

Key Data in Healthcare – Integrated Care

Health
Food Chain Safety
Environment

.be

Colophon

Subject:

This report outlines, through a set of key indicators, the activities undertaken by the Federal Public Service (FPS) Health, Food Chain Safety and Environment, in cooperation with other public authorities, in the area of integrated care. It provides an overview of the development and organisation of integrated care in Belgium and highlights the added value of integrated care.

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FOREWORD

This edition of Key data in healthcare, which focuses on integrated care, occupies a special place in our series of publications entitled Key data in healthcare. Whilst previous editions were frequently able to rely on a broad set of key figures available within the FPS Health, Food Chain Safety and Environment, this does not apply to the same extent in the case of integrated care. However, that does not mean that integrated care is any less important. Above all, it demonstrates that integrated care is a complex and cross-cutting issue that cannot easily be captured in all cases by traditional indicators.

Today, more than ever, integrated care is regarded by policymakers and by the general population as an essential approach. Against the backdrop of an ageing population, rising rates of chronic conditions and increasingly complex healthcare and support needs, there is a growing need for a healthcare system that works together more effectively across disciplines, sectors and levels of authority. For members of the public, integrated care holds the promise of increased coherence, greater continuity and a range of care and support services that meet people's actual needs more effectively.

With this edition of Key data in healthcare, we aim above all to raise awareness of integrated care, clarify what integrated care actually entails, and demonstrate how it contributes to high-quality, continuous, and well-coordinated care. In doing so, we rely not only on the available data, but also provide context on the underlying concepts, policy developments, and practical applications in the field. I hope that this publication will contribute towards a better understanding of this important development and to the ongoing debate on how we can organise our healthcare system with an eye towards the future!

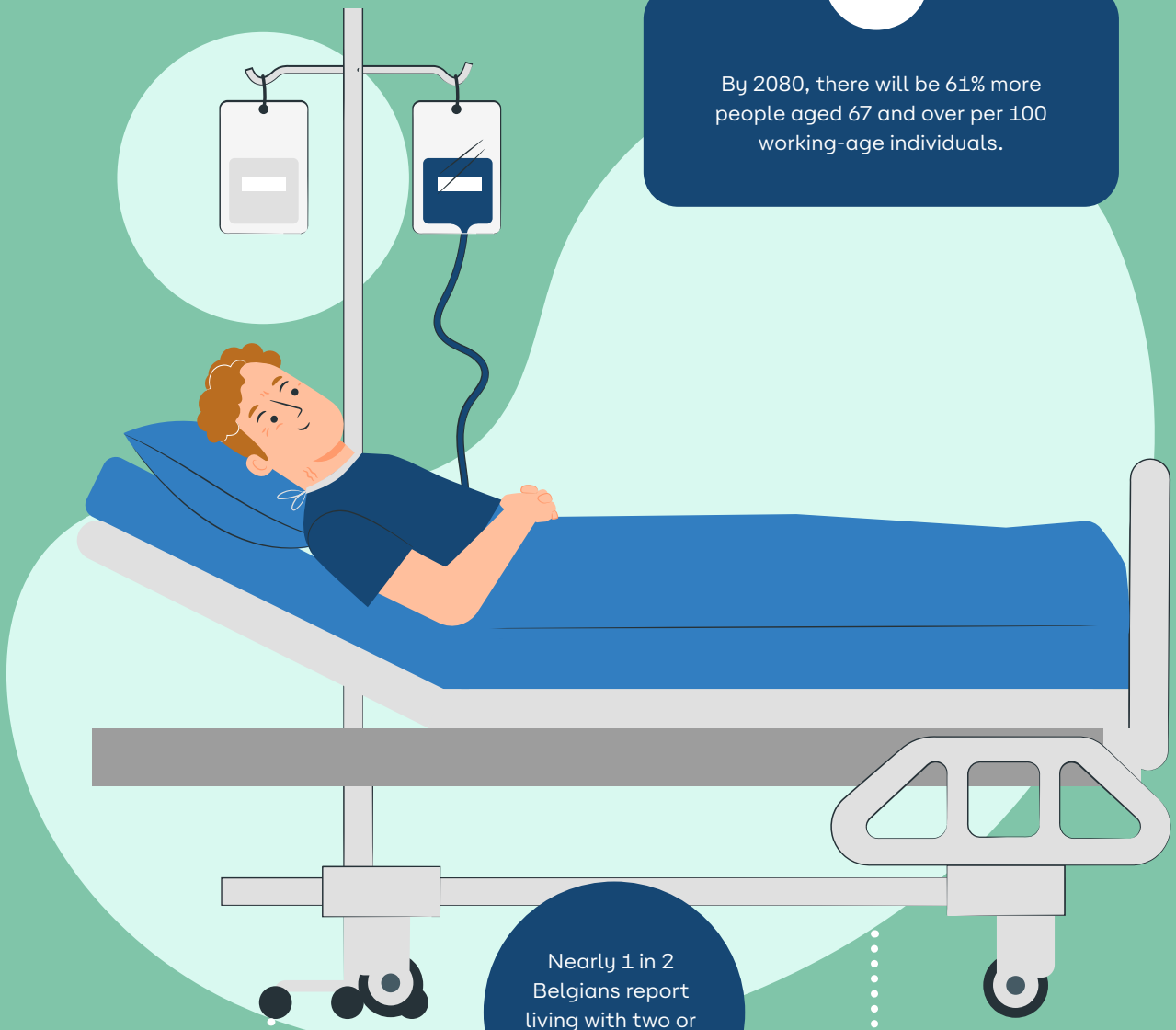
Sabine Stordeur,

Director-General of the Directorate-General for Healthcare

1 INTRODUCTION

61%

By 2080, there will be 61% more people aged 67 and over per 100 working-age individuals.



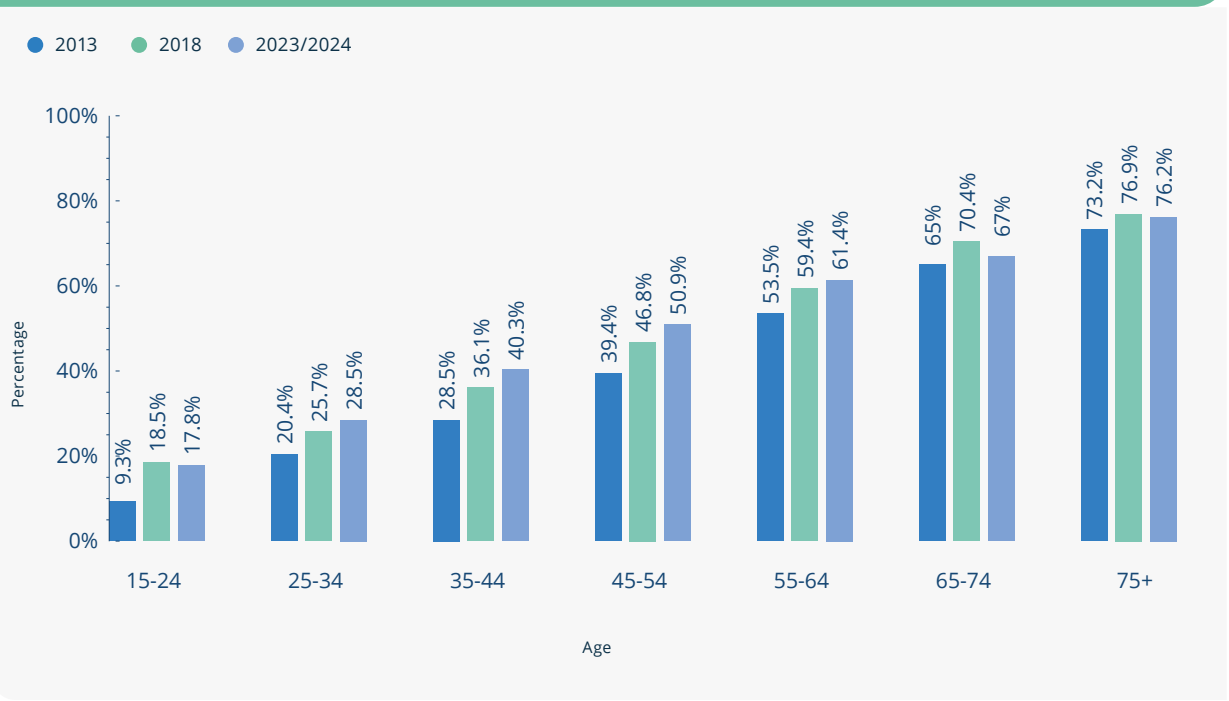
Nearly 1 in 2 Belgians report living with two or more chronic conditions.

1 in 7 Belgians has official chronic condition status.

Fragmented care can generate more than €4,000 in additional costs per patient.

The Belgian healthcare system is evolving within a changing context. Our population is ageing and more and more people are living with one or more chronic diseases. The number of people aged 67 or over is increasing, compared to size of the working-age population. **In 2080, for every 100 people aged 18 to 66, projections show that 45 people will be aged 67 or over; in 2025, that figure was 28.**[1] **In addition, 48% of Belgium's population aged 15 or over report having had two or more chronic illnesses in the past 12 months.** These are primarily older adults who have two or more chronic conditions, but in recent years, there has been a notable increase amongst people **aged 25 to 64.**

Trends in the percentage of the population aged 15 or over who report having had two or more chronic conditions in the past 12 months (2013–2023/2024)



These figures from the Belgian Health Survey (2013-2024) are based on self-reporting. The available objective information about chronic illnesses in Belgium is often limited to certain conditions. We do know that the greatest 'burden of disease' is caused by musculoskeletal disorders such as lower back pain, mental disorders and cancers [2] and that approximately 15% of Belgium's population has the chronic condition status – a status granted to eligible individuals when their healthcare expenses exceed a certain threshold.[3]

These developments are leading to increasingly complex healthcare needs, while healthcare services are under pressure due to staff shortages and high workloads. Furthermore, the healthcare system in Belgium has historically been organised in a fragmented manner across various sectors and professional groups, which has helped create its current structure and operation. This sometimes makes it difficult for patients to understand their care pathway and for healthcare and social service providers to work together smoothly. This fragmentation also leads to additional costs: according to analyses, these can amount to **more than 4,000 euros per patient** .[4]

1 Source: 1992–2024: observations, Statbel; 2025–2080: projections by FPB and Statbel. Retrieved from https://statbel.fgov.be/nl/themas/bevolking/bevolkingsvooruitzichten#news

2 Sciensano. Burden of disease: Disability-Adjusted Life Years, Health Status Report, 26 June 2025, Brussels, Belgium, https://www.healthybelgium.be/en/health-status/burden-of-disease/disability-adjusted-life-years

3 Source: http://www.ima-aim.be

4 OECD (2023), Integrating Care to Prevent and Manage Chronic Diseases: Best Practices in Public Health, OECD Publishing, Paris, https://doi.org/10.1787/9acc1b1d-en

At the same time, digitalisation and innovative technologies in healthcare are opening up new opportunities. For example, digital tools make it possible to share information more effectively amongst healthcare and social service providers, to monitor health metrics more closely and to organise care more efficiently. Efforts to promote digital skills and boost the creation of interoperable digital infrastructure are necessary in order to achieve this.

Something else that is changing, is the patient's role. We are moving from a situation where patients are more 'passive' recipients of care to one in which they are more informed recipients and 'co-decision-makers' within the care and support process. This calls for a different approach to collaboration, in which healthcare and social service providers, patients and their support networks make decisions together, plan together and work together to provide goal-oriented care.

All of these developments underscore the need for **integrated care**. This means that various healthcare and social service providers coordinate their efforts, and that the person concerned is a partner within the care process. It's not just about medical care, but also about assistance with daily activities, social support and the involvement of informal caregivers.

Based on the World Health Organization's framework,[5] we can define integrated care as:

"An approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions."

In simple terms, integrated care for an individual can mean the following:

"I can plan my care with people who work together, understand me and help me get the care that's most important for me."

