Visit to Community Health Centre Botermarkt by a Parliamentary Delegation from Romania.

In the presence of her Excellency Andreea Pastarnac, Ambassador of Romania in Belgium



- **WELCOME !**
- **Bine ați venit!**



- ***23 October 2026***

gent:

Core PHC principles: accessibility, continuity, coordination, equity, person-centeredness…from concepts to practice and policy.

1. **The patient's voice : TRUST**
2. What matters to the patient ? Goal-Oriented Care
3. Integrated care requires integrated records for primary and secondary use.
4. PHC approach at nano-, micro-, meso- and macro-level : More than 5 C's ?
5. Illustrated with Practice-examples from Community Health Centre Botermarkt

Opinion on Definition primary care – Definition

Core-definition

'The Expert Panel considers that primary care is the provision of universally accessible, integrated person-centered, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people's care

The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.'

Sextuple Aim



Michael Matheny, Sonoo Thadaney Israni, Mahnoor Ahmed, and Danielle Whicher, Editors. 2019. Artificial Intelligence in Health Care: The Hope, the Hype, the Promise, the Peril. NAM Special Publication. Washington, DC: National Academy of Medicine. Translated, adapted, and reproduced with permission from the National Academy of Sciences. Courtesy of the National Academies Press, Washington, D.C.

1. The patient's voice: « TRUST »



Box 1. OECD's Patient-reported Indicator Surveys (PaRIS)

The Patient-Reported Indicator Surveys (PaRIS) is an OECD initiative that systematically measures the outcomes and experiences of healthcare that matter most to people. The survey focusses on people aged 45 years and older living with chronic conditions who receive primary care. Data collection of the first cycle took place in 2023-2024, and results were published in February 2025.

PaRIS offers a unique multi-level dataset linking patient perspectives with the primary care settings where care is delivered. In addition to Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs), the dataset includes information on primary care practice characteristics (workforce composition, service provision, and digital tool availability) and patient background factors (sociodemographic characteristics, health behaviours, and healthcare capabilities, including digital health literacy).

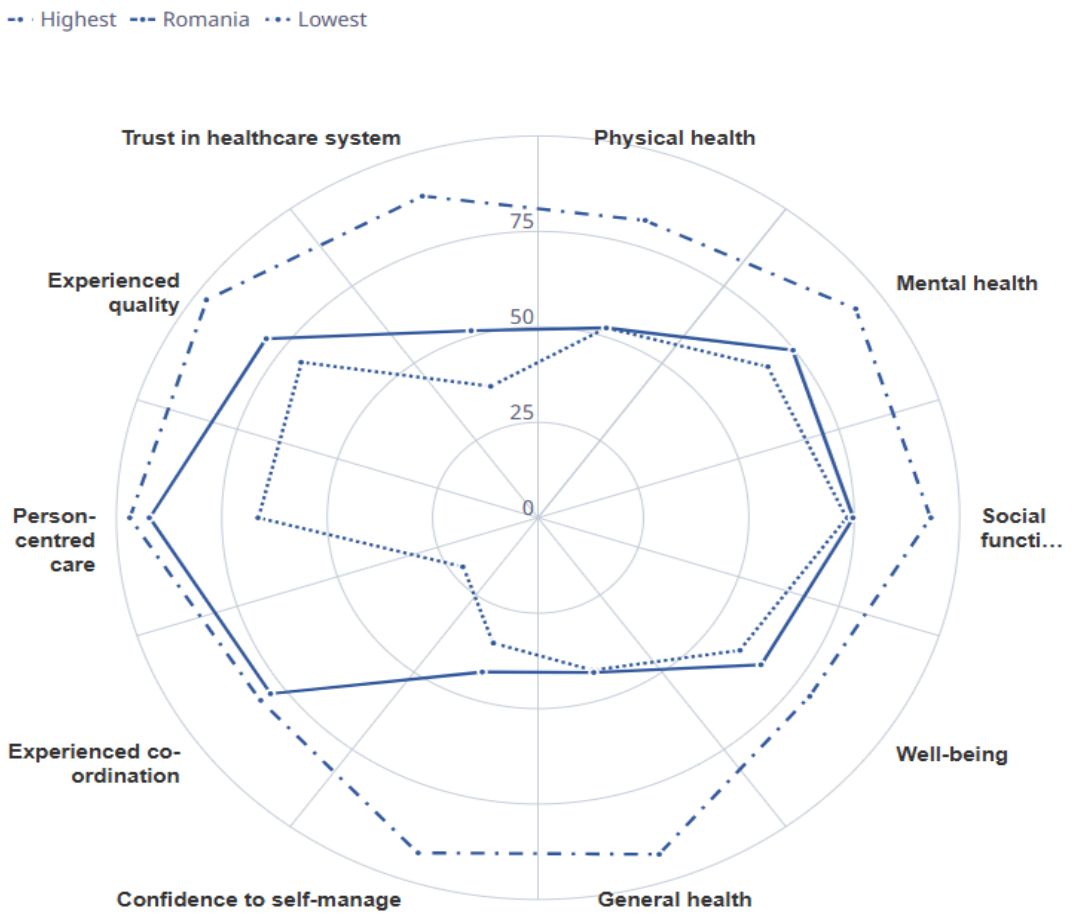
PaRIS includes data from:

- 107 011 patients
- linked to 1 816 primary care practices
- in 19 countries

Note: For more information, including publications, questionnaires, and FAQs, see: www.oecd.org/health/PaRIS.

Figure 1. PaRIS 10 Key Indicators

Percentage of people with one or more chronic conditions reporting positive outcomes or experiences



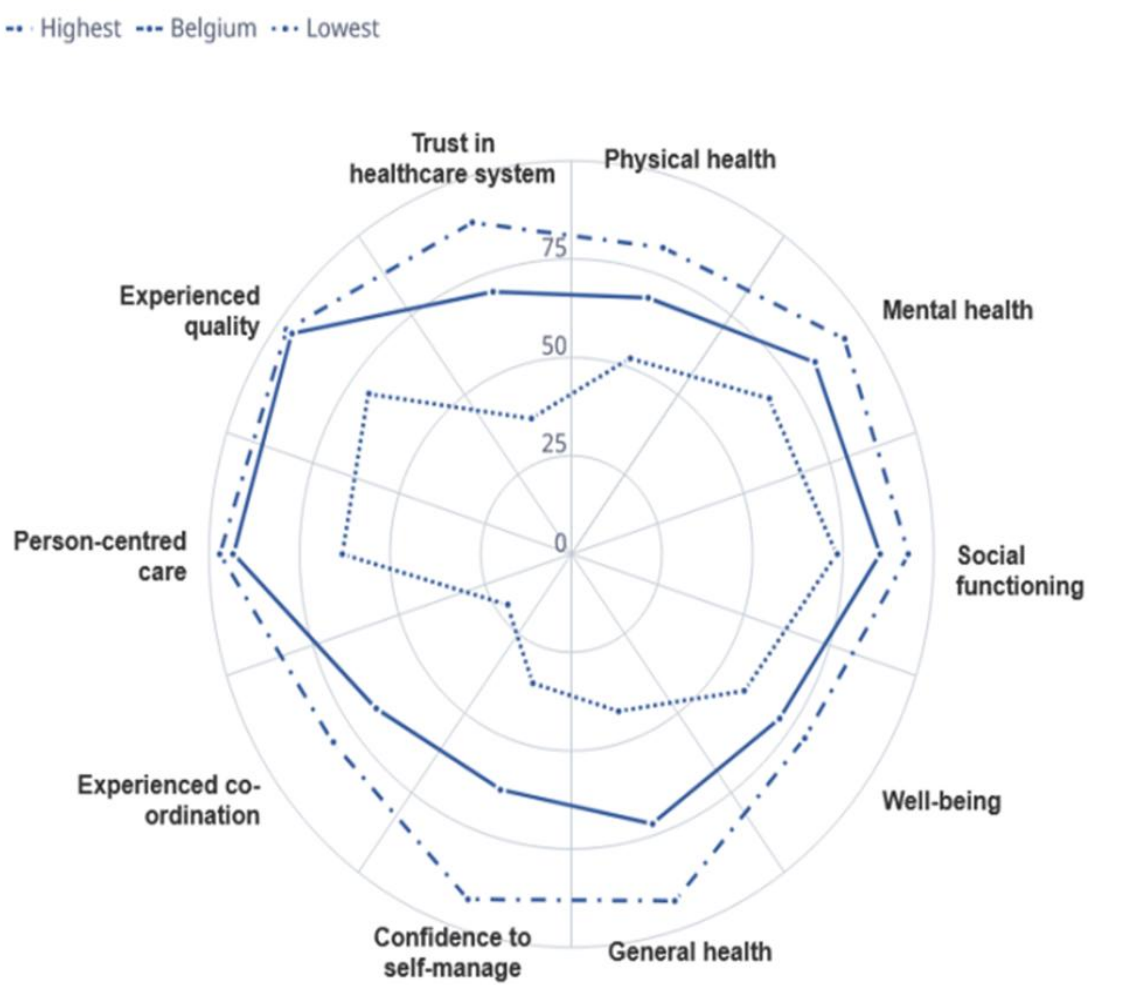
Note: For all indicators, percentage values are shown, measuring the percentage of people reporting a positive outcome or experience (for example, patients reporting being in good, very good or excellent general health). See Table 1, for more information on the cutoffs for positive responses and the scales used. Highest (lowest) represents the highest (lowest) values found for each indicator among 17 PaRIS countries.

Source: OECD PaRIS 2024 Database.

ROMANIA

Figure 1. PaRIS 10 Key Indicators

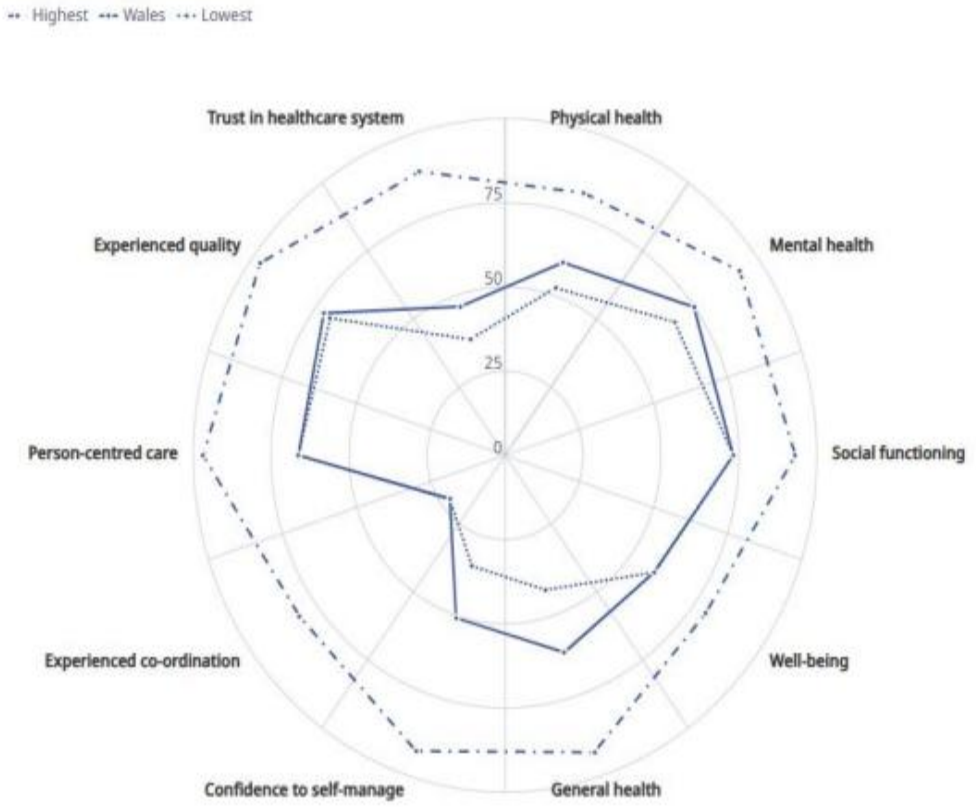
Percentage of people with one or more chronic conditions reporting positive outcomes or experiences



BELGIUM

Figure 1. PaRIS 10 key indicators

Percentage of people with one or more chronic conditions reporting positive outcomes or experiences



WALES

Trust in Healthcare System:

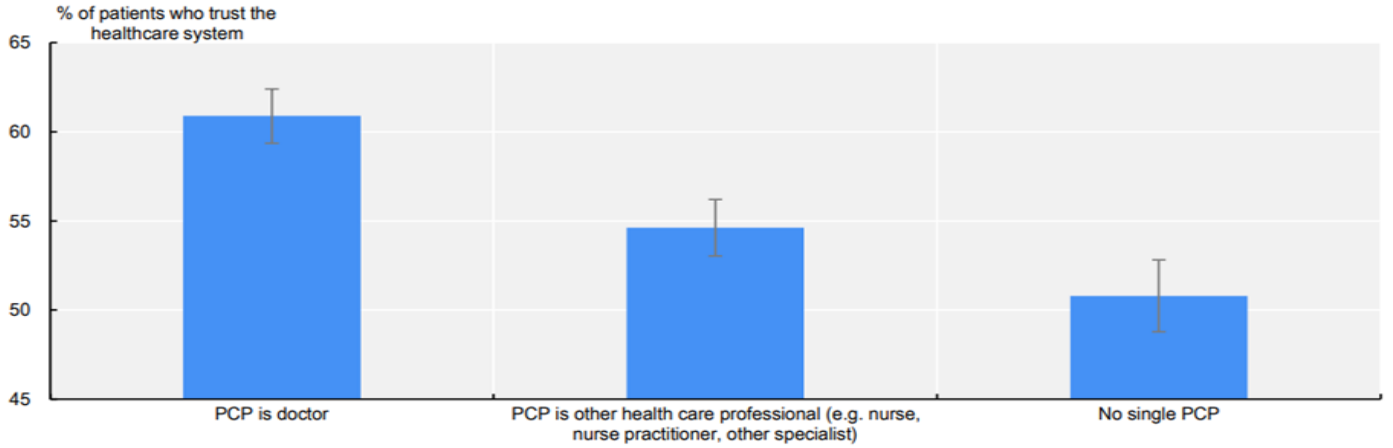
Wales : 45 %
Romania: 50 %
Slovenia : 62 %
Belgium: 70 %

The role of TRUST in HEALTH CARE PROVIDERS and in the HEALTHCARE SYSTEM.

Figures: DATA on TRUST

Figure 6.15. People are more likely to trust the healthcare system if they have a doctor they see for most of their health problems, and less likely to trust it if they have no main point of contact

Average percentage of people with trust in the healthcare system based on the type of their primary point of contact in the healthcare system

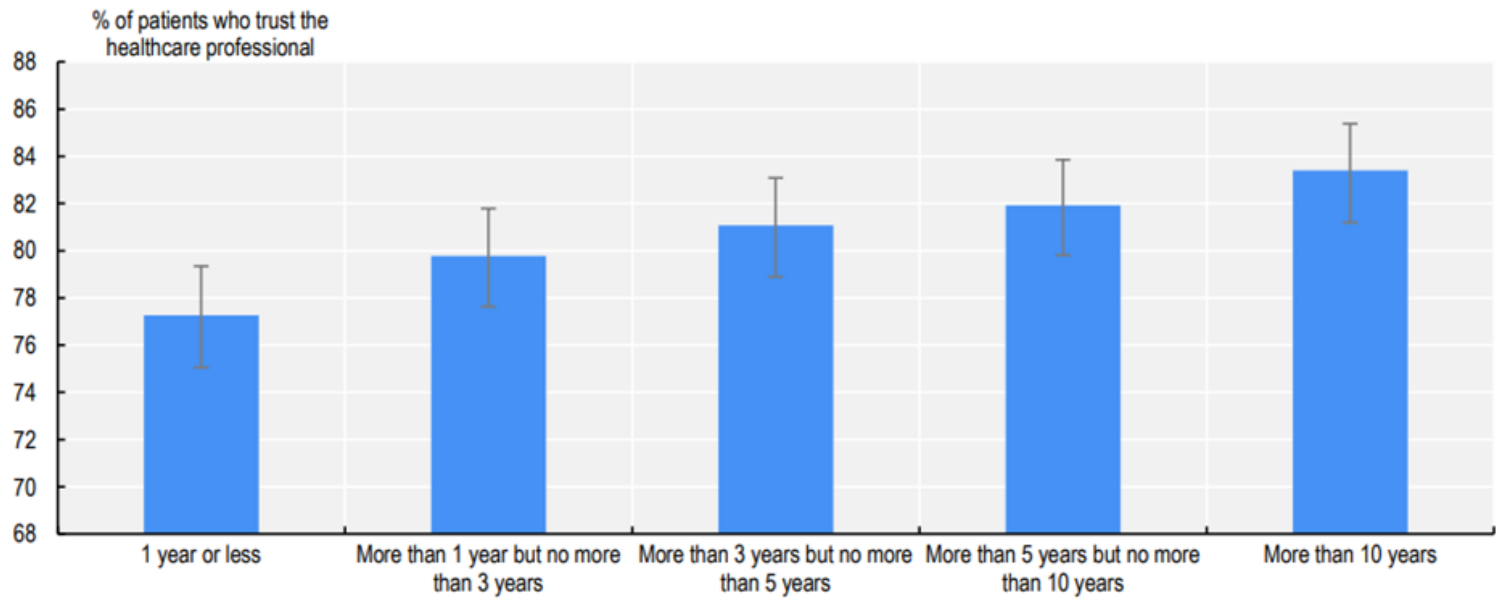


Note: Trust in healthcare system: Response to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree" versus "neither agree nor disagree, disagree, strongly disagree". Primary care professional (PCP). Error bars show the range of the comparative interval. Data based on PaRIS19 Participating Countries.
Source: OECD PaRIS 2024 Database.

