INTEGRATED CARE IN BELGIUM

Connecting the dots

Health care - Social care - Daily life

CHRISTELIJKE MUTUALITEIT

Study visit | Brussels
22 October 2026

NAOMI AERTS

My background and perspective

Clinical practice • Implementation research • Social care policy

CLINICAL FOUNDATION

Nursing background

- Nurse by background
- Master’s degree in Nursing and Midwifery

RESEARCH FOUNDATION

Implementation research

- PhD in Medical Sciences, University of Antwerp
- Prevention in primary care and community settings
- SPICES Horizon 2020 project

POLICY & SOCIAL CARE

Current role at CM

- Staff Member for Well-being and Integrated Care
- Integrated-care policy and implementation (Focus on Flanders)
- Particular focus on the actor role of CM Social Work Services (DMW)

Our guiding question

> ***How can a fragmented system organise care and support around what matters to people?***

Health care • Social care • Daily life

What we will cover

1. Why integrated care is needed in Belgium
2. Integrated care in the Belgian context
3. Shift from pilot projects to structural policy
4. The Flemish translation of integrated care
5. The role of health insurance fund CM and its Social Work Services (DMW)
6. Opportunities, challenges and mutual learning

One message to remember

> **Integrated care is not primarily about creating new services. It is about connecting existing expertise around the goals and needs of the person.**

Recognize • Connect • Strengthen • Sustain

01

Why integrated care?

People’s lives do not follow professional, organisational or institutional boundaries.



The challenge in numbers

Belgium faces a high burden of chronic disease, population ageing and persistent health inequalities

2019

Nearly 90%

of deaths are caused by noncommunicable diseases

40% are linked to modifiable risk factors

2018

29.3%

reported a chronic condition

15.2% reported multimorbidity

2026

20.7%

of Belgium's population is aged 65+

22.1% in Flanders

2020

9.3 years

life-expectancy gap between the highest and lowest socioeconomic groups

6.3 years among women

The challenge is not only to treat more illness, but to prevent it, address unequal living conditions and organize coherent support across sectors.

Why change is needed

Complex needs

Chronic conditions, multimorbidity and social needs often interact across several life domains

Fragmentation

Care and support are divided across professions, organizations and authorities

Transitions

Continuity is vulnerable between home environment, primary care, hospitals,...

Workforce pressure

Staff shortages require better coordination and smarter use of professional expertise

