Adding Value to health care systems

Belgium and Romania

Evidence on the Romania–EU and rural–urban gaps, and an action-research path to integrated, value-based care



Motto

“the availability of good medical care tends to vary inversely with the needs of the population served”

Julian Tudor Hart, “The inverse care law”, The Lancet, 1971



The case in four numbers: Romania's value gap is also a rural gap

5.0 years

Life-expectancy gap, Romania vs EU-27 (76.5 vs 81.5 years, 2024)

2.3×

Treatable mortality vs EU-27 (199.7 vs 86.8 per 100 000, 2023) – highest in the EU

29.8%

Rural women 20–69 with a cervical smear in the last 3 years (EU rural: 69.1%, 2019)

39.8%

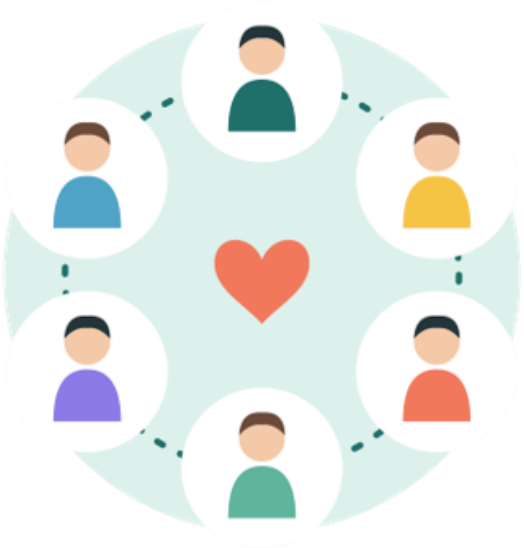
Rural Romanians at risk of poverty or social exclusion (cities: 13.7%; EU rural: 21.4%, 2025)

So what? Romania loses value mainly through deaths that timely, effective care should prevent, and through prevention and primary care that do not reach rural and poor communities. Integrated, community-based care is a direct response to both – which is why the Belgian experience is relevant.

Sources: Eurostat demo_mlexpec (2024, estimated), hlth_cd_apr (2023), hlth_ehis_pa8u (EHIS 2019), ilc_peps13n (EU-SILC 2025); extracted 24 Oct 2026. Treatable mortality = standardised death rate, ages <75.

Value-based health care – definition

Value-based healthcare (VBHC) means achieving the best possible health outcomes for patients relative to the resources used, while considering what matters most to patients



Sources: European Commission Expert Panel on Effective Ways of Investing in Health (EXPH). Defining value in “value-based healthcare”. Luxembourg: Publications Office of the EU, 2019. doi:10.2875/35471.

The four dimensions of value-based care

1. PERSONAL VALUE

Does care achieve the outcomes and goals that matter to each patient?

2. TECHNICAL VALUE

Are the best possible outcomes achieved with the resources available?

3. ALLOCATIVE VALUE

Are resources distributed fairly across patients, needs and services?

4. SOCIETAL VALUE

Does care support social participation, solidarity and connectedness?

The dimensions can reinforce one another—but they can also conflict.

Source: EXPH (2019). Defining value in “value-based healthcare”. doi:10.2875/35471.

Why the current systems lose value

Unwarranted variation

Differences in care that are not justified by patient needs or preferences.

Underuse

Effective care is not provided when patients could benefit from it.

Overuse

Tests, treatments or services are provided when they are unnecessary or low value.

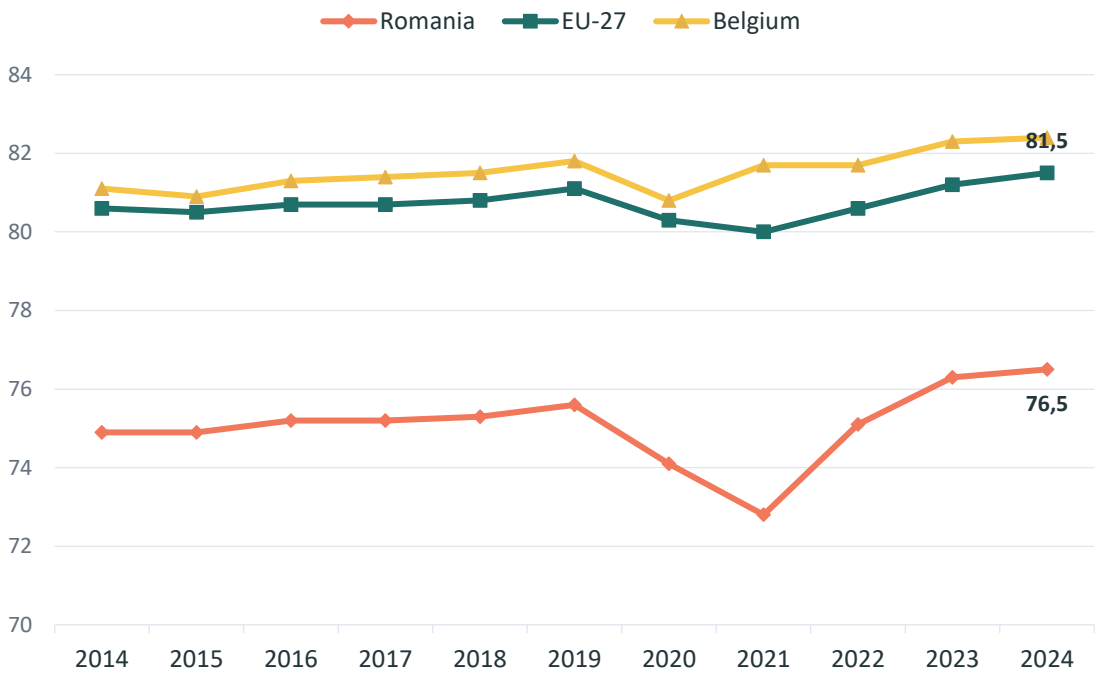
The goal is not to reduce care indiscriminately, but to reduce low-value care and close gaps in effective care.

Framework: unwarranted variation, underuse and overuse as sources of lost value – see EXPH (2019), doi:10.2875/35471.

