Disability-relevance of quality assurance systems in social services

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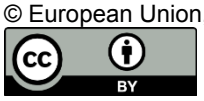

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Table of contents

1 Executive summary

1.1 Definition and framework of the quality of personal social services

Social services designed to improve independent living for persons with disabilities are based on specific Acts, such as the Youth Act 2014, the Social Support Act 2014, the Long -Term Care Act 2014, the Participation Act 2003 and the Act on Reintegration of People with Disabilities 1998. Legal definitions of the quality of social services are provided in the legislation for youth care, long-term care and social support. The definitions are based on general principles. One of them is that services should be client oriented and tailored to their needs. The national disability strategy 'Onbeperkt Meedoen' states that accessibility, quality and availability of social services are essential for persons with disabilities to participate in society.

There are no well-defined standards for what social support, youth care and reintegration services should be. Municipalities and the national public authority for unemployment and disability reintegration services (UWV) are free to decide on the level of provision and the quality of services they provide. They are required to conduct yearly client satisfaction reviews (a short set of questions and a rating system) and to make sure that any service provider who is contracted will use a quality management tool. Almost all the available quality assurance systems are process oriented, not outcome oriented.

In residential long-term care, providers have developed more than a procedural system. They have an agreement on how to define quality of residential care, and they define it as quality of life. Residential care providers have also developed a system for the involvement of users of their service and a system to assess and evaluate instruments for assessing quality of life.

In social services, responsibility for providing good quality lies mostly with the providers and individual professionals. They should have a specific educational level, they should follow ongoing training in order to be registered, and they should abide by standards set by their sectoral organisation. The assumption is that working according to standards results in good quality. The same assumption applies to medical professionals working in long-term care and youth protection institutions. The professionals should register, in their case on a legally based register, and to work according to the appropriate standards. Working at a substandard level of quality may result in being removed from the register.

Providers of long-term care are required to register as care providers if they employ more than 10 employees. Registration comes with various conditions: providers must establish a client council; they must publish a yearly report on governance and on quality of services; they must be certified to use a quality assessment tool; and they must report abuse etc.

The Health and Youth Care Inspectorate supervises all care and support providers.[1] The Inspectorate will assess whether standards are followed and will see to it that care providers have a quality management system in which all legal and voluntary requirements are being followed. The Inspectorate will publish reports of all inspections online, but there is no ranking system or other instruments to compare levels of quality.

All quality assurance systems are controlled by the service provider, and there is rarely an objective assessment by outsiders. The position of users of social services in quality assurance methods is not well aligned with the principles of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). The general rule is that users of social services should be consulted via a client advisory council and through the use of a client satisfaction review system. There is no known research on the impact client councils or client satisfaction reviews have on quality assurance.

1.2 Evaluation of the quality of social services

Some studies on evaluating quality assurance systems in residential care found that they are not adequately suited to the needs of clients with more complex needs and that providers tend to use the outcomes to adapt individual care plans instead of using them for a dialogue and a learning process between staff and clients on how life is organised within the institution.

1.3 Impact of quality assurance mechanisms

The impact of quality assurance systems in social support care is very low. A national satisfaction review on the quality of social support provided by municipalities showed a consistent general satisfaction rate. Nonetheless, several surveys focused on outcome results of social support and youth care show severe and consistent substandard levels of quality of care.

1.4 Recommendations for the Netherlands

Set out minimum standards for what social services should encompass and what level of quality is expected. Service quality assessment can only succeed if minimum standards are clear for both providers and users.

Abolish simple client or customer reviews, as they do not provide reliable information on outcome results and because they exclude specific groups who cannot use written reviews.

Arrange for broader qualitative questioning of users of social services, aimed not at assessing perceived service quality but at assessing quality of life and how social services are succeeding in contributing to quality of life. Use this questioning for continuous feedback to organisations on how to improve individual services and how to improve quality at organisation level.

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[1] General website of the Health and Youth Care Inspectorate: https://www.igj.nl/. See, in particular, the web page on supervision of the governance of care providers: https://www.igj.nl/publicaties/publicaties/2020/07/03/kader-goed-bestuur.

1.5 Recommendations for the European Commission

Set out minimum standards for what social services should encompass, what level of quality is expected and how services should be aligned with the CRPD.

Make an inventory of good practices and disseminate them among Member States.

2 Conceptualising quality of essential services provided directly to the person: framework, definition, and research in the European States

2.1 Definitions and frameworks

Social services designed to improve independent living for persons with disabilities are based on specific Acts, such as the Youth Act 2014,[2] the Social Support Act 2014,[3] the Long -Term Care Act 2014,[4] the Participation Act 2003[5] and the Act on Work and Income According to Labour Capacity 2005.[6] Legal definitions of quality of social services are provided in some of these act.

The national disability strategy 'Onbeperkt Meedoen' states that accessibility, quality and availability of social services are essential for persons with disabilities to participate in society. One of the tools to ensure accessibility is the provision of independent client support when accessing provisions based on the Social Support Act and Long -Term Care Act.

The following definitions are used in this report:

- Youth Act. The legal definition for the quality of social support to all minors with a disability or in need of child protection is: 'The youth care provider and certified institution shall provide responsible support, which is understood to be support at a good level and which is safe, effective, efficient, client-oriented and which is tailored to the real needs of the young person or parent.'[7]

  The Youth Act 2014 provides protection to minors (in all cases in which some kind of abuse or violence or other safety hazard occurs) and provides social support to minors with a disability. Social support may mean providing support with personal care at home, in specific day-care centres for children with disabilities or personal care and supervision in schools (whether regular or special). The Act also provides for adapted local transport.

