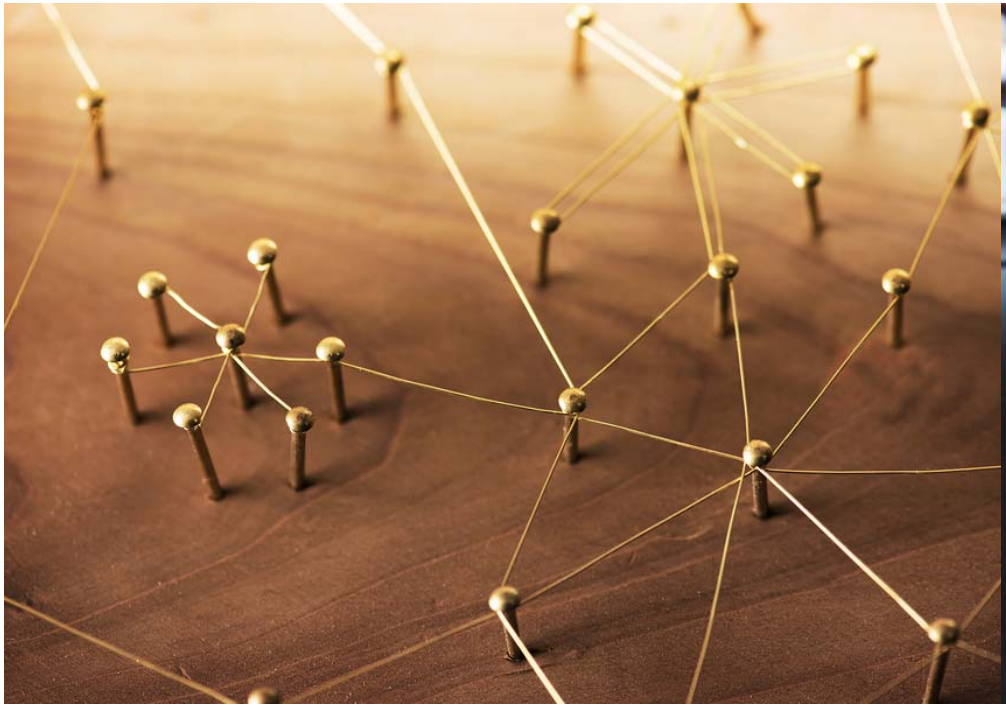
KCE REPORT 277Cs

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

SHORT REPORT

GOVERNANCE MODELS FOR HOSPITAL COLLABORATIONS



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HEALTH SERVICES RESEARCH

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GOVERNANCE MODELS FOR HOSPITAL COLLABORATIONS

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FOREWORD

Several studies were launched in the context of the larger reform of the Belgian hospital landscape and payment system, and KCE was assigned a number of them. Some of these studies are very technical, like for instance the clustering of pathology groups – dry as dust and only appreciated by the inner crowd of experts. Other subjects, like in this study, are far more exciting, because they deal with relationships and the balance of power, with inventing new concepts and structures, with building the future in concrete terms.

After decades of relative stagnation, it seems that now the so complex Hospital Act is finally getting refreshed. Large parts will have to be re-written completely to offer a framework for the new, future-oriented healthcare landscape with collaboration, task distribution and integrated care as leitmotiv. Well-balanced, new governance models have to ensure that the motivation and incentives are in the desirable direction such that they support the switch from competition and rivalry to collaboration and rational-minded task distribution. Thus, no old ideas parading as new ones but time to start from scratch. At least so to speak because fortunately we could fall back on a lot of literature and instructive experience both from Belgium as from abroad.

We took up this challenge together with the dynamic team of the 'Universiteit Gent/Universitair Ziekenhuis Gent', and we sincerely thank them for this nice partnership. Furthermore, the research team received valuable input from field experts: members of hospital management committees, boards and medical councils, etc. We would like to thank all of them for their time and commitment.

We hope that the result of this study corresponds with the high legal and managerial complexity of the subject but also appeals to the common sense from the many executive staff on the field who are enthusiastic and passionate to build the future.

Christian LÉONARD
Deputy general director

Raf MERTENS
General director

SHORT REPORT

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1. INTRODUCTION

1.1. Scope and objectives

The number of collaborations between Belgian hospitals has vastly increased during the last decade. The reasons for collaboration vary and include financial pressure (e.g. the common exploitation of shared services such as a HRM department), government regulations (e.g. cardiac care programmes), sharing scarce human resources (e.g. interventional radiology) and providing patient-centred integrated care. Following the new regulation guidelines in the Action Plan of the minister of Social Affairs and Public Health (April 2015), hospitals have to become part of a larger care collaboration,[1] in which they will need to join forces to better coordinate and integrate patient care across hospital boundaries and enhance task distribution. Possible examples of such collaboration and task distribution are the concentration of highly-specialised services, such as rare cancers, in reference centres[2, 3] or the rationalisation of general care services such as maternity services. The basic principles in the Action Plan have recently been operationalised in a vision statement of the minister (October 2016). We discuss the main lines of the vision statement in the concluding section 5.

As mentioned in several policy documents[1-3] the collaborations and governance structures in the current Belgian Hospital Act[a] are not sufficient to guide these new developments. New governance models are needed to support hospital collaborations that facilitate task distribution and the care coordination across hospital boundaries. The overall goal is to provide better quality of care in an efficient way.

This study aims to identify governance models (see Box 1) that support collaborations enhancing task distribution and cost-effective care and to define recommendations for the Belgian legislator to adjust the current Hospital Act accordingly. We focus on collaborations between hospitals involving at least clinical services (e.g. cardiac care programme) and/or major medical equipment and not only focusing on collaborations for support services (e.g. IT, maintenance, etc.). The specific research questions can be found in Table 1.

Box 1 – Definition of governance

In this study we define **governance** as an interaction between people or a group of people (governance-actors) wherein the decision making is not the responsibility of only one party, but where a complex interplay of control and balancing mechanisms should enable governors to make decisions whereby the interests and goals that lie in the foundations of their relationship (in this case the coordination of patient care across hospital boundaries and task distribution) are realised.[4]

Governance relates to five key attributes: (1) accountability, (2) transparency, (3) participation of affected interests, (4) integrity and (5) policy capacity. Governance problems can be traced to one or more of these attributes.[5]

1.2. Methods

The study applies several research methods: literature review; case studies; stakeholder consultation. The main steps of the research are summarised in Table 1. To enhance the readability of this short report it was decided to not always refer to the respective legislation. We refer the reader to the scientific report where all relevant references are made.

[a] Article 67 of the coordinated Law of 10 July 2008 on hospitals and other healthcare institutions (hereinafter referred to as the 'Hospital Act') provides that special norms can be enacted for hospital groups, mergers and associations of hospitals.

Table 1 – Research questions and methods

Research questions (what)	Method (how)
How can governance and the governance of hospital collaborations be defined? **Clarification of:** • **the concepts of governance (public versus corporate governance)** • **the concept of hospital governance** • **governance of hospital collaborations**	• Ad-hoc search of the (grey) literature to identify reference books and reports
Which governance models, that aim to support task distribution and collaboration between hospitals, are described in the literature? What lessons can be learned from these governance models?	• Literature review of peer-reviewed studies
What is the Belgian legal context of the governance of current initiatives that aim to support task distribution and collaboration between hospitals?	• Review of relevant legislation and official documents • Expert consultation
Which types of governance models can be identified and what are the barriers and facilitators in the current Belgian (legal) context?	• Six case studies of Belgian hospital collaborations, selected on the basis of the type of governance model and collaboration initiative. Information was gathered during interviews in the participating hospitals and was complemented with telephone interviews, with separate sessions for: o Physician representatives o Administrators o Hospital management (chief executive officers, chief medical officers etc.) o Network coordinators • The case descriptions were validated by a key informant per collaboration initiative
Which lessons can be learned from an analysis of healthcare systems abroad that underwent reforms on the domain of governance models in order to stimulate task distribution and collaboration between hospitals?	• Selection of four international cases with data collection based on: o Literature (grey literature: research reports, legal documents, papers from professional organisations) o Interviews with key contact persons per country/collaboration (visits, telephone, Skype) • The case description was validated by at least one country expert per country
Which governance models are supporting task distribution and collaboration between hospitals? **What is the support of Belgian stakeholders for the proposed**	• Several governance models that have the potential to better support task distribution and collaboration between hospitals in the future were drafted by the research team and presented to Belgian stakeholders to evaluate feasibility and support. This was done via:

models?	o The organisation of roundtables for Dutch- and French-speaking participants. In each language group three roundtables were organised, respectively oriented towards: ▪ Hospital managers ▪ Representatives of medical councils ▪ Administrators
What are the legal possibilities and constraints which can have an impact on new legislation on hospital governance?	• For each proposed solution the legal possibilities and constraints were analysed, taking into account Belgian and European legislation.
Scientific validation	• Review of this report by three independent scientific experts.

2. TYPES OF HOSPITAL COLLABORATIONS AND GOVERNANCE MODELS

2.1. Types of hospital collaborations

In this study a collaboration is defined as a partnership between organisations with a collective goal and an integrated strategy to achieve this goal. Only collaborations with the overall goal to enhance the quality, knowledge and expediency of patient care are included. These collaborations can be at the level of a hospital, but also at department or service line level. A service line focuses on one type of pathology or service across hospital borders. The care programme for cardiology, for example, focuses on a specific service with specialised treatments (B3: cardiac surgery; B2: interventional cardiology) and basic treatments (B1: invasive diagnostic cardiology).[6] Since not all hospitals are allowed to deliver these specialised treatments, they collaborate to guarantee this type of care for their patients.

Different types of collaboration are mentioned in literature, such as hospital alliances and joint ventures.[7, 8] The two types of collaboration most discussed in literature are health networks and health systems (see the upper part of Figure 1).[9] **Health networks** are created to function as interdependent wholes while maintaining each organisation's separate legal identity. Bailey and Koney (2000)[10] developed a specific definition for networks in healthcare organisations. A network is identified as an integrated service system with the goal of improving service delivery. The authors differentiate two network forms: horizontal and vertical networks. The collaboration within horizontal networks is between similar care organisations, which offer more or less the same services. Vertical networks are identified as collaborations between organisations with different service offerings.

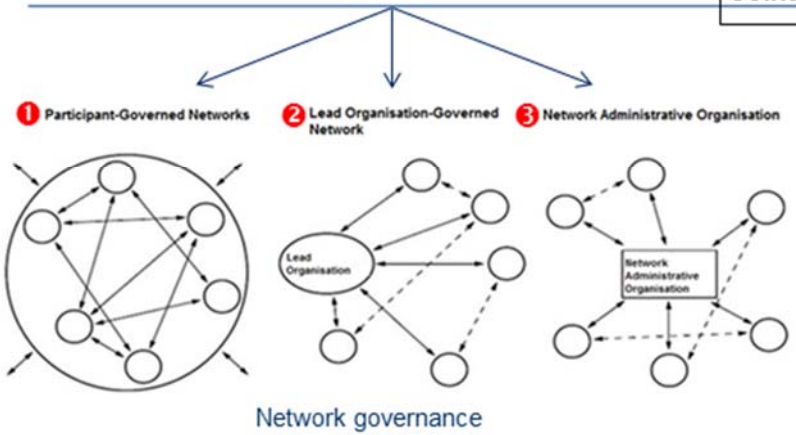
A **health system** consists of a corporate body that owns and/or manages several healthcare facilities. It is a legally recognised permanent arrangement in which common ownership, management, or leasing exists for all or most of the components.[11] Health system affiliation represents a stronger form of integration in comparison to health networks.[12] Health networks are more loosely coupled collaborations than health systems because the autonomy of the individual organisations is still present. However, health networks as a collaboration form do not only rely on 'informal' relationships, but also on contractual agreements.[13]

Box 2 – Definition of collaboration

The concept **collaboration** is used in this study as an overall concept for a partnership between organisations. It encompasses all types of collaboration, including health networks and health systems. When reference is made to a health network or a health system, the above-mentioned definitions are applicable.

Figure 1 – Types of collaboration: health networks and health system

	Health networks	Health systems
Forms	More **loosely coupled** multihospital arrangement, in which hospitals are linked in a number of ways such as **contract agreements** to pursue specific objectives	**Formally structured** multihospital system, in which hospitals are tightly coupled and are linked through **formal and structured relationships**
Ownerships	**Multiple ownerships** **Each hospital** maintains its separate **legal identity**	**Single ownership** Owned and managed by a certain **legal entity**
Decision making	**Joint planning and decision making** **Independent implementation**	Planning by a **central administrative authority** **Jointly pursue common interests**



Source: Yu and Chen (2013)[9]; Provan and Kenis (2008)[14]

2.2. Types of governance models

Since most collaborations that are identified in literature are health systems or health networks, we focus on the governance structures within these types of collaboration. According to Provan and Kenis (2008)[14] governance of health networks 'involves the use of institutions and structures of authority and collaboration to allocate resources and to coordinate and control joint actions across the network as a whole'. As inter-organisational collaboration can be organised in different ways, several forms of governance structures exist within health networks. Provan and Kenis[14] identified three types of governance structures in networks, namely participant-governed network, lead organisation-governed network and network administrative organisation (see the lower part of Figure 1).

The '**participant-governed**' or 'shared governance' or 'self-governed' network form has no separate governance entity and governance is the responsibility of each organisation in the network. Power is more or less equally spread among the organisations. Trust is crucial in this form. The second form, the '**lead organisation**' is characterised by a dominant organisation in the network that takes responsibility for the governance in the network. In the third form, the '**network administrative organisation**', a separate entity is created for governance reasons. In the lead organisation and network administrative form, organisations in the network give up part or all decision-making power to respectively the lead organisation or the administrative entity. These leading organisations or entities develop some authority over the other organisations and a kind of hierarchy might be established.

Health systems have a different governance structure than the structures described within the framework of Provan and Kenis.[14] Therefore, we identified a **health system as a fourth more integrated governance structure** (see Figure 1). In a health system a hierarchical control method is applied, meaning that a central board is in charge of the overall coordination (similar to a lead organisation network).[15] This single ownership is held by a sole party in the health system (as opposed to a health network), all hospitals or other facilities are part of one organisation with one ownership. However, operational decision making can be performed at the level of individual hospitals or at the sector level (e.g. all general hospitals) or at the level of the business units (e.g. individual departments or care programmes).

2.3. Governance mechanisms at macro level

External factors, such as macro-level mechanisms that are used to coordinate the healthcare system, also affect the governance of hospitals and hospital collaborations. These are often called '**governance mechanisms**', as they influence to a large extent the way hospitals and healthcare organisations are internally governed. Three types of governance mechanisms can be identified: 1) authority and hierarchy of the state; 2) markets and 3) civil society.[16]

- When the healthcare sector is centrally steered, the governance mechanism '**authority**' is most present. If authority is the core concept, central administrative regulations and orders, rules and planning are used to govern the different actors. In Denmark, for example, the system is to a large extent steered by the regional authorities.[17, 18] As such, there are no boards on hospital level but only one overarching board on a regional level wherein regional politicians participate. Also in Belgium, the government intervenes through planning, authorisation and financing regulations, but leaving substantial freedom to the healthcare sector.
- '**Markets**' are characterised by competition, negotiations and exchange between several actors and their working is based on price mechanisms. The logic is that through competition, hospitals will increase quality while reducing costs.[19] Hence, the market is assumed to balance the healthcare sector without the need of the government to intervene a lot. This mechanism is present in the United States healthcare system. Intermountain Healthcare,[20] for example, invests in the best quality of care but also in efficiency to attract patients in their region. Competition has improved performance of Intermountain. Because of its success, the organisation kept on growing which complicated governance and decision making. To maintain the quality and the task distribution in their services, they became an integrated health system.

- '**Civil society**' is comprised of groups or organisations working in the interest of the citizens but operating outside the public and for-profit sectors. Organisations and institutions that make up civil society include labour unions, not-for-profit organisations and other service agencies that provide an important service to society.[16] As most healthcare organisations are not-for-profit in Belgium, the healthcare sector is mostly influenced by this mechanism.

Nowadays, societal needs like housing, healthcare and education, are increasingly fulfilled by a combination of the three mechanisms. These three mechanisms affect the way governance in hospitals and collaborations is organised and mixed forms, such as regulated competition, occur. This makes the already complex interplay of control and balancing mechanisms, i.e. good leadership[21] and good governance structures[22] even more complex. As a result networks occur to engage public, private and civil society actors at transnational, national, regional and local scales in shaping the future of our societies.[23]

Box 3 – Governance structure and governance mechanism

The concept **governance structure** refers to the use of institutions and structures of authority at the level of hospitals or hospital collaborations.