Part 1 – The evidence

Romania vs the EU, rural vs urban: where value is lost

Romania vs EU: the life-expectancy gap has not closed in a decade



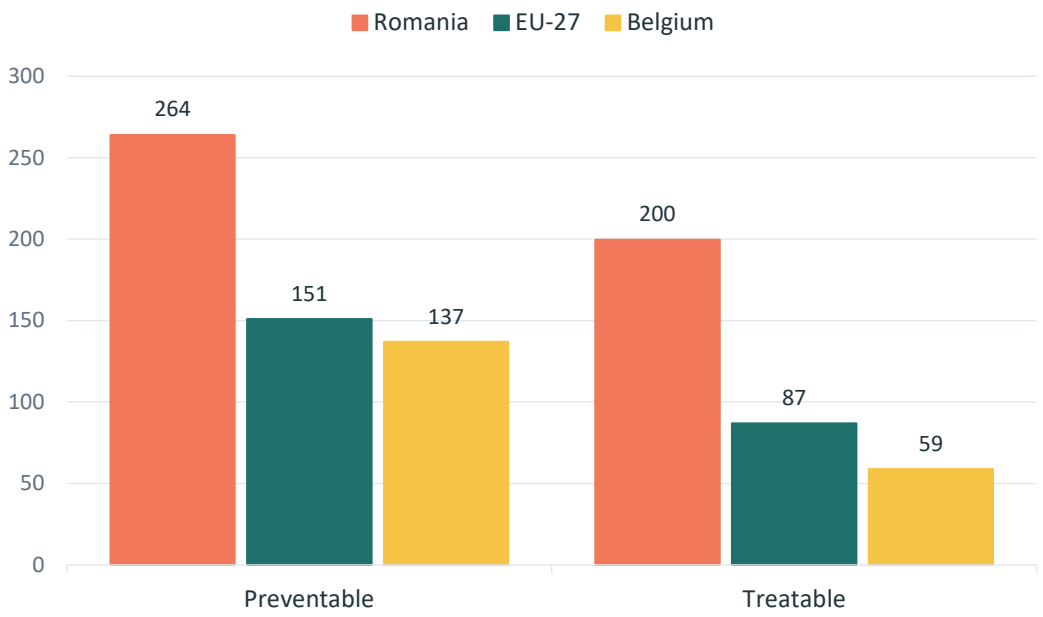
What the trend says

- Gap 2014: 5.7 years; 2024: 5.0 years – slow convergence.
- COVID-19 hit Romania twice as hard: −2.8 years (2019→2021) vs −1.1 in the EU.
- Healthy life years at 65: 7.0 (RO) vs 10.3 (EU) and 11.8 (BE) in 2024.

Source: Eurostat demo_mlexpec (life expectancy at birth, total; RO 2019–2024 flagged “estimated”); hlth_hlye (HLY at 65, 2024; RO break in series). Extracted 24 Oct 2026.

Avoidable deaths: Romania has the highest treatable mortality in the EU

Standardised death rate per 100 000 (<75 years), 2023



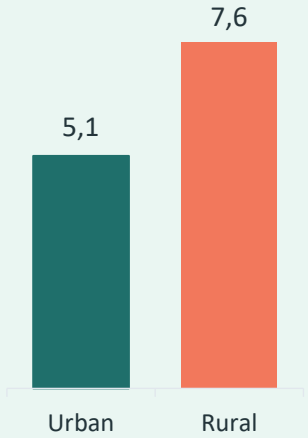
Why it matters for value

- Treatable deaths measure health-system performance (timely, effective care). Romania: 2.3× the EU rate; 3.4× Belgium.
- Preventable deaths (1.75× EU) call for public-health and primary-prevention action.
- Total avoidable mortality: 463.7 vs 237.7 per 100 000 – 3rd highest in the EU-27.

Source: Eurostat hlth_cd_apr – treatable and preventable mortality of residents (OECD/Eurostat 2022 list), 2023, extracted 24 Oct 2026. Ranking among EU-27 computed from the same table.

Born, living and ageing in rural Romania: the outcome and access gap

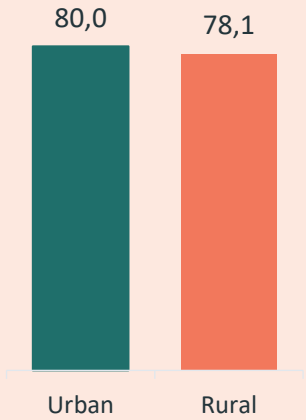
Infant mortality, per 1 000 live births (2024)



+49%

rural vs urban

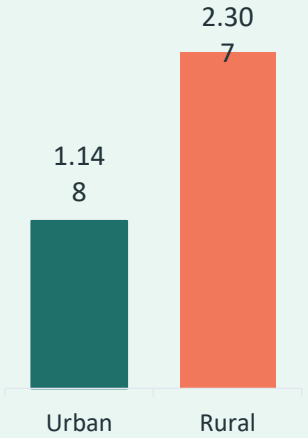
Life expectancy of women, years (2023)



−1.9

years, rural vs urban

Inhabitants per family doctor (2024)



2.0×

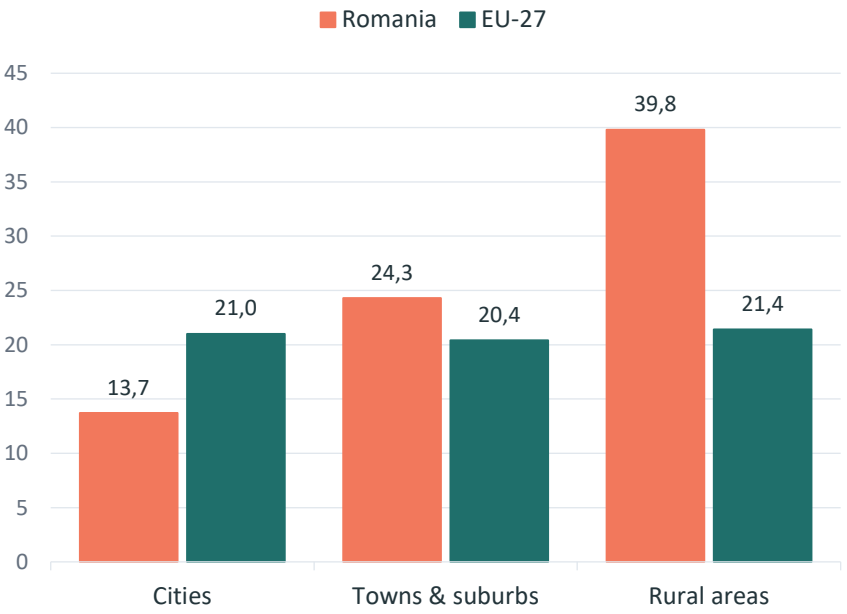
rural vs urban

Context: 48.1% of Romanians live in rural areas (1 Jan 2024). Earlier INS data (2019, provisional) put the overall urban–rural life-expectancy gap at 3.0 years (men 3.5; women 1.8).

