17. Healthcare board leadership and governance: conceptual framings and controversies

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INTRODUCTION

The rapidly changing healthcare landscape and accompanying new challenges have led to rethinking the traditional models of governance and board leadership. For example, the increase in scale, increasing complexity and specialisation, and the evolution toward more patient-centred care in healthcare organisations cannot be underestimated. The challenge is to find a good fit between this changing context and the different components of governance: the structure, composition and functioning of the board and other governing bodies. Key drivers consist of a combination of executive and non-executive members, internal and independent, professional and lay contributions, and the requirement for diverse perspectives and skills to be brought together in order to reach collective decisions in the best interest of the organisation, its strategy and operational accountability (Chambers et al., 2020). A good functioning board is crucial to strategic leadership, as the board is important in setting the tone (Millar et al., 2015), being visible (Gautam, 2005) and committed to improving healthcare quality (Millar et al., 2013; Brown, 2005).

Even though the challenges are more or less the same in every healthcare system, governance configurations can still diverge to a large extent, between and even within national systems. One reason is that in the healthcare sector, where organisational goals are diverse and complex, the legal framework for governance is usually much more comprehensive and more intrinsically linked to the responsibilities, financing, and functioning of the institutions than in commercial companies. The impact of legislation on the governance practice of, for example, hospitals goes beyond the formal governance framework and is mainly noticeable in the margin of executives' decision-making autonomy in operational and strategic domains. Their decisions are to a large extent guided by financing, programming, and licensing rules, while having the responsibility to provide safe, high-quality and effective patient care. As such, boards have to combine corporate and clinical objectives.

Beyond that, various structures for hospital boards exist. The main variance consists of the adoption of a one-tier (unitary) versus two-tier (dual) board structure. In a one-tier structure, there is a single board composed of both executive and non-executive directors. In a two-tier structure, there is a separate management board and supervisory board. Board structures in hospitals will often be influenced by the dominant corporate model in the country concerned: e.g. the one-tier structure in Anglo-Saxon countries (United Kingdom, United States) and the two-tier structure in Germany, the Netherlands, and Belgium. However, the hospital sector also has its own dynamics. For example, the two-tier board model allows for a greater opportunity for stakeholder inclusion, such as patient representatives, funders, or representatives of local authorities, than the one-tier board model (Solomon, 2020).

The configuration of the hospital organisation can also play a role in the board structure. For example, single hospitals mostly have a straightforward board structure. However, hospitals which are part of a larger network system can have multiple boards, which makes them more complicated. Another factor in the configuration of healthcare boards is whether the hospitals operate as for-profit or non-profit entities.

All these factors mean that a one-size-fits-all board structure is hard to accomplish in the healthcare setting. In this chapter, we provide the conceptual framings for healthcare board governance and clarify the main controversies in healthcare board governance practice in order to guide boards to promote effective leadership in their specific context.

CONCEPTUAL FRAMING OF HEALTHCARE BOARD GOVERNANCE

The governing board is ultimately accountable for the performance of a hospital, so understanding the board's various roles is important (Kovner, 1990). The board's roles can be divided into three main parts: control, strategy, and service (Humprey and Hung, 1998). This classification, however, does not imply that these roles are mutually exclusive as boards may fulfil a combination of all three roles.

Different theoretical perspectives and conceptual framings are used to capture the full range and richness of healthcare board governance roles and to explain their behaviour (Chambers et al., 2017; Mannion et al., 2017). All theoretical perspectives attempt to identify how boards work and how the mechanisms of a board's actions can lead to certain outcomes (Mannion et al., 2017; Chambers et al., 2020). Agency theory remains the dominant model that grounds most empirical work in healthcare governance, but other theories have something to offer in different circumstances and can emphasise the different roles (Millar et al., 2013). This can result in potential insights into the relationships between boards and organisational performance.

In what follows we try to summarise what has been written about the board's roles and the underlying theoretic perspectives related to these roles in a healthcare board context (based upon Bennington, 2010; Chambers et al., 2020; De Regge and Eeckloo, 2020; Mannion et al., 2017). A summary of relevant theories for healthcare boards is provided in Table 17.1.

Table 17.1 Relevant theories for healthcare boards

	Characteristics/ properties
Agency theory	Membership of principals (e.g. congregations, local authorities, shareholders) Emphasis on monitoring the mission and requirements of founders
Stewardship theory	Membership of experts Emphasis on supporting managers Proactive attitude
Stakeholder theory	Membership of stakeholders or their representatives Emphasis on negotiating and defending interests of stakeholders
Resource dependency theory	Membership of actors who can influence access to resources Externally directed

Source: Adapted from Eeckloo, 2008.

