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# Creating 21st century primary care in Flanders and beyond





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## Abstract

Primary health care is the cornerstone of a strong, supportive health system, as was recognized in the 1978 Alma-Ata Declaration and the 2018 Declaration of Astana. It has an important role now in meeting the global United Nations Sustainable Development Goals and the goals of WHO's 13th General Programme of Work for 2019–2023. This report focuses on primary care developments in Flanders, Belgium. Following state reforms in Belgium, the region is now upgrading and integrating its primary care services, aiming to improve their effectiveness and efficiency and the quality of life of both users and providers of those services. It is doing so through careful planning, sustained engagement across society, and systematic, well organized implementation. The report also touches on primary care developments in other parts of Europe – in Catalonia in Spain, Slovenia, Botoșani in Romania and Utrecht in the Netherlands – and concludes with lessons that these different experiences suggest might be useful to others.

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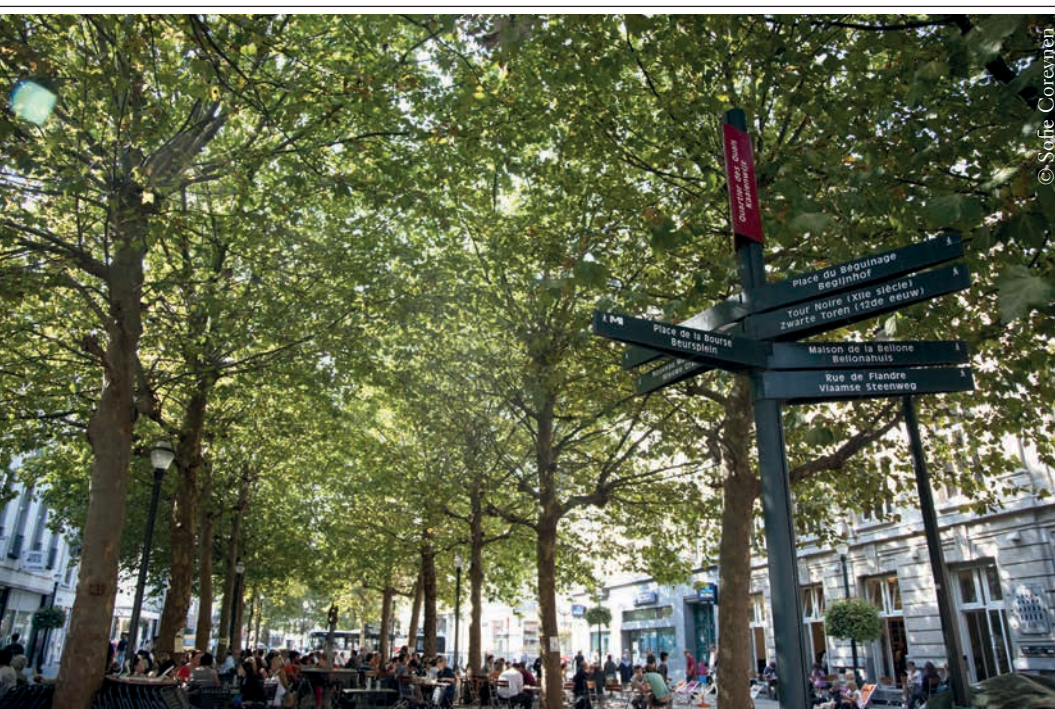
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## *Foreword by the Flemish Government*

*Flanders, Belgium, currently is reforming its primary care system. This report describes how, through political will, imagination and careful management, frustration with the existing system gave way to a shared, ambitious vision of the future. This could not have happened without hard work and courage.*

*The view that the system was not working well could simply have been accepted as inevitable. What allowed change was a willingness at the highest level to say this was not good enough and recognize that a far better system was within reach.*

*By opening up discussion on exactly what was wrong, new creativity and energy were released. A bottom-up approach ensured all who would be affected were part of the conversation. This broke down fences between different groups and encouraged honesty and confidence. Outside experience and expertise to support change were welcomed.*



*The result was a shared determination to create services that better integrate the efforts of those working in health care and social care and on improving well-being – services that could much more effectively meet the needs and hopes of the public.*

*This did not happen by chance. From the start there was careful preparation and planning. Through the course of many meetings, trust and belief grew and momentum developed. Sustained political support was vital; an established professional consensus strengthened the ability of the Minister to advocate and facilitate change and win broader political support.*

*The process is not complete. A new planning capability has been established at different levels within the system. New structures will have the power to develop services locally across Flanders to meet local needs. Local creativity and initiative should lead over time to greater satisfaction for professionals and those in need. This is not a reform with defined endpoints but an opening-out of possibilities. In future years, each local area can learn from its neighbours in a continuing process of adaptation and innovation. In addition, there will be continuing evaluation of progress and fine-tuning of the process to ensure that the emerging system is relevant and effective. What is certain is that as a result, primary care in Flanders will be far better suited to 21st century needs.*

**Dirk Dewolf**

General Administrator, Flanders Agency for Care and Health

## *Foreword by the WHO Regional Office for Europe*

*Primary health care is an element of fundamental importance in the health-care system. It is the first point of contact for local people and has a huge potential to protect, promote and manage their health. If the primary care part of the system is healthy and flourishing, the whole health system is more likely to be effective and efficient.*

*Since primary care is a local service, it is continually in touch with local attitudes and expectations, and is quickly affected by changing social conditions. That is good and natural and causes no problems, so long as primary care is supported to adapt and respond to change. In some systems, however, primary care can be given too little attention, with the eyes of politicians, the media and the public focusing too much on problems with hospital services. If primary care is neglected, the system as a whole can go out of balance.*

*It therefore is vitally important that primary care is constantly assessed and nourished to ensure it remains fit for the present and the future. This report presents examples of how countries and regions are reviewing and updating their services to meet the needs of today and tomorrow.*

*The main section of the report focuses on the reform now under way in Flanders, Belgium, which is an active member of the Regions for Health Network (RHN) of the WHO European Region. A frequent topic of interest in meetings of the Network is how to create the momentum that can facilitate change. Sometimes a window appears that allows progress; this has been discussed in previous RHN publications.*

*The case of Flanders shows how the windows opened there, and how the opportunities were taken. Through careful preparation and engagement, major advances have been made possible. Seldom can we evidence so clearly how a process of change has been managed from its origins through to near-completion, in a sequence of events likely to extend over more than a decade.*

*This report also includes several brief accounts of how reforms and developments have occurred in other countries and regions. Each set of changes is rooted in the precise local circumstances, yet each helps reveal how countries across the WHO European Region value and support primary care, and are looking to ensure it remains able to play its hugely important role in creating and protecting healthy people.*

**Francesco Zambon**

Coordinator, Investment for Health and Development in Healthy Settings, and focal point for the Regions for Health Network, WHO European Office for Investment for Health and Development, Venice, Italy



## Executive summary

Primary health care is the cornerstone of a strong, supportive health system. This was recognized in the 1978 Alma-Ata Declaration and was confirmed in the 2018 Declaration of Astana. It remains as important in the 21st century, with the world community committing itself to achieving the global United Nations Sustainable Development Goals and WHO embracing a mission to “promote health, keep the world safe, serve the vulnerable”, as it was in the past.

The preferred term now in many places, including Flanders, is primary care, because the aim is to integrate health and social care. The precise term does not matter – what is essential is the provision of local services that meet the needs of the time and area.

Flanders is a region of Belgium with 6.5 million inhabitants and is an active member of the Regions for Health Network (RHN), which operates in the WHO European Region. A major reallocation of functions from federal level in Belgium to the level below gave Flanders the once-in-a-generation chance to create the primary care services it wanted. Its ambition has been to create services that provide high-quality integrated care for every person in need and, where necessary, to informal carers.

In working towards that ambition, Flanders has had to take a range of factors into account. Many individuals, groups and organizations are entitled to express a view on the changes and are part of the design and implementation process. Those in need are entitled to choose freely who provides their care. The region has a tradition of professional autonomy and entrepreneurial independence. A number of federal, regional and local agencies work in the care field, and all have needed to be engaged.

The reform aims to tackle well defined challenges. There has been fragmentation and bureaucracy in the existing system. Pressures are growing through the ageing of the population and the rise of chronic conditions. Changing expectations, scientific innovation and new communication possibilities unsettle existing certainties, while also offering opportunities for improvements. Budgets are limited.

What stands out is the seriousness of the commitment in Flanders to creating a better system. The reform, still in progress, is radical, visionary and far-reaching.

To achieve the vision, the primary care system will be substantially reoriented and restructured, with complementary adjustments in many other areas of government and administration. A major aim is to create mechanisms that will support improvement in care integration over time. Primary care zones are being set up at local level to support better coordination and improve planning. These will be brought together to help organize services for larger groups of the population. A new Flemish Institute for Primary Care has been established to provide a permanent source of expertise and stimulus.

Implementation of the reform is being managed carefully and systematically. All relevant interests are being engaged in a bottom-up process of development. Digitization is seen as an important catalyst for change and an aid to better collaboration. The whole reform process is expected to be completed by 2025.

Primary care is also being adapted to meet changing circumstances in other regions. Brief case studies in this report explain some recent developments in Catalonia in Spain, Slovenia, Botoșani in Romania and Utrecht in the Netherlands. These bring out some of the differences across the European Region in approaches to primary care, but also the careful attention its importance rightfully attracts.

The report concludes with some lessons that these different experiences suggest might be useful to others.



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# 1 Primary care remains vital to health and care

The Alma-Ata Declaration on Primary Health Care was agreed by WHO Member States in 1978 (1) and has served as a source of inspiration and spur to action within WHO and the countries of the world ever since. The declaration was wide-ranging and ambitious, specifying that primary health care needed to:

- reflect local conditions and the best knowledge
- address the main local health problems
- fully include at least a wide range of specified core elements
- draw in and coordinate the efforts of many different sectors
- empower and engage communities and individuals
- link to referral systems, prioritizing those people most in need
- combine the efforts of all the relevant workforce as a health team.

While in some places the term primary care is sometimes preferred, the importance of the concept was again re-emphasized in Health 2020, the health policy framework for the WHO European Region, adopted in 2012. It states (2), “Health 2020 remains committed to a primary health care approach as a cornerstone of health systems in the 21st century”.

Health 2020 is seen as an essential step to delivering Agenda 2030, which was adopted in September 2015 at a meeting of representatives of all the countries of the United Nations (3). The Agenda specified 17 goals at global level – the United Nations Sustainable Development Goals (SDGs). These are seen as being “integrated and indivisible”; that is, they should be treated as component parts of a single effort.

The main health goal is SDG 3, which comprises 13 targets, and good health contributes to and benefits from efforts to achieve all the SDGs. A central idea of the SDGs is that “no one must be left behind”; this requires action to tackle inequality in all its dimensions, with a focus on the needs of people who are particularly vulnerable. Good primary health care is an important element in ensuring everyone has a fair chance in life.

The WHO Europe roadmap to implement the 2030 Agenda (4) (Box 1, Fig. 1) is a vital source of assistance for countries in Europe in deciding what to do, consistent with taking forward Health 2020.

**Box 1. Key components of the WHO Europe roadmap to implement the 2030 Agenda**

The five interdependent strategic directions:

- advancing governance and leadership
- leaving no one behind
- addressing health determinants
- establishing healthy places and
- strengthening health systems

The four enablers:

- investment for health
- multipartner cooperation
- health literacy, research and innovation
- monitoring and evaluation

Source: WHO Regional Office for Europe (4).

