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| The Dutch Decentralisations |
| A search for the interest, roles and influence of relevant actors |

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**Abstract**

Since 1 January 2015 Dutch municipalities have become responsible for tasks arising out of the new Youth Care Act (Jeugdwet), the Social Support Act (Wet maatschappelijke ondersteuning, Wmo 2015), and Participation Law (Participatie wet). This decentralisation in the social domain can be understood as one of the most important developments in Dutch domestic governance in the last century.   
 The Netherlands is well-known for its consensus-based society, which refers to the achievement of wide agreement in important political issues. During the establishment of a new policy a broad platform of support is required among all parties that are affected by the new policy. According to the Advocacy Coalition Framework (ACF) of Paul Sabatier (1991) the policy-making process, in terms of agenda-setting and other phases, is dominated by elite opinion. In contrast, the policy cycle-actor hourglass approach of Howlett, Ramesh and Perl (2009) states that the policy universe is involved in agenda setting, and is based on the public opinion. In short, the ACF emphasizes the role of elite actors while the hourglass approach highlights how broad-based public opinion drives policy change.  
 The Dutch decentralisation is a very topical issue, showing the need for scientific research on the establishment of this new public policy. This research could contribute to the implementation and evaluation of the decentralisations. This thesis enters the debate about the causes of policy change by asking how the interests, roles and influences of relevant actors explain the decentralisation of Youth Care Act and the Wmo 2015 in the Netherlands. The information that is used in the thesis, derives from official documents of parliament, for example meeting reports, but also, position papers, reactions on government formation, and research reports.   
 The main conclusion of the thesis is that the advocacy coalition framework gives a better explanation how the interest, roles, and influences explain the decentralisation than the policy cycle-actor hourglass. Besides, the external environment played a tremendous role in this. Overall, in the entire policy-making process mainly a few actors are involved, deriving from the government, and umbrella organisation. This means that the decentralisation of the health care system in the Netherlands is less concerned with the public opinion.

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# Chapter 1: Introduction

Since 1 January 2015 Dutch municipalities have become responsible for tasks arising out of the new Youth Care Act (Jeugdwet), the Social Support Act (Wet maatschappelijke ondersteuning, Wmo 2015), and Participation Law (Participatie wet). To finance these new responsibilities, the General State Budget for 2015 reveals an increase of the municipal fund that is one-and-a-half times greater than in recent years; approximately 8 billion euros out of the national government’s budget is transferred due to the tasks municipalities need to execute in respect to matters relating to labour, care, and young people.[[1]](#footnote-1) In particular, the social domain is now the most important function of municipalities. This means that the decentralisation in the social domain can be understood as one of the most important developments in Dutch domestic governance in the last century.[[2]](#footnote-2)

The decentralisation with regard to youth assistance, care, and labour participation did not happen by chance. As stated in the 2010 coalition agreement, the First cabinet Rutte (Rutte I) pushed for a phased implementation of youth care into local governance.[[3]](#footnote-3) This same agreement specifies that organisations that provide basic care need to cooperate in a neighbourhood or village-based network. Subsequently, in 2011 umbrella organisations of different sublevels of government (municipalities, provinces, and water management authorities) and the state have signed the governance agreement to achieve more effective and executive governance.[[4]](#footnote-4) These agreements refer also to the importance of providing public services close to citizens and therefore to the decentralisation of assistance currently provided under the general law on exceptional medical expenses (AWBZ) and youth care at the local level.[[5]](#footnote-5)   
 The Netherlands is well-known for its consensus-based society, which refers to the achievement of wide agreement in important political issues. During the establishment of a new policy a broad platform of support is required among all parties that are affected by the new policy. In a consensus-oriented political system, it is important to ask which groups will be affected by the decentralisation of care. In addition, which interests play a role in the entire decentralisation process? Moreover, if the government desires to achieve a broad-based common policy the different stakeholders need to be taken into account. Yet, who are these stakeholders?

In the Coalition Agreement of 2010 and the Governance Agreement, it seems as if the decentralisation process was a choice made by government for electoral reasons. However, according to the Advocacy Coalition Framework (ACF) of Paul Sabatier (1991) the policy-making process, in terms of agenda-setting and other phases, is dominated by elite opinion.[[6]](#footnote-6) This elite has the control over generation and legitimation of technical knowledge, and it is through these channels that elite actors shape policy agendas and the selection of alternatives. In contrast, the policy cycle-actor hourglass approach of Howlett, Ramesh and Perl (2009) states that the policy universe is involved in agenda setting, and is based on the public opinion.[[7]](#footnote-7) In short, the ACF emphasizes the role of elite actors while the hourglass approach highlights how broad-based public opinion drives policy change.  
 This thesis enters this debate about the causes of policy change by asking how the interests, roles and influences of relevant actors explain the decentralisation of Youth Care Act and the Wmo 2015 in the Netherlands. This question can be broken down into several sub-questions: Who are the main actors in the decentralisation process? What are the interests of these various actors? What are the roles of the various actors in policy-making process? How did relevant actors use their resources to try to influence the policy-making process?

This analysis presented in the thesis has both scientific and social importance. Although the new laws entered into force on 1 January, the decentralisation process is currently in the implementation or evaluation phase. Furthermore, several parts of the laws have not taken full shape yet. Therefore, the Dutch decentralisation is a very topical issue, showing the need for scientific research on the establishment of this new public policy. In addition, this research could contribute to the implementation and evaluation of the decentralisations, because it is still possible to adjust components of the decentralisation strategy. For this reason, a good understanding of the multiple actors involved , as well as their interests, is necessary for any attempt to modify the policy.   
 To indicate which actors participated and which interests influenced the adoption of the decentralization legislation, the ACF and the policy cycle-actor hourglass are used. These theories generate very different predictions concerning the causes of policy change. In the advocacy coalition framework, the outcome of the process is due to negotiations among elites in the policy subsystem. In contrast, in the policy cycle-actor hourglass the outcome of the process is conditional of public opinion in the separate stages of the policy cycle.  
 The thesis draws on several types of documentary sources in order to identify the actors and interests involved. These data consist of reports of plenary and commission meetings of the parliaments, letters to the parliament by the Minister of Health, Welfare and Sports and the Secretary of State, reactions to these letters by several actors in the form of position papers and agreements.   
 The thesis is organized as follows. In the second chapter some background information concerning the Dutch decentralisations is provided, in which the main characteristics of the Youth law, and Wmo 2015 are presented. Third, the theories on public policy and decentralisation are explained. In addition, the methodology used in this thesis is explained. Chapter five discusses the context of the decentralisations. In the following chapter, a stakeholders analysis is set out. Since the policy cycle-actor hourglass is based on the policy cycle model, chapters seven up to ten are structured according to the different stages of the policy cycle; in other words, agenda setting, formulation, decision-making, and implementation. Chapter eleven concludes the thesis by discussing the implications of the analysis for research on public policy in the Netherlands and theories of policy change.

# Chapter 2:The enormous decentralization

**Since 1 January 2015, municipalities in the Netherlands are responsible for youth care, elderly care, and labour participation. This change means that municipalities have taken over important tasks that the national government used to carry out. To execute these tasks, the national government has also given the municipalities much freedom to implement policy according to local needs and preferences. In practice this means that policy in the 393 Dutch municipalities is not uniform; instead, the 393 municipalities may formulate policies that meet national standards but at the same time are tailored to local conditions. This chapter provides the empirical background to the analysis that follows. The first part of the chapter describes the Youth Care Act. The second part provides information on the Wmo 2015.**

The standpoint of the Second Rutte cabinet is to facilitate and stimulate citizens’ ability to provide for themselves. Citizens are together with their environment and network above all responsible for a healthy life and active participation in society.[[8]](#footnote-8) This means that a successful appeal for customised goods, such as a mobility scooter, a stair lift, or individual supervision, cannot be taken for granted anymore. Instead, the emphasis is shifted to general facilities that are readily available in surroundings and usable by everybody. In the event that general facilities are not suitable, an appeal can be made for customised goods.

Until 2015, help to youth and their guardians was divided into the following three arrangements: the Youth Act, the General Act on Exceptional Medical Expenses (Algemene Wet Bijzondere Ziektekosten, AWBZ), and the Healthcare Insurance Act.[[9]](#footnote-9) As a result of the decentralisations, municipalities will become responsible for all forms of youth aid, aggregated in the Youth Care Act. Municipalities were already accountable for functions such as education, childcare, youth healthcare, support for raising children, and minor assistance. Because of the transition of these tasks, they will also become liable to closed facilities for youth rehabilitation, former provincial youth care, mental health for youth, care for youth with mental disabilities, supervision and nursing, protection of children and youth, and juvenile rehabilitation.[[10]](#footnote-10) Therefore, the role of provinces in the area of youth care will be expired.  
 Hence, municipalities must ensure integral support and care to adolescents and their guardians in all thinkable problems in growing up and parenting.[[11]](#footnote-11) As a result, there will be more emphasis on preventive and early detection. Starting point is that there are more effective and more efficient cooperation around families. Municipalities have a duty means that municipalities are responsible for all the help is provided to young people. The age limit for youth care is 18 years and can be extended up to 23 years if the aid is not applicable under a different legal framework.[[12]](#footnote-12)

If necessary, municipalities need to cooperate at regional level, especially at the domain of youth rehabilitation and certain specialist forms of care. Since this is related to a small target group, which need specific knowledge and expensive forms of care, it is both a substantive and financial gain when facilitated in partnership. Inventory under municipalities has led to set up 42 youth care regions in which municipalities working together at a supra-local level.

Municipalities are responsible for a number of tasks related to the social domain since 2007. The purpose of the Wmo 2007 is to enable people to participate in society. This law is primarily intended for the elderly, people with mental health problems and people with disabilities.In 2015, the AWBZ is redesigned in such a way that only intramural elderly- and disability care will remain a part of the act. The idea is that people should be able to continue to live in their own environment for as long as possible, even if there is a need for care and support. Therefore, municipalities as the most imminent government to citizens become responsible for the organisation of care. Hence, the former AWBZ is split into the Wmo 2015 and the long-term care Law (WLZ). This implies that the Wmo which is implemented in 2007 is extended in 2015.  
 The Wmo 2015 makes municipalities accountable for support, counselling, and care. Simultaneously, the possibilities to entitlement to these forms of care are restricted.[[13]](#footnote-13) For example, counselling is not an automatic right to a customised good anymore, but more focused on general facilities and self-reliance. Questions regarding counselling are: What are the person’s possibilities? What can be done by the surrounding peoples? And, what kind of assistance is required? The Wmo 2015 is meant for people with a disability, chronical disease, elderly, people with a psychosocial disorder, people who require shelter, shelter for women, and assisted living.[[14]](#footnote-14)

For both the Youth Care Act as the Wmo 2015, municipalities are responsible for the continuing of care in the transition year. This means that clients will receive the care they are entitled to prior to 2015 until one year after ratification of the new laws. In other words, clients still have the right to specific care until no later than 31 December 2015. Hence, municipalities must indicate during 2015 clients again for the care that will be delivered from 1 January 2016 onwards.[[15]](#footnote-15)

# Chapter 3: Theoretical framework

**This chapter sets out the theoretical framework that structures the analysis of the decentralisation of youth care and social support. The chapter describes and discusses two major approaches to the study of the public policymaking; the policy cycle framework and the ACF. The chapter describes the central assumptions and claims of each approach, and discusses how each approach can help to explain the decentralisation of youth care and social support. Before discussing the nuts and bolts of each of these theories, the chapter discusses the concept of decentralization and maps the network of actors involved in social care and health care systems.**

**Definition of Decentralisation**

Decentralisation can be defined as the devolution of powers, responsibilities over powers, and resources from the national level into a subnational government.[[16]](#footnote-16) Between 1980 and 2004 half of the member states of the European Union transferred powers to a subnational government.[[17]](#footnote-17) Decentralisation has two different definitions, which often causes confusion; it is defined as a policy process and as a state of a system.[[18]](#footnote-18) When decentralisation is used as a policy process it refers to the process in which national policy is transferred to subnational governments. In contrast, a system decentralisation is a state structure in which subnational governments are responsible for certain tasks that are not executed by the national government, as in a decentralised unity.

Decentralisation can be divided into ‘territorial decentralisation’ and ‘functional decentralisation’. In the case of territorial decentralisation, powers are assigned to the government of a certain demarcated area, such as, provinces or municipalities. In functional decentralisation tasks are allocated to an organisation responsible for a specified public service such as, water management boards.[[19]](#footnote-19)

In addition to the division into territorial and functional decentralisation, the role of sub-national governments in policy-making can take an autonomy or a co-governance form. Autonomy provides local governments with independent authority in policy, whereas co-governance refers to the implementation and execution of national policy by local governments.[[20]](#footnote-20) Nevertheless, autonomy is not without any constraints, as municipalities, for example, are only allowed to perform authority over policy within given boundaries.

The decentralisation of youth and elderly care in the Netherlands is a typical example of transformation of autonomy from national government to municipalities. Therefore, in this research decentralisation is defined as the devolution of autonomy on a certain domain by the national government to a territorial bounded sub-national government level. Furthermore, the term decentralisation is used in this research as a process of transformation of tasks.

**Key actors in healthcare reform**

The goal of this thesis is to explain the political drivers of decentralisation of youth and elderly care in the Netherlands, so it is necessary to map the structure of the health care system within which both types of care are located. The decentralisation of elderly care, and youth care from national to subnational government in the Netherlands is a form of healthcare reform. The healthcare system can be regarded as consisting of a relationship among the following five major actors: the healthcare providers, the population, the state, the organizations that generate resources, and the other sectors that produce services with health effects (see Figure 1). People who need or receive care are part of the population and are not identified as a separate actor. Hence, the central components of the health system are the population, the state, and the providers of healthcare. That is why a reform of the system originates in an evolving relationship between these actors.

As such, the population consists of numerous forms of organisations such as households, society, trade unions, and interest groups. As well as the population, the provider can be considered a homogenous category. This category does not only consists out of a great variety of types of healthcare, but also out of different types of professionals. As a result, not all providers pursue the same interests. In addition, the population is made up by multiple groups that can be subdivided for example, into income, employment, educational level, and geographical location. Figure 1 illustrates that healthcare reform mainly arises out of changes in the relationship between the provider, state and population.

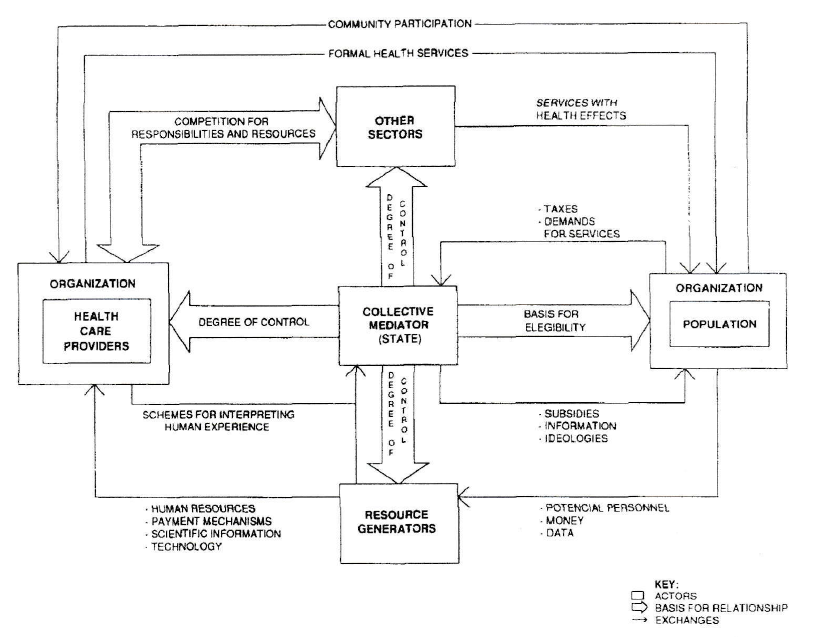


Figure 1: Components and relationships of health systems[[21]](#footnote-21)

**Why decentralisation (or not)?**  
Stakeholders are actors who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or could have an active or passive influence on the decision-making

and implementation processes.[[22]](#footnote-22) These stakeholders do have interest in whether care services are decentralised to municipalities or not.

*Citizens and interests groups*As a consumer of care, citizens and clients are affected by the decentralisation of care. It is in their interest that there are no major consequence of the new policy in their disadvantage. Therefore, clients and the representative organisations have preferences concerning the policy about how they receive care.

In 1787 James Madison mentioned the involvement of interest groups in society. In the Federalist Papers (no.10) he noted the following:

“ The smaller the society, the fewer probably will be the distinct parties and interests composing it; the fewer the distinct parties and interests, the more frequently will a majority be found of the same party; and the smaller the number of individuals composing a majority, and the smaller the compass within which they are placed, the more easily will they concert and execute their plans of oppression. Extend the sphere, and you take in a greater variety of parties and interests; you make it less probable that a majority of the whole will have a common motive to invade the rights of other citizens; or if such a common motive exists, it will be more difficult for all who feel it to discover their own strength, and to act in unison with each other.” [[23]](#footnote-23)

Thus, according to Madison, interest groups attach value to the size and coherence of the group. When a citizen or a small group of inhabitants have a different interest than the majority, there is a greater risk of suppression within a smaller community. This would mean that interest groups strive to a more balanced distribution of powers and the preservation of individual freedom. Besides, at the local or regional level interest groups are not as effective as at the national level, because of the fragmentation.[[24]](#footnote-24)

For the normal functioning of human beings, habits are a necessity, because they enable us to perform without any attention. At the same time, habits can be a boundary to behavioural changes, while societal challenges may insist on this.[[25]](#footnote-25) Development in public policy makes it necessary for people to adapt different behaviour. These changes of policy come along with uncertainty for stakeholders, as it is not clear beforehand what influence the changes will have and how it will affect the stakeholder. People experience uncertainty as unpleasant.[[26]](#footnote-26) Due to deficiency of information, citizens are less capable to arrive at a balanced opinion. In order to form an opinion on the outcome, people return to information that is within reach, namely information about the followed procedure. Furthermore, when people consider the procedures as fair and equitable, the outcome will also be judged as fair and equitable.[[27]](#footnote-27) However, this is only true when people are not familiar with a just outcome in the specific subject. When people do have sufficient information concerning the specific subject, procedure and treatment are being reduced.[[28]](#footnote-28) Nonetheless, interest groups generally have sufficient information at their disposal to have an opinion on a just outcome.   
 For this reason, citizens and interest groups’ motives are in line with four leading motives; they will maintain what was applicable in the past, larger societies need a larger scale so that minorities can be accommodated, and, consequently, contribute and the system will function better.

*Healthcare providers*Healthcare providers are important because together with the state and the population they shape the healthcare system. As the performer of the decisions which are made in the new policy, it is for providers important to contribute to a policy that can be execute. Therefore, provider can be expected to have concerns in the policy-making process. Currently, no literature is available on the providers’ position during decentralisations and healthcare reform.   
 Decentralisation implies more competition among health care providers. Before the decentralisation in 2015, providers’ representatives negotiated with health care insurances about the required tariffs, the content of the treatment and the delivered quality.[[29]](#footnote-29) All care that is financed under the public system is provided according to these tariffs.   
 The new health care system offers less certainty to health care providers on tariffs for provided care. All municipalities individually or in regional arrangements will contract providers in which prices match the required quality. This means that providers and municipalities need to negotiate budgets and the amount of delivered care. Therefore, providers can experience more concurrence of other providers than in the past. For providers it would be relevant to limit the competition as much as possible.   
 In addition, health care providers often deliver care to their clients for a long period. In the new situation the client’s future is uncertain. The question is whether the client will receive the same care. Moreover, they want to know where they stand and what to expect. Thus, it is in the interest of the health care provider to provide clarity to their clients.

*Municipalities*Municipalities are also important actors in policy-making about decentralisation because they administer policies decided at the national level. Thus municipalities can be expected to have strong preferences concerning the rules about how they provide services and provide other goods at the local level. The commission ‘Municipality Act & Constitution’ of the association of Dutch Municipalities (VNG) refers to the local government as the ‘First Government’. A report of this commission, established in 2007, aimed at strengthening of the autonomous position of municipalities and positive differentiation between municipalities. To accomplish this, a tilt of the state is required so that municipalities are no longer the executor of nationally established policies .[[30]](#footnote-30) It is therefore important for municipalities to have greater autonomy, with its own policy suited to the people.   
 In addition, municipalities are said to have better insight into the people’s needs and problems, as the municipality is in close proximity. The idea of customisation sought by the decentralisations also provides new care arrangements. So far, clients could receive care that was arranged nationwide. However, the clients’ situations and complaints do not coincide and the 'one-size-fits-all' principle is not always an adequate solution. Through decentralisation, it is possible that customisation to clients is available and innovation taking place in the healthcare provision.

*National Government*The economic crisis of 2007-2008 puts the government’s financial situation under pressure. This means that the government should investigate possibilities to keep the finances under control. As previously considered in the Fiscal Federalism of Oates, local authorities can deliver effective and efficient services, as they have better insight into what is required. Decentralisation enables that the finances for health care can be reduced. In addition, the demand for care increases by demographic trends. The aging society ensures that there will be more demand for care. This also triggers a substantial increase in finance. The financial aspects are, therefore, an incentive for the government to decentralise tasks.   
 The decentralisation operations that have occurred to date, in addition to an orientation of the management of financial expenses, also had an orientation to an acceptable division of responsibilities and risks.[[31]](#footnote-31) By widening the administrative structure, decentralised unitary state gathers more weight .[[32]](#footnote-32) This means that a government’s motive can be a distribution of power to more weight towards decentralised unitary state.

The previous sections map the stakeholders involved in the health care system in order to identify the structure of interests affected by decisions to decentralise care functions. Both theories that are used in this thesis emphasises the influence of stakeholders, although in different ways. Therefore, the interests of the different actors are explained prior to the used theories.

**Theories of policy analysis**

The Policy Cycle-Actor Hourglass is a policy cycle model which helps clarify the different, though interactive, roles played in the different stages in the process by policy actors, institutions, and ideas.[[33]](#footnote-33) The policy cycle-actor hourglass is a helpful instrument to distinguish the different decisions and interventions that occur and which actors were involved in which stages in the creation of policy. In this theory the outcome of the policy-making process is due to the public opinion. The population plays a large part in the policy-making process. In contrast, the Advocacy Coalition Framework (ACF) explains policy change within a policy subsystem that consist of multiple advocacy coalitions. Because of their technical knowledge the policy elite is responsible the agenda setting and for the outcome in the policy process.

