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Policy implementation in the health sector of the federal state of Belgium: An ethnographic approach

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ABSTRACT

When analysing public policies, an implementation gap is often attributed to unclear or irrelevant goals, implementers' disobedience and/or the numerous layers of government involved. This paper focuses on the multi-layer problem, wondering whether aspects other than the number of layers have an influence on the implementation gap in federal contexts, for example, the layers' degree of autonomy or the competencies 'allocation. It addresses the following research question: from an organizational point of view, to what extent does federalism, as a specific institutional configuration, influence the constitution of an implementation gap as part of a public policy implementation process? This research focuses on the implementation of public policy in the Belgian health sector intended to integrate care for chronic patients. It highlights the blockages that may occur in a multi-layer federal country like Belgium, showing that federalism can become dysfunctional if the allocation of competencies was made in an incoherent manner.

KEYWORDS Implementation gap; Public policy; Federalism; Integrated care; Ethnography

Introduction

The first reflections in the field of public policy analysis started in the USA during the first half of the twentieth century and became, during the 1950s, a field of study called the 'policy sciences' (Duran 2010; Hassenteufel 2011). This new field of study, focusing on public decision-making, was intended to rationalize public action by enhancing the efficiency of public policies. At that time, policy sciences drew on two premises:

- Decisions can be rational; and

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- Implementation flows naturally: a rational decision is necessarily a good one, and therefore will be easily implemented, without any difficulties (Hassenteufel 2011; Pressman and Wildavsky 1984).

This vision, in which implementation viewed as a technical and apolitical administrative matter was taken for granted (Hupe and Hill 2016), was thereafter put into question with the advent of the field of sociology of organisations, the authors of which began to criticise the very idea of rational choice, replacing it with the notion of bounded rationality (Friedberg 1997; Simon 1990). Considering that 'analysing the implementation [consists of] explicating how a public programme is appropriated, and not only the way it has been designed' (Lascoumes and Le Galès 2012, 27), they also highlighted the difficulties encountered by the administration in putting into practice the decisions made by the policy-makers (Duran 2010; Kay and Boxall 2015; Lascoumes and Le Galès 2012). Hence, progressively, the focal point moved onto the implementation and evaluation processes as well as onto the interactions between the diversity of actors involved, acknowledging the fact that they each have their own action logic (Hassenteufel 2011).

In the 1970s, Pressman and Wildavsky (1984) were regarded as forerunners in the field of public policy implementation analysis. In their book entitled *Implementation*, they provided an in-depth analysis of a specific pilot project implementation, the Oakland project, launched in the federal American context during the 1960s and intended to deal with unemployment of minorities. Based on the idea that implementation, viewed as an evolutionary process, is an integral part of the policy process in the same way as decision-making processes (Hupe and Hill 2016), their analysis highlighted the existing distortions between the decisions made and their concrete implementation, between expected and real outcome. In policy implementation literature, this phenomenon is called an implementation gap (Hupe and Hill 2016), an implementation deficit (Pressman and Wildavsky 1984) and even sometimes an implementation failure (Hupe and Hill 2016).

An implementation gap is often attributed to unclear or irrelevant goals, implementers' disobedience (Hill and Hupe 2003) and/or also to what Hupe (2011) calls the multi-layer problem, i.e. the numerous layers of government involved. 'If there are multiple layers then some transformation is inevitable in the transmission of a policy objective from top to bottom, whatever the degree of consensus' (Hill and Hupe 2003, 472). Thus, the more the layers, the greater the implementation gap is likely to be, as Pressman and Wildavsky (1984) explain. Therefore, if one follows their logic, the implementation gap can be expected to be exacerbated in federal states, inherently multi-layered.

Indeed, federalism

refers to the advocacy of multi-tiered government combining elements of shared rule and regional self-rule. It is based on the presumed value and validity

of combining unity and diversity, i.e. of accommodating, preserving and promoting distinct identities within a larger political union. The essence of federalism as a normative principle is the perpetuation of both union and non-centralization at the same time. (Watts, 2008, 8; as cited in Caluwaerts and Reuchamps 2015, 280)

Accordingly, the federal institutional type of state organization is characterized by the coexistence of multiple decision-making layers, each federate entity having an important autonomy regarding its competencies (Blaise 2015; Tulkens 2007).

Hence, regarding the multi-layer problem, one can wonder whether aspects other than the number of layers can have an influence on the implementation gap in federal contexts, for example, the layers' degree of autonomy or the allocation of competencies. This paper intends to make a contribution to policy implementation research by raising the following research question: from an organizational point of view, to what extent does federalism, as a specific institutional configuration, influence the constitution of an implementation gap as part of a public policy implementation process? To answer this question, the paper focuses on the empirical case of the implementation of a specific public policy, the joint public health plan in favour of chronic patients entitled 'Integrated Care for Better Health' (IC4BH) in the health care sector in the federal state of Belgium. Actually, Belgium is a case of what Stepan (1999, 22) calls 'holding-together federalism', the current federal Belgian institutional equilibrium being the result of an incremental process of institutional layering (Thelen 1999). What makes the case of healthcare in Belgium particularly interesting is that legislative authority pertaining to the specific sector of health care, has been divided between two levels of government (Federal and Regions).

