

The aim of the law of the EPD was to make (crucial) medical information rapidly available for medical professionals who were responsible for a patient's health. This would ensure that many avoidable medical mistakes could be prevented. The EPD would prove especially useful for (emergency visits by) older patients, who have a higher risk of co-morbidity, are less well-informed about their own condition, and who have a higher risk on poly-pharmacy. The main objection of the senate to support the amendment was that it held a potential threat for private and sensitive patient information. In a survey, many physicians were worried that private patient information was not sufficiently secured. If the system was hacked or the UZI codes of a medical professional were cracked, personal information of many Dutch citizens could potentially be available to unauthorized persons in an instance. Also, it would be a daunting task to train the thousands of medical professionals involved to gain more knowledge about the different ICT-systems, relevant privacy laws and – potentially – new codes of ethics.

The senate also expressed their discontent with the fact that the Ministry of Public Health, Welfare, and Sports had already sent a letter to all Dutch citizens over 18 in November 2009, explaining to them the what the Law of EPD would mean for them, and giving them the chance to opt out (meaning citizens had a right to refuse information sharing by GPs, pharmacists, and medical professionals).

3. Demarcating the Dutch cure and care services

3.1 Assessment for AWBZ⁴

Everybody who wants to be eligible for funding from the AWBZ has to be assessed by the CIZ. The CIZ works with a funnel model to assess the care needs of an individual. This funnel model is given in figure 7.