*Policy Cycle-Actor Hourglass*  
Policy-making is fundamentally about connecting policy goals with policy means.[[34]](#footnote-34) This process of matching has a technical dimension and a political one. The technical dimension will identify the most optimal relation between means and ends, as some means are more suitable to the problem than others. The political dimension reflects that not all involved actors are equal minded about the solution.[[35]](#footnote-35)

Throughout deliberation, the process from problem to solution consists of multiple stages. Harold D. Lasswell (1971) simplified the analysis of the public policy-making process by setting up a distribution of seven stages, also known as the policy cycle.[[36]](#footnote-36) These stages describe how public policy should be formulated: (1) intelligence, (2) promotion, (3) prescription, (4) invocation, (5) application, (6) termination, and (7) appraisal.[[37]](#footnote-37) The first stage starts with gathering, processing, and dissemination of information. After this, it moves to promotion of particular options by those involved in making the policy decision. Third, the decision-makers describe the course of action. Next, a set of sanctions is described when some fail to comply with this course of action. Fifth, the course will be applied by the courts and bureaucracy. Sixth, runs its course until it is terminated or cancelled. Finally, the policy will be evaluated against the original aims and goals.[[38]](#footnote-38)

This policy model has been influential in policy analysis, but nevertheless has several weaknesses. For example, it is mentioned that Lasswell, as well as Dye (2013), in his definition lacks the influence of external factors on public policy-making.[[39]](#footnote-39) In reality, public policy-making is not a product delivered by a restricted group consisting of members of the government, rather several groups in society have influence on the establishment of a new policy. In addition, Lasswell’s model takes as a premise that policy-making is a rational process in which political decision makers decide according to their ratio. However, in a political decision-making process decision is also based on emotions and emotional reactions. Another deficit in Lasswell’s model is the position of the evaluation after the entire policy cycle is completed and substituted. Nevertheless, evaluation often takes place during the current policy to apply necessary adjustments.   
 As a result, scientists have attempted to adapt the model into a more viable model. The most applied policy cycle model is made by from Gary Brewer (1974). The policy cycle in this model consists of the following five stages:

1. Invention/initiation (agenda setting)
2. Estimation (formulation)
3. Selection (decision-making)
4. Implementation
5. Evaluation

The first stage is also called ‘agenda setting’. In this phase the problem needs to be recognised and identified. Second, in the estimation or ‘formulation’ stage, the risks, costs, and benefits of the different policy solutions occur. Additionally, the selection or ‘decision-making’ stage refers to executing a selected option. In the fourth stage, implementation concerns the execution of this selected option. Finally, the evaluation refers to the monitoring of the results of the policy and a possible reconceptualisation of problems and solutions.[[40]](#footnote-40)

Yet, this policy-cycle model is a simplistic version of reality. In fact, policy is not made through a chronological process, as stages may overlap or take place at the same time. Furthermore, the government is not solely concerned with one policy-making process at a time and different policy processes can influence each other. Still, the policy-cycle is a helpful instrument to distinguish the different decisions and interventions that occur and which actors were involved in which stages in the creation of policy.

As previously discussed, agenda setting is the first, and possibly the most critical stage of the policy-making process. Problems emerge and the government should create a means to resolve the problem.[[41]](#footnote-41) The public agenda consists of issues that have ‘achieved a high level of public interest and visibility’.[[42]](#footnote-42) Issues on this public agenda are (1) the subject of widespread attention, (2) require action, and (3) are the appropriate concern of some governmental unit. These issues often arise in small groups, which concern expanding the awareness of the problem.[[43]](#footnote-43) Thus, the initiative to address a problem is taken by the people, an interest group, or the media and politics and, eventually, policy will follow.[[44]](#footnote-44) Although the interaction between the various actors and stakeholders is dependent on the issue not a single actor is dominant, but the entire policy universe can be involved.[[45]](#footnote-45)

Once an issue is placed on the agenda and is acknowledged as a problem, several courses of action are formulated. In the stage of formulation, multiple solutions available for addressing the problem are identified.[[46]](#footnote-46) One of the characteristics of formulation is that this cannot be limited to one set of actors. Therefore, two or more formulation groups will produce competing courses of action.[[47]](#footnote-47) The formulation stage consists of the following four sub-stages: appraisal phase, dialogue phase, formulation, and consolidation.[[48]](#footnote-48) In the appraisal stage, information, data, and evidence are collected and used as input. The dialogue phase facilitates communication between the different policy actors, who mainly have adapted different positions in possible solutions. After the dialogue, public officials take all the information and options into consideration and formulate a proposal for the ratification. Objections of the people whose strategies and instruments have been set aside, can address these in the consolidation phase.[[49]](#footnote-49) Throughout the formulation stage, only a subset of the policy universe is involved, as this core is directly involved in the policy-making process.[[50]](#footnote-50) This means that in the formulation phase, only the elite is involved.

During the decision-making stage, one or more of the options that have been debated in the previous stages are approved.[[51]](#footnote-51) From a network point of view, it is not possible assess policy-making by merely taking official political institutions into account.[[52]](#footnote-52) However, networks are not involved in the actual decision-making stage. In public policy, the government is the only player in this stage without any policy subsystems such as interest groups and sub-governments. Yet, this does not mean that others do not act; stakeholders can engage in different lobbying and influential activities. This in contrast to office-holders, stakeholders only have a voice in the decision-making process and not a vote.[[53]](#footnote-53)

After decisions are made, the policy needs to be implemented into action. Implementation is ‘what develops between the establishment of an apparent intention on the part of government to do something, or to stop doing something, and the ultimate impact in the world of action’.[[54]](#footnote-54) Moreover, implementation includes three core elements, which are: specification of details, allocation of resources, and decisions.[[55]](#footnote-55) This implementation is considered the top-down stage in which the government formulates policy and these laws are enforced. Since the 1970s it is more common to think of this phase as a more bottom-up process. Bureaucrats are still the most significant actors in policy implementation. However, bureaucrats at different levels of government lack information and knowledge on shaping this policy into execution. Therefore, policy subsystems become important contributors in shaping the launch of programmes implementing policy decisions.[[56]](#footnote-56)

As the policy process commences with addressing a problem in need of a solution, the policy means to solve the problem in the end. After implementation, the government wants to ensure that the chosen solution connects with the problem. Results and outcomes in the evaluation stage are an embedded part of the political process and debate.[[57]](#footnote-57) consequently, it determines whether de policy meets the former defined problems and is terminated or that the problem and solutions need to be reconceptualised and the entire process has to start again. Subsystems, the general public and the media all will have various assessments on the working and effects of the policy and interests to support or to disclaim it.[[58]](#footnote-58) In addition, stakeholders will have different knowledge and interests, and, therefore, there will never be a universally satisfying policy.[[59]](#footnote-59)   
 As explained earlier, different actors and stakeholders are involved in the various stages of policy-making. To illustrate, Howlett, Ramesh, and Perl (2009) use the ‘policy cycle-hourglass’ configuration of actors who are engaged in the stages of the policy process (see Figure 2). According to this model in the first stage of the policy-making process the policy universe is concerned. Subsequently, the number of participants is reduced to the policy subsystem and eventually to only authoritative government decision-makers during the decision-making stage. Once implementation begins, the number of actors increases again to the policy subsystem and expands to the entire policy universe during evaluation.[[60]](#footnote-60)

*Hypotheses from the Policy Cycle-Actor Hourglass*

In this Policy Cycle-Actor Hourglass the policy universe that consist of people, interest groups, and other groups in society will set issues on the agenda. The agenda-setting phase is available for the entire society. Therefore, the Policy Cycle-Actor Hourglass states that the agenda-setting’ phase is separated from the wider policy-making process and can be initiated by the public opinion. This leads to the hypothesis that the decentralisation of healthcare in the Netherlands is initiated by the public opinion.   
 As the formulation stage is dominated by the elite, only a few actors are involved in this phase. This subsystem consists of ‘only those actors with sufficient knowledge of a problem area, or a resource at stake, to allow them to participate in the process of developing possible alternative courses of action to address the issues raised at the agenda-setting stage’.[[61]](#footnote-61) As shown before, the key actors in the health care system are the providers, state and population. Thus, for the formulation stage the hypothesis can be formulated:

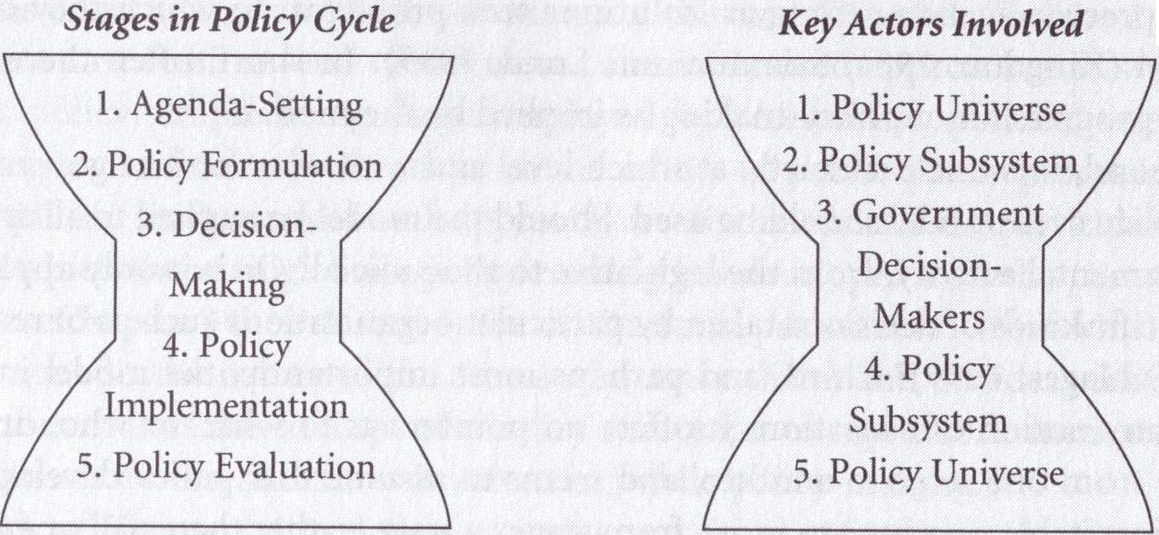


Figure 2: The Policy Cycle-Actor Hourglass of Howlett, Ramesh, and Perl[[62]](#footnote-62)

The most influential stakeholders in the formulation are municipalities, care providers, client organisation, and the government.

Then, in the decision-making stage the only actor that participate actively is the government decision-makers. It should be noticed that the decisive government in the decentralisations in the Netherlands is the national parliament. Since the parliament consists of multiple political parties, and new policy will only be adopted when the majority of the parliament agreed, the parties that form the coalition have more influence. Therefore, a third hypothesis can be formulated stating that during the decision-making stage the most influential actors are the political parties of the coalition.

Finally, the most influential actors in the implementation stage are again the policy subsystem. This means that merely the key actors of the health care system play a part. Consequently, the fourth hypothesis that can be formulated is: during the implementation stage, the most influential stakeholders are municipalities, care providers, client organisations, and the government.

*Advocacy Coalition Framework*

Ever since the Middle Ages, various groups of interest are incorporated in the policy-making process in order to overcome conflicts. The policy-making process consists of a complex set of interacting elements over time. Normally, hundreds of actors from interest groups as well as the government, researchers, and journalists are involved in one or more aspects of the process.[[63]](#footnote-63) Naturally, all these actors have different values, interests, and preferences. The policy universe can be seen as an aggregation of international, state, social actors, and institutions that directly or indirectly effect the policy process. For this reason, these actors of different sectors can be considered as policy subsystems.[[64]](#footnote-64)

In 1939 Ernest Griffith states the following:

“Ordinarily the relationship among these men – legislators, administrators, lobbyists, scholars – who

are interested in a common problem is a much more real relationship than the relationship between

congressmen generally or between administrators generally. In other words, he who would understand the present pattern of our present governmental behavior, instead of studying the formal institutions… may possibly obtain a better picture of the way things really happen if he would study these ‘whirlpools’ of special social interest and problems.”[[65]](#footnote-65)

Thus, Griffith already noticed the possibility of intervention in the policy-making process by subsystems or sub-governments.

Another influential work concerning the subsystem theory was carried out by Leiper Freeman(1955). He build on Griffith’s work by defining subsystems as a ‘pattern of interactions of participants, or actors, involved in making decisions in a special area of public policy’.[[66]](#footnote-66) Additionally, although every subsystem may affect a small part of policy, aggregating the influence of subsystems constitutes a policy.

These definitions are synonyms for what is currently called a network concept. Over the years, scholars have introduced multiple models to incorporate the manner in which ideas, actors, and institutions interact in the policy process.[[67]](#footnote-67) There is no universal definition, yet the existing definitions ‘all share a common understanding, a minimal or lowest common denominator definition of a policy network, as a set of relatively stable relationships which are of non-hierarchical and interdependent nature linking a variety of actors, who share common interests with regard to a policy and who exchange resources to pursue these shared interests acknowledging that co-operation is the best way to achieve common goals‘.[[68]](#footnote-68) These relationships can be formal institutional as well as informal linkages. Moreover, the actors are interdependent and policy emerges from the interactions between them.[[69]](#footnote-69)

Policy networks assume that governments require these policy subsystems to create policy, the government has to solve problems emerging from, for and within that society.[[70]](#footnote-70) When society opposes to formulated policy by the government, society will reject to adapt to the policy. Yet, it is in the government’s interest that policy is supported by society and executive organisations.   
 The dominant way of thinking about the policy process in terms of the policy cycle framework is advanced by Paul Sabatier (1991). Because, policy change does rarely occur as a result of a specific piece of research.[[71]](#footnote-71) Instead, ‘the more normal pattern is for a process of ‘enlightenment’ whereby the findings accumulated over time gradually alter decision-makers’ perceptions of the seriousness of the problems, the relative importance of different causes, and/or the effects of major policy programs’.[[72]](#footnote-72) Analysis, ideas, and information are a fundamental part of the political stream and a major force for change.[[73]](#footnote-73)  
 Sabatier has developed the Advocacy Coalition framework (ACF) that views policy change as a function of three sets of factors: The interaction of competing advocacy coalitions within a policy subsystem/community, changes external to the subsystem, and the effects of stable system parameters on the constraints and resources of various actors (see Figure 3). Advocacy coalitions consists of actors of organisations who share a set of basic beliefs on a certain domain. The policy subsystem is composed of all actors who play a part in the ‘generation, dissemination, and evaluation of policy ideas’. The elite of different advocacy coalitions in the policy subsystem will be competing for influence over and in the entire decision-making process.[[74]](#footnote-74) Change in a policy subsystem results from an interplay between ‘relatively stable parameters’ and external events which frame the constraints and resources of the elite and the interactions in the subsystem.[[75]](#footnote-75)

The beliefs of the advocacy coalition are structured in a hierarchy of secondary aspects, policy core and deep core (see Figure 4).[[76]](#footnote-76) On top of the belief system are deep core beliefs. These beliefs are normative/empirical believes that span an entire policy subsystem. In Sabatier’s opinion, policy core beliefs are resistant to change, but are more pliable than core beliefs.[[77]](#footnote-77) These policy core beliefs structure participation in advocacy coalitions, and, therefore, coalition membership is predicted to remain stable for decades.[[78]](#footnote-78) The secondary aspects are more likely to change and are a critical prerequisite to major policy change. These latter are assumed to be more readily adjusted in the light of new information, or changing strategic considerations.[[79]](#footnote-79)

Although, some scientists consider the process of defining the issues and agendas in the context of social or environmental pressure of ‘public opinion’, Sabatier states that the agenda-setting and other phases of the policy process is dominated by elite opinion.[[80]](#footnote-80) The elite can derive from control over the generation and

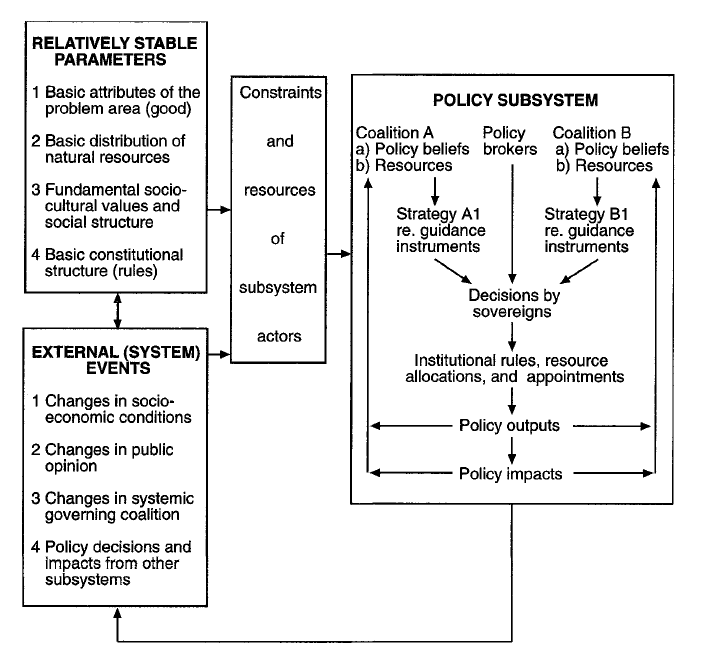


Figure 3: Revised diagram of the Advocacy Coalition Framework[[81]](#footnote-81)

legitimation of knowledge in policy areas that require specialist technical knowledge, such as health.[[82]](#footnote-82) This elite network can exert influence over policy-making.   
 One of the assumptions of the ACF is that the core basic attributes of a governmental action programme is unlikely to be changed in the absence of significant perturbations external to the subsystem.

Moreover, actors within an advocacy coalition will show substantial consensus on issues pertaining to the policy core, although less so on secondary aspects. At a particular moment, each coalition adopts one or more strategies involving the use of guidance instruments as a means of altering the behaviour of various governmental institutions in an effort to realize its policy objectives. Conflicting strategies from various coalitions will be mediated by policy brokers, which search for a compromise. The end result is one or more governmental programs, which in turn produce policy outputs at the operational level.

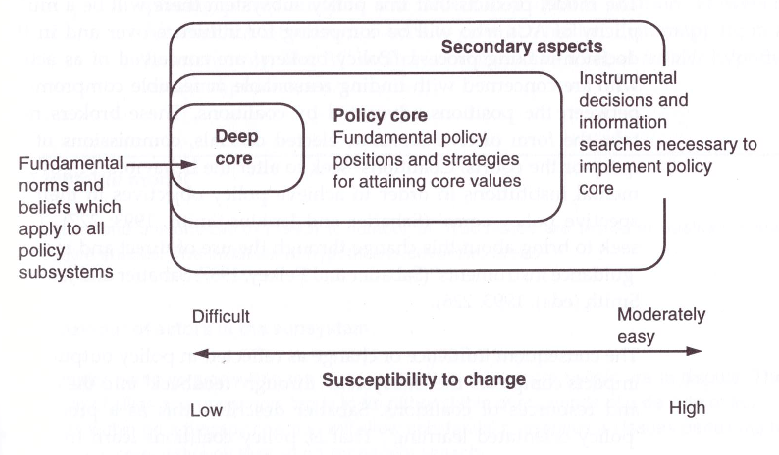


Figure 4: The structure of beliefs[[83]](#footnote-83)

*Hypothesis from the Advocacy Coalition Framework*

Sabatier states that policy change will occur as an interplay between stable parameters and external events which will influence the beliefs and ideas of the elite in the advocacy coalition. Besides, the policy process takes place within the policy subsystem, in which the struggle between advocacy coalitions shapes the outcome. Even in the decision-making stage is influenced by the elite, because politicians respond to what elite experts state. Therefore, as an alternative to the Policy Cycle-Actor Hourglass, the hypothesis is formulated: The decentralisation of healthcare in the Netherlands is dominated by the elite opinion during the entire decision-making process.

**Conclusion**

The healthcare system consists of three key actors, namely healthcare providers, the State, and the population. Therefore, changes in the relations between these three actors will lead to healthcare reform. As the Dutch healthcare system for youth care and social support is decentralised to municipalities, the national state and local government both have their own interest in this.   
 The population or client organisations will be opponents of the decentralisation. New policy will come along with uncertainty, which give people an unpleasant feeling. Even if, the current policy does not meet the requirements of a functioning system clients are not a proponent of policy change and will maintain the already acquired rights as much as possible.

On the other hand, municipalities and the State consider decentralisation as a possibility to establish efficient and effective policy. By organising care close to citizens is more suitable to situations of the inhabitants and therefore more efficient. In addition, municipalities are a proponent of the distribution of authority. Decentralisation will give municipalities more autonomy and, therefore, more power.   
 Healthcare providers have an economic motive to consider decentralisation. When new policy give providers the opportunity to have economic advantage, the incentive is present to be a proponent of decentralisation. Another possible incentive is the opportunity for innovation.

Both, the policy cycle-actor hourglass and the advocacy coalition framework explain the process of policy change. In the policy cycle-actor hourglass the different stages of the policy-process each has its own dominant stakeholders. This leads to multiple hypothesis relating to the policy cycle-actor hourglass theory. The first hypothesis that derive from this theory is that the decentralisation of healthcare in the Netherlands is initiated by the public opinion. The second hypothesis is formulated: the most influential stakeholders in the formulation are municipalities, care providers, client organisation, and the government. A third hypothesis can be formulated stating that during the decision-making stage the most influential actors are the political parties of the coalition. And the final hypothesis that can be formulated is: during the implementation stage, the most influential stakeholders are municipalities, care providers, client organisations, and the government.

On the contrary, the advocacy coalition framework consider the elite opinion as a dominant factor in the policy-making process. The alternative hypothesis that derives from the advocacy coalition framework is formulated: the decentralisation of healthcare in the Netherlands is dominated by the elite opinion during the entire decision-making process.

# Chapter 4: Method

**In this thesis the decentralisation of youth care and social support is used to generate deeper insight into the role and interest of actors affected by policy change. Both the policy cycle-actor hourglass and the ACF use stakeholders analysis to describe the policy outcome. Though the policy cycle-actor hourglass and the advocacy coalition framework offer different perspectives concerning the role of stakeholders in the policy process. Whereas the ACF emphasizes the influence of elites, the hourglass perspective is based on a much more open view of stakeholder influence. It is not just elites who drive policy change, but rather, shifting coalitions of stakeholders, including non-elites in different stages of the policy process.**

Stakeholders are actors who have an interest in the issue under consideration, who are affected by the issue, or who – because of their position – have or could have an active or passive influence on the policy-making process.[[84]](#footnote-84) Stakeholders analysis is an approach for generating knowledge about actors, so as to understand their behaviour, intentions, and interests; and for assessing the influence and resources they put pressure on the decision-making or implementation process.[[85]](#footnote-85)

All stakeholder analysis address a similar set of questions:

1. Who are the stakeholders to include in the analysis?
2. What are the stakeholders’ interests and beliefs?
3. Who controls critical resources?
4. With whom do stakeholders form coalitions?
5. What strategies and venues do stakeholders use to achieve their objectives?

