Commissioning for integration

exploring the dynamics of the “subsidy tables” approach in Dutch social care delivery

Kist, Floor; de Bruijn, Hans; Jonker, Catholijn

DOI
10.1108/JICA-12-2023-0094

Publication date
2024

Document Version
Final published version

Published in
Journal of Integrated Care

Citation (APA)
Kist, F., de Bruijn, H., & Jonker, C. (2024). Commissioning for integration: exploring the dynamics of the “subsidy tables” approach in Dutch social care delivery. *Journal of Integrated Care*, *32*(3), 331-350. https://doi.org/10.1108/JICA-12-2023-0094

Journal of Integrated Care

Commissioning for integration: exploring the dynamics of the "subsidy tables" approach in Dutch social care delivery

Floor Kist
Faculty of EWI, TU Delft, Delft, Netherlands
Hans de Bruijn
Faculty of TBM, TU Delft, Delft, Netherlands, and
Catholijn Jonker
Faculty of EWI, TU Delft, Delft, Netherlands

Received 15 December 2023
Revised 8 May 2024
Accepted 13 June 2024

Abstract

Purpose – The objective of this paper is to develop a redesigned commissioning process for social care services that fosters integrated care, encourages collaboration and balances professional expertise with client engagement.

Design/methodology/approach – This study employs a two-pronged approach: a case study of a municipality's use of subsidy tables and a literature scoping review on integrated care research.

Findings – The paper introduces a new framework for the study of the new "subsidy tables." A well-defined and extensive consultation process involving both social care providers (suppliers), the Service Triad, and client representation adds to the existing research on supplier consultation, and on how to define the outcomes for clients via client engagement.

Research limitations/implications – While aspects are clearly relevant to the Netherlands, the design of the commissioning process of social care has international relevance as well: finding definitions, formulating outcomes and incentives, designing a more collaborative instead of competitive process, stakeholder engagement and consultation.

Practical implications – Several Dutch municipalities started using the "subsidy tables" method for commissioning integrated social care. This paper offers clear improvements that benefit the commissioners, the social care providers and their clients.

Social implications – Improving the commissioning process of integrated social care will lead to better fitting care for people who need social care.

Originality/value – This paper is one of the first to do a thorough analysis of the "subsidy tables" method for commissioning integrated social care.

Keywords Commissioning integrated social care, Self-reliance in social care, Local government, Professional autonomy, Paper type, Case study

Paper type Case study

1. Introduction

In 2015, the Dutch government decentralized the delivery of social care to local government, based on the assumption that they would possess a closer understanding of their

The authors want to thank former Wethouder J. Rouwendal and the municipality of Leidschendam-Voorburg for their interest and assistance.

Declaration of competing interests: The authors declare that they have no competing financial interests that could have appeared to influence the work reported in this paper. At the time of researching this article in 2020, F.J. Kist was a member of the municipal council then a member of B&W in Leidschendam-Voorburg, but was not involved in designing the process of subsidy tables, nor during the process in 2018–2019.

Journal of Integrated Care

1476-9018
DOI 10.1108/JICA-12-2023-0094

constituents' needs. The legislative changes also meant a greater focus on client self-reliance, integrated and tailor-made interventions, and professional autonomy. However, truly integrated social care remains elusive.

Several municipalities have tried to innovate integrated social care by transferring from individual subsidy grants for individual providers to commissioning joint and integrated proposals by several social care providers (Drahmann *et al.*, 2021). By introducing "subsidy tables," the municipalities hoped to facilitate dialogue and cooperation among care providers, enabling them to pool resources and expertise to deliver general integrated preventive social care that addresses broader social needs.

1.1 Choosing the case

For the municipality of Leidschendam-Voorburg (LV), the first iteration of the subsidy tables in 2018 lead to proposals that were no different than previous individual proposals. Having spent more time and energy in order to get almost similar results is the reason behind the choice of LV for the case. Other municipalities, like Gouda and Schiedam, using subsidy tables had different results. For LV, observations and evaluations have highlighted several issues:

(1) Lack of clear, shared definitions for key concepts such as "integrated care."

(2) Goals and expected outcomes of the subsidy tables were not been explicitly defined or communicated.

(3) No client involvement in the commissioning process and development of proposals.

(4) Lack of clarity about available finances led to competitive rather than cooperative behaviors among providers.

While the last issue is specific to the situation in LV, the first three issues are recurring themes in the field of research on integrated care (Amelung *et al.*, 2021) and "wicked issues" (Head, 2019). They also explain the difficulty of commissioning integrated social care. While there is extensive research on commissioning integrated care, most of it is pertinent to health care in the United Kingdom and the United States. There is British research on health and social care, and there is an increasing body of research on commissioning social care in the Netherlands (Heuzels, 2017; Uenk, 2019). The subsidy tables, however, are a relatively new occurrence in the Netherlands that could use more studying. While aspects are clearly relevant to the Netherlands, the design of the commissioning process of social care has international relevance as well: finding definitions, formulating outcomes and incentives, designing a more collaborative instead of competitive process, stakeholder engagement and consultation.

1.2 Objective of this paper

This is why the objective of this paper is to develop a redesigned commissioning process for social care services that fosters integrated care, encourages collaboration and balances professional expertise with client engagement. This process aims to:

(1) Ensure that care providers deliver integrated care where possible, defining the degree of integration and identifying where it is needed.

(2) Shift from competitive practices to a collaborative approach, engaging providers and stakeholders in a service triad model that includes clients, providers and commissioners.

(3) Allow care professionals the autonomy to apply their expertise in the design and delivery of care services.

(4) Facilitate interventions that increase clients' self-reliance, promoting sustainable outcomes.

(5) Introduce incentive structures that motivate care providers to collaborate effectively and deliver integrated care.

1.3 Article structure

This paper offers a comprehensive examination of social care commissioning processes, with a particular focus on LV's use of subsidy tables.

The section Methodology introduces a two-pronged approach: an in-depth case study of LV's subsidy tables and a literature scoping review on integrated care research.

The section Literature Review investigates research and theoretical frameworks that shed light on the complexities of social care commissioning. This includes discussions on integrated care, commissioning approaches and theories such as agency theory and stewardship theory. The literature review also addresses key aspects like self-reliance, supplier consultation and transaction costs.

The section Case Study provides a real-world context to explore the challenges and opportunities in commissioning integrated social care. It examines the regulatory and financial framework, participants and outcomes, as well as review findings from the subsidy tables process.

The section Findings synthesizes insights from both the literature review and case study, highlighting key challenges such as unclear definitions, collaboration vs competition and incentive structures. It also explores the balance between professional autonomy and collaboration, monitoring and evaluation, and transaction costs.

The section Recommendations proposes two distinct commissioning processes: a Request for Proposal Consultation Process and a Collaborative Proposal Process. These processes aim to clarify roles and responsibilities, streamline procedures and enhance collaboration while addressing gaps in LV's existing approach.

The final section Discussion and Implications discusses how these recommendations integrate theoretical and empirical insights, and explores their broader implications for both theory and practice. We also identify areas for further research, including investigating the balance between agency theory and stewardship theory, incentive structures and transaction costs.

2. Methodology

This study employs a two-pronged approach: a case study of LV's subsidy tables and a literature scoping review on integrated care research.

2.1 Case study approach

The case study is needed to investigating the intricacies of LV's subsidy tables, as there is limited existing research on this topic. A comparative study across different municipalities utilizing subsidy tables would lack the depth and specificity provided by an in-depth case study.

