

## **EXPERTISECENTRE INDEPENDENT LIVING IS PREPARING A REPORT ON MARKET FORCES IN CARE**

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**Peter Lambrechts**

**Expertise Centre Independent Living**



## INTRODUCTION

Towards the Flemish elections of 2009 the role of market forces became an important theme in the debate on waiting lists in the care for the disabled. The debate concerning the 'economics of care' is not only a hot topic in Flanders. On an international level a debate about the cost and efficiency of public service in the care is also developing. At times there even has been talk about the end of the 'modern welfare state'. The aging of the population and – more recently – the economical crisis have only increased the call for more efficiency. Discussions about the retreat of the state and the implementation of market forces in the public health care have an effect in the whole of Europe. Europe itself, as an authority, could actually be playing an increasing role in this matter.

The final approval of the Directive on services in the internal market on 12 December 2006,<sup>1</sup> has only invigorated the debate. The so-called 'Directive on Services', which was initially called the Bolkestein-Directive, has for the first time established a connection between on the one hand the care and assistance offered in the field of welfare and on the other hand the European Union's internal market regulations (freedom of services and freedom of establishment)<sup>2</sup>.

Moreover there are different European countries where market forces, as organizational mechanism, already define the 'care market'. This is the case – to a great extent – in countries such as the UK and the Netherlands. In Sweden, the role of the market of the assistance of disabled people, has already been an established fact for some 15 years now<sup>3</sup>.

## FROM DEMAND-BASED CONTROL TOWARDS MARKET FORCES

Since market forces as a concept are strongly connected with terms as liberalization, privatization and commercialization, we have noticed that this concept has various connotations. As a result the definition of the concept of market forces is very diverse and subject to ideological motivations<sup>4</sup>.

But apart from ideological position-taking there are some other factors which influence and determine the use of the term 'market forces'. The policy experience in different countries also plays an important role, as well as the specific 'scripts' (frame of reference from one's own world and work environment) which are being used by different parties<sup>5</sup>.

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<sup>1</sup> Directive 2006/123/EG of the European Parliament and the Council of 12 December 2006 on services in the internal market, *PB* 2006, L 376/36.

<sup>2</sup> Verdonck Ingrid & Prof.dr. Put Johan, Steunpunt Welzijn, Volksgezondheid en Gezin "Ontwikkelingen betreffende de Europese Dienstenrichtlijn en de zorgsector" 2008

<sup>3</sup> [Directe financiering in de zorg. Stand van zaken in 8 Europese landen.](#)  
- Auteurs: Decruynaere Elke, Van Hauwermeiren Juliska, Expertisecentrum Onafhankelijk Leven.  
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<sup>4</sup> Verdonck Ingrid & Prof.dr. Put Johan, Steunpunt Welzijn, Volksgezondheid en Gezin "Begrippen en effecten van marktwerking: een literatuurverkenning" 2008

<sup>5</sup> Dr. Paulus A., Dr. van Raak A. en Dr. Mur-Veeman I. Marktwerking is ... ?  
<http://www.bestuurskunde.nl/publicaties/bestuurskunde.php?artikel=2001,8,10,5,4>

When one does not clearly define what one is talking about, and when one is not prepared to investigate in a balanced and unbiased manner in which way the care is best organized, one risks to get entangled in a semantic non-discussion and to end up in an ideological war. This was the case when the theme was brought up during the recent regional elections in 2009. Nevertheless there exists a rather strong support for demand-based control as most important principle in the organization of the care for the disabled. This is shown by the fact that the Flemish Parliament in plenary session has adopted the Decree of 12 December 2001<sup>6</sup> concerning the personal budget. In the explanatory memorandum of this decree it is clearly stated that the decree aims at the realization of the right to autonomy of disabled people by means of a needs-based care as well as a needs-based financing of services and facilities (=demand-based control) through personal budgets.

At the care congress of 11 December 2003 academics, care personnel and care users exchanged ideas about the future of care. There existed a unanimity with regard to demand-based control as a starting point in the care.