When discussing the control role, **agency theory** clarifies the need for control by the board. This concerns the relationships that exist between principals and their agents. An agency, in broad terms, is any relationship between two parties in which one, the agent (i.e. professional managers) represents the other, the principal (i.e. the board), in daily operational transactions. As professional managers are 'the only ones with specialized knowledge to operate the company and they gradually gained control' (Mizruchi, 1983: 427) managers can take advantage of their power. As such, it is assumed that, unless monitored, agents such as healthcare professionals and executives will seek to pursue their own interests, rather than meet broader organisational objectives. Agency problems can be reduced by the board monitoring the management team (Tosi et al., 2003).

Mannion et al. (2017: 12) described the role of hospital board in terms of agency theory as follows: 'the hospital board is cast as an instrument for monitoring and holding employees to account for their actions and performance'.

Literature supports the importance of the strategic role of the healthcare board (Ford-Eickhoff et al., 2011). **Stewardship theory** acknowledges this particular role of the board (Boyd, 1995). As against agency theory, stewardship theory assumes that employees are not motivated purely by self-interest, as employees most often commit to the realisation of broader organisational goals, and so are devoted to serving as effective stewards of an organisation's resources. Rather than controlling management, stewardship theory fosters the empowerment of the agent. Giving them control allows them to use their in-depth knowledge, experience, and commitment to maximise organisational profitability (Davis et al., 1997; Muth and Donaldson, 1998); Ford-Eickhoff et al. (2011) discussed how hospital boards should have an impact on their hospitals' strategic focus through their participation in the strategic decision-making process, rather than only acting as monitoring and advisors.

The hospital board's role in stewardship theory was defined by Mannion et al. (2017: 12) as follows: 'the role of the board centers on nurturing an appropriate supportive culture of shared values and shared goals, and there is less emphasis on developing strategies for monitoring, incentivizing or coercing performance'.

Stakeholder theory underlines the interconnected relationships between a business and its customers, suppliers, employees, investors, communities, and others who have a stake in the organisation, not only shareholders (Freeman et al., 2010). The theory argues that a firm should create value for all stakeholders. Board members represent the different interests of members with a stake in the organisation (Freeman et al., 2010). For healthcare organisations, stakeholder theory consists of a range of overlapping interests, both competing and cooperative. The theory elaborates on the interest of each separate stakeholder in the governance process, and the emphasis is placed on how different stakeholder interests can be addressed, integrated, and balanced. The task of the board is to ensure that the interests they represent are reflected in the hospital's policy. The board itself acts as the medium through which potential conflicts between various stakeholder groups are settled (Eeckloo, 2008). Apart from that, fundamental changes in healthcare require identifying the leading stakeholders and thinking about how they affect the introduction and progress of changes to the system. Mannion et al. (2017: 12) delineate the role of the hospital board in the context of stakeholder theory as: 'to interpret and represent the views of all those with a stake in ensuring the delivery of good quality care, and to make difficult trade-offs between different stakeholders including staff, regulators, patients and the public'.

According to Mintzberg (1983), boards can execute four service roles: gaining control over influencers outside the organisation, networking, improving the reputation of the organisation, and giving advice to the organisation. The board should ensure that the organisation has the resources it needs to survive and achieve its goals. As such, another theory that is frequently combined with agency theory to describe board governance behaviour is the **resource dependency theory**. From the point of view of resource dependence, boards act as an interface between the organisation and its environment (Pfeffer, 1972; Muth and Donaldson, 1998), from which the organisation tries to gain the resources it needs (Muth and Donaldson, 1998). Board directors are one such resource, who can, for example, leverage their own network to benefit the organisation. Organisations can use the board to attempt to gain resources and become somewhat independent of their surroundings (Pfeffer, 1972). In resource dependency theory, the board can supply expertise, advice, counsel and legitimacy, while giving access to resources and helping improve reputations (Mintzberg, 1983; Muth and Donaldson, 1998; Pfeffer and Salancik, 1978).

Mannion et al. (2017: 12) describe this role of the hospital board as follows: 'The key function of the board then is to effectively manage internal and external relationships so as to leverage influence and resources. Board members are therefore expected to use their skills and contacts to act as "boundary spanners" with key partners as a means of acquiring resource, expertise and strategic advantage.'