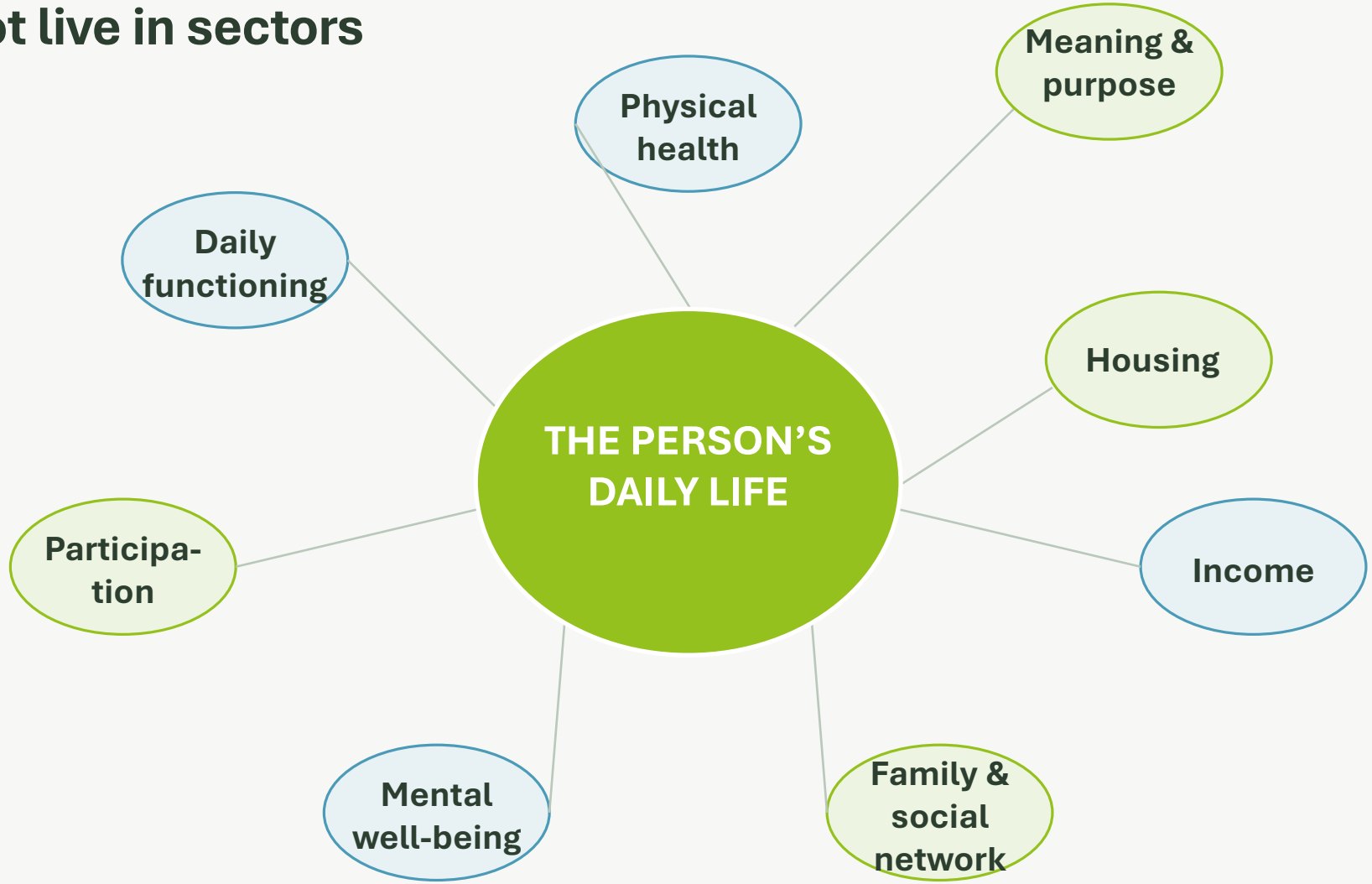
Financial pressure

Resources must be used appropriately without reducing accessibility

Participation

People aught to be partners in decisions about their lives and care

People do not live in sectors



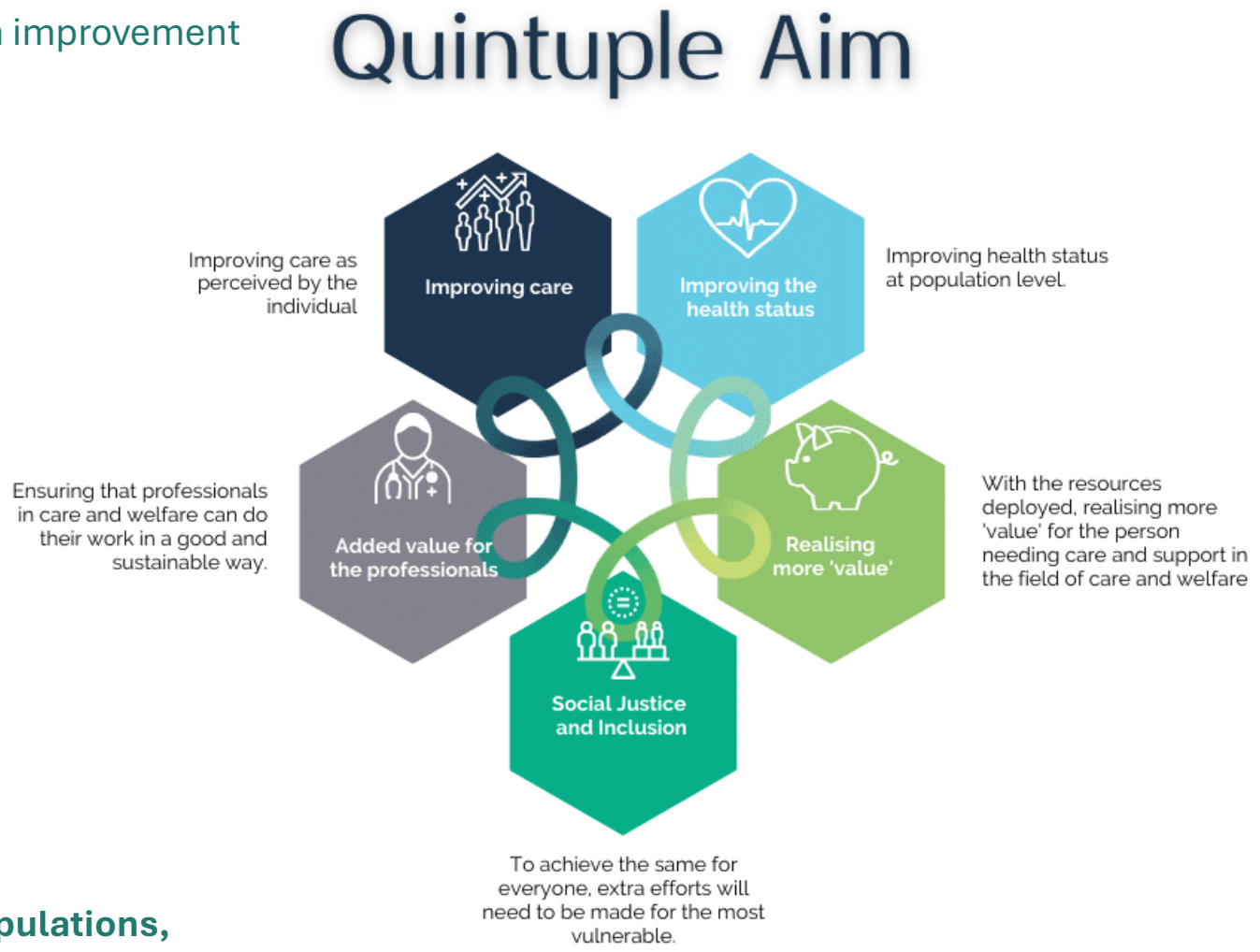

SPECIALIST CARE TREATMENT
SPECIALIST HOSPITALS
LOCAL AMBULANCE SERVICES
CONSULTANT
MATERNITY SERVICES
RURAL HOSPITALS & COMMUNITY HUBS
QUICK ACCESS ACUTE SERVICES
MORE LOCAL SERVICES
CLEAN AIR & WATER
DENTAL
CONNECTED COMMUNITIES
TECHNOLOGY
LNC
DIRECT ACCESS
PEOPLE CENTRED
YOUR HEALTH
FAST TRACK
LIBRARY
VOLUNTEER SERVICES
HOME
PATIENT PARTNERSHIP
COMMUNITY MENTAL HEALTH
SPECIALIST MENTAL HEALTH
LEARNING
REHAB AND RESTORATIVE SUPPORT
ACTIVITY
URGENT GP SERVICES
PUBLIC TRANSPORT
HOME BASED SUPPORT
WHANAU ORA
PEER-LED SERVICES
ADVICE
CHILDREN'S SERVICES
SUPPORTED SELF MANAGEMENT
SCHOOL BASED SERVICES
LAB SERVICES
PHARMACY
COMMUNITY REFERRED RADIOLOGY
GENERAL PRACTICE
COMMUNITY NURSING
WELL BEING
24/7 URGENT CARE CENTRE
INTEGRATED HEALTH AND SOCIAL SERVICES
BASED ON THE KING'S FUND VISUALISATION
our health system

Integrated care is a means, not the final goal

The Quintuple Aim provides a shared direction for system improvement

THE QUINTUPLE AIM

- Better experience of care and support
- Better population health outcomes
- More value from available resources
- Better well-being of health and social care professionals
- Greater health equity



Integrated care should create value for people, populations, professionals and society.

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.

A working definition

> “Care and support organized around the person’s goals and multidimensional needs, through coordinated collaboration across professions, organizations, settings and sectors.

PERSON-CENTRED • GOAL-ORIENTED • COORDINATED • CONTINUOUS • CROSS-SECTORAL

02

Belgian context

Integrated care in a system with divided (shared) responsibilities.



Shared policy responsibilities

A functional map of the Belgian context for integrated care

Federal level

- Mandatory health insurance and reimbursement
- Hospitals and healthcare professions
- Federal care programs and national agreements

Federated entities

- Prevention, welfare and primary care organization
- Community-based and long-term support
- Implementation adapted to each entity

Territorial and local implementation

- Primary Care Zones and Care Councils
- Local authorities and regional networks
- Health, social care and community organizations

ACTORS WORKING ACROSS THESE LEVELS

health insurance funds • providers • hospitals • social services • local authorities • community organizations

No single level can organize integrated care on its own.

Why “interfederal” matters

Integration is needed across all levels of government, as well as across professional disciplines.

> **Healthcare responsibilities are divided. People’s needs are not.**

Shared direction
Common vision, language and priorities

Agreements across authorities
Governance, roles and implementation

Health & social care
Coordination across sectors and settings

Legal and digital foundations
Purposeful data sharing and interoperability

Aligned financing
Resources for coordination and continuity

Integrated pathways cross financing boundaries

One care and support pathway may involve professionals and organizations financed by different authorities

FEDERAL HEALTHCARE FINANCING

- Healthcare professions under federal health-insurance legislation
- Medical and paramedical services
- Hospitals and specific federal programs
- Reimbursement through mandatory health insurance



FLEMISH CARE AND WELFARE FINANCING

- Welfare and social care providers
- Community initiatives and long-term support
- Primary care organization and local implementation
- Flemish welfare and social care financing mechanisms

Shared program | **Shared roles** | **Shared information** | **Coordinated payment rules** | **Prevent double financing**

Who pays depends partly on which professional or organization performs the role. Integrated care therefore requires agreements across financing systems.

Why integration is difficult in Belgium

The system was not originally designed for continuous, cross-sectoral care

1 Acute and episodic orientation

Care has traditionally been organized around separate episodes of illness and treatment.

2 Fee-for-service financing

Payment mainly rewards individual activities rather than coordination, prevention and continuity.

3 Fragmented governance

Responsibilities for health care, social care and support are divided across authorities and sectors.

4 Unclear territorial responsibility

No single actor has traditionally been accountable for the needs of a defined population.

KCE PRIORITIES FOR FURTHER DEVELOPMENT

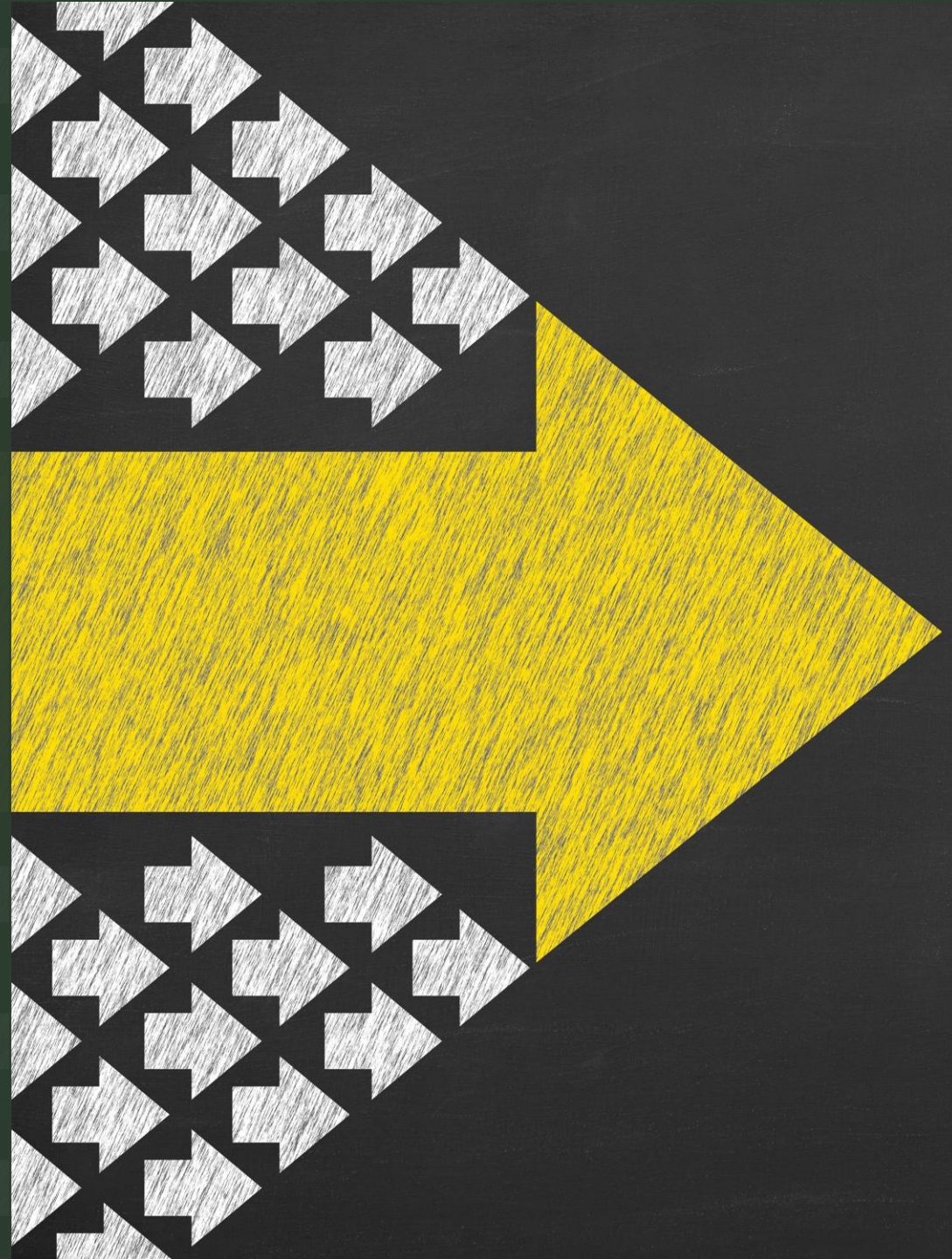
Political framework	Defined territories	Financing reform
Clear and sustained direction	Meaningful geographical areas for population responsibility and collaboration	Support coordination and continuity

These system conditions help explain the shift from temporary projects to structural policy.