*“recently there have been many discussions about the opposition between an offer-based care and a demand- or needs-based care. For example there is the debate about the degree of care planning and more specifically about the (desired) degree of initiative that the care organizations have to take as well as the extent to which the care organizations are being controlled by the authorities. The discussions also revolve around the character of the financing: do persons who need care have to be subsidized for organizing care? When we try to answer these questions we have to look first at the person who needs care and his or her environment. A future care model shall have to put forward a coherent and balanced vision to this respect, but in any case this vision will have to take the user as a starting point.”*

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There is a consensus about the need for a custom-tailored care and demand-based control. Also more recently, during a public hearing of the Flemish Parliament's parliamentary committee for Welfare, Public Health and Family of 21 April 2009<sup>8</sup> where a year-long analysis of the Flemish Agency for Disabled Persons (Vlaams Agentschap voor Personen met een Handicap)<sup>9</sup> about the evolution of care demands was presented, stakeholders have confirmed this yet again. On top of the demand for more means for the sector, again there has been a plea for a radical reorganization and an efficient renewal of the care. This plea comes from the need and the necessity to be able to realize custom-tailored care and assistance, with demand-based control and freedom of choice as most important principles. In reality this change manifests itself in a new, general form of financing, i.e. the personal budget.

So there exists a consensus about the principle of ' demand-based control '. But this consensus is lost in discussions about the implementation of market forces in the care and assistance.

Nevertheless everybody who is in favour of demand-based control, is fundamentally pro implementation of market forces. Because demand-based control happens to be one of the possible market forces, just like benchmarking, performance-based contracts or tendering

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<sup>6</sup> <http://jsp.vlaamsparlement.be/docs/stukken/2001-2002/g868-4.pdf>

<sup>7</sup> <http://www.gripvzw.be/nieuwsbrief/printbaar/051112.pdf>

<sup>8</sup> <http://jsp.vlaamsparlement.be/docs/stukken/2008-2009/g2252-1.pdf>

<sup>9</sup> [http://www.vgph.be/index.php?id=481&no\\_cache=1&sword\\_list\[\]=hoorzitting](http://www.vgph.be/index.php?id=481&no_cache=1&sword_list[]=hoorzitting)

<sup>9</sup> That is the administration which takes care of the organization and implementation of the care for disabled.

which can be applied upon the implementation of market forces<sup>10</sup> in care. Of course market forces can be introduced to a different extent and in different ways through one of these market mechanisms. Therefore, the question is not whether we have to choose between an absolute free market on the one hand or an absolute government control on the care on the other hand. There exist many gradations and variants in between these two extremes.

The main question is how the evolution from less government control towards a greater role for the market will influence the care and assistance, and as a consequence influence the quality of life of disabled persons. Should this be seen as a threat or an opportunity? In order to be able to find out we need to know what we are talking about. An essential first step is to have an understanding of the economical terminology used. That is also why it may be useful to start by elucidating some closely related terms.

## DEFINITION OF TERMS

One of those terms is privatization. **Privatization** means that certain services which were previously completely state-ran, can be henceforth offered entirely or partly by private companies<sup>11</sup>. An example of this are the recent privatizations in the telecommunication sector throughout Europe. On the contrary of popular belief the care and assistance of disabled people in Flanders is practically entirely privatized and this has always been the case. The only exceptions are some services and utilities which are controlled by local authorities, Public Welfare Centres (OCMW's, Openbaar Centrum voor Maatschappelijk Welzijn) or provincial authorities. The private actors on our care market are however 'non-profit' or 'social-profit' organizations (most of them vzw's – associations without a view to profit), which are subsidized and regulated by our government. The government has these care providers on a tight leash.

Everybody who wants to start or expand a service or utility in the care for the disabled, has to ask the Flemish Agency for Disabled Persons (VAPH) for a permission and a recognition<sup>12</sup>. To be able to obtain such a recognition you have to offer care and assistance that complies with one of the 16 recognition categories (e.g. Home for the non-working) and which on top of that fits into the central planning. This planning is based on the budgetary limits of the expansion policy and is carried out on basis of the regional care plans of the Regional Consultation of Handicap Care (Regionale Overleg Gehandicaptenzorg). Before approving a recognition decision the leading public servant of the VAPH has to go through a whole administrative process. In spite of the strong privatization of the Flemish care for the disabled there is not a trace of market forces.

**Commercialization** on the other hand means that you also allow 'for-profit' actors on the market. Meaning that there is a policy of creating broader possibilities for entrance on the market so that there may be a fair competition between commercial care providers and social-profit care providers. In Flanders there exists no possibility for private profit-oriented companies to enter the care market. Legal regulations exclude every 'for-profit' company<sup>13</sup>.

