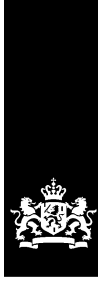

Sociaal en Cultureel Planbureau

Summary

The market for domiciliary care

Municipal procurement policy and public use of services provided under the Dutch Social Support Act 2007

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Key findings in a nutshell

This study focuses on the market for domiciliary care (home care) in the Netherlands and those who use it. It investigates domiciliary care provided under the Social Support Act 2007 (Wmo 2007), and in particular the way in which municipalities procure domiciliary care services and what consequences this has for service users. The main research questions addressed are as follows:

1. Can municipalities influence the price when procuring domiciliary care services?
2. What noticeable effect does the procurement and co-payment policy of their municipality have on users?

In answering the first question, we examine the procurement method used and the collaboration between municipalities in this regard. To answer the second question, we look at the freedom of choice of users and at the contribution expected from them in the form of a co-payment. We also investigate the relationship between co-payments and use of services by clients.

The analysis covers the period 2007-2013, because not enough data are available for the period since the introduction of the Wmo 2015. We would also have liked to include the quality of domiciliary care in this study, but no objective criteria are available to enable this quality to be measured across municipalities. And while client satisfaction data are available for most municipalities, they show virtually no variation between municipalities and are therefore not suitable for measuring (differences in) quality.

The principal findings in relation to these two research questions are set out below.

1a. Different tendering procedures are not accompanied by differences in prices, market shares and freedom of choice.

1b. The prices paid by municipalities which purchase services independently are comparable to those paid by collaborating municipalities.

2a. The amount of the co-payment paid by users depends more on their personal circumstances (use of services, income and household composition) than on where they live.

2b. Co-payments limit the use of domiciliary care to some extent. An increase of 1 percent in the co-payment per hour of care received goes along with a reduction of 0.5 percent in the number of hours of care used.

Developments in the domiciliary care market

This study covers the period 2007-2013, i.e. the first seven years after the introduction of the Social Support Act (Wmo) in 2007. Before discussing the key findings of our analysis of the domiciliary care market, we describe the main developments in that market. The Wmo 2007 transferred responsibility to local authorities for providing domiciliary care to independent community-dwelling citizens who were not able to run a household without help. This decentralisation was accompanied by institutional changes which had consequences for the domiciliary care market. For example, the Wmo 2007 required local authorities to procure domiciliary care through a tender procedure. Municipalities use a wide variety of tender models for this, and a substantial number changed their models during the period studied. Following amendments to the Wmo in 2012, local authorities are no longer required to procure domiciliary care through public tender. This explains the recent rise of administrative tenders, in which the local authority engages in consultations with a number of care institutions and reaches agreements.

However, the majority of tender models are public, such as the 'most economically advantageous tender' (MEAT) and the 'Zeeuws model'. In a MEAT procedure, the local authority selects providers based on price per hour and quality. In the Zeeuws model, the local authority admits all providers which meet minimum quality standards and are willing to provide care at the hourly price fixed by the local authority.

The requirement to put domiciliary care out to tender has resulted in new providers entering the market in virtually all Dutch municipalities. These are sometimes existing domiciliary care organisations, operating outside their traditional catchment area, and sometimes newcomers: organisations that have not provided domiciliary care before. In the first few years following the decentralisation, a fair number of providers also left the market or were taken over by other domiciliary care organisations. These were predominantly small or very small providers which provided care to only a few users.

Overall, the average number of providers per municipality fell slightly between 2007 and 2013. This does not automatically mean that the freedom of choice of users also reduced; in fact for many it actually increased, for example because budget guarantees for providers (a guarantee of a minimum budget for a provider) were replaced by framework contracts. Framework contracts do not guarantee providers a minimum volume or budget, which means users are no longer automatically referred to a particular provider and can therefore decide for themselves from which provider they wish to receive domiciliary care.

