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The Dutch Social Support Act in the shadow of the decentralization dream

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A substantial reform in the social domain is taking place in the Netherlands. Different schemes involving social care and support, basic income provisions and youth care are being transferred from the national to the local level. The political focus on decentralization as a solution for the increasing public expenses has raised renewed discussions about the classic administrative dilemma of central, uniform regulation on the one hand and free space for democratic communities on the other. This article addresses the administrative dilemma in relation to the Social Support Act that has been in force since 2007. This Act is being implemented by the municipalities and will increase in scope as a result of the reforms at hand. The article examines to what extent the municipalities succeed in achieving the objectives of the Act and how the consequences of the administrative dilemma affect the achievements.

Keywords: social support; social welfare; decentralization; localization; local welfare; Netherlands

1. Introduction

A major reform of the care system and social services is going on in the Netherlands, prompted by steadily rising costs that have placed the systems under great pressure. During the past two decades, many reports and recommendations have been written by public advisory boards and organizations of interest groups, reflecting different views and opinions on the future of (long-term) care and social support. There seems to be consensus about one thing in particular: action is needed to create a sustainable and coherent social domain. Subsequent governments have tried to respond on topical issues such as the ageing population, the increasing administrative burden on care professionals, the rise in the number and cost of medicines and medical devices, the growing awareness and expectations of citizens regarding the quality of their lives, and, last but not least, the economic downturn.

Unfortunately, public policy has proved to change with the political colour of each government, often resulting in unfinished reforms, a waste of public money, and uncertainty about the (near) future on the part of citizens in need of care, care providers, and other stakeholders within the social domain. The current government, in charge since November 2012, has pinned its faith on ongoing decentralizations as a means to clamp down on the rising costs. The reform plans relating to social care and support include a shift of elements from the national public insurance scheme for long-term care to the Social Support Act of 2007, which is implemented by the municipalities. Other decentralizations in the social domain relate to national income provisions for disabled people and to youth care, together presented as the 3 Ds (three decentralizations), planned to have been unrolled by 2015 (Government, 2012; State Secretary for Health, Welfare and Sport, 2013).

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The focus on decentralization touches on a longstanding and thorny issue in the Netherlands. This issue concerns a 'classic administrative dilemma' (Tweede Kamer, 2004/2005, p. 8; Witteveen, 2006): the dilemma between uniform, central regulation on the one hand and the ideal of decentralization on the other. Public policy shows a changeable and rather ambivalent history at this point. Social tasks such as healthcare and poor relief were local responsibilities at the beginning of the twentieth century, shifting towards the central government during the building of the welfare state, and starting to shift back to the local level again in the late 1980s after the 'peak' of the welfare state. The trend back to municipal responsibilities during the last three decades is, however, far from univocal and does not seem to be based on clear and well-considered administrative choices (Gilsing, 2010, p. 41; Van den Berg, 2013). Furthermore, all too often a shift of tasks from the central to the local level goes hand in hand with substantial budget cuts – the current reforms being exemplary – which feeds the idea that the central government passes the buck to the municipalities by using decentralization as a tool to economize.

The development of the Social Support Act (SSA) is a good example of the ambiguous attitude of the government towards the administrative dilemma. On the one hand, the legislator wants the municipalities to create their own local social welfare systems, but, on the other hand, it appears that the local authorities do not receive the amount of policy freedom they need or wish to achieve the objectives of the SSA. In recent literature, which has emerged in response to the political focus on decentralization, it is pointed out that simultaneously with the increase of municipal tasks within the social domain, a trend of decreasing political freedom regarding these statutory tasks has become noticeable (Allers & De Kam, 2010; Knop, 2012; Van der Veer, Schalk, & Gilsing, 2011; Vonk, 2012). This contradictory development has been referred to as a 'decentralization paradox'.

Building on the current discussion, this article seeks to examine how the municipalities implement the SSA and how the paradoxical or opposite policies and developments may affect the realization of its objectives. The assessment of the implementation of the Act focuses on the questions to what extent the objectives of the SSA are achieved so far and which (internal) problems municipalities encounter that impede the realization of the objectives; this is done on the basis of existing evaluation reports using empirical data (Putters, Grit, Janssen, Schmidt, & Meurs, 2010; SCP, 2010b, 2013; SGBO, 2012a, 2012b, 2013). Then, elaborating on the recent decentralization discourse, current developments and policies are discussed that may cause or exacerbate the problems municipalities encounter in implementing the SSA. A discussion of these issues is not only relevant for the Netherlands. On the contrary, it is instructive in general since the administrative dilemma is an actual issue in other countries as well (Binder, Slits, Stoquart, Mullen, & Buhigas Schubert, 2007; Kroneman, Cardol, & Friele, 2012; Robinson, 2007a; Saltman, Vrangbaek, Lehto, & Winblad, 2012; Trommel, 2013).

The article is structured as follows. First, the development, objectives and content of the SSA will be briefly described, including the current reform plans. In the next section how municipalities implement the Act will be examined and to what extent they manage to achieve the objectives. Subsequently, current developments and policies will be discussed that relate to the decentralization paradox and may hamper municipalities in their efforts to realize the objectives. The last section contains some concluding remarks on the results of the municipalities regarding the objectives of the SSA and the practical impact of the administrative dilemma.

2. The Social Support Act as a local instrument

2.1 Background

The SSA has been in force as of 1 January 2007. It replaced the Act on Facilities for Handicapped Persons of 1994 (*Wet voorzieningen gehandicapten*) and the Welfare Act of 1994 (*Welzijnswet*). Furthermore, a part of the Exceptional Medical Expenses Act (EMEA) was transferred to the SSA and thus constituted the major part of the new Act. The Act on Facilities for Handicapped Persons was implemented by the municipalities; they had to make their own regulations concerning facilities for handicapped persons within the general framework of the Act. The Welfare Act prescribed a combination of policies at the national, provincial and municipal level relating to subjects such as youth care, child care, social support, emancipation, care for the elderly, care for the handicapped and integration of ethnic minorities. However, diverging visions on welfare at the different policy levels and the diversity of priorities within the range of welfare interventions had impeded a coherent implementation of the Welfare Act (SCP, 2002).

