
Analysing Costs and Benefits of Homelessness Policies in the Netherlands: Lessons for Europe

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› **Abstract_** *Although cost-benefit analysis is commonly used to evaluate social policies, studies on the benefits and costs of homelessness are still scarce in Europe. This paper reports on a cost-benefit analysis of homelessness policies in the Netherlands. This analysis was prompted by a need for government to evaluate the 'return on investment' in a plan for social relief in the main cities. The cost-benefit analysis conducted substantiates claims that the first stage of this plan generated positive results. Moreover, it indicates that a planned shift to prevention and 'housing first' during the second stage will generate financial benefits. The results indicate that investing €1 in effective homelessness policies avoids at least €2 of costs in other important domains (health care, criminal justice and housing), with the net saving depending on the target group. Both the results and the analytical framework developed have been broadly endorsed by academic experts and field practitioners as suitable and plausible. The findings have been used by local policy makers to improve their policies. The planned large-scale decentralisation of long-term health care can further improve incentives for optimising homelessness policies. The framework can be used for follow-up research at a regional/local level and for cross-national comparisons.*

› **Key Words_** *Homelessness policies, cost-benefit analysis, social investment, effectiveness, prevention, decentralisation*

Introduction: Rationale for cost-benefit analysis

In recent years two important developments have influenced social policies in many western countries: A diminishing availability of public funds and increased expectations with regard to quality. These developments have spawned further initiatives to optimise public policy efforts, both within specific policy areas and for cross-cutting initiatives that span more than one policy area. This has generated a number of key principles for public policy. The most important of these are:

- General efficiency: delivering qualitatively good services at the lowest possible costs;
- Client orientation: focussing on clients and their social context, whereby outcomes should be attuned to individuals' specific needs and capabilities;
- Continuity of support: guaranteeing continuous support, both over time and between different responsible authorities, including clear case management;
- Timely support: emphasising and increasing prevention (social care) and primary care (light/short care for mainly one dimensional problems) instead of expensive secondary care (specialised care/cure for complex problems);
- Coordinated support: more efficient coordination (integral service provision) of social, primary and secondary care through optimisation of different policy-chains (e.g. social support/welfare, public and general health care, mental health care, and youth/family care).

Cost-benefit analysis can test various claims of efficiency and effectiveness and hence contribute to efforts to optimise social policies. Homelessness is one of the most complex policy domains. A number of studies on the costs and benefits of initiatives to tackle homelessness have been performed in Anglo-Saxon countries such as Australia, the USA, Canada, and the United Kingdom (e.g. Ministry of SDES, 2001; Mondello *et al*, 2007; Culhane, 2008; Zaretsky *et al*, 2008; Larimer *et al*, 2009; UK Government, 2010).

On the European continent, such studies are much scarcer but they do exist. A recent example is a national cost-benefit analysis of the effects of homelessness policies (HP) in the Netherlands, conducted in winter 2010 for the Ministry of Public Health, Welfare and Sport (Cebeon, 2011). Important developments in responding to homelessness in the Netherlands, which triggered the analysis, are outlined below.

Dutch context

About ten years ago, thousands of people lived on the streets in the Netherlands (mainly in the largest cities) or stayed for lengthy periods in overnight shelters. This was partly caused by the insufficient capacity of community shelters. The high level of homelessness had consequences for society as a whole as well as for homeless individuals. It generated a great deal of public disorder and petty crime and also resulted in a deterioration in the health status of many homeless people due to their care avoidance.

The urgency of the situation prompted a joint effort by the Dutch government and the four principal cities, (known as the G-4) Amsterdam, Rotterdam, The Hague and Utrecht, resulting in a Plan for Social Relief. During its first stage (2006-2009) the plan focussed on providing immediate improvements in the conditions for those homeless people living on the streets, by active guidance and supporting their move towards rehabilitation as well as measures to prevent homelessness targeted at those at serious risk of eviction or those leaving detention/institutions.

Based on the G-4 agreement, the cities developed strong links with a chain of relevant partners, such as (mental) health care providers and housing corporations. They adopted a new approach consisting of the following elements:

- Every homeless person applies for support at a *central municipal access point*. They are then screened by public health care professionals to check if they meet the admission criteria¹ (see Planje and Tynman, 2013 for further information on the admission criteria);
- An integrated plan is made for every homeless person, which covers all relevant areas of life. On this basis, *personalised trajectories* out of homelessness are initiated and managed by a service provider professional;
- Progress and results are *monitored* based on uniformly registered client-information; periodic meetings are held between municipal supervisors and client-managers on individual trajectories;
- *Seamless co-operation* by all chain partners in a structural framework under municipal policy guidance. Agreements are made with health care insurance boards and housing corporations on the provision of long-term health care and housing;
- The formation of (outreaching) *flexible assertive community treatment-teams* which facilitate the intensified participation of (mental) health care providers and others as necessary;

¹ Important criteria are lack of a registered residential address, living in the region for at least two years, suffering from multiple problems, and not being self-sufficient.