Material and methods

This inductive (Musselin 2005) and ethnographic research focused on two specific integrated care pilot projects located in the French-speaking Walloon Region of Belgium. It began in December 2016, during the conceptualisation phase (see below) and ended in April 2020 during the first half of the execution phase (again see below). The ethnographic approach, also known as field research, is a holistic, discovery-based and hypothesis-free research method from the social sciences. It allows a phenomenon to be studied as it happens in real-world settings (Robinson 2013; Soukup et al. 2017) and therefore facilitates a deep and detailed understanding of a setting, a context and/or a phenomenon (Quivy and Campenhoudt 2009). The corollary is that the research findings are often not generalizable on their own (Soukup et al. 2017) and need to be put into perspective with

findings from other research. Indeed, the fact that ‘knowledge cannot be formally generalized does not mean that it cannot enter into the collective process of knowledge accumulation in a given field or in a society’ (Flyvbjerg 2006, 227).

As part of a triangulation approach (Jick 1979), the three complementary types of information sources listed below were mobilised with the purpose of establishing the validity and reliability of the analysis (Robinson 2013):

- Written documents (Primary and secondary sources)

A literature study (scientific literature) was conducted regarding the following topics: policy implementation, federalism, integrated care and chronic diseases.

In parallel, a documentary analysis pertaining to the empirical case was conducted: several political, legal and operational documents were read, for example, the IC4BH joint plan itself, other documents sent by the authorities for the attention of pilot project consortia, and the documents produced by the two pilot projects under study, for example, their respective loco-regional action plans and official meetings ‘minutes. Besides these formal archival sources, more informal written sources were also used, e.g., collective email conversations between the members of a same body or working group.

- Actions and interactions

The direct observation method was used to observe what was happening through interactions and to observe innovation in action. The researcher attended 97 meetings – 213h in total and took field notes for every one of those (see Appendix 1 listing all the meetings attended). She spent 172h attending and observing meetings of two pilot projects (66h30 for the first project and 105h30 for the second one). She also attended specific meetings, called plenary sessions and “intervisions”, organised by the public authorities (41 hours) in order to communicate with pilot project consortia and monitor their work.

Regarding the data analysis, field notes were read several times to have a comprehensive understanding of the course of events and also in order to put into perspective the qualitative data collected with those gathered during the interviews.

- Discourses

The researcher conducted 24 semi-structured interviews, lasting between 33 and 98 minutes, with different categories of people identified thanks to the snowball effect, i.e., policy-advisers and public officials involved in devising and implementing the new policy (n=9), pilot project coordinators (n=8) and pilot project stakeholders (n=7) (see Appendix 2 listing the interviewees’ profiles). A specific interview guide was written for each interviewee.

The interviews were each fully recorded, fully transcribed and analysed manually through open coding, a method of analysis from grounded theory methodology that allows the emergence of *ad hoc* core categories identified in the

empirical material through repeated successive readings (Bryant and Charmaz 2011). The purpose of meeting these people was to identify their formal and informal roles, the way they personally experienced the process, their knowledge (what they knew, but also what they did not know) and their feelings about it.

Given that the research question guiding this paper focuses on organisational aspects pertaining to federalism, sociology of public action (Hassenteufel 2011; Lascoumes and Le Galès 2012; Torenvlied and Akkerman 2004) was coupled with concepts of the sociology of organisations (Axelsson and Axelsson 2006; Friedberg 1997; Lawrence and Lorsch 1967) in the discussion to analyse the collected empirical material.

Results

Belgium: A federal state

The unitary state of Belgium became independent in 1830. Progressively, it has become a layered federal state, the polity of which has changed a great deal since the first State Reform, which occurred in 1970. It marked the beginning of a still ongoing process of federalisation and devolution, justified by a wish for more autonomy. At that time, it resulted in the creation of two types of autonomous federate entities in addition to the federal government: three linguistic communities and three economic regions (Blaise 2015).

Since 1970, the central state has delegated more and more competencies to the federate entities, a process called 'defederalisation' or 'regionalisation' or also 'regional decentralisation' (Schokkaert and Van de Voorde 2011, 6). The Belgian federal state is characterised by a limited number of federate entities (six in total, compared to, for example, 16 *Länder* in Germany, 50 states in the USA and 26 states in Brazil) and the specific coexistence of two types of federate entities (Communities and Regions) (Blaise 2015).