  The Youth Act requires municipal councils to set up an action plan for implementing the rights of people with a disability at local level, implying that social services should be aligned with the rights set out in the Convention on the Rights of Persons with Disabilities.[8]

- Social Support Act: The legal definition provided by the Social Support Act 2014 is: 'Social support shall be safe, effective, efficient and client oriented; tailored to the real needs of the client and aligned with other support the client receives; provided in accordance with the responsibility that rests upon providers resulting

2 Youth Act 2014 *(Jeugdwet)*, https://wetten.overheid.nl/BWBR0034925/2023-01-01.
3 Social Support Act 2014 *(Wet maatschappelijke ondersteuning)*, https://wetten.overheid.nl/BWBR0035362/2022-07-01#Hoofdstuk3.
4 Long Term Care Act 2014 *(Wet Langdurige Zorg)*, https://wetten.overheid.nl/BWBR0035917/2022-07-01.
5 Participation Act 2003 *(Participatiewet)*, https://wetten.overheid.nl/BWBR0009565/2005-09-01.
6 Act on Work and Income According to Labour Capacity 2005 *(Wet Werk en Inkomen naar Arbeidsvermogen)*, https://wetten.overheid.nl/BWBR0019057/2023-01-01.
7 Article 4.1.1. of the Youth Act 2014.
8 Article 2.2.f of the Youth Act 2014.

from professional standards; provided with respect for and observance of the rights of the client.'

Social support is to be provided to all persons with a disability. Provisions include cleaning services and personal care provided at home, adapted transport, day-care centres, group home living and direct payments for personal assistance.

The Social Support Act requires municipal councils to set up an action plan for implementing the rights of people with a disability at local level (the same requirement as the Youth Act, implying that social services should be aligned with the rights within the CRPD.[9]

- Long-term care: The legal definition used for quality of long-term care under the Long Term Care Act 2014 is: 'Good care is care of good quality and of a good level; which is in any case safe, effective, efficient and client oriented, which will be granted on time and which is adapted to the real need of the client; whereby care providers and care professionals act in accordance with the responsibility that rests upon them, resulting from professional standards and quality standards; whereby the rights of the client are carefully observed and the client is also otherwise treated with respect.

  This definition is not set in the Long -Term Care Act itself, but in the Act on Quality, Complaints and Conflicts in Care,[10] which applies to all medical care, medical home care and residential long-term care. Long-term care is provided when persons with a disability are in need of 24/7 supervision in order to keep them safe. There is no reference to the UN CRPD in either the Long -Term Care Act or the Act on Quality, Complaints and Conflicts in Care.

- Reintegration services: Under the Participation Act 2003, municipalities are to provide cash benefits, reintegration into paid labour services, sheltered employment and opportunities to participate in the local society to people who are unemployed or disabled (to all people with a disability but without entitlement to a disability benefit). The Participation Act does not define what reintegration services entail, nor does it provide a definition of good quality of reintegration services. The clause in the Youth Act and Social Support Act to use a local plan to implement the CRPD locally is also part of the Participation Act.[11]

  The Participation Act requires municipalities to set up an action plan for implementing the rights of people with a disability at local level, implying thereby that social services should be aligned with the rights within the CRPD.

[9] Article 2.1.2.h of the Social Support Act 2014.
[10] Article 2 of the Act on Quality, Complaints and Conflicts in Care 2015 *(Wet Kwaliteit, Klachten en Geschillen Zorg)*, https://wetten.overheid.nl/BWBR0037173/2023-01-01.
[11] Article 8d of the Participation Act 2003.

The Act on Reintegration of People with Disabilities 1998[12] grants reintegration services to people entitled to a disability benefit. The Act does not define quality of reintegration services, however, and there is no reference to the CRPD in the Act.

Regarding the framework, there are no national standards for quality of youth social support, for general social support nor for reintegration services, and there is no central description of the expected quality of such services other than the legal definition as described above. There are explicit standards formulated for medical treatments, medical care and aspects of long-term care.

In social services, responsibility for providing good quality lies mostly with the providers and individual professionals. They should register and work in accordance with the standards set by their sectoral organisation, and the assumption is that working according to these standards results in good quality. Professionals working in social support, such as client supporters for persons with disabilities, and professionals working in reintegration services, such as job coaches, are usually required to register with independent sectoral organisations. They can qualify for registration by showing proof of their education and ongoing training.

A legal requirement for municipalities is to conduct a client satisfaction review (by asking a set of standardised questions) among users of social support each year.[13] Such a legal requirement does not apply to reintegration services.

Municipalities and the authority for unemployment and disability reintegration services (UWV) will tender out social services. In this tender process they are expected to describe the level of quality they expect. For further detail, see Section 3.1.

The common approach is that the level of quality is described in general terms (based on the legal definition of social support), and care providers who wish to participate in a tender are required to be certified to use one of the available quality management models.[14]

If users of social services wish to dispute the quality of social services offered by municipalities or the UWV, they may lodge a complaint with the municipality or UWV[15] itself, or with the National Ombudsman. There is also the option to lodge complaints about services offered by service providers with the provider itself. Care providers are legally required to set up a complaints procedure and an independent complaints commission. The Health and Youth Care Inspectorate can receive individual complaints and may use them when the specific care provider is inspected, but the Inspectorate will never handle individual complaints as such.

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[12] Act on Reintegration of People with Disabilities *(Wet op de (re)integratie arbeidsgehandicapten)*: https://wetten.overheid.nl/BWBR0009565/2005-09-01.

[13] Requirement in the Social Support Act 2014.

[14] Some voluntary models for (self-)evaluation of quality of care are described on a web page of the Netherlands Youth Institute *(Nederlandse Jeugdraad)*: https://www.nji.nl/effectieve-jeugdhulp/kwaliteitsbeleid#:~:text=Kwaliteitskader%20Jeugd&text=beschrijft%20voor%20welke%20werkzaamheden%20jeugdhulpaanbieders,wanneer%20dat%20niet%20nodig%20is.

[15] Web page on complaints procedure at the UWV (authority for unemployment and disability reintegration services): https://www.uwv.nl/particulieren/klantenservice/klachten-bezwaar-beroep/ik-heb-een-klacht/detail/afhandeling-klacht.

In the traditionally more medically oriented services such as youth protection and long-term care the legal requirements and supervision regulations are stricter than in reintegration or social support services. Those who provide a form of medical care (in long-term care institutions and in youth protection) are legally required to register as medical professionals (doctors, nurses or therapists) and are required to work in accordance with the professional standards in their specific professions.[16]

Individual professionals who are not regarded as medical staff (assistants and various kinds of therapists) in long-term care and youth care must have specific education and training, and they should be registered as such. Individual professionals and companies that employ professionals in long-term care and youth care must apply for formal registration[17] with a public administrator.[18] When registering, individual professionals will be made aware that they should report any incidents of violence and abuse, they will be asked if they will administer medicines and follow the obligations that come with that, and they will be asked if they have a complaints procedure and if clients are given the opportunity to discuss how they are supported.

