Utrecht	

Topic	Question
Introduction	• Introducing persons, subject, permission to record 1. Kunt u vertellen wat uw functie binnen de gemeente/samenwerkingsverband is?
General social care services • public procurement • open house • subsidy	2. Kunt u globaal aangeven hoe WMO (eventueel samen met jeugdzorg) zorg in uw gemeente georganiseerd is? 3. Hoe vindt deze samenwerking plaats? Koopt het samenwerkingsverband als geheel de WMO in of zijn er uitzonderingen 4. Uw gemeente gebruikt een subsidie, overheidsopdracht en open house methode voor de inkoop WMO. a. Waarom is hiervoor gekozen?
Pre-selection phase • Social service triad: municipality/care provider/client	5. Kunt u aangeven hoe het proces verloopt bij een nieuwe inkoopronde? 6. Hoe komt de raamovereenkomst tot stand? Intern of in dialoog met zorgaanbieders 7. Is er direct contact of meer administratief/indirect bij aanmelding van een zorgaanbieder 8. Wat voor informatie van zorgaanbieders wordt verzameld in de inkoopfase, voordat er een contract ondertekend wordt?

	9. Loopt u in die informatiefase tegen privacywetgeving aan? *Vermoeden van malafide zorgaanbieders.*
Selection phase • Quality criteria • Competition: ex ante/ex post	1. In welke mate vindt er vooraf selectie plaats? a. Hanteert u bijvoorbeeld kwaliteitscriteria voordat een contract gegund wordt? 2. Is er na de gunning nog verder onderzoek naar de aanbieder nodig? 3. Wat voor contract (termijn, bekostigingsvorm) ontvangt de zorgaanbieder? 4. In welke mate is er sprake van concurrentie tussen zorgaanbieders? 5. Wat is het aantal WMO gecontracteerde zorgaanbieders en hoeveel daarvan verlenen actief zorg in uw regio?

Monitoring phase • Monitoring • Social community teams	1. Kunt u aangeven op welke wijze monitoring van kwaliteit plaatsvindt? Verschil bij Zin als PGB? 2. Onderhoudt uw gemeente met alle gecontracteerde zorgaanbieders nauw contact? a. In hoeverre is dit mogelijk? 3. Hoe weet u dat cliënten tevreden zijn over de verleende service?
Ill-intentioned care providers • Information sharing • Collaboration • Social service triad: municipality/care provider/client	1. Op welke wijze worden frauduleuze aanbieders aan de poort geweerd? (per fase) 2. Via welke kanalen krijgt u fraudesignalen binnen? Zowel vooraf, als naderhand? 3. Hoe voorkomt u dat zorgaanbieders achter uw rug om (Samen met de cliënt) frauderen? 4. Waar loopt u tegen aan in de aanpak van zorgfraude? 5. Vindt er samenwerking en communicatie met andere instanties plaats om ondermijning tegen te gaan RIEC, IKZ? a. Zo ja, op welke wijze en zo nee, waarom nie
Conclusion	• Thanking for the interview