In this edition of Key data in healthcare, we show how integrated care is being implemented in Belgium and how this approach can contribute towards an accessible, cohesive and more future-proof healthcare system in Belgium.



5 WHO Regional Office for Europe. Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery. 2016 https://iris.who.int/bitstreams/6eb1da76-189c-4bbd-ac79-62523037ffae/download

2 ORGANISATION OF INTEGRATED CARE IN BELGIUM

3

3 Priority Application domains

Perinatal care
Vulnerable individuals
Children and adolescents with obesity

Meso-level structures act as the bridge between policy and practice



More than 50% of our health is not determined by healthcare. Lifestyle and living conditions make the difference

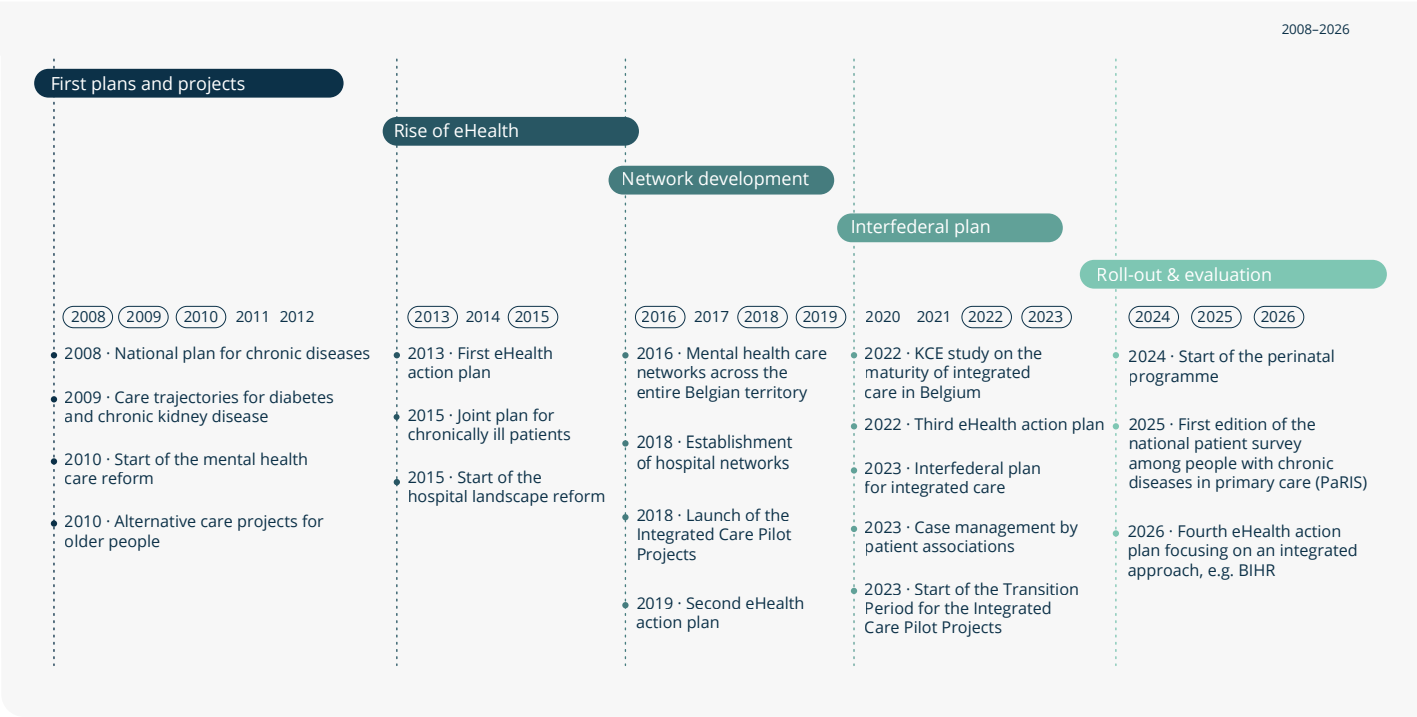
The right care for every level of need: for 80% of the population, primary care and self-management are sufficient; 15% require coordinated care, and 5% need case management

2.1 The evolution of integrated care in Belgium

In Belgium, we have already been working for years to develop a healthcare system which, amongst other things, enables healthcare and social service providers to work together more effectively. In recent years, this trend has been further reinforced by new plans and projects, both at federal level and within the federal regions. This initiative aims to address the historical fragmentation of care, the shortage of healthcare and social service providers and the increasing complexity of care needs, and is in line with international recommendations regarding the continuity of care and person-centred care.

The timeline below provides an overview of how federal initiatives relating to integrated care have evolved in recent years.

Evolution of policy initiatives at federal level in the context of the development of integrated care



The timeline shows, amongst other things:

- The emergence of various care pathways that require collaboration with different disciplines to develop a single care plan for the individual (e.g. care pathways for diabetes and renal insufficiency and projects focusing on alternative forms of care for older adults).
- The evolving healthcare landscape with an increasing role for supporting mesostructures – such as mental healthcare networks or hospital networks on a regional level – to facilitate collaboration and integrated care in the field.
- Ongoing digital developments in healthcare arising from the various action plans for eHealth. This should ultimately result in a single, unified electronic patient record, known as the Belgian Integrated Health Record (BIHR).

The Federal Knowledge Centre for Health Care (KCE) emphasises the fact that the transition to more integrated care is a necessity. In a report from 2022[6], the KCE explains that our healthcare system is still too focused on acute care and 'payment per service'. In the current context, this approach no longer works well when it comes to issues such as an ageing population, chronic diseases and people with multiple conditions. That is why the KCE is proposing three things:

1. A clear policy framework for integrated care
2. A delineation of healthcare regions in Belgium
3. A reform of the funding system

For more information, please visit
https://www.kce.fgov.be/en/kce-press-release-kce-reports-359-towards-integrated-care-in-belgium-stakeholders-view-on-maturity

On 8 November 2023, a major step was taken towards this goal: the Interfederal Plan for Integrated Care was launched and signed by all of Belgium's ministers of health. This plan is helping to organise and coordinate care and support more effectively. It views the individual or patient as a full partner in the care and support process, encourages collaboration between disciplines by means of joint care planning, for example, and seeks to break down barriers between healthcare, well-being and social services.

Eight agreements have been reached between the various government agencies in this plan:

01 The Interfederal Plan for Integrated Care provides a shared framework for initiatives by the various levels of government to work together on the Quintuple Aim objectives (see below) and on integrated care.

02 Structural cooperation between the federal regions and the federal government takes place via the Inter-Administrative Platform. This platform supports the high-quality implementation and coherence of the key components of integrated care.

03 Policy initiatives are based as much as possible on person-centred and goal-oriented care, using a broad and interdisciplinary approach that brings together care and well-being.

04 The federal regions and the federal government align their interpretations of key concepts in integrated care with the definitions set forth in the Interfederal Plan for Integrated Care. Where necessary, this can be done in an asymmetrical manner, taking into account the unique characteristics of each federal region.



6 Lambert A-S, Op de Beeck S, Herbaux D, Macq J, Rappe P, Schmitz O, Schoonvaere Q, Van Innis A.L, Vandenbroeck P, De Groote J, Schoonaert L, Vercruysse H, Vlaemynck M, Bourgeois J, Lefèvre M, Van den Heede K, Benahmed N. Transitie naar (meer) geïntegreerde zorg in België – Synthese. Health Services Research (HSR). Brussels: Federal Knowledge Centre for Health Care (KCE). 2022. KCE Reports 359As. D/2022/10.273/50.

05 Working closely with citizens and adopting a population-based approach are key features of this approach. Both horizontal and vertical collaboration across sectors is essential in this regard. This requires a strong and responsive meso level that supports the micro level and operates within the policy frameworks on the macro level.

06 In collaboration with the federal government, each federal region is examining how best practices from ongoing federal initiatives can be sustainably embedded at meso level, and how these can be further rolled out and funded under Agreement 8.

07 The federal regions and the federal government are committed to data-driven health and welfare policies that support collaboration, communication and data sharing. The alignment between the Interfederal Plan for Integrated Care and the Action Plan e-Health is monitored within the Inter-Administrative Platform and translated into concrete actions.

08 The federal government and the federal regions will ensure that resources that strengthen integrated care are allocated efficiently and in a coordinated way. This is achieved by adopting a coordinated approach and by means of funding mechanisms that promote integrated care, to which each level of government contributes within its own areas of jurisdiction.

For more information about the Interfederal Plan, please visit
https://www.riziv.fgov.be/nl/professionals/info-voor-allen/het-interfederaal-plan-voor-geintegreerde-zorg

The Interfederal Plan currently serves as the shared framework for the continued development of integrated care between the various authorities responsible for healthcare in Belgium. It builds on previous experience and initially focuses on three Application domains, namely:

- Perinatal care
- Vulnerable individuals
- Children and adolescents with obesity

The perinatal programme, which focuses on early detection and an interdisciplinary approach regarding pregnant women with psychosocial vulnerabilities, is currently being rolled out throughout Belgium. The first 1,000 days are crucial for a child's physical, mental and social development. Investing in that period is essential in order to provide every child with equal opportunities from the very beginning. Reports from the KCE show that prenatal and postnatal care and support in Belgium are not always timely, accessible or tailored to the needs of (expectant) mothers, particularly for women in psychosocially vulnerable situations.

For more information, please visit
https://kce.fgov.be/en/publications/thematic-pages/focus-on-pregnancy-and-birth

The other two programmes are still under development. By implementing integrated care programmes, we aim to link care and well-being together more effectively for specific target groups and to achieve greater continuity of care within the care and support process.

Overall, Belgium is working towards a healthcare model that is simpler, more coordinated and better organised. A model that encourages collaboration is based on what people truly need and is sustainable for the future.

2.2 How to achieve integrated care : the Rainbow Model

Integrated care can be organised according to Pim Valentijn's Rainbow Model. That model shows that integrated care consists of various layers that interact with one another. It helps healthcare and social service providers, organisations and policymakers to collaborate more effectively and organise care in a logical manner. The model recognises that healthcare is complex and that multi-level collaboration is necessary in order to achieve the best outcomes for patients.

The Rainbow Model by Pim Valentijn



For more information about the Rainbow Model, please visit
https://www.essenburgh.com/en/lp-care-innovation-the-rainbow-model-for-integrated-care/

The various layers of the model are explained in more detail in this chapter.

However, the principles of integrated care only truly come to life when applied to a specific situation. A case study illustrates how integrated care is put into practice and how the different levels of the rainbow model – the system, organisation and care delivery – work together to provide person-centred and goal-oriented care.



Nathalie (26) lives with her partner, Johan (28).

The couple has two young children: Luna (1.5 years old) and Timo (4 years old). Timo has autism and is participating in an outpatient rehabilitation programme for that condition. Nathalie is pregnant with their third child. Nathalie works at the local supermarket under a 4/5 contract. Johan is unemployed and is receiving unemployment benefits. Finding a job is proving difficult. They live in a rented, private two-bedroomed apartment. The family is experiencing financial difficulties. The couple is two months in arrears on their rent. They can't make ends meet, but they also like buying 'must-haves' and brand-name clothing online on a regular basis. Their financial problems are causing stress within the family. Nathalie and Johan have frequent heated arguments. Because of these worries (and with the arrival of a third child), Nathalie is feeling mentally unstable. Nathalie has a general practitioner, but she hardly ever sees him. She realises that she isn't feeling well mentally, but she doesn't dare go to a psychologist and doesn't know how to go about that either. She's also afraid of her husband's reaction. The only healthcare provider she currently sees on a regular basis is her gynaecologist, who usually doesn't have much time for a genuine chat and always sees both parents together.

