

ORIGINAL RESEARCH

The Dutch long-term care reform: Moral conflicts in executing the Social Support Act 2015

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Abstract

On 1 January 2015, a new long-term care reform entered into force in the Netherlands, entailing amongst others a decentralization of long-term care responsibilities from the national government to the municipalities by means of a new law: the Social Support Act 2015. Given the often disputed nature of the reform, being characterized on the one hand by severe budget cuts and on the other hand by a normative reorientation towards a participation society, this article examines to what extent municipalities in the Netherlands take (potential) moral conflicts into account in their execution of the Social Support Act 2015. In doing so, the article applies a ‘coherentist’ approach (consisting of both rights-based and consequentialist strands of ethical reasoning), thereby putting six ethical principles at the core (non-maleficence & beneficence, social beneficence, respect for autonomy, social justice, efficiency and proportionality). It is argued that while municipalities are indeed aware of (potential) moral conflicts, the nature of the new law itself leaves insufficient room for municipalities to act in a sufficiently proactive and supportive/empowering manner on these challenges.

Keywords: ethical reasoning, long-term care reform, moral conflicts, The Netherlands.

Conflicts of interest: None.

Introduction

Background

In 2006, the Council of the European Union made reference to “a set of values that are shared across Europe” in its ‘Council Conclusions on Common Values and Principles in European Health Systems’ (1). The Council Conclusions stipulate that “[t]he health systems of the European Union are a central part of Europe's high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development. The overarching values of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions” (1). This set of values was subsequently reinforced a year later in the European Commission’s ‘White Paper Together for Health: A Strategic Approach for the EU 2008-2013’ (2), comprising the EU’s health strategy supporting the overall ‘Europe 2020’ strategy (3).

The healthcare sector, and more specifically the long-term care sector, has always been a source for ethical debate. Typical ethical issues (or moral conflicts) in long-term care decision-making include the debate on whether we should only look at people’s deficits or also to their rest capacities (4), “the nature and significance of the elder's diminished capacity for self-care and independent living”, the question “whether an older adult should continue to live at home”, “the obligation of the elder to recognize and respect the limits that family members may justifiably set on their care giving responsibilities”, a loss of autonomy “when the decision is made to change either the elder’s place of living or support services” and “the balance to be struck between independence and safety” (5).

However, as argued by Ranci and Pavolini (6), “[o]ver the past two decades, many changes have happened to the social welfare policies of various industrial countries. Citizens have seen their pensions, unemployment benefits, and general healthcare policies shrink as ‘belt tightening’ measures are enforced”. At the same time, Ranci and Pavolini (6) argue, “long-term care has seen a general growth in public financing, an expansion of beneficiaries, and, more generally, an attempt to define larger social responsibilities and related social rights”. Consequently, Pavolini and Ranci (7) conclude that “[f]aced with the problems associated with an ageing society, many European countries have adopted innovative policies to achieve a better balance between the need to expand social care and the imperative to curb public spending”. The adoption of such innovative policies is referred to here as reforms in long-term care policies.

The unfold of long-term care reforms even seems to be exacerbated in the aftermath of the 2008 economic crisis, when many European countries introduced austerity measures that in many cases appeared to have adverse effects on health systems and/or social determinants of health (8-12). Moreover, Schröder-Bäck et al. argue that “[t]he current protracted economic crisis is giving rise to the scarcity of public health resources in Europe. In response to budgetary pressures and the Eurozone public debt crisis, decision makers resort to a short-term solution: the introduction of austerity measures in diverse policy fields. Health and social policy tend to be easy targets in this regard, and budget cuts often include a reduction of healthcare expenditure or social welfare benefits” (13). Jongen et al. (14) add to this that “this crisis has had a much more direct and short-term influence on the quality of countries’ long-term care system than more gradual developments such as population aging and declining workforces, mainly due to austerity measures being the result of, or being accelerated by, this crisis”.

Also the Council Conclusions make reference to this changing context of many European countries’ long-term care system, by stating that “[i]t is an essential feature of all our systems that we aim to make them financially sustainable in a way which safeguards these values into the future” (1). Moreover, the document stresses patient empowerment, by stating that “[a]ll

EU health systems aim to be patient-centred. This means they aim to involve patients in their treatment, to be transparent with them, and to offer them choices where this is possible, e.g. a choice between different health care service providers” (1). At the same time, the Council Conclusions acknowledge that “[d]emographic challenges and new medical technologies can give rise to difficult questions (of ethics and affordability), which all EU Member States must answer. [...] All systems have to deal with the challenge of prioritising health care in a way that balances the needs of individual patients with the financial resources available to treat the whole population” (1).