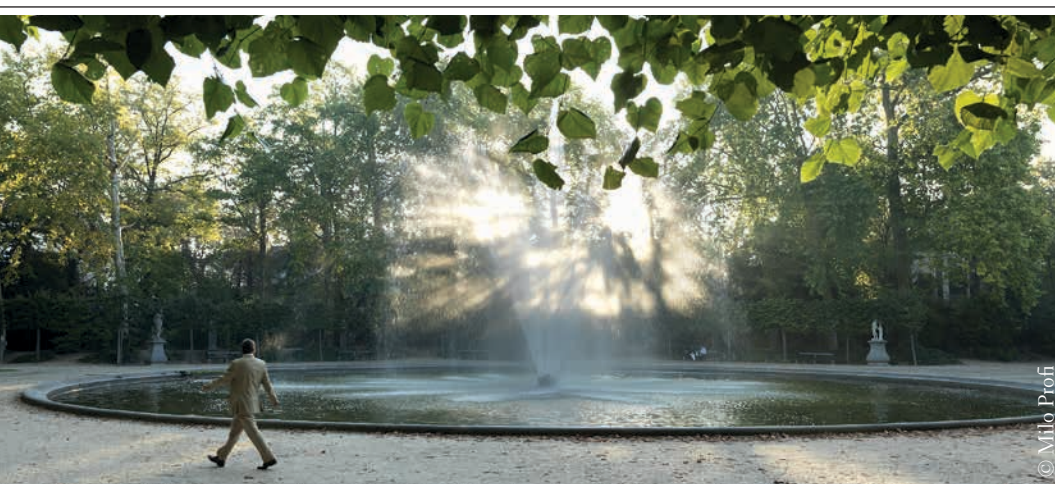
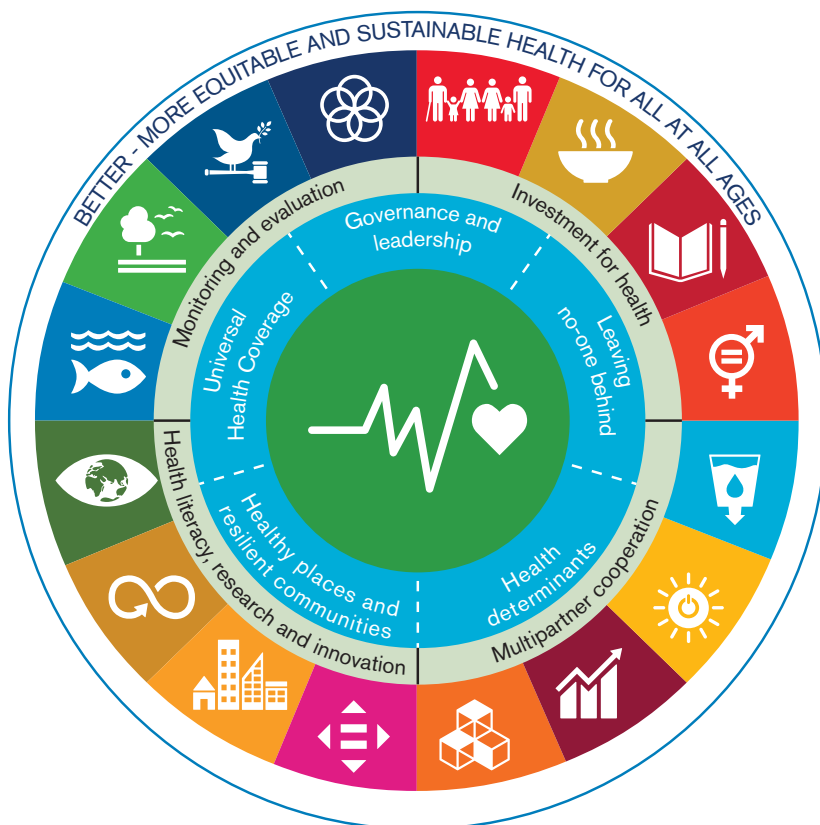


Fig. 1. The elements of the WHO Europe roadmap to implement the 2030 Agenda



Source: WHO Regional Office for Europe (4).

A global conference on primary health care in 2018, celebrating the 40th anniversary of the Alma-Ata Declaration, adopted the Declaration of Astana. The new declaration (5) confirms the view that:

*primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health related Sustainable Development Goals.*

It identified important factors that would influence the success of primary health care (Box 2) (5). An operational framework was drawn up to assist countries in turning the vision in the Declaration into action (6).

## Box 2. Success factors in the Declaration of Astana

The success of primary health care will be driven by:

- knowledge and capacity-building
- human resources for health
- technology
- financing
- empowered individuals and communities
- aligning stakeholder support to national policies, strategies and plans

Source: WHO (6).

Next steps in improving primary health care should be seen in the context of the recently adopted WHO 13th General Programme of Work, which sets the agenda for WHO and its partners globally for the years 2019–2023, endorses the 2015 Sustainable Development Agenda and establishes a mission for WHO to “promote health, keep the world safe, serve the vulnerable” in that period. It sets out three interconnected strategic priorities and goals (Box 3). Primary health care will be vital in helping realize these (7).

## Box 3. Strategic priorities and goals of WHO’s 13th General Programme of Work, 2019–2023

Ensuring healthy lives and promoting well-being for all at all ages by:

**Achieving universal health coverage** – 1 billion more people benefitting from universal health coverage

**Addressing health emergencies** – 1 billion more people better protected from health emergencies

**Promoting healthier populations** – 1 billion more people enjoying better health and well-being

Source: WHO (7).

## 2 Why does Flanders want to change a strong system?

### 2.1 BUILDING ON A STRONG FOUNDATION

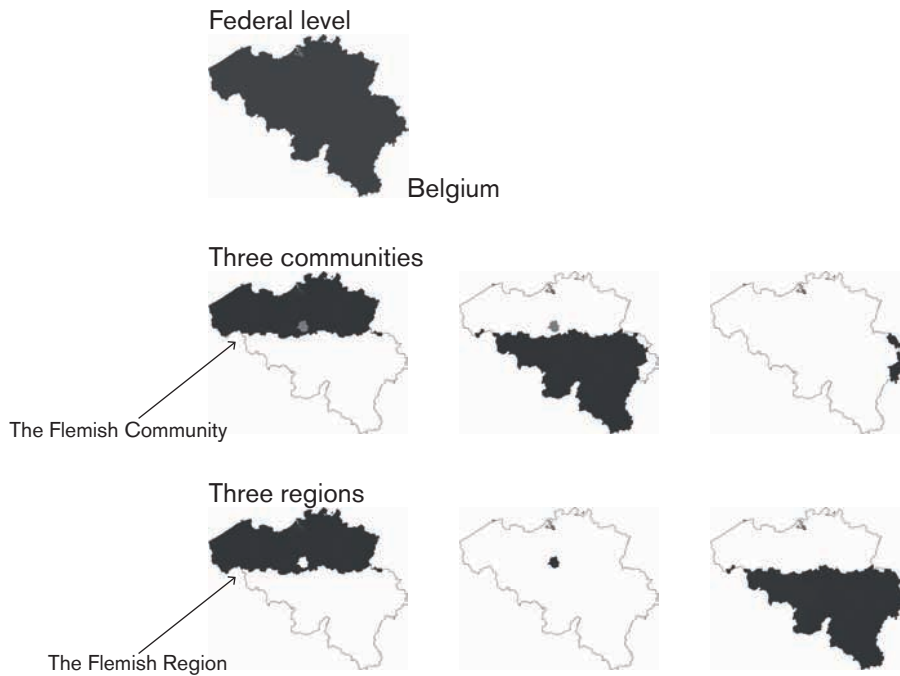
As a region of Belgium, Flanders has for years had one of Europe's stronger health systems. A recent change in responsibilities within Belgium has opened the way to reform and update the health system to meet new challenges and match current aspirations. Through reform, Flanders wants to

- strengthen and simplify primary care;
- establish the basis for strong integrated care;
- strengthen well-being initiatives, social care and health care and their interaction;
- build on the existing strengths and values of the Flemish system; and
- address emerging weaknesses.

Belgium is a constitutional monarchy with a parliamentary system. It is a federal state, with a federal level for all Belgium, three regions and three communities (Fig. 2). The three regions are the Flemish region, the Walloon region and the region of Brussels-Capital. The three communities are the Flemish community, the French community and the German community. Responsibilities are divided between federal level, the communities and the regions.

The federal state has been responsible for foreign affairs, defence, justice, fiscal policy, domestic affairs, social security and a share of public health. The regions are responsible for territorial matters, such as policy on the economy, energy, agriculture and environment. The three communities are responsible for so-called person-related matters, such as education, cultural affairs, language, and health and welfare, insofar as they are not part of the social security system. Brussels has a particular regime in which the Flemish- and French-speaking communities have their respective institutions to work on relevant community issues and a Common Commission to deal with Brussels-related issues. The Belgian federated entities also have responsibilities for international aspects related to their competences (8).

Fig. 2. Regions and communities of Belgium



Source: Flanders Agency for Care and Health.

Flanders is the biggest of the regions by population. In 2018, 11.4 million people lived in Belgium, of whom 6.5 million lived in Flanders (9). The number of people aged 55+ has been growing faster in the Flanders and Walloon regions than in the Brussels-Capital region since the beginning of the 21st century (10). The ageing of the population is happening more quickly in the Flanders region than in the other regions due to 30 years of lower fertility and the fact that the large post-war generations have already reached, or soon will be reaching, age 65 (11).

Belgium has a well developed health system. A description of the Belgian health system in 2010 (12) described how in broad terms the federal level dealt with:

- regulating and financing compulsory health insurance
- setting minimum standards for the running of hospital services
- financing hospital budgets and very specialized medical care units

- legislating to cover different professional qualifications
- registering pharmaceuticals and their price control.

The regional level was responsible for:

- health promotion and prevention;
- maternity and child health care and social services;
- different aspects of community care;
- coordination and collaboration between primary health care and palliative care;
- implementation of accreditation standards and determination of additional accreditation criteria for hospital services and planning; and
- financing of hospital investment.

International reports tend to examine Belgium as a whole rather than its component regions. Belgium's health system is generally considered very successful. A comparison in 2016 showed that within the EU15 (countries belonging to the European Union before May 2004), the health system in Belgium is well resourced, being ranked fourth for its number of hospital beds (6.3 beds/1000 inhabitants) and second for its number of doctor consultations (7.4 consultations per capita) (13). It is seen to be an effective system in that amenable mortality in Belgium is low (14).

A review of health and health care in Belgium in 2017 (15) reported that:

- the Belgian population enjoys a relatively high life expectancy;
- cardiovascular diseases and cancer are the leading causes of death, though the number of people dying from Alzheimer's disease and other dementias has risen;
- musculoskeletal problems, diabetes and depression are among the leading causes of poor health;
- unhealthy lifestyles account for more than one fourth of the overall burden of disease; and
- social inequalities in unhealthy lifestyles are large.

Belgians seem to have been broadly content with their health-care system. In 2013, no fewer than 97% in a Eurobarometer survey expressed the view that the overall quality of health care in Belgium was good (16). A comparative study of the strength of primary care in 31 countries in Europe published in 2013 found Belgium to be one of the countries with relatively strong primary care, scoring well on continuity and comprehensiveness (17,18). Moreover, steps have been taken in recent decades to strengthen primary care in the country (19).

## 2.2 IMPORTANT CHARACTERISTICS OF THE FLEMISH SYSTEM

All health systems differ. The problems and opportunities facing Flanders have been in part related to the way in which its health and social care services have developed. These need to be understood by anyone wishing to learn from the Flanders experience; so, what is special about the system in Flanders?

### 2.2.1 Responsibilities shared by many levels and actors

The health field in Flanders has many important actors. Sharing of powers between federal and regional level was mentioned above, but in addition, local authorities and other organizations, both public and private, have important responsibilities and the freedom to set their own priorities (20).

Because responsibility is split, federal and regional levels have to work together to avoid policy clashes. Flanders has its own health minister, whose remit covers health and social care, working through the Flanders Agency for Care and Health. The Interministerial Conference on Public Health is a forum in which health ministers can discuss policy intentions and develop consensus strategies, protocol agreements or cooperation partnerships if a common legal basis appears necessary. Joint approaches in areas such as e-health, chronic illnesses and hospital reform have been agreed through this mechanism. Liaison between the Flemish Government level and the representative of local authorities, the Flemish Association of Cities and Municipalities, has also been improving (21).

