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The introduction of hospital networks in Belgium: The path from policy statements to the 2019 legislation☆

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ABSTRACT

In April 2015, the Belgian Federal Minister for Social Affairs and Public Health launched an Action Plan to reform the hospital landscape. With the creation of "localregional clinical hospital networks" with their own governance structures, the plan follows the international trend towards hospital consolidation and collaboration. The major complicating factors in the Belgian context are (1) that policy instruments for the redesign of the hospital service delivery system are divided between the federal government and the federated authorities, which can result in an asymmetric hospital landscape with a potentially better distribution of clinical services in the Flanders hospital collaborations than in the other federated entities; and (2) the current regulations stipulate that only hospitals (and not networks) are entitled to hospital budgets. Although the reform is the most significant and drastic transformation of the Belgian hospital sector in the last three decades, networks mainly offer a framework in which hospitals can collaborate. More regulation and policy measures are needed to enhance collaboration and distribution of clinical services.

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1. Introduction

Worldwide in the healthcare sector, new forms of collaboration and governance structures have been developed as a response to the growing pressure to reduce costs without affecting quality or access to care [1,2]. There is a common trend towards hospital consolidation and the creation of hospital groups and multihospital networks, particularly in the United States and, more recently, in European countries [3,4]. For instance, 2007 saw a structural reform in Denmark, which introduced a system with five regions (replacing 13 counties) and 98 municipalities (replacing 275 smaller municipalities). The reform aimed to encourage the specialization of the most complex hospital services across the country into fewer hospitals (the number of hospital beds has fallen from 25,000 in 1996 to 18,000 by 2009) and also provided an opportunity for the government to further rationalise the size and number of hospitals across the country [5]. To answer these challenges in Belgium, the Minister for Social Affairs and Public Health launched an Action Plan in April 2015 to reform the hospital landscape [6].

Currently, the dominant form of hospital care organization in Belgium is the standalone hospital with its own governance structure (board, executive management and medical council) offering the widest possible range of medical services to be competitive with other hospitals in the region. In combination with the dense Belgian hospital landscape this results in a high degree of dispersion and fragmentation in both general services (such as emergency departments [7] and maternity services [4]) and more specialized services (like complex cancer surgery [8] and major trauma care [9]). This reform thus aims to enhance collaboration that facilitates task distribution (i.e., agreements between hospitals about the supply of hospital services with the intention to decrease fragmentation) and to strengthen the coordination of care by introducing interorganizational networks, where more than two organizations

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work together with a collective goal and an integrated strategy [10]. In the reform plans, such collaboration is called "local–regional clinical hospital networks". The focus is on collaborations between hospitals around general clinical services. Another axis of the reform plan is to concentrate complex, rare, high-cost care procedures in a limited number of reference centres in Belgium. These reference centres then require collaboration on the supraregional level.

To achieve this goal, the April 2015 Action Plan described the principles of a redesigned hospital landscape: (1) hospital capacity planning should be based on population needs; (2) greater division of tasks and collaboration initiatives between hospitals, and between hospitals and other care settings is needed; (3) hospitals should be part of a network; payments and permission to perform certain activities should increasingly be granted to networks instead of to individual hospitals. The Action Plan's basic principles have been operationalized in a vision statement (October 2016) and were given concrete shape in a concept paper in June 2017. A draft Act amending some provisions of the Hospital Act of 10 July 2008 was prepared and submitted for review to the Council of State in March 2018 (see Box 1 for the main outlines for this Act) [11]. On 28 February the Law was approved in Parliament, stating that hospital networks should be implemented by the 1 January 2020. However, due to the choices made during the reform process and the specific context variables, it is unclear to what extent these legal provisions will result in the goals of the reform namely, increasing the level of task distribution and coordination. In what follows, we discuss the main reasons why this new Law alone might be insufficient.

Box 1: Core elements of the draft Act on hospital networks (March 2018).Network

- The Belgian hospital landscape will consist of no more than 25 local–regional clinical hospital networks.
- Each general hospital is obliged to join one and only one local–regional clinical hospital network.
- Collaboration is within a contiguous geographic area and hospitals in the network must offer care assignments that are complementary to each other.
- A distinction is made between local–regional and supraregional care assignments. Local–regional care assignments must be provided within each local–regional network; supraregional care assignments may not be offered within each local–regional network.
- Patients have free choice of provider.

Governance

- The local–regional clinical network has a governance structure consisting of three bodies: network board, chief medical officer (or board of chief medical officers), and medical network council.