In 2021, the three economic regions are as follows:

- The Flemish Region
- The Walloon Region
- The Brussels-Capital Region

Belgium has three official languages: Dutch, French and German. The three communities correspond to these three linguistic groups as follows:

- The Flemish Community
- The French Community, also called the Wallonia-Brussels Federation
- The German-speaking Community

In Belgium, the allocation of powers between the central and sub-state levels is based on the principle of the exclusivity of the distribution of competencies; the federal level as well as Communities and Regions each have their own competencies. This configuration is expected to avoid conflict of authority between the different levels and guarantee the federal entities' autonomy (Popelier, Cantillon, and Mussche 2011). Each entity also has its own government, its own parliament and its own administration. They manage their own budget and can launch their own policies in their territory in accordance with their competencies. At every level, elections are organised every five years so that the Belgian citizens can elect their representatives. As each level has its own parliament and its own government, they do not each have the same majority coalition. The stereotypical view is one of Wallonia being to the left and in favour of more government – with Flanders being more liberal and less reluctant to accept market forces' (Schokkaert and Van de Voorde 2011, 15). Accordingly, each federate entity has its own political rhythm and orientations (Blaise 2015), which can lead to the emergence of disparities between territories. They often make different choices and allocate resources differently. To sum up, Figure 1 below demonstrates the different entities in charge of running Belgium, which have different competencies but are legally on an equal footing regarding their power to make decisions on their own territory.

The Sixth state reform

The institutional agreement that officially crystallised the wish to launch the Sixth State Reform dates from December 2011. The legal conception of this

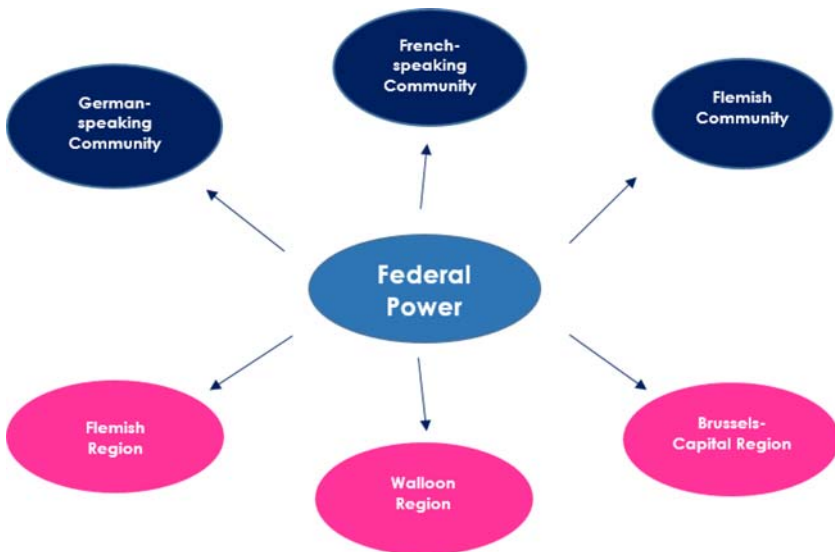


Figure 1. Belgium, three communities and three regions (Blaise 2015, 65).

reform, entitled 'A more efficient federal State and more autonomous entities'¹, has been divided into several phases. The second stage was completed in 2014 and concerned the transfer and redistribution of some competencies and financial means between the federal state, the Communities and the Regions. In that context, health competencies were mainly allocated to the federal and regional levels. They were previously mainly split between the federal state and the Communities.

The Regions became in charge of health prevention and promotion, help and home care services as well as some competencies pertaining to primary care. The federal government kept the compulsory health insurance management under its responsibility as well as the other competences pertaining to primary care and other elements listed in Appendix 3. Since 2014, the federal entities have been in a transitory phase during which they have assumed their new competencies and progressively begun to put them into practice. The IC4BH plan took shape in this context.

The chronic disease challenge

Like other countries in the world, Belgium has been facing a sharp rise in chronic diseases over recent decades. As the leading cause of mortality worldwide, they negatively affect the health and life quality of populations (Paulus, Van den Heede, and Mertens 2012) and put health care systems under budgetary pressures (Schokkaert and Van de Voorde 2011).

As it is, the current Belgian health care system is not adequate to meet chronic patients' needs (Belgian Ministry of Social Affairs and Public Health 2015), which are very specific (Baszanger 1986) given that those patients have to manage their particular conditions in the long term. Furthermore, they often have several chronic affections, a phenomenon called multi-morbidity (Ording and Sørensen 2013). Dealing with multi-morbidity implies the intervention and collaboration of multiple care professionals and organisations (from first and second lines of care) in chronic patients' care trajectories, and also of non-medical stakeholders (Amelung et al. 2017).

Due to the single disease approach ubiquity in the Belgian health care system since its inception, the latter is characterised by a high degree of specialisation, but also a lack of effective coordination, cooperation and collaboration between practitioners (Belgian Ministry of Social Affairs and Public Health 2015). These are, nevertheless, indispensable when dealing with chronic diseases challenge (Amelung et al. 2017) and characterise what is called 'integrated care', which is identified in scientific literature as a good solution to enhance care delivered to chronic patients (Minkman 2017).

Integrating care requires a global 'system transformation' (Amelung et al. 2017, 7). The Belgian public health ministers therefore decided to launch, in October 2015, a joint public health plan for chronic patients entitled

'Integrated Care for Better Health' (IC4BH), with the purpose of moving from a fragmented to an integrated care system for patients with chronic diseases.