- *Increased capacity*, most notably in the provision of meaningful daytime activity, debt relief as well as specialised long-term supported/supervised accommodation, which includes people with very complex problems due to chronic addiction and/or mental illness.

With the execution of this first stage, the desired breakthrough has largely been achieved. The situation has improved considerably for homeless and potentially homeless people themselves as well as for society at large. The new approach has helped many homeless people get off the streets, leading them into supported pathways out of homelessness and improved the well-being of many clients by creating stable incomes, health and housing. Moreover, it has prevented many people from becoming homeless; the number of evictions and people becoming homeless after being released from prison or long-stay institutions has decreased. Another result is a significant decrease in petty crime committed by homeless people.

Substantial social investments have been made in order to achieve these results. Total expenditures of the G-4 plan amounted to around €175 million up to 2009. The G-4 cities contributed about one third of that figure. Partly in light of tighter public budgets and also because of the magnitude of the investment required, the question was raised as to what extent these expenditures have provided positive (financial) benefits.

At the same time, more fundamental challenges remained that called for additional efforts. To address them, the Dutch government and the G-4 agreed on a second stage of the plan (2010-2013). The purpose was to shift efforts towards enhancing the capabilities of vulnerable persons/families (including residential clients) to be self-sufficient in various domains, including social networks, employment and daytime activity.

Therefore a national analysis of costs and benefits was needed that would:

1. Develop a methodological framework to assess the costs and benefits for the entire policy domain;
2. Establish the main benefits of HP in other policy domains and, where possible, quantify them;
3. Demonstrate how available public budgets for homeless people could be allocated more effectively.

It was decided that the analysis should be broader in scope than the G-4 plan, because the results have to be relevant also for other large cities that have developed similar plans. This policy review first highlights the cost-benefit model developed and its operationalisation. It proceeds by describing and quantifying the main benefits for each target group, which are compared with costs. Finally, the limitations of the study and lessons for future policy and research are discussed.

Model and Operationalisation

Character of the study

An exploration of existing cost-benefit analyses in the Dutch field of homelessness yielded only a small number of relevant studies. The most comprehensive is a study by Gort (2007), who used (administrative) data of the municipality and the police and justice department for a sample of about one hundred clients in supported pathway out of homelessness, in conjunction with insights from (former) police and public health experts to make an internal business case for the city of Rotterdam. Through extrapolation to the total client-group he concluded that investing €1 in homeless services and (mental) health care generates more than €2 of cost savings for police/justice and insurance companies. Another example regards a study at the level of one service provider. Boers (2006) analysed how specialised supported housing by this provider affected the reconviction rate of about one hundred clients who have left penal institutions. She quantified the reduction in social costs and compared these with total service costs. The main limitations of these studies were a focus on specific target groups (many of which were higher need clients) and benefits for the criminal justice system, while the effects of homeless services were entangled with those of (mental) health care.

Usually, cost-benefit studies focus on the costs and benefits of individual policy programmes, which are often limited in scope (for a particular period) and have rather well-defined goals and target-groups. The basic cost-benefit model then can be derived from available official documents together with input from relevant officials (policy-makers). Often, such analyses are facilitated by (readily available or quickly gathered) targeted data with a direct link to the programme.

In essence, our study was set up along similar and broadly accepted methodological lines. However, to perform a total cost-benefit analysis for the entire policy field (national/meta-level) from a small, specific knowledge base meant that we had to invest much (more) time in:

- Defining and delimiting scope, in terms of target-groups, policy aims, time horizon, baseline situation, and relevant categories of costs and benefits (HP versus other domains);
- Setting up a basic model that transcends the level of specific programmes and can still generate meaningful insights regarding the costs and benefits of policy-efforts;
- Gathering existing data (including policy/scientific research and official sources of public service costs) from different sources, and linking it in a meaningful way to the policy field and identified target-groups (defining which types of service costs can be regarded as benefits of HP and how to operationalise these avoided costs).

Table 1: Definition and estimated numbers of target groups

Target group	Definition	National numbers*
1. Potentially homeless people	Vulnerable people/families at serious risk of eviction, including formerly homeless and/or formerly clinical clients of mental health institutions	60000
2. Actually homeless people	People without a residence, who need to resort to staying outdoors, in a public shelter or with friends or family, without knowing where they will stay the next night	17800
3. Residentially homeless people	People registered as habitants of institutional housing for homeless people	13000

* Sources: 1. City-plans for social relief and Bos *et al.* 2010, p. 2. Central Bureau of Statistics 2010, p. 3. City-plans for social relief.