This analysis targeted four main thematic areas: the process of the subsidy tables, the characteristics of participants, the results of the subsidy initiatives and the strategies used by participants. The documents included policy documents, internal reviews and formal communications to the municipal council, all publicly available on the municipal website. To ensure a comprehensive understanding, the study analyzed these documents to answer specific questions grouped under each theme. These questions aimed to uncover details about the informedness and responsiveness of the participants regarding the process, the visibility and interaction among participants, the alignment of outcomes with objectives and

the strategic behaviors adopted by participants. Responses were systematically cataloged and presented in a table format within the paper to allow for transparent comparison and analysis.

This approach allowed for an in-depth examination of the subsidy tables without conducting formal interviews, thus maintaining the integrity of the research given the potential conflict of interest by one of the authors' involvement in the municipal council. Ten informal meetings with key players provided contextual insights, but all findings are substantiated by the review of municipal documents.

2.2 Literature scoping review

The second method involves a scoping review of the literature on integrated care research, encompassing a wide range of topics related to commissioning processes, collaboration and social care outcomes. This review provides theoretical and empirical context, framing the case study's findings and informing the recommendations for redesigning the subsidy tables process.

By combining the in-depth case study with a broad literature scoping review, this methodology provides a comprehensive and nuanced understanding of LV's subsidy tables and integrated care commissioning, bridging gaps in current research and offering actionable insights for both theory and practice.

3. Literature review

This literature review explores relevant research and theories that explain the elements and challenges involved with social care commissioning processes. These theories provide a foundation for analyzing the interactions between various stakeholders involved in the subsidy tables, including municipal governments, social care providers and the clients.

3.1 Defining integrated care

Integrated care is not a single intervention to reach specific goals, it's usually a set of practices shaped by contextual factors. In practice, this can lead to integrated care as overlapping, interrelated, and, at times, conflicting strategies and experiences (Hughes *et al.*, 2020, 2022). Integrating health care services may improve client satisfaction and experiences of care and it may also improve service efficiency. It creates "frameworks of care" that reduce fragmentation and duplication of health care, which can lead to poor patient outcomes, inefficient services and wasted resources (MacAdam, 2008; Curry and Ham, 2010; Ham and Walsh, 2013). Research has uncovered more than 175 overlapping definitions of integrated care. In most cases a "user-centered" definition seems to be a recurring term where integrated care is involved (Amelung *et al.*, 2021). Integrated care also supports individuals to remain within their communities and to counter threats to their independence (Ham and Walsh, 2013). Just like health care, social care is best delivered in an integrated way (Carnwell and Carson, 2005; Nelson *et al.*, 2018).

The integrated approach fits in a wider insight that multi-actor collaboration is seen as a new type of governance that can deal with society's complex issues and replaces the bureaucratic paradigm in policy making, policy implementation and social service delivery (Mandell and Steelman, 2003; Bryson *et al.*, 2006; O'Leary and Vij, 2012; Fleishman, 2013; Marek *et al.*, 2015; Amsler and O'Leary, 2017; Ansell *et al.*, 2017; Head, 2019; Relampagos, 2020). Although, the "cult of collaboration" also has its critics who suggest that collaboration is just another way for organizations to work together (O'Flynn, 2009).

For health care, successful integration is supported on having a shared purpose and a clear vision of what integrated care will achieve (Ham, 2011). While a definitive definition is

lacking, collaborative studies suggest that local stakeholders agree on their definition and meaning for integrated care as a means to guide their collective actions (Fleishman, 2013).

3.2 Commissioning integrated care

3.2.1 Agency theory. A commission can be seen as "a contract under which one or more persons (the principal(s)) engage another person (the agent) to perform some service on their behalf which involves delegating some decision-making authority to the agent" (Braun and Guston, 2003). The Agency Theory, based "new institutional economics," supposes rational actors that strive to maximize their own benefits, thereby introducing a conflict of goals between the principal and the agent. It also introduces an information asymmetry when a principal contracts the agent because of their specific knowledge and professionalism to deliver a service. This asymmetric information relationship opens a discussion on best ways to reward and/or control the service delivery (Jensen and Meckling, 1976). Therefore, defining outcomes may be a good way to level the information asymmetry. However, it is reasonable to suppose that outcomes depend on both the agent's actions and random environmental events. This makes judging the agents' influence on the outcomes more difficult. And the difficulty increases when multiple agents are involved in joint service delivery (Rose and Willemain, 1996; Van Slyke, 2006). When the principal defines the required outcomes, he must be certain that they are observable and verifiable.

In the case of the policy goals for social care, there may well be conflicting expectations between local government policies attempting to reduce costs and clients who may say they need more care. Given the political setting, there may even be an added element involving multiple principals. In the case of the subsidy tables, the city council delegates the process to B&W, which in turn delegates it to a team within the municipal organization. This creates a layered system of principals and agents, with the challenges of possibly conflicting goals and monitors for those goals.

3.2.2 Stewardship theory. However, given the public context, information asymmetry is less of a problem if the agent's interests are aligned with the principal's. This is the basis for the stewardship theory that supplements the principal-agent theory in the public sector. Given the economic rationale of the theory, the question is if the theory could be applicable to nonprofit organizations at all? Unlike organizational economic theories, Stewardship theory emphasizes collective, pro-organizational, contractual behavior in which a higher value is placed on goal convergence than on agent self-interest (Caers *et al.*, 2006; Van Slyke, 2006).

The difference between the Agency theory and the Stewardship theory affects how the commissioning process can be shaped.

3.2.3 Outcomes. Measuring the impact of social care can be difficult because changes in health and wellbeing can take years to emerge (Bardsley *et al.*, 2013; Humphries and Wenzel, 2015). Integrated care can lead to integrated care as overlapping, interrelated, and, at times, conflicting strategies and experiences (Hughes *et al.*, 2020, 2022). Furthermore, objective and conclusive outcomes of integrated health care are difficult to define. More so, when more agents are concerned, Fleishman (2013) argues that collaboration and integrated services "make policy more effective, efficient, or equitable in some concrete way. Further, these benefits must accrue at the community or societal level." Fleishman's studies conclude that "literature on collaboration as a whole lacks conceptual development on the outcomes of collaboration, particularly the benefits of collaboration." Her main research task is to identify benefits unique to collaboration. This also means an understanding of processes that bring them about. Fleishman argues that the literature also lacks the specification of mechanisms or processes by which outcomes emerge. Moreover, there is no theoretical basis indicating one agent's specific part in the whole of outcomes. Fleishman suggests that outcomes of social services delivery will remain ambiguous without a deeper understanding of the processes of collaboration in integrated social care.

It also means that in a commissioning process, the principal should ultimately define what integrated care is supposed to achieve. Given the information asymmetry this is no simple task.

3.2.4 Self-reliance. Decentralizing the responsibility of social care delivery to local levels has been guided by a prime objective: fostering self-reliance, empowering individuals to assume control of their lives, and minimizing dependence on governmental social care. The concept of self-reliance took center stage in late 20th-century discussions around healthcare and social care (Lupton, 1998).

Often, it is viewed as a tangible outcome of effective social care provision (Vernon and Qureshi, 2000). The discourse on self-reliance is vast, encompassing ethical considerations (Sniderman and Brody, 1977; Roberts and Huberfeld, 2015; Zwaard, 2021), outcome measurement in healthcare (Vernon and Qureshi, 2000; Heuzels, 2017), conceptual definitions (Vlind, 2012; Brink, 2013; Dudevszky and Lohman, 2015; Meinema, 2017), empowerment (Orrego *et al.*, 2016), and its diverse interpretations across various stakeholder groups (Denters *et al.*, 2019; Eggink *et al.*, 2020; Lenkens *et al.*, 2020; Appleton *et al.*, 2021; Różyk-Myrta *et al.*, 2021). Given the different definitions and descriptions in the literature, referring to the Dutch legal framework will provide an outcome for the case study. As defined in *Wet maatschappelijke ondersteuning 2015*, the primary legislation for social care in the Netherlands, self-reliance denotes the holistic capability – physical, cognitive, psychological and financial – to engage in standard societal interactions.