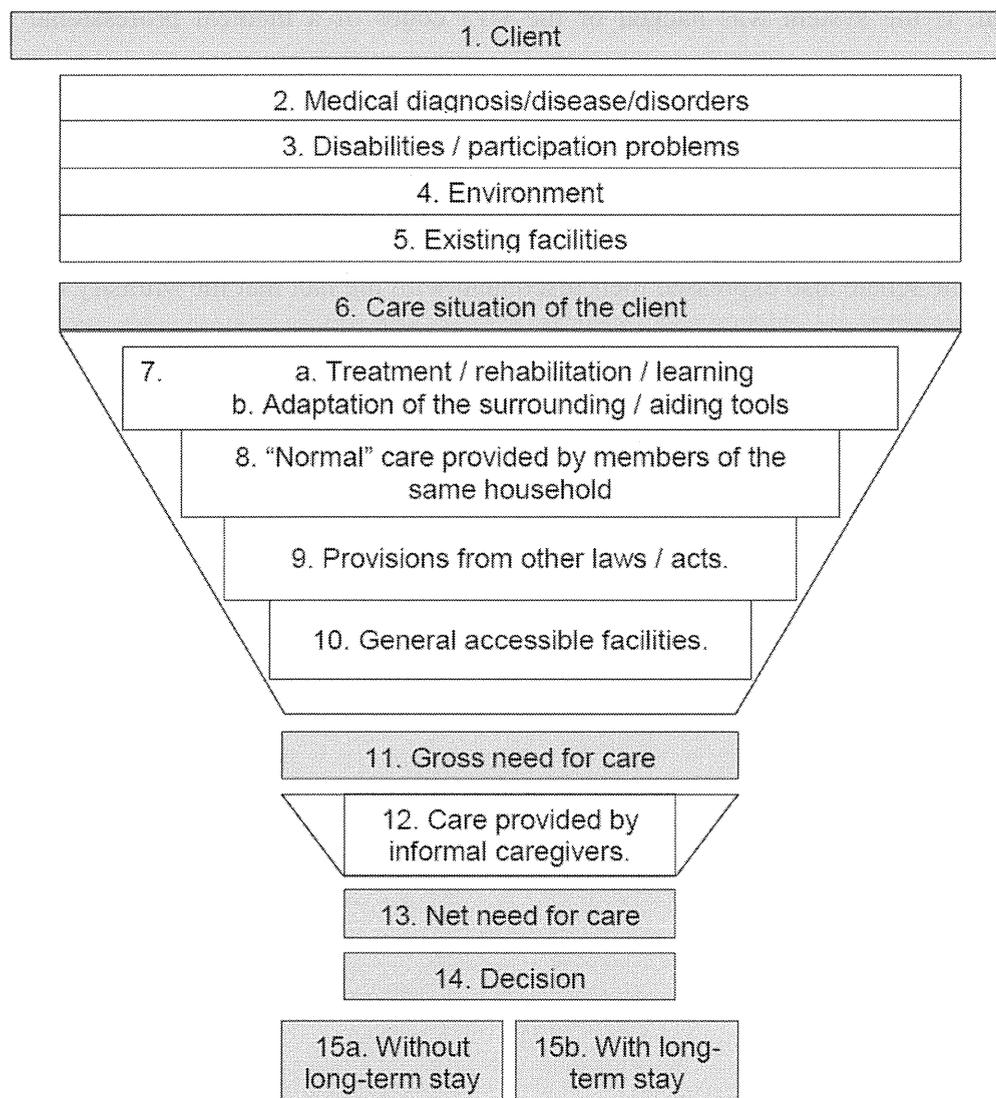


Figure 7: The CIZ funnel model.

⁴ Mainly based on [6].

The steps described in the CIZ funnel model are explained below.

1. The client can file in an application for AWBZ funding, but a health care professional may also do this by the client's request. An emergency application can only be filed in by a health care professional.
2. The CIZ assesses whether there are sufficient grounds for care from the AWBZ. There are two main grounds for care, divided into six parts: (1) a somatic, psycho geriatric or psychiatric ailment / limitation; (2) a mental, physical or sensorial handicap. Function disorders are scored on a scale from 0 to 3:
 0. No problems / no help required from another person.
 1. Problems / needs help, supervision or guidance occasionally.
 2. Problems / needs help, supervision or guidance often.
 3. Problems / needs help, supervision or guidance continuously.
3. Disabilities and participation problems are also scored from a scale from 0 to 3:
 0. Can pursue this activity him- or herself / no help required from another person.
 1. Can pursue this activity him- or herself / needs supervision or stimulation from another person.
 2. Can barely pursue this activity / help required from another person.
 3. Cannot do this activity independently / another person needs to take over.
4. The environment is defined by three main factors:
 - The nature and size of the care activities that are provided by other care facilities and informal caregivers. Within AWBZ indication-setting family-members, neighbors and friends can be deemed informal caregivers.
 - The health, burden and future care possibilities of other care facilities and informal caregivers.
 - The current living situation of the individual, his/her possible problems with the home, surroundings and living behavior, and his/her possible need/desire to move.
5. These are provisions the client can already use through regulations or acts in the fields of living, public health, health care, labor and education.

6. The care situation of the patient is described as a clear “picture” by the CIZ of the client in his/her surroundings.
7. In this step, the CIZ weighs if there are existing and adequate or new solutions to the problems in the care situation through treatment, rehabilitation or learning. Treatment cannot be enforced when the integrity of the body can be harmed (e.g. surgery). Besides these solutions, there might be other possibilities to improve the client’s situation that have priority over care from the AWBZ (see point 8, 9, 10).
8. Normal care is the care that partners, parents, children or other co-residents are deemed to give each other on a “normal” basis. Possible overburdening of these co-residents is taken into account.
9. If a person needs care, the AWBZ will only provide the care that is not financed by other laws. Therefore, the AWBZ is also called the “law for risks that cannot be insured”. If other acts, mainly the ZVW, are in place to offer certain health care or welfare services needed by the client, these services have precedence over potential AWBZ services.
10. General provisions are not regulated by law and can also offer solutions to the client’s needs, such as shopping services, child support facilities, et cetera.
11. Determining the need for care concerning the nature, size, duration and terms of delivery, without a decision concerning accommodation.
12. Here, the compensating opportunities by voluntary informal caregivers are assessed. Also assessed is the care that those informal caregivers are willing and able to give in the future.
13. After the subtraction of informal care giving from the gross need for care, the net need for care is hereby defined. Six weeks after the application was filed, the client is informed of the indication. In principle, an indication is valid for 15 years. Adult clients with a stabile disability sometimes have an indication that remains unchanged for many years, maybe even up to 15 years. Often, diseases or disabilities that require long-term care and demand exceptionally high expenses, are progressing. This means that an indication usually changes much sooner than 15 years, sometimes even multiple times per year. This is usually the case for the

elderly receiving AWBZ care, since they become more fragile, ill or disabled in a relatively rapid manner.