2.2.1 Objectives of integrated care (external)

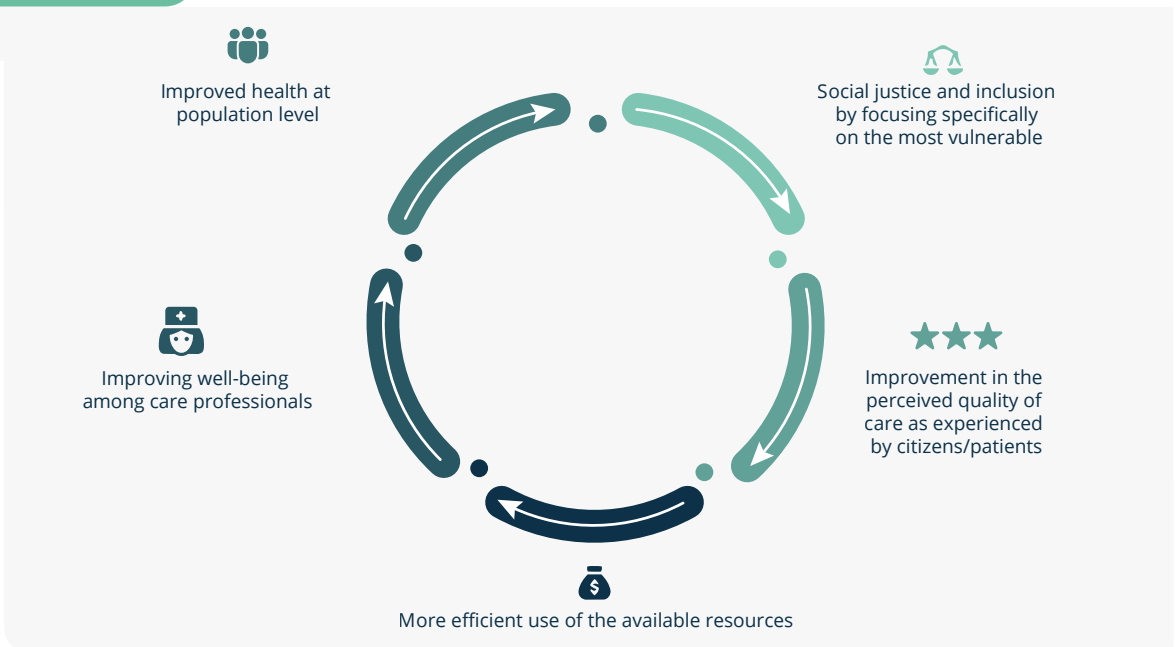
The Rainbow Model starts from the outer side, based on the goals we are pursuing with integrated care, namely:

- better public health in Belgium
- improved quality of care experience for citizens
- more efficient use of the available resources

Over the years, two additional key objectives of integrated care have been identified, namely

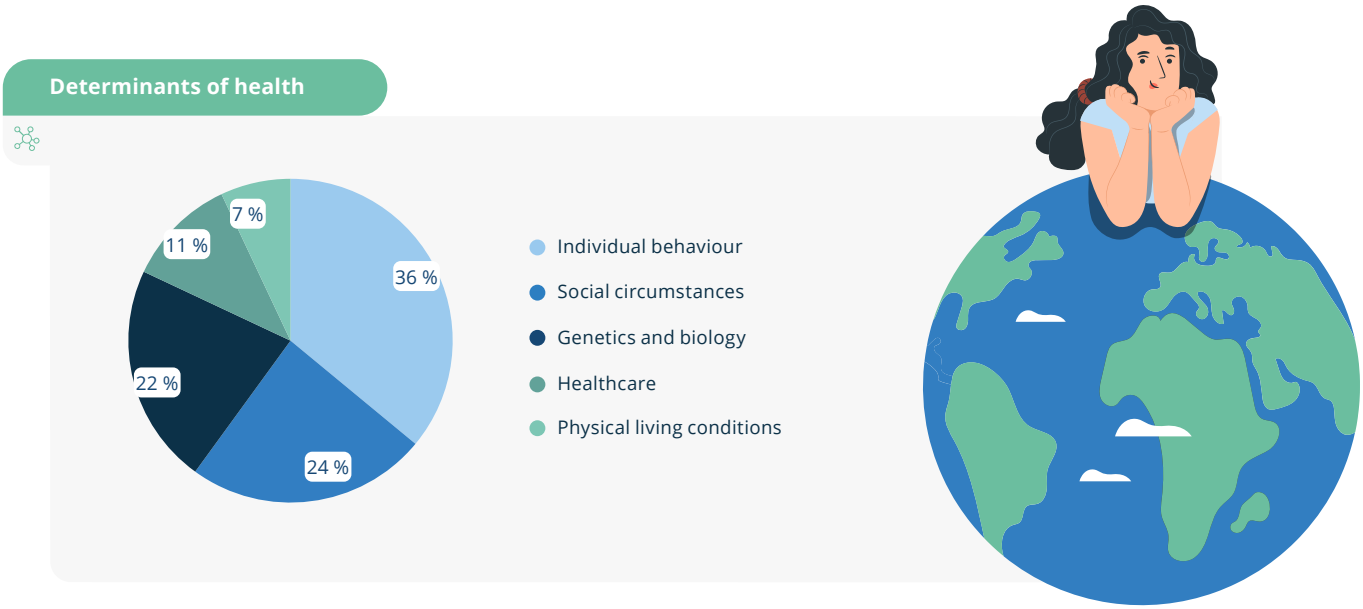
- more well-being amongst professionals working in the health and welfare sector
- more equitable access to healthcare

Quintuple aim



In 2025, the Institute for Healthcare Improvement expanded its goals to include a sixth objective: a focus on sustainability and the environment within the healthcare sector.[7]

It is important to consider all factors that influence health, such as a person's social context or living conditions. Research shows that healthcare accounts for only 11% of health outcomes. Health behaviours (e.g. smoking, dietary habits, alcohol consumption or physical activity) and social and physical living conditions (such as income, education, living environment and social network) together account for more than 50%.[8] By actively involving people in their own care and moving away from working in separate 'silos' both within and outside the healthcare sector, we can achieve much greater health benefits. This core principle also forms part of the basis for the Interfederal Plan for Integrated Care.



2.2.2 Integration on different levels (underlying layers)

The underlying layers of the Rainbow Model illustrate the various levels at which care needs to be integrated in order to achieve high-quality and coordinated care. Each layer is explained below, from the outside in.

2.2.2.1. System integration

Integrated care begins with system integration. For high-quality integrated care, it is important that the system itself is coordinated. That means: clear rules, well-thought-out policies and funding that meets the needs of the population. This will ensure that healthcare organisations and healthcare providers are able to work towards the same goals.

System integration is carried out by the '**macro level**'. This is the level of the various authorities responsible for healthcare and welfare policy. They establish the legislation and the funding and provide support in relation to aspects such as methodological guidelines or digital support for integrated care on the ground. Thanks to strong support at this level, the lower levels can work together in a consistent and high-quality manner.

7 Alami H, Lehoux P, Miller FA, Shaw SE, Fortin JP. An urgent call for the environmental sustainability of health systems: A 'sextuple aim' to care for patients, costs, providers, population equity and the planet. Int J Health Plann Manage. 2023 Mar;38(2):289-295. doi: 10.1002/hpm.3616. Published online 3 Feb. 2023. PMID: 36734815.

8 Determinants of health. Goinvo. 2020. Retrieved from https://www.goinvo.com/vision/determinants-of-health/

In Belgium, the macro level for the coordination of integrated healthcare policy is represented by the administrative bodies of the following authorities:

- **Federal government:** Federal Public Service Health and the National Institute for Health and Disability Insurance (NIHDI)
- **Flemish Community:** Department of Care
- **Walloon Region:** Agence pour une Vie de Qualité (AVIQ)
- **Brussels-Capital Region:** Vivalis, Iriscare and the French Community Commission (COCOF)
- **German-Speaking Community:** Ministry of the German-Speaking Community
- **French Community:** Office for Birth and Childhood (ONE)

Depending on the subject matter, additional administrative bodies may be involved.



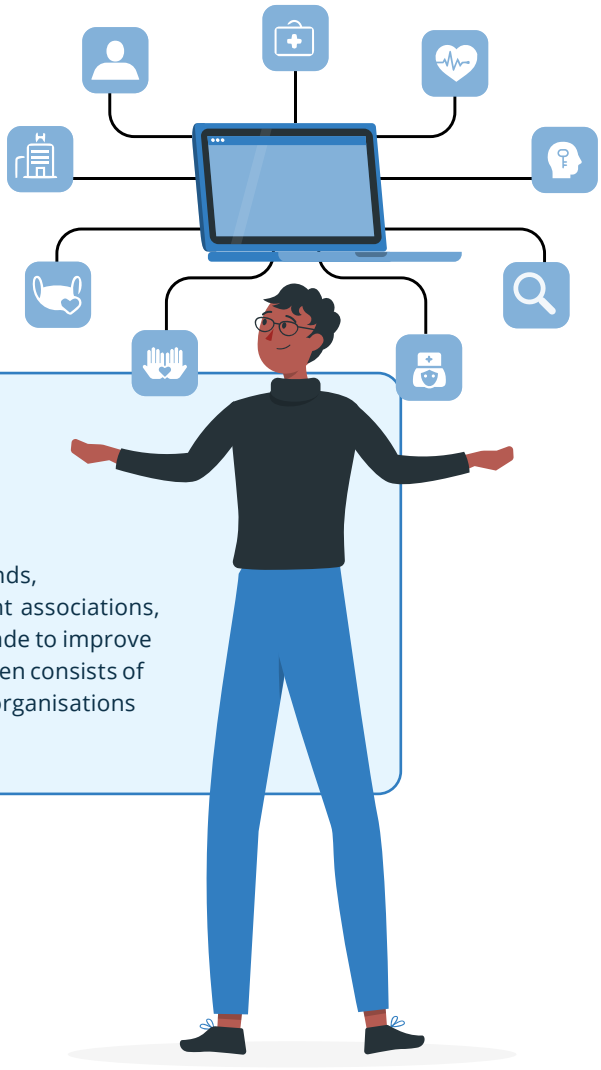
How is system integration achieved in the case of Nathalie and her family?

Via the perinatal programme. This is an interfederal programme that establishes a common policy framework for healthcare and social service providers, enabling them to collaborate on behalf of a single family (such as Nathalie's), regardless of jurisdictional levels. The programme encourages healthcare and social service providers to work together with the aim of providing continuous and integrated care that is tailored to the needs of pregnant women with psychosocial vulnerabilities and their families.

2.2.2.2 Organisational and professional integration

Below the system level is the level of the organisations and of healthcare and social service providers.

- **Organisational integration** means that the operations of health and social services organisations (e.g. hospitals, home care agencies, public centres for social welfare, etc.) are more effectively coordinated. This can range from agreements on referrals to joint projects or long-term collaboration focused on specific themes, target groups, or processes.
- **Professional integration** involves coordination and collaboration between individual healthcare and social service providers, by means of consultation, the distribution of roles, or other forms of collaboration across different patients, for example.



Organisational and professional integration are driven and supported by the **meso level**. This is the intermediate level between individuals (professionals, citizens) at the micro level and policy makers or the system at the macro level. The meso level organises integrated care on a locoregional level. It brings together organisations, facilities, networks, health insurance funds, local governments, healthcare and social service providers, patient associations, informal caregivers and volunteers. At this level, agreements are made to improve collaboration between healthcare and social service providers. It often consists of an interdisciplinary umbrella organisation that represents various organisations or professionals in the field.

In the Interfederal Plan for Integrated Care, this meso level was assigned five key tasks:

01 **Population management:** to help tailor healthcare and support services in a region to the needs of the local population. Based on data and insights, initiatives are launched to improve health and predict future needs.

02 **Promoting integration:** to bring healthcare and social service providers together, to support networking, to facilitate agreements between organisations and to promote interdisciplinary and trans-institutional collaboration.

03 **Supporting change management:** to help foster a culture of integrated care by sharing best practices, to organise peer review sessions, to inform healthcare and social service providers and to gather feedback.