These groups can be seen as different stages of homelessness. Each stage requires a particular approach to improve people's situation, involving a mix of instruments (prevention, guidance, shelter and rehabilitation). The model only takes into account the costs of (initial) HP efforts that are needed to realise the desired effects (stabilisation or a move to another target-group). Such efforts include both temporary expenses (such as the start up of trajectories) and longer term expenses (such as aftercare by providing housing support). The costs of the 'stable situation' itself (i.e. maintaining the initial or improved situation) are left out of the equation.

A basic assumption in the analysis is that by preventing undesirable changes (for example the shift from 'potentially homeless' to 'actually homeless' through eviction) and stimulating desirable changes (for example the shift from 'residentially homeless' to 'potentially homeless'), various types of costs in other domains are being avoided/offset. The study shows that these benefits of HP are most substantial in health care and criminal justice, and to a lesser extent also materialise in the domain of housing.

Operationalisation

To operationalise the model (i.e. to fill in the qualitative and quantitative links) several steps were taken for each target-group. As a first step, the main potential cause-effect relationships were described to make clear which effects HP are likely to achieve in different situations. Secondly, a baseline situation was defined in order to isolate HP results from a situation 'as if there was no HP'. Thirdly, we gathered existing data about the service utilisation of people in target-groups and approximated their costs in different domains. These data were quite heterogeneous, varying in scope (one subgroup or all groups; one type of service or a broad range), content (definitions, time-periods, etc.) and quality (from practitioners' observations to scientific design). We used this input to quantify the service utilisation costs of target-groups in all relevant domains. The resulting quantities involve observing a time horizon of about ten years to incorporate both short and long-term effects.

A next step was to conceptualise the effectiveness of HP in establishing cost offsets elsewhere. We tested assumptions on (a) success rates for HP in stimulating desirable changes and preventing undesirable changes (numbers of affected people in target-groups) and (b) the degree to which outcomes can be attributed to HP. HP are not executed in isolation but within a chain of mutually dependent institutions. Examples of chain partners are mental health care providers (outreaching teams, addiction care), providers of general welfare support (early intervention, guidance and short-term support), income related welfare support (budget-control assistance, debt relief, labour participation), police/justice department (fighting public disturbances and crime) and housing corporations (preventive housing support). The inherent overlap of responses to homeless people generates a necessity for cooperation. HP cannot result in desired effects without effective contribution from other actors and vice versa. Hence, provisions for target-groups must be applied and analysed in coherence with other domains. Final steps were to determine the benefits in different domains (using the results of previous steps) and to compare total benefits with total costs of HP.

Results

Intended effects and required HP efforts (see Figure 1)

Targeted HP efforts can generate different types of effects with regard to people in each target-group. The cost-benefit analysis focussed on effects that are expected to be the most notable, in terms of appearance as well as substance. Both these intended effects and the required HP efforts are summarised in table 2.

Table 2: Intended effects and required HP efforts per target-group

Target-group	Intended effect of HP	Targeted HP efforts
Potentially homeless people	1. Unstable situation is stabilised with help of HP efforts and (most) potentially homeless people are prevented from becoming actually homeless (again).	Limited guidance/support to keep people 3 years in trajectory. Limited ambulant housing support for 2 years.
	2. Eviction cannot be averted and with help of HP efforts some potentially homeless people are guided directly to supported housing (housing first), in order to prevent them from becoming actually homeless. Indirectly, these efforts keep several people from becoming a repeat offender.	Transitional use (3 months) of overnight shelter until supported housing is available. Guidance and 1 year aftercare: case management, extra intensive for those at risk of becoming repeat offender.
	3. Eviction cannot be averted and with help of HP efforts some potentially homeless people are guided directly to protected housing in order to prevent them from becoming actually homeless. Indirectly, these efforts keep several people from becoming a repeat offender.	Transitional use (3 months) of overnight shelter until protected housing is available. Guidance and 1 year aftercare: case management, extra intensive for those at risk of becoming a repeat offender
Actually homeless people	1. With help of HP efforts some (self-supporting) actually homeless people are guided directly to independent housing (e.g. without structural support).	Transitional use (3 months) of overnight shelter until housing is available. Limited ambulant housing support for 3 months to enable a new start. Guidance and 6 months aftercare: Limited case management for further stabilisation.
	2. With help of HP efforts some actually homeless people are guided to permanent housing with ambulant support.	Transitional use (3 months) of overnight shelter until housing is available. Ambulant housing support for 6 months to enable a new start. Creating social support system to guarantee new situation. Guidance and 3 year aftercare: Limited case management for further stabilisation.
	3. With help of HP efforts most actually homeless people are guided to supported housing. Indirectly, these efforts keep several people from becoming a repeat offender.	Transitional use (3 months) of overnight shelter until supported housing is available. Heroin-assisted treatment for 1 month (start-up). Supported collective housing for 6 months to get used to housing. Structured daytime activities for 6 months. Guidance and 1 year aftercare: case management, extra intensive for those at risk of becoming a repeat offender.