All care providers who employ more than 10 professionals are legally obliged to provide their complaints procedure, to set up an advisory council of clients and to register their complaints procedures, their internal plans for the ongoing training of their employees, employees' work schedules, the number of hours they will work and their revenue model.[19] Care providers and individual care professionals are not legally obliged to be registered, but they cannot be contracted if they are not, unless they work as an informal carer at a specified reduced hourly rate.

The Dutch National Health Care Institute[20] decides on specific care standards and on evaluation instruments to measure the effectiveness and efficiency of these standards. Standards will be developed and proposed by working groups, in which experts, alongside representatives of the patients or service users, will be represented.[21] These care standards describe what care should be offered for specific illnesses or conditions and in long-term care. The standards serve as a minimum level of quality that should be offered. Care options that are not accepted as a specified standard by the National Health Care Institute cannot be financed by care insurers. Moreover, the national Government may refuse a new standard for providing care if it deems the collective cost for such care to be too high.[22]

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16 Act on Professions in Individual Medical Care 1993 (*Wet op de Beroepen in de Individuele Gezondheidszorg*, BIG), https://wetten.overheid.nl/BWBR0006251/2022-04-01.

17 The requirement to register is in the Care Providers Admission Act 2020 *(Wet Toetreding Zorgaanbieders)*, https://wetten.overheid.nl/BWBR0043797/2022-01-01.

18 Registration must be applied for at a public administration office called CBIG under the Ministry of Health. See: https://www.cibg.nl/over-het-cibg#:~:text=De%20letters%20CIBG%20stonden%20oorspronkelijk%20voor%20Centraal%20Informatiepunt%20Beroepen%20Gezondheidszorg.

19 For all requirements, see: https://www.toetredingzorgaanbieders.nl/vergunning-aanvragen.

20 Dutch National Health Care Institute *(Zorginstituut Nederland)*: https://www.zorginstituutnederland.nl/.

21 In accordance with a guideline on developing standards: https://www.zonmw.nl/fileadmin/zonmw/documenten/Kwaliteit_van_zorg/Ontwikkeling_kwaliteitsstandaarden/Leidraad_voor_kwaliteitsstandaarden__28AQUA_29.pdf.

22 Article 11c and 11d of the Act on Quality, Complaints and Conflicts in Care 2015, https://wetten.overheid.nl/BWBR0037173/2023-01-01.

Providers of residential long-term care for persons with disabilities have agreed on a set of voluntary agreements for how to monitor and report on quality of care for all their individual clients. There is a specific agreement on quality for nursing homes for the elderly: the Nursing Home Care Quality Framework.[23] There is also an agreement by care providers specifically for persons with disabilities living in institutions, called the *Quality Compass for Disability Care 2023-2028*.[24] Quality of care is described as care that contributes to quality of life and the ability for clients to make their own decisions in life. See Section 3.5 for further detail.

Providers of long-term care are obliged to publish and submit an annual report on good governance.[25] This report should contain a section on the quality of care they provide. The mandatory client council shall be consulted on quality of care. These yearly reports on quality of care and the data gathered by the National Heath Authority are published on a website[26] where service users may consult them and compare the quality of care provided by the service providers. This website is not accessible in Easy Read format. The National Health Authority does not analyse the annual reports, and there is no easy comparison available.

A private federation of patient associations *(Nederlandse Patientenfederatie)* provides a website that is easier to read, listing care providers with contact details and a mark for quality of care. This quality mark is solely based on client reviews, which must be submitted online (similarly to reviews in use in the leisure sector for hotels, Airbnb, etc.), without any further scrutiny.[27] This online reviewing system is a remnant of the 2008 reorganisation of long-term care in the Netherlands, in which central coordination and financing of long-term care was reorganised into a free market model where people with disabilities are linked to an individual budget with which they can shop around for a care provider who provides care at a level of quality and a style to their liking. The assumption is that care providers who get poor reviews will attract fewer clients and will be forced to change or to leave the market. However, such free choice in the long-term care sector has not reaped the expected results: Persons seeking a place in a residential care unit are very limited in their choice because of waiting lists and the custom on the part of care providers to select clients according to their own criteria.

[23] Nursing Home Care Quality Framework *(Kwaliteitskader Verpleeghuiszorg)*, Dutch National Health Care Institute *(Zorginstituut Nederland)*, 2017, https://www.zorginzicht.nl/binaries/content/assets/zorginzicht/kwaliteitsinstrumenten/kwaliteitskader-verpleeghuiszorg---2021.pdf.

[24] *Kwaliteitskompas Gehandicaptenzorg 2023-2028*, https://www.vgn.nl/system/files/2022-09/Kwaliteitskompas%20GHZ%202023-2028.pdf.

[25] Health and Youth Care Inspectorate website on good governance demands for care providers: https://www.igj.nl/publicaties/publicaties/2020/07/03/kader-goed-bestuur.

[26] Open data from the National Health Care Institute is available at: https://www.zorginzicht.nl/openbare-data; the Ministry of Health website provides annual reports by all care providers, at: https://www.jaarverantwoordingzorg.nl/gegevens-bekijken; two websites on care provision and quality levels that are more accessible for service users are Zorgkaart Nederland (https://www.zorgkaartnederland.nl/keuzehulpen) and Kiezen in de GGZ (https://kiezenindeggz.nl/).

[27] See *Zorgkaart Nederland*: https://www.zorgkaartnederland.nl/?zoekterm=gehandicaptenzorg.

The Health and Youth Care Inspectorate supervises all care and support providers.[28] The Inspectorate will assess whether standards are followed and will see to it that care providers have a quality management system in which all legal and voluntary requirements are being followed. The Inspectorate will publish reports of all inspections online, but there is no ranking system or other instruments to compare levels of quality.[29]

The European Quality Framework for Social Services is not mentioned in any of the systems for quality assurance in the Netherlands.