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<sup>10</sup> Blokland D. Een afwegingskader voor marktwerking in semi-publieke sectoren TPEdigitaal 2008 jaargang 2(1) 47-61

<sup>11</sup> Verdonck Ingrid & Prof.dr. Put Johan, Steunpunt Welzijn, Volksgezondheid en Gezin "Begrippen en effecten van marktwerking: een literatuurverkenning" 2008

<sup>12</sup> <http://www.vaph.be/vlafo/view/nl/776477-Vergunning+en+erkenning.html>

<sup>13</sup> Art. 8bis BVR van 15/12/1993 Publicatie : B.S. 11.3.1994

Great resistance on the international level against commercialization in the care<sup>14</sup> arises. One of the more commonly used ethical arguments is that it is wrong to use public means, destined for the support of people with a deficiency, for making profit. An interesting comparison can be made with the care for the elderly, since elderly care is also subsidized with public means and organized similarly. Elderly care is subsidized per 'client' on the basis of a care needs assessment, but in contrast with utilities and services in disability care there exists a certain freedom when it comes to the determination of the personal contribution of the residents to these utilities and services. Moreover there is no 'entry prohibition' for commercial providers into this sector. For example: in every Flemish province there is a mixed offer of nursing homes for the elderly, as well as service flats. In that offer we find a score of commercial residential utilities for elderly people<sup>15</sup>, which are subsidized and recognized in the same way as the public or non-profit providers of care and assistance. These commercial utilities are not thought to be morally unethical, as long as they subject themselves to certain regulations.

Another term is **liberalization**. As the word itself suggests it is about 'making free'. In economic theory this means that the government takes away restrictions and obstacles to enter a certain market and thus allows competition. There exist many parallels with commercialization. As to commercialization, the focus is on allowing profit-oriented parties and free competition. Liberalization primarily focuses on the creation of a freedom of choice for the consumer and putting an end to monopolies and dominance of certain parties through giving way to market forces and alternative providers.

This brings us to the most difficult term to define: **market forces**. If we describe market forces in an abstract way then we end up talking about absolute free competition, free price-setting, etc. the market is then a so-called hypothetical place where demand and supply meet one another and are being guided as it were by 'an invisible hand', and where it comes down to the maximization of profits of material and immaterial products and services<sup>16</sup>. Market forces then automatically lead to a perfect balance between demand and supply, on the level of price as well as quality.

## **THE CARE AS A CASE: THE REGULATED MARKET IN FLANDERS.**

So far for theory, but is this economic principle also applicable to the so-called 'care market'? The care and welfare market is atypical and has therefore been called a quasi-market<sup>17</sup>. or 'regulated market', in order to differentiate it from the so-called 'free' markets, where there is no need of intervention or regulation from the government. Market mechanisms can very well be applied to such a regulated care market<sup>18</sup>. PhD. Put describes market forces as follows: *"a form of organization whereby the balance between demand and supply as well as the quality of the offer is automatically obtained through the free initiative of- and mutual competition between the care providers"*.

<sup>14</sup> <http://www.zorggeenmarkt.nl/manifest.php>

<sup>15</sup> [http://www.zorg-en-gezondheid.be/adressen\\_ouderenzorg.aspx](http://www.zorg-en-gezondheid.be/adressen_ouderenzorg.aspx)

<sup>16</sup> Dr. Paulus A., Dr. van Raak A. en Dr. Mur-Veeman I. Marktwerking is ... ?

<http://www.bestuurskunde.nl/publicaties/bestuurskunde.php?artikel=2001,8,10,5,4>

<sup>17</sup> Le Grand J. "Quasi-Markets and Social Policy", *The Economic Journal* 1991

<sup>18</sup> Canoy M. Marktwerking in de zorg : ondernemende zorg of zorgende ondernemers /TPEdigitaal 2009

From this we cannot only learn that market forces do not only influence the price and quality of the offer, but also that market forces are an organizational- or steering mechanism. However, the main question is: how will this steering mechanism shape the Flemish care market and what will be the consequences for disabled people?

To be able to investigate this we will first have to focus on the actual situation of the care demander. When in Flanders a disabled person needs assistance and/ or guidance which surpasses the capacities of his or her personal network, or when he or she chooses to no longer be dependent on his or her parents, he or she has to turn to the VAPH. A provincial assessment committee will decide whether you have access to a certain recognition category or care formula on the basis of a multidisciplinary report by a care-MDT (Multi Disciplinary Team)<sup>19</sup>. Your specific demand for assistance will then follow an administrative process and is thus converted into one of those existing recognition categories. The fact that the assistance is subsidized and formally monitored as a total package, i.e. as the formerly described care formula, makes it very difficult if not impossible for care providers to give customer-tailed care.