Network board

- Every hospital has at least one representative on the network board, who is also on the hospital board.
- The network board has at least one independent board member.
- At least one-third of members must be experts in healthcare, of which at least one a physician not employed by the collaborating hospitals.
- The network board is responsible for establishing the strategy of allocating care assignments to individual hospitals; coordinating the supply of care assignments; ensuring accessibility of local–regional care assignments; choosing reference points and establishing referral agreements; developing an admission policy; defining task agreements; coordinating care with other providers within the geographic area of the network; making arrangements about the financial means.
- The board of each hospital in the network is responsible for implementing the strategic decisions taken by the network board.
- A two-thirds majority is required to allocate care assignments to individual hospitals; the allocation is binding.

Network chief medical officer (CMO) or network board of CMOs

- The network has a CMO, or a board of the CMOs of all hospitals in the network.
- The network CMO is responsible for a coherent medical policy.
- Decisions taken by the network CMO take precedence over and, are opposable to, decisions of the CMO of the hospitals.

Medical network council

- The medical network council represents the medical specialists in the network.
- The medical council of each hospitals advises the hospital board on transfer to the network level of matters related to the medical specialist's status.
- The medical network council is exclusively authorized for matters transferred to the network level.

Hospital and physician payments

- The Minister for Health can assign a separate hospital budget for the local–regional clinical network. The individual hospitals may voluntarily transfer part of their hospital budget to the network.
- When the general financial agreement is transferred to the network level than the rules for the medical specialists' remuneration and contribution (to medical activity operating costs) on network level can be decided [8].

2. Challenges in the reform policy process to improving the distribution of clinical services and coordination

The main stakeholders involved in this policy process were the policy-makers on the different levels of government, the hospitals and their federations, and the physicians and physician unions.

2.1. Policy levers for enhancing collaboration are the responsibility of different governments

Specific agenda dynamics will produce different policy frames on multilevel policy levels when implementing a reform at country level [12]. This is a great challenge in the case of a large reform, since relations between different policy levels will have to be effectively coordinated. In Belgium, the responsibilities within the hospital service delivery system are divided between the federal government and the federated authorities. In short, the federal level is responsible for the definition of the basic legal characteristics of hospitals, payments to hospitals and physicians, and the definition and application of national planning criteria for hospitals and

hospital beds (e.g., six acute geriatric hospital beds per 1000 inhabitants over 65 years of age), hospital services (e.g., the number of PET- scanners), care programmes (e.g., the number of stroke units), and so on. The federated authorities (Flanders, Brussels, and Wallonia) are responsible for defining and granting licencing standards (for example, criteria regarding the required staff, equipment, and infrastructure) and budgets to invest in hospital infrastructure.

In the context of the networks, it is up to the federal state to specify the "governance structure of the networks" and to make it compulsory for hospitals to be part of a local–regional clinical network by making this a basic legal characteristic of hospitals; to work out the payment rules for local–regional clinical networks, and to determine the maximum number of networks and services (e.g., the maximal number of local–regional clinical networks, maternity units, and beds) for the country. However, it is up to the federated entities to define and grant the licencing criteria of the local–regional clinical networks. In other words, the federated entities determine which hospital collaborations are approved, which criteria their services need to fulfil (such as staff requirements for maternity services), and which services are licenced (for example, which maternity services fulfil the licencing requirement and receive a licence). They also allocate the investment budgets (e.g., deciding whether a hospital receives a budget to build or renovate its maternity unit).

This fragmentation of responsibilities delayed the reform, since the different governments had to find an agreement on the main lines of the reform. Although a joint declaration of the different governments was published in 2015 [13], differences in vision and action were apparent. The vision of the Flemish government was most in line with the federal reform plans, which resulted in a joint letter from the Federal and the Flemish Ministers of Health addressed to Flemish hospitals. This letter included deadlines for those steps in the reform that are in line with federal plans but for which the Flemish government is responsible. This increased the pace of formation of hospital collaborations in Flanders, while the pace was slower in the other federated entities. As such, the complex structure of the Belgian state risks slowing down this policy process and could result in an asymmetric hospital landscape with a potentially better task distribution in the Flanders' hospital collaborations than in the other federated entities.

2.2. Bottom-up developments are running ahead of top-down guidance

The Minister has regularly stated that the initiative for creating local–regional clinical networks belongs to the hospital sector. This bottom-up development of the local–regional clinical networks leaves room to collaborate with desired partners. This agrees with the literature on healthcare policy which states that clinical leaders are uniquely capable of enrolling colleagues; this is partly because their ability to relate to each other by means of historical and institutional structures, often resulting in unique coalitions that span the collegial networks and thus reconfigure the policy context [14]. Nonetheless, this bottom-up approach has permitted hospitals to negotiate on high-end medical services, rather than focusing on the priority, rationing basic general services. Hospitals attempt to predict the enhanced centralization of complex and high-cost services in their local–regional clinical network. By embedding these often financially lucrative and attractive services within own their local–regional network, they seek to prevent them being further centralized in supraregional collaborations.