2.2 Research studies and national debates

Three studies mapping known instruments for evaluating the quality of life in long-term care for persons with (mostly intellectual) disabilities, psychosocial disabilities and elderly persons were published in 2015. The study by a private research agency, ZonMw, together with the National Health Authority, on mapping instruments in institutions for persons with (intellectual) disabilities, described how care providers used a wide range of instruments, some of them of their own invention, some certified. The study also said that most of these methods were based on interviewing individual clients, that the instruments were not well suited to the needs of clients with more complex needs, and that the results of the individual assessments were in many cases being used to improve individual care plans rather than feeding into a debate within the institution on improving the quality of services there as a whole.[30]

The University of Utrecht evaluated a version of the quality framework for care providers for persons with disabilities living in institutions. The report, by the university's Usbo research institute, examines the effectiveness of the framework's method and how staff in institutions worked with it in practice.[31] The report found that the interviews by staff members of individual clients in institutions on their perceived quality of life tended to focus on how individual care plans could be fitted into the somewhat bureaucratic system of filing all individual care plans, and that the assumption that the interviews would lead to a genuine dialogue and learning process between staff and clients on how life was organised within the institution had not yet been realised. The report noted that the method had not yet fully achieved an ongoing reflection of how work was being done in the institutions. Part of the quality framework involves regular 'visitations' between institutions. The report noted that staff had a tendency to perceive visitations by fellow institutions as a judgment process, and they

[28] General website of the Health and Youth Care Inspectorate: https://www.igj.nl/. See, in particular, the web page on supervision of the governance of care providers: https://www.igj.nl/publicaties/publicaties/2020/07/03/kader-goed-bestuur.

[29] All inspection reports are published at: https://toezichtdocumenten.igj.nl/.

[30] Nijhof, E., and Vunderink, L. (2015), *Mapping the quality of life in care for persons with disabilities. An inventory of instruments that are being used. (Het in kaart brengen van de kwaliteit van bestaan in de gehandicaptenzorg en -ondersteuning – Inventarisatie van instrumenten die worden gebruikt)*, Barneveld, Significant, https://www.zorginstituutnederland.nl/publicaties/rapport/2015/03/24/het-in-kaart-brengen-van-de-kwaliteit-van-bestaan-in-de-gehandicaptenzorg-en--ondersteuning-rapport-significant.

[31] Schiffelers, M-J., Kuiper, M., and van der Spek, M. (October 2021), *Samen voor Sectorontwikkeling: Lerende evaluatie kwaliteitskader gehandicaptenzorg (kkghz). USBO advies* (Together for Sector Development: Learning Evaluation Quality Framework Care providers), https://dspace.library.uu.nl/bitstream/handle/1874/420045/Eindrapport_Kwaliteitskader_gehandicaptenzorg_2021.pdf?sequence=1&isAllowed=y.

tended to invite like-minded institutions in order to attract non-critical judgment on the quality of their work. The report gives recommendations to improve the framework and its instruments, such that staff do not perceive the framework as leading to yearly judgments, but as an instrument to provide a continuous voluntary dialogue on how organisational structures and personal efforts can lead to better quality of life for individual residents. There is no reference in the report to the CRPD principles.

A research report on client satisfaction reviews of social support issued by municipalities in 2022 provides an analysis of the review methods used.[32] Until 2021, municipalities were obliged to use a standard list of questions in order to facilitate easier comparison between them. As of 2022, it is allowed to deviate from the standard questioning list, allowing for more qualitative questioning and making it possible to approach specific groups of clients who are numerically a minority among people using social support (such as parents of young children with disabilities as opposed to the larger group of elderly residents). The study shows that a small minority of municipalities had started to make use of more qualitative questioning but, in order to save time and costs, they resorted to online questioning, thereby reducing the response by people who have not adapted to digital invitations.

Other research on social service quality assessment instruments could not be found. There are, however, many studies on social services outcomes. Examples include research on the availability and accessibility of social support offered by municipalities;[33] research on reintegration services offered by the administrative authority UWV[34] and studies by the Ombudsman (see Section 4.2 for further detail).

An alarming report by the Justice and Security Inspectorate in 2022, based on inspections of the quality of youth protection institutions, observed a substandard level of quality of care by youth care providers, resulting in youth not being properly protected and receiving inadequate treatment due to staff shortages, inadequate funding and a continuous shirking of responsibilities by local and national Government. The Inspectorate had also noted this substandard level of quality in reports in 2019, and it stated in 2022 that no improvement could be noted.[35] Based on these and other reports, the Justice and Security Inspectorate and the Health and Youth Care Inspectorate announced in 2022, in a letter to national Government, that they would cease to issue improvement orders to providers as they could not be expected to improve the quality of care as long as central and local Government could not agree

[32] Kroese, D., van Huizen, N., Heuzels, L., van Werkhooven, J., and Vroom, L. (2022), *Landelijke rapportage cliëntervaringsonderzoek Wmo, verantwoordingsjaar 2022*. (Annual report, Client Satisfaction Review Social Support 2022), I&O research, https://open.overheid.nl/documenten/ronl-7f02ebf4113b1cbc9b647fc0b0adda8182182918/pdf.

[33] National Ombudsman, *'Terug aan tafel, samen de klacht oplossen'* (Back at the table, resolving complaints together), 2 March 2017, https://www.nationaleombudsman.nl/publicaties/onderzoeken/2017035-onderzoek-naar-klachtbehandeling-in-het-sociaal-domein-na-de.

[34] National Ombudsman (2019), *Klachten uit zicht, mensen buiten beeld? Een onderzoek naar de behandeling van klachten van mensen met een arbeidsbeperking.* (Complaints out of sight, people out of sight? A survey on treatment of persons with a labour incapacity).

[35] Justice and Security Inspectorate (May 2022), *Rapport Stand van zaken jeugdbeschermingsketen* (State of Play Report on Youth Protection), https://www.inspectie-jenv.nl/Publicaties/rapporten/2022/05/13/rapport-stand-van-zaken-jeugdbeschermingsketen.

on ways to better facilitate the work of youth care providers. The letter said: 'our supervision options have been exhausted'.[36]

The Netherlands Institute for Social Research regularly evaluates the Long -Term Care Act, the Social Support Act and the Participation Act. These evaluation reports implicitly take CRPD principles into account, but not explicitly. The institute focuses on outcomes, not on quality assurance systems within social support systems. One specific study by the Netherlands Institute for Social Research was dedicated to the outcome of the agreement on a quality assurance system for quality of life in nursing homes for the elderly.[37] In 2018, under the Nursing Home Care Quality Framework, the Ministry of Health, Welfare and Sport launched a programme called 'At home in the nursing home: Dignity and pride in every home'.[38] This programme prioritises giving sufficient time, attention and high-quality care to nursing home residents. Residents were interviewed on quality of care and quality of life and on whether improvements could be perceived as a result of the Ministry's programme. A slight improvement of the quality of care was noted in the report, but not an improvement in quality of life.