Stakeholders analysis helps to focus on mapping the activities of multiple stakeholders employing multiple strategies in multiple venues.[[86]](#footnote-86)

*Boundaries*

Each policy-making process consists of changing bundles of organisations, events, and activities. The basic objective of a structural analysis of politics is to explain the distribution of power among actors in a social system as a function of the position that they occupy in one or more networks.[[87]](#footnote-87) Furthermore, network analysis provides a basis for the study of social relationships that exist within a system of inter-related units and derives mainly from sociology and anthropology .[[88]](#footnote-88) The purpose of network analysis is ‘to explain, at least in part, the behaviour of network elements… and of the system as a whole by appeal to specific features of the interconnections among the elements’.[[89]](#footnote-89) By applying a network analysis, it is possible to judge what effects membership of a network have on the outcome of the policy process. It is important to determine where the boundaries lie for inclusion in the system. Occasionally, the boundaries of a network are self-evident, yet, particularly in a larger system it is required to determine the limits. There is no list indicating which actors play a role in a certain policy network. To indicate the marked terrain covered by the policy and which actors are involved, Laumann, Marsden, and Prensky (1989) offer two metaphysical perspectives: the nominalist and the realist approach.[[90]](#footnote-90)  
 The realist approach makes use of the participants in the system. This approach assumes that the actors know who belong to a system or who does not. In addition, this method assumes that the social network exists because the participants experience the existence. This would mean that a cross-section of the representatives could inform about the significant members and activities. However, this approach is less accessible in larger, complex national policy, as participants are possibly only at the height of a portion of the members of the system.   
 The nominalist approach arises from a conceptual framework designed according to the researcher's theoretical agenda.[[91]](#footnote-91) The network boundaries are thus determined based on criteria established by the investigator. These limits correspond to the analyst’s research area and is more closely attuned to the state organisational perspective.[[92]](#footnote-92) Hence, this method makes it possible to delineate the complex system surrounding the Wmo 2015 and the Youth Care Act. Therefore, this study uses a nominalist approach to specify the domain boundaries.   
 The decentralisations in the social domain in the Netherlands relate to three components, namely the Youth Care Act, the Wmo 2015, and the Participation Act; this often referred to as the decentralisation of 3Ds. However, because the municipalities have little impact on local employment and therefore can do little to stimulate the employment growth of people with a labour disability, the region will play an important role in this issue.[[93]](#footnote-93) This means that this decentralisation is often isolated and is dealt with separately from other decentralisations. In addition, the decentralisation of the Participation Act falls mainly under the Ministry of Social Affairs and Employment. The other two decentralisations belong to the Ministry for Health, Welfare, and Sport. The interests and actors are therefore divided. In this study, the decentralisation of the Participation Act is disregarded and attention is only put on the decentralisations of the Wmo 2015 and the Youth Care Act. Additionally, only the treatment of the principal act is examined and the underlying treatment areas of these two domains are omitted except when a subarea affects the main law.  
 The used boundary definition in this thesis is formulated as:   
 *The decentralization policy change with respect to the Wmo 2015 and the Youth Care  
 Act. For the Wmo 2015 is taking into account the overall long-term care reform, but only to the  
 portion that will be decentralised to the local authorities.*

Because it is a policy-making process, the government is the main actor in the bounded domain. The government determines what is included in the law and what is not. It is therefore important that the actor is acknowledged as a network participant by the government. Without recognition, the actor cannot exert influence. The list of recognised policy actors in the national decentralisation process are therefore compiled from three sources: [[94]](#footnote-94)   
 (1) Organisations that are mentioned in government documents. It could include  
 reports of committees as well as plenary debates. In addition, in the explanatory  
 memorandum on the law, it is explained what parties were consulted and which  
 involved the contribution. Actors that are mentioned in policy documents are also  
 referred to as a part of the network. For the Youth Care Act, there have been six  
 committee meetings and one plenary debate. For the Wmo 2015 there have  
 been seven committee meetings and two plenary debates. During these meetings,  
 several dozen organisations attended. Only a few are in examination and  
 implementation actually considered by as interested.  
 (2) Organisations listed by the national newspapers by the keywords decentralisation,  
 youth, care, social support, and act. The time period which is used is 2009 until 2015. In  
 this period, the main part of the policy cycle took place.   
 (3) Since 1 July 2012, the Parliament administrates a public register which registers the  
 lobbyists and interest groups with a permanent pass to the Parliament.

In order to identify the process and outcome, official documents of parliament, for example meeting reports, are taken as the main source of information. Moreover, these reports indicate what steps are taken and what the government acted on different issues. The organisations or interest groups which are listed in these reports are involved. In addition, also, the position papers and input of organisations is taken into account for these documents give insight in the interests.

*Policy cycle*

As noted earlier, policy-making is a process that can be divided into multiple manageable steps.[[95]](#footnote-95) This policy cycle can supposedly be subdivided into different stages. Lasswell (1971) suggested seven stages, Bridgman and Davis (2000) use eight stages, and the often used policy cycle by Brewer (1974) only mentions five stages. It is widely agreed that the policy cycle is an ideal type model of reality. In this study, the Brewer’s policy is used to unravel the outcomes of the different stages. Due to the topical treatment of both the Youth Care Act and the Wmo 2015 it is not possible to include the evaluation in this research. Therefore, only the agenda setting, formulation, decision-making, and implementation are explored. For each stage the following five issues are analysed:

1. Which are the members of the network in that stage?
2. What are the characteristics for that stage?
3. What are the essential resources for that stage?
4. What is the position of the ministry in the network?
5. What is the stage outcome?

Moreover, these various stages possibly overlap occasionally. As a result, agents can play a role in different stages of the policy cycle at the same time.   
 A policy cycle approach views government as a process rather than a collection of institutions.[[96]](#footnote-96) Therefore, Brewer’s policy-cycle model is not only useful because it separates the different stages in the policy-making process, but it also aids to clarify the different actors and their interests throughout the process.[[97]](#footnote-97) As it is difficult to measure power, scientist choose to focus on elements of power to measure the actors’ contribution to policy. Influence seems to be the closest to power, because it refers to achieve change on a giving issue. Furthermore, it denotes control over political outcome, as actors have power if they manage to influence the policy outcome in such a manner that they become closer to their ideals.[[98]](#footnote-98)   
 As previously pointed out, the model entails a complex process into manageable steps. In addition, no policy process is the same. Context, actors and complexity influence the policy process in various manners. This makes the policy cycle an ideal type model, and helpful to structure the process.

**Conclusion**The thesis give an insight in the different actors involved in the policy-making process of decentralisation of youth care, and social support to municipalities. The Participation Act is not considered in this thesis, because this decentralisation differs from the other decentralisations.   
 Both the policy cycle-actor hourglass and the ACF are a manner to do stakeholder analysis. The policy cycle-actor hourglass uses policy cycle analysis to determine what actors played a part during the stage and what the outcome is. Each stage is analysed separately and is assessed of the network members, characteristics of the network, essential resources, the position of the ministry, and outcome of the stage. The data that is used to analyse the stage, is mainly submitted by official documents and position papers that organisations use to manipulate the outcome.   
 In the ACF the stakeholders in the policy-making process all have a belief system. This beliefs are the core of a coalition. To determine the influence of the coalitions on the outcome, it is analysed who the stakeholders are, what their interests and beliefs are, control of critical resources, different coalitions, and what strategies they use. Recognised policy actors are distributed of government documents, national newspapers, and the Dutch lobby register. The beliefs and interests of the stakeholders is retrieved from position papers.

# Chapter 5: The context of health sector reform.

**Healthcare reforms do not happen on its own. This chapter provides the background concerning the context of the decentralization of care that is necessary before turning to the empirical analysis of the policy-making process. According to the ACF, change in policy is a result of an interplay of ‘relatively stable parameters’ and external events.[[99]](#footnote-99) These external events can be divided into the following five categories: (1) demographic and epidemiological change; (2) processes of social and economic change; (3) politics and the political regime; (4) ideology, public policy and the public sector; and (5) external factors.[[100]](#footnote-100)**

**Relative stable parameters: The Dutch state system**

The Netherlands is often paradoxically referred to as a ‘decentralised unitary state’. Johan Rudolf Thorbecke, Prime Minister, designed the state system with the Constitution (1848), the Provincial Government Act (1850), and the Municipal Government Act (1851). Nowadays, this distribution of sublevels of government still applies. Thorbecke was a follower of the Organic Theory of the State which claims that the state and its component parts are dynamic entities and are relatively autonomous from their environment.[[101]](#footnote-101) In addition, provinces and municipalities are for the most part independent and have their own duties and responsibilities. Nonetheless, at the same time, they are dependent on the national government and can only operate within the framework the government created.[[102]](#footnote-102) For Thorbecke, the unitary state does not refer to hierarchy and central integration, but to organic interdependence, the sense of consensus-building, and mutual adjustment that turns out to be of central concern to traditional analysts of the Dutch state system.[[103]](#footnote-103) Strikingly, this Dutch system is often referred to as ‘the House of Thorbecke’, while a house is a static object and Thorbecke’s principle is an organic ensemble in which the elements adjust to each other and their environment.  
 Although the Dutch state system is a stable system, the constitution and the other mentioned Acts emphasize decentralisation. Municipalities and provinces are organic parts of the State and need to have their own responsibilities. This contributes to the advocacy coalition framework, that states that the interplay between relative stable parameters like the state system and external events change policy.

**External events**

*Demographic and epidemiological change*

One of the key items in healthcare reform are developments in demography. The quantity of population increases and the composition of population changes. People generally have a higher life expectancy than in former decades. These changes trigger that the demand for care increases and therefore the associated costs.   
 These developments are also evident in the Netherlands. While fifty years ago, in the 1960s, the population consisted of 11,417,000 people, this number had grown to 16,829,000 in 2014.[[104]](#footnote-104) In the same period, the grey pressure has risen from 16.8% to 29.0%.[[105]](#footnote-105) This grey pressure is the ratio between the number of people aged 65 or over and the number of people between 20 and 65. By contrast, the green pressure is the proportion between the number of people between 0 and 20 years old and the number of people between 20 and 65 years old. This green pressure has decreased from 71,4% to 38,2%. As such, this means that the number of people aged 65 or older relatively utilise more healthcare grows rapidly, whilst the number of people, who contribute to a large part of the state income by an income tax, decreases sharply. Between 1960 and 2013 the average life expectancy at birth is increased from 71,99 to 81,23, which is an increase of almost 10 years in 50 years’ time.[[106]](#footnote-106)

Simultaneously, the average educational level of the Dutch population is higher than 50 years ago. 32% of Dutch people between 25 and 64 years old is in the possession of an academic degree. This is 8% more than in 2005 and significantly higher than the OECD average of 24%.[[107]](#footnote-107) In general, people with a lower educational level make more use of healthcare compared to higher educated people. Although the average educational level of Dutch people has risen, this increase is especially noticeable in the population between 25 and 34 years old. Of the population between the 55 and 65, less than a quarter is highly educated, while the size of the number of elderly people with a lower education is also relatively comprehensive.[[108]](#footnote-108). The baby boomers, who are born in the period 1946-1955, are succeeded by a much smaller generation that is born until the beginning of the 1990s. Thus, not only is the number of highly educated people low among the post-war generation, this group is also many times larger than later generation. At this moment, the large baby boomer generation reaches the age at which healthcare consumption increases.

*Processes of social and economic change*

Despite the continues debate between Marx and Weber, they had a correspondence on a crucial point, as ‘they imply that key social, political and economic characteristics are not randomly related; they tend to be closely linked…’.[[109]](#footnote-109) Certain cultural and political changes do appear logically linked with the dynamics of a core syndrome of modernisation, involving urbanisation, industrialisation, economic development, occupational specialisation, and the spread of mass literacy.[[110]](#footnote-110) In due time, great cultural developments will emerge. These developments are initiated by intergenerational change.[[111]](#footnote-111) These intergenerational changes are not visible from one day to the next, but gradually evolve. Because the health sector consists of a relationship between population, provider, and state, the system’s organisation is also affected by cultural, political, and economic changes.   
 Especially after the Second World War, the government started to interfere with the organisation and finances of public facilities.[[112]](#footnote-112) In addition, even though social groups were well organised in pillars with the relevant particular facilities, the responsibility of care by government expanded. Consequently, poverty reduction and healthcare could no longer be arranged at the local level. Along with the depillarisation, civil society became fragmented.[[113]](#footnote-113) First, the solution was conducted in market mechanism and privatisation; in the meantime, however, more attention is devoted to strengthen the regulatory function of the welfare state.[[114]](#footnote-114)   
 Furthermore, due to the economic crises in 1973 and 1981, the system’s financial sustainability became untenable and it became necessary to reduce public expenditures. In addition, a movement of ‘reinventing government’ transferred from the United States and pleaded to empower citizens to become more capable of making their own choices.[[115]](#footnote-115) As a result of the market mechanism, public facilities became less expensive and Efficiency and upscaling were emphasized by the State.   
 Especially the economic crisis of 2007-2008 implicated that there was a strong focus on the negative results of market mechanism. The market cannot comply with the public characteristics of public policy. However, the government is not capable enough to respond to necessities of society.[[116]](#footnote-116) This is why the government aims to achieve active citizenship and more own responsibility of citizens. The initiative of civil society is given the opportunity to perform a more important role because of the normative, practical, and financial boundaries of the welfare state.[[117]](#footnote-117) The welfare state remains as a safety net for people who are not able to participate. Hence, the Dutch State moves from a welfare state to a participation society.[[118]](#footnote-118)

*Politics and the political regime*

The prevailing political processes and political regimes provide an important element for explaining the content and feasibility of reform, the stakeholders, and the key features of the policy-making process.[[119]](#footnote-119) After the elections in 2010, the First Rutte cabinet (Rutte I), named after the new prime minister, the right wing party Volkspartij voor Vrijheid en Democratie (VVD) and the Christian party Christelijk Democratisch Apel (CDA) entered into force and closed a Parliament support agreement with the Partij Voor de Vrijheid (PVV). The latter is occasionally referred to as an extreme right party. This minority government did not obtain a majority in the First Chamber and was especially dependent on the support of the reformed party Staatskundig Gereformeerde Partij (SGP).[[120]](#footnote-120). This cabinet was faced with a significant cut in spending of 18 billion euros. After the collapse of the government in 2012, a new cabinet was formed out of the VVD and the labour party Partij van de Arbeid (PvdA). The main objective of the Second Rutte cabinet (Rutte II) is to get the public finances in place, a fair distribution of the burden, and the creation of a sustainable economic growth. To accomplish this assignment, a broad set of reforms are proposed pertaining to the housing market, the labour market, and the healthcare system.[[121]](#footnote-121)

In both governments, the VVD is the major party. The VVD is labelled as a liberal party. This party’s leading principles are freedom and responsibility. In principle, this party stands for the people’s independence of government, but those who they are not capable in societal participation on their own, will be supported.[[122]](#footnote-122) This party ensures a limited government, which will only perform when the tasks cannot be performed by society itself. In doing this, the state needs to be subservient to citizens and their freedoms.[[123]](#footnote-123) Moreover, the state is responsible for the safety of its citizens.   
 The other coalition party, the PvdA, by contrast, is a progressive social democratic party. In the party’s principles, the following five ideals of a social democracy are formulated: freedom, democracy, justice, sustainability, and solidarity. People’s right to a decent living is central. Similar to the VVD, the PvdA feels that people should be giving a change to meet up with their own needs. The difference is that the latter expects the state to guarantee a minimal level of social security.[[124]](#footnote-124) Yet, the VVD applies for the opposite, as the citizens first need to try to provide for themselves by their own capabilities, and when this is not possible, the state will be supportive. Thus, the starting point of both parties corresponds, but the idea behind it differs.   
 Together the VVD and PvdA do not own a majority in the First Chamber. This means that for every topic, partners should be found to create a majority. Between 2012 and 2015 particularly the Democraten ’66 (D66), the SGP, and the ChristenUnie (CU) supported the government’s policy proposals to create a majority in the First Chamber. The only parties that can be considered as genuine opposition are the Socialistische Partij (SP) and the PVV.[[125]](#footnote-125)

*Ideology, public policy and the public sector*

The Netherlands is known as a country that consists of minorities. Up until now, no political party ever has succeeded in obtaining a majority of the votes. In addition, the attending parties in the Netherlands cannot be arranged by a single ideological dimension.[[126]](#footnote-126) The three main ideological currents can be divided into the social democrats, the Christian democrats, and the liberals. Moreover, there is a wide range of parties that touches more or less upon these three ideological currents.[[127]](#footnote-127)  
 After the Second World War, a consultation economy arose in which, next to the government, employers’ and employees’ associations play a significant role. This so-called ‘poldermodel’ is often seen as an inefficient manner of decision-making. However, in the Netherlands, a necessity exists to incorporate different social stakeholders into decision-making process.[[128]](#footnote-128) This Dutch system of policy-making is characterised by consultation-intensive and consensus-seeking.[[129]](#footnote-129) This societal form in which organised and autonomous social factions are imbedded in political structures dates back thousands of years and is characteristic to ‘Dutch’ polity.[[130]](#footnote-130) Furthermore, the Dutch government is a key player with a central function, not only as arbitrator between different parties, but also with an active role without being a dominant player. As a key player, the government possesses enough power to smooth the process between negotiation with interest groups and decision-making.[[131]](#footnote-131)   
 Moreover, this corporatist system ensures that interest groups will not be able to influence the policy-making system externally, but they are incorporated into the process and, therefore, responsible for defending the outcome to their constituencies. An important part of corporatism are strong, well-organised interest groups.[[132]](#footnote-132) Since depillarisation, the linkage between political parties and interest groups has rather weakened; political parties and interest groups are not related anymore by the pillar they share.[[133]](#footnote-133) Although connections are often notable between ‘social’ interest groups and left-oriented political parties and business groups and right-wing parties, this relationship is less strong.[[134]](#footnote-134)

*External factors*

External factors, which can influence the policy-making process, are related to the role and position of international agencies, the demands of international economic competitiveness, and the effect of processes of transition in other countries.[[135]](#footnote-135)  
 The European Union (EU) is aware that public health is a national affair. For the period 2008-2013, the EU prepared a White Paper in which the strategic framework is proposed to strengthen the collaboration of community in areas in which the separate member states cannot act effectively enough. In this White Paper, four principles and three strategic goals are proposed. The principles consists of: (1) a strategy based on common fundamental health values; (2) health is the most important asset; (3) health related to all of the policy areas; and (4) a larger EU contribution in global health. The first principle, for example, requires the right for patients to participate in decision-making and knowledge in the field of health and need to be included into common health policy. The three strategic goals are (a) the encouragement of health in an ageing Europe; (b) citizens need to be protected against health threats; and (c) support of dynamic health systems and innovative technologies. The first goal relates to an ageing society and the commission will support necessary measures to improve the health of elderly people, employers, and children. In this manner, the society becomes more productive and people will age healthier. The commission also considers the creation of a framework to assure safe and superior healthcare services. Hence, there should be measures through which member states can focus on innovation of healthcare systems.[[136]](#footnote-136)

**Conclusion**

This chapter considers the political, social and economic context of the decentralisation of social care in the 2010s. The chapter emphasizes five external factors: (1) demographic and epidemiological change; (2) processes of social and economic change; (3) politics and the political regime; (4) ideology, public policy and the public sector; and (5) external factors. The demography of the Netherlands changed in recent years. The population is growing and the grey pressure increase. At the same time, the growing group of elderly demanding healthcare is less educated than later generations. Research has shown that less educated people demand more care than highly educated people. The growing number of aging people and the lower education level, contribute to an increase of healthcare demand and finances.   
 The Dutch state system is a decentralised unitary state. This defines the relationship between the different components of the state system. It is not a hierarchic organised system, rather a fluid organism consisting of interdependent components. Strikingly, this Dutch system is often referred to as ‘the House of Thorbecke’, while a house is a static object and Thorbecke’s principle is an organic ensemble in which the elements adjust to each other and their environment. The distribution of sublevels of government which Thorbecke designed in the nineteenth century still applies.

As one of the external events that influence policy change, the demography of the Netherlands changed in the past decades. Not only did the average life expectancy increased with ten years since the 1960s, also the average educational level is higher than fifty years ago. At the same time, the babyboom generation reaches the age at which healthcare consumption increases.

The economic crisis of 2007-2008 implicated that there was a strong focus on the negative results of market mechanism. The market cannot comply with the public characteristics of public policy. However, the government is not capable enough to respond to necessities of society.[[137]](#footnote-137) This is why the government aims to achieve active citizenship and more own responsibility of citizens.

In recent years, the Dutch government is not as stable as before. The governments since 2002 are not able to serve the term of four years. In the past thirteen years, the VVD only was absent from the government from 2006 until 2010. Since 2012, the Dutch government consists of the unique compilation of the right-wing party VVD and the labour party PvdA. These two parties do not have a majority in the First Chamber and need create a majority with other parties.  
 The Netherlands is known for their consensus-based policy. This corporatist system ensures that interest groups will not be able to influence the policy-making system externally, but they are incorporated into the process. Moreover, the Netherlands can be classified as a country of minorities in which no political party ever obtained a majority of votes.   
 An external factor to Dutch policy is the influence of European policy or views. Although the European Union is aware that health policy is of national affair, the production of white papers and strategic goals possibly influence health policy in the member states.

# Chapter 6: Stakeholders analysis

**This chapter presents an analysis of the stakeholders relevant for the decentralisation reform, and it does so from the perspective of both the ACF and the hourglass framework. The advocacy coalition framework considers policy as the outcome of a negotiation among elites within policy subsystems. The policy cycle-actor hourglass approach emphasizes the influence of multiple stakeholders at different stages.**

**Who are the stakeholders to include in the analysis?**

Official documents of the Government give a good picture of the organisations involved in the creation of the policy. In the case of the decentralisations the Government makes in multiple documents the distinction between municipalities, client organisations and healthcare providers. It is that the Government considered three sets of stakeholders. An analysis of the actors who are appointed in official documentation, show that there are multiple actors involved in the emergence of the new laws (see appendix 1). The party that is mentioned in all documents is the association of Dutch municipalities (VNG). From this, it can be concluded that the municipalities are considered as a major stakeholder. In addition, the VNG has a lobbyist to Parliament and it is the actor that is most mentioned in newspaper articles about the decentralisation of youth care and Wmo 2015. Also in both cabinet formations, the VNG delivered input and has responded to the coalition agreement.  
 The healthcare providers are united in a number of organizations, depending on the background of the provider. The analysis shows that, with regard to the Youth Care Act in particular, youth care Netherlands, Royal Netherlands medical examiners (KNMG), municipal health service (GGD Netherlands) Youth Care Netherlands, Mental Health Care Netherland (GGZ-Netherlands), and health insurers Netherlands (ZN) have played a role. These parties are attended a Committee meeting and/or referred to in the plenary of the law. In addition, they are also almost all mentioned in the explanatory memorandum to the Youth Care Act. It is striking that youth care and Bureau youth care, both have submitted no response or input during the formation of the Cabinet in both 2010 and 2012. Bureau youth care is most referred to in the national newspapers at the topic youth care.

When looking at the Wmo 2015, it appears that MEE-Netherlands, Federatie Opvang, regional setting supervised living (RIBW), Actiz, Disabled Care Association Netherlands (VGN), ZN, and GGZ-Netherlands are involved in the development of the policy. These parties are all mentioned in the explanatory memorandum of the Wmo 2015, attended a Committee meeting and/or named in the plenary debate. Actiz is the most in the media associated with the Wmo 2015. It should be noted that the number of newspaper articles in which stakeholders called for the Wmo 2015, were considerably lower than in the Youth Care Act.  
 It is striking that MEE-Netherlands, Actiz, VGN, youth care Netherlands, GGD, and GGZ-Netherlands all are affiliated with ‘Youth port’ and/or ‘Care port’. These organizations are working together to a vision of the future of youth and care in Netherlands. They organise debate and discussion meetings where health insurers, regulators, science, Ministry and politics are present. These organizations also have a fixed lobbyist at the Parliament.  
 From the client perspective in youth care, there are five organizations that are involved in both the meetings as mentioned in the explanation of the Youth Care Act. The Rural mental health care platform (LPGGZ), Defence for Children (DFC), National Client forum Youth (LCFJ), the Council of the children's protection (RvdK), and the children's ombudsman are the only organizations that are referred to several times. The LCFJ turns out to be part of the national organisation Client Councils (LOC). For this client organisations is no clear lobbyist appoints in the lobbyists register. Moreover, some lobbyists are registered to have multiple client organisations as a client. That no lobbyist mentioned a specific client organization as under direct control would not necessarily say that they have no lobbyist in Parliament. The children's ombudsman and RvdK are the organizations that are appointed in the national newspapers in relation to the youth care the most.