There is a huge number of definitions pertaining to the concept of 'integrated care', often viewed as the opposite of fragmented or episodic care (WHO 2016). In the IC4BH plan, the authorities stressed the idea that integrated care is achieved when beneficiaries 'receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system' (WHO 2008b, 1). Whatever the case, almost all definitions emphasise that collaboration, cooperation and coordination are key elements to integrating care (Amelung et al. 2017). In Belgium, the challenge was to make hands-on professionals who usually do not work together, and sometimes even ignore everything about their mutual existence and roles, interact with each other.

Due to its contextual nature (Amelung et al. 2017), integrated care can be achieved in several ways. Hence, the authorities chose to put this joint plan into practice through an iterative and incremental implementation process and opted for a project-based approach. Instead of designing concrete actions themselves, they asked interested hands-on professionals to gather by territory and to build their own experimental integrated care pilot projects in order to identify and test bottom-up solutions at the local level.

The case of the Belgian joint plan integrated care for better health: background

In 2008, the federal plan 'Priority to chronic patients' was launched and marked the beginning of a reflection about a more global approach to chronic diseases in Belgium. In July 2011, the Belgian Health Care Knowledge Centre (KCE²), was asked to produce a position paper on that topic. This report, summarizing the challenges in this field through 20 recommendations, was published in December 2012.

In parallel, the Sixth State Reform was initiated, redesigning the institutional landscape by redistributing health competencies mainly between the federal and regional levels. Through the IC4BH plan, originally initiated at the federal level, the federal authorities intended to develop/transform some elements that were then transferred under the competency of Regions. Accordingly, inter-institutional collaboration became necessary, as illustrated in this excerpt:

If we want to have a certain harmony between what is done between the federal government, the communities and the regions, all these ministers must meet. Therefore, there is an inter-ministerial committee on health care that is scheduled twice a year, once in the spring and once in the fall. The ministers don't do the heavy lifting themselves. They may or may not approve documents [...] prepared by the inter-cabinet working group [on chronic

diseases] that meets practically every Wednesday morning and is composed of members of the federal and regional cabinets and members of the administrations. (Interview with a federal public official, January 2017)

Importantly, the creation of the inter-cabinet working group on chronic diseases dates from 10 December 2012, when the authorities began the conception of the future plan intended to implement integrated care for chronic patients, which would need to be a joint plan, after the Sixth State Reform.

On 30 March 2015, the Belgian health ministers signed a joint declaration defining the plan's mission and vision. It also established the first collaboration modalities between the federal state, the Communities and the Regions regarding integrated care for patients with chronic disease(s). Eventually, on 19 October 2015 the joint plan IC4BH initiated at the federal level was approved by the Belgian health ministers.

Integrated care pilot projects

The plan's implementation began in January 2016, when the authorities published a guidance leaflet for future pilot projects. In this document, they described their aim as well as the 18 integrated care components identified following the KCE position paper publication and which should be developed to achieve integrated care (see Appendix 4). In the guidance leaflet, one can also find the specific modalities and guidelines pertaining to the future experimental pilot projects, which would be launched to gradually implement integrated care with the help of local partners, in an iterative and incremental manner.

The authorities envisaged an implementation process divided into four phases (Belgian Ministry of Social Affairs and Public Health 2015):

- The preparation phase (February 2016–May 2016), during which, the stakeholders interested in creating an integrated care pilot project were asked to gather in multi-disciplinary local consortia and write a joint expression of interest.
- The conceptualisation phase (July 2016–September 2017 [instead of January 2017 as expected, according to what was written in the guidance leaflet]), during which the members of the 20 selected consortia designed their projects together. They had to write a detailed application file including a 'loco-regional action plan' describing their common vision, their strategic and operational objectives, as well as the actions they would implement if they were selected for the execution stage.
- The execution phase (January 2018–December 2022), which was initially supposed to last four years. Twelve out of the Fourteen selected pilot

projects (two pilot projects gave up) are expected to implement their 'loco-regional action plan'.

- The expansion phase, supposed to occur after the execution phase and during which the successful pilot projects will have to evolve to cover the entire Belgian population.

Furthermore, the IC4BH plan was based on the Triple Aim principles. These involved reallocating available financial means more effectively, while at least preserving or even enhancing equity and quality of care. Pilot project consortia were given the mission of reducing health care expenditure in their pilot zone. The actions launched during the execution phase were expected to affect the Belgian health care budget by generating savings at the national level. In return, the authorities planned that, at the end of each year, each pilot project would be provided with a budgetary envelope called the 'budgetary guarantee' corresponding to the savings they would have generated in their pilot zone and intended to be used to implement new actions, generate new savings and so forth. Importantly, it was not foreseen that pilot projects would have any budgetary guarantee at their disposal during the first year of their execution phase. During the conceptualisation phase meetings, pilot projects' consortia regularly asked for an initial public pre-funding in order to finance their actions as from the beginning of the start-up year, a request which was never accepted by the federal authorities. Similarly, the regions have always refused to make budgets available for these pilot projects, given that these projects were launched as part of a policy originally initiated by the federal level.