StatLink https://stat.link/lvhk97

Figure 6.18. People's trust in their healthcare professional grows over time

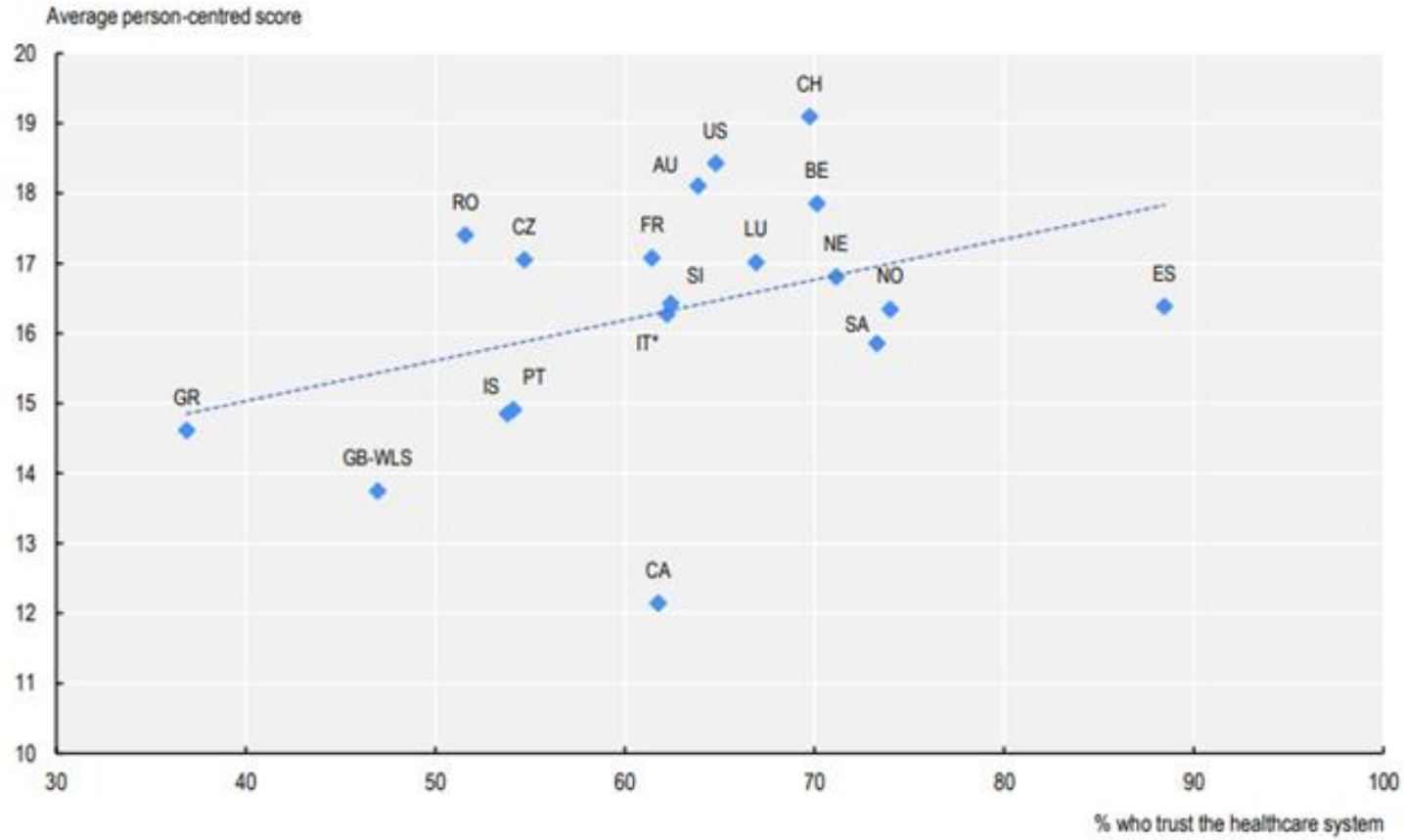
Percentage of people trusting their healthcare professional based on the length of time they have been seeing their professional



Note: Trust in healthcare professional: Response to question: "Did you have confidence and trust in the healthcare professional you saw or spoke to?", "Yes, definitely; Yes, to some extent" versus "No, not really; No, definitely not". Error bars show the range of the comparative interval. Data based on PaRIS19 Participating Countries.
Source: OECD PaRIS 2024 Database.

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Figure 6.9. Countries who perform better on patient-centredness overall often also have higher levels of trust in healthcare systems at the national level among PaRIS respondents

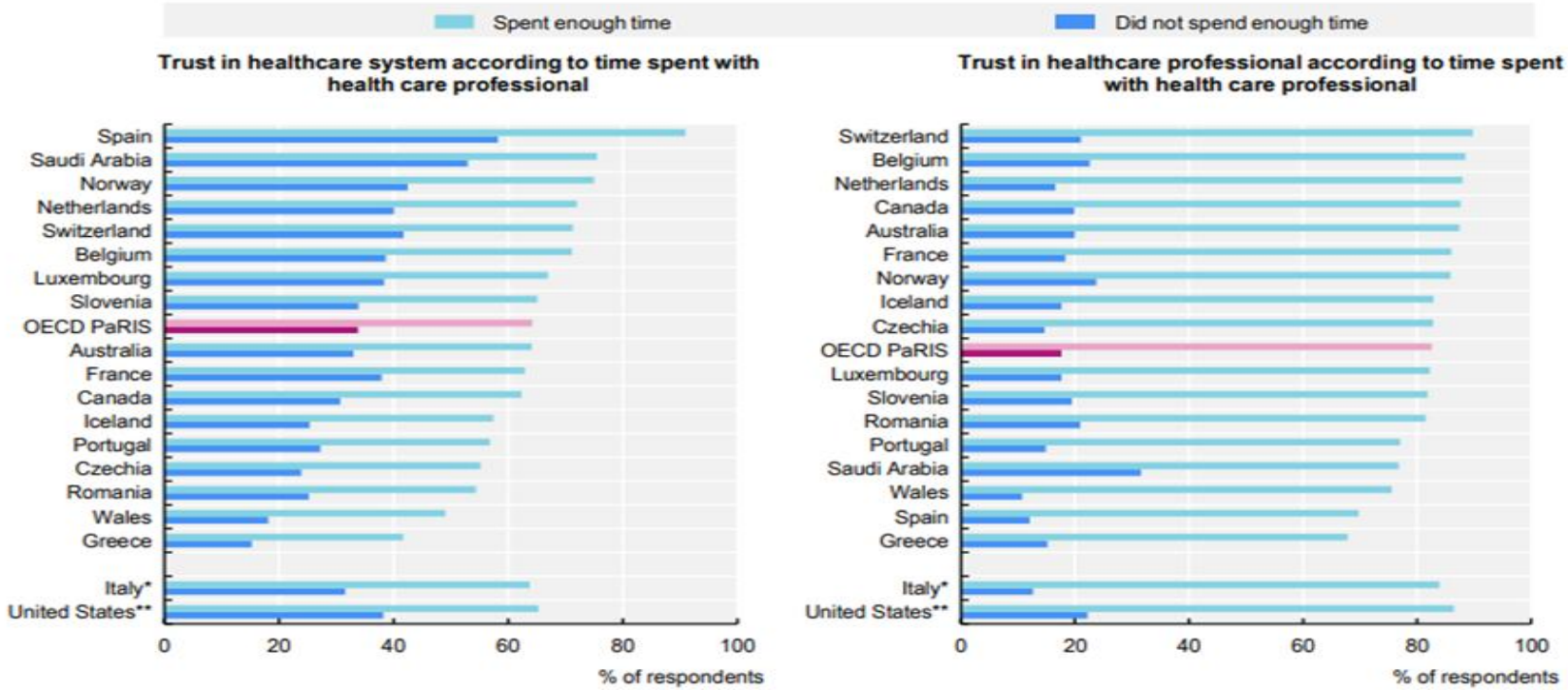


Note: Person-centred care: P3CEQ Questionnaire. Response to eight questions measuring if care is person-centred. Scale ranges from 0 to 24, higher scores represent better person-centred care. Trust in healthcare system: Response to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree" versus "neither agree nor disagree, disagree, strongly disagree". *Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. **United States sample only includes people of 65 years and older.
Source: OECD PaRIS 2024 Database.

StatLink https://stat.link/gtrqc4

Figure 6.12. Trust in healthcare systems drops by 30 percentage points when people don't feel their care professional spends enough time with them

Average percentage of respondents who trust in the healthcare system and their healthcare professional according to the experience of having their healthcare professional spend enough time them

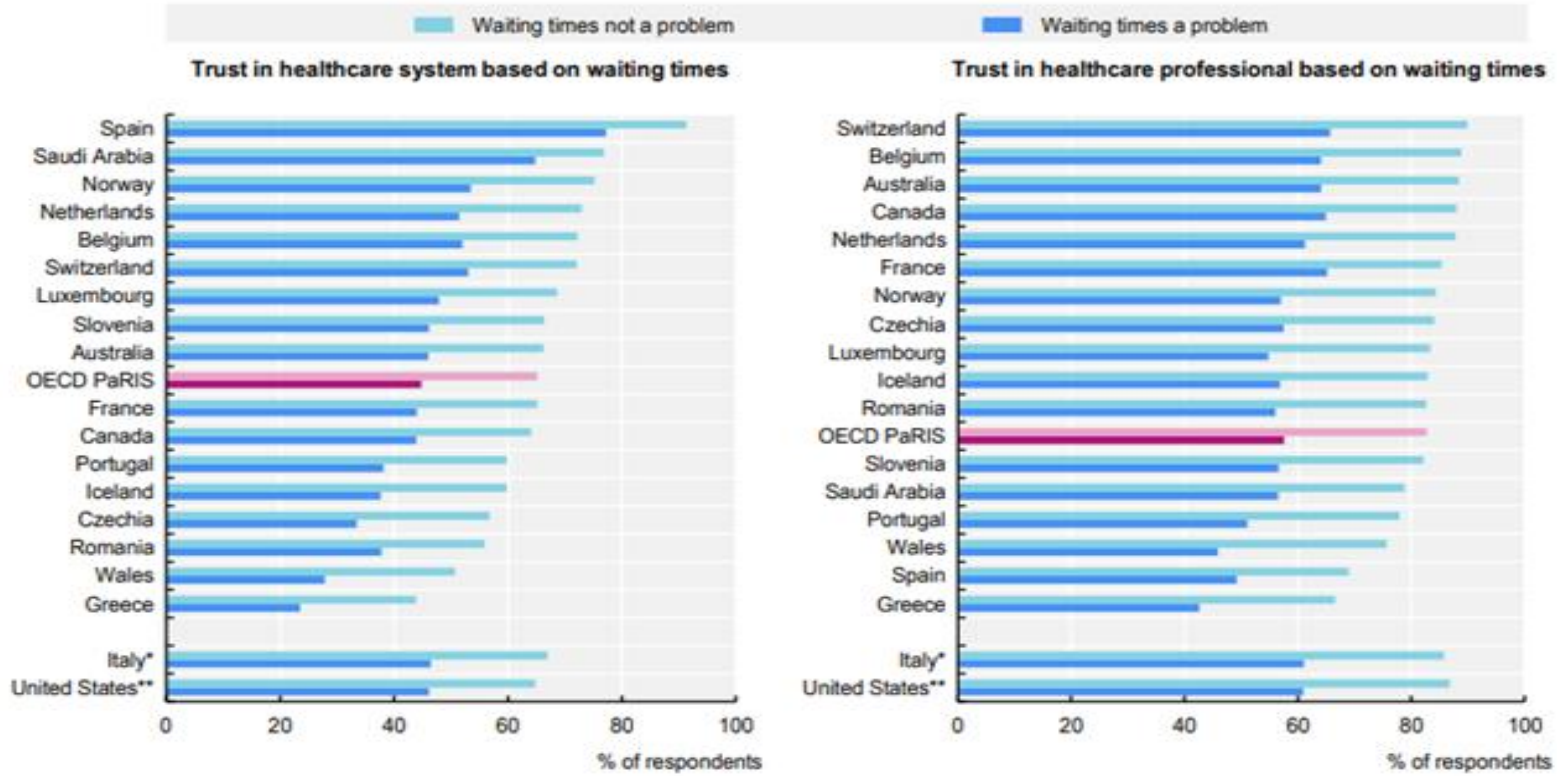


Note: Trust in healthcare system: Response to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree" versus "neither agree nor disagree, disagree, strongly disagree". Trust in healthcare professional: Response to question: "Did you have confidence and trust in the healthcare professional you saw or spoke to?", "Yes, definitely;" versus "Yes, to some extent; No, not really; No, definitely not". *Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. **United States sample only includes people of 65 years and older. All differences for Trust in the healthcare system are statistically significant ($p<0.05$). All differences for Trust in the healthcare professional are statistically significant ($p<0.05$).
Source: OECD PaRIS 2024 Database.

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Figure 6.14. People who have experienced problematic waiting times to access care are less likely to trust the healthcare system and their healthcare professional

Average percentage of respondents who trust in the healthcare system and their professional according to the experience of having experienced problematic waiting times

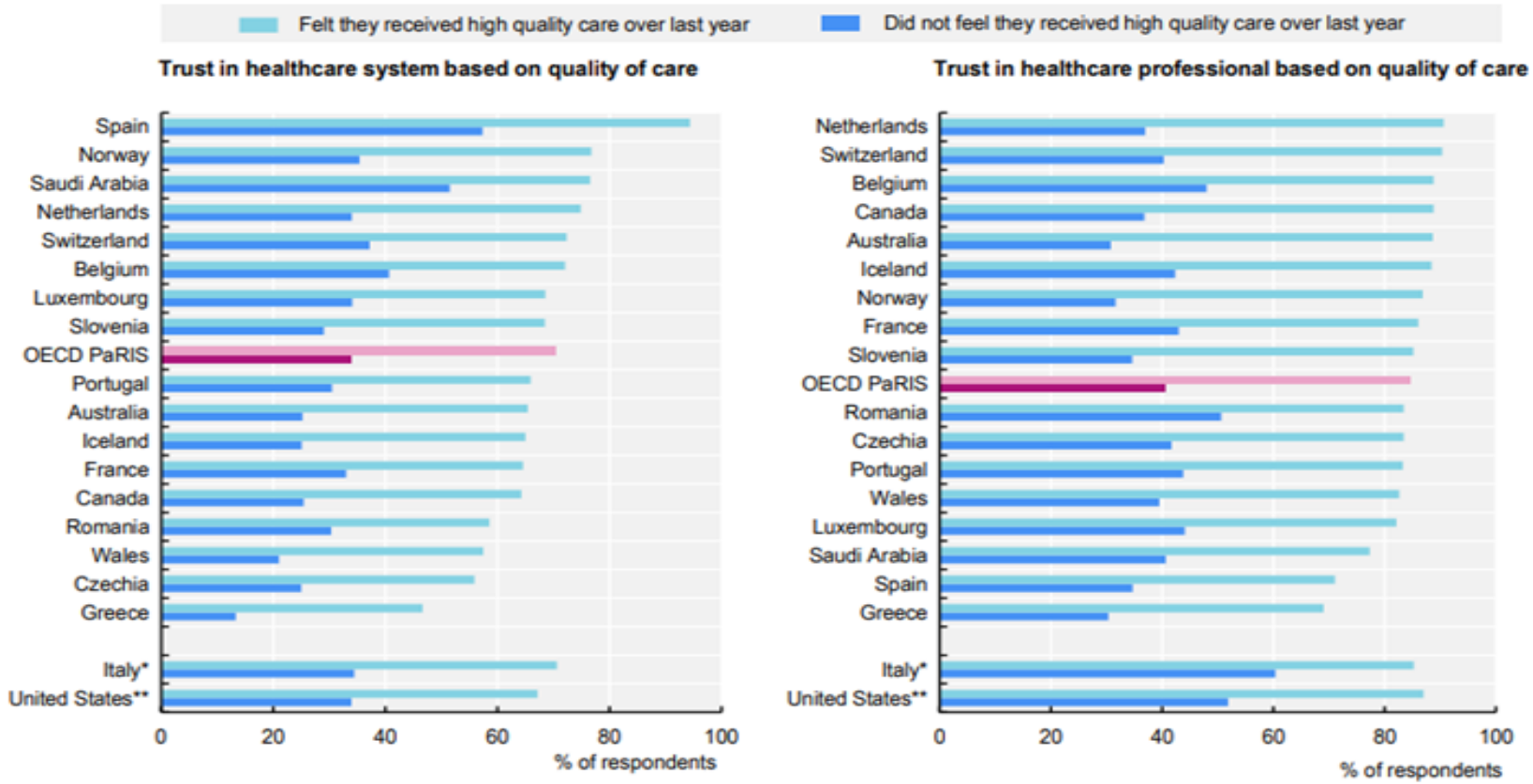


Note: Trust in healthcare system: Response to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree" versus "neither agree nor disagree, disagree, strongly disagree". Trust in healthcare professional: Response to question: "Did you have confidence and trust in the healthcare professional you saw or spoke to?", "Yes, definitely;" versus "Yes, to some extent; No, not really; No, definitely not". *Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. **United States sample only includes people of 65 years and older. All differences for Trust in the healthcare system are statistically significant ($p<0.05$). All differences for Trust in the healthcare professional are statistically significant ($p<0.05$).
Source: OECD PaRIS 2024 Database.

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Figure 6.8. PaRIS respondents with chronic health conditions tend to trust the health system when they have received high quality of primary care

Average percentage of people who trust in the healthcare system and their healthcare professional according to how they rated the medical care that they have received in the past 12 months from their primary care practice



Note: Trust in healthcare system: Response to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree" versus "neither agree nor disagree, disagree, strongly disagree". Trust in healthcare professional: Response to question: "Did you have confidence and trust in the healthcare professional you saw or spoke to?", "Yes, definitely;" versus "Yes, to some extent; No, not really; No, definitely not". *Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. **United States sample only includes people of 65 years and older. All differences for Trust in the healthcare system are statistically significant ($p<0.05$). All differences for Trust in the healthcare professional are statistically significant ($p<0.05$).

Source: OECD PaRIS 2024 Database.

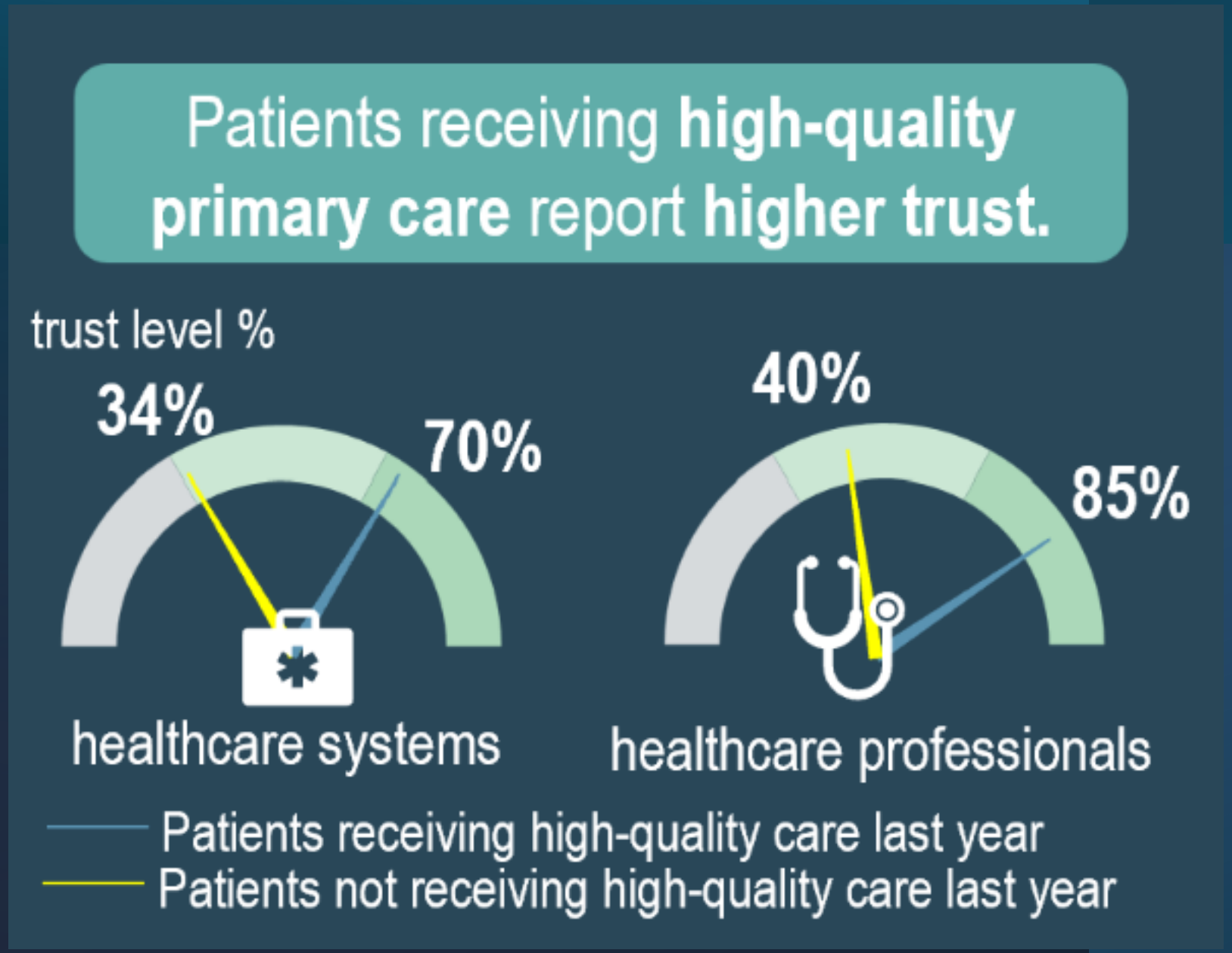
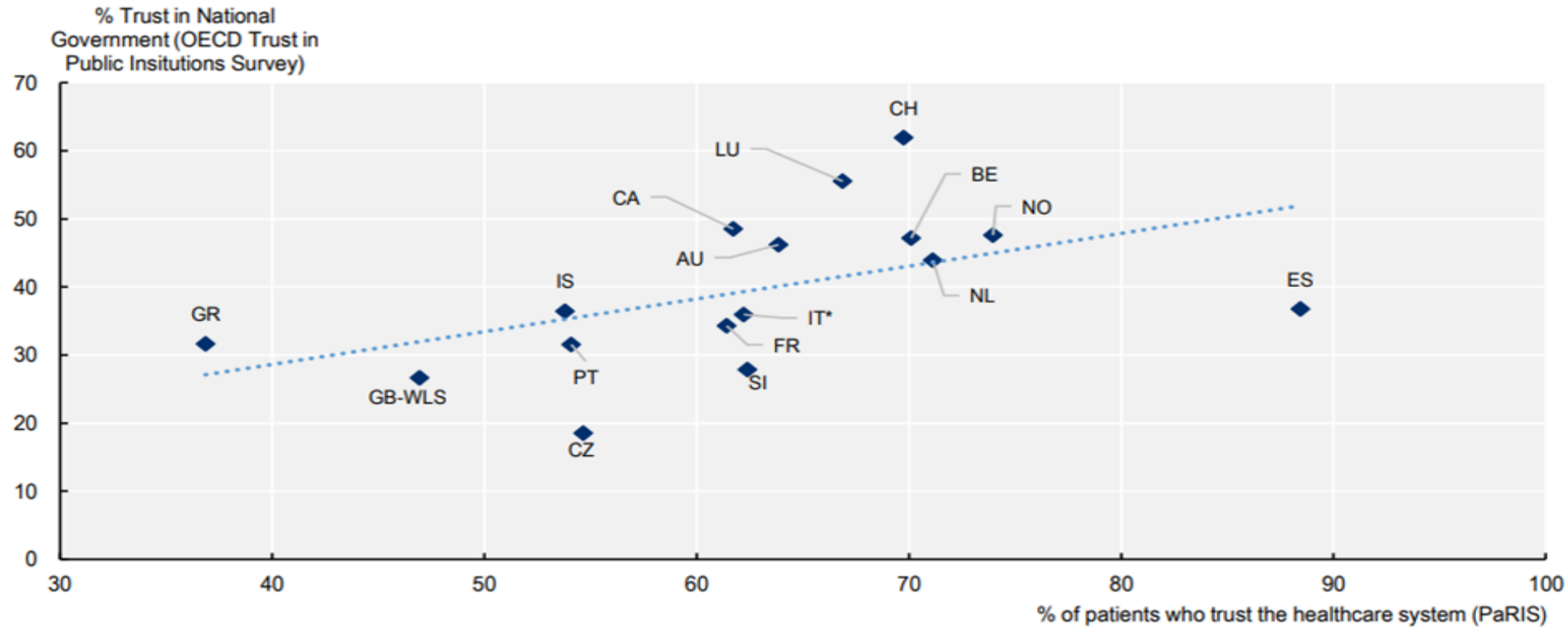