03

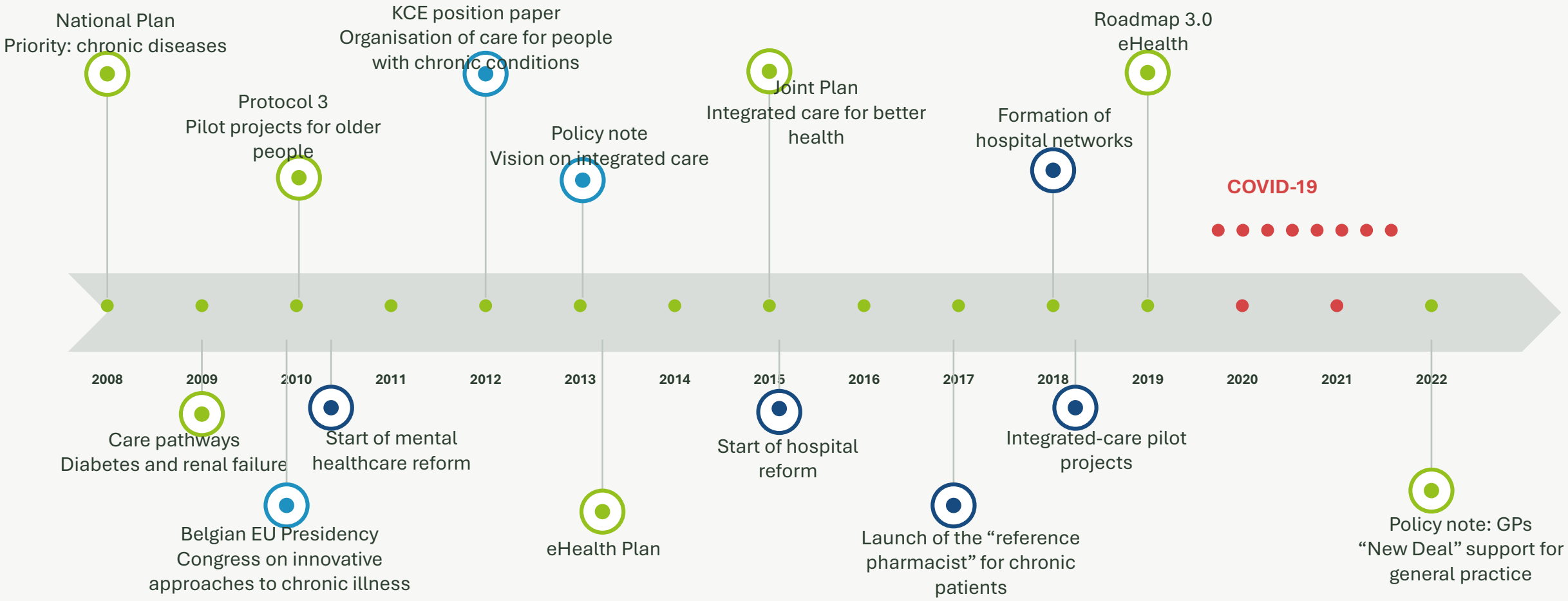
From projects to structural policy

Belgium is moving from temporary experimentation towards progressive structural implementation.



Before the Interfederal Plan: integrated care at federal level

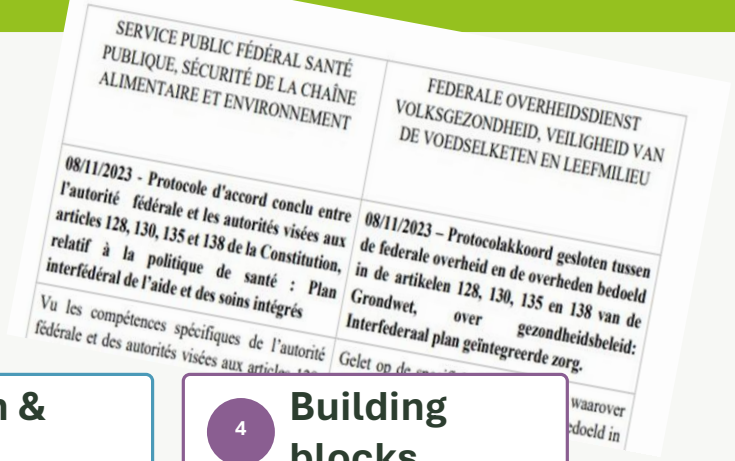
2008-2022 - A decade of plans, reforms and pilot projects — but limited structural integration



The crucial lesson: Belgium generated experience through successive reforms and pilots, but structural integration remained unfinished.

8 November 2023: a shared Interfederal Plan

From fragmented initiatives to a common framework for structural implementation


SERVICE PUBLIC FÉDÉRAL SANTÉ PUBLIQUE, SÉCURITÉ DE LA CHAÎNE ALIMENTAIRE ET ENVIRONNEMENT

FEDERALE OVERHEIDSDIENST VOLKSGEZONDHEID, VEILIGHEID VAN DE VOEDSELKETEN EN LEEFMILIEU

08/11/2023 - Protocole d'accord conclu entre l'autorité fédérale et les autorités visées aux articles 128, 130, 135 et 138 de la Constitution, relatif à la politique de santé : Plan interfédéral de l'aide et des soins intégrés

08/11/2023 – Protocolakkoord gesloten tussen de federale overheid en de overheden bedoeld in de artikelen 128, 130, 135 en 138 van de Grondwet, over gezondheidsbeleid: Interfederaal plan geïntegreerde zorg.

Vu les compétences spécifiques de l'autorité fédérale et des autorités visées aux article

Gelet op de

waarover

bedoeld in

PROTOCOL AGREEMENT

8 NOVEMBER 2023

Purpose

Organize broad and sustainable implementation of integrated care in Belgium through structural collaboration at macro level.

Federal government + federated entities

Eight shared commitments

1 Shared framework

Common vision and language

2 Governance

Structural interfederal collaboration

3 Person & goals

Person- and goal-oriented care

4 Building blocks

Common concepts and functions

5 Meso level

Strong and accountable implementation

6 Good practices

Sustainable structural embedding

7 Digitalization & population management

Data, tools and population approaches

8 Financing

Models that support integration

The plan formalizes a shared long-term direction and creates the basis for translating integrated care into practice.

2024–2026 | Progressive implementation

From a population-wide ambition to three priority application areas

The plan concerns the whole population, but implementation starts in phases

BELGIAN POPULATION — **Phased implementation through application areas proportionate to available and agreed resources.**

1 Perinatal care

Pregnant women, children and families during the first 1,000 days

IMPLEMENTATION UNDERWAY

- First interfederal program
- Health + psychosocial support

2 Vulnerable persons

People with interacting health, functioning and social-support needs

UNDER DEVELOPMENT

- Broad application area
- Flemish focus: vulnerable older people and people with dementia

3 Childhood obesity

Children and adolescents: prevention and integrated treatment

UNDER DEVELOPMENT

- Context-oriented, interdisciplinary approach
- Links prevention, care and daily life

These areas provide practical settings for developing generic building blocks: care coordination, case management, data sharing and co-financing.

Federal programs and reforms

The Interfederal Plan is the shared framework, but it is not the only federal route towards more integrated care

INTERFEDERAL PROGRAMS

Perinatal care
Vulnerable persons
Childhood and adolescent obesity

NATIONAL DISEASE-SPECIFIC PLANS

Rare Diseases Plan 2026–2030
Cancer Plan 2026–2036
Integrated pathways around specialized expertise



PILOT PROGRAMS & federal reforms

Protocol 3 and ZP3 projects
Chronic-care pilots
‘New Deal’ for general practice
Mental health reform

COORDINATION INITIATIVES

Patient associations
Pathology-specific case management
Hospital and territorial navigation models

POLICY CHALLENGE **Connecting these developments into one coherent, needs-based system instead of adding parallel pathways.**

Three connected levels

MICRO | Around the person

Goals • care team • care plan • early detection • coordination • case management

MESO | Local and regional

Networks • implementation • population management • monitoring • learning

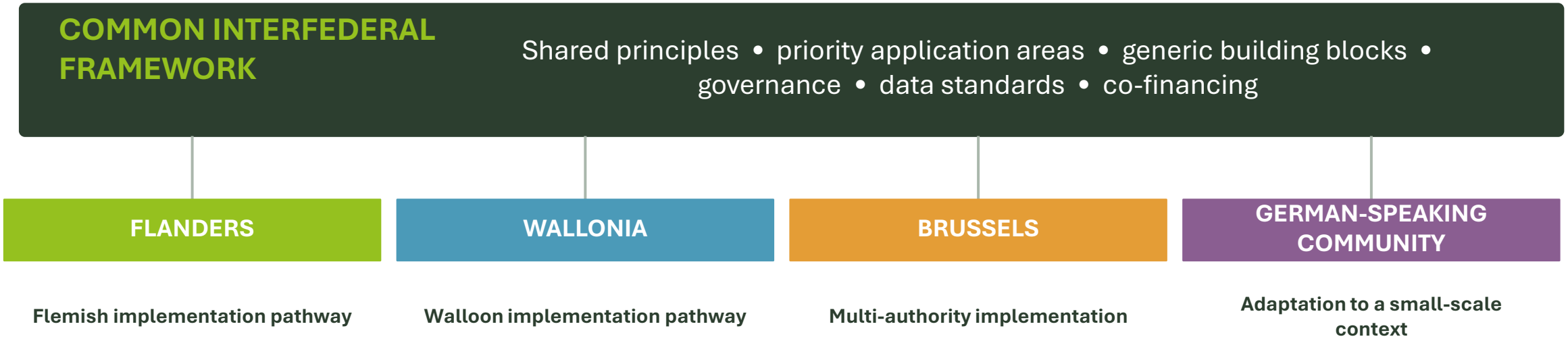
MACRO | System conditions

Governance • regulation • financing • data sharing • accountability

The levels are interdependent.