04 **Implementation support:** to provide guidance on the implementation of specific initiatives, such as interfederal programmes relating to integrated care.

05 **Evaluation and monitoring:** to track the implementation of initiatives, to identify bottlenecks, to gather feedback from the field and to provide feedback to the micro and macro levels.

In each federal region, there is currently one meso-level organisation that plays a central role in supporting integrated care. The table below provides an overview of the meso-level organisations in each federal region that are relevant to the organisation, implementation and monitoring of integrated care.

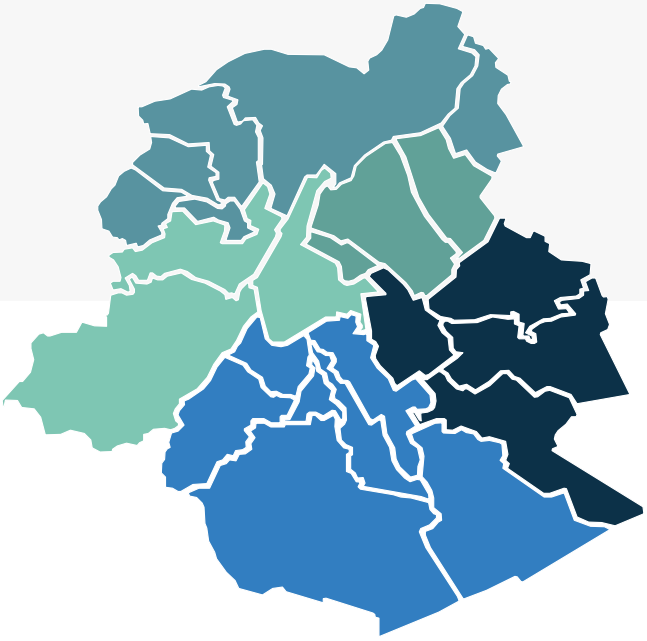
- Brussels-Capital Region: **Care zones**
- Walloon Region: **Local-Regional Health Organisations** (OLS), which are still in the process of being established
- Flemish Community: **Care Councils**, active in the primary care zones. In addition, regional care zones were recently defined as a higher-level building block and a forum for strategic coordination.
- German-speaking Community: In the German-speaking Community, there are no separate mesostructures due to the scale of operations. There, the tasks are carried out by the ministry itself.

They are responsible for the efficient organisation of primary care in a defined region, in coordination with the local neighbourhoods and the region, to ensure that the range of care and support services provided effectively meets the needs of the population.

Brussels-Capital Region [9]

Mesostructure	Care Zones (bassins d'aide et de soins / zorgzones)
Number	5 care zones
Size/Operating area	Max. 350,000 residents (at least 5 neighbourhoods) per zone
Composition	An Action Council for each healthcare zone, with representation from: • Public entities such as municipalities and the Public Centre for Social Welfare (PCSW). • The non-profit sector (regardless of the entity that recognises it). • Members of the liberal professions and paramedical professionals, whether self-employed or employed. • Citizens (or their representatives)
Contact details of mesostructures	Coordination of Care Zones by Brusano https://www.brusano.brussels/nl/zorgzones/

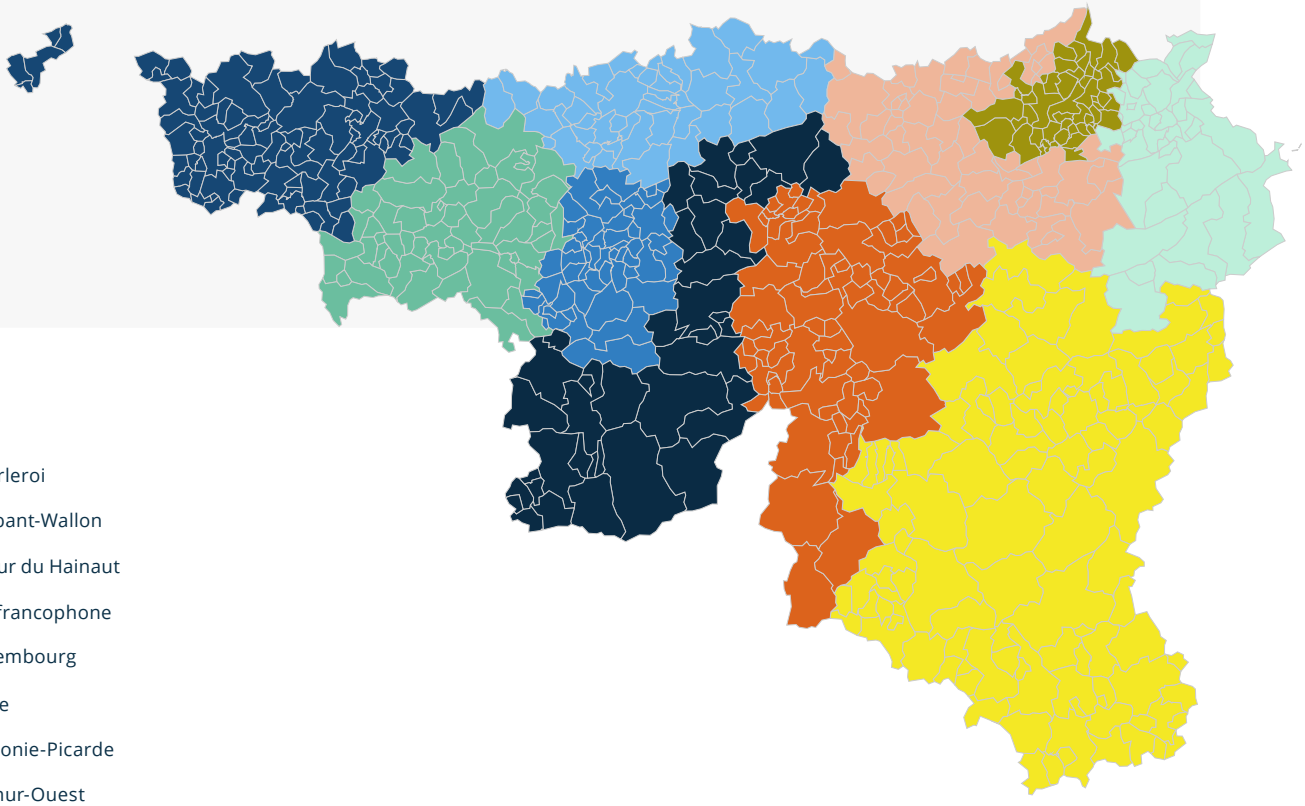
- South care zone
- Centre-west care zone
- North care zone
- South-east care zone
- North-east care zone



9 https://www.brusano.brussels/nl/de-hulp-en-zorgzones/

Walloon Region

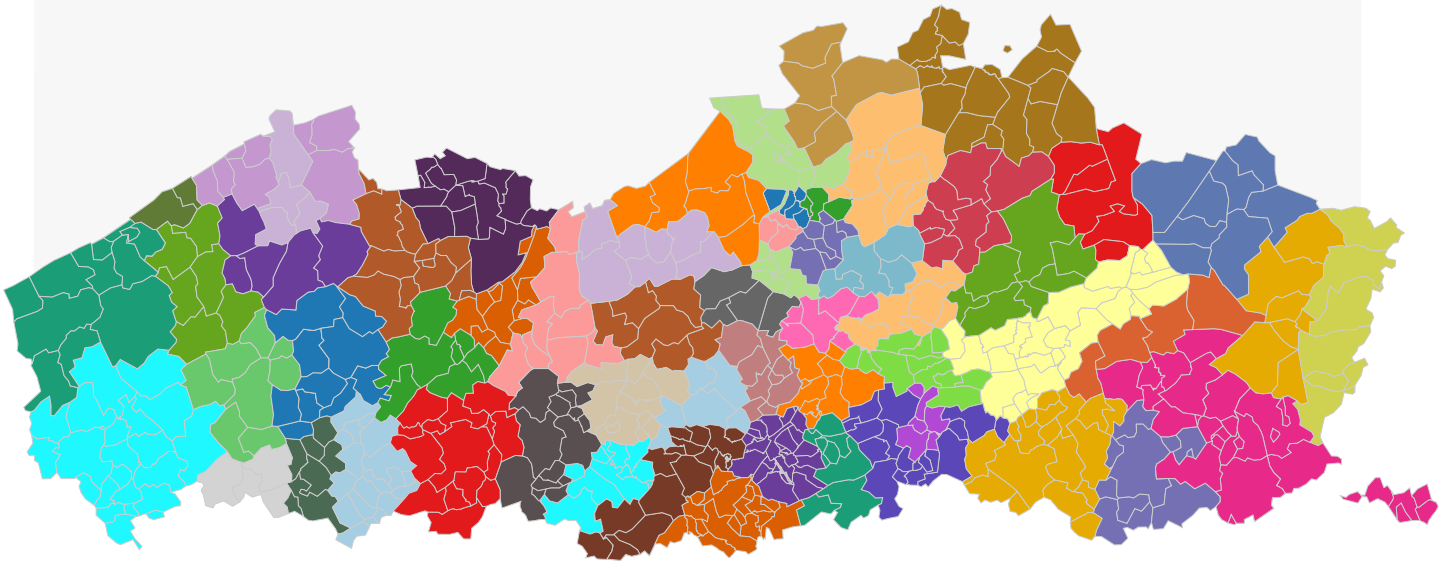
Mesostructure	Local-Regional Health Organisations
Number	10 local regional zones
Size/Operating area	Between 200,000 and 550,000 residents per zone.
Composition	Transition consortia were selected following a call for proposals. These consortia include various primary care providers and have partnerships with hospitals, for example
Contact details of mesostructures	https://www.aviq.be/fr/actualites/organisation-premiere-ligne-daccompagnement-et-de-soins



- Charleroi
- Brabant-Wallon
- Coeur du Hainaut
- Est-francophone
- Luxembourg
- Liège
- Wallonie-Picarde
- Namur-Ouest
- Namur-Est
- Huy-Waremme

Flemish Community [10]

Mesostructure	Care councils
Number	60 care councils, 59 in Flanders and 1 in Brussels. Each care council operates within a single primary care zone.
Size/Operating area	At least 60,000 residents per zone and one or more cities or municipalities
Composition	Oversight is performed by the Healthcare Council, which is made up, as a minimum, of: • Local governments. • Primary care providers. • Organisations for people who need care and support. • Recognised organisations for informal caregivers and service users. • Facilities that are recognized, licensed, or subsidized by the Flemish Agency for People with Disabilities and by the Opgroeien Agency
Contact details of mesostructures	https://www.eerstelijnszone.be/



- AMALO
- Antwerpen Centrum
- Antwerpen Noord
- Antwerpen Oost
- Antwerpen Zuid
- Baldermore
- Bonstato
- BraViO
- Brugge
- BruZEL
- Dender
- Dender Zuid
- Demerland
- Druivenstreek
- Gent
- Haspengouw
- Herkenrode
- Houtland en Polder
- Kemp en Duin
- Kempenland
- Klein-Brabant Vaartland
- Kortrijk-Kuurne-Harelbeke
- Leuven
- Leuven Noord
- Leuven Zuid
- Maasland
- Mechelen-Katelijne
- Middenkempen
- Middenkust
- Midden WVL
- MidWestLim
- Noorderkempen
- Noord-Limburg
- Oostkust
- Oostende-Bredene
- Oost-Meetjesland
- Pajottenland
- Pallieterland
- Panacea
- Regio Aalst
- Regio Grimbergen
- Regio Menen
- Regio Waregem
- RITS
- Rupelaar
- Schelde en Leie
- Scheldekracht
- Vlaamse Ardennen
- Voorkempen
- Waasland Noord Oost
- Waasland Zuid-West
- WE40
- Westhoek
- Westkust & Polder
- West-Limburg
- West-Meetjesland
- Zennevallei
- ZORA
- Zuid-Oost Hageland
- Zuid-Oost Limburg
- Zuiderkempen

10 https://www.departementzorg.be/nl/eerstelijnszones-en-zorgraden

In addition, there are other mesostructures in Belgium that have been embedded within a sustainable policy framework. Below is a (non-exhaustive) overview of existing mesostructures fulfilling a task relating to integrated care.