The Exceptional Medical Expenses Act (EMEA), the still existing universal insurance scheme for long-term care, had become a source of political concern at that time because of the ever-rising costs it involved. Its insurance package had considerably expanded over time, including, for example, care and nursing at home, domestic help, day care, prevention programmes and assistance with activities of daily living (State Secretary for Health, Welfare and Sport, 2008). Simultaneously, the expenditure on long-term care had increased from 0.8% of the gross domestic product (GDP) in 1968 to 4.0% in 2005 (Schut & Van den Berg, 2010, p. 417; Sociaal-Economische Raad, 2008, p. 63). In an attempt to turn the tide, a new trend was followed at the beginning of this century towards a limitation of entitlements, cost-cutting, and a stricter division between cure, (long-term) care and support. For these reasons, certain provisions of the EMEA were (re-)allocated to the Health Insurance Act (e.g. concerning medical aids), while domestic help, which was one of the quickest-growing sections of homecare, was included in the newly introduced SSA. An important change was that the SSA no longer prescribed entitlements to specific facilities, but instead a general obligation for municipalities to provide social care and support within the framework of the Act.

2.2 Objectives

The main objectives of the SSA are to promote participation in society, to support people with a limitation to function autonomously (to do things independently), to advance active involvement in society on the part of all citizens (active citizenship), and to promote social cohesion (Klosse & Noordam, 2010, p. 419; SCP, 2010b, pp. 28–33; Tweede Kamer, 2007/2008). An overarching element of these objectives is self-responsibility and self-organization, which was reason for the then State Secretary of Health, Welfare and Sport to speak of the creation of ‘a new way of welfare’. This implies that great emphasis is put on the responsibility of individual citizens for their own wellbeing, that of their families and that of their communities; self-organization and voluntary support from the person’s own social network have primacy over support and services on the basis of the SSA. Only when problems get too big or complicated to be solved by the (social and familial network of the) person in question, do the municipalities have to organize support. To facilitate self-responsibility and self-organization, the possibility of a personal budget is included in the SSA as an alternative to provision in kind. Another objective of the SSA that connects with self-responsibility and self-organization is to support voluntary caregivers, whose participation is essential for the achievement of the main objectives.

2.3 Implementation at the local level: reasons and objectives

With the adoption of the SSA, the legislator has indicated that the objectives of the SSA can best be achieved if the Act is implemented at a local level. This is in accordance with the administrative principle that 'government tasks are left to the most decentralised, legitimate tier of government, given the scale and the interests involved, assessed on who can do the job best' (Raad voor de financiële verhoudingen, 2011, p. 20). In the Netherlands, the decentralized government involves provinces and municipalities, which are autonomous and democratically elected authorities. Autonomy means that the authorities can determine their own tasks and priorities within the frameworks set by law (Act on Municipalities, Article 108). This is incorporated in the Dutch Constitution, which stipulates that provinces and municipalities have the power to regulate and administer their own internal affairs (Article 124). In fact, they are free to undertake any tasks they deem necessary unless they are unauthorized to do so (*e.g.* in cases where the matter is already regulated at the central level); in the performance of their tasks they are, in principle, not subordinate to the central government. Apart from autonomy, the Constitution stipulates that the central government can delegate specific tasks and responsibilities to local governments by means of law; this is called co-administration. The amount of leeway to execute these tasks and powers may differ depending on the laws and regulations at stake. The delegation of social care and support as embodied in the SSA is an example of municipal co-administration.

The choice to make municipalities responsible for the provision of social care and support was based on the well-known (but contested) assumptions regarding decentralization that local authorities are more familiar with their citizens' needs and wishes than the national government, and have better insight into ways to enhance civic participation (Robinson, 2007b; Scott, 2009; Tweede Kamer, 2004/2005, pp. 7–8). As needs and wishes differ per municipality, the idea was that the municipalities would develop a variety of policies attuned to the specific local situation. Furthermore, the legislator wanted a more coherent offer regarding care and support in line with other local services. It was assumed that coherent, integral local policies would lead to tailor-made provisions in the direct living environment, which was deemed necessary for the achievement of the SSA objectives. Another objective of the decentralization was efficiency. Although the implementation of the Act did not directly go together with budget cuts, cost-containment was a main reason for the reform as such (Tweede Kamer, 2004/2005, p. 6). It was assumed that municipalities would be able to provide more social care and support with less money while retaining good quality care. An argument for this assumption was that coherent policies tailored to the local situation would lead to an efficient use of resources. Furthermore, the conflation of separate budgets regarding different regulations into one local fund, with the municipaliy as the only executive and risk-bearing body, would stimulate innovation and result in a more efficient pattern of spending (Putters et al., 2010, p. 33; SCP, 2010b, p. 34). To realize such a local approach, it was the deliberate intention of the legislator to create a fair amount of policy freedom for the municipalities regarding the implementation of the tasks within the legal framework set through the SSA.

2.4 The legal framework for local policy

In contrast to the EMEA, the SSA does not contain concrete entitlements for citizens, but rather establishes an obligation for the local authorities to organize social care and support through general and individual provisions (SSA, Articles 1 and 4; Sijtema, 2009; Van Rooij & Boersma, 2011). General provisions relate to policy areas such as public mental

health care, care of addicts or the promotion of social cohesion in communities, and address all citizens. Individual provisions flow from the obligation of the municipality to compensate for the limitations persons with disabilities or chronic psychological or psychosocial problems encounter in carrying out tasks independently in their daily lives and in participating in society. This 'duty to compensate' implies that the municipality must make provisions in order to obtain the required result, namely independence and participation of the applicant. The way and the means deployed to reach this result are to be determined by the local authorities within the framework of the SSA. The individual provisions constitute the main part of the municipal tasks following from the SSA.