14. If the indicated care of the client is necessarily paired with the need for a protective or therapeutic living environment or permanent supervision, the decision is paired with an indication for long-term stay. Otherwise, no long-term stay is deemed necessary by the AWBZ.

As defined in paragraph 1.2.1 care from the AWBZ can be divided into six major categories: (1) personal care, (2) nursing care, (3) counseling (individual or group), (4) treatment (individual or group); (5) long-term residence, (6) short-term residence. If no long-term stay is indicated, care needs are defined according to different levels. The following kinds of levels are possible:

- Levels on the basis of an average amount of hours of care per week. These levels are defined for personal care, nursing care and counseling (individual).
- Levels on the basis of “day-parts” (period with a maximum of 4 hours) for counseling (group) and treatment (group).
- Treatment (individual) is not defined by levels.

The CIZ bases its indication partly on the information and diagnoses from related professionals. Table 11 shows which health care professional is involved for which of the six grounds (one professional may offer the diagnosis, but multiple professionals may also be involved, either separately or as a multidisciplinary team). A decision about indication by the CIZ is valid for no more than 15 years, although in almost all individual cases indications change much sooner. Some younger clients with (relatively stable) mental or physical handicaps might receive an indication-setting that remains unchanged for years. Older clients usually suffer from progressive illnesses or handicaps, implying that indications will change often for them.

Table 12: Professionals who are involved with diagnosing the clients health status for the AWBZ.

	General practitioner	Specialist	GZ-psychologist*	Medical educationist
Somatic ailment / limitation	X	X		
Psycho-geriatric ailment / limit.	X	X	X	
Psychiatric ailment / limitation	X	X	X	
Physical handicap	X	X		
Mental handicap	X	X	X	X
Sensorial handicap	X	X		

*GZ-psychologist is a "health care psychologist": a specialized psychologist, who is entitled to make diagnoses.

3.2 Compensation from the AWBZ fund

When an indication for a client does not include residence for more than three full days, his or her care needs are defined according to function and level. Table 13 (next page) shows how levels are defined for the different functions of AWBZ care without residence (> 3 days).

When an indication for a client includes residence for more than three full days, his or her care needs are defined according to care weight packages or ZZPs. AWBZ care providers receive standard compensation fees for each level of function or ZZP. These standard compensation fees are established by the NZa. These fees are "maximum" fees, and care offices have the ability to negotiate lower compensation fees with providers. These fees may not be lower than 94% of the standard compensation fee concerning residential care, and not lower than 85% for non-residential care.

Table 10 on page 30 shows how the different functions and levels are defined. This table also shows the compensation from the personal budget for each function and level: please note that the compensations mentioned in table 10 do not equal compensations made for care in kind to AWBZ institutions.

Table 13: AWBZ-care with no residential care for more than 3 full days per week is defined and compensated by function and level according to this table.

Function	Levels are defined by:
Personal care	Average number of hours/week
Nursing care	Average number of hours/week
Counseling (individual)	Average number of hours/week
Counseling (group)	“Dayparts”/week
Treatment (individual)	“Dayparts”/week
Treatment (group)	Not expressed in levels
Transportation	Related to the level of group counseling and group treatment

[Following text until “!!” moved from 3.3.6] A ZZP is a total package of care that fits the individual circumstances of the client, which concerns living, nursing care, treatment and daytime activities. Different gradients of ZZPs exist for different types of care. The different kinds of care weight packages can be categorized according to the grounds of AWBZ care. Table 14 shows the grounds and its set of ZZPs.

Compensation for transportation is offered, dependent on the amount of group counseling and group treatment. Clients who need care with long-term residence more than three full days are classified into so-called “care weight packages” (ZZPs). A long-term health care institution – such as a nursing home – that admits a client, receives a monetary compensation from the AWBZ fund via the CAK on the basis of the client’s ZZP level. When a client is appointed one, two or three full days of stay with care (short-term residence), care is defined by function and level.

