With the knowledge of tomorrow

Towards a future-oriented healthcare policy

Summary

Questions

How will Dutch healthcare develop in the long term? And what opportunities and dilemmas must the healthcare system be prepared for? These are the questions at the core of this advisory report. Because crystal balls only appear in fairy tales, there are no cut-and-dried answers available. What we can do, however, is explore the possible options, as well as their consequences for healthcare organisations and government policy.

For example: what trends will we see in life expectancy and quality of life, both of which have continued to exceed expectations for decades? Opinions on the matter are divided. Equally uncertain are the expected differences in health between higher and lower educated people. There are a variety of possible scenarios regarding growth in the healthcare sector, which also raises the issue of the extent to which we are prepared to finance healthcare expenses collectively, and to ensure that healthcare remains accessible to everybody.

Exploration of autonomous changes in healthcare

The long-term changes that may take place in healthcare are not primarily related to internal developments. The healthcare sector does not develop isolated from society and from the economic, political, technological and socio-cultural changes that affect it. To the government and healthcareorganisations, these changes are largely autonomous, and mean that we live in a very dynamic time where certainties are few and far between.

Compared to other sectors, much has remained unchanged in healthcare, despite the developments listed above and the shifting of responsibilities towards market parties following the changes to the system in 2006. Future developments may cause this to change, however, undermining existing assumptions and established roles in healthcare. It is for this reason that this scenario study explores the tendencies and signals of possible breaks in trends, and extrapolates them to produce a number of future images of healthcare. Because the course and speed of these developments is uncertain, the report describes two different future scenarios constituting a 'stress test', as it were, against which to measure current healthcare policy and existing healthcare parties.

These scenarios and images of the future are not predictions, nor are they desirable outcomes in all respects. This will partly depend on individual opinions, and the perspectives from which they are evaluated. The intended benefit of such futures studies is not to predict the future as accurately as possible, but to answer the question as to how healthcare parties can best prepare for possible future developments. This helps to avoid potential undesirable consequences, and maps out the necessary policy considerations that these developments entail.

To allow for the inclusion of developments that are more far-reaching and less evident, the year 2040 has been chosen as the planning horizon.

Future scenario: *Provincials*

In the *Provincials* scenario, the Netherlands concentrates on its own strength and values, on upholding national sovereignty, on protecting employment by discouraging migrant workers, and on the redistribution of wealth. This scenario includes stagnating economic growth in the long term, with little to no migration and relatively slow technological developments. Conversely, socio-economic developments will prevent large differences in society, to the benefit of social cohesion and mutual trust. Dutch people will generally focus on the non-material values of their own culture, and maintain small circles of personal involvement.

Medical and social technology will be developed and disseminated relatively slowly. Growth in life expectancy will stagnate, reaching 82 (for men) and 85 (for women) in 2040. There will be little to no reduction in rates of poor health. Without policy changes, healthcare expenses will rise to approximately 22% of GDP, around 18% of which will be collectively financed. There is very little allowance for improvements to healthcare that entail additional costs. The economy's zero growth, relatively low labour participation and the deteriorating relationship between the economically active and inactive will shrink the financial support base for collective healthcare expenses. The gap between the available medical/technical possibilities and those that are collectively financed will grow.

It will be possible to detect illnesses and risk factors at an increasingly early stage. Healthcare will become more patient-oriented, moving towards DIY healthcare. People in long-term care will need to be more active and find more solutions among themselves, making use of digital healthcare and support from simple robots. They will organise their healthcare, provide shared services and share risks via healthcare groups and buyers' cooperatives,

based on common values and preferences and reciprocity. Existing power structures within healthcare will form an opposing force, however.

Future scenario: *Cosmopolitans*
There is another possible scenario, however. The *Cosmopolitans* version assumes long-term economic growth. The labour market is more flexible, unemployment is low, and the number of migrant workers increases significantly, both in healthcare and other sectors. This greatly increases diversity in society, as well as differences in income. Dutch citizens act primarily according to their own responsibilities, and seek out their own opportunities. The ratio of economically active versus inactive will worsen, but not as much as in the *Provincials* scenario, providing a greater financial support base for solidarity.