Importantly, the federal context in which the pilot projects implementation had to take place impacted the sequence of events. It created gaps between what the federal authorities had planned and what really happened. For example, the conceptualisation phase lasted longer than expected. The guidance leaflet stated that the pilot project consortia had to submit their application files by the end of January 2017 and the execution phase was supposed to begin in March 2017. Actually, the deadline was postponed several times between January 2017 and September 2017. The first time, pilot project coordinators and members asked for this postponement because they needed more time to build their projects and complete the application form.

Thereafter, the deadline was again postponed several times to a later date, but for other reasons. Under the existing legislation, the authorities had to publish a Royal Decree (RD) in order to open the one-month application period after the conceptualisation phase. This was a mandatory legal prerequisite. In this document, they had to describe in legal terms the conditions under which pilot projects would be selected for the execution phase. Before publication, the RD project had to be approved by several institutions, notably the Inspectorate of Finance³ as well as the Council of State.⁴ It

appeared that the Inspectorate of Finance took more time than expected to analyse and approve the document and that the Council of State asked the authorities to make modifications in the RD text, which again they did not expect.

Actually, the Inspectorate of Finance was concerned that the anticipated savings at the federal level, as a result of pilot project actions, would not be actual savings, but would rather consist of a displacement of costs towards the Regions and, consequently, an unwanted increase in their expenditure. This fear was shared by regional public officials:

The purpose of these projects is to save money at the level of hospitals, it is crystal-clear! The purpose is to reduce the number of days of hospitalisation, which will have consequences in terms of home-care ... And further, on whom does it depend? It depends on the regions! [while hospitals depend financially on the federal level] So more funding will be necessary for the regions [but will probably not be provided]. [...] There will be outgrowths on the first care line and on the help and home care services, for which we are competent. (Interview with a regional public official, April 2017).

As for the Council of State, it declared the collaborative RD proposal illegal given that it mixed elements falling under the jurisdiction of the federal government and others pertaining to regional competencies (e.g. health promotion, health prevention and well-being matters), as illustrated in this interview excerpt:

It is not acceptable that we lag behind in this process. [...] It took a little more time than expected. In our country, we have something that is called the 'Council of State' and if this institution does not give a positive opinion, we simply can't [...] publish the Royal Decree. It is the situation we are in right now because we wanted the projects to include health promotion and welfare actions [as stated in the draft RD], two fields of competence that fall within the jurisdiction of federate entities (Regions) [following the Sixth State Reform]. We said, 'we are going to include federate entities in the process, so that they can make suggestions'. (Interview with a federal policy-advisor, June 2017).

The Council of State expressly asked to eliminate the elements that were not under the federal government's jurisdiction, although they were indispensable to the development of integrated care (e.g. health prevention and promotion, a regional competence, is listed as one of the 18 components of integrated care in Appendix 4). Accordingly, those items relating to regional competencies were removed from the RD text, which was resubmitted and then approved. Eventually, the Royal Decree was published by mid-August 2017. The application files had, thus, to be submitted by mid-September 2017, eight months after the initial deadline.

The RD proposal rejection and the related delays had not been anticipated by the public officials in charge of the plan, who blamed the reshaped

institutional landscape stemming from the Sixth State Reform. The latter impacted the whole process, making the implementation of an integrated care system more complicated:

The big problem is that, in Belgium, regarding everything pertaining to curative aspects and medical care, it is the federal which is competent, but everything that pertains to well-being and prevention, it is the federate entities. [...] This Sixth State Reform led us to a situation in the context of which working together around the patient has become almost impossible [...]. It has brought more disintegration whereas we want to integrate things together. (Interview with a federal policy-adviser, June 2017).

Nevertheless, a non-fragmented and patient-centred governance is required to evolve towards more care integration, according to both public officials and pilot project stakeholders:

When we say 'integrated', in the plan, we wrote it, it is integrated from the micro to the meso and up to the macro political level. It really has to be integrated between all the levels, and also with other public policies. (Interview with a federal public official, March 2017).

Nevertheless, this global integration was difficult to achieve in practice due to the Sixth State Reform. For example, a specific department called the 'inter-administrative cell' had to be created in order to jointly manage and coordinate the operational implementation of the plan:

It's called inter-administrative because it was decided by all the health ministers in Belgium and, in theory, it was supposed to bring together people from the different health administrations. In practice, it is essentially federal, [i.e. gathering public officials from the] NIHDI [National Institute for Health and Disability Insurance] and the [Federal Public Service of] public health, but the idea was, and still is, that the communities and regions invest a little bit more in ... [But] actually, they have not found anyone who would have the time to devote to this. (Interview with a federal public official, March 2017).

So, in practice, integration was difficult to apply at the macro-level:

Following this Sixth State Reform, we are in a hyper-paradoxical and 'paradox-ing'⁵ situation [...], which entails that this health care reform will [probably] not come into being precisely because of the current division of competencies. (Interview with a regional public official, April 2017)

This regionalisation is not completed, it has gone too far, or not enough ... I don't know, but it jeopardises a lot of things. (Interview with a general practitioner, representative of a GPs' association, June 2017).

