

Frame stories: Stakeholder Prospects for the Dutch health care sector

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Abstract

Background: Stakeholders in the Dutch health care sector published prospects for the future. Since stakeholders are important actors in policy making, yet their prospects have not received much attention, this study analyses their prospects. This study aims to gain insight in how the stakeholders in the Dutch health care sector envision the future of health care in the period 2015-2025? The answer to this question is framed by the following four questions: 1) How is the future of health care envisioned with specific regard to quality, availability, accessibility and affordability by the stakeholders? 2) How do stakeholders envision their own role in the future health care? 3) How have stakeholders applied methodology from futures studies in their prospects? 4) Given that uncertainty about the future is inevitable, how do the stakeholders address uncertainty about the future in their prospects?

Methods: 9 prospects from 18 stakeholder organisations in total, concerning the period 2015-2025 were subject to Grounded Theory analysis. Inductive and deductive coding resulted in axial coding networks for each of the research questions. Deductive coding was based on results of preliminary inductive coding and on the research questions. Through analysis of the networks each research question was answered.

Results: The results show that stakeholders remain committed to the four public values but differ in their view how to uphold the values, facing pressures from increasing demand and decreasing personnel supply. Stakeholder roles will be affected by an independent and involved patient, leaving the provider to take a more coaching role. Challenges can be expected regarding task redistribution to lower levels and integral care provision. Ambiguity exists regarding the potential of redistribution of care to informal care givers. Moving to the construction of the prospects, the results show stakeholders primarily used forecasting but mixed this with room for future uncertainty and departed from normative viewpoints. Uncertainties were primarily reduced but in some cases acknowledged. Acknowledgement of uncertainty was found to enhance credibility. Normative uncertainties were not discussed.

Conclusion: The majority of differences in the content were linked to implementation of views. Increased patient responsibility will affect the role of providers. The prospects can be characterised as 'subjective forecasts with room for future uncertainties'.



Chapter 1 Introduction

1.1 The overall topic of the research

1

The future of Dutch health care is uncertain as policymakers in the Netherlands increasingly face challenges to ensure public values like availability, accessibility, affordability and quality of health care. It has become clear that increasing health care consumption and new technologies put pressure on the health care budget (Den Exter & Buijsen, 2012) and on the delivery of health care. Health care expenditure has risen to 15.4% of GDP in 2012 (CBS, 2013), even though the Dutch economy has been in recession for the past five years (NOS, 2013a; RIVM., 2013). Moreover, future studies of planning agencies have shown that the current organisation of health care is not financially sustainable on the long run (CPB, 2010; Ewijk, Horst, & Besseling, 2013; Kooiker, Klerk de, Berg ter, & Schothorst, 2012; SER, 2012).

The uncertainty the health care sector faces is shown by the responses to the ambition of prime-minister Mr Rutte (at the time of writing) to leave the welfare state behind and transform the Dutch society into a 'participatory society' (NOS, 2013a, p. 6). Moving to a participatory society could potentially have a big impact on health care arrangements as we know them. The prime minister sketches the participatory society as people being expected to take responsibility, as much as they can, for their own life and their environment. The responses from the media citing public organisations are characterised by uncertainty about what the future will hold and whether public values like accessibility and quality can be uphold. For example with regard to quality the complaints of the father of state secretary Mr van Rijn about the quality of care his demented wife receives caused significant public turmoil (Herderscheê, 2014; Landeweer, 2014); in newspaper Trouw the potential of the participatory society is questioned (Dijk, 2014). Other concerns expressed question the power of health insurers, in particular the dominance of four major health insurers and the right to a free choice of health care provider (LHV, 2014; NU.nl, 2014; RTV Drenthe, 2014; Snijders, 2014; Vereniging van Arts en Auto, 2014).

Even though the prime-minister strongly believes in increasing public participation in society, it is not him alone who determines the future of Dutch health care. The Dutch policy arena is characterised by stakeholder involvement and consensus (Hoek, 2007; Rinnooy Kan, 2006). Stakeholders like trade unions, employers' organisations and professional associations are often involved in policy making by achieving consensus. When looking at expectations for the future of health care one can look at the futures studies of planning agencies like the Netherlands Bureau for Economic Policy Analysis (Centraal Planbureau, CPB) and the Netherlands Institute for Social Research (Sociaal Cultureel Planbureau, SCP). However, the Dutch stakeholder involvement makes it

very interesting to broaden attention to their expectations and visions. Stakeholders in health care include physicians, nurses, patient organisations, health insurers amongst others. What are their expectations for the future? Where planning agencies aim to provide neutral prospects, the stakeholders will have their own particular interests and plans for the future. How do stakeholders foresee the future of healthcare and do they use data from futures studies of planning agencies in their own prospects? Moreover, successful implementation of policy depends on the support of the stakeholders. This makes it very interesting to explore the prospects of a wide range of professionals and institutions.

1.2 Importance of the topic

This study comes in a time where reforms and budget cuts are lining up. These reforms will have a big impact on society. Taking a societal perspective this study provides political parties, policy makers and stakeholders with an analysis of the prospects of important stakeholders in the Dutch healthcare. Exploring the future potentially strengthens governance, as the strategy advisor of the Dutch coalition government argued in 2008. Futures studies are perceived as an important part of the policy process: foresight helps policy makers to prepare themselves for the future, on the other hand it stretches their view beyond today's business (van Asselt, Faas, van der Molen, & Veenman, 2010b). Ample futures studies are published by planning agencies (CPB, 2010; Kooiker, et al., 2012; SER, 2012), however the prospects of stakeholders have not been researched. Politicians and policy makers could benefit from this analysis when searching for cooperation with stakeholders to make and successfully implement policies (Eigenraam, 2013; NOS, 2013b). They benefit from knowing what to expect from the stakeholders in the policy debate. Moreover the stakeholders in health care may want to inform themselves as well of the prospects of their colleagues.

From an academic perspective this study finds its relevance in the knowledge it will add about stakeholder prospects. Currently, academic literature about exploration of the future has a strong focus on futures studies written by professional planning agencies and policy makers and the methods that are used in future studies. Futures studies aim to explore the future in an objective manner and decrease the lack of knowledge. Prospects on the contrary have not received much attention. Regrettably (at least for the Netherlands), since the stakeholders who publish the prospects play an important role in policy making and implementation (Eigenraam, 2013; NOS, 2013b).

A more specific topic concerning the methodology of prospects that receives attention here is 'uncertainty'. This study explores how 'uncertainty' about the future is dealt with in the prospects of stakeholders in healthcare. Uncertainty can apply to the possibility of events happening or trends occurring, and to their magnitude. Also attitudes of stakeholders with regard to their interests and

responsibilities can change. In today's rapid developments in society a certain degree of uncertainty is inevitable (de Vries, Verhoeven, & Boeckhout, 2011). Certainty and the lack thereof are central to futures studies but often dealt with differently (van Asselt & van Bree, 2011). Futures studies can aim to decrease uncertainty or exploit uncertainty to create multiple scenarios depending on differences of conditions. These approaches are often discussed in academic literature referring to futures studies, but how uncertainty is dealt with in prospect documents has not been previously researched and discussed. Therefore, to gain more insight into this, paradigms and literature of methodologies of futures studies are applied to the prospects.

1.3. Research aim and research question

The aim of this qualitative study is to gain insights into the content of prospects of stakeholders the Dutch health care field with regards to the vision on the public values (availability, accessibility, affordability, and quality) and how they envision themselves to fulfil their respective roles in the future.

Next to the contents of the prospects, this study aims to gain insights into the application futures studies methodologies for the construction a prospect. Lastly, it aims to pay specific attention to how uncertainty surrounding expectations is dealt with.

Because the study explores both the content of the prospects and the processing of futures studies' methodology and addressing uncertainty into the prospects four questions frame the research. The research questions are therefore stated as follows:

How do stakeholders in the Dutch health care sector envision the future of health care in the period 2015-2025?

- *How is the future of health care envisioned with specific regard to quality, availability, accessibility and affordability by the stakeholders?*
- *How do stakeholders envision their own role in the future health care?*
- *How have stakeholders applied methodology from futures studies in their prospects?*
- *Given that uncertainty about the future is inevitable, how do the stakeholders address uncertainty about the future in their prospects?*

1.4 Data

Stakeholders were selected based on their contribution to health care in the Netherlands. This results in a wide range of stakeholders including professional organisations from physicians and nurses, patients and insurers. Examples of stakeholders that were included in this research are the

Association of Medical Specialists (Orde van Medisch Specialisten), the association of health insurers (Zorgverzekeraars Nederland) and patients' representatives (Nederlandse Patiënten en Consumenten Federatie). In total nine documents have been selected, covering 269 pages in total and including 18 different stakeholders. The data collected for this study is derived from published documents which express the visions for the future of health care. The period of time discussed by the prospects ranges from 2015 to 2025.

As mentioned before, the data was provided by published documents, as opposed to interviews or newspaper articles. Using documents assured that the vision of the whole organisation is represented instead of a personal view one would get from an interview. Moreover, texts consist of written words which facilitate the analysis since the data do not need to be transcribed in words. The data were analysed through inductive analysis based on grounded theory.

1.5 Methodological approach

This study consists of document analysis using qualitative data and methodology. It makes use of the Grounded Theory Method which is an approach to establish theory from qualitative data and is characterised by its systematic, inductive and comparative nature (Bryant & Charmaz, 2007). Through detailed analysis the data is deconstructed in first stages of coding and consequently synthesised to form theory. The developed theory is thus 'grounded' in the data it emerged from.

Grounded theory suits the aims of this study as it enables to find answers to the research questions in the documents while staying close to the original text. Staying close to the original text is essential as the messages of the stakeholders are what matters most. To do so this analysis was based on different stages of inductive coding. Different perspectives with regard to the future of healthcare were identified through inductive and open coding. They were then related to each other via axial coding. Analysing the codes, their interdependency and relations allowed for identification of the dominant themes of the prospects. Next to analysing the expectations with regard to the future, the manner in which uncertainty is dealt with in the documents was studied. Uncertainty can be expressed in multiple ways and can be emphasised or reduced.

Chapter 2 Theoretical Background

This section gives a theoretical background to both public values in health care and methods for the exploration of the future and how uncertainty can be dealt with. Existing literature and dominant perspectives are discussed. The public values are availability, accessibility, affordability, and quality and underlie the policies constituting the Dutch health care sector.

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2.1 Public values

Public values, also described as public goals or interests are frequently discussed in governance studies. This study uses the phrasing 'public values'. Because the terms 'public values' and 'public goals' are, often confusingly, used interchangeably the distinction between the two is and the choice for the term 'public values' are explained. Namely, 'public values' are seen as inspiration or principles one wishes to stick to, hence the emphasis is on where to depart from. Conversely, the phrasing 'public goals' emphasises that something is striven for or wishes to be achieved. The phrasing 'public values' is used here as the stakeholder prospects emphasize the principle-nature of the 'public values'.

From the literature it can be understood that public values emerge through socio-political consideration which politicians and policy makers are required to undertake. The WRR describes their role as 'interesting' as governments strive for public order and public goals (WRR, 2013). According to Maarse (2012) they function as inspiration for policy. Politicians and policy makers can also use public values as instrument to stimulate policy making by putting the focus on wider goals that need to be achieved (Maarse, 2012). Wider goals should be seen in terms of overarching values or principles that society wishes to maintain. This description of Maarse further shows the interconnectedness of public values and public goals as he uses both terms in one sentence.

Furthermore, according to Roscam Abbing (1991) in times of scarcity and reforms, public values can help to prioritise and make decisions (1991). He also notes that the interpretation of values is not set in stone, stating that when new policies are not in line with traditional values a new interpretation of values may be necessary.

Interestingly, Hadorn (1991) takes a 'preference based approach' and expresses public values as preferences for the outcomes of health care. In this logic people, or health care stakeholders, for example prefer health care to be of good quality or affordable for all. This understanding thus rather sees public values as goals rather than values. Health care policies will inevitably have consequences that benefit the one stakeholder more than the other. Therefore, also health care stakeholders are expected to have preferences for public values in health care and it is interesting how they see their

role in achieving these. Moreover, the preferences for certain outcomes are likely differ between the stakeholders.

Four public values in particular underlie much of the Dutch health care sector: availability, accessibility, affordability, and quality. The importance of these values is illustrated by the Dutch government which introduced market forces in the health care sector while clearly stating that these should not interfere with the public interests in health care (Maarse, 2012). These values have a long history in Dutch health care as they were explicitly laid down in international treaty law in 1966. Namely, in article twelve of the International Covenant on Social, Economic and Cultural Rights the right to highest attainable standard of health is laid down as a basic human right. In General Comment no. 14 (The right to the Highest Attainable Standard of Health: General Comment no.14 (2000) on Health) the obligations for the state are described as follows:

Availability is related to the physical availability of health care facilities, goods and services. Stakeholders can differ in their opinion to what extend experimental medical technologies should be available or what care should be made available by whom. *Accessibility* can be explained in different ways. Firstly, it refers to physical accessibility a criterion that could be threatened with the redistribution of hospital care. Also health care must be universally accessible, i.e. free from discrimination. Secondly, *affordability* is perceived as financial accessibility. Health care should be affordable for all and in an equitable system not excessively burden low income households. Good *quality* health care will yield beneficial medical result and satisfied recipients of care. Hospitals and other health care facilities are expected to deliver good quality health care.

As the ICESCR is ratified by 160 states, the treaty is seen as reflecting global consensus on the human right to health (Rhodes, Battin, & Silver, 2012). In this study the values of financial accessibility and affordability are separated to be able to distinguish between micro level affordability (financial accessibility) and macro level affordability (affordability). The term financial accessibility is chosen as on an individual level not being able to afford health care is associated with limited access to care (Eurostat, 2015).

Furthermore, it is important to emphasise that the public values' meaning is subject to interpretation. Even the covenant itself leaves considerable room for interpretation. One reason according to Maarse (2012) for subjective interpretation is the context in which the value is discussed. For example, with regard to availability it can be discussed who is responsible for making health care available. Additionally, spatial proximity and freedom from discrimination are both related to accessibility of care but will be present in very different contexts.

Another reason for subjectivity in interpretation is that the values are not mutually exclusive. Maarse (2012) describes this as he links accessibility with availability; a service needs to be available before it can be accessed and further depends on the financial accessibility. Many would also agree

that the quality of a health system is also defined by the accessibility or availability. For example long waiting lists could be regarded as a sign of low quality.

Two interesting points for the prospect analysis come up out of this discussion. The first is point made by Maarse (2012) that behind identically formulated values considerable differences in interpretation become clear when trying to bring the values into practice. This leads to interesting questions on how the Dutch stakeholders have interpreted the public values, what aspects they have emphasised and how their interpretation is affected by their professional context.

The other interesting point, referring to the contextual influence, values are discussed as being transient, dependent on time and culture in the academic literature (Maarse, 2012). Even though these four values may be widely shared and have been incorporated into law, the ICESCR also was established almost 50 years ago. This leads to the question what other values gained recognition in the meantime perhaps even in favour of the traditional values. The analysis will point out what values thrive and inspire the Dutch stakeholders.

2.2 Exploring the future

Futures studies aid policy makers by systematizing thinking about the future and contribute to the development of future-oriented policies (van Asselt, Faas, van der Molen, & Veenman, 2010a). Prospects can also fulfil this role to expand views into the future. Here, the approaches for developing futures studies are used to analyse the construction of the prospects. They are chosen as methodological framework for research question three because of the following: as described in the previous section futures studies and prospects share the goal of increasing the availability of information about expectations for the future. Both types of publications aid policy makers, politicians or the general public in informing themselves about possible developments for the future. The difference between the two being that futures studies often have an empirical nature whereas prospects have an interpretative nature aimed at achieving insight. The different approaches to establish futures studies are further chosen to underlie the analysis as this allows gaining insight in the way the prospects were developed. Where for the development of futures studies practices have been developed, this has not been done for prospects.

Here, before current understandings of futures studies are discussed, a brief history is described. Many developments have influenced people's thinking about the future over time and have shaped futures studies to how they are performed today. After the French Revolution and during the Renaissance people's perception on the future changed. No longer was God determining the future the only line of thinking, now possibilities for shaping the future by human actions also gained recognition (Adam, 2010). 'The future' developed further from a topic in philosophy to a

serious professional activity. In policy making futures studies are support for systematic study of what the future may bring by using scientific knowledge, hereby the process of developing future-oriented policies is supported (van Asselt et al., 2010b).

A boost in, now called, “futures studies” in Europe came after World War II with the need for planning policies in the reconstruction of economies and society (van Asselt, et al., 2010b). Futures studies further developed in the 1960s and 1970s. Institutions like the OECD (1961) and the Club of Rome (1968) were established and together with different companies (e.g. Shell) they engaged in futures studies and thereby developing several distinct approaches to them. The rich developments of the past have made futures studies an established and institutionalized activity and an important tool for policy makers.

2.3 The future: determined versus open

Based on the work of van Asselt, et al. (2010b) current perspectives on the future can be divided by two axes. The first one distinguishes between a predetermined future and a completely blank future. At the one end the future is perceived as being predetermined, for example by fate or a God. In this view what the future will hold is set and which means that humans cannot influence the future. At the other end, the future is perceived to be empty or open. In this view ‘empty’ and ‘open’ mean that nothing about the future is set before it actually takes place. Here another axis presents itself: does this mean the future is constituted through chance alone or can human action exert a shaping force on the future? It is this last axis that is focussed on given the topic of this master thesis.