Although sharing some characteristics, every long-term care reform is embedded within peculiar national traditions and is therefore unique. This is true all the more for the latest Dutch long-term care reform, that entered into force on 1 January 2015, and which can be considered as the latest major step in a more all-encompassing ‘market-oriented reform’ of the Dutch healthcare system in general. The 2015 reform can be characterized as having a “hybrid structure” (15), characterized, on the one hand, by a “reign in expenditure growth to safeguard the fiscal sustainability of LTC” (16), and on the other hand by a “multiplicity of regulations to safeguard public values” (15). More concretely, as argued by Maarse and Jeurissen (16), the 2015 long-term care reform consists of four interrelated pillars: expenditure cuts, a shift from residential to non-residential care, decentralization of non-residential care (implying a transfer of responsibilities in that policy domain from the national government to the municipalities), and a normative reorientation. The latter refers to the notion that “[u]niversal access and solidarity in LTC-financing can only be upheld as its normative cornerstone, if people, where possible, take on more individual and social responsibility. The underlying policy assumption is that various social care services may be provided by family members and local community networks” (16). Indeed, a general shift in focus from formal care provision to informal care provision is added by Jongen et al. (17) as a key element of the 2015 Dutch long-term care reform. It is, however, exactly this normative reorientation, and its underlying assumption of an increased informal care provision, that is often disputed. As argued by Maarse and Jeurissen (16): “An important line of criticism is not only that informal care is already provided at a large scale, but also that the potential of ‘unexplored’ informal care is overestimated. Furthermore, the negative externalities for caregivers who deliver informal care are underestimated”. Moreover, while residential care remains under the responsibility of the national government after the entry into force of the 2015 long-term care reform, and a large part of non-residential care came under the responsibility of the health insurers, it is the municipalities that became under the Social Support Act 2015 (SSC 2015) [in Dutch: *Wet maatschappelijke ondersteuning (Wmo) 2015*] responsible for particularly those parts of non-residential care dealing with support directed towards the social participation of people with severe limitations (in the wordings of the official legal text of the Social Support Act 2015 (authors’ own translation): “people with disabilities, chronic mental or psychosocial problems”), as well as with support for informal caregivers (17). Indeed, the official legal text of the Social Support Act 2015 stipulates that “citizens who themselves or together with people in their immediate environment are not sufficiently self-sufficient or insufficiently able to participate [in society], must be able to rely on organized support by the government” (authors’ own translation). However, municipalities have a large discretion in making this obligation to provide support concrete (the so-called ‘postcode [zip code] rationing’), which may lead to unequal access to long-term care in different municipalities (16).

Literature research

So far, the academic literature has not extensively scrutinized the potential moral conflicts resulting from the implementation of the Social Support Act 2015, and is more about

organization and logistics than about ethics. The available literature either touches upon mere elements of an all-encompassing ethical debate, or upon the perspective of specific groups. As an example of the former, van der Aa et al. (18) consider the presumed impact of the 2015 long-term care reform on such elements as good quality of care and solidarity. Van der Aa et al. argue that the above-mentioned ‘zip code rationing’ might well lead to differences between municipalities in the degree of solidarity as perceived by citizens (‘zip code solidarity’). Furthermore, van der Aa et al. argue that it should not be taken for granted that municipalities, by simply making an efficiency move, can guarantee an equal level of care quality with the decreased budget they are faced with for executing their new long-term care tasks. Next, Grootegoed and Tonkens (19) consider the impact of the Dutch shift in focus from formal to informal care provision on such elements as respect for autonomy or human dignity and argue that “the turn to voluntarism does not always prompt recognition of the needs and autonomy of vulnerable citizens” and furthermore that “the virtues of voluntarism may be overstated by policy makers and that the bases of recognition should be reconsidered as welfare states implement reform”. Examples of literature focusing on the perspective of specific groups include the articles by Dwarswaard et al. (20) and Dwarswaard and Van de Bovenkamp (21) on, respectively, self-management support considered from the perspective of patients and the ethical dilemmas faced by nurses in providing self-management support (whereby self-management is defined as “the involvement of patients in their own care process” (21), and in that way relates to the above-mentioned notion of individual responsibility).

Study objectives and research questions

No comprehensive ethical approach towards the impact of the Social Support Act 2015, however, appears yet to exist. The current study intends to fill in this gap, by answering the following research question: To what extent did/do municipalities in the Netherlands take potential moral conflicts into account when implementing and executing the Social Support Act 2015?

As the core of the 2015 Dutch long-term care reform is characterized by, on the one hand, severe budget cuts, and, on the other hand, by a normative reorientation towards a participation society wherein people are expected to take on more individual and social responsibility (16,17), we additionally formulated the following sub-research questions: 1. How do municipalities divide scarce resources in the social domain in a fair way?; 2. How do municipalities empower citizens towards a participation society? In answering both research questions we consider the potential moral conflicts experienced by municipalities, as executors of the Social Support Act 2015, with regard to those entitled (or proclaim to be entitled) to receive support on the basis of the Social Support Act 2015, as well as with regard to relatives providing informal care to the previous group. Despite the fact that the nature, as well as corresponding reforms, of individual countries’ long-term care systems differ, the systematic approach of assessing moral conflicts resulting from the introduction of new long-term policies as applied in this study could also be transferred to other countries where long-term care reforms are being implemented. At the same time, several policy lessons could be derived from the experiences of Dutch municipalities with the 2015 long-term care reform.

Methods

Research method and study design

To answer our research question, a mixed-method research approach was chosen. First, a document analysis was conducted, in order to explore if, and to what extent, ethical values and principles are literally incorporated in the legal text of the Social Support Act 2015. For

this analysis we only considered the primary source (the legal text itself) and no other, secondary documents (such as municipal policy documents). Second, policy advisors (responsible for the long-term care policy domain) of all 390 Dutch municipalities were invited to complete an online survey. Henceforth, no sampling technique had to be applied, although of course we had to compile a mail distribution list consisting of either the general e-mail addresses of municipalities, or the e-mail addresses of the specific departments the intended policy advisors are working. In some smaller municipalities these policy advisors were not only responsible for the long-term care policy domain, but for the whole social domain (next to the long-term care decentralization, municipalities were simultaneously also faced with decentralizations in the field of youth care and in the field of labor participation of people with an occupational disability); in large municipalities more than one person might be responsible for the long-term care policy domain. However, in our explanatory notes we specifically asked to forward our demand to one of the intended policy advisors, in order to avoid multiple respondents from the same municipality. The reason for choosing policy advisors, instead of politicians, had to do with the potential political bias that politicians might have with regard to the topic of this study. Indeed, the potential ethical implications surrounding the long-term care decentralization constitutes a politically sensitive issue in many municipalities, as clearly came to the forefront in one of the two test-interviews, which was conducted with the mayor of a municipality (the other test-interview was conducted with a professor of old age medicine). Moreover, while each municipality also has several so-called ‘Social Support Act consultants’ [in Dutch: *Wmoconsulenten*], who do the actual fieldwork, implying the one-to-one contact with individual (potential) clients, these employees are believed to lack an overarching helicopter view. In principle, participation in the online survey was anonymous, except when a respondent declared to be willing to participate in an in-depth telephonic interview. These in-depth interviews constituted the third step in our mixed-method research approach, and were intended to expand on the survey, instead of asking new questions. Anonymity of these respondents has been guaranteed by omitting persons’ and municipalities’ names here.

