

# The Dutch Experience with Private Social Services

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## Introduction

When we have to judge the way social services of general interest in the care sector in Denmark are being operationalised, the Dutch example may form an interesting mirror for our Danish counterparts. Especially so, because The Netherlands and Denmark share a lot of cultural and social-economical traits. Before entering into examples of how the Dutch system works with private provision and clients' choice, it is important to have an idea of the background of the Dutch situation. The Netherlands have gone through a fundamental change in the way in which we look at the administration of social security, and the way the incentives and privatisation of services in this system work or should work.

The Netherlands started out in the 1980's with a system pretty much like the one most European countries know; an number of social insurances for the working force, a welfare system for those structurally outside the workforce, a pension scheme for the elderly, and a centralized system of care arrangements, with services for the elderly (or disabled for that matter). These provisions and benefits were awarded by sectoral or regional authorities along strictly bureaucratic lines. In the long run this system proved to be top heavy and costly. A process of ever easier admittance to the system, high benefit levels combined with a bureaucratic administration system proved an excellent recipe for a cost explosion in the social system.

A deep economic crisis in the eighties, partly caused by these high social costs, forced the respective governments to introduce fundamental changes in the social security system and its administration. Both the level of benefits, as the procurement of the provisions for elderly or handicapped people (including sick or disabled workers, welfare clients etc.) were revised. All in all there has been a fundamental change from public administration towards more private participation in the social insurances, and more choice for the clients (be it employers, employees, unemployed, sick workers, elderly or handicapped).

In the Dutch view these changes necessarily depend on each other. Only if there are more organisations involved (and competing) in the field of social policy, is it possible for clients to make a choice. This point of departure has led to the creation for a large market of social services in very many different ways.

The first fundamental step in this direction has been the factual abolishment of the Sickness Benefits Act. Ever since 1996 sick employees can no longer claim benefit while sick. Their

employer is responsible now for their income. Every Dutch employer is by law obliged to pay his sick employees at least 70% of his wage, for a period of - at most - two years. This employer's risk of wage payment during sickness was often insured through the private insurance companies, so here the private insurance market stepped in place of a public benefit system.

As most employers are unable to supervise their employees during sickness, they have to hire private occupational health services (called "arbodiensten"), which provide both control activities and deliver rehabilitation and reintegration services. Sometimes the arbodiensten perform these tasks themselves, very often they hire smaller specialized companies for certain reintegration tasks. It is these private reintegration services that form the core of the 'reintegration market' of the Netherlands. They offer a wide variety of services like training, education, (para)medical treatments as for example "back schools", and personal support. Also the public disability insurance and the municipalities make use of these reintegration services, for their clients: the disabled, the unemployed and the people on welfare.

A second contribution to the market of private social services is the care sector. Over the nineteen nineties a system of personal care budgets was introduced in the National Exceptional Medical Expenses Act which gave clients of the care sector much wider possibilities of choosing their own individualized form of care, like medical care, daily personal care or psychological support. The administration of the long term care assistance is in the process of being transferred from medical institutions that provided for the care themselves, to the municipal authorities who contract care providers. A growing number of services like house hold assistance, or transport facilities for the handicapped or the elderly are also provided for by the private sector now.

Revolutionary was the new Dutch (basic) health care insurance. As of January 1 2006 all Dutch residents are obliged to insure themselves with a private health care insurance company. For the basic services there is a flat rate contribution, for supplementary services there is a full free market. Again, this system of free choice of insurer and (limited) free choice of insured package has given citizens a wider choice of care providers, for example psychotherapy or physiotherapy, and has given another boost to the market of social services.

This development does not mean that there is a true free market in the care or reintegration systems. In both cases the limits are narrowly prescribed by law. Within these bounds however there is more competition and choice between private providers than there ever was before.

As in Denmark, the Netherlands also face the challenge of providing services to a quickly expanding population of elderly. In this comment paper however we will not focus on these services as such, but instead on the role of private versus public providers, and of the clients themselves, in delivering or purchasing services. The Dutch developments in this field have certain parallels with the "Free Choice Reform" as we understand it from the Host Country Paper.