Hospital networks [11]

Description

- Since 1 January 2020
- Every hospital is part of a hospital network
- Objective: to use resources more efficiently, to share investments and to promote expertise by distributing tasks

Number

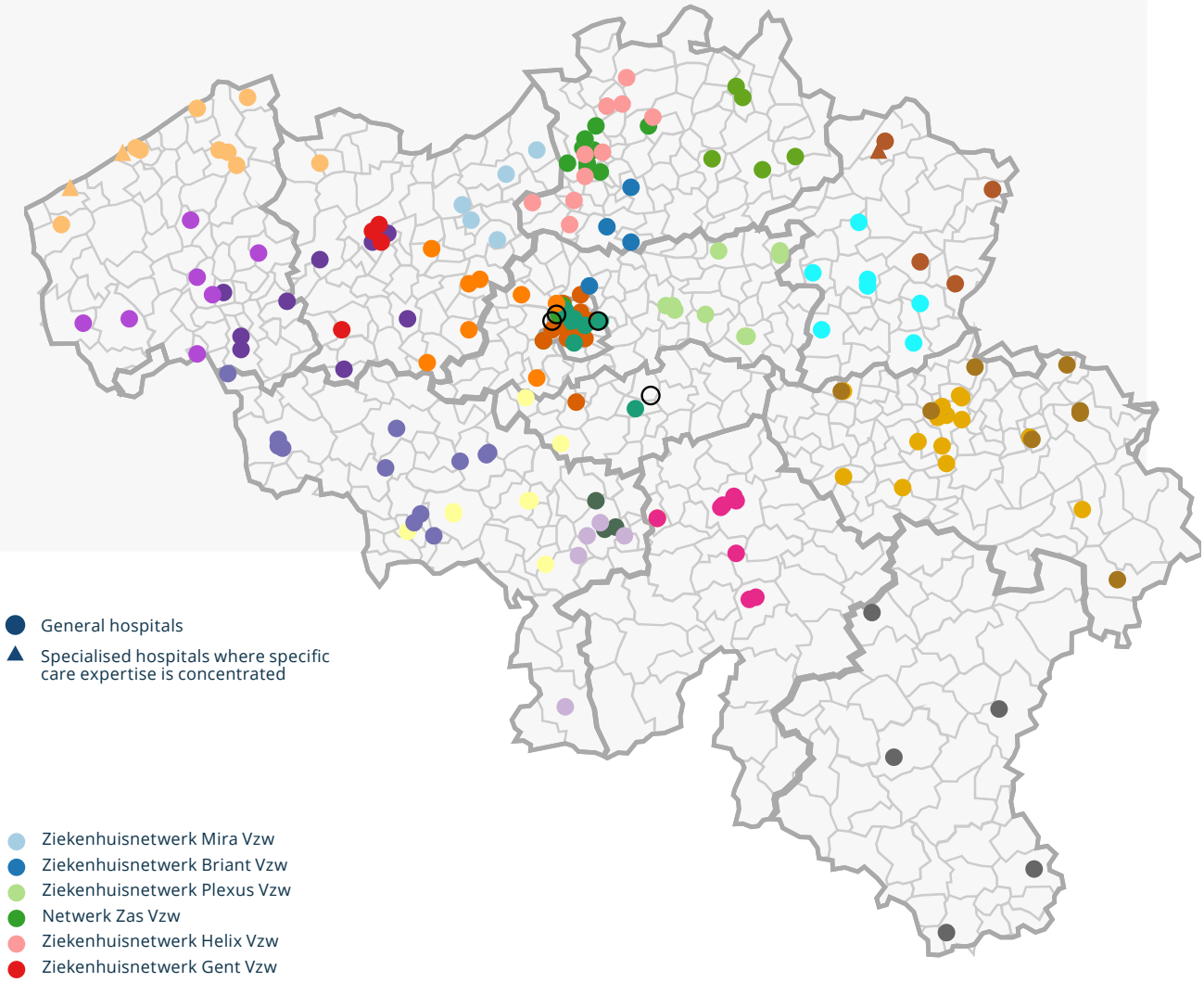
In 2026, 23 local regional hospital networks have been recognised in Belgium.

Size/Operating area

Based on the number of accredited beds and spaces of each hospital. This ranges from 991 to 4,462 certified beds and spaces.

Composition

General and university hospitals



11 https://www.healthybelgium.be/en/key-data-in-healthcare/general-hospitals/organisation-en

Networks in mental healthcare for adults [12]

Description

- The mental healthcare reform began in 2010 with the creation of networks for adults, including the elderly as a target group.
- Five functions: (1) promoting mental healthcare, prevention, early detection and early intervention; (2) mobile treatment teams; (3) psychosocial rehabilitation; (4) intensive specialised residential mental healthcare units; and (5) specific housing options and residential programmes.

Number

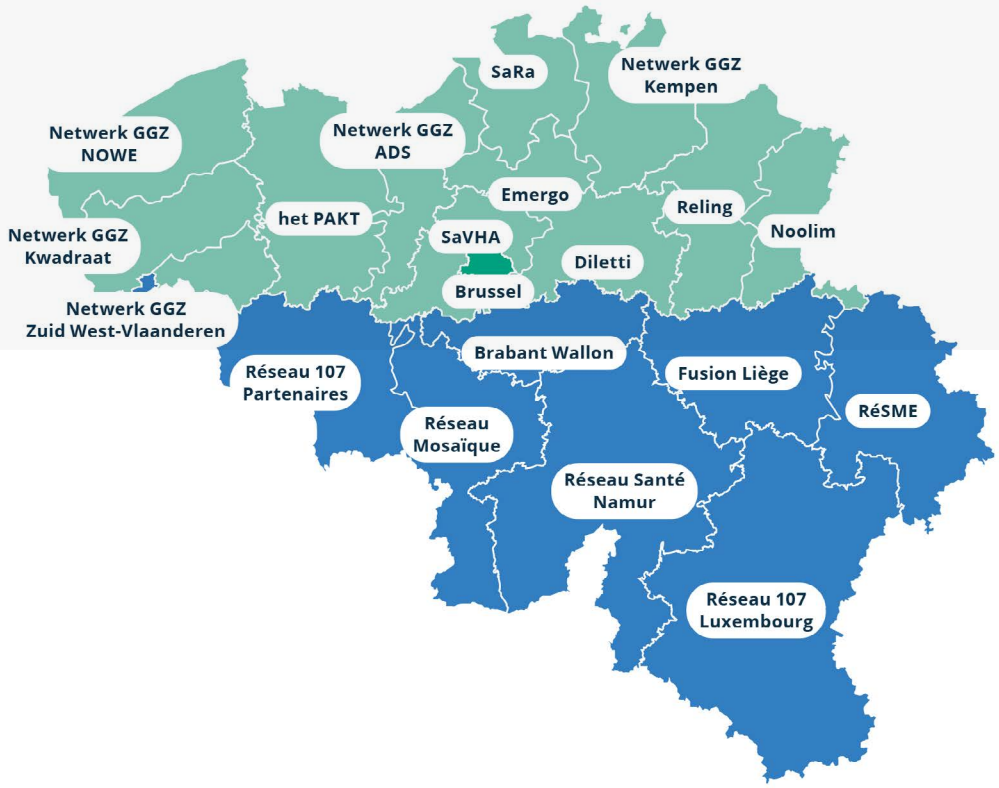
20 mental healthcare networks for adults

Size/Operating area

Operating area defined by the network based on needs and healthcare available.

Composition

A network encompasses the full range of mental healthcare services and associated sectors within an operating area defined by them. A network coordinator is appointed for each network.



12 https://www.healthybelgium.be/en/key-data-in-healthcare/mental-healthcare/mental-healthcare-for-adults/networks-in-mental-healthcare-for-adults

Networks in mental healthcare for children and adolescents [13]

Description

Networks in mental healthcare for children and adolescents (GGKJ/SMEA networks) that focus on children, adolescents and young adults aged 0 to 23.

Number

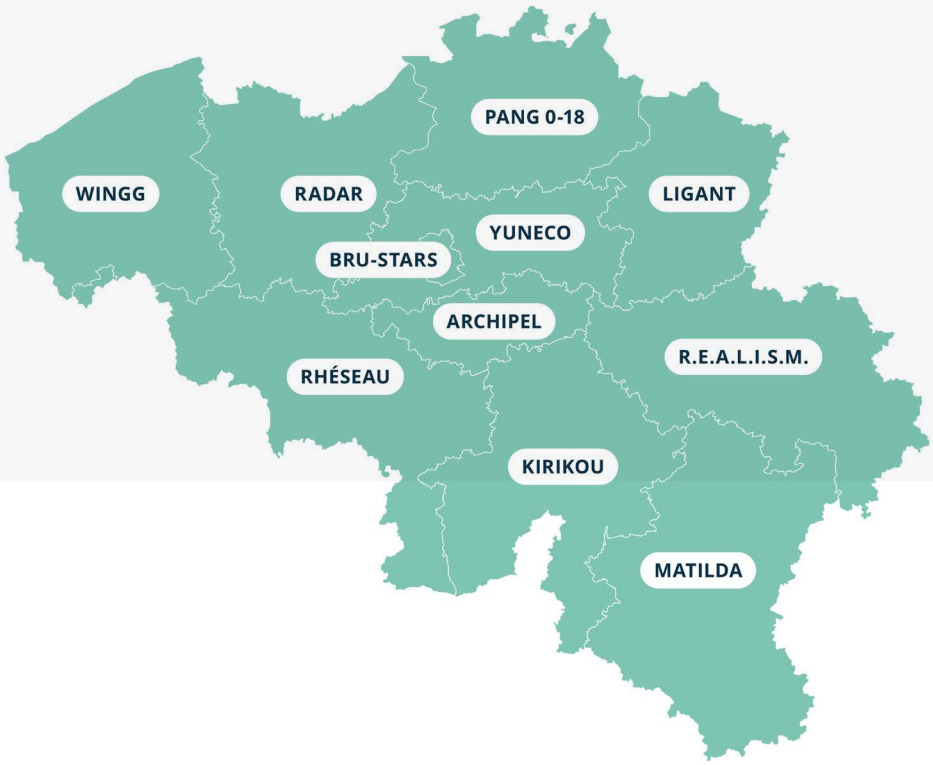
11 GGKJ/SMEA networks.

Size/Operating area

The working areas of these networks correspond to the territories of the provinces and the Brussels-Capital Region.

Composition

Each network consists of all the relevant actors, services, institutions, healthcare and social service providers, etc. of the sectors involved (mental healthcare, healthcare in the broader sense and civil society) that work together and coordinate their policies.



13 https://www.healthybelgium.be/en/key-data-in-healthcare/mental-healthcare/mental-healthcare-for-children-and-adolescents/networks-in-mental-healthcare-for-children-and-adolescents



What role does the meso level play in the case of Nathalie and her family?

To provide integrated care for Nathalie and her family, collaboration is needed between various healthcare and social service providers from both the healthcare and welfare sectors.

The meso-level organisations referred to above – Brusano and the Care Zones, Local-Regional Health Organisations (OLS) and Primary Care Zones (ELZ) – play a supportive and coordinating role in this regard. To implement the perinatal programme, local meso-level organisations are setting up working groups with all relevant healthcare and social service providers to establish clear agreements on collaboration. These working groups are examining which healthcare and social service providers can take on which roles in supporting pregnant women and their families. In Nathalie's case, the work being undertaken at meso level ensures that the healthcare and social service providers working with Nathalie already know each other, have built a relationship and can collaborate smoothly.

The meso level uses available statistical data to assess the situation within its operating area. Amongst other things, this gives them an idea of how many women give birth each year in their region, at which hospitals these women give birth and which psychosocial vulnerabilities are most common. In addition, they gather a great deal of information from conversations with local healthcare and social service providers and with pregnant women themselves. Based on this information, the meso level can tailor care and support in their region to best meet the identified needs.