Theoretical framework and conceptual model

For the analysis of the potential moral conflicts surrounding the implementation and execution of the Social Support Act 2015, we applied a ‘coherentist’ approach (consisting of both rights-based and consequentialist strands of ethical reasoning) as offered by Schröder-Bäck et al. (22), thereby putting six ethical principles at the core that are considered to capture the specificities of the current study (non-maleficence & beneficence, health maximisation / social beneficence, respect for autonomy, social justice, efficiency and proportionality). Taking into account the variety of seemingly similar concepts such as ‘ethical dilemmas’, ‘moral conflicts’, ‘moral dilemmas’, et cetera, it should however first be clarified which definition is applied in this study and what is meant with it. Given the heavily-loaded connotation of the term ‘ethical dilemma’, we prefer the term ‘moral conflict’ here. Subsequently, based on the Stanford Encyclopaedia of Philosophy (23), we define a ‘moral conflict’ as follows: A moral conflict appears if one thinks one has good moral reasons to do one thing, but also good moral reasons to not do it, or do something that is in conflict with it. So either decision is not perfect. Or, in other words: a moral conflict arises if the moral norms and values we would like to follow guide us to conflicting/opposing actions. A coherentist ethical approach, then, implies that an ethical analysis “should be based on a variety of plausible norms and values” and that none of the traditional ethical approaches is therefore superior to the other (22). Instead, they all contribute important moral insights. Schröder-Bäck et al. (22) add to this that “their norms do weigh prima facie the same and need to be plausibly unfolded and specified in a given setting. When they are contextualised

and specified they develop their normative weight and power”. This prima facie status of the ethical principles thus “supports the process of careful ethical deliberation and reflection”. Moreover, specifying the more ‘overarching’ ethical approaches into a concise set of ethical principles is considered as a useful, practical, tool for medical and public health ethics (24). Each of these six principles will be discussed in detail in the following.

Non-maleficence and beneficence: non-maleficence implies that “a healthcare professional should act in such a way that he or she does no harm, even if her patient or client requests this” (25). Beneficence is connected to non-maleficence, the only difference being that non-maleficence involves the omission of harmful action and beneficence actively contributes to the well-being of others (25). Because of their intimate connection, both principles are considered under one heading here. Considering the overarching approaches to ethical reasoning as mentioned above, the principles of non-maleficence and beneficence correspond to the ‘do no harm’ principle under the consequentialist approach to ethical reasoning.

Health maximisation / social beneficence: although in the literature one can find either of these terms, we refer to social beneficence as the norm that says that it is a moral goal to improve the wellbeing of people on an aggregated population level. Social beneficence resembles in a significant way the consequentialist principle of utilitarianism. Utilitarianism is the ethical theory that requests from an action or omission to be in such a way that the maximization of best consequences would follow.

Respect for autonomy: the ‘respect for autonomy’ principle implies a tempering of the “paternalistic benevolence contained in the principles of non-maleficence and beneficence” (25). In that way, the ‘respect for autonomy’ principle is closely related to the ‘human dignity’ principle under the rights-based approach to ethical reasoning. Moreover, without taking into account the ‘respect for autonomy’ principle, it would under the principle of health maximisation / social beneficence alone be allowed “to use individuals (or whole groups) for other than their own ends and even sacrifice them if only this provided a greater net benefit, i.e. maximised health” (24).

Social justice: the principle of (social) justice as referred to under the rights-based approach to ethical reasoning can be considered another side constraint to the principle of health maximisation / social beneficence. As Schröder-Bäck et al. (24) put it: “It does not only matter to enhance the net-benefit; it also matters how the benefits and burdens are distributed”. Moreover, this also includes “a fair distribution of health outcomes in societies, which is often discussed in terms of public health as ‘health equity’” (25), which is considered by Daniels as a matter of fairness and justice (26). In fact, the principle of ‘equity’ constitutes the core of the values of the ‘Council Conclusions on Common Values and Principles in European Health Systems’. As Schröder-Bäck et al. (22) put it: “The other three overarching values can be conceptualised as specifications of equity (and of social justice).

Access to good quality of care and universality can be seen as a reiteration of the core demands of equity and justice”, while “solidarity is seen as a characteristic that describes the willingness of members of communities to be committed to the principle of justice or to each other”. In short, one could argue thus that “[j]ustice approaches in health care often demand nothing more than universal access to good quality care” (22). Or, as the World Health Organization (WHO) puts it: “universal health coverage (UHC) is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (27).

Efficiency: efficiency requires the efficient use and distribution of scarce health resources (24).

Proportionality:the principle of proportionality, finally, emphasizes that it is “essential to show that the probable public health benefits outweigh the infringed general moral considerations. All of the positive features and benefits must be balanced against the negative features and effects“ (24). In their ‘ethical criteria for immunization programmes’, Verweij and Dawson (28) combine the principles of efficiency and proportionality under one heading, by stating that a “programme’s burden/benefit ratio should be favourable in comparison with alternative [...] options”.

Data collection

For the document analysis, we specifically considered the presence of the values as stipulated by the ‘Council Conclusions on Common values and principles in European Union Health Systems’, as well as the six ethical principles elaborated on above. Next, for the survey and in-depth interviews, these principles have been broken down into representative survey/interview questions, allowing for a structured and comparative analysis of potential moral conflicts. Schröder-Bäck et al. (25) applied a similar approach within the context of developing a curriculum for a short course on ethics in public health programmes, by suggesting a checklist consisting of several questions around each of the ethical principles they applied in their study (largely comparable to the six principles as applied in the current study). With the respective author of that study, one question for each of the above six principles was chosen, adapting them to the specificities of the current study, and translated into Dutch (see Table 1 for the final survey/interview questions).