The concept macro-level **governance mechanism** refers to the governance of the healthcare system at national or regional level. Three types of governance mechanisms can be identified: authority and hierarchy of the state, markets and civil society.

3. CURRENT HOSPITAL GOVERNANCE AND COLLABORATION TYPES

This chapter gives an overview of the current governance structures in Belgian hospitals (section 3.1) and hospital collaborations (section 3.2). The chapter concludes with a number of shortcomings in the collaborations and corresponding governance structures as currently defined in the Hospital Act (section 3.4). These shortcomings were identified on the basis of a legal analysis of the Hospital Act, as well as from the Belgian case studies (section 3.3) and the round-table discussions.

3.1. Governance of Belgian hospitals

The institutional governance in Belgium is still focused on single hospitals wherein several actors interact to govern the hospital (see Figure 2).

3.1.1. The General Assembly

Each hospital that is organised as a not-for-profit association has a general assembly which is composed of the members of the not-for-profit association.[24] The general assembly has some reserved powers such as the amendment of the statutes of the hospital, the appointment and discharge of the board members and the approval of the budget and financial statements.

Other similar structures exist, for instance in hospitals that are linked to Public Centres for Social Welfare ('OCMW'/'CPAS'), intercommunal collaborations or universities.

3.1.2. The Board

At the highest hierarchical level, a hospital is governed by the hospital board. It fulfils the role of the 'administrator' as defined in the Hospital Act. The board is responsible for the organisation, functioning and financial flows of hospital activity.[24] In the hospital board experts in healthcare or in other fields, such as financial, legal or ethical, usually have a seat. In public hospitals, (local) politicians are also represented. An overall commitment and expertise of board members is important. Also the independence of the board is crucial.[24] It is for example generally recommended that the board consists of a majority of non-executives. A common practice in Belgian hospitals consists of executives seating in each other's board. The underlying idea is that it leads to a win–win situation, as it yields reference material for both institutions. Until now, executives of neighbouring hospitals do not easily participate in each other's board. After all, this practice is not always free from any exercise of power and influence. Therefore, it is advisable that charters of good governance such as those published by the hospital umbrella organisations[25] are implemented by each hospital board.

3.1.3. The executive management

Each hospital has a chief executive officer (CEO), who is appointed by the hospital board and is directly and exclusively accountable to it. His/her tasks include the management of the hospital. The CEO co-operates closely with those responsible for the medical, nursing, paramedical, administrative and technical departments. Together they constitute the executive management.[26]

3.1.4. The role of the medical specialist in hospital governance

Chief medical officer

The involvement of physicians in the decision-making structures is crucial. This is regulated via the function of chief medical officer (CMO), the medical council and other advisory bodies such as the 'permanent consultation committee'.[26]

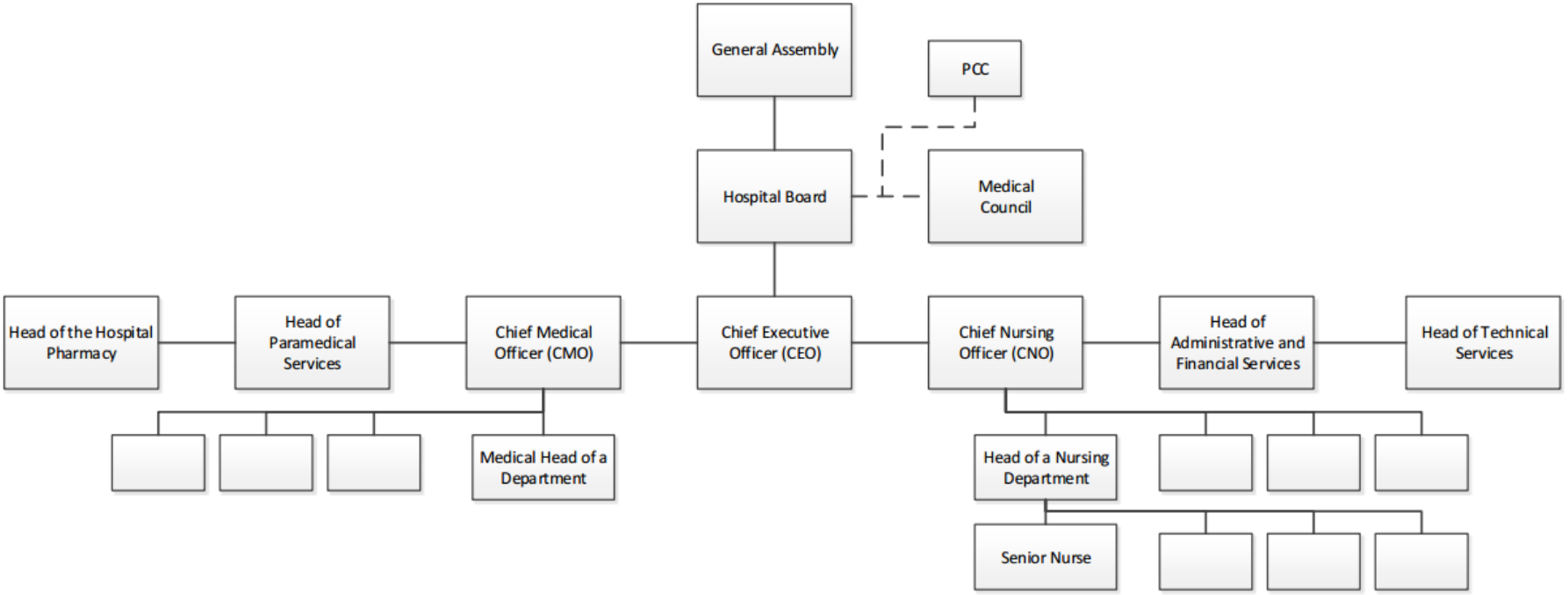
The CMO is appointed by the board (after a so-called reinforced advice ('verzwaard advies'/'avis renforcé') of the medical council) and has the responsibility to involve physicians in the hospital activities in an integrated way. Physicians have professional medical autonomy. Consequently, regulations imposed on physicians by means of the Hospital Act concern the working conditions (e.g. organisation of working hours and on-call availability) and not the therapeutic and intellectual activities. In addition, the degree of the say of the hospital management in the working conditions of the hospital physicians varies according to their employment status. In the vast majority of hospitals physicians are self-employed while only in university and some public hospitals physicians are employees or civil servants.[26]

Medical council and permanent consultation committee

The hospital board is obliged to ask for advice from the medical council (an elected body) on 18 matters (e.g. yearly budget estimates; changes in medical departments; modification of the destination of service that has an influence on the medical activity). The hospital board is not obliged to follow this advice except for six matters with so-called 'reinforced advice', for example concerning the general regulation; determination of staff that is financed via deductions on physician fees; decisions about medical equipment financed by physician fees. In case the hospital board disagrees with the reinforced advice and fails to achieve consensus, a quite cumbersome arbitration process, including the appointment of a mediator, is started.[26]

Via the permanent consultation committee (PCC) of physicians and board members a legal possibility was created to replace the procedure of advices from the medical council by a procedure with direct deliberation between both parties (that subsequently needs to be ratified by the respective committees of the participating organisations). However, if the medical council or the hospital board disagrees or the permanent consultation committee fails to find a consensus, there is a fall back on the normal procedure.

Figure 2 – Institutional governance in Belgium



Source: Organisational chart in a Belgian context, p138, Eeckloo (2008)[4]

3.2. Types of hospital collaborations and their governance model as defined in the Hospital Act

The Hospital Act provides three types of collaboration between hospitals in which governing bodies of the participating hospitals (see section 3.1) play a central role: an association[27], a group[28] and a merger[29]. Furthermore, three articles of the Hospital Act (article 10, article 11 and article 107) relate to types of collaboration between hospitals and other care providers requiring authorisation from the competent minister. On the basis of article 11 four types of clinical collaborations, all with a specifically defined governance structure, have already been regulated by different royal decrees: cardiac pathology, paediatrics, stroke and rare diseases. In addition to the collaboration forms that are included in the Hospital Act, numerous collaborations emerge with contractual agreements. The governance of these collaborations is defined on a contractual basis.

In this section we focus on the three dominant collaboration forms in the Hospital Act: hospital group, hospital association and hospital merger (for more details about other collaboration forms we refer to the first legal chapter in the scientific report).

3.2.1. Hospital association

Aim and scope

A hospital association ('ziekenhuisassociatie'/'association d'hôpitaux') is a collaboration between two or more hospitals aiming at the joint exploitation of one or more care programmes/ hospital departments/ hospital functions/ hospital units/ (medical) technical departments. It allows hospitals to collaborate in a limited way on a specific topic and is thus a more flexible collaboration form compared to a hospital merger or hospital group.

The association agreement contains a detailed description of the activities that are run by the association and to which catchment area (population) this applies. In particular the type of care programmes, services, functions, hospital sections, medical services, medical-technical services or technical services are specified in the collaboration agreement. The agreement needs the approval of the administrator of each participating hospital following the advice of the medical council.

A specific type of association is the so-called 'association of a care area'. This concept was introduced to adjust the hospital supply to the actual needs of the target population within a particular area. The objective is to specialise or focus hospital functions, medical services, medico-technical services or care programmes operated by the association of care area on a minimal number of sites within a maximum period of ten years from the approval of the convention of the association. To be authorised as an association of a care area, the association must fulfil the authorisation norms for associations as well as additional norms, including the territorial criterion in particular. The territory of the care area should be an administrative district or jointly adjacent administrative districts having at least 150 000 inhabitants. Due to this geographical criterion, the rules require that if a hospital has multiple sites, only the activities organised on sites that are located in the territory of the care area will be integrated in the association. It is not required that all hospitals in the specified territory participate in the association of a care area. However, the reasons why the association does not include all hospitals in the territory must be stated when submitting the agreement for authorisation.

Governance structure

The collaborating hospitals can choose the legal form of the association by creating a legal entity managing the association, or without creating a new legal entity. In case of a new legal entity, the agreement of the association will regulate the legal form of the association and the composition of the governing bodies. Hence, the decision-making committees in the legal entity will have the structure described in the Hospital Act. When no new legal entity is founded, the governance structure will be established following the Hospital Act and described in the agreement.

Each association must appoint a **general coordinator, a nurse coordinator and a medical coordinator**. The general coordinator is responsible for organising and coordinating the administrative activities in collaboration with the CEOs of the participating hospitals. The nurse and medical coordinator are responsible for organising and coordinating the nursing and medical activities of the association, respectively (Table 2).

Hospitals are also required to have an association committee and a common medical committee. The **association committee** is composed of board members appointed by each participating hospital. The exact composition of the committee as well as the required majorities in order to take decisions have to be described in the association agreement. Members of executive management can be invited by the committee as an expert even if they are not allowed to vote.

The **common medical committee** is composed of physicians appointed by the different medical councils. The composition and functioning of the common medical committee is described in a written agreement concluded between the medical councils of the participating hospitals which is attached to the agreement of the association. The mandated members of the common medical committee have to defend the agreements (reached in consensus) in their own medical council.

An association also has the possibility to create a permanent consultation committee that decides on matters related to the association for which the advice or the agreement of one or more medical councils is required. The purpose of the PCC is to facilitate the decision making by attempting to find a consensus. If such a consensus is reached, the members mandated by the board and medical councils of the participating hospitals will be required to defend the consensus in their hospital.

3.2.2. Hospital group

Aim and scope

A hospital group ('groepering van ziekenhuizen'/'le groupement d'hôpitaux') is a collaboration between hospitals with agreements about task distribution and complementarity on the level of services, disciplines and equipment in order to meet the needs of the population and to improve the quality of healthcare (e.g. to increase the process of patient referral and continuity of care). The Royal Decree of 30 January 1989 imposes a maximum distance of 25 km between collaborating hospitals.[28] In addition, a hospital group should not lead to a monodisciplinary hospital site, except in the case of geriatric or specialised (Sp-)services.

Governance structure

The governance structure of a hospital group can consist of a new legal entity but it can also be based on contracts, specifying issues such as the collaboration aim; the allocation of tasks; the envisaged rationalisation; financial agreements, regulation of disputes.

A hospital group must have a **common medical committee** which is composed of representatives of the medical councils of the participating hospitals. A second obligation is to install a **coordination committee**, which is composed of representatives of the boards of the hospitals of the group. The medical coordinator, the coordinator for the nursing department and the general coordinator who are appointed for the hospital group, attend the meetings of the coordination committee. The coordination committee convenes several times a year and submits an annual report about the hospital group to the minister responsible for authorisations. The committee supervises the execution of the group contract and should be consulted on all decisions regarding new buildings, extensions, rebuilding of hospitals, changes relating to the type of beds or services, taking into account the complementarity and the quality of healthcare. Each decision regarding investment, the creation of new services or of new medico-technical services by the hospitals of the group, must be approved by the coordination committee. Without this decision no authorisation can be obtained (Table 2).

3.2.3. Hospital merger

Aim and scope

A hospital merger ('fusie van ziekenhuizen'/'fusion d'hôpitaux') is the most far-reaching form of collaboration since it involves joining two or more hospitals in one hospital with one single administrator. Hospitals can only merge if they are located within a range of maximum distance of 35 km. The legislation contains rules on the distribution of different hospital services and functions between the different hospital sites (e.g. if the merged hospital has several similar hospital services spread over different sites, each service must separately comply with the existing authorisation norms).

Governance structure

In case of a merger a legal entity may disappear, another legal entity may be created or an existing legal entity may absorb another one. The merger plan must be drawn up in such a way that there is one hospital board, one CEO, one CMO, one chief nursing officer (CNO) and one medical council for all hospitals involved in the merger. The merger plan (specifying issues such as the aim; legal form; staffing and financial problems; compliance with authorisation norms) must be submitted to the minister responsible for the authorisation of hospitals (Table 2).

Table 2 – Governance structures of current collaboration forms

Collaboration	Legal entity	Governance structure	Decision power	Additional legal requirements
Hospital association	• Creation of a new legal entity • or by contract between hospitals	• **Association committee**: composed of mandated board members appointed by each participating hospital. The composition of the committee has to be described in the association agreement. • **Common medical committee**: composed of physicians appointed by the medical councils of each participating hospital. • Permanent consultation committee (PCC): composed of the members of the association committee and of the common medical committee. • General coordinator, medical coordinator and nurse coordinator: appointed by the association.	• All decisions should be discussed with the medical council in each hospital. • Unclear about the decision making in the board, unless described in the statutes of the association.	• **Specific requirements for an 'association of a care area'**:[30] (1) to specialise or concentrate care; (2) covering a minimum of 150 000 inhabitants; (3) participation is not compulsory for all hospitals of the territory concerned.
Hospital group	• Creation of a new legal entity • or by contract between hospitals	• **Coordination committee**: composed of representatives of the boards of the hospitals of the group. The coordination committee complies with the requirements described in the group agreement. • **Common medical committee**: composed of physicians appointed by the medical councils of each participating hospital. • General coordinator, medical coordinator and nurse coordinator: appointed by the group.	• Approval by the coordination committee of decisions regarding investment, the creation of new services or of new medico-technical services by the hospitals of the group. • Authorisation depends on this approval.	• A group must comply with several conditions to be authorised (e.g. maximum distance of 25 km between hospitals). • Homogeneity of group services must be guaranteed within two years after signing the group contract.
Hospital merger	• Legal entity may disappear • Creation of another legal entity • or absorption of	• Governance structure of a hospital (see 3.1).	• Decision power as in 3.1.	• Hospital boards must ask their medical council to give advice concerning the merger plan. • A hospital merger must comply with several conditions to be authorised, such as:

	an existing legal entity under one administrator with one single authorisation	o a maximum distance of 30 km between hospitals; o the merger plan has to be submitted to the minister responsible for the authorisation of hospitals.

3.3. National and international cases

The governance characteristics of six national cases and four international cases were investigated. In Table 3 and Table 4 a short overview is provided. The cases are discussed in the next section.