### **2.2.2 Social health insurance**

The basis of the Belgian system is social health insurance. It is not a private system, nor a national health service system like those in northern and southern Europe, but is similar in some ways to the systems in Austria, France, Germany, Luxembourg, the Netherlands and Switzerland (22).

Health insurers are not-for-profit organizations with various backgrounds – socialist, liberal, Christian, independent, nationalist – and are funded by the state. Commercial insurance companies have very limited access to the health market. Patients pay a small amount out of pocket to health-care professionals, and most costs are reimbursed by the health insurers (23,24).

Flanders also has a system called Flemish Social Protection. This is a Flemish Government system organized separately from, and parallel to, the health insurance system, covering non-medical care expenses by providing material and/or financial support according to people's needs (25).

### **2.2.3 Physicians' freedom and diversity in social care**

Primary medical care in Belgium is mainly private (or, perhaps more accurately, not for profit) and is based on the principles of independent medical practice. Independent medical practitioners (and other professionals) are remunerated via fee-for-service payments, with patients having free choice of physician. The vast majority of physicians work as independent, self-employed health professionals (26).

No referral system between general practitioners (GPs) and other specialists exists, and every citizen has free access to medical specialists and hospital care, even as their first point of contact with the health-care system. Unlike in some countries, GPs therefore do not have a gatekeeping role (27).

Social-care professionals are organized through a multitude of organizations, some linked to the public sector and some private initiatives. They are accountable to different authorities and depend on different financing mechanisms (20).

### 2.2.4 Freedom of choice for patients

Belgium promotes freedom of patient choice. Patients have free choice of health-care professionals and health-care institutions (including hospitals), and also have free choice of sickness funds. The sickness funds cannot refuse a patient, which means patients: can contact several health-care professionals before choosing one; are able to choose to consult with another health-care professional; and may change their choice of health-care professional (26).

Since 2002, every person in Belgium has been eligible to have a global medical file, which is held by a GP of his or her choice. As a result, the charge to the patient for a GP consultation is reduced. This encourages continuity of care and should reduce frequent changing from one GP to another (28).

### 2.2.5 Equity

Like other countries, Belgium faces health inequalities. The system aims to support vulnerable populations. Almost everyone has access to mandatory social insurance and a broad benefit package (coverage is 99%) (29). There is a maximum bill for people in vulnerable situations. Despite the measures taken to improve the financial accessibility of health care, however, the reported situation regarding the inequalities indicator “having delayed contacts with health services for financial reasons” reveals important inequalities (30). The delay is more evident among those with a lower education level and even more marked when the income level is relatively low (31).

### 2.2.6 Population health planning

The Flemish health and social system involves a large number of strong independent actors, including health- and social-care professionals and elements of the political structure. None is formally responsible for population health planning. The reform offers a new opportunity to strengthen such planning through the creation of primary care zones.

## 2.3 PRESSURES AND PROBLEMS

The decision in Flanders to reform primary care resulted from a growing sense of the need for change, coupled with an important opportunity to make it happen. Some of the issues suggesting change was needed were related to the way the Flemish system operated, and these are discussed below. Others were similar to those affecting other countries, including (32,33):

- **demographic and epidemiological change** – population ageing, rising levels of cancer linked to ageing and increases in chronic conditions, with many people having more than one problem;
- **scientific and technological developments** that create new opportunities for prevention and treatment, change the pattern of health-care costs and potentially allow services to be restructured and relocated;
- **new information and communications technology (ICT)** that can facilitate changes in care patterns, support home care, and improve decision-making and quality of care;
- **changes in expectations, attitudes and behaviour** linked to globalization and social and cultural developments, resulting in, among other things, better informed service users and changes in the availability of volunteers and informal carers;
- an increase in people's **desire for autonomy and control**; and
- **greater awareness of the social health gap**, what causes it and what might help tackle it.

These points are affecting many countries. Belgium faced some particular issues that needed attention. Reports have suggested its system is expensive, with large inequalities in health, a relatively high number of hospital beds and a relatively high level of admissions for chronic conditions (14).

Other reasons relating particularly to Flanders were causing a growing feeling among those responsible for, and working in, the health field that improvement was needed. The lack of a single organizational framework across Flanders or at local level meant that individual care providers often worked separately, with little understanding of other services. Funding arrangements, based on reimbursement for specific care interventions, did

not encourage professionals to work together as a team or provide integrated care over an extended period. Health care and social care were not well coordinated. The resulting fragmentation meant the person in need of care had less sense (or chance) of control, and care providers and workers could be burdened by administration and meetings (32).

Over the years, a broad consensus consequently emerged in Flanders in favour of reform at primary care level to increase satisfaction among people with care needs and their informal caregivers, and to improve the performance of the care system as a whole (34).

## 2.4 THE 2010 CONFERENCE ON PRIMARY CARE

The widely shared sense that the system could work better both for professionals and the public offered an opportunity to open discussion on reform. Developing a plan of action, however, was neither simple nor straightforward. Because suggestions that the system was failing might provoke defensive feelings and divisions, it was vital to move carefully and ensure all concerned parties felt fully engaged through a bottom-up, inclusive approach.

This preparation took a year, starting at the end of 2009. Six working groups were set up, looking at the positioning of primary care in the system, information technology development, development of multidisciplinary working, first-line prevention, ways of preventing shortages of care providers and better mental health services. The groups' findings were tested across the Flemish part of Belgium and with political parties from September 2010 (35).

After this very carefully managed process of consensus-building, the relevant minister brought all the important stakeholders together in a conference in December 2010 to seek agreement on the way forward. The role of the minister was important. Stakeholders might see suggestions for reform as a threat or criticism. Careful preliminary work was essential to ensure that those attending were open to change and that the minister could be confident of a favourable response to his suggestions.

The conference aims were to improve:

- the quality of primary care through more and better professional collaboration between the various care providers; and
- the quality of life and work of care providers by supporting and facilitating collaboration and by reducing the administrative burden they faced (36).

The conference accepted that action was needed to get primary health and social care professionals to work together. A number of initiatives followed.

There was a strong feeling that information technology could help reduce fragmentation and bureaucracy. Vitalink, a digital platform allowing data-sharing among professionals, and later eenlijn.be, a project to improve the digital literacy of professionals, were set up. There were also pilots trialling psychology services in primary care.

It was recognized that there needed to be a stronger commitment to well-being, more attention to improving the integration of health and social services and, in the longer term, some decisions on future structural reform (37).

Perhaps the main positive results were that a more open relationship was established between different professional groups, with an expectation that further change was possible. The Flemish Government set up a partnership platform bringing together 40 representatives of virtually all the stakeholders in primary care to foster collaboration, meeting three times a year to oversee the legacy of the conference and discuss subjects of collective interest. This helped prepare a common agenda for the future (38).

It was agreed a further meeting would be held in 2013 to assess progress (20).

## 2.5 THE SIXTH STATE REFORM IN BELGIUM

The 2010 conference showed the appetite for primary care reform. The opportunity to make important progress came with the decision in 2011 to reallocate responsibilities between federal and regional levels as part of the Sixth State Reform, the latest in a series of reforms in the Belgian state system. This was due to come into force in 2014.

One of the objectives of the Flemish Government in the negotiations on the Reform was to secure the ability to improve health-care provision and respond more purposefully to the desire for improvement. It achieved some success, gaining significant new powers.

However, while Flanders took over the main responsibility for many important areas, including long-term and mental health care, care of older people, the organization of primary care, disease prevention, health promotion, and care at home and for disabled people, loose ends remained. For example, while many aspects of hospital policy and primary care management were transferred, the day-to-day funding of hospitals remained a federal competence, and while most aspects of primary care management were transferred, responsibility for primary care provision outside normal working hours was not (20). The unique opportunity and momentum created by the changes nevertheless was fully recognized (34).

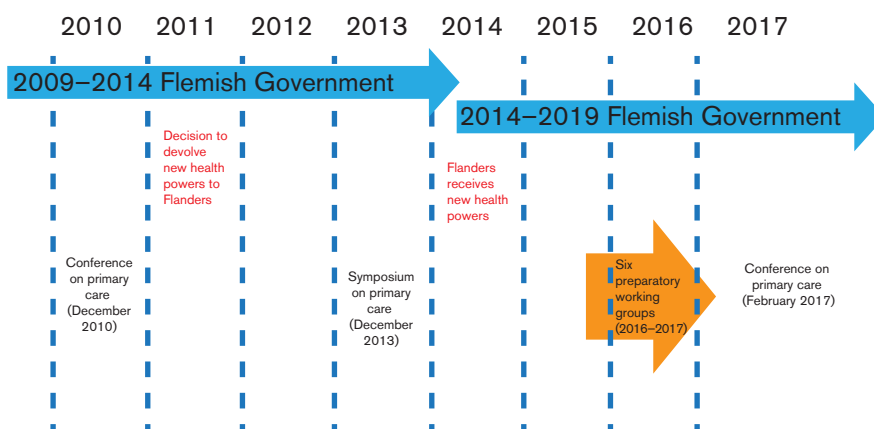


## 3 Planning the reform in Flanders

### 3.1 THE 2013 SYMPOSIUM

Preparing the reform took several years (Fig. 3). It had been decided at the 2010 conference to hold a follow-up event in 2013, the year before regional elections, to review progress. An interim symposium on primary care was therefore held in December 2013 for this purpose. The meeting concluded that existing initiatives were beginning to bear fruit and should be extended (20).

Fig. 3. Initial stages in the reform process



Source: Flanders Agency for Care and Health.

The meeting acknowledged a wide-ranging definition of primary care in the Flemish context, seeing it as care which:

- refers to directly accessible, ambulatory, general care for non-specified health-care or welfare-related problems, whether physical, psychological or social in nature;
- generally represents the first contact with professional care;
- can offer diagnostic, curative, rehabilitation and palliative care provision for the large majority of problems;
- offers prevention for individuals and risk groups in the local population;

- takes into account people's personal and social context;
- ensures continuity of care over time and between care providers; and
- supports the informal care available to patients/clients (39).

The potential of the State Reform was becoming understood by that time, and Flanders started working towards improved organization of integrated and personalized care (2). Following the 2014 elections, the new Flemish Government Coalition Agreement for 2014–2019 indicated an intention to:

- “strengthen, align, simplify and integrate primary care structures”;
- slow down “duplication of unnecessary diffusion of high-tech and highly specialized services” and encourage cooperation between hospitals; and
- support networks across the care and welfare sectors to help hospitals, GPs and the residential care sector in primary care to work horizontally to create integrated care.

The intention was not to change everything, but to build on existing strengths to refocus care from a disease-oriented approach toward a patient-centred one (20,36).

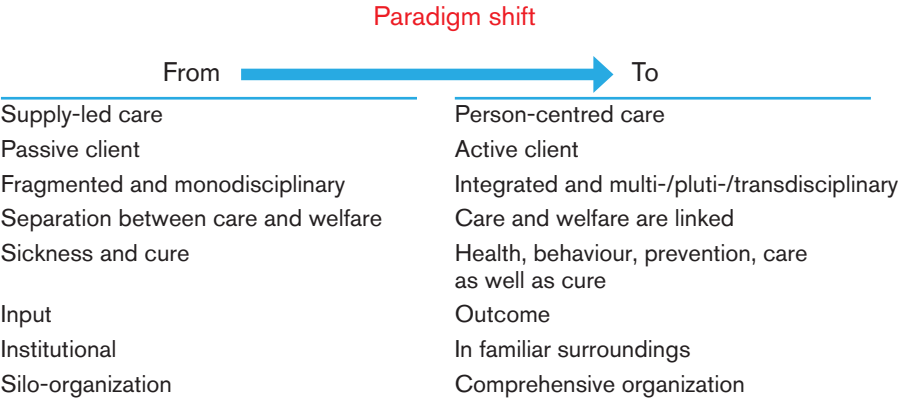
### 3.2 TOWARDS SYSTEM TRANSFORMATION

The aim is to place the person with a care need at the centre. The core idea is that each person is entitled to the care and support that allows the best possible quality of life, and this requires a system that is more effective and transparent and which gives the individual and informal carers a higher degree of satisfaction (34,40). The implication is that the individual patient/client must be more involved in decisions concerning his or her own care, and that all involved recognize him or her as the expert in both the medical condition and support needs (34).