From the Wmo there are a large number of client organisations involved in the emergence of the new policy. The Dutch patients and clients federation (Npcf), Chronic Disability Council (CG-Council), the Platform mental disabled (Platform VG), LOC, Per Saldo, Anbo, CSO, LPGGZ, Mezzo, the organisation of Wmo-councils, Ieder(in), and Foundation Present are all present in the committee meeting. It should be noted that from 1 January 2014, the CG-Council and Platform VG are merged into Ieder(in). In particular, Npcf, Per Saldo, and Mezzo are referred to at all meetings and in the explanatory memorandum. Despite that Ieder(in) is not mentioned in the explanatory memorandum, this organization is most mentioned in the national newspapers. In the formation period of the two cabinets, the client organisations have been less active than healthcare providers and municipalities.

In sum, the key players for municipalities is the VNG. The client organisations that come into play are Per Saldo, LPGGZ, MEE-Netherlands, Mezzo, the organisation of Wmo-councils, DFC, the RvdK, and the children's ombudsman. From the care providers Actiz, GGZ-Netherlands, VGN, ZN, Bureau youth care, LHV, GGD-Netherlands, youth care Netherlands, and the KNMG played a role.

**Stakeholders**

*Municipalities*

At 1 January 2015 the Netherlands has 393 municipalities. The interests of these municipalities are collectively represented by the VNG. The deep core of the VNG is cited as, strength and quality at the local level. Therefore, in 2007, the VNG produced a report that stated that municipalities are the 'first Government’, because this is the government that has the best view of society and concrete problems, consider solutions and offer overview. Strong municipalities are in the interests of citizens. [[138]](#footnote-138) In addition, at the end of 2014, the VNG has developed a route to formulate the strategy and the municipalities’ collective agenda. Recurring was the need to strengthen and vitalize the local democracy.[[139]](#footnote-139)  
 Research of Vilans (2014) show that, with regard to the long-term care, municipalities all focus on 'the use of own strength '. In this, municipalities want to organise care according to customer's demand. Starting points in this is ' simple ' and ' efficient '.[[140]](#footnote-140)  
 The vision document that the VNG has prepared together with the municipalities, indicates that to strengthen and vitalise the power and quality of municipalities, they should have an answer to the changing society. Municipalities can gain trust by placing the citizen at the centre of policy and to develop a vision on the new role of the municipality in society.[[141]](#footnote-141) However, the vision from municipalities is based on an activity theory and on activating citizens and let them appeal their own strength as much as possible.[[142]](#footnote-142) At the same time, citizens envision this approach as a decrease in service.

In sum, the VNG lobbies for more autonomy for municipalities. A strong authority comes together with more control and power, and positions municipalities not only as an implementing organisation of the state but as an independent policy maker. Although policy of the state is established with a framework that local policy should meet, municipalities can develop policy suitable to the ‘couleur locale’. The decentralisation of health care to municipalities gives them control over more spheres of life, and, therefore, can establish more coherence between policies.   
 The VNG is an important partner for the government. When municipalities do not agree with the proposed policy, the execution of the policy is at risk. As the interest of the government is to transfer policy to municipalities in order to be more effective and efficient, the government need municipalities to consent with the policy proposal. Therefore, employees of the VNG have regular consultations with staff of the ministries. The VNG indicates that, therefore, influence of legislation and regulations starts in an early stage. In addition, in administrative meetings, municipality representatives negotiates with ministers and State Secretaries. Also, the lobby is focused on the Second and First Chamber and important civil society organisations.[[143]](#footnote-143) The lobby register of parliament shows that the VNG has a lobbyist who has access to Parliament.[[144]](#footnote-144)

*Client organisations*

Clients are organized in a number of umbrella organisations. These organizations are mainly focused on a particular condition or diseases. This means that this organization have a shared vision, but a different background.   
 The client organisations CG-Council, CSO, LOC, MEZZO, NPCF, Per Saldo and LPGGZ have together developed a vision on the decentralisations. However, this vision goes beyond the decentralisation, and covers the care system as a whole. The core belief of these organisations is that 'people want to get involved and when support is needed –temporarily or long term– this must be aimed at (recovering) self-reliance and –if possible– lasting participation'.[[145]](#footnote-145) The client organisations find the participation in society of greater importance than the financial costs involved. The vision of client organisations is emancipatory. This means that the client is not only considered as a unique person, but also that this person gives direction to his own life, including the part where care is needed.[[146]](#footnote-146)

The client plays a prominent role in the healthcare reforms, according to all the government’s documents. These clients are represented by the client organisations, which thereby also have a prominent role in the decentralisation process. The State Secretary for Health, Welfare and Sport sent a letter to Parliament on 28 March 2014 stating that NPCF, LPGGZ, and Ieder(in) have contributed to the working agreements about the transition. In this working agreements states that the Ministry supports the strengthening of the position of clients (councils) with the program ' for citizens '. In addition, the program provides also the monitoring of the effects of the reforms for the disabled. In this program are Ieder(in), CSO, LOC, LPGGZ, Mezzo, NPCF, and Per Saldo involved.[[147]](#footnote-147) By this program, the client organisations acquired an important position for itself.

Foremost, clients and their representative organisations want to take part in the policy-making process. The state needs municipalities and healthcare providers to execute the new policy. In this, the state is more dependent on the willingness of municipalities and providers to cooperate than on clients and their organisations. This does not imply that client organisations are not important to the government, but the government is less dependent on them for the execution of health care. Therefore, it is in the interest of client organisations to take part in the policy-making process and not only be dependent on the interest of the municipalities and providers, but also incorporate the interest of the receivers of healthcare.   
 In addition, another problem why client organisations are falling behind is the opposed interest to the government. The government wants to decentralise in order to produce more effective and efficient policy at the local level. In contrast, clients have interest in suitable and proper care. The problem is that suitable and proper care not always correspond with efficiency.   
 A strong resource of the client organisations is the public opinion. Every individual can become a client in the future. By responding to the emotion of the population the client organisation creates support for their interest. Particular the parliament, which is dependent on the population’s vote during elections, is sensitive to public opinion. The policy can only be adopted by parties in the parliament, therefore the client organisations have a strong resource.

*Healthcare providers*

In the official documents of the government concerning the decentralisation, legislation explicitly appointed a number of providers’ associations. This includes Actiz, GGZ-Netherlands, VGN, ZN, Bureau youth care, LHV, GGD-Netherlands, youth care Netherlands, and the KNMG. Strikingly, healthcare providers use the same vision in many cases as the client organisations. All vision documents are based on ' care that contributes to the quality of life and citizenship '. [[148]](#footnote-148) Therefore, this is, also, an emancipatory vision on care. The difference between the client organisations and the healthcare providers is the way in which it is approached. Client organisations take clients as the main object. On the other hand, healthcare providers are supplier of care and should also involve a financial component. In this, providers position themselves as social entrepreneurs.[[149]](#footnote-149)  
 Therefore, research by Vilans (2014) shows that the strategy of healthcare providers is to focus to the offered service. This means that the supply is narrowed and provider’s non-profitable services are divested. The providers experienced that much is spoken about money, both by municipalities as well as providers.[[150]](#footnote-150) Although, healthcare providers are a semi-public organisation, at the same time they are dependent on the amount of service they can provide to clients and the associated benefits from this care.

Healthcare providers have direct access to clients, carers and volunteers. This is why, the Ministry involves this actor, for example for communication.[[151]](#footnote-151) As reciprocity, providers are in the possession of a negotiation means. In addition, the healthcare providers are the performers of the policy. Especially, in a consensus oriented country like the Netherlands, it is important that the care providers as performers of the care are involved in the process. This means that providers have a good negotiation resource; the government need providers for the execution.

**Coalitions**

Self-interest seems to be the attention at both the municipalities and healthcare providers. None of the actors can disagree with the common vision, however when it should get concrete, it turns out to be complex. One agrees that care must be integrated into the customer's demand and fusion of processes and organisational boundaries. In reality, each party still thinks from its own specialty.[[152]](#footnote-152)  
 The healthcare providers and client organisations are more on a same level. In the implementation period, a vision document of the client organisations is endorsed, together with MEE-Netherlands and Actiz.[[153]](#footnote-153) It is easier to create coalitions for these relationships. Actiz has also indicated in the strategic plan to establish (temporary) coalitions with multiple stakeholders, in which the parties can strengthen each other in their advocacy.[[154]](#footnote-154) In this, parties are not appointed.

**Analysis**

The policy cycle-actor hourglass states that different stakeholders are influential at different stages of the policy-making process. Especially, in the agenda-setting stage the public opinion is decisive. During the formulation and the implementation only the policy subsystem is involved, and in the decision stage the actors involved are shrinking to the parties in the parliament. On the other hand, the ACF states that the outcome of the policy process is due to the elite opinion.

According to documents the government focusses on three stakeholders: municipalities, clients, and providers. These three groups have their own core belief. Municipalities consider decentralisation as a strengthen of their authority. In the belief of municipalities, citizens need to be activated and entitle to their own capabilities. On the contrary, client organisations and healthcare providers puts the client and its capabilities at the centre. Healthcare should connect with the needs and wants of the client. Municipalities have preferable resources; the government are dependent on the willingness of municipalities of the execution of the policy. The VNG is deeply involved in different negotiations and input of the new policy.   
 Client organisations are in a situation in which the interests are opposed to the governments interests. Suitable, tailored, and proper care are not always similar to efficient policy. Besides, the government is not entirely dependent on the cooperation of clients. At the same time, client organisations have the resource to be capable to address the public opinion. Especially the parliament, which is responsible for the ratification of policy, is sensitive to the public opinion.  
 Like the client organisations, providers consider that healthcare should connect with the needs and the wants of the client. The difference between client organisations and providers is that providers also need to take a financial component into their interests. Although, providers have a societal vision, they remain entrepreneurs. It is in the providers’ interests to have enough financial resources. The resource that providers have in the negotiations is the dependence of the government; without the satisfaction of providers new policy will not be executed.

# Chapter 7: Agenda setting

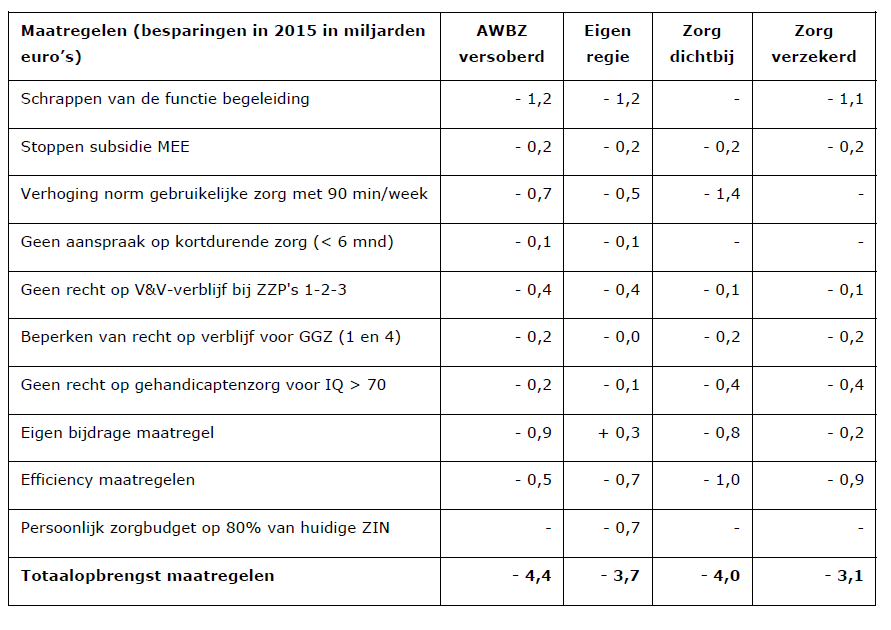
**Agenda setting is the first, and possibly the most critical stage of the policy-making process. Problems emerge and the government should create a means to resolve the problem.[[155]](#footnote-155) The policy cycle-actor hourglass predicts that issues are put at the policy agenda by the policy universe. This means that the public, an interest group, or the media and politics can try to put an issue on the political agenda. In contrast, the advocacy coalition framework argues that elites largely control knowledge and on the basis of this expertise, set issues at the agenda.**

*WMO 2007*

The Wmo entered into force on 1 January 2007. The goal of this act was to contribute to the possibility of citizens to continue to live independently and participate in society as long as possible. The Wmo replaced the Disability Provision Act (WVG), the Welfare Act, and the component Home Care out of the General Law on Exceptional Medial Expenses (AWBZ). Because the WVG and the Welfare Act already were municipalities’ responsibility, the functions of municipalities are expanded with a part of the AWBZ and public mental healthcare (OGGz). The convergence of these regulations must provide the possibility to provide integral policy.   
 This new act has been adopted under the Second Balkenende cabinet (Balkenende II), which governed between 2003 and 2006. This government consisted of the CDA, VVD, and D66. During former elections, most political parties pleaded for a transfer of the support function out of the AWBZ to the Wmo. The Christian democratic standpoints of the CDA in this amendment of the law are based on participation, the principle of subsidiarity, and an integrated approach.[[156]](#footnote-156)   
 During the first evaluation of the Wmo in 2010, it was concluded that the act functioned in the sense of implementation in most municipalities with the available instrument the act offered. As such, there is a focus on a connection between multiple adjacent policy areas. Despite the great steps in development to a more suitable local policy by municipalities, there were still some suggestions for improvement. For example, the interest of audiences with a mental disability or a chronical physical condition are not represented enough. In addition, there is not enough attention for people with a social disorder and caregivers deserve more support. For applicants of social support it is not always straightforward that they have the opportunity to choose between healthcare done in kind and a personal budget (pgb).[[157]](#footnote-157)

*Report on reconsideration of long-term care*

In September 2009, Prime Minister Balkenende and the Ministers Bos and Rouvoet offer a letter to the Second Chamber in which the ambitions of the cabinet are formulated. Naturally, the financial and economic crises come with some challenges. These challenges are, for example, to prevent the economy to become part of the negative downward spiral, with structural burdens in the future.[[158]](#footnote-158) The proposed reconsiderations are aimed at a thorough preparation of decision-making. By supporting the economy in 2010, the government hopes for recovery of the economy in 2011.  
 One of the nineteen created working groups, which will reconsider policy, is a working group that focuses on long-term care.[[159]](#footnote-159) At the introduction of the AWBZ in 1968, the act contained a collective finance of intramural care, establishment for mentally handicapped, and establishments for physical and mental disabled. By autonomous developments and additions of other care facilities, the AWBZ expenditures are significantly extended in recent years. The created working group has as its objective to develop variances in policy that can offer structural savings.   
 In April 2010, the working groups provided a report of reconsideration of long-term care. This report considers four alternatives for reorganisation of the AWBZ. These consists of (1) to sober down AWBZ; (2) own accountability; (3) care nearby; and (4) care insurance. In the first option, to sober down the AWBZ, achieves the desired saving of 20%. In this option, rehabilitation is transferred to the Healthcare Insurance Act (Zvw). Moreover, some extra spending is transferred to the Wmo and other collective financed policies. Yet, the healthcare administration offices, the implementing body of the AWBZ, remains in the current entity. In option two, own accountability, a part of the consumers who are entitled to care in kind will be converted to PGBs. As such, clients can provide for their own needs and preferences in care. The volume of a PGB is 80% of the care in kind budget. Option three, care nearby, will bring all intra- and extramural nursing and care plus all extramural mental healthcare and disabled services under responsibility of municipalities. In the local policy, better considerations can be made among others on own contribution and PGB. In option four, care insurance, the administrative responsibility of extra- and intramural nursing and care and mental healthcare are deposited with the health insurance companies. Overall, all options are based on a more effective spending of finances. Nonetheless, to sober down the AWBZ will produce the most savings. The option, care nearby, produces 4 billion euros in 2015 (See Table 1).

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*Table 1: Possible savings on the long-term care.[[160]](#footnote-160)*

*Evaluation of Youth Care Act*

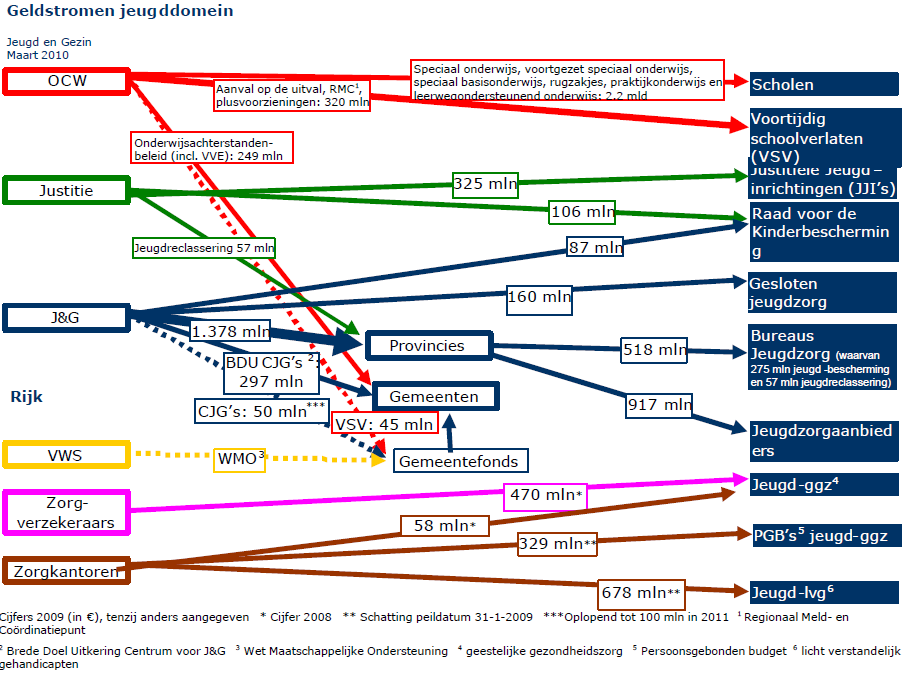
Five years after the implementation of the Youth Care Act, it needed an evaluation. Subsequently, on 11 November 2009, the evaluation report is offered to the Parliament.

When the Youth Care Act was accepted, five objectives were formulated with respect to the access, objectified integral indications, integral approach of indicated youth care, connection between multiple youth care domains, anchoring of the right, the governing role of provinces, and the financial controllability.[[161]](#footnote-161) The evaluation demonstrates that despite that youth and their parents receive the care they are entitled to, there is still a deviation from an optimal situation. Furthermore, the report concludes that the principles on indication and finance systems possibly need to be revisited, because these two principals have not been established in the five years of the Youth Care Act.[[162]](#footnote-162)

*Explorations of the Future Youth Care*

Conform to the motion Dijsselbloem,[[163]](#footnote-163) adopted on 4 November 2009, the presidium of the general commission of Youth and Family suggests to establish a parliamentary working group which will explore the future of the Youth Care and investigate the larger problems in Youth Care. The working group consists of parliament members of the political parties SP, GroenLinks (GL), PvdA, CU, CDA, VVD, and PVV. This creates a wide acknowledgement for the outcome of the eventual report. Through an analysis of the causes of the problems, the working group presented a joint vision for improvements in Youth Care.[[164]](#footnote-164) In recent years, the demands for Youth Care has increased. The report of the parliamentary working group defined Youth Care as “the care which exceeds prevention, and is more than simple advice or mild support for raising children”.[[165]](#footnote-165)   
 Moreover, the working group notes that the society has a lower acceptance of deviant behaviour and risks. The emphasis has shifted to adjust light deviant behaviour and accountability and hedging problems. In addition, there are a number of perverse incentives in the youth care system. On the one hand, this is caused by the financial system, and, on the other hand, prevention is not financially stimulated. The working group concludes that three changes need to be adapted. First, society will have to learn how to handle deviations and risks. Second, the youth care system will have to be reorganised. Finally, there should be more emphasis on integral support for multi-problem families.[[166]](#footnote-166)

In 2009, the funding within the youth field went over five flows; the Ministries of Education, Culture and Sports (OCW), Justice and Youth and Families (J&G) as well as health insurers and care agencies funded components of the domain (see Figure 3). The working group believes that this is an obstacle to effective cooperation and results in unnecessary administration.[[167]](#footnote-167)

  
Figure 5: Financial currents in 2010 in the youth care[[168]](#footnote-168)

The working group’s conclusion is that one single funding flow should be established for the current prevention policies, the current voluntary provincial child welfare, assistance for young mildly mentally handicapped (Youth LVG), and mental health for youth (Youth mental healthcare). In addition, as assessment procedures in the voluntary framework costs a generously amount of time that cannot be spent on necessary care, it is proposed to abolish it. Moreover, municipalities are a logical organisation to organise prevention and voluntary assistance.[[169]](#footnote-169)

*Cabinet Vision: Perspective for youth and family*  
On 20 February 2010, Prime Minister Balkenende announced that the government comprising the CDA, PvdA, and Christian Union has collapses because of the Uruzgan issue. The government did not manage to reach an agreement on a possible continuation of the Dutch military operations in the Afghanistan province Uruzgan.[[170]](#footnote-170) The Labour Party resigned from the cabinet. This happened just weeks before local elections would take place.   
The cabinet continued to govern in a caretaker capacity until a new government could be installed. This cabinet consisted of the Christian parties CDA and CU presented on 9 April 2010, the government’s vision on the future of support and youth care. The principles in this vision include the removal of perverse incentives, limiting the number of administration and financing flows, and quality assurance. To connect the support and care for young people as much as possible to (local) regulations such as education and work or support in debt, the report represents the vision to transfer to municipalities the outpatient services in the future. Through placement of all these tasks under a party that also bears responsibility for welfare, education, and other adjoining policy, not only an integrated approach to care is established, but also an incentive is created to invest in early intervention and prevention.[[171]](#footnote-171)   
 This new policy entails responsibilities for municipalities to require sufficient administrative capacity. The implementation of specialised youth care can only be done at the regional level on the scale of the Municipal Health Service Regions (GGD regions). Where previously five organisations were involved, only the municipalities and Health Insurance Act (ZVW) performers are involved in the new situation (see figure 6).[[172]](#footnote-172)

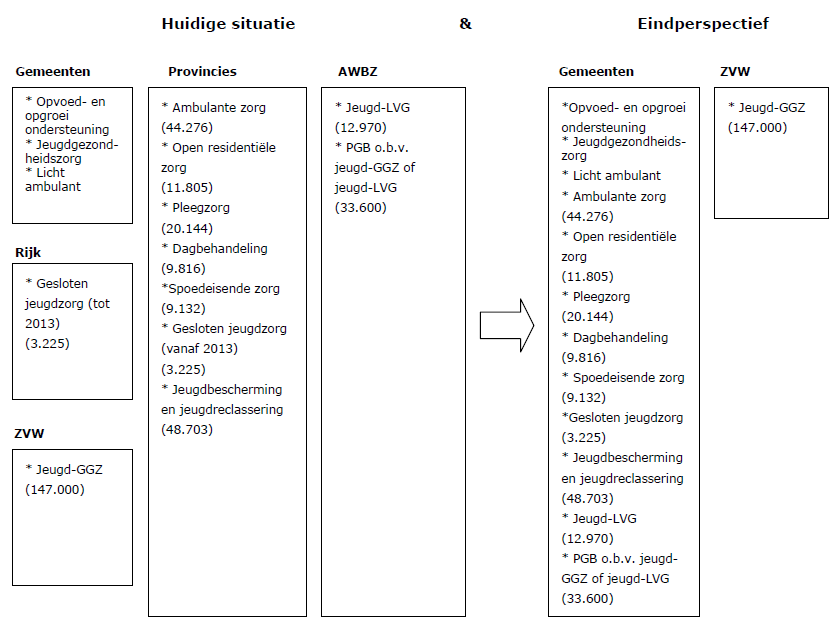


Figure 6: The distribution of tasks in the old and the new youth care system.