Target-group	Intended effect of HP	Targeted HP efforts
	4. With help of HP efforts other actually homeless people are guided to protected housing. Indirectly, these efforts keep several people from becoming a repeat offender.	Use of emergency shelter for 1 week. Transitional use (3 months) of overnight shelter until protected housing is available. Heroin-assisted treatment for 1 month (start-up). Structured daytime activities for 6 months. Guidance and 1 year aftercare: case management, extra intensive for those at risk of becoming a repeat offender.
Residentially homeless people	1. With help of HP efforts some residentially homeless people move to supported permanent housing.	Ambulant housing support for 6 months to enable a new start. Sustaining a social support system for 1 year to guarantee new situation. Guidance and 3 years aftercare: Case management for further stabilisation.
	2. The situation of most residentially homeless people in supported housing is stabilised and with help of HP efforts they are prevented from becoming actually homeless again.	Case management for 3 years.
	3. With help of HP efforts some residentially homeless people move on from protected to supported housing.	Supported collective housing for 1 year to get used to housing. Guidance and 1 year aftercare: Case management.
	4. The situation of residentially homeless people in protected housing is stabilised and with help of HP efforts they are prevented from becoming actually homeless again. Indirectly, these efforts keep several people from becoming a repeat offender.	Case management for 3 years, extra intensive for those at risk of becoming a repeat offender.

Quantification of Benefits and Costs (see Figure 1)

In order to quantify HP benefits per effect, it was necessary to estimate (a) the number of people in the target-group who make a desired movement with the help of HP efforts and (b) how much HP contribute to avoiding/reducing costs in other domains. The way these indicators of effectiveness and the intended effects of HP were operationalised, is summarised in Table 3.

Example: to quantify effect 1 of potentially homeless people (situation with HP), it was assessed that approximately 85 percent of this target-group (a) can be supported so as to prevent them from becoming actually homeless (situation without HP). About one third of the resulting cost avoidance elsewhere can be attributed to HP efforts (b).

Table 3: Part of target-group and HP contribution per effect

Target-group	Effect	Intended effects: from... to...		(a)	(b)
		Situation without HP	Situation with HP	% Target-group	HP contribution
Potentially homeless people	1	Actually homeless	Potentially homeless	85%	33%
	2	Actually homeless	Residential homeless: Supported housing	12%	50%
	3	Actually homeless	Residential homeless: Protected housing	3%	50%
Actually homeless people	1	Actually homeless	Outside target-groups of HP	2.5%	50%
	2	Actually homeless	Potentially homeless	15%	50%
	3	Actually homeless	Residential homeless: Supported housing	30%	67%
	4	Actually homeless	Residential homeless: Protected housing	20%	67%
Residentially homeless people	1	Supported housing	Potentially homeless	3%	50%
	2	Actually homeless	Residential homeless: Supported housing	54%	67%
	3	Protected housing	Supported housing	6%	67%
	4	Actually homeless	Residential homeless: Protected housing	34%	67%

In the cost-benefit analysis, an effect is defined as a particular change in the living situation that people in the target-group make as a result of HP. Column (a) shows approximately which part of each target-group experiences the effect. In the case of potentially homeless people, the figure for effect 1 was mainly derived from data about the number of G-4 evictions related to rent arrears or complaints. In 2006-2009 about 10-12 percent of the target-group fell into this category (Maas and Planije, 2010). The inverse of this figure is taken as representative for the number of people who are able to sustain their tenancies. Estimates for the other effects were mainly derived from the observations of Wolf *et al* (2002) regarding the number of marginalised people who have been actually homeless in the recent past.

Estimates for effect 2 of actually homeless people were derived from observations of Wolf *et al* (2002) about the number of people who have been homeless for less than one year. The figures for effect 3 and 4 were derived from Cebeon (2010a),

while expert estimates provided the basis for the figure of effect 1. For residentially homeless people, the estimates were mainly derived from Cebeon (2010a). This study provides insight regarding the 'moves' residential clients and (reached) actually homeless people in Amsterdam would be likely to make within coming years. Asked for their opinion, experts accepted these estimates as broadly suitable indicators. They also provided informed estimates for the risk of becoming a repeat offender: About one third of the group affected by effect 2 and 3 of potentially homeless people, effect 3 of actually homeless people and effect 4 of residentially homeless people, and about half for effect 4 of actually homeless people.

Note that the numbers in column (a) for actually homeless people do not add up to the entire target-group. The main reason for this is that HP did not yet effectively reach substantial numbers of actually homeless people. Some other people have to be guided to medical institutions, e.g. due to severe mental illness and/or problematic drug/alcohol use. To a much lesser extent, this reason also holds for some residentially homeless people.