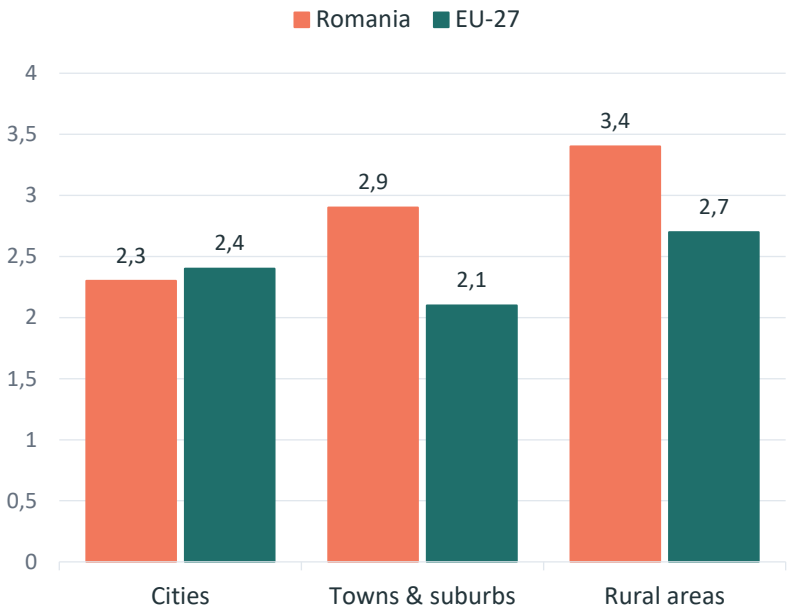
Sources: INS, Evenimente demografice în anul 2024 (Table 7; semi-final data – the final 2024 national rate is 6.6, Eurostat demo_minfind); INS press release for Women's Day (2023 data); INS, Activitatea rețelei sanitare… 2024 (no. 162, 30 Jun 2025); INS, World Population Day release (2019 data); INS, România în cifre 2025.

The rural gradient: poverty and unmet need concentrate outside cities

At risk of poverty or social exclusion, % of population, 2025



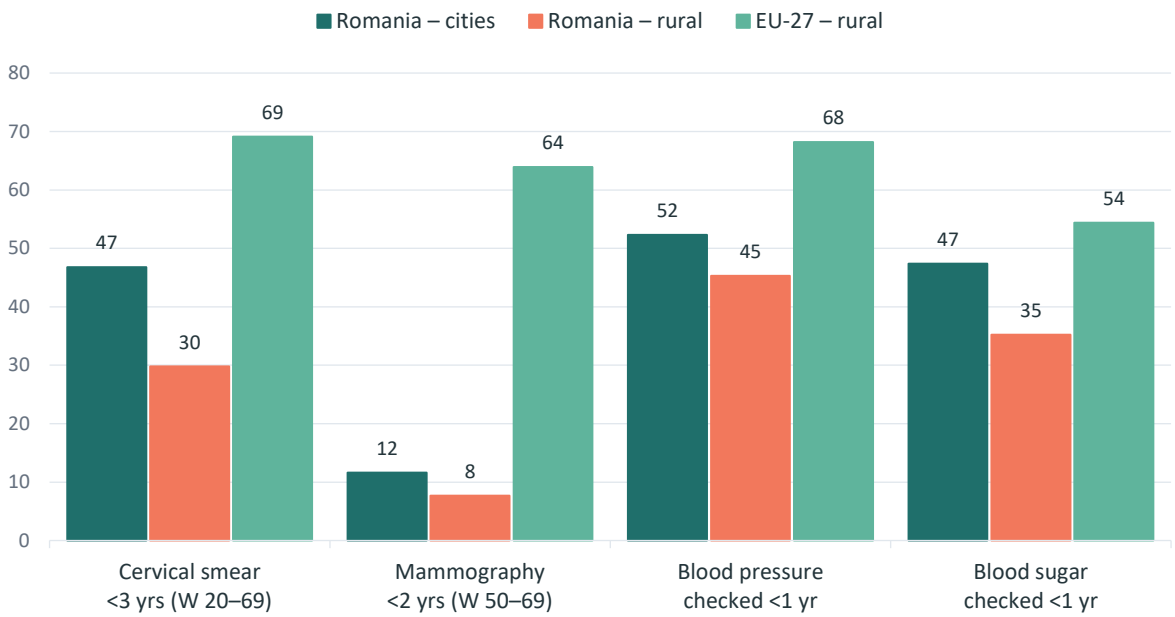
Unmet need for medical examination*, % aged 16+, 2025



Source: Eurostat ilc_peps13n and hlth_silc_21 (EU-SILC 2025), extracted 24 Oct 2026. *Reasons: too expensive, too far to travel or waiting list. Rural Romanians: 2.9× the poverty/exclusion rate of city dwellers; unmet need 1.5× (3.4 vs 2.3).