Table 3 – Governance structures in the national cases

Type of governance model	Organisation	Description
Resemblance with a health system	Emmaüs	• Emmaüs is a not-for-profit association that provides health and social care to a large group of inhabitants in the province of Antwerp. Emmaüs consists of twenty-four facilities whereof two hospitals. • **Not-for-profit association** with one board of Emmaüs, **two hospital boards, executive management committees and medical councils for each hospital**.
	Vivalia	• Vivalia is an **intercommunal collaboration** in the province of Luxembourg. Vivalia consists of four hospitals with six hospital sites. • The governance structure of Vivalia consists of **one board** comprised of politicians from Luxembourg province and the municipalities. There are no boards at hospital level, only **medical councils and executive management committees**.
Lead organisation network	Iridium	• The Iridium cancer network is a collaboration for the purposes of radiotherapy, oncology, and hematology. Iridium cancer network comprises seven hospitals with GZA ('Gasthuiszusters Antwerpen') as lead organisation. • The governance structure of Iridium follows those of an association. • Iridium is a **not-for-profit association and a hospital association**.
	Vlaams Ziekenhuisnetwerk (VZN)	• The main goal of VZN is to develop a sustainable knowledge network in which the joint optimisation of the quality of care and the quality of management is ensured by sharing and valorising the knowledge within the network. VZN is a collaboration of 25 organisations (centralised structure). • VZN is a **not-for-profit association** and consists of **a board and a medical committee**. VZN also has several clinical and administrative **working groups.** The general assembly controls the board which oversees the activities of the executive committee.
Participant-governed network	Réseau Zenith	• Réseau Zenith is an emerging collaboration which aims to include four general hospitals. The goal is to provide complex specialised services within the collaboration (e.g. cardiac surgery). • There is an **overarching board** Réseau Zenith (each hospital has one vote) and an **executive committee** which is

		responsible for issues organised on a collaboration level. It has not yet been decided whether there should be a new medical committee on the collaboration level, or whether there should be a delegation of the existing medical councils. • There is equal decision right in the overarching board.
	Klinik Sankt Joseph, Centre Hospitalier Chrétien (CHC), Sankt Nikolaus Hospital	• There are three hospitals in the collaboration with equal decision right. The goal of the collaboration is to enhance patient transfers and collaborations for certain care programmes. • Each **hospital board** and **medical council** of the participating hospitals decide about strategic decisions that might impact the individual hospitals' budgets. The **strategic committee** has the ultimate responsibility for implementing the collaboration, but has no decision-making power over services that are still provided by the individual hospitals. The **operational committee** is responsible for the effective implementation of the goals defined by the strategic committee and for achieving the objectives of the collaboration. • There is equal decision right in the strategic committee.

Table 4 – Governance structures in the international cases

Type of governance model	Country	Organisation	Description
Centrally steered, some **resemblance** with a **health system**	Denmark	Southern Region of Denmark	• The Southern Region operates **four hospital units** (with different sites) in different areas and different cities and towns in the region. • Hospital governance is organised predominantly at a regional level (facilitates task distribution between facilities).
Health system	US	Intermountain Healthcare	• Intermountain Healthcare is a not-for-profit health system and runs and owns 22 hospitals and a large range of clinics and services. • Intermountain has evolved to a structurally integrated health system. • There is a centralised management structure with a shared general ledger and coordinated budget planning.
Participant-governed network	Italy	Oncological network for the Area Vasta della Romagna (AVR)	• AVR has laid the foundations for a new management model called the Comprehensive Cancer Care Network (CCCN) based on the integration of entities without a defined hierarchy or central governance that manages all the services offered and defines the role of the components of the network. • The CCCN is steered by the government. There is consultation between the strategic management board and the professional board.
Participant-governed network	The Netherlands	Embraze	• Embraze consists of seven hospitals in Southwest Netherlands and two radiotherapy centres that have joined their oncology care services. • Governance is organised bottom-up, with network tumour groups at the bottom. There is a board and an executive committee.

3.4. Shortcomings in the current collaboration initiatives and in the Hospital Act that hinder successful coordination and task distribution

The three types of collaboration between hospitals that are currently regulated by the Belgian Hospital Act allowed hospitals to collaborate on several domains. Yet, these legal collaboration forms are no longer sufficient to guarantee coordination between and task distribution among the participating hospitals. In some cases the hospitals search for other legal forms (such as a not-for-profit association or by making a specific contract between the different parties that is not regulated by the Hospital Act). From the legal analysis of the Hospital Act as well as from the Belgian case studies and the round-table discussions a number of shortcomings in the collaborations and corresponding governance structures as currently defined in the Hospital Act could be identified. These shortcomings should be viewed as barriers to set up a collaboration and a governance structure that stimulate collaboration and task distribution.

3.4.1. The relationship between committees of the collaboration and the participating hospitals

Lack of power at the collaboration levels makes the decision-making process lengthy

An important governance problem which was expressed during the round-table discussions and interviews in the context of the Belgian case studies is the lengthy decision-making process. Most interviewees attributed the time-consuming decision-making process to the lack of power of the committees at the level of the collaboration (hospital group or association). After all, decisions require discussions in the competent committees of the participating hospitals and negotiations within or between hospitals, in case of disagreements. Several round-table participants stressed the need for governance models that allow the delegation of (partial) decision-making rights to the governance structures at the level of the collaboration.

Regulation at the level of the collaboration is limited. It is possible under the existing Hospital Act to create a common medical council of two hospitals that work closely together. Article 5, § 6 of the Royal Decree of 10 August 1987 provides that in case of collaborating hospitals, the board and the medical staff may send a common and concurrent request at the Joint Committee of Hospital Administrators and Hospital Physicians ('Paritaire Commissie Geneesheren-Ziekenhuizen'/'Commission Paritaire Nationale Médecins Hôpitaux') at the Federal Public Service of Public Health to organise elections for one single medical council.[31] In addition, regulation has been provided for ethics committees established for a hospital group[28] and for the ombudsfunction when they have a collaboration agreement (article 71 of the Hospital Act).

The medical council and hospital collaboration initiatives: driving force or brake?

There was a general consensus during all six round-table discussions that the participation of physicians is of utmost importance to obtain successful collaborations. Several round-table participants indicated that physicians are often the initiators and driving force behind collaborations. Nevertheless, many of the participants (mainly board members and hospital CEOs) also identified physicians as an impeding factor. The reasons for this differed: the fear of losing financially attractive activities, different financial regulations, travel distance between hospitals, the fear of being less involved in decision making in a large organisation, the need to know different procedures in each hospital, etc.

As such, the current legal obligation to ask advice from the medical council was identified as a major barrier for smooth collaborations by many of the round-table participants. Although there is a legal distinction between a regular and a reinforced advice, it was pointed out that in practice this often does not make a large difference given that in case of strong opposition from the medical council (also on topics without a reinforced advice) collaborations are doomed to fail.

3.4.2. The composition and functioning of the boards

Collaboration and conflicts of interests

At present, board members or members of the executive management of one hospital may be appointed as a board member in another hospital that is member of a collaboration initiative or they may be appointed as a board member of the legal entity that is created to facilitate collaboration among hospitals. This may lead to a conflict of interests potentially influencing governance decisions (e.g. lack of task distribution). The problem of conflict of interests was identified in several of the Belgian cases and the round-table discussions and the need for the implementation of 'good governance principles' was emphasized. Several participants in the roundtables for medical councils also condemned the lack of legal rules to make all governance decisions of the board more transparent for the medical staff. Of course, such transparency works in two directions.

Collaboration is a time-consuming undertaking for the involved decision makers

Board members, members of the medical councils, physicians and executive management invest a lot of time in preparing and attending board meetings as well as in negotiations with the different stakeholders (both within their hospital as with stakeholders from other hospitals). This is not only due to the legal set up of the collaboration committees (requiring, for instance, the participation in several coordination committees with feedback loops to the own hospital board). It is, according to the round-table participants, also due to the organisation of the current healthcare landscape given that collaboration initiatives often emerge(d) ad-hoc which resulted in a situation where hospitals collaborate with many different partners on different domains. Governing all these collaboration forms is time-consuming and is estimated as unsustainable in the long run.

An additional legal complication is the structure of the association that does not allow members of the executive management to participate in the association committee.

3.4.3. Distance and catchment area requirements for collaborations: outdated or relevant?

The distance criteria for a group (max. 25 km) and merger (max. 35 km) were considered as outdated by the round-table participants and interviewed case study participants and an important limitation when setting up collaboration initiatives. However, disagreement among round-table participants existed on whether or not to include distance as a criterion to establish a collaboration. According to some, distance does not play a role (e.g. in terms of accessibility; physician mobility) in a small country as Belgium and therefore they advocated flexible arrangements allowing them to collaborate with hospitals with a similar ideological background, rather than being forced to work together with their neighbours. Other stakeholders were in favour of legal rules on distance on the condition that a certain degree of freedom is kept in the selection process of partners to avoid that existing valuable collaborations from the past could not continue to exist.

In contrast with the legal requirement for associations of a care area to cover a minimum population of 150 000 inhabitants, no such specifications were included in the Hospital Act for mergers or hospital groups. Furthermore, the restriction for associations of a care area to collaborate with hospitals from contiguous areas implies that in case a hospital has multiple sites, only the activities organised on sites that are located in the territory of the care area will be integrated in the association. With regard to an association, no specific references are made to distance.

3.4.4. Different types of partners

Article 15 §2 of the Hospital Act specifies that hospitals are operated by a legal entity whose sole statutory purpose is the operation of one or more hospitals, healthcare institutions or medical-social institutions. Hence, current legislation allows a legal entity to operate hospitals and, for example, institutions for the elderly, but it may pose difficulties for the development of large networks including also organisations that do not provide care. Moreover, the competence of the federated entities with regard to care provided outside hospitals, to norms of hospital services and functions, to additional norms regarding the planning requirements and the authorisation of forms of collaboration, may hinder the creation of (supra) regional networks. An example of this problem is that in case a hospital collaboration crosses the borders of a specific federated entity, authorisation of the hospital collaboration by all federated entities is required.

3.4.5. Hospital staff

Physicians' legal agreements with the collaboration

The Hospital Act requires to have a written general regulation related to the legal relationship between the hospital administrator and the physicians working in the hospital (article 144). Moreover, there should also be an individual agreement between the hospital and the physician. However, there is no legal obligation to have a regulation related to the rights and duties of the collaboration administrator and the physicians working in the collaboration. There are also no direct agreements between physicians and the collaboration, only between the physicians and the hospital where they work.

Physicians working in several hospitals lose voting power

Collaborations that require physicians to work in several hospitals have also implications for the medical council elections. If two hospitals A and B decide to collaborate and, as part of this collaboration, organise services on different hospital sites so that physicians of hospital A also work in hospital B, it will be no longer possible for this physician – if he/she works fulltime – to have the maximum of four votes. Hence, physicians who work in two hospitals have a maximum of two votes in each of the hospitals.

New physician appointments risk to be cumbersome

Physicians working in several hospitals also encounter difficulties with regulations regarding physician appointments. An example is that for new appointments of medical staff that will work in several hospitals of the collaboration, all medical councils in the collaboration have to give their advice before a physician can be appointed. This is very time-consuming and was identified as a barrier in the national case studies.

Medical leadership roles restricted to single hospitals

A CMO of a hospital or the chief of a medical department has to work exclusively at one hospital.[32] This requirement does not allow the creation of large regional networks with one CMO or one medical head of service. This problem exists especially in case of associations since the 'hospital group' rules already state that the CMO and the head of a medical service department can be working in one or more hospitals within a group.[28] This problem was also identified in the national cases.

Fee-for-service payments hinder referrals

Individual hospitals or physicians referring to a collaborating hospital have no financial benefits at the moment because of the fee-for-service system.[25] They do not receive payments for sending a patient to another care provider unless there is the possibility to pool and redistribute the income of the physicians. Hence, physicians are not encouraged to collaborate across hospital boundaries

Deductions on physician fees

The Hospital Act stipulates that physicians must contribute to the financing the costs of medical activities in the hospital.[33] The deductions on physician fees cover costs directly or indirectly linked to providing medical services (e.g. use of rooms, purchasing and maintenance of equipment, staff). The Hospital Act provides *inter alia* that the physician fees related to hospitalised patients (article 147) or related to services accomplished in medical-technical services for patients who are examined or treated in a hospital but who are not hospitalised (article 148) have to be centralised. The administrator may also deduct a certain percentage of physician fees to allow the implementation of measures to maintain and promote medical activities at the hospital. In this case, the administrator and the medical council will fix the percentage by mutual agreement. This agreement is binding for hospital physicians. However, the situation is not always clear in hospitals and this often leads to disputes between physicians and hospitals.

Two main problems can be identified in the context of collaborations between hospitals. First, different agreements per hospital can exist. As such, physicians working in different organisations might need to work under different terms. Second, it is unclear whether such a system can be used at collaboration level (instead of a single hospital), whether it can be used to cover the costs from other hospitals, whether it can be applied to cover costs for care delivered at home, etc. During the round-table discussions and in the national case studies, variation of financial agreements between physicians and hospitals was identified as one of the main barriers. At this moment, if no agreement can be found on this issue no collaboration is set up.

Insufficient flexibility for staff mobility

Larger collaborations also often require other staff than physicians to work in different hospitals. This is especially the case for more integrated systems that aim to transfer personnel from one organisation in the collaboration to another, e.g. the health systems in the national case studies. The existing legal forms of collaboration between hospitals do not cover such flexible staff arrangements. In principle, a hospital cannot allow its own personnel to work for other hospitals of the collaboration. Nevertheless, the system of the so-called employer groups provides a procedure allowing the use of employees of an employer's group for different users. Since the Act of 25 April 2014 regarding various provisions on social security, modifying the Act of 12 August 2000, an employer's group must have the form of an economic collaboration (as mentioned in book XIV of the Corporate Act) or of a not-for-profit association and the provision of staff must be the only statutory purpose of the group. As such, this type of employer's group permits, under the latter conditions, the creation of a pool of employees or co-sourcing. This offers an opportunity to have employees working at several sites of a collaboration and on several days of the week.[34] However, it is not easy to give a general account of a common policy of employees in view of fiscal rules and rules related to employees and social security.[35]

In case of a transfer of an undertaking, the collective labour agreements (CLA) n°32bis have to be applied.[50] In principle there is one competent joint committee for each undertaking and the CLA concluded within the joint committee is applicable. The scope of a joint committee should be determined by the main activity of the undertaking, unless another criterion is defined in the foundation document. This rule is an application of European Directive 2001/23/EG. Yet, it should be noted that the application of this Directive in the Belgian Act has some shortcomings for statutory staff employed by public authorities. As such, for this group of staff some specific negotiations are needed to deal with acquired rights of the staff involved.

3.4.6. Authorisation and payment at the collaboration level

Authorisation and hospital payment at the level of the same legal entity

It is difficult to share revenues in a collaboration since the payment of the hospital budget, called the budget of financial means (BFM), is related to the legal entity running a hospital. Although theoretically possible (via a specific Royal Decree for granting a BFM on the level of the concerned hospital collaboration), in practice collaborations cannot receive a BFM even if they have an own legal entity (e.g. a not-for-profit association). As this is a large barrier to collaborate, it was mentioned in all national cases. Although one of the national cases is a not-for-profit association (which has an own balance sheet), the income of the main activity of the collaboration has to be part of the balance sheet of one of the hospitals in order to obtain a BFM.

The hospital budget for a specific medical department, medical activity or service line is not transparent

The national hospital budget is allocated to individual hospitals by a complex set of rules and criteria. The allocation model does not allow to assign the budget to specific medical activities or services which might complicate a collaboration between hospitals for specific service lines. Moreover, some medical disciplines are profitable, others generate losses. Hospitals have both types of disciplines and gains and losses offset each other to some extent. However, when hospitals start to collaborate, it is to be expected that they will all aim to have the most profitable services in their hospital.

Another complicating factor for a collaboration might be the dependency between activities or services. For example, the emergency department (ED) is very important for a hospital since there are a lot of referrals from the ED to the other departments in the hospital.

Authorisation and task distribution

The level of authorisations was mentioned as an important factor in stimulating task distribution, but not only for financial reasons. Interviewees in the cases identified the need to not only authorise care programmes, such as cardiology care programmes, on the individual hospital level but also on the collaboration level for the services run in the collaboration. For the cardiology care programme for example, it is necessary to have a B1, B2 and B3 service. Each hospital in the collaboration is authorised for one of these services. It was identified in the national cases that these authorisations should also be provided on the collaboration level to enhance task distribution and share revenues. As such, collaborations would be able to decide how and where services are provided. Moreover, care programmes as they exist today are considered as too limited. Iridium for example would like to have a broader care programme for oncology, not just for radiotherapy. More and adjusted care programmes should be described in the legislation.

In addition, the authorisation rules for hospitals and care programmes are defined as ‘chain’ authorisations, meaning that it is difficult to allocate one specific care programme separately from other care programmes or services. It is, for example, not possible to close the paediatric ward of a hospital: closing this ward would require closing the maternity ward of the hospital too.