Alternatively, some empirical research has introduced other less frequently used, and perhaps less familiar, theories and frameworks to clarify board behaviour. Group **decision process theories** focus on how information is processed and managed in boards, the ways in which information affects group decisions, and the group decision-making dynamics that underlie those decisions (Brown, 2005); **performative and symbolic framings** focus on the importance of the symbolic and ceremonial value of boards, and explore board performances in a dramaturgical sense (Freeman et al., 2016); in **upper echelon theory** top executives view their situations – including opportunities, threats, alternatives, and likelihoods of various outcomes – through their own highly personalised lenses (Hambrick et al., 2008); the **theory of requisite variety** suggests that an organisation's internal diversity must be as great as the variety and complexity of its environment if it is to deal with the challenges posed by the environment; this has been employed by Ford-Eickhoff and colleagues (2011) to support the need for sufficient board diversity. Other empirical research has also referred to broader domains such as service and process management within production management (Blank and Van Hulst, 2011; Goldstein and Ward, 2004).

We can conclude that considerable conceptual work has described the different perspectives and frameworks for explaining board roles and behaviour. However, only a limited amount of empirical research on healthcare boards uses one or more of these theories as a framework (De Regge and Eeckloo, 2020). The fact that there are not many unambiguous relationships in healthcare boards shows that we cannot reduce the behaviour of board members to a single agency problem. However, this position is not always endorsed in scholarly research.

CONTROVERSIES IN HOSPITAL BOARD GOVERNANCE PRACTICES

Governance is by definition a multidimensional construct, with many interactive mechanisms that must function simultaneously. This can lead to certain controversies that may hamper effective leadership at board level. In this section, we describe the main controversies we

recognise in today's board practices. A clear vision of how to deal with them is key to board effectiveness.

The Ideal Form of the Board

Although much of board governance research has focused on the structure and composition of boards, little agreement has been reached on the size and composition of the ideal board (De Regge and Eeckloo, 2020). There is some indication that boards must be neither too large nor too small. Likewise, there seems to be no consensus on the background and skills of effective board members (Chambers et al., 2017). This is due to the fact that the ideal board configurations will always be contingent on the corporate model (e.g. one-tier versus two-tier) and the internal and external environment (e.g. competition, crisis, and so on). The literature discusses two main types of governance models: philanthropic model and corporate model (Alexander and Lee, 2006) (see Table 17.2). The philanthropic model involves a large board whose members have a wide selection of stances and backgrounds. There should also be no more than a few inside directors, very little participation by managers, no payment for service on the board, a lack of management accountability to the board, the possibility of members sitting on the board for consecutive terms, and a focus on the preservation of assets. This contrasts with the characteristics of a corporate model, where there is typically a small board composed of members with narrower, more strongly focused backgrounds and perspectives, the existence of compensation for board service, the active participation of management on the board, the direct accountability of management to the board, limits on consecutive terms on the board, a large number of inside directors, and an emphasis on strategic activity (Alexander et al., 1988). According to Alexander et al. (1988), a corporate governance model is favoured over the philanthropic one.

However, understandings of governing boards have advanced, developing from a structural angle that takes into account factors such as board size, composition, and committee structures to include a behavioural angle that is, a focus on the dynamics among board members. Converting into dynamic and effective boards demands 'creating a climate of trust and candor, fostering a culture of open dissent, ensuring individual accountability, and evaluating the board's own performance' (McDonagh and Umbdenstock, 2006: 379). Nadler (2004: 102) stated: 'The key to better corporate governance lies in the working relationships between

Table 17.2 The board characteristics of a philanthropic board model versus a corporate board model (adapted from Alexander et al., 1988)