Patients receiving high-quality primary care report higher trust.
trust level %
34%
70%
40%
85%
healthcare systems
healthcare professionals
Patients receiving high-quality care last year
Patients not receiving high-quality care last year

Figure 1.13. In countries with higher trust in the national government, people have also more trust in the healthcare system

Percentage of people who says they trust the national government and percentage who trust the healthcare system



Note: Data from the OECD Trust in Public institutions relates within-country distributions of responses to the question "On a scale of 0 to 10, where 0 is not at all and 10 is completely, how much do you trust the national government?". A 6-10 to " high or moderately high trust". "OECD" presents the unweighted average across countries. OECD Trust Survey Data is for the United Kingdom. Data from the OECD PaRIS: Response to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree" versus "neither agree nor disagree, disagree, strongly disagree". * Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions.
Source: OECD Trust Survey 2023 and OECD PaRIS 2024 Database.

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Conclusion regarding TRUST(1).

The overall conclusion is that there is a relationship between trust in the healthcare system and trust in the national government. Although we cannot establish causality based on these data, this correlation is an important finding.

As shown in the figures above, individual relationships form the basis for trust, upon which broader trust in healthcare systems is built. PaRIS data demonstrate that consistent, positive interactions via a single/central healthcare professional foster a sense of trust and reliability at the interpersonal level. Moreover, these individual experiences of trust at the primary care level can significantly influence a patient's perception of the entire healthcare system, thereby shaping their overall confidence in the healthcare system's ability to deliver quality care. This spillover effect highlights the crucial role that personal interactions (the ‘nano-level’ and ‘micro-level’ in healthcare) play in increasing the credibility and reliability of healthcare institutions, ultimately leading to a more trusted and resilient healthcare environment.

Conclusion regarding TRUST (2).

Trust, like other essential aspects of the healthcare system infrastructure, must be invested in, built up, and maintained. Healthcare systems and policymakers play a crucial role in fostering trust among people with acute and chronic conditions by ensuring transparent communication and accessible, patient-centered care.
When we link this to the importance of trust, social cohesion, ‘the sense of belonging’, and democracy, and how healthcare plays a role in this, the hypothesis emerges that the quality of (primary) care can make a significant contribution to social connection and the sustainability of democracy.

This opens new perspectives on how we view healthcare in this changing society.

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Challenges in patients with multimorbidity

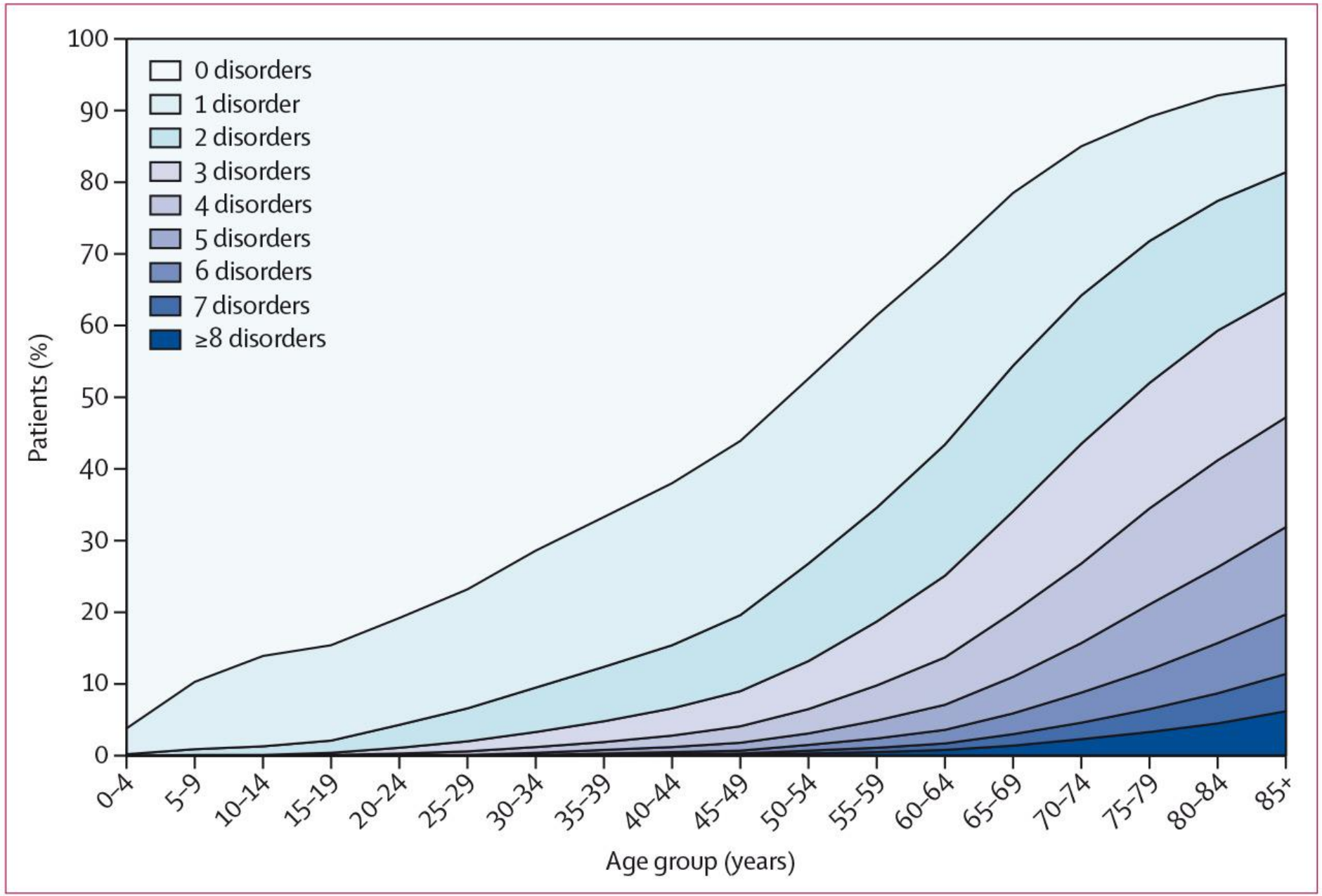


Figure 1: **Number of chronic disorders by age-group**

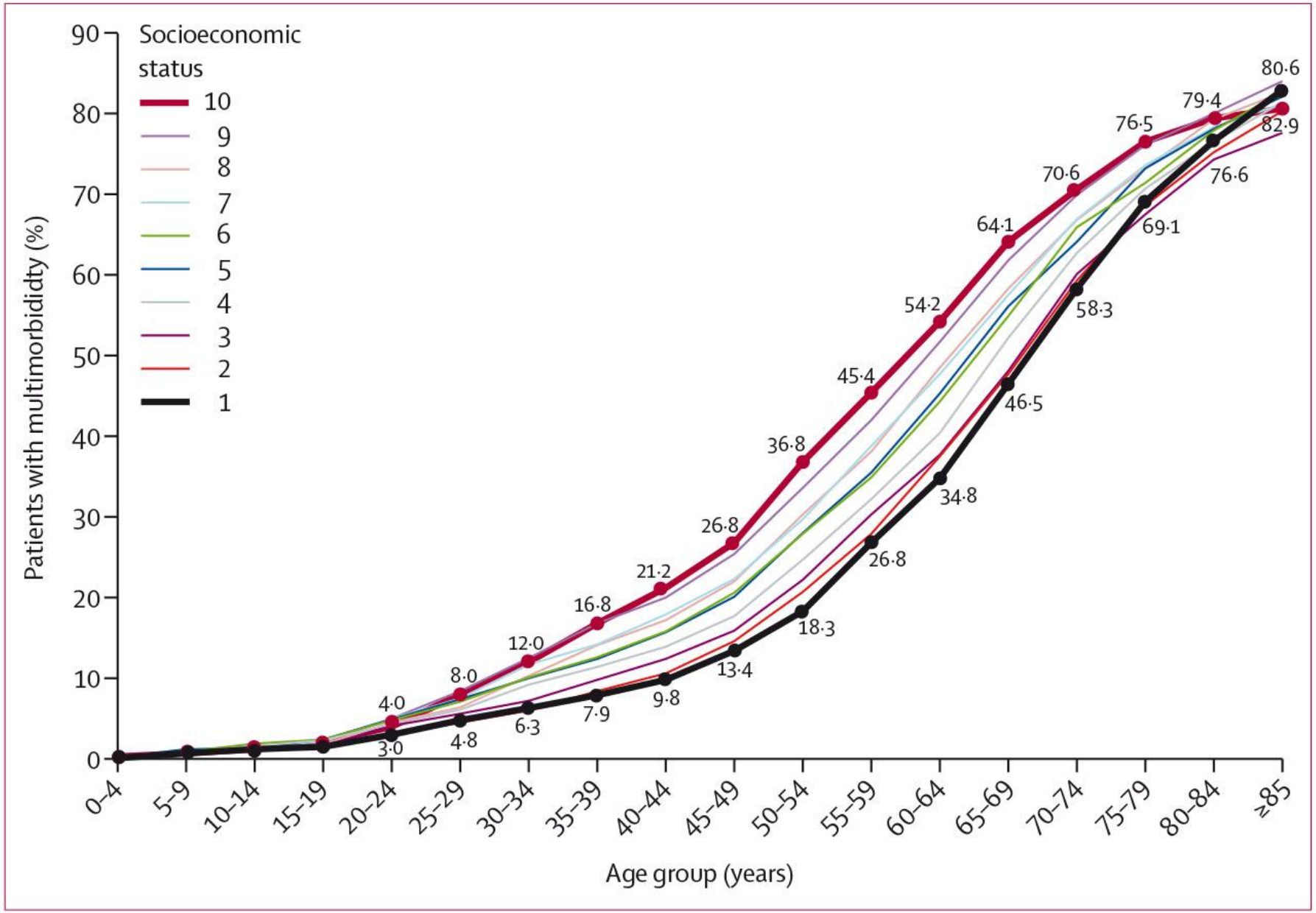


Figure 2: **Prevalence of multimorbidity by age and socioeconomic status**

On socioeconomic status scale, 1=most affluent and 10=most deprived.

Debate & Analysis

James Mackenzie Lecture 2011:

multimorbidity, goal-oriented care, and equity



INTRODUCTION

Today we face an important demographic and epidemiological transition, confronting us with the challenge of non-communicable diseases (NCDs), which occur more and more in the context of multimorbidity. In the next decade, multimorbidity will become the rule, no longer the exception: 50% of the those aged ≥65 years have at least three chronic conditions, whereas 20% of the ≥65-year group have at least five chronic conditions.[1] In the case of COPD, for example, more than half of the patients have at least one comorbid disease.[2]

HOW DO WE ADDRESS PATIENTS WITH MULTIMORBIDITY TODAY?

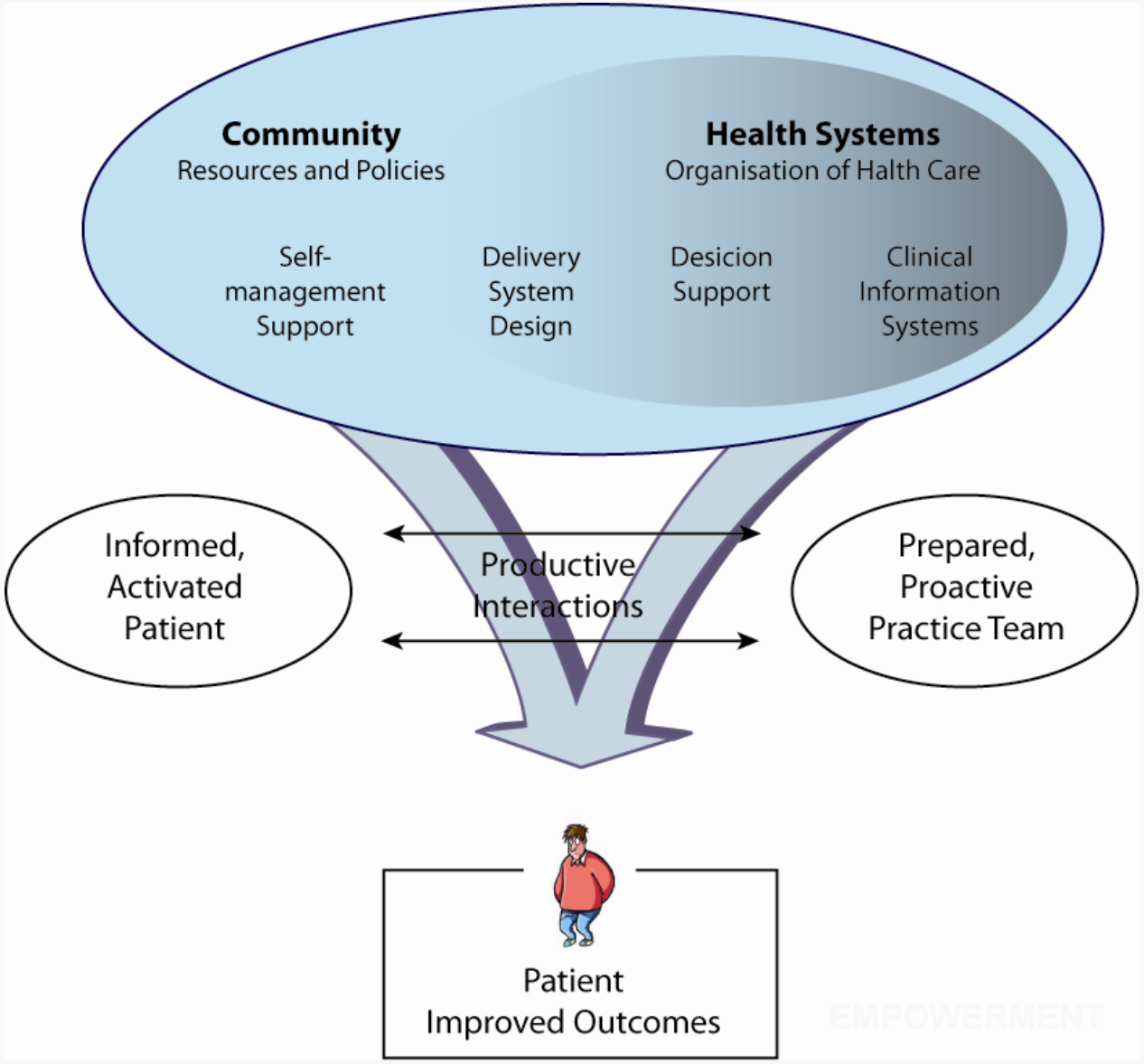
work in a situation of multimorbidity'?

Let us illustrate this with a patient from our general practice, we call her 'Jennifer' (Box 1).