Another important problem are the considerable long waiting lists for most of the care forms, which makes up for the fact that it often takes years before receiving care as a care demander. This also due to the fact that the government has a limited annual budget which is not sufficient to satisfy all the care demands. The most recent care report<sup>20</sup> reveals that the number of care demanders increases every year. On the 31<sup>st</sup> of December 2008 there were 17 265 active care demands of which 10 785 were urgent and of 364 care demands have been registered for more than 2 years, without any solution.

In the meantime your demand has turned into a file, which is being taken care of by a contact person at the mediation meetings of the Centrale Registratie van Zorgvragen (Central Registration of Care Demands; CRZ mediations or what was previously referred to as 'waiting list meetings'). This contact person is a collaborator of a utility or a referring instance or in very exceptional cases a collaborator of a users association.

His task is to mediate so that your file gets on the top of the list for getting a place in the 'open offer'. Reality however is that there are manifold 'suitable' candidates for each open offer. The VAPH tries to give priority to the most urgent care demands through the care regulator. Upon each so-called match between an urgent care demand and an available offer many people again miss their chance to 'get in'. The care regulator puts a high pressure and responsibility on these meetings so that they keep a positive attitude and keep on looking for solutions for what basically is a lost case scenario. The contact persons have to keep adapting to the circular letters that come in quick succession, they have to deal with urgency codes or priority groups and emergency situations, but this cannot help for the fact that many disabled people have to wait for years on end without receiving the necessary assistance. Sometimes this lack of suitable assistance leads to situations where people find themselves living on the streets or end up in jail, nursing homes or psychiatric institutes. Because of the few possibilities and the care regulator policy people with an urgent care demand actually have no freedom of choice. You may call yourself lucky if you receive care before your lack of assistance leads to a crisis situation. But even if you receive care you have no guarantee whatsoever that this corresponds with your specific, individual care need and you are in a very vulnerable position and not able to change your situation. The only

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<sup>19</sup> Handinfo Vlaams Fonds 4<sup>e</sup> herziene uitgave maart 2006

<sup>20</sup> <http://www.vaph.be/vlafo/view/nl/464335>

recognition category of the VAPH which makes an exception to this rule is the personal assistance budget (PAB)<sup>21</sup>. This form of direct payments enables the disabled person to have an impact on his or her assistance. Although we still have to be watchful to government measures which could curtail the freedom of choice and the demandbased control which are so typical of the PAB system<sup>22</sup>.

It is clear that the actual solution which our government offers to disabled care demanders fails. Even if we make abstraction of the budgetary problems, then the organization of the care is inadequate. The way in which it is organized is so methodical and is so out of contact with the reality of individual care needs that customer-tailed care is out of question...

This not only contrasts with the broad consensus about customer-tailed care and demand based control. There is also the fact that concepts like quality of life or the citizenship paradigm are so widely accepted with disabled persons and the broad civil society that a structural reorganization of the care and assistance can no longer wait<sup>23</sup>. This can all be seen as a part of the paradigm shift which is actually taking place, but we will not discuss this topic further into detail in this article.

We have come to the conclusion that the strict monitoring of the nature and price of the care by the Flemish government has very negative consequences for the Flemish care demanders. Direct payments and demand-based control may be a positive change. That is also why the sector carries such high hopes with regard to the ongoing experiment with the personal budget (PGB)<sup>24</sup>.

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<sup>21</sup> <http://www.bol-budiv.be/pab/> en <http://www.vaph.be/vlafo/view/nl/10526-Persoonlijke-assistentiebudget+%28PAB%29.html>

<sup>22</sup> [Eerste uitvoeringsbesluit van het Decreet betreffende de zorg en bijstandsverlening](#)

- Author: Jos Huys

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<sup>23</sup> Goed leven zonder instituut G. Van Hove & J. Van Loon in Alert 2006 nr 4  
<http://www.pow.be/Portals/pow/alert/pdf/AT324084GLZ10VLJ.pdf>

<sup>24</sup> <http://www.vaph.be/vlafo/view/nl/3136548-Persoonsgebonden+budget+%28PGB%29.html>  
<http://www.bol-budiv.be/pgb/>

## **PROVISIONAL CONCLUSION**

If we take as a starting-point the aforementioned description of the way in which demand and supply in Flanders (do not) find one another today, we may start investigating what changes were to be desirable by using certain market forces.

The Expert Centre Independent Living invests time and money in study work on this theme. In July 2009 Peter Lambreghts has started working on this topic as a policy staff member. Market forces in the care are a complex subject which needs to be analyzed with due thoroughness and expertise, because this is a subject too important to be left aside.

In the mean time we hope to have aroused your interest with this introduction to our report in progress. We will publish our first full report at the end of 2009.