To achieve this, a paradigm shift (Fig. 4) in the policy around the organization of care, from supply-directed to demand-directed care, is necessary. This is needed to be able to offer people-centred and integrated health-care services that allow the citizen to decide as far as possible his or her best possible

quality of life. In support of this aim, the public will be helped to develop care literacy skills.

**Fig. 4. The cultural paradigm shift**



*Source:* Flanders Agency for Care and Health.

The WHO model of integrated care identifies the informal caregiver, volunteers and the neighbourhood as the first protective and supporting skin around the person in need, who takes central place. It is when care needs become more complex that primary care must be activated. In face of the increasing care needs of an ageing population, it is clearly of vital importance that reliable, strong and well developed primary care is available. This can reduce the burden on more expensive specialized care and help create an accessible, effective and high-quality care system for everybody. Well organized primary care can also reduce social inequalities in health care by optimizing accessibility to care and taking on a signposting function (41).

### 3.3 A LEARNING PROCESS

The Flemish approach from the start of the process aimed to be inclusive, enabling all with an interest to help mould development of the reform. Once the decision to transform a fragmented system of primary care into a strong primary care service was made (41,42), a similar open and engaging approach was applied to the way design and implementation has been taken forward. The approach is based on learning and involvement rather than central command and control.

One element has been **proactive engagement with experts**. Those leading the reform drew on international literature and experience, published, and presented at conferences and in webinars by WHO, the International Foundation for integrated care, the European Commission and the B3 action group on integrated care of the European Innovation Partnership on Active and Healthy Ageing (20). Study visits were made to the United Kingdom (Scotland and Wales), and Flanders noted the lessons set out in WHO documents on how to implement reform (43):

- make sure the journey is participatory and is developed with stakeholders;
- impose mandatory public accountability on the players and organizations concerning the resources deployed and the quality of care and services provided;
- recognize confidence cannot grow without transparency in the operation of the organizations and services;
- watch over integrity and good governance; and
- provide supporting arguments for policy choices and ensure capacity to take decisions based on sound data, experience and intelligence.

The reform process from the start was characterized by a **participatory process** aiming to engage all stakeholders, professional levels in health and social care, civil society organizations, and formal and informal care organizations. The Flemish Government described the task as a “collective quest” (34). This was seen as the best way of promoting trust in the process (20).

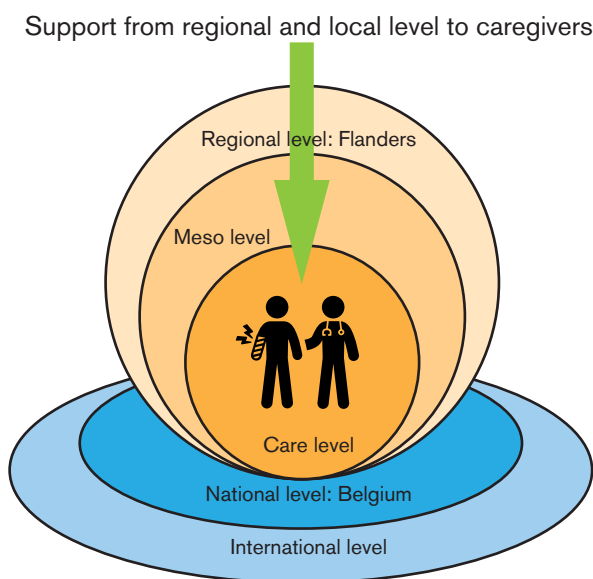
A notable aspect of the Flanders approach is the use of private sector organizations in a **managed approach to the preparation and implementation of strategy**. One of these assisted in managing the process of preparing the 2017 conference (44), another helped convert the programme into a set of 13 implementation projects and put them in motion (45), and a third managed pilot projects testing the role of the new primary care zones (see below). These agencies have helped ensure that the participatory process worked smoothly and effectively.

A **bottom-up approach**, in several senses, was adopted. The Flemish Government explicitly did not want to impose collaborative models from

above, but recognized the need to leave space for enterprise and initiative (34). Moreover, the aim was to improve effectiveness at the lowest level – that of citizens, the care team of informal and formal carers, and the neighbourhood – but without adding new burdens. It was recognized that working at that level should be made easier.

The way of achieving this was through strengthening working at the next level up – the level where support for different elements of the primary care system can be restructured and better organized (Fig. 5). The Flanders approach calls this the meso – middle – level. This would be done by working with those who actually delivered and received the care. By starting at the lowest level and working up through to the higher levels (regional, national and international), the aim was to create ownership and trust and to tilt the system successfully towards patient-centred integrated care.

Fig. 5. Support to caregivers



Source: Flanders Agency for Care and Health.

In addition, as will be shown below, the reform created primary care zones at meso level to support improvements tailored to the circumstances and choices in each local area.

Following realization at the 2010 conference that too much attention was being paid to health care and not enough to the wider aspects of social care and well-being and the ways in which these different elements interlink, the aim at all levels, from government to local level, is to **strengthen all three elements together – health care, social care and well-being – in an integrated framework**. This necessarily involves all these bodies working together to decide how to achieve the best common working arrangements.

There is also an acceptance that **changes should be tested**; it must be “a process that must be evaluated at regular intervals and, if necessary, be adjusted” (34). This too allows learning before major changes are made.

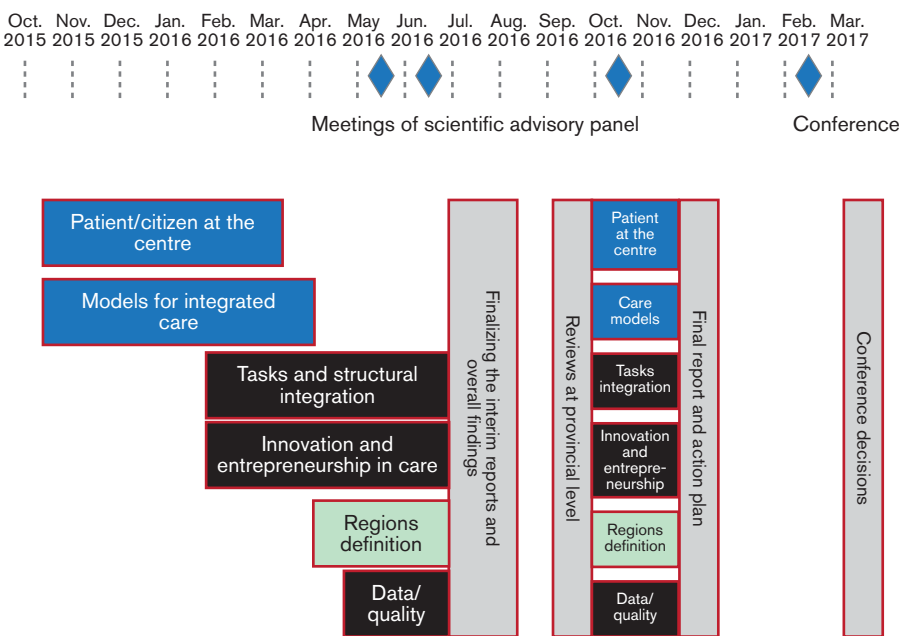
The commitment to an open learning approach does not mean that there is a lack of organization. Flanders is looking to maintain the coherence and quality of the system. Every decision and policy for advancing the reorganization of primary care and local services is examined against the five essential building blocks for **good governance**: transparency, accountability, participation, integrity and capacity (20,46).



3.4 THE 2017 CONFERENCE

Six working groups were set up in autumn 2015 to prepare the way forward (Fig. 6). Each had a balanced representation of, among others, people from primary care organizations and providers, professional groups, experts and those receiving services. Each working group was given objectives (47).

Fig. 6. Preparations for the 2017 conference, showing the role of the working groups



Source: Flanders Agency for Care and Health.

The working groups commenced work on a phased basis. The first two began with the core tasks. One looked to develop a Flemish model of integrated care, based on existing models, that would align with the work at federal level on integrated care for people who had chronic illnesses. The other was to develop a vision and scenario that gave a leading role in integrated care to the citizen and the person with a care need across all aspects of care.

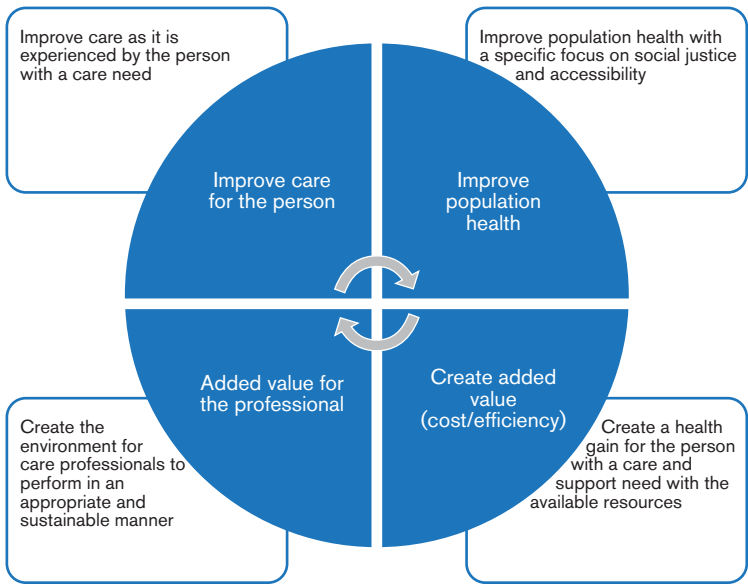
A third group, starting a little later, looked at defining the functions and tasks necessary for achieving an integrated care approach at meso level, and what support structures were needed. Using its conclusions, a fourth group later began work on a proposal for setting up care regions.

The innovation and entrepreneurship group considered how to roll out learning from care projects that had been assessed positively, and the sixth group was tasked with developing a model for evaluating the quality of care within an integrated care approach.

The process was supported by a steering committee, including the chairs of the working groups and representatives of the minister’s office and the Agency for Care and Health, with support also from a private sector agency.

The groups’ conclusions were reviewed by a scientific panel, which advised that reform should also contribute to achieving all four elements of the quadruple aim: improvements in patient experience, population health, efficiency and the well-being of the care team (Fig. 7) (39,48). All findings were fed into a major conference in February 2017. The partnership platform set up following the 2010 conference also had a part in preparing the 2017 conference (38).

Fig. 7. The quadruple aim



Source: Flanders Agency for Care and Health.

The conference agreed the policy direction for the period through to 2025. Its conclusions included the following points (41):

- the autonomy of the person in need is central and the system is there to help achieve that;
- community-driven care needs to be developed, supporting informal carers and better aligning social and health care;
- professional care needs to be recognized and supported, and better linked to family and residential care;
- care teams need to be customized to support the individual in accordance with his or her life goals;
- the care process would continue to be digitized;
- stronger support would be developed for local care providers over time;
- care boards and regional care platforms would each contribute to the smooth continuation of care provision, the care boards at primary care zone level and the regional care platforms at regional care zone level;
- care boards would develop and support integrated care at local level;
- regional care platforms would enhance cooperation among hospitals and specialized care, centres for dementia, palliative care, prevention and mental health networks; and
- a Flemish Institute for Primary Care would be established.