*Elections 2010*

After the fall of the cabinet, new parliament elections were called for on June 9, 2010. In April, the election campaign started. This campaign was dominated by the questions how and to what extent each party aimed at the economic crisis and the growing budget deficit.[[173]](#footnote-173) The major issue in the election was the mortgage interest rate. Other important issues were (the expenses of) healthcare system and the immigration and integration of ethnic minorities.[[174]](#footnote-174)   
 The Central Plan Bureau (CPB), which calculates the election programmes of the various parties, noted that aging has a greater impact on the state budget than previously estimated. On balance, most parties cut back on healthcare, except for the SP and PVV of which the expenses remain unchanged, while healthcare spending in the VVD, D66, and SGP decrease most.[[175]](#footnote-175)   
 In the VVD election programme 2010, the party states explicitly that the direction of child welfare in municipalities must be lodged with space to provide for customisation. The justification for this is that less bureaucracy and regulation should be imposed. Instead, there must be more financial focus on prevention and that efficiency within the sectors can be increased.[[176]](#footnote-176) The VVD considers it important that proper care is available and affordable. This is best provided on a small-scale, close to people, and personalised, but it should also be affordable and accessible. In addition, the VVD announces further adjustments to the AWBZ. Here, however, it is not mentioned that municipalities are part of this adaptation.[[177]](#footnote-177)  
 The PvdA too foresees changes in the AWBZ. The focus on prevention is to ensure that health problems of citizens reduce. The PvdA sees a strong connection between health, education, labour, and welfare. As tasks of the AWBZ and Youth Care are to be transferred to municipalities with adequate resources, reliance on care can be directly prevented. Furthermore, cooperation is required on a regional scale in which a central municipality construction can be used.[[178]](#footnote-178)  
 The CDA believes that especially the milder forms of youth care should be located in municipalities. Heavier help will have to be organised between multiple municipals. In the future, more parts of the AWBZ should be transferred to the Wmo. Additionally, the CDA is neutral about the decentralisation of tasks to municipalities.[[179]](#footnote-179)  
 The SP is the major opposition party located on the far left side of the political spectrum and has strong views concerning healthcare, social security, and welfare. The SP believes that market forces will lead to competition between healthcare providers and health insurers and entails unnecessary bureaucracy for the caregiver. Instead of limiting the AWBZ, it should be improved and care should be delivered on a small scale close to the citizens. Municipalities will have more financial resources to implement the Wmo. In addition, the SP is of the opinion that the youth, when possible, belongs under supervision of local authorities. Virtually all parties choose a different organisation for long-term care (AWBZ), but only the SP wants to maintain the healthcare system of 2010.[[180]](#footnote-180) It is striking that where the previous party wants to outsource more tasks to others, the SP seeks greater regulation and implementation by the State.[[181]](#footnote-181)   
 Of the remaining smaller parties, the PVV manifesto says nothing about the decentralisation of tasks to municipalities. D66, however, is proponent of transferring the AWBZ, care, child welfare, and social security to the local government which they mention multiple times in the elections. Namely, D66 regards the local government as the primary government .[[182]](#footnote-182) GL and CU reported a transfer of tasks to the municipalities. Moreover, all parties mention the high healthcare expenses as motivation to decentralise. In addition, it is cited the care should be provided in people’s environment and must be supplied as custom work.  
 During the elections of 2010, 75% of the population cast a vote. The VVD emerged as the winner with almost 20.5% of the votes and this corresponds to 31 seats. The Labour Party won 30 seats with 19.6%. The PVV and CDA followed with 24 and 21 seats respectively.[[183]](#footnote-183) This means that there were at least three parties required in order to form a majority. Yet, the great fragmentation in the outcome made a coalition almost impossible. After multiple options, a unique formation was established that had not previously occurred in Dutch history. The VVD and CDA jointly reached agreement on forming a government. Since these parties had no majority, the PVV agreed to support the cabinet without compromising ministers. This meant that it was a minority government with support partner.[[184]](#footnote-184)   
  
*Reactions to the formateur*During the cabinet formation, the formateur of the government received about thirty letters, notes, or opinions in the field of elderly care and child welfare.[[185]](#footnote-185) These came mostly from bodies representing client organisations, healthcare providers, health insurers, juvenile courts and juvenile rehabilitation or youth protection, and municipalities. Many of these groups are represented by an umbrella organisation or sector associations. In addition, the various parties involved understand the cuts to be implemented by the government. On the other hand, they want to avoid major cuts because excessive reductions in healthcare spending cuts lead to lower quality care.[[186]](#footnote-186)  
 Many of the organisations are calling for a stronger position of the patient and citizens in the care process. Nonetheless, this does not mean that citizens do not need support from professionals. The focus should be more on their own control and empowerment of citizens. In particular, client organisations point to the capabilities of people, as “people are more than their need for care”.[[187]](#footnote-187) Thus, people should have the opportunity to actively participate in society and to take responsibility. Moreover, the provision of care should be demand-driven rather than supply-driven. By acting more client- or citizen-centred, it points to both the duty of personal responsibility that clients or citizens have and the right to decide how life is organised. This also entails that the own control and self-reliance can be observed as an opportunity for economic savings or as a neglected citizen right.  
 The package of measures forwarded by the client organisation has three pillars: (1) self-direction; (2) greatly simplifying the organisation of care; and (3) the downsizing of the implementation structure. The organisation of care should be arranged less bureaucratic, as the reduction of administrative burdens could lead to savings of 10%. Furthermore, when the system is client-orientated, the client can also function as a purchaser. This allows the implementation structure to be limited. These proposals would generate savings of 2.1 billion euros.[[188]](#footnote-188)  
 A report commissioned by Actiz, the trade organisation of 440 healthcare providers, indicates that care providers are ready for a new ambition. Healthcare providers have no incentive to proceed with care innovation, seize opportunities and guidance to independence, and a healthy life. It was considered that the provider performed what was ordered from the indication. Therefore, there should be more autonomy to the healthcare so that they can act like entrepreneurs. A healthcare provider should experience an incentive to make him or herself redundant as soon as possible.[[189]](#footnote-189)   
 The VNG, where all Dutch municipalities are members of, is in favour of government tasks that are organised as close as possible to the citizen. The VNG calls for a strengthening of the mandate of municipalities in the area of care and youth. In order to enable municipalities to implement effective local care, the VNG opts to transfer parts from the AWBZ to the WMO, including the associated resources. Furthermore, municipalities should be responsible for child welfare, focusing on preventive policies and low-threshold services in the neighbourhood. In addition, municipalities should have the leading role in the drafting of new legislation and funding system.[[190]](#footnote-190)  
 Overall, all parties recognise that prevention and early intervention must be sufficiently institutionalised. Hence, problems should be addressed before they escalate and a heavier demand for care will not only produce cuts, but policy is also more in line with the implementation of a pleasant life.

*Coalition and Tolerance Agreement 2010-2014*As the various election programmes indicated, youth is a topic which returned in the coalition agreement presented on 30 September 2010. The way in which youth care is organised, it will not operate efficient. The government is therefore taking measures for youth care to transfer in phases to the municipalities. These are the youth mental healthcare (J-GGz), provincial youth care, secure youth, juvenile probation, juvenile justice, and mentally disabled youth. Prevention and voluntary assistance will be organised by municipalities in close coordination with restraint relief.[[191]](#footnote-191)   
 While the decentralisation of youth care is explicitly mentioned, this is not the case with long-term care. Nevertheless, the government does indicate that good basic care should be organised as close as possible to the citizen in a network of care in the districts and villages. Here, however, a role for municipalities is not explicitly mentioned.[[192]](#footnote-192) It has been reported that the government is in favour of decentralisation and task shifting towards provinces and municipalities. In addition to the coalition agreement between the VVD and CDA, a support agreement with the PVV is also prepared. This latter agreement proposes a number of system choices in AWBZ. One of the measures is the transfer of day care and counselling to the WMO carried out by the municipalities. These functions can be best controlled close to the client and municipalities know the people and situation better. This measure has to start in 2014. With this plan, the government will allocate 0.7 billion euros extra for the AWBZ.[[193]](#footnote-193) The transfer of the child welfare functions to local authorities is accompanied by an efficiency reduction of 0.1 billion in 2015 and 0.3 billion structural.[[194]](#footnote-194)

*Comments on coalition agreement*Soon after the publication of the coalition agreement and the support agreement, several stakeholder organisations responded.  
 The umbrella organisation of the municipal health service (GGD Netherlands) is positive about the planned approach to the youth care. This would provide local authorities with a financial incentive to invest in detection and prevention. This argument stems from economic self-interest, the GGDs have, among others, the task to implement early detection and prevention among adolescents. This incentive means that more use is made of the GGD. The GGD also state that they do not hope that the efficiency gains that the coalition assumes means reductions concerning preventive healthcare. In addition, the GGD notes that the partitions separation in the child welfare is positive for young people.[[195]](#footnote-195)   
 The VNG came up with a comprehensive response. The VNG mentions an efficiency reduction of 80 million euros in 2015 and 300 million euros structural in youth care and from 2014, 140 million structural on day care and support in the AWBZ. The VNG expects to receive adequate financial resources from the government. When this does not happen, this can lead to significant financial risks.[[196]](#footnote-196) The transfer of the functions day care and support from the AWBZ is in line with the commitment of the municipalities in recent years and it is appropriate to the transfer the domestic help in 2007 and package measures in 2009. Nonetheless, for municipalities, the implementation costs are still a concern. Not only does the government desire to save 5%, the financial resources that will transfer to the municipalities are also not included implementation costs. This means that municipalities should deploy additional capacity, but must accomplish this with the same resources as before. In addition to the financial resources, the policy space for municipalities is also of interest. Municipalities would like to play a role in the whole area of 'cure and care'. This means that the linkage between local healthcare and preventive WMO activities creates opportunities.[[197]](#footnote-197)   
 With respect to child welfare, there is still much uncertainty for municipalities, as it is not clear which parts of the social services are decentralised, when this will happen, and how the budget is distributed among municipalities. The VNG indicates to be a supporter of the decentralisation of youth care, but only if there re sufficient funds, discretionary, and performance space.[[198]](#footnote-198)   
 In addition to the municipalities that become responsible for youth care after decentralisation, the inter-provincial consultation (IPO) lose these tasks. The IPO believes that the standpoint of decentralisation should be in the interests of children in youth care and the development, which municipalities offer. The association notes that the provinces with youth care have created efficiency and quality gains in the last few years. They feel that this gain should not be penalised with a reduction of 90 million euros.[[199]](#footnote-199) Moreover, the IPO believes that the implementation also has an important historical and financial motive in response to the coalition agreement.  
 Not only sub-national government parties have a reaction to the coalition in 2010, as the proposed changes in the AWBZ/Wmo and youth care also relate to the healthcare providers. As previously mentioned, Actiz, the sector association for providers in the areas of elderly, chronically sick, maternity ,and childhood health, represented more than 440 members. In a response, Actiz noticed that healthcare providers are not negative over the coalition agreement, even though there are some critical notes.[[200]](#footnote-200) Research demonstrates that clients do not have unlimited demands for care since clients are aware that healthcare is a scarce commodity. The transfer of supervision and day care from the AWBZ to municipalities causes fragmentation in care and there is fear about the lack of knowledge and ignorance of local authorities. Yet, it is positive for the municipalities that all youth care will be gathered in one financial framework. At the same time, due to the transfer of youth care, municipalities receive a larger share of risk youth in their file and will have less focus on primary prevention.[[201]](#footnote-201) Nonetheless, the coalition agreement does provide space for innovation in healthcare and healthcare providers should be given the freedom commence this innovation.  
 In general, the responses to the coalition agreement are positive and critical. This is because the coalition agreement only refers to the change in the healthcare system. Although it is noted that the youth care, counselling, and day care are decentralised to municipalities, there is no further elaboration on the coalition agreement of the actual measures.

**Analysis**The policy cycle-actor hourglass predicts that the policy is set by the public opinion. Thus, if the policy cycle-actor hourglass concerning agenda-setting is correct, it should we notable that the reason to decentralise the healthcare in the Netherlands is because of the policy universe. In contrast, the ACF predicts that the agenda is set by elite opinion. That is, the elite has the knowledge and resources to put the decentralisation on the policy agenda of politics.   
 Although the coalition agreement drawn up by the VVD and CDA for the period 2010-2014, the agenda was already set in the previous period. The report from the working group on youth care and the report on reconsideration of long-term care have provided input to virtually all election programmes of the political parties in 2010. In sum, all election programmes, except the one of the SP, indicate that there must be a rethinking of both the youth care system and the long-term care system. Yet, the effects are not specifically appointed in most programmes, which makes it less clear to voters for which a choice is made. Various interest groups and representatives have published perspectives and opinion pieces during the election campaign and during the government formation. These publications served as input for the election and the coalition agreement.  
 Thus, it can be concluded that many actors were involved in the agenda setting. It is striking that the choice of the policy universe (the voters) is limited. Formally, there should be a role for the actual agenda setting in the coalition agreement; however, as the various parties expressed nearly the same position, the agenda was already set before the policy universe could influence this. Furthermore, several umbrella organisation and interest groups attempt to exert influence during the elections and during the formulation of the coalition agreement. For the VNG, this lobby has resulted in the fact that some tasks from the youth care system will be transferred to the municipalities and it is established in the support agreement which day care and counselling from the AWBZ are transferred to WMO. In all, the providers are not completely negative about the decentralisations.  
 This chapter illustrates that the issue of decentralisation is not put on the agenda by the public. Multiple actors played a part, but mainly the experts and political parties produced reports on the topic and made it part of the election campaign. Therefore, it can be concluded that the theory of ACF is more suitable to the agenda-setting of the decentralisation of healthcare in the Netherlands than the policy cycle-actor hourglass theory.

**Agenda Setting**

|  |  |
| --- | --- |
| Networks members | - State - Political parties - Public - VNG - IPO - Healthcare providers - Client organisations |
| Networks characteristics | - Significant uncertainty   - Understanding cuts |
| Essential resources | - Election programmes  - Lobby memos/letters  - report reconsolidation long-term care  - Explorations of the future Youth Care |
| Position ministry in network | The government is especially in the first phase of the agenda-setting on the foreground. The studies were carried out on the initiative of the government. |
| Stage outcome | Coalition Agreement 2010-2014 in which the change of the youth system and long-term care has been recorded. |

# Chapter 8: Formulation

**Once an issue is placed on the agenda and is acknowledged as a problem, several courses of action are formulated. In the stage of formulation, multiple solutions for addressing the problem are identified.[[202]](#footnote-202) This stage consists of appraisal, dialogue, formulation, and consolidation. Both the policy cycle-actor hourglass and the ACF predict that only those actors with sufficient knowledge of a problem area, or a resource at stake will participate in the process of developing possible alternative courses of action to address the issues raised at the agenda-setting stage.[[203]](#footnote-203)**

**Governance agreement**As stated in the coalition agreement, Rutte I aims to achieve a smaller, more powerful and serving government. Part of this is also the transfer of substantial duties and responsibilities to local governments.  
 The motto of the 2011-2015 governance agreement concluded between the VNG, IPO, water boards and the government is "decentralize where possible, centralize where necessary". The government will have to argue why a task should be performed centrally. At the same time local authorities will ensure adequate implementation force in decentralizations. This may also mean that a number of tasks should be carried out on regional level.[[204]](#footnote-204)  
 To perform the decentralizations proposed in the coalition agreement, the recipient government should feel confident that this actually belonged to the possibilities. The involved actors believe that this needs policy authority, adequate funding, a retreating national government, potential phasing and adequate implementation. In the social domain is a decentralization in the fields 'Work Capacity’, AWBZ and youth care provided. After adoption of the Governance agreement principles and process agreements which are mentioned in the coalition agreement will be worked out in partial agreements and be concluded between the minister and the relevant local authorities. It is also determined at any partial agreement which community organizations will be involved in what way..[[205]](#footnote-205)  
 In the governance agreement a number of principles are noted, namely:  
1. Decentralizing means release and thus a maximum policy authority and minimal accountability obligation.  
2. The performance space is increased by limiting the imposed quality and burden arrangements.   
3. Pilots and experiments have no precedential.  
4. Regarding guidance and supervision: financing is through general funds, not inter-administrative supervision will be set and only necessary interagency information is requested.[[206]](#footnote-206)  
For municipalities and other local authorities these agreements and principles aim a considerable autonomy and policy space.  
 In the governance agreement 2011-2015 are the first principles for the various areas of decentralization set out in more detail. The AWBZ function guidance will be cancelled and a provision will be made in a provision. This will require reinforced or modification on a number of articles from the Wmo in 2007. This is partly related to the quality of the guidance and the monitoring quality by municipalities. In addition, municipalities are obliged to carry out periodic client experience surveys among clients who received counselling and domestic help. With this the influence of clients is guaranteed in the evaluation phase. Also, the national government, which becomes responsible for the system is not responsible anymore for the policy content, will refrain from vertical supervision.[[207]](#footnote-207)  
 The framework will be transferred in stages from 2013 to municipalities. This means that municipalities from 1 January 2013 are responsible for new clients and from 1 January 2014 for all clients who use guidance. Also, the agreement stipulates that for the summer of 2011 by government and municipalities jointly study for which specific groups specific measures should be taken. To carry out this decentralization government and VNG are responsible for a correct transfer of client data to municipalities. About the financial consequences no concrete arrangement is made. It will be an amount between € 2.1 and € 3.3 billion. Incidentally, it made the message that an efficiency discount of 5% will be made on the total indexed budget. The Ministries of Health, Welfare and Sport (VWS), the Interior and Kingdom Relations (BZK) and the VNG will develop a distribution model to distribute the benefits of decentralization municipalities based on objective differences between municipalities. Also considerations are needed on what resources pertaining execution should be transferred from the ministries to municipalities. With the decentralizations the implementation of the various ministries will be lower and increase implementation tasks of municipalities.[[208]](#footnote-208)   
 For the decentralisation of youth care decentralisation is that it is developed in conjunction with appropriate education, based on the assumption that the responsibilities of education and municipal leaders are clear and that the support for child, family and teachers is transparent. The decentralisation relates to all care for young people in the government, provinces, AWBZ and Health Insurance Act (Zvw). By the summer of 2011 there must be obtained clarity on specific measures for specific target groups. In principle, all youth care will be transferred, provided no compelling and substantial reasons to keep a certain target group at the national level. The three actors, government, VNG and IPO, establish jointly a transition plan that will be sent to the Second Chamber. Furthermore, it is stated that both municipalities and provinces must be capable to use the maximum space to experiment and innovate. The entire decentralization should be completed in 2016. This devolution will be involved with a financial saving of € 80 million in 2015, rising to € 300 million from 2017. From 2016 onwards there will be a structural transfer of 90 million euros from the provincial to the municipal funds. As in the decentralization of assistance from the AWBZ applies for the decentralization of youth care, the Ministry of Health will carry out an independent investigation into the costs of execution.[[209]](#footnote-209)   
 On 8 June 2011 the general assembly of members of the VNG agreed with the Governance Agreement with the exception of the section 'Work Capacity. Initially, this was considered by the government as a rejection of the entire Governance Agreement. Through some mutual exchange of views both parties accept the negotiated agreement as a binding basis for constructive cooperation in the future.[[210]](#footnote-210)

**Appraisal and dialogue with partners**

*Youth Care Act*

Between 18 July and 29 August 2011, Deloitte commissioned by the Ministry of Health, Welfare and Sport held discussions with stakeholders in the field of Youth. The objective here was threefold: (1) collecting information on groups with specific concerns in the review of the youth care system; (2) Mapping discussions points; and (3) Identification of measures that may be taken. For this, talks are held with the Youth Care Netherlands, William Schrikker Group, SGJ (Christian youth), Association of Orth pedagogic Treatment Centres (VOBC), GGZ-NL, youth care advisers of municipalities and client organisations.[[211]](#footnote-211)

In the progress letter of April 2012, the State Secretary reiterate that the change in youth care aims that no child is to be offside. This is consistent with the International Convention for the Rights of the Child (UNCRC). To achieve this, municipalities gain as well as in the Wmo 2015 to organize the responsibility to talk with the child and his parents to find out what the actual support is needed. The administrative vision that is underneath is that the government closest to the citizen can realize the best customization and innovation as it has decompartmentalised frameworks.[[212]](#footnote-212) In the progress letter a number of parties are appointed that are important for the success of the change as the children's helpline, family doctors, and the Council for Child Protection (RvdK). These three parties should be independent of the local authorities in continue to perform their tasks.