Our experience in this matter is taken mainly from the field of labour reintegration of the disabled and the long-term unemployed, where the shift from public to private provision of services – including the use of vouchers or personal budgets – has taken its most explicit form. The experiences with this system however may be useful for the provision of care and support for all groups of citizens.

## Private re-integration services for handicapped and unemployed: Make or Buy?

Even though the introduction of market elements has been widespread in Dutch social security, as sketched above, the *degree* to which this privatisation is applied instead of public provision of re-integration services has been subject to change. Around 2000, the public administrating body for unemployment and disability benefits (called UWV) was obliged by law to buy all re-integration services for their clients (benefit recipients) from private providers, using an open tender system for selecting and contracting these. (Likewise, the Dutch municipalities, administrating the welfare benefit system, were obliged to buy all services for their clients from private providers.) This "forced market" attracted many private providers: it is estimated that by 2008 some 2,000 private parties (a few very big ones plus a lot of small) were active at the supply-side of the market.

This system of forced market has been much criticized however – both in politics as by UWV and municipalities, and in the media – for allegedly being not very (cost-)effective; the image of private providers deteriorated greatly, as being profit-driven rather than result-driven. Thus, over the last few years the rules have been relaxed and UWV and the municipalities have more discretion in either buying services in the market or performing these services themselves (as they did before the wave of privatisation came over them). In the eternal dilemma of "make or buy", the recent development in the Netherlands has been towards more "make" and less "buy". It is expected that this will diminish the size of the private market and will expel many (especially smaller) providers – they simply do not have the "critical mass" for surviving in a shrinking market.

Likewise, as formerly the UWV and municipalities bought complete "blocs" or "packages" of services for a client (resulting, hopefully, in re-integration in paid jobs – and thus often financed on a "no cure, no pay" or "no cure, less pay"-basis), they now often only buy limited separate services and themselves perform the administration, guidance and supervision of their clients in their way back to the labour market.

## Individual choice of providers by clients: the Dutch individual re-integration contract IRO as a case

There is however one major exception to the Dutch tendency from "buy" towards "make": the introduction of individual, tailor-made re-integration packages. The client may opt for such an individual package, where he or she is the designer of his or hers route back to work and chooses a (private) re-integration provider and –programme himself. For clients of UWV (disabled and unemployed) this arrangement is called the IRO (Individual Re-integration Contract); municipalities may offer a similar option to their clients (welfare) called the PRB (Personal Re-integration Budget)<sup>1</sup>.

These IRO- and PRB-packages are still completely bought in the market of private providers (with some important differences between the two; in the IRO arrangement the public body UWV is still the budget holder and contract party, in the PRB arrangement the client himself is the contract partner and is responsible for the budget). In many cases the private provider is paid according to

<sup>1</sup> Interestingly, the introduction of individual choice and personal budgets in work re-integration was inspired, *inter alia*, by the favourable experiences with personal budgets in home care.

the "No cure, less pay"-principle (in this sense the system is an arrangement of the "voucher"-type).

The IRO system has recently (2008) been evaluated. Some of the main conclusions are:

- The system is quite popular. From the start of the system in 2006 up to March 2008 some 90.000 IRO-packages have been started, compared to some 150.000 "traditional" packages. The IRO-option got more popular over the years: in 2007, even six out of ten packages started were of the IRO type.
- Especially the active role of the client in IRO services, and the resulting "empowerment" of the client, is regarded as a crucial success factor. IRO-clients are more satisfied with the services provided to them, than clients with "traditional" services delivered by the public body UWV are.
- IRO-packages are more expensive compared to traditional services (by a factor of 1.2 to 1.3), ...
- ... but are also more effective in getting clients back to work (by a factor 1.2 to 1.5). For disability benefits recipients, the costs-per-placement are lower than with traditional services by a factor 0.7 – 0.9. For unemployed however the costs-per-placement are higher (by a factor 1.0 – 1.4).
- IRO packages attract clients with a relatively good position in the labour market (for example, they attract more well-educated clients and clients with relatively good health). The relative success of IRO packages thus may in part reflect a "creaming"-effect.
- The IRO arrangement attracted many (mainly small) private providers to the supply-side of the market; some 2,500 (!) providers have been involved in IRO packages, many of whom solely supplied IRO (no regular packages).
- The market price mechanism is in misbalance in the IRO system: the client chooses his own provider and service package, but he is not the one who pays, not being the budget holder. This entails the risk of upward pressure on the prices of services.