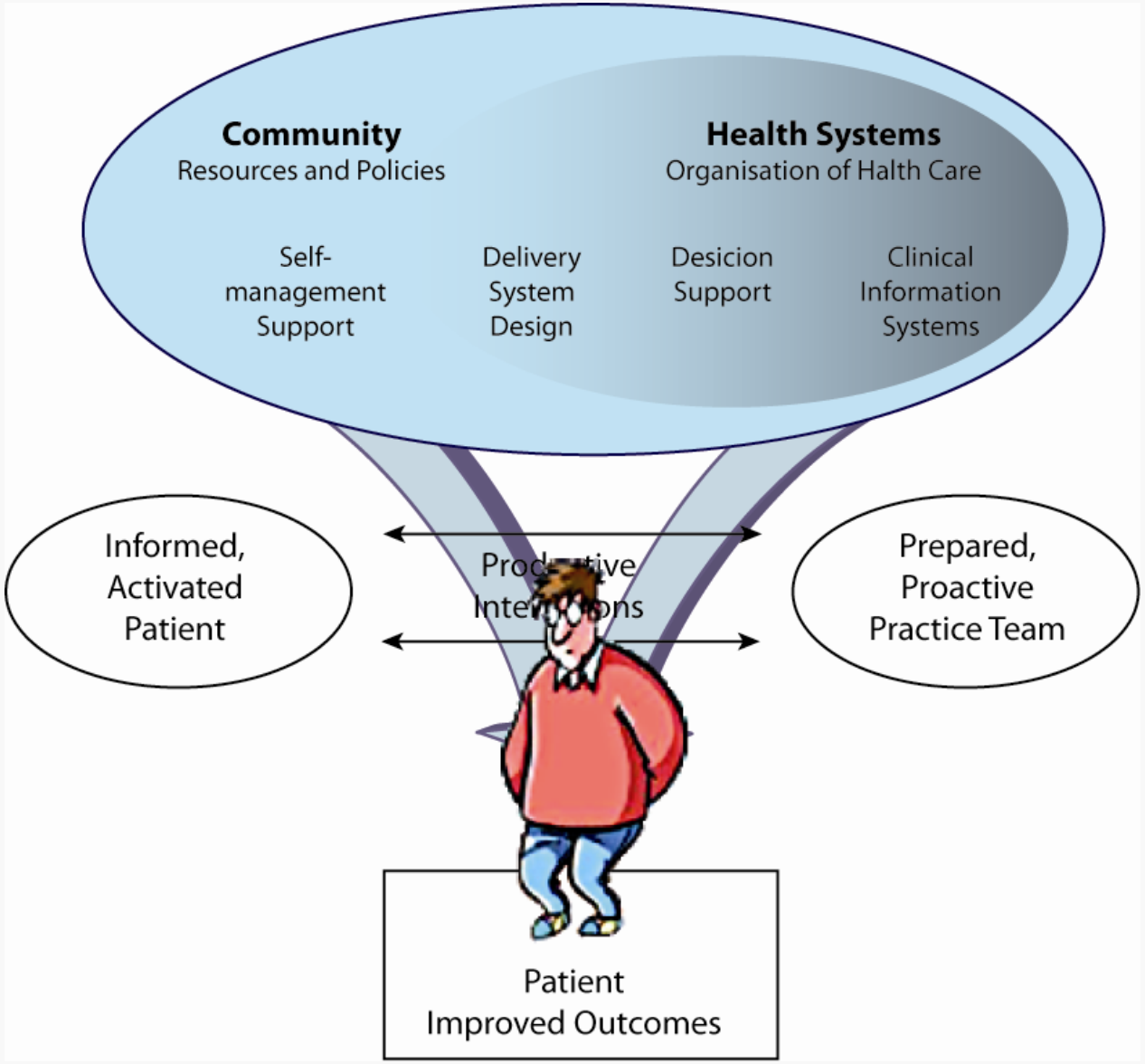
According to the actual guidelines, Jennifer is faced with a lot of tasks[4]: joint protection, aerobic exercise, muscle strengthening, a range of motion exercising, self-monitoring of blood glucose, avoiding environmental exposure that might exacerbate COPD, wearing appropriate foot wear, limiting intake of alcohol, maintaining body weight. Her medication schedule includes 11 different drugs, with a total of 20 administrations a day. The clinical tasks for the GP include vaccination, blood pressure control at all clinical visits, evaluation of self-monitoring of blood glucose, foot examination, and laboratory tests. Moreover, referrals are needed to physiotherapy, for ophthalmologic examination, and pulmonary rehabilitation. So, Jennifer's reaction is not unexpected.

Jennifer's case clearly illustrates the need for a paradigm-shift for chronic care: from problem-oriented to goal-oriented care. In 1991, Mold and Blake[5] recognised that the problem-oriented model, focusing on the eradication of disease and the prevention of death, is not well suited to the management of a number of chronic illnesses. Therefore they proposed a goal-oriented approach that encourages each individual to achieve the highest possible level of health as defined by that individual. Goal-oriented care assists an individual in achieving their maximum individual health potential in line with their individually defined goals. The evaluator of success is the patient, not the physician. And what really matters for patients is their ability to function (functional status), and social participation. So, certainly in the context of multimorbidity, there is a need for a shift from 'chronic disease management' towards 'participatory patient management', with the patient at the centre of the process. For many people, giving meaning to the chronic illness process they are going through, is of the utmost importance. Safety and avoiding side-effects (not having to suffer more from the treatment than from the disease) is very important. Patients expect comprehensiveness in their care instead of fragmentation.

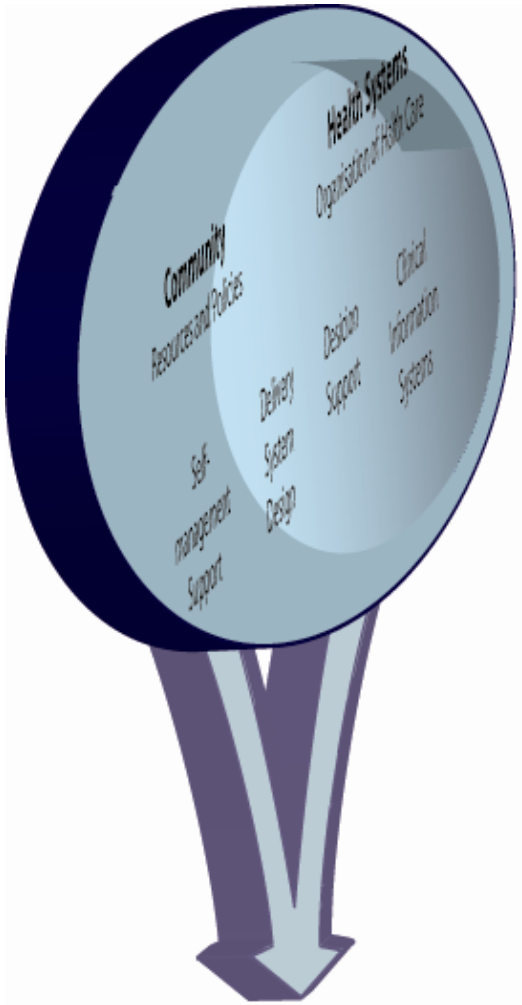
A recent survey of 'chronic disease management' in 10 European countries[6] illustrated that most of the programmes use a vertical disease-oriented approach. Although much has been learnt from vertical disease-oriented programmes, evidence suggests that better outcomes occur by addressing diseases through an integrated approach in a strong primary care system. Vertical disease-oriented programmes for HIV/AIDS, malaria, tuberculosis, and other infectious diseases foster duplication and the inefficient use of resources, produce gaps in the care of patients with multimorbidity, and

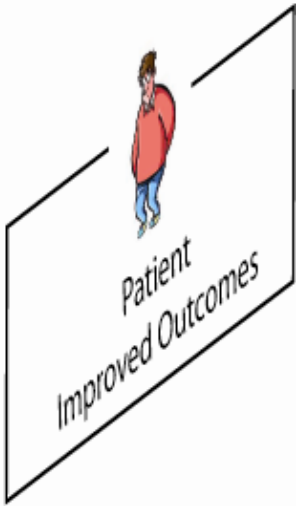


Wagner EH. Effective Clinical Practice 1998;1:2-4


Community
Resources and Policies
Health Systems
Organisation of Halth Care
Self-management Support
Delivery System Design
Desicion Support
Clinical Information Systems
Informed, Activated Patient
Prepared, Proactive Practice Team
Patient Improved Outcomes

But…


Health Systems
Organisation of Health Care
Community
Resources and Policies
Clinical
Information
Systems
Decision
Support
Delivery
System
Design
Self-
management
Support


Patient
Improved Outcomes

Julia is 75 years old. Fifteen years ago she lost her husband. During the last 15 years she has been through a laborious medical history: operation for coxarthrosis with a hip prothesis, hypertension, diabetes type 2, COPD and osteoartritis. Moreover there is osteoporosis. She lives independently at her home, with some help from her youngest daughter Elisabeth. I visit her regularly and each time she starts saying: "Doctor, you must help me". Then follows a succession of complaints and unwell feeling: sometimes it has to do with the heart, another time with the lungs, then the hip, …

Each time I suggest – according to the guidelines - all sorts of examinations that did not improve her condition. Her requests become more and more explicit, my feelings of powerlessness, insufficiency and spite, increase. Moreover, I have to cope with guidelines that are contradictory: for COPD she sometimes needs corticosteroids, which worsens her glycemic control.

The adaptation of the medication for the blood pressure (at one time too high, at another time too low), cannot meet with her approval, as does my interest in her HbA1C and lung function test-results.

After so many contacts Julia says: “Doctor, I want to tell you what really matters for me. On Tuesday and Thursday, I want to visit my friends in the neighbourhood and play cards with them. On Saturday, I want to go to the Supermarket with my daughter. And for the rest, I want to be left in peace, I don’t want to change continually the therapy anymore, … especially not having to do this and to do that”.

In the conversation that followed it became clear to me how Julia had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Julia’s goals. I visit Julia again with pleasure ever since: I know what she wants, and how much I can (merely) contribute to her life.

Sum of the guidelines

Patient tasks

- Joint protection
- Energy conservation
- Self monitoring of blood glucose
- Exercise
  - Non weight-bearing if severe foot disease is present and weight bearing for osteoporosis
  - Aerobic exercise for 30 min on most days
  - Muscle strengthening
  - Range of motion
- Avoid environmental exposures that might exacerbate COPD
- Wear appropriate footwear
- Limit intake of alcohol
- Maintain normal body weight

R

- Physical th
- Ophtalmol
- Pulmonary

Time	Medications
7:00 AM	Ipratropium dose inhaler Alendronate 70 mg/wk
8:00 AM	Calcium 500 mg Vit D 200 IU Lisinopril 40mg Glyburide 10mg Aspirin 81mg Metformin 850 mg Naproxen 250 mg Omeprazol 20mg
1:00 PM	Ipratropium dose inhaler Calcium 500 mg Vit D 200 IU
7:00 PM	Ipratropium dose inhaler Metformin 850 mg Calcium 500 mg Vit D 200 IU Lovastatin 40 mg Naproxen 250 mg
11:00 PM	Ipratropium dose inhaler
As needed	Albuterol dose inhaler Paracetamol 1g

Clinical tasks

- Administer vaccine
  - Pneumonia
  - Influenza annually
- Check blood pressure at all clinical visits and
- sometimes at home
- Evaluate self monitoring of blood glucose
- Foot examination
- Laboratory tests
  - Microalbuminuria annually if not present
  - Creatinine and electrolytes at least 1-2 times a year
  - Cholesterol levels annually
  - Liver function biannually
  - HbA1C biannually to quarterly

Patient education

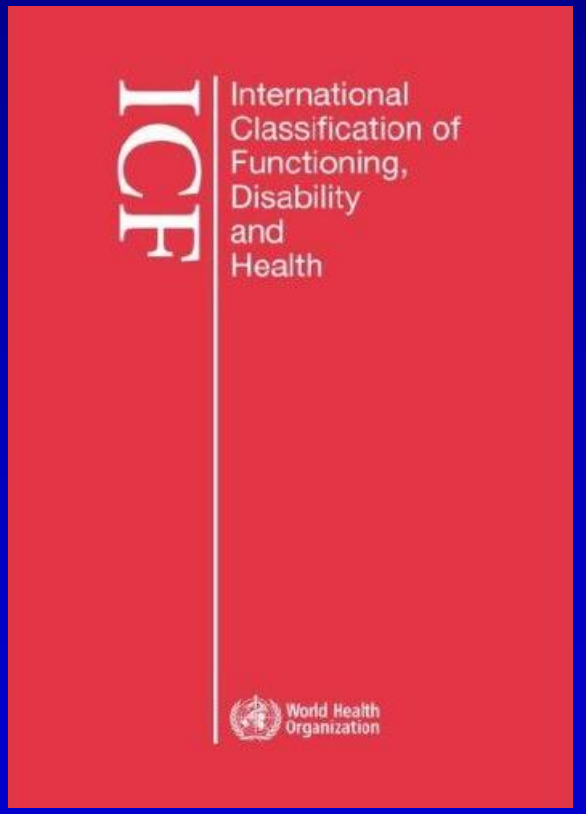
- Foot care
- Oesteoartritis
- COPD medication and delivery system training
- Diabetes



Boyd et al. JAMA, 2005

What really matters for patients is

- Functional status
- Social participation



“Disease-oriented versus goal-oriented care”

	Disease-oriented	Goal-oriented
Definition of Health	Absence of disease as defined by the health care system	Maximum desirable and achievable quality and/or quantity of life as defined by each individual

Special Article

Goal-Oriented Medical Care

James W. Mold, MD; Gregory H. Blake, MD; Lorne A. Becker, MD

ABSTRACT

The problem-oriented model upon which much of modern medical care is based has resulted in tremendous advancements in the diagnosis and treatment of many illnesses. Unfortunately, it is less well suited to the management of a number of modern health care problems, including chronic incurable illnesses, health promotion and disease prevention, and normal life events such as pregnancy, well-child care, and death and dying. It is not particularly conducive to an interdisciplinary team approach and tends to shift control of health away from the patient and toward the physician. Since when using this approach the enemies are disease and death, defeat is inevitable.

Proposed here is a goal-oriented approach that is well suited to a greater variety of health care issues, is more compatible with a team approach, and places a greater emphasis on physician-patient collaboration. Each individual is encouraged to achieve the highest possible level of health as defined by that individual. Characterized by a greater emphasis on individual strengths and resources, this approach represents a more positive approach to health care. The enemy, not disease or death but inhumanity, can almost always be averted.

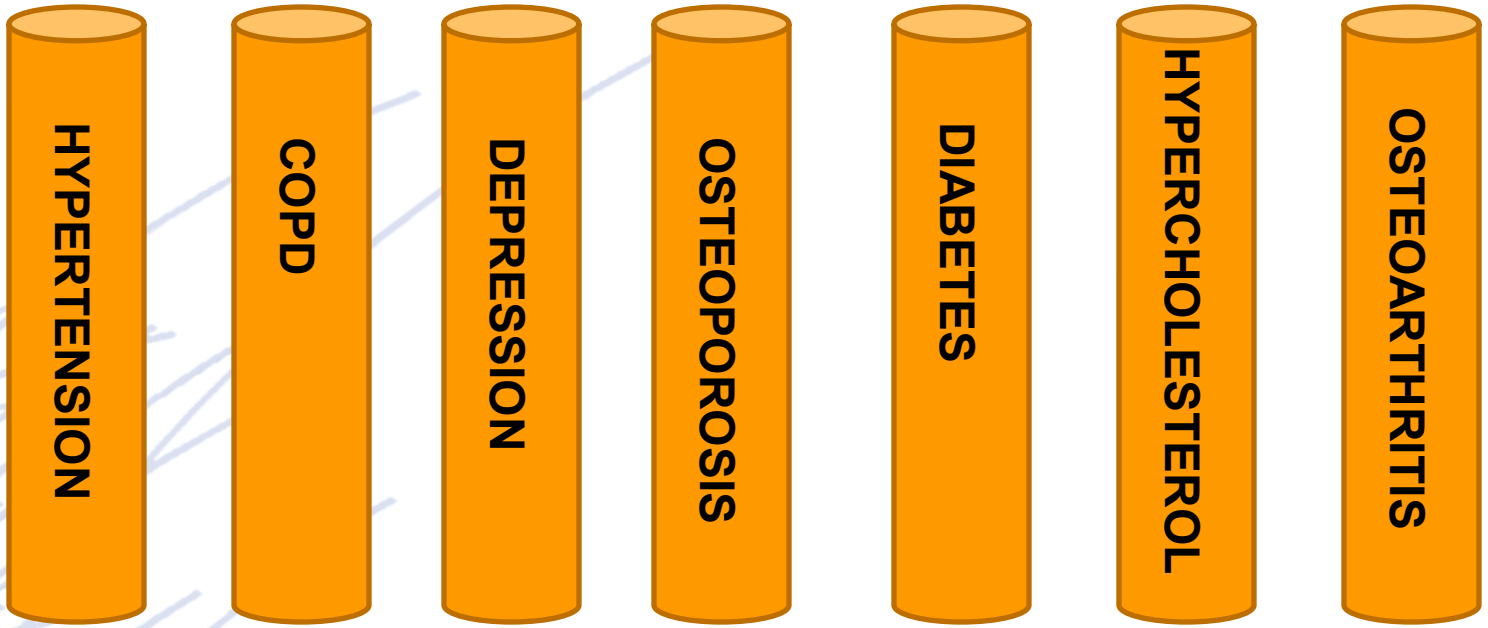
(Fam Med 1991; 23:46-51)

1. There exists an ideal "health" state which each person should strive to achieve and maintain. Any significant deviation from this state represents a problem (disease, disorder, syndrome, etc.).
2. Each problem can be shown to have one or more potentially identifiable causes, the correction or removal of which will result in resolution of the problem and restoration of health.
3. Physicians, by virtue of their scientific understanding of the human organism and its afflictions, are generally the best judges of their patients' fit with or deviation from the healthy state and are in the best position to determine the causes and appropriate treatment of identified problems.
4. Patients are generally expected to concur with their physicians' assessments and comply with their advice.
5. A physician's success is measured primarily by the degree to which the patients' problems have been accurately and efficiently identified and labeled and appropriate medical techniques and technologies have been expertly applied in an effort to eradicate those problems.

This conceptual model is ideally suited to the understanding and management of acute and curable illnesses. It has

Vertical Disease Oriented Approach

- Mono-disease-programs ?



The challenge: vertical disease- oriented programs and multimorbidity

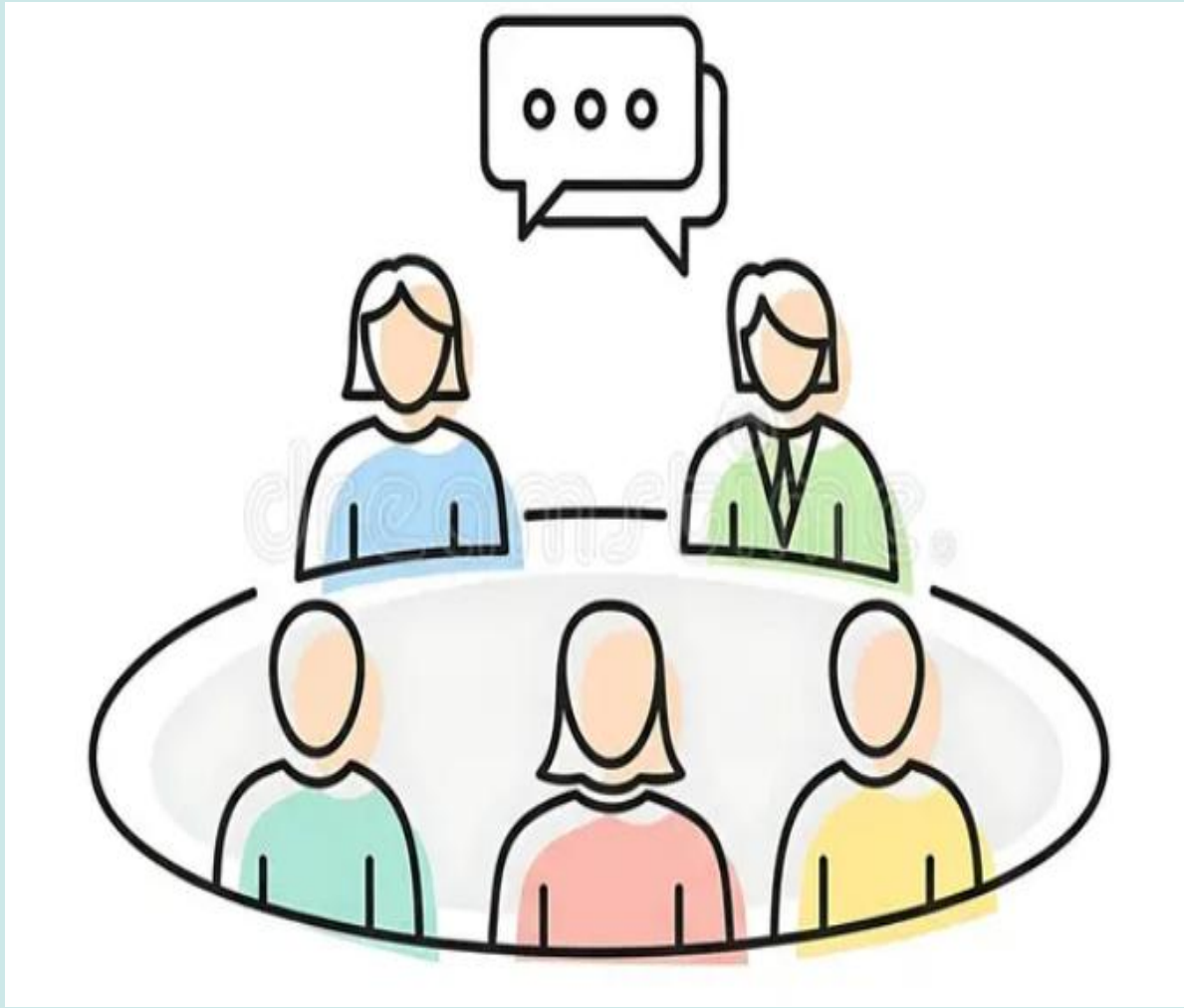
- Create duplication
- Lead to inefficient facility utilization
- May lead to gaps in patients with multiple co-morbidities
- Lead to inequity between patients

INTERPROFESSIONAL TRAINING FOR GOAL-ORIENTED CARE: OVER 2000 PRIMARY CARE PROVIDERS HAVE ALREADY BEEN TRAINED IN FLANDERS.