One shared direction, different implementation pathways

The Interfederal Plan applies across Belgium, while implementation is adapted to each federated entity



Focus: Flanders, where implementation is currently most advanced. As governance structures, care networks and actors differ across Belgium's regions, the role of health insurance funds also varies by regional context.

THE DESTINATION IS SHARED; STRUCTURES, TOOLS, TIMING AND FINANCING PATHWAYS MAY DIFFER.

04

The Flemish translation of integrated care & the Interfederal Plan

From a shared interfederal direction to implementation in Flanders.

Government of Flanders

DEPARTEMENT ZORG

Vlaanderen
is zorgzaam en gezond samenleven

CHRISTELIJKE MUTUALITEIT

A healthy and caring society for everyone

The broader Flemish policy context for integrated care and support

PEOPLE
Strengthen people in their health and well-being

- Support mental well-being
- Promote healthy living
- Build climate resilience



CARE SYSTEM
Organize high-quality, integrated and accessible care

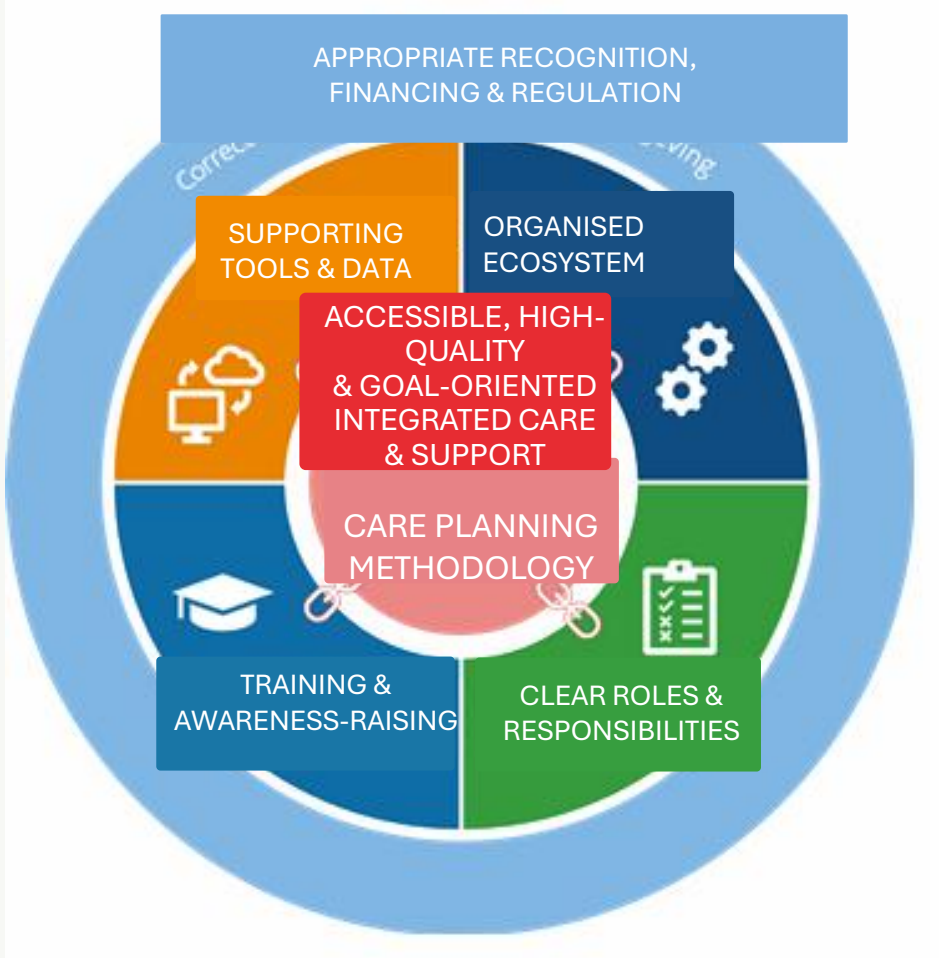
- Organize integrated care
- Organize high-quality care
- Keep care accessible

SOCIETY
Foster a caring society in which everyone can participate

- Connect with & care for one another
- Combat poverty & under protection
- Value people working in care
- Involve & support older people

The Flemish implementation model for integrated care and support

Care planning is supported by four building blocks and an enabling framework



What the model makes visible

Outcome
Accessible, high-quality and goal-oriented integrated care and support

Method

Care planning around the person's goals and multidimensional needs

Building blocks

Roles, ecosystem, competencies, tools and data

Enabling framework

Recognition, financing and regulation

The intended change: goal-oriented care

From reactive, fragmented care towards a prepared team around the person



Individual life goals

Start from what the person wants to preserve, regain or achieve.

Shared care plan

Translate goals and multidimensional needs into realistic actions.

Person retains control

Professional support should strengthen rather than replace agency.

Care and support team

The person, informal network and relevant professionals.

Goal-oriented care changes the order of thinking: first understand the person's goals, then organize care and support around them.

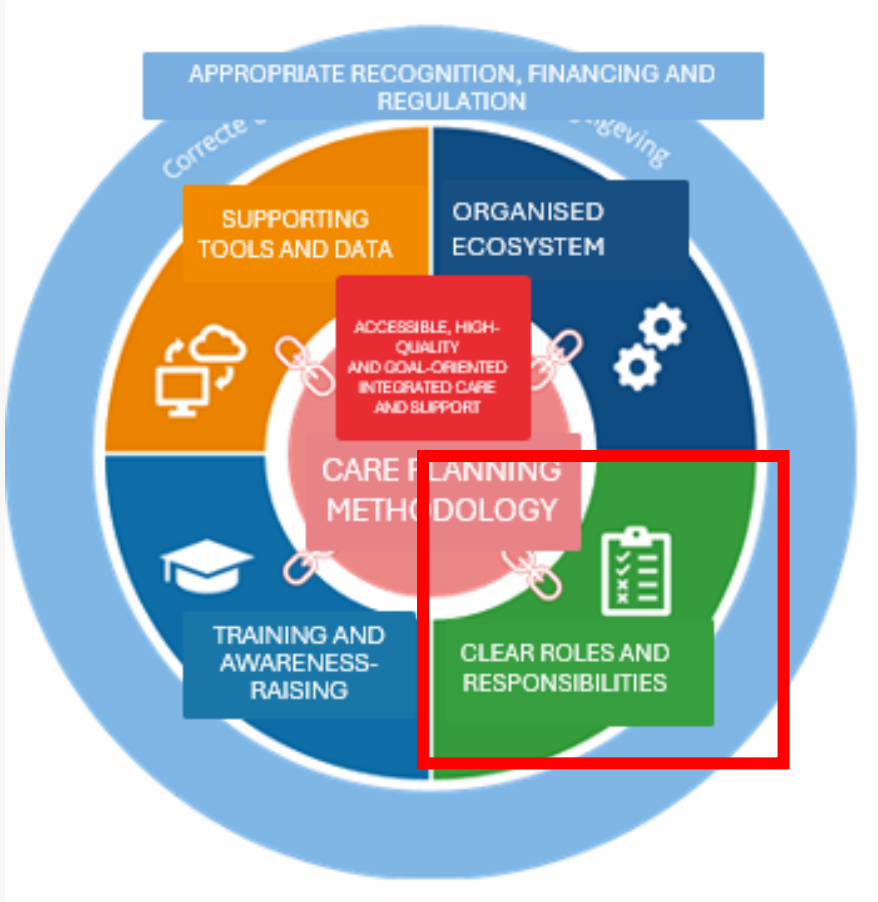
Goal-oriented care starts with another question

> **What matters to you?**
>
> Not only: What is the matter with you?

- What would a good day look like?
- What does the person want to preserve, regain or achieve?
- Which professional goals contribute to those life goals?
- Which actions are useful, acceptable and realistic?

Care coordination and case management

Two distinct functions



CARE COORDINATION

WITHIN THE CARE AND SUPPORT TEAM

- Maintains overview of the care process
- Aligns goals, actions and responsibilities
- Monitors the shared plan
- Safeguards continuity and transitions
- Ongoing function within the regular process
- Can be taken up by the person, informal caregiver or a professional team member

CASE MANAGEMENT (CAMA)

TEMPORARY & EXTERNAL REINFORCEMENT

- Used when the process is absent, stalled or highly complex
- Provides independent analysis, mediation and guidance
- Supports the person and regular team
- Aims to restore a workable process
- Exceptional and temporary
- Requires a recognized organizational and quality framework

Care coordination is ongoing alignment within the team; CAMA is temporary reinforcement when the process cannot carry the complexity.