With regard to an ‘open’ future’ combined with a large power for people to shape the future Van Asselt et al. (2010a) gives an example of beliefs held by those creating ‘new countries’ in the overseas territories of America and Oceania in the 18th and 19th century. There was a strong belief in the human potential and power to shape the future according to ones wished and preferences; the future was seen as malleable, subject to planning and could be improved. Another example of malleability of the future can be found in the works of Marx who assumes a high malleability of the communist state (van Asselt, et al., 2010a) The communist state and the centrally planned economy are clear examples of the belief in shaping the future.

However, a radical belief in the potential of human creation does not prove to be viable in the long run according to Adam and Groves (2007). They call the belief in an empty future the “fiction of the empty future” (p.13). For example, events like the current economic crisis, the nuclear disaster of Tsjernobyl and natural disasters occur unexpectedly. Moreover, failures in policy also illustrate that the future cannot be created. To illustrate, the decentralization of reimbursement decisions in the UK was a decision thought through by policy makers. Nevertheless, it led to unwanted treatment

variations in the country known as the 'postcode lottery' (Bungay, 2005; Henderson, 2009). Also short term outcomes of policy can also be unexpected. The case of the Dutch government's campaign for HPV vaccination is an example of this. The vaccination campaign had only a 49% turn out as opposed to 70% that was aimed for. This was an unexpected disappointment for the public health department (NRC, 2009).

These examples of radical perspectives on the future call for another approach. By believing that people can only think about the future and not create it a middle way can be found. Rather than perceiving the future to be empty or predetermined it should be perceived as a combination of today's and future influences of which the outcome is yet uncertain. Hence, the future is open, but not empty (Adam & Groves, 2007). According to Van Asselt, et al. (2010a) the 'open but not empty' view is often at the basis of modern futures studies.

Generally futures studies are used by policy makers and strategic advisors of companies. Bezold (2001) outlined three purposes of futures studies for governments that can also apply to prospects. The first purpose is to facilitate understanding of the future for policy makers in general. The second goal is to facilitate policy makers to make better decisions between different policy options. Thirdly, by doing so policy makers should be able to create the future they prefer.

The first two purposes are shared by this study as well. Like futures studies, prospects open the mind to the future which may get less attention usually due to everyday challenges. Future studies and prospects both increase the understanding of what the future may hold but prospects do this through providing the subjective vision of the author rather giving value neutral expectations. In other words: prospects do not aim to focus on an objective future but on the subjective future in the view of the author.

The second purpose is also shared by the prospects that are analysed here. As mentioned before in the Netherlands cooperation from stakeholders is necessary for successful implementation. Therefore, informing yourself of the prospects of stakeholders is immensely helpful in preparing yourself for the future. This study does not take on the third view that this would allow for subsequent creation of the future. That would require a too strong belief in our ability to determine the future and the power of policies to determine the future.

2.4 Current practices in futures studies

Following the brief history of futures studies and the assumptions that underlie futures studies, this section explains more about current approaches of futures studies. These approaches are *forecasting*, *foresight* and *normative futures studies* (van Asselt, et al., 2010b). According to Mack (2013) the distinction between these approaches is based on the assumption whether the future is within our control or not.

Forecasting aims to create an image of the future without unexpected events. Therefore, assumptions based on continuity of past trends are extrapolated to the future (Hajer, 2000; van Asselt, et al., 2010b). Where Van Asselt, et al. (2010b) emphasize that that forecasting is not equal to 'predicting the future, Wachs (1982) describes forecasting as predicting the future and he claims the future is created by people. Of course, from Wachs point it views it follows logically that is one is able to create the future, it is also possible to predict it.

The strength of the translation from present-day data into a claim about the future is often put central in literature. Wachs however, brings variety in the literature by focussing on the technological methods behind the inference. He emphasizes that a critical attitude remains necessary when it comes to data collection, processing and calculations made. This is important to highlight since most forecasts, like those of OECD and Centraal Planbureau are assumed to be unbiased, policy neutral and yet have a big impact on policy making. Even through the stakeholder prospects are not assumed to give an empirically reliable view, this should not be an excuse for lowering standards on methodology. Wachs argues that the assumptions and judgments which have to be made, selection of data and models allow for subjectivity of the forecaster. He illustrates that forecasters often assume that variables that have been stable in the past will remain stable in the future too. Thus, also when it comes to prospects it will be valuable to reflect on the empirical basis of the prospects. How have the stakeholders dealt with of current trends; have they assumed linearity of trends and have they referred to sources to strengthen the factual basis of their expectations? Or have the stakeholders chosen to leave an empirical basis behind and to examine the values and assumptions they wish to exert in the future.

Robinson (1988) also criticises the role of forecasting as serving unbiased information about the likely future to facilitate decision making. . He stresses the manner in which forecasts are perceived as (scientific) evidence by policy makers and get a normative role. Robinson questions this strong belief in forecasting. He argues that predictions about future economic activity can become the cause of present decisions. Ultimately mixing cause and effect, this means that forecasts do not portray the future but justify the subsequent creation of that future. Since prospects can use information from futures studies to underpin the assumptions they are based on, for example about economic growth, they should be cautious to avoid mixing cause and effect.

A less predictive form of futures studies is *foresight*. Foresight assumes that the future is unknown and explores multiple possible futures. As opposed to forecasting the lack of knowledge is put centre stage. Trends are not assumed to develop linearly but may change over time (van Asselt, et al., 2010b). Exploiting the uncertain variables often leads to multiple scenarios, a horizon scan or identification of weak signals. It will be interesting to see whether the stakeholders have used the opportunity of uncertainty to establish different scenarios and if so what results they achieved. Foresight is well known within governance and its benefits are well described. Leigh (2003)

describes the benefits of long-run scenario planning to be that policies are more likely to be durable and effective. Governments will be more focused, creative and innovative. Central to Leigh's discussion is the explorative nature of foresight. Those engaging in foresight can 'spot opportunities', identify unanticipated consequences and use a variety of information sources. Leigh's observations indirectly describe the potential of prospects. A creative, innovative and original prospect is not only an inspiration for the stakeholder to whom the prospect belongs but also for stakeholders around him. Because prospects are less bound by methodological requirements than futures studies they are more open to vary in their methodology.

The importance of foresight for good policy is also strongly advocated by Walker (2007). Walker also emphasizes the lack of knowledge- change will come but this can bring both 'desired opportunities' and 'undesired risks'. Like many others who engage in foresight, Walker too praises the neutrality and independence of the foresight studies resulting in confidence about the 'facts' that are put on the table. Nevertheless, this confidence in the empirical strength is what Wachs (1982) questions; the confidence expressed by Walker cannot be verified since the foresight methodology is not further specified in the article. Also the Scientific Council for Government Policy (Wetenschappelijke Raad voor het Regeringsbeleid, WRR) by van Asselt, et al . (2010a) warns that predictions from forecasts about the ageing of society were seen as a mere fact and consequently dominated government policy. In the words of the WRR these predictions 'colonised the future'. This calls again for caution for the interpretation of foresight studies as well as forecasting studies.

The other part of the spectrum of future studies is constituted by normative futures studies. Foresight and forecasting are built around cognitive uncertainties and do not judge social and normative uncertainties. They (generally) refrain from giving value judgements and stick to predictions with an empirical nature. Normative and social uncertainties are central to the normative approach and value judgments are based on desirability, values or political preferences (van Asselt, et al., 2010b). In normative futures studies the values, cultural values or habits are applied as norms according to which the vision of the future is established. Normative futures studies make the normative dimension explicit by accompanying their vision of the future by comments about desirability, preferences, values or political statements. Normative is thus understood here as any statement or wording that indicates a preference for a certain framing principle, value or direction.

Normative futures studies relate to prospects about the Dutch health care sector as almost anyone in society will have preferences and an opinion about the system, whether someone is a patient, a tax or premium payer, but also groups of stakeholders or political parties will have their opinion. The four public values are widely agreed upon as norms for health care (International Covenant on Economic, Social and Cultural Rights, 1966) but how they will be achieved is open to debate.

Normative futures studies can be divided in back casting and critical futures approach. In back casting a desired future is portrayed, which is followed by the steps that need to be taken to achieve the portrayed future. Policies can then be designed with the aim to achieve the portrayed future (van Asselt, et al., 2010b). An example of back casting in the area of health care would be to visualise as hospital board that your hospital is ranked as best in the country within an x number of years. This would be then followed by identification of the steps that are necessary to achieve this. For example by policies of strengthening protocol compliance, investing money in ill-performing wards or more drastically: ceasing the activities of ill-performing wards. In Figure 2.1 an example of back casting is provided. The figure further shows that back casting thus has a strong self-fulfilling character.

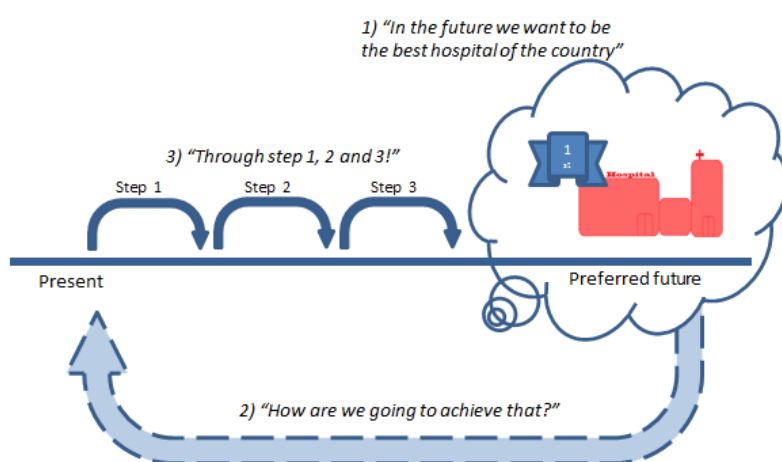


Figure 2.1 Back casting.

The other approach within normative futures studies is called critical futures. Critical futurists do not aim to establish one vision of the future but explore several normative perspectives on the future emphasizing that these are driven by different desires, values or cultural, etc. (van Asselt et al., 2010a). Where forecasting, foresight and back casting assume normative consensus, a critical futures approach questions this. In critical futures studies the emphasis is on diversity and conflict between different normative perspectives that are present in society. Principles and values like the four public values could be a starting point for a critical futures study.

It could explore for example if these values are shared by different groups in society or how they are interpreted by different groups. When looking at the future when using a critical futures approach the uncertainty on how normative perspectives may be adhered to or given meaning to in the future is central.

Even though both foresight and a critical futures approach result in several perspectives for the future they have a very different nature. Scenarios developed through foresight are grounded in different empirical possibilities for trends to develop, e.g. economic growth or epidemiological

factors. A critical futures approach aims to unravel the consequences or causes of normative preferences; for example with regard to predictions about ageing populations a critical futures study could question the dominant notion of age or question why there is an interest in researching populations in principle. From this deconstructive nature it follows that a critical futures study could also conclude with only a deconstructed disquisition and without a clear constructive statement.

Table 2.1 summarises the four approaches to futures studies and Figure 2.2 shows the relationship of the four approaches in proportion on two axes of cognitive and normative uncertainties.

	Forecasting	Foresight	Back casting	Critical futures
Cognitive dimension	Aimed at increasing cognition over the future	Exploring and exploiting cognitive uncertainty	Aimed at increasing cognition on how to achieve a portrayed future	Not concerned with cognitive dimensions of the future
Evolution of the past into the present into the future	Continuity and stability assumed	Change and uncertainty assumed	Change assumed	Uncertainty assumed
Power-over-future dimension	Little room for human power to shape the future	Room for human power to shape the future	Future is shaped by human behaviour; self-fulfilling nature	Not concerned with exerting power over the future
Normative dimension	Normatively neutral: Normative consensus assumed Little/no normative uncertainty	Normatively neutral: Normative consensus assumed Little/no normative uncertainty	Normatively neutral: Normative consensus assumed Little/no normative uncertainty; desired future is centre stage	Normatively pluralistic: Normative consensus not assumed Normative uncertainty is exploited
Result	A surprise free forecast	Different scenarios for the future	The pathway on how to shape a desired future	Comparison of different normative perspectives; emphasis on diversity and conflict

Table 2.1 Methods for future exploration.

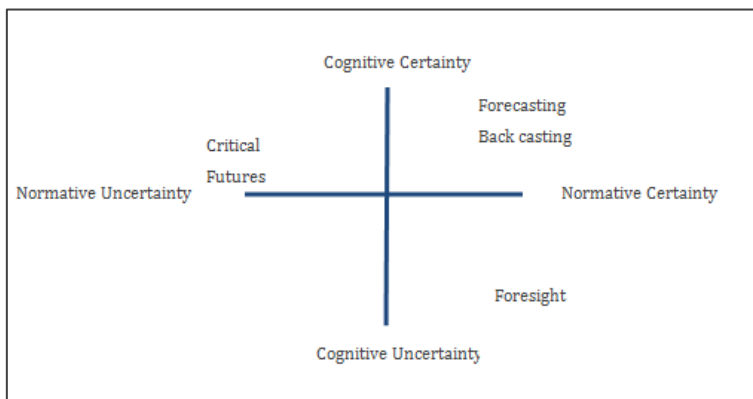


Figure 2.2 Cognitive and normative uncertainty.

The stakeholder prospects in this research are based on normatively neutral foresight or forecasting studies. However, the prospects differ in nature; some do have normative contents whereas others refrain from value judgements.

The literature shows that overlap in terminology still occurs frequently. The terms futures studies, forecasting and foresight are not used consistently. This study however adheres to the terminology as determined by van Asselt, et al. (2010b), because they are clearly demarcated in the publication of van Asselt et al. (2010b) (futures studies, forecasting, foresight and critical futures) and were based on research of the WRR. Furthermore the authors diverge on the assumptions about the reliability of the forecasts and foresights. As Wachs (1982) points out much of the data are perceived as facts, whereas they cannot be verified as they hold a claim about the future that has not arrived yet. This study does not assume that because of the lack of verification the prospect should be treated as fiction (nor does Wachs himself), but when working with prospects it is wise to be aware of the possible limitations to reliability.

2.5 Uncertainty

In the previous section it became apparent that futures studies and prospects are associated with uncertainty. The increasing awareness amongst policymakers that uncertainty about the future is inevitable further acknowledges the importance to engage in futures studies in an aim to clarify uncertainty (de Vries, et al., 2011; Petersen & Van Asselt, 2003). Examining uncertainty is not only relevant for policymakers, but because of their influential positions it is also relevant for the stakeholders in the health care sector. While developing their outlook on the future the stakeholders were confronted with uncertainty. To illustrate, reforms and budget cuts are lining up, patient's preferences and their role in health care may change. What will the consequences of reforms be and how is the stakeholder going to work with changing circumstances given their abilities but also given their values? Or do they come with their own proposals which represent their values or interests that counter current trends?

These questions touch upon the different types of uncertainty that are associated with exploring the future which are also found in table 2.1 and figure 2.2, namely cognitive and normative uncertainty. Cognitive uncertainty refers to the cognitive limitations of knowing the present or the future in this case. Whereas normative uncertainty is generally understood as uncertainty about what those involved in the matter concern to be the leading normative values; these could be aligned, but also diverse or even conflicting.

Based on the assumption that examining uncertainty is essential for a good exploration of the future this section gives an overview of literature on both cognitive and normative uncertainty.

Traditionally much of the work relating uncertainty and policy concerns cognitive uncertainty and comes from the environmental policy field. Additionally, there is a vast amount of work from economic scholars aiming to quantify uncertainty. In the Netherlands cognitive uncertainty is a topic that features frequently in studies of government institutions such as the Netherlands Environment Assessment Agency (PBL, Planbureau voor de Leefomgeving) and the Netherlands Bureau for Economic Policy Analysis (CPB, Centraal Planbureau). This study introduces the application of uncertainty in a new field, and will provide a better understanding of how uncertainty is or could have been presented in the prospects.

The PBL and CPB conducted a large study in 2008 on the role of uncertainties in environmental policy related knowledge (Mathijssen, Petersen, Besseling, Raman, & Don, 2008) and it is argued that policy makers now recognise the need for guidance on how to deal with uncertainty.

The WRR reiterates the need for guidance on how to deal with uncertainty in several publications and provides tools for doing so (2011, 2010a & 2010b). According to the WRR uncertainties should be perceived as a given and policy makers should focus on the 'taming uncertainty'. According to the WRR dynamics in societal, economic, political or natural systems may be too complex to assess and foremost to control them to arrange desired outcomes (Van Asselt et al., 2010a). They recommend that uncertainties should therefore be made explicit and calculations should be applied to translate uncertainty into a risk problem (de Vries, et al., 2011).

The International Risk and Governance Council (IRGC) is an organisation that provides guidance on the governance of systemic risks of all kinds. According to this organisation dealing with cognitive uncertainty is also done by cognitive processing of risk characteristics. In the interpretation of the IRGC cognitive uncertainty should be regarded and treated as a risk (International Risk Governance Council, 2005). From their point of view cognitive uncertainty refers both to the lack of knowledge itself as well as the process of gaining knowledge.

Around the same time as the IRGC was founded, a report called 'Guidance for Uncertainty Assessment and Communication' was produced by van der Sluijs et al. (2003). This guidance identified 5 dimensions of presenting identified uncertainty. They show what facets of the 'uncertain event' could be described. This report is in line with the WRR recommendation to address uncertainty explicitly; these dimensions further specify how to do so. 1) Location; where do the uncertainties occur in the problem, e.g. in the policy context or social circumstances? 2) The level of uncertainty, ranging from complete ignorance to being actually very determined. 3) The nature of the uncertainty depends on the source of uncertainty: lack of knowledge or variability? 4) The qualification of knowledge base; referring to the research underpinning the uncertainty. The fifth dimension refers to the value laden nature of the presentation, the inherent subjectivity as a consequence of choices in data selection and analysis. This approach shows that uncertainty is perceived as something that may happen or not, as it is referred to as 'event'. This is comparable to

the understanding of the IRGC which calls for the clarification of the risk – of an event happening. However, after a shared understanding of what constituted an uncertainty the IRGC calls for quantification of the uncertain event into a risk, whereas, van der Sluijs, et al. (2003) call for extensive analysis of the all facets of the uncertain event. These two approaches would thus lead to different results, a single number or percentage compared to an extensive description. Furthermore, it must be obvious to anyone that despite their efforts to decrease the uncertainty around risks, the interpretation of risks is still often debated (de Vries, et al., 2011).