While it is at the discretion of the municipalities how they realize the prescribed results, the Act does set out a number of preconditions for the municipalities to comply with. This involves first and foremost the obligation of the City Council to draw up a plan for a period of four years maximum that must convey the Council's main objectives regarding the different fields of performance, the way a coherent policy will be executed and the actions that will be taken to reach the objectives (SSA, Article 3). Special attention should be given to quality guarantees, the needs of small target groups, and the required freedom of choice for the applicants. As regards the formulation of policies, the SSA requires participation on the part of the citizens (Article 11). The City Council should give the citizens and their representatives the opportunity to formulate their needs and wishes in a timely manner.

Regarding the 'duty to compensate', the SSA contains a number of specific instructions that limit local policy freedom to a certain extent. The Act says that municipalities have to organize and supply provisions in such a way that applicants (SSA, Article 4):

- can maintain a household (*e.g.* domestic help; a stair lift; grocery service; meals on wheels; assistance with cooking; child day-care)
- can move in and around their homes (mostly a wheelchair)
- can move within the local community with a means of transport (*e.g.* the use of a collective transport system or car adjustments)
- can meet other people and enter into social associations (*e.g.* financial compensation for an accompanying person for the purpose of being accompanied to sports activities).

Compensation means that the service provided must outweigh the limitations by as much as possible, in such a way that the person in question is able to start from a position equivalent to that of a person without limitations (Klosse & Noordam, 2010, p. 423). However, if applicants are able to organize the necessary support themselves they do not qualify for provision under the terms of the SSA.

Provisions may include services in kind or a personal budget for the applicant to purchase the care or support her/himself. It is the competence of the local authorities to decide whether or not a person qualifies for the provision applied for. Furthermore, the municipalities are free to decide in each particular situation whether they offer a collective service, such as 'meals on wheels' or group activities for the elderly, or a strictly individual provision, as long as sufficient compensation in the individual situation is achieved. The City Council is obliged to establish a local by-law in which the individual provisions are specified in more detail. This by-law must include a so-called 'provision list' and formulate under what conditions a personal budget can be provided. The choice for a personal budget may be refused only if there are strong reasons for refusal. A strong reason may be that financial compensation could undermine a collective provision. For example, budgets for individual travelling costs could undermine the local collective transport system.

2.5 Financing and administration

The SSA is mainly financed through national taxes and to a small extent through personal contributions. The greater part of the budget that is allotted by the central government to the municipalities for the implementation of the Act is included in the general 'fund for municipalities'. The distribution of this fund among the municipalities takes place according to a special formula on the basis of a number of local characteristics, such as family composition, age of the population, level of income, need for job-related care, health situation and geographical factors. The municipalities can use this budget at their own discretion – not necessarily on social support – within the boundaries of the law. As regards three fields of performance, namely relief social support, public mental health care and addiction policies, the municipalities receive separate, earmarked, budgets on the basis of more specific criteria. Apart from this, the SSA provides for so-called 'stimulation allowances' for the promotion of social support in general, which can be applied for by the municipalities (Article 21). The whole budget for the SSA amounted to €5.5 billion in 2010 (SCP, 2010b, p. 170). This equals around €233 per inhabitant. The amounts are not very accurate because not all municipalities cluster the same expenses under the heading of the SSA.

The municipalities are allowed to ask for contributions for individual provisions from persons aged 18 years and older (SSA, Article 15). The Minister sets, by decree, maximum amounts. These maximum rates vary depending on the age and income of the applicant and his/her partner. The local authorities are free to determine the level of contributions as long as the maximum amounts are taken into account, and the personal contribution may not be higher than the actual cost of the provision. The Minister has appointed the Central Administration Office (*Centraal Administratiekantoor*) to determine and collect the personal contributions. Often, persons with a minimum income are (partly) compensated for their personal contributions by the municipalities.

2.6 The Social Support Act 2015

The reforms in the social domain involve major changes in the SSA. Currently, all forms of out-patient care and support that go beyond cleaning services are covered by the long-term care insurance on the basis of the Exceptional Medical Expenses Act (EMEA). The services covered by the EMEA include: mental health care; care and support in nursing homes and other forms of intramural care; nursing at home; personal care and support at home; day activities (individual and in groups); and short-term residence (respite care). According to the current plans, this Act will be abolished as of 2015. Instead, a new Act concerning long-term care is being prepared that will only cover the most severe, long-term intramural care for people in need of care for 24 hours a day. The responsibility for all forms of in-patient and out-patient medical care, including long-term mental health care, will be transferred to the health insurance. Finally, social care and support at home, such as support with activities of daily living, extramural day activities and respite care, will become the responsibility of the municipalities. To realize these new tasks, parts of the respective EMEA budgets will be transferred to the municipalities, however, with budget cuts ranging between 15% and 25%.

This shift of responsibilities does not mean that the entitlements to social care and support as prescribed by the EMEA will be moved to the new Social Support Act of 2015 (further referred to as: SSA 2015). An important difference between the EMEA and the SSA is, after all, that the latter does not contain concrete entitlements for citizens. The switch from individual rights towards municipal obligations is emphasized in the draft SSA 2015 in several ways. The current SSA, as noted above, prescribes a municipal duty to compensate

and sets specific results that have to be obtained (the possibility to keep a household, to move around and to meet other people). In the SSA 2015, the duty to compensate as well as the specific results to be reached will be deleted and replaced by a general obligation of the City Council to provide social care and support. This can be done through 1) general provisions and 2) tailor-made provisions where people with a limitation, or with chronic psychological or psychosocial problems, are not able to participate in society or to function independently, either by themselves or with the help of their social networks. This general formulation is supposed to add to the municipal policy freedom. Also the replacement of the term 'individual provision' by 'tailor-made provision' is intended to erase any reference to individual entitlements in order to provide for more local leeway.