The evaluation of the national Disability Strategy 'Onbeperkt Meedoen' and follow-up letters to Parliament[39] acknowledged in 2022 that accessibility and availability of social services is not satisfactory, albeit without any specific references to the critique mentioned in studies on social services outcomes by the Health and Youth Care Inspectorate, the Netherlands Institute for Social Research and the Ombudsman.

2.3 Analytical reflection

The quality assurance system for social services such as general social support and reintegration services relies heavily on obliging professionals to work according to professional standards, which consist of set criteria for the level of education of staff and procedural requirements for service providers, such as the requirement to establish a client council, the requirement to produce a quality management system and the requirement to maintain a general complaint mechanism. Criteria for the type and level of education leads to the exclusion of unqualified staff, but it does not in itself guarantee that the quality of services is being maintained adequately.

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36 Health and Youth Care Inspectorate, letter to the Minister of Justice and the Junior Minister for Healthcare and Youth, 9 September 2022, https://www.igj.nl/binaries/igj/documenten/brieven/2022/09/13/signaalbrief-toezicht-jeugdbeschermingsketen/Signaalbrief+toezicht+jeugdbeschermingsketen.pdf.

37 Sociaal en Cultureel Planbureau (The Netherlands Institute for Social Research) (2021), *Leven in een Verpleeghuis* (Life in a nursing home: National overview of living conditions, perceived quality of life and care for older nursing home residents in the Netherlands in 2019), https://www.scp.nl/publicaties/publicaties/2021/02/19/het-leven-in-een-verpleeghuis.

38 Ministry of Health, Welfare and Sport (2018), *Thuis in het Verpleeghuis: Waardigheid en trots op elke locatie* (At home in the nursing home: dignity and pride at every location), the Hague, https://www.waardigheidentrots.nl/wp-content/uploads/2018/04/Programma-Thuis-in-het-Verpleeghuis.pdf.

39 The follow up letter on the Disability Strategy 2022: https://www.rijksoverheid.nl/onderwerpen/rechten-van-mensen-met-een-handicap/documenten/kamerstukken/2022/04/19/kamerbrief-over-vervolg-coordinerende-aanpak-implementatie-van-het-vn-verdrag-handicap.

Legislation on youth care, social support and long-term (residential) care provides definitions of the quality of services, consisting of unspecified general principles, some of which are aligned with the principles of the CRPD. Services should be 'client oriented; tailored to the real needs of the client and aligned with other support the client receives'. The quality of youth care and social services is not further specified on a national level, nor on a local level. This alone makes it very difficult to assess the quality of social services, because it is difficult to measure the implementation of general principles.

Service providers are expected to use a quality assessment instrument, but they are free to choose what instrument to use. There is no general transparent debate on what assessment instruments are best suited to develop an ongoing debate on where the quality of services should be aimed. Most instruments are process oriented, not outcome oriented. This process orientation explains why providers in both social support and youth care oblige everyone to use quality assessments, while still delivering substandard outcome results so severe that the National Ombudsman and the Inspectorate published alarming reports on the quality of services.

The position of users of social services in quality assurance methods is not well aligned with CRPD principles. The general rule is that users of social services are to be consulted in two ways: through a client advisory council and using a client satisfaction review system. There is no known research on the impact client councils have on quality assurance. Client satisfaction review systems mainly consist of issuing standard questions and a rating system, often written or online. Such rating systems often result in a more or less fixed satisfaction result. Most users rate services around 7/10, even if outcome surveys severely criticise policy outcomes. These satisfaction reviews give no opportunity for an open conversation on the level of service quality. Using a system of written or online questions also has the disadvantage that it excludes users who are not able to use these methods. The legal requirement to make local plans to implement the CRPD is not followed by the majority of municipalities. The minority of municipalities who do have an implementation plan focus on (wheelchair) accessibility in the built environment, not on social services.[40]

Providers of residential care for people with (mostly intellectual) disabilities and for the elderly are a positive exception. They explicitly developed their own definition of quality of support in line with some CRPD principles (quality of life domains, as defined by Robert Schalock). Moreover, providers are in the process of involving clients in their quality assurance system in a more qualitative way, with the aim of involving all types of service users, even those with severe cognitive disabilities. They have set up their own advisory council to assess quality assurance systems and evaluate their system.

All quality assurance systems, even the well-developed ones in residential care, are controlled by the service provider. There is rarely an objective assessment by outsiders. This may explain why surveys on outcome results may find very poor quality of services, regardless of the quality assurance in place, as was reported in youth care and in social support by municipalities.

[40] Briels, B., and Movisie (October 2022), *VN-verdrag Handicap in gemeenten; Flitspeiling stand van zaken. Flitspeiling 5* (UN CRPD in Municipalities – Flash Monitor 5), https://www.movisie.nl/sites/movisie.nl/files/2022-10/Movisie-VNG-flitspeiling.pdf.

3 Quality assurance and evaluation of the quality of social services

3.1 Types of quality assurance

The quality assurance process for social support and youth care to be delivered under the responsibility of municipalities involves conducting a yearly satisfaction review among service users, based on a standard set of questions. Conducting an annual satisfaction review is a legal requirement in the Social Support Act. Municipalities are expected to require service providers who participate in a tender to obtain certification that they use one of the available quality management models.[41] An example of such a voluntary model is HKZ, which develops standards for quality of social services in cooperation with service providers.[42] These standards are reviewed by a voluntary advisory council of professionals working in social services and a representative of VNG, the association of municipalities.[43] Another option for providers is to use an ISO certification.[44]

The public authority UWV sets detailed conditions for providers of reintegration services who wish to participate in tenders. These conditions concern the level of education of employees, good governance, the choice of a complaint mechanism and the use of a client satisfaction interview method. Taking, as an example, a set of conditions for providers of job coaching services, the UWV requires service providers to gain a client rating of at least 6.5, where 10 is the highest level of satisfaction.[45]

Professionals working in social support, such as client supporters for persons with disabilities and professionals working in reintegration services (e.g. job coaches) are usually required to register with independent sectoral organisations. They qualify for registration by showing proof of education and ongoing training.