The categorisation of the WRR (de Vries, et al., 2011), the approach of the IRGC and the five dimensions described by (van der Sluijs, et al., 2003) all advocate strongly to make uncertainty as tangible as possible in order to be dealt with by policy makers. As this study concerns the health care field instead of the environmental field and concerns prospects instead of futures studies, it will be interesting to examine how the stakeholders in health care have dealt with uncertainty about the future. The concepts of tangibility, risk and categorisation will aid the analysis of uncertainty by functioning as cues for the interpretation phase. Have the stakeholders explicitly addressed uncertainty in their prospects? If so, has the stakeholder attempted to 'tame' the uncertainty? If so, has the stakeholder translated the uncertainty into a risk proposition or has it described different dimensions of the uncertainty? Or have such actions not been taken as the stakeholder omitted to explore the uncertainties it came across?

The other type of uncertainty is normative uncertainty. In the interpretation of the WRR normative uncertainty it refers to uncertainty about who the future stakeholders will be, what interests with respect to the future are of concern, what values are at stake and what images of the future are considered as plausible or desirable by different actors (van Asselt et al., 2010a). According to the interpretation of the WRR exploring normative uncertainty is highly relevant for the stakeholders themselves and hence for this study as a consequence. Normative consensus should not be assumed according to the WRR when different groups in society are involved who have different interests. In this case the name of the actors, the stake-holders, makes it clear that there are different groups involved all holding a stake of the whole. Moreover, as the stakeholders represent large groups of professionals or patient within stakeholder differences should also be considered. Furthermore, normative uncertainty should be explored as distribution of shared resources and public interests are at stake. Since health care consists of scarce goods and services, is faced with high (and increasing) demand and is largely collectively funded exploring normative uncertainty is relevant.

The IRGC holds a pragmatic approach and emphasizes the consequences of normative uncertainty, namely preventing agreement on the appropriate values, priorities, assumptions, or boundaries necessary to define possible outcomes for action (IRGC,2005). The IRGC further states that normative uncertainty can aid in determining what can be regarded as tolerable, for example in

reflecting on quality of life or ethics in health care. Hence, on the one hand normative uncertainty is perceived as an issue preventing progression of the futures exploration, whereas on the other hand the ambiguity can be used as an exercise to gain insight in the different values held by groups in society. If such reflections were included in a prospect it would provide great insight in the values and norms of a stakeholder. Conversely, if none such thing is included it shows that the stakeholder has assumed that normative consensus exists.

From these interpretations it appears that normative uncertainty is perceived from a societal perspective, Scott and Montgomery place further emphasis on the societal dimension of norms. Scott (as cited in, Petersen & van Asselt, 2003) argues that a public authority needs structures with a cognitive, regulative and normative nature to govern. The societal dimension of normative structures is according to Scott found in the actors and their relations. In policy making, as well as in the stakeholder prospects studied here, these relations are characterised by participation of actors. Montgomery (1987) reflects on the normative foundations of policy and describes the existence of 'some norm or ethical standard' that is embraced, by a large enough share of the community to allow a public authority to govern. Both Scott's and Montgomery's accounts point out that legitimacy based on a shared agreement on norms and value in society is crucial for policy implementation. As Scott and Montgomery refer to normative certainty rather than uncertainty their accounts justify the questions of this study on uncertainty about the normative viewpoints of the stakeholders. Firstly, normative uncertainty can apply to the within-relations of the stakeholders. Namely, the stakeholders themselves are organisations that consist of a large amount of members (e.g. individual physicians) or a smaller amount of organisations (e.g. health insurers). This means that in order to achieve a legitimate representation of the members in the prospects those who have established the prospect will have had to deal with normative uncertainty. It is interesting to see whether the prospects have given space to normative variance or ambiguity or have assumed normative consensus. Secondly, these same questions can be applied to the between-relationships of the stakeholders. Achieving consensus is essential in Dutch policy making, for which normative consensus – at least to a workable level- is required. Moreover, shared understanding of values and norms is not only important on the level of policy makers but just as much for the health care professionals and patients who engage in professional or patient-professional relations on daily basis.

Chapter 3 Research methods

3.1. Nature, type, design of the research

This study has an explorative, descriptive and analytical nature. The prospects and their contents are described and analysed. This study also has an explorative nature since prospects are not commonly subject to research.

3.2. Data collection

As this study concerns the prospects of a range of stakeholders a framework of inclusion criteria was established. Firstly, the included prospects were published by relevant stakeholders. Relevance was judged on the impact the stakeholder has on the population, looking at the number of people affected and the significance of the impact on one's life. The stakeholders together cover the different roles of provider, patient and payer.

Next, the prospect's time span is an exclusion factor. The prospects must concern at least the year 2015 and maximum the year 2050. The limit was set at 2050 to avoid too large differences with shorter term prospects. No prospects were found that went beyond 2025.

The majority of data was selected at the start of the research process. Because of the constant cyclic nature of grounded theory the prospects of the KNMP and the working group of young professionals were added later. A list with a description of the organisations and prospects can be found in Appendix 1: Overview Stakeholder Organisations and Prospects

3.3. Steps in the research procedure

Firstly, the prospects were gathered, which functioned as data for the results section. Secondly, a general survey of literature using online databases and library collections was performed to collect information for the theoretical background chapter and research methodology chapter. The databases used were the Social Sciences Citation Index through Web of Science and the International Social Sciences Bibliography. Thirdly, the theoretical background and methodology chapter were written. Fourthly, the data was processed through a qualitative analysis deriving its framework from grounded theory. This analysis also contains several steps (4.II -4.VII) which will be described in more detail.

Steps in the research procedure:

1. Identifying stakeholders and collecting prospects
2. Collecting literature for theoretical background and methodology
3. Establishing the introduction, background and methodology chapters
4. Data analysis: grounded theory
 - I. Describing the stakeholders
 - II. First phase coding: superficial coding to identify sensitising concepts
 - III. Axial coding: refine codes and express in network
 - IV. Selection of text fragments
 - V. Second phase coding: detailed and based on text fragments
 - VI. Axial coding: refine codes and express in network
 - VII. Interpretation and integration: connecting codes and answering research questions
5. Establishing the results and discussion
6. Establishing the conclusion

Since the study includes four research questions the steps IV till VII were repeated for each research question.

3.4. Data analysis

As outlined above the analysis can be divided in several stages. Section 3.4.1 discusses the use of grounded theory; the subsequent sections discuss the application in detail.

3.4.1 Grounded theory

Grounded theory is based on the works of Barry Glaser and Anselm Strauss (Glaser & Strauss, 1967). Grounded theory works through deconstructing data to achieve high granularity, after which inductive analysis is applied and a coherent theory is built as a result. Grounded theory figuratively 'sieves' the relevant information out of the data.

Strauss and Corbin (1998) define theory in Mortelmans (2011) as "a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena." In this study theory is aimed for in a sense that the results should be able to explain the phenomena in the data but since the data is very much bound by the field and the time it was constructed in prediction is not of interest.

This 'integrated framework' was achieved through open coding, axial coding and integration (Mortelmans, 2011). The cyclic nature of grounded theory resulted in two phases of coding: first a superficial coding phase was performed to establish sensitising concepts which guided the second

phase of coding which was more in depth, inclusive and aimed interpretation of the data. The sensitising concepts were used as guidance for the second phase coding rather than a strict framework to be completed.

Coding was performed with an open and inductive approach, aiming to stay as close to the 'raw material' as possible. Furthermore, the value of inductive coding further lies in allowing for deeper interpretation of the results as it shows how "concepts are identified" and highlights "their properties and dimensions" (Corbin and Strauss, 1990; in Mortelmans 2011, p.355). Even though inductive coding was preferred, deductive coding was also applied as the concepts of research question three and four could not be found concretely in the data.

Grounded Theory was not only chosen for the results it would yield but also because it emphasises the procedural side of analysis. Data were compared against each other continuously and if necessary the analysis could be refined or expanded (Mortelmans, 2011). The cyclic approach is represented in this study through the two phases of coding. Moreover, the cyclic nature is also shown by the fact that even after the first and second phase coding were completed, newly published prospects of the Royal Dutch Pharmacists Association (KNMP) and a working group of different young health care professional associations (e.g. young pharmacists and young medical specialists) were included.

Another distinctive feature of grounded theory is the use of memos. Throughout the analysis short memo's helped to remember insights which were – if still relevant- later applied in the analysis. Memos are extensively described in (Corbin & Strauss, 2008) and are also discussed in (Bryant & Charmaz, 2007). Corbin's memos present in the 2008 book almost have a diary like style; they are very personal and of considerable length. For this study memos were kept on sheets of paper and in a word document which was frequently read to see if past notes could be applied now. The memos were concise and concerned with the research process; as such they were not personal as the memos described in Corbin & Strauss (2008). The memos proved to be a great contribution to the analysis their application is described in more detail later.

3.4.2 Describing the data sources

The data sources for this study were prospects published by stakeholders in the Dutch health care sector; for example, the association of medical specialists and the association of health insurers. The prospects included the vision of the respective stakeholder on the future of health care in the Netherlands in the next 5 to 10 years. To facilitate understanding an overview of the stakeholders and their characteristics can be found in **Appendix 1: Overview Stakeholder Organisations and Prospects**

3.4.3 Identifying sensitising concepts

As described above, a mixed approach was used of inductive and deductive coding. As the aim was to stay as close as possible to the original wording of the prospect a superficial first stage coding was performed used in-vivo coding to establish sensitising concepts directly from the data. (Corbin & Strauss, 2008; Mortelmans, 2011). The division into two phases of coding occurred naturally from the desire to obtain a quick overview of shared concepts amongst the prospects and then which could be described later with more detail. The two stage coding represents the cyclic nature of grounded theory and allowed to strengthen and refine the results throughout the process (Mortelmans, 2011).

The first stage coding used in-vivo coding, which meant that the codes consist of the exact words found in the raw data; hence the codes are in Dutch. These codes are referred to as the empirical sensitising concepts. The expression Glaser (1992) used in (Mortelmans, 2011) illustrates the approach taken in first phase of the analysis very well: “my mind is blank as to what codes will appear from the data”. Further sensitising codes were derived from the research questions and as such serve as deductive sensitising concepts. As the first stage of coding revealed that the concepts related to futures studies and uncertainty were not mentioned explicitly in the data, they had to be derived from the research questions. The research questions in turn were formulated based on literature; hence those sensitising concepts are based indirectly on the literature. Ultimately, the sensitising concepts were thus applied in a deductive manner in the second, in depth analysis, but initially they were derived through inductive and deductive setting. The approach for establishing the sensitising concepts is described in detail below.

Text fragment	Notes	Code
Het aantal 65plussers is fors gestegen, van 2,5 miljoen in 2010 naar 3,4 miljoen in 2020. Ook het aantal 80plussers is met bijna dertig procent toegenomen.	Zorg thuis nieuwe verwoording thuiszorg/langdurige zorg?	Vergijzing Evenwicht vraag-aanbod Zorg thuis
Toch is er op de markt van de zorg thuis in 2020 een		

evenwicht tussen vraag en aanbod.		
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Coding was performed using a matrix as seen in Table 3.1, with a first phase open coding example from the Dutch patient and consumer federation (NPCF). The chosen codes covered enough of the meaning and not be too simplistic, but also not be too long or detailed to exclude other concepts unfairly (Mortelmans, 2011). For example, looking at the data in Table 3.1 this led to applying the code 'vergrijzing' ('ageing of society') in preference over a code '65+ over 3.4 million in 2020', which is truly in-vivo but too detailed. The code 'elderly in society' would be too general and not reflect the increase of elderly in society. In the first phase codes were based on paragraphs, which gave the risk that the codes cover more than they should but saves time and still allowed to get an overview of the main themes in the prospects. Therefore, this simple method would be inferior in the second stage of coding but since these codes only functioned to set a framework this was not of concern.

Table 3.1 Example coding matrix first coding.

The first phase of coding provided a list of general codes; these can be seen as the main themes of the prospects. This list was translated in a network (see Figure 3.2) using the approach of thematic analysis as described by (Attride-Sterling, 2001). Creating networks worked as a means to express the relations between inductively obtained codes and overarching themes. The themes were classified as basic themes, organizing themes and global themes. The basic themes were statements made in the text that did not tell much about the text itself as they were very particular; these are the outer concepts in the network such as the before mentioned 'vergrijzing' (ageing of society). Organising themes cluster basic themes regarding similar issues, these are the second level of concepts such as 'huisartsen' (general practitioners) or 'ziekenhuizen' (hospitals). The global themes summarise the most important topics of the text, for example 'zorg als arbeidssector' (care as employment sector) and 'inrichting stelsel' (organisation of the system) (Attride-Sterling, 2001). All codes in the network were used as sensitising concepts in the second phase of coding.

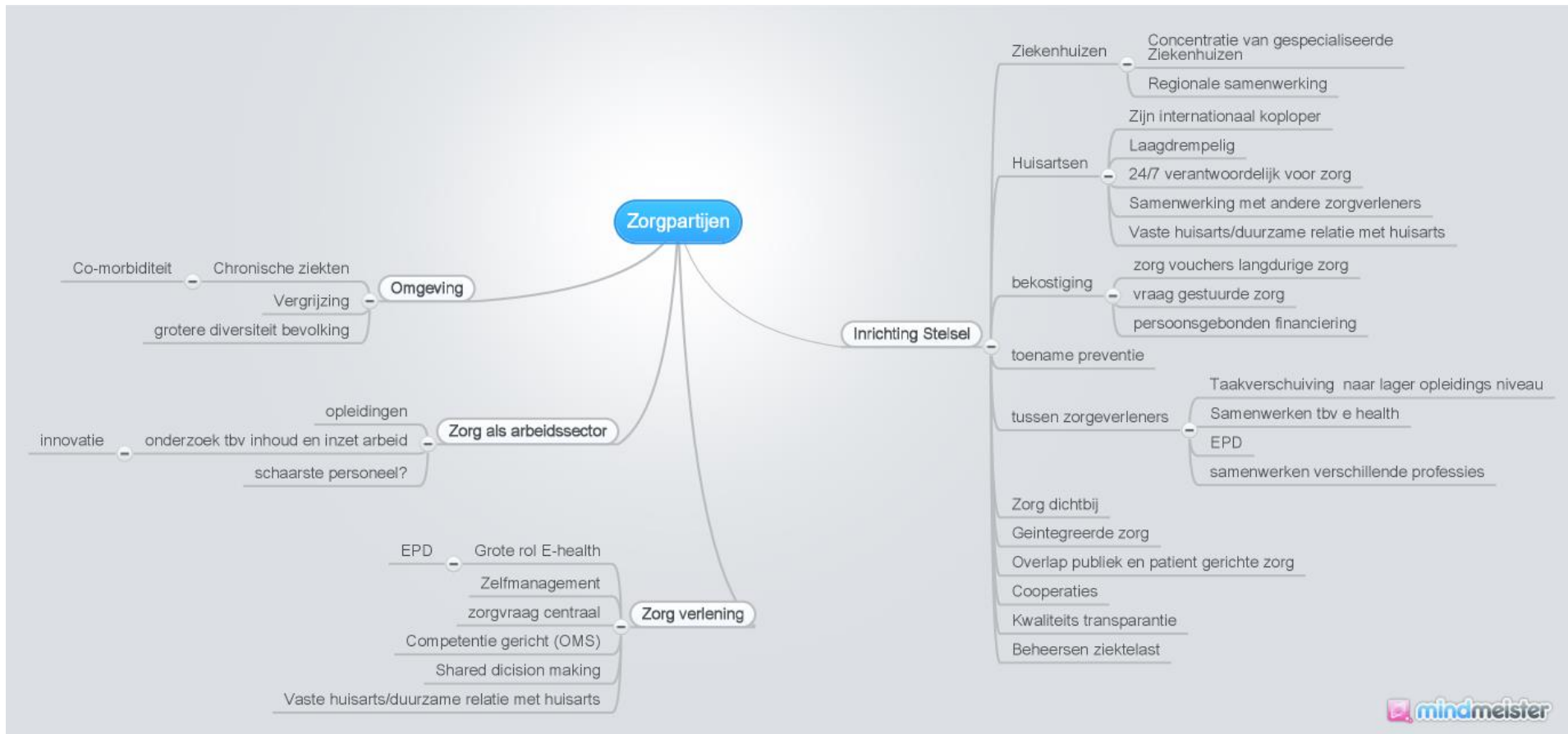


Figure 3.2 Network first coding.

As explained, the remaining sensitising concepts were derived from the research questions. The research questions are as follows:

How do stakeholders in the Dutch health care sector envision the future of health care in the period 2015-2025?

- *How is the future of health care envisioned with regard to quality, availability, accessibility and affordability by the stakeholders?*
- *How do stakeholders envision their own role in the future health care?*
- *How have stakeholders applied methodology from futures studies in their future prospects?*
- *Given that uncertainty about the future is inevitable, how do the stakeholders address uncertainty about the future in their prospects?*

These questions result in the following sensitising concepts: quality, availability, accessibility, affordability, role, uncertainty, forecast, foresight, scenario, normative uncertainty, critical futures and futures studies. It is not expected though that these concepts will be found literally in the texts, instead they serve as liberal guide while scanning the data.

