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Decentralization of social policy in the Netherlands

Wouter Vermeulen

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Abstract

The Netherlands has recently embarked on a considerable decentralization of social policy. As of 2015, municipalities have new responsibilities in the domains of youth care, long-term care and income support. This contribution discusses some of the associated opportunities and risks. The grant design incentivizes municipalities to minimize expenditure on their new tasks, which may yield efficiency gains but also entails a risk of underprovision. The ever larger role of municipalities in social-service provision fosters the exploitation of economies of scope, but some important interactions with policies for which other parties are responsible remain. In particular, health-care insurers become partly responsible for the provision of home care and institutional care remains a central government task. This may induce underprovision of municipal services and substitution towards services provided by other parties. Finally, the efficient scale for provision of some of the decentralized services, such as specialized youth care, appears to exceed the size of many municipalities. A brief discussion of policies to take optimal advantage of the opportunities and mitigate the risks concludes the paper.

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1 Introduction

As of 1 January 2015, municipalities in the Netherlands have acquired important tasks in three broad domains of social service provision. They became responsible for all youth care services, ranging from universal and preventive services to highly specialized care. Through a major reform of the long-term care system, municipalities also acquired an important role in the assistance of people with physical or mental health problems in their home environment. Finally, they now provide income support for less than fully disabled persons who have no employment history (as opposed to former employees), as well as social welfare services such as mediation, training and subsidized employment. This decentralization on the expenditure side is not accompanied by a decentralization of revenues. Instead, the new tasks are funded through a lump-sum central government grant that takes account of differences in spending needs. As a result, the total grant amount from the central government has risen by about 25 per cent, or roughly one per cent of Gross Domestic Product.

One important source of motivation for these decentralizations is the expectation that as municipalities become the main supplier of social services, they will be better able to tailor provision to individual needs. In particular, the scope for overall efficiency enhancement through prevention and early intervention is believed to be considerable. Municipalities are in a position to invest in such policies and shifting the burden of more involved types of support and care onto them means that they may also reap the rewards, thus strengthening their incentive. As municipalities are expected to perform the decentralized services more efficiently, their budget is cut considerably relative to prior expenditure on these tasks. In the wake of the Great Recession and the need for fiscal consolidation it entails, these budget cuts constitute the second important source of motivation.

What are the main opportunities and risks of the decentralizations from an economic point of view? This contribution provides an overview, largely drawing on two earlier reports that CPB Netherlands Bureau for Economic Policy Analysis wrote at the request of the central government (CPB, 2013; 2014).2 After a more detailed discussion of each of the decentralizations in turn (section 2), we will focus on three broad themes. The first is the role of financial incentives for municipalities (section 3). While the decentralizations strengthen financial incentives for cost-efficiency in the social domain, we will discuss several externalities that make these redistributive services prone to underprovision. This risk is particularly relevant for services for which the level of provision is difficult to measure and enforce.

A second theme is the interaction between different types of services (section 4). On the one hand, broadening the range of services that are locally provided may enhance efficiency through economies of scope. On the other hand, interaction of decentralized services with

[2] CPB Netherlands Bureau for Economic Policy Analysis is an independent think tank that performs scientific research aimed at contributing to the economic decision-making.

services provided by the central government or other parties may give rise to externalities or undesired substitution. Information on the use of social services at the individual level allows for a crude assessment of the relevance of these opportunities and risks quantitatively for the long-term care and labour-market domains. While economies of scope appear to dominate in the domain of income support and social welfare services, interaction of municipal care with long-term care provided by the central government and by health insurers gives rise to considerable risks. In particular, as the central government remains responsible for institutional care, municipalities are not rewarded for investments that enable clients to stay at home and there is an incentive to substitute home care for institutional care.

Loss of scale economies is the third theme that will be touched upon in this contribution (section 5). This is particularly relevant for specialized types of youth care, for which both the number of users and the number of providers per municipality are small. High transaction costs and limited bargaining power appear to necessitate intermunicipal cooperation for the largest part of the youth care budget. However, intermunicipal cooperation has its own drawbacks, such as reduced accountability. The paper concludes with a discussion of policies to take optimal advantage of the opportunities and mitigate the risks of the decentralizations (section 6).