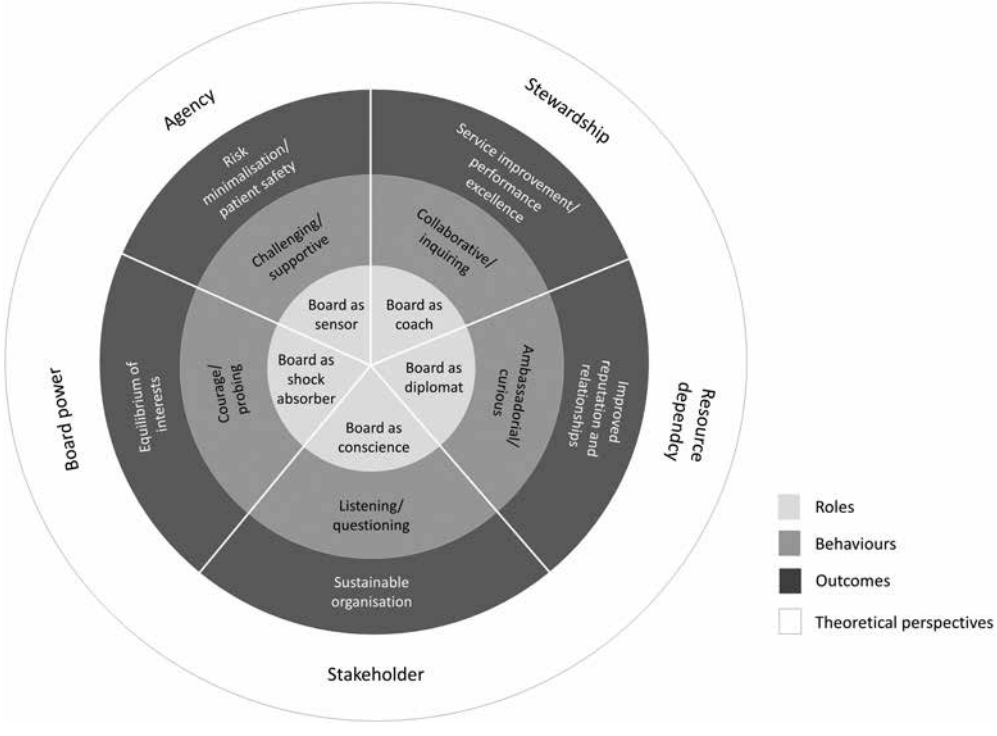
	Philanthropic board model	Corporate board model
Board size	Large	Small
Background and perspectives	Broad, wide range	Narrow, focused
Management participation	Limited	Active
Management accountability	Indirect accountability	Direct accountability
Compensation for board service	No compensation	Compensation
Term limits	Consecutive	Limited
Focus	Preservation of assets	Strategic activity

boards and managers, in the social dynamics of board interaction, and in the competence, integrity, and constructive involvement of individual directors.'

It is frequently pointed out that group and team dynamics are important for effectiveness of governance (Miller-Millesen, 2003). As such, relationships rather than structures become important factors in governance (Nadler, 2004).

Specific aspects of board behaviour and relationships that have been studied include, for example, the degree of transparency, clarity and inclusiveness in the decision-making process of the board (Kane et al., 2009). Likewise, Chambers et al. (2017) have recommended that healthcare boards be closely involved with and supportive of management. Very little research has reported on such aspects (De Regge and Eeckloo, 2020). However, the few reports that do exist suggest that the monitoring described by agency theory becomes stronger and, at the same time, managerial and stewardship behaviour are enhanced. This does seem to resonate with the dynamics of an engaged board (Chambers et al., 2017).

Recently increased attention has also been paid to the roles of hospital boards in particular. Further, Chambers et al. (2020) described a number of board roles and behaviours that could be used to achieve better performance (see Figure 17.1). In their view, boards fulfil the role of (1) conscience, (2) shock absorber, (3) diplomat, (4) sensor, and (5) coach of the organisation. To each of these modes, a theory describing the purpose of the board, its contextual



Source: Adapted from Chambers et al., 2020.

Figure 17.1 Interconnectedness of roles, behaviours and outcomes of the dynamic healthcare board

assumptions, its mechanisms and its intended outcomes were associated. This research illustrated the complexity of relationships between context, focus, behaviours and outcomes.