The VV-ZZP is explained here, to give an example of how care weight packages are used and demarcated. As can be seen in table 15 (next page), the ten VV care weight packages can be categorized according to seven factors. Interpretation of the symbols can roughly be done as follows: 0 = not applicable, ++ = supervision and/or stimulation, ++++ = help, ++++++ = complete take-over. The ninth and tenth VV-ZZP apply to short-term care for specific client groups. The ninth VV-ZZP applies to clients in rehabilitation. The tenth VV-ZZP applies to palliative care for terminally ill clients, who can no longer live in their own home.

Table 14: Grounds for AWBZ care and their care weight packages

Ground	Special circumstance	ZZP series
Somatic ailment/limitation	-	VV
Psycho-geriatric ailment/limit.	-	VV
Mental handicap	-	VG
	Slight mental handicap	LVG
	Strong behavioral disorder / slight mental hand.	SGLVG
Physical handicap	-	LG
Sensory handicap	Hearing disorder and communication handicap	ZGaud
	Visual handicap	ZGvis
Psychiatric ailment/limitation	-	GGZ

Table 15: VV-ZZPs

ZZP	Counseling		Care			Nursing care	Problem behavior
	Social self-reliance	Psycho-soc. funct.	Personal care	Mobility	Motor funct.		
VV1	+	0	+	+	0	0	0
VV2	+++	+	++	+	+	+	0
VV3	++++	++	++++	+++	++	+	0
VV4	++++	+++	++	+	+	+	+
VV5	+++++	++++	++++	++++	++	+	+
VV6	++++	+++	+++++	+++++	+++	++	0
VV7	+++++	+++++	++++	+++	++	++	+++
VV8	+++++	+++	+++++	+++++	+++++	++++	+
VV9	+++	++	+++	+++	++	++	0
VV10	+++++	++++	+++++	+++++	++++	+++	+

Central to the first eight VV-ZZPs is that the higher the level of ZZP the higher the compensation from the AWBZ via the Central Administration Office (CAK). Every VV-ZZP includes different classified illnesses and limitations. For example, clients in VV-ZZP 7 have a relatively higher score on problems with social self-reliance, psycho-social functioning, and problem behavior, than clients in VV-ZZP 8. This means that VV-ZZP 7 includes many psycho-social or psycho-geriatric elements, or other psychologically classifiable problems, and VV-ZZP 8 more problems or illnesses concerning physical instead of psychological problems. VV-ZZP 8 is on a higher level because illnesses with this character involve higher health care expenditure, not because the illnesses or problems are more serious or detrimental. !!

Table 16 shows the compensation fees for VV-ZZPs in 2011. The 10 VV-ZZPs can be given with or without treatment, and they all include daytime activities.

Table 16: (Maximum) compensation fees for VV-ZZPs in 2011, set by the NZa.

Care weight package	Compensation fee in euros/day (no treatment)	Compensation fee in euros/day (including treatment)
VV1	58,55	-
VV2	74,77	-
VV3	90,49	113,18
VV4	103,27	125,96
VV5	141,51	165,38
VV6	141,55	165,42
VV7	166,62	197,39
VV8	194,20	224,97
VV9	137,76	196,15
VV10	212,42	243,20

3.3 Types of long-term care institutions

The two most important institutions delivering long-term (AWBZ) care are nursing homes and care homes. Other homes are also defined in this paragraph.

3.3.1 Nursing homes

Nursing homes have two main functions. First, they house and provide care for seriously ill and/or disabled clients who have lost so much of their independence and mobility that they need intensive personal and nursing care. Second, they offer personal and nursing care to clients who are housed in other institutions, such as care homes or hospices. Residence, medication, tools and all forms of care (including specialist care) that is provided in a nursing home is compensated through the AWBZ. If a client leaves a nursing home for care in a hospital, all care is compensated through the ZVW.

There were 479 nursing homes in the Netherlands in 2009. In that same year, the capacity of all nursing homes in the Netherlands totaled 74,430 persons.

3.3.2 Care homes

Care homes provide care for clients who can no longer live in their own home. Clients can receive home care, personal care, and some basic nursing care (e.g. wound dressing, help with medication intake) in care homes. So-called “regular” care homes are controlled by the government and receive most of their compensation for residence and care from the AWBZ fund (besides out-of-pocket expenditure). Private care homes are not compensated through the AWBZ fund, but by clients themselves. Clients may use their PGB to pay for residence and care in a private care home. A care home was usually called a care home, but this term is not used often anymore.