In the more medically oriented services such as long-term care, the main quality assurance process is the legally required demand for all workers to register as medical professionals (doctors, nurses or therapists) and to work according to the professional standards in their specific professions.[46] The assumption is that working according to standards results in good quality. Anyone who is found to have delivered poor quality can be removed from the register.

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41 Some voluntary models for (self-)evaluation of quality of care are described on a web page of the Netherlands Youth Institute *(Nederlandse Jeugdraad)*: https://www.nji.nl/effectieve-jeugdhulp/kwaliteitsbeleid#:~:text=Kwaliteitskader%20Jeugd&text=beschrijft%20voor%20welke%20werkzaamheden%20jeugdhulpaanbieders,wanneer%20dat%20niet%20nodig%20is.

42 Harmonisation quality evaluation in the care sector (*Harmonisatie Kwaliteitsbeoordeling in de Zorgsector*, HKZ): https://www.hkz.nl/.

43 See HKZ, *'Het Centraal College van Deskundigen voor Zorg & Welzijn'*, https://www.hkz.nl/over-hkz/#ccvd.

44 One example is ISO 9001/2015, as offered by a commercial agency, BSI.

45 Recognition framework personal support *(Erkenningskader uitvoering persoonlijke ondersteuning)*, UWV, 2012, https://www.uwv.nl/zakelijk/Images/erkenningskader-uitvoering-persoonlijke-ondersteuning-2012.pdf.

46 Act on Professions in Individual Medical Care 1993, https://wetten.overheid.nl/BWBR0006251/2022-04-01.

Individual professionals who are not regarded as medical staff in long-term care and youth care (assistants or various kinds of therapists) must have specific education and training and they should be registered as having such qualifications. Individual professionals and companies that employ professionals in long-term care and youth care must apply for formal registration[47] at a public administrator.[48] When registering, individual professionals will be made aware that they should report any incidents of violence and abuse, they will be asked if they will administer medicines and follow the obligations that come with that, and they will be asked if they have a complaints procedure and if clients are given the opportunity to discuss the way they are supported.

The National Health Care Institute[49] decides on specific care standards and on evaluation instruments to measure the effectiveness and efficiency of these standards. Standards will be developed and proposed by working groups in which experts will be represented alongside representatives of patients or service users.[50] These care standards describe what care should be offered for specific illnesses and conditions and in long-term care (although in long-term care the description is set out in non-specific, abstract terms). These standards serve as a minimum level of quality that should be offered. Care options that are not accepted as a specific standard by the National Health Care Institute cannot be financed by care insurers.

3.2 Types of services

Social services designed to improve independent living for persons with disabilities are based on specific Acts, such as the Youth Act 2014, the Social Support Act 2014 the Long Term Care Act 2014, the Participation Act 2003 and the Act on Reintegration of People with Disabilities 1998. For these services, some forms of assessment procedure are required, sometimes conducted on a voluntary basis.

3.3 The formal bodies

In social support, municipal councils are responsible for implementing assessment procedures. In the case of social support this means conducting a yearly satisfaction review and requesting certification for the tendering process. In reintegration services, the UWV and municipal councils are responsible for quality assessment procedures, mainly by requiring certification from providers who participate in tenders.

In long-term care and medical care, individual professionals are responsible for registering either on legally based registers for the medical professions or with sectoral organisations. Providers who employ professionals are responsible for hiring only registered employees.

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47 The requirement to register is in the Care Providers Admission Act 2020, https://wetten.overheid.nl/BWBR0043797/2022-01-01.

48 Registration must be applied for at a public administration office called CBIG under the Ministry of Health, https://www.cibg.nl/over-het-cibg#:~:text=De%20letters%20CIBG%20stonden%20oorspronkelijk%20voor%20Centraal%20Informatiepunt%20Beroepen%20Gezondheidszorg.

49 See: https://www.zorginstituutnederland.nl/.

50 In accordance with a guideline on developing standards: https://www.zonmw.nl/fileadmin/zonmw/documenten/Kwaliteit_van_zorg/Ontwikkeling_kwaliteitsstandaarden/Leidraad_voor_kwaliteitsstandaarden__28AQUA_29.pdf.

Care insurers, both public and private, are responsible for contracting only those care providers and professionals who meet the registration demands.

The public Health and Youth Care Inspectorate and the Inspectorate for Justice and Safety will carry out inspections if care providers use a quality assessment system.

The National Health Care Institute[51] decides on specific care standards in medical care and on evaluation instruments to measure the effectiveness and efficiency of these standards.

3.4 Stakeholders, experts by experience and organisations of persons with disabilities

The Social Support Act and the Participation Act require municipalities to set up and consult an advisory council of users of social support. These councils usually consist of representatives of local organisations of different types of users, such as elderly residents or people with disabilities. Advisory client councils are also required for reintegration services for unemployed persons and for recipients of disability cash benefits. All care providers employing more than ten employees are legally required to establish a client council. It is up to municipalities and service providers to decide on how to select the members of such a council.

Providers of residential long-term care for persons with disabilities have agreed on voluntary agreements[52] for how to monitor and report on quality of care for all their individual clients.

Organisations of persons with disabilities were consulted for both voluntary agreements. An advisory council set up by care providers assesses methods of interviewing persons with a disability and issues certificates for the different methods of interviewing persons with disabilities. One of the criteria used by the council is how persons with disabilities were involved in developing the method and how persons with severe disabilities are included.[53]

National Government, the association of residential care providers VGN and care insurers made an agreement on a five-year policy programme for residential care for people with (mostly intellectual) disabilities. The agreement aims to address the low influx of staff in the sector and to ease the rising costs of residential care. Representative organisations of residents were not involved in the agreement in any way. The main organisation of parents of people with intellectual disabilities condemned the agreement because of that lack of involvement, stating its fears that it would lead to a poorer quality of life within institutions.[54]

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51 See: https://www.zorginstituutnederland.nl/.

52 As part of the Nursing Home Care Quality Framework. See: https://www.zorginzicht.nl/binaries/content/assets/zorginzicht/kwaliteitsinstrumenten/kwaliteitskader-verpleeghuiszorg---2021.pdf; *Kwaliteitskompas Gehandicaptenzorg 2023-2028*, https://www.vgn.nl/system/files/2022-09/Kwaliteitskompas%20GHZ%202023-2028.pdf.