3.2.5 Supplier consultation and service triad. One way to deal with the information asymmetry between principal and agents is to consult them on the commission. Collaborating with social care providers for the preparation of the commissioning process ("buyer-supplier consultation") helps the exchange of information between parties, and better taken the actual delivery of social care into account. Existing literature on buyer-supplier collaboration suggests that such partnerships can bring different benefits, including innovation, cost-efficiency and enhanced coordination (Corsten and Felde, 2005). However, findings from Hoegl and Wagner (2005) in the context of product development indicate more varied outcomes. The available studies deal mostly with commercial contracting and not with the social care sector. In addition, research concerning the UK health care system underscores challenges in collaborative public procurement due to factors like local politics, differing priorities and reliance on supplier data (Walker *et al.*, 2008, 2013). Some research has delved into public service procurement, including the health and social care sectors, but their primary focus has been on the relational risks and factors influencing collaboration (Grudinschi *et al.*, 2014).

Studies on integrated health care often identify client satisfaction as an important outcome, and suggest client consultation as well. In the case of commissioning social care, this is useful when dealing with the "service triad" (Li and Choi, 2009; Uenk, 2019; Uenk and Telgen, 2019). This typically occurs when an organization outsources the service delivery for the organization's end customers to a third party. The triad influences the relationship and the interdependency of the principal and the agent, adding a new level of ambiguity. However, by introducing client consultation along with supplier consultation, the agents' advantage of client engagement is reduced. In studies on consultation, the direct relationship with social care clients remains underexplored.

3.2.6 Co-creation and negotiation. The specific setting of the subsidy tables leads to a discussion about if Game theory is applicable. There is a principal that commissions social care delivery of collaborating agents. The available budget is limited which suggests there is a zero-sum game with incomplete information, and with multiple agents. Although the agents compete against each other for the division of the budget, the main goal of the subsidy tables is for agents to collaborate to deliver social care. Game theory usually suggests that the "players" have conflicting interests, It tries to describe strategic interactions given the

constraints the players face. The theory also suggests that there is a set of rules governing the game that expresses what the players are playing for and in what order. There should also be a definition on what players stand to gain or to lose (Mediavilla *et al.*, 2017). More recently, there has been a development in bargaining theory, a branch of game theory dealing with choice of suppliers. There is limited knowledge about the design and application of supplier selection processes based on game theory (Mediavilla *et al.*, 2017). Because the process of subsidy tables is a form of commissioning social care delivery, the bargaining theory could apply. However, the goal of the process is not necessarily to choose between different suppliers, but to have them collaborate to deliver social care.

The position of B&W in designing the process of the subsidy tables, setting the budgets, accepting or rejecting the joint proposals and supporting the actual collaboration process of the participants makes its role difficult to define in terms of game theory. The theory doesn't usually consider an arbiter or referee. Maybe the participants are collectively playing against B&W which then supposes it is a player with other rules and goals than most other players. Since Game theory applies the same rules to all its players, B&W does not fit into it. The usefulness of Game theory in this case is doubtful.

Instead, we note that among different forms of collaboration, alliance contracting, a method designed for multifaceted projects across diverse organizations, is emerging as a potent tool for social care delivery (Billings and de Weger, 2015; Clark *et al.*, 2015). Its emphasis on risk-sharing promotes a collaborative ethos that fosters learning (Smith, 2001; Billings and de Weger, 2015; Clark *et al.*, 2015; Sanderson *et al.*, 2018) and suppresses opportunistic behavior (Laan *et al.*, 2011). For instance, the Social Inclusion Outcomes Framework, piloted by Stockport in 2011, offers a holistic approach to mental health care with categories that align with LV's policy objectives (Clark *et al.*, 2015).

3.2.7 Incentives. In the Agency Theory, principals use incentives to align the agent's goal with theirs. With multiple collaborating agents, the principal faces an additional challenge of coordinating their efforts and ensuring they do not work at cross-purposes (Gibbons, 1998; Tsiachristas, 2016). Usually, incentives are monetary. From the viewpoint of the Stewardship theory, however, in which the goals of the principal and the agent are mostly aligned, the incentive could be a good outcome of the services provided for their clients. In health care, the term "humanomics" may start to replace the "economics" approach of incentives, because "it incorporates treatment based on personal need, preferences and capacity, it interacts with the context in which it is implemented, and its success depends highly on human behavior" (Tsiachristas, 2016).

The difference between the Agency theory and the Stewardship theory affects how the incentives can be shaped and introduced into the commissioning process of integrated social care.

3.2.8 Transaction costs. Studies on transaction costs in integrated health care discuss the costs from the point of view of the principal (Stiles *et al.*, 2001; Laugesen and France, 2014; Bokkes, 2019; Victor and Paulo, 2023), or the agent acting for a principal (Bech and Pedersen, 2005). A recurring framework is that of "Transaction cost economics" (TCE), a conceptual framework for analyzing health care transactions and quantifying their impact on health care structures, processes and outcomes. TCE examines the "make-or-buy" decisions involved in integrated care delivery – whether it is more efficient for the organization to produce certain services internally (make) or to procure them from external providers (buy) (Stiles *et al.*, 2001). Literature on collaborating municipalities suggests there is a cost to the collaboration itself (Allers and Geertsema, 2016; Allers and de Greef, 2018).

For the situation in LV, three possible transaction costs can be argued: (1) the "make-or-buy" transaction costs for the municipality, (2) the additional transaction costs involved with the subsidy tables compared to the individual subsidy grants for both municipality and participants, and (3) the transaction costs involved in the collaboration between participants

in order achieve and maintain integrated care. The available literature on integrated social care only addresses (1).

For the redesign of the commissioning process transaction costs for (2) and (3) should be investigated further.

The research and theories will serve as a framework to redesign the commissioning process for integrated social care, specifically in the case of Leidschendam-Voorburg. In the next part, the case study will be extensively reviewed.

4. Case study

Leidschendam-Voorburg is a municipality near The Hague with approximately 76,000 residents. As of January 2020, it ranks as the 48th most populated out of 355 municipalities in the country. A distinguishing feature of LV is its aging population; 22% of its inhabitants are over 65 years old. Like many municipalities, LV has been grappling with escalating social care costs.

4.1 Subsidy tables in LV

In 2016, LV implemented the "Social Compass: social policy framework 2017–2020" (LV, 2017), aimed at fostering a sense of belonging and participation among its citizens. Prior to 2018, LV provided individual subsidy grants to social care providers. However, this approach lacked an integrated perspective on social care activities. To promote collaboration and harness the specialized knowledge of social care providers, LV launched subsidy tables in 2018 for general integrated preventive social care. It chose five subsidy tables based on their care and social policy agenda:

(1) *Growing up and upbringing:* Every child deserves a safe environment to grow up in. This is the basis for each child to develop into a self-reliant inhabitant that contributes to society. In order to achieve this youth needs a safe and healthy environment in and around families that leads to opportunities.

(2) *Financial, digital and lingual self-reliance:* Financial self-reliance leads to a good sense of self and participation. LV's goal is for its inhabitants to be financially self-reliant and have sufficient language and digital skills to participate in society.