Hospital departments for “multimorbidity patients” start a “goal-oriented approach”!



Questions ?
Reflections ?



Core PHC principles: accessibility, continuity, coordination, equity, person-centeredness,…from concepts to practice and policy.

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2. What matters to the patient ? Goal-Oriented Care
3. **Integrated care requires integrated records for primary and secondary use**
4. PHC approach at nano-, micro-, meso- and macro-level : More than 5 C's ?
5. Illustrated with Practice examples from Community Health Centre Botermarkt.

BIHR (Belgian Integrated Health record)



Sextuple Aim



Michael Matheny, Sonoo Thadaney Israni, Mahnoor Ahmed, and Danielle Whicher, Editors. 2019. Artificial Intelligence in Health Care: The Hope, the Hype, the Promise, the Peril. NAM Special Publication. Washington, DC: National Academy of Medicine. Translated, adapted, and reproduced with permission from the National Academy of Sciences, Courtesy of the National Academies Press, Washington, D.C.

BIHR adresses the goals of Sextuple Aim and enables Integrated Care.

- Belgium has significantly increased its investment in health information and communication technology in recent years to support the digitalisation of its health system. A growing proportion of Belgians are using digital tools to make online medical appointments and access their health records. A central component of the eHealth Action Plan (2025-2027) is the development of the future Belgian Integrated Health Record, a digital platform providing real-time access to comprehensive patient information for health professionals across different care settings.

CONCEPT : 6 overarching goals of BIHR

- Supporting quality, continuity and safety of care;
- Empowering citizens/patients to actively work with their BIHR (consult, add and, if necessary, propose adjustments/corrections of incomplete/erroneous data);
- Empowering healthcare providers to use BIHR as a unique communication medium;
- Facilitating the exchange of data (including via AI) about care and health in the context of primary and secondary use of data, including use of data in the context of Population Health Management;
- Innovation and stimulation of research and development;
- Digitizing and optimizing administrative processing.

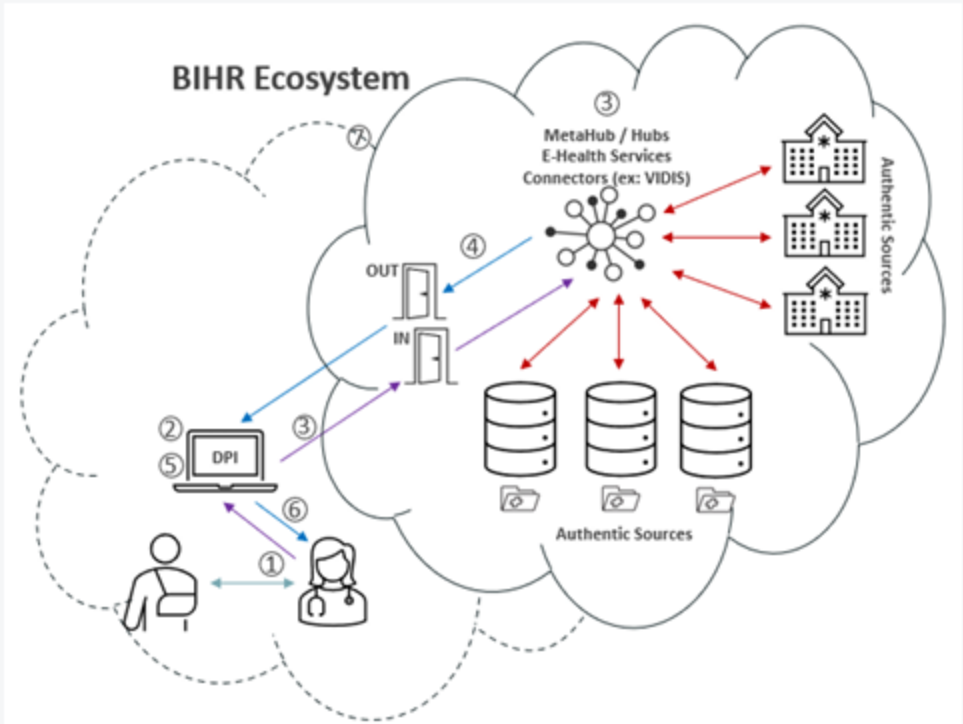
4. Read

Reading pathway: “I inform myself”

1 Open the patient record
The EHR connects automatically to BIHR.

2 Identify the care context
Role, access rights and patient consent define what may be consulted.

3 Show trusted information
Visible provenance, new items highlighted, integrated into the record.



Key message

Interoperability is not just exchange.
It is discovery + control + context + traceability.
Primary care: Episode of Care structures contacts and continuity.

1.BIHR-rubrics < Authentic Sources:

The **“authentic sources”** are data relating to care for a person's well-being and health, which are published by the care provider in a consistent and standardized manner and are accessible to the care providers who have a therapeutic relationship with the person, and to the person themselves .

All data are in a FHIR (Fast Heathcare Interoperability Resources) compatible format and are encoded using SNOMED CT terminology.

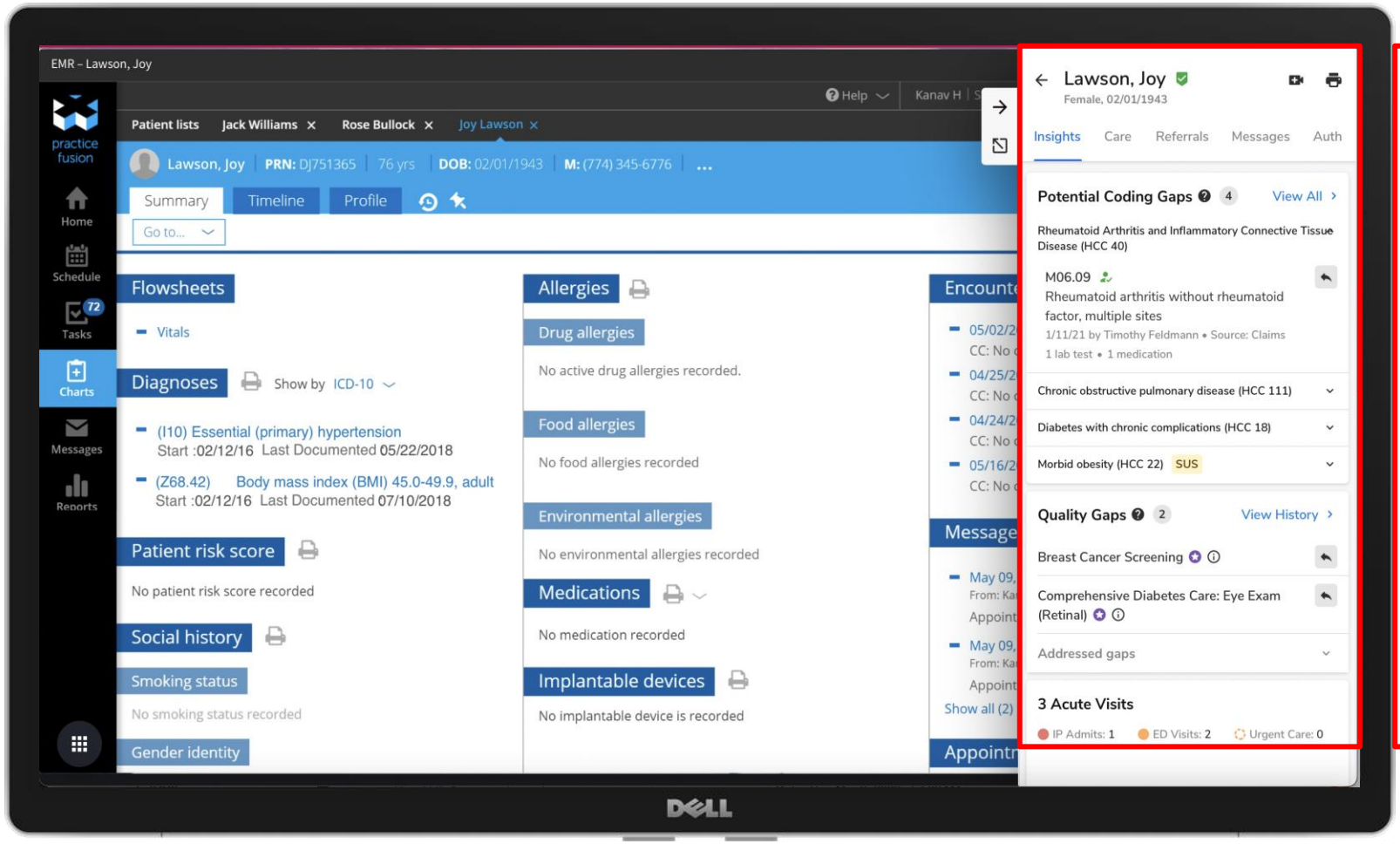
Problem list (health & wellbeing) evolving to IPS	Clinical data (linked → Problems) as ‘Caresets’	Laboratory
Imaging	Medication-overview	Vaccinations
Allergy	Telemonitoring-data	Social Factors
Family Context	Life-goals	Care-Plan & Care-Team
Belrai	Patient Will	Implants

BIHR Work Environment : USER-FRIENDLY INTERACTION : 'SCREEN~~PERSON~~PROVIDER'

' Quality outcomes with point of care insights

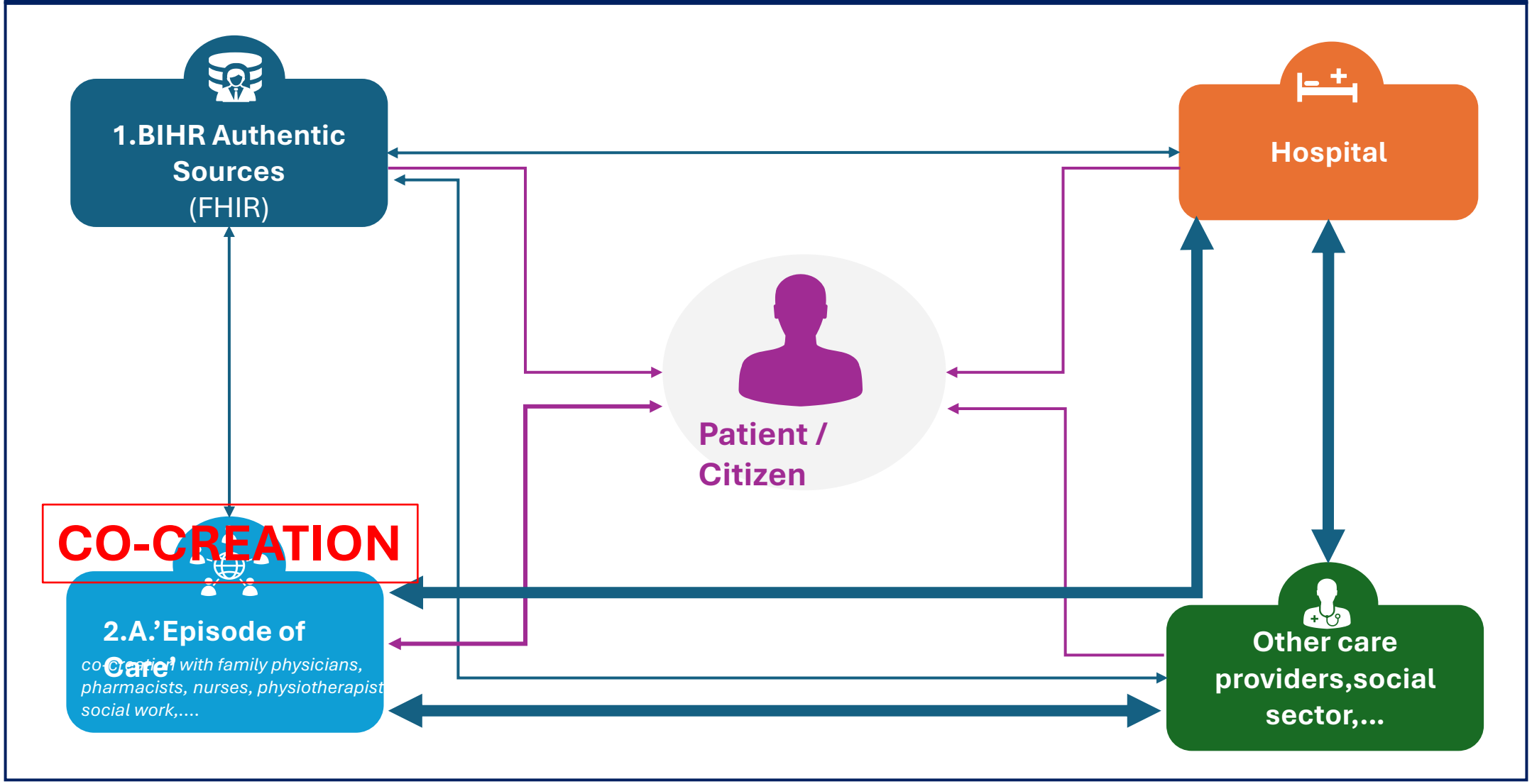
Consolidates patient information, in-network co-creation of information (family physicians, pharmacists,nurses, physiotherapists), and helps in engaging the physicians and primary care providers to put in practice integrated goal-oriented care and population health management.

The BHIR Work Environment (BWE) uses Clinical Decision Support, interacting in real-time with the patient data (e.g. AB-prescription and renal function, medication-interactions,…). Moreover algorithms and appropriate AI will support the coding process, the 'creation' of the relevant clinical data 'Careset',the problem-list,…



During the consultation,there is a continuous analysis of information 'in the background', producing 'warnings, reminders, follow-up information, …

Relation between 1. 'BIHR Authentic Sources' and 2.'BIHR Work Environment' in different settings



Structured FIHR-compatible information transfer

2.B. Linking Pathways

Patient/citizen can read and add information according to a user-friendly and safe procedure.

Patient/citizen can read information (f.ex. through Patient Health Viewer)

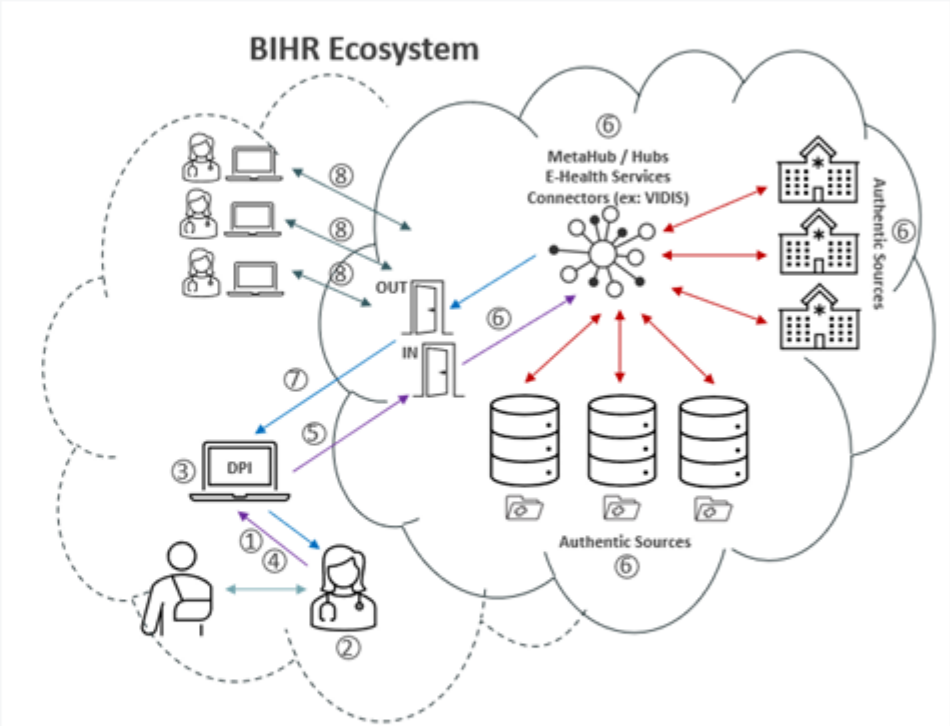
5. Share

Publication pathway: share what matters

1 Update in the usual EHR
Diagnosis, prescription, observation, vaccination…

2 Encode and validate
FHIR + Patient Summary CareSets (published by RIZIV/INAMI) + SNOMED CT structure the data; the practitioner signs and remains clinically accountable.

3 Share automatically
Conformity is checked, a new version is created, and authorised actors can use it.



Key message

Document once. Reduce shadow workflows. Reduce unmanaged PDF exchange.

What about Artificial Intelligence ?

Dr Benn Gooch, General Practitioner

« I Was an Enthusiastic Early Adopter of AI Scribes. Here's Why I Stopped »

The Notes Weren't Mine

I sat down to review a patient I had seen six weeks previously. I read the note. It was accurate. It was comprehensive. It contained no factual errors that I could identify. And I did not recognise it.