3.4.4 Selection of text fragments

The second phase of coding was preceded by the selection of text fragments from the stakeholder prospects. As Mortelmans (2011) describes the data was first broken apart after which it was rebuild through axial coding and integration.

The text fragments consisted of a couple sentences, depending on the density of information, and conveyed a message that related to the research questions. From these fragments roughly one or two codes were inducted. The fragments ensured in-depth coding as they were in fact an extra step of narrowing down and each sentence could be read separately.

3.4.5 Second coding: detailed and based on text fragments

The second phase of coding had to yield more in depth results than the first phase. Therefore, the method of coding was similar to the first phase coding but much more detailed and with performed with much more precision. The demarcation of concepts was quite liberal. If a statement was meaningful for answering the question it was coded. Since the stakeholders used many different phrases to refer to the sensitising concepts the inclusion of a statement within a concept was generous. It was preferred to include a statement by attaching a code as it could easily be discarded later on, as including at a later stage would be more difficult. The following matrix in Table 3.3 with an example from the prospect of the NPCF was used for coding:

Text fragment	Code	Notes
Het aantal 65plussers is fors gestegen, van 2,5 miljoen in 2010 naar 3,4 miljoen personen in 2020. Ook het aantal 80plussers is met bijna dertig procent indrukwekkend toegenomen. Toch is er op de markt van zorg thuis in 2020 een evenwicht tussen vraag en aanbod. Dat evenwicht is soms wankel, want de grote en nog altijd stijgende zorgvraag trekt een zware wissel op mensen en middelen.	Empirische informatie Forecasting Beschikbaarheid in gedrang	Geen referentie empirische informatie Thuiszorg → zorg thuis? Beschikbaarheid in evenwicht, maar in gedrang.
Zoals verkenningen van het RIVM in 2010 al aangaven, worden mensen ouder	Forecast	Verwijzing naar RIVM 2010

Table 3.3 Example coding matrix second coding.

The fragment in Table 3.3 refers to the same as in Table 3.1. However, in Table 3.3 the full fragment was selected and it shows this resulted in a more comprehensive set of codes. Firstly, the statement provides empirical information on the expectation of elderly in society by forecasting. Secondly, availability is discussed in terms of demand and supply. This led to the codes ‘empirical information’, ‘forecasting’ and ‘availability threatened’. The column assigned for notes helped the interpretation and integration of the codes by allowing getting back to ideas that arose during the coding.

3.4.6 Axial coding: refine codes and express in network

The second phase coding was followed by axial coding. Axial coding was described by Strauss and Corbin (1990) in Mortelmans (2011) as the process of relating categories to their subcategories on the level of properties and dimensions.

A graphical depiction, in a similar network-style to that described in section 3.4.3, was created for each research question and formed the basis of the analysis. The networks allowed for organising the results and identifying the relations and dimensions of the concepts. As stakeholders may have used different wording, the nuances between the languages of the stakeholders could be expressed now.

The networks were built through relating the codes and ordering them in categories and show patterns of association. In the networks belonging to research question one and two (appendices two and three) each of the codes carried a label with the name of the stakeholder(s) the respective code was used by. For research questions three and four the networks (appendices four and five) were first organised by stakeholder and then by codes, this also reflects the deductive approach that was used to establish the sensitising concepts for these questions. Due to the vast size

of the networks an example is presented here in Figure 3.4 and the complete networks are presented in Appendix 2: network results research question 1

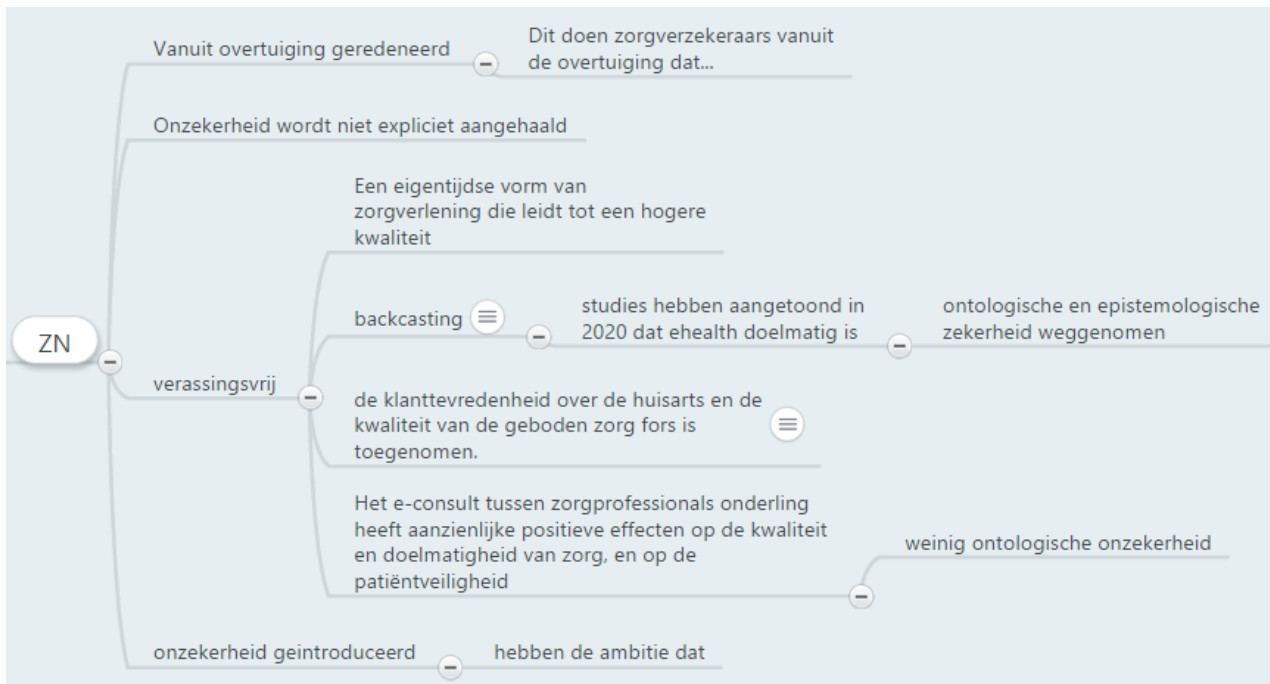


Figure 3.4 Snapshot network uncertainty.

The networks hold properties of several approaches. For example, like code trees, often used in grounded theory, the networks make use of a hierarchical structure to organise categories, concepts and codes. Furthermore, the networks are a representational means as they make the procedures used in the process of going from text to integration explicit (Attride-Sterling, 2001). To illustrate, as shown in figure 3.4 the network belonging to the research question regarding uncertainty included a code which stated that uncertainty was reduced by applying a back casting technique ('studies hebben aangetoond in 2020 dat EHealth doelmatige is'), which is linked to the category of surprise free ('verassingsvrij'). The concepts of back casting and surprise free both belong to the terminology of futures studies and not to the terminology of uncertainty. Nonetheless, the network allows for the integration of the 'external' terminology. Another example of explicit representation is shown by the lowest two elements in figure 3.4: 'hebben de ambitie dat' (ambitioning to) is a code directly derived from the text, the element before that is the integrating element ('onzekerheid geïntroduceerd' (introduction of uncertainty)), which gives meaning to the code in relation to the theory about uncertainty. Namely, it tells us this is an example of a stakeholder introducing uncertainty himself.

The codes (mostly in-vivo) are the lowest order in the networks, e.g. 'hebben de ambitie dat' (ambitioning to). The next levels were constructed by higher and lower level categories. A lower level

category occurred when a pattern of codes could be identified which pointed to the same thing (Dey, 1993 in (Mortelmans, 2011)), for example 'verassingsvrij' (surprise free) in figure 3.5. Since the data described such rich and complex issues several higher level categories were applied to go from the particular codes to the more general topics. Higher level categories were a pragmatic way of organising; for example to order based on profession or task, like care or cure or as in figure 3.5 based on stakeholders. Lower and higher level categories spontaneously occurred when it was necessary to organise the coding. As described in (Attride-Sterling, 2001) this is a way of shedding light on the meaning, richness and magnitude of social life. Careful deliberation and continuous adaption of the codes ensured they covered the categories and remained exclusive. It was a process of puzzling, questioning the relations between codes, concepts and categories.

3.4.7 Integration: connecting codes and answering research questions

After axial coding the networks were interpreted and analysed, the interpretation was driven by the networks and the memos established during the coding phases. The results of the interpretation took a narrative form to facilitate comprehension for the reader and is in line with narrative form of the original data (Corbin & Strauss, 2008). It is in this phase that the codes were translated from Dutch to English to suit the narrative.

The first step of the integration was to structure the results by answering each of the research questions separately. The clear structure enables the readers to distinguish and understand the different angles the data is looked at by each research question. The perspective required for understanding the roles the stakeholders see for themselves is very different from using it to gain insight in how uncertainty was dealt with; a clear structure prevents confusion.

Next, the interpretation of each question was structured by the higher level categories. The highest level categories chosen for structuring were the sensitising concepts; the first question is structured along the four public values; the second question along the different responsibilities of patients, care, cure, and funding; the third question along the sensitising concepts foresight, forecasting, back casting and critical futures; the fourth question along the approaches of reducing uncertainty, explicitly addressing uncertainty or introducing uncertainty.

The integration of the individual codes was driven by whether different stakeholders addressed the same issues or conversely, did not address and issue, were the only one too or had a prospect very different from the other stakeholders. For example the network of belonging to the four public values shows with regard to accessibility that this was discussed in terms of physical and financial accessibility, next the network shows that for the future changes in physical accessibility were foreseen as basic and complex care were foreseen to be distributed differently than is currently done. This was translated to the result section by first describing the different understandings of accessibility and later describing the expectations for physical accessibility of basic and complex care

which were characterised by mutual understanding. As a result of this approach not all codes and categories that were present in the networks were integrated in the results. Doing so would have led to an excessive length and inclusion of many items with limited relevance in relation to the issues that are shared by the stakeholders. Hence, inclusion was determined based on relation to a sensitising concept; whether a code or category was discussed by more than one stakeholder; whether the issue discussed concerned change from current practices or concerned an impact on health care practice.

The integration of the elements of the networks into the answers was based on comparing and contrasting the prospects, and setting the codes of interest side by side in order to find out how they relate to one another. This process was supported by asking questions and incorporating the memos. Questioning was especially useful as it forced to critically assess the reasoning. The questions derived from grounded theory had different natures: analytical, contrasting (Mortelmans, 2011), comparing, sensitising and theoretical (Corbin & Strauss, 2008). A lot of the reasoning was based on sensitising, comparing and contrasting, for example “Stakeholder A and B both describe that the share of elderly in society will rise; what impact to they foresee, what action to they propose, how do these compare?” or “How do the approaches to deal with uncertainty differ between stakeholders, are they in line with theory, what results do the different approaches yield?”.

Questions that focus on the processes concerned the following: “What process, how does the process develop, what are the meaning and consequences of a process?” For example: “What trend or development can be seen in the high frequency of referring to quality of delivery of care, and in the frequent emphasis of quality of life?” “Is quality rather understood as an experience than an outcome? Does this emphasis on experience also relate to quality being described as a tool rather than outcome?” Or for example: “stakeholder D and E both refer to an increase of multidisciplinary health care provision, how do they perceive this to affect their role?”

The memos and notes further aided the integration. They ensured that the analysis was grounded in the data as they provide an analytical point of view that was established during the analysis. The memos and notes allowed for going back to the ideas of that stage much later in the research process. Examples of the memos are given in figure 3.5. To illustrate specifically, the first memo discusses that stakeholders frequently leave ‘room for variation’; this memo contributed to the study as it was later included in the result section and supported by literature from the WRR who mentioned the same effect and labelled this as ‘leaving a band with’.

"The prospects often provide one vision, which makes sense, so most of the prospects apply forecasting. However, it is often mentioned 'we do not want to pin things down'; 'this is not a blue print'. This means room for variation or change is accounted for. Although, this does not go as far as considering the room for variation as different scenarios. So, it's not foresight, but rather an 'open forecast' (in results)."

"The health professionals increasingly act as a coach, where the patient is the centre of attention and is holds decision power. The health care professional supports the decision process and performs some tasks (e.g. care and of course complicated tasks like surgeries) (in results)."

"Use photos from inventions from the past to show how people are bound by their reference (in presentation)."

"Unfortunately there are no prospects from stakeholders together apart from the young professionals. This could have given more insight in the views of the stakeholders beyond their own profession (in discussion)."

Figure 3.5 Examples of memos.

Particular challenges occurred with the research questions regarding methods of futures studies and uncertainty. As the stakeholders did not elaborate on the methods they used to structure their perspective on the future or how they dealt with uncertainty, the integration required more consideration to stay close to the meaning of the stakeholder which was either implicit or perhaps even without awareness. What further made this difficult was that the stakeholders did not apply the methods in the same way as advocated in the literature, instead often only certain aspects were used. Figuratively speaking the advocated methodology was shortened and diluted. Therefore, to ascertain that a code was integrated correctly it was often necessary to go back to the raw data and reflect on whether the assumption made was correct. A specific example of this is the Netherlands's Association of Hospitals (NVZ) applying back casting, though not as advocated as way to frame the whole prospect applying the steps as different chapters but to a single sentence: "This increase in labour productivity can we realise by: Investing in education; developing attractive employment conditions; stimulating social innovation". Despite the statement consisting of only one sentence, after reflection it was still considered as an act of back casting.

3.5. Validity and reliability of results

The study undertakes a qualitative analysis of the stakeholder prospects in terms of their content and in terms of how have they been constructed. The three quality requirements for qualitative research listed by Mortelmans (2011) are internal validity, reliability and external validity. These will be applied to the methodology.

The validity of the constructs here depends on the strength and coherence of the inductive coding and axial coding. There is a risk of weakening the internal validity because of misinterpreting codes and thereby failing to recognise patterns during the axial coding (Mortelmans, 2011). To ensure the validity constant comparison was an integral part of the analysis. This was done through the two cycles of coding the analysis was revisited and furthermore through frequent revisiting of the raw data.

Reliability refers to replicability and consistency of the analysis. Replicability is difficult to achieve with this study, due to the unavoidable influence of the researcher. But when leaving rigid requirements objectivity behind, the approach used here could be duplicated and should lead to similar results.

Room for subjectivity existed in the selection of text fragments and coding due to projection of personal interpretation. Acknowledging that personal influence is unavoidable, the impact of this was minimised. To prevent subjective projection questioning was applied whether the interpretation was correct and the interpretation was contrasted by asking what else the fragment could convey. If this question led to any ambiguity the original material was read again to get more guidance from the context. Using in-vivo codes was another important method to avoid personal projection on the codes.

The translation from Dutch to English posed a particular challenge for this study. Since the analysis is grounded in the data, the exact phrasing used by the stakeholders is of great importance for the comparison of the prospects. If due to limitations of the congruence between the English language of the study and the Dutch language of the raw data it was not possible to find a suitable translation a neutral term with the closest literal translation was used.

The external validity of this study is limited, in the sense that extrapolation to a broader social domain or other social domains are difficult. Firstly, the health care sector is particular in its dynamics between different stakeholders and the professionalization of professional organisations. Secondly, the stakeholders selected represent a larger part of the actors in the Dutch health care sectors, extra extrapolation will not yield a lot of extra information. However, theoretical generalizability could be achieved by using the same method of establishing sensitising concepts a comparable analysis could be performed within a different sector or within the health care sector in a different country as long as the sector is characterised by a playing field with a range of stakeholders.

The results are presented as a written interpretation of the grounded theory analysis. Each research question is answered separately.

4.1 Research Question 1: Public Values

Research question 1: How is the future of health care envisioned with specific regard to availability, accessibility, affordability and quality by the stakeholder?

The public values of availability, accessibility, affordability and quality drive current health care policies. The prospects show that the values remain leading in the future. As Maarse (2012) stated, these values are not limited to a single interpretation and consequently they can be translated in a variety of behavioural norms. The variety in the interpretations of the stakeholders shows that in this case Maarse's statement holds. The views regarding each of the values have been limited to the most significant statements as to avoid too a too lengthy discussion which would not foster understanding.

4.1.1 Quality

The network in appendix 2 shows that quality is an important aspect of care. Over twice the number of codes is associated with quality than with other values. First, the conceptualisation of quality is discussed, followed by a discussion of quality in context: the relation between quality and health care costs, improving quality and how transparency can turn quality into a means rather than just an end.

The concepts referring to quality directly consist of: 'best possible care' (OMS, 2012; Werkgroep Zorg 2025, 2013), 'good care' (V&V2020, 2012), 'quality of high level' (Werkgroep Zorg 2025, 2013), 'safe and of good quality' (KNMG, 2011), 'good quality care' (KNMP, 2013; LHV/NHG, 2012; Werkgroep Zorg 2025, 2013), 'optimal care' (KNMP, 2013), 'adequate and appropriate care' (LHV/NHG, 2012), 'good care is outcome oriented care' (OMS, 2012), 'yield the biggest effect' (LHV/NHG, 2012), 'high-pitched' (KNMP, 2013; Werkgroep Zorg 2025, 2013) and 'good quality health care policies' (Werkgroep Zorg 2025, 2013).

The phrasing of quality listed here shows that a large number of stakeholders emphasise high level quality of care. The results show consensus on that health care in the Netherlands should go beyond an acceptable level and aim to be the best possible. Furthermore, several stakeholders made the statement that health care in the Netherlands is amongst the world's best. The OMS and NVZ

compare Dutch health care to the outside world and state that ‘the available international data all point in one direction: Dutch health care is of high quality’ (OMS, 2012, p. 13) and that the Dutch health system is known for high quality while incurring relatively few costs (NVZ, 2013). The LHV/NHG further describe that GP care in the Netherlands belongs to the best in the world (LHV/NHG, 2012).