Prevention does not reach rural Romania: screening coverage by place of residence

% of the target population reporting the test, EHIS 2019



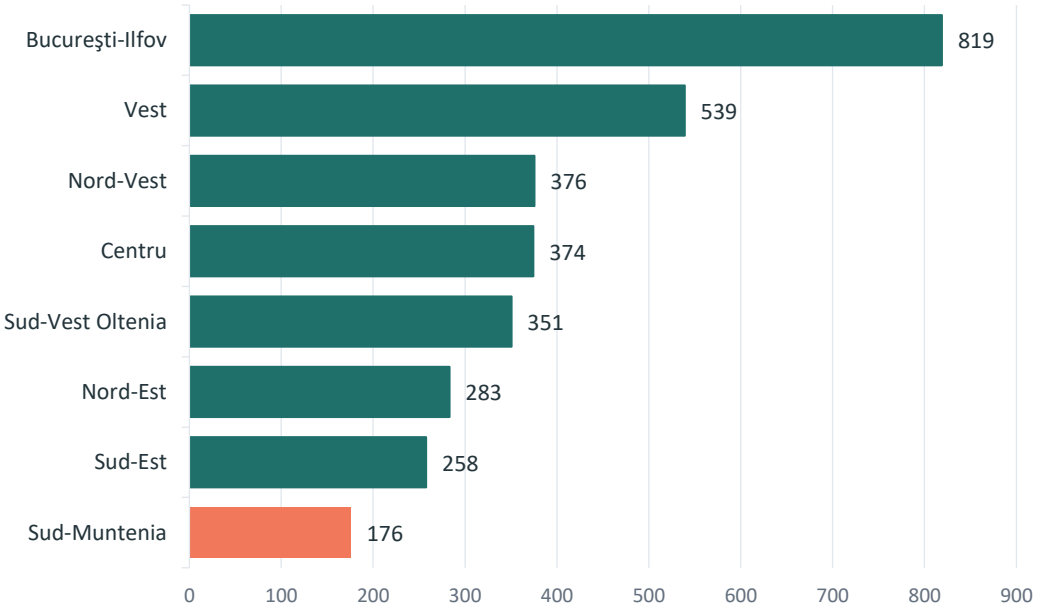
Implication

- Rural women are 17 points less likely than urban women to be screened for cervical cancer.
- Colorectal test <2 yrs (50–74): 3.2% rural vs 33.3% EU.
- Proactive outreach (Belgian lesson 2.2) is the missing link.

Source: Eurostat European Health Interview Survey 2019 – hlth_ehis_pa8u, pa7u, pa2u, pa5u (degree of urbanisation), extracted 24 Oct 2026. Self-reported; latest wave with published Romanian data. Organised screening programmes have expanded since 2019 – the baseline must be re-measured.

Not too few doctors – doctors in the wrong places

Practising physicians per 100 000 inhabitants, NUTS-2 regions, 2024



4.7×

more physicians per inhabitant in Bucureşti-Ilfov than in Sud-Muntenia

381 vs 334

physicians per 100 000: Romania vs Belgium – the national average hides the gap

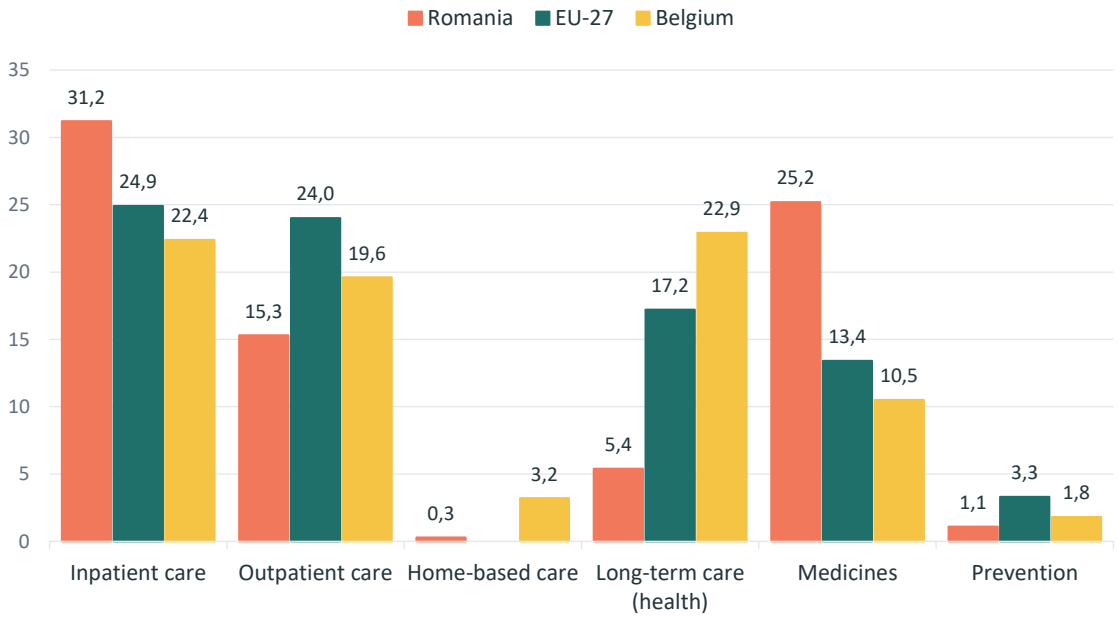
31.6%

of family doctors work in rural areas, where 48.1% of Romanians live (2024)

Sources: Eurostat hlth_rs_physreg and hlth_rs_prs2 (practising physicians), 2024, extracted 24 Oct 2026; INS, Activitatea rețelei sanitare și de ocrotire a sănătății în anul 2024 (press release no. 162, 30 Jun 2025); INS, România în cifre 2025 (population at 1 Jan 2024).

Where the money goes: hospitals and medicines, not community care

% of current health expenditure, 2024 (curative + rehabilitative where applicable)



48%

of the EU average spent per person: 1 969 vs 4 075 PPS (2024)

6.2% of GDP

on health in Romania vs 10.2% in the EU-27 (2024)