There were 1,131 care homes in the Netherlands in 2009. There were 290 homes combining services of care and nursing homes. In that same year, the capacity of all care homes totaled 96,170 persons. Table 17 shows the usage of care and nursing homes by gender, age and marital status in 2008 and 2009.

Table 17: Share of users (%) in care homes and nursing homes by gender, age and marital status, 2008-2009 (source: SCP).

Category	Level	Share of users (%) in:		
		Care home	Nursing home (somatic)	Nursing home (psychogeriatric)
Gender	Male	23	29	23
	Female	77	71	77
Age	55-64	1	8	3
	65-69	2	5	3
	70-74	3	11	6
	75-79	10	18	14
	80-84	23	20	25
	85-89	32	22	27
	90+	30	15	22
	Average age	85.8	80.5	83.4
Marital status	Married	9	25	23
	Divorced	5	7	5
	Widowed	76	57	65
	Never married	10	11	6

3.3.3 Related institutions

Other different forms of elderly homes and care institutions exist in the Netherlands. These are defined below:

- Care farms are agricultural or horticultural companies that offer daytime activities for people with mental or physical disabilities and (demented) elderly. These daytime activities can be compensated through the AWBZ.
- Home care organizations. Home care organizations deliver home care for clients living at home or in long-term care institutions. Home care organizations can be from the municipality or privately owned. Home care can be funded by the client or through the WMO.
- Hospices. Anyone who is diagnosed with a terminal illness and will (probably) live no longer than 3 months, may be moved to hospices, where only palliative care is given. There are also “almost home” institutions, where there are volunteers working to improve the well-being of the terminally ill. “High-care hospices” offer medical services comparable to hospital services for the terminally ill.

3.4 Staff working in the context of the AWBZ

The different types of staff that work within the confines of AWBZ care are given in this paragraph.

3.4.1. Nursing staff

Basically, there are five levels of nursing and caring staff in the Netherlands. Level 5 is the highest level and attained by earning a *Bachelor of Nursing* after studying and practicing this occupation in an institute for *Higher Occupational Education* (HBO). Students following a Bachelor of Nursing may specialize in geriatrics, pediatrics, psychiatry, hospital care, and “social nursing” (related to prevention, vaccination, and health advice).

Level 4 nurses finished the highest level in a *Secondary Occupational Education* (MBO) school. The main difference between level 4 and 5 nurses is that level 5 nurses focus on coordinating and managing in their studies, and are prepared to bring scientific findings into practice. Both level 4 and 5 nurses may become a nursing specialist after following a master. Nursing specialists may treat patients (e.g. give injections, prescribe medication) and have the authority to work more independently. Five specialisms are protected within the Law on BIG for nursing specialists: preventive, acute, intensive, chronic, and mental care.

Level 5 nurses can also become a *nurse practitioner* after following a *Master of Advanced Nursing Practice*. Nurse practitioners (NPs) can see patients in the polyclinic, make diagnoses, and prescribe medication. They often work besides a general practitioner. The target group of NPs exist mostly of chronic patients. By treating chronic patients, nurse practitioners help in preventing these patients from intensively visiting the more “expensive” medical specialists.

Members of caring staff with level 1, 2 or 3 are officially not nurses, but fall under the category of home care staff.

3.4.2 Home care staff

Home care staff are not qualified to give medical care, and only assist in domiciliary tasks, such as cleaning, bathing, and dressing. Home care helpers with a level 1 training may prepare meals and help in other domiciliary tasks. These tasks may be performed at the client's home, but also in care homes or nursing homes. Level 2 home care helpers may also provide personal care, such as helping people in and out of bed, getting dressed or undressed, and showering or bathing. Level 3 home care helpers receive additional training in preparing schedules, making individually tailored domiciliary- and personal care plans, and making reports. They may also qualify for a degree in *Individual Health care* (IG), for which they must learn basic nursing tasks such as assisting with taking medication or injecting oneself.