In line with the ambition to strengthen social care, a major conference on “Social Work of the Future” was organized in 2018. This too was the result of careful preparation. Seven working groups consisting of field workers from different sectors and areas of practice were established in November 2016. Their findings were then reviewed by three stakeholder panels consisting of users, providers, civil society, authorities and education institutes, and the conference determined the way ahead (49).

## 4 A new system in Flanders

### 4.1 IMPLEMENTATION

Carrying through the Flanders primary care reform is a large task. As one of the supporting private sector organizations involved notes, “Approval is one thing, actually to implement the intended changes is something else” (45).

Initial scoping suggested nearly 30 sets of laws and regulations needed to be amended to achieve the desired result (50). The implementation programme was structured as a set of 13 implementation projects (Box 4). Taking all this forward is a major process of change management and needs to create a sense of shared ownership across a wide variety of actors and disciplines. It is an evolving process, including elements such as appointing a programme manager, preparing legislation, and redeploying staff and budgets as part of a systematic, phased, integrated approach.



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#### Box 4. Transition programme projects

1. Development of the primary care zones (zones are geographical areas) and governance structure
2. Development of regional care platforms
3. Development of the Flemish Institute for Primary Care
4. More capacity in primary care and financial incentives for GPs, such as administrative assistance and facilitating establishment of practice location in areas with low levels of coverage
5. Coordination of care and case management for people with complex care needs
6. Digital primary care, such as developing a digital care platform
7. Quality of care and management of complaints
8. Community care
9. Informal care: care provided by family, friends and others
10. Basic training and continuous education
11. Communication on primary care reform
12. Health literacy and patient participation
13. Social mapping: inventory of all health professionals and organizations

*Source:* Flanders Agency for Care and Health.

Each of the 13 projects is a complex piece of work that requires careful, focused attention to ensure that anticipated results and benefits are achieved.

#### 4.2 THE TASKS

The process has many aspects and components, but can be summarized as including six major elements:

1. putting the person with the care need at the centre
2. integrating all aspects of the reform
3. continuing to digitalize the care process

4. giving stronger support to local care providers through structural innovation
5. integrating health and social care services
6. aligning other resources.

#### **4.2.1 Putting the person with the care need at the centre**

The key concept here is to protect and enhance personal autonomy. An individual's autonomy should be respected and, where it is impaired, the care process should give priority to regenerating it. The individual chooses the informal caregiver and the care team members (40,50). A patient's charter is to be developed (36).

To strengthen the individual's ability to exercise self-management, the reforms aim to improve care literacy through improving sources of information and relevant knowledge and skills. The importance of giving and receiving information on the condition and care is also recognized (41).

The relevant governmental decrees are being changed and the implementation process managed to reflect these expectations, the option of including health and well-being skills in the school curriculum is being explored and a tool is being developed to help patients with long-term problems to formulate life and care aims.

In support of this aim, special attention is being given to informal carers. Flanders identifies informal care as that given on a voluntary basis by people with a social or family link with the person with a care need. These people may face their own difficulties, and the Flanders reform proposes to recognize informal carers fully as partners in the care process who may also need professional support. A plan is being implemented to support that group, addressing the issue of social recognition, relations with professionals and the special position of young carers. The current special expertise point will be included in the Flemish Institute for Primary Care (51,52).

#### 4.4.2 Integrating all aspects of the reform

It is important to identify all elements that need to be involved in the revised arrangements and ensure they are able to operate effectively within the reformed system. In this regard:

- the opportunity is being taken to strengthen aspects of health care provided, such as that for mental health problems at primary care level (52);
- Flanders has been collaborating with the Government of Belgium on the latter's initiative on integrated planning for people with chronic illnesses (36);
- complex care is a particular point of interest, with the aim of having a digital care and support plan for everyone who needs one by 2025 (also see below) (53); individuals needing such care will form part of their own care team and select the other members and the care coordinator (54);
- new ways of providing care coordination for people with a major and particularly complex need for help and care will be explored, with support being given to improving integrated care planning by care boards and the Flemish Institute for Primary Care (also see below (55));
- the signposting service in local welfare agencies is being strengthened (56), and there will be action in support of efforts to improve neighbourhood-driven care and combat loneliness and isolation (57) (a new decree on local social policy has been approved (58));
- responsibility for engaging and coordinating the very wide-ranging set of local professionals from different sectors will sit with the newly created local care boards (see below), and their collaboration will increasingly be supported through digital data-sharing (59);
- residential care, which is also subject to changing social and demographic circumstances and is currently being refashioned, will be represented on the care board (60,61); and
- home care, which seeks to keep the person in need of care in his or her chosen home as long as possible, is also under review in the context of the reform (62), as is social work (36,63).

### 4.2.3 Continued digitization of the care process

In 2017, just over 70% of Flemish people had a general medical file in a GP practice, well short of the Flemish Government's ambition to complete digital collaboration of GP medical files by 2020. It also wants multidisciplinary sharing of care and support plans by 2025 and is investing in Vitalink. To facilitate sharing, a tool called BelRAI<sup>1</sup> is under development as an instrument that care providers can use to measure care needs in a uniform way. Today, Vitalink is serving as the basis for sharing information relating to:

- the individual health record summary
- the individual medication schedule
- the vaccination scheme
- cancer screening results
- childcare reports.

Its growing use is monitored via a dashboard.

Primary care actors, mainly GPs and pharmacists, have shared responsibility for creating and maintaining the health record summary and medication schedule. Other health-care actors who use Vitalink are nurses, dentists and midwives, home-support organizations and hospitals.

Eénlijn.be is a broad change project aiming to promote the use of ICT applications in primary care through training, e-learning and a helpdesk, and to promote partnerships among primary care players. It seeks to promote sharing of data among primary care players by using the Belgian national e-Gezondheid [e-health] services (64).

Eventually, all these elements will assist in producing the digital care and support plan, help provide a common language for care providers, support continuity and quality of care and interdisciplinary and intersectoral collaboration, and promote systematic, standardized monitoring of care need (65).

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<sup>1</sup> BelRAI is the Belgian adapted version of the internationally validated taxonomy instrument interRAI<sup>TM</sup> ([www.interrai.org](http://www.interrai.org)).

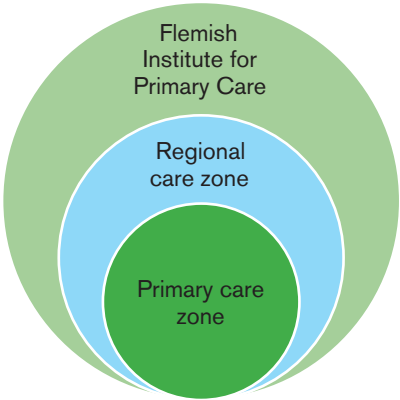
Every person with a care need and his or her informal caregiver (under certain conditions, such as securing permission from the person) is given access to his or her shared information via a user-friendly application and can, in time, manage and share personal data from his or her own personal electronic file, communicate with care providers, make appointments, add data and have virtual consultations (66).

#### 4.2.4 Giving stronger support to local care providers through structural innovation

The Flanders reform aims to restructure, simplify and integrate what is already in place, so that it works better (67). To improve care across the system, rebalance services, better integrate local services and help GPs and hospitals to work better together, population health planning must be better (see section 2.2.6) and service coordination provided in a way that has not previously existed (66). The reform will introduce three tiers of support (Fig. 8).



Fig. 8. The new support structures in the Flemish health system



Source: Flanders Agency for Care and Health.

4.2.4.1 Primary care zones (PCZs)

Primary care zones (PCZs) (68) are new structures that will create the basis for effective integrated care and services in the locality. The aim was that the boundaries of each should be locally agreed, with each serving a community of 75 000–125 000 inhabitants. By 2019, all 60 zones were agreed in principle – 59 in Flanders and one in Brussels (Fig. 9).

Fig. 9. Primary care zones (coloured) and regional care zones (numbered)



Source: Flanders Agency for Care and Health.

Their prime responsibilities will be to support multidisciplinary and intersectoral collaboration at practice level, with a developing role over time as they mature.

In mid-2020, they are required to start (69):

- aligning the organization and provision of high-quality care and support;
- supporting local social policy;
- supporting profession-specific associations;
- supporting primary care professionals and the organization of multi- and interdisciplinary collaboration; and
- cooperating on the Flemish health objectives relating to prevention and propose their own objectives.

Over time, they are expected to pick up many other tasks, such as tackling bottlenecks, developing planning and supporting ICT developments. One of the roles will be to create an integrated equity focus (70). The PCZs will provide a capability hitherto underdeveloped in the Flemish system – a local focus on service development and problem-solving. They will assess the needs of a given population and identify what response is necessary.

Each PCZ will be directed by a care board that includes four clusters of representatives – from local authorities, the health sector, the well-being sector, and people with a need of care and support – each to be equally represented, with a maximum 24 members (69).

The PCZs will gradually take on staff from other structures previously set up to help support local coordination and development: primary care collaborations, integrated home-care services and local multidisciplinary networks for chronic conditions. Funding for these groups will cease from July 2020 and the financial resources will go directly to the PCZs (71).

The existence of PCZs will not limit patients' freedom of choice: they will still be able to choose professional services freely from inside or outside the PCZ in which they reside (71).

An external consultant was commissioned to support two pilot areas in setting up PCZs over two years from spring 2017. The aim is to see what lessons can be learnt for wider application. A newsletter, websites and symposiums are being used to keep all interested abreast of what is happening, and lessons

learnt (72). As a result, each zone has been encouraged to set up a change team and a change forum. Transition coaches have been employed to help the PCZs to take ownership of the process of change (73).

#### *4.2.4.2 Regional care zones (RCZs)*

Each PCZ, with others, will be part of a regional care zone, each governed by a regional care platform (RCP) (74,75). RCZs are expected to cover a population of 350 000–400 000 inhabitants (Fig. 9).

The functions of the RCP are to:

- create a coordinated set of services at larger population level (where the PCZ population would be too small) for matters such as palliative care, dementia, mental health and prevention; existing staff and budgets will be absorbed in the new structure; and
- work towards strengthening connections between hospitals, specialized care and primary care to ensure continuity of care and development of a regional strategic care plan.

Since hospitals serve a larger population than the average PCZ, it is intended that where possible, RCZs will match the developing hospital network areas.

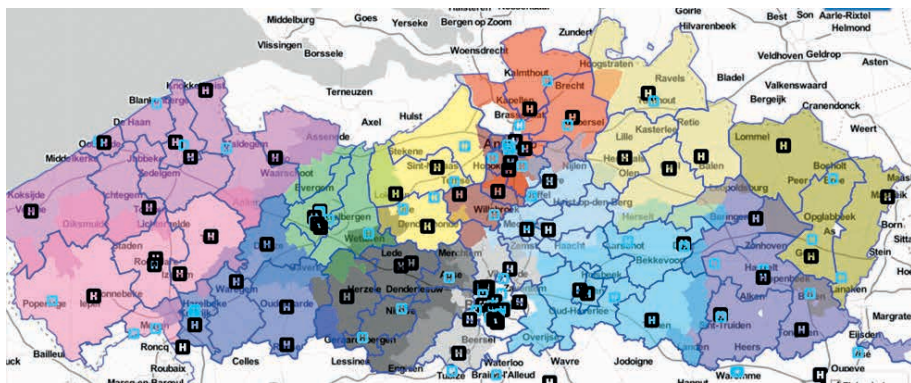
Implementation of the primary care reform coincided with a reform of the hospital sector in Belgium. Hospitals in Belgium are financed by the federal government (except in relation to infrastructure). Recent decades have seen hospital mergers in Flanders. A new policy now requires hospitals to join a hospital network to increase efficiency in the sector. The aim is for hospitals to work closely together and complement each other. Every hospital should offer basic health care, with only certain hospitals offering specialist care. The network coordinates organization, so that patients in need of specialist care will be referred to the right hospital. The goal is to have a maximum of 14 networks (Fig. 10).