Another notable development is that the domiciliary care markets in municipalities have become more equitably distributed among providers over time: in many municipalities, new entrants have taken over a substantial part of the market from the market leader (the provider

delivering the most hours of care within the municipality). This trend can be explained partly by the reduction in local authority referrals for 'extensive' domiciliary care with organisational responsibility ('HH2' in Dutch), involving tasks such as cleaning the fridge and at the same time throwing away products that are beyond their use-by date, and an increase in referrals for 'standard' domiciliary care ('HH1'), for example simply cleaning the fridge. New providers were better placed than existing domiciliary care organisations to respond to the changing relationship between HH1 and HH2 care by taking on cheaper staff. Despite this, in 2013 the market leaders still provided around 60 percent of all domiciliary care in Dutch municipalities.

Market leaders within a municipality thus have a large market share, but this does not lead to significantly higher prices. That runs counter to what might be expected where a local authority has few alternatives when procuring services: if there are not enough alternative providers to take on clients from the biggest care provider, the local authority has no choice other than to pay the price demanded. This does not appear to happen in this market, however: the price charged by providers with a market share of 60 percent is only 2 or 3 percent higher than that of small care providers. And this applies only for municipalities where there are price differences between providers; there are also many municipalities where price differences are not possible because of the use of the Zeeuws procurement model. These findings indicate that reducing the market shares of large providers is not an effective strategy for controlling the costs of domiciliary care.

The reason that large providers do not demand much higher prices may lie in the institutional design of the Wmo 2007 and the policy pursued by local authorities in this regard. The (threatened) entry of new providers in response to the tender procedure may have had a dampening effect on prices. In addition, local authorities promote freedom of choice for users by entering into contracts which do not offer budget guarantees to providers. This means that users are no longer referred to a specific provider, but are able to choose their own. It is plausible that an increase in freedom of choice encourages providers to offer competitive prices as well as adequate quality. It was also intended that tasks such as providing support with daily living would also be transferred to local authority responsibility after 2015. Competitive pricing then increases the chance that providers will be able to deliver domiciliary care in 2015 and, as providing services increases the profile of providers and enables them to exploit synergies between the different forms of support, this increases the chance that they will also be able to provide other support services after 2015.

Notes on key findings

The key findings described in this report stem from our study of the market for domiciliary care and those who use it. A further explanation of these findings is given below.

1a Different tender procedures are not accompanied by differences in prices, market shares and freedom of choice

There is no relationship between tender models and prices: prices within municipalities which use the MEAT model are virtually the same as in municipalities which employ the Zeeuws model or use administrative tendering. Where a local authority switches to a different tender procedure, this also does not lead to significant price changes. The tender procedure chosen thus does not determine the price. Moreover, different models lead to a comparable distribution of the market among providers.

A plausible reason for this is that, regardless of the tender procedure used, virtually all municipalities contract several providers. For example, almost all municipalities which procure domiciliary care using the MEAT method – no pre-selection – award contracts to several providers. In terms of the number of active providers within the municipality, the MEAT method therefore does not produce very different results from the Zeeuws method or the administrative tender model. The different tender models thus generate a comparable degree of freedom of choice and create virtually no differences in competitive pressure.

While all tender models ensure that there is competition between providers after contracts have been awarded, therefore, the market shares of providers remain quite stable within a contract period. This may be because users value continuity of care provision. However, it also limits the competitive pressure felt by domiciliary care providers. Re-tendering for domiciliary care enables new providers to enter the market and leads to the disappearance of some existing providers. We therefore do see substantial shifts in market share between successive tender rounds. In other words, a new tender appears to be the perfect moment for municipalities to seek a different distribution of the market.