The reason for choosing merely one question per category had to do with the practical limitations of using open-ended questions in an online survey: based on Andrews (29) as well as on two test-interviews we conducted, the response rate to open-ended survey questions is considered to be substantially lower than in the case of closed-ended survey questions, especially when the number of questions would be too high. The questions covering each of the six ethical principles were preceded by a general question on the identification of potential moral conflicts (intended to trigger respondents, before directing them into the six predefined categories), and followed by two general questions on the way (if applicable) municipalities deal with the identified moral conflicts.

Data analysis

The document analysis implied a scrutinization of the presence (or non-presence) of the values and principles elaborated on above in the legal text of the Social Support Act 2015, either in terms of a literal incorporation in the legal text, or in terms of indirect referrals to the respective values and principles.

The data of the surveys and interviews were analysed through the application of a directed approach to qualitative content analysis (30). We chose for this approach, as it allows for an analysis that “starts with a theory or relevant research findings as guidance for initial codes” (30). In that way, we were enabled to directly apply our theoretical framework of ethical reasoning in the interpretation and categorisation of the research data, with the six predefined ethical principles as initial coding categories. Within each of these categories, we clustered the respondents’ answers in ‘dominant response clusters’ as a way of quantifying to some extent our qualitative survey results. This approach allowed for an organized inclusion of the main results in this article. Obviously, qualitative results can never completely be quantified, as each specific answer remains unique. Therefore, in order to add some extra weight to our results, we included direct respondents’ quotes to several of the dominant response clusters.

Table 1. Survey/Interview questions

Part 1: Identifying potential moral conflicts		
Q1: According to you, what are the most important moral conflicts (if any) your municipality has been faced with in the context of implementing and executing the Social Support Act 2015?		
Ethical principles	Original selected ‘check marks’(25)	Adapted questions
Ethical principle 1: <i>Non-maleficence & beneficence</i>	Overall, for both non-maleficence and beneficence, is it possible to assess whether more benefit than harm is produced by intervening (or not intervening) and, if so, on what side (benefit or harm) does the equation finally fall?	Q2: According to you, will more people (both care recipients as informal caregivers) have advantage or disadvantage as a result of the introduction of the Social Support Act 2015? How do these advantages and disadvantages look like?
Ethical principle 2: <i>Health maximization / social beneficence</i>	Does it [the proposed intervention] have a sustainable, long-term effect on the public’s health?	Q3: According to you, will the Social Support Act 2015 have a sustainable, long-term, effect on the quality of life of the entire (older) population?
Ethical principle 3: <i>Efficiency</i>	Awareness of scarcity of public money; saved money can be used for other goods and services.	Q4: According to you, how does your municipality deal with the availability of the scarce resources that are available for the Social Support Act 2015?
Ethical principle 4: <i>Respect for autonomy</i>	Does the intervention promote the exercise of autonomy?	Q5: According to you, does the Social Support Act 2015 provide sufficient opportunity for people’s freedom of choice with regard to the care and support they wish to receive (and the way how they receive it)?
Ethical principle 5: <i>(Social) justice</i>	Does the intervention promote rather than endanger fair (and real) equality of opportunity and participation in social action?	Q6: According to you, do people under the Social Support Act 2015 have an equal opportunity to live their lives the way they want (or, in other words: is the freedom of choice as mentioned in the previous question also practically possible for every person)?
Ethical principle 6: <i>Proportionality</i>	Are costs and utility proportional?	Q7: According to you, will costs and utility under the Social Support Act 2015 be proportional?
Part 2: Dealing with moral conflicts		
Q8: According to you, how does your municipality deal with the moral conflicts as identified under part 1? Or, in other words: what are your municipality’s solutions to these moral conflicts?		
Q9: According to you, are there, for your municipality, alternative ways of executing the Social Support Act 2015, that will lead to less moral conflicts?		

Results

Document analysis

In terms of the values as stipulated by the ‘Council Conclusions on Common values and principles in European Union Health Systems’, the legal text of the Social Support Act 2015 only literally makes reference to the value of ‘access to good quality care’, although quality of care should be understood here as ‘good quality of (social) support’. Indeed, as was explained in the previous chapter, the Dutch long-term care system is, as of 1 January 2015, divided into three laws, of which the Social Support Act 2015 constitutes the one mainly dealing with social types of care (directed at increasing or maintaining the self-sufficiency and social participation of vulnerable citizens) instead of traditional healthcare. The municipalities’ responsibility under this law can therefore best be understood as providing adequate social support services instead of providing actual healthcare services. Nevertheless, this focus on social types of care instead of traditional types of healthcare, or on ‘well-being’ instead of ‘health’ as a desired outcome of support, does not imply that the Social Support Act 2015 should not be based on certain key ethical values or principles. Also the Council Conclusions (1) go further than traditional healthcare, by implying that “[t]he health systems of the European Union are a central part of Europe’s high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development”. With regard to good quality of social support, then, Article 2.1.1 of the Social Support Act 2015 stipulates that “[t]he municipal council is responsible for the quality and continuity of services” (authors’ own translation), while Article 3.1 continues by stating that “[t]he provider shall ensure the provision of good quality services” (authors’ own translation). Services either refer here to ‘general services’ (in Dutch: *algemenevoorzieningen*), or to ‘customized services’ (in Dutch: *maatwerkvoorzieningen*). The latter, subsequently, is defined in the legal text as a “range of services, tools, home adaptations and other measures, tailored to the needs, personal characteristics and capabilities of a person” (authors’ own translation). Solidarity is by definition an important component of this law, and is referred to in the first sentence of the legal text, which points out that “citizens bear a personal responsibility for the way they organize their lives and participate in society, and that may be expected of citizens to support each other in doing so to the best of their ability” (authors’ own translation). The values of universality and the, more overarching, value of equity (being part of the principle of social justice in our theoretical framework) are indirectly referred to in the introduction of the legal text by stating that “citizens who themselves or together with people in their immediate environment are not sufficiently self-sufficient or insufficiently able to participate [in society], must be able to rely on organized support by the government” (authors’ own translation). As a result of the limited literal inclusion of these ethical values, it is not surprising that the more specified ethical principles derived from these values are hardly included in literal terms in the legal text neither. The only exception here is the ‘respect for autonomy’ principle, that could be derived from the wording of Article 2.1.2 (4.c), which stipulates that municipalities in their social support policy should specifically take the freedom of choice into account of those citizens that are entitled to customized support services.