Product and process innovation within healthcare picks up speed in this scenario. The expansion of medical possibilities means that healthcare expenses exceed 30% of GDP, around 25% of which will be collectively financed if no changes in policy. (Healthy) life expectancy will continue to develop according to the highest predictions. The differences in health between the highly and less well educated will increase, however.

Increased understandings of individual health prospects and of what constitutes health mean that people will start to eat and live differently. Healthcare will shift its focus from a curative approach to one aimed at improving performance. Medical possibilities will be used to push physical and mental boundaries (i.e. enhancement).

Information technology will provide access to medical data for the general public, and improved consumer information on healthcare will become available on an international scale. People will be able to do more themselves and make their own choices, leading to a radically new way of providing healthcare. It will be almost entirely possible to process requests for primary healthcare and social services digitally. International competition among healthcare providers will increase in this scenario, causing highly complex healthcare to concentrate in several European centres. Making use of cross-border healthcare will become more common in this scenario. Elderly people, the disabled and dementia sufferers will organise their day-to-day lives and their own care from home, with the help of their social network, robots, home electronics, digital coaching products and private healthcare (migrant workers). Citizens will organise themselves into international healthcare groups and buyers' cooperatives.

Dilemmas and opportunities for healthcare and healthcare policy
Based on the foresight study, the Council has drawn a number of conclusions and identified several opportunities and dilemmas concerning public healthcare objectives.

In the future, we will be spending more and more on healthcare. Compulsory insurance against high, unexpected healthcare costs will remain necessary. But in order to retain solidarity in healthcare, rising healthcare expenses will force us to make fundamental choices regarding how care is distributed: do we aim for maximum health benefits for everyone (efficiency), or do we give priority to those who need the most healthcare or assistance (equity)? Efficiency can be achieved in the *Provincials* model by insuring only the required care up to a maximum health benefit amount (collective austerity), and in the *Cosmopolitans* model by insuring fewer risks collectively and offering more freedom of choice (less collective, more private). If health and the use of healthcare can be more easily predicted and influenced through behaviour, then it would seem evident that people would take greater responsibility and make fewer claims on the collective insurance.

To meet rising healthcare needs, healthcare must become more efficient. A turnaround will be required from labour-intensive care towards person-oriented care. Market incentives (competition for the *Cosmopolitans*) or system incentives (tariff regulations for the *Provincials*) will be required in order to encourage healthcare providers to have more tasks performed by nurses and patients themselves, or to automate them. This decision will depend on the future scenario. This development cannot succeed without solid investments in human healthcare skills and a shift in the mentality of healthcare professionals.

Another question is that of who will direct healthcare in the future. The Dutch government currently has the authority to set up its own healthcare system based on solidarity in which health insurers, in principle, have a control function. European legislation concerning the free movement of healthcare services among Member States is at odds with this national authority. If consumer information on healthcare products and providers is made available internationally, healthcare consumers will have a wider choice. The internationalisation of healthcare offers prospects for better, cheaper healthcare, however it will make it more difficult for the government to establish its own healthcare system based on solidarity. This development will have far-reaching consequences for the pivotal role of health insurers, and also offers opportunities to the Netherlands for exploiting export opportunities in healthcare.

In addition to the dilemmas involved in the distribution of collective healthcare resources, the future will also bring ethical considerations into play, particularly where the right not to know, the right to privacy, and freedom of choice

are concerned. Regarding the latter, the question is how far the government can go in gently promoting healthy choices on the one hand, and how much freedom of choice should be offered in the deployment of healthcare resources to improve the human condition on the other.

Health insurers and healthcare providers will need to respond timely to the changing responsibilities and services that are expected of them. After all, in the future citizens will need to do more, pay more, and take more responsibility themselves. In turn, this will require more participation opportunities in healthcare and care facilities, as well as opportunities for reclaiming initiative from the welfare state.