We examined the sensitivity of these estimates for their impact on the resulting benefit-cost ratios (BCR). In all scenarios the risk of becoming a repeat offender is downgraded by one quarter. If proportion 1 of the potentially homeless group changes by 5 percent and these people become part of subgroups 2 and 3, then the BCR changes by about 1 percent. This 'inelastic' impact points to the dominance of subgroup 1 (i.e. the success of prevention). For the actually homeless group a scenario was tested in which more/less people were guided to forms of 'housing first' (effect 1, 2 and 3) instead of to protected housing (effect 4). If subgroup 4 changes by 25 percent, while the other groups change inversely with an according percentage, the BCR changes by about 6-8 percent. A comparable scenario was tested for the residentially homeless group by supposing that more/less people move on (effect 1 and 3) instead of staying for longer periods in institutional housing (effect 2 and 4). If subgroups 2 and 4 change by 5 percent, while the other (small) groups change inversely by 25 percent, the BCR changes by about 3 percent. Although exact figures are impossible to establish, it seems reasonable to conclude from these analyses that the estimates provide a quite robust basis for a quantification of HP benefits.

As column (b) shows, the avoided costs cannot be entirely attributed to HP efforts. To a varying degree, the cost difference is also due to efforts of other chain partners. These multiple influences call for a separation of the contribution of HP from that of others. Due to a lack of actual data, we made global estimates of the HP contribution, mainly based on expert knowledge. Important considerations were that the role of HP in a situation of independent living (potentially homeless: effect 1) is generally smaller than in a situation of social exclusion. In the latter case, HP normally have a leading role in guiding people to a residential setting (e.g. actually

homeless: effect 3 and 4) and helping clients to improve their situation and move on to a more self-supporting setting (e.g. residentially homeless: effect 2, 3 and 4). Given the involvement of so many other institutions, it does not seem to be realistic to assume much higher HP contributions.

Total HP benefits have been quantified by multiplying the mean avoided utilisation costs per person of all included public services (see Appendix) with the relevant numbers of people in the target-group (a) and the attribution-factor of HP (b). The results are summarised in Table 4 and compared with total costs.

Example: the tenancies of 51 000 potentially homeless people can be sustained with the help of HP efforts (effect 1), which wards off the descent into actual homelessness. In the domain of health care, this probably avoids about €700 million of expenses that would otherwise have been spent on these people if they had descended into actual homelessness.

Table 4: Quantified benefits and costs of HP per target-group (€million)

Target-group	Effect	N*	Benefits: Housing €million	Benefits: Work & income €million	Benefits: Health care €million	Benefits: Criminal justice €million	Total benefits of HP €million	Total costs of HP €million
Potentially homeless people			38	pm	920	314	1272	589
	1	51 000	38	pm	702	208	948	461
	2	7 200	0	pm	171	81	252	102
	3	1 800	0	pm	46	25	71	26
Actually homeless people			0	pm	374	183	557	280
	1	450	0	pm	11	4	15	6
	2	2 700	0	pm	55	17	72	61
	3	5 350	0	pm	172	83	254	143
Residentially homeless people			0	pm	136	81	217	69
	1	400	0	pm	344	126	469	135
	2	7 000	0	pm	2	1	3	3
	3	800	0	pm	172	47	219	68
			0	pm	18	-2	16	15
	4	4 400	0	pm	151	80	231	48

* N = number of people: fraction from Table 3 times total target group. pm = pro memoria: presently unavailable, but to be added later.

Due to rounding a minor discrepancy exists for a number of figures.

Table 4 indicates that HP efforts help to avoid approximately €1.3 billion of expenses that would otherwise have been spent on public services used by potentially homeless people if they transitioned into actual homelessness. For the other target-groups total HP benefits can reach approximately half of this figure (€0.5 to €0.6 billion). The benefits in the case of actually homeless people result most notably

from providing shelter to large groups by guiding them towards supported or protected housing (effect 3 and 4). Avoiding a relapse into actual homelessness generates the main benefits in case of residentially homeless people (effect 2 and 4). In all cases, the benefits of HP manifest themselves most forcefully in health care and to a lesser extent in the domain of criminal justice.

These HP benefits were compared with total costs of targeted HP efforts, required to realise these effects. These costs have been quantified mainly by using an available dataset, gathered by Cebeon (2009).² This is one of the most complete financial datasets and covers data (specified extracts from administrations) of centre-municipal expenses on homeless-related public services.

Comparing total benefits with total costs of HP shows that social investment in HP appears to generate clear positive net-results for all target-groups. Spending €1 on HP efforts helps to avoid costs of public services in other domains that range from about €2 (in the case of actually homeless people) to €3.5 (in the case of residentially homeless people).

Conclusion

The study successfully addressed the goals set by the Ministry of Public Health (see section 1): It generated a usable framework for public policy, it described the main effects of HP for three target-groups and it provided a first quantification of benefits (avoided costs of public services in other domains) at a meta-level. The main results are summarised in Table 5.