3.4.7. VAT and collaboration between hospitals

According to the type of collaboration, collaborating hospitals sometimes have to pay VAT to each other since the fiscal authority is of the opinion that, when hospitals are collaborating in order to provide a complete level of care to those needing it, the care institutions themselves provide each other services and supply goods at cost price. Especially for services not only related to medical services, VAT problems were identified in the national cases and roundtables. Therefore it is important to identify the characteristic features of the transaction in question to determine whether the taxable person delivers to the consumer. A service will be regarded as ancillary to a principal service if it does not constitute for customers an aim in itself, but a means of better enjoying the principal service supplied. The

ancillary service will have the tax treatment of the principal service[b]. Hence in some cases VAT will have to be paid, for example when one of the hospitals provides food for another hospital when this hospital restaurant temporarily has a problem.

Hospital collaborations have to take into account the new regulations about the VAT regime of a cost-sharing association ('kostendelende vereniging'/'association de frais') and VAT, introduced on 1 July 2016. The Act of 26 May 2016 amended the Code of the VAT regarding the exemption of services provided to their members by 'independent groups of persons', meaning 'an organisation with legal personality (such as a not-for-profit association) and an organisation without legal personality, acting under its own name as a separate organisation or group towards its members and third parties.' The group can legally exist separately of its members, but this is not a requirement. If the group has no legal existence distinct from its members, the group needs to operate under its own name towards its members and third parties as a separate entity.

The Belgian administrative practice refers to an independent group usually with the notion 'cost-sharing association'. A cost-sharing association is a permanent community of interest founded by physical persons or legal entities in order to rationalise and reduce their administrative and operating costs. Typically, the expenditure of its members occurs on a communal basis. The objective of cost-sharing associations is to save the costs associated with exempted or non-taxable activities of their members.

3.4.8. Data and privacy

Who is responsible for the patient file?

The importance of one medical file in a collaboration was repeatedly addressed in the national cases. Article 20, §1, of the Hospital Act states that the medical file must be kept by the hospital and that the CMO supervises the patient file. It is not regulated whether a collaboration can keep the patient files and if so, which CMO should supervise the patient file.

Who is responsible for patient rights and care delivered?

An important issue addressed in the round-table discussions is the legal responsibility when providing care in collaborations. If medical staff is working on behalf of a collaboration, the question was raised about who is responsible for ensuring that patient rights are complied with. Article 30 of the Hospital Act provides that the hospital should comply with the Act on patient rights. Moreover, the hospital is liable for non-compliance with the Act on patient rights by the healthcare professionals working in the hospital, unless otherwise communicated to the patient. There are no rules regarding the responsibility and liability of a collaboration of hospitals, especially if this collaboration receives authorisation for certain services, care programmes, or if medical staff is hired at collaboration level.

3.4.9. Level of competition

In principle, agreements between undertakings, like hospitals and decisions of associations or groups of hospitals must not hinder competition in the healthcare market. At the moment there is no real healthcare related entity that controls hospitals and ensures that market principles are adhered to. Collaborations face no restrictions and can be as large as they want. This might, however, create monopolies in certain regions.

[b] For the viewpoint of Zorgnet-Icuro, see Zorgnet-Icuro (2015)[36]

4. REFORM PROPOSALS: THE COEXISTENCE OF THREE MODELS OF GOVERNANCE STRUCTURE

The previous chapter has uncovered some barriers in the current legislation that hinder hospital collaborations and governance structures that promote task distribution and the organisation of patient care across hospital boundaries (section 3.4). In this section, **three new governance models** are proposed wherein the type of collaboration and the governance structures are described. These models are based on the literature and on lessons learned from the international and Belgian case studies, as well as on stakeholder and expert consultation. For each governance model we describe some **generic characteristics** that were found in literature and in the international case studies, the proposed **governance structures** and to what extent **stakeholders support** these proposals. Next, we analyse **how the current legislation could be adapted** to allow for the establishment of the proposed models.

We start this section with a short description of the intertwined role of the type of collaboration and the governance structure as well as other context factors that limit the impact of the 'governance models' as such.

4.1. Context factors limit the role of new governance models

It should be kept in mind that the governance structure is only one possible instrument to establish a successful collaboration between hospitals. Indeed, the impact of governance structures is hard to disentangle from the impact of the collaboration type itself. Also the governance mechanisms steering the health sector at a macro level play an important role. Moreover, a collaboration and hence also its governance structure are not fixed and can evolve over time. Internal and external influences effect the choice and the outcomes of a selected governance model.[37] Hence, it is not possible to define a 'one size fits all' solution.

4.1.1. The intertwined role of the collaboration type and the governance structure

The literature does not provide a clear answer on how governance in different collaboration models should take shape. One of the reasons is that governance models and collaboration models are hard to assess separately. The type of collaboration can bias results of the impact of the governance structure.[9] According to Provan and Kenis (2008),[14] the successful adoption of a type of governance structure is related to the characteristics of a network: the level of trust, size (number of participants), consensus about the goal, and the nature of the task (specifically, the need for network-level competencies). A mismatch between governance structure and organisational characteristics can harm the performance of the alliance.[38] However, Kim and Burns (2007)[22] have shown that types of collaboration have less impact than the governance structure. This indicates that governance does play a role in the performance of organisations, although evidence about outcomes and performance related to the type of governance structure is rather limited.

4.1.2. The intertwined role of governance structures and governance mechanisms

Several authors[38-41] suggest that it is not the choice of governance mechanism or structure in itself that affects collaboration effectiveness, but the fit between both. Country-specific differences in the governance mechanisms in the healthcare sector are often reflected in variations in the collaboration expectations, governance structures and outcomes.[42] That is, state policies make a difference in the ease with which collaborative arrangements are formed and are sustained. However, this relationship should be further investigated.

In the Belgian healthcare system, the civil society as a governance mechanism plays an important role. Contrary to for example Denmark, where 95% of the hospital beds are public and centrally steered by the regional and national government, the Belgian government does not steer the formation and development of collaborations in a same way. At the moment, Belgian hospitals determine with whom they collaborate and for what. Competition (i.e. 'the market') is clearly playing a role in these decisions.

However, authority still plays an important role because the government determines the legal framework wherein collaborations are established. The government can steer collaboration by adjusting the legislation or they can create financial incentives for collaboration. According to the round-table participants the current absence of a clear policy framework restrains the hospitals from taking the next step. So the governance mechanism in Belgium is a complex interplay between hierarchy of the state (authority), markets and civil society.[16]

4.1.3. Collaborations and governance structures are evolving concepts

Collaborations as well as their governance structures can evolve over time,[14] For example, although Iridium and Vlaams Ziekenhuis Netwerk (VZN) are characterised as lead organisations they are both evolving towards participant-governed networks. In Iridium the voting right might change since a new partner with an authorisation for radiotherapy entered the collaboration. In VZN the voting right has already changed since the general hospitals are taking more responsibility. Also in the international cases evolutions in governance were identified. In Italy, a new management model for the Oncology Network of Romagna was established, shifting from the hub and spoke model to the promotion of a shared governance of a Comprehensive Cancer Care Network of Romagna (CCCN) which also has characteristics of a participant-governed network. The reason for these evolutions differs. In the Belgian case studies the responsibility of the other partners grew, therefore they evolved to a more equal decision-making structure. In Italy the importance of the professionals' vision increased. Consequently, the governance structure changed in order to integrate more professionals in the process of decision making.

Emerging collaborations, such as the Belgian Réseau Zenith and the collaboration between Sankt-Jozeph, CHC, and Sankt-Nikolaus and Embraze in the Netherlands, emphasize the importance of equality in decision making and have opted for a participant-governed network to govern their collaboration. However, some interviewed members of these collaborations mentioned that in the long run the governance structure could evolve to more integrated structures as in a health system, where the governance of the collaboration is put on a central level. For others, such an integrated structure is a bridge too far.

4.1.4. Number of partners in the collaboration

Provan & Kenis (2008) identified the number of partners as one of the elements having an impact on the effectiveness of the governance structure. Round-table participants stated that the number of partners in collaborations for specific treatments or service lines is in general rather limited. In these cases, the participant-governed network model is a feasible model, whereas in larger networks a lead organisation may be more appropriate.[14]

4.1.5. Goals of the collaboration

The type of governance structure that is selected also depends on the goals of a collaboration. A large knowledge-sharing collaboration such as VZN has different goals than a collaboration that aims to provide a cardiology care programme. Networks with a high level of goal consensus will need another governance structure than when only a few goals have to be aligned.[14] Hospitals that aim to collaborate with a limited number of partners for different treatments and service lines will need another governance structure than large horizontal collaborations not restricted to one group of collaborating hospitals but focusing on one specific rare pathology.

4.1.6. A more integrated collaboration performs better in the long run

The above findings highlight that both internal and external characteristics of a collaboration influence governance structure and performance. Hence, different governance structures will be needed depending on these characteristics. However, in the limited available literature we can find indications that more integrated collaborations perform better in terms of financial performance. Collaborations with higher levels of integration, lower levels of complexity and involving some risk sharing between partners are most likely to experience improved hospital financial performance.[43] The presence of a more formalised management structure and the application of more corporate governance principles increase collaboration and financial performance which is in some cases related to task distribution.[44, 45] Since governance structures in networks are more loosely coupled and more complex than in health systems,[46] these results might indicate that health systems financially perform better in the long run.[47] The literature about the impact on other performance measures (e.g. quality of care) is too scarce to draw conclusions.

4.2. Health system

4.2.1. Generic characteristics of a health system as a governance model

4.2.1.1. Characteristics of the health system as collaboration type

Integrated form of collaboration, often including other partners than hospitals

Internationally there are some prime examples of health systems, such as Intermountain Healthcare or Kaiser Permanente.[20, 48, 49] These examples illustrate that integrated governance forms can enhance task distribution and collaboration in healthcare.[9] A health system is a tight governance form in which the participating members strive for the same goals and are bound through formal structures with a high level of integration. Participants in the national cases acknowledge that, when the goal of the hospitals is to collaborate on a large number of services, an integrated structure like a health system is appropriate.

Typically, but not necessarily, other organisation types (e.g. nursing homes; mental healthcare facilities, polyclinics, home care services, specialised services for treatment and revalidation) than hospitals may also be part of the health system (e.g. Intermountain Healthcare and Emmaüs). The collaboration with other types of organisations enhances the expertise and appearance of the collaboration.

Task distribution through improved planning

One of the main advantages of a health system is the optimisation and task distribution of services. At least, this is the case when organisations are at a manageable distance (e.g. rationalisation, sharing and harmonising care services and technology). After all, in a health system the provision of care can be more easily planned. Two international cases, Intermountain Healthcare and the Southern Region of Denmark, both illustrate this. In Intermountain Healthcare planning models are used when allocating services to a region. In the Southern Region of Denmark the planning of care is based on the characteristics of the region and the quality provided in the hospitals. As such, planning of health care facilities and services can be tailored to the population needs of that region. Existing health systems in Belgium such as Emmaüs open up opportunities to reflect on strategic decisions at system level, while the single organisations still can have a certain degree of autonomy. This enhances trust and communication between partners.

The integrated form of a health system does not only allow better task distribution and service delivery, but supporting services such as IT can be shared which also enhances efficiency in the collaboration (for a list of advantages and disadvantages see Table 5).

4.2.1.2. Characteristics of the governance structures in a health system

Integrated governance structure with a hierarchical method of control for the whole organisation

In a health system, organisations agree to collaborate in some kind of closed system where an overarching board is in charge of the collaboration. Health systems have a different governance structure than the structures described within the framework of Provan and Kenis. Therefore, we defined a health system as an 'integrated governance structure' (see Figure 1). In a health system, a hierarchical control method is applied, meaning that a central board is in charge of management and coordination.[50] There is single ownership in the health system: all hospitals or other facilities are part of one organisation with one ownership.

Keeping some degree of autonomy at the level of the participating entities

In a health system the central board directs all institutions on the overarching level (Table 6). Yet, this does not exclude the preservation of some level of independence for the institutions that are part of the health system, if only because they can be located on separate locations. Operational decision remains typically decentralised at the level of individual hospitals, the sector (e.g. all general hospitals versus nursing homes) or business units (e.g. individual departments or care programmes). This requires delegation of power (e.g. decision autonomy below a defined budget) from the central level to the local entities, given that the central board holds the final responsibility. As such internal governance processes within the collaboration also matter.

When the size of health systems becomes too large, governance problems might arise

Both in the national and international cases some examples were observed where the hierarchical level in a health system appeared to decrease effective decision making and efficiency (cf. Vivalia and the Southern Region of Denmark). A potential explanation is that governance becomes more difficult when the scale of the health system increases. Emmaüs is, in the Belgian context, an example of a large organisation. To deal with this issue of large scale and scope, they installed separate boards per sector (e.g. care for the elderly, mental health) and hospital. A drawback might be a difference in vision between the different boards.

Collaboration with organisations outside the health system not always obvious

The round-table participants stated that it will be more difficult for individual entities within a health system to collaborate with facilities outside the health system (Table 5). Due to the distance between institutions within the Belgian health systems (especially in the Emmaüs case), hospitals in the health system are collaborating with other partners outside the system. This complicates task distribution, collaboration and governance within the health system. First, the existing collaborations across the boundaries of a health system are difficult to govern as the board of a health system is composed of representatives of many different facilities in the health system and not only of the hospitals involved. Hospitals outside the health system are only interested in the collaboration with other hospitals, not with other facilities such as nursing homes or youth care facilities. Second, the board of the health system is at a 'different level' than the board of a single hospital. This implies an uncertainty at what level the collaborating hospitals can discuss goals of the 'external' collaboration. Hence, external institutions are reluctant to evolve to a higher level of collaboration and integrated governance with organisations within the health system.

In the international cases (Intermountain and the Southern Region of Denmark), there is limited need for collaboration outside the health system. As both cases provide all levels of care with high quality they do not often need to collaborate outside their health system. The hospitals within the health system work closely together based on the patients' pathways.

Stakeholder engagement at all levels is a key to success

It is important to involve the relevant stakeholders as much as possible in all levels of the health system. For example, the majority of physicians involved in executing Intermountain's clinical processes are independent, community-based practitioners. Intermountain does not try to control physicians' practice behaviour by top-down command and control through an employment relationship.[51] Instead, they rely on solid process and outcome data gathering and feedback, professional values that focus on patients' needs, and a shared culture of high quality. Moreover, as patients are an important stakeholder in healthcare, they should also be able to participate in the decision making in hospitals.[52]

Table 5 – Strengths and weaknesses of health systems

Strengths	Weaknesses
• Transmural, cross-domain experience • Resource sharing and supporting services (logistics) • Financial buffers • Central governance • More time for strategy • Well-known trademark	• The large scale sometimes decreases effective decision making and efficiency • Distance between hospitals may complicate task distribution • Small hospitals feel less involved in the decision-making process • Difficult to collaborate with hospitals outside the health system • Boards at different levels also complicate the governance of collaborations

4.2.2. Proposed governance structures

Authorisation, budget and personnel

This model meets some challenges identified in the Belgian situation and more precisely in the current legislation. As a health system is one organisation, **authorisation** is possible on a higher level and it is not necessary to provide each service at each location. More precisely, the 'holder of the authorisation' is the health system while the scope of the authorisation' can still be at the level of the entities of the health system. Also the **budget** is allocated to the overall organisation which makes it less important where a patient is treated. The **exchange of physicians, other healthcare professionals and other employees** is easier because they work in one single organisation and have to follow the same regulations and conditions.

Integrated care

The governance structure also enables more **integrated forms of healthcare**, since other types of organisations also can be part of the health system. However, the diversity of the different collaborating partners can also complicate the collaboration because of different statutes, cultures, visions, size, type of organisations, etc. To minimise the heterogeneity (and complexity) of a health system, a legitimate choice could be to include, during the start-up phase of the health system, only hospitals in the collaboration. However, the ultimate goal of a health system should be to offer a wide range of organisations and not only hospitals.

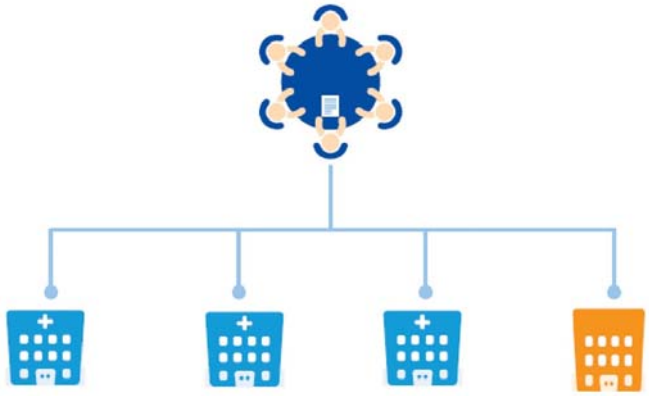
Degree of integration: four submodels

Although this governance structure provides an answer to a lot of the identified current problems, this high level of integration is still a giant step for most of the emerging collaborations. Transforming the current scattered and fragmented hospital landscape to one that is built around health systems may, therefore, seem somewhat utopian on the short (and even on the medium) term. Moreover, the health system model in itself also includes some risks (e.g. the need for involvement of different stakeholders, complex decision making due to hierarchal levels, etc.). Therefore, there is a genuine need that the legislator provides the opportunity to develop a health system under different formats (see submodels in Table 6).