The federal and regional levels do not have the same work culture or the same funding rules. They are governed by different political coalitions and do not have the same political orientations, agenda or priorities. So, if, for the federal level, integrating care was viewed as a top priority, it was not necessarily the case for the Regions, which were still appropriating the

competencies they inherited after the Sixth State Reform and launching their own public policies regarding other matters. More than that, there were discrepancies between them about how the implementation of the pilot projects should be operated, coupled with a lack of communication and effective cooperation between the federal and regional levels. This conversation excerpt between a Regional high-ranking official (RHRO) and Walloon pilot projects 'representatives (WPPR) illustrates how Regional officials were informed of important elements via the pilot projects stakeholders instead of learning them directly from the federal authorities:

RHRO: *'How much is the [federal] pre-funding?'*

WPPR: *'There is no pre-funding'.*

RHRO: *'How so? There is no pre-funding?!'*

WPPR: *'No'*

RHRO: *'How is this possible? Launching pilot projects without pre-financing ... It's not going to happen like that!'*

(Field notes of observation, March 2017)

And yet, this is how it happened ... This also created a climate of distrust between the federal and regional levels, which made the coordination of their respective work even more difficult:

The FPS [Federal Public Service of Public Health] is the brain of this project [the IC4BH plan] and the federated entities only had to follow [...]. That is serious, it is a major problem [... and contributes to] my growing disinterest, because the FPS imposed these projects, made meetings with organisations that now depend on the regions and they do not realise that their little projects [...] will have consequences on the way the Regions operate, on the way they are funded. And they do not care about that. [...]. And so what I'm seeing ... the federal level is taking over: they pretend to ask our opinion. It's called false participatory democracy and honestly, I didn't know anything about it but I learned a lot in terms of power games. We [the Regions] just don't have our opinion to give [even though] the consortia are made up of more than 90% of structures that depend on the Regions. And so, through this project, they are in fact "re-federalizing" [i.e. they are taking back control]. They give their directives, their priorities. It is madness (...) and now, their privileged interlocutor is the FPS whereas these are our organisations. In the meantime, we subsidise them so that they can do their work, which they do less of. And that's a concern. (Interview with a regional public official, April 2017)

For Pilot project stakeholders, this blurred context created confusion and misunderstandings when it came to putting things into practice:

We are in permanent difficulties of coherence and coordination and we waste a lot of time and energy in having to give a little coherence to things that are totally fragmented. (Interview with a psychologist, March 2018)

Furthermore, the distribution of health competencies at the macro level did not coincide with the differentiation between stakeholders' roles on the ground. Accordingly, the same professional can rely on both the federal and regional levels regarding his/her work and can receive orders from both levels, without either necessarily conferring with each other. Pilot projects stakeholders were even sometimes asked to be in two different places at the same time:

It's a big structural problem. Here, it's the federal government [that is in charge of the integrated care pilot projects] and not the federated entities, whereas in the end, everything on the front line is strongly linked to regional responsibilities. For me, there are gaps. But that is Belgium, in the end. For example, here, there is a meeting, a session for the coordinators that had been scheduled while the Walloon Region had simultaneously invited them at the same time to talk about the budgets of the pilot projects: no coordination, you see. So, they [the authorities] don't talk to each other enough. (Interview with a coach, March 2017)

Hands-on professionals can feel powerless about the often uncoordinated – sometimes even contradictory – instructions they received from the different levels of power. As a result, if the pilot project consortia wanted to launch innovative actions simultaneously involving federal and regional competencies, they did not always know who their interlocutor should be. They often lost a great deal of time trying to identify who they had to contact to discuss the matter. Then, if the suggested actions seemed relevant to the chosen interlocutor, it took further time for the different levels of power to consult and coordinate with each other, sometimes even leading to lasting blockages.

More than that, as with what happened with the RD, during the execution phase pilot project consortia learned that they were simply not legally allowed to finance some actions of their loco-regional action plan, for example, certain types of health prevention actions, with the budgetary guarantee paid by the federal level, because those actions fell under the exclusive competence of the Regions. These actions were, nevertheless, completely relevant in a context of care integration, but pilot project consortia would not be able to implement them due to a lack of eligible financial resources. The situation seemed quite absurd for hands-on professionals who considered that, it will always be better to prevent people from becoming sick rather than taking care of them when they already have a chronic condition.

As a result, several hands-on professionals also expressed the fact that, in this context, they were not able to have full confidence in the authorities, who were losing their credibility:

We are asked to integrate [things], to think about the powder that explodes twice while we already have invented the wheel. The only problem is that

they do not talk to each other and they do not finance things so that they inter-leave. (Interview with a pilot project member, 2018)

This excerpt also shows that the authorities were not able to set a good example. They asked pilot project stakeholders to work in an integrated manner whereas they were not able to do it themselves due to their inability to overcome the structural fragmentation arising from the Sixth State Reform.