This view is contrasted by the association of nurses and care givers and the health insurers, even though they recognise the high quality of Dutch health care, they also state that quality of care is under pressure in the Netherlands (V&V2020, 2012; ZN, 2011). The nurses and care givers support their claim by stating it is a result from a general lower education level amongst nurses and carers and market forces in health care and management targeted at cost control (V&V2020, 2012). The health insurers state that quality is under pressure as a result of the strongly increasing demand for care and a possible lack of health care professionals (ZN, 2011).

4.1.1.1 Attributes of optimal care: process and outcomes

Quality is further discussed as the process of delivering high quality care (process oriented) and as the results that are achieved by delivering high quality care (results oriented).

Together the stakeholders provide a wide range of attributes related to the process of providing good quality care. According to the associations of GPs good quality care expresses itself through “patient orientation, effectiveness, safety, outcome orientation, timeliness, appropriate care and equality” (LHV/NHG, 2012, p. 6). The KNMP provides a similarly broad definition and includes the following attributes “optimal, person orientation, individual patient care and shared decision making” (KNMP, 2013, p. 18). Both conceptualisations indicate that quality is not seen as one dimensional but many dimensions contribute to good quality care. Notably, the patient-physician relationship is emphasised. Patient emphasis is also found in the prospect of the NPCF, which states that the patient’s demand for care should be “decomposed” when the request for care is made (NPCF & STOOM, 2010, p. 15). These statements reveal that the supply side of care is no longer the centre of attention but will shift to the patient. This could also be seen as preliminary step to the shift of more responsibility to the patient which is described by several stakeholders in research question two.

Quality could also be expressed through outcomes of care, rather than through the process. This can be done through quantifying desired outcomes to assess the level of quality. However, the stakeholders do not seem to favour defining quality through outcomes. Only the OMS briefly mentions adding years to life as a result of health care (OMS, 2012).

Alternatively, outcomes of good quality are described in terms of ‘quality of life’ by V&V, ZN, the KNMP, the young professionals and the GPs. V&V describe the outcome of care as a “good quality of life” and emphasize the importance of being able to fulfil activities of daily living (V&V2020, 2012). The health insurers, focussing on eHealth, argue comparably that eHealth enables people to live

independently for a longer period of time contributing to their quality of life. The association of pharmacists also followed this line of thought: “To promote quality of life for patients, by effective, safe and outcome oriented use of medication. That is what it is all about”. [...] “The patient has the need to adjust its medication optimally to his/her lifestyle, behaviour and active role in society” (KNMP, 2013, p. 6). The young professionals equally support quality of life, but also called for a different perspective on health care. According to them “health and general wellbeing should be prioritised instead of diseases and diagnoses” (Werkgroep Zorg 2025, 2013). The associations of GPs put quality of life in the context of chronic patient care suggesting its substantial importance in patients with long-term diseases (LHV/NHG, 2012). Hereby, the GPs argued that quality of life is subject to the patient’s experience.

The emphasis on quality of life is taken a step further by the nurses and care givers and the working group of young professionals who call for a new definition of health. The ‘old’ definition being that of the World Health Organisation: “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organisation., 1946). Recently, the Dutch Health Council and ZonMW proposed a new definition of health - “the ability to adapt and to self-manage in the face of social, physical and emotional challenges” (V&V2020, 2012, p. 29; Werkgroep Zorg 2025, 2013, p. 5). According to the working group of young professionals this definition puts more emphasis on the potentials of people in life despite being diagnosed with a disease. The nurses and care givers indicated they see this as a more achievable perspective on health, rather than ‘complete physical, mental and social well-being’. They further advocated shifting focus from the disease to the ability of the person to adapt and self-manage.

Another interesting notion with regard to quality of life was given by the Order of Medical Specialists. The OMS raise the question to what extend medical possibilities should be exhausted if they only bring a limited addition to people life expectancy and quality of life. They later repeat that quality of life should get more attention in protocols and should be considered in treatment decision (OMS, 2012). The medical specialists did not further elaborate as they did not go beyond raising the question and withheld themselves from any judgements on the limits of medicine.

Two points should be highlighted from these results: firstly that quality is perceived as person oriented and as relating primarily to the quality of health that a person can experience and secondly that health is very much perceived as a means to being able to live independently and fulfil activities of daily living. The departure from ‘perfect physical health’ could be explained by the increased presence of chronic diseases; according to the WHO these people would all be deemed unhealthy. It would be fair to expect from the future (even more than today) that people living with chronic conditions are not fully determined by the limitations of their condition but instead have many abilities left. The second striking emphasis regards being able to ‘fulfil activities of daily living’ and ‘self-management’. The results show that the stakeholders attach great importance to independence

and a 'productive' life. It is not hard to empathise with the notion that is unfair to judge that any health impairment would make a person unhealthy/ill, or that any impairment would make someone redundant to life. However, it is also interesting to question the new understanding: What would this mean for anyone who cannot live independently? Are people with mental disabilities unhealthy per definition, or children?

4.1.1.2 Quality in context

The stakeholders have also given their perspectives on how the quality-related aspects of care should be dealt with in context of other factors. The results of the grounded theory analysis showed that considerable attention was placed on the relation between quality and costs, and more specifically on who is responsible for finding the right balance.

In public debate it is questioned whether the issue of quality vs. costs should be placed within the consultation room, or should be kept on a higher level with the ministry of health or with the health insurers. The OMS stands out as it does not shy away from laying the responsibility with the medical specialists; they state it is a duty for the medical specialist to make the right choices within a limited budget. It further advocates that medical specialists should become more aware of the costs related to treatment (OMS, 2012). Conversely, the NVZ and the young professionals focus on the role of health insurers and hospitals to control costs. The NVZ first states that high quality should lead to a reduction in costs, for example due to a reduction in hospital re-admissions (NVZ, 2013). They then advocate that health insurers and hospitals together should have the responsibility to control costs and should negotiate price and quality of care. While, the young professionals propose to go beyond negotiations and wishes to grant health insurers the power to be selective in procurement based on quality and price (Werkgroep Zorg 2025, 2013). The results show that most stakeholders have not provided their view on this matter and that the OMS favours an approach where quality and costs are discussed on an individual basis whereas the NVZ and the young professionals propose a top down approach. Bringing the discussion of costs within the consultation room would mean that the price of treatment will become subject to judgement of the physician(s) which inevitably affects the patient-physician relationship. Furthermore the statement of the NVZ provides an interesting insight in their opinion as it reveals that quality itself is subject to negotiation. It is interesting to think what would happen if different levels of quality- and their price tags – would be negotiated; what would patient's responses be like? Would patients be outraged or would they trust the physician they have known for a long time?

4.1.1.3 *Improving quality*

This chapter started by stating that the stakeholders consider quality of care to be good in the Netherlands. Nevertheless, all stakeholders support further improvements in quality. The results of the grounded theory show divergent proposals of which many lack focus and are not backed up by strong arguments and concrete examples. Or conversely, some of the proposed improvements are that specific they do not fit within a larger view.

According to the NVZ improvement of health care will be promoted by the regulated market forces. As an argument they state that “GPs and hospitals together organise the patient’s path of care” and that “organising care closer to home makes care more ‘friendly’ for the patient, and at the same time more effective and efficient” (NVZ, 2013, pp. 4,5). However, this argument is hard to interpret as it does not provide support from market forces but only refers to cooperation and care in the patient’s home environment (NVZ, 2013). They later do call for insurers to not solely procure care on the basis of price but on the basis of quality. This measure would have been a more logical argument as to how market forces improve quality. The NVZ further stated that to sustain innovation and improve efficiency “affordable financing to invest in quality” is necessary (NVZ, 2013, p. 5). This statement is also difficult to interpret as what constitutes ‘affordable financing’ or how it should be realised is not described. It seems to suggest that the funding should be sustainable and available, perhaps in a designated fund for innovation or efficiency gains.

The GPs do not propose any specific measures to improve quality but see it as a continuous pursuit. Improving quality consists in their prospect of constant quality monitoring and continuous improvement of the quality of care and practice management.

V&V is concerned about the negative effects of budget pressure and decreasing education level, and care being “organised too much from managerial perspective and too little from professional quality. Over-regulation is impending: too many protocols, guide lines and arrangements” (V&V2020, 2012). To improve quality they propose to strengthen the position and professional autonomy of nurses and care givers. They also provided detailed descriptions of the legal implications of their proposals to change the structure of the nursing profession.

The Order of Medical Specialists provides a variety of specific measures to improve care: increasing efforts to prevent unnecessary practice variation and avoidable complications, cooperation with the first line providers and end-of-life care should be improved (OMS, 2012).

The proposals show that the understanding of the urgency for quality improvement varies. The GPs and medical specialists both only advocate improvements that have a continuous nature and do not identify serious issues in relation to care quality. Conversely, the V&V is very much concerned with recent developments in care, and they advocate of radical overhaul of the nursing profession to mitigate these. Moreover, the serious nature of their concerns is also shown by the

elaboration of their plans in comparison to the single statement of ‘improving cooperation with first-line providers’ used by the OMS.

4.1.1.4 Quality and transparency

Another aspect to quality that is described extensively is the aim of many stakeholders to increase the transparency of the quality of care (KNMG, 2011; LHV/NHG, 2012; OMS, 2012; V&V2020, 2012; Werkgroep Zorg 2025, 2013). According to the association of nurses and care givers demand comes from “society, but also individual clients or their next-of-kin ask for transparency in health care and demonstrable quality”.

Quality is linked explicitly to visibility by the associations of GPs, the OMS and the KNMG, and indirectly by the other stakeholders (KNMG, 2011; LHV/NHG, 2012; OMS, 2012). Measuring, monitoring and making quality based results publicly available will lead to better quality according to the OMS and to increasing trust according to the NVZ (NVZ, 2013; OMS, 2012). LHV/NHG seemed motivated by maintaining a good public image and public trust as they state they should “work visibly on improving quality” (LHV/NHG, 2012). Transparency of quality is thus seen as a means to communicate performance and to foster trust.

Both the proposals of the medical specialists and the association of hospitals reveal the wish to be actively involved in decision making around transparency. The medical specialists and the NVZ propose to build the quality policy on clinical registrations. According to the Order of Medical Specialists norms should be established according to best practices in a bottom up approach, this means that medical specialists will be involved in establishing those norms (OMS, 2012). The NVZ advocates to involve hospitals in decision making about what information is collected, “so they can contribute to improving quality of care” (NVZ, 2013, p. 8). Though it is not discussed by the stakeholders, it is not hard to imagine that there is an interest for the hospitals and medical specialist to be involved in the establishment of the norms their performance will be judged by later on.

The stakeholders differ in opinion on how transparency should be achieved, and what impact this will have on workload. Where the OMS warns that quality improvement can only be achieved with a strong commitment and adequate financing, the young professionals do not ask for commitment and finances but simply argue that transparency will be effective through helping health care providers to reflect on their performance.

The results show that the young professionals and the nurses and care givers disagree on the implications of data collection on workload. The young professionals argue that central collection of data will minimise the administrative burden for the professional, however the nurses and care givers are of the opinion that “accountability results in many extra actions (measuring) and administration (processing), which comes at the cost of attention and care for the client” (V&V2020,

2012, p. 18). With this statement V&V also distinguishes itself from the other stakeholders by reflecting on the pragmatic implications for daily practice.

The findings show that quality information can also serve as a means to organise financing as proposed by the NVZ the KNMG and the young professionals. The NVZ already stated that procurement of care by insurers based on quality and not only on costs is key to maintaining quality. Differences in visions have been highlighted with respect to the source and perspective of quality data. The NVZ argued that clinical registrations should function as indicator, while the KNMG argues that financing should be based on the professional's or the institution's performance according to a 'value for money' concept, alternatively, the young professionals emphasise the added value from the patient's perspective (KNMG, 2011; NVZ, 2013; Werkgroep Zorg 2025, 2013). The Order of Medical Specialists also discussed quality financing based but only proposes to 'explore options' as they say that good quality process and outcome indicators have not been established yet. They do not provide suggestions but only express they expect that small scale experiments will take place in the future (OMS, 2012).

The results show that quality is an important value for the stakeholders. Quality of care is mostly seen in terms of the process of care delivery and in terms of what care contributes to quality of life. Hereby the stakeholders emphasise the importance of the patient rather than the supply side of care. The results suggest that particular issues which affect quality differ between the stakeholders due to differences in motivation and proposals for improvement.

4.1.2 Availability

From the prospects it appears that availability of care is also of concern in the Netherlands. Compared to quality, stakeholders provided less concrete descriptions of their understanding of availability. In the prospects availability is discussed along two lines; firstly availability of care is described as referring to personnel and resources being available to provide care. Along the second line, availability of care is linked to increased availability of new technologies through innovation.

4.1.2.1 Availability of personnel and resources

The first line along which availability is described refers to availability of personnel and resources and is most prominent in the prospects. The nurses and care givers, the NVZ and the KNMG seem worried about the trends of a continuously increasing demand for care accompanied by a declining labour force. V&V described this as follows: "The expected deficits on the labour market are big and resources get more limited. A lot of the informal care givers are of age, the younger ones often have a job. The number of volunteers steadily decreases" (V&V2020, 2012, p. 21). According to V&V, the Netherlands is not adequately prepared as they state the first step of estimating the number of professionals which is required in the future has not even been made. The KNMG does not refer

explicitly to availability, but does state that the “number of professionals lags with an increasing demand for care” (KNMG, 2011, p. 2). The NVZ states that “the availability of a sufficient number of well-educated physicians and nurses in our hospitals is the most important prerequisite for good care” but it will be “almost impossible” to find these people (NVZ, 2013, p. 10). Therefore, it proposed to increase labour productivity by investing in education, establishing good employment terms and social innovations. The NVZ explains social innovation for example as task redistribution and sustainable human resource management (NVZ, 2013).

Interestingly, the NPCF poses a view unlike that of the other stakeholders. They expect that demand for long term care will not increase as much as predicted as a result of an improved general health status (even in light of chronic conditions) and a well suited supply of care (NPCF & STOOM, 2010). This is noteworthy since most stakeholders expect an increase in disease burden, due to the prevalence of chronic diseases and multi-morbidity.

The results indicate that a number of stakeholders are particularly concerned about a decline in personnel. The V&V attributes to a general decline of the labour force where the KNMG and NVZ do not indicate a specific cause. The point of view of the NPCF is noteworthy as they as patient's federation should be very concerned with the availability of health care professionals. The results suggest that the NPCF has great trust in the increased self-management and self-security of people in the future and as a result for much of the long term care employment of nurses will suffice. Their optimism is contrasted by the concerns of V&V. Moreover, while the V&V expects that the availability of formal care will be limited in the future the young professionals, GPs and the NPCF state that informal care will become more important in the future. However the stakeholders that find themselves working in the hospital sphere have not provided any views on informal care (KNMG, 2011; NVZ, 2013; OMS, 2012; ZN, 2011). Because of these contrasting views it remains unclear whether future health care professionals will be able to meet future demands.

The results show that the views on informal care use are related to the views on to increasing self-security and reliance on people's own social networks. The young professionals argued that self-security will be stimulated by society and people will make better use of informal care. According to them is grounded in patient's preferences: “It is more pleasant for the patient to be taken care of by someone close and informal care is often cheaper than intramural care” (Werkgroep Zorg 2025, 2013, p. 6). The young professionals also paid attention to the implications of informal care duties for people, expecting it to result to considerable pressure, and argued that financial compensation or informal care leave should be arranged (Werkgroep Zorg 2025, 2013). The LHV/NHG listed ‘strengthening informal care’ together with increasing patient responsibility as one of their principles, and states that patients will be suggested to use their own social networks rather than relying on formal care. In the future they will cooperate closely with informal care givers to meet the needs of their patients and the informal care givers themselves (LHV/NHG, 2012). The NPCF relies on

formal estimations and quotes the Netherlands Institute for Social Research (Sociaal Cultureel Planbureau) which foresees an increase of 5% in the number of informal care givers (NPCF & STOOM, 2010, p. 20). They continue by describing limiting factors for informal care, increased labour participation of women (but possible if met by improvement of leave policies) and the reluctance of elderly to burden their children with their need for assistance. The results show that the KNMP only mentions that pharmacists of the future will know their patients and their care networks, formal and informal (KNMP, 2013). In contrast, the nurses and care givers have a distinctively different opinion on informal care. They focussed on the limitations of relying on informal care. They predicted that less informal care givers will be available due to ageing of care givers and to the demands younger people have from work and family life. Moreover, they expected that people's needs will be too demanding to be fulfilled by un-skilled informal care givers (V&V2020, 2012).

The findings show that the perspectives are characterised by close cooperation between formal and informal care givers and acknowledging support that informal care givers may require. The findings further indicate that concerns mostly exist in the social domain: whether people will accept and feel free to ask help from their relatives and whether leave policies will be adjusted.

4.1.2.2 Innovation

The second line along which availability of care is discussed is related to innovation and new types of care that will be available. None of the stakeholders expect innovation to drastically change care provision, but this does not withhold a number of stakeholders from considering innovation as essential.

EHealth is most obviously described as a new technology entering, and benefitting health care as a result of innovation. The young professionals write that smartphones and tablets will replace pagers, to be used for e-consulting and multi-disciplinary eHealth applications (Werkgroep Zorg 2025, 2013). Next, the KNMP predicts to use eHealth motivating this by pharmacy 'being a profession grounded in science and innovation'. They further describe that in the future new possibilities for complex and/or personalised medicine will be applied but did not elaborate on this (KNMP, 2013).