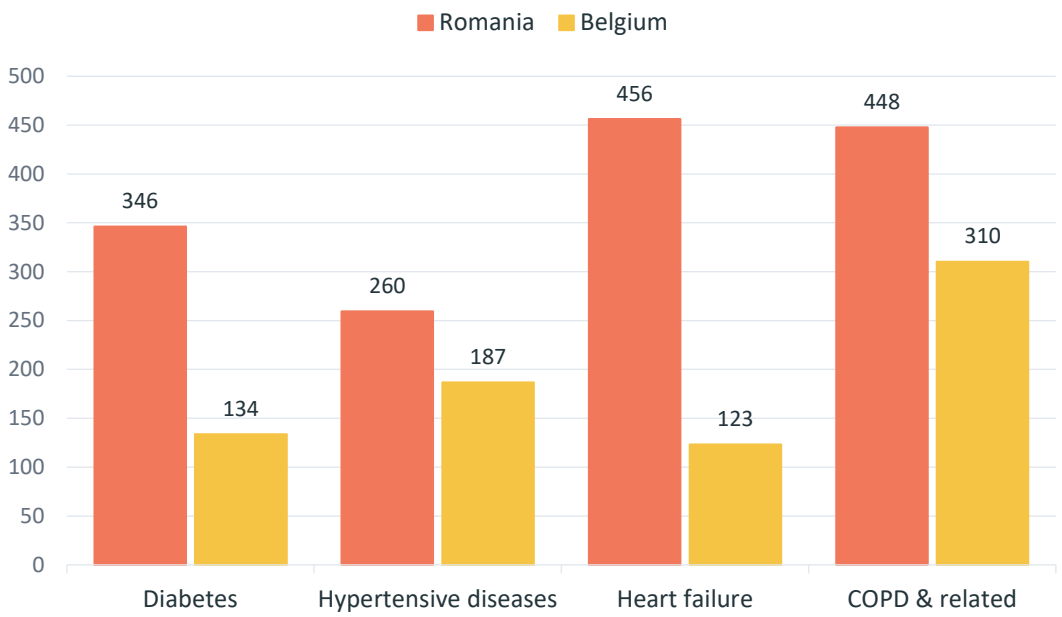
22%

of spending paid out of pocket (EU: 15%) – a barrier for poor rural households

Source: Eurostat hlth_sha11_hc (by function) and hlth_sha11_hf (by financing scheme), System of Health Accounts, 2024, extracted 24 Oct 2026. EU-27 home-based care not published (blank). Medicines = pharmaceuticals and other medical non-durables (HC.5.1).

A hospital-centred system: conditions that primary care should manage end up in hospital

In-patient discharges per 100 000 inhabitants (crude), 2019 – pre-pandemic



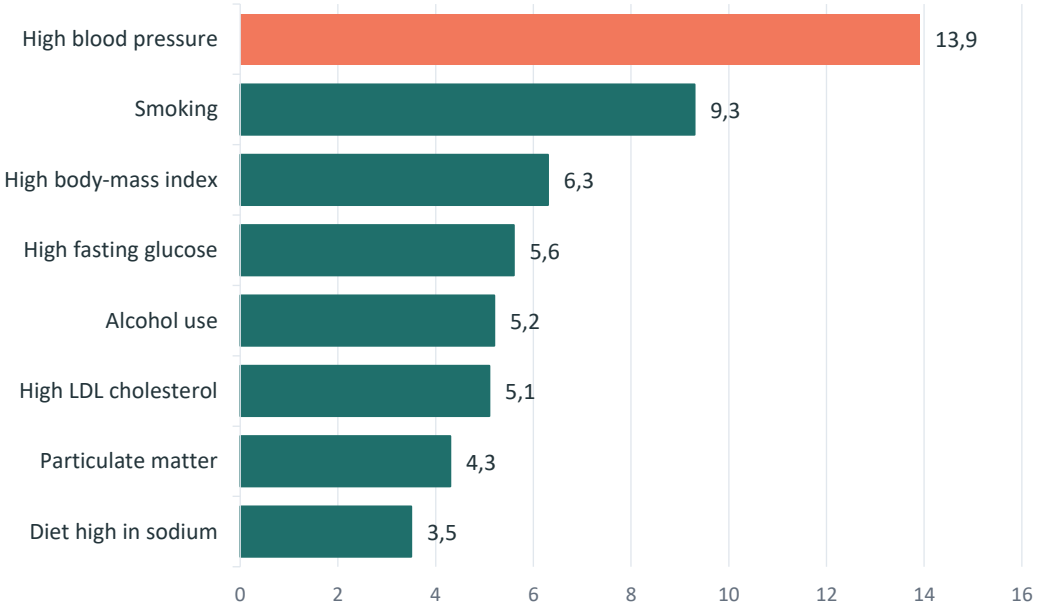
Reading the signal

- Diabetes admissions 2.6× and heart-failure admissions 3.7× Belgium – despite Romania's younger population.
- Hospital beds: 728 per 100 000 vs 511 EU-27 (2023).
- OECD/Observatory (2025): Romania had the highest diabetes-related admission rate in the EU in 2023.

Sources: Eurostat hlth_co_disch2 (historical series to 2021; 2019 used to avoid COVID-19 distortion); hlth_rs_bds1 (2023); OECD/European Observatory, Country Health Profile 2025: Romania, p. 10. Crude rates, not age-standardised; coding and admission practices differ – indicative only. Extracted 24 Oct 2026.

What drives the burden: risks that primary and community care can control

Romania 2023 – % of all DALYs attributable to each risk (GBD 2023)



Value lever

- High blood pressure alone: 13.9% of DALYs (95% UI 11.3–16.7).
- Six of the top eight risks are detected and managed in primary care (BP, glucose, lipids, BMI, tobacco, alcohol).
- A registered, risk-stratified population list is the precondition – the Belgian forfait logic.

Source: GBD 2023 Disease and Injury and Risk Factor Collaborators. Lancet 2025;406(10513):1873–1922. doi:10.1016/S0140-6736(25)01637-X (PMID 41092926); values from the IHME GBD 2023 database, age-standardised, both sexes. Attributable shares overlap and are not additive.

Reading the evidence through the four dimensions of value

	Romanian evidence	Integrated-care response
1 **Personal value**	Unmet need 3.4% rural vs 2.3% cities; low screening uptake	Care planned with the person; PROMs/PREMs in every pilot
2 **Technical value**	Treatable mortality 2.3× EU; heart-failure admissions 3.7× Belgium	Protocol-based chronic care, case management, avoidable-admission tracking
3 **Allocative value**	Inpatient 31% of spending; home care 0.3%; prevention 1.1%	Shift money to registered, risk-adjusted community budgets
4 **Societal value**	39.8% of rural residents at risk of poverty/exclusion	Health–social integration; social workers and health mediators in teams

Framework: European Commission Expert Panel on Effective Ways of Investing in Health (EXPH), 2019. Figures: preceding slides (Eurostat, 2019–2025).