Finally, a number of tips are provided to professionals working at meso level to help them implement integrated care:

Recommendations at meso level concerning the organisation of integrated care

- Base your approach as much as possible on the care and support needs of residents in the region, so that the services provided are well aligned with what people actually need.
- Aim to provide a clear overview of regional healthcare services, so that collaboration and coordination become easier.
- Bring different sectors together and explore where common goals and shared responsibility can come into being.
- Facilitate interdisciplinary teamwork so that expertise is utilised more effectively.
- Encourage participation amongst patients and informal caregivers so that their experiences and insights can help determine the direction of the work.
- Encourage quality improvement in the field by creating opportunities for learning, reflection and course correction

Points for attention at meso level concerning the organisation of integrated care

- Try to create additional structures (such as new non-profit organisations) only when truly necessary and think, above all, in terms of a network-based approach.
- Avoid a top-down process that is too rigid and actively involve local stakeholders in decision-making and implementation.
- Do not assume there is a single, uniform approach; instead, leave scope for regional differences and tailored solutions.
- Try to break down sectoral silos by encouraging collaboration and shared perspectives.

2.2.2.3 Clinical integration

At the lowest level of the rainbow is the integration of 'services', or the coordination of the actual care and support provided to a specific individual. Various interventions are coordinated with one another, by means of interdisciplinary guidelines, care pathways, or inter-federal programmes, for example.

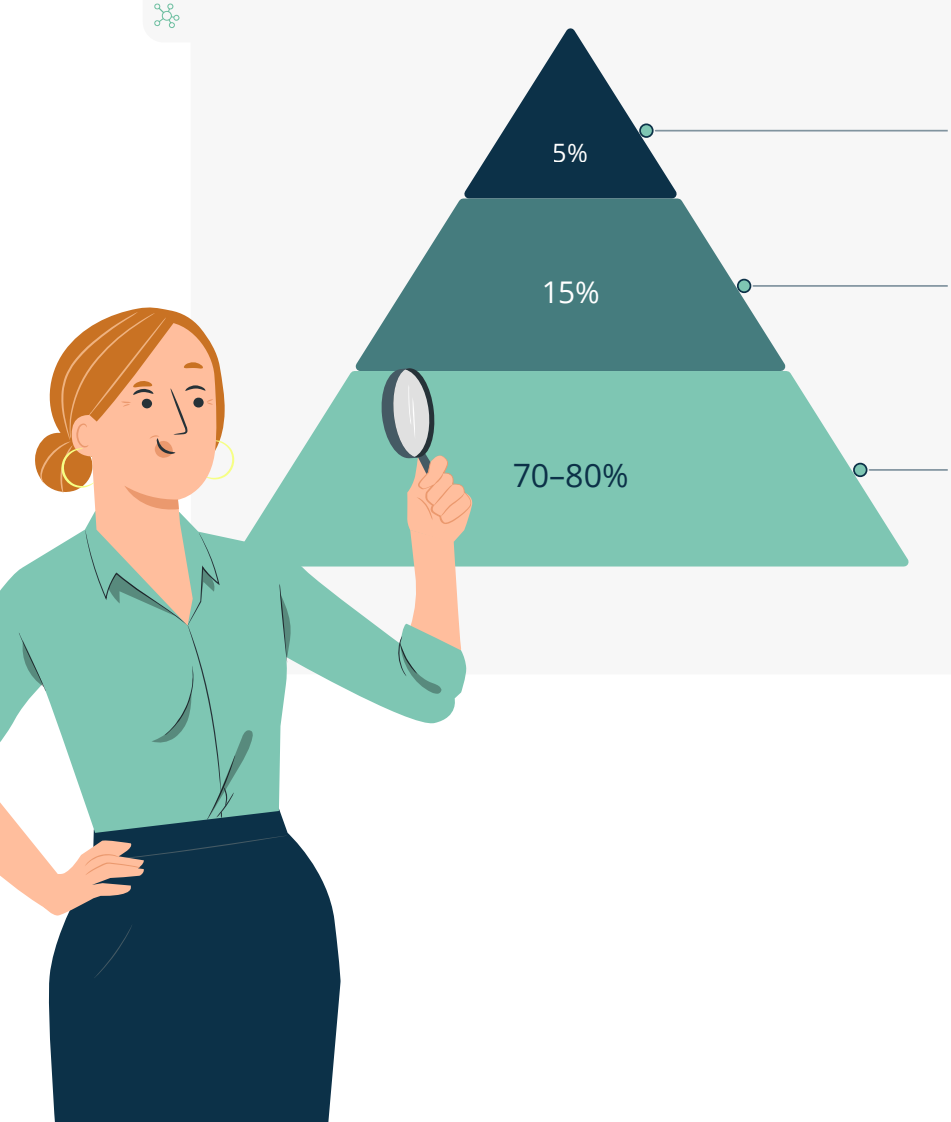
The integration of services or of actual care and support is carried out at **micro level**. The micro level refers to the care and support that is organised directly for and in collaboration with individuals or local groups. This is the level at which the interdisciplinary team collaborates with the individual and his or her environment. Neighbourhood and community teams also operate at this level. The focus is always on the individual and on his or her own needs and goals. Healthcare and social service providers coordinate their support to ensure that their work is as integrated, person-centred and goal-oriented as possible.

What kind of care and support and for whom?

The basic principle is simple: not everyone needs the same amount or intensity of care and care works best when it is provided in a proportionate and targeted manner.

Kaiser Permanente, an American healthcare organisation, developed a model that shows how healthcare can be organised most effectively for a population, based on its healthcare needs.

Population distribution and the organisation of coordinated care



Individuals with highly complex care and support needs (5%) > Case management

Individuals with moderately complex care and support needs (15%) > implementation of coordinated care

Individuals with low-complexity care and support needs (70–80%) > self-management by the individual concerned and/or a (family) caregiver, and primary care

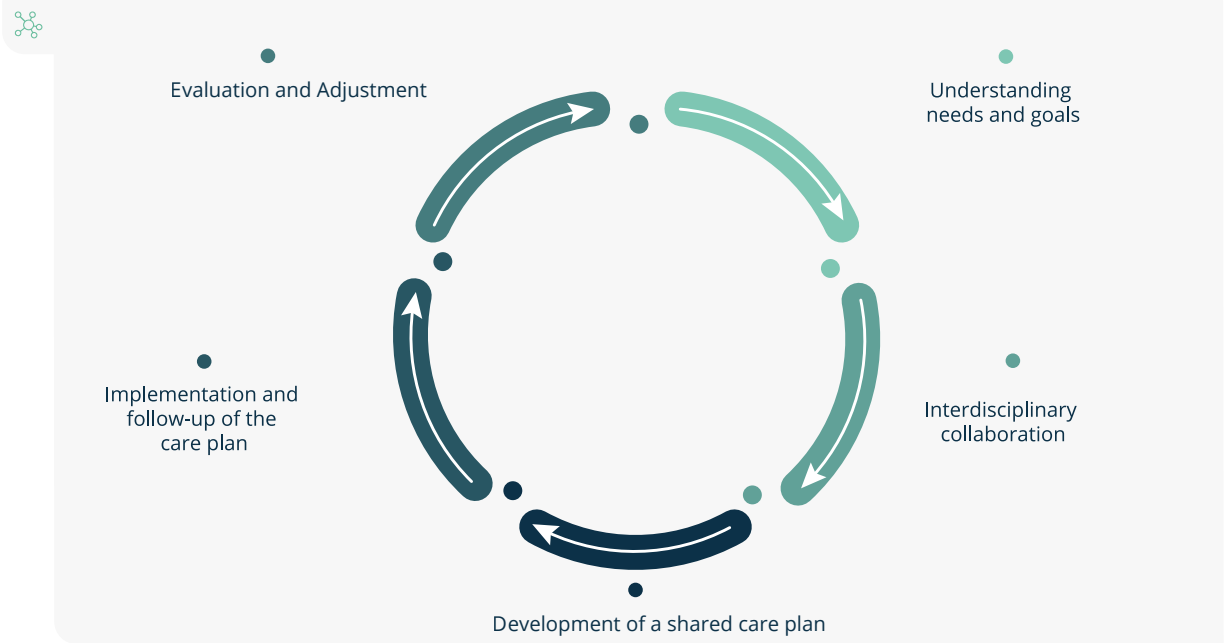
This pyramid is made up of three levels. The bottom layer of the pyramid contains the largest group of people: the **healthy population and individuals with low-complexity care and support needs.** These people generally require little care and have only occasional contact with primary care providers or social service providers. For this group, the focus should be on prevention, self-care and self-management, with the goal of preventing or managing problems so that more intensive care can be avoided. They coordinate their own care and support. It is important to focus as much as possible on health promotion and prevention so that people can remain in the bottom tier of the pyramid for as long as possible.

The middle tier includes **people with greater care and support needs** (e.g. individuals with multiple health problems, unstable chronic conditions, or a combination of medical, psychological and social needs). These individuals require regular guidance and are often supported by professionals from various disciplines. Within this group, it is important to avoid fragmentation and to ensure that healthcare and social service providers work together to address what matters most to the individual. The reason for this is to prevent the person's situation from becoming complicated. A healthcare or social service provider will coordinate the healthcare and support.

At the top of the pyramid is a small but vulnerable group of **people with highly complex needs**. They require intensive, often specialist and interdisciplinary care. In these situations, it is especially important to create stability, improve quality of life and avoid unnecessary crises and escalations. The group of people at the top of the pyramid will potentially experience the greatest impact on their quality of life and accounts for a large portion of health insurance expenditures in Belgium.[14] This often requires intensive care coordination or case management.

Integrated care for an individual in plain language

Below, we have provided an explanation of **integrated care for an individual by referring to five simple steps.** The description is based on the Interfederal Plan for Integrated Care, which emphasises that care and support providers should work together to care for an individual person by means of a single shared care plan and an integrated approach.



14 Onafhankelijke Ziekenfondsen (Independent Health Insurance Funds), 2025. De concentratie van de gezondheidsuitgaven in 2023 en de evolutie ervan sinds 2014. (The concentration of healthcare spending in 2023 and how it has changed since 2014) Retrieved from https://www.mloz.be/sites/default/files/ressources/20250401_Studie_De%20concentratie_van_de_gezondheidsuitgaven_in_2023_en_de_evolutie_ervan_sinds_2014.pdf



Understanding the needs and goals

Integrated care is always person-centred and goal-oriented. This means that, in integrated care, the person's needs and goals are both central. Care and support are tailored to each person's unique needs and goals.

Person-centred care is based on the person as an individual: his or her needs, abilities, values and preferences. This approach is always based upon a bio-psychosocial perspective. This means looking beyond mere medical issues or diagnoses and paying attention to the psychological, social and contextual factors that influence the person's functioning and well-being. This perspective acknowledges the relationship between health issues and social problems.

Goal-oriented care complements this by explicitly focusing on what the person wants to achieve. Care and life goals are determined together with the individual (and, where relevant, with family members and healthcare and social service providers) and guide the healthcare and support provided. This is not only about medical goals, but also about goals relating to quality of life, participation, self-reliance and daily functioning. By making these goals explicit, care is tailored not only to what is necessary, but also to what is meaningful to the individual. Life goals provide direction for care goals.



Interdisciplinary collaboration

When needs are more complex, various healthcare and social service providers are involved. Together with the individual (and their support network), they form a single care team, working together and exchanging information to provide personalised, goal-oriented care.



Developing a joint care plan

Whenever a high level of care is needed, or if the individual or caregiver requests it, a single shared care plan is drawn up. That plan describes:

- Healthcare and life goals
- Actions
- Roles and responsibilities
- Timing

The care plan provides everyone with clarity and guidance regarding the care and support to be provided.