Because municipalities will become responsible for the implementation they will also bear the responsibility for the quality. These quality standards for youth will be included in the municipal policy regulations. However, there are some requirements that apply to all forms of youth and are in line with the principles of the UNCRC. The progress is noted that the effect of these requirements will be made in consultation with local authorities and relevant parties.[[213]](#footnote-213)  
 The progress letter of April mentioned a number of knowledge institutes and advisory boards. Thus, it refers to an opinion on the support of families of the Council for Social Development (RMO), and the transition office will use expertise of Dutch Youth Institute (NJI), Dutch Centre for Youth Health, Trimbos Institute, Movisie and ZonMW.[[214]](#footnote-214)

At the request of the parliament an official working group 'Transitional measures' of VNG, IPO and the State has with Youth Netherlands, MO group, VGN / VOBC, GGD Netherlands, GGZ Netherlands, the inspection youth care, and client organizations appointed the risks and possible control measures in the transition phase. Because of the broad inventory these risks are different in nature, size and weight. The results of the report are included by the government in the elaboration of the bill.[[215]](#footnote-215)

From 19 July to 18 October 2012, the draft bill was offered for consultation via the Internet. Because of this open consultation to stakeholders and the public at large they are involved in the legislative process. With this, visibility is given to the decisions to date and the opportunity to actively participate with the bill.[[216]](#footnote-216)  
 The consultation yielded 100 public responses. Remarkable here is that a dozen responses are posted by individuals not associated with any interest group or client representative. These citizens are mostly parents with children who use the current youth care. They express their concerns about the new system. The mayor and aldermen would be insufficient to make decisions on issues such as child protection and juvenile rehabilitation and care. Municipalities get too much policy space. Furthermore, it is not entirely clear to them if the care that is needed and also provide previously was also put through in the new system. At the same time appoint municipalities that they see a discrepancy between the responsibility they receive and the limited powers they receive.[[217]](#footnote-217)

*Wmo 2015*

In a letter on the future of the AWBZ which the then State Secretary for Health, Welfare and Sport to send the House on 23 September 2011 shows the progress of the decentralizations. Which indicated that by 1 January 2014 everyone will receive guidance from municipalities. For municipalities, providers and client organizations to prepare timely and good, the Ministry of Health, Welfare and Sport, together with the VNG established a transition office that provides support.[[218]](#footnote-218)   
 In the months prior to this letter there are 32 events organized throughout the country in which the parties had the opportunity to meet local partners. In addition, there is information shared during the meetings. These meetings have given the Department insight into the needs of stakeholders and potential bottlenecks. Also, the Secretary of State agreed with the umbrella organisations of providers, individual care providers, patient and client's organizations to keep in touch on which these parties encounter. The same applies to municipalities.[[219]](#footnote-219)  
 As agreed in the Governance Agreement after consultation of patient and client organisations, healthcare providers and municipalities a comprehensive review is identified in which client groups will be appointed who may need further measures. Besides the VNG MEE Netherlands has a prominent role in the letter. Due to the concentration of facilities and support by local authorities it is also required to offer support. For the further development of client support the department makes consultations with the VNG, MEE Netherlands and patient- and client organizations.[[220]](#footnote-220)

Because the government in the spring of 2012 falls are some parts of the reform program declared controversial. This makes that the functions guidance remains at least in 2013 part of the AWVZ and the choice of decentralization is thus at the next cabinet.[[221]](#footnote-221)

Immediately after taking office, the State Secretary for Health, Welfare and Sport appointed an administrative direction group in Long-Term Care. In this context, field parties think along on the impact of the measures in the coalition agreement.[[222]](#footnote-222) In the direction group, the VNG, Actiz, VGN, ZN, CG-council, NPCF, GGZ Netherlands and BTN took place. In addition, the direction group is completed by the platform mental healthcare, Shelter Federation and the LOC. In the paper 'Reforming the long-term support and care’ the government's intention of Rutte II are developed. As of 1 January 2015 municipalities will receive a broad responsibility for the support of citizens who cannot fully participate.[[223]](#footnote-223)

In a progress letter on 2 October 2013, the State Secretary noted that it is a good practice to provide the legislative proposals for consultation to the parties concerned. This should ensure proper coordination with the practice and sufficient public support. After speaking with representatives of clients and patients, providers, organisations of caregivers and municipalities and VNG the various input is weighed and may or may not be included in the bill.[[224]](#footnote-224)   
 The bill for the Wmo 2015 is not available for consultation via the internet to a wide audience. The government has opted for an interactive consultation with a large group of closely involved stakeholders. This was decided because this approach offered the opportunity to clarify the choices made in the bill and the parties had the opportunity to provide a good substantive input. There was no time because of the timeframe to turn a wide internet consultation.[[225]](#footnote-225)

**Elections 2012**

After just two years, the cabinet Rutte I falls on April 23, 2012. This is due to the different positions of the VVD, CDA and PVV regarding further cuts of 14.4 billion euros. New elections are organized for 12 September of the same year.  
 During the elections, the VVD, as in 2010, is elected as the major party. Also the Labour Party won seats. The PVV, CDA and GL all have a big loss in seats. After negotiations come VVD and Labour on 29 October 2012 with a draft coalition. On 5 November the new government is sworn, again led by Mark Rutte. In the Coalition Agreement 'Build Bridges’ the budgetary cuts to emerge from the economic crisis are a central theme. Also during the formation period in 2012 are about 25 letters, notes and advice related to (youth) care sent to the formateur.  
 The Coalition Agreement noted that problems are experienced with the bureaucratic density in a number of sectors and domains. Also for (youth) care problems with stakeholders will be explored and possible solutions are sought.[[226]](#footnote-226) The Coalition Agreement recognizes that the government did not function when it comes to (youth) care. Therefore the new cabinet also wants to decentralize youth care and extramural care of the AWBZ to municipalities. The decompartmentalisation of the youth care budget this can be additionally reduced by 150 million euros. These savings can be achieved through prevention, a shift to lighter care, and sharper pricing of healthcare providers. However, the personal contribution which was provided in the Youth Care in 2015 is undone. This brings an annual € 70 million less in revenues.[[227]](#footnote-227)  
 According to the Coalition Agreement, municipalities are fully responsible for activities in the field of support, counselling and care, and becomes part of the Wmo 2015. The restrictions on support will commence in 2014, the entire extramural care will be transferred to municipalities by 2015. The Coalition Agreement declares a structural saving of 1,700 million euros. The financial resources available to municipalities will contain 75% of the current national budget.[[228]](#footnote-228)

**Explanatory memorandum**

In both the Youth Care Act and the Wmo 2015 there is a draft version of the bill sent for consultation to representatives of clients, professionals, healthcare providers, municipalities and advisory bodies. The Youth Care Act also received 180 responses of organisations and individuals because of internet consultation. The explanatory memorandum to both laws reports extensively on the responses and opinions. There is also articulated how the comments have been incorporated in the bill.

*Youth Care Act*  
From the perspective of the municipalities, the VNG, the alliances of large municipalities (G4 and G32), regions of municipalities and individual municipalities responded. These administrative bodies were of the opinion that there is insufficient control options included in the bill to achieve the transformation objectives and efficiency. Municipalities would like to see less detailed legislation, that responsibilities are formulated in terms of results, there is a simplified regulatory quality regime and supervision is streamlined. In addition, comments made about the allocation of municipal management on youth protection and the role of general practitioners in referring children to the youth mental health. [[229]](#footnote-229)

The explanatory memorandum indicates that significant changes were made to the bill in response to a government consultation with the VNG. Thus, the responsibilities are more formulated in terms of results. The quality and the supervisory are simplified. The position of municipalities with respect to allocation of aid in the context of youth protection is clarified and for the position of general practitioners it is included that national and local agreements must be made between general practitioners and municipalities on the referral to youth care.[[230]](#footnote-230)

From the client perspective, the Children's Ombudsman, Defence for Children International (DCI), the national youth forum clients (LCFJ), the National Platform for mental healthcare, the National Youth Council (NJR), and individual parents responded. These reactions were mainly related to the legal certainty and equality. The organizations call for more national quality standards, more safeguards for access to care, participation of children and parents, and an accessible complaints and disputes handling. The children's ombudsman and DCI advocate to only enter the Youth Care Act when municipalities are sufficiently equipped.[[231]](#footnote-231)  
 Following the comments from client perspective, there has been a tightening of the legal articles about participation and complaint. The quality standards are simplified at the request of municipalities, but some basic quality requirements will be nationally controlled. It is the space sought between national requirements and local policymaking. The Government agrees with the Children’s Ombudsman and DCI that municipalities should be optimally prepared for their new roles. Therefore a number of safeguards are included.[[232]](#footnote-232)

The responses from the field parties are divided into different types of care. Youth Care Netherlands (JN), Youth Care Offices, Dutch Association of Foster Parents (NVP) and the Association of Provincial Authorities (IPO) react from the (provincial) youth care. The IPO believes that the bill is does not sufficiently contribute to simplification and less bureaucracy. This perspective calls for a national quality framework for the entire youth domain. The NVP believes that there must be a right of approval for foster parents with the assistance plan and that the participation of foster parents and foster parent councils should be regulated.[[233]](#footnote-233)

Again, the legal quality is simplified by the comments. A national quality framework is proposed in which both requirements for light and heavy forms of care are established. Also for foster care it is arranged that there is right of consent and participation.[[234]](#footnote-234)

The Royal Dutch Society for the Promotion of healing arts (KNMG), mental health Netherlands, and Netherlands Health Insurers (ZN) have shown objections against the transfer of the youth mental health services to municipalities. This would create a snap with the mental care of adults. This is in the way to innovation. If the decentralization of youth mental health will be enacted, the organizations wishes to consult on this with the government and the VNG.   
 Following these reactions it is adjusted in the legislation that general practitioners may refer not only to youth mental health, but to all forms of youth care. In addition, it is clarified in the notes that youth mental health also includes serious dyslexia. In response to the comments, the consultations between the government, the VNG and youth mental health sector intensified and established a joint work agenda .[[235]](#footnote-235)  
 Several organizations, including the Care Assessment Centre (CIZ), signalling that related to care for young people with intellectual disabilities (youth-vb) delimitation based on IQ creates problems. According to the government that is the reason the act provides for the complete transfer of youth-vb to municipalities .[[236]](#footnote-236)

Organizations responding to the youth protection and juvenile rehabilitation component are the Council for Child protection, Youth Care Netherlands, the Council for Criminal Justice and Youth Protection, the Children's Ombudsman, the Council of Chief Constables and the Public Prosecutor (OM). These organizations support the intent of the bill and believe that municipalities are better able to develop an integrated policy. However, some risks are seen in the policy area of municipalities and the forced framework. A number of imposed measures should be implemented uniform throughout the country. The prosecution recommends to impose conditions on the implementation of mandatory Judicial measures. Also, the prosecution indicates a problem surrounding the funding of forced youth care. There is a possibility that municipalities want more say because they are responsible for the budget. In this the government should be involved in the execution of a judicial measure. The Council of Chief Constables want to prevent the differences between municipalities are exponentially. The top local cooperation would have to be less voluntary.[[237]](#footnote-237)  
 The legislation is amply supplemented to reflect this reactions. When court imposes a measure or juvenile probation, it must be able to run without any intermediaries. The court may therefore dedicate a measure directly to a certified institution. By this uniformity, equality and legal certainty is guaranteed .[[238]](#footnote-238)  
 From the perspective of education the MBO council and PO-counsel have indicated that cooperation with education should be mention explicitly in the Youth Care Act. In response, the government indicated passages around alignment with education more explicit, with taking into account the municipal policy freedom .[[239]](#footnote-239)  
 The bill is submitted for consultation to various advisory and inspections. The Council for the Judiciary (RvdR), the Dutch Association for the Judiciary (NVvR), the Council for Criminal Justice and Protection of Juveniles (RSJ), the Dutch Bar Association (NOvA), the Public Prosecutor (OM), the Data Protection (CBP ), Actal, the Commission's Impact Assessment (CET) and Integrated Supervision of Youth Affairs (ITJ) have an opinion on it. These organizations are in favour of decentralization, but are not convinced of the velocity of the process. There is some concern about the legal certainty and equality which are not sufficiently guaranteed in the Act. Actal believes that the ambition for the bureaucratic density that emerges in the Act is not enough .[[240]](#footnote-240)   
 Due to the comments of these organisations, the Act amended in a number of parts. The responsibility of municipalities has been thoroughly revised, the quality requirements are applicable to all forms of youth care, the closed youth care no longer require certification, authorisation and files are modified, information obligation is included, and supervision has been clarified.[[241]](#footnote-241)

*Wmo 2015*

For the Wmo 2015 the VNG, G4 and G32 used the consultation possibility. The VNG finds it questionable whether municipalities will have legal handles with the proposed control principle for customized facilities to reject the request if an applicant is sufficiently able to do that by itself or in collaboration with its surroundings. Besides municipalities advocate for more discretion. Also the contribution to be collected by a central organization does not fit within the decentralized concept. The Act indicates according to VNG little confidence of the government in municipalities when it comes to responsibility for guaranteeing the quality of social support.[[242]](#footnote-242)  
 Following the responses of municipalities and VNG is the deadline for processing an application and associated research changed in the reasonable period of eight weeks. The government understands the concerns of municipalities about the (financial) consequences of transitional, but believes that this is a right that people derive from the current AWBZ indications. However, a number of measures relating to the provision of facilities services are cancelled. It is up to municipalities to decide how they deal with the transition to a implementation based on this Act.[[243]](#footnote-243)

The client organisations NPCF, CG-Council, Platform VG, LOC, Per Saldo, ANBO, CSO, LSR and MEE Netherlands have given a written feedback as a response to the draft Act. In this reaction, the emphasis on legal certainty and equality and advocate maintaining the compensation requirement. These organizations have made a number of proposals in which the legal position of the client is strengthened. The client organisations also point to the responsibility of municipalities to provide support to people who tend to avoid care and evade the sight of municipalities. They are also in favour of an application procedure of six weeks. The discretion of municipalities should be somewhat limited when it comes to quality. This should be provided and guaranteed for all clients. Quality should be evaluated from the perspective of the client, that is legal transcendent. They also call attention to the accumulation of excess in the different measures and the impact on income for the chronically ill, disabled and elderly. Privacy is an issue which is not yet entirely clear and client organizations are not in favour of data exchange without the consent of the client. Remarkably, the client organizations asking to settle in the bill that homeowners are obliged to cooperate with home modifications that are provided through a customized facility or PGB. MEE Netherlands has explicitly requested to secure the independence of the client support.[[244]](#footnote-244)  
 After verbal consultation with these organizations, the Act has changed on a number of issues. The uncertainty for clients associated with the change in the law is somewhat limited by tightening the Act in terms of customization facilities and provide a qualitative assessment criterion. The municipality must therefore base on the results of the study ensure that the given facility is appropriate to the situation of the person concerned and contributes to the person’s ability of self-reliance and participation. In accordance with the proposals made by the client organizations are the conditions to qualify for a pgb adapted. It is also the task to support avoiders is tightened and the concerns about data sharing are taken. Additionally, it is included in the Act that homeowners are required to cooperate with home modifications. With respect to client support is included in the definition that the college of mayor and aldermen must ensure that in the event the client support is based on the interest of the client and there can be no contribution charged for client support.[[245]](#footnote-245)  
 From the field parties MEE Netherlands, Federation of Shelters, RIWB alliance, MEZZO, Actiz, BTN, VGN, GGZ Netherlands, MO-group, WMO-councils and BVKZ been a reaction to the concept Act. These parties advocate not to rally protected living under the definition of shelter, but to position as its own form of support. Another observation concerns the opportunity to emphasize doing a citizens' initiative. There should also be greater use of experience experts in providing support and a certificate of good conduct (VOG) should not be mandatory for employees. The organisations also advocate for the legal obligations of the establishment of base rates to all of the services provided under the Wmo 2015 performed by third parties.[[246]](#footnote-246)

As a result of these comments, the Government tightened up and expanded the Act. Protected living is no longer positioned as part of shelter. In section 2.1.3, paragraph 3 is a more powerful wording included that give inhabitants the opportunity to do policy proposals. The provision on base rates is updated on the new situation as expressed by the organisations .[[247]](#footnote-247)

In addition to the clients organizations, administrative parties and field parties there is a response of advisory bodies and implementing organisations: the legal organizations the Council for the judiciary, the Dutch Association for case-law and the administrative litigation section of the State Council. This legal organizations give among other things that there are risks attached to the policy space and decide freedom of municipalities. The Council for the judiciary sees thereby the risk that there will be increasing use being made on the judiciary and also pose a financial claim towards the Government to fix. The Council for the judiciary carries two substantive points. First, the new method is a derogation of the General Administrative Law Act and this can lead to ambiguity and reduce the legal protection. Secondly, the Council has restraint in relation to the power to enter a dwelling without the consent of the occupant.[[248]](#footnote-248)  
 The Government refutes the note of the Council to the derogation of the General Administrative Law Act. Though some points are tightened in the light of these observations. The comment about the unwanted entry of a home is ultimately deleted from the Act. The Government notes that an increase in the number of claims on the legal apparatus will be arranged by means of the budget.[[249]](#footnote-249)

**Analysis**

Both the policy cycle-actor hourglass and the ACF predict that the formulation stage is dominated by only those actors with sufficient knowledge of a problem area, or resources at stake. This suggests that a specific group of actors is involved in the formulation of different solutions to the problem that is set at the agenda in the former stage.  
 Partly due to the fall of the cabinet, the formulation stage has the longest time confiscated. After the swearing of Cabinet Rutte I there is an accordance with the municipalities and the provinces, an Governance Agreement. In this agreement the first decisions are made of the decentralisation of youth care and parts of the AWBZ to the Wmo 2015.   
 During the formulation stage are multiple actors involved. In the appraisal primary research and consulting agencies ensured the information input. In addition, also have healthcare providers contributed to the sharing of information from the practice. This information ensures that there can be a dialogue between the different stakeholders. The dialogue takes place at various levels: in working groups and in response to a legislative text for consultation.  
 It is striking that in the case of the Youth Care Act the Government has opened up the consultation for the entire policy universe. This means that everyone had the possibility to post a comment and be involved in the final legal text that is offered to the Parliament. This is not in line with both theories. In the Youth Care Act the policy universe is incorporated into the formulation stage. This suggests that, in case of the Youth Care Act, the policy cycle-actor hourglass and the ACF are not sufficient enough to predict which actors are incorporated in the formulation stage of the decentralization of healthcare in the Netherlands. In the case of the Wmo 2015, is shown that the elite opinion indeed is dominant in the formulation of policy.   
 The individual reactions during the internet consultation indicate a fear from the current user of youth care. Parents are worried that in the new policy children do not receive the care they had right to in previous years. At the same time, they are aware, however, that the current policy is inadequate. These reactions show that citizens are mainly concerned because they can't overlook what they get in return. On the other hand, representatives of clients and patients respond mainly from a legal perspective. According to these organisations it should be laid down in the law where patients and clients are entitled to.

The reactions of the VNG and municipalities show that the policy freedom formulated in the Act is experienced as insufficiently. By naming that there is a discrepancy between the responsibility that municipalities receive and the possibilities that municipalities receive to meet them, ask the municipalities for more policy freedom and its autonomy. For municipalities is the distribution of power thus a motivation for decentralisation.

In the coalition agreement of cabinet Rutte I the decentralisations are mainly linked to savings. The Cabinet believes that the decentralisations will bring a decent saving. Due to the economic crisis, cuts are a strong element for this cabinet. In addition, the Cabinet is opinioned that municipalities are closer to the citizen and thereby deliver better customization.   
 The healthcare providers believe that something has to change to the current healthcare system. Providers are in favour of policy freedom so they can make more use of innovation. At the same time, they also see threats in the decentralisations. The policy freedom of municipalities makes that possible 393 different types of policy will establish. If healthcare providers should match all this different policies the administrative burden will increase.

|  |  |
| --- | --- |
| Formulation Stage | |
|  |  |
| Network members | - Government  - VNG (municipalities)  - IPO (Provinces)  - Client- and patient organisations  - Providers  - Insurance companies  - (legal) Advisory bodies and research companies  - the policy universe (in the Youth Care Act) |
| Network characteristics | - Constructive  - Critical  - Interests  - Negotiations |
| Essential Resources | - Different reports/ factsheets  - Position Papers  - Working groups  - Reactions to government output |
| Position Ministry in Network | Act as a negotiator and a key player. The government decides who is part of the game by involvement of working groups and negotiations. And eventually the ministry decides what is in the Act that will be submitted to the Parliament. |
| Stage outcome | The Youth Care Act and the Wmo 2015. |

# Chapter 9: Decision-making

**This chapter analyses the decision-making stage surrounding the healthcare reforms. As discussed in previous chapters, the policy cycle consists of several stages, and the actual decision-making phases is one of the most important, because the decision makes the policy irrevocable.   
 According to the policy cycle-actor hourglass only the government is involved in this stage. The outcome of this stage is a negotiation between political parties. On the other hand, in the advocacy coalition framework the outcome of the decision-making is the outcome of the negotiations in the policy sublevel.**

**Youth Care Act**

In October 2013, before the fall recess of parliament, the Second Chamber debated on the Youth Care Act. The bill has already been submitted to the Second Chamber on 28 June.   
 The present system does not meet a number of areas. For example, the Youth Care Act has a financial incentive towards expensive specialised care, the collaboration with children and families is not optimal, deviant behaviour is unnecessarily medicalised, and as a result of these problems the expenses increase.[[250]](#footnote-250) The new Youth Care Act aims to simplify the system to be more effective and more efficient and to strengthen the self-reliance of younger citizens. To achieve this objective, there should be a focus on prevention and assume the responsibilities and opportunities of young people and parents. In addition, there should be demedicalisation and customisation offered to reduce costly specialised help. Decompartmentalisation of various types of assistance to families and the associated budgets, offer a better opportunity for integrated care and innovations in support. In addition, there should be a reduction in the regulatory burdens to provide the professional with more opportunities.

*Plenary debate Youth Care Act*The plenary debate on the Youth Care Act already is planned for 2013. This leaves more than a year between the adoption of the law and the actual entry into force. However, a number of parties in parliament believe that the process is not carried out careful enough and it is completed under pressure. In particular, the opposition parties PVV, SP, and D66 demand a postponement of at least one year. The underlying argument relates to the concerns expressed by the partners involved such as GGZ Netherlands, VNG, LHV (LHV), Youth Care Agencies, the Children’s Ombudsman, and Defence for Children.[[251]](#footnote-251) The other parties believe that procrastination leads to leaning on those involved. The topics that will be discussed broadly in the debate can be categorised into the responsibility of the municipalities, quality and professionalism, and youth mental healthcare.[[252]](#footnote-252)

All parties believe that the current youth system is not functioning properly. The fragmentation of policy means that aid cannot be implemented vigorously and cannot be efficiently arranged. Thus, the need for reform is felt by all. However, the SP has some basic objections against the proposed new youth care system. The social party’s criticism refers to the policy space that municipalities receive. As such, the party sees too many possibilities in which municipalities shirk their responsibilities to young people and their parents under the cover of self-reliance, and new policy may lead to differentiation between the municipalities.[[253]](#footnote-253)  
 The contributions of the various political parties make use of input from various interest groups and umbrella organisations. The contributions of these different groups is interpreted differently by the political parties, and the municipalities are repeatedly mentioned. Some political parties, especially the SP, use the standpoint that municipalities want postponement of the Youth Care Act because of insufficient clarity and time. At the same time, other parties, such as the CU, state that municipalities are pleased with the law and prefer decision-making so that implementation can be executed in the municipalities.   
 In the preparatory phase, a roundtable discussions with the Parliamentary Standing Committee for Health, Welfare and Sport occurred, including users of child welfare, communities, providers, and experts. That the contributions from this interview are taken to the plenary debate of the Youth Care Act becomes clear due to some comments made by the various parties.   
 In the committee, a number of parties, such as the University of Leiden, Defence for Children and Youth Care Agency, have highlighted various conventions relating to children’s rights, European and international.[[254]](#footnote-254) During the plenary debate, the CU, SP, and GL have observations concerning the Youth Care Act related to various child rights treaties. CU and GL speak about the international Convention on the Rights of the Child towards asylum children, as these children should have the same rights as Dutch children for which the CU submits an amendment.[[255]](#footnote-255) The SP believes that the new Youth Care Act and decentralisation to local authorities means that there is inequality, which is contrary to the Convention on the Rights of the Child.[[256]](#footnote-256)

While the relevant lecturers, professors, and parents are not satisfied with the conditional authorisation in the Youth Care Act, the juvenile judge, who speaks during the roundtable, believes that this can be interpreted positively. The conditional authorisation can result in minors who have serious developmental and behavioural problems can be incorporated into a secure youth institution without the intervention of the juvenile court; this based on previously conditional authorisation by the court to secure youth care.[[257]](#footnote-257) The SGP has picked up the negative signal towards the conditional authorization and submitted an amendment for this.[[258]](#footnote-258) The party believes that this authorisation is a restriction on young people’s freedom. In addition, the VVD asked the State Secretary several questions about the conditional authorisation and expects a detailed explanation for this.  
 The reference index is a system in which personal data of children and adolescents up to the age of 23 is registered by aid workers and professionals when there is reason for concern. However, parents are not satisfied with this recording and see this as a privacy breach. In the plenary debate on the bill, D66 asks questioned about this instrument. The party wonders, for example, if stakeholders are also notified of placement in such a system. The SGP joins the questions posed by D66. Here, however, no adjustment to the bill are proposed.