Part 2 – What Belgium did

A staged, evaluated integrated-care reform – and what its evaluation shows

1. What Belgium did: a staged integrated-care plan

Belgium's integrated-care initiative provides an example of a policy approach intended to improve coordination around people and communities. The initiative was promoted at national level and followed a staged process:



1

Joint federal–federated plan "Integrated care for better health" for chronic patients (2015)



2

12 locoregional pilots launched 1 Jan 2018 (6 Flanders, 5 Wallonia, 1 Brussels)



3

Realist, mixed-methods evaluation (Quadruple Aim); first results July 2021



4

Interfederal Plan for Integrated Care: protocol signed 8 Nov 2023

Sources: INAMI-RIZIV, "Soins intégrés en faveur des malades chroniques" and "Plan interfédéral soins intégrés" (web pages); INAMI Bulletin 2019/3-4 (parl. question 6-1944); Goderis G et al. Int J Integr Care 2020;20(3):12, doi:10.5334/ijic.5435. Note: INAMI dates the plan to Oct 2015; a 2018 ministerial answer gives 30 Mar 2015.

1. What Belgium did: developing an integrated-care initiative

This sequence offers a practical policy lesson: new care models can be tested and evaluated before decisions are made about wider adoption.

Caveat: the evaluators could not demonstrate impact on patient outcomes; evaluation capacity and stable funding were missing for most projects. Romania should fund evaluation from day one.



Sources: Kenis I et al. Int J Integr Care 2025 (ICIC24 abstract), doi:10.5334/ijic.ICIC24253; Smeets M et al. Int J Health Policy Manag 2023, doi:10.34172/ijhpm.2022.7143.

2. Key characteristics of the Belgian integrated-care approach



2.1. Care designed with the patient

The approach emphasizes defining care with the patient rather than simply providing care for the patient. This places the person's needs, preferences and goals at the centre of planning and supports patient empowerment and participation in decisions.



2.2. Population health management and proactive outreach

Population health management involves identifying the needs of a defined population and reaching out proactively to people who may be vulnerable or at risk of being left behind. Rather than relying exclusively on patients to seek help, services can work to identify barriers and connect people with appropriate support earlier.

2.3. Integration of information

The integration of databases and information systems can help professionals build a more coordinated view of people's needs and reduce fragmentation between services. For implementation, data sharing needs clear governance, appropriate safeguards for privacy and practical arrangements that allow authorized professionals to use information effectively.

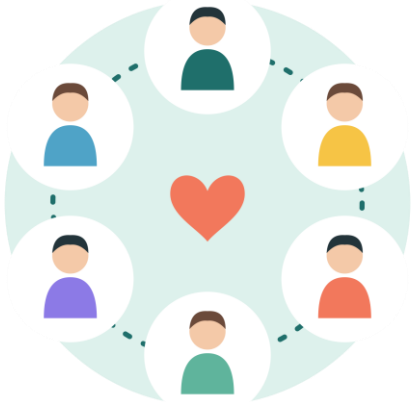


2. Key characteristics of the Belgian integrated-care approach

2.4. Primary Health Care Zones and community health centres

Flanders created 60 primary care zones (eerstelijnszones) with care councils operating since 1 July 2020 – a regional competence; Brussels and Wallonia are building their own models. Community health centres organise multidisciplinary care close to the population.

- The proposed model brings together different professional roles, potentially including nurses, family doctors, optometrists, psychologists and other providers. A multidisciplinary team can address a broader range of needs and improve coordination, provided that responsibilities, referral pathways and communication between team members are clearly defined.



Sources: VIVEL (Flemish Institute for Primary Care), “Zorgraden”; INAMI-RIZIV, “Maisons médicales”.

2. Key characteristics of the Belgian integrated-care approach

2.4. Primary Health Care Zones and community health centres

41 variables

Community health centres (maisons médicales / wijkgezondheidscentra) are paid a capitation (“forfait”) per registered patient and discipline. Since the 2013 reform, mature centres receive amounts adjusted for 41 patient variables – age, sex, socio-economic status and health conditions such as diabetes or heart disease.

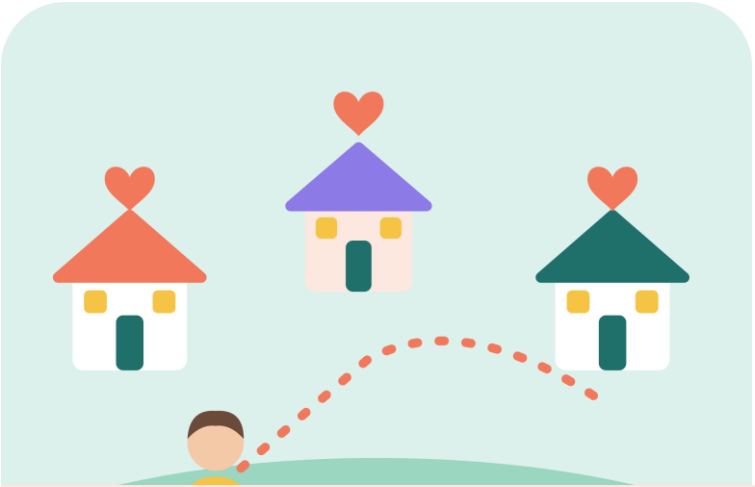


Centres are funded on a weighted per-capita basis, with the funding being influenced by the above risk assessments of the persons registered for the centre’s care. The centre then decides how to distribute resources among participating staff. This arrangement gives local teams flexibility to organize services around the needs of their population, to maximize cost efficiency of their services, to prevent perverse incentives/duplication of effort.

Sources: INAMI-RIZIV, “Maisons médicales”; Legrève C, Jamart H, Defrenne F. Le forfait nouveau est arrivé. Santé conjuguée 2013;65 (Fédération des maisons médicales).

2. Key characteristics of the Belgian integrated-care approach

2.4. Primary Health Care Zones and community health centres



Centres hire social workers who enable the proactive outreach of vulnerable people and hence realise population health management.

Evidence (KCE 2008, matched cohorts of ~25 000 patients each): capitation practices had the same total insurer cost (€1 267 vs €1 280 per patient) – more primary care, less spending elsewhere – and equal or better quality on several indicators.

Source: Annemans L, Closon J-P, Closon M-C, et al. Comparison of the cost and quality of two financing systems for primary care in Belgium. KCE Reports 85A, 2008.

2. Key characteristics of the Belgian integrated-care approach

2.5. Improved access supported by nurses' professional autonomy

Belgian capitation can cover general practice, nursing and physiotherapy, giving nurses a funded, autonomous role in the primary-care team – a model for Romanian areas without a family doctor.