Implementation and follow-up of the care plan

The care team implements the plan and follows up on it. The **coordination of care** is important in this regard: it ensures that care remains coherent and does not become fragmented. Care coordination can be carried out by:

- the person himself or herself
- an informal caregiver
- a healthcare or social services provider from the care team



If the needs are complex and the individual or caregiver is unable to manage them on their own, a care coordinator is assigned. This healthcare or social services provider maintains an overview and ensures that care is properly coordinated.

In highly complex situations, **a case manager** may be called in.

A case manager:

- is an external position and is not therefore part of the care team
- provides temporary assistance (as briefly as possible and for as long as necessary) by analysing the situation as a whole
- ensures that the problem that exists is clearly defined
- guides the team and the individual in finding solutions.

A case manager can also be called in if a care team has not yet been put in place (therefore acting in an initiating role). Both roles aim to ensure care and support that are coordinated and well organised.



Evaluation and course correction

The care team regularly reviews how the care plan is being implemented. Where necessary, the care plan is adjusted so that it more closely reflects the changing needs. If the care and support process were to go off track, the coordination of the care provided would be adjusted (e.g. by referring the case to a healthcare or social service provider) or a case manager would be brought in.



What does integrated care mean, specifically, for Nathalie and her family?

Integrated care requires not only collaboration between healthcare and social service providers, but also collaboration with Nathalie's family. Healthcare and support must be based on the family's needs and goals.

The midwife at the hospital screens Nathalie for psychosocial vulnerabilities using Born in Belgium Pro, a digital screening tool for healthcare and social service professionals. The following vulnerabilities then come to light: financial problems, housing problems and mental health issues. Nathalie feels that people are listening to her and that her mental and financial difficulties are being acknowledged.

During a counselling session, the results of the screening are discussed and Nathalie and the counsellor explore how the difficulties can be addressed and by whom. The necessary care and support are provided based on the needs identified. As a result, Nathalie feels that the care and support are tailored to her needs and are therefore personalised and goal-oriented.

During the consultation, the midwife suggests appointing a care coordinator. Nathalie agrees that a social worker at the hospital should take over the care coordination, since she does not feel ready to take on this responsibility herself. The care coordinator ensures that Nathalie receives appropriate, personalised care and support. As a result, Nathalie experiences continuity in her care.

A care team is put together for Nathalie, based on her needs and screening results: Nathalie is referred to her municipality's Public Centre for Social Welfare (PCSW) for a social/financial intake. She is also given the contact information of a primary care psychologist in her neighbourhood. The care coordinator monitors how care and support are being provided and adjusts them as needs change, for example, as the pregnancy progresses and during the postpartum period.

A second consultation will take place during the third trimester of Nathalie's pregnancy. That consultation will examine how care and support are progressing and how the difficulties identified earlier have evolved. During the consultation, the delivery and the postpartum period will be discussed and preparations made.

Nathalie's case shows that integrated care is not a stand-alone intervention, but rather an approach in which care and support are tailored to the needs of an individual and their family, with a focus on continuity, collaboration and self-direction.

Finally, here are some tips for healthcare and social service professionals about how to provide integrated care:

Recommendations at micro level

- Try to focus as much as possible on the bio-psychosocial needs of the individual and their environment, so that care and support are well aligned with the person's living environment.
- Involve the person as an active partner in the care and support process and allow them the freedom to take charge and be self-reliant, wherever possible.
- Collaborate with other healthcare and social service professionals in an interdisciplinary way, so that expertise and perspectives can reinforce one another.
- Aim to work in as evidence-based as possible, focusing on what has proven effective in practice.
- Actively seek to establish a link between healthcare and well-being so that support can be provided in a broader and more integrated manner.

Points for attention at micro level

- Be mindful of the broader life context of the individual and their informal caregivers, so that care is not disconnected from their everyday reality.
- Do not limit the exchange of information with that person to what is strictly necessary; instead, create opportunities for dialogue and clarification.
- Do not focus solely on curative care; also consider prevention, well-being and long-term support.
- Do not view care planning merely as an administrative task, but as a tool for providing targeted and coordinated care.
- Do not make decisions on the person's behalf, but support him or her in taking an active role in the care and support process.

2.2.3 Enablers for integrated care (foundation layer)

The Rainbow Model identifies the enablers for the successful implementation of integrated care.

Functional or strict enablers

This covers the practical and technical aspects of organising integrated care, such as:

- Interconnected ICT systems
- Co-financing
- Human Resources policy
- Planning and Coordination

In Belgium, there are three key considerations with regard to the strict enablers:

1. There is no single, unified digital patient record.
2. The financing of healthcare is still primarily performance-based.
3. Healthcare and social service providers frequently still work separately, in silos or as independent practitioners.

These obstacles can be addressed in various ways, including by establishing care pathways and care programmes with tailored funding and care organisation that overcomes fragmentation, together with the necessary digital tools. Various initiatives are being implemented to address this issue.

Normative or soft enablers

This is about shared values and a common vision amongst healthcare and social service providers or organisations. This includes:

- Trust and openness
- A shared mission and goals
- An informal, collaborative culture

What helps is a meso level that facilitates networking and the development of a shared vision amongst stakeholders within a given region.



What are the key enablers in the case of Nathalie and her family?

- **Strict enablers**
  - *The digital screening tool (Born in Belgium Pro) must be accessible to healthcare and social service professionals, with the ability to collaborate, share information and provide appropriate referrals to care and support*
  - *Funding must be provided for screening, counselling sessions, coordination and collaboration*

- **Soft enablers**
  - *Improving care and support for pregnant women with psychosocial vulnerabilities as a shared goal*
  - *Providing implementation coaches who teach healthcare and social service providers in the field how to collaborate and apply the programme with an integrated mindset*

3 THE ADDED VALUE OF INTEGRATED CARE – WHAT ARE THE ADVANTAGES?

A robust evaluation of integrated care combines hard data, the experiences of patients and healthcare professionals, and organisational insights

Only 1 in 2 primary care practices in Belgium appears prepared for optimal care coordination

€

Inadequate funding remains the biggest barrier to achieving more integrated care

Integrated care works: better quality of life, fewer hospital admissions, and fewer unmet care needs



Evaluating integrated care is complex because it has various effects (e.g. clinical, social, financial and organisational). The quintuple aim, which was explained in Chapter 2, serves as a guide in the evaluation of integrated care.

Patient outcomes (e.g. in terms of health outcomes and satisfaction) are often used to help demonstrate the added value of integrated care. The effects of integrated care programmes on care utilisation (such as the number of emergency admissions) or organisational effects (such as changes in collaboration between healthcare and social service providers, the drawing up of care plans) are also frequently measured. A thorough evaluation of integrated care brings together hard data, the experiences of patients and healthcare and social service providers, and organisational insights.

However, the Handbook of Integrated Care [15] emphasises that evaluating integrated care as a comprehensive package is difficult, if not impossible. Integrated care has a broad definition and there are many (external) factors that contribute to its success. Furthermore, data is often fragmented because information from different healthcare and social service providers or organisations needs to be extracted from different systems and combined. It is recommended to first measure the impact of key elements that help achieve integrated care, such as strengthening primary care, transmural care, targeted care, proactive screening, or care coordination. The WHO identified five strategic directions relating to person-centred and integrated care: empowering and engaging people, strengthening governance and accountability, reorienting the model of care, coordinating services and creating an enabling environment. [16]

3.1 International evidence



The available international evidence regarding integrated care in terms of accessibility and continuity of care in primary care, hospital utilisation and patient outcomes and experiences is clearly positive. A meta-review of 27 systematic reviews found that the majority of the reviews reported that integrated care had resulted in positive effects, such as a reduction in the number of hospital admissions and readmissions, improved patient adherence to treatment and an improvement in perceived quality of life.[17]

As far as the financial implications are concerned, less evidence is available to suggest that the implementation of integrated care leads to a reduction in costs. Integrated care requires a cultural shift on the ground and initially, additional resources are often needed in order to bring about this change. A reduction in costs was primarily observed in studies that lasted longer than one year.[18]

In the United States, significant cost savings were observed within "Accountable Care Systems" [19]. "Accountable Care Systems" are groups of doctors, hospitals and other healthcare providers that enter into an agreement with a health insurance plan and work together to provide coordinated, high-quality care to the plan's members. The cost savings achieved by providing coordinated, high-quality care are distributed amongst the various partners concerned. In this way, healthcare providers are paid not only for the care they provide to patients but also for the proactive care they provide to prevent illness, complications or relapse.

Examples of cost savings in Europe have already been recorded in Europe as well. In Germany, the "Gesundes Kinzigtal" approach to integrated care resulted in cost savings, without compromising the quality of care provided. This encourages healthcare providers to improve prevention and care coordination, and the cost savings (shared savings) are also distributed amongst the healthcare providers involved. [20]

15 E. Nolte, Evidence supporting integrated care, editors V. Amelung, V. Stein, E. Suter, N. Goodwin, E. Nolte, R. Balicer (Eds.), Handbook integrated care, Springer International Publishing, Cham (2021), pp. 39-52

16 World Health Organization. (2015). People-centred and integrated health services: An overview of the evidence. Interim Report. Geneva: World Health Organization.

17 Nahara Anani Martínez-González, Peter Berchtold, Klara Ullman, André Busato, Matthias Egger, Integrated care programmes for adults with chronic conditions: a meta-review, International Journal for Quality in Health Care, Volume 26, Issue 5, October 2014, Pages 561–570, https://doi.org/10.1093/intqhc/mzu071

18 Rocks, S., Berntson, D., Gil-Salmerón, A. et al. Cost and effects of integrated care: a systematic literature review and meta-analysis. Eur J Health Econ 21, 1211–1221 (2020). https://doi.org/10.1007/s10198-020-01217-5

19 https://www.advisory.com/daily-briefing/2025/09/09/aco-savings

20 Healthy Kinzigtal Programme in Germany: case study. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

3.2 National evaluation initiatives

In Belgium, too, efforts to evaluate integrated care have already been under way for years.



The 2022 KCE study (see before) examined the level of maturity of integrated care in Belgium as perceived by professionals in the field.[21] However, this study showed that, according to the professionals surveyed, integrated care in Belgium is still in its infancy. The professionals identified the healthcare system's current funding mechanisms as the main barrier in that regard. Performance-based funding does not encourage interdisciplinary, person-centred or health-centred practices. However, the KCE's patient surveys have in fact shown that more than 60% of respondents are satisfied with the way that healthcare is organised in Belgium. On the other hand, the majority of respondents indicated that they were (almost) never asked about their own goals or about any side effects they experienced during the care and support process. Many also received only limited information or treatment options. This suggests that the respondents experienced little integrated care.

Another initiative that sought to gather patients' experiences with integrated care is the **Patient-Reported Indicator Survey (PaRIS)**[22] . PaRIS is an international initiative of the Organisation for Economic Cooperation and Development (OECD), in which Belgium participates. The study focuses on what has been missing from healthcare systems until now: **systematic data on the extent to which the primary care provided meets the needs of people with chronic conditions.** The study uses questionnaires to collect data on the experiences and health outcomes of individuals with chronic conditions who are over 45 years of age and have had at least one visit to a primary care physician in the past 6 months. The study therefore gives a voice to people with chronic conditions, which should enable both policymakers and healthcare and social service providers to improve the quality of our care.

The 2025 PaRIS study shows that countries differ greatly in terms of how well people with chronic conditions are able to use digital health information, how care is coordinated and how many people with chronic conditions are involved in their own care. Experiences and health outcomes also appear to vary, depending on a person's socio-economic status, sex and the number of health conditions involved. The results encourage countries to align their healthcare systems more effectively to the needs of people with chronic conditions, while learning from successful examples in other countries.