The municipalities will also receive a little more freedom in financial respects, since several partitions of the budgets for different social tasks will be removed and personal contributions for provisions may be made subject to the income and assets of the person concerned and his/her spouse. Striking in the SSA 2015 is the considerable increase of formal obligations for the City Council. The Act enumerates a much longer list of topics and instructions in relation to the City Council's periodical policy plans and the local by-laws. Furthermore, it contains detailed rules on different procedures. For example, the application procedure for tailor-made provisions is elaborated in great detail, prescribing the exact obligations of the municipality during the different phases of the procedure. Another change concerns the provision of personal budgets. The qualifying conditions will be tightened and local authorities will have more opportunities to refuse a personal budget.

The reforms are deemed necessary in order to improve the financial sustainability of long-term social care and support. Furthermore, citizens' demands have changed over time; while they live longer, they also wish to lead a good quality life in old age; for example, by living in their own homes for as long as possible and by not being excluded from society. In general, the reforms should result in citizens and families being able to take care of themselves in a better way and to participate in society in good health; in tailor-made support and services; in less bureaucracy; and in a removal of the boundaries between the different provisions in order to better serve multi-problem families through one coach who formulates one integral plan for the entire household (Minister of the Interior and Kingdom Relations, 2013; State Secretary for Health, Welfare and Sport, 2013). The municipalities are considered the most appropriate administrative level to realize these objectives.

3. The implementation of the SSA: achieving the objectives?

3.1 Introduction

In view of the claim that municipalities are the obvious administrative level to be responsible for the provision of social care and support, this section seeks to examine to what extent the municipalities have succeeded in achieving the objectives of the SSA so far. As explained above, the overall objective is participation on the part of all citizens. In view of this overall objective, the SSA is meant to:

- promote coherence of policies resulting in tailor-made provisions geared to the local characteristics and situation
- promote active citizenship and self-organization
- provide demand-steered social care and support of good quality in order to help people to participate and function autonomously in daily life for as long as possible
- create freedom of choice, notably by offering the possibility of a personal budget
- promote informal care and support.

These five points are subsequently evaluated below on the basis of existing reports. In addition, the possible implications of the current reforms for the achievement of the objectives are briefly discussed. With the adoption of the SSA, it was decided that the Netherlands Institute for Social Research would regularly evaluate the implementation of the Act. The first evaluation concerned the period of 2007 to 2009, while the second evaluation, covering the years 2000 to 2013, was not available yet at the time of writing. This section mainly draws on SCP reports (SCP, 2010b, 2013), as well as on a study of the implementation of the SSA by Putters et al. (2010), and the 'Benchmark SSA' of the year 2011 (SGBO, 2012a). It must be noted that most of these studies only relate to the first three years of the SSA; comprehensive evaluation reports covering later years are not (yet) available. The 'Benchmark SSA' includes data until the year 2011, but only covers 30% of the municipalities, since participation in the benchmarking is voluntary. Especially underrepresented are the large municipalities, which means that the figures provided must be considered as rough indications only that mainly serve to identify trends and issues.

3.2 Coherence of policies

One of the leading ideas behind the decentralization was that local authorities know better what their citizens need and that they are able to combine measures at the local level to meet those needs. A coherent system of local social policies would lead to a wide range of provisions attuned to the specific characteristics and situation of the municipality concerned. This would combat 'spillover' and contribute to client satisfaction. As a tool to advance integral policies, the SSA obliges the City Councils to establish policy plans. The evaluations show that, in 2008, 93% of the municipalities had indeed formulated an overarching vision on social care and support. At the same time, however, this was actually translated into policy plans that more or less addressed an integral approach towards the different policy areas in only 53% of municipalities (SCP, 2010b, pp. 59–60). Moreover, only 28% had a strong focus on integrating policies. The individual ideas and ambitions of local aldermen and other policy makers appear to be crucial at this point (Putters et al., 2010, p. 153). It has also been found that large and more urban municipalities establish more coherent policy plans than smaller ones (Putters et al., 2010, p. 12).

Many actors in the social domain mentioned that coherent local policy was hampered because other laws and regulations had to be taken into account apart from the SSA, such as the EMEA and the laws on tendering. In practice, many EMEA clients also apply for SSA support, but integral solutions are rendered difficult because of the organizational and financial barriers between care and support provided under the two acts. For example, the person who helps with the household is paid for by the SSA while the person who assists with getting dressed and doing the shopping is paid for by the EMEA.

Overall, it can be concluded that coherent policies within the social domain have proved not to be easy to realize for several reasons, and that municipalities still have a long way to go in this respect. In any case, the evaluations show that it is not easy for municipalities to develop integral policies addressing different areas within the social domain. The reforms at hand are responsive to this point, notably by the shift of a part of home care to the SSA, which will remove the boundaries between services provided under the EMEA on the one side and the SSA on the other. At the same time, a new barrier will be created, namely between the SSA and the Health Care Insurance Act, since most forms of home care will be shifted from the EMEA to the health insurance. In fact, the boundaries will just shift a little, but hardly be removed. As regards the 3 Ds together

(social care and support, youth care and income provisions for the handicapped), the idea is that this will further increase the possibilities for coherent policies and for combining measures and provisions, resulting in cost savings. Considering the experiences during the first years of the SSA, it might take several years before the municipalities manage to embed their vision on social tasks and, more importantly, to translate this into practice.

3.3 Cooperation with other parties and citizen participation

One of the reasons to assign the implementation of the SSA to the municipalities was the assumption that the latter are in a better position to communicate and cooperate with other parties and mobilize citizens than the central government or the regional care offices that organize the care on the basis of the EMEA. The direct involvement of the various stakeholders was supposed to lead to demand-steered services, more informal care, and client satisfaction. Cooperation partners include interest groups, voluntary organizations and client representatives, but also providers of care and support such as home care organizations and cleaning agencies.