## The application of market mechanisms in work re-integration services: some challenges and dilemma's

In experiences with clients' free choice, vouchers and personal budgets, there are challenges and dilemma's that policy makers and public administrative bodies have to cope with. Many of these seem to be the same across different fields of policy and different countries. In this section we will list some of these dilemma's that had to (and often still have to) be faced in the Dutch experience. The first, and not the least, dilemma was discussed in the previous section: the *make or buy*-dilemma. Others include:

- *Are clients' competences adequate?* It requires a certain level of skills, knowledge, and the like, to manage a personal budget and to pick adequate providers and services. Who judges and monitors whether a client is competent to handle freedom of choice and

budget responsibility? Or should anyone applying be allowed to a budget without previous test, assessment and the like?

- *Are providers' competences adequate?* Who has an overview over the market of private providers? Who, if anyone, evaluates which parties should and should not be allowed to the market? Who guarantees a minimum quality level? Should there be some system of certification or licensing, and who is monitoring the market and evaluating the adequacy of the supply-side? Should the client receive guidance in choosing from the many possible providers?
- *Should providers be obliged to take in any client choosing them (or being sent to them)?* If not, how to prevent mechanisms of "cherry picking", creaming, etc., - leaving the less profitable rest to the services of the public system – a clear case of inequality?
- *How about expensive services?* If there is a standard level of payment (and especially, if payment is on a "no cure, less pay" basis), it is risky for a provider to apply expensive services such as (full time) education, even though this may be the most effective service in the longer run.
- *What is the success criterion of a service, and who evaluates it?* The standard goal of labour reintegration (in NL) is placement in a regular job of at least 6 months' duration. But for some clients, also smaller steps towards paid work may take a client closer to the labour market. Should providers also be rewarded for such "partial successes"?
- *Freedom of expenditure.* Is the client having been awarded a personal budget completely free in spending it? Or should he/she buy services from a limited list of preferred providers and preferred services? Should he/she account for the spending of the budget – and thus be subject to bureaucratic procedures?
- *How to attract private providers to the market?* Demand does not automatically evoke supply in the reintegration market. In order to invest in quality of services, stability of staff, networking with employers etc. a provider will require a certain stability of his future turnover. Collective contracts must have a certain "mass" and contract duration for providers to enter the market. What is an optimal size and duration of contracts? If framework contracts are used, who will guaranty a minimal size of turnover, without disturbing the freedom of choice for clients?
- *Are there economies of scale if the supply side of the market consists of many small providers?* Experiences with the IRO system show that individual choice leads to a preference for (very) small providers. Is this efficient? What overhead costs are involved (on both sides of the market) in contracting, billing, evaluating etc. of over 2,000 providers?

## Conclusion

Our experience in the Netherlands is that increasing choice for clients of the social sector can contribute to cost awareness, and may be effective for an important percentage of the clients. It does not however make life simple for the responsible authorities. In the end the state and/or administrative organisations will remain responsible for the quality and effectiveness of the system. Difficult choices will have to be made, as the demand for services will always be bigger than we can afford to pay. All in all though we can conclude that the reforms the Netherlands have introduced over the last two decades have made our social system stronger and better geared to the needs of modern society. As such it may be an example for other countries, like Denmark, in the process of modernizing their social systems.