(3) *Integration, basic skills and talent development:* By investing in basic skills and talents, inhabitants can grow as individuals. This increases their sense of self and increases their chance to acquire skills that contribute to society in a way that suits them best.

(4) *Self-reliance:* Inhabitants should lead their own lives and not be (extensively) reliant on municipal social care. Self-reliance increases a sense of self.

(5) *Belonging and inclusive:* The Netherlands is known for its tolerance, but acceptance of some others lags. LV aims for solidarity and inclusiveness. A strong sense of community and civil society increases inhabitants' self-reliance. Bringing together community actions increases a sense of community support.

4.2 Regulatory and financial framework

Based on the social policies and the Subsidy Regulation (LV, 2019a), the council of mayor and aldermen (B&W) [1] has established specific rules for the subsidy tables (LV, 2019d). The Subsidy Regulation allows the municipality to commission "activities" for social care, not services. This distinction is important because commissioning services could be framed as market competition as defined by European Competition Legislation.

Subsidy tables do not make decisions on subsidies. They formulate an advice for B&W. Each subsidy table reports on targets, activities and results and finances. Because the subsidy table is not a formal entity, each participant will request its own subsidy grant and also provide a financial account. The subsidy tables work with a yearly financial cycle. However, requests for proposals are formulated for a period of two years.

Participation in the subsidy tables is no guarantee for subsidy or any other financial income. For participants, that have received subsidies during a longer period of time, and receive substantially less or no subsidy can apply for financial support for the necessary friction costs. Participants pursue collaborative professionalism.

For each subsidy table, B&W prepared formal requests for proposals (LV, 2019c). These four to eight-page documents provided current background information about the situation to be addressed, which policy goals are involved, what is excluded from the request, how monitoring will be done, and the available budget. They zoom into specific social care policies and should indicate which results the service delivery should achieve. And they set the financial rules and conditions for the joint proposals.

Participants at the subsidy tables have great freedom in their proposals. The proposals should be implemented at reasonable costs. This means that pricing should resemble prevalent prices. The participants take these requirements into account and provide considerations in their proposals.

The joint proposals should include:

(1) Considerations about the activities;

(2) Targets on policy goals;

(3) Monitoring indicators;

(4) Proposals from individual participants and individual requests for funding;

For the activities of the subsidy table participants, a total of €11.9mn was available. Compared to the total of subsidies granted for these policy goals, a budget cut of €150,000 had been made.

4.3 Participants

At the beginning of the process, there was no initial selection of participants and tables. Each participant had access to each table. All participants were already recipients of municipal subsidy grants and active in different policy fields. They are professional non-commercial or volunteer organizations that already provide social care in the municipality, meaning they have different levels of professionalism; some organizations are small voluntary bodies. Some of them have agreements with several municipalities in the region.

38 participants were involved in the subsidy tables. Growing up and upbringing (12), Financial, digital and lingual self-reliance (11), Integration, basic skills and talent development (8), Self-dependence (11), Sense of community and Inclusion (6). One participant participated at five tables, two at three and two at two.

Participants could include other municipal partners as advisory participants, like schools and the regional health care organization, that aren't entitled to subsidies. For example, the subsidy table dealing with Growing up and Upbringing asked schools to assist in defining the needs of children and young adults, and advise on the fitting social care.

4.4 Subsidy table reviews

The municipality organized over ten distinct sessions per subsidy table with social care providers. After the first iteration of the subsidy tables, all participants felt the outcomes

were underwhelming. While every table presented a joint proposal, most were merely replications of the previous year's individual provider proposals. There was a notable absence of genuine integrated social care initiatives and a lack of emphasis on enhancing client self-reliance.

In a formal review every table analyzed the situation and suggested improvements (LV, 2019b). In Table 1, the findings of the review are organized into questions and answers, and summarized.

LV's subsidy tables process, introduced to promote collaboration among social care providers and to deliver integrated services, has faced various hurdles:

(1) Lack of clear definitions and objectives for integrated care led to replication of existing activities and limited collaborative proposals.

(2) Participants struggled to balance collaboration with competitive strategies, resulting in proposals that often prioritized individual interests.

(3) Financial uncertainty and a lack of alignment between the subsidy tables process and the municipality's budget cycle created additional challenges.

(4) Participants had varying levels of professionalism, funding structures and operational scales, complicating joint proposals and pricing services.

(5) Difficulties in measuring outcomes and the lack of clear criteria led to uncertainty in assessing the effectiveness of proposals.

These challenges highlight gaps in LV's subsidy tables process, providing a foundation for redesigning the commissioning approach. The findings section will explore these issues in detail, integrating insights from both this case study and the literature review to offer a comprehensive framework for redesign.

5. Findings

This section offers an analysis of the challenges and opportunities in commissioning integrated social care in LV. The findings address key research elements, exploring how to design a process that ensures integrated care, balances collaboration with professional autonomy and introduces effective incentives.

5.1 Enduring integrated social care

While the subsidy tables were intended to promote collaboration among social care providers and deliver integrated services, several factors hindered the realization of these goals. The absence of clear definitions and objectives for integrated care was a key issue. This lack of clarity was evident in both the case study and the literature review, which revealed over 175 overlapping definitions of integrated care, with no consensus on a definitive definition. In LV's case, this ambiguity led to varied interpretations and inconsistent applications of integrated care principles among participants, making it difficult to align their efforts towards a common goal.

Participants also lacked information about each other's activities. This information asymmetry, traditionally between the principal and the agent, also surfaced among collaborative agents.

Participants at the subsidy tables, possibly as a defensive mechanism, focused on replicating their existing activities rather than proposing new, integrated solutions. Those had been accepted in previous years, so could not be disregarded. This was a direct reflection of the challenges highlighted in the literature, where collaboration and integration are often hindered by unclear goals and objectives.

About the process at the subsidy tables

Were participants informed about the process of the subsidy tables to reach joint proposals?

Yes

Were participants able to adjust the process of the subsidy tables to reach joint proposals?

Yes

Were participants informed about the rules of subsidy tables?

Yes

Was each step in the process clear?

No

Were participants able to follow the steps in the process?

No

Did the process help with reaching a joint proposal?

No

Were there any steps in the process that made it difficult to reach a joint proposal?

- The goal of the subsidy table was clear, however the steps in the process weren't (well) defined
- The request for proposals was formulated during the collective process for the subsidy tables, and not available at the beginning
- Participants discussed how they would work together in order to reach a joint proposal
- At the beginning of the process, the budget was not defined. That made discussions difficult. The budget cycle of the municipality did not run parallel to the work at the subsidy tables.
- The Covid-19 pandemic gave uncertainty about the available budgets for the subsidy tables.

About the participants

Were all participants known to each other?

Some

Were participants aware of each other's social care activities?

Not for all

What differences existed between participants?

- Most participants were already subsidized
- Some participants had other funding resources, but requested subsidies
- Most participants have different forms of funding. (1) fully subsidized organization: organizations that are solely dependent on local government subsidies; (2) partially subsidized organization: organizations that have their own income next to certain subsidized activities; (3) subsidized organization through separate activities: separate activities may be financed with separate subsidies; (4) lumpsum subsidized organization: the organization is fully financed based on a general public task
- Some participants have employees, some have a lot of volunteers, others have a combination
- Some organizations operate regionally, others operate only locally
- For some participants, if they receive less subsidies than before, it will probably mean laying off employees
- Some participants have a seat at more than one subsidy table, others are only involved with one
- Participants have different sizes in terms of employees and annual budget.