2 The three decentralizations

This section provides some more detail on each of the three decentralizations in turn. With regard to youth care, responsibilities were highly fragmented prior to 2015. Municipalities were mainly responsible for universal and preventive services, aimed to facilitate the normal development of children. Provinces provided or coordinated more specialized care and support in case of serious development and / or parenting problems, either residential or at home, as well as youth protection, youth probation and foster care. Health insurance companies were responsible for youth mental health care. The central government was responsible for the most specialized types of care, long-term care for physically or mentally disabled youths, as well as for juvenile justice policy and related institutions. As of 2015, municipalities carry the administrative and financial responsibility for almost all of these tasks, while their budget is cut by about 10 per cent relative to previous expenditure.

Municipal tasks in the domain of home care prior to the present decentralizations included provision of benefits for the disabled, such as transportation, a wheel chair or home improvements, and assistance in daily housekeeping activities like cleaning and shopping. The central government was responsible for the largest part of long-term care, including the part of home care not covered by municipalities. The decentralization of long-term care to municipalities is part of a wider reform of the long-term care system, in which health insurers also obtain new responsibilities. The general idea is that the central government remains responsible for institutional care and that the responsibility for home care is split between health insurers and municipalities, with medical care (nursing, bathing, dressing)

going to the insurers and nonmedical care – a mix of rather heterogeneous services ranging from training in the use of medical aids, assistance in the organization of daily structure to social day care – going to the municipalities. For these tasks, their budget is cut by about 10 per cent relative to previous expenditure. Furthermore, the municipal budget for assistance in daily housekeeping activities is roughly halved. At the same time, access to institutional care will become considerably more restrictive, which should raise the demand for home care. Municipalities are supposed to accommodate these budget cuts by tightening eligibility criteria, by appealing more on informal care and by increasing their reliance on universal rather than individual services, such as community centre work. They can also charge user fees.

Municipalities were already responsible for social assistance and welfare to work programs for people with full ability to work. The present decentralizations extend this responsibility to less than fully disabled persons who have no employment history, whereas eligibility criteria for income support are tightened for this group. The reform applies to new applicants and not to people who make use of disability insurance already. The central government remains responsible for this latter group, as well as for fully disabled persons. This implies that, unlike the other two decentralizations, it will take several decades for this reform to come fully into effect. The amount of the structural budget cut is therefore considerably less certain. One unknown on which it depends is the extent to which less than fully disabled persons will succeed in finding employment. The central government estimates that expenditure on this group will roughly halve. Furthermore, the provision of employment in sheltered workshops for less than fully disabled persons will be drastically reduced and municipalities, who become financially responsible, should resort to other social welfare services such as wage subsidies instead. This reform is estimated to yield a cut of about 25 per cent of the current budget for sheltered workshops.

3 Externalities and the risk of underprovision

The decentralizations create the opportunity to encourage cost-efficient provision of social services through financial incentives. The new tasks are funded with an unconditional block grant, which provides strong incentives for municipalities to exploit their knowledge about local needs and costs and to implement policies that minimize spending. The agencies that previously carried out the decentralized tasks did not face such high-powered incentive schemes. For example, the regional agencies that previously provided home care could not claim the remainder of their budget, whereas costs exceeding this budget were compensated if due to exceptional circumstances. This lack of strong financial incentives in a sector that is prone to supplier-induced demand may have resulted in overspending. The steep rise in the

use of specialized youth care, witnessed over a period in which the number of youths hardly increased, may also reflect overspending.[3]

Experiences with previous decentralizations of social assistance and assistance in daily housekeeping activities underline the importance of financial incentives. In 2004, the central government transformed the funding of municipal welfare provision from a 75 per cent matching grant into an unconditional block grant – although various insurance mechanisms remained in place. This incentivized municipalities to enforce the eligibility criteria more strictly and to provide effective welfare to work programs. The total number of welfare recipients has decreased as a result.[4] In 2007, municipalities became responsible for assistance in daily housekeeping activities and they were funded through an unconditional block grant. This led to a reduction in expenditure, partly because municipalities substituted more basic for more advanced types of assistance and partly because they were able to reduce tariffs of providers considerably in the procurement process.[5]

While the strong financial incentive to minimize municipal spending may enhance cost-efficiency, it also entails a risk that municipalities provide less of the decentralized services than socially desirable. The redistributive nature of these services provides a first source of externalities. As emphasized by the classical literature on fiscal federalism, an incentive to underprovide redistributive services arises when beneficiaries tend to move to the municipalities in which provision is most generous.[6] This type of shopping behaviour in the Tiebout sense certainly occurs, but perhaps not on a scale that seriously undermines local social service provision. With regard to the present decentralizations, the risk appears to be most relevant for youth care, as young families are generally more mobile than elderly recipients of long-term care.