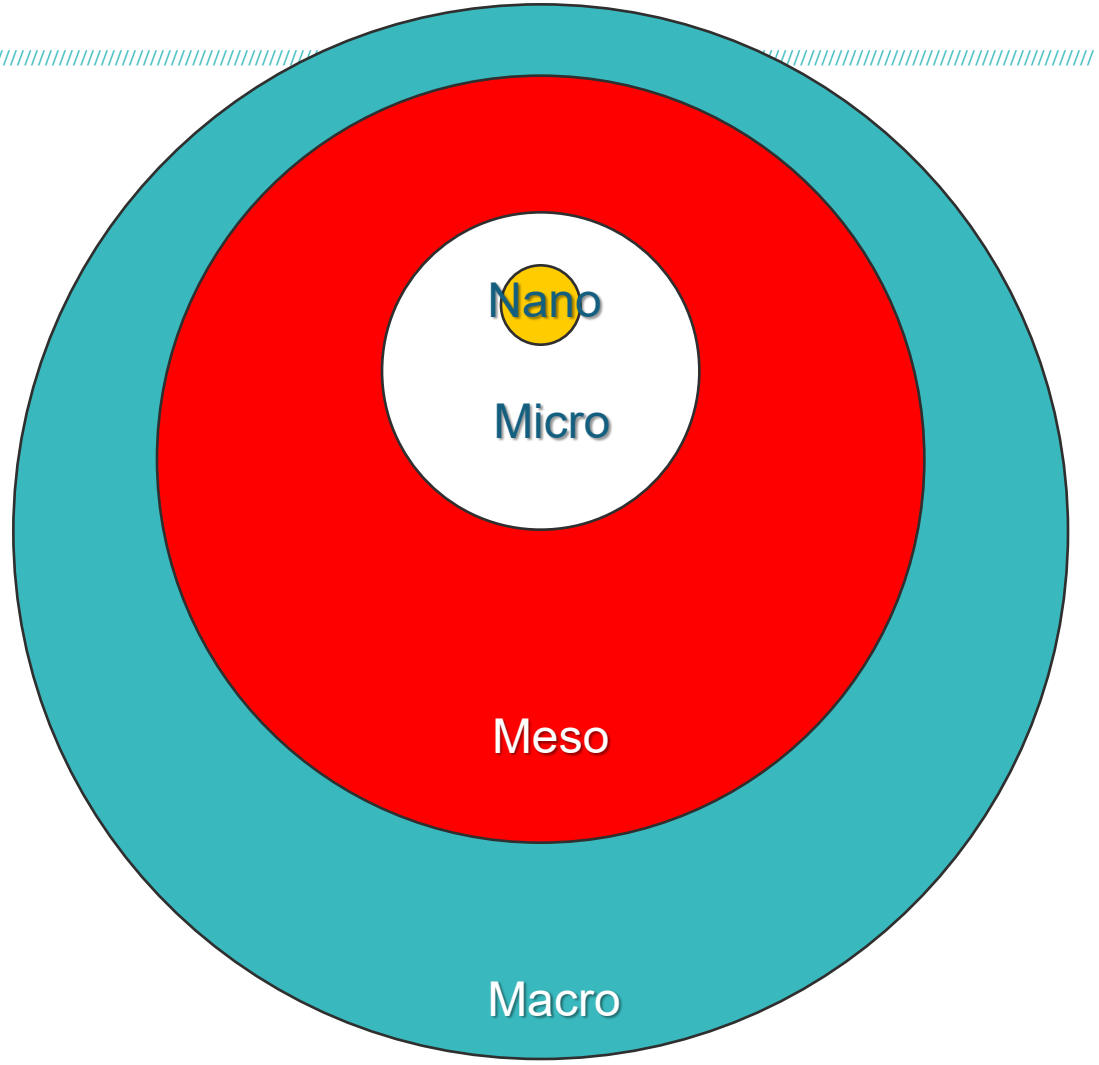
The voice in the note was not my voice. The emphasis was not my emphasis. The clinical narrative — the selective, interpretive story that a GP constructs to capture not just what was said but what mattered, what worried them, what they decided to watch and why — was absent. In its place was a faithful transcription of everything spoken, organised by structure rather than by clinical significance.

I had not written that note. An algorithm had written it, in response to sounds it had heard, and I had approved it, hurriedly, at the end of a session. Now, six weeks later, I was reading someone else's account of a consultation I had conducted — and I couldn't recall the patient clearly enough to reconstruct what had been left out.

Core PHC principles: accessibility, continuity, coordination, equity, person-centeredness,… from conceot to practice and policy.

1. The patient's voice : TRUST
2. What matters to the patient ? Goal-Oriented Care
3. Integrated care requires integrated records for primary and secondary use
4. **PHC approach at nano-, micro-, meso- and macro-level : More than 5 C's ?**
5. **Illustrated with examples from Community Health Centre Botermarkt**


Commitment
Context
Cultural competence
Continuity
Cure
Care
Compassion
Cohesion
Connectedness
Cure
Continuity
Commitment
Community
Cure
Cohesion
Complexity
Context
Cultural competence
Comprehensiveness
Cost-effectiveness
Coordination
Cure
Care
Cultural competence
Context
Confidentiality
Cost-effectiveness
Complexity
Cohesion
Clinical competence


Nano
Micro
Meso
Macro

Nano-level:

The person is the starting point of the process

- Active
- Informed
- Service
- Multicultural





Accessibility

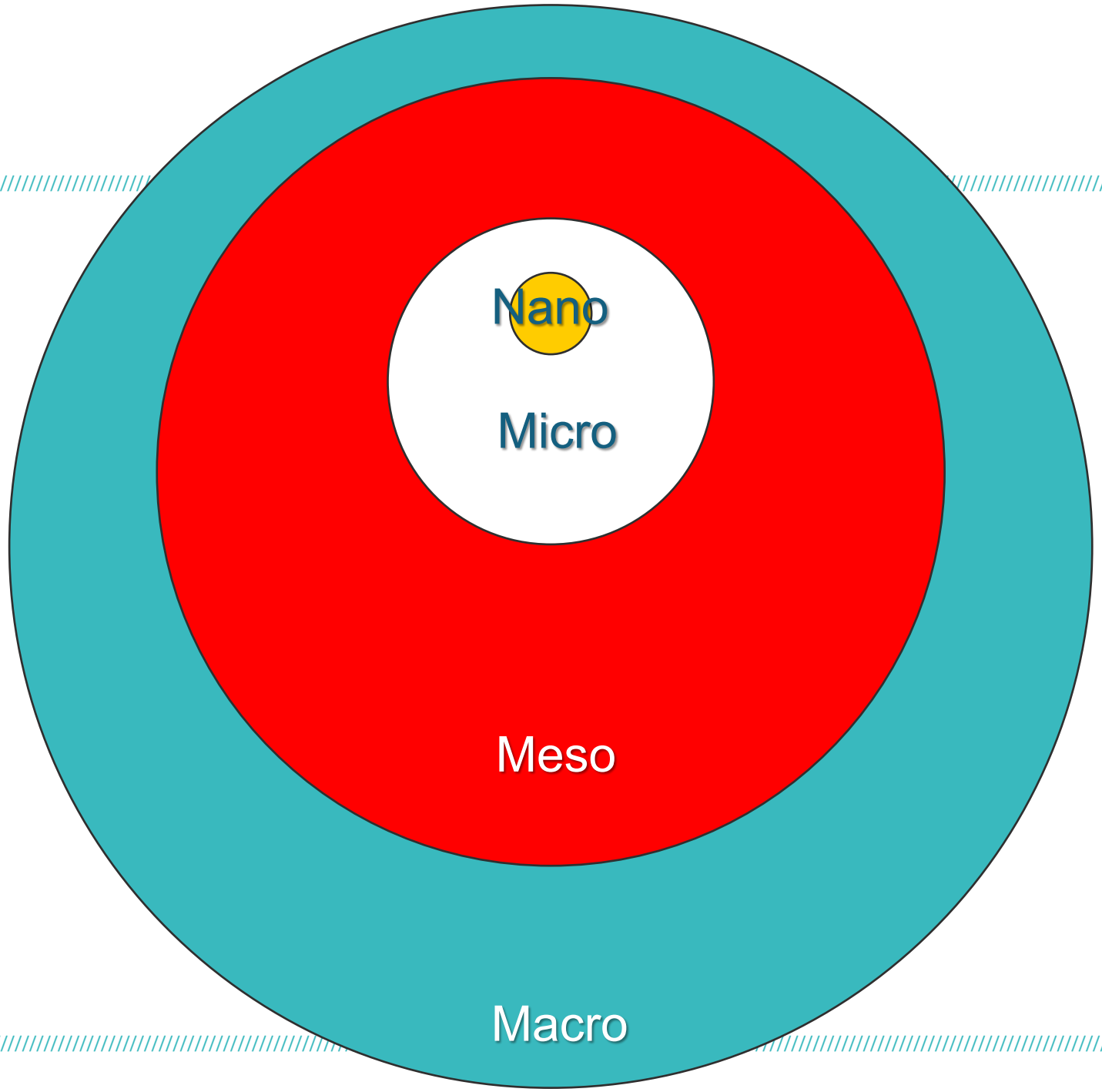
Equity

Characteristics of PHC / patient encounters

- Commitment - Connectedness
- Clinical Competence
- Cultural Competence
- Context
- Comprehensiveness
- Complexity
- Coordination
- Continuity



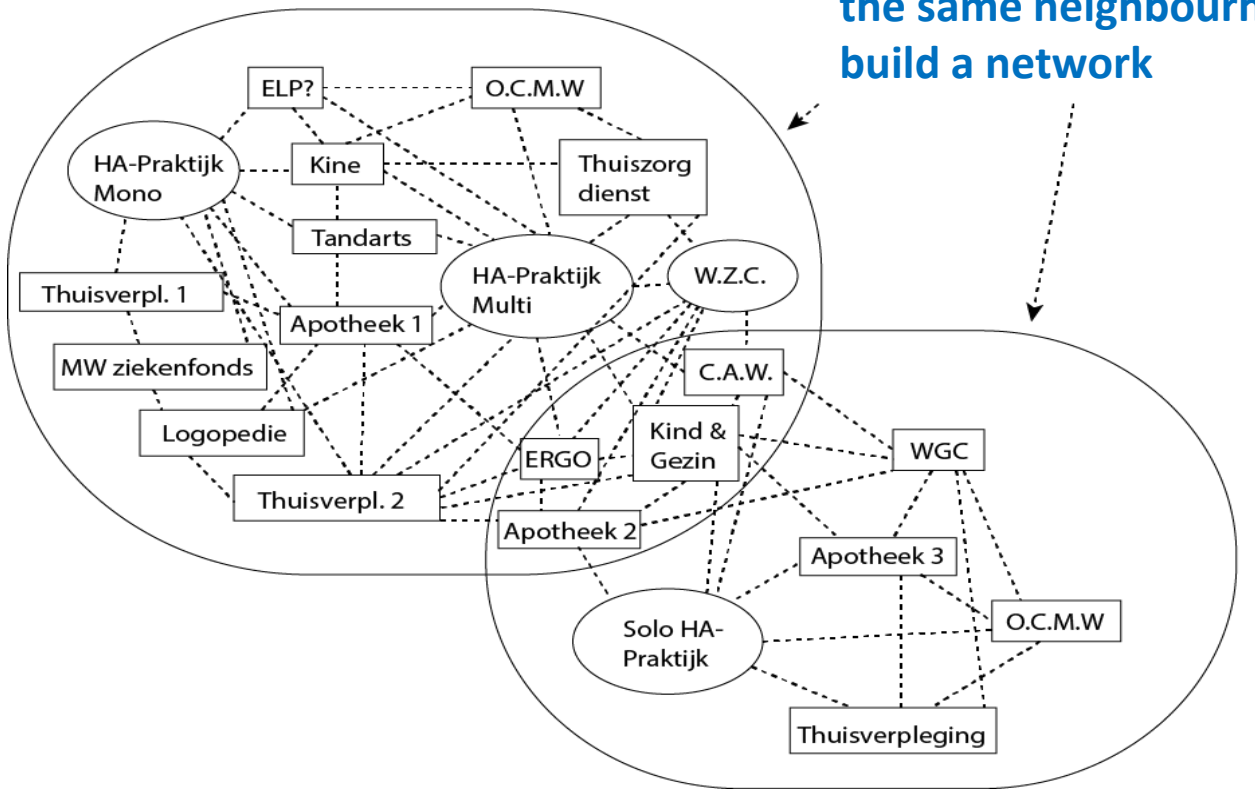
Compassion ↔ Computer


Nano
Micro
Meso
Macro

INNOVATION : PRIMARY CARE NETWORKS: > 5.000 INHABITANTS (RURAL) > 10.000 INHABITANTS (URBAN)

MICRO-level

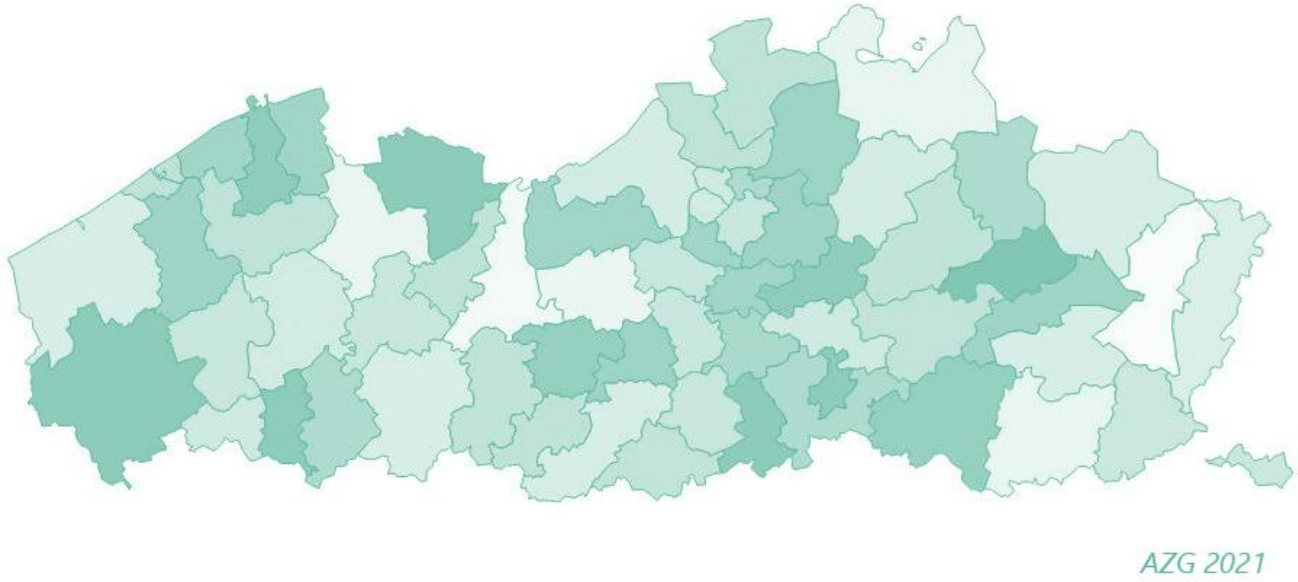
Primary Care Practices in the same neighbourhood build a network



Primary Care Practices:
°Monodisciplinary (FFS)
Multidisciplinary (FFS)
°New Deal practices (Mixed payment) (2024)
°'Medical Homes' and Community Health Centres (Integrated Needs Adjusted Capitation) (1982)

Primary Care Zones (°01/07/2020)

MESO-level



60 Primary Care Zones

- 70.000 to 125.000 inhabitants

Care Council:
-Health Care Providers
-Social Care Providers
-Patients and Informal Care Givers
-Local Authorities

Flemish Institute for Primary Care (Vivel) to support and strengthen Primary Care in Flanders.

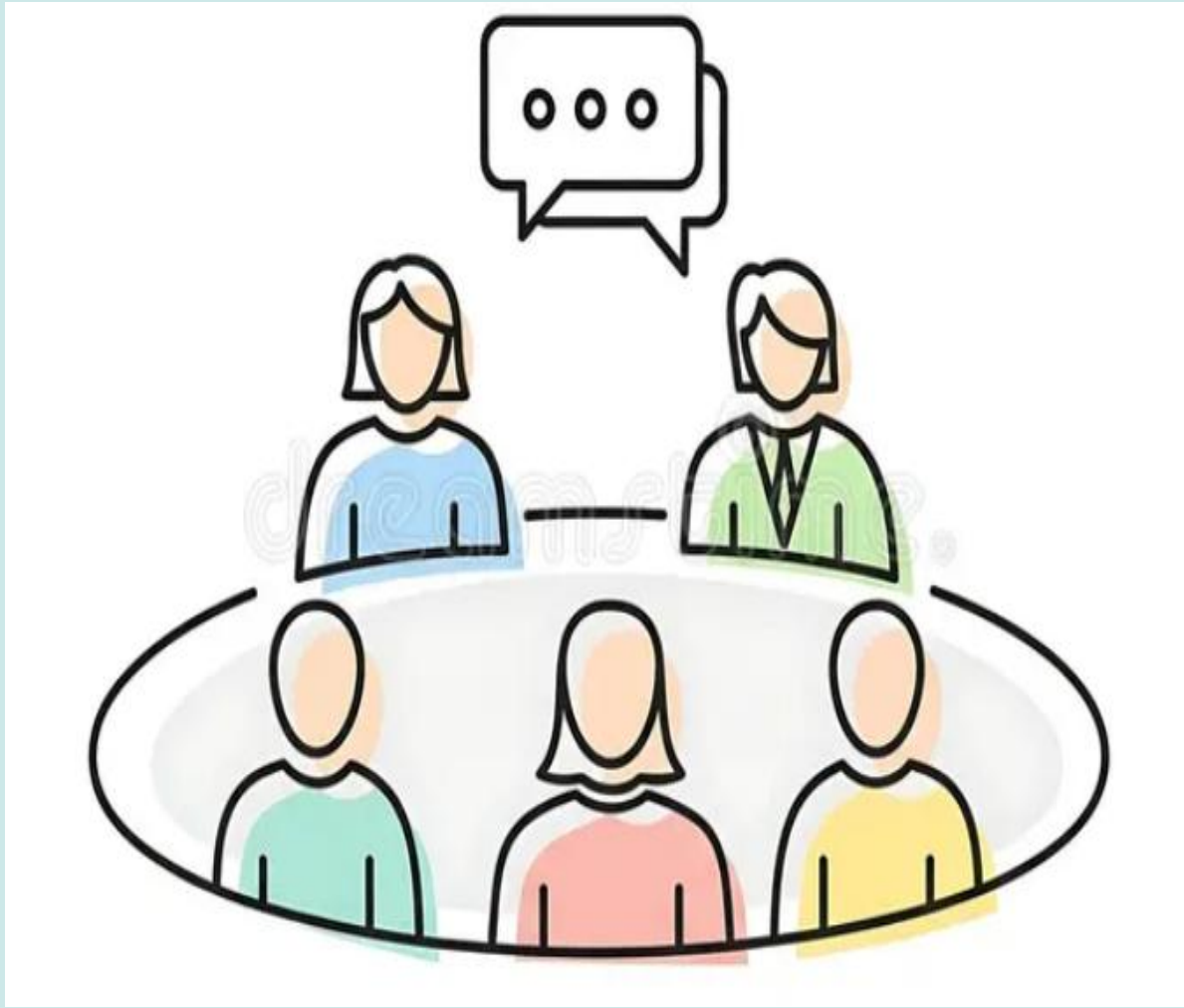
MACRO-level

1. Collecting and analyzing information and data and making these available for the Primary Care.
2. Development of strategies, methodologies and tools to support resilient organisation of Primary Care.
3. Advising, coaching, training and sensibilisation
4. Improving and moniutoring accesibility and quality of Primary Care in Flanders.
5. Implementing the Program on Integrated Care

Problem: 2025 : 50 % reduction of financing for Flemish Institute for Primary Care

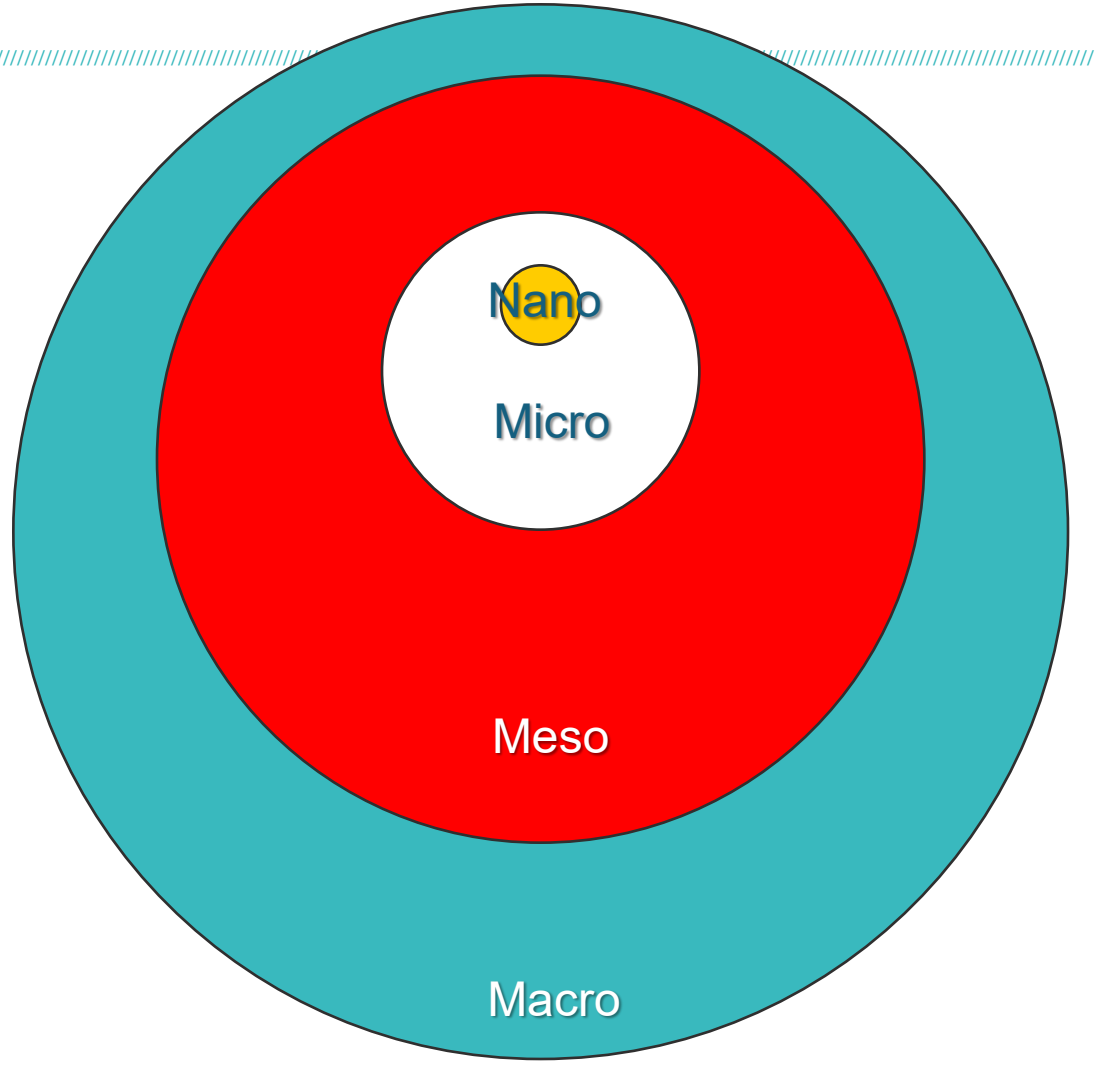
Conclusion: Resilient Primary Care Organisation Models are in place at Nano-, Micro-, Meso- and Macro-level

Questions ?
Reflections ?