As an evolution is detected in the hospital collaboration structures which requires different forms of governance structures, one can presumably expect an evolution in the degree of integration as well. Boards can be located at three levels: the collaboration level, which is the top level of the system, the sector level (e.g. elderly care or general hospitals), and the lowest level, the level of the individual institutions (e.g. a single hospital).

- Submodel 1 puts the emphasis on the central governance with no local boards in the individual institutions or sectors. At the level of the individual institutions or sectors, an executive committee is appointed for the management in the organisations (with delegated power from the central level). Submodel 1 could be defined as an advanced health system model as decision-making rights in the local boards are eliminated and solely assigned to the health system level. This might enhance the efficiency of decision making and create the opportunity to obtain and achieve one strategic vision throughout all participating institutions in the health system. Yet, it may fail to gain support and involvement of all concerned institutions. There might be a risk that central decision-making bodies (e.g. board and medical council) are composed of several representatives of the individual institutions resulting in very large bodies. Stakeholders agreed that this should be avoided at all costs since it hinders efficient decision making.
- In submodel 2 the board and medical council are retained on institution or sector level. In this submodel it is important to describe in the statutes which decision rights are allocated to which level. This model can be described as a less integrated version of the health system, but it gives the opportunity to evolve towards other submodels in the health system and to keep an important level of decision-making rights on institution/sector level, providing the individual institutions with a higher level of participation in decision making. A disadvantage of submodel 2 is the larger risk for conflicts of interest in decision making and for a misaligned strategy.
- Submodel 3 (the current model at Emmaüs) and submodel 4 (the current model at Vivalia) are situated in between submodels 1 and 2.

Table 6 – Governance structure in a health system

HEALTH SYSTEM			
	**Overall characteristics** • One overall Board • The health system has the final responsibility • Common daily management • The executive committee is in charge of the management of the system • The health system holds all authorisations		
Submodel 1	**Submodel 2**	**Submodel 3**	**Submodel 4**
Health system board Medical council on system level No board on institution / sector level No medical council on institution / sector level	Health system board Medical council on system level Board on institution / sector level Medical council on institution / sector level	Health system board No medical council on system level Board on institution / sector level Medical council on institution / sector level	Health system board No medical council on system level No board on institution / sector level Medical council on institution / sector level
• All decisions are made at the system level • Executives committees in the individual institutions execute guidelines from the board within the scope of decision-making rights that are delegated to them	• There are medical councils and boards on institution/sector level • For certain topics decision-making rights can be delegated to the institution/sector board • For certain topics the advice function can be delegated to the institution/sector medical council • The decision-making rights are described in the statutes of the health system • The medical council and board at system level may have the right to recall decisions	• For certain topics decision-making rights can be delegated to the institution/sector board • The rights of the board are described in the statutes of the health system	• Executive committees in the individual institutions execute guidelines from the board • The medical councils on institution/sector level give advice to the health system board (the advice procedure must be regulated by the legislator or described in the statutes of the health system)

4.2.3. Stakeholder perspectives on the health system model

A model with potential for task distribution

Stakeholders indicated that a health system is a very good structure for future hospital collaborations as it will enhance task distribution, since the budget is organised on the level of the health system as one organisation and everybody is aiming for the same goal. However, stakeholders stated that not all collaborations are ready for integration at this level.

Stakeholder engagement is challenging

It may be difficult to align the different stakeholders, and in particular the physicians, of the different organisation types - for example, hospitals, elderly care, and psychiatric care. The diversity of the different partners can complicate the collaboration.

During the round-table discussions the suggestion was made to compare this model with a holding, implying one central holding in charge of the governance. A top-down structure is of major concern to the physicians, who doubt whether a distinct centralisation of decision making in the health system is viable, as many medical decisions need to be taken on the hospital level. Also the relationship with the medical council was identified important. It was emphasized that physicians should be able to participate as experts in the general overarching board.

Balancing central power with autonomy and involvement in the decision-making process

Not all decision making should be organised at the central level. Especially physicians are of the opinion that medical-related decisions should be taken at hospital level. Strategic decisions related to quality, volume, innovation and investments can be taken on the overarching level and more operational decisions can be allocated to the individual hospitals or to a sector board. A sector board could meet the concerns about the complexity of the governance of different entities (hospital versus elderly care versus psychiatric care). In this case, a governance structure with a board and medical committee per organisation type (sector) can be established.

Apart from that, the diversity of different institutions in the health system could lead to a lower degree of involvement from the individual institutions. Some stakeholders, therefore, believe that part of the decision making should stay at the individual hospital level. Other stakeholders disagreed and stressed that to enhance task distribution it would be better to centralise these decisions on the health system level. In these cases, the central board could decide which organisations provide what services resulting in a better potential for rationalisation of services (e.g. in case of overcapacity) and task distribution (e.g. in case of dispersion of complex and/or high-cost services).

The hospital managers emphasised the need for some risk sharing from all stakeholders (including physicians), to have greater involvement in management and dedicated decision making. There was also some doubt on the part of hospital managers whether there would be any added value in hospitals keeping their own autonomy in a health system. If hospitals have no autonomy left, the health system resembles more a merger of hospitals (see Box 4). Finally, it was suggested to avoid thinking of the health system as a strictly closed system, as it is important to allow collaboration with partners outside the system.

Box 4 – A health system versus a hospital merger, group or association

- **Authorisation**: the health system holds all authorisations, while in a hospital merger there is only one hospital that receives the authorisation. In a group or association, the participating hospitals receive the authorisation.
- In a health system different types of **governance structures** are possible (e.g. common medical council or medical council per sector).
- In a health system also **other organisations than hospitals** can collaborate. This is not allowed in a merger, group or association.
- In a health system **decisions** are made on a central level unless otherwise stated in the statutes.

Submodels 1 and 4 are the recommended models. The choice between both depends on the composition (number and type of partners) of the health system. Submodel 1 is preferred because it has the most efficient and powerful governance model, unless the number of partners and sectors becomes too large. In that case submodel 4 is the preferred model but for efficiency reasons a model with a medical council only at the sector level and not at the level of each individual institution is recommended.

4.3. Coordinated network

4.3.1. Generic characteristics of a network as a governance model

4.3.1.1. Characteristics of the network as collaboration type

In Belgium as well as internationally an increasing number of networks for hospital collaborations are set up. In this study we defined networks as 'collaborations that are created to function as interdependent wholes while maintaining each organisation's separate legal identity'.[10] A network consists of autonomous units that have joined together to achieve a common purpose. In this sense a hospital group and a hospital association could be classified as a network (unless the hospital group is realised via one legal person who has, simultaneously, received the authorisations of the participating hospitals; this situation results in a health system).

Also other types of networks are emerging in Belgium. Many collaborations form a not-for-profit association to collaborate or sign a collaboration contract. Six networks were investigated (see Table 3). In the national (n=4) and international cases (n=2) autonomy of the individual organisations was identified as an important positive characteristic of the network. The individual hospitals keep their own authorisation and can decide autonomously. This, however, does complicate the procedure of decision making (see supra). In all networks (cf. all cases) trust was identified as a very important characteristic. Without trust it is very difficult to develop a successful collaboration.

4.3.1.2. Characteristics of the governance structures in a network

Provan and Kenis (2008)[14] describe three different types of governance structures for a network (see Figure 1). Two lead organisations and two participant-governed networks were selected in the national cases. Table 7 shows the results of the analysis of both types of networks. In the Embraze network in the Netherlands a participant-governance structure was identified, which resembles a lot the participant-governed networks in Belgium. In the Comprehensive Cancer Care Network of Romagna in Italy (CCCN) the network is more steered by the government but there are some characteristics of a participant-governed network as they aim for more shared governance in the collaboration (see Table 4). Through the international cases, it became clear that the governance mechanisms play a significant role in the governance of health institutions or collaborations. Hence governance structures differ depending on the country.

Table 7 – Analysis Lead organisation and Participant-governed networks

Lead organisation		Participant-governed	
Strengths	**Weaknesses**	**Strengths**	**Weaknesses**
• Expertise of lead organisation • Central governance • Increased coordination and decision making • Decision making often in consensus	• Dominant partner • Barriers to joining collaborations	• Trust between partners • Equal partnership • Autonomy • Bottom-up decision making	• Time for decision making • Complex governance • Lack of agreement

Participant-governed networks

In all participant-governed networks the trust between partners was identified as even more important than in the lead organisation. The equal partnership and decision right, identified in all participant-governed networks except for CCCN, increase the coherence and motivates all partners to strive for the same goal. The bottom-up decision making enhances the engagement of all partners, also of the physicians, which was identified as an important facilitator for a network. Embraze and CCCN work with clinical expertise groups that advise the boards of the network.

In the two Belgian cases, physicians participate in the overarching governance bodies. The mean weakness of this governance structure is that the process of decision making can be blocked when one of the partners does not agree. This complicates decision making and can be very time consuming and frustrating. However, as is the case in the analysed Belgian case studies, a procedure can be provided in the statutes of the collaboration to deal with such problems.

Lead organisation

In the studied lead organisation networks the coordination was carried out by one lead hospital. The lead organisations had a lot of expertise which increased the knowledge and performance in the networks. The centralised governance also enhanced decision making when difficult choices had to be made. The two lead organisation networks are moving towards the structure of a participant-governed network. In both cases, the dominance of one partner was perceived as a barrier to enter the network. But the main reason for possible changes in the governance structure were changes within the network. In one of the networks other organisations started to take more responsibility. In the other case, a new partner with the same profile and reputation as the lead organisation entered the network. Moreover, both networks also mentioned that most decisions are taken in consensus, so they already have characteristics of a participant-governed network.

Network Administrative Organisation (NAO)

There was no NAO identified as governance structure in the Belgian or international cases. Hence, weaknesses and strengths were more difficult to identify. Following Willem (2010)[53] the NAO is characterised by its independence and this independence might be reflected in the development of a set of values that might deviate from the values of the organisations in the network. However, due to its formal controlling and coordinating role, the NAO might be able to bring organisations together even if these organisations have different value patterns. A NAO as a governance structure is considered to be most effective when there:

- is a moderate level of trust;
- are a moderate number to a lot of participants;
- is relatively high goal consensus and
- the need for network competences is high.[54]

4.3.2. Proposed governance structures

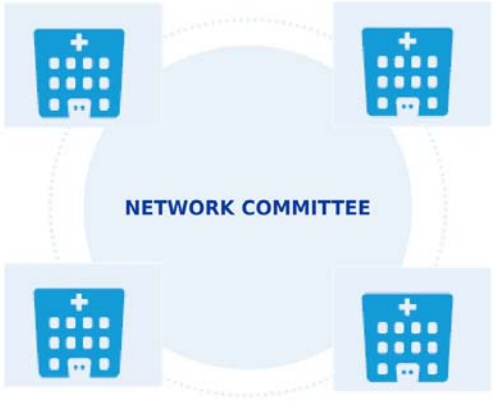
To avoid confusion with the general term 'network' (see also Box 1), which is often used for any form of collaboration, we use the concept **coordinated network** for the second model.

Goals of the coordinated network

The proposed coordinated network model can be used for networks between hospitals with diverse collaboration goals (optimisation of a patient pathway; the organisation of physician on duty services and rotation systems; ICT collaboration, etc.) as well as for networks with other actors (e.g. nursing homes).

Building on the problems identified in the current legislation, two new governance structures are proposed for the coordinated network model (see Table 8). The proposed governance structure is a participant-governed network unless otherwise described in the statutes of the network. This structure was selected based on the fact that in lead organisations the decision-making structure evolves or might evolve to a participant-governed network. The equality in the decision-making process in participant-governed networks was evaluated as a strength in the national cases. However, in the round-table discussions this characteristic was questioned (see supra). Other governance structures can be selected and described in the statutes of the collaboration. Hence, the coordinated network can also opt for a NAO[14] or a lead organisation.

Table 8 – Governance structure in a coordinated network

COORDINATED NETWORK	
	**Overall characteristics** • Boards remain at hospital level • Medical councils remain at hospital level • The individual hospital has the final responsibility • The individual hospital keeps its own authorisation • There is a network committee consisting of physicians and administrators of individual hospitals to enhance decision making at the level of the network • The network committee can take decisions concerning the network • These decisions are delegated and are described in the statutes of the network (the decisions can also be described in the new legislation) • Participant-governed network unless otherwise described in the statutes of the network
Submodel one: Network with feedback mechanisms	**Submodel two: Network with delegated power**
• The individual hospitals can always recall decisions taken by the network committee	• Once a hospital has decided to delegate decisions to the network level, the hospital is not authorised anymore to recall decisions at network level

Authorisation as well as many decision-making authorities remain at the hospital level

In the network the authorisation of the hospital, hospital services and hospital functions stays at the hospital level. The authorisation of a care programme can be given to the network (as in a hospital association). Hence, also the medical councils and boards remain at the hospital level. A network committee, consisting of representatives of the medical council and of the members of the board of the individual hospitals, takes decisions on the level of the network. In the round-table discussions and in the national cases, the complexity of decision making in relation to the medical council was often discussed.

Since the network committee includes both physicians and members of the board, this will enhance decision making as both have to come to an agreement. The decisions that are delegated to the network committee should be described in the statutes of the network. Also the type of governance structure (a coordinated network with feedback mechanisms or with delegated power) should be described in the statutes (if not regulated by law). Moreover, also an explicit list of mandated topics should be established. If the network committee has decision right for mandated topics as described in the statutes of the organisation, there should be a derogation of articles 136-142 in the Hospital Act as the medical councils of the participating hospitals are no longer competent for the decisions mandated to the coordinated network.

A coordinated network with feedback mechanisms has far softer decision rights compared to a network with delegated power. In a coordinated network with feedback mechanisms a hospital can recall the decision if it does not agree with it. In a coordinated network with delegated power the decisions that are mandated cannot be recalled anymore.

The coordinated network may serve different purposes and may include not only hospitals, but also nursing homes, general practitioners, etc. The collaboration between hospitals and other health actors of the network can be based solely on a contract without the collaboration being a separate legal person. Nevertheless, the collaboration can also operate through the creation of a legal person.

The coordinated network model is no mere replacement of two forms of collaborations described in the Hospital Act, i.e. the hospital group and the hospital association (see Box 5). It closely resembles a hospital association and a hospital group, except that non-hospitals can be part of it and decisions can be mandated to a higher level. The objectives of a coordinated network as well as the involved partners can be different from those of a hospital group or a hospital association. Since continuity in the organisation of healthcare is important, several stakeholders proposed not to abolish the existing rules of a hospital group or a hospital association immediately.

Box 5 – A coordinated network versus a hospital group or association

- In a coordinated network it is possible to assign authority for part of the **decision making** to the collaboration level (submodel 2).
- Other organisations besides hospitals can collaborate.
- A coordinated network has a **coordination committee** that also includes physicians.

4.3.3. Stakeholder perspectives on the coordinated network model

The coordinated network model offers little safeguards for task distribution

As stated before, the 'coordinated network model' was identified for more loose types of collaborations. A typical example concerns an emerging collaboration between hospitals with cold feet to jump in far-reaching collaboration forms. However, these looser ties are also the main concern of this type of collaboration, as it does not put enough pressure to participate. The level of task distribution will depend on the purpose of the coordinated network.

How equal should a participant-governed coordinated network be?

It was also identified that participant-governed coordinated networks might increase acceptability of the collaboration by all involved actors. Nevertheless, round-table participants also indicated that participant-governed coordinated networks which are based on equality entail the risk of status quo. Participating organisations might call upon their veto right when they have fear of losing activities. As such this will not serve enhanced coordination and task distribution.

Coordinated networks will have different HRM policies

Difficulties might arise as there are different HRM policies in the collaborating hospitals, and it is likely to be difficult to adapt the different contracts of the physicians. It would be more feasible in this model for physicians to retain their contracts and conditions with the hospital. An important condition to deal with this limitation will be the involvement of physicians in the board of the coordinated network.