Discussion

After analysing the actual course of events as part of the IC4BH plan implementation, one can notice a gap between policy goals set by policy-makers and real outcomes on the ground (Hill and Hupe 2003), for example, the delays with respect to what was originally planned or the fact that the pilot project consortia would not be able to implement some actions which did not fall under the federal-level jurisdiction even if the latter seemed relevant to integrate care. Admittedly, this implementation gap might be *inter alia* explained by the number of layers involved.

In a centralized state, the implementation of the IC4BH public policy would have required the involvement of a variety of stakeholders from all levels of the health care system. In a multi-layer federal context (Hill and Hupe 2003), as in Belgium, an even greater number of layers and stakeholders were expected to play a role in the process. So it would be risky to deny the impact of the number of layers involved in this implementation gap, viewed as a multi-factorial phenomenon. This research rather stresses that this factor might not be the only one influencing the implementation gap constitution: the specific Belgian institutional configuration and the way health competencies were distributed between the different autonomous entities might also have had an influence.

Implementing integrated care, which is by nature inter-sectoral, entailed working on different aspects ranging from prevention to the management of complex cases (see Appendix 4 regarding the components of integrated care). Hence, well-being policies (including health prevention and promotion and home care services) and health care policies are intertwined in care integration. They both contribute to enhance people's quality of life and health (Schokkaert and Van de Voorde 2011), but in Belgium they fall under the competencies of different jurisdictions and are designed separately, although their implementation often involves the same workers in the field.

Accordingly, integrating care appears to be neither just a health insurance matter, nor just a care question; it goes far beyond medical aspects. It is definitely not as simple as making hands-on professionals collaborate on the ground (micro level), which is obviously necessary to develop integrated care, but not sufficient. It also raises important organisational issues, requiring inter-organisational, inter-professional and also inter-institutional

collaboration between structures and people involved (Axelsson and Axelsson 2006; D'Amour et al. 2008), especially in the Belgian federal context characterized by entangled levels of authority (Lascoumes and Le Galès 2012).

The wish to integrate care created horizontal interdependences between the stakeholders at every level of the health care system: between the pilot project stakeholders (meso level) who depended on each other to initiate the implementation of the actions they designed together and between the professionals (micro level) expected to work together to provide integrated care to their patients, but also between the federal and regional levels (macro level) depending on each other to achieve their respective agendas, due to the specific Belgian health competencies distribution.

These horizontal interdependences were coupled with vertical interdependences between the macro, meso and micro levels. Indeed, the authorities inevitably depended on the meso- and micro-level stakeholders for the IC4BH plan implementation, while the latter depended on the authorities to initiate innovative actions on the ground, for example, requiring changes in legal texts or authorized exceptions to current legal provisions. From these interdependences stemmed the need to interact in order to create dynamics of cooperation, collaboration and coordination (Friedberg 1997) at and between all the levels (macro, meso and micro) of the health care system, i.e. both horizontal and vertical multi-level collaboration, cooperation and coordination, which were nevertheless difficult to achieve in practice due to the institutional autonomy of the different governing entities each having different priorities and goals, which impacted the work of professionals in the field.

Indeed, all these professionals had their own institutional constraints, since they did not have the same role in the care production chain and did not fall under the jurisdiction of the same level of authority, which made collective action complicated by a mirror effect. Indeed, they had different interlocutors, who asked them to change many things simultaneously. They received different and, according to them, uncoordinated requests from the federal and the regional levels, which was destabilising and led to inconsistencies or sometimes even absurdities in the action implementation process.

As part of the IC4BH policy implementation, the current federal configuration even created competition between policies on the ground. Hands-on professionals had to choose which was their priority. Besides, those policies were sometimes even directly incompatible (Pressman and Wildavsky 1984), making things even more complicated. Thus, the way the multi-layer federal context in which the actions had to happen was designed created blockages, hindering the implementation process as originally intended and creating distortions between the authorities' decisions and the concrete implementation of these decisions (Hassenteufel 2011).

Metaphorically, one could say that Belgium looks like a hydra, in reference to the Lernean Hydra in Greek mythology. This beast, which Herakles has to fight, has several heads on one body. If the heads want to go in different directions, it is probable that this will lead to a standstill at the body level and put in danger the equilibrium of the entire body, heads included. Importantly, the comparison stops at the question of the disequilibrium and/or standstill resulting from the existence of several heads. The purpose is obviously not to say that Belgium is or should be as monstrous as the Hydra.

Integrating care is intrinsically not easy, but the Belgian federal context made it even more difficult given the complexity in the functioning of the bureaucratic Belgian apparatus. This still ongoing federalisation process, synonymous with regionalisation and devolution, has progressively disintegrated the former centralised state, leading to more differentiation and fragmentation in the distribution of competencies.

In sociological terms, Lawrence and Lorsch (1967, 3–4) define differentiation as

the state of segmentation of [an] organizational system into subsystems, each of which tends to develop particular attributes in relation to the requirements posed by its relevant external environment. Integration is defined as the process of achieving unity of effort among the various subsystems in the accomplishment of the organization's task.

