Medical-specialist care in 20/20: a summary

Summary

The medical specialist care landscape in 2020 will look very different from how we know it at present. The need for change is driven, on the one hand, by the strong growth in the demand for healthcare that the years ahead will bring and, on the other, the limited financial scope for meeting that demand both now and in the future. Furthermore, the nature of the demand for healthcare is changing: we expect to see increasing numbers of chronically ill patients who, moreover, will often be suffering from multiple disorders simultaneously.

Looking ahead to medical specialist care in the year 2020 reveals an image of healthcare networks, in which different types of healthcare professionals cooperate, both between themselves and with their patients, in order to deliver integral care to the patient. Although the healthcare networks will be organised in a number of different ways and their composition will vary over time, they will share a regional approach when it comes to delivering care. After all, healthcare must be provided from close by wherever possible and only from far way when absolutely necessary.

In concrete terms, this means that people must have 24/7 access to a local healthcare centre from where the entire care chain – from first-line to chronic medical care – is coordinated. Outpatient facilities will be integrated in these centres, which will be linked to regular medical follow-up services with specific indications. These healthcare professionals, sometimes monodisciplinary, sometimes multidisciplinary, will work in group practices that will sometimes be independent treatment centres, special-area or special-focus clinics. Each network will feature one or more specialist-care hospitals or top-level referral functions; the 'special medical', highly complex, highly capital-intensive functions as well as the training tasks will be divided among these hospitals.

Turning this future vision into reality will require a substantial, but primarily healthcare-focused, scaling up of the 'first-line' care and the rollout of health centres across the country that are equipped with medical-specialist facilities.

Hospitals will have to make choices regarding their function profiles. They will no longer each offer the full range of medical specialist care. This is why they will always be part of a healthcare network that will also feature a university medical centre or specialist-care hospital. The university medical centres will cooperate much more intensively than is presently the case. The same level of cooperation will be seen among the specialist-care hospitals and the university medical centres and hospitals. All in all, this will involve several dozen institutions that will have shared among themselves the top-level referral and highly specialised medical functions on the basis of a national system. This will be covered by the label 'general.'

Finally, a multi-level accident and emergency service will have to be established; a care chain comprising a general practitioner (HAP, HAP+), ambulance services, clinical accident and emergency services, intensive care and trauma care. The accessibility and availability of the general practitioner in emergencies will need to be improved substantially, in first-line care, but also through the GP's physical presence in the accident and emergency department.

Given the significant implications of the new landscape, this emergency care network will not evolve of its own accord. The current healthcare system and the government's policy proposals aimed at substantially shifting the risks involved in providing care to the shoulders of the healthcare providers and healthcare insurers provide a good basis for change, but are in themselves not enough to bring about the desired situation. More is required.

This future vision can only become reality if there are public quality standards. The quality institution being established should therefore be accorded the powers needed to bring about observance of quality standards by the healthcare professionals concerned and, where necessary, enforce it. Professors of medicine must play a leading role in this process, particularly in the compliance with norms and standards.

Furthermore, the funding of medical-specialist care must be based on actual results as quickly as possible, i.e. based on health benefits. As long as remuneration is based on a treatments system (Diagnosis Treatment Combination, DBC or Diagnosis Treatment Combinations on their way to transparency, DOT), the main incentive at play is to do as much as possible. Moreover, funding should involve a distinction between – relatively – simple standardised care and more complex medical-specialist care. It is the healthcare insurers that must stimulate such a development. Finally, incentives for substitution are required in the funding of first and second-line care. This could be the combination of the capitation fee (first line) and integral performance-linked funding (second line).

Hospitals will have to make choices regarding their care offering: focus on the care at which they excel and let other institutions provide other types of care. The healthcare insurers have a role to play in these types of decisions, but their role is not an exclusive one. Healthcare providers can make cooperative agreements with one another as well as agree on dividing care functions, although such cooperation must be on the condition that it benefits the quality of care. Healthcare providers will need to substantiate this in advance and present their proposals to the Dutch Healthcare Authority (NZa), which will assess the effects on the quality, accessibility and effectiveness of the healthcare provided. In testing compliance with the prohibition on cartels, the Netherlands Competition Authority (NMa) will follow the opinion of the NZa.

To bring about multi-level accident and emergency services, the accident and emergency function of hospitals must be governed by legally binding regulations that provide for the geographical distribution, regional budgets, performance criteria and care standards. Only large (i.e. general) hospitals and university medical centres have accident and emergency departments. One large accident and emergency service centre per region would be sufficient. The healthcare providers in a healthcare network divide the various tasks within the multi-level accident and emergency services in accordance with a legally binding protocol that reflects public standards. Emergency assistance (not clinical accident and emergency services) will be form part of the mandatory responsibilities of a healthcare centre (or HAP) and will be purchased in a standard manner by the healthcare insurers.