An incentive for underprovision also arises in the absence of household mobility, when the altruistic value that people attach to redistribution transcends municipal boundaries. This would imply that locally provided social services benefit the entire society, whereas individual municipalities bear the full burden. The quantitative significance of such altruistic preferences is difficult to measure, but there appears to be a widely felt aversion towards intermunicipal variation in the level of social services − particularly in the health care domain.[7] Reducing this level thus imposes a cost on society that is not internalized by individual municipalities. A flip-side to this argument is that proximity to the needy may actually raise the demand for redistribution.[8] It is more difficult to ignore suffering when it occurs at your doorstep. This suggests that the risk of underprovision may vary according to the proximity of municipal inhabitants to the beneficiaries of the newly decentralized social services. For example, people may be more aware of how their municipality treats the

[3] SCP (2011) documents that between 2000 and 2009, the annual growth in the use of specialized youth care amounted to about 7 percent, whereas the number of youths grew by 0.25 per cent per year over this period.
[4] Van Es (2010) reports that the decentralization has reduced the number of welfare recipients by about 8%, mainly due to a higher outflow.
[5] SCP (2010) documents that in 2008, municipalities spent 16 per cent less on assistance in daily housekeeping activities than the budget received from the central government, while the total number of hours provided did not fall.
[6] See Boadway and Wildasin (1984) for a textbook treatment.
[7] Allers et al. (2013) report results from a questionnaire that indicate the widespread aversion towards differences in the level of social service provision across municipalities.
[8] The notion of redistribution as a local public good originates from Pauly (1973).

elderly in need of long-term care, than of the treatment of youths in need of mental health care, simply because more people have needy elderly in their family or social network.[9]

A third source of externalities that may induce local underprovision is the interaction of decentralized social services with services that are provided by other parties.[10] For example, when welfare provision was decentralized to municipalities in 2004, the central government remained financially responsible for the income support of disabled persons with no employment history. As it is not always easy to draw a line between the disabled and other welfare claimants, the two programs are to some extent substitutes. Municipalities faced a strong financial incentive to divert claimants to the centrally financed income support program, which increased considerably as a result.[11] Such externalities appear to be relevant for the present decentralizations as well, particularly in the domain of long-term care. The next section will explore this issue in more detail.

The externalities discussed above do not have to lead to underprovision, if the central government can enforce a minimum level of service provision. Decentralized social services vary in the extent to which the government does or is able to do so. There are, for example, precise conditions for welfare eligibility, even if access to substitutes such as disability insurance is not always easy to delineate. For the newly decentralized long-term care services, objective measurement and enforcement of quality standards appear to be difficult.[12] Measurement and enforcement are likely to be even harder for specialized youth care. There are, therefore, limits to the extent to which the central government can mitigate risks of underprovision through monitoring and regulation in these domains. Moreover, regulation reduces the scope for municipalities to tailor provision to individual needs. Hence, municipalities are granted considerable leeway in determining eligibility – particularly in the domain of long-term care.

The impact of financial incentives also depends on the extent to which municipalities spend grants on the budget categories to which they relate. The stickiness to budget categories – even for grants of a lump-sum nature – is known in the literature as the flypaper effect. It mitigates the impact of incentives on cost-efficiency, while offering some safeguard against underprovision at the same time. For assistance in daily housekeeping activities, it appears that about half of a change in the grant that is unrelated to changes in needs is nonetheless spent on this service.[13]

[9] A related argument is that the provision of these services may hold some insurance value, as people may need them in the future (Hoynes and Luttmer, 2011).
[10] See Marton and Wildasin (2007) for a formal analysis of this type of externality in the context of substitution between welfare and Medicaid in the US.
[11] Roelofs and Van Vuuren (2011) find that since the 2004 decentralization of welfare, at least one third of inflow into the disability insurance program was diverted from social assistance
[12] CPB and SCP (2015) document the considerable regional variation in utilization of different types of long-term care, as well as a widespread discrepancy between formal assessments of individual needs and the actual utilization of care. This analysis applies mostly to care for which the central government was responsible and for which provision was supposed to be uniform across the country.
[13] See Kattenberg and Vermeulen (2015). This paper also finds an impact on the number of hours provided, whereas substitution between basic and advanced types of assistance appears to be an important channel of adjustment.