Therefore, fragmentation arises in a context of differentiation when there is a lack of collaboration and communication between those sub-systems, which seemed to be the case between the federal level and the federate entities in the context of the IC4BH plan implementation.

Designed with the purpose of avoiding conflicts of authority, this uncoordinated multi-level governance (Torenvlied and Akkerman 2004) created a lack of global coherence in the decision made by the different levels as well as an incoherent implementation process leading to the development of an implementation gap. One can even claim that there is a lack of coherence in the health care competencies distribution itself between the federal level and the federate entities, which impacted the implementation of the IC4BH plan. Incidentally, the legal constraints regarding the use of the budgetary guarantee illustrate how 'the fragmentation of competencies generates a dispersion of already very limited means and prevent sometimes from having a global view of the healthcare system' (De Troyer and Krzeslo 2004, 114), which seems nevertheless essential when implementing integrated care.

The research confirms the view of Tulkens (2007) who states that, in a federal state, the entities' autonomy is coupled with the inevitable coexistence between those entities, which creates a need to organise the coexistence and cooperation between the entities – to integrate their decisions

and actions, one might even say. Accordingly, the challenge is to find a way to design coherent public policies and to implement them in a coherent manner in the Belgian multi-level policy-making system, as there is a lack of what Torenvlied and Akkerman (2004, 32) call 'cross-level policy coherence'. Therefore, one could say that, in the case of the IC4BH plan implementation, the cross-level incoherence of the Belgian institutional configuration pertaining to health care acted as a multiplying factor in the constitution of the implementation gap, which can be noticed when comparing the expected outcomes and the real unfolding of events as part of the IC4BH policy implementation.

Conclusion

This paper presents a comprehensive analysis of federalism in action by focusing on the implementation of a specific innovative public policy in a federal context. It highlights the blockages that may occur in a multi-layer federal country like Belgium, showing that federalism can become dysfunctional if the allocation of competencies is not made in a coherent manner.

Indeed, as part of the IC4BH plan implementation, the governing entities' autonomy coupled with institutional fragmentation led to a lack of coherence between the decisions made at the different levels, involving in turn a lack of coherence between the actions undertaken in the field. This multi-level incoherence acted as a multiplying factor in the constitution of the implementation gap when undertaking the task of integrating care.

Importantly, the problem does not come from the fact of allocating different competencies to different level of authority per se. Indeed, after the sixth State Reform, the health sector could have been fully assigned to the federal level or fully delegated to the Regions. Instead, health competences, including legislative authority pertaining to this sector, were divided between two levels (Federal and Regions), which raised specific issues of collaboration between those levels. Therefore, it is not so much federalism that is to blame as the concrete form it takes in Belgium, with health-related competencies divided between two levels of government coupled with an inefficient collaboration and power games between those levels.

The wish to integrate care raised the issue of the multi-level integration, i.e. integration at and between all the interdependent levels of the Belgian health care system. The Sixth State Reform exacerbated the need to oil Belgium's complex machinery, so that the different levels and sectors can interact and work in a coherent manner with each other from the planning stage at the decision-making level, not only in the field at the therapeutic level. Hence, this research stresses the importance of working in a comprehensive integrated manner at every level of the health care system.

The interest of these observations is twofold:

- It may help the Belgian authorities realise that the current competencies' distribution is inefficient and should either be modified (fully assigned to the federal level or fully delegated to the Regions) or compensated by better collaboration between institutional levels;
- It may be of interest at an international level for policy-makers who would want to modify the institutional structure of their state, showing them the importance of designing the distribution of competencies carefully.

To conclude, as this stage, it would be relevant to conduct similar research in other sectors and countries to make a comparison given that each federal state has its own distribution of competencies.

Notes

1. https://www.belgium.be/fr/la_belgique/connaitre_le_pays/histoire/la_belgique_a_partir_de_1830/constitution_de_l_etat_federal/sixieme_reforme_etat (accessed 12 March 2020).
2. The KCE is 'a parastatal body funded by the federal government' (<https://kce.fgov.be/en/funding>). It 'is an independent research centre that provides scientific advice on topics related to health care' (<https://kce.fgov.be/en/missions-and-values>).
3. The Inspectorate of Finance is an interfederal public institution which is in charge of controlling the legality, the regularity and budgetary feasibility of public spending initiated by all the different governments in Belgium (Federal State, Regions, Communities) (<https://www.inspfin.be/en>).
4. The Council of State is 'an advisory and jurisdictional institution at the junction of the legislative, executive and judicial powers'. This institution 'owes its existence [...] to the wish of the legislator to offer recourse to all natural and legal persons being wronged by irregular administrative acts'. It has 'the power to suspend and annul administrative acts that are contrary to the legal rules in force. The Council of State is also the Administrative Supreme Court. As a cassation court it reviews the external and internal legality of the decisions of lower administrative jurisdictions. The Council of State rules by means of judgments on the applications' (http://www.raadvst-consetat.be/?page=about_competent&lang=en).
5. This neologism means that this situation begets new paradoxes according to the interviewed public official.

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