The NPCF does not describe specific tools that would become available through innovation but instead focuses on the implications for people's lives. They state that patients look for "the best mix of technology and person effort". New technologies will allow people to better self-manage their conditions in their home-environment. With regard to health care personnel the NPCF describes that new technologies have reduced the pressure on health care professionals, which helped to prevent the predicted staffing shortages from happening (NPCF & STOOM, 2010).

The LHV/NHG provided very little vision regarding innovation, but also the health insurers lacked in this perspective. The LHV/NHG only stated that GPs should participate in innovation (LHV/NHG, 2012), while health insurers have not discussed any implications of innovation. Even

though their prospect focuses a particular innovation, eHealth, the ZN only mentions that innovation should be stimulated (ZN, 2011).

The Order of Medical Specialists discusses a different aspect of innovation and availability - "Should all technology that is available be used?" They describe that many technologies have – and will become available but the time has come to question what sensible medical care is, and what the limits are to sensible medical action. The OMS hereby provides an interesting point of view that which is not touched by the other stakeholders (OMS, 2012).

While discussing innovation the stakeholders mostly adopted the perspective of the user (both professional and patient), who mostly benefits from increased efficiency and extra convenience as a result of innovative eHealth applications. EHealth further seems to be primarily considered as means for self-security as it enables people to live at home longer. This innovation also allows for the shift of care from institutions to the home environment of the patient, for example consultations or monitoring.

In summary, the stakeholders are concerned about the lack of health care professionals to meet the growing demand of care; the NPCF is the only stakeholder who does not share these concerns. The results indicated that informal care, which is a possible solution to this problem, is not seen as a panacea. Some mitigation is expected from innovative form of care delivery, in particular eHealth which will give people more tools to manage their condition themselves and remain living independently. Yet, it is striking that innovation is not discussed more in prospects, which after all, look at the future. This suggests that even though technologies like domotica, health apps and 'the internet of things' are rapidly developing, these have not been embraced by current stakeholders.

4.1.3 Accessibility

Accessibility is commonly conceptualised as physical accessibility and financial accessibility. Physical accessibility refers to the ease of access to care in a physical sense. Financial accessibility refers to the extent that health care is financially affordable for patients and does not cause financial hardship. The OMS, NVZ, KNMG, ZN and young professionals have stated that accessibility of health care is a priority to them. Unlike with 'quality', the stakeholders have not defined 'accessibility' or elaborated on the conceptualisation into physical and financial accessibility. Accessibility will be discussed in terms of spatial proximity, in relation to eHealth and as financial accessibility.

Alternatively, the prospects of the GPs and the pharmacists provide another conceptualisation of accessibility. Both stakeholders state that their care should be of "low-threshold" ('laagdrempelig'), which could be translated as 'approachable' rather than merely accessible (KNMP, 2013; LHV/NHG, 2012). The KNMP describes that the pharmacy is firmly integrated into society and also being regularly visited by a large group of non-sick people. "The patient knows his pharmacist and the

pharmacist know his patients”, as said by the KNMP (KNMP, 2013, p. 16). “The GP knows his/her patients and the patients know their GP”, as stated by the GPs (LHV/NHG, 2012, p. 29). Accordingly, it could be said that having a ‘low threshold’ is (literally) the final step to make care accessible.

4.1.3.1 Accessibility in context

Firstly, the results of the analysis suggest that the terms accessibility and affordability can be considered as competing interests. And both can be expected to become a hot topic if the proposed “concentration and dispersion” of health care facilities is realised and if health insurers become more selective the reimbursement of care. On the one hand unlimited accessibility is seen as leading to high expenditure, whereas stringent cost control can come at the expense of accessibility. The NHG/LHV used this to describe the importance of their role as gate keeper. They described that as a gatekeeper they decide on a patient’s access to care and by doing so they have a great impact on the efficiency of health care (LHV/NHG, 2012). The recognition of this efficiency gain will be important for the GPs as it is an important reason for their existence in the health care system. The young professionals explicitly pose the two interests as competing by describing that accessibility is accompanied by high expenditures but also make the link the other way round stating that rising health care costs impede accessibility in the future (Werkgroep Zorg 2025, 2013). Additionally, the NVZ states that cost control should not come at the expense of accessibility (NVZ, 2013).

Secondly, financial accessibility refers mostly to whether the individual can afford the use of health care; key in the interpretation is whether financial costs related to care do not impede the access an individual has to care. In these prospects financial accessibility is not discussed in a meaningful sense. This could be explained by the fact that in the Netherlands individual costs at point of care have been traditionally very low, almost non-existent. However, recent years have seen an increase in private payments for health care (for example due to the increased deductible) but these have not been reflected in the prospects. As this is a highly politicised topic it is understandable that the stakeholders have refrained from commenting on this, but it also meant that an opportunity for articulating their view on an important topic has not been used.

The stakeholders that do discuss topics related to affordability are the NPCF and the OMS. As it has done before the NPCF shows its preference for market forces in health care as they foresee an increase of “self-paid wellness and entertainment services” in long term care (NPCF & STOOM, 2010). These services would complement existing care as demand for such services would grow in coming years. The NPCF seems to focus on the availability of care, of which the scope would increase, but even though they do advocate that a share of the elderly will continue to live in poverty and is in need of extra support, they fail to reflect on whether access to these (private) services will depend on patients’ financial means (NPCF & STOOM, 2010). The OMS only provides a macro-level perspective,

stating that in order to keep care accessible it must remain affordable (on macro-level) and calls upon to medical specialist to participate in this (OMS, 2012).

Compared to the financial side, the physical side of accessibility is described in more detail by stakeholders. The providers emphasise that patients should experience no or few physical barriers of access to health care, mostly in terms relating to spatial proximity. The OMS, young professionals, KNMG and NVZ describe that in the future health care will become more geographically dispersed as complex and specialised care will be centralised whereas general and basic care will remain in close access of patients. Yet, even though the proposed concentration and dispersion will affect the spatial accessibility in terms of distance and time travelled and moreover this is regarded as a priority the stakeholders have not seriously addressed this issue. Instead the KNMG and young professionals merely describe that basic care should be easily accessible everywhere (KNMG, 2011; Werkgroep Zorg 2025, 2013). The young professionals provide the most detailed views stating that thematic clinics should be established and that highly complex, low volume care should be organised on a regional level (Werkgroep Zorg 2025, 2013). that The NVZ also joins the commitment to proximity stating that ‘proximity remains important for conditions that require frequent visits’ (NVZ, 2013, p. 6). The OMS also discusses the ‘reallocation of health care’, but does not discuss possible implications on accessibility (OMS, 2012). Interestingly, considering that the statement of the young professionals is the most detailed, it is obvious that the stakeholders have not engaged in a meaningful discussion of the consequences of concentration and dispersion of care. Moreover, the stakeholders merely express their hypothetical opinion e.g. the NVZ states ‘cost control should not come at the expense of accessibility’, but they have omitted to provide further insight in what their boundaries would be. As the NVZ does advocate the concentration and dispersion of care, insight in what they consider being a fair compromise and how to organise that in the future would have strengthened their vision.

Additionally, some stakeholders paid attention to eHealth. ZN, the OMS and the young professionals perceive eHealth as having a positive impact on accessibility of care by reducing the need for face-to-face contact (Werkgroep Zorg 2025, 2013); increasing accessibility through social media, tele-consultations and mobile-health (OMS, 2012); and making care-processes more accessible (ZN, 2011). The NPCF proposes to establish ‘digital policlinics’ which would allow people to access a policlinic from any device with internet connection (NPCF & STOOM, 2010).

On the whole, accessibility of care has not been discussed in depth by the stakeholders. None of the stakeholders have provided an in depth interpretation as to how they relate accessibility to spatial proximity or financial accessibility to individual affordability. Namely, when looking at the proposed actions prospects of concentration and dispersion of care and increasing private services and payments for care spatial proximity and financial accessibility could become a challenge in the future.

4.1.4 Affordability

The rise in health care expenditure in the past decades has put affordability on the agenda of the stakeholders. Affordability is discussed in terms of whether the population as a whole or the state can afford the current level of health expenditure and whether this level is sustainable with regard to the future. Like with the other public values 'affordability' is described as a priority by several stakeholders. The OMS, KNMG and the young professionals have listed 'affordability' as priority (KNMG, 2011; OMS, 2012; Werkgroep Zorg 2025, 2013). The stakeholders frequently state that affordability of health care is under pressure now and will be so in the future. Safe-guarding affordability is discussed along the lines of cost containment (and its implications) and increasing efficiency in health care provision.

The OMS, V&V, KNMG, KNMP, NVZ and the young professionals pay most attention to the expenditure rise and the need for cost containment, whereas the nurses and care givers do not go into much detail. The common, well known explanations for the expenditure rise are all brought forward by the stakeholders. The OMS refers to a greater demand for hospital care by the growing elderly population. Furthermore, the KNMG links it to the ageing society and higher costs of medical care as a consequence of innovation (KNMG, 2011; OMS, 2012). According to the KNMG "if policies remain unchanged health care quality will decrease in quality but increase in costs" (KNMG, 2011, p. 1). There is some variation in reasoning as the young professional's state that the increase is only partly due to the ageing of society. While, the KNMP does not elaborate on the causes of rising expenditure it does affirm that pressure on affordability has never been as high (KNMP, 2013). The NPCF however, also puts affordability as major challenge but is optimistic about the financial sustainability of the health care system. Savings along the way and increasing self-security will prevent a threat to affordability (NPCF & STOOM, 2010).

Now quality, availability and accessibility have been discussed, the pressure for cost containment sheds further light on the interrelatedness of the public values, as discussed by (Maarse, 2012) as well. The dynamics between the public values are described differently by the stakeholders. The results of the grounded theory analysis do not lead to expect the stakeholders would disagree on the matter, rather the difference in emphasis may implicitly reveal the priorities of the stakeholders. The young professionals, for example, describe that accessibility is accompanied by high costs, thereby making the latter a consequence of the former (Werkgroep Zorg 2025, 2013). Whereas, the KNMG does not link the pressure on affordability to accessibility but links it to quality. They fear that if policies would remain unchanged health care expenditure would only increase further while quality would decrease. Instead, the KNMP shifts the focus to solidarity stating that the pressure on affordability and solidarity has never been as high as it is nowadays (KNMP, 2013). These differences may reveal the stakeholders' priorities. For example, the KNMG is concerned about the consequences of quality which can be explained as hospital care is very costly and quality could be compromised on

as a result of budget pressures. Compromises on quality would directly affect physicians and it can be expected they would have difficulty to provide lower quality care. Alternatively, the young professionals and the KNMP choose to emphasise societal consequences by referring to accessibility and solidarity. This concern fits in with the prospects as the young professional's take a societal perspective rather than a professional or supply side perspective throughout their prospects and the KNMP states in the beginning of their prospect that they are led by what society demands. Conversely, the prospect of the KNMG is characterised by a supply side orientation.

4.1.4.1 Cost containment

A major question in the prospects is how costs can be controlled, and to a lesser extent who is responsible. In the prospects safeguarding affordability is mostly discussed in terms of cost containment.

Together the stakeholders provide a wide range of options for cost containment. The NPCF expects self-management "to contribute to reducing costs" and expects demand for care at home to be reduced (NPCF & STOOM, 2010, p. 29). They are optimistic about the challenge to deliver better quality with less means. Next, according to V&V it is the task-substitution that will lead to significant savings (V&V2020, 2012). Additionally, the OMS does not advocate to adjust care provision like V&V and the NPCF but advocates the use of clinical registrations: "the example of Sweden, with the medical specialist in 'director's' role, seem an interesting way for the medical specialist to contribute to quality improvement, cost reduction and transparency" (OMS, 2012, p. 25). The OMS further emphasizes the responsibility of the medical specialist in achieving savings. With regard to funding policies the OMS warns to shy away from policies that include volume incentives (OMS, 2012)

The next suggestions for cost containment are based on the financing of care. The NVZ calls for saving costs through the relation between hospitals and health care insurers. "From now on health insurers will negotiate the price and quality of the care to be procured with hospitals. This way health insurers and hospitals act together in controlling the increase in health care costs and increasing quality of hospital care" (NVZ, 2013, p. 4). In the long run they say however, permanent innovation is required to stay on top of costs (NVZ, 2013). This proposal shows that opposing views exist as the KNMG has stated that the availability of new medical innovation is one of the reasons health care expenditure is rising (KNMG, 2011). Conversely, the NVZ perceives medical innovations as a gain for health and as a gain for efficiency. As both refer to medical innovations there may be a difference in how they qualify innovation, for example taking a supply side perspective on research costs and costly treatment options or a societal perspective in which the benefits of innovation are also included.

Next, the young professionals provide a lot of suggestions to curb expenditure in varying degree of tangibility. They first lay the responsibility for cost containment with the health care

insurers, who should not reimburse inappropriate and ineffective care. They further advocate the use of generic medication and prevention (Werkgroep Zorg 2025, 2013). The associations of GPs do not come with concrete suggestions but emphasize the need for “sensible and economical care” and the role of the GP as gatekeeper (LHV/NHG, 2012, pp. 11, 13).

What is most striking from this long list of results is that each of the stakeholders proposes a different method how to save costs, the only overlap being the health insurers who should enforce cost control, a role which in fact they already fulfil. The results suggest that the proposals are primarily related to the stakeholder’s field, the young professionals being the only exception. By limiting their solutions to their own field, the stakeholders seem to take responsibility and do not suggest that it is up to another stakeholder to save costs. Moreover, by calling upon their own responsibility the stakeholders also increase the chances of them staying in control of developments.

4.1.4.2 Efficiency

In addition to cost saving, the stakeholders advocate increasing efficiency. The terminology of stakeholders like the LHV/NHG, OMS, KNMP, KNMG, V&V, ZN, NVZ and the young profession includes realising most effect (OMS, 2012), efficient care (KNMP, 2013; OMS, 2012) increasing efficiency (ZN, 2011), high efficiency (NVZ, 2013; OMS, 2012), consistent high efficiency (NVZ, 2013), cost-effective action (LHV/NHG, 2012), efficacy (KNMP, 2013) and “good care is efficient care as well” (OMS, 2012, p. 43). These results show similarities to the results concerning quality, merely achieving quality or efficiency is not sufficient. The stakeholders describe that care should be consistently highly efficient and efficiency should be further improved.

In a similar style to cost-containment, the stakeholders discussed a number of ways to achieve or improve efficiency. These can be categorised into availability, provision of care and organisation of care.

Firstly, as mentioned before the LHV/NHG state care should be “sensible and economical” (LHV/NHG, 2012, pp. 11,13). However, the LHV/NHG is not consistent throughout the document with the requirement for care to be cost effective. To illustrate, in the case of preventive care the GPs state that they will only engage in care that has been proven to create added value (LHV/NHG, 2012). Without further specification “added value” remains a vague term, it could be understood as ‘effective’, but it can surely not be understood as cost-effective. For care to be cost-effective, or efficient, a calculation including costs and benefits needs to be made, whereas effective care only needs to lead to the desired outcome, irrespective of costs. The lack of specificity of the LHV/NHG is contrasted by the similar proposal of the young professionals which includes the specific information that in 2025 the ‘Funnel of Dunning’ will be applied to decide whether new treatments will be made available (Werkgroep Zorg 2025, 2013).

Secondly, efficiency of care is discussed in relation to provision of care. To increase efficiency the KNMG focuses on good quality medical practice by aiming to reduce the number of interventions that are necessary to complete a treatment (KNMG, 2011). According to the NVZ efficiency should rather be sought in providing care as close to the patient's home environment as possible (NVZ, 2013). Additionally, eHealth is suggested as an efficient way of providing care according to ZN and OMS (OMS, 2012; ZN, 2011). Furthermore, according to the nurses and care givers working with standards in nursing care saves time that could be used to provide patients with personal attention. The LHV/NHG proposes that a correct response to the health care need in question will lead to more efficiency (LHV/NHG, 2012). In a similar line of thought the OMS states that "good care is efficient care" (OMS, 2012, p. 43).

The third line of suggestions concerns efficient organisation. According to the LHV/NHG and V&V the proposed task distribution between medical specialists, GPs and nurses will also increase efficiency (LHV/NHG, 2012 & V&V, 2012). The OMS also sees task redistribution leading to more efficiency, but states that quality norms should be established first. Additionally, the OMS states that better cooperation between medical specialists and first line health care in general will result in greater efficiency (OMS, 2012).

The results show that the stakeholders are concerned with the increasing pressure on affordability. The stakeholders did not elaborate much on affordability itself, but provided a range of practical measures to safeguard affordability by saving costs and increasing efficiency. With regard to both aims a large variety of measures was proposed, which were mainly limited to the stakeholder's own field. This indicates that the stakeholders have a preference for measures that fall within their responsibility and over which they could exert control.

4.1.5 Conclusion

Summing up the first research, it has become evident that the stakeholders attach great importance to public values. Quality, accessibility and affordability are recognised as a priority, leaving out availability. This is interesting as it could be explained if the stakeholders did not consider availability to be of concern in the Netherlands. On the whole the stakeholders describe that the four public values will be under pressure in the future as a result of growing demand for care and limitations to the available budget and personnel. With regard to quality the results show that it is discussed in terms of the process of delivering care by some and by others in terms of the outcomes for health and life that care generates. Firstly, quality is further placed in context when the stakeholders discuss methods to further improve quality. The analysis shows that these proposals cover a wide range of possible methods for improvement. Notably, the proposed methods remain rather abstract. The only noticeable deviation is the V&V, the stakeholder which also problematized quality most, provides a thorough proposition to reform the nursing profession.