A network board with mandated decision rights: opinions differ

Opinions on the governance of the coordinated network model were divided. On the one hand, it was suggested that this model might require an overarching independent governance with feedback loops towards the participating hospitals. It was also indicated that experts, such as physicians, need to be represented in the network board. On the other hand, it was proposed to form a committee on the network level with the same structure and conditions as the hospital boards. This network committee would have decision-making rights over all network-related services. The proponents of the latter model stated that the continuous feedback loops to the individual hospitals are unworkable. Even with a network committee, feeding back to the individual hospitals remains time-consuming and ineffective. The hospital board members explicitly proposed to assign the authorisations on network level and not on the level of the individual hospital boards. They also emphasized the need for a supervising third party (i.e. NAO) that would coordinate, guide, and monitor the collaboration. All participants agreed that 'shopping' in multiple networks would be counterproductive and make governance complex, and that the network should not be too 'big' (should not have too many partners): the smaller, the more flexible.

If a coordinated network is chosen, a network with delegated power is recommended (submodel 2), since the evaluation of current networks has shown that feedback mechanisms to the individual institutions are inefficient and time-consuming (submodel 1).

4.4. Autonomous collaboration initiative

4.4.1. Generic characteristics of the autonomous collaboration initiative as a governance model

Based on the problems identified in the study, a third model is proposed. During the case studies it was mentioned that in addition to the authorisation of care programmes also the services provided in a hospital that are part of a care programme, such as the B1, B2 and B3 in the cardiology care programme, should be authorised on the level of the collaboration. The collaboration should also be able to receive a hospital budget (BFM). Iridium, for example, is a hospital association and a not-for-profit association. However, personnel is employed by GZA and the income of the organisation is integrated in the balance sheet of GZA. This is mostly because the organisation cannot receive funding via the BFM since Iridium is not a hospital (a prerequisite to receive a hospital budget). Moreover, it is GZA and not Iridium that is authorised for radiotherapy.

In the national cases it was often suggested that a network should be able to receive authorisations and hospital budget at the collaboration level. However, if a network would be authorised on the collaboration level, many problems of a legal, financial, and organisational nature can occur when a hospital leaves the collaboration. The loose structure of a network implies more risks than an integrated structure since it is not clear who is responsible. If organisations aim for authorisation at the overarching level, they will need to form a more integrated structure (as in a health system) or a new organisation should be developed with a limited scope.

The new organisation can evolve from a collaboration for specific services, or a combination of several services but is not meant for the collaboration between entire hospitals. The new organisation is, in this study, named an 'autonomous collaboration initiative'.

Characteristics of the autonomous collaboration initiative as collaboration type

The 'autonomous collaboration initiative' enables collaboration for specific service lines and supporting services. When hospitals do not want to integrate all their services but want to intensively collaborate for a few services, a new organisation can provide an answer. The autonomous collaboration initiative can be used for supporting medical services (e.g. laboratory and pharmacy) or for medical equipment collaborations (e.g. radiotherapy.) It can also be applied for high expertise or innovative care, high technology care or for specific care programmes, such as diabetic or cardiology programmes.

Characteristics of the governance structures in an autonomous collaboration initiative show resemblance with a joint venture structure

A collaboration with the goal to provide only specific service lines or supporting services is often discussed in literature as a joint venture. In a joint venture two or more organisations work together with an economic purpose. They want to carry out a joint economic activity, profits and losses will be shared. This form of collaboration may have a temporary or a permanent character. A joint venture is often established for new developments that imply a financial risk but also new profits. The main goal of the proposed 'autonomous collaboration initiative' is to enhance the collaboration and share financial means. As in a joint venture, there should also be the possibility to reinvest money on services in the founding hospitals or other types of organisations.

In a joint venture there is a lot of shared decision making with physicians since they are often the initiators of the collaboration. Bader et al. (2007)[55] discuss that physicians want control on the decisions that affect daily operations in the joint venture and their revenues. The hospital wants to ensure that the venture supports the hospital's mission, is profitable and does not compete with other hospital services. Both medical and management expertise is necessary. The operating level board should also focus on operational issues where physicians play a significant role. Bader et al. (2007)[55] define two types of joint ventures. The first type is aligned with the goals of collaborating hospitals by having a sufficient percentage of the votes in the board. Moreover, following an example of McKinsey & company, Bamford and Ernst (2005)[56] recommend joint ventures in or between public organisations to have at least one outside

member of the board, a strong chair and an external audit. They also recommend that joint venture board members are evaluated and rewarded for their joint venture services. A second type is the type that is not aligned anymore with a hospital.

4.4.2. Proposed governance structures

Autonomous collaboration initiative with its own board and medical council

The 'autonomous collaboration initiative' obtains the authorisation and follows the governance structure of a hospital, such as a hospital board and a medical council. This organisation has the overall responsibility of all issues that concern the collaboration. In literature the importance of physicians in the board was identified. However, it is the collaboration and the founders of the collaboration that decide who will be represented in the board.

An autonomous collaboration initiative: attached or disconnected from the hospital?

Two submodels with a different governance structure are outlined. In the first submodel, the new organisation stays linked to the hospital. There should be a joint board aligned with the percentage of the ownership. However, it is important for the board members of such a model to strive for the goals of the autonomous collaboration initiative as well as for the goals of the individual hospitals. This can result in conflicting situations. Moreover, in such a model the possibility to reinvest money in other services of the participating hospitals (than the services provided by the autonomous collaboration initiative) will be put on the table. In other words, it should be made possible to reinvest part of the 'profit' in services in the individual hospitals. It is however uncertain if there is a situation of 'more than reasonable profit margins' in combination with subsidies from public authorities.

The second model is independent and not aligned anymore with the hospital, the founders of this autonomous collaboration initiative decide who can be a board member. This submodel can also be used for private clinics that did not arise from a collaboration.

Independent management

When the aim is to create a totally independent organisation from the entities that collaborate to create it, it is important to provide a management that respects the independence of the new organisation. This is important for both submodels. The new structure must have a management that will serve its own interests and not the interests of those who created it.

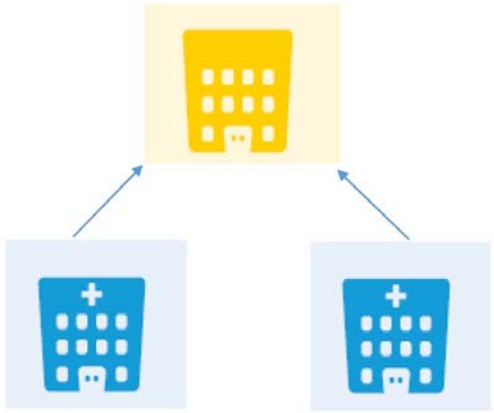
When we take the example of organisations that are co-owned by various municipalities in a region (e.g. an intermunicipal company such as Vivalia), difficulties can occur related to conflicts of interest.[57] If the role of the general assembly is to represent the member institutions, it must be ensured that managers are not acting in the interest of the institutions they represent, but work well on behalf of the autonomous collaboration initiative.

In this respect, it is not necessary that each member is represented in the board. Again, it is clear from the example of an 'intermunicipal company' that a board of managers comprised of too many managers can harm effectiveness by hampering united and effective decision making.[57]

Box 6 – An autonomous collaboration initiative versus a hospital association

- An autonomous collaboration initiative has its own **legal structure**.
- **Authorisation** can be given to this legal entity.

Table 9 – Governance structures in an autonomous collaboration initiative

Autonomous collaboration initiative	
	**Overall Characteristics** • Authorisation at level of new organisation • New board at new organisation level • New medical council at new organisation level • The autonomous collaboration initiative has the final responsibility
Submodel one: Autonomous collaboration initiative linked to hospitals	**Submodel two: Autonomous collaboration initiative not linked to hospitals**
• The new organisation stays linked to the hospitals (e.g. outpatient endoscopy centre) • Joint board wherein the decision right is aligned with each hospital's percentage of ownership • The new organisation is essentially a format for negotiating and reaching consensus on operating a hospital's service that benefits all parties	• There is no link anymore with the hospitals (e.g. a specialised centre for radiotherapy) • Although an agreement can be made to use hospital equipment or space (e.g. the autonomous collaboration initiative can rent equipment or material from the hospital) • Independent organisation that outlines own goals and statutes

4.4.3. Stakeholders perspectives on the autonomous collaboration initiative

Potential for quality improvement and process optimisation

The advantages of this model include quality enhancements (due to standardisation of care and expertise sharing), ease of organisation, independence, and flexibility in collaboration with other partners outside a health system or network. The autonomous collaboration initiative had the most support during the roundtables with medical council members. Other stakeholders pointed out that this model might not be achievable for all types of care.

What will happen with the remaining hospital?

A major concern for this model was the loss of income for hospitals when separating the most profitable services from the hospital and the loss of authorisation when separating some services. However, the stakeholders also clearly indicated the need for this model at present. Cherry-picking is a notable risk: the autonomous collaboration initiative, or even the current physician associations (under Belgian legislation) could cherry-pick the most profitable services. These autonomous collaboration initiatives should thus be joint ventures of some kind run by the hospitals with very clear contracts between partners. The partners would share the risk but also the profit. The governance structure of this new organisation level is comparable to the current hospital board, and independence of the founding hospitals will be necessary.

Competition

When these new collaborations are not aligned with the hospital (as in submodel 2), this can be a threat. There are clear risks of competition, e.g. existing collaborations can experience a higher level of competition when an autonomous collaboration initiative is introduced. However, submodel 2 can be a good solution for more supportive services in a collaboration since these services require a different type of expertise and there is less competition between hospitals for these supportive tasks.

Moreover, the legislator should avoid duplication of services and care programmes when providing authorisations for autonomous collaboration initiatives. The goal is to enhance task distribution and collaboration, not the opposite. As such other policy instruments such as programming will be needed.

A step in the transition towards a health system model?

The model of autonomous collaboration initiatives can facilitate an evolution towards a health system. Stakeholders mentioned that a network can establish some new such initiatives to enhance the collaboration on a higher level for certain services. In a next step this could evolve towards a health system.

Submodel 1 is recommended because of the link between the autonomous collaboration initiative and the hospitals, with all partners sharing profits and risks. The autonomous collaboration initiative is an independent organisation with a governance-structure that is comparable with the current board of a hospital.

4.5. How the reform proposals address current shortcomings

In section 3.4 shortcomings in the current collaborations and their governance structures were identified. In Table 10 these shortcomings are confronted with the governance structures of the three new models detailed in sections 4.2 to 4.4.

We start this section with a short description of the legal form of operation of the three models, because the legal form can have an impact on the capacity of a model to face current barriers. We end section 4.5 with some issues that are related to the broader healthcare landscape.

4.5.1. Legal form of operation

Health system

In order to make a choice about the legal form of the health system, it is important to verify the current legal requirements and consequences (e.g. in terms of running a hospital or receiving payment) of a particular form. The Hospital Act does not require a hospital to be run by a not-for-profit organisation, this can also be a for-profit or commercial organisation.

However, to be eligible for infrastructure grants, a hospital has to be run by a not-for-profit structure.

European state aid rules do not impose specific criteria for the choice of legal form but the Public Procurement Directive of 2014 allows a Member State to reserve tendering procedures for health services to organisations with employee share or active board participation of employees and where profits are reinvested with the aim of fulfilling the purpose of the organisation. It is also possible to restrain, for specific activities and in exceptional circumstances, access to certain services for not-for-profit organisations, but it must then be justified in the light of Articles 49 and 56 of the Treaty on the Functioning of the European Union (TFEU), such as freedom of establishment/free movement of services.

In the current legislation a not-for-profit organisation, or even a for-profit company, may be a member of another coordinating not-for-profit organisation. Thus for a health system this provides the opportunity to work together with for-profit organisations (e.g. catering facilities, laboratories). In a not-for-profit association, decisions can be delegated but this mainly concerns the management. For for-profit companies, the Act on Corporate Governance has provided the possibility of setting up a management committee to which certain decisions can be delegated.

The legislator could limit the legal status of a health system to a not-for-profit association. In that case, there will be some important legal consequences as a not-for-profit association is an independent entity with rights and duties. For example, the members cannot be held personally liable for the debts of the organisation.

Coordinated network

Networks already exist under the current legislation. The hospital group and the hospital association defined in the Hospital Act could be considered as prototypes of networks (with the exception explained in 4.3.1.1) since they correspond to the definition of 'interdependent wholes while maintaining each organisation's separate legal identity'. Other types of networks also occur (e.g. not-for-profit associations or collaborations only based on a contract).

Current legislation allows freedom of choice regarding the type of legal entity. The legislator does not provide a mandated legal entity for a hospital group or association. Also other types of networks have free choice of legal entity. The form in each case is established by the drafting of an agreement[53] or by the creation of a legal entity, accompanied by the drafting of the statutes. Although the type of legal entity is not specified, the most common legal form is a not-for-profit association.

Autonomous collaboration initiative

In principle the autonomous collaboration initiative should be able to choose any legal form. As it is nowadays foreseen for hospitals, the legal form has no effect as long as the hospital is authorised. A similar approach could be used for the new organisation.

The legislator could choose to limit the possibility to obtain financial means to a certain legal form. Also for this model, European state aid rules and the Public Procurement Directive of 2014 hold (see previous section on the health system).

4.5.2. The potential of the proposed models to address shortcomings in the current forms

Table 10 lists the barriers in current legislation to set up a collaboration and a governance-structure that stimulate coordination and task distribution, as identified in section 3.4. The purpose of the overview is to analyse whether the new models have the potential to meet each of the shortcomings. In this assessment, we start from the assumption that the Hospital Act and other legislation will be adapted to allow the establishment of the three models. Hence, Table 10 shows whether the models solve a shortcoming faced by current collaboration forms or not. In the latter case, it is indicated whether additional changes in current legislation could solve the problem.

Table 10 – Health system governance structures and shortcomings in the current legislation

Shortcomings	Health system	Coordinated network	Autonomous collaboration initiative
Lack of power at the collaboration level	There is always a board at the health system level implying a strong power to take strategic decisions at the level of the collaboration. The strength of this power depends on the submodel and whether there is also a board on institution/sector level or not. Large boards should be avoided to enable efficient decision making. The recommended submodels (submodels 1 and 4) are characterised by sufficient power at collaboration level.	In submodel 2 decisions taken by the network committee cannot be recalled anymore by the individual hospitals. However, the network committee can only take binding decisions on issues that concern the network goals. If a network, for example, concerns the ICT collaboration then the network committee cannot decide about other (care) issues in hospitals. In general, running services, departments and care programmes remains the responsibility of individual hospitals. Hence decision power at the collaboration level remains limited.	As the new organisation has its own governance structures, the decision making is less complex than in former collaborations. In addition, these governance structures have central power over the services, departments or care programmes that are run by the new organisation.
Role of medical council: driving force or brake?	The role of the medical council depends on the submodel (advice function of medical council at institution/sector level and number of advice topics for the medical council at health system level). The recommended submodels both provide a common medical council for the participating hospitals: at the collaboration level (submodel 1) or the sector level (submodel 4).	Medical councils remain at hospital level as in the current collaborations. The network committee includes physicians which can enhance decision making. Submodel 1 (with delegated power for the network committee) is preferred over submodel 2 (with feedback mechanisms to individual medical councils) to prevent that individual medical councils can block decisions.	As the new organisation has its own governance structures (including a medical council), the decision making is less complex than in former collaborations.
Conflicts of interest	Conflicts of interest are less likely since all partner organisations belong to the same system. However, a charter of good governance principles could be developed.	Not solved by the model: a charter of good governance principles could be developed.	Conflicts of interest are less likely since the autonomous collaboration initiative has its own governance structure. However, a charter of good governance principles could be developed.
Collaboration is time-consuming	The number of feedback loops between the hospital and collaboration level is reduced (depending on the submodel).	In a coordinated network with delegated decisions that cannot be recalled by individual hospitals, the number of meetings will be reduced.	The decision-making process is less complex, but time consumption depends on the number of autonomous collaboration initiatives that are initiated.
Distance	To be determined by legislation (see section 4.5.3)	To be determined by legislation (see section 4.5.3)	To be determined by legislation (see section 4.5.3)