Most municipalities have realized cooperation and citizen participation by establishing SSA councils or platforms; in 2011, one or more SSA platforms were active in around 99% of the municipalities (SGBO, 2013, p. 6). The platforms are to promote the interests of the different target groups of the SSA and other stakeholders. To give an impression of their actual composition, the SSA platforms are, apart from municipal officers, composed of: representatives of persons with a physical limitation (membership in about 95% of these platforms), young adults aged 16 to 23 years (in 41%), informal caregivers (in 91%), and persons with a mental or psychiatric disorder or limitation (in about 84% of the platforms) (SGBO, 2013, p. 6). Other partners that frequently take part are housing corporations, social welfare organizations and home care organizations. Some groups are structurally underrepresented, such as the homeless and victims of violence in the home. On average, around 27 organizations are involved in SSA platforms in one municipality (SCP, 2010b, p. 104).

The role of the Council is, in practice, mainly of an informative, and sometimes advising nature. The first evaluation report of the Netherlands Institute for Social Research (SCP, 2010b, pp. 104, 133) shows that in 57% of the municipalities the SSA platform members, on average, are of the opinion that their interests are well protected; when only taken into account the opinions of client organizations, this number amounts to 43%. Furthermore, in 83% of the municipalities the platform members agree, on average, with the statement that the advice of the platform is sufficiently transferred into policy; however, the figure is 37% when looking at the client organizations only. The latter give the quality of policy cooperation a mere 5.4 out of 10; municipal officials are a bit more positive, but still only give a 6.2. Concerning the realization of the policy, the scores are even lower, 5 and 5.5 respectively. It must be kept in mind that, in the absence of more recent studies, these figures all relate to 2008, the second year of existence of the SSA. It is possible that the learning processes within the municipalities and the platforms have led to better results in the meantime; the next evaluation report will give a decisive answer.

In any case, it can be concluded that most municipalities managed to create a formal framework for structuring cooperation and participation, but that the practical application is lagging behind. In many cases, the existence of SSA platforms does not result in full cooperation with and participation of the various stakeholders, some target groups are generally underrepresented, and there is a large discrepancy between the perception of

clients groups and municipal officials. Considering the fact that the reform plans are heavily based on the concepts of participation and cooperation, it is clear that the municipalities are still facing a big challenge at this point.

3.4 Demand-steered care and support of good quality

The SSA requires municipalities to help people function autonomously in daily life and to participate in society, as laid down in the 'duty to compensate'. The SSA, in this sense, involves a paradigm shift compared to the EMEA that gives rights to specific provisions in specific situations. The shift from individual entitlements to prescribed provisions towards the obligation of municipalities to compensate for the limitations of their citizens requires a change in the approach to clients. Under the SSA, the request for support calls for a demand-driven instead of a supply-steered approach. The evaluation reports address the question regarding how municipalities deal with this 'turning over' (SCP, 2010b, 2013; SGBO, 2013). The overall outcome is that municipalities in general are aware of this paradigm shift, but there are great differences between municipalities in the intensity and the way they deal with this issue. In 2012, 44% of the (responding) municipalities stated that they actually had started with the demand-steered integral approach, while 19% indicated that they wanted to start with it in 2013 (SGBO, 2013, p. 14). A study that covers 2013 still shows that some municipalities pro-actively change procedures and discuss new working methods with stakeholders, while others just place different accents without making deliberate choices (SCP, 2013, p. 162). Also Van der Veer et al. (2011, p. 275) concluded that demand-steered approaches are visible at the implementing level, but that policy visions at this point are generally lacking. Actors indicate that the development of a broadly accepted demand-steered and integral approach is a long-term process that can take many years and requires new skills such as creativity and communication skills, and specific expertise in changing processes.

A demand-steered approach implies that the municipality takes into account the applicant's entire situation including the possibilities of support from her/his social network. For this purpose, a so-called 'kitchen table conversation' has been introduced in many municipalities: in a first meeting, a municipal consultant talks with the applicant, together with other members of the household, and establishes the needs of the person in question as well as the possibility to resolve problems within their own social network. A kitchen table conversation was part of the intake procedure in 42% of the municipalities in 2011, mostly performed by consultants with a university degree employed at the municipality (SGBO, 2012a). In 2012, 75% of the municipalities organised such conversations, however not necessarily as part of the intake procedure (SGBO, 2013, p. 16).

The claim is that municipalities are able to provide care and support of the same quality with less money, as a result of the integral, demand-steered approach. As regards the quality of provisions, Table 1 on client satisfaction shows that clients are generally content with the care and support they receive and that this has remained stable over the course of time. Apparently, the new approach does not affect the extent of satisfaction (Table 1).

No figures are available (yet) that may or may not affirm the efficiency claim. The SCP evaluation of 2013 (p. 136) questions whether policy makers and aldermen think that the new approach can result in cost savings. The cost-saving measures they mentioned were higher contributions, lower reimbursements, stricter entitlement conditions and a broader package of collective provisions. Only the latter may be connected with the new approach; most measures could as well (or better) be taken at other administrative levels.

Regarding the question of whether the provisions indeed contribute to the possibility of independently staying in one's own home and to participate in society, the figures have not been very stable over time; in fact, they show a downwards trend. In 2010, 73% of the respondents answered that the support contributed 'much' or 'reasonably' to independent living, against 81% in 2009. On the crucial question of whether the provisions had helped them to participate in society, 66% of the respondents answered 'much' or 'reasonably' in 2010 against 74% in 2009. In particular, clients who were over 75, who mostly used only one individual service, namely domestic help, indicated that the support did not contribute to their participation in society. It is possible, though, that the support has prevented less participation. It is the downwards trend over the years that may raise concerns in particular.

The draft SSA 2015 re-emphasizes self-responsibility and informal care and takes as a starting point what a person (still) can do instead of what he/she cannot do. This is underscored by the deletion of the 'duty to compensate' that is replaced by the concept of 'tailor-made provisions'. This is meant to leave the municipalities more freedom in the choice of adequate care and support other than individual provisions; for example, through collective services (Tweede Kamer, 2013/2014, p. 30). Furthermore, the draft includes new regulations regarding the application procedure, explicitly prescribing, in a rather detailed manner, how the demand-steered integral approach must be followed during the application procedure. This may force municipalities to press ahead with the new way of thinking and acting. However, these processes are difficult to monitor and the new regulations do not remove the obstacles municipalities experience in realising the paradigm shift.