If any, what effect did the differences have on reaching a joint proposal?

- It was hard to judge the services of other participants and its effects
- Not every participant was able to price their services
- A lot of time is spent figuring the finances. That took time away from formulating joint proposals

Were there any participants that should not have been admitted to the subsidy table?

No

There was discussion about the mental health care institution. They are not funded by subsidies. They request subsidies for social care projects. That funding would not be available for other participants. And the projects would mean more work for other participants at the subsidy table. A letter by three participants was written to the council of B&W to protest the situation

About the results

Were participants aware of the required results in the requests for proposals?

Yes

Did the joint proposal address the required results?

(*continued*)

Table 1. Review of subsidy tables

No

If not, why not?

- Due to the difficulty of the process at the subsidy tables and the uncertainty of the available budgets, most participants opted to continue their activities
- Some of the policy goals are very abstract, so that it is not easy to indicate how activities will improve them
- It isn't always clear how activities affect the policy goals
- Preventive interventions are difficult to measure. For the youngest youth, there is a consensus that interventions in the first 1,000 days yields the best results
- The table Growing up and Upbringing managed to break down their population in specific groups, which helped describing the results and which helped formulate joint proposals
- It isn't clear what criteria the council of B&W use to assess the joint proposal
- There was almost no effort to combine activities for a better result

Were the required results leading for the discussion about the joint proposals?

No

If not, why not?

Most of the discussions at the subsidy tables were about the process and/or about the finances

Did the council of B&W adjust any joint proposals?

- At one of the tables the participants agreed on a joint proposal that went over budget. The council of B&W refused the proposal and requested one the fit the budget. The participants agreed to each reduce their budget by a fixed percentage
- At one of the tables an existing meeting place for the elderly was no longer proposed. The municipal council requested the council of B&W to re-instate it, without increasing the budget.

Strategies used by participants

Which strategies were used by participants?

- Most participants merely proposed existing activities
- Some participants suggested that part of their subsidy would be better spent with another participant. They expected that other participants would do the same, but that didn't happen
- Some participants formally protested that other participants with different funding would be subsidized at the expense of their organizations

Table 1. **Source(s):** Authors' own work

The case study's findings reinforce the need for clear, shared goals, information and definitions in the commissioning process. The literature emphasizes the importance of a shared purpose and vision for successful integration, which was lacking in LV's process. More than that, a clear process of commissioning would have helped. LV apparently opted to do an extensive consultation process with the social care providers instead.

The redesigned commissioning process needs to establish clear objectives and definitions for integrated care, ensuring that all participants are aligned in their efforts.

5.2 Collaboration vs competition

The case study reveals tensions between collaboration and competition in the subsidy tables process. That many participants in the subsidy tables tended to propose existing activities rather than developing joint proposals, could indicate a competitive mindset: opting to maintain their individual projects, and protect their funding, over collaborating with others, thereby limiting the potential for integrated care solutions.

This finding suggests that the Agency theory, emphasizing self-interest of individuals and organizations, is the theoretical framework in play. Based on the societal theme and non-profit character of the participants, one would have expected Stewardship theory to offer an alignment between the municipality and the participants. Based on the extensive consultation by LV of the social care providers, they seem to have worked within the stewardship framework. This may also explain the lack of incentives.

5.3 Incentive structures

The focus on maintaining the status quo reflects a need for incentive structures that can motivate participants to pursue integrated care solutions. Literature highlights the importance of incentive structures that can align participants' goals and reduce competition. Agency theory emphasizes monetary incentives as a way to achieve this. Stewardship theory, on the other hand, emphasizes outcome-based incentives, where successful service delivery and client outcomes serve as a motivating factor for care providers. However, there is a lack of definitive structures of incentives to promote collaboration for integrated care.

In the context of LV's subsidy tables, integrating both monetary and outcome-based incentives may help guide participants to pursue integrated care solutions that address policy goals.

5.4 Professional autonomy and collaboration

Professional autonomy is one of the objectives promoted by social care legislation. This seems to have inspired LV to do an extensive consultation with the social care providers. However, the municipality could have attempted to direct that professionalism more. They are professionals in social care, but maybe not in the design of a commissioning process. They may have an interest in their clients, but maybe less in the overall societal and financial outcome.

Participants ranged from small voluntary bodies to larger organizations with steady funding and a broader scope of services. Even between the larger, professional organizations these disparities led to difficulties in pricing services, evaluating participants' contributions and aligning activities towards joint goals. These factors contributed to a focus on maintaining existing activities, limiting the potential for collaboration and integrated care solutions.

The literature suggests that collaborative design can still allow for professional autonomy, but the subsidy tables lacked clear processes to enable this balance. Collaborative models, such as alliance contracting, can foster cooperation while allowing professionals to leverage their expertise. LV's process did not provide for this.

To address these issues, the redesigned commissioning process needs to establish clear processes that balance collaborative goals with professional autonomy.

5.5 Monitoring and evaluation

The case study reveals that the difficulty of measuring social care outcomes led to uncertainty in proposals and assessments. From the point of view of the participants, outcomes could have been the improved care of their clients. For the municipality, financial gains or a preventive effect on other forms of care, could be required outcomes. A lack of clear criteria for evaluating integrated care activities, which made it challenging for participants to understand how their efforts aligned with policy goals.

The literature emphasizes the importance of clear, measurable outcomes and monitoring mechanisms to ensure successful integrated care delivery. Integrated care frameworks should incorporate mechanisms for ongoing monitoring and evaluation, allowing for adjustments and improvements as needed. This approach also addresses information asymmetry between principals and agents, ensuring that outcomes are both observable and verifiable.

5.6 Transaction costs

The only provision about transaction costs concerning the subsidy tables is related to participants who will have less subsidy grants as a result of the joint proposals. They can apply for financial support for the necessary friction costs. The costs of integrating care have not been discussed, but could impair collaboration if they are too high. This issue will need to be addressed in the commissioning process redesign.

The findings reveal key challenges and opportunities in commissioning integrated social care, particularly in terms of ensuring integrated care, balancing collaboration with professional autonomy, establishing incentive structures and dealing with certain transaction costs. These insights, drawn from both the case study and the literature review, provide a foundation for redesigning the subsidy tables process.

6. Recommendations

One of the notable findings involves the lack of a clear procedure and evaluation framework for joint proposals, which is common in service contracts. The municipality's initial consultation process lacked guidance for participants about their roles and key decision points. This led to confusion and ineffective collaboration. To address this, we propose two distinct processes:

(1) *Request for proposal consultation process:* The municipality leads and determines the use of consultation for unified proposals.

(2) *Collaborative proposal process:* Social care providers spearhead this, with the municipality playing a supportive role.

Clarifying these processes will streamline roles and responsibilities. Additionally, adding client representation into the consultation alters service triad dynamics, enhancing feedback mechanisms.

Error! Reference source not found. Describes the original the individual grant process, and the author's prescription for the two processes indicated above. For these two processes, Table 2 underscores the complexity and nuances of each approach while emphasizing the importance of collaboration and clarity.

The comparison with the original individual grant process indicates the differences, but especially the added workload for both the social care providers and B&W.

6.1 Consultation process

The municipality leads this process, clarifying policy goals, commissioning process goals and identifying target groups. In the case study the table on Growing Up and Upbringing managed to distinguish difference groups that need different support.

This process involves defining self-reliance for each target group, outlining outcomes for each, and identifying where and how integrated social care is more effective than individual activities. The consultation adds a discussion on goals, groups and the shape of integrated care. For this topic, there is discussion on the acceptable costs of integrated care, if they turn out to be higher. This not only addresses the topic of transactions costs, but could also suggest incentives when integrated care is less costly. Where participants might be reluctant to lower their budgets, the municipality could propose a financial incentive, balanced with the social outcome.