4 Interaction between different types of social services

The ever larger role of municipalities in the provision of social services may allow them to take advantage of economies of scope. Information sharing is probably an important source of such economies. For example, providers of assistance in daily housekeeping activities may signal the need for other types of home care, or providers of job seeking assistance may signal mental problems. Sharing information will be easier if provision of the implied social services is the responsibility of one party, the municipality. This, in turn, will facilitate the match of services to individual needs. Economies of scope may also arise through sharing of other costs, for instance relating to administration or accommodation.

The transformation of social service provision that is now taking place appears to be tailored to the exploitation of economies of scope indeed. Many municipalities have set up neighbourhood teams that determine eligibility for social services and provide some of these services themselves. The teams are partly staffed by generalists – social workers with sufficient knowledge across all domains to make an overall assessment of the needs of a client. This approach is motivated by the fact that many households make use of multiple services at the same time. A generalist may be better able to coordinate these services. The assignment to specific neighbourhoods should reinforce the acquaintance of the social workers with local inhabitants and the local issues at play.

Another advantage of the increase in municipal responsibilities in the social domain is that it reinforces the incentive to invest in prevention. The overall need for social support may decrease if problems are diagnosed and addressed in an early stage. If the more involved types of support that are saved upon are a municipal responsibility, then their efforts in this respect are rewarded. The neighbourhood teams and the generalist approach are indeed set up with the explicit objective to facilitate prevention and early intervention.

Incentives are not as well aligned when different parties are responsible for related services. Municipalities have no financial incentive to invest in preventive policies that reduce expenditure of, for instance, health insurers or the central government. A further issue arises when substitutable services are provided by different parties, as this creates an incentive for diversion. The rise in uptake of disability insurance after the 2004 decentralization of welfare provision, discussed in the previous section, illustrates the relevance of this mechanism. An important empirical question is therefore to what extent the newly decentralized services relate to either services for which municipalities are responsible already, or to services provided by other parties.

To what extent do the newly decentralized services interact with other municipal services, or with services for which other parties are responsible? CPB (2014) provides some insight into this question by exploring data on the use of a wide range of social services in the domains of

care and income support at the individual level. The data refer to usage in 2011. Services may be classified into services that are now decentralized, services for which the municipality was already responsible and services provided by other parties. Of all users of services that are decentralized as of 2015, 58% would now use municipal services only. Of this group, 38% used services from multiple providers before. However, 42% of all users of the newly decentralized services also made use of social services that are provided by other parties. This suggests that the decentralizations may indeed foster the exploitation of economies of scope for certain groups, but also create risks of underinvestment and diversion for others.

Classifying the services into income support, care for which the municipalities are now responsible and care for which either the central government or health insurers are responsible provides some insight into the composition of these groups. Consider all users of care for which the municipalities are now responsible. Of this group, 24% also received income support from programs for which the municipalities are now responsible. Economies of scope may therefore be realized for the group of people that combine income support with the use of nonmedical home care. Assistance in daily structure, for example, may help clients in getting fit for the labour market. Municipalities have an incentive to invest in this type of care, as it may ultimately reduce their expenses on welfare. For some people, social day care and sheltered work may be substitutable, so municipalities are in a better position to allocate them to the appropriate type of support now that they are responsible for both. Moreover, as municipalities are now responsible for both welfare and income support of people with limited ability to work, the risk of undesired substitution between social assistance and disability insurance is reduced. Hence, it seems that the decentralizations offer some significant opportunities for the exploitation of economies of scope when it comes to the interaction between care, income support and social welfare services.

With regard to the long-term care sector as a whole, however, incentives do not appear as well aligned. Of all users of care for which the municipalities have become responsible, 42% also made use of care for which either the central government or health insurers are now responsible. For the group that combines municipal home care with home care provided by the health insurers, there may be underinvestment on behalf of municipalities in for instance training in skills that reduce the need for nursing. Social day care may prevent mental problems that would require medical care. For the group that used municipal home care and institutional care within the same year, diversion is a relevant risk, as home and institutional care may be close substitutes. This is relevant, for instance, for elderly people suffering from dementia. Moreover, municipalities have little incentive to invest in care for people who are or may become eligible for institutional care. The risk of underinvestment also matters for the municipal support of informal care givers, who may play an important role in reducing the demand for care by other providers – including institutional care.