The current decentralization wave has cost-reduction as an important objective. Looking at the developments so far and the vision of the policy makers in charge, it seems likely that savings will not in the first place follow from the new way of (local) welfare, but rather directly come at the expense of the clients of the services. One way or another, the government accepts the fact that the new situation will affect the care and support people receive in terms of amount and duration of care, the kind of provision (more emphasis on collective services), and costs (Tweede Kamer, 2013/2014, p. 3).

3.5 Freedom of choice

In view of the promotion of self-organization, the SSA offers applicants the option to choose between services in kind and a personal budget. It has been shown that there are big differences in the share of clients with a personal budget among the municipalities, ranging from 3% to 66% in 2010 (SGBO, 2012b). In 72% of the municipalities this share was between 6% and 20%. In practice, a personal budget is mostly used to purchase domestic help; only in isolated cases is it granted for a wheelchair or other appliances. Regarding the municipal duty to inform the applicant, around 75% of the clients who had domestic help were informed about the possibility to opt for a personal budget, and most of

Table 1. Client satisfaction.

Client satisfaction (mark: out of ten)	*2008*	*2009*	*2010*
Application procedure	7.2	7.4	7.3
Domestic help	7.9	7.8	7.8
SSA appliance	7.4	7.3	7.3
Collective transport system	6.7	6.9	6.9

Source: SGBO (2012b)

them were also familiar with its advantages and disadvantages. For the municipalities, personal budgets mean extra administrative work and require the provision of extensive and accurate information for the applicants, as well as monitoring and supervision. Furthermore, it is sometimes difficult for the municipalities to claim back unused parts of the personal budget. These might be reasons why the municipalities are sometimes reluctant to offer the option of a personal budget.

Under the SSA 2015 it will be easier for the municipalities to refuse the provision of a personal budget, which will affect the freedom of choice of the applicant. An entitlement to a budget will become subject to stricter requirements which will reflect the preference for collective provisions offered by the municipality, and take into account efficiency and susceptibility to fraud. For the municipalities, this is good news since a focus on collective provisions might be necessary in order to realize savings. For the clients, however, this will involve a decrease in self-determination.

3.6 Support and promotion of informal care

Informal care plays an important role in the assessment of the kind and amount of social care and support to be granted in each particular situation. The SSA defines informal care as 'long-term care, not given within a professional framework, to a person in need of care by a person from their direct environment, whereby the provision of care directly follows from a social relationship, and whereby the care goes beyond the usual care among members of the same household' (Article 1(1)(b)). The Netherlands Institute for Social Research has performed an extensive investigation on informal care in the Netherlands on the basis of information gathered in 2001 and 2008 (SCP, 2010a). The type of caregiven may range from house cleaning to personal care and support. It appeared that 3.5 million citizens aged 18 years or older (20% of the adult population) gave informal care at some point, among whom were more than 2.3 million who gave care for more than eight hours per week and/or over a period longer than three months.

Reasonably, the SSA states that the municipalities have to develop policies to initiate, facilitate and support initiatives relating to informal care. Furthermore, the Act obliges the local authorities to offer support in cases where informal caregivers are temporarily not able to perform their tasks. The SGBO evaluation (2012a) shows that in 2011, on average, the municipalities spent €1.95 per inhabitant on the support of informal caregivers and €2.50 on the support of volunteers, of the €252 on total SSA expenditure. In most municipalities, a 'support point' for informal care and support is established to coordinate supply and demand and to provide the necessary information. Furthermore, most municipalities provide some sort of 'respite care', for example by organizing temporary care at home and/or in an institution in order to relieve caregivers when they are overburdened and need a period of rest. Other forms of support include: the provision of courses for informal caregivers; meetings with fellow caregivers; and recreational activities. In addition, some municipalities released informal caregivers receiving social assistance from their obligation to seek a job. It has been found that it has become more and more difficult for citizens to engage in volunteer work regularly and for a longer period because of the growing emphasis on labour participation, especially for women. Nevertheless, compared to 2010, the municipal expenses for this field of policy in 2011 decreased by 5.5%, and the spending of approximately 1% of the total budget on the support of informal caregivers does not seem a lot compared to the importance attached to informal care.

The reform plans frequently refer to the increasing importance of voluntary and informal care and the strengthening of a participating society. The draft SSA 2015 does not

contain concrete rules in this respect, but requires the City Council to address the support of informal caregivers in their obligatory policy plan.

4. How the administrative dilemma affects the implementation of the SSA

4.1 Introduction

From the previous section it appears that the municipalities have difficulties in fully realizing the objectives of the SSA. Several reasons for these difficulties have been pointed out, such as the cultural shift that has to take place within the municipalities from an approach that is based on entitlements towards a demand-steered way of thinking and working. This has proved to be a complicated and slow process. The main complaint of the municipalities is that they do not have enough policy freedom to do the job. Although the SSA is meant to leave them significant policy freedom, the Act, as the legal framework, contains a number of regulations that actually limit their leeway. First of all, the 'duty to compensate' and the specific results to be obtained in this respect (keeping a household, moving around and meeting other people) give a rather concrete direction to the municipal tasks (Witteveen, 2006, p. 81). Furthermore, the way of financing restricts the local leeway, for example due to some partitions within the local budget and the impossibility for municipalities to increase the budgets through local taxes, and because the municipalities are very limited in stipulating financial limitations for individual provisions. For example, several municipalities that had created an additional financial requirement, notably an income limit, have been reprimanded both by the Court and the State Secretary of Health. Other policy restrictions following from the SSA involve the rules regarding quality guarantees, freedom of choice, and the obligation to deliver policy plans and evaluations, demanding resources in terms of time and money.

In view of the extension of municipal tasks under the SSA 2015, the Association of Dutch Municipalities is concerned about the limited discretionary power of the local authorities. The central government expects the municipalities to be innovative and efficient, but they feel curbed by the legal framework within which they have to operate. The draft SSA 2015 is responsive in this respect by increasing policy freedom through a more general formulation of the municipal tasks. At the same, however, the articles containing instructions about the policy plan and the municipal by-law have become at least twice as long as in the current Act. In addition many other rules have been added, for example regarding the application procedure and the provision of a personal budget.