3.5 Separating AWBZ care from care from the ZVW and WMO

When a client receives care, it is not always distinctly clear from which health care act compensation for expenses is provided. The focus of this paragraph lies on the AWBZ and how care from the AWBZ fund can be separated from compensation from the ZVW and the WMO. Point 9 of the CIZ funnel model stipulates that care is not funded by AWBZ insofar a client is entitled to comparable care services from other legal care provisions. This means that – if possible – care from the ZVW or WMO precedes care from the AWBZ. If care services are not provided through the ZVW or WMO, it is provided through the AWBZ. How AWBZ funding is separated from funding from the ZVW and WMO is explained below. This is explained on the basis of the six types of AWBZ care; for each type of care a different paragraph. The next paragraph clarifies what health care services are provided by the AWBZ in an institution.

3.5.1 Provisions

Most expenses for care and residence in a regular care home or nursing home are paid for by the AWBZ. These regular institutions are therefore also called AWBZ-institutions. The client will have to pay for care and residence when he or she is staying in a private care home or nursing home. The client may use money from a PGB in this case.

Personal care, nursing care, home care, counseling and other products and services are provided through the AWBZ when a client is staying in a regular institution. The client partly pays for these services and products he or she is receiving through the compulsory AWBZ deductible. The other products and services mentioned here refer to, for example, toilet paper and foot care. These products and services are also called *provisions*. Most provisions are only paid for by the client himself if they are medically speaking not a necessity. Examples of provisions that the client may receive through AWBZ financing are given below:

- Three meals a day, sufficient drinks (such as coffee, tea or soft drinks), fruit and some (healthy) snacks. Alcoholic beverages and other snacks are not paid for.
- Certain care products, such as plastic gloves, wet towels or toilet paper. More “general” care products such as shower gel, soap, shaving equipment, toothpaste a toothbrush, et cetera are not paid for.
- Washing, drying, ironing and dry-cleaning of clothing. Clothing that needs extra washing for medical reasons is not paid for.
- Personal care services that are a medical necessity or cannot be done by the client him- or herself. An example is nail clipping in case the client has a certain disability, or foot care in case of diabetes or a disability.
- A cable connection for television. The television and a TV-membership is not provided.

3.5.2 Limits of the AWBZ: Personal care

Clients who need moveable living provisions for the short term (less than six months), such as a shower stool, may receive them from a lending service from the AWBZ. If a client requires provisions for the longer term (more than six months), he or she will receive this from the municipality through the WMO. If clients apply for personal care provisions from the WMO, they may receive them from the lending service from the AWBZ first, because the WMO cannot always directly provide them. When adjustments to the client’s home are required, the AWBZ can also bridge the gap between the application for – and the realization of – these adjustments. The ZVW also provides for personal care services. These services concern:

- Aiding tools (e.g. for putting on and taking off support stockings). The AWBZ provides for professional help, when the use of such aiding tools has become too problematic.
- Request for patient-specific distribution and dose-preparation of medication is done by the pharmacist (formerly by home care). A health care professional may assist a patient with the preparation or taking of medication when medication cannot be systematically pre-dosed by the pharmacist (e.g., when medication intake changes often or fluids or ointments are prescribed).
- Teaching of self-care or learning specific skills that result from a prescribed treatment or action by a medical specialist (e.g., using a stoma or preparing tube feeding), unless the client is unable to learn or implement the skills.

3.5.3 Limits of the AWBZ: Nursing care

The demarcation of nursing care delivered by the AWBZ and the ZVW is complex. The essence of how nursing care is separated remains the same though: if nursing care is necessary with regard to a medical specialism – whether there it concerns nursing care in combination with hospital stay or not – it is arranged through the ZVW; otherwise it is provided by the AWBZ. The Health Insurance Board (CVZ) separates ZVW from AWBZ with regard to nursing care according to three factors:

- The seriousness of the ailment or treatment (Life-threatening? Risk?).
- The complexity of the situation (Stabile? Predictable?).
- The amount of interference by a medical specialist (Instructions? Supervision? Interference? Control?).