To verify before use: whether a nurse-only centre can be recognised and funded on its own (not confirmed in official INAMI sources).



Source: INAMI-RIZIV, "Verzorging in medische huizen" (disciplines covered by the forfait).

Part 3 – Romania: what already exists

Bottom-up models and national building blocks

3. Integrated care at community level in Romania

3.1. A number of integrated value-based services have been developed bottom-up, responding to effective needs of specific populations - examples:

Slatina-Timiș (Caraș-Severin): community health centre run since 1999 by a mutual-aid association (ADAMS) – family doctor, chronic-patient follow-up, home care, outreach to vulnerable people

Harghita County home-care network – the claimed coverage (≈90% of the county vs 15–20% nationally) is not yet documented; nationally, only 2.9% of people 65+ used home care (EHIS 2019)

NoRo centre, Zalău (since 2011): integrated medical, social and educational services for people with rare diseases and their families; >2 000 patients in its first 10 years

Sources: ADAMS / slatina-timis.be (self-published); Eurostat hlth_ehis_am7u (2019); Agerpres, 28 Jun 2021 (NoRo). No independent evaluation was found for these three models.

3. Integrated care at community level in Romania

3.2. Cost effectiveness

These models are reported to reduce hospitalisation, but no published cost-effectiveness analysis was found for them. Producing that evidence is a core aim of the pilots proposed below.

3.3. Integration of information systems

Initial steps for databases integration have been achieved as substantial effort has been made to propose an Order for database integration. The legal provision (Ministerial Order) is now at the final-draft stage and awaiting approval, followed by capacity building of public and private operators, systematic collection of data and data analysis.

Search of published and grey literature, Oct 2026. The draft ministerial order on database integration is reported here by the authors (status as of 2026).

3.4. National building blocks Romania can scale from

1 Legal basis

Emergency Ordinance 18/2017 on community health care: integrated community centres (Art. 11), financed from local budgets; community nurses and Roma health mediators.

2 Infrastructure (RRP, Component 12)

Target of 200 integrated community centres built/renovated (201 objectives approved, Jun 2023; €40.2 m) and 3 000 family-medicine practices equipped (€180.45 m). Completion not yet verified.

3 A tested model

UNICEF Minimum Package of Services, Bacău (from 2015; 34 rural, 4 urban municipalities): unvaccinated children −40%, school drop-out −60% (UNICEF before–after data).

4 Scale experience

ESF-funded “integrated community services” project: 139 rural and small-urban communities, 40 months (Ministry of Labour with Health and Education).

Sources: OUG 18/2017 (consolidated, MS 24 Nov 2023); Ministry of Health, PNRR C12 I1.4 and I1.1 beneficiary guides (2022) and approved list (15 Jun 2023); UNICEF Romania, Minimum Package of Services – evaluation (2019); fiscalitatea.ro, 12 Sep 2018 (press). OECD/Observatory 2025 confirms plans for RRP-financed integrated community centres.

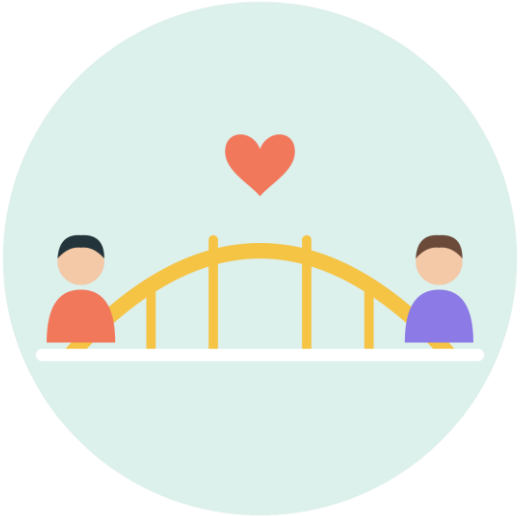
Challenge the evidence: what a sceptic would say

Integrated care is not a cost-saver by default	Reviews find better patient satisfaction, perceived quality and access; effects on costs and hospital use are inconsistent. Do not promise savings – measure them.
Belgian pilots: process success ≠ proven outcomes	Belgian evaluators “were unable to prove the impact of the projects on patient outcomes”; evaluation capacity and stable funding were missing. Process gains are not health gains.
Self-reported data flatter Romania	Only 5.4% of Romanians report bad health (EU 8.8%) despite 2.3× treatable mortality: expectations and reporting differ. Target with objective data.
Rural is not uniform	Home-care use at 65+ is higher in rural (3.9%) than urban Romania (1.5%); regional life expectancy varies by only 2.3 years while physician density varies 4.7×. Context decides design.
Transferability is limited	Belgium spends 2.5× more per person and has a dense primary-care and nursing workforce; copying structures without money and people will fail.

Sources: Baxter S, et al. BMC Health Serv Res 2018;18:350 (integrated-care review); Eurostat hlth_silc_18 (2025), hlth_cd_apr (2023), hlth_ehis_am7u (2019), demo_r_mlifexp and hlth_rs_physreg (2024), hlth_sha11_hf (2024).

4. What lessons can be shared

The Belgian experience, as summarized above, highlights several areas for consideration in Romania as potential directions for policy development.



4. What lessons can be shared

- Reform takes time (Belgium started in 2015)
- National leadership to set direction is critical;
- Allow for pilots , evaluate outcomes using transparent measures, and disseminate effective practices before scaling them up
- Introduce proactive outreach to identify vulnerable people and connect them with appropriate care.
- Improve data sharing.
- Make professionals happy, promote multidisciplinary work
- Consider funding and organizational arrangements **that give local teams flexibility** while maintaining accountability for quality and access.
- Prioritize interventions by target groups, geographical settings

Part 4 – From lessons to action

A feasible action-research path to pilot integrated, value-based care in rural Romania

Why action research: learn while changing, with the people who deliver and use care

1. **Plan**
   Co-design the change with community, team and payer
2. **Act**
   Introduce one change at a time in the pilot site
3. **Observe**
   Routine data, PROMs/PREMs, interviews
4. **Reflect**
   Joint review in the local steering group; adapt

↻ *Repeat every quarter in each site*

What it adds to a classic pilot

- Research with, not on, communities: patients, nurses, GPs, mediators and mayors shape the change (participatory action research).
- Short, documented cycles let a model adapt to each rural context instead of failing as a fixed protocol.
- Builds local analytic capacity – the gap Romania's bottom-up models still have (cost-effectiveness rarely published).
- Mirrors Belgium's staged logic: framework → pilots → evaluation → scale-up.