Board Diversity

A large body of literature examines the relationship between female board representation and organisational performance. A meta-analysis of 140 studies (Post and Byron, 2014) studying this relationship found that female board representation is positively related to the boards' two primary responsibilities: monitoring and strategy involvement. Concerning healthcare board composition and diversity this remains an understudied topic (De Regge and Eeckloo, 2020). Despite extensive efforts women leaders in healthcare remain significantly underrepresented in leadership positions, nonetheless, they represent around 70% of the workforce (Bismark et al., 2015; Kalaitzi et al., 2017; Berlin et al., 2020). Women encounter persistent obstacles to advancement, particularly for senior positions (Berlin et al., 2020). The recent systematic review of Mousa et al. (2021) concludes that there are well-known persistent barriers to women advancing in healthcare leadership. This topic of women advancing in healthcare leadership is covered in more detail in Chapter 18 of this volume by Mousa and colleagues, and also in Chapter 38 by Chand on career progression of racially minoritised women leaders. The arguments for change are compelling, but the challenges appear intractable and progress is slow. A solution could be introducing mandates to increase gender diversity. This is already common in, for example, Norway, Spain, France, and Iceland. These countries have laws requiring that women comprise at least 40% of boards at publicly listed companies (Berlin et al., 2020). Likewise, Sweden has implemented legislation with a target of 25% female representation on boards (Hoel, 2004; Singh et al., 2006).

However, concentrating on only one form of diversity, namely gender, is not sufficient. There is also a wider literature on the importance of diversity in boards and other decision-making bodies, including ethnicity and other characteristics as well as gender (see, e.g. Miller and Del Carmen Triana, 2009; Carter et al., 2003; Creary et al., 2019). For example, Carter et al. (2003) concluded that (1) organisations that make a commitment to increasing the number of women on boards also have more minorities on their boards and vice versa; and (2) they also found a positive relation between organisation value and diversity on the board of directors. As such, social diversity (e.g. gender, race/ethnicity, and age diversity) is important for increasing the diversity of perspectives represented on the board (Berlin et al., 2020).

An aspect more frequently addressed in healthcare board literature is professional diversity, although mainly focusing on the added value of clinical representation on boards. In the last decade clinical involvement in healthcare boards and in the management increased (e.g. Mason et al., 2013; Mannion et al., 2015; Mazurenko et al., 2019). Most of the literature demonstrates that clinical participation in boards positively affects hospital performance.

Division of Responsibilities

A clear allocation of tasks and responsibilities is crucial to any organisation (Asahak et al., 2018). It can be assumed that each governance level provides its own added value within the organisation. In practice, however, it appears that responsibilities are not always clearly delineated in hospitals. On the one hand, board members have a typical monitoring role, focusing on control and general policy. Yet on the other hand, board members in many hospitals also

play a significant operational role, which should be the sole realm of executive management, as it distracts the board from its strategic function (Dewaelheyns et al., 2009). The board has limited time. If it spends hours and hours on trivial matters, it will not be able to address significant and strategic matters (Arnwine, 2002, 2009). Moreover, board-management collaboration quality may be compromised if managerial autonomy is too highly restricted (Büchner et al., 2014). A stricter distinction between different organisational functions contributes to a more efficient and transparent decision-making process. This could be supported by the implementation of strategic plans and policy cycles. In such plans, the common vision is translated into strategic and operational goals. It should also contain criteria by which executives can be held accountable. In this way, board members can safely take a step back from operational management without completely abandoning it.

Information and Knowledge Asymmetry Between Management and the Board

Strong collaboration between the managers of hospitals and their boards leads to improved performance (Büchner et al., 2014). However, hospital executives might experience that board members lack the expertise to really form a countervailing power that might challenge management in all aspects of hospital activity. While this can arise from the board being inadequately composed, a more fundamental reason can be found in the increasing complexity of care and the organisation of care. If board members convene only once a month and have general political, economic, or legal backgrounds, they cannot be expected to have profound knowledge of, say, the suitability of hospital financing or the quality expectations of the hospital's primary (clinical) processes. It can certainly be expected that this knowledge is present among executive and middle management. This results in an asymmetry in information and knowledge, which not only increases the risk of *agency problems* (i.e. those with responsibility for management pursuing their own interests rather than those of the organisation), but also denies the executive management the ability to receive feedback and support on these items.

Issues of how to define and measure board effectiveness are not simple (Allen et al., 2004). The challenge is to find the right instruments to allow board members to oversee the entire spectrum of hospital activity, but in a way and on an aggregate level that fits their role, functioning, and expertise. The responsibility for this rests partly with the executive management itself. While some executives may prefer passive boards with little initiative, more conscientious executives welcome board initiative and oversight (Miller and Bergman, 2008). In many hospitals, performance management instruments such as balanced scorecards[1] (Voelker et al., 2001; McDonald, 2012) and Key Performance Indicators (KPIs[2]) (Gartner and Lemaire, 2022) have been introduced at the management level. Their added value is precisely that they provide a transparent manner for steering and evaluating the organisation and its activities. However, it is important to encourage stakeholder involvement, system maturity, leadership support, management capacity, employee involvement, innovative cultures, and goal clarity because these increase the effectiveness of performance management system (Andrews, 2014). Such additional instruments are still not sufficiently present at the board level (Drew and Kaye, 2007).