It is clear that the current reforms will not solve the decentralization paradox. Despite the political focus on decentralization and municipal policy freedom, the central government does not actually step back. With the provision of detailed instructions it tries to ensure that the centrally set objectives will be met at the local level. These administrative splits are not only visible in the text of the SSA itself. There are several policies, facts, and trends that illustrate as well and counteract the intended local freedom of policy in the social domain. In this section, they are briefly discussed and their effect on the implementation of the SSA is examined.

4.2 Scale of municipalities

The decentralization trend is motivated by the idea that it is the local authorities that are most familiar with their citizens and know best their needs and wishes because of the small scale of a municipality. It is argued that this proximity will result in tailor-made, coherent, and more efficient care, less bureaucracy and that it will promote participation. In 2013,

the Netherlands counted 408 municipalities, with, on average, 41,000 inhabitants (CBS, 2013). Only 27 of them have a population of more than 100,000. However, the central government currently exerts pressure on the municipalities towards an increase in scale through the merging of smaller cities into bigger ones (Government, 2012, Chapter XIII). For reasons of efficiency, the intention of the government is to have, over time, only municipalities of at least 100,000 inhabitants. In fact, there are two opposite policies that reflect two different views on how to realize cost efficiency. On the one hand, integral, client-centred care in small communities would lead to efficient, tailor-made provisions and may prevent unnecessary expenses. But, on the other hand, it would be more efficient and cheaper if one large municipality invented the wheel rather than having several smaller municipalities all developing the same thing independently.

The simultaneous implementation of these two policies (which may both be valid) seems rather paradoxical and is not accompanied by an integral view on the decentralization of social tasks. The necessity for municipalities to scale up may impede the development of coherent local policies attuned to the specific local situation.

4.3 Supervision and accountability

Other paradoxical central policies relate to supervision and accountability. The SSA includes a mechanism of horizontal accountability, which implies that the political systems within the municipalities are supposed to correct undesirable policies. The municipal administrations have to give account of their policies to the representatives of the people: the City Council. Neither the current nor the new SSA includes any vertical supervision mechanism; the legislator has, deliberately, not provided for any steering on the part of the state. Strikingly, in 2012 a new Act was adopted that regulates intergovernmental supervision in general (Wet Revitaliserend Generiek Toezicht). This Act has replaced several specific regulations regarding supervision included in different acts involving municipal and provincial tasks. The new Act on intergovernmental supervision applies to all the tasks of municipalities and provinces following from co-governance. It specifically assigns the supervision of tasks within the social domain to the central government. It stipulates that the central government can interfere in municipal affairs if the tasks are not (properly) executed, or if a decision is made which is against the public interest or the law.

This Act implies an extension of competences on the part of the central government to interfere in local social policy and decision-making (Munneke, 2013; Vonk, 2012, p. 10). This does not accord with the horizontal accountability mechanism incorporated in the SSA. In fact, on the one hand, the legislator obliges the municipalities to create a local welfare system with their own supervision and accountability mechanisms, but, at the same time, it creates new possibilities for the central government to interfere in local affairs if it does not agree with the local interpretation of legal obligations. This may not encourage city councils to stretch their wings and develop new policies, methods and procedures in their imposed search for innovation and cost reduction.

4.4 The principle of equal treatment

One of the consequences of an increase of municipal policy freedom and the quest for local solutions involves an increase of differences in the provision of social care and support among municipalities. From past experience we know, however, that citizens accept such differences only to a limited extent (Allers & De Kam, 2010; Knop, 2012). When citizens no longer consider the differences acceptable, the central government has

shown itself to be ready to interfere by setting national guidelines through intergovernmental agreements or even by legislation. In other words, apparent differences in services among municipalities have in the past led to a limitation of their discretionary power. In relation to the SSA 2015, the Minister now emphasizes that differences will emerge and that citizens will have to accept that. This statement reflects the reasonable fear that an easy shift in the feelings of citizens regarding justice and equality of care is not evident, and it is hard to believe that this single warning will be enough to counterbalance a long national tradition of centrally defined univocal entitlements based on the principle of equal treatment. Also the municipalities are aware of the fact that such a cultural shift will not happen overnight. They have voiced their concerns that, after SSA 2015 coming into force, many citizens will go to court when their respective municipality provides less care, or care of lower quality, or less freedom of choice, or if they levy higher personal contributions than a neighbouring municipality. Indeed, the Council for the Judiciary (2013) has already predicted a large influx of court cases under the new Act.

Contrary to the previous points, the issue concerning municipal freedom versus equal treatment does not follow from two different central policies, but rather from a changed paradigm that has to find its way into society. It is difficult to tell how this will happen, but, in any case, it will take time. Meanwhile, the SSA compels the municipalities to set their own local priorities and spearheads, but, at the same time, the fear of lawsuits may make municipalities cautious of distinguishing themselves, especially by implementing cost-efficient measures.

4.5 Policy freedom limited by court decisions

One feature of the SSA that extends the municipal leeway compared to the EMEA is the shift from individual entitlements to prescribed provisions on the part of citizens, towards the 'duty to compensate' on the part of the municipalities. It is the role of the local authorities to decide how to compensate for the limitations of an applicant in participating and doing things independently. This new approach has brought about questions as to the precise scope of the compensation (Raad voor de Volksgezondheid en Zorg, 2010). Counterparts of the compensation principle are the applicant's own possibilities and social network; a request for an individual provision can be refused if an applicant can organize support by her/himself. Not surprisingly, the assessment of individual versus collective responsibility has been the subject of many court cases. In several cases, the Central Appeals Court (the administrative court in the last instance) has emphasized that the municipalities have an obligation to take proper measures *in each individual case* to compensate for existing limitations in a person's ability to cope independently and to take part in society. The Court stressed that neither the law, nor the parliamentary documents give rise to an unresponsive or restrained assessment of a particular situation regarding individual provisions (Centrale Raad van Beroep, 2008).