Each network will have to create a regional strategic care plan. Each hospital will need an individual strategic care plan concerning the development of its services based on the regional plan, which must be approved by the Flemish Government. In the long term, the regional strategic care plan will have to be

developed by hospitals, primary care, social care, patient organizations and municipalities together, based on population needs. Government approval is necessary for the recognition and funding of new services.

By aligning the development of PCZs, RCZs and the hospital networks, the overall system can be more sustainably grounded, more rationally planned and better managed (76).

Fig. 10. Hospital networks in Flanders



Source: Flanders Agency for Care and Health.

#### 4.2.4.3 The Flemish Institute for Primary Care (VIVEL)

Creating a Flanders-level structure to oversee the primary care system is a natural development from the integrated thinking that lay behind the regional conferences in 2010 and 2017 and led to the current reform. The Flemish Institute for Primary Care (38) fills an essential role by forming a focus at Flemish level to support the continued development of primary care and work with the government, universities and research organizations.

Established in mid-2019, the Institute, known by its Flemish initials as VIVEL, will draw on the resources of four universities, six colleges and a number of other institutions, as well as the Flemish Patient Platform, a cluster of care and well-being actors and a prominent representative of the home-care sector. It is seen as a “knowledge centre for primary care” (77,78).

VIVEL's activities have been grouped into six main tasks (71):

- channelling information and data to all actors on the front line;
- developing evidence-based strategies, methodologies and implementation tools to support the organization of primary care;
- coaching, training and awareness-raising;
- stimulating innovation;
- creating and monitoring accessibility to, and the quality of, primary care in Flanders; and
- advising the Flemish Government.

#### 4.2.5 Integrating health and social care services

The need to promote better integration of health and social care services is continually kept in view in taking forward these tasks; this is one of the prime aims of the reform.

#### 4.2.6 Aligning other resources

There is a need to ensure that other important resources and institutions are refocused to support the new arrangements through, for example, education. Professional training will be reviewed and changed to ensure that all staff understand the nature and requirements of the integrated care approach and are competent in using the developing digital systems. As mentioned above, health skills will also be introduced as a learning aim in schools (79).

A second issue is to ensure that sufficient staff of the right calibre are trained and available to meet the needs of the population under the new arrangements. The Flemish Government will work with the Government of Belgium, academic and professional organizations, and local municipalities to achieve this (80).

Encouragement will be given to developing integrated, multiprofessional practices among independent care providers at primary care level and to ensuring all parts of the region have an adequate level of service, based on sociodemographic and socioeconomic factors (81). Innovation and entrepreneurship will be supported by Flanders Care, which has the task of promoting new ideas in the health sector that have an economic spin-off, and the Flemish Institute for Primary Care (82). The Institute will also help to develop a quality policy to support the new arrangements with the relevant body covering care (83).

## 5 What is happening elsewhere?

While the scale of the changes in Flanders is unusual, Flanders is not alone in making adjustments in its system of primary care to ensure that it continues to be as effective and efficient as possible. The following examples differ greatly from each other, but each shows how countries and regions are making efforts to keep services relevant and valuable to those who rely on them.

### 5.1 THE NATIONAL STRATEGY FOR PRIMARY HEALTH CARE AND COMMUNITY HEALTH IN CATALONIA, SPAIN

Catalonia is one of the 17 autonomous communities in Spain and has a population of about 7.5 million. It is known for having a universal health-care system, with good health and quality of life outcomes and full powers in public health. Like other areas, however, it must adapt to confront changing conditions, such as the ageing of its population and the increase in the number of people with chronic diseases and disabilities. As a consequence, Catalonia is developing a new strategy for primary health care and community health (known as ENAPISC from the initial letters of its title in the Catalan language) to strengthen primary health care and community health so it can serve even better as the backbone of the public health system.

The strategy's key points are to:

- boost the community focus as a basis for generating health and fighting health inequities;
- guarantee a model of person-centred care that takes into account people's physical and mental health and social circumstances;
- respond to demographic changes and the rise in numbers of people with multiple health problems;
- guarantee quality and safety in health services;
- tackle inequities through reducing differences between areas and increasing the sustainability of the public service; and
- consolidate professional leadership and encourage citizen participation.

An important feature of the strategy is its bottom-up approach, working through *technical commissions*. Each commission, composed of 15–20 expert professionals, develops over a year or so a document setting out an organizational model and the portfolio of services relevant to its appointed area of work. Currently, these include mental health and addictions, community health, sexual and reproductive health care, chronic and complex care, continuing and urgent care, paediatric care and the portfolio of services, with others to follow.

The work is carefully aligned with other initiatives involving the Catalan Health Service, the Catalan Ministry of Health, the Public Health Secretariat and other organizations and ministries.

Once a commission has agreed its document, it is shared with more than 500 professionals and institutional representatives from scientific societies, organizations, and professional and citizen associations. They can feed back comments, contributions and corrections using a pre-prepared questionnaire. If the feedback is broadly positive, the document is revised as appropriate and then adopted. If largely negative, the document is redrafted. The strength of this methodology is that its careful design guarantees its validity, transparency and consistency. To date, only the mental health and addictions outcome document has been adopted, after getting agreement from more than 80% of those questioned, with others expected to be issued by the end of 2019.

The documents will then guide future service arrangements. It is expected that primary care will take more of a role in leading and coordinating patients' care as a result. The care will be provided to a greater extent in or close to people's own home environment and will be better focused on individual needs and outcomes.

## 5.2 INTEGRATING POPULATION AND INDIVIDUAL SERVICES IN SLOVENIA TO REDUCE COMMUNITY HEALTH INEQUALITIES THROUGH HEALTH-PROMOTION CENTRES

The Slovenian health-care system provides access to universal and comprehensive health care for all Slovenian citizens, regardless of income. The country has a long tradition in primary health care, which is the first

point of patient contact and has a strong gatekeeping role. Care is provided by a wide range of health professionals, including doctors, nurses, dentists and others.

In 2002, health-promotion centres were introduced in all 61 primary health care centres across Slovenia as part of the national cardiovascular disease prevention programme. GPs identified and referred at-risk patients to the health-promotion centres, where they could participate in lifestyle intervention programmes free of charge.

The cardiovascular programme has screened more than half of the adult population for lifestyle and risk factors over the last 16 years. Every year, almost 50 000 patients take part in lifestyle interventions run by the health-promotion centres.

While health in Slovenia has improved over the decades and premature deaths have fallen, inequalities persist. Health illiteracy, poverty and unemployment among vulnerable groups can make it difficult for them to access health services, especially preventive services. Gender differences in health remain and inequalities in health among schoolchildren are increasing, particularly among those from lower socioeconomic groups. As in many other European countries, years of economic and financial crisis have also exacerbated health inequalities.

Measures were taken to upgrade the health-promotion centres in response to this widening health gap. In collaboration with the National Institute of Public Health, the primary health care centres extended their role to include conducting public health interventions at community level. Population needs assessments were carried out, on the basis of which the health-promotion centres developed more accessible services for particular at-risk groups.

To better focus on such groups, three health-promotion centres piloted a new approach to integrating the different services targeting vulnerable groups at community level between 2013 and 2016, financed by grants from Norway. They worked with a variety of local actors – municipalities, health-care and social-care institutions, educational institutions, the Project Learning for Young Adults training programme, adult education centres and various

nongovernmental organizations. As a result, these work better together and can develop support networks and self-help groups, improving access to preventive services and treatment. Partners in the local groups for health promotion set common goals in the areas of prevention, health promotion and health inequality, and plan and implement measures to reach them.

Drawing on this experience, the model was extended in 2018 to an additional 25 centres across Slovenia, co-financed by the European Social Fund. The aim is to strengthen the role of primary health care centres in public health and preventing diseases, promoting health and reducing health inequalities through, for instance, newly developed prevention programmes for new-borns and their mothers, children, adolescents and adults and improved access by disabled people to primary health care centres. This is part of a larger effort to improve local access for all groups to health promotion and prevention programmes. Further progress will require leadership and political will.

### 5.3 IMPROVING HEALTH THROUGH USE OF COMMUNITY NURSES IN ROMANIA

Botoşani county, population around 450 000, lies in Moldavia in the far north-east of Romania. It has a poor and ageing population. In the past, many inhabitants did not register with a family doctor, as they could not afford to pay for health insurance. Evidence has suggested that people delay visits to doctors and treat children themselves at home. The development of community-based health workers has therefore been of great importance.

A pilot network of 20 community nurses was set up in Botoşani in 2000, coordinated by the Mother and Child Care Institute in Bucharest. Their services in 2019 now extend to 94% of the population, with 97 community nurses and 18 health mediators currently providing community health services in six cities and 73 rural localities.

The current legal framework, established in 2017, specifies that community health services' care is provided in an integrated system with social services. Community nurses work closely with family doctors, local public health authorities, specialized medical services, social services and other agencies. Their focus is on community work and home visits.

The effectiveness of their work to date is evident in a number of areas, with improvement in coverage and access. The number of people registered with a family doctor has risen to around 80% in areas where the community nurses are active. The people they support have better access to information, health education and prevention services generally.

Under the guidance of the Botoşani Public Health Directorate, working with the Public Health Department, the community nurses have been involved in a wide range of initiatives. Besides addressing obvious health concerns like alcohol, sexually transmitted diseases and diet, they have also worked on issues such as domestic violence, health provision for children with migrant parents, support for older people with no family and reducing school dropout rates.

As a result of these and other efforts, there is evidence of improved health outcomes in the community, including a fall in tuberculosis cases, improved vaccination rates and reduced infant mortality. A further benefit has been reduced pressure on acute beds, as more effective care is now available in the community.

#### 5.4 POSITIVE HEALTH IN THE UTRECHT REGION, THE NETHERLANDS

Primary care at its best requires an understanding of the individual in his or her life context. The Positive Health approach provides this broader view on health. Rather than concentrating on a specific illness, it focuses on people by recognizing six dimensions: bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social and societal participation, and daily functioning. By showing a person's scores against these six dimensions in a web diagram, a total picture emerges of his or her health.

Machteld Huber, founder of the Positive Health movement, has set up the Institute for Positive Health in Utrecht. The Institute focuses on stimulating, strengthening and accelerating the Positive Health movement. More than 40 groups and agencies have already joined the Health Hub Utrecht, which forms the umbrella for all regional parties engaged in Positive Health. The goal is that by 2030, a happy and healthy life should be within everyone's reach.

A successful example of Positive Health in action is the integrated neighbourhood approach taken in the Overvecht area of Utrecht. Compared to other neighbourhoods in the municipality, residents here face more health and psychological issues, poverty, loneliness and an accumulation of personal problems. The Powerful Basic Care approach that is being applied here takes into account residents' vulnerability and strengths by providing care at the right moment. Powerful Basic Care focuses on customization and collaboration between the medical and social domains, ensuring that the care provided fits in with people's own health skills.

In this integrated approach, all professionals in the field of health care, social well-being and prevention in the neighbourhood work closely together, making use of the 4 Domains Model (4D Model) developed on the basis of practical experience. The four domains are body, mind, societal and social, with the patient in the middle. The 4D Model can be used as a tool to communicate with a patient, providing insight into what is happening in the four domains, the relations between them and how this affects the patient's perceived health. In addition, the model facilitates collaboration between care professionals across the domains and prevents duplication of effort.

The health insurer Zilveren Kruis and the Nivel Research Institute carried out research into the Powerful Basic Care approach from 2014 to 2016 which showed that the approach is effective and delivers the desired result. Thanks to the Powerful Basic Care approach, the quality of care experienced by individuals improved, as did the general health of the population as a whole. The approach led to lower costs of care. In addition, care providers experienced less work pressure, and job satisfaction levels increased.

The successful Powerful Basic Care approach is now also being applied in other health centres in Utrecht, Rotterdam, The Hague and Amsterdam. Implementation in these municipalities is supported by health insurers and Achterstandsfondsen [Funds for Deprived Areas].

## 6 What lessons do these examples offer?

Drawing on the examples described in Chapter 5, this chapter will offer a summary of some points that might be valuable to others aiming at system change.