Hospitals have tended to shift to governance structures with more external input (Saltman et al., 2011), by involving external stakeholders, in particular patients or their representatives (i.e. users), in the hospital's decision structures (Malfait et al., 2018).

However, Malfait et al. (2018) question whether involvement in strategic hospital policy decision-making is a necessity for effective stakeholder involvement. As their results in a Belgian study showed, stakeholder committees had a crucial role on the hospital operational level but did not affect the strategic decision-making processes in the involved hospitals.

Boards and Clinical Leadership

As already alluded to above, the literature has shown that the monitoring of clinical performance by hospital boards (as the highest governing body) is crucial to the quality policy of hospitals (Jha and Epstein, 2010; Phipps, 2017; Millar et al., 2013). Hospital boards, as they are charged with developing appropriate organisational strategies and cultures, have an important role to play in safeguarding the care provided by their organisation (Millar et al., 2015). Positive associations have been found in the United States between clinical performance (based on the results of publicly available quality indicators) and the installation of a quality committee within the hospital board, defining strategic goals related to quality, allowing frequent interaction on quality strategies between board and medical staff, and enabling evaluation of senior executives on the basis of quality indicators (Jiang et al., 2009, 2012). Board members should verify which systems are to be measured, as well as improving and securing quality and safety in the hospital.

The Dual Structure Makes It Difficult to Integrate Physicians

Physicians and other care professionals are the key players in a hospital's care process. However, in many countries, physicians function to a certain extent as independent entrepreneurs within the hospital, since they are often not employed by the hospital and function as independent medical groups or in other physician organisations. This is especially the case when medical care is reimbursed by fee-for-service payment methods, as this could serve as a personal incentive to maximise production. Because of this position, integrated organisational governance will always remain a significant challenge. A suitable response is to involve hospital physicians in the overall hospital policy, within a transparent structure and following clear engagements.

One of the solutions is to make hospital physicians members of the hospital board (either directly or through representatives). Their expertise is undeniably an added value for the board. Research has shown that hospital boards on which physicians are represented are more capable of finding an equilibrium between strategy, internal control, and external relations (Lee et al., 2008; De Regge and Eeckloo, 2020). However, involving hospital physicians also involves certain risks, such as internal conflicts of interest, conflicts of interest with the industry, a shift to a more operational focus, and the temptation to delegate the quality monitoring role to these 'physician-directors' (Goeschel et al., 2010). Clear arrangements, including the use of a code of conduct, are thus crucial.

Guidelines for Good Governance

Several recommendations for good practice can be offered to hospital boards. From research, we know that the way board members interact with each other is a good predictor of hospital performance, even in terms of financial results (Kane et al., 2009). Too often, the focus

is on structural aspects (composition, meeting frequency, etc.) and on the role of the hospital board, including control versus stewardship (De Regge and Eeckloo, 2020). The optimal structure and role depend to a large extent on internal and external contexts (Bennington, 2010). However, the internal dynamics and processes of the board also have to be taken into account as predictors of the performance of the hospital (Freeman et al., 2016). While the availability of summaries of quality indicators to board members is undoubtedly important, so equally are the operation of processes of organising that make it possible for local actors to use such information to make interventions to sensitively hold executives to account with regard to patient safety processes and outcomes (Freeman et al., 2016). Thus, of key importance is that the decision-making process is transparent to all board members. All points of view should be considered equally. Board members should also feel comfortable raising concerns, even when there is a broad consensus among the rest of the board members. This avoids 'group thinking', which is a social psychology phenomenon characterised by the domination of distinct ways of thinking, typical in cohesive groups (Searle et al., 2014). Furthermore, it is important to have a process in place for checking the fundamental assumptions behind important decisions, for validating the decision-making process, and for evaluating the risks involved.

Making significant decisions outside of board meetings should also be avoided. To create such an open and constructive context, certain practices can be helpful, such as establishing a recruitment profile for new members, providing an adequate education programme, annually evaluating the functioning of the board, and conducting solid reporting and follow-up on decisions.

In order to create a culture that promotes leadership, Miller and Bergman (2008) found the following practices of key importance: recruiting people to the board who have a passion for the mission of the organisation and connecting board members with the organisation's work through direct experience, conversations with programme staff and compelling stories that illustrate the importance of the organisation's work.