53 *Kwaliteitskompas Gehandicaptenzorg 2023-2028*.

54 KansPlus, *'Reactie KansPlus op bestuurlijk akkoord 'Transitie naar een toekomstbestendige gehandicaptenzorg'* (KansPlus response to the 'Transition to futureproof disability care' administrative agreement), 4 April 2022, https://www.kansplus.nl/2022/04/04/reactie-kansplus-op-bestuurlijk-akkoord-transitie-naar-een-toekomstbestendige-gehandicaptenzorg/.

3.5 Methods and methodologies

The most common tool used for quality assurance in residential care are interviews conducted by staff members among all individuals living in the institution, asking how they perceive their quality of life and how the support and care that has been provided as set out in the individual care plan contributes to a better quality of life. The definition of 'quality of life' is based on a model developed by Schalock: physical well-being, psychosocial well-being, meaningful relations and contacts, participation in society, personal development, material well-being and self-determination.[55] These principles align with the principles of the CRPD, but are not specifically mentioned as such. All care providers will assess the perception of every individual client on their quality of life at least once every three years and will incorporate the results into the individual's personal care plan.

An advisory council set up by care providers assesses methods of interviewing persons with a disability and issues certificates for the different methods of interviewing persons with disabilities. The objective in the certification process is to have assessment methods in which a person with (even severe intellectual) disabilities can express their will. This process of individual residents' assessment of satisfaction with their quality of their life is expected to feed into two annual reports on the quality of all care provided in the institution. These reports are expected to form the basis for an ongoing discussion within the institution, the client council and the inspectorate on how to improve the care and living conditions provided.

Different methods of interviewing are being used: open conversations, asking a set of questions or an invitation to make a video comment. These interviews can be used to reset agreements in individual care plans and are supposed to feed into internal debate on the quality of the support provided. A specific tool is used, in which both staff and policymakers within an organisation, as well as users of social services, are interviewed on the quality of services, combined with meetings in which the outcomes of the interviews are discussed among all groups together. This method is based on social role valorisation and full inclusion of persons with disabilities, and is aligned with the principles of the CRPD.[56]

The two voluntary agreements on quality in residential care concern methods used in the Netherlands that align with CRPD principles, which is mainly because the quality-of-life dimensions as defined by Schalock are being used and because users of social services are adequately involved in the assessment.[57]

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[55] Verduro, M.A., Keith, K., and Stancliffe, R.J., 'Quality of Life and its measurement: important principles and guidelines', *Journal of Intellectual Disability Research*, vol. 49, part 10, Oxford, pp. 707-717, https://www.researchgate.net/publication/7601052_Quality_of_life_and_its_measurement_Important_principles_and_guidelines.

[56] See the Inclusionlab website: www.inclusionlab.nl/ and a network of professionals in social services, available at: http://www.netwerkperspectief.nl/.

[57] Quality of Care Framework 2017-2022 *(Kwaliteitskader gehandicaptenzorg)* by the national steering group for disability care *(Landelijke stuurgroep kwaliteitskader gehandicaptenzorg Utrecht),* May 2017, https://www.vgn.nl/system/files/article/file/Kerndocument%2B1.%2BKwaliteitskader%2B2017-2022.pdf.

In most other social services, the most common tool is to ask users to give a review and rate their satisfaction with services.

3.6 The indicators and the principles

1. Yearly satisfaction review of social support and youth care

Municipalities are legally required to conduct an annual satisfaction review among service users, using a standard set of questions. The assumption of this standard set of questions is that the results of the reviews allow for a comparison to be made between municipalities and between different periods. Users are asked, in this standard set of questions: if they knew where to ask for support; if they were helped adequately and in a friendly way; if they knew they had the right to independent client support during the application process; how they perceived the quality of the support they were provided with, if the support helped them to do the things they wanted to do; whether they were enabled to take better care of themselves; and whether the support enabled them to lead a better quality of life.[58] The questions do not refer to the CRPD or to the European Quality Framework.

Municipalities are free to supplement the standard set of questions with any other questions or quality assurance tools.

2. The tools used in residential care are form free and depend on the choices that providers make

Private organisations are hired to produce quality assurance tools, although their set of questions and tools are not publicly available. It is therefore not possible to describe the indicators used in detail.

A specific tool by Inclusionlab based on social role valorisation and full inclusion of persons with disabilities is aligned with the principles of the CRPD.[59]

[58] For an example of a set of questions by a private company performing satisfaction reviews for municipalities, see: https://www.zorgfocuz.nl/verplichte-vragen-clientervaringsonderzoek-wmo/.

[59] See Inclusionlab website: www.inclusionlab.nl/ and a network of professionals in social services, available at: http://www.netwerkperspectief.nl/.

4 The impact of quality assurance mechanisms and systems and promising practices: strengths and weaknesses

4.1 The impact of quality assurance mechanisms

The impact of quality assurance systems in social support care is low. A national satisfaction review on the quality of social support provided by municipalities showed a consistent general satisfaction rate of 7 to 8 on a scale of 10 (10 being the highest level of satisfaction) on availability of social support.[60] Nonetheless, the National Ombudsman published two highly critical reports on the availability of social support based on outcome results after a long series of complaints were lodged with the Ombudsman.[61]

Other outcome reports by the Netherlands Institute for Social Research, the Justice and Security Inspectorate and the Health and Youth Care Inspectorate show severe and consistent substandard levels of quality of care.[62]

4.2 The role of human rights NGOs, Ombudsman, and other related offices

There are no known comments or actions by human rights NGOs on quality of services that are relevant for people with disabilities. The Netherlands Institute for Human Rights is not allowed to receive and handle individual complaints on discrimination in delivery of social services if these services are the responsibility of local or national government or their public bodies.

After many complaints about social services were lodged, the Ombudsman published reports on the accessibility and availability of youth care, long-term care and other social support in 2018[63] and in 2023.[64] Reports by the Ombudsman are focused on outcome results, not on quality assurance systems within social support systems.

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60 Letter to Parliament and report on yearly satisfaction review social support: https://www.rijksoverheid.nl/documenten/kamerstukken/2023/03/21/kamerbrief-over-landelijke-rapportage-clientervaringsonderzoek-wmo-verantwoordingsjaar-2022.