Collaboration between hospitals and other types of institutions	Enables more integrated forms of healthcare since other types of organisations also can be part of the health system.	Enables more integrated forms of healthcare since other types of organisations also can be part of the coordinated network.	Enables more integrated forms of healthcare since other types of organisations also can be part of the autonomous collaboration initiative.
Hospital staff			
• **Legal agreement between physician and collaboration**	As a health system is one organisation, this will enhance the process to equalise the physicians' legal agreements with the organisation.	Since the authorisation and responsibility is at the level of the individual hospitals, there are less incentives to equalise the physicians' legal agreements.	As an autonomous collaboration initiative is one organisation, this will enhance the process to equalise the physicians' legal agreements with the organisation.
• **Voting power of physicians working in different hospitals**	To be adapted in legislation Solved in submodels 1 and 4 (medical council on system level)	To be adapted in legislation	To be adapted in legislation
• **New physician appointments can be cumbersome**	Only solved in submodels 1 and 4	Not solved: advice of medical councils of individual hospitals is required.	Solved
• **Role of medical leadership**	Solved since there will be one CMO per health system, responsible for strategic decisions at the health system level, who can delegate operational decisions to CMOs at the level of the institutions.	Not solved	Solved
• **Fee-for-service hinders referrals**	Subject to larger reforms of payment systems	Subject to larger reforms of payment systems	Subject to larger reforms of payment systems
• **Deductions on physician fees**	Enhances equal treatment of deductions	Not solved The statutes of the physicians and their financial agreements with the individual hospitals have to be harmonized, which implies a reinforced advice of the medical councils.	Solved
• **Mobility of other staff**	The exchange of physicians, other healthcare professionals and other employees is easier because they work in one single organisation and have to follow the same regulations and conditions (taking account of CLA n°32bis – see section 3.4.5).	Not solved, except for the exchange of employees when the network is a not-for-profit association and the provision of staff is the only statutory purpose of the group.	Solved since the new organisation can engage salaried employees as well as self-employed personnel. When all staff of the participating hospitals is transferred, the regulations of CLA n°32bis apply; in case of transfer of part of the staff, it will be necessary to observe within each hospital the breaking contract terms as provided.
Authorisation and task	Solved	Not solved	Solved

distribution		Although authorisation stays at the level of individual hospitals, it could be decided that belonging to a network is a precondition for receiving this authorisation. In this case, also the network should have a legal status. However, this precondition will not be sufficient to prevent competition between hospitals in the network.	
Payment of hospital budget	Solved	Not solved	Solved (if legislation is adapted such that organisations that are not a hospital are allowed to receive a BFM). This could also create opportunities for a new legislation that enhances a pathology-based allocation of financial means for collaborations.
VAT	Solved if established under a not-for-profit association	The coordinated network will have to take into account the new regulations about the VAT regime of a cost-sharing association ('kostendelende vereniging'/'association de frais') and VAT, introduced on 1 July 2016 if they are not part of the same legal entity.	Since the autonomous collaboration initiative is one organisation, problems with VAT are solved.
Data and privacy			
• **Responsibility patient file**	Health system	To be defined in the Hospital Act	Autonomous collaboration initiative
• **Responsibility patient rights and delivered care**	Health system	Individual hospital or new legal framework to be established	Autonomous collaboration initiative

4.5.3. The healthcare landscape

Collaboration and concentration

The increased power held by large **health systems** operating in a geographic area raises concerns about a possible connotation of monopoly power with a loss of freedom of choice for patients but also for physicians. A first measure could be, following the Dutch example, to notify the establishment of a health system to the Competition Authority. In addition, an evaluation could be performed of the impact of the concentration on the provision of care to the patient or the risks of the concentration on the quality and the accessibility of care. In the Netherlands this evaluation is done by the Dutch Healthcare Authority (NZa; 'Nederlandse Zorgautoriteit'). Such evaluation also examines the involvement of different stakeholders (patients, physicians, employees, etc.) in the set-up of the collaboration. A similar institute in Belgium could take up that role.

If a **coordinated network** wants more impact, control and supervision on the way hospitals are operating in the network, and thus on the legal persons who are members of the network, then competition rules become important. If there is a concentration of activities, also the coordinated network will have to be reported to the Competition Authority.

Competition law subjects the collaboration between companies to strict conditions in order not to disrupt the market. Such rules should also be followed by creating and operating an **autonomous collaboration initiative**.

The role of hospitals in autonomous collaboration initiatives

In an autonomous collaboration initiative we allow that some care services can be run separately and do not have to fulfil the current legislation to run a hospital. It was suggested by round-table participants that also for this model a link with the founding hospitals is retained, and that the autonomous collaboration initiatives will also need to be authorised and controlled by the government in order to **preclude unfair competition**. Procurement legislation, the rules on state aid and abuse of dominant position will also play an important role. The government will be able to decide the form of the autonomous collaboration initiative. These decisions need not necessarily occur through public procurement legislation at the level of the Member State (or potentially at the level of the organisation between hospitals themselves, although the recent procurement rules provide flexible formulas for the organisation of healthcare services). The state aid rules will however have to be strictly respected. It will be important, if support is given, to outline how it includes services of general economic interest with a clear allocation decree that establishes which financial aid can be used (and how reimbursement takes place in case of overcompensation). It is important that the legislation provides clearly, if they have public service obligations, an obligation to cooperate with the new organisation. If the autonomous collaboration initiative is charged with a service of general economic interest, it will be legally obliged to collaborate with hospitals.

If the Belgian legislator decides to opt for the development of an autonomous collaboration initiative this will be challenging, as it will have an impact on many aspects of current hospital legislation.

It will be important to specify **for which areas of care** such an organisation can be created. Whilst it is difficult to list the interventions concerned as medicine evolves very quickly, it could still be advantageous to provide a framework to regulate the areas concerned.

The goal is **not to create a parallel healthcare supply circuit**, but rather to enable the current hospitals to make a shift towards a reformed hospital landscape with better coordination and task distribution. It therefore seems right that existing hospitals should have a role in the creation of the autonomous collaboration initiative, in particular if it concerns complex healthcare.

To encourage hospitals to participate in the development of autonomous collaboration initiatives, incentives will be needed. Whilst for certain complex forms of healthcare, the use of an existing hospital is necessary, it is at the same time necessary not to restrain the use of such structures only to hospitals. Doing so in situations where it is not justified may infringe the principle of freedom to provide services. It would therefore be possible to imagine a system in which the creation of these structures for specified domains could be done without the participation of hospitals, for example

cosmetic or eye surgery structures that already have developed without hospitals. For other areas, such as cancer care, it would be necessary to legally embed the participation of at least one or two hospitals.

Besides participating hospitals, it could also be interesting to analyse a possible collaboration with **private partners or institutions abroad**. It would be essential to introduce safeguards to avoid any conflict of interests. A possible example is a distributor of medical devices that participates in the creation of a specialised care structure pursuing an activity requiring the use of a medical device equivalent to the one sold by the distributor.

The government will have to make a choice to either adapt the Hospital Act or to adopt new legislation. The legislation concerning autonomous collaboration initiatives may also be a way to provide a regulatory framework for **private clinics**, regardless of whether this is done by an amendment of the Hospital Act (and the extension of the scope) or by an act alongside the Hospital Act. In any case, the new regulation will require the cooperation of the communities (for example to determine the content). This form will also be linked to certain conditions in term of access to ICU, emergency department, etc. Agreements will have to be concluded with collaborating hospitals. A legislative framework that supports this goal should be provided.

To avoid duplication of healthcare provision, it may be useful to analyse the possibility for hospitals to **transfer their beds** to create a new organisation. Such a transfer could be done via the transfer of a branch of activity.

Distance

Most of the participants indicated the need for a geographic logic in the collaborations. It is a challenge for the legislator to create certain rules regarding distance and transport times. First, in historically formed collaborations sometimes large distances exist between facilities. Second, the culture and motivation to collaborate might be considered more important than the distance between hospitals. Forced collaborations with different cultures experience more difficulties to establish a joint strategy. However, distance and competition are important and may cause problems in terms of quality and efficiency.

5. A CLEAR FRAMEWORK SUPPORTING THE INTRODUCTION OF NEW GOVERNANCE MODELS FOR HOSPITAL COLLABORATIONS

The establishment of a clear policy framework

Many of the round-table participants emphasized that a clear policy framework (e.g. programming of costly and/or complex procedures; strict authorisation norms including minimal volume thresholds; restricting reimbursement of specialised services to specific centres) is required to trigger a more fundamental collaboration between hospitals. According to the round-table participants the absence of a clear policy framework restrains the hospitals from taking the next step. Furthermore, there are not enough incentives to collaborate as the current legislation does not financially encourage the hospital collaborations (or penalise non-collaboration) and there is no clear vision on how task distribution will be organised.

The last major reform of legislation on hospitals goes back to 1987, with the coordinated Hospital Act of 7 August 1987. The round-table participants and other consulted stakeholders also emphasized that a new framework to design the hospital landscape should be able to last for a long period of time and provide a stable environment for the sector.

The basic principles in the Action Plan of the minister have recently been operationalised in a vision statement (October 2016) which is intended to provide such framework. The main lines of the framework are listed in Box 7. It should be kept in mind that the term ‘network’ in the vision statement is a more general term than the concept of coordinated network in this report.

Box 7 – Preliminary vision statement of the minister of October 2016

- The healthcare landscape consists of loco-regional clinical hospital networks, each covering about 400 000 to 500 000 inhabitants (or potential patients). This would result into about 25 loco-regional clinical hospital networks for the country.
- The partners in the loco-regional network are hospitals (not hospital functions, departments, care programmes, etc.).
- General and specialised hospital care assignments ('zorgopdracht'/'mission de soins') are provided by each loco-regional network (but necessarily by each hospital in the network).
- Reference networks are set up for supra-regional collaborations, i.e. for care assignments that are not provided in each loco-regional network.
- The partners in such a reference network are the loco-regional networks and the hospital providing the care assignment. Hospitals providing care assignments at supra-regional level are called 'reference points' ('referentiepunt'/'point de référence').
- The involvement of physicians will be organised at the level of the network.
- The scope of (evidence-based) programming will be enlarged. Programming will be done at the national level with an allocation formula to apply the programming results to the level of the federated authorities.

The combination of the three models

Although the establishment of a clear framework is considered a prerequisite for hospitals, round-table participants and other stakeholders also emphasized the importance of leaving sufficient initiative to the sector in the choice of collaboration type and governance structures.

All round-table participants agreed that the three models should be made possible, as each model reflects a different stage in the collaboration. The coordinated network model (model 2) is particularly suitable for initiating collaborations, as the intensity of the commitment between the partners is lower. As the collaboration matures the coordinated network model can develop over time and eventually result in a health system (model 1). The autonomous collaboration initiative (model 3) allows to develop collaborations on activities with a limited scope.

As such this model is suitable for collaborations on innovative and highly-specialised care that aim to improve quality or reduce costs. The autonomous collaboration initiative also enables collaboration for specific care programmes and supporting services. To make this possible, it is thus important that the legislation is flexible enough to allow the development of the three proposed governance models.

In all models, the emergent context of large physician associations in which physicians of different hospitals participate will have to be taken into account. Hospital collaborations will have to adapt to this new reality, by concluding and monitoring collective agreements with these large groups of doctors.

Supra-regional collaborations

For services that are provided by a limited number of hospitals (e.g. for pathologies with a low prevalence, highly-specialised or high-cost services, etc.) the autonomous collaboration initiative or the coordinated network are suitable models. However, for services that are provided by a very limited number of hospitals (e.g. 1 or 2 hospitals in Belgium) and/or when there is no interaction needed among the referring hospitals (e.g. to agree on quality standards; exchange of staff), the proposed governance models might be too cumbersome. In these specific cases contractual agreements might be more appropriate.

The preferred model can evolve over time

As evolution is important in collaborations, each model can reflect a different stage in the collaboration. Because the autonomous collaboration initiative allows to integrate a limited number of services, it can be an intermediate step between a coordinated network model (model 2) and the health system model (model 1). Hence, models 2 and 3 can be considered transitional models to move towards a health system. If four hospitals want to collaborate, for example, they might opt in the start-up for a network model (model 2). After a while they might decide to establish a care programme for cardiology and set up an autonomous collaboration initiative (model 3) which is combined with model 2. As the collaboration expands towards a larger number of care programmes (with a centralisation in model 3), the collaborating partners might decide to become a health system (model 1), especially when they arrive at a point where they collaborate for the majority of services.

Moreover, if different models are combined, also governance structures can be combined. The governance structure of submodel 2 in model 2 (i.e. a coordinated network model with delegated power) could for instance be combined with the structure of submodel 1 in model 3 (i.e. autonomous collaboration initiative linked to hospitals). In this case, the network committee (or a delegation of it) could take up the role of the board in the autonomous collaboration.

In addition, governance within collaborations will also depend on the goals of the collaboration. The governance of service lines which focus only on one pathology or care programme will be different from the governance of a health system. As such, not only the governance structures can evolve but also internal governance processes.

Enhancing task distribution

Although the three proposed models have the potential to stimulate cooperation and task distribution between hospitals, changing the Hospital Act to allow new collaboration types or governance models will not be sufficient to achieve the desired results. It was identified that mainly the health system and the new organisation models (i.e. models 1 and 3) will lead to more task distribution. Incentives to opt for more integrated models can be provided by the legislator. In addition, certain preconditions supporting the introduction of new governance models for hospital collaborations have to be fulfilled, such as changes in the fee-for-service payment system and the allocation of the BFM or regulations concerning distance and competition.

Governance

New forms of governance structures will, on itself, not resolve all problems related to task distribution.

A collective goal and an integrated strategy

In this study a collaboration is defined as a partnership between organisations with a collective goal and an integrated strategy to achieve this goal. When the goals of the individual partners in a collaboration are not aligned and/or there is no integrated strategy, the governance structure alone will not be able to solve this problem. A similar organisational culture and ideology will enhance collaboration.

Governance mechanisms

As the fit between governance structures and governance mechanisms determines governance performance, governance mechanisms also are an important success factor. External influences play an important role in governance. When compared to other countries such as Denmark or the US, the Belgian governance mechanism is mainly driven by civil society. Consultation and involvement of the sector in reforming hospital collaborations and governance-structures are essential for creating a mindset for reform.

Good governance practice

As the level of transparency, accountability, participation, integrity and capacity are core concepts to establish ‘good governance practice’, the internal governance of an organisation is also a precondition to make the three models work. Leadership, for example, was identified as an important prerequisite to establish good collaborations. Having competent managers and administrators is a basic requirement. In the different governance types it is essential to ensure that attention is paid to collaboration between the hospitals and facilities within the collaboration.

The establishment of a health system alone, for example, does not directly imply a true collaboration between the organisations of the health system. Only when such collaboration is effective, it can lead to quality-oriented and cost-effective care.

Quality

Accountability in healthcare does not only refer to costs and task distribution but also includes quality as an important performance measure. As such the government should focus on quality measures to control and authorise collaborations since task distribution and controlling costs is not enough. Participation in accreditation programmes such as NIAZ Qmentum and JCI can contribute to this goal.

Stakeholder involvement

Stakeholder involvement is very important in governance. Several studies indicate the importance of medical and other types of professionals in the board.[58] Also other stakeholders such as patients should be able to participate in the decision making of hospital collaborations.[52]

The Supervisory Authority

Hospital market concentration should be monitored in all types of governance models. Following the example of the Netherlands that has a Supervisory Authority, the Belgian legislator may provide something similar and make it compulsory for (specific forms of) collaborations to get the approval of the government in advance. For example, in a loco-regional network of hospitals, with the governance structure of a health system, a monopoly might be expected to emerge with a potential risk of restricted patient choice.

Keep hospital groups and associations in a transition period

To enhance a smooth transition to the new proposed models, it is appropriate to retain the current legislation on hospital associations and hospital groups. Moreover, where possible the rules on hospital associations or hospital groups can be applied in a number of the proposed models. For example, some rules about hospital groups[28] and hospital associations can be related to a health system or rules about hospital associations can be related to a coordinated network. Although it was mentioned by the round-table participants that a hospital group may become obsolete when the possibility of a health system is created, they agreed to keep the hospital group legislation (and hospital association) for reasons of continuity and legal certainty.

However, the new models have some advantages over the existing ones: the possibility to take decisions and receive authorisations on the collaboration level; the models are flexible and can be combined; the responsibilities of the collaboration versus the participating institutions is clearer.

Collaboration between different government levels

The macro-level governance for healthcare is characterized by shared responsibilities between the federal and federated level since the interconnected policy instruments to regulate the healthcare sector (i.e. planning, programming, authorisation and the payment system) are not all attributed to the same level of competency. Due to the 6th State reform a transfer of powers from the federal government to the federated authorities came into effect on 1 July 2014. The federal government is responsible for the planning of global hospital capacity and for the translation of this planning into programming standards and criteria. Federated authorities have the power to define the norms hospitals, care programmes etc. have to comply with to be authorised. However, these norms have to respect the organic legislation, the federal programming criteria and the federal power to regulate the practice of medicine. Hence, since the 6th State reform the need for coordination between the federal state and the federated entities has been strengthened, especially for collaborations that imply hospitals and homes for the elderly since the federated level is responsible for elderly care.