Shifting to the Governance of Inter-Hospital Collaborations

Working with partner organisations, beyond hospitals, is becoming increasingly important (Popp et al., 2014). There is an international trend for hospitals to become part of larger care networks, rather than functioning as isolated entities (De Pourcq et al., 2017). The reasons for collaboration vary and include financial pressure, government regulations, the need to share scarce human resources, and the provision of patient-centred integrated care. Beyond that, there are many benefits to collaborating with each other, for example, increase efficiency, coordination and quality of care (Popp et al., 2014; De Pourcq et al., 2017). Here also, leadership plays an important role as it involves using hierarchies, markets or networks and knowing when to use exit, voice or loyalty (Hartley and Benington, 2010).

It is clear that the creation of hospital collaborations, such as hospital networks, is not sufficient to achieve task distribution (De Pourcq et al., 2017). It is rather an essential first step that should be accompanied by policy measures, such as a payment reform, more stringent planning of services, and the adoption of licensing criteria. A payment reform should, for example, allow budgets for basic services (like emergency departments) to be allocated on the network level, rather than on the hospital level. The planning of services should include specifications of the maximum number of services to be implemented, together with stricter licensing criteria (Addicott and Shortell, 2014; Elrod and Fortenberry, 2017).

Inter-institution collaborations have been considered from a range of perspectives, but less attention has been given to their governance. Some authors have suggested there is little difference in substance between networks and systems (Alexander et al., 2003; Prybil et al., 2010), but others have sought to show differences (Bazzoli et al., 1999; Zhu et al., 2014; Nauenberg and Brewer, 2000), in particular suggesting that networks are more decentralised and differentiated than are systems (Bazzoli et al., 1999). System affiliation is also a tighter contractual type of integration than is seen in networks (Zhu et al., 2014). Tight integration is usually limited and the board usually remains decentralised in health systems (Alexander et al., 2003). Provan and Kenis (2008) argue that in networks, the focus on governance involves the use of institutions and structures of authority and collaboration to allocate resources and to coordinate and control joint action across the network as a whole, and as such governance is less straightforward than in more integrated health systems. In their systematic review, De Pourcq et al. (2019) claimed that the choice of governance model for inter-hospital collaboration should also take into account external determinants and the collaboration structure itself.

DIRECTION FOR FUTURE RESEARCH

Up until now, there have only been a limited number of scientific outputs that discuss healthcare board leadership in depth. There is a need to investigate further what board leadership is, what forms this leadership takes, what is encompassed by board leadership qualities, and how an organisational culture can be built which encourages and supports board members to step up to their leadership responsibilities. These qualities are important within the board, but also between boards and other teams which they interact with (for example, the board chair–executive director relationship). Beyond that, boards are social groups which each have their own distinctive culture. Consequently, boards that work well have incorporated governance and personal initiative into their organisational culture. As such, studying these topics through analysing the board dynamics is recommended.

Although in most of the studies conducting research on board effectiveness survey data (primary and secondary) is used, we also recommend longitudinal qualitative studies to capture the above-mentioned topics of interest, and to gain insight into the board team dynamics.

In addition, boards need to consider their ability to change when needed (for example due to environmental situations), therefore exploring how external factors influence board leadership will be insightful as well.

CONCLUSION

Board leadership is strategic in nature and affects organisation outcomes. However, the unique setting of healthcare and the complex environment in which healthcare organisations operate make it difficult to deliver straightforward guidance on how to govern these organisations. In this chapter, we elaborated on some important controversies which illustrate the challenge of effective board governance. Recently the focus has turned from the composition and structures of boards to the relationships within the board and between the board and management. What is more, different governance models are used which all have different advantages and

disadvantages, but in all these models the way boards interact internally and with others is of utmost importance.

More governance challenges are ahead as healthcare becomes more orientated towards inter-organisational collaborations. It seems logical that alongside this tendency, forms of collaborative governance supported by all stakeholders, are to be encouraged. Boards play an important role in this endeavour.

NOTES

1. A balanced scorecard is a strategic management performance metric used to identify and improve various internal business functions and their resulting external outcomes. The balanced scorecard measures four main aspects of a business: learning and growth, business processes, customers, and finance.
2. A key performance indicator is a quantifiable measure of performance over time for a specific objective.

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