Furthermore, the VVD and D66 jointly submit an amendment stating that the Council for Child Protection and the certified institution will be obligated to perform full and truthful reports or petitions containing important and objective facts.[[259]](#footnote-259) Juvenile court take a decision based on objective facts and events. At the roundtable and in its position paper, parents have made the point that opinions and facts in reports are often confused.   
 During the discussion, the National General Practitioners (LHV) mentions the possibility of infringement of referrals from medical examiners by the municipality. This concern is translated into the plenary debate by a number of political parties, that stated that municipalities should not get involved in medical specifics and should not treat each case by assessing whether that care is really necessary. Consequently, this gives a signal that a medical specialist may be overruled in assigning specialized care. The VVD is certain that this distortion should be eliminated by the State Secretary. The SP suggest an amendment to prevent that the Mayor and Aldermen can determine what the professional standard is.[[260]](#footnote-260) In addition, the CDA has tabled an amendment to ensure that municipalities cannot restrict the professional standards which are handled by healthcare providers.[[261]](#footnote-261)

Ms. Calkoen of the juvenile court, has noted during the roundtable that the section closed youth care should be transferred to the Civil Code. The argument for this is that all the measures on forced framework are gathered in the Civil Code, and by adding secure youth care to this will create clarity.[[262]](#footnote-262) Moreover, during the plenary legislative consideration, the VVD asked the Secretary of State for clarification about why the conditional outplacement secure youth care is not included in the Civil Code.[[263]](#footnote-263)

*Amendments and Motions*

Ultimately, there are 35 amendments and 14 motions put to the vote. The CDA has tabled most of the amendments, followed by the SP. Moreover, the amendments tabled by the SP are rejected overwhelmingly, while the coalition parties’ amendments are all adopted. Furthermore, the SP and D66 have submitted the most motions; most of D66’s motions were accepted, while all of the SP’s were rejected (see Figure 3). Despite the 27 amendments adopted in the Youth Care Act, the PVV, SP, PvdD, and 50+ voted against the bill and the parties VVD, PvdA, CDA, D66, CU, GL, and SGP voted for the new Youth Care Act (33 votes versus 116 votes).[[264]](#footnote-264)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Party | Amendments | | | Motions | | |
|  | Submitted | Adopted | Rejected | Submitted | Adopted | Rejected |
| SP | 8 | 1 (12,5%) | 7 (87,5%) | 4 | 0 | 4 (100%) |
| PvdA | 6 | 6 (100%) | 0 | 1 | 1 (100%) | 0 |
| VVD | 3 | 3 (100%) | 0 | 0 | 0 | 0 |
| CU | 5 | 2 (40%) | 3 (60%) | 3 | 0 | 3 (100%) |
| PVV | 0 | 0 | 0 | 1 | 0 | 1 (100%) |
| GL | 4 | 3 (75%) | 1 (25%) | 0 | 0 | 0 |
| CDA | 9 | 4 (45%) | 5 (55%) | 2 | 2 (100%) | 0 |
| D66 | 5 | 4 (80%) | 1 (20%) | 4 | 3 (75%) | 1 (25%) |
| 50+ | 0 | 0 | 0 | 0 | 0 | 0 |
| SGP | 5 | 4 (80%) | 1 (20%) | 1 | 0 | 1 (100%) |
| Total | 45 | 27 (60%) | 18 (40%) | 16 | 6 (37,5%) | 10 (62,5%) |

Figure 3: Submitted amendments and motions including voting.[[265]](#footnote-265)

*Wmo 2015*Less than a year before the entry of the Wmo 2015, the bill is offered in January 2014 to the Second Chamber. This means that only one year is available for parliamentary debate and the actual implementation by the municipalities.   
 In the explanatory notes of the Wmo 2015, nursing and care are set up under the regulation of the Insurance Act, despite earlier reports. The discussions showed that a majority of the clients fall under both type of care, and therefore it is opted for a different allocation of responsibilities between the municipalities and health insurances.[[266]](#footnote-266)   
 This bill intended more integral policy between care and support in neighbourhoods, districts, and villages and to ensure proper support in its own environment. this requires municipalities to enter into partnership with health insurers, healthcare, education, preventive health, welfare, housing and employment, and income. In addition, quality policy should be developed in consultation with client organisations and providers.   
 This new law builds on the earlier Wmo 2007. At the time of treatment of the latter in 2006 in the parliament, it was already stated that this was only a prelude to expansion of municipal responsibility for long-term support. Due to the positive assessment in the evaluation of the Wmo 2015 and the demonstrated strengthening of its own power and direction of people, extending the act is a logical continuation.[[267]](#footnote-267)

*Care agreement* On 16 April 2014, the government parties VVD and PvdA conclude the budget negotiations on long-term care reform. The ‘Care Agreement’ should lead to more security in the transition. By both the transition to the Wmo 2015 and Youth care when transferring to the municipalities, care continuity must be provided. This means that clients cannot become caught between different schemes. In addition, through additional means, the municipalities receive more time to focus on an appropriate range of support for the people. Finally, there is an agreement that offers more certainty to elderly and mentally disabled people who can no longer live at home. As a result, additional resources are made available for long-term care and youth care amounting to 360 million euros in 2015 to a structural 200 million euros starting from 2016.[[268]](#footnote-268) These amounts are in addition to the amount already reserved for reforming long-term care and child welfare.   
 Furthermore, 2015 should be seen as a transitional year. The care and support that clients received in 2014 continue in 2015. This gives municipalities the opportunity to make new and appropriate support offerings. This means that care indications from clients do not end immediately yet will be reassessed no later than 31 December 2015. Only then care can be altered, and this also applies to the Youth Care Act. The other part of the money that will be available to the Youth Care Act is to ensure a smooth transition to the new system of youth care providers with a regional or national focus.[[269]](#footnote-269)   
 The objective of the reform of long-term care is that people are given the opportunity to live as long as possible at home. Guidance and daytime activities are not only for the elderly or people with disabilities an opportunity to stay at home longer, it is important for carers and the network that these facilities are available. In the Care Agreement, 195 million euros in 2015 and 30 million euros structuralfrom 2018 has been made available.[[270]](#footnote-270) These amounts are added to the sub fund social domain, which means that municipalities can use these at their discretion in the social domain and not specific to day care. There are always people that are not to reside in the home. By providing additional funds, there is more certainty that the elderly and the mentally handicapped can get a place in a care facility if necessary. The additional financial resources that become available in the healthcare agreement brought austerity in long-term care from 25% to 6% in 2015 and 11% in 2016[[271]](#footnote-271). It should, however, be said that this applies to the long-term care reform in general, the Wmo 2015 is a part of this. Yet, they do not specify what this means for the discounts in the Wmo 2015 specifically.   
 The Secretary of State indicated in his letter to the parliament that in consultation with client organisations, providers, insurers, and municipalities, the agreements to which the parties have agreed will be implemented.[[272]](#footnote-272)   
 As previously mentioned, the government parties VVD and PvdA do not have a majority in the Senate. Consequently, the should seek supportive partners for the legislative proposals of long-term care reform and youth care to ratify it. Nevertheless, the additional agreements in the care agreement, assured the government of a majority in both the Second and First Chamber.

*Plenary debate Wmo 2015*During the two-day plenary of the Wmo 2015 in the parliament on 22 and 23 April 2014, a few issues have been addressed explicitly. The main topics in the discussion are tailor provision and compensation liability, including client support, employment, quality and monitoring, day care, long-term mental healthcare, district nursing and collaboration, contribution, premium, participation, personal budget, finance , (extramural) care, transition and transitional.[[273]](#footnote-273)  
 In particular, the CDA and GL are in favour of postponing the introduction of the new law. The underlying argument is that there is less than a year between the actual consideration of the bill and the introduction on 1 January. The other parties, however, argue that all stakeholders have the right to clarity and real action. State Secretary van Rijn includes in his reply to the debate that it is not the first time that there is spoken about the new law, as the previous government has already made preparations for the transfer of day care and guidance to municipalities.[[274]](#footnote-274)   
 Furthermore, the PVV is entirely against the new law. This law undermines the welfare state and to the opinion of the party is better renamed into the "Away with the Elderly Act". This party believes that by saving on overhead costs and capital charges, the care can be arranged so that more money goes to healthcare and therefore also receives a saving. Additionally, the SP is conservative and even asks the Secretary how to ensure that a number of fundamental rights, such as day care and opportunities at homes, remain accessible. Moreover, all parties stress the importance of client involvement, both in policy-making and in the preparation of individual care plans. Hence, it should be tailor-made delivered. The difference between the parties is the level of trust in the municipalities. Proponents of the law questions the discretion of local authorities to be able to focus on policies suitable for the relevant municipality. This also implies that no legal arrangements are made about the organisation and the actual determination of customisation features of the municipalities. Additionally, opponents of the law counter that this discretion can result in the municipalities to unilaterally impose provisions without taking into account the client and his or her network.[[275]](#footnote-275)  
 Another much-discussed subject are carers and volunteers. The new legislative objective that municipalities provide support focused on staying as long as possible in their own environment and self-reliance and participation in society.[[276]](#footnote-276) As such, greater demands will be made on carers and volunteers. With the objective to reinforce these groups’ efforts, there should be a commitment to link informal and formal support and care. In addition, the caregiver will play a prominent role in the coordination of care needed by the client. For this, professional client support is also included in the legislation.[[277]](#footnote-277) Lastly, all parties believe that especially carers must enjoy sufficient support.   
 Furthermore, the indirect influence of other parties in the treatment of the act in parliament is striking. A large portion of the used arguments are derived from reports. These reports are drawn up by research organisations or by the organisations involved. The SP refers in its first term to a report by umbrella organisation Actiz.[[278]](#footnote-278) Subsequently, the CDA draws the conclusion, based on a report by the Council for the Environment and infrastructure, that the introduction of the Wmo 2015 on 1 January 2015 must be discussed, and a report by the Social and Cultural Planning Office[[279]](#footnote-279) is cited by the PvdA to defend the changes in care.   
 In addition to reports from various organisations, multiple parties frequently use practical examples. For instance, the SP used several cases to back up arguments or positions and D66 sent in preparation 26 profiles of people who are faced with changing care to answer to the State Secretary. These profiles are cited several times by different parties. Alderman Janny Bakker of the municipality Huizen, is explicitly mentioned by the PvdA to argue that municipalities are ready for the decentralisation of tasks.[[280]](#footnote-280)   
 In the end of March, the Parliamentary Standing Committee on Health, Welfare and Sport held a roundtable with stakeholders who could put forward their views. The commentators were divided in this conversation in the target groups client perspective, practices, and governance. Significantly, a number of terms and interests used in this roundtable found repetition in the plenary of the Wmo 2015.  
 Ultimately, the interest group for clients with a PGB have posited the view in the roundtable that the principle of compensation was not sufficiently secured in the new law. In the first period of treatment in parliament, the PvdA, VVD, SP, and CDA expressed the same view. The VVD together with the PvdA are responsible for an amendment to include the compensation principle more explicitly in the Act.[[281]](#footnote-281) The CDA also tabled an amendment in which the compensatory anchor was founded in the new Wmo 2015.[[282]](#footnote-282) These two amendments differ in the principles; the PvdA and VVD believe that the principle of compensation must reflect the principle of customisation, while the CDA explains compensatory as the offsetting obligation to compensate limitations. In the latter, the offset is placed above the customised provision.   
 Both client organisations MEE and Ieder(in) stressed the importance of the independent client supporter. In particular, the emphasis on independent emphatically was placed forward. This independent client supporter needs to facilitate the client’s interests as a counterforce to the provider. GL, PvdA, and D66 have emphasised the importance of the independence of the client supporter. Therefore, the PvdA, tabled in an amendment, in which MEE is appointed as a possible actor for the independent client sponsor, yet the PvdA also indicates that this may not always be a paid professional.[[283]](#footnote-283)

The caregiver is an issue cited by most parties. However, the national association for caregiving and volunteer caregiving, Mezzo, specifically refers to the position of the caregiver at the kitchen table conversation and the overload of carers. Generally, almost all parties mention the importance of carers. In particular, the PvdA, SGP, and CU elaborate on the argument of Mezzo by suggesting an amendment in order to secure the position of the caregiver during the kitchen table conversation law.[[284]](#footnote-284) Moreover, the CDA has tabled an amendment relating to caregiver burden; the capabilities and workload of the caregiver must be involved in the kitchen conversation and that the municipality should not have the opportunity to place a heavier burden on caregivers when they already have excessive burdens.[[285]](#footnote-285)   
 During consideration of the act in the roundtable, several client organisations asked attention for the accumulation of personal contribution. By requesting a contribution in several legislations, the possibility is created that clients pay contribution up to a few thousand dollars. The SP desires to prevent this by removing the entire personal contribution.[[286]](#footnote-286) The CDA has tabled an amendment calling for anti-accumulation provision under the Wmo 2015 and the Long-term Care Act, meaning that requested claims in a family situation have a contribution ceiling.[[287]](#footnote-287) In addition, the SGP recognises the undesirable consequences of stacks of personal contributions. By contrast, the party does not see the need to regulate this through the law, but table a motion that called on the Government to make this problem known in municipalities and actively monitor how local authorities implement contributions in practice.[[288]](#footnote-288)

The ANBO, the representative of Dutch seniors, urged in the round table for clarity and communication. The clients, to whom the new legislation relates, want to be informed of the consequences of the changes. The CU and D66 share the view that communication and education is essential in the changes in healthcare, as this causes fear and uncertainty. Both parties therefore call on the Secretary of State to launch targeted communications.[[289]](#footnote-289)

Moreover, the VNG, the umbrella organisation of health insurers (ZN), and other stakeholders highlighted the importance of good cooperation between health insurers and municipalities. Because of a lack of clear definition of roles, there is a possibility of sliding clients between the two parties. To anchor this cooperation, the PvdA has tabled an amendment, which urged cooperation and facilitation when one of the parties is not sufficiently prepared to so.[[290]](#footnote-290) Even parties, such as the SP, D66, SGP, and CU, stress the importance of readiness for cooperation between municipalities and health insurers.

*Amendments and motions*Ultimately, there are 91 amendments and 20 motions tabled. The SP submitted the majority of the amendments (15), yet none of these have been adopted. In addition, none of the amendments suggested by the opposition party PVV were approved by the chamber. However, opposition parties CDA and GL achieved some result. Among the parties, which became part of the Care Agreement a week earlier, the so-called tolerance partners, all motions and amendments were adopted (see figure 4).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Party | Amendment | | | Motion | | |
|  | Submitted | Adopted | Rejected | Submitted | Adopted | Rejected |
| SP | 15 | 0 | 15 (100%) | 6 | 0 | 6 (100%) |
| PvdA | 10 | 10 (100%) | 0 | 1 | 1 (100%) | 0 |
| VVD | 8 | 8 (100%) | 0 | 0 | 0 | 0 |
| CU | 6 | 6 (100%) | 0 | 2 | 2 (100%) | 0 |
| PVV | 7 | 0 | 7 (100%) | 1 | 0 | 1 (100%) |
| GL | 12 | 8 (67%) | 4 (33%) | 2 | 0 | 2 (100%) |
| CDA | 12 | 2 (17%) | 10 (83%) | 2 | 0 | 2 (100%) |
| D66 | 10 | 10 (100%) | 0 | 2 | 2 (100%) | 0 |
| 50+ | 3 | 1 (33%) | 2 (67%) | 1 | 0 | 1 (100%) |
| SGP | 8 | 8 (100%) | 0 | 3 | 3 (100%) | 0 |
| Total | 91 | 53 (58%) | 38 (42%) | 20 | 8 (40%) | 12 (60%) |

Figure 4: Submitted amendments and motion in Wmo 2015 including votes.[[291]](#footnote-291)

The motions of the opposition parties, which are not part of the signatories to the Care Agreement, gained little support, as none of the motion assumed by this group is adopted. Simultaneously, all the motions of both the coalition parties as well as the tolerance partners are adopted. The Wmo 2015 is eventually adopted with the votes of the VVD, PvdA, SGP, CU, D66, van Vliet and Group Bontes / van Klaveren, while the SP, PVV, CDA, GL, PvdD, and 50+ voted against (102 versus 48).

**Analysis**This chapter discussed the process of decision-making. It was hypothesised by the policy cycle-actor hourglass that during the decision-making stage the most influential actors are the political parties of the coalition. On the contrary, the ACF predicted that, as in all the other stages, the elite opinion dominates the policy-making process and, therefore, also the decision-making stage.   
 As noted earlier, there is no clear boundary between the different stages. This means that the decision-making phase can be defined in several ways. In this research, it was chosen to not only include the actual voting, but also the period preceding the decision. During this period, the Second Chamber developed its opinion by means of the input of multiple stakeholders.  
 In preparation for the decision on the two bills, the Standing Committees had expanded time taken to hear views of interest groups and stakeholders and these are included in the plenary debate and amendments. In addition, an explicit reference is made frequently to conducted research, practical experiences, and interviews.  
 In the policy cycle hourglass of Howlett, Ramesh and Perl, it is established that during the decision-making only the government is involved and allowed to cast a vote. It is acknowledged that subsystems do play an important role in a network society. In a pluralistic system like the Netherlands, subsystems are influential to political parties by roundtable discussions and through media. Exclusion of subsystems and policy-universe as actors in decision-making does not reflect the impact of these actors. Amendments are often a product of external input. Political parties use the interest and knowledge of third parties to create an appropriate and supported law. Thus, the policy cycle-hourglass would be more suitable when the indirect forces of third parties are involved.   
 At the same time, the prediction of the ACF is not sufficient enough either. The decision-making process concerning Dutch decentralisation indicates that the actual decision-making is not a government action, but an action of coalition parties. Both the Wmo 2015 as the youth law triggered a significant number of amendments and motions. In fact, 80% of the submitted amendments in youth law derived from opposition parties of which 50% is adopted, similar with 67% of total adopted amendments. In the event of motions, 94% obtained from opposition parties of which 67% were accepted, equal to 83% of the approved motions. In decision-making on Wmo 2015, the government parties reinforced by reaching an agreement with three relatively smaller opposition parties. Taking this into account, 54% of the submitted amendments originated from an opposition party, which were not a support party. Merely 21% of these amendments was adopted, in accordance with 20% of the total of the adopted amendments. Particularly in the Wmo 2015, government parties and support parties determined the eventual act. However, the influence of opposition parties in Youth Law is significantly higher, as half of the suggested adjustments were adopted.   
 As shown above, both the policy cycle-actor hourglass and the ACF partly predict the involved actors. The actors involved are more than merely the political parties in the coalition as is stated by the policy cycle-actor hourglass. Although the subsystem is not able to cast a vote, the different expert meetings, roundtable conversations, and position papers have influence on the political actors prior to the voting on policy. At the same time, the coalition parties determine which amendments are adopted and which one are rejected. Thus, whether the policy cycle-actor hourglass or the ACF is the best predictor for the actors which are dominant in the decision-making stage is determined by the scope of the decision-making stage.

**Decision-making**

|  |  |
| --- | --- |
| Networks members | - Ministry  - Coalition parties - Opposition parties - Support parties  - (indirect: interest groups, advocates, media, experts) |
| Networks characteristics | - Politics/Powers  - Negotiation  - Majority |
| Essential resources | - Ideology  - Round table discussions  - Position papers  - Research reports |
| Position ministry in network | Ministry clarifies ambiguities of House of Parliament. Simultaneously defend legislative proposal. Mostly supported by coalition parties. |
| Stage outcome | Adopted legislation |

# Chapter 10: Implementation

**In the implementation stage, which will be analysed in this chapter, the ratified policy must be put into practice. ‘The effort, knowledge, and resources devoted to translating policy decisions into action comprise the policy cycle’s implementation stage’.[[292]](#footnote-292)   
 Both the policy cycle-actor hourglass and the ACF predict that actors with knowledge are influential in this stage. Usually, only a narrow range of subsystem actors become involved in the implementation.[[293]](#footnote-293)**

**Progress**

*Youth Care Act*

On 1 September 2012, the government, the VNG and IPO commissioned the TSJ to monitor the progress of the decentralisation of the implementation of the Youth Care Act. In five reports, the TSJ give some critical notes on the progress of the implementation of the Youth Care Act by municipalities. Moreover, it is important that municipalities on 1 January 2015, implemented the new law in such a way that there is continuity of care delivered.  
 In the final report of the TSJ, the Commission notice that the objectives, as the continuity of care, maintaining care infrastructure and reduction of friction costs are not met, because the many uncertainties surrounding the financial budgets.[[294]](#footnote-294) There prevails among municipalities the assumption that the budget that is mentioned in May 2013 is not correctly calculated. The municipalities did a tender among healthcare provider what the care use has been in the past. These figures do not correspond to the data provided by the government.[[295]](#footnote-295)  
 As a result of this uncertainty, the State Secretary made 200 million euros available up to 2018 for (youth care) institutions that are at risk of problems. The savings that municipalities need to make may adversely affect institutions. After negotiations, it was decided that the Government is giving financial support to organisations that have problems.[[296]](#footnote-296)

*Wmo 2015*

The implementation of the Wmo 2015 on 1 January 2015, requires a decent effort of both municipalities, health insurers, providers and client organisations in a relatively short time span. To be able to follow the progress of municipalities there is a transition monitor operational from the beginning of 2014. All municipalities are connected to the monitor and indicate which steps in the process are completed.[[297]](#footnote-297)  
 In addition, the progress of the implementation is not only based on the information submitted by municipalities. Also, the information submitted by clients and providers is incorporated. The program ‘Attention for everyone’ (AVI) investigates the experiences and solutions of clients and carers in twelve municipalities. This study is not representative of the Dutch population, but gives useful insight into the experiences of clients. The State Secretary for Health, Welfare and Sport has regular consultations with the umbrella organisations of healthcare providers. Also, providers submit information via monitors. [[298]](#footnote-298)

The information that the Secretary of State provided the parliament on 4 July 2014 show that the municipalities are developing in the implementation. Though, client reports show that these stakeholders are worried about the impact of the reform. To limit the uncertainty among clients and caregivers, municipalities and the government need to provide timely and good information. The State Secretary highlights that municipalities are capable to implement their responsibilities.

The umbrella organisations of providers Actiz, GGZ Netherlands, VGN, BVKZ, the MO-group, MEE-Netherlands, the Federatie Opvang, and BTN delivered monitor reports in October. In the same period, there have been meetings with aldermen, that focus on the process of purchasing the establishment of access, the care and support for specific groups, and communication with citizens. Aldermen indicate that there is any doubt about the adequacy of budgets. [[299]](#footnote-299)  
 The monitors of providers show that providers expect a decline in both rate and volume after the decentralisations, although the actual discount percentages will only become clear when the actual contracts are signed. Also, they experience many differences between municipalities and expect that this leads to an increase in administrative burdens.

**Implementing decree**

An implementing decree settle cases that are too detailed to include in the legislation. This decision is vested in the Government and do not have to go through the full decision-making process. Downside of this, is that the representation of the people has no opinion on this decision. Because of this, there is no strong democratic legitimacy. This makes that in the implementing decree no business may be arranged, which does not find support in the present law.