The Consultation process focusses the participants on their professionalism, autonomy and expertise. This process also allows the client representatives to provide valuable insights into the expected outcomes for the clients. The consultation also makes it possible to introduce mechanisms for ongoing monitoring and evaluation, allowing for adjustments and improvements as needed. It concludes with a formal request for joint proposals, providing a clear roadmap for participants.

6.2 Collaborative proposal process

Once the Consultation process delivers goals and expectations, the social care providers start their proposal process, working collaboratively to design actionable proposals that align

	Individual grant process	Request for proposal consultation process	Collaborative proposal process
Goal	For social care providers to propose social care activities that fit municipal social care policies	For the municipality to do a request for actionable joint proposals that fit municipal social care policies and outcomes	For the social care providers to propose actionable joint proposals that fit municipal social care policies and outcomes
Key steps	1 Clarify policy goals for specific social care provider 2 Discussion on activities that fit the budget. 3 Proposal submission	1 Clarify policy goals, and goals of commissioning process 2 Identify target groups 3 Define self-reliance for target groups 4 Define outcomes per target groups 5 Identify where and how integrated social care is more effective than individual activities 6 Basic discussion on activities that fit the budget. 7 Formalize a request for joint proposals for social care activities	1 Tune target groups 2 Tune activities that support target groups towards more self-reliance 3 Tune benefits of integrated activities 4 Discuss level of integration needed 5 Identify costs of integration v expected outcomes 6 Focus on (integrated) activities that fit the budget. 7 Formalize joint proposals for social care activities
Duration Stakeholders involved	Three + meetings Municipality and social care provider	Duration: four + meetings Municipality, social care provider and client representation	Duration: five + meetings Municipality, social care provider and client representation
Advantages	1 Clear and simple lines of communication 2 Easy process	1 Integrated approach for specific target groups is easier to achieve 2 Better view of costs and benefits of integrated approach 3 Managed expectations about outcomes 4 Responsibility for integration lies with collaborating social care providers 5 Allows for innovations in joint approaches 6 Better request for proposals because of supplier consultation	1 Social care providers can test their proposals with municipality and clients in an early stage 2 Better view of costs and benefits of integrated approach 3 Managed expectations about outcomes 4 Allows for innovations in joint approaches 5 Better proposals because of municipal and client consultation
Challenges	1 Many social issues require integrated care. Discussions with individual social care providers places the responsibility of integration with the municipality, not the social care provider 2 With one social care provider it is difficult to discuss results on a societal level. It's only possible to monitor if the activities have been implemented 3 A discussion about activities instead of outcomes is not conducive for innovation	1 Process is more complicated 2 Social outcomes will always keep a level of vagueness and difficulty in relating activities to social outcomes 3 Greater possibility of shifting budgets between social care providers	1 Process is more complicated 2 Social outcomes will always keep a level of vagueness and difficulty in relating activities to social outcomes 3 Greater possibility of shifting budgets between social care providers, and possibility that a social care provider will not be included in the proposals 4 A higher level of uncertainty for the social care providers who may resist changes in the process

Source(s): Authors' own work

Table 2. Three commissioning processes for integrated general and preventive social care

with policy goals. The process involves refining target groups, fine-tuning activities that support them and balancing integration costs against expected outcomes. Adding client representation to the consultation alters the service triad dynamics, enhancing feedback mechanisms and aligning proposals with clients' needs.

This process encourages open communication between participants and includes client representation to ensure proposals reflect their needs. It ends with joint proposals from each subsidy table. The evaluation of the proposals by the municipality should be easier after the consultation process' clarifications and definitions.

The recommendations do not aim to introduce bureaucratic elements. However, clarification of process, goals and outcomes is necessary to implement integrated social care. In almost every aspect involved terms and outcomes are ambiguous that need further definition. The two prescribed processes take the theoretical en empirical review into account. The clarification involved streamlines roles and responsibilities, ensuring participants understand their place in each stage.

The following discussion will explore how these recommendations integrate insights from the literature and case study, highlighting their implications for both practice and theory.

7. Discussion and implications

The case study and literature review provide a broad theoretical framework for understanding the challenges and opportunities in commissioning integrated social care. By reviewing a wide range of topics, this paper introduces extra context for the commissioning of integrated care. The tension between Agency theory and Stewardship theory as defining framework is evident. Both seem to be applicable up to a certain extent. Further research into where one could delineate them is necessary. This also opens further investigation on incentives for integrated social care, where both financial and outcome aspects are involved. The introduction of the costs of collaboration (transaction costs) can be useful when doing further study on incentives.

A well-defined and extensive consultation process involving both social care providers (suppliers), the Service Triad, and client representation adds to the existing research on supplier consultation, and on how to define the outcomes for clients via client engagement.

The paper introduces a new framework for the study of the new "subsidy tables." At the moment, research is incidental and related to more legalistic aspects (Drahmann *et al.*, 2021).

Given the multifaceted nature of the subsidy tables, the ambiguousness of social care and local politics, our study cannot claim to be exhaustive. Theories such as policy implementation theory, stakeholder theory, theory of change and resource dependence theory may delve deeper.

Notes

1. B&W refers to "college van burgemeester en wethouders," the executive board consisting of the mayor (burgemeester), who is appointed by the king, and several aldermen (wethouders) who are elected by the municipal council.

References

Allers, M.A. and de Greef, R. (2018), "Gemeentelijke samenwerking verlaagt uitgaven meestal niet", *Openbare Financiën ESB*, No. 18, pp. 38-41.

Allers, M.A. and Geertsema, J.B. (2016), "The effects of local government Amalgamation on public spending, taxation, and service levels: evidence from 15 Years of municipal consolidation: effects of local government amalgamation", *Journal of Regional Science*, Vol. 56 No. 4, pp. 659-682, doi: 10.1111/jors.12268.

Amelung, V., Stein, V., Suter, E., Goodwin, N., Nolte, E. and Balicer, R. (Eds). (2021), *Handbook Integrated Care*, Springer International, Cham, doi: 10.1007/978-3-030-69262-9.

Amsler, L.B. and O'Leary, R. (2017), "Collaborative public management and systems thinking", *International Journal of Public Sector Management*, Vol. 30 Nos 6-7, pp. 626-639, doi: 10.1108/IJPSM-07-2017-0187.

Ansell, C., Sørensen, E. and Torfing, J. (2017), "Improving policy implementation through collaborative policymaking", *Policy and Politics*, Vol. 45 No. 3, pp. 467-486, doi: 10.1332/030557317X14972799760260.

Appleton, P., Hung, I. and Barratt, C. (2021), "Internal conversations, self-reliance and social support in emerging adults transitioning from out-of-home care: an interpretative phenomenological study", *Clinical Child Psychology and Psychiatry*, Vol. 26 No. 3, pp. 882-893, doi: 10.1177/13591045211005827.

Bardsley, M., Stevenson, A., Smith, J. and Dixon, J. (2013), *Evaluating Integrated and Community-Based Care: How Do We Know what Works?*, Nuffield Trust, London, p. 24.

Bech, M. and Pedersen, K.M. (2005), *Transaction Costs Theory Applied to the Choice of Reimbursement Scheme in an Integrated Health Care System*, University of Southern Denmark, Denmark.