Survey and interviews

Having considered the literal inclusion of the ethical values and principles in the legal text of the Social Support Act 2015, a next step in our research process was to examine to what extent municipal policy advisors consider the execution of the Social Support Act 2015 to be in compliance with the six ethical principles as applied in this study. In totality 70 policy advisors completed the survey, constituting 18 per cent of Dutch municipalities. In total, ten

of these respondents also appeared to be willing to participate in an in-depth interview. The results of the surveys and in-depth interviews are described question by question in the following section and discussed simultaneously (as the in-depth interviews were intended to expand on the survey results instead of asking new questions). Given the number of respondents, only those answers that most frequently resulted from our analysis (the ‘dominant response clusters’ mentioned above) are discussed here. The direct respondents’ quotes that are included are believed to represent the respective cluster best and are the authors’ own translations from Dutch to English.

Question 1 (general identification of moral conflicts). Although not all respondents confirmed the existence of moral conflicts with regard to the implementation and execution of the Social Support Act 2015, most respondents did identify one or more moral conflicts. In general, our respondents identified three types of moral conflicts. First, the conflict of adhering to the Social Support Act’s underlying theory of moving towards a participation society vs. the limited budget and time-frame that is offered to municipalities for supporting this change process. Indeed, the theoretical idea of moving towards a society wherein citizens take up more individual and social responsibility and where care and support is provided on a customized basis and closer to home, is considered by many as a positive normative development. However, the severe budget cuts that accompany the long-term care decentralization (expected to lead to budgetary shortfalls), as well as the rapidity of the reform process, hamper municipalities’ opportunities for supporting this development. Or, as one respondent put it: “Pragmatism prevails over quality demands”. Second, respondents identified the conflict of how to efficiently coordinate responsibilities between the three different long-term care Acts. The fact that municipalities under the long-term care reform only got responsibility for parts of the long-term care sector might lead to unclarity and confusion, not the least among (potential) recipients of care/support, regarding under which Act one is entitled to care/support. Moreover, some respondents indicated that an insufficient coordination between the three laws sometimes results in a lack of incentives among municipalities to invest in prevention and informal care support, as the financial benefits of these investments might not be evident for the ‘own law’, but only for the ‘other laws’. The third moral conflict identified relates to the correct assessment of citizens’ self-sufficiency and their ability to social participation vs. their care/support needs and the urge to empowerment. The fact that municipalities have a large policy discretion in executing their responsibilities under the Social Support Act 2015 even complicates this point, as similar situations might well lead to different assessments in different municipalities. Particularly difficult, then, is how to justify these differences to citizens.

Question 2 (ethical principle 1: non-maleficence and beneficence). Most respondents appeared to have a rather neutral stance when it comes to assessing the non-maleficence and beneficence of the Social Support Act 2015, arguing that the Act leads to advantages for some and disadvantages for others, especially on the short-term. Or, as one respondent put it: “It depends on the individual perception of people whether they experience the introduction of the new Social Support Act as an advantage or a disadvantage”. Moreover, getting used to a new situation always takes time, especially for those citizens that were already entitled to care or support under the pre-2015 situation. Advantages primarily include the provision of customized care closer to home, in line with people’s specific living conditions, instead of standard care provisions like in the pre-2015 situation. Disadvantages primarily include the, already above-mentioned, high degree of policy discretion of municipalities regarding their allocation of support measures—which tends to lead to perceptions of ‘unfairness’ or ‘subjectivity’ among citizens—, a lower level of formal care provision as experienced by individual citizens and consequently the increasing burden on informal caregivers.

Question 3 (ethical principle 2: health maximization / social beneficence). The decreasing level of formal care provision can also be considered as a disadvantage on a societal level, when considering the more long-term expected consequences of the implementation of the Social Support Act 2015. At the same time, a decreasing level of formal care provision is not considered by all respondents as a disadvantageous development. As one respondent put it: “If we execute it [the Social Support Act 2015] well, this will increase quality of life. However, this also entails that we should carefully deal with informal caregivers”. One of the more long-term advantages is indeed believed to be the creation of a better awareness and appreciation among citizens about care in general, as a result of the diminishing resources for formal care provision, leading to a more inclusive society—characterized by the emergence of a new quality of life—wherein people have a better esteem of their own possibilities as well as a better appreciation of each other. At the same time, many respondents pointed out that this ‘emergence of a new quality of life’ is not so much due to the Social Support Act 2015 (or the long-term care reform in general), but more to overarching trends such as demographical developments (people get older and older), technological developments in healthcare (which facilitate people in achieving a decent quality of life) and changing ways of thinking about care in general (such as other perspectives on civic engagement and patient empowerment). As one respondent put it: “The quality of life has always had a different standard than the generation before”. Or, as another respondent put it: “Laws don’t have an influence on quality of life”.