Core PHC principles: accessibility, continuity, coordination, equity, person-centeredness,… from conceot to practice and policy.

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2. What matters to the patient ? Goal-Oriented Care
3. Integrated care requires integrated records for primary and secondary use
4. **PHC approach at nano-, micro-, meso- and macro-level : More than 5 C's ?**
5. **Community Health Centre Botermarkt**


Nano
Micro
Meso
Macro

1978: Declaration on PHC in Alma Ata and ….



A view of the auditorium

… 2026 bringing
Declaration back to Almaty
(Office of the WHO
European Centre for PHC)



1978:Start of…Community Health Centre Botermarkt



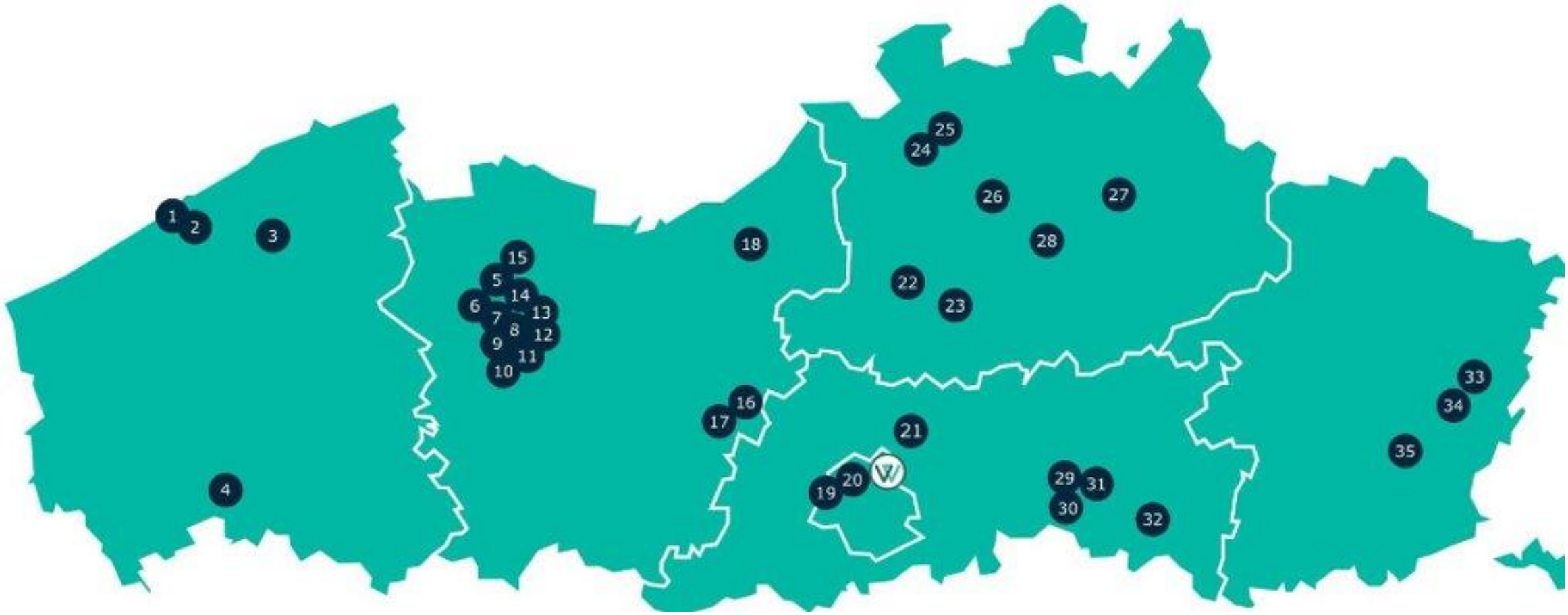


- 1978 family practice in poor neighbourhood
- 1980 first nurse, social worker and foundation of the community health centre, not-for-profit organisation
- 1986 interprofessional team; inter-sectoral platform for health and wellbeing
- 1995 capitation financed system
- 1996 community oriented primary care 1
- 2006 teaching platform Ghent University
- Today: 5900 **citizens from 95 countries**



Community Health Centre
Botermarkt Ledeberg 2006

UNIVERSITEIT GENT



We are a big family

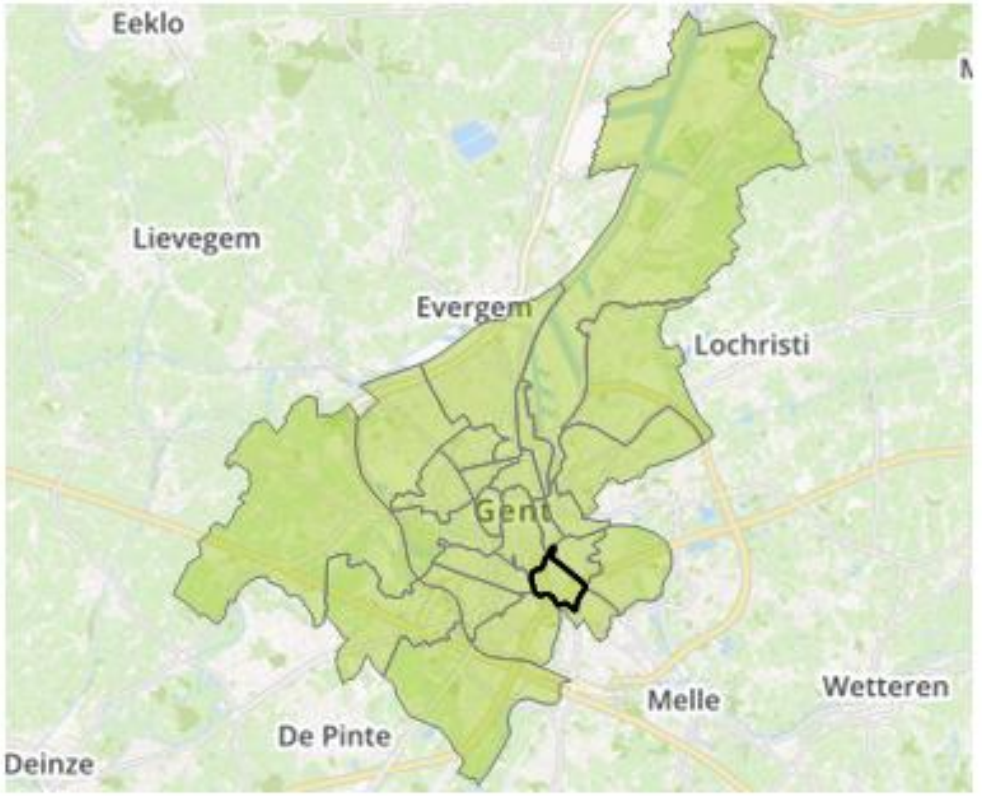
Wijkgezondheidscentrum Botermarkt

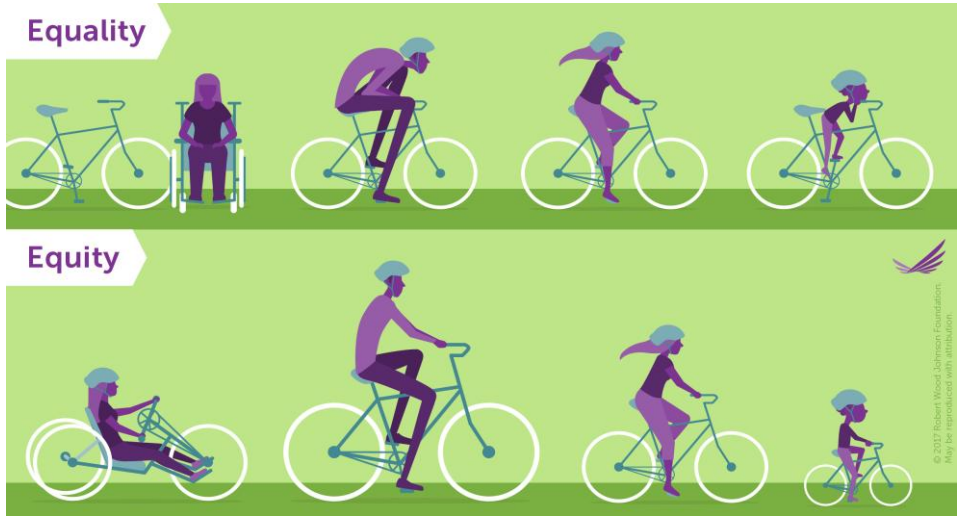
An organisation is not build by bricks, it's build by people. Navigating in a volatile world and leaded by a vision on society and the future

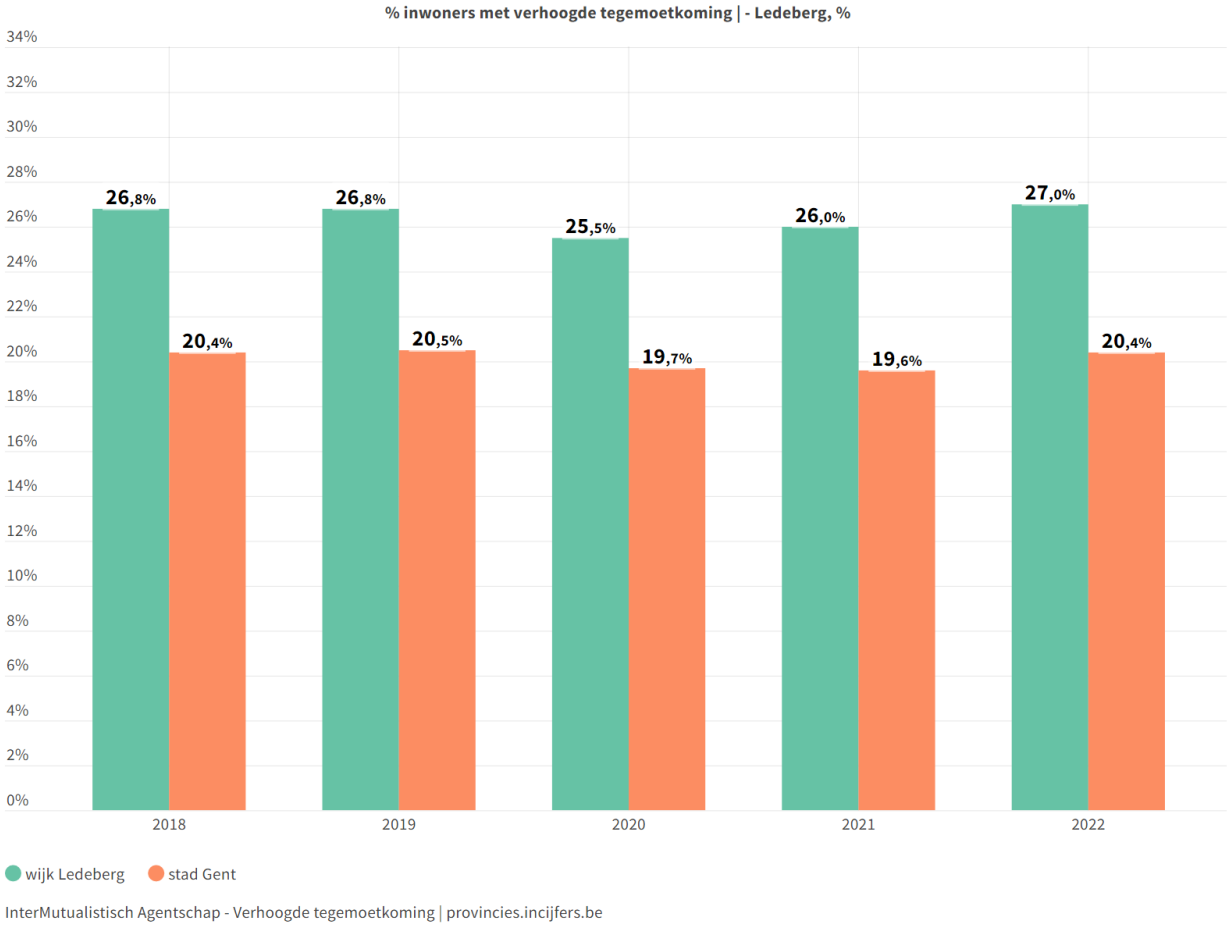


What's in the DNA of a WGC?

- We work in and with the community
- Solidarity & universal proportionalism
- Accessible
- Equity and health promotion







% of people who are entitled to extra reimbursement for health care costs due to a low income

GREEN= Ledeberg
RED = Gent

A challenging neighborhood

A diverse neighborhood

Aandeel inwoners met niet-Belgische herkomst



47,7%

Ledeberg



38,8%

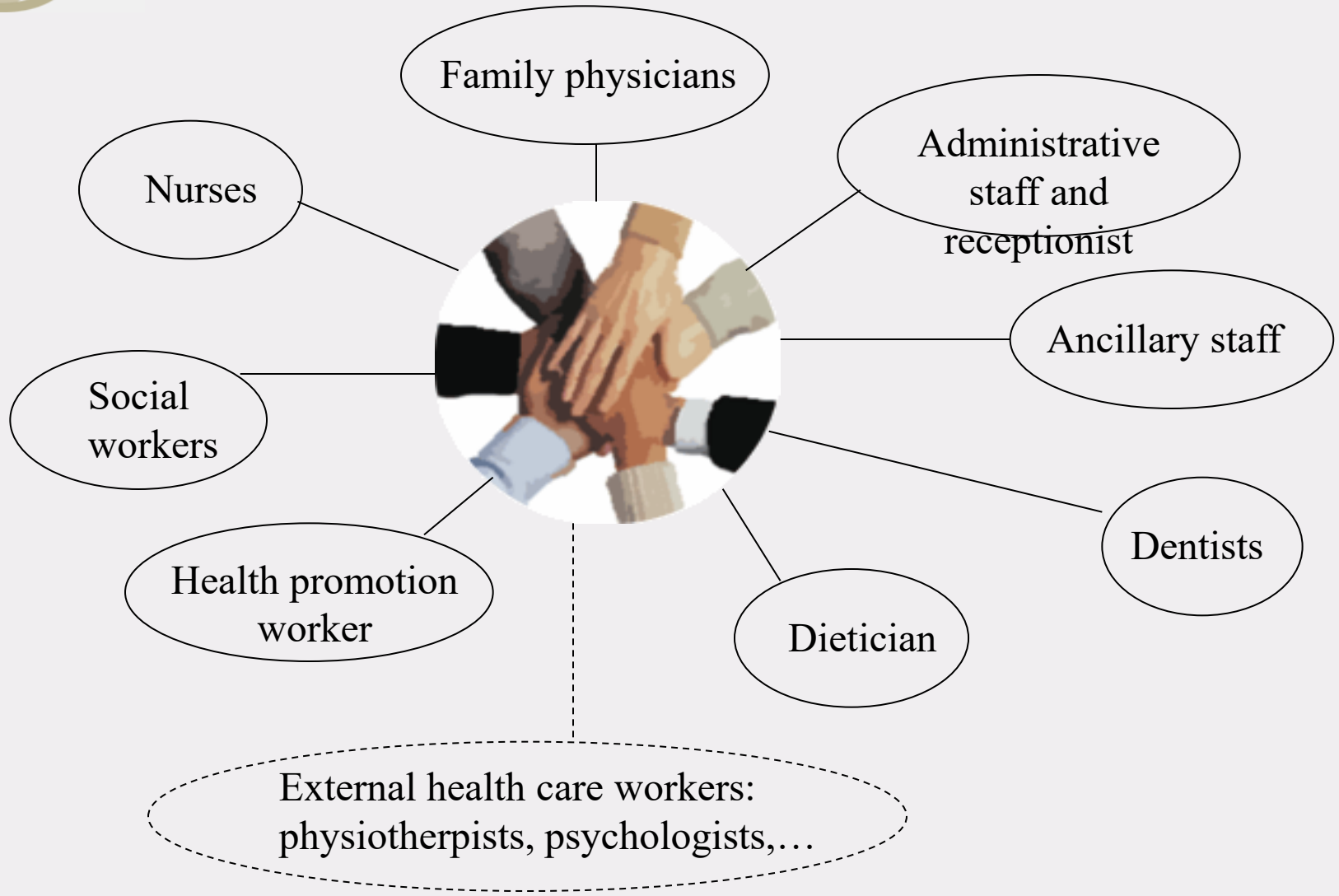
Gent



Community Health Center Botermarkt Ledeberg!