With regard to youth care, the decentralization offers significant opportunities for the exploitation of economies of scope, as municipalities become responsible for all kinds of youth care and the sector was highly fragmented before. Interactions with other types of social services may also be considerable. Nevertheless, some potential issues remain. One is

that at the family level, mental youth care may interact with mental care for adults and the latter is a responsibility of the health insurers. Health care insurers also bear financial responsibility for general practitioners and the provision of medicines. Finally, the payoff of effective treatment of childhood physical and mental health problems may last well into adult live and is unlikely to be fully internalized by individual municipalities.[14]

5 Scale and cooperation between municipalities

One of the potential disadvantages of decentralization is the loss of scale economies, as lower levels of government necessarily cater to smaller populations – in the Netherlands, the average number of inhabitants per municipality amounts to about 40 thousand. Our discussion in this section will focus on youth care, for which this issue seems particularly relevant. For most specialized forms of youth care, the average number of users per municipality does not exceed fifty and for some forms it is even considerably smaller. For example, the average number of users per municipality of the most specialized type of residential youth care equals four. In contrast, this average is about 150 for the most basic types of youth care and almost twice that number for the most common type of home care that recently has been decentralized. Developing policies and contracting providers for only a handful of youths are costly and making arrangements at a higher level of aggregation allows sharing these fixed costs over a larger number of users.

Economies of scale also prevail in the provision of specialized youth care. Hence, the number of providers in a region is typically small. For example, the average number of providers within a range of 25 kilometres from a municipality equals one for the most specialized type of residential youth care and it equals two or three for most other types of specialized care. This means that municipalities have little choice and providers have considerable bargaining power in the procurement process. Municipalities may increase their countervailing power and get a better deal by making arrangements at a higher level of aggregation.

The law of large numbers is another source of scale economies that seems particularly relevant for specialized youth care. There is a random element in the need for care that evens out when the population gets larger. For small municipalities, though, the demand for specialized types of care may be quite unpredictable and as specialized care tends to be costly, this involves considerable uncertainty about expenditure needs. Under the current financial arrangements, the financial risk is entirely borne by municipalities, but it may be reduced by risk sharing at a higher level of aggregation.

[14] Goodman et al. (2011) document the considerable long-term consequences of childhood physical and mental problems in several areas, including labour market performance and lifetime income. The effects of psychological health disorders during childhood appear to be far more important over a lifetime than physical health problems.

Against this background, it is no surprise that municipalities cooperate on the provision of specialized youth care. It turns out that about ninety per cent of the entire budget for youth care will be spent by cooperations of municipalities. These cooperations carry out the procurement, and in some cases, also share financial risks. Procurement of the most specialized types of care is even coordinated at the national level.

Although intermunicipal cooperation in the provision of youth care facilitates the exploitation of scale economies, it comes at the expense of reduced accountability.[15] In contrast to municipal governments, these cooperations are not directly accountable to an electorate. Furthermore, the influence of individual municipalities is diluted in these large cooperations, which for youth care consist of about ten municipalities on average. Reduced accountability may lead to a lower quality of care or higher costs. The ability to tailor policies to local circumstances and exploit economies of scope within the youth care sector and the wider social domain is also diminished.

6 Conclusions and policy

The ever larger role of municipalities in the social domain may create economies of scope and the grant system incentivizes to fully exploit them. The decentralizations may thus enhance the efficiency of social service provision. Nevertheless, there are several externalities that may induce municipalities to underprovide these services and some important scale economies may be lost – or recouped at the expense of reduced accountability.

These opportunities and risks play out differently in the three domains in which responsibilities were decentralized. Prior to the decentralizations, the youth care sector was particularly fragmented, so it stands to gain most from the exploitation of economies of scope, although the efficient scale of provision of specialized youth care – the largest part of the budget – exceeds the size of most municipalities. Underprovision is also a concern, as objective measurement and enforcement of a minimum service level are particularly difficult in this sector. The risk of underprovision of municipal home care is reinforced by the interaction with other segments of the long-term care sector, which may lead to costly diversion to institutional care. Interaction of home care with income support and social welfare services may generate economies of scope. Furthermore, decentralization of disability insurance mitigates a diversion problem in the domain of income support.