Question 4 (ethical principle 3: respect for autonomy). Respect for autonomy was considered by most respondents as being sufficiently covered by the Social Support Act 2015, specifically through the inclusion of the freedom of choice as mentioned under Article 2.1.2 of the Social Support Act 2015. Concretely, the freedom of choice as referred to in Article 2.1.2 implies either the choice between several by the municipality selected providers (when one is entitled to customized care services) or a fully open choice (when one is entitled to a personal budget). Yet, respondents did put several remarks to this freedom of choice. First, due to the large discretion municipalities have in executing the Social Support Act 2015, the interpretation of freedom of choice differs between municipalities (indeed, some municipalities offer a larger selection of providers than others). As one respondent put it: “The new Social Support Act isn’t designed as to ‘support wishes’, nor as a ‘right to support’”. Therefore, there is a strong dependence on supplemental local rules”. Second, in practice, freedom of choice is not always considered as an added value by people, especially by vulnerable people that are often just looking for good quality support. As one respondent put it: “For that [freedom of choice] there is little attention among people. Moreover, it is questionable whether that is actually needed; people merely want good quality care instead of freedom of choice” (author’s own translation).

Question 5 (ethical principle 4: social justice). In line with the previous question, the question about social justice was basically about people’s capabilities of making use of their right to freedom of choice. Answers to this question were divided. On the one hand, many respondents considered the majority of people that are entitled to support under the Social Support Act 2015 to be indeed capable of making use of their right to freedom of choice. Moreover, when necessary, support is offered to clients by the municipality. As one respondent put it: “The municipality is actively cooperating with ‘client supporters’ to facilitate people as good as possible in their freedom of choice” (these ‘client supporters’ are people that work independently from the municipality). On the other hand, other respondents emphasized that not everyone, especially vulnerable groups in society, are capable of applying their freedom of choice, neither has everyone a social network at her/his disposal to support them in doing so. Moreover, freedom of choice depends to some extent on people’s

own resources. Indeed, under the Social Support Act 2015, the own financial contributions people are expected to pay for the care/support they receive have grown as compared to the pre-2015 situation, which might lead to the avoidance of care/support (31). As a result, respondents argue, differences in society grow when it comes to the possibility of people to make use of their freedom of choice under the Social Support Act 2015. As one respondent put it: “A barrier to care is created, that leads to a split in society: if you have money you can buy care yourself; if you little money you’ll have to do it with a stripped care system”.

Question 6 (ethical principle 5: efficiency). With regard to the allocation of scarce resources, respondents’ views could be divided into three main groups. One part considered the budget available for the execution of their long-term care responsibilities, which was substantially lowered as compared to the pre-2015 situation, to be leading in the allocation of resources, implying that care/support demands are (according to these respondents) considered more critically—on the basis of stricter indications—as compared to the pre-2015 situation. As one respondent put it: “The resources are distributed as indicated by the national government”. Moreover, some municipalities try to focus on general (collective) support services instead of on customized (individual) support services in order to remain within their budgetary margins. A second groups considered demand to be key in decision-making, implying that as much as possible is done to do what is necessary, at least for the most vulnerable groups. In case of shortages, solutions are (according to these respondents) considered to be the appeal to general municipal resources or the transfer of resources from other policy domains within the municipality. Indeed, many municipalities are currently searching for more integral ways of working between the different parts of the social domain within their municipality (17). One respondent formulated it as follows: “It starts with the client and we do what is necessary; many roads lead to Rome”. A third, though smaller, group took a more neutral stance and considered the underlying idea of the long-term care reform (truly progressing towards a participation society) to be key in decision-making, implying that ‘new’, ‘creative’, or ‘innovative’ solutions have to be sought in balancing between a limited budget and the existing (or even growing) care/support demand. One respondent covered this point by stating that we should “learn people how to fish instead of supplying the fish”. Apart from an increased focus on prevention (e.g. by supporting, or cooperating with, citizens’ initiatives and/or informal care organizations), it remains however unclear what is exactly meant by ‘innovative solutions’.

Question 7 (ethical principle 6: proportionality). Next, respondents were asked whether they think the Social Support Act 2015 can be considered as a proportionate measure for the goals it intends to pursue. In general, respondents considered this proportionality indeed to be present, thereby primarily making the comparison to the pre-2015 situation, which was considered by many as ‘unfair’ and ‘untenable’ due to the often exaggerated care demands of people (the so-called ‘claim-mentality’). Or, in the words of one respondent: “A greater reliance on an own network / own resources will eventually replace the claim-mentality (‘I am entitled to’) and thus be cheaper”. Another group of respondents considered the underlying idea of the decentralization (providing care and support on a customized basis and closer to home) as a positive normative development, while being worried about the budget cuts that accompanied the decentralization. As one respondent put it: “There will only be a balance in case of sufficient budget and autonomy for municipalities”. For this group of respondents, the Social Support Act 2015 is considered to be putting a disproportionate burden on society. For part of this latter group, this disproportionality is likely to reduce in the longer-term, due to a gradually reducing ‘claim-mentality’ within society. For another part, however, the reduction of long-term care costs in the longer-term will not be the result of a more efficient provision of long-term care, but will simply be the result of the mere fact

of less available financial resources (and thus less possibilities), leading logically to less expenses in the long-term care sector.

Question 8 (dealing with moral conflicts). The last two questions of the survey referred to the way municipalities deal with the identified moral conflicts. In general, most respondents pointed to the importance of communication and transparency here. On the basis of regular deliberations, meetings and conversations with both care/support providers, surrounding municipalities, care/support recipients and their informal caregivers, and other stakeholders, the execution of the Social Support Act 2015 is evaluated regularly and adapted where necessary. Moreover, although the large discretion that municipalities have in assessing citizens' care/support needs is considered by many citizens as unfair or subjective (as we mentioned before), the best way of dealing with this discretion according to our respondents is to critically assess each individual situation in-depth, offer customized support where possible, be open and transparent towards care/support recipients and their informal caregivers, and thoroughly explain the choices made where necessary. As one respondent captured it: "Continue discussions, while in the meantime also ensuring that the necessary care delivery continues".