Method reference: Cornish F, et al. Participatory action research. Nat Rev Methods Primers 2023;3(1). doi:10.1038/s43586-023-00214-1.

Proposed roadmap: modify, implement, pilot, decide

0 Phase 0
Months 0–6

Prepare & enable

- Inter-institutional steering group (MoH, CNAS, INSP, DSP, local authorities, patients)
- Legal enabler: ministerial order allowing pilot payment and data linkage
- Baseline from linked data; site selection; ethics

1 Phase 1
Months 6–18

Co-design & launch

- Registered, risk-stratified population lists
- Integrated team formed; pathways for hypertension, diabetes, heart failure, COPD, screening
- Action-research cycle 1

2 Phase 2
Months 18–36

Implement & iterate

- Quarterly action-research cycles in each site
- Shared dashboard (value indicators)
- Mid-term review; adapt the model

3 Phase 3
Months 36–48

Evaluate & decide

- Independent mixed-methods and economic evaluation vs matched comparison areas
- Go / adapt / stop decision; normative package for scale-up

Proposal by the authors, modelled on the Belgian sequence (framework → pilots → evaluation → dissemination). Durations are indicative and depend on the legal enabler and funding.

Pilot design: who, where, what and how it is paid

1 Where

Three to four contrasting rural micro-areas: one in a high-deprivation region (e.g. Nord-Est), one in the lowest-density region (Sud-Muntenia), one building on an existing model (e.g. Slatina-Timiș or Harghita home care); matched comparison areas.

2 Who

Integrated team around a registered list: family doctor, community nurse, Roma health mediator, social worker; pharmacist and physiotherapist linked; tele-consultation with specialists. Nurse-led satellite where no family doctor is present (Belgian lesson 2.5).

3 What

Proactive outreach to the whole list; risk stratification; protocol-based care for hypertension, diabetes, heart failure, COPD; navigation to cervical, breast and colorectal screening; home care; social referral.

4 How paid

Blended: existing capitation + fee-for-service, plus a risk-adjusted per-capita top-up for the registered list and a small bonus for outcome targets (e.g. blood-pressure control, screening coverage); local health–social budget pooling.

Proposal by the authors. Site examples follow the regional evidence in Part 1; Slatina-Timiș, Harghita and NoRo are described in Part 3.

Measuring value: a compact indicator set for every pilot site

Domain	Indicator (baseline → every 6 months)	Data source
Health outcomes	Blood pressure <140/90 among registered hypertensives; HbA1c <7% among diabetics	Practice registries / electronic records
Avoidable hospital use	Admissions for ambulatory-care-sensitive conditions, age-standardised (OECD definition)	Hospital discharge data (DRG), CNAS
Equity	Screening coverage and outcomes: rural vs urban, Roma and low-income groups	Screening registries; list data
Patient-reported	PROMs (EQ-5D-5L) and PREMs (OECD PaRIS questionnaire)	Patient survey
Cost	Total health + social cost per registered person; cost per QALY	CNAS claims linked to social data
Workforce	Retention, workload, job satisfaction of team members	Staff survey
Implementation	Reach, adoption, fidelity, maintenance (RE-AIM)	Action-research logs, interviews

Indicator choices follow the four value dimensions (EXPH 2019) and the Quadruple Aim; PaRIS = OECD Patient-Reported Indicator Surveys; RE-AIM = implementation-science evaluation framework.

What must change first: enablers, risks and mitigations

Enablers to modify first

- Ministerial order allowing pilot payment: risk-adjusted per-capita top-up for a registered list, within the CNAS framework contract
- Adopt the pending order on database integration; pseudonymised linkage of CNAS, hospital, screening and social-assistance data
- Use OUG 18/2017 integrated community centres and RRP-funded facilities as the delivery platform
- Formalise task sharing: community nurses, health mediators, social workers in the team contract
- Pooled local health–social budget (local council, CNAS, county public-health directorate)

Main risks → mitigation

- **Too few family doctors in pilot areas** → nurse-led satellites, tele-consultation, rural incentives
- **Project funding ends** → CNAS contract line negotiated from Phase 0
- **Data protection blocks linkage** → GDPR impact assessment; pseudonymised linkage by a trusted third party
- **Capitation encourages under-treatment or patient selection** → risk adjustment plus outcome monitoring
- **Political turnover** → cross-party steering group; publish results openly

Proposal by the authors. Legal references to be checked against the current consolidated texts before submission.

Conclusions

Belgium offers approaches worth testing – patient partnership, population health management, data integration, multidisciplinary teams with autonomous nurses, risk-adjusted capitation and staged pilots. Its own evaluation shows that outcomes must be measured from day one.

Romania's need is greatest where services are thinnest: treatable mortality 2.3× the EU, rural cervical screening below half the EU level, twice as many people per rural family doctor.

Next step: a 48-month action-research pilot in contrasting rural areas, with a legal enabler, risk-adjusted payment, a value indicator set and a pre-agreed scale-up decision.



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Annex – Critical review of the previous version and changes made

Issue in the previous version	Change in this version
No quantitative evidence on Romania's needs, the EU gap or the rural–urban gap	Ten evidence slides from Eurostat, INS, OECD and GBD 2023, each with source and year
Unsourced claims (Harghita coverage, "cost-effectiveness has been calculated", 42 risk criteria)	Sourced where verifiable; otherwise flagged "to be documented"
Belgian timeline and levels of government blurred (federal pilots vs regional primary-care zones)	Dates checked against official and evaluation sources; levels distinguished
Terminology and drafting errors ("value best care", "The notes also emphasize…"), wrong static slide numbers, mixed fonts and title positions	Corrected to "value-based care"; text rewritten; automatic slide numbers; fonts and titles harmonised
Lessons stated, but no route to implementation and no metrics	Action-research roadmap, pilot design, indicator set, enablers and risks
No counter-evidence or limits	Challenge slide and caveats in every source note
No references	Reference list with DOI, PMID or official URL

Thank you