Care coordination: basic responsibility and intensive work

The need for additional support rises with process complexity

Complexity is multidimensional
Care needs • care process • care team • family and social context • coordination workload

BASIC COORDINATION

Part of regular care and the basic responsibility of providers

MORE COMPLEX PROCESS

More life domains, actors, transitions and interdisciplinary work

INTENSIVE COORDINATION

Additional time & process responsibility may justify specific remuneration when agreed criteria are met

Status in 2026: the distinction is being refined; final criteria, thresholds and financing modalities not yet decided

Supporting tools and data

The model requires shared planning, assessment and population insight



Alivia

Shared digital care and support plan

Goals • team collaboration • actions • roles • follow-up & coordination

Assessment & program specific tools

BelRAI • BIB• …

Needs • functioning • Supports care planning & follow-up • Potential link with complexity assessment

Population data

Regional needs and inequities

Service planning • needs & access across regions • reach & equity • monitoring • learning

Key challenge: interoperability and avoiding duplicate registration across systems.

Alivia: a shared digital care and support plan

A collaboration tool for the person, informal network and care and support team





Shared goals

What matters to the person and what the team wants to achieve

Team and roles

Who is involved and who takes which responsibility

Actions and follow-up

Agreements, timing, progress and adjustment

Continuity

One shared reference across transitions and organizations

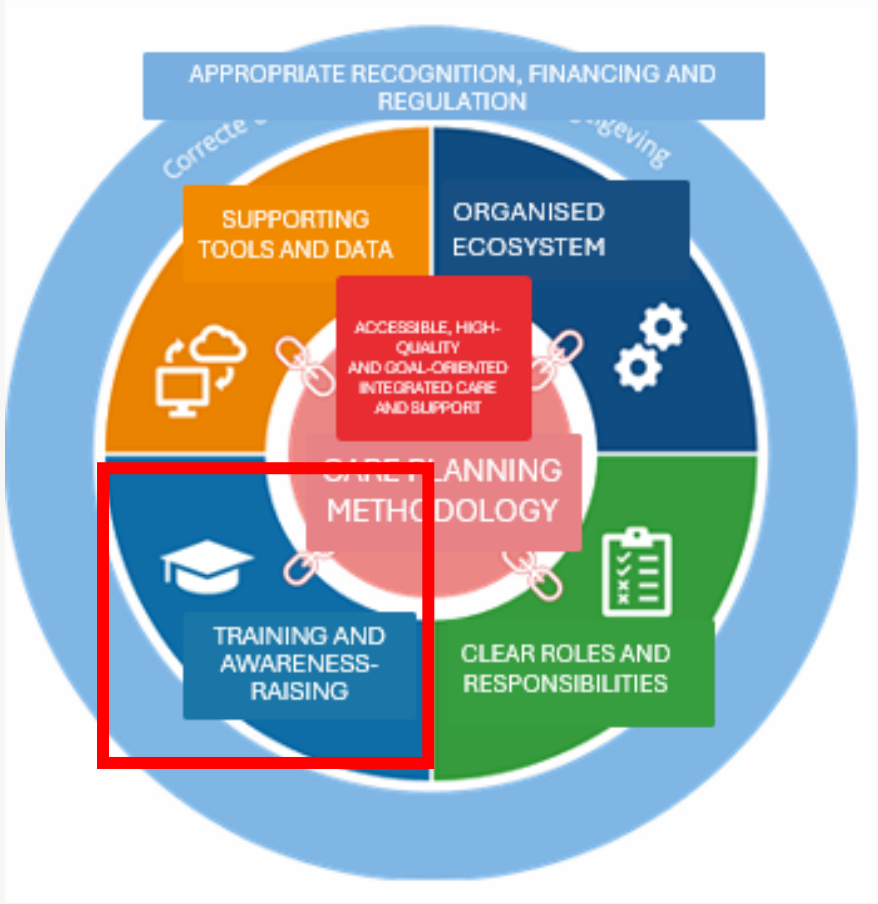
PROGRESSIVE ROLLOUT

Progressive development and rollout in selected settings and programs.

Alivia combines shared care planning with administrative functions for selected programs and roles linked to specific funding mechanisms.

Training and awareness-raising

New roles and tools require more than training



Shared language

Common understanding of goal-oriented care, ZOCO, CAMA & team roles.

Competencies

Care planning, facilitation, network work, mediation & digital collaboration.

Implementation support

Coaching, pilots, local ownership & practical guidance.

Learning system

Monitor experience, outcomes & unintended workload, then adjust.

Training alone is insufficient without ownership, practical support and feedback from implementation.

An organised ecosystem

GIZO connects collaboration around the person with territorial and policy coordination



Around the person

- Health care
- Social care
- Informal network
- Shared goals and plan

Across organizations

- Primary care
- Hospitals
- Mental health
- Palliative care
- Local services

Across levels

- Local implementation through Primary Care Zones
- Supra-local alignment through Regional Care Zones
- Flemish and interfederal policy coordination

Horizontal integration links sectors;
vertical integration links practice, networks and policy.

Two connected reform lines in Flanders

Meso-level reform facilitates integrated care, but has a broader system function

REFORM OF THE MESO LEVEL

OVERARCHING STRUCTURAL REFORM

- Regional Care Zones
- Future governance of Care Councils
- Strategic alignment of networks
- Population management, planning and programming

INTEGRATED CARE AND SUPPORT

SUBSTANTIVE FRAMEWORK AND PROGRAMMES

- Integrated care collaboration Agreement
- Three priority programs
- Care coordination and case management
- Alivia and data sharing
- Generic implementation building blocks

Regional structures facilitate GIZO, while also supporting wider strategic planning and collaboration.

Meso level shift: Two complementary levels for territorial collaboration

Local implementation through Primary Care Zones • Supra-local alignment through Regional Care Zones

From “defined territories” to a Flemish geographical reference framework

Primary Care Zone

Local collaboration & implementation close to citizens

- Responds to local needs and partnerships
- Brings together professionals and organizations
- Supports local implementation of integrated care programs
- Care Council as the local collaborative platform

Regional Care Zone

Supra-local alignment and strategic capacity

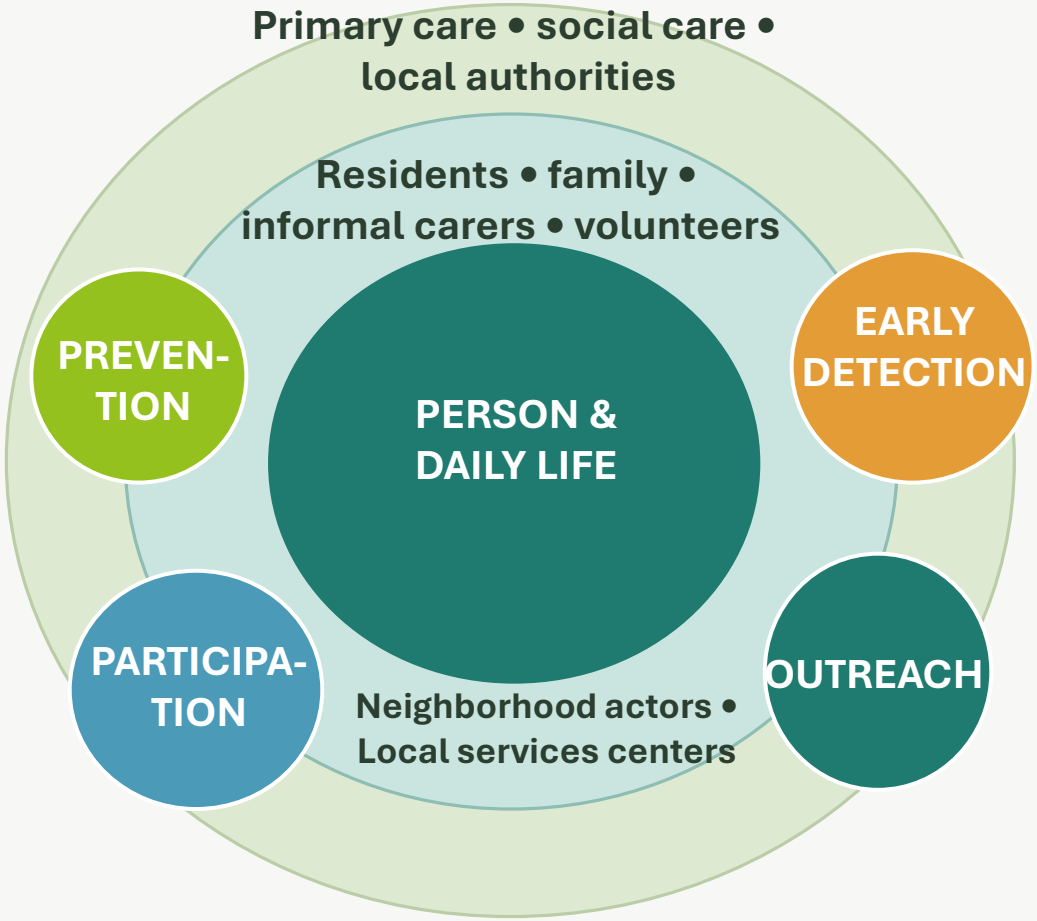
- Pools expertise, capacity and coordination
- Aligns sectors and regional networks
- Provides a reference scale for regional organisations
- Potential future level for population management and strategic planning

PRINCIPLE Organise locally what requires proximity; organise regionally what requires scale, expertise or supra-local alignment.