What can be done to fully exploit these opportunities and mitigate the risks? In the first place, the funding of municipalities may be altered in various ways. Allocative efficiency and accountability in the local public sector may be enhanced by decentralizing revenues

[15] See Seabright (1996) for a formal analysis of the trade-off between the benefits of improved coordination at higher levels of aggregation and the costs in terms of reduced accountability.

alongside expenditures.[16] The share of municipal expenditure that is funded with local taxes is particularly low in the Netherlands from an international perspective.[17] A larger local tax base would also facilitate the absorption of shocks in social expenditures, which in turn strengthens the local budget constraint. Soft budget constraints may be a particularly relevant issue for the decentralized provision of care, as the central government would incur a significant political cost by allowing local governments to fail in providing these services.[18]

To the extent that the decentralized services remain funded through central government grants, it is not evident that an unconditional block grant provides the best incentives. The introduction of matching grants or other types of risk sharing provisions would mitigate the concern of underprovision.[19] Specialized youth care is perhaps the most obvious candidate, as both the risk of underprovision and the demand for insurance appear to be particularly relevant for this sector.[20] Moreover, voluntary risk sharing in cooperations may be insufficient because of an adverse selection problem: municipalities with the least favourable risk profile have the largest incentive to insure.

The risk of underprovision may also be addressed by conditioning grants on output measures. The inflow into institutional care may well be the most promising example. Rewarding a low inflow relative to a benchmark based on demographic and socioeconomic characteristics incentivizes municipalities to invest in preventive home care and it reduces the risk of diversion.

Grant design is not the only way to mitigate the risk of underprovision. The misalignment of incentives that arises through interaction with social services provided by the central government or other parties may alternatively be addressed by shifting these services to the municipal level too. The decentralization of income support and social welfare services for less than fully disabled persons who have no employment history provides an important example in this respect. Nevertheless, an allocation of tasks that removes all interactions between centrally and locally provided social services is unlikely to exist, as long as both layers of government remain involved.

The central government will also address the risk of underprovision by monitoring the quality of local social services in several ways. The collection of reliable and consistent information on local service provision and outcomes is important in this respect. Such

[16] See for instance Rodden (2003) or Oates (2005) for a general discussion of the merits of funding local spending by local taxes and Asatryan et al. (2015) for recent empirical evidence from OECD countries. Using micro-simulations for the Netherlands, Van Eijkel and Vermeulen (2015) find that distributional effects of a shift from the national earned income tax to either a tax on the use of residential real estate or a head tax may be reduced considerably by design of the reform.
[17] In 2010, this share averaged 37 per cent in all OECD countries, but it did not exceed 10 per cent in the Netherlands (OECD / KIPF, 2012).
[18] In a sample of OECD countries, Crivelli et al. (2010) find that soft budget constraints, as measured by reliance on central government funding and borrowing autonomy, increase decentralized healthcare spending. Nevertheless, in spite of generous provisions, municipal bailouts have been comparably rare in the Netherlands in recent decades (Allers, 2015).
[19] Wildasin (1991) shows that subnational governments may be incentivized to provide optimal redistribution through a system of matching grants. Moreover, as Smart and Bird (2009) point out, a grant that shares in actual costs may provide a second best way of targeting funds to where need is highest when cost drivers or need factors are difficult for the granting authority to measure accurately – which is typically the case when tasks are newly decentralized.
[20] For instance, when specialized youth care was decentralized in Denmark in 2007, an insurance fund was set up to compensate municipalities for excessive costs. In 2015, this fund covers 25 percent of expenses in excess of about 100.000 euros per client and 50 percent for expenses in excess of about 200.000 euros per client.

information also allows for benchmarking, which facilitates voters in the evaluation of their local government and enables municipalities to learn from best practices. Ultimately, innovation may well be one of the main fruits of decentralization, but reaping it requires thorough investments in the collection, analysis and exchange of information.

Finally, the scale economies involved in some of the new tasks raises the issue of efficient municipal size. Municipal amalgamation has been a persistent trend in Dutch history that is unlikely to stop in the near future. However, the trade-off with accountability also arises in this context – witness for instance the negative relationship between municipal size and turnout at local elections.[21] Furthermore, it is not obvious that the central government should play a proactive role in this respect.[22]

[21] Gerritsen and Ter Weel (2014) find that turnout in local elections falls with 2.5 percentage points after a municipal amalgamation. For municipalities in which the population size more than doubles, the effect is particularly strong and it lasts for several elections.

[22] As the number of municipalities involved in an amalgamation is usually small, transaction costs may be sufficiently limited for Coasian bargaining to achieve an efficient outcome.

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Publisher:

CPB Netherlands Bureau for Economic Policy Analysis
P.O. Box 80510 | 2508 GM The Hague
T +31 70 3383 380

info@cpb.nl | www.cpb.nl

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