*Youth Care Act*

It is in the interest of young people and their parents that there is a good implementation of the Act. Because of the responsibility of the State, the Youth Care Act included that the government has the power to included detailed rules. In the Youth Care Act, these detailed rules are formulated as following:

- access to the youth care

- the quality of youth care

- certification

- professionalisation

- protective youth care

- the registry system

- the social security number

- policy information

These arrangements are for consultation offered to Actal, the Netherlands Court of audit, the CBP, the Council for the judiciary, the NVvR, NOvA, the Council for criminal legal application and youth protection, and the VNG. In addition, the decision is offered on internet for consultation. As a result, the government received almost fifty comments from other organizations and individuals, including responding of the LPGGz, Netherlands, NVVP, GGZ-Netherland, Advisory and Complaints bureau youth care (AKJ), DCI, GGD-Netherlands, Collaborative Monitoring Youth (STJ), RvdK, and VGN responded.[[300]](#footnote-300)  
 A large number of comments related to the position of non-legitimate children that need youth care. For example, DCI does not consider it appropriate that different rules apply for these children than for legitimate children. Exclusion of non-legitimate children is in contravention of the UNCRC. The Government considers it fair to make any distinction, because the circumstances of a non-lawful resident child can quickly change, such as a temporary residence permit may be void.[[301]](#footnote-301)  
 The professionalisation chapter of the decree was not part of the broad consultation. Conversely, this is submitted for consultation to the VNG. Among other things, the VNG has point on the establishment of the quality framework. This process has been established with the involvement of Actiz, doctors youth care Netherlands (ANJ), LOC, GGZ-Netherlands, youth care Netherlands, MO-group, Dutch Institute of psychologists (NIP), Dutch Association of social workers (NVMW), VGN, and the VNG and has used a bottom-up approach. After the VNG’s comment, this path is more explicitly positioned in the notes.[[302]](#footnote-302)

The VNG believes that the implementing decree insufficiently reduced the regulatory burden and proposes a number of articles that should be deleted. Therefore, the government deleted the second paragraph of article 2.1. However, the remaining proposals of the VNG will not be retrieved. Also, the government provide a delegation authority in this. This is not a sign of distrust towards municipalities, but keeps open the possibility for further rules if some uniformity is desired.[[303]](#footnote-303)

Actal, the Advisory Board for regulatory burden’s review, recommends that in all subjects of the implementing decree it is indicated why detailed legislation is applied. Furthermore, the advisory board suggests to establish a ' perception monitor ' to control experienced pressure in the Youth Care Act, that is available for both citizens and professionals. Also, Actal proposes the monitoring to be applied only with data that is important for the system responsibility of the State.[[304]](#footnote-304)

The government indicates that these detailed rules automatically result from the Youth Care Act. In addition, the purpose of the Youth Care Act is to give more space to the professional and to reduce the regulatory burden. The various ministries involved, are jointly trying to figure out how to monitor the bureaucratic pressure that comes along with the decentralisations. In addition, the government’s opinion is that the regulatory burden that the professional experience not always comes from national rules, but by internal requirements of healthcare providers. And with respect to the delivery of data, the government replies that the Central Bureau of Statistics (CBS) already collects all this information. The government will not collect other data than that the CBS has already available and therefore provides no additional regulatory burden.[[305]](#footnote-305)

CBP has tested the implementing decree on the protection of personal data. In the organisation’s opinion are two topics visible: the registration risk youths and personal data for policy information. First, the CBP recommends to incorporate more evidence about the need of a registry system. In addition, it must be more explicit how the registry system is related to the tasks of the municipalities and the corresponding processing of personal data. Second, the CBP advises to opt out of the decision to implement the processing of personal data for policy information as no argumentation can be given that corresponds with the European Convention for the protection of human rights (ECHR).[[306]](#footnote-306)  
 The government considers, however, that the mid-term review shows that the registry system add a clear value. This registry system has the advantage of a family functionality in it, because it contributes to less fragmentation and a more family-oriented approach. The tasks of the municipality in relation to the registry system are regulated in the Youth Care Act. Also, in relation to the processing of personal data for policy information, the Youth Care Act and the implementation decree comply with other laws and regulations such as the ECHR. In addition, leaflets are produced in which privacy information for municipalities is available and that municipalities will help in making the right trade-offs in the organisation and implementation of the legal tasks.[[307]](#footnote-307)

*Wmo 2015*

The most important parts of the implementing decree wmo 2015 are: when foreigners are eligible for a customized facility, the contribution to cost of a customized facility or pgb, the continuity of the aid relationship and arrangements with health insurance companies. The concept of this implementing decree is only submitted to the VNG. The VNG has indicated to have any comments about this decision.[[308]](#footnote-308)

**Conclusion**

The implementation stage is a more detailed expression of the Acts. These implementations are not under the authority of the parliament. However, the parliament does have the authority to control whether the implementation and the execution complies with the Acts. The policy cycle-actor hourglass and the ACF both state that the elite of the policy subsystem is the dominant actor in the implementation. Especially, the elite’s knowledge is necessary to implement policy in such a manner that it feasible after implementation.  
 As the municipalities are a main contributor in the execution of the decentralised healthcare, the VNG is the only actor that is consulted in the implementing decree of both the Youth Care Act and the Wmo 2015. Client organisations and healthcare providers have less control in this stage. At the same time, the legal advisory organisations are not mentioned in the former stages and is a new actor.   
 This chapter shows that especially municipalities, which are directly charged with the execution of the policy, have more possibilities to influence the policy-making process in the implementation stage. In addition, organisations that have knowledge on legal issues are more concerned in the implementation stage than in the other stages. This does not mean that providers and client organisations are disposed, but the focus of the government is more towards municipalities and legal advisory organisations.   
 At the same time, surprisingly, the implementing decree of the Youth Care act is not only offered for consolidation to the VNG and legal advisory organisation. Moreover, via internet the policy universe is offered the possibility to give a comment. This is not in line with the policy cycle-actor hourglass and the ACF, that state that in the implementing stage merely the policy subsystem is involved. Though, the question is, whether these comments of individuals are incorporated.   
 All the stakeholders execute monitors in the implementation stage. These outcomes give the State Secretary insights in the progress of the implementation. The monitor of the municipalities show that this actor is making progress over time. At the same time, clients recognise concerns on the actual outcome for clients and the guaranteed care continuity. Possibly, this is an effect of insufficient communication. Although the purchasing of care by the municipalities is not completed yet, the providers already expect a decline in rate and volume. Moreover, their concerns are that the result will be financial problems.

In both the youth care and Wmo 2015 municipalities expect the data that is provided by the government does not match the data that is provided by the providers. The data of the latter shows a higher number of delivered care in the past years. This indicates that the budget that is provided by the government does not met the actual costs that municipalities have. Also, the TSJ indicates that the uncertainty on the budget slows down the implementation process.

The different monitors that monitor the implementation process, also have a control mechanism which is focused on the other actors. Especially, the monitor of the clients are focussed on the progress of the municipalities. The monitor of the providers is more considered with the discrepancy of the volume of care that municipalities purchase, and the actual care that providers consider is needed. This is not only from the standpoint of continuity of care. Moreover, the restricted volume comes along with a financial problem as well.

**Implementation**

|  |  |
| --- | --- |
| Networks members | - Government  - VNG  - TSJ  - Policy universe (Youth Care Act)  - Legal advisory organisations  - Providers  - Client organisations |
| Networks characteristics | - Detailed  - Control of each other  - Self interest |
| Essential resources | - Monitors  - Working groups  - Implementing decree |
| Position ministry in network | Act as a negotiator, a key player, and an arbitrator. The government decides who is part of the game by involvement of working groups and negotiations. And eventually the ministry decides what is in the implementing decree. At the same time, the ministry controls the process of implementation by different monitors. |
| Stage outcome | On 1 January 2015 the new Acts entered into force. This means that most of the detailed parts of the Acts need to be regulated. Still, there are multiple parts that are not realised yet. The stage outcome is that on 1 January 2015 clients who are entitled to care, receive this care. |

# Chapter 11: Conclusion

On 1 January 2015 municipalities became responsible for tasks because of the Youth Care Act, and the Wmo 2015. Consequently, the budget of municipalities is one-and-a-half times greater than in recent years. As a result, municipalities are an important actor in the social domain and healthcare system.   
 The main question in this research is: How do the interests, roles and influences of relevant actors explain the decentralisation of Youth Care Act and the Wmo 2015 in the Netherlands? This thesis investigated the role and interests of actors in the decentralisations using two theories. On the one hand, the policy cycle-actor hourglass stated that the policy universe is incorporated into the policy-making process and that agenda setting is due to the public opinion. In addition, the outcome of each stage of the policy cycle is dependent of the negotiations between relevant stakeholders with variable resources in that particular stage. According to the policy cycle-actor hourglass in the formulation stage only those actors that have the knowledge and resources are allowed to participate. Subsequently, in the decision-making stage only the subset of the policy subsystem composed of government decision-makers can play a part. Eventually, the number of involved actors increases in the implementation stage again, which means that the policy subsystem is involved.  
 On the other hand, the ACF states that the entire policy-making process occurs in a policy subsystem, in which the policy elite is dominant. The agenda setting is partly dependent of relative stable parameters and external events. According to the ACF, the new policy is an outcome of negotiation between multiple advocacy coalitions within the subsystem. The hypothesis which derives from the ACF is formulated: the decentralisation of healthcare in the Netherlands is dominated by the elite opinion during the entire decision-making process.

Concerning the agenda setting, the hypothesis that derives from the policy cycle-actor hourglass is formulated: the decentralisation of healthcare in the Netherlands is initiated by the public opinion. This thesis has shown that the policy making process is not initiated by the public policy, but rather by the elite opinion that has the technical knowledge to consider something as a problem.   
 Then, according to the policy cycle-actor hourglass as well as to the ACF the policy subsystem is involved in the process of formulation policy options to the recognized problem. In the decentralisation of the Youth Care Act it is identified that government also consulted the policy universe by internet consultation. This suggests that, in case of the Youth Care Act, the policy cycle-actor hourglass and the ACF are not sufficient enough to predict which actors are incorporated in the formulation stage of the decentralization of healthcare in the Netherlands. In the case of the Wmo 2015, is shown that the elite opinion indeed is dominant in the formulation of policy.   
 The policy cycle-actor hourglass states that in the decision-making stage the only actor that participate actively is the government decision-makers. The hypothesis that is formulated is stating that during the decision-making stage the most influential actors are the political parties of the coalition. However, this research has also shown that the number of actors that is involved in this phase depends on the scope of the decision-making stage. When merely the voting procedure is regarded as the decision-making stage, it is plausible that only the political parties have influence. However, this politicians will have multiple resources to inform themselves before they cast the vote. In this period, the knowledge of the elite is important for decision-makers to make a well-founded decision. Therefore, both theories predict a part of the process.

In this thesis, the last stage which is involved is the implementation. The hypothesis that can be formulated according to the policy cycle-actor hourglass is that during the implementation stage, the most influential stakeholders are municipalities, care providers, client organisations, and the government. This research shows that in the Dutch decentralisation especially municipalities, which are directly charged with the execution of the policy, have more possibilities to influence the policy-making process in the implementation stage. Hence, although the focus of involved actors is even more narrow than in the formulation stage, it is not obvious to reject or adopt the idea that the elite is involved.  
 The policy cycle-actor hourglass, consider the different stages of the policy as single processes. However, the stages does not follow one another and sometimes even occur simultaneously. Although, the policy cycle is an ideal model to observe the policy process, the distribution into isolated stages makes the analysis sometimes more complex. In addition, some activities in the policy-making process have influence in different stages at the same time. The policy cycle, therefore, is not as ideal as it is described. In addition, the outcome of the policy-making process cannot be described as the sum of the single stages. This theory does not analyse the coherence between the stages. With this study, the hypothesis that each stage of the policy cycle provide different sets of outcome and participation of the actors is not rejected, though it is not accepted. It is true that each stage provide different sets of outcome and participation. However, this does not explain how the interest, roles, and influences of actors explain the decentralisation. The policy cycle-actor hourglass can only declare the interest, roles and influences of actors in each single stage.   
 On the contrary, the advocacy coalition framework consider the policy to be created within the policy subsystem. The outcome is the mediation between rival coalitions. In the decentralisation of healthcare, the municipalities on the one side, and healthcare providers and client organisation on the other side, have different core beliefs. Municipalities have a focus on the activation of people, while the other two organisations consider the client as a unique person, which gives direction to his own life. Care need to be emancipative. Especially, the monitors of the implementation stage show the distrust of each other and the tendency to control the process of the municipalities. Therefore, the advocacy coalition framework gives a better explanation how the interest, roles, and influences explain the decentralisation.

A limitation in this study is that the policy is too new to fully analyse. Some parts of the implementation are still evolving and the evaluation has not yet taken place. Therefore, to create an overall insight, it is available to perform this research again in a few years when the Acts have taken full shape. Also, it is recommendable, to take solely one Act in further research. This gives the opportunity to enhance the policy-making process and the roles, interests, and influences of actors more.

Further research in this field should be carried out to give a more comprehensive view whether these theories can predict the influence, roles and interests of relevant actors. Comparative analyses can give a more stable base to reject or adopt a theory. Therefore, it is recommendable to increase the number of cases to see whether the conclusions of this research also apply to other cases.

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**Appendix**

Stakeholders analysis

EM= Explanatory Memorandum

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Organisation | EM  WMO | EM  Youth | Plenary debate wmo 2015 | Plenary debate Youth | Committee Wmo | Committee Youth | Newspaper 2010- 2015 | Cabinet formation 2010 | Cabinet formation 2012 | lobbyist | Other |
|  |  |  |  |  |  |  |  |  |  |  |  |
| VNG | X | X | X | X | X | X | 50 Wmo/ 27 Youth | X | X | X | Governance Agreement |
| G4 | X | X |  |  |  |  | 0 Wmo/ 1 Youth | X |  | X |  |
| G32 | X | X |  |  |  |  | 0 wmo/ 1 Youth | X | X | X |  |
| NPCF | X |  | X |  | X |  | 1 wmo/ 2 Youth |  | X |  |  |
| CG-Raad | X |  |  | X | X |  | 0 Wmo/ 0 Youth |  | X |  |  |
| Platform VG | X |  |  |  | X |  | 0 Wmo/ 0 Youth |  |  |  |  |
| LOC | X |  |  |  | X |  | 1 Wmo/ 1 Youth |  |  |  |  |
| Per Saldo | X |  | X |  | X |  | 5 Wmo/ 5 Youth |  | X |  |  |
| ANBO | X |  |  |  | X |  | 6 Wmo/ 0 Youth | X | X |  |  |
| CSO | X |  |  |  | X |  | 1 Wmo/ 0 Youth | X | X |  |  |
| LSR | X |  |  |  |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| LPGGZ | X | X |  | X | X |  | 2 Wmo/ 7 Youth |  |  |  |  |
| MEE-NL | X |  | X | X | X |  | 1 Wmo/ 1 Youth | X | X | X |  |
| Federatie Opvang | X |  |  |  | X |  | 0 Wmo/ 0 Youth | X | X |  |  |
| RIWB | X |  |  |  | X |  | 0 Wmo/ 0 Youth |  |  |  |  |
| MEZZO | X |  | X |  | X |  | 6 Wmo/ 0 Youth | X |  |  |  |
| Actiz | X |  | X |  | X |  | 7 Wmo/ 1 Youth | X | X | X |  |
| BTN | X |  |  |  |  |  | 1 Wmo/ 0 Youth |  |  |  |  |
| VGN | X |  | X |  | X |  | 2 Wmo/ 1 Youth | X | X | X |  |
| GGZ NL | X | X |  | X | X |  | 1 Wmo/ 15 Youth | X | X | X |  |
| MO-groep | X |  |  |  |  | X | 1 Wmo/ 0 Youth | X | X | X |  |
| Koepel Wmo | X |  | X |  | X |  | 4 Wmo/ 0 Youth |  |  |  |  |
| BVKZ | X |  |  |  |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Raad vd Rechtspraak | X | X |  | X |  |  | 1 Wmo/ 0 Youth | X |  |  |  |
| Nl Ver Rechtspraak | X | X |  |  |  |  | 0 Wmo/ 0 Youth |  | X |  |  |
| RvS | X |  | X | X |  | X | 9 Wmo/ 7 Youth |  |  |  |  |
| CBP | X | X |  | X |  |  | 2 Wmo/ 4 Youth |  | X |  |  |
| ST. Present |  |  | X |  | X |  | 3 Wmo/ 0 Youth |  |  |  |  |
| Ieder(in) |  |  | X |  | X |  | 10 Wmo/ 3 Youth |  |  |  |  |
| Vóór Welzijn |  |  |  |  | X |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Welzijn Lansingerland |  |  |  |  | X |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Doeboerderij An’t Hoag |  |  |  |  | X |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Buurtzorg NL |  |  | X | X | X |  | 3 Wmo/ 1 Youth |  |  |  |  |
| JP van den Bent stichting |  |  | X |  | X |  | 0 Wmo/ 0 Youth |  |  |  |  |
| FNV abvakabo |  |  |  |  | X |  | 17 Wmo/ 10 Youth | X |  |  |  |
| CNV |  |  |  |  | X |  | 7 Wmo/ 1 Youth | X | X | X |  |
| ZN |  | X | X | X | X | X | 2 Wmo/ 3 Youth | X | X |  |  |
| Jeugdrecht UvLeiden |  |  |  |  |  | X | 0 Wmo/ 1 Youth |  |  |  |  |
| DFC |  | X |  | X |  | X | 0 Wmo/ 3 Youth |  |  |  |  |
| Kinderpostzegels |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Eigen kracht centrale |  |  |  |  |  | X | 0 Wmo/ 3 Youth |  |  |  |  |
| TSJ |  |  |  | X |  | X | 0 Wmo/ 4 Youth |  |  |  |  |
| NJI |  |  |  | X |  | X | 0 Wmo/ 6 Youth |  |  |  |  |
| Adri van Montfoort |  |  |  |  |  | X | 0 Wmo/ 1 Youth |  |  |  |  |
| Platform jongere uit JZ |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| LCFJ |  | X |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Belangenver. Medewerkers JZ |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Kindertelefoon |  |  |  | X |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Oudernetwerk Gelderland |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| LVB sector lijn 5 |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| BJZ |  | X |  | X |  | X | 0 Wmo/ 24 Youth |  |  |  |  |
| LHV |  |  | X | X |  | X | 1 Wmo/ 3 Youth | X | X | X |  |
| TJO |  |  |  |  |  | X | 0 Wmo/ 4 Youth |  |  |  |  |
| JGGZ Vermeier |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| GGD NL |  |  | X | X |  | X | 1 Wmo/ 8 Youth | X | X | X |  |
| Horizon |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| JZ NL |  | X |  | X |  | X | 0 Wmo/ 12 Youth |  |  | X |  |
| Raad Kinderbescherm |  | X |  | X |  | X | 0 Wmo/ 6 Youth |  |  |  |  |
| Jolande Calkoen |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Yorneo |  |  |  |  |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Kinderombudsman |  | X |  | X |  | X | 0 Wmo/ 16 Youth |  | X |  |  |
| NJR |  | X |  |  |  |  | 0 Wmo/ 1 Youth |  |  |  |  |
| IPO |  | X |  | X |  | X | 0 Wmo/ 0 Youth | X |  | X | Governance Agreement |
| NPV |  | X |  |  |  |  | 0 Wmo/ 0 Youth | X |  |  |  |
| KNMG |  | X |  | X |  | X | 0 Wmo/ 2 Youth |  | X |  |  |
| CIZ |  | X | X |  |  |  | 0 wmo/ 0 Youth |  | X |  |  |
| Raad v strafrechttoep en jeugdbescherming |  | X |  |  |  | X | 0 Wmo/ 1 Youth | X |  |  |  |
| Raad van Korpschefs |  | X |  |  |  |  | 0 Wmo/0 Youth |  |  |  |  |
| OM |  | X |  | X |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Mbo-raad |  | X |  |  |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| PO-raad |  | X |  | X |  |  | 0 Wmo/ 1 Youth | X |  |  |  |
| NOvA |  | X |  |  |  |  | 0 Wmo/0 Youth |  |  |  |  |
| CET |  | X |  |  |  |  | 0 Wmo/0 Youth |  |  |  |  |
| ITJ |  | X |  |  |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Actal | X | X |  | X |  |  | 0 Wmo/ 2 Youth | X | X |  |  |
| STJ |  | X |  |  |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| TSJ |  |  |  | X |  | X | 0 Wmo/ 3 Youth |  |  |  |  |
| Opella |  |  | X |  |  |  | 1 Wmo/ 0 Youth |  |  |  |  |
| Meander |  |  | X |  |  |  | 0 Wmo/ 0 Youth |  |  |  |  |
| Arduin |  |  | X |  |  |  | 1 Wmo/ 0 Youth |  |  |  |  |
| CPB |  |  | X | X | X |  | 3 Wmo/ 2 Youth |  |  |  |  |
| Fier Frieslân |  |  |  | X |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| Dr. Leo Kannerhuis |  |  |  | X |  | X | 0 Wmo/ 0 Youth |  |  |  |  |
| NVvP |  |  |  | X |  |  | 0 Wmo/ 2 Youth |  | X |  |  |
| Movisie |  |  |  | X |  |  | 8 Wmo/ 0 Youth |  |  |  |  |
| SCP |  |  | X | X |  |  | 8 Wmo/ 4 Youth |  |  |  |  |

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2. Parliamentary Papers II, 2013/2014, 33 750 VII, no. 12 [↑](#footnote-ref-2)
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4. Parliamentary Papers II, 2010/2011, 29 544, no. 336 [↑](#footnote-ref-4)
5. Ibid., [↑](#footnote-ref-5)
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7. M. Howlett, M. Ramesh & A. Perl, 2009 [↑](#footnote-ref-7)
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21. J. Frenk, 1993, p. 19 [↑](#footnote-ref-21)
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23. J. Madison, 2003, p.57 [↑](#footnote-ref-23)
24. M. Boogers, 2014, p. 148 [↑](#footnote-ref-24)
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27. M.a. Hogg, 2007, p.73 K. van den Bos, 2009, p. 93 [↑](#footnote-ref-27)
28. Ibid., p. 105 [↑](#footnote-ref-28)
29. R. Saltman, J. Figueras & C. Sakellarides, 1999, p. 157 [↑](#footnote-ref-29)
30. VNG commission ‘Municipality Act & Constitution’, 2007, p.4 [↑](#footnote-ref-30)
31. Rob/Rfv, 2000, p. 14 [↑](#footnote-ref-31)
32. Ibid., p. 16 [↑](#footnote-ref-32)
33. M. Howlett, M. Ramesh & A. Perl, 2009, p.13 [↑](#footnote-ref-33)
34. Ibid., p.4 [↑](#footnote-ref-34)
35. Ibid. [↑](#footnote-ref-35)
36. Ibid., p. 10 [↑](#footnote-ref-36)
37. H.D. Lasswell, 1971, p. 28 [↑](#footnote-ref-37)
38. M. Howlett, M. Ramesh, A. Perl, 2009, p. 11 [↑](#footnote-ref-38)
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