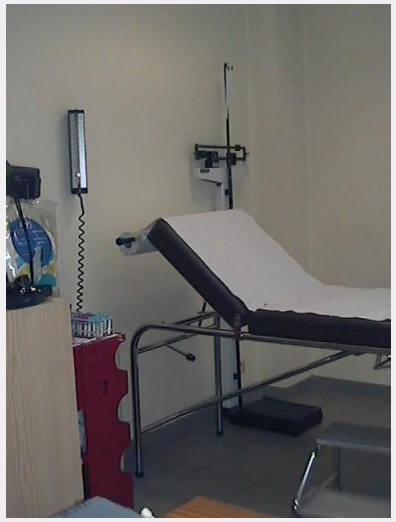
Botermarkt
wijkgezondheidscentrum vzw

INTERDISCPLINARY TEAM



Botermarkt
wijkgezondheidscentrum vzw

Family Physicians



- During the day 08.00-19.00
  - Consultations and appointments
  - Home visits (<10%)
- At night (from 19.00 until 08.00):
  - Organised night-duty with all FPs in Ghent
- During the weekend (Friday 18.00 pm to Mo 08.00 a.m.):
  - One “on call” FP-posts per 150.000 inhabitants in Ghent-region

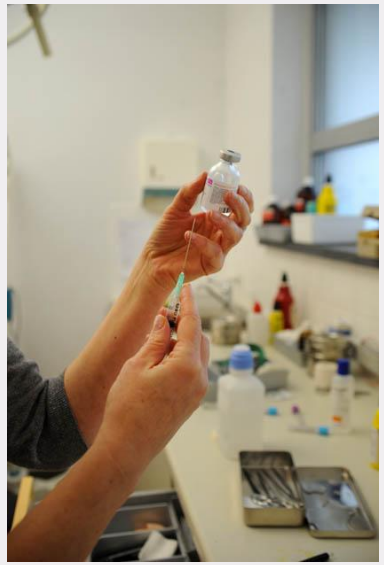
Botermarkt
wijkgezondheidscentrum vzw

Nursing

- Appointments
  - Immediate (walk-ins) appointments available: care substitution
- Home care for vulnerable patients with mobility limitations

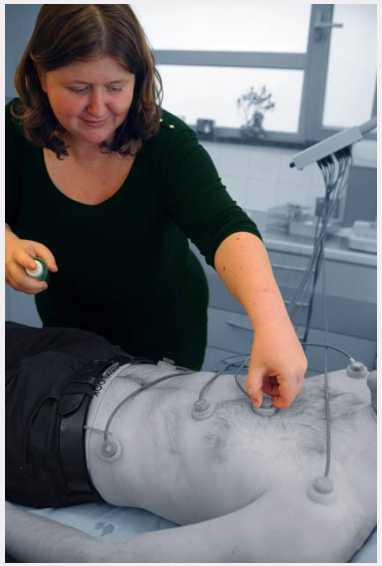






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wijkgezondheidscentrum vzw

Nursing Responsibilities



- **Curative care**: wound care, ear irrigation, wart treatments, palliative care,…
- **Prevention**: flu/Covid vaccinations, contraceptive injection…
- **Diagnostic Procedures**: ECG, blood tests, spirometry, …



Empowerment: Diabetes Clinic, inhaler-training appointments





Botermarkt
wijkgezondheidscentrum vzw



2006: Accessible Dental Care and Oral Hygiene

Botermarkt
wijkgezondheidscentrum vzw

Care Substitution

Care is provided by the person most equipped for the task and most knowledgeable about the subject. Subsidiarity is the principle!







Botermarkt
wijkgezondheidscentrum vzw

Social Work



- 2 FTE social workers
- Social work in the health centre includes :
  - first intake, exploring the problem
  - information and counseling
  - advocating, mediating
  - supporting, psychosocial guidance
  - undocumented residents
  - administrative support, application for allowances, budget-planning
  - establishing patient centered networks of care

Health promotion and social work in WGC Botermarkt

- Network with professionals in the neigbourhoud
- Make connection with residents in the neigbourhoud
- Be a co-workerof the multidisciplinary team of the Botermarkt
- Mandating in Ghent policy meetings

- GOAL: be aware of the signals about needs in the neigbourhoud
  - Take action
  - Advocate for the social and health rights of the most vulnerable people

Botermarkt
wijkgezondheidscentrum vzw

Integrated care

- Comprehensive goal-oriented approach!
- Taking environment/context at home into account!
- Coordination by patient, informal care-givers, professional







Botermark
wijkgez





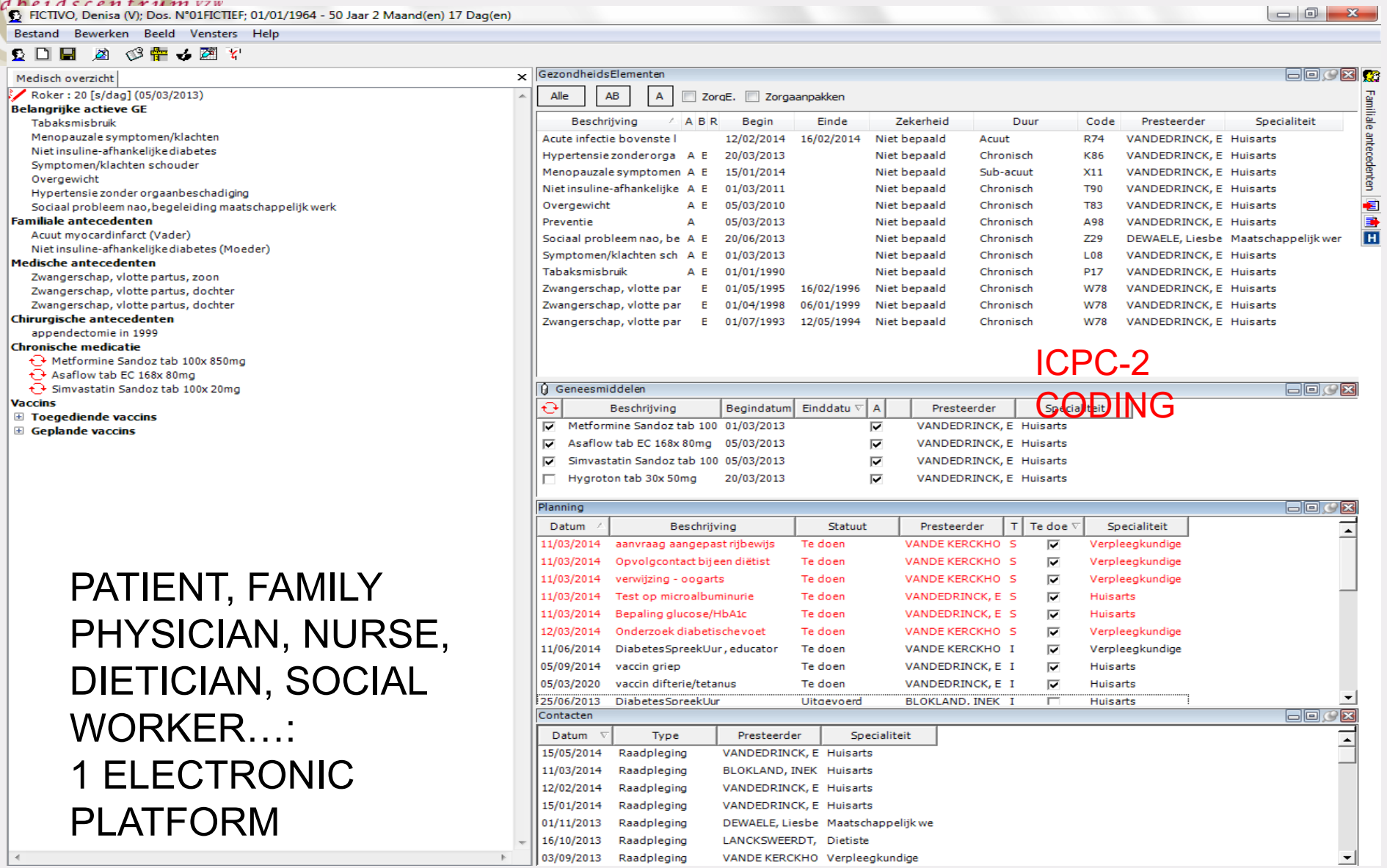
INTERPROFESSIONAL DISCUSSION



NURSING TEAM: PLANNING MEETING

Botermarkt
wijkgezondheidscentrum vzw

Shared Electronic Patient Record



ICPC-2 CODING

PATIENT, FAMILY PHYSICIAN, NURSE, DIETICIAN, SOCIAL WORKER…:
1 ELECTRONIC PLATFORM

Botermarkt
wijkgezondheidscentrum vzw

• Diabetes clinic: empowerment

- Programme:
  - Contact with family physician: 1 x /year; biomedical and behavioural follow-up by the nurse: 4 x /year, following specific guidelines
  - contact with dietician/diabetes educator (2 x / year)
  - enabling patients to exchange experiences via group activities
  - “diabetes-cooking” (3 x / year)





Botermark
wijkgeze

Ledeberg beweegt!

LEDEBERG MOVES!



Various activities

- Zumba
- Sport after school
- Learning to cycle
- …







Consolation spot

LEDEBERG

GENT

History

- Mourning is universal
- Often hidden for others, social isolation
- Medicalisation <--> normalisation
- 'How To?'

- We need a public space
- We need a partnership with citizens and healtcareworkers



It's a process with the community

- We will continue to build on this with the residents of the neighbourhood:
- A walkabout, guided by professionals and voluntary residents.
- "road signs' with QR codes > everybody can do the walk on their own.
- Residents tell their story in a podcast: Why are they mourning?
  - Lost a child, suicide
  - Lost a partner, cancer
  - Have to cope with depression, difficult family history
  - Have to cope with alcohol addiction, is ashamed
  - Lost a father as baby, has no memories of him. But older siblings have them so vivid... She does not feel whole.

EDITORIAL

Time to Do the Right Thing: End Fee-for-Service for Primary Care

Michael K. Magill, MD

Department of Family and Preventive Medicine, University of Utah School of Medicine, Salt Lake City, Utah

Ann Fam Med 2016;14:400-401. doi: 10.1370/afm.1977.

You can always count on Americans to do the right thing - after they've tried everything else.

-Winston Churchill

Current fee-for-service (FFS) payment rates for physician visits trace to the origins of Blue Cross Blue Shield insurance in the 1930s. At that time, rates were set that paid generously for hospitalizations and for procedures, such as surgery.[1,2] Payments for so-called "cognitive services" were lower per minute of physician time. This disparity has been perpetuated since the 1980s in the calculation of rates set by the Centers for Medicare & Medicaid Services (CMS), based on "Relative Value Units," for payment of the Evaluation and Management codes most often billed by primary care physicians.[3] Despite recognition by the Medicare Payment Advisory Commission (MedPAC)[4] and others[5] of the adverse effects of inadequate payment for primary care, only limited progress has been made toward correction of the disparity. This may be due, at least in part, to treatment of total payment for physicians as a zero-beginning in 1945[8] and expanded in the Health Maintenance Organizations (HMOs) of the 1980s and 1990s.[9] Following collapse of many of the HMOs, payers have experimented with multiple smaller changes in payment models, mostly incremental adjustments to existing FFS, perpetuating structural disadvantages for primary care.

In this issue of the *Annals*, Basu, et al report on their study in which they calculated potential effects on primary care practice costs and revenue resulting from 3 modifications of FFS payment: increased FFS, traditional FFS plus per-member per-month (PMPM), and traditional FFS plus PMPM plus pay-for-performance (P4P).[10] The authors drew on extensive published literature about how primary care practices can staff and organize to deliver patient-centered medical home (PCMH) services such as enhanced access, care management, and alternative visits, and the impact of these changes on revenue and expense within the practices. The authors created simulated models of these financial effects based on detailed profiles of patient demographics, insurance coverage, and disease burden. They conducted tens of

How to finance community-oriented primary care ?

=> Integrated Needs-Adjusted Capitation

The integrated needs-based mixed capitation system:

- stimulates prevention, health promotion and self-reliance of the people,
- as there is a global payment for all disciplines, there is an incentive to task-shifting and subsidiarity,
- prevents risk selection
- stimulates a global approach to a broad range of problems, avoiding the fragmentation and disease-orientation

The “needs-variables”

- Demographic variables
- Social-economic variables
- Morbidity variables
- Contextual variables

“The CHC receives every month an integrated capitation per patient on the list, reflecting the average of the needs of the patient in the centre.”

Challenge for the future

- More participation of residents in the neighborhood
  - Communication
  - Maintenance
  - Organize walkabouts
  - Other creative ideas
- Finding funding for materials and personnel
- Building a Primary Care Network Ledeberg



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Contact

wijkgezondheidscentrum
Botermarkt

WHOCC on Family Medicine and PHC-Ghent University (since 2010)

- Multidisciplinary team working on research, education and policy

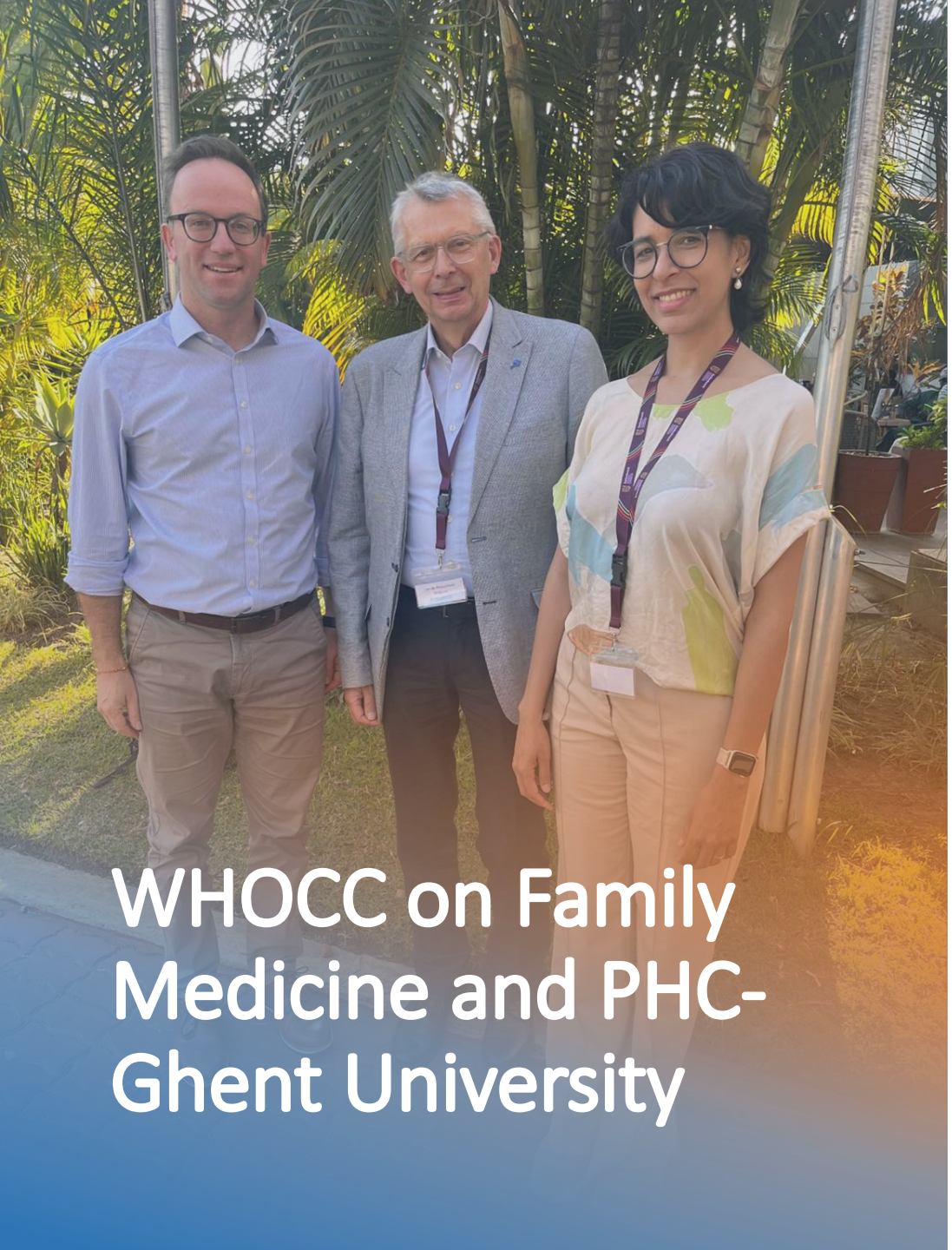
- Head Prof Em. Jan De Maeseneer
- Director Prof. Oliver Van Hecke
- Coordinator Bianca Silva

DEPARTMENT OF PUBLIC HEALTH AND PRIMARY CARE

WHO Collaborating Centre
Family Medicine and Primary Health Care

GHENT UNIVERSITY





WHOCC on Family Medicine and PHC- Ghent University

- Members:
  - Prof em. Jan de Maeseneer,MD,PhD (Head)
  - Prof. Oliver Van Hecke MD, DPhil
  - Sara Willems, MA, PhD
  - Pauline Boeckxstaens, MD, PhD
  - Peter Pype, MD, PhD
  - Peter Decat, MD, PhD
  - Veerle Vyncke, MA, PhD
  - Diego Schrans, MD, PhD
  - Charlotte Scheerens, MA, PhD
  - Bianca De Sá e Silva, MD

- Department of Public Health and Primary Care
  - Unit Family Medicine
  - Diverse expertise in the unit and the broader department
  - ICRH, WHOCC on Sexual and Reproductive Health

Terms of Reference and activities

TOR 1 To support WHO's development of global goods (norms, standards, guidelines) on primary care and family medicine.	• Public health intervention evaluation and healthcare classification system implementation.
TOR 2 To contribute to knowledge generation and management in the area of public health services, primary care and their integration under WHO leadership.	• Strengthen the evidence base and knowledge management for PHC.
TOR 3 To provide technical assistance at the request of WHO to promote primary care-based health systems, as appropriate at regional or country level.	• Participate in network of PHC collaborating centres.
TOR 4 To assist WHO by providing expertise to enhance the competencies of family physicians and interprofessional cooperation in primary care globally.	• Technical input for WHO support to Member States engaged in PHC reform or strengthening.

DEPARTMENT OF PUBLIC HEALTH AND PRIMARY CARE

WHO Collaborating Centre
Family Medicine and Primary Health Care

GHENT UNIVERSITY

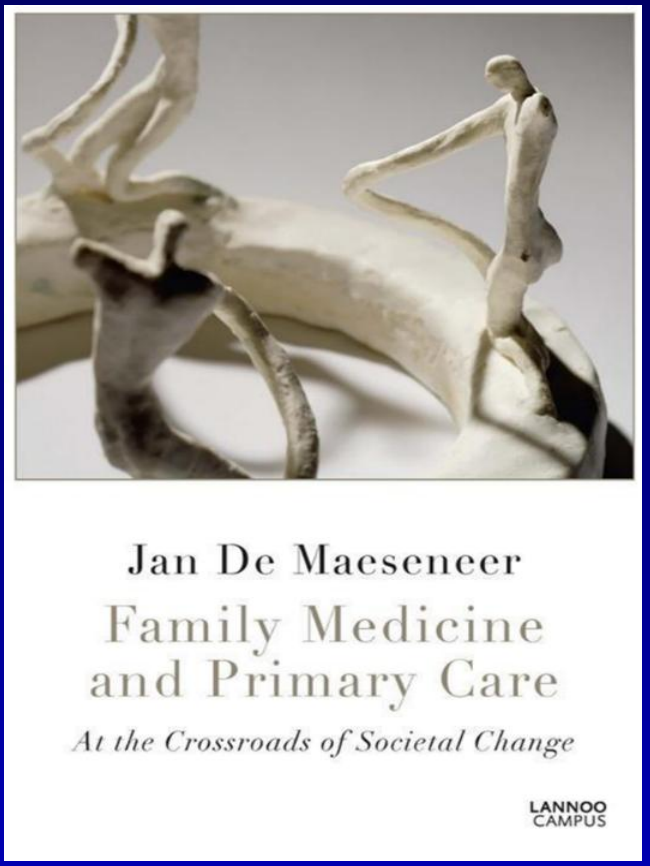
Contact:

jan.demaeseneer@ugent.be

Family Medicine and Primary Care at the Crossroads of Societal Change

At:
https://www.bol.com/nl/nl/p/family-medicine-and-primary-care/9300000272034074/
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or:
https://books.google.be/books/about/Family_Medicine_and_Primary_Care.html?id=TArOEQAAQBAJ&redir_esc=y

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