Secondly, availability is discussed in terms of budget and personnel. The organisations of health care professionals and hospitals are worried that because of increasing demand for care in the future there will not be sufficient amounts of personnel to meet the future demand for care. Informal care is proposed to substitute formal care but the stakeholders remain ambiguous to what extent informal care is a reliable and viable solution. Most notably, it are the nurses and care givers who doubt that informal care givers will be able to provide care without further support. This doubt could reflect the interests of the nurses and care givers who could see informal care givers as competition. Competition could give them feelings of animosity but also of genuine concern as to whether informal care givers will be able to supply the same quality of care.

Thirdly, accessibility is mostly discussed in terms of spatial proximity to care. Even though accessibility is listed as a priority which is expected to be negatively influenced as a result redistribution of health care facilities, the stakeholders do not express great concern toward this public value. The results show that the stakeholders accept that complex care will only be available further away, while they state that basic care should remain within close proximity. However, elaboration on what types of care are considered basic and what is considered 'close proximity' would have strengthened the argumentation.

Fourthly, affordability is considered to be under pressure as a result of increased demand for health care. Again, the results show that the stakeholders proposed an array of measure to control costs and improve efficiency. The OMS argue that the medical specialist should be involved decision making regarding treatment expenses. Their point of view is not explicitly mentioned in direct relation to decision making but throughout their prospect they argue that more care is not always better and that innovation does not always yield a significant benefit. It is understandable that as ultimate experts of care the OMS wishes to be involved in decision making. Yet, they should be wary not to cut off their nose to spite their face as this means the individual medical specialist could get involved in medical ethical disputes as they also are in a relationship based on trust with the patient and his next of kin. Alternatively, the NVZ and the young professionals advocate a significant role for the health insurer. The findings still point out differences here as the NVZ advocates 'negotiation between hospitals and health insurers', which seems to assume a level playing field, the young professionals argue that health insurers should have the power not to reimburse ineffective and inappropriate care. What's more is that recently public concern about the power of the health insurer has been growing, documented in newspapers and leading to government crisis as a result of cancellation of the minister of health's biggest bill of 2014 (Hulst, 2014; van Aartsen, 2014; van den Brink, 2014). What the balance of power between insurers and providers should be, and how this should be achieved is of debate.

The results show that despite the stakeholders all highly regard the four public values; the prospects vary greatly on how to uphold the values in the future. The variation of proposed measures

is not only found between stakeholders but also within prospects. The variation between the prospects can be explained by the position of the stakeholder and the role it fulfils. The prospects largely concern the stakeholder's respective field which ensures that the stakeholders discuss their own responsibility with regard to upholding the values. Moreover, taking responsibility also allows the stakeholders to exert their power on the implementation of policies. This is explicitly illustrated by the example of the OMS who proposes it to have a large role in decision making, for the same reason several stakeholders are keen to allocate themselves pivotal roles.

4.2 Research Question 2: Stakeholder Roles

Research question 2: How do stakeholders envision their own role in health care in the future health care?

By describing their vision for the future, the stakeholders give insight in their expectations for the role they will be fulfilling in the future. The most notable development is the increased attention for the patient. All stakeholders describe that the patient is put centre stage and will be more involved in his/her care process. This will also have consequences for the roles of the other stakeholders. After the central role for the patients these consequences and the increasing cooperation between stakeholders are further elaborated on.

4.2.1 Patients centre stage

First it is important to highlight the increase on the focus on the patient and his demand for care. The patient is put centre stage through 'demand based health care'. Stakeholders stress that health care will not be determined by existing supply but by the needs of those who seek care. The results show there are various views on how demand based health care will take shape. The NPCF gives an example where the care seeker is perceived as a consumer. In their prospect the 'care seeker' has a profound influence by proposing the use of 'care vouchers'. These care vouchers grant decision making power to the care seeker. The NPCF further sees demand based health care as an incentive for further introduction of market forces in the health care sector. The NPCF consistently takes a consumer based views and advocates room for the consumer's wishes and preferences (NPCF & STOOM, 2010). Beyond using 'care vouchers' the care seeker is positioned by them as client to whom care providers can submit a proposal how they would deliver the requested care. With vouchers "they find the necessary care themselves". This system triggers the market to supply goods and services that align with demand best." (NPCF & STOOM, 2010, p. 19).

Additional results show that other stakeholders equally refer to the patient as the centre of attention but associate different implications. Firstly, the nurses & caregivers describe that patient centeredness means that “nurses reason from the needs and preferences of the patient, take the patient perspective and/or that of the family and those around them as starting point” (V&V2020, 2012, p. 14). This view is more conservative since it is still the provider who is in control of decision making and it will depend on his/her ability to identify with the needs of the care seeker. Secondly, the OMS shares a similar conservative view care as they advocate ‘shared decision making’. However, “Keeping the directing role for the health care professional will be essential to maintain expertise and morale in health care” (OMS, 2012, p. 7). Even though truly equal, ‘shared decision making’ may be challenging to achieve, it can hardly been considered as innovative. Thirdly, the GPs describe that their care is and will be characterised by being ‘person orientated. To achieve a long term, trustworthy relationship with the GP is key rather than decision power for the patient. Lastly, the association of hospitals (NVZ) claims “demand based care” in their prospect for the years 2010-2015 to be their “societal mission”, but then omits to discuss how it will take shape. Moreover, throughout the prospect the mission is not reflected, as all reasoning starts from the perspective of the hospital (NVZ, 2013).

While these stakeholders all claim to put the patient centre stage, the results shows differences in understand of which party is exactly in control. Where the NPCF allocates power to the patient/consumer, the OMS and the KNMG describe demand based health care as ‘tailor made’, comparable to the prospect of V&V, (KNMG, 2011; OMS, 2012). These differences lead to questions about the extent to which health care professionals are ready to hand over control to patients, or to what extend patients are educated enough to understand their own needs. This may differ between different types of care, for example between supportive care at home and specialist care. Additionally, these perspectives give an insight in the opinions on market forces in health care. The prospect of the NPCF shows that a market based approach is favoured in order to meet patient’s demands, whereas the NVZ shows a more planning based approach when it comes to distributing care rather than a demand based approach. Moreover, the close long term relationship described throughout the prospect is a sign that the GPs are not in favour of a marked based system in which continuity could be challenged by flexibility.

4.2.2 The role of the future patient

As a consequence of the development of increasing attention for the patient, the stakeholders also foresee increasing involvement of the patient in his/her care process. The patient will take on more responsibility and initiates the execution of care and treatment.

As described above the NPCF foresees the patient in a new role as 'patron of care'. In their eyes a voucher based system will give patients, in their role as consumer, the power to shape supply with their demand (NPCF & STOOM, 2010). The proposal of the NPCF is contrasted by that of the OMS which proposes a more reserved form of patient participation. As discussed above the OMS describes that patients will be more involved through shared decision making but the medical specialists remains in control (OMS, 2012).

Yet, the OMS still sees a greater responsibility for patients in their treatment, namely into 'managing' their chronic condition according to the OMS. Particularly the medical specialists emphasised the role of the patient during the treatment process. According to them patients will actively participate in their treatment by 'self-management' (OMS, 2012). Self-management becomes increasingly important since treatment will take place more often in the home environment of the patient rather than in the hospital. This view is also shared by the insurers who state that technical innovation like home-tests and e-Health increase the opportunities for home based disease management (ZN, 2011). The NPCF shares this view and is of the opinion that people can take care of their needs in their direct environment. "Starting point for care at home in 2020 is: what is sir or madam able to him/herself, what can family members or people in the neighbourhood do, what support or service can people purchase themselves?" (NPCF & STOOM, 2010, p. 11). The NPCF even goes one step further by proposing financial consequences for people when they do not take up their responsibility. According to the NPCF this fits within their view of society. In 2020 society is characterised by "rights and duties", "everyone carries responsibility. Who does not want that, will notice it in his/her wallet" (NPCF & STOOM, 2010, pp. 11,12).

The nurses and care givers also describe this new role of the patient. They provide a detailed explanation in which self-management is conceptualised as follows: "self-management is the individual capacity of people to, where possible prevent health problems, and, when these do occur to cope with the symptoms, treatment, the physical, mental and social consequences of the health care problems and adjustments to life style. Hereby, one is able to monitor his/her own health status and the respond in a way that contributes to a satisfactory quality of life." (V&V2020, 2012, p. 28).

The results show that these stakeholders share the opinion that patients will become more involved but differ to what extent patients should be involved and whether this should be enforced or not. The OMS poses patient participation as a logical consequence of care moving to the home environment, whereas the nurses and care givers reason from the individual capacity to self-manage which will lead to a more satisfactory life. The analysis points out that the views of these health care professionals have a more positive nature up against the view of NPCF emphasizing people's responsibilities and duties and financial consequences.

4.2.3 Role of the future health care providers

The results show that as a consequence of the increase in 'self-security' health care professionals become involved in a later stage which is paired by a higher need for support compared to the current point of professional involvement now. Generally this means that the health care professionals are called for support when the patient's condition is worse and/or more complicated. Depending of the particular health care professional this will to a greater or lesser extent change his/her role. Some of the stakeholders have diverging views on this process. To illustrate the influence of 'self-security' on the involvement of health care professional, the nurses and care givers describe that the first step is to assess what the patient can do him/herself and next the potential of informal care givers used. Only the last step will be to engage in professional care (V&V2020, 2012). Physicians (KNMG, 2011; LHV/NHG, 2012; OMS, 2012) do not mention the increase of self-security as such but describe the increased responsibility of patients towards arranging their own treatment and care.

The nurses and care givers indicate that they expect to play a major role in the support of self-management and will deal with more complicated tasks as a result of task substitution to a lower level. They describe the role of the health care professionals they represent as follows: "Nurses, nursing specialists and care givers are professionals who focus on the support of the self-management of people, those close to them, their social network, aiming to maintain or improve daily functioning in relation to health and disease and quality of life" (V&V2020, 2012, p. 29).

The expression 'support for self-management' seems contradictory, and is a clear example of the lack of confidence of nurses and carer in the ability of people to manage care on their own which is sensed throughout the results. Next to a supporting role, V&V expects an intensive care giving role as a result of more complex health care needs of people living at home as well as people who live in an institution. "Clients and residents need more and more intensive care than before. Clients remain living at home longer, hospitals send patients home or to the nursing home earlier" (V&V2020, 2012, p. 18). Due to these developments an increased need for nursing care is expected. In other words, in the view of the nurses and care givers people do not stay at home longer because of increased independence, but rather because support and new technologies enable this (V&V2020, 2012).

The role of nurses and care givers would also be affected by the task substitution to lower levels of care. "The work which was done by the care giver 10 years ago is now done by the helper. The care giver now does the work which was done by the nurse 10 years ago". "Now the education level is decreasing the risk of mistakes in care increases" (V&V2020, 2012, p. 18). The nurses and carers warn that as a consequence future nurses need to be higher educated. Alternatively, they say some nurses will choose to educate themselves further to become a 'specialist nurse'. The specialist nurse would play a big role after the task substitution when they take over tasks from physicians and

treat patients independently. The increased presences of protocols and standardisation of care enables nurses to carry out this more responsible and independent role (V&V2020, 2012).

These results suggest that nurses will take the role of 'self-management supporter' and of nursing specialist as they deal with nursing specific tasks but also work on a more social level to support clients with managing their care and network of informal care givers.

Next, the associations of GPs give a more broad overview of their responsibilities compared to the nurses and care givers (LHV/NHG, 2012). The responsibilities show the broad scope of tasks of GPs and the consequences of the increasing patient independence and involvement in his/her own care process. The broad scope of the responsibilities of the GP is emphasised by the broadly defined first priority: "A future proof application of the core values of GP care – generalist, person aimed and continuous – which provides an adequate answer to the demands of various groups of patients in society" (LHV/NHG, 2012, p. 6).

The GPS describe that the nature of their role will see a slight change as a consequence of the increased independence and involvement of the patient (LHV/NHG, 2012). Firstly, they will function as a guide for the patient: "Strengthening of the coordination- and guide role of the GP for all patients who are in need, namely the growing group of vulnerable elderly and children and people with multiple chronic conditions." (LHV/NHG, 2012, p. 7). By using the word 'guide' the GPs show they put emphasis on the patient and their role will be more consultative by providing information and experience. Another example of a more subtle role is stated by the GPs as seeing themselves as supporting 'self-management'. In this role the patient is put centre stage again as he manages his health care himself and the GP moves to the background as provider of support. The GPs state that they will adopt a strategy of 'watchful waiting', leaning back when the patient's condition and competences allow to do so and increase their involvement when necessary (LHV/NHG, 2012). This strategy will mean that GPs will pay extra attention to high risk patients and take a step forward to coordinate care for those with multi morbidity to ensure comprehensive care and prevent irrelevant care consumption in the second line. The duty to ensure comprehensive care is further described in the aim to increase cooperation with paramedics and medical specialists.

Thus, the results show that the GPs reiterate the supportive role in self-management as described before by the nurses and care givers. This is added to the role as a guide in health care in which they function as an agent to refer people to appropriate and efficient care. This last role shows that the GPs do not only serve the patients but also the efficiency of the health care system.

The medical specialists united in the OMS and KNMG do not discuss major changes in the role of the medical specialist (KNMG, 2011; OMS, 2012). Yet, the OMS does describe a new role as 'ambassador of healthy behaviour'. As ambassador of healthy behaviour the medical specialists describe they would address life style factors related to chronic illnesses by initiating preventive action. Moreover, the role of the medical specialist would be affected by the increased involvement of

the patient in his own treatment and shared decision making. In line with the nurses and care givers and the GPs this prospect shows that the attitude of the medical specialist is set to become more consultative while decision making power is shared with the patient.

Thus, considering that medical specialists in the future will only come into play when one has a serious condition and that even that case much of the management of the disease will be done by the patient itself or nursing professionals, the ambition to become ambassador of healthy behaviour seems out of place. Instead, medical specialists would only be involved in tertiary prevention.

The results show that according to some stakeholders future health care will not only be provided by professionals. In fact informal care givers are expected provide a significantly bigger share of care than before by V&V, the NPCF, KNMP and the young professionals. However, the KNMG, OMS, NVZ and ZN do not discuss informal care at all. Even though the current budget cuts do not directly affect hospital care it would have benefitted the prospects of the KNMG, OMS and NVZ if they would have discussed cooperation with informal care givers as they will inevitable have to deal with this in the future. The nurses and care givers do discuss informal care giving and state that good quality health care will not be achievable anymore without cooperation between professional care givers and informal caregivers. "In the future it will not be possible to deliver good care without good cooperation with informal care givers and volunteers. [...] Informal care givers and volunteers need to feel welcome, be coached and – sometimes – also be limited in care." (V&V2020, 2012, p. 18). However, they are also afraid that most people will not have enough time to fulfil the promise of informal care delivery, and will end up being under a lot of pressure as there are not enough informal care givers available. This will lead to an increased demand for professional care in their view (V&V2020, 2012).

The NPCF does not foresee a shortage of informal care givers provided that possibilities to combine work and care obligations increase (NPCF & STOOM, 2010). They state that leave schemes and care giving schemes should be improved and suggest that informal care givers may need (psychosocial) support. The KNMP seems to assume that informal care will be standard in the future as they mention twice that it is important for the pharmacist to personally know the patient's formal and informal care network (KNMP, 2013). They do not further elaborate on informal care which could either suggest that informal care is regarded as standard by that time or is not of significant importance. The young professionals describe that informal care givers will be more involved in stimulating 'self-security'. From the next sentence "The pressure on an informal care giver is often considerable" it can deduced that the young professional envision that informal care givers carry significant responsibilities (Werkgroep Zorg 2025, 2013, p. 6). To mitigate the pressure the young professionals call for attention and the provision of support and financial compensation to allow people to take of time from work to care for others (Werkgroep Zorg 2025, 2013).

These three stakeholders all see difficulties arising for informal care givers, but the results show that they hold different attitudes to solving them. The NPCF and the young professionals propose to mitigate these through adjustment of leave arrangements whereas the V&V does not provide solutions to support informal care giving but resorts to extra formal care as solution. This could be explained by the competition that formal care at home may fear from informal care, but could also arise from the insight V&V has in the nursing and care giving leading them to be concerned by the lower level of quality that informal care givers would provide.

4.2.4 Providers of integrated and multidisciplinary care

The KNMG, the young professionals and the OMS describe that in the future the medical specialist will operate within the integral care approach and the medical specialist will thus find himself more surrounded by and having to cooperate with other physicians, nurses and paramedics (KNMG, 2011; OMS, 2012; Werkgroep Zorg 2025, 2013). How multidisciplinary care will be implemented and what the implications are for the role of the health care professionals is discussed as follows. The NPCF and the OMS propose extensive cooperation: integrated cooperation in (small scale) care teams. In these care teams providers from various disciplines, like physicians and paramedics would work together (NPCF & STOOM, 2010; OMS, 2012). In their prospect GPs, propose local GP partnerships where GPs and nurses work together which also collaborate with external paramedics. However, how cooperation will take shape exactly is not discussed, in what way will responsibilities be shared by the different providers? A more discreet example comes from the medical specialists and GPs who propose to establish 1.5- line centres where medical specialists and GPs work together to treat patients outside of the hospital (LHV/NHG, 2012; OMS, 2012). However, this proposal does not include other types of care, with whom also should be cooperated.

From the prospects it appears that none of the stakeholders expects their role to change significantly apart from needing to cooperate more. However, cooperation does require a new role to be fulfilled: that of the 'coordinator', functioning as a 'connecting pivot'. Who will take on this role?