The CVZ has defined four categories to demarcate nursing care from AWBZ or ZVW:

1. Complex nursing care, which is assigned and supervised by a medical specialist, and for which he or she is available for intervention, and of which he or she needs feedback, is arranged through the ZVW. An example is intra-venal therapy at home.
2. Less complex nursing care directly connected to a medical specialism, for which supervision and intervention are not necessary, and which the client may reasonably

expect to receive in a hospital is also arranged through the ZVW. An example is periodical injections under the responsibility of the medical specialist.

3. Less complex nursing care directly connected to a medical specialism, for which supervision and intervention are not necessary, and of which the client may not reasonably expect to receive in a hospital, is arranged through the AWBZ. An example is frequent treatment or treatment for an immobile client.
4. Nursing care assigned by the GP of which the client may reasonably expect to receive in a GP's office belongs to the ZVW. Nursing care assigned by the GP of which the client may not reasonably expect to receive in a GP's office belongs to the AWBZ. An example is repetitive wound dressing at home or at a long-term care institution.

Nursing care under direct management and responsibility (assign, instruct, receive feedback) of the medical specialist belongs to the ZVW. This also applies to instruction and information that necessarily goes together with the act or treatment, such as the instruction how to use a catheter or how to perform an injection. When it is established from these categories that nursing care is not directly under the responsibility of the ZVW, other factors should also be taken into account. These are given in figure 8 (next page). The administration of a health care provider is responsible for demarcating the care that is delivered, so compensation can be retrieved from either the health care insurer or the AWBZ budget they receive.