The 14 Regional Care Zones define a geographical framework. They do not yet determine a complete governance model or division of responsibilities.

Neighbourhood-oriented care: where integration meets daily life

A recent Flemish policy direction linking local communities, informal support and professional care



Why it matters for GIZO

CONNECTS — health care, social care and community resources close to where people live

EXTENDS — integrated care beyond professional services to prevention, participation and informal support

ENABLES — early detection, outreach and local responses to shared population needs

LOCAL IMPLEMENTATION OF INTEGRATED CARE

STATUS: policy direction • financing, roles and territorial coverage still to be specified

Interfederal plan implementation status in October 2026

A mix of decided elements, implementation in progress and unresolved design choices

DECIDED / IN PLACE

- Interfederal protocol agreement
- Primary-care principles
- Enabling meso structure reform
- Perinatal program implementation

UNDER DEVELOPMENT

- Intensive care coordination model
- Regional CAMA organization
- Alivia rollout
- Local and regional Governance

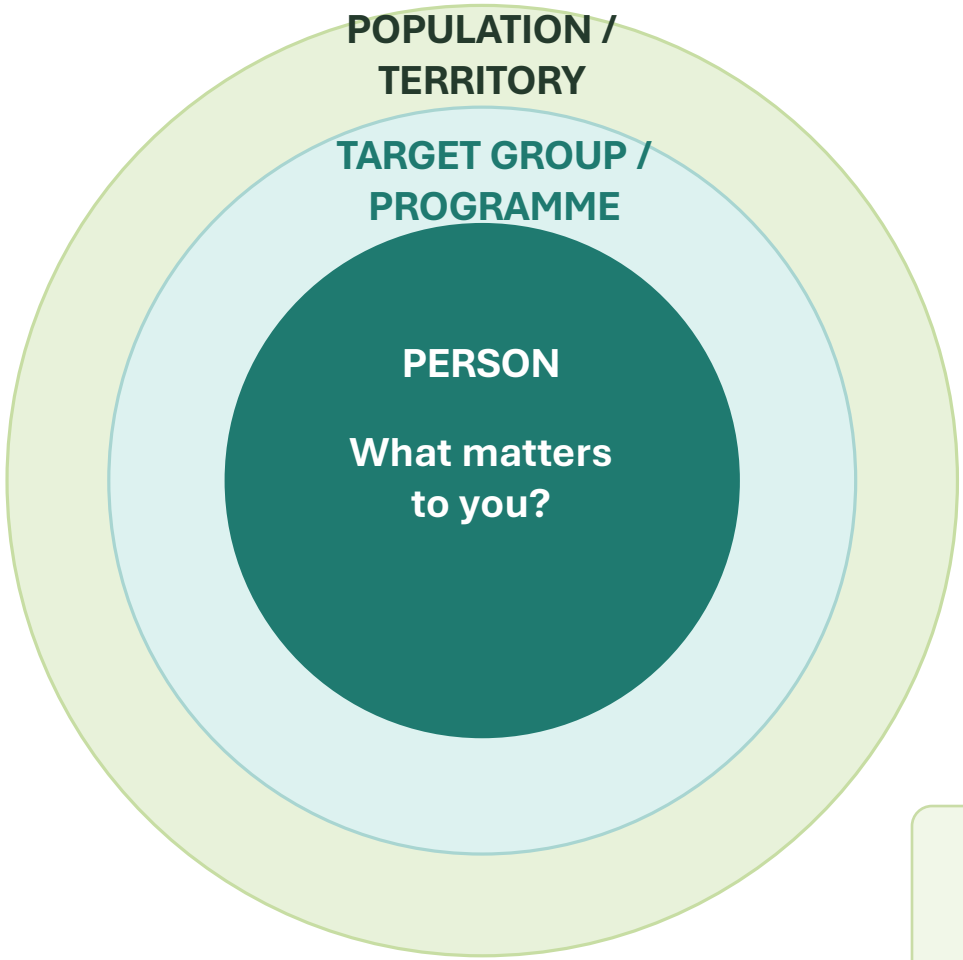
OPEN / NOT FINAL

- Final financing amounts
- Eligibility thresholds and instruments
- Cofinancing and payment rules
- Detailed regional responsibilities
- Administrative and data requirements

The model illustrates a transition in progress, it is not a completed Flemish system.

Three lenses, one Flemish implementation logic

The lenses are complementary: each answers a different implementation question



1

PERSON

Goal-oriented care • care and support team • Alivia • ZOCO/CAMA

2

PROGRAM / TARGET GROUP

Perinatal care • vulnerable older people and dementia • childhood obesity

3

TERRITORY / POPULATION

Primary Care Zones for local implementation • Regional Care Zones for future planning and alignment

Flemish policy connects the three lenses, but implementation maturity differs: person-level concepts are most developed; regional population responsibility is still emerging.

From broad application areas to concrete Flemish focus

Programs' phased implementation without reducing people to one category

1 PERINATAL CARE

BROAD APPLICATION AREA

Pregnant women, children and families

Universal screening & proportionate additional support when vulnerabilities are identified

IMPLEMENTATION UNDERWAY

2 PEOPLE IN VULNERABLE SITUATIONS

BROAD APPLICATION AREA

Current Flemish focus: vulnerable older people and people with dementia

Early detection, support in the living environment, care coordination & CAMA are being developed

UNDER DEVELOPMENT

3 CHILDHOOD OBESITY

BROAD APPLICATION AREA

Children and adolescents

Prevention, early support & integrated treatment across specialized care, primary care, family & daily life

UNDER DEVELOPMENT

A program provides focus. It should not become a new silo: people need one coherent pathway.

Population-oriented action in Flanders: what is concrete?

The direction is visible, but a full regional population-management model does not yet exist

CONCRETE TODAY

Local signals and program action

1

- Primary Care Zones support local implementation
- Neighborhood-oriented care emphasizes prevention, early detection and outreach
- Program monitoring and professional signals identify recurring needs

EMERGING

Regional alignment and capacity

2

- Regional Care Zones create a common geographical scale
- Potential role in data analysis, capacity planning and strategic alignment
- Programs can connect population needs with local implementation

NOT YET FIXED

Mandate, data and accountability

3

- Who owns population outcomes?
- Which datasets and access rules?
- How planning, financing and evaluation will be organized?

Flanders has territorial building blocks and concrete program examples, but regional population responsibility, governance and financing are still being designed.

05

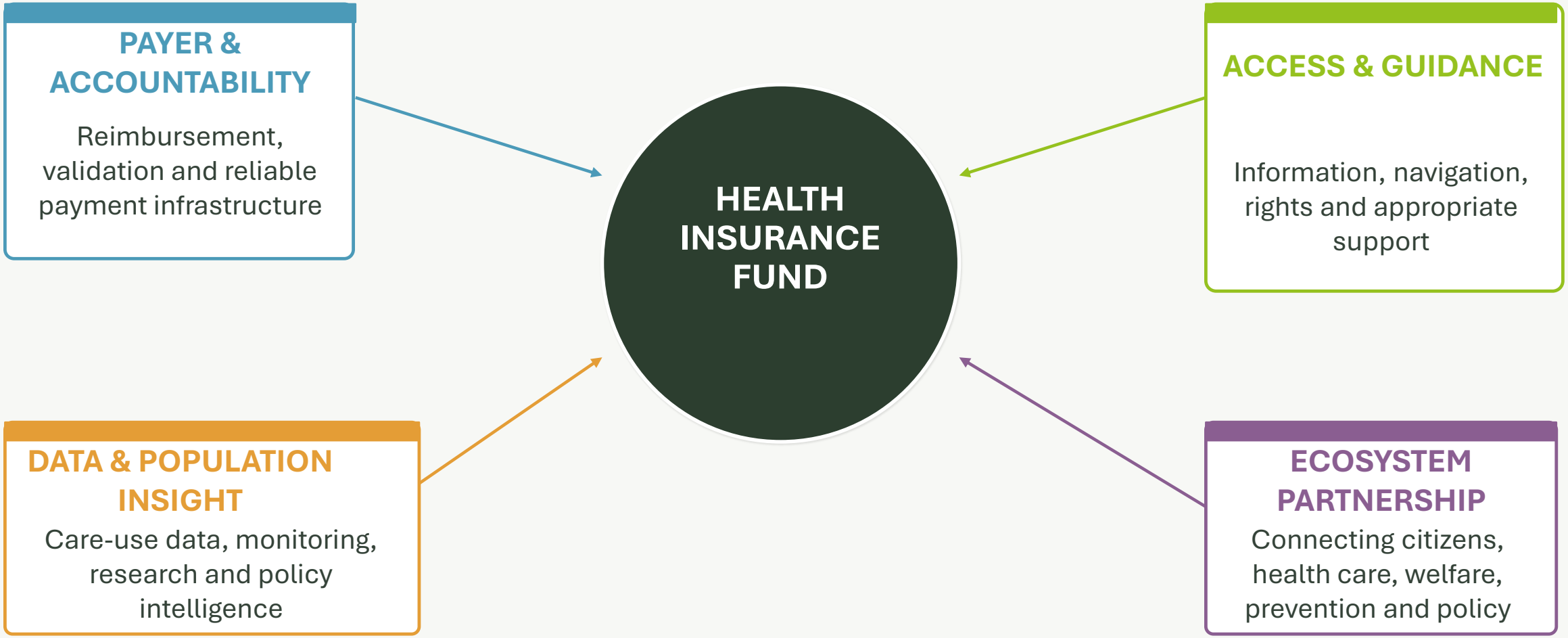
Health insurance funds and social work

Where CM can add distinctive value: reach, rights, social determinants, coordination and continuity.