1b The prices paid by local authorities which purchase services independently are comparable to those paid by collaborating municipalities

Municipalities can procure domiciliary care independently or in collaboration with neighbouring municipalities. Whichever method is used, however, the hourly prices set for domiciliary care are comparable. Procurement on a larger scale therefore does not appear to increase municipalities' purchasing power. Despite this, collaboration between municipalities when procuring services is popular: in the period 2007-2013, around 90 percent of Dutch municipalities procured domiciliary care collaboratively. It may be that collaborating municipalities benefit mainly from each other's procurement expertise and from sharing the costs of tendering.

However, these benefits of collaboration may be achieved at the expense of the ability to offer local customisation. To retain this possibility, many collaborating municipalities opt to divide the tender into segments. Geographical segments, which often coincide with an individual municipality, are generally characterised by specific prices and quality standards. In reality, therefore, municipalities then procure services per segment, which means they are actually not procuring on a larger scale; this does not however have the effect of driving up prices. Where municipalities have different preferences, therefore, it is recommended to include segmentation in the tender specification, as long as municipalities weigh this collaboration against the increasing administrative and implementation complexity.

2a The amount of the co-payment paid by users depends more on their personal circumstances (use of services, income and household composition) than on where they live

Do the procurement methods used by municipalities have a noticeable effect on users? Municipalities require users to make a contribution towards the cost of providing domiciliary care, up to a certain maximum. The amount of this maximum co-payment depends on the user's income, age (whether or not they have reached state retirement age) and household composition (single or multiple-person), and is capped by central government. As an average, the co-payment rises by 0.4 percent for every 1 percent increase in the price charged by providers. Local authorities may choose to lower the maximum co-payment, but this is exceedingly rare. The price differences between municipalities are relatively small (compared with the differences in co-payments) because most municipalities charge the full amount (subject to the set maximum) on to users. In addition, the co-payment is capped at national level. As a consequence, the amount of the co-payment depends mainly on the number of hours of care used, the user's household composition, age and income, and not so much on where the user lives.

2b Co-payments limit the use of domiciliary care to some extent

In municipalities where the hourly co-payment increases by 1 percent, the use of domiciliary care declines by 0.5 percent. The availability of informal care cannot prevent citizens from using domiciliary care, but is associated with a lower care intensity.

Extrapolation to the Wmo 2015

Although this study is limited to the market for domiciliary care under the Wmo 2007, the insights obtained are relevant for the municipal procurement policy under the Wmo 2015, given the substantial parallels between the two laws. Domiciliary care providers often also provide 'new' Wmo services, such as support with daily living. In addition, when procuring 'customised services' under the Wmo 2015, municipalities may opt to work together and often employ the same procurement models as for the Wmo 2007 (Van Eijkel et al. 2015).

At the same time, there are of course differences. For example, under the Wmo 2007 almost all municipalities paid domiciliary care providers for each hour of care delivered. Under the Wmo 2015, there are far more contracts in which providers are paid for delivering a particular kind of care, without it being specified precisely what form this care takes (specifying a 'clean house' rather than a set number of hours' domiciliary care). This encourages providers to work efficiently, but also increases the risk that too little support will be offered (Van Eijkel et al. 2015). This not only has potential consequences for quality, but also affects citizens by giving them less control over the level of their co-payment, which they can no longer reduce by using fewer hours of help.

Although the prices charged by large domiciliary care providers are barely higher than those of smaller providers, it is not clear that this also applies for the care tasks which were decentralised in 2015. The new forms of help, such as support with daily living, are more complex than domiciliary care, reducing the risk for existing providers that newcomers will enter the market. Benefits of scale in delivery also play a bigger role with these services: there are fewer users per individual service, which in practice means there is scope for only one or a small number of providers within a municipality (or even a region). These factors lead us to suspect that providers in markets for the new Wmo services are in a stronger negotiating position vis-à-vis local authorities than on the domiciliary care market. The choice of procurement model is then more important.

What does this mean for the citizen? The possible efficiency gains and lower co-payments for domiciliary care users referred to above, may be offset by the strong negotiating position of providers, resulting in higher co-payments for those who use support services.