Table 5: Summary of main results

Target-group	Main effects of HP	Benefit-cost ratio
Potentially homeless people	Preventing eviction and a relapse into actual homelessness. Quick provision of supported housing ('housing first') whenever eviction does occur. Such prevention keeps a number of these people from turning to become a repeat offender.	2.2
Actually homeless people	Encouraging exit to self-sufficiency ('ordinary life'). Offering guidance to supported permanent housing ('housing first'). Offering guidance to institutionally supported/protected housing. This keeps a number of these people from turning to become a repeat offender.	2.0
Residentially homeless people	Preventing a fall/relapse into actual homelessness, with the side effect of keeping a smaller group from becoming a repeat offender. Encouraging moving on from protected to supported institutional housing, and from supported institutional housing to supported permanent housing.	3.5

² For correct comparisons, these data (fiscal year 2008) have been updated.

For all target groups, opportunities were distinguished for further optimisation of individual situations through specifically directed efforts by HP and partners in relevant policy chains (especially mental health care). These underpin the need and focus of the second stage of the G-4 plan: More (effective) prevention, housing first, and helping residential clients to move on.

Apart from the quantitative results, the study generated the following important findings:

- *Prevention is better and cheaper than cure*: although it is difficult to establish the precise benefits of prevention, quantitative results (combined with qualitative insights) can contribute to more balanced decision making with regard to HP. The study showed that HP avoid the use of expensive public services if they succeed in fulfilling their preventive function, especially among the potentially homeless and residentially homeless groups;
- *Sheltering homeless people is better and cheaper than leaving them on the streets*: by providing adequate shelter, guidance and support, HP help to avoid significant costs of services in other domains, especially health care and criminal justice. The study (quantitatively) showed that the efforts to seek proper shelter for actually homeless people and to guide them into an pathway out of homelessness, have offset costs elsewhere (over and above the costs of HP efforts);
- *Effective homelessness policies require efforts from all chain partners*: (potential) cost savings appeal to all actors in the affected domains and point to important benefits of joint and integral approaches to the target groups of HP. In this multidisciplinary dynamic, it is important to communicate clearly the key role and contribution of each of the actors involved. In addition, perverse incentives need to be avoided or addressed in a situation where the benefits do not accrue equally to all actors in the chain.

Discussion

Limitations of study

Although attractively broad in its scope (an entire policy field), this study had limitations as well. First of all, by focussing on *public* costs and benefits, it was not a full societal cost-benefit analysis. Not taken into account were costs of privately funded services for homeless people, nor private costs for clients or society (citizens and firms). Among others, such costs include informal (private) care for homeless people as well as private costs due to crimes or offences committed by homeless people.³

Further, the study did not aim to quantify all public benefits. The accent was on domains with substantial benefits. We noted that substantial differences in HP effects exist across different public domains. In health care and criminal justice, for example, benefits are substantial, as the use of high cost facilities can be avoided due to clear benefits of HP. In other domains (e.g. work and income), benefits are much more limited, because the contribution of HP to effects is more limited.⁴ On the basis of a first screening of available information, the domain of work and income was excluded from the analysis (but mentioned as per Table 4). Other reasons for the exclusion of services/domains concern relatively low costs (avoiding their use does not result in substantial benefits) as well as insufficient data. Examples are care by general practitioners, welfare services and some types of offences. Although the unexamined benefits of excluded services/domains can play a role with certain target-groups, in general, they are not expected to lead to fundamentally different outcomes of the cost-benefit analysis.

Third, due to limitations in the available data it was assumed that moving from one target-group to another does not change the cost-benefit structure of each group. However, in domains like criminal justice and work and income such an assumption may be too strong due to behavioural influences. For example, if only a few people live on the streets, efforts by the police and criminal justice system could be less than estimated. This in turn reduces the quantified benefits for people who are prevented from becoming actually homeless. Despite limitations, the model and its outcome have been broadly accepted as suitable and plausible, and supports efforts to improve HP in the Netherlands and cross-nationally.

³ Although (the prevention of) such private costs have not been quantified, their (quantitative and qualitative) significance is beyond any doubt. Informal care and support form an essential part of the available spectrum of assistance for homeless people. In addition, societal cost of transgressions by members of the target-groups (both damage and grief) can be substantial.

⁴ For example, often becoming potentially homeless after being actually homeless has no effect on employment status and hence does not avoid any unemployment support/benefit.

Lessons for policy:***Decentralisation as a promising approach to optimise benefits***

The findings of our study have already been used by policy-makers in several cities to prevent large cuts in HP budgets and to improve HP by shifting the focus to prevention and housing first. On a higher policy level, initiatives have been taken to improve the current cost-benefit imbalance for local government as well. At the moment, municipalities bear the main HP burden, while other actors (e.g. national government and health insurance companies) gain most of the HP benefits. This provides adverse incentives to municipalities to generate benefits by investing in (better) HP. Recently, the Dutch government has planned large-scale decentralisation of important parts of long-term health care (LTHC) and all youth care to municipalities.⁵ These decentralisations shift responsibilities for tasks that yield potential HP benefits to municipalities. This contributes to restoring the costs-benefit balance for HP and realigns policy incentives.