RECOMMENDATIONS[c]

To the Minister of Social Affairs and Public Health

- **In the context of the implementation of 'the Action Plan for the reform of the hospital payment system' it is recommended to adopt three new collaboration models (i.e. 'health system'; 'coordinated network' and 'autonomous collaboration initiative') in the Hospital Act with for each of these models a governance model that:**
  - **provides a well-defined framework to the healthcare sector that supports task distribution and collaboration between hospitals (and other care organisations);**
  - **allows flexibility to the healthcare sector to tailor the governance model to the goal of the collaboration and to the number and type of partners involved;**
  - **includes physician involvement on the level of the collaboration.**
- **A health system has the following governance model:**
  - **The board of the health system holds final responsibility as well as the responsibility for its strategic aims. The day-to-day management is the responsibility of an executive committee on the health system level.**
  - **The strategic decisions are translated to operational decisions by an executive committee at the level of the hospital.**
  - **Two options are provided for the advisory role of the medical council:**
    - **A common medical council on the level of the health system;**
    - **A common medical council per sector (e.g. a separate medical council for general hospitals and one for psychiatric hospitals). These sector-specific medical councils give advice to the board of the health system.**
  - **Authorisation and payment of hospitals, hospital departments and services are allocated to the legal entity that runs the health system.**

[c] The KCE has sole responsibility for the recommendations.

- **A coordinated network has the following governance model:**
  - **A network committee with a representation of physicians, the executive management and the boards of the network partners, has decision authority on the activities of the coordinated network with no feedback to the respective committees from the participating hospitals required.**
  - **The governance structure of the individual partners (board, executive management, medical council) continues to exist but also delegates power to the network committee. These responsibilities are explicitly included in the foundation agreement of the coordinated network or in the statutes of the legal entity that runs the coordinated network. This can only be done in compliance with the stipulation of Title IV of the current Hospital Act.**
  - **Authorisation and payment of hospitals, hospital departments and services are not allocated to the level of the coordinated network. Within the authorisation norms of hospitals, hospital departments and services it can be made compulsory to be part of a coordinated network.**
- **The autonomous collaboration has the following governance model:**
  - **The autonomous collaboration initiative holds the final responsibility. A permanent link with the founding hospitals has to be foreseen via voting rights in the decision-making committees.**
  - **Own medical council, conformable to the adjusted Hospital Act**
  - **Own Board, conformable to the law on the involved legal entity**
  - **Own day-to-day management**
  - **Authorisation and payment of hospital departments and services are allocated to the autonomous collaboration initiative.**
  - **To enable the development of autonomous collaboration initiatives, the current Hospital Act should be extended or a specific legal provision should be created.**
    - **In the first scenario the current law on categorical hospitals could be used.**
    - **In the second scenario article 81 of the current Hospital Act could be used by including new rules for services that could take place within or outside the hospital.**
  - **In case certain care programmes and/or services are organised via autonomous collaboration initiatives it is important to ensure that the remaining hospitals still meet the 'definition of a hospital'.**

- **Creating new hospital associations or hospital groups should no longer be allowed but to preserve legal certainty it is recommended to maintain them provisionally in the Hospital Act.**
- **To facilitate the above objectives it is necessary to adjust the current legal provisions:**
  - **It should be allowed to organise hospital specific committees (e.g. medical pharmaceutical committee, transfusion committee, ethical committee) at the level of the collaboration.**
  - **Physicians who work in multiple hospitals (of a hospital collaboration) should no longer lose voting power for the composition of medical councils (Royal Decree of 10 August 1987).**
  - **Chief medical officers and chiefs of medical departments should be allowed to perform tasks in multiple hospitals of the collaboration as is already foreseen in the current provisions of the hospital group.**
- **Prerequisites and recommendations for a new legal framework:**
  - **A healthcare-specific competition authority that monitors concentration should be identified or established to ensure that the freedom of choice for the patient or physician is not restricted in case of new hospital collaborations.**
  - **Current distance criteria in the legislation on hospital mergers and hospital groups should be replaced by new concepts (e.g. number of inhabitants in the attraction zone of a contiguous geographical area of a particular collaboration initiative) that comply with the scheduled reforms of the hospital landscape.**
  - **Quality criteria should be defined to analyse the performance of a future collaboration and to evaluate the performance after the establishment of the collaboration.**
  - **The responsibilities regarding data management and privacy should be clearly stipulated in the new collaboration models.**
  - **The hospital budget ('BFM'/'BMF') should be defined more in terms of pathology, service line or care programme such that the development of autonomous collaboration initiatives can take place in a transparent way.**

- **In case of collaboration initiatives with external reference points for rare and complex problems, agreements sui generis should be provided, because it is not necessarily the case that there is a relationship between the referring entities. Hospitals can opt for one of the new governance models proposed in this report, in case it concerns reference functions were also mutual dependent relationships between the referring entities (e.g. common quality management) are indicated.**

To the hospitals and hospital umbrella organisations

- **In a first phase it is recommended to start with collaborations between hospitals only in order to enable agreements on the distribution of general and specialised services per geographical area.**

- **In the context of the execution of the plan integrated care for people with chronic conditions it is recommended to include the interaction between loco-regional governance and collaboration between hospitals within the scope of the pilot projects.**

- **In the start-up of collaborations the model which best fits with the objectives of task distribution and rationalisation should be chosen:**
  - **A coordinated network is recommended as a first step in the transition towards a health system for loco-regional collaboration initiatives for general and specialised services. During this transition period it is recommended to combine the coordinated network with autonomous collaboration initiatives for well-defined (clinical, legal, hospital budget) care programmes or services.**

- **It is recommended to develop a charter with the principles of 'good governance' for collaboration initiatives between hospitals, with a commitment to (among others):**
  - **prevent that conflicts of interests hinder collaborations and task distribution between hospitals (e.g. procedure to appoint new members for the board, independent board members, etc.);**
  - **prevent that the number of members of the different governance structures becomes too large;**
  - **professionalize the governance structures;**
  - **guarantee that the stakeholders of the individual institutions of the collaboration have a voice in the decision-making process (e.g. advisory committees with patient representatives).**

To the federated entities

The authorisation norms of hospitals, hospital departments, hospital services, care programmes and pathology-specific collaboration initiatives should be aligned with the proposed models.

REFERENCES

1. Beleidscel van de minister van Sociale Zaken en Volksgezondheid. Plan van aanpak - Hervorming Ziekenhuisfinanciering. 2015. Available from: http://www.vbs-gbs.org/fileadmin/user_upload/News/2015/nl/Plan_van_Aanpak_Ziekenhuisfinanciering_Commissie_VG_20150428.pdf
2. Vandeurzen J. Beleidsnota 2014-2019. Welzijn, Volksgezondheid en Gezin. Vlaamse regering 2014.
3. Vandeurzen J. Nieuw Vlaams ziekenhuislandschap. Focus op de patiënt. 2016. Available from: https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/08072016_Nota_Nieuw%20Vlaams%20Ziekenhuislandschap.pdf
4. Eeckloo K. Hospital Governance in Vlaanderen: Exploratieve studie in internationaal perspectief. Leuven: 2008. Doctoral Dissertation. Available from: http://hdl.handle.net/1979/2612
5. Greer S, Wismar M, Figueras J, McKee C. Governance: a framework. In: Greer S, Wismar M, Figueras J, editors. Strengthening Health System Governance. Better policies, stronger performance: Open University Press; 2016. Available from: http://www.euro.who.int/__data/assets/pdf_file/0004/307939/Strengthening-health-system-governance-better-policies-stronger-performance.pdf?ua=1
6. Koninklijk Besluit van 15 juli 2004 houdende vaststelling van de normen waaraan de zorgprogramma's "cardiale pathologie" moeten voldoen om erkend te worden, B.S. 13 september 2004.
7. Clement J, McCue M, Luke R, Bramble J, Rossiter L, Ozcan Y, et al. Strategic hospital alliances: impact on financial performance. Health Affairs. 1997;16(6):193-203.
8. Esposto A. Contractual integration of physician and hospital services in the US. Journal of Management and Governance. 2004;8(1):49-69.
9. Yu S, Chen M. Performance impacts of interorganizational cooperation: a transaction cost perspective. Service Industries Journal. 2013;33(13-14):1223-41.

10. Bailey D, Koney K. Strategic alliances among health and human services organizations: From affiliations to consolidations. Sage Publications; 2000.
11. Alexander JA, Weiner BJ, Metzger ME, Shortell SM, Bazzoli GJ, Hasnain-Wynia R, et al. Sustainability of collaborative capacity in community health partnerships. Medical Care Research and Review. 2003;60(4 suppl):130S-60S.
12. Zhu X, Ullrich F, Mueller K, MacKinney A, Vaughn T. Trends in hospital network participation and system affiliation, 2007-2012. Rural policy brief. 2013(2014 6):1-5.
13. Willem A, Gemmel P. Do governance choices matter in health care networks? An exploratory configuration study of health care networks. BMC health services research. 2013;13(1):229.
14. Provan K, Kenis P. Modes of network governance: Structure, management, and effectiveness. Journal of public administration research and theory. 2008;18(2):229-52.
15. Proenca EJ, Rosko MD, Dismuke CE. Service collaboration and hospital cost performance: direct and moderating effects. Medical care. 2005;43(12):1250-8.
16. Adler P. Market, hierarchy, and trust: The knowledge economy and the future of capitalism. Organization science. 2001;12(2):215-34.
17. Olejaz M, Nielsen A, A R, HO B, Krasnik A, Hernández-Quevedo C. Denmark. Health System review. Health Systems in Transition 2012;14(2).
18. Vrangbaek K. The Danish Health Care system In: Mossialos E, Wenzl M, Osborn R, Anderson C, editors. International Profiles of Health Care Systems, 2014: The Commonwealth Fund; 2015. p. 33-42.
19. L'Enfant R. Samenwerking tussen organisaties. Handvaten voor een praktijk van netwerkvorming. In: Desmet A, Baert H, Bouverne-de Bie M, L. Verbeke L, editors. Handboek Samenlevingsopbouw in Vlaanderen Brugge: Die Keure; (2008).
20. Bohmer R, Edmondson A, Feldman L. Intermountain Health Care. In: Harvard Business School; 2013.
21. Alexander J, Comfort M, Weiner B, Bogue R. Leadership in collaborative community health partnerships. Nonprofit management and leadership. 2001;12(2):159-75.
22. Kim K, Burns L. Success factors in hospital network performance: evidence from Korea. Health Services Management Research. 2007;20(3):141-52.
23. Klijn EH, Koppenjan JFM. Governace networks in the public sector. Routledge: Oxon; 2016.
24. Eeckloo K, Van Herck G, Van Hulle C, Vleugels A. From Corporate Governance To Hospital Governance: Authority, transparency and accountability of Belgian non-profit hospitals' board and management. Health Policy. 2004;68(1):1-15.
25. Hellings J. Hospital Governance Aanbevelingen 2012. Brussel: ICURO vzw; 2012.
26. Van de Voorde C, Van den Heede K, Mertens R, Annemans L, Busse R, Callens S, et al. Conceptual framework for the reform of the Belgian hospital payment system. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE); 2014 26/09/2014. KCE Reports 229 Available from: https://kce.fgov.be/sites/default/files/page_documents/KCE_229_Hospital%20Financing_Report.pdf
27. Koninklijk Besluit van 25 april 1997 houdende nadere omschrijving van de associatie van ziekenhuizen en van de bijzondere normen waaraan deze moet voldoen, B.S. 18 juni 1997.
28. Koninklijk Besluit van 30 januari 1989 houdende vaststelling van aanvullende normen voor de erkenning van ziekenhuizen en ziekenhuisdiensten alsmede tot nadere omschrijving van de ziekenhuisgroeperingen en van de bijzondere normen waaraan deze moeten voldoen, B.S. 21 februari 1989.
29. Koninklijk Besluit van 31 mei 1989 houdende nadere omschrijving van de fusie van ziekenhuizen en de bijzondere normen waaraan deze moeten voldoen, B.S. 5 juli 1989.
30. Psy 107. Guide vers de meilleurs soins en santé mentale par la réalisation de circuits et de réseaux de soins. Bruxelles: 2010.

31. Koninklijk besluit van 10 augustus 1987 tot vaststelling van de regels met betrekking tot de samenstelling en de werking van de medische raad in uitvoering van de artikelen 24, 25 en 26 van de wet van 23 december 1963 op de ziekenhuizen, B.S. 18 augustus 1987.
32. Koninklijk besluit van 15 december 1987 houdende uitvoering van de artikels 13 tot en met 17 van de wet op de ziekenhuizen, zoals gecoördineerd door het koninklijk besluit van 7 augustus 1987, B.S. 25 december 1987.
33. European Commission. Annual Growth Survey 2016. European Commission 2015.
34. Hendrickx F, Vanderpoorten A. Poolen van personeel, co-sourcing en de werkgeversgroepering in het arbeidsrecht. Recht in beweging 2016; 23ste VRG-Alumnidag. Antwerpen:311-27.
35. Nationale Raad voor Ziekenhuisvoorzieningen. Advies inzake maatregelen om samenwerking tussen ziekenhuizen te bevorderen. Brussel: 14 juni 2012.
36. Zorgnet-Icuro. Regionale ziekenhuisnetwerken. Brussel: 2015.
37. Guo L, Lach P, Mobbs S. Tradeoffs between internal and external governance: evidence from exogenous regulatory shocks. Financial Management. 2015;44(1):81-114.
38. Hoetker G, Mellewigt T. Choice and performance of governance mechanisms: matching alliance governance to asset type. Strategic Management Journal. 2009;30(10):1025-44.
39. Powell W. Neither market nor hierarchy. The sociology of organizations: classic, contemporary, and critical readings. 2003;315:104-17.
40. Lenssen G, Arenas D, Lacy P, Pickard S, Albareda L. Corporate responsibility, governance and accountability: from self-regulation to co-regulation. Corporate Governance: The international journal of business in society. 2008;8(4):430-9.
41. Detomasi DA. The multinational corporation and global governance: Modelling global public policy networks. Journal of Business Ethics. 2007;71(3):321-34.
42. Wildhaber F, Collerette P, Pelletier D, Heberer M. Benchmarking Inter-Hospital Alliances against Industry Best Practices. Management and Organizational Studies. 2015;2(4):p23.
43. Nauenberg E, Brewer C, Basu K, Bliss M, Osborne J. Network structure and hospital financial performance in New York State: 1991-1995. Medical Care Research and Review. 1999;56(4):415-39.
44. Moscovice I, Christianson J, Johnson J, Kralewski J, Manning W. Rural hospital networks: implications for rural health reform. Health care financing review. 1995;17(1):53.
45. Alexander JA, Ye Y, Lee SYD, Weiner BJ. The effects of governing board configuration on profound organizational change in hospitals. Journal of Health and Social Behavior. 2006;47(3):291-308.
46. Bazzoli GJ, Shortell SM, Dubbs N, Chan C, Kralovec P. A taxonomy of health networks and systems: bringing order out of chaos. Health services research. 1999;33(6):1683.
47. Lin BYJ. Integration in primary community care networks (PCCNs): examination of governance, clinical, marketing, financial, and information infrastructures in a national demonstration project in Taiwan. Bmc Health Services Research. 2007;7.
48. Feachem RG, Dixon J, Berwick DM, Enthoven AC, Sekhri NK, White KL. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente. Commentary: Funding is not the only factor. Commentary: Same price, better care. Commentary: Competition made them do it. BMJ. 2002;324(7330):135-43.
49. James BC, Savitz LA. How Intermountain trimmed health care costs through robust quality improvement efforts. Health Affairs. 2011;30(6):1185-91.
50. Proenca E, Rosko M, Dismuke C. Service collaboration and hospital cost performance: direct and moderating effects. Medical care. 2005;43(12):1250-8.
51. Ackoff R. Creating learning organizations. Syst thinker. 1992;3(10).
52. van der Meide H, Olthuis G, Leget C. Patient Participation in Hospital Care: How Equal is the Voice of the Client Council? Health Care Anal. 2015;23(3):238-52.

53. Willem A. Trust in whole networks in the public and nonprofit sector: The impact of public sector characteristics. Brussel: 2010.

54. Kenis P, Provan K. Modes of network Governance: Structure, Management and Effectiveness. Journal of Public Admnistration Research and Theory. 2008;18(2):229-52.

55. Bader BS, Zablocki E, Lockee C. Joint venture governance: on often overlooked succes factor. Great boards. 2007;7(1):1-6.

56. Bamford J, Ernst D. Governing joint ventures. McKinsey on Finance. 2005:12-6.

57. GUBERNA. La gouvernance des intercommunales. 2012. Available from: http://www.guberna.be/sites/default/files/general/Gouvernance%20intercommunales%20wallonnes_rapport.pdf

58. Kuntz L, Pulm J, Wittland M. Hospital ownership, decisions on supervisory board characteristics, and financial performance. Health care management review. 2016;41(2):165-76.

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