Question 9 (dealing with moral conflicts: alternatives). Subsequently, respondents were asked whether they foresaw alternatives with regard to the execution of municipalities' long-term care responsibilities. Many pointed to the unlikelihood of such an option, as the Social Support Act 2015 is an established fact by law. Others argued that neither option would be perfect and that turning to an alternative law now would be going back to square one. Most respondents, however, interpreted this question not so much in terms of alternatives to the Social Support Act 2015 in itself, but in terms of possible alternatives in the execution of this law. Most of these respondents pointed to the potential release of more financial resources by the national government. At the same time, respondents acknowledged that although the availability of more financial resources would make life easier, it would not dissolve moral conflicts. A second alternative would be a clearer delineation between (or integration of) the different long-term care Acts. Respondents argued for example that it would have made more sense if the complete package of non-residential care services was put under responsibility of either the municipalities, or the health insurers. Currently, the majority of non-residential care services is under responsibility of the health insurers, and only a small part under responsibility of the municipalities. Finally, respondents pointed to the need for more innovative and unorthodox solutions, arguing that the Social Support Act 2015 is not an aim in itself, but a means to deliver good care/support. Or, as one respondent put it: "Every law has an Article 5", implying that governments should sometimes turn a blind eye in the execution of policies.

Discussion

Principal findings and conclusions

The aim of this study has been to examine to what extent municipalities in the Netherlands take/took potential moral conflicts into account when implementing and executing the Social Support Act 2015. We intend to answer our research question by relating the results corresponding to each of the six principles of our theoretical framework back to the coherentist approach of ethical reasoning this framework was based on. As was mentioned before, the coherentist approach is based on two main strands of ethical reasoning, being the 'rights-based approach' and the 'consequentialist approach'. Within a consequentialist approach, "actions are judged for their outcome and overall produced value" (22). This approach is basically founded on such principles as 'health maximisation' and 'do no harm' (22), corresponding to the principles of non-maleficence & beneficence and social

beneficence in our theoretical framework. In a public health context a consequentialist approach to ethical reasoning implies that health should be maximised, “as long as health maximisation is not endangering the maximisation of the overall utility of people” (22). As was described in the previous chapter, most of our respondents appeared to have a rather neutral stance with regard to assessing the non-maleficence and beneficence of the Social Support Act 2015, emphasizing that it depends to a large extent on the individual perception of people whether they experience the introduction of the new Social Support Act as an advantage or a disadvantage. With regard to social beneficence we found that, despite worries about the decreasing level of formal care provision, most respondents considered the creation of a better awareness and appreciation among citizens about care in general to be one of the more long-term advantages of the Social Support Act 2015. At the same time there are also doubts about the impact that a law can have on such developments as new ways of thinking about long-term care (referred to above as a ‘normative reorientation’ towards long-term care). Indeed, concepts such as the concept of ‘positive health’ as developed by Huber et al. (4) are gaining importance within the healthcare sector. The concept of ‘positive health’ considers health as “the ability to adapt and to self manage” (4) instead of considering it under the traditional WHO definition as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (32).

A rights-based approach is basically founded on such principles as ‘human dignity’ and ‘justice’, corresponding to the principles of respect for autonomy and social justice of our theoretical framework, and claims that “persons have rights to fair equality of opportunity” (22). In a public health context this implies that people have a right to (equal opportunity) “to receive appropriate healthcare and live in environments in which social determinants of health are distributed in a fair way” (22). As we saw in the previous chapter, most respondents considered respect for autonomy to be sufficiently covered by the Social Support Act 2015, mainly by its emphasis on freedom of choice. At the same time, however, our respondents pointed out that exactly freedom of choice is something that is not always of added value in a context wherein people are often just looking for good quality support. Moreover, while social justice (people’s capabilities of making use of their right to freedom of choice) was considered to be sufficiently present for the majority of people, it is also exactly this point that respondents appeared to be most worried about in light of the Social Support Act 2015, especially when applying it to vulnerable groups in society. Indeed, the legal text of the Social Support Act 2015 hardly stresses the importance of such notions as ‘equity’, one of the core underlying values of the principle of social justice. Although the legal text stipulates that “citizens who themselves or together with people in their immediate environment are not sufficiently self-sufficient or insufficiently able to participate [in society], must be able to rely on organized support by the government”, it remains unclear when exactly someone is ‘insufficiently self-sufficient’, ‘insufficiently able to participate in society’, and (in case someone is entitled to support) when one is entitled to ‘general services’ and when to ‘customized services’. Indeed, as was argued by Maarse and Jeurissen (16), municipalities actually have a large policy discretion with regard to the allocation of support measures (the so-called ‘zip code rationing’), which may lead to unequal access to long-term care. In fact, this point was one of the three main moral conflicts as identified by our respondents under question 1 of the survey. Moreover, as argued by Van der Aa et al. (18), with the advent of the Social Support Act 2015 a shift can be witnessed from a ‘right to care’ to a ‘right to customized support’. Next, although solidarity is by definition an important component of the Social Support Act 2015, the Act foresees a shift from formal to informal solidarity (18). It remains, however, doubtful how much can be expected of this informal solidarity. As Maarse and Jeurissen (16) already pointed out, “the potential of

‘unexplored’ informal care is overestimated. Furthermore, the negative externalities for caregivers who deliver intense informal care are underestimated”. Finally, the legal text of the Social Support Act 2015 stipulates that “it is desirable to set new rules, in order to bring citizens’ rights and duties more in line with each other” (authors’ own translation), which tends to imply a decreasing government responsibility for citizens’ rights to equality of opportunities regarding access to good quality care/support.