Beyond that, smaller hospitals want a guarantee of their survival within networks, and thus request high-end medical services as a condition of joining a network. Hence, on the initiative of the Flemish Minister for Welfare, Public Health, and Family, representatives of small Flemish hospitals (licenced for less than 400 beds) discussed their role in the reformed hospital landscape, and proposed introducing what they called "proxy emergency, maternity, and paediatric services". Essentially, their proposal can be summarized as an attempt to obtain a situation in which all hospitals continue to provide a wide range of services, though potentially with a downscaled size [15].

To be coherent with the reform plans, the most logical collaborations are those between hospitals located to near each other. Yet most of these hospitals were, and remain, competitors that are seeking to attract patients and healthcare professionals from the same pool; they also often have ideologically different backgrounds. This rivalry cannot always be transcended, and hospitals may wish to consolidate historical partnerships that seem less suitable to the envisaged reform. A substantive body of theory and research on the role of culture in mergers suggests that cultural differences can create major obstacles to achieving integration benefits. However, the opposite view—that differences in culture between merging firms can be a source of value creation and learning—has also been advanced with empirically support [16]. In any case, post hoc corrections by the government would seem to be challenging, given that hospitals are investing a great deal of energy, time, and resources into the negotiations. These findings show the importance of combining both strategies; this can be referred to as a bottom-up-top-down strategy [17].

2.3. Collaboration is not easy when the money does not follow (yet)

Network literature shows the importance of investing resources on the network level [18]. However, this seems to be a major shortcoming of the Belgian legislation. The Act stipulates that the Minister for Health can allocate a separate hospital budget ("Budget of Financial Means", BFM) to a local–regional clinical network. In the absence of a ministerial decree implementing this provision, this measure cannot be carried out immediately. Of course, voluntary agreements concerning financial arrangements can be concluded within the network.

In absence of a BFM on the network level, hospitals are not inclined to give up certain services. The current rules for calculating and allocating the national budget to individual hospitals mean that they will lose money, change their activities, or even have to close services or departments. Since a two-thirds majority of the network board is required to allocate care assignments to the individual hospitals, it will be very difficult to rationalize the supply of services within the network. Hospitals will ask for additional budgetary allocations to cover the start-up costs of the networks and to finance new network functions.

2.4. Who holds the power?

The need to involve stakeholders in collaboration governance has previously been discussed [19]. Taking into account multiple perspectives and different interests, and including of the voices of stakeholders, should permit the development of thoughtful decisions that taking a broader view of who will benefit or be harmed by any given action [19]. Furthermore, decisions produced through strong engagement processes tend to be fairer, more durable, more robust, and more efficacious [20]. However, stakeholders will also attempt to sway the decisions and actions of the organization so as to achieve results in a way consistent with their needs and stakes [21].

In response to stakeholder pressure, some requirements were relaxed between the concept paper and the Act. An example is the definition of the geographical area of a network: in the con-

cept paper, the network had to cover about 400,000–500,000 inhabitants, and in large cities the areas could partly overlap. This requirement to cover a specific target population is not present in the Act. However, the Act still states that there is a maximum of 25 networks nationwide, implying an average of 400,000–500,000 inhabitants per network. Stakeholders representing hospitals located in less populated areas and in the Brussels Capital Region were against defining networks in terms of inhabitants. In fact, about 35% of the patients in hospitals in the Brussels Capital region come from the other two regions, Flanders and Wallonia.

A second example concerns the maximum number of collaborations for supraregional care assignments; this number was increased from a maximum of two to three reference points per local–regional clinical network. The hospital sector feared that, without such an increase, it would be necessary to halt existing collaborations that were perceived as successful.

A third example concerns the governance structure of the network. In the concept paper, the composition of the network board left a good deal of discretion to the individual network, while the role of the network chief medical officer and the network medical council were described in much greater detail. The physician unions reacted strongly to the lack of guarantee of representation on the network board. As a result, compared to the governance structure of individual hospitals, the role of physicians under the networks will become much more significant. Physicians are present in all governing bodies: at least one-third of board members must be experts in healthcare, of which at least one must be a physician not employed by the collaborating hospitals; the network medical council contains physicians only; and of course, the network chief medical officer must be a physician. The hospital management is required to seek advice from the medical council on numbers of topics listed in the Act. In the current version of the Hospital Act, so-called “reinforced advice” is required for six topics (such as the general agreement between medical staff and the hospital and the determination of which staff members are financed by deductions to physician fees). This implies that, if the hospital management disagrees with the reinforced advice (and in practice fails to achieve consensus with the medical council after a deliberation process), a rather cumbersome arbitration process must be initiated. In the new Act, the number of topics requiring reinforced advice has been increased [11,22].