The role of Health insurance funds

A system partner with four complementary contributions to integrated care



Why CM is well positioned to connect

Five organisational assets that can support integrated care across levels

1

REACH

A broad and diverse membership base and multiple contact points

2

CONTINUITY

Contact across life stages, transitions and changing support needs

3

DATA & INSIGHT

Member signals, care-use data and intermutual population intelligence

4

LOCAL PRESENCE

Social work, volunteers, community initiatives and local partnerships

5

INTERMUTUAL VOICE

Shared policy contribution and implementation through intermutual structures

These assets allow CM to connect people, professionals and policy.

INDIVIDUAL

rights, guidance and social work

LOCAL

community partnerships and Primary Care Zones

REGIONAL

population insight, expertise and alignment

SYSTEM

policy, financing and data infrastructure

The role is connective: translate practice signals into collective learning, access and policy.

CM Social Work Services (DMW)

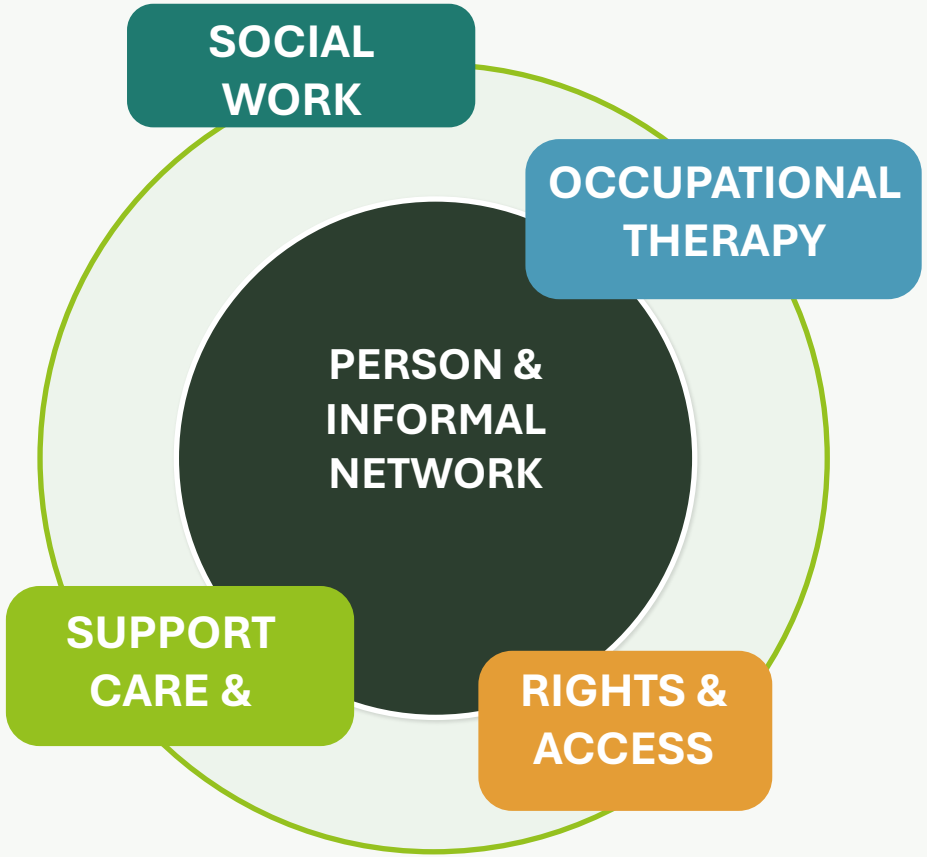
Supporting people with complex care and support needs

LOW-THRESHOLD & PROACTIVE ACCESS

Self-referral, professional referral, proactive outreach or a turning point in life or care

BROAD TARGET GROUP

All ages and health conditions, with particular attention to vulnerability and complex home situations



MULTIDISCIPLINARY TEAM

Social workers and occupational therapists combine social and functional expertise

CONTINUITY OVER TIME

A trusted contact who knows the full story and follows the person's situation

How people enter — and how DMW works

Different entry routes, one generalist and person-centred method



NO WRONG DOOR & EQUITABLE ACCESS

Help directly, reduce barriers or ensure a warm connection to the right support.

GENERALIST & SYSTEMIC

Look across life domains, the household and the informal network.

GOAL-ORIENTED

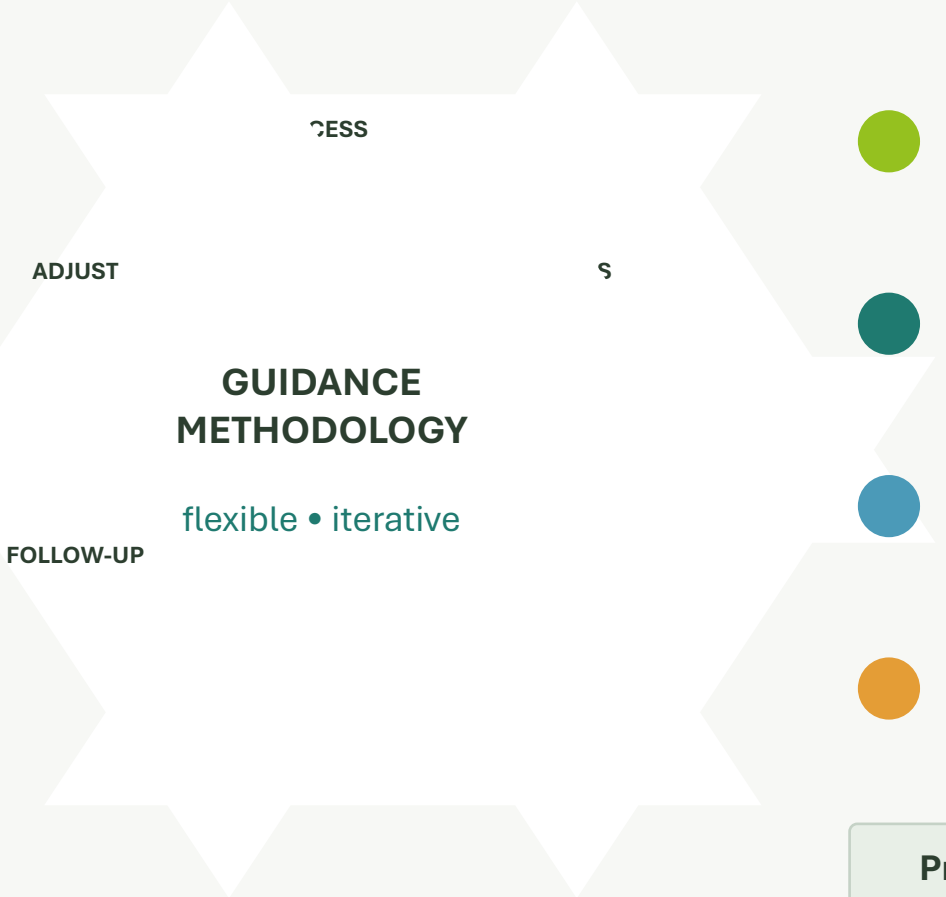
Start from what matters and formulate realistic goals together.

COLLABORATION & COMPLEMENTARITY

Connect formal and informal actors and clarify complementary roles.

What DMW does in practice

A flexible guidance methodology, supported by a broad professional offer



DMW contributes throughout the pathway

UNDERSTAND & SET GOALS

Broad assessment, life goals, context and caregiver capacity

SECURE RIGHTS & PRACTICAL SUPPORT

Benefits, services, aids, housing adaptations and financial protection

COMBINE SOCIAL & FUNCTIONAL EXPERTISE

Psychosocial guidance, occupational therapy, autonomy and participation

CONNECT & COORDINATE

Informal care, multidisciplinary consultation, mediation and continuity

Proactive action - whenever signals indicate unmet need.

Structured, but never rigid: goals, support and the network are adjusted as circumstances change.

A case begins with daily life — not with a programme

Young-onset dementia case

“

I cannot manage this anymore.

Partner of a recently retired person whose behaviour and daily functioning had changed.

The question was relational and practical. The underlying issue was not yet diagnosed.