In the mean time, the case law has shaped the meaning of the compensation principle in considerable detail and most municipalities incorporate the court decisions in their local by-law. Thus, on the one hand, the demarcation by the judge of what the municipal duty entails in specific situations has strengthened the rights of citizens, but, on the other hand, it restricts the discretionary power of the municipalities. It is likely that the legislator has not anticipated this development, all the more since in 2006 the State Secretary assumed that the Court would exercise restraint concerning the interpretation of the duty to compensate (De Lange, 2012, p. 84; Tweede Kamer, 2009/2010). In order to create more local leeway, the compensation principle has now been deleted in the SSA 2015, and

replaced by a more general formulation. It will be seen whether the Court will nevertheless build on its previous case law or take a new direction by referring to the municipal discretionary power.

Another issue is the way municipalities deal with the case law. A court decision in an individual case does not mean that the same decision would be taken in another case – not many situations of persons in need of social support are exactly the same; and, obviously, different circumstances may lead to different decisions. The automatic incorporation of court decisions in the local by-laws may unnecessarily generalize individual cases, and this behaviour does not seem to accord with the complaints of municipalities about their lack of policy freedom.

4.6 The ambiguous position of the municipalities

The position of municipalities in the decentralization issue is ambiguous in further respects. The umbrella Association of Dutch Municipalities continuously voices its concern about the municipalities' limited discretionary power (Vereniging van Nederlandse Gemeenten, 2013, 2014). The Association stresses that the municipalities are expected to implement the SSA 2015 with a much smaller budget and that this will only be possible if, among other things, they receive a maximum amount of policy freedom. Understandably, they are afraid that with the increase in tasks to be performed with less means, they will not have enough leeway to make the choices and set the priorities necessary to economize. At the same time, however, many municipalities do not deploy the freedom they receive under the SSA. For example, the SSA requires the municipalities to formulate a local by-law on individual provisions. This is an outstanding opportunity for local authorities to develop their own policies and procedures attuned to the local situation. Nevertheless, what happens in practice is that almost all municipalities copy the model by-law composed by the Association of Municipalities (which has also been referred to as a shadow department of the Ministry of Internal Affairs, Witteveen, 2006, p. 77) that includes all relevant case law. It has also been established that information provided by the central government strongly influences local policies (Van der Veer et al., 2011, p. 272). Thus, on the one hand, the municipalities demand more discretionary power, but, on the other hand, they voluntarily choose for uniformity and hand over a part of their power to the Association of Municipalities, the central government, and the Court. Apparently, despite their quest for policy freedom, it takes time for the municipalities to adapt to diminished central steering and to actually deploy the space they have been granted.

5. Conclusions

It can be concluded that the municipalities, by and large, implement their statutory tasks in accordance with the legislative framework. For example, the prescribed policy plans are being produced, local SSA platforms have been installed, and there is general awareness of the necessary shift from a supply-steered towards a demand-steered approach. The foregoing also reveals, however, several issues that do not concur with the formulated objectives of the SSA or that do not confirm the presuppositions on which the SSA is based. More specifically, it has become apparent that it may be quite optimistic to assume that the municipalities will develop coherent policies within the entire social domain and be able to effectively cooperate with the various stakeholders. Although the formal structures for co-operation have been realized in most municipalities, the effectiveness of

partnership is (still) poor, at least from the perspective of the client groups. Moreover, the transformation from the provision of care or support on the basis of clearly prescribed entitlements towards a demand-steered approach that should take into account the client's entire situation has been found difficult to realize and is far from completed.

The experience with the SSA teaches us that such transformation processes within bureaucratic organizations are unfolding at a very slow pace and that their success greatly depends on the efforts and skills of individual members of the City Council and municipal officials. Also the efficiency claim that accompanies the decentralization policies cannot be confirmed so far; savings envisaged by local officials largely involve economy measures that are not related to the new local approach but could just as well be taken at the central level. Furthermore, the personal budget as an exponent of freedom of choice and self-organization has not been widely embraced by the municipalities. This contrasts with the centrally implemented EMEA under which the provision of a personal budget is an incorporated entitlement that actually enables applicants to organize their own care. An important pillar of the SSA is the commitment of informal caregivers. It was assumed that informal care can best be promoted at the local level; however, it has not been found that municipalities actually succeed in mobilizing more informal caregivers.

The political claim that the SSA can best be implemented at the local level does not seem to be evident. Several impediments for the municipalities to make the shift have come to the fore, such as unwieldy organizational structures, lack of specific skills, and adherence to traditional working methods. In addition to these rather internal obstacles, the decentralization processes are being counteracted by different developments and central policies. The proclaimed local policy freedom is actually restricted by the sometimes extensive instructions within the legislative framework; financial restrictions; central directions regarding a scaling-up of municipalities; central supervision and interference possibilities; the general adherence to the principle of equal treatment following from the central welfare state paradigm; and by the municipal docility towards uniform guidelines.

All in all, the 'new way of welfare' envisaged by the State Secretary seems not exactly within reach. The shift from central to local responsibilities is a complicated exercise that will not necessarily be successful and the current reform plans will not solve the problems. In fact, the decentralization dream gets bogged down in the persistent administrative dilemma between a maximum of municipal policy freedom on the one hand and uniform, central regulation on the other. The government has not made a clear choice between these two paradigms, but rather wants them both. It has in mind the ideal of democratic local communities shaping their own specific systems of social welfare, but at the same time it does not depart from the dogma of the centrally steered welfare state. Unfortunately, a dilemma implies that the one possibility in principle rules out the other. By trying to simultaneously proceed with the two basically opposing paradigms, neither the advantages of a decisive and uniform central administration nor the benefits of demand-steered local welfare will be realized. It would be advisable for the government to reconsider this quandary and develop a clear, coherent, and long-term supra-ministerial vision on the division of tasks within the social domain.

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