### 6.1 CHOOSE WHAT SUITS YOUR NEEDS

As Flanders recognizes (44):

*There is no international travel guide for this collective journey to that new horizon. Those journeys can vary from country to country and are of course dependent on the nature and structures of the care and welfare system already in place, and the care culture that has grown there.*

Flanders is an excellent example of a region that based its reform on a clear understanding of:

- why it was changing – with a clear vision for integrated, person-centred primary care;
- where it was changing – tailoring its actions to the values and circumstances of its own area and population; and
- how it was changing – specifying the principles it was trying to follow.

Flanders' own assessment is that it is essential to (20,84):

- respect others' competences when setting up frameworks and strategies;
- identify and strengthen connecting factors, such as methodological and scientific support, evaluation and financing; and
- set out clear goals, governance structure and coordination.

Each of the case studies in Chapter 5 show how services have been adapted or developed to tackle a specific identified local concern.

## 6.2 “LUCK IS WHAT HAPPENS WHEN PREPARATION MEETS OPPORTUNITY”

This phrase is perhaps seldom more relevant than in the Flanders case. Analysis of weaknesses and a desire for change happened before a golden opportunity came to achieve it, and that opportunity was taken enthusiastically and systematically.

## 6.3 LEARN FROM EXPERTS; TEST WITH PEERS

Flanders did not make the mistake of trying to solve all its problems on its own. It surveyed the evidence and drew inspiration and insight from reliable, experienced sources, including WHO (85,86) and the International Foundation for Integrated Care (87).

In designing and implementing its solutions through these and other methods, Flanders kept in contact with other countries and regions undertaking reforms, using (among others) the European Commission Structured Reform Support service and programme, and ensured that progress was collaborative, participatory and locally owned.

## 6.4 WORK WITH THE POLITICS

The Flanders changes are very wide-ranging, and a long but limited timeframe has been set. Careful and purposeful leadership allowed a situation to develop in which professional consensus helped create and support political willingness to make change happen. The changes in Flanders benefited from the fact that the same minister remained in post, but also from a broad acceptance that change was both possible and necessary. Also important in Flanders has been the fact that a single minister had most of the relevant responsibilities within a single portfolio.

## 6.5 PEOPLE MATTER MOST

The essence of health care is that someone with a skill helps someone with a need. The case studies together show three crucial ways in which this simple

relationship can be empowered further through changes in the way staff were able to work:

- by adding new skills;
- by creating the circumstances in which those with different skills can work more confidently and more easily together; and
- by using the skill and enthusiasm of professionals to help design a new way of working.

The scale of the changes differed across the examples, but the essential importance of ensuring that staff who were appropriately trained to meet the new ambition would be in place is a common factor. Creating the right staff to work in the new system in Flanders is accepted as being vital to its success.

The examples also show a recognition that the process is not simply one way, from the provider to the recipient. The person with a need must often be an active and willing partner if the service is fully to succeed. It is where both parties respect each other and work together over the long term that health can best be protected and improved.

## 6.6 ONE-SYSTEM WORKING

What happens in primary care is not cut off from the rest of the world. It is but one element in a larger system, a wider world. All the examples show how primary care is being better linked with other dimensions – public health, social care, hospital care and the everyday life of local people whose lives it aims to improve. Better integration and more open working with others can produce a far better overall result – a healthier population and more contented and effective professionals.

## References<sup>2</sup>

1. WHO called to return to the Declaration of Alma-Ata. In: World Health Organization [website]. Geneva: World Health Organization; 2019 ([https://www.who.int/social\\_determinants/tools/multimedia/alma\\_ata/en/](https://www.who.int/social_determinants/tools/multimedia/alma_ata/en/)).
2. Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.euro.who.int/en/publications/abstracts/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century-2013>).
3. Sustainable Development Goals. In: United Nations Development Programme [website]. New York (NY): United Nations Development Programme; 2019 (<http://www.undp.org/content/undp/en/home/sustainable-development-goals.html>).
4. Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being. Copenhagen: WHO Regional Office for Europe; 2017 (EUR/RC67/9 + EUR/RC67/Conf.Doc./4; [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/345599/67wd09e\\_SDGroadmap\\_170638.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0008/345599/67wd09e_SDGroadmap_170638.pdf?ua=1)).
5. Declaration of Astana. Global Conference on Primary Health Care: from Alma-Ata towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and United Nations Children's Fund; 2018 (<https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>).
6. Primary health care: transforming vision into action. Operational framework: draft for consultation. Technical Series on Primary Health Care. Geneva: World Health Organization and United Nations Children's Fund; 2018 ([https://www.who.int/docs/default-source/primary-health-care-conference/operational-framework.pdf?sfvrsn=6e73ae2a\\_2](https://www.who.int/docs/default-source/primary-health-care-conference/operational-framework.pdf?sfvrsn=6e73ae2a_2)).

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<sup>2</sup> All weblinks accessed 19 May 2019.

7. Draft thirteenth general programme of work, 2019–2023: report by the Director General. Provisional agenda item 11.1: Seventy-first World Health Assembly. Geneva: World Health Organization; 2018 (A71/4; [http://apps.who.int/gb/ebwha/pdf\\_files/WHA71/A71\\_4-en.pdf?ua=1](http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1)).
8. Belgium, a federal state. In: About Belgium [website]. Brussels: Government of Belgium; 2019 ([https://www.belgium.be/en/about\\_belgium/government/federale\\_staet](https://www.belgium.be/en/about_belgium/government/federale_staet)).
9. Population of Belgium from 2008 to 2018, by region (in millions). In: Statista [website]. New York (NY): Statista Inc.; 2019 (<https://www.statista.com/statistics/517196/population-of-belgium-by-region/>).
10. Statistieken over de vergrijzing. Portret van de bevolking van 55 jaar en ouder [Statistics on ageing. Portrait of the population of 55 years and older]. Brussels: Statistics Belgium; 2017:3 ([https://statbel.fgov.be/sites/default/files/files/documents/Analyse/NL/analyse%2055%20NL\\_tcm325-284281.pdf](https://statbel.fgov.be/sites/default/files/files/documents/Analyse/NL/analyse%2055%20NL_tcm325-284281.pdf)) (in Dutch).
11. Flemings and Walloons. In: Institut National D'Études Démographiques [website]. Paris: Institut National D'Études Démographiques; 2019 ([https://www.ined.fr/en/everything\\_about\\_population/demographic-facts-sheets/focus-on/flemish-walloon/](https://www.ined.fr/en/everything_about_population/demographic-facts-sheets/focus-on/flemish-walloon/)).
12. Gerkens S, Merkur S. Belgium. Health system review. Health Systems in Transition 2010;12(5):xxvii ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0014/120425/E94245.PDF?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0014/120425/E94245.PDF?ua=1)).
13. Country Cooperation Strategy: WHO–Belgium 2016–2022. Geneva: World Health Organization; 2016:8 (<http://www.euro.who.int/en/countries/belgium/publications/country-cooperation-strategy-who-belgium-2016-2022>).
14. State of health in the EU: Belgium. Country health profile 2017. Paris: OECD/European Observatory on Health Systems and Policies; 2017:16 (<https://doi.org/10.1787/9789264283299-en>).
15. State of health in the EU: Belgium. Country health profile 2017. Paris: OECD/European Observatory on Health Systems and Policies; 2017:2–5 (<https://doi.org/10.1787/9789264283299-en>).

16. de Raedt L. Introduction to the Belgian health system. Brussels: FPS Public Health, Food Chain Safety and Environment; undated ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/BRUS21.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/BRUS21.pdf)).
17. Kringos D, Boerma W, Bourgueil Y, Cartier T, Dedeu T, Hasvold T et al. The strength of primary care in Europe: an international comparative study. *Br J Gen Pract*. 2013;63(616):742–50.
18. Kringos D, Boerma W, van der Zee J, Groenewegen P. Europe's strong primary care systems are linked to better population health, but also to higher health spending. *Health Aff (Millwood)* 2013;32(4):686–94.
19. Gerkens S, Merkur S. Belgium. Health system review. *Health Systems in Transition* 2010;12(5):64–5 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0014/120425/E94245.PDF?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0014/120425/E94245.PDF?ua=1)).
20. Wallyn S, Massant D. Reorganise primary care in Flanders Region: change management and process 2010–2017. *Int J Integr Care* 2017;17(5):A270 (<http://doi.org/10.5334/ijic.3581>).
21. Section 2.4. Overheden op één lijn [Public authorities in one line]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:12–3 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
22. Mossialos E, Dixon A, Figueras J, Kutzin J, editors. Funding health care: options for Europe. Copenhagen: WHO Regional Office for Europe; 2002 (<http://www.euro.who.int/en/publications/abstracts/funding-health-care-options-for-europe-2002>).
23. De geneeskundige verstrekkingen die uw ziekenfonds terugbetaalt [The medical benefits that your health insurance fund reimburses]. In: Rijksinstituut voor ziekte- en invaliditeitsverzekering [National Institute for Health and Disability Insurance] [website]. Brussels: Rijksinstituut voor ziekte- en invaliditeitsverzekering; 2019 (<https://www.inami.fgov.be/nl/themas/kost-terugbetaling/door-ziekenfonds/Paginas/default.aspx>) (in Dutch).

24. What you need to know about the Belgian health system. In: International House Leuven [website]. Leuven: International House Leuven; 2019 (<https://www.internationalhouseleuven.be/social-security-healthcare/what-do-you-need-to-know-about-the-belgian-health-care-system>).
25. Vlaamse sociale bescherming [Flemish social protection]. In: Partena Ziekenfonds [Partena Health Insurance] [website]. Kortrijk: Partena Ziekenfonds; 2019 ([www.partena-ziekenfonds.be/vlaamsesocialebescherming](http://www.partena-ziekenfonds.be/vlaamsesocialebescherming)) (in Dutch).
26. Gerkens S, Merkur S. Belgium. Health system review. Health Systems in Transition 2010;12(5):153–54 ([https://ec.europa.eu/health/sites/health/files/state/docs/chp\\_be\\_english.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/chp_be_english.pdf)).
27. Gerkens S, Merkur S. Belgium. Health system review. Health Systems in Transition 2010;12(5):65 ([https://ec.europa.eu/health/sites/health/files/state/docs/chp\\_be\\_english.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/chp_be_english.pdf)).
28. Gerkens S, Merkur S. Belgium. Health system review. Health Systems in Transition 2010;12(5):62 ([https://ec.europa.eu/health/sites/health/files/state/docs/chp\\_be\\_english.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/chp_be_english.pdf)).
29. State of health in the EU: Belgium. Country health profile 2017. Paris: OECD/European Observatory on Health Systems and Policies; 2017:6 (<https://doi.org/10.1787/9789264283299-en>).
30. Performance of the Belgian health system – report 2015. KCE report 259C. Health Services Research. Brussels: Belgian Health Care Knowledge Centre (KCE); 2015:57 ([https://kce.fgov.be/sites/default/files/atoms/files/KCE\\_259C\\_performancereport2015\\_0.pdf](https://kce.fgov.be/sites/default/files/atoms/files/KCE_259C_performancereport2015_0.pdf)).
31. Rapport 3. Gebruik van gezondheids- en welzijnsdiensten [Report 3. Use of health and welfare services]. Gezondheidsenquête 2013 [Health Information Survey 2013]. Brussels: Wetenschappelijk Instituut Volksgezondheid; 2015:806 ([https://his.wiv-isp.be/nl/Gedeelde%20%20documenten/AC\\_NL\\_2013.pdf](https://his.wiv-isp.be/nl/Gedeelde%20%20documenten/AC_NL_2013.pdf)).
32. Section 2.2. Waarom hervormen? [Why reform?]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:9–11 (<https://www.zorg-en-gezondheid.be/sites/default/files/>

- atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf) (in Dutch).
33. De Maeseneer J. Synthesenota wetenschappelijke reflectiekamer [Synthesis of scientific memorandum reflections]. Brussels: Flanders Agency for Health and Care; 2017 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELC-Synthesenota%20Wetenschappelijke%20Reflectiekamer%202017.pdf>) (in Dutch).
  34. Section 1. Op één lijn voor een sterke eerste lijn [Adopting one line for strong primary care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:4–5 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
  35. Reorganization of primary care in Flanders: location and change process 2015–2019. Brussels: Government of Flanders; 2015 (<https://ehff.eu/wp-content/uploads/2013/03/C.PrimaryCare-ChangeProcess-Flanders2015-2017-Vision.pdf>).
  36. Section 2.5. Reeds afgelegd beleidstraject [Policy phase already undertaken] In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:13–6 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
  37. Nuyens Y. De eerste lijn in beweging? Voortgangsrapport 2010–2013 [Primary care in motion? Progress report 2010–2013]. Symposium eerstelijnsgezondheidszorg [Primary health care symposium]. Brussels, 7 December 2013. Antwerp: KU Leuven & Universiteit Antwerpen; 2013 ([https://www.kennisplein.be/Documents/Mentalis/syntheserapport%20yvo%20nuyens\\_20131128%20-%20with%20summaryfinal.pdf](https://www.kennisplein.be/Documents/Mentalis/syntheserapport%20yvo%20nuyens_20131128%20-%20with%20summaryfinal.pdf)) (in Dutch).
  38. Section 3.2.3. Het vlaams niveau: van samenwerkingsplatform tot een Vlaams Instituut voor de Eerste Lijn [Flemish level: from partnership platform to a Flemish Institute for Primary Care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health

and Care; 2017:48–50 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).