Billings, J. and de Weger, E. (2015), "Contracting for integrated health and social care: a critical review of four models", *Journal of Integrated Care*, Vol. 23 No. 3, pp. 153-175, doi: 10.1108/JICA-03-2015-0015.

Bokkes, W. (2019), "Maatschappelijke initiatieven, subsidies en transactiekosten", *Beleidsonderzoek Online*, No. 1, doi: 10.5553/BO/221335502019000001001.

Braun, D. and Guston, D.H. (2003), "Principal–agent theory and research policy: an introduction", *Science and Public Policy*, Vol. 30 No. 5, pp. 302-308, doi: 10.3152/147154303781780290.

Brink, C. (2013), "Zelfregie eigen kracht zelfredzaamheid en eigen verantwoordelijkheid", *MOVISIE*, available at: https://www.movisie.nl/publicatie/zelfregie-eigen-kracht-zelfredzaamheid-eigen-verantwoordelijkheid-begrippen-ontward

Bryson, J.M., Crosby, B.C. and Stone, M.M. (2006), "The design and implementation of cross-sector collaborations: propositions from the literature", *Public Administration Review*, Vol. 66 No. 1, pp. 44-55, doi: 10.1111/j.1540-6210.2006.00665.x.

Caers, R., Bois, C.D., Jegers, M., Gieter, S.D., Schepers, C. and Pepermans, R. (2006), "Principal-agent relationships on the stewardship-agency axis", *Nonprofit Management and Leadership*, Vol. 17 No. 1, pp. 25-47, doi: 10.1002/nml.129.

Carnwell, R. and Carson, A. (2005), "Understanding partnerships and collaboration", in *Effective Practice in Health and Social Care: A Partnership Approach*, Open University Press, New York, pp. 3-20.

Clark, M., Ryan, T. and Dixon, N. (2015), "Commissioning for better outcomes in mental health care: testing Alliance Contracting as an enabling framework", *Mental Health and Social Inclusion*, Vol. 19 No. 4, pp. 191-201, doi: 10.1108/MHSI-07-2015-0026.

Corsten, D. and Felde, J. (2005), "Exploring the performance effects of key-supplier collaboration: an empirical investigation into Swiss buyer-supplier relationships", in Kopfer, H. (Ed.), *International Journal of Physical Distribution and Logistics Management*, Vol. 35 No. 6, pp. 445-461, doi: 10.1108/09600030510611666.

Curry, N. and Ham, C. (2010), *Clinical and Service Integration: The Route to Improved Outcomes*, The King's Fund, London, available at: https://www.kingsfund.org.uk/publications/clinical-and-service-integration

Denters, B., Jonker, J. and Rijnkels, H. (2019), "Draagkracht als alternatief voor zelfredzaamheid", *Sociaal Bestek*, Vol. 81 No. 1, p. 4.

Drahmann, A., Jongkind, D.K., Verboeket, L.W., van den Brink, J.E. and Ortlep, R. (2021), "Aan tafel! De subsidietafel in de netwerksamenleving: Een eerste verkennend onderzoek", in *Bestuursrecht in het echt: Vriendenbundel voor prof. mr. drs. Willemien den Ouden. Deventer*, Wolters Kluwer, pp. 87-107, available at: https://hdl.handle.net/1887/3278657

Dudevszky, S. and Lohman, S. (2015), *Activering Sociale Netwerken: Een onderzoek naar het vergroten van zelfredzaamheid door de inzet van Eigen Kracht-conferenties in Rotterdam*, Wmo, Werkplaats Rotterdam.

Eggink, E., Woittiez, I. and de Klerk, M. (2020), *Maatwerk in meedoen: Een vergelijking van zelfredzaamheid, hulpbronnen en kwaliteit van leven tussen mensen met en zonder een verstandelijke beperking*, Sociaal Cultureel Planbureau, Den Haag.

Fleishman, R. (2013), *Addressing Trans-boundary Challenges through Collaboration: How Organizations 'Harmonize' Actions and Decisions across Problem Landscapes*, Syracuse University Syracuse University, available at: https://surface.syr.edu/etd/5

Gibbons, R. (1998), "Incentives in organizations", *NBER*, Vol. 12 No. 4, pp. 115-132, doi: 10.1257/jep.12.4.115, available at: http://www.nber.org/papers/w6695

Grudinschi, D., Sintonen, S. and Hallikas, J. (2014), "Relationship risk perception and determinants of the collaboration fluency of buyer–supplier relationships in public service procurement", *Journal of Purchasing and Supply Management*, Vol. 20 No. 2, pp. 82-91, doi: 10.1016/j.pursup.2014.03.004.

Ham, C. (2011), "Integrated care: What is it? Does it work? What does it mean for the NHS?", *The King's Fund*, p. 8.

Ham, C. and Walsh, N. (2013), *Making Integrated Care Happen at Scale and Pace*, The King's Fund, London, p. 8, available at: https://www.kingsfund.org.uk/publications/clinical-and-service-integration

Head, B.W. (2019), "Forty years of wicked problems literature: forging closer links to policy studies", *Policy and Society*, Vol. 38 No. 2, pp. 180-197, doi: 10.1080/14494035.2018.1488797.

Heuzels, L.H. (2017), *Decentralisations in the Dutch Social Care Sector: researching Approaches of Municipal Commissioning of Social Care on Patient Perceived Quality of Care and Self-Reliance*, Universiteit of Twente, Drienerlolaan.

Hoegl, M. and Wagner, S.M. (2005), "Buyer-supplier collaboration in product development projects", *Journal of Management*, Vol. 31 No. 4, pp. 530-548, doi: 10.1177/0149206304272291.

Hughes, G., Shaw, S.E. and Greenhalgh, T. (2020), "Rethinking integrated care: a systematic hermeneutic review of the literature on integrated care strategies and concepts", *The Milbank Quarterly*, Vol. 98 No. 2, pp. 446-492, doi: 10.1111/1468-0009.12459.

Hughes, G., Shaw, S.E. and Greenhalgh, T. (2022), "Why doesn't integrated care work? Using Strong Structuration Theory to explain the limitations of an English case", *Sociology of Health and Illness*, Vol. 44 No. 1, pp. 113-129, doi: 10.1111/1467-9566.13398.

Humphries, R. and Wenzel, L. (2015), *Options for Integrated Commissioning: beyond Barker*, The King's Fund, p. 64, available at: https://www.kingsfund.org.uk/publications/options-integrated-commissioning

Jensen, C. and Meckling, H. (1976), "Theory of the firm: managerial behavior, agency costs and ownership structure", *Journal of Financial Economics*, Vol. 3 No. 4, pp. 305-360, doi: 10.1016/0304-405X(76)90026-X.

Laan, A., Voordijk, H. and Dewulf, G. (2011), "Reducing opportunistic behaviour through a project alliance", *International Journal of Managing Projects in Business*, Vol. 4 No. 4, pp. 660-679, doi: 10.1108/17538371111164065.

Laugesen, M.J. and France, G. (2014), "Integration: the firm and the health care sector", *Health Economics, Policy and Law*, Vol. 9 No. 3, pp. 295-312, doi: 10.1017/S1744133114000139.

Lenkens, M., Rodenburg, G., Schenk, L., Nagelhout, G.E., Van Lenthe, F.J., Engbersen, G., Sentse, M., Severiens, S. and Van De Mheen, D. (2020), "I need to do this on my own resilience and self-reliance in urban at-risk youths", *Deviant Behavior*, Vol. 41 No. 10, pp. 1330-1345, doi: 10.1080/01639625.2019.1614140.