These plans build on quite successful experiences in social support. In 2007, a first part of LTHC (household service⁶) was decentralised to municipalities within a new legal framework: The Social Support Act (SSA). Given this new set of tasks, many larger municipalities developed new (comprehensive) practices. The most important are:

- An optimised access to services, through the creation of 'one-stop shop' for citizens who need support;
- A more integral screening of the real and most urgent needs of citizens and a stronger focus on their capabilities instead of disabilities;
- Improved efficiency, through use of markets (buying services through procurement), a streamlined back-office (contract-management, registration of service use, etc.) and increasing inter-municipal cooperation;
- More organisational coherency, through horizontally connected chains; municipalities have intensified cooperation with local partners (such as housing corporations, welfare organisations and health care providers). This has improved their service in a number of ways; a greater ability to customise support for clients (demand-orientation), a stronger focus on social networks and collective solutions, as well as being more closely attuned to the characteristics of (neighbourhoods in) the municipality.

⁵ Secondly, these reforms involve the formation of social teams, that are more or less responsible for the (entire) support of vulnerable families (including forms of child care) in a borough/suburb and hence form horizontally integrated services.

⁶ Help with instrumental activities of daily living (e.g. cleaning) as well as advice on keeping one's household.

Overall, these practices have proven to generate positive results. For example, in the first years since the introduction of SSA more citizens have received support while informal carers provided more help as well. The average costs per user have decreased, mainly by a shift in product-mix, client satisfaction is stable at relatively high average levels, and the new tasks have been performed at cost levels below budget (De Klerk *et al*, 2010; Van der Torre and Pommer, 2010).

Although the economic crisis has changed the policy context considerably, decentralisation still seems to be a promising approach to yield net-benefits of policies, both in the field of homelessness as well as in other social policy-domains. Its success largely depends on the creation of two conditions to facilitate improvements. First, policy goals and domain boundaries are defined broadly (using general laws). An important innovation of the SSA in this respect was the shift from individual rights to claim certain services to the requirement of municipalities to support citizens in strengthening self-sufficiency and societal participation. Municipalities have substantial freedom to make local choices with regard to services, policy⁷, organisation and cooperation with local (private) partners; this allows them to ensure that initiatives are coherent with the nature of local needs and to provide tailor-made support.

Secondly, municipalities receive an integral, sufficient and stable budget, which they can largely spend as they see fit. SSA budgets are distributed as a general grant that is allocated on the basis of global, cost-orientated objective indicators. This type of budget allocation allows for variations that arise from demographic and social-economic differences between municipalities and from changing circumstances over time. This allocation system is coupled with regular financial and outcome monitoring, which periodically brings the budget allocation in line with observed changes in policy and costs over time. In this process, special attention is focussed on mapping perverse incentives and modifying the system in order to adjust for them (Huigsloot and Boerboom, 2007).

Inspired by this success, municipalities have indicated willingness to receive larger parts of LTHC within their jurisdiction, to further increase synergies. They have found a willing ear in government. The costs of providing LTHC are ever increasing, partly as a result of the supply-oriented organisation of care and perverse financial incentives.⁸ All of these challenges can be addressed through decentralisation. Recently, government planned to decentralise almost all long-term home care to municipalities as well as parts of long term institutional care, starting from 2015.

⁷ For example setting minimum levels of care and benefits, as well as the conditions under which citizens are liable for them.

⁸ Incentives are focussed on maintaining (or expanding on) the status quo, with weak incentives to prevent the use of expensive (institutional) facilities.

Municipalities will receive the available budgets (based on current service use) with a substantial efficiency discount. This discount is derived from both municipal SSA-experiences as well as research that indicated room for increased efficiency in the current LTHC-system (e.g. Cebeon, 2010b, Ministry of Finance, 2010). As a result, the associated structural resources of municipalities for SSA-related tasks will more than double, to about €10 billion.

Lessons for research: framework for comparative (European) analyses

The framework developed for cost-benefit analysis makes it possible to assess the financial effects of policy in such an intricate public domain as preventing and tackling homelessness. Additional research can generate a more refined model. Such research can occur along multiple lines. A first line is by widening the scope of possible HP effects under examination and by specifying different aspects of the model. Relevant input can be gathered from (longitudinal) case studies as well as from client-data. Incidentally, the availability and specificity of client-data is currently increasing, as more (larger) Dutch municipalities have started gathering (detailed) information on the level of self-sufficiency of clients in various life domains. Such information can be used to show how HP efforts impact the lives of clients over time.