61 National Ombudsman (May 2018), *Zorgen voor Burgers* (Care for citizens report), https://www.nationaleombudsman.nl/nieuws/dossier/toegang-tot-voorzieningen.

62 Health and Youth Care Inspectorate, letter to the Minister of Justice and the Junior Minister for Healthcare and Youth, September 2022, https://www.igj.nl/binaries/igj/documenten/brieven/2022/09/13/signaalbrief-toezicht-jeugdbeschermingsketen/Signaalbrief+toezicht+jeugdbeschermingsketen.pdf.

63 National Ombudsman (May 2018), *Zorgen voor Burgers* (Care for citizens report), https://www.nationaleombudsman.nl/nieuws/dossier/toegang-tot-voorzieningen.

64 Jonquière, A., Hemels, H., Prins, J., and Visser, E. (April 2023), *Burger in zicht! Een onderzoek naar participatie en invloed van de burger in de Wet maatschappelijke ondersteuning.* (Citizen in Sight! A study on Participation and Influence by Citizens on the Social Support Act), National Ombudsman, https://www.nationaleombudsman.nl/system/files/bijlage/20230413%20Ombudsman_Rapport_Burger%20in%20zicht.pdf.

4.3 Promising practice

Three case studies	Public service	Private	NGO
Describe the type, scope and aim of the service used by persons with disabilities.		Residential care for people with (mostly intellectual) disabilities	
What quality assurance systems exist? Is there a timeframe? What is the relevant authority? (questions under Section 3.1, 3.2, 3.3) Does the quality assurance system explicitly address disability issues?		Interviews by staff members of every individual resident (and their relatives) every two years on their quality of life within the institution	
Which methods and methodologies were used in the quality assurance system? (questions in Section 3.4)		Methods may vary from using a set of standard questions to more open conversations.	
How are people with disabilities / disability organisations involved in the assessment process? Are they consulted? (questions under Section 3.5)		The client council of the institution will be consulted on the method used.	
What indicators are used in this particular quality assurance system?		There is no open set of indicators. The question will address eight domains of quality of life as defined by R. Schalock.	
Which CRPD principles are included in the quality assurance framework?		Participation, empowerment, person centred, continuous, outcome oriented.	
What evidence is there that the respective quality assurance system has an impact on the quality of the social service delivered to persons with disabilities, on the attractiveness of the sector and on the skills of the workforce?		The assumption that the interviews of residents lead to a genuine dialogue and learning process between staff and clients on how life is organised within the institution has not yet been realised.	

One promising practice is the method used by a private organisation, Inclusionlab, which uses qualitative questioning and assesses the quality of social services based on the principles of social role valorisation.[65] This method was used widely in residential care in the Netherlands from 1999 to 2014,[66] and after that occasionally in

[65] See: https://socialrolevalorization.com/srv-theory/.
[66] During that period, use of the tool was financed by the Ministry of Health, Welfare and Sport.

residential care and in one case in a municipality.[67] The method consists of interviewing users of social services, the staff who assess applications for the services (in the case of municipalities) or those who provide services (in the case of care providers. The questions aim at assessing quality of life and assessing whether persons with disabilities are being adequately facilitated to lead a meaningful life within the community. Interview outcomes are discussed at meetings in which service users, staff and management discuss the outcomes and how their services could better facilitate life within the community for persons who apply for social support.

4.4 Analytic reflection

The quality assurance system of social services in the Netherlands is not well developed. With the exception of purely medical care, in which standards of care and requirements for professionals are in defined in detail, there are no clear standards for what social services should offer and what the required levels of quality should be.

There is a general tendency to assure quality of social services by requiring a specific level of education and training among professionals working in social services. The assumption is that service providers will define what services they will offer and what the level of quality is (when contracted), and that employees with the right level of education and training will ensure the quality of their work.

Most social services organisations that tender out (municipalities, for instance) will require service providers to be certified as using a quality assurance system. Almost all available quality assurance systems are focused on procedures, so service providers are required to select and buy a procedural quality assurance instrument.

Only in residential long-term care have providers developed more than a procedural system. They have an agreement on how to define quality of residential care, and they define it as quality of life. Residential care providers have also developed a system for the involvement of users of their service and a system to assess and evaluate instruments for assessing quality of life.

For other social services, only procedural requirements have been set for involving service users. In social support and reintegration services, the establishment of client councils is a legal requirement. Yearly satisfaction reviews are also mandatory for service providers, although there are no prescriptions for what to ask, who to ask and how to ask.

Both the Social Support Act and the Participation Act require municipalities to adopt a local implementation plan, thereby implying that CRPD principles should be incorporated in social support policies for persons with disabilities and in quality assurance systems. Less than half of municipalities currently have a local CRPD implementation plan, and these local plans mainly address the accessibility of the built environment.

[67] Municipality of Zeist, *Luisteren & Transformeren* (Listen and Transform), https://www.burotroje.nl/documenten/Luisteren%20&%20Transformeren%20in%20Zeist.pdf.

All quality assurance systems, even the well-developed ones in residential care, are controlled by the service provider. There is rarely an objective check by outside agencies.

The position of users of social services in quality assurance methods is not well aligned with CRPD principles. The general rule is that users of social services are to be consulted via the establishment of a client advisory council and the use of a client satisfaction review system. There is no known research on the impact that client councils have on quality assurance, however. Client satisfaction review systems mainly consist of issuing standard questions and a rating system, often written or online. Such rating systems often result in a more or less fixed satisfaction result. Most users rate services around a 7 or 8 out of 10, even if the outcome surveys severely criticise policy outcomes.

5 Recommendations

5.1 Recommendations for the Netherlands

Set out minimum standards for what social services should encompass and what level of quality is expected. Service quality assessment can only succeed if minimum standards are clear for both providers and users.

Abolish simple client or customer reviews, as they do not provide reliable information on outcome results and because they exclude specific groups who cannot use written reviews.

Arrange for broader qualitative questioning of users of social services, aimed not at assessing perceived service quality but at assessing quality of life and how social services are succeeding in contributing to quality of life. Use this questioning for continuous feedback to organisations on how to improve individual services and how to improve the quality at organisation level.

5.2 Recommendations for the European Commission

Set out minimum standards for what social services should encompass, what level of quality is expected and how services should be aligned with the CRPD.

Make an inventory of good practices and disseminate them among Member States.

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