Li, M. and Choi, T.Y. (2009), "Triads in services outsourcing: bridge, bridge decay and bridge transfer", *Journal of Supply Chain Management*, Vol. 45 No. 3, pp. 27-39, doi: 10.1111/j.1745-493X.2009.03169.x.

Lupton, C. (1998), "User empowerment or family self-reliance? The family group conference model", *British Journal of Social Work*, Vol. 28 No. 1, pp. 107-128, doi: 10.1093/oxfordjournals.bjsw.a011302.

LV (2017), "Sociaal Kompas, beleidsplan sociaal domein 2017-2020", *Gemeente Leidschendam-Voorburg*.

LV (2019a), "Algemene subsidieverordening leidschendam-Voorburg 2019", available at: https://lokaleregelgeving.overheid.nl/CVDR624567/1 (accessed 6 September 2022).

LV (2019b), "Evaluatie proces nieuwe werkwijze subsidies", *Gemeente Leidschendam-Voorburg*.

LV (2019c), "Initiatiefvragen subsidietafels 2020", *Gemeente Leidschendam-Voorburg*.

LV (2019d), "Spelregels subsidietafels 2021-2022", *Gemeente Leidschendam-Voorburg*.

MacAdam, M. (2008), *Frameworks of Integrated Care for the Elderly: A Systematic Review*, Canadian Policy Research Networks, p. 35.

Mandell, M. and Steelman, T. (2003), "Understanding what can be accomplished through interorganizational innovations the importance of typologies, context and management strategies", *Public Management Review*, Vol. 5 No. 2, pp. 197-224, doi: 10.1080/1461667032000066417.

Marek, L.I., Brock, D.-J.P. and Savla, J. (2015), "Evaluating collaboration for effectiveness: conceptualization and measurement", *American Journal of Evaluation*, Vol. 36 No. 1, pp. 67-85, doi: 10.1177/1098214014531068.

Mediavilla, M., Mendibil, K. and Bernardos, C. (2017), "Game theory in supplier selection process: an action research study", *24th EurOMA Conference*, Edinburgh, Scotland, p. 11, available at: https://www.researchgate.net/publication/326996766_Game_theory_in_supplier_selection_process_An_action_research_study

Meinema, T. (2017), *Wat Werkt Bij Eigen Regie*, Movisie, Utrecht, p. 29.

Nelson, K.M., McKinnon, A.I., Farr, A., Rance, J.Y. and Phillips, C.J. (2018), "The development of a collaborative framework for commissioning health and social care", *Journal of Integrated Care*, Vol. 26 No. 4, pp. 286-295, doi: 10.1108/JICA-01-2018-0001.

Orrego, C., Ballester, M., Perestelo, L. and Sunol, R. (2016), "Patient empowerment as a promising avenue towards health and social care integration: results from an overview of systematic reviews of patient empowerment interventions", *International Journal of Integrated Care*, Vol. 16 No. 6, p. 347, doi: 10.5334/ijic.2895.

O'Flynn, J. (2009), "The cult of collaboration in public policy", *Australian Journal of Public Administration*, Vol. 68 No. 1, pp. 112-116, doi: 10.1111/j.1467-8500.2009.00616.x.

O'Leary, R. and Vij, N. (2012), "Collaborative public management: where have we been and where are we going?", *The American Review of Public Administration*, Vol. 42 No. 5, pp. 507-522, doi: 10.1177/0275074012445780.

Relampagos, C. (2020), *Collaboration in Public Administration*, California State University, Northridge.

Roberts, J.L. and Huberfeld, N. (2015), "Health care and the myth of self-reliance", *SSRN Electronic Journal*, [Preprint]. doi: 10.2139/ssrn.2647808.

Rose, D. and Willemain, T.R. (1996), "The principal-agent problem with adaptive players", *Computational and Mathematical Organization Theory*, Vol. 1 No. 2, pp. 157-182, doi: 10.1007/BF01299067.

Różyk-Myrta, A., Brodziak, A., Derkacz-Jedynak, M. and Sudoł-Malisz, M. (2021), "Various aspects of caring for elderly people in the interest of their self-reliance and independence, according to own propositions", *International Journal of Occupational Medicine and Environmental Health*, Vol. 34 No. 3, pp. 339-350, doi: 10.13075/ijomeh.1896.01570.

Sanderson, M., Allen, P., Gill, R. and Garnett, E. (2018), "New models of contracting in the public sector: a review of alliance contracting, prime contracting and outcome-based contracting literature: new models of contracting in the public sector: a review of alliance contracting, prime contracting and outcome-based contracting literature", *Social Policy and Administration*, Vol. 52 No. 5, pp. 1060-1083, doi: 10.1111/spol.12322.

Smith, J. (2001), *Alliance Contracting: When is it the Best Project Delivery Method? Master*, University of South Australia, London.

Sniderman, P.M. and Brody, R.A. (1977), "Coping: the ethic of self-reliance", *American Journal of Political Science*, Vol. 21 No. 3, p. 501, doi: 10.2307/2110579.

Stiles, R.A., Mick, S.S. and Wise, C.G. (2001), "The logic of transaction cost economics in health care organization theory", *Health Care Management Review*, Vol. 26 No. 2, pp. 85-92, doi: 10.1097/00004010-200104000-00010.

Tsiachristas, A. (2016), "Financial incentives to stimulate integration of care", *International Journal of Integrated Care*, Vol. 16 No. 4, p. 8, doi: 10.5334/ijic.2532.

Uenk, N. (2019), *Commissioning of Social Care Services: Municipal Commissioning Approaches for Social Care Services – Evidence from a Countrywide Live Experiment*, Universiteit Utrecht, available at: https://dspace.library.uu.nl/handle/1874/383180

Uenk, N. and Telgen, J. (2019), "Managing challenges in social care service triads – exploring public procurement practices of Dutch municipalities", *Journal of Purchasing and Supply Management*, Vol. 25 No. 1, pp. 5-17, doi: 10.1016/j.pursup.2018.08.001.

Van Slyke, D.M. (2006), "Agents or stewards: using theory to understand the government-nonprofit social service contracting relationship", *Journal of Public Administration Research and Theory*, Vol. 17 No. 2, pp. 157-187, doi: 10.1093/jopart/mul012.

Vernon, A. and Qureshi, H. (2000), "Community care and independence: self-sufficiency or empowerment?", *Critical Social Policy*, Vol. 20 No. 2, pp. 255-276, doi: 10.1177/026101830002000204.

Victor, J. and Paulo, A. (2023), "Transaction costs in healthcare: empirical evidence from Portuguese hospitals", *Cogent Business and Management*, Vol. 10 No. 2, 2220479, doi: 10.1080/23311975.2023.2220479.

Vlind, M. (2012), *Zelfregie in de praktijk – Een kwalitatief onderzoek naar eigen regievoering van kwetsbaren in de zelfredzame samenleving*, Universiteit Amsterdam, Vrije.

Walker, H., Bakker, E., Schotanus, F. and Harland, C. (2008), "Choosing an organisational form: the case of collaborative procurement initiatives", *International Journal of Procurement Management*, Vol. 1 No. 3, p. 297, doi: 10.1504/IJPM.2008.017527.

Walker, H., Schotanus, F., Bakker, E. and Harland, C. (2013), "Collaborative procurement: a relational view of buyer-buyer relationships", *Public Administration Review*, Vol. 73 No. 4, pp. 588-598, doi: 10.1111/puar.12048.

Zwaard, W.van der (2021), *Omwille van fatsoen: de staat van menswaardige zorg*, Den Haag, Boom bestuurskunde.

Corresponding author
Floor Kist can be contacted at: floor@floorkist.nl