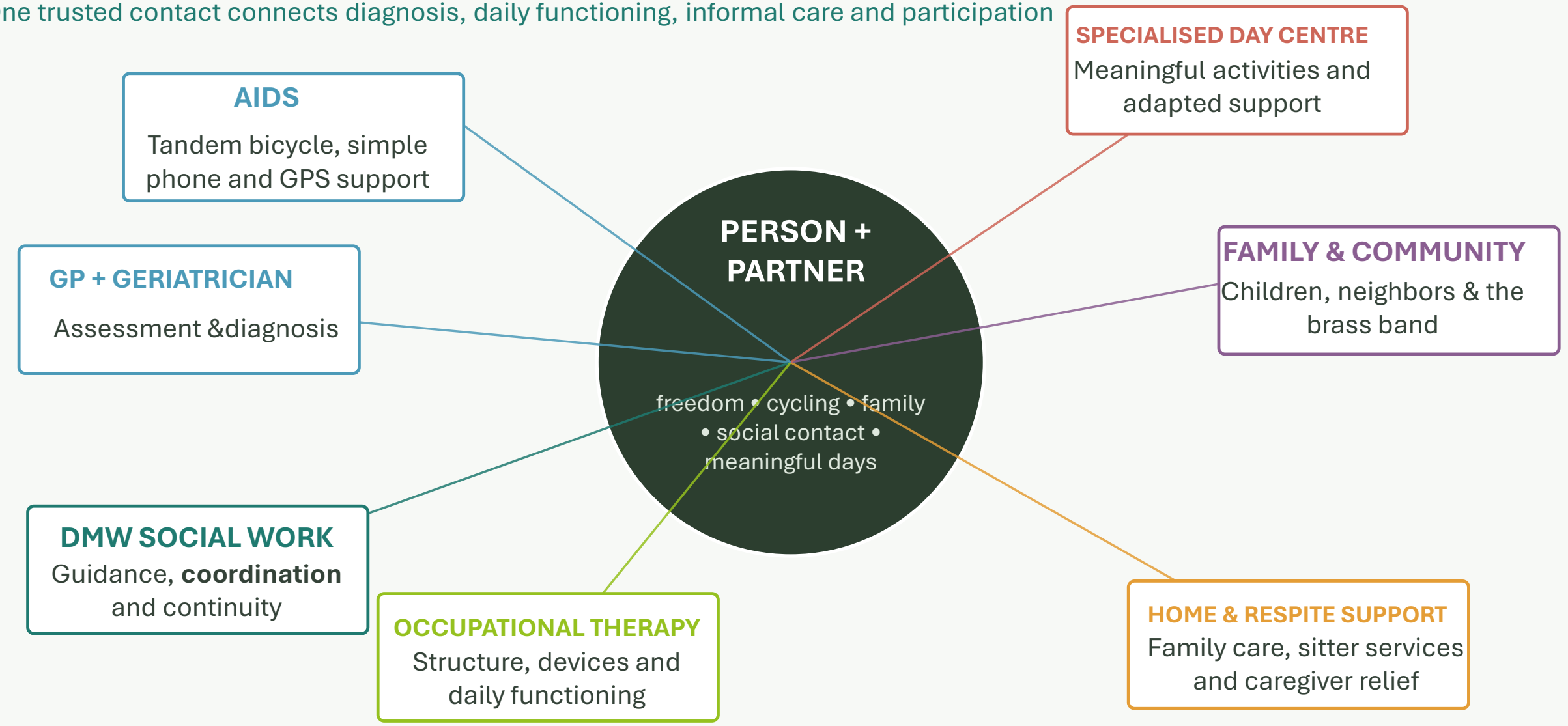
What DMW noticed in daily life

Changes at home	Apathy, irritability and everyday tasks becoming difficult
Participation declining	Less cycling, gardening and participation in the brass band
Caregiver overload	Confusion, conflict, guilt and increasing exhaustion
Family hesitation	Children and neighbours were not yet involved
No clear diagnostic pathway	Symptoms could also resemble depression or burnout

Integrated care started with recognising patterns in everyday life and taking the first concern seriously.

Building a coordinated response

One trusted contact connects diagnosis, daily functioning, informal care and participation



What made the difference?

Integrated care did not change the diagnosis — it changed how people could live with it

> **The client changes from a name in a file into a real person with a legitimate care and support need.**
>
> *Social worker, CM DMW*

FOR THE PERSON

Autonomy & identity preserved
Participation adapted, not abandoned
More calm & meaningful daily life

FOR THE CAREGIVER

Better understanding & practical tools
Relief & space for personal well-being
One contact who knows the full story

FOR THE NETWORK

Earlier detection & clearer roles
Expertise used at the right time
Fewer avoidable crises through follow-up

“I never expected that all these people would make time together just to help me.” — *patient feedback reported by the GP*

How today's DMW practice relates to integrated-care policy

Clarify a stepped model while preserving continuity for the person

REGULAR DMW SUPPORT — Broad assessment • rights • guidance • network support

CARE COORDINATION — Ongoing alignment within the regular care and support team

INTENSIVE CARE COORDINATION — Additional time and process responsibility when complexity exceeds ordinary practice

TEMPORARY CASE MANAGEMENT — External process reinforcement when no workable team exists or the process repeatedly stalls ~ MDO

> **Sometimes there is a need to bring everyone together across professional boundaries, to find solutions when ordinary collaboration has reached its limits. That neutral connecting role becomes crucial in the most fragile situations.**
>
> *General Practitioner*

Where DMW can contribute now — and where the strongest future fit lies

Participate, learn and stay within a clear mandate

NOW

Perinatal programme

Targeted participation in selected zones within the regular DMW mandate & responsibilities

LEARN

Implementation test case

Clarify referral, digital access, role boundaries and added value

STRONG FIT

Vulnerable persons

Older people and people with dementia align closely with current DMW expertise and reach

SUSTAIN

Structural role

Needs recognition, capacity, shared information and appropriate financing



PERINATAL POSITIONING

Complementary role for relevant DMW target groups & complex support needs
No general coordination role for all vulnerable pregnant women & No formal Born in Belgium screening
Participation within existing mandate, capacity & financing

WHAT NEEDS TO BE IN PLACE

Clear, complementary **roles** across health & welfare actors
Purposeful **access** to shared digital tools and information
Time & capacity for intensive guidance and coordination
Recognition and sustainable **financing**

Perinatal care is a useful learning environment. The vulnerable-persons programme is likely to show DMW's strongest substantive contribution.
Integrated care requires both healthcare and social-care expertise.

06

Opportunities, challenges and mutual learning

Belgium offers experience and emerging structures — not a finished model.



What facilitates integrated care?

Four assets Belgium and Flanders can build on

A SHARED DIRECTION

The Interfederal Plan creates common principles, priorities and building blocks.

PRACTICE ALREADY EXISTS

Social workers, clinicians, local services and informal carers already connect in the field.

CONNECTING ACTORS

Health insurance funds combine rights, population insight, local outreach and social work.

INTERMUTUAL COLLABORATION

Health insurance funds jointly prepare policy discussions and contribute to implementation.

The opportunity is not to start again, but to strengthen what already connects the system.

RECOGNISE → **CONNECT** → **STRENGTHEN** → **SUSTAIN**

"Integrated care does not have to be invented from scratch."

From overlapping roles towards a strong model

Existing “case-management” models often combine activities that the future framework distinguishes as care coordination and case management

EXISTING LANDSCAPE

- Patient associations
- Protocol 3 / ZP3 projects
- Pathology-specific programs
- Hospital navigation models
- Health insurance funds and social work

Often labelled “case management”

OVERLAPPING FUNCTIONS

Needs assessment

Navigation and access

Bringing professionals together

Following up actions

Care-plan coordination

Process analysis and repair

Temporary intensive support

The same activity may be described differently depending on the programme or authority.

DESIRED MODEL

CARE COORDINATION

Ongoing coordination within the regular care and support team

CASE MANAGEMENT

Temporary external process reinforcement to start or restore a workable pathway

Health insurance funds and their social work services are jointly reflecting on how existing expertise can contribute to this future distinction.

Perinatal care: shared ambition, parallel pathways

The first major programme makes integrated practice and implementation tensions visible

EARLY DETECTION & SCREENING • PRENATAL ADVICE • HEALTH AND SOCIAL SUPPORT • MULTIDISCIPLINARY CONSULTATION • CARE COORDINATION • CONTINUITY DURING THE FIRST 1,000 DAYS

FEDERAL PATHWAY

Born in Belgium Professionals
Programme-specific screening and workflow
Central administration and payment
Financing for eligible health professionals

ALIGNMENT GAP

FLEMISH PATHWAY

Primary Care Zones and implementation support
Participation of welfare actors
Development of Alivia
Future ZOCO/CAMA framework and financing

Integration requires connected roles, tools, data sharing and payment rules across both pathways.

Implementation challenges: from initiatives to sustainable integration

The main challenge is no longer to prove that collaboration is possible, but to make it coherent, scalable and sustainable

PARALLEL GOVERNANCE

Responsibilities and decisions remain divided across authorities and programs.

FRAGMENTED FINANCING

Coordination crosses federal healthcare and Flemish welfare-financing boundaries.

DIGITAL FRAGMENTATION

BiB, Alivia, BelRAI and program platforms need clear roles and interoperability.

IMPLEMENTATION CAPACITY

Coordination requires time, professional capacity, support and sustainable financing.

ALIGN GOVERNANCE • FINANCING • DATA • CAPACITY AROUND ONE PERSON AND ONE COHERENT PATHWAY

Questions for mutual learning

Four questions to open the discussion

1. **How do we keep care person-centred while scaling programs?**
2. **How do we connect health care, social care and daily life in practice?**
3. **Who keeps the overview when situations become complex?**
4. **How are coordination, outreach and collaboration recognised and financed?**

INTEGRATED CARE IN BELGIUM

Study visit | Brussels
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