In Belgium, 59 general practices took part in the study and a total of 4,687 completed questionnaires were analysed. The results of the study from Belgium show that:

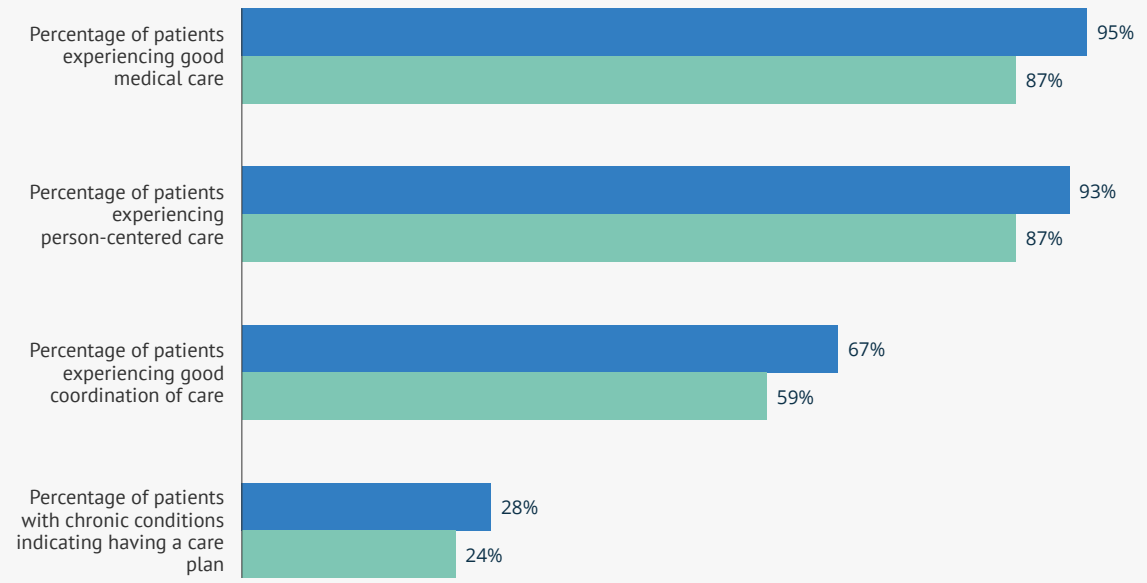
- more than 95% of respondents in Belgium reported receiving high-quality healthcare
- more than two thirds of respondents in Belgium feel that their care is well coordinated, although only a small group indicated that the coordination taking place between healthcare providers was good. This often leads to delays or repeated tests.
- Individuals with chronic conditions who have a care plan ("A written agreement between a person and his or her care provider that specifies the type of care to be provided over a longer period, how that care will be organised and what responsibilities the person will assume in managing his or her own care.") experience a higher degree of person-centred care. However, it was found that care planning is not standard practice.
- Less than half of the respondents said they always received enough information whenever they needed it in order to manage their own health and well-being.

21 Lambert A-S, Op de Beeck S, Herbaux D, Macq J, Rappe P, Schmitz O, Schoonvaere Q, Van Innis A.L, Vandenbroeck P, De Groote J, Schoonaert L, Vercruysse H, Vlaemynck M, Bourgeois J, Lefèvre M, Van den Heede K, Benahmed N. Transitie naar (meer) geïntegreerde zorg in België – Synthese. Health Services Research (HSR). Brussels: Federal Knowledge Centre for Health Care (KCE). 2022. KCE Reports 359As. D/2022/10.273/50.

22 D. Annaert, R. Ekelson, S. Bensemmane, A. Van Vyve, R. De Schreye. Patient-Reported Indicator Surveys (PaRIS): Insights from Belgium. Focused on people living with chronic conditions. Brussels, Belgium: Sciensano. 2025, June. Report number: D/2025.14.440/15.

Below are some key figures from the PaRIS study for Belgium, compared to the OECD average:

Perceived quality of primary care amongst individuals with at least one chronic condition, based on four indicators (comparison between Belgium and the OECD)



In addition to people with chronic conditions, the participating general practices themselves were also surveyed. That survey shows that less than half of the participating primary care practices were well prepared to coordinate care effectively. **Furthermore, the involvement of non-physicians in long-term care, at 46%, remains limited, compared to the OECD average of 83%.**



Patient experiences aren't just about numbers; they're also about listening to people's stories. Below is a patient's testimonial about his experiences with integrated care as part of an integrated care project for older adults, which included occupational therapy, psychological support and case management.

Patient testimonial

"Ever since I enrolled in the NIHDI's integrated care programme for older adults [23], my life has felt a lot easier. The integrated approach has really made a difference in my everyday life. With the help of the case manager – my point of contact – I was able to get in touch with a home help service. The home help, who comes round every Tuesday at around 10 a.m., not only provides practical help but also brings a sense of peace. They do my grocery shopping now that I can no longer drive and they're happy to take care of my ironing. However, it goes beyond that; their arrival gives me a sense of structure and their presence feels comforting. Sometimes we just have a little chat and that means more than they themselves might realise.

Even when my husband was still alive, I could already see how well the healthcare providers worked together. The occupational therapist gave us a clear explanation about assistive devices and taught him how to get in and out of bed more easily. She also arranged for a walker and a wheelchair. Everything was arranged for us. A company came to our house to take measurements, and we didn't have to

23 https://www.riziv.fgov.be/nl/thema-s/kwaliteitszorg/ouderenzorg/alternatieve-vormen-van-ouderenzorg-projecten

worry about a thing. That kind of care, where you feel like they're really listening to you and suggesting solutions, is worth its weight in gold. Likewise, with the help of the occupational therapist, I was referred to a psychologist, because I needed more than just a listening ear.

Since my husband passed away, the psychologist has been coming by every two weeks. I had already known her for a long time, since the time when she was there for my husband during his difficult times and supported me through it all. She listens and gives me tools to cope with my grief. Her visits really do make me happy.

I also eat at the neighbourhood restaurant every week. It's nice to run into people there whom I've known since I was a child. After the meal, I sometimes play Uno or cards in the common room. That little bit of social interaction gives me a feeling of warmth and connection.

Perhaps what matters most to me is having a single point of contact. It makes me feel safe. I don't have to tell my story over and over again. My social worker knows what's going on and refers me to the right person when necessary. I know there's a strong team behind the scenes that meets regularly to discuss my situation and afterwards, I always get clear feedback – both for myself and my children. That inspires confidence. "The feeling that you're not in this alone."

The PaRIS results show that interdisciplinary collaboration between healthcare and social service providers and the coordination of primary care can still be improved. Below is a testimonial from a psychologist with whom we have already established a fruitful collaboration and built a network.

Testimonial from a psychologist

"As a self-employed psychologist with a private practice, it's easy to become isolated and find it difficult to get in touch with the various healthcare and social service providers involved in a case. The local gatherings organised by the mental health network have been a huge help in 'breaking the ice'. As a primary care psychologist, I have been contacted regularly ever since by the local community health centre and the Public Centre for Social Welfare (PCSW). This kind of collaboration within a local network now happens much more spontaneously and is a breath of fresh air for me. Over the years, we've come a long way: from 'everyone sticking to their own little corner' to true interdisciplinary collaboration."

"As a psychologist, I often see young teenagers who come in with their parents at the request of an institution or the parents themselves, even though the teenager has not actually requested help themselves. When a youth centre with a gym asked for our help regarding anxiety, increasing substance use and intrafamilial conflicts, I saw an opportunity to interact with young people within their own space of safety and connect with the things that interest the young people themselves by offering group sessions on-site in collaboration with a youth worker.

Thanks to the group-based dynamic, which was perceived as supportive, there was clearly less individual resistance, and the young people proactively shared ideas with one another about resilience. During initiatives of this type, we pay close attention to what is happening within the group, as well as to how each individual participant responds. Some young people then spontaneously ask for individual guidance. We reach out to other young people ourselves in order to suggest an individualised programme.



In summary, we can say that integrated care offers potential benefits for patients and their families, for healthcare and social service providers, for the healthcare system and for society as a whole. In Belgium, the organisation and added value of integrated care are primarily assessed by the competent authorities at macro level (KCE, Sciensano), but also by scientific experts and practitioners by measuring patient satisfaction, perceived coordination and collaboration amongst healthcare and social service providers and outcome measures (and, to a lesser extent, cost savings) for specific populations. In the future, efforts will continue to identify indicators that best reflect 'good integrated care' and for which high-quality data can be collected.

4 CONCLUSION AND VISION FOR THE FUTURE



The Federal Public Service for Public Health intends to work with other government agencies to continue reforming the healthcare system so that integrated care becomes the norm. This means that care will be based on the individual's needs, rather than on existing structures or sectors. In that regard, continuing to focus on the functional and normative framework of the rainbow model will be crucial, if integration is ultimately able to be achieved at the various levels:

Functional (strict) enablers

1. **Organising care in a simpler and more collaborative way:**

Governments need to work together more effectively to avoid fragmentation. The Interfederal Plan formed an important first step in this regard. However, these efforts must be reinforced within a sustainable and stronger legal framework, such as a cooperation agreement on integrated care, ratified by the various parliaments. The preparatory work for this is currently in full progress.

2. **Adaptation of the funding system**

The system, which is based primarily on "fee-for-service" payments, does not encourage collaboration. New models should reward collaboration, prevention and quality by means of shared budgets and flat-rate, population-based funding. In this context, the FPS Public Health and the NIHDI, for example, are working on reforming the nomenclature and funding of hospitals. In the past, there was also a strong focus on reforming mental healthcare. Various initiatives are coming into being to address this issue.

Normative (soft) enablers

1. **A culture of collaboration and new skills:**

Healthcare and social service providers need to collaborate more closely within interdisciplinary teams. Training, trust and shared decision-making are important. This should be taught during the training of healthcare and social service professionals. Integrated care is a way of thinking and working. There is also a greater focus on communication regarding integrated care, as well as on support for its implementation – for example, by deploying implementation coaches within the perinatal programme. Meso structures play an important role in this regard.

2. **Greater emphasis on prevention and community-based care:**

By providing support more quickly and organising care closer to where people live, the need for more intensive forms of care can be prevented. Local networks and primary care zones play a key role in this. The authority to implement this lies with the federal regions.

Functional (strict) enablers

3. **Greater digitalisation as a catalyst for data collection, communication and collaboration:**

Smooth and secure data sharing between healthcare and social service providers is essential. People should have greater access to and control over their own data. Work is under way to create a "Belgian Integrated Health Record" and significant steps have already been taken in recent decades to strengthen digital healthcare – such as the development of the eHealth action plans, the launch of mijnGezondheid (and, more recently, its accompanying app), which provides citizens with online access to their electronic health records, and mandatory electronic procedures for healthcare and social service providers – the majority of which are facilitated by supporting European regulations.

4. **Focus on equal opportunities for everyone:**

Integrated care must address both individual needs and differences between neighbourhoods and communities, so that everyone receives the right care. The threshold posed by existing and future policies will be lowered by ensuring that initiatives are distributed geographically, based on local needs, by means of financial measures and by means of social protection provided by means of a robust health insurance system.

Normative (soft) enablers

3. **The patient as an active partner in the process:**

Patients are expected to take on a more active role within their care and support process. Various measures are being taken to that end, such as health literacy campaigns, a greater focus on supporting informal caregivers and greater emphasis on discussing life goals with patients and making shared decisions with them.

To find out about the FPS Public Health's current campaign on health literacy, please visit:
https://www.health.belgium.be/nl/nieuws/2026-3-gezondheidsvaardigheden-nieuwe-nationale-campagne-komst

We can conclude that Belgium's integrated care policy is indeed heading in the right direction and has the potential to make our healthcare system more future-proof, but that the transition to a fully integrated care model is still far from complete. In the coming years, therefore, efforts will continue to focus on initiatives that seek to gradually bridge the gap between vision and practice, based on a shared policy framework to which all authorities in Belgium are committed. Our hope is that integrated care initiatives can gradually be translated into structural policy. Only by means of sustained efforts and investments that are grounded in clear and coherent policy decisions can a culture of collaboration be established and integrated care truly be achieved.

In summary: Belgium has taken some important first steps, but there is still a long way to go before integrated care is no longer just a goal, but a natural part of our healthcare system.



Health
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