Although these changes include the voice of the stakeholders, they will lead to a prolonged and more complex decision-making in the networks.

3. Discussion

This analysis shows that achieving a distribution of clinical services between hospitals in a network and better integrated care is a major challenge for policy makers. Pina et al. (2015) and Christiansen and Vrangbæk (2018) state that fragmentation of care exists on multiple governmental levels (federal, state, and local) [23,24]. Indeed, integration is an approach that aims to resolve some of the recurrent difficulties of modern bureaucracies: hyperspecialization, organizational focus, and lack of cross-organizational engagement [25]. This study indicates that the Belgian reform will not be sufficient to achieve this goal. It instead represents an essential first step that should be accompanied by other policy measures, such as payment reform, more stringent planning, and adaptations to licencing criteria. For example, a payment reform with budgets for basic services allocated on the network level could support the objectives of the reform. Service planning should specify the maximum number of services to be implemented, together with more strict licencing criteria. The process of reforming these criteria is far less developed than the legal framework for the clinical networks. Furthermore, it reveals a different pace between the federated entities. While the federated entities in Brussels and Wallonia wait for federal reform plans to become clear before undertaken action, the available policy levers are being used in Flanders to the maximum extent to enhance hospital collaboration and the distribution of clinical services.

Another challenge in the Belgian context is the absence of a governance structure that might commission services on the level of geographically defined areas. In other countries, this is played by local commissioners [1,2]. In the reform, this responsibility is divided between the governance structure located on the level of the hospital networks and the regulating authorities. This is challenging, since it will require that the members of the governing bodies be able to transcend the interests of their individual hospitals. It is questionable whether this will happen frequently, since the medical network council will equally represent each hospital, and a two-thirds majority will be required to decide on task distribution. This would have been easier if the network boards and medical councils had more autonomy and fewer members. On the other hand, if successful, it will certainly enhance the involvement of all hospitals and clinicians, and perhaps increase the confidence of all partners in the network.

Further, legislation imposes only a relatively light form of hospital collaboration, in the form of an obligation for hospitals to be part of a local–regional network. After all, the individual hospitals in a network only collaborate for specific objectives maintaining their separate legal identities. This might lead to a lower level of collaboration than intended by the reform. Studies in other countries also point to the difficulties and challenges in switching from a competitive environment to increased collaboration. In the Netherlands healthcare organizations seem reluctant to share their most specialized human resources, limiting the knowledge-sharing effects of this type of relation due to the price-competitive market. A higher level of collaboration only occurs within broader geographical areas where there is less competition [26]. A study in Italy showed the importance of the pivotal role of a regulatory body in balancing competitive and cooperative incentives and the strong influence of medical professionals on the collaborative relationships [27].

Since the Belgian reform does not trigger a far-reaching form of collaboration, we point out that a more integrated form of collaboration – such as a health system – leads to a better task distribution of services and more efficiency. Indeed, according to Provan and Milward (1995) high levels of integration among organizations improve the quality of service delivery and thus results in better outcomes on the client level [28]. Single ownership in a multihospital system leads to tighter and more formal relationships between the different hospitals. The decision making is delegated to a central governance structure which increases efficiency and facilitates governance based on the common interest of all parties involved [29]. However, aiming for more integration also entails a number of challenges, especially in the context of professional service organizations [30]. For example, more attention needs to be paid to the way in which professional values are connected to organizational strategy and the procedures that will complicate the decision-making process.

While the current reform does not exclude the development of health systems, it does not stimulate it either. The above arguments clearly illustrate that some important steps have been taken in this ambitious reform of the Belgian hospital sector, but also that to make the ambition of the reform a reality some additional policy measures will be required.

4. Conclusion

The current reform plans envisage enhanced collaboration between hospitals through local–regional clinical hospital networks (rationalizing basic care services in geographical areas) and supraregional collaborations (further centralizing highly specialized services). This reform plan is both ambitious and urgently needed. When its objectives are achieved, it will be the most significant and drastic transformation of the Belgian hospital sector in the last three decades. Yet networks are only a first step, offering a framework in which hospitals can collaborate. To enhance task distribution, further regulation and policy measures are needed. After all, the reform must transform historic rivalries between hospitals from the same region into collaboration and an agreement on task distribution. This will require top-down restrictions and allocation mechanisms on the network level.

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