Two other lines that additional research can take, are (i) incorporating the specifics (e.g. target groups, types of public services, types of cost) of regional/local or other national contexts in more policy-oriented studies, and (ii) fine-tuning to particular target groups (e.g. youngsters or families with multiple problems) and applying the methodology to social investments in a broader range of policy areas (such as prevention of addiction and domestic violence). These lines can be explored, using the framework developed for cross-national comparisons as well. The need for such analyses has recently been stressed by the European Commission in its Social Investment Package. They could be devised by clearly defining target groups, types of services and cost categories. Then data can be gathered in different countries about the costs of a basic set of services, and used to build (stylized) national cases. In this way, the framework enables comparisons, which can stimulate discussion about how to improve social policies, by generating insights from good or best practices and providing references to guarantee certain (minimum/effective) policy-efforts. Exploring the cost-benefit framework along these lines can produce useful insights on how social policies can improve the lives of vulnerable citizens and provide budgetary savings at the same time.

Appendix: Mean Service Utilisation Costs per Person

Mean (annual) utilisation costs per person in the target groups for public services in different domains were derived from data about numbers of users, mean usage frequencies, volumes and durations of use. The resulting mean utilisation costs were calculated over a period of ten years (without discounting for future prices) and are reported (rounded off numbers) in Table 6 for each target group.

Table 6. Mean utilisation costs (€'s per person) for public services in different domains

Public service – Target group	Potentially homeless €	Actually homeless €	Residentially homeless in supported housing €	Residentially homeless in protected housing €	Repeat offender €
Housing					
Eviction	1 490	–	–	–	240
Rehousing	380	–	–	–	60
(Dis)Connecting electricity, gas, water	190	–	–	–	30
Forgone rents	160	–	–	–	30
Health care					
Institutional long term health care	–	–	–	–	18 930
Ambulant guidance (home care)	3 510	0	8 780	47 390	5 270
Medicines	7 750	1 860	9 300	9 300	5 330
Methadone treatment	730	1 090	1 450	1 450	1 070
(Poli)Clinical care	5 740	10 330	6 120	6 120	7 260
Emergency transport	120	990	250	250	510
Hospital emergency treatment	40	1 190	170	170	550
Hospital ambulant treatment	530	150	300	300	250
Clinical cure of (drug) addiction	1 320	10 930	1 580	1 980	5 170
Clinical cure of mental illness	1 320	20 370	1 320	1 660	8 850
Assertive community treatment	0	3 750	2 500	2 500	2 400
Flexible assertive community treatment	9 000	2 250	4 500	0	3 780
Missed premiums	1 260	3 190	1 890	630	2 100
Criminal justice					
Theft and financial crimes	2 770	8 320	4 160	2 080	6 850
Damage and public order	390	1 050	520	260	870
Offences under Opium Act	400	1 200	600	300	1 000
Institution for repeat offenders	–	–	–	–	30 340
Municipal special Investigation officers	580	1 550	770	390	1 280
Close following of criminals by police	1 390	4 180	1 390	1 390	3 230
Aftercare for ex-prisoners	170	670	240	90	370
Basic policing (public disturb.)	580	1 550	770	390	1 280

Explanation: – = not relevant for this target group. Main sources: **Housing**: Volkskredietbank Groningen 2007, Berenschot 2010, Cebeon 2010a, Maas and Planije 2010; **Health Care**: Mensink *et al*, 2008, Theunissen *et al*, 2008, Bos 2010, GGZ NHN 2009, Altena *et al*, 2010, Van Bergen *et al*, 2010, CVZ 2010, Cebeon 2010c, VWS 2010, NZa 2010/2011, Vektis 2010, Zorgverzekeraars Nederland 2010; **Criminal Justice**: Groot *et al*, 2007, Czyzewski and Van de Wetering 2009, De Heerand Kalidien 2009, Wartna *et al*, 2009, Tollenaar and Van der Laan 2010, Buster and De Rooij 2010, Weijters and More 2009.

Using these data, the costs saved per person were quantified for each effect per target-group. For example, effect 1 of potentially homeless people regards a desired movement from being actually homeless (which is prevented) to being potentially homeless (tenancy is sustained) (see Table 2). The costs avoided in this way were quantified by calculating the differential between the costs of a 'mean user' in both target-groups. For emergency transport costs this cost differential is about €870 (€990 minus €120). Quantification of the other effects and target-groups follows in the same manner. An exception is made for health care services with utilisation costs that are intentionally higher in the desired situation (given health problems of people). In these cases the cost savings were taken to be zero. Well-known examples are connected with suboptimal use of medicines, ambulant guidance, and hospital ambulant treatment by actually homeless people compared with other target-groups. When these people are guided into shelter/institutional housing, they may access health care services they were unable to (but nevertheless entitled to receive) during their homelessness.

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