39. Section 2.1. Wie of wat is de eerste lijn? [Who or what is primary care?]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:8–9 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
40. Section 3.1.1. Regie in eigen handen [Control in their own hands]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:17–9 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
41. Section 3.1.1.3. Gezondheidsvaardigheden en zelfversterking [Health skills and empowerment]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:17–9 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
42. Section 5. Samenvatting [Summary]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:68–73 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
43. European framework for action on integrated health services delivery (EFA IHSD). In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/european-framework-for-action-on-integrated-health-services-delivery-efa-ihsd>).

44. Section 1.2. Lijnen ombuigen naar cirkels [Bending lines into circles]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17. [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:5–7 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
45. Conferentie “Reorganisatie Eerstelijnszorg Vlaanderen”. Toelichting visie op de reorganisatie van de eerstelijnszorg. [“Reorganization of Primary Care in Flanders” conference. Explanation of the vision on reorganization of primary care]. In: Möbius [website]. Brussels: Möbius; 2019 (<https://mobius.be/nl/evenementen/conferentie-reorganisatie-eerstelijnszorg-vlaanderen/>) (in Dutch).
46. Reorganiseer de eerstelijnszorg in Vlaanderen [Reorganize primary care in Flanders]. In: Levuur [website]. Leuven: Levuur; 2019 (<https://levuur.be/case/eerstelijnszorg/>) (in Dutch).
47. Greer S, Wismar M, Figueras J. Strengthening health system governance – better policies, stronger performance. Maidenhead: McGraw Hill Education/Open University Press; 2016.
48. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2004;12:573–6.
49. Een solide toekomst voor het sociaal werk. Sociaalwerkconferentie 2018 [A solid future for social work. Social work conference 2018]. In: Weliswaar [website]. Brussels: Department of Welfare, Public Health and Family; 2018 (<https://www.weliswaar.be/sociaal-werk-conferentie-2018>) (in Dutch).
50. Section 4.3. Eigenaarschap van de reorganisatie delen [Sharing ownership of the reorganization]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:67 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
51. Section 3.1.2. Informele zorg [Informal care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:19 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/>

files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf) (in Dutch).

52. Section 3.1.4. De mantelzorger is een volwaardige partner in de zorg [The informal caregiver is a fully fledged partner in health care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:20–1 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
53. Section 3.1.15.1. Complexe zorg: goede digitale registratie en samenwerking [Complex care: good digital registration and collaboration]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:33–5 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
54. Section 3.1.15.2. Complexe zorg: het multidisciplinair zorgteam en de zorgcoördinatie [Complex care: the multidisciplinary care team and care coordination]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:35–6 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
55. Section 3.1.15.3. Complexe zorg: case management in actie [Complex care: case management in action]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:36–8 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
56. Section 3.1.6. Wegwijzers in de zorg [Signposts in health care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:23–4 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).

57. Section 3.1.7. Meer zorg in de buurt [More care in the neighbourhood]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:24 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
58. Section 3.1.8. Lokaal sociaal beleid [Local social policy]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:24–5 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
59. Section 3.1.9. De zorgaanbieders in de eerste lijn [Health-care providers in primary care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:25–7 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
60. Section 3.1.10. De woonzorgactoren maken structureel deel uit van de eerste lijn [Residential care players are structurally part of primary care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:27–8 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
61. Section 3.1.12. Woonzorgcentrum [Residential care services]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:29–30 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
62. Section 3.1.11. Gezinszorg [Family care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:28–9 (<https://www.zorg-en-gezondheid.be/sites/default/files/>

atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf) (in Dutch).

63. Section 3.1.13. Diensten maatschappelijk werk [Social work services]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Intergrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:30–1 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
64. Section 3.3.5. Een digitale eerste lijn [A digital primary care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Intergrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:60–1 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
65. Section 3.1.15.1. De eerste lijn is vragende partij voor een goede afstemming met de ziekenhuizen [Primary care requests good coordination with hospitals]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Intergrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:40–1 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
66. Section 3.1.15.4. De eerste lijn gaat voor digitale zorgcoördinatie [Primary care opts for digital care coordination]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Intergrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:39–40 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
67. Section 3.2. Ondersteuning van de zorgaanbieders [Support for health-care providers]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Intergrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:42–50 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).

68. Section 3.2.1. De eerstelijnszone [The primary care area]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:42–6 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
69. Richtlijnen en procedure voor de samenstelling van voorlopige Zorgraden van de eerstelijnszones [Guidelines and procedure for the composition of provisional care levels of primary care zones]. In: Agency for Care and Health [website]. Brussels: Agency for Care and Health; 2019 (<https://www.zorg-en-gezondheid.be/richtlijnen-en-procedure-voor-de-samenstelling-van-voorlopige-zorgraden-van-de-eerstelijnszones>) (in Dutch).
70. Ontwerp van decreet betreffende de organisatie van de eerstelijnszorg, de regionale zorgplatformen en de ondersteuning van de eerstelijnszorgaanbieders [Draft decree concerning the organization of primary care, regional care platforms and the support of primary care providers]. Brussels: Flemish Government; 2019 (VR 2019 0102 DOC.0114/2BIS; <https://www.vlaanderen.be/nbwa-news-message-document/document/0901355780270315>) (in Dutch).
71. Veelgestelde vragen over de hervorming van de eerstelijnszorg [Frequently asked questions about primary care reform]. Brussels: Agency for Care and Health; 2019 (<https://www.zorg-en-gezondheid.be/hervorming-van-de-eerstelijnszorg-in-vlaanderen>) (in Dutch).
72. Workitects helpt organisaties om slagvaardiger te worden en meer werkbaar werk te creëren [Workitects helps organizations to become more effective and to create more workable work]. In: Workitects [website]. Leuven: Workitects; 2019 (<http://www.flanderssynergy.be/nieuws/108>) (in Dutch).
73. Wiki over eerstelijnszones [Wiki about primary care zones]. In: ELZ [website]. Leuven: Flanders Synergy/KU Leuven/Vlaanderen is Zorg/Agentschap Innoveren & Ondernemen; 2019 (<https://www.eerstelijnszones.be/wiki/Hoofdpagina>) (in Dutch).
74. Section 3.2.2. De regionale zorgzone (op regionaalstedelijk zorgregioniveau) [The regional care area (at regional–urban care

- level)]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:46–8 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
75. Tekst aangenomen door de plenaire vergadering van het ontwerp van decreet betreffende de organisatie van de eerstelijnszorg, de regionale zorgplatformen en de ondersteuning van de eerstelijnszorgaanbieders [Text adopted by plenary of the draft decree concerning the organization of primary care, the regional care platforms and the support of primary care providers]. Adopted by the Flemish Parliament on 3 April 2019. Brussels: Flemish Government; 2019 (1878 (2018–2019) – Nr. 3; <http://docs.vlaamsparlement.be/pfile?id=1475222>) (in Dutch).
  76. Zorgstrategisch plan Vlaanderen studieopdracht [Strategic plan for care in Flanders]. Leuven: Deloitte/KUL University of Leuven; 2017 ([https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/ppt\\_Zorgstrategisch\\_Plan\\_Vlaanderen\\_def.pdf](https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/ppt_Zorgstrategisch_Plan_Vlaanderen_def.pdf)) (in Dutch).
  77. Bradshaw L. New institute combines expertise to improve primary health care. In: Flanders Today [website]. Brussels: Ackroyd Publications/Mediahuis NV; 2019 (<http://www.flandertoday.eu/new-institute-combines-expertise-improve-primary-health-care>).
  78. Besluit van de Vlaamse Regering houdende de regels voor de erkenning en subsidiëring van een partnerorganisatie als Vlaams Instituut voor de Eerste Lijn [Decision of the Flemish Government on the rules and accreditation of a partner organization as Institute for Primary Care]. Brussels: Flemish Government; 2019 (C – 2019/40767; [https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/BVR%20VIVEL\\_BS.pdf](https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/BVR%20VIVEL_BS.pdf)) (in Dutch).
  79. Section 3.3.1. Basisopleiding en permanente vorming [Initial training and continuing education]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:51–2 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).

80. Section 3.3.2. Zorgcapaciteit in de eerste lijn [Care capacity in primary care]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17 ]. Brussels: Flanders Agency for Health and Care; 2017:52–3 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
81. Section 3.3.3. Ondersteuning van eerstelijnspraktijkvormen [Support for primary care practice]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:53–6 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
82. Section 3.3.6. Innovatie en ondernemerschap [Innovation and entrepreneurship]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:62–3 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
83. Section 3.3.7. Kwaliteitsbeleid [Quality policy]. In: Een geïntegreerde zorgverlening in de eerste lijn. 16.02.17 [Integrated care in primary care. 16.02.17]. Brussels: Flanders Agency for Health and Care; 2017:63–4 (<https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf>) (in Dutch).
84. Good governance for better health policies. In: European Observatory on Health Systems and Policies [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/about-us/partners/observatory/news/news/2016/01/good-governance-for-better-health-policies>).
85. WHO global strategy on people-centred and integrated health services: interim report. Geneva: World Health Organization; 2015 (<https://www.who.int/servicedeliverysafety/areas/people-centred-care/global-strategy/en/>).
86. WHO framework on integrated people-centred health services 2016. In: World Health Organization [website]. Geneva: World Health

Organization; 2019 (<https://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>).

87. International Foundation for Integrated Care. In: International Foundation for Integrated Care [website]. Oxford: International Foundation for Integrated Care; 2019 (<https://integratedcarefoundation.org>).





## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Primary health care is the cornerstone of a strong, supportive health system, as was recognized in the 1978 Alma-Ata Declaration and the 2018 Declaration of Astana. It has an important role now in meeting the global United Nations Sustainable Development Goals and the goals of WHO's 13th General Programme of Work for 2019–2023. This report focuses on primary care developments in Flanders, Belgium. Following state reforms in Belgium, the region is now upgrading and integrating its primary care services, aiming to improve their effectiveness and efficiency and the quality of life of both users and providers of those services. It is doing so through careful planning, sustained engagement across society, and systematic, well organized implementation. The report also touches on primary care developments in other parts of Europe – in Catalonia in Spain, Slovenia, Botoșani in Romania and Utrecht in the Netherlands – and concludes with lessons that these different experiences suggest might be useful to others.

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