Our first sub-research question was specifically directed towards the way municipalities divide scarce resources in the social domain in a fair way. As we saw in the previous chapter, our respondents’ views towards principles of efficiency and proportionality were quite divergent. On the one hand, the availability of less public resources for long-term care and the higher own financial contributions people are expected to pay for the care/support they receive might eventually lead to a more conscious use of care (and in that way contribute to the normative reorientation of creating a true participation society). On the other hand, however, these developments might unconsciously lead to the creation of an access barrier to care (especially for the less affluent in society) or to the avoidance of necessary care. In fact, the conflict of adhering to the Social Support Act’s underlying theory of moving towards a participation society while at the same time having to deal with the limited budget and time-frame that is offered to municipalities for supporting this change process was one of the three main moral conflicts as identified by our respondents under question 1 of the survey. Moreover, within the context of the Social Support Act 2015 ‘efficiency’ might primarily be understood as a way of justifying the budget cuts that accompanied the long-term care decentralization, instead of as a moral obligation to efficiently use scarce health resources. At least part of the solution to the dilemma of how municipalities then can divide scarce resources in the social domain in a fair way might be provided by the ‘accountability for reasonableness’ approach of procedural justice by Daniels and Sabin (33), which offers a “minimum ethical standard in times of economic downturn characterized by scarcity of resources and when not all needs are being satisfied” (13). The accountability for reasonableness approach requires certain conditions to be met in order for a process of allocating scarce healthcare resources to be ‘fair’: the process (including the reasoning behind it) has to be transparent to the public, the reasons by which decisions were made have to be relevant, and it should be possible to revise any decision in case of new evidence or arguments (13). These conditions are quite in line with our results under question 8 (dealing with moral conflicts), emphasizing the importance of communication and transparency in the process of dealing with moral conflicts (such as the division of scarce resources).

Finally, in order to answer our second sub-research question (regarding the way municipalities empower citizens towards a participation society), it has to be determined how the kind of efficiency goals as discussed under the previous sub-question can be reconciled with moving towards a participation society; or, in other words, does the latter lead to the former, or does the former require the latter? Is thus “participation” a good value or a fig leaf or metaphor for a liberalist mindset? We argue that although participation is an intended goal of the Social Support Act 2015, citizens are insufficiently supported to achieve that participation. As we argued before, ‘support’ under the Social Support Act 2015 is intended to be limited to those citizens who themselves or together with people in their immediate environment are not sufficiently self-sufficient or insufficiently able to participate. Or, as Maarse and Jeurissen (16) put it: “The WMO 2015 gives applicants a right to publicly funded support if they cannot run a household on their own and/or participate in social life”. However, proactively supporting citizens towards the initial goal of creating a participation society (e.g. by focusing on preventive measures), is much less pronounced in the legal text of the Social Support Act 2015. Article 2.1.2 (c, d and e) points in general terms at,

respectively, the early determination of citizens' support needs, the prevention of citizens' reliance on support, and the provision of general support services (provided without the prior examination of the recipient's need, characteristics and capabilities). However, how to achieve these points is left to the municipalities' discretion. In the same vein, Article 2.1.2b points out that "the different categories of informal caregivers should be enabled as much as possible to perform their duties as informal caregiver" (authors' own translation), but this point is not specified in the remainder of the legal text. This point is therefore, we argue, much less concrete as compared to the old 2007 Social Support Act (under which municipalities were merely responsible for domestic help), where support for informal caregivers was concretized in such sub-themes as information, advice, emotional support, education, practical support, respite care, financial support and material support. At the same time, this high degree of policy discretion for municipalities under the 2015 Social Support Act gives room for 'innovative and unorthodox solutions', as was indicated by several of our respondents, although this may require the availability of more financial resources and/or a clearer delineation between (or integration of) the different long-term care Acts (the latter being one of the three main moral conflicts as identified by our respondents under question 1 of the survey).

Coming back to our main research question ("To what extent did/do municipalities in the Netherlands take potential moral conflicts into account when implementing and executing the Social Support Act 2015?"), we conclude by arguing that while municipalities are indeed aware of (potential) moral conflicts, the nature of the new law itself leaves insufficient room for municipalities to act in a sufficiently proactive and supportive/empowering manner on these challenges, as well as on the long-term aim of the Social Support Act 2015 of achieving a true participation society. The reasoning behind this argumentation is that although the new law appears to emphasise such ethical principles as social beneficence and respect for autonomy, the lack of emphasis on notions of social justice threatens to impede the effectuation of the intended goals in practice. Moreover, the Social Support Act 2015 seems to be mainly directed towards achieving a certain outcome (the maximisation of social beneficence through the creation of a participation society), instead of stipulating how that outcome should exactly be achieved in a fair manner. As such, the Social Support Act 2015 insufficiently seems to provide equality of opportunity with regard to long-term care access, both between citizens within the same municipality, as (and perhaps especially) between different municipalities. At the more short-term, taking into account a minimum set of ethical principles allows for the allocation of (seemingly scarce) resources that is, at the least, as fair as possible.

Study strengths and limitations and suggestions for further research

The principle strength of this study has been the application of a broad ethical approach towards scrutinizing a new, and still sensitive, policy responsibility of Dutch municipalities. We have shown that taking into account a minimum set of ethical principles, raises awareness of (potential) moral conflicts within the context of the new Social Support Act. Being aware of such conflicts, at its turn, helps in executing the new responsibilities under the Social Support Act in an appropriate manner (or in justifying decisions towards citizens) and gives room for municipalities to act in a as proactively as possible manner on the challenges resulting from these new responsibilities. Next, the fact that all Dutch municipalities were invited to participate in our study led to a reasonable response rate, in terms of reaching a saturation point in our data analysis. At the same time, the limited response rate to the invitation for a telephonic interview might have led to a certain selection bias, as not all respondents have given the same level of in-depth explanation to their survey answers. Moreover, it might have been valuable if additional questions were added to the in-

depth interviews, although also the semi-structured character of these interviews already allowed for a certain (though limited) degree of further exploration within and beyond the initial interview items. Finally, also our argument with regard to the allegedly insufficient support with regard to achieving a participation society leaves room for further research, as this is exactly a topic that holds a more long-term perspective. As such, it may be worth considering within a number of years to what extent the Social Support Act 2015 actually contributed (or not) to the creation of a true participation society.

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