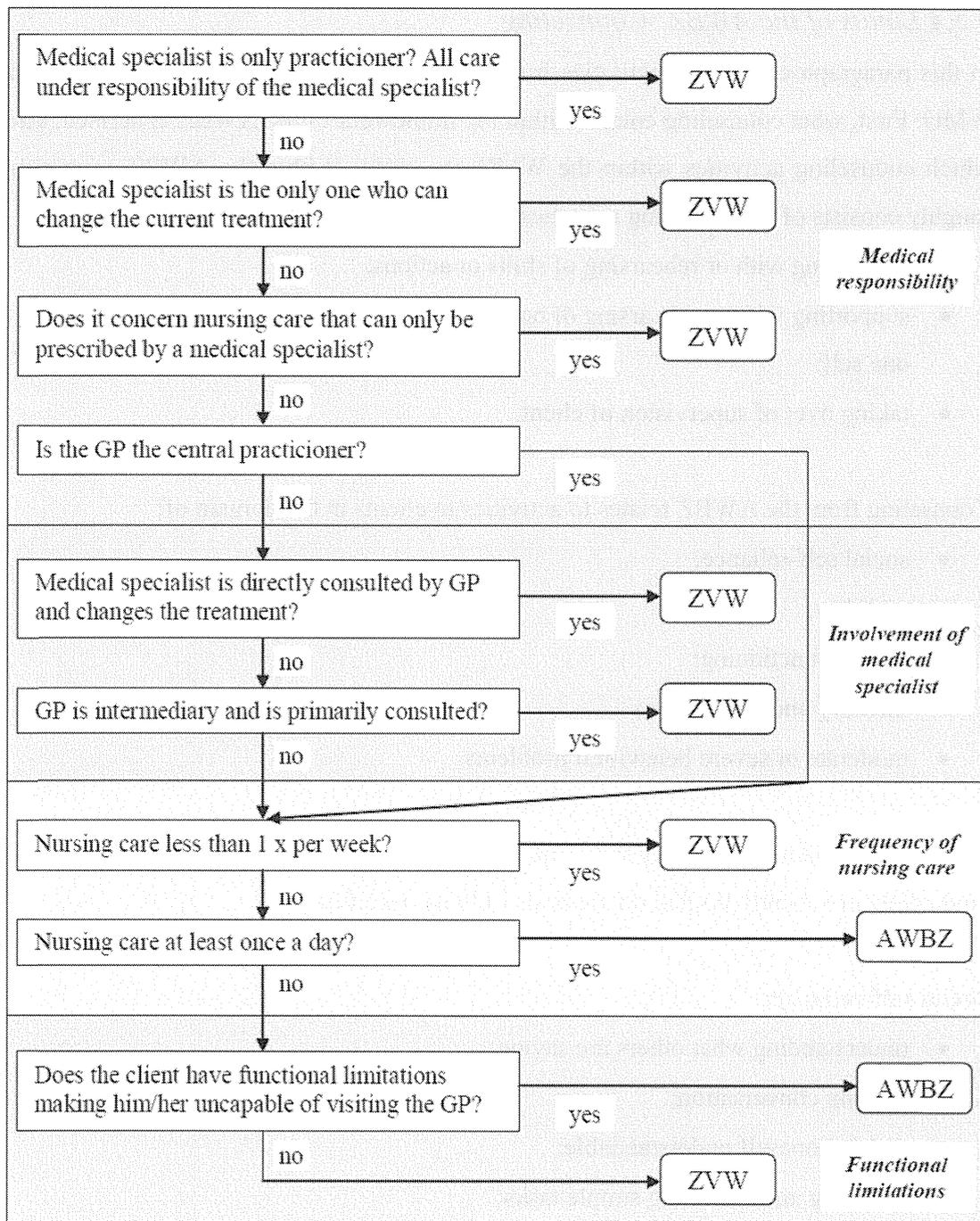


Figure 8: Schedule of demarcation nursing care ABWZ from ZVW (source: [6] page 102).

3.5.4 Limits of the AWBZ: Counseling

In this paragraph counseling activities from the AWBZ are separated from those of the WMO. First, what counseling entails within the framework of the AWBZ is defined, after which counseling activities within the WMO are given. Within the AWBZ counseling roughly consists of the following activities:

- supporting with or rehearsing of skills or actions;
- supporting with or rehearsing of bringing structure into one's life or managing one self;
- taking over of supervision of client.

Counseling from the AWBZ relates to activities to clients in the domain of:

- social self-reliance;
- mobility;
- mental functioning;
- memory and orientation;
- moderate or severe behavioral problems.

These five domains are further specified here. The five domains are labeled as slightly, moderately or severely limited on the basis of these specifications.

Social self-reliance:

- understanding what others are saying;
- making conversation;
- making oneself understandable;
- initiating and executing simple tasks;
- reading, writing, calculating;
- using communication aids;
- daily routines and activities;
- solving problems and taking decisions;
- arranging daily routine;

- controlling budget and arranging monetary tasks;
- initiating and executing complex tasks;
- keeping up with administrative tasks.

Mobility:

- maintaining bodily position;
- making crude hand and arm movements;
- making fine hand and arm movements;
- lifting lighter objects;
- making coordinated movement with legs and feet;
- changing bodily position;
- going up and down the stairs without aid;
- moving with aids;
- moving within the house without aids;
- using public transport;
- using own transportation;
- walking short distances;
- lifting heavier objects.

Mental functioning:

- concentration;
- memory and reasoning;
- perception of surroundings.

Orientation:

- orientation as a person;
- orientation in space;
- orientation in time;
- orientation to a place.

Behavioral problems:

- destructive behavior towards oneself and/or the other, literally and figuratively speaking;
- obsessive behavior;
- physically aggressive behavior;
- manipulative behavior;
- verbally aggressive behavior;
- self-harming or self-damaging behavior;
- sexual behavior transgressing certain borders.

Care that can be provided through the WMO precedes potential AWBZ care. With regard to counseling the WMO provides care by offering clients help with regard to participating in society. Municipalities are responsible for this help and every municipality can decide how to compensate for the client’s limitations. As described in paragraph 1.3.1 on pages 18-20 there are nine performance fields. How municipalities organize and conduct aid for elderly clients with limitations are given in table 17 below.

Table 17: Performance fields within the WMO and examples concerning elderly welfare

<i>Performance field</i>	<i>Examples</i>
Improving social cohesion and livability of villages and neighborhoods.	Club houses, ‘drop-in centres’, neighbourhood activities, sports, park benches, social/cultural activities, contact networks for people in vulnerable positions, contact stimulation, safety, social work.
Support to the youth and parents who experience problems with upbringing.	<i>No example with regard to older people.</i>
Giving information, advice, and support to clients.	One desk policy (the goal is to have on reception desk for all provisions), client and civil participation, handling of complaints.
Supporting informal caregivers and	Voluntary services, chore aid, service point informal