Firstly, most stakeholders describe that the care seeker himself should take on the role of 'care director', and mediate the cooperation of the different care providers. Following that, several stakeholders state that they would be suitable to take this role as well each outlining their strengths. The medical specialists see themselves as pivotal in the care process and as such would be suitable to oversee the process, also they describe this role could be fulfilled by someone in the social network of the patient or the GP (OMS, 2012). The results show that the KNMG and the GP associations emphasise the consultative function of medical specialists and favour to move executive tasks to the basic care and 'care at home' (KNMG, 2011; LHV/NHG, 2012). The GPs see themselves as having final responsibility. "To warrantee coherent and efficient care the GP will remain – after referral –

coordinating care for the patient as much as possible. The specialist has a more consultative function, for example through shared consultation hours and (tele) consults.” (LHV/NHG, 2012, p. 16). A different strength is listed by the nurses and caregivers who describe the “bridge function” that the nurse plays in relation with physicians (V&V2020, 2012). Alternatively, the young professionals make a clear distinction between the one who ‘directs’ and the one who coordinates: “The patient who is in such a care trajectory has a fixed contact. Often this is the GP, who coordinates care and when necessary discusses with other disciplines. However, direction lies with the patient, if preferred together with the GP or case manager” (Werkgroep Zorg 2025, 2013, p. 11).

These proposals show that many stakeholders are interested in fulfilling the role of coordinator. Given that care will be provided multidisciplinary being the coordinator would allow the provider to be informed about all care activities that are taking place and possibly to influence the other care providers, or even influence who those other providers will be. In spite of the benefits that arise from being a coordinator, stakeholders would also be wise to consider the accompanying additional workload, a downside which is not mentioned by the stakeholders but could cause stress and needs to be met with sufficient funding.

4.2.5 Conclusion

On the whole, the analysis shows that the stakeholders foresee their professions to require the same tasks and responsibilities in the future as they currently do; nevertheless the above describes some significant changes. The biggest driver of change is the increased independence, ‘self-security’, of the patient. As a result, the patient is expected to remain independent much longer and it should be the patient who from his need for care is the one who initiates care, directs care and if possible coordinates the different health care providers. The stakeholders differ in their opinion to what extent patients will be able to do this. The nurses and care givers however, still expect that patients will need considerable support in ‘managing’ their conditions. This means that the role of the nurse or care giver will shift more to that of a health and living coach.

Another development affecting the role of nurses and care givers is that of task redistribution which will increase the complexity of the responsibilities of nursing professionals. The role of GPs and medical specialists will also take on a more consultative and coaching role, as a result of increasing patient autonomy. It is expected that the role of informal care givers will increase substantially and that informal care givers will have difficulty dealing with the pressure related to their care duties. The stakeholders differ in their perspective whether these pressures can be mitigated by compensation and support policies or whether the demand for formal care will only increase.

Next, the roles fulfilled by health care professionals will also be influenced by the proposed ‘integral care’. Delivering integral care in a multi-disciplinary care team or network will require from

the professionals to first consider how the treatment they consider will fit in with other care the patient is receiving. Health care providers will thus not be able to perform in a solitary manner anymore. Integral care delivery also leads to a newly established role, the person responsible for coordinating and communicating between the different health care providers. So far, the proposals indicate that competition will arise among the stakeholders to whom this role will be allocated.

4.3 Research Question 3: Explorations of the future

Research question 3: How have the stakeholders applied methods of futures studies in their prospects?

The research questions provide windows through which we can not only view the stakeholders' prospects but also how they have sketched these. This question looks at the approaches that the stakeholders have used to construct their prospects. Approaches that are used in contemporary futures studies include forecasting (predicted future with least unexpected events), foresight (possible scenarios as the future cannot be predicted) and normative futures studies (following or exploring normative assumptions) (Van Asselt et al., 2010b). Even though, none of the prospects explicitly discusses its choice for a certain approach, they could be recognised through the grounded theory. The results of the analysis with regard to each of the approaches are discussed below.

4.3.1 Forecasting

Forecasting was the central approach for constructing the prospect of the OMS, NPCF, KNMG, KNMP, ZN, LHV/NHG, V&V and the young professionals. Forecasting was identified by recognising language that conveys a strong statement and describes a 'surprise free' prospect. It is most easily recognised when a stakeholder simply states what something will be like in the future. For example, forecasting is applied by the health care insurers in saying that "customer satisfaction about the GP and the quality of care offered has increased significantly" (ZN, 2011, p. 4). This statement shows that the health care insurers are certain that patient satisfaction will increase over time. Another example comes from the GPs who state that "within the surgery patients do not deal with more than two GPs, who adjust care consciously between them." (LHV/NHG, 2012, p. 13).

The order of medical specialists uses a more restrained approach for describing their perspective on the future. For example, with regard to clinical registrations they use the phrase "we propose the following plan of action"; using the wording "we propose" shows they take a step back as it were and 'merely' make a proposal (OMS, 2012). Another way the strength of a forecast has often been lessened by the stakeholders is by creating 'room for variation'. Leaving 'room for variation' can

be compared to the 'band width' which is described by van Asselt et al. (2010b). The band with refers to a certain margin of uncertainty. Here it is used to lessen the prediction as it allows for some more variation of the indicator. In this case the stakeholders have not performed numerical analyses, but the results show that the stakeholders also felt the need to give some room for variation to their predictions. The medical specialists do this in several ways: firstly they state they do not want to provide a blue print, hereby the OMS immediately warns the reader not to interpret the prospect as the only way the OMS would like to proceed in the future and that there is room to adjust the proposed plans. Secondly, a more subtle way to lessen the overall strength is referring to a survey amongst medical specialists that yielded ambiguous results; and they state that they will utilise the potential of eHealth (OMS, 2012). By referring to ambiguity amongst the specialists they also inform the reader that currently there is no one solution for the future. In the last statement of 'utilising the potential of eHealth' the OMS leaves it to the future how eHealth will exactly be used; an open future.

Furthermore, as any stakeholder would want to avoid making incorrect predictions, authors of prospects may tend to leave room for variation even more than authors of futures studies as they have not performed equally grounded analyses. The results show that the NVZ also uses the approach of 'leaving room for variation': they state they do not wish to provide a blue print. Another good example is found in their statement "hospitals should find out how they can cooperate regionally" (NVZ, 2013, p. 5). The vision of NVZ here is for hospitals to cooperate, but by delegating the exact execution to the hospitals they do avoid having to provide information about time scales or which hospitals should cooperate.

Another approach within forecasting is 'extending the present'. The underlying assumption here is that past/currents trends, patterns and dynamics will continue. The analysis shows that this approach is applied by V&V and the OMS. From the analysis it seems that V&V focuses on current issues as a result of consultations with nursing staff. An illustration of this is: "we propose a new professional structure, based on the established necessity of more clear relations between the professions" (V&V2020, 2012, p. 34). This new professional structure is further discussed in length in the prospect. Apparently, at the moment there is a need for more clarity; however that may not be the case in the future. A more future oriented motivation could have been that in light of multidisciplinary health care clear relations need to be established. This example shows that for V&V current challenges and issues are leading in their reasoning rather than expectations about the future.

Next, the results show that compared to V&V, the OMS focuses more on trends than current issues while extending the present. "In the previous chapters we described trends that are determinative for the future of specialist medical care. [...] For all the pillars we will, in this and in the chapters 6,7 and 8, address the purport of the changes in specialist medical care that are necessary to respond to trends." (OMS, 2012, p. 27). These trends are later identified as; "developments, like

consumerism, demographic developments, new technologies and treatments, unhealthy lifestyles, force health care to a fundamental transition" (OMS, 2012, p. 7). In this case extending the present ensures that the prospect is grounded in developments that are present in society of which some, if not most, could be expected to continue for some more years. This suggests that extending the present may be a good way to predict situations within the next five years but may be questionable to predict over twenty years away, by which time trends are more likely to have changed.

Although extending the present may seem reasonable now, the KNMG provides a counterargument. "The KNMG federation is of the opinion that decisions about changes in health care should be taken in the light of a long term vision about health care. It should be prevented that measures that seem to benefit today's health care and costs, appear to be adversely for tomorrow's care." (KNMG, 2011, p. 1). With this warning the KNMG aligns itself with the WRR (Van Asselt et al., 2010a), which also warns that extending the present can result in 'a colonisation of the future'. This colonisation is understood as self-fulfilling or self-denying prophecies that materialise because people act according to them. The statement of the KNMG shows that they are afraid that today's interests will not turn out to be in line with long term interests.

4.3.2 Foresight

Contrary to forecasting, foresight gives a central role to the uncertainties that present themselves in a future study. With foresight uncertainty is channelled through presenting different scenarios of the future. However, the results show stakeholders have chosen to shape their prospects as forecast rather than as a foresight. Arguably, this is understandable as these prospects are expected to express a (strong) vision on what the future will bring and how the stakeholder expects to function in the future. Moreover, for this reason a prospect is also not equal to a futures study conducted by planning agencies.

A notable exception is the OMS' prospect. This prospect contains a clear, and structured example of applying to foresight methodology could be found in chapter 10 of the prospect of the Order of Medical Specialists. In "chapter ten: to new forms of organisation for the medical specialist" (OMS, 2012, p. 52) they provided four different scenarios in which the medical specialist is involved in hospital governance. "Co-governance by the medical specialist can take shape in several organisational frameworks. In this chapter we sketch a number of options, but we do not select an ideal framework. This will be different for each hospital." [...] "Preferably, institutions and medical specialists will make their own choices on a local level." (OMS, 2012, p. 53).

Even though the majority of the prospect of the OMS is constructed through forecasting the OMS distinguishes itself here by presenting a well-structured application of foresight. This is a contrast as the other stakeholders do not explicitly address their method of future exploration. Interestingly, the motivation for using foresight is different from that in futures studies. Within future

studies foresight is described as a way to handle lacking cognitive information to make a single prediction. Whereas in this case uncertainty does not seem to be an initial issue that needs to be resolved. Instead, because of a variation of situations that is inevitable, as each hospital setting is unique, the OMS using forecasting to illustrate the variation it wishes to materialise. Where from the multiple scenarios in a traditional futures study only one will become reality, here all four scenarios for the medical specialist can materialise.

4.3.3. Normative influences

Even though the stakeholders have used forecasting to construct their prospects, which generally does not include value judgements, the results point out that the stakeholders have let normative assumptions influence their prospects. This is a clear departure from the requirements for a forecast in the traditional sense. Within normative futures studies two approaches can be distinguished: back casting and critical futures. Back casting provides one, normative and ideal future with steps how to achieve this whereas critical futures put emphasis on explores several normative perspectives (van Asselt, et al., 2010b). On the one the hand this can result in ‘colonisation of the future’, if only one normative perspective is dominant and only that perspective is translated into the prospect (van Asselt, et al., 2010b). On the other hand, in van Asselt, et al. (2010b) it is argued that more radical critical futurists argue to include multiple normative perspectives and to explore the dynamics between these. In these ‘pluralistic futures’ the normative uncertainties are emphasised. The analysis shows that influences of back casting and critical futures can both be found in the prospects but that they have not been applied as the main structure of a prospect.

Firstly, the results show limited application back casting in three of the prospects. This finding coincides with the remarks of van Asselt et al. (2010b) which argues that back casting is not practiced much in the Netherlands and if practiced they are rather ‘politically correct’, i.e. in line with current policy objectives and seem to be established without much discussion.

The first example of back casting is found in the prospect of the nurses and care givers. The final chapter of their prospects proposes an agenda for V&V for the next couple of years to come, called “What needs to happen? (V&V2020, 2012, p. 41). Here, the actual forecast set out in the preceding chapters of the prospect is set as the ‘future ideal’. The agenda then describes the necessary steps for the adjustment of the professions to realise the future portrayed in the forecast. It further describes the steps that should be taken and which parties should be engaged. Next, the NVZ and ZN also briefly apply back casting by describing how the increase of labour productivity should be achieved (NVZ): “This increase in labour productivity can we realise by: Investing in education; developing attractive employment conditions; stimulating social innovation” (V&V2020, 2012, p. 10). The ZN applies back casting in their statement of “In 2020 several large scale efficacy and efficiency

studies have shown that eHealth, as a part of a care process, contributes to improving efficiency in health care, while quality remains equal and often even increases" (ZN, 2011, p. 4). In line with the remark of van Asselt, et al. (2010b), it should not be expected that increasing labour productivity and efficiency appraisal of eHealth will incur much opposition as they are politically correct. These three examples show that the basic notion of back casting has found its ways in the forecasts, but only in a very simple and brief application. Because the applications of the NVZ and the ZN are so subtle, it leads to wonder whether they even have consciously incorporated the back cast. The example of the V&V shows that within the context of a prospect a back cast is well suited to end the prospect. It allows the stakeholder to do both incorporate a more abstract long term view while concluding with more concrete short term steps.

Secondly, the analysis points out that the prospects of the organisations representing physicians, pharmacists and the young professionals are influenced by certain normative principles and values in a way similar as found with critical futures. The difference is however that the stakeholders do not utilise the normative perspectives as the core of their prospect. Rather, it is fair to state that the prospects are 'influenced' by normative elements. The results further show that normative influences are derived from principles, for example those found in the four public values. This section shows examples of the way normative influences have been applied, therefore no attention is paid to content of the influences.

Firstly, the results show that the importance of the normative influences varies between the stakeholders. For the LHV/NHG normative influences form the basis of their prospect. The importance of normative influences on the prospect of the LHV/NHG is shown by the large number of normative influences they describe. Moreover, the importance can also be deduced from the large amount of visual attention given to their "starting points" as they fill an entire page and are highlighted by big bright red letters (LHV/NHG, 2012, p. 6). To illustrate, the starting points include amongst others: generalist, person oriented, continuous, quality, engaging patients, a close patient-physician relationship, etc. Moreover, the LHV/NHG already refers to the normative basis behind their prospect in the introduction. In fact the introduction starts with "Modernisation on a human scale" which is the "leading motto for the formulation" (LHV/NHG, 2012, p. 5). Additionally, the first 'starting point' lists the 'core values' "generalist, person oriented and continuous" (LHV/NHG, 2012, p. 6), these core values are further frequently found (separate and together) throughout the prospect. Words like "starting points", "leading motto" and "core values" show the importance for the LHV/NHG. They also show that values function as a guide for the LHV/NHG.

The KNMG uses a similar approach as they express the normative influences of their prospects as 'starting points'. Amongst others, these starting points include the following concepts: safe and of good quality, accessibility, affordability, pays attention to wellbeing next to discomfort, etc. Like the GPs, the KNMG still give considerable visual weight to their 'starting points'. More

interestingly, though in the formulation of the sentences introducing the principles they implicitly put a lot of emphasis on one aim “1. STARTING POINTS OF CARE. The KNMG federation advocates integral care which is targeted at improvement of (public) health and which is: [...]”- followed by the starting points (KNMG, 2011, p. 1). By putting ‘integral care’ in the sentence leading to the list of principles it implicitly has a lot of importance, whereas it also could have only been mentioned in the list. Although, as fifth “more integrated than fragmented” (KNMG, 2011, p. 1), is listed which has a similar meaning.

Alternatively, the KNMP and the OMS do not give extra attention to normative influences, apart from listing them in text. Even though the KNMP states that certain principles lead their prospect, they do so in a completely different way: “society demands accessible, affordable and good quality pharmaceutical care. Society demands this in 2013 and in 2020 as well. However, the meaning and interpretation do change.”(KNMP, 2013, p. 14). They continue by listing their ‘starting points for pharmaceutical care’. However, instead of listing their own principles they reason from what ‘society demands’, which poses an interesting change of perspective. The – changing – demands of society are thus the indirect determinative elements for the course of action of the KNMP.

The order of medical specialists mentions their starting points in the introduction of the prospects but does not put extra emphasis on them by adding visual effects. Compared to the LHV/NHG the OMS has almost hidden their starting points in their introduction. “In this prospect we present measures which are necessary to further improve specialist medical care. We applied the following starting points for formulating these.” (OMS, 2012, p. 9). This fragment shows that the chosen starting points are not perceived as rigid norms but rather as inspiration, as it were, in the back of the minds of the authors.

The young professionals and the nurses and care givers both do not pay much attention to normative influences. Instead, these two are discussed together as they both call for a radically different definition of health. The young professionals only provided a short list of guiding principles and describe this as “concepts central to our vision on the future of the care landscape in the Netherlands” (Werkgroep Zorg 2025, 2013, p. 5). Then, they advocate a new definition of health. This definition is radical in the sense that it removes the focus from the physical body and places it on the ability to adapt and to self-manage. (V&V2020, 2012; Werkgroep Zorg 2025, 2013). This shift of focus could be seen as a form of radical critical futures as the current paradigms of ‘health’ are challenged. Only, where critical futures would analyse this shift, these stakeholders provide an answer.

On the whole the findings show that the prospects manage normative influences without being dominated by them. The stakeholders take a pragmatic approach and refer to the principles and values as their starting points. Additionally, it is interesting to see that the prospects have not only been framed by traditional values like the four public values but also by more practice oriented

principles like integral care provision. It can be said the normative nature rather expressed itself as a guide than a strict framework and as such a narrow view of the future was prevented.

4.3.4 Conclusion

By publishing prospects the stakeholders aim to inform other stakeholders and the public of their perspective on the future. The results show that the forecasting was the primary choice for constructing the forecasts. The analysis shows it helps in doing so by constructing strong statements in order to support a convincing message. Within forecasting the stakeholders have either provided very certain, 'surprise-free' prospects or have left more room for variation by providing frameworks. The forecasts have two major influences. The forecasts are mainly based on current trends which are extrapolated to expectations for the future and are inspired by normative influences that are derived from principles or 'starting points'. The results further showed that the second approach to futures studies, foresight, has not been used to construct the prospects. It was only used by the OMS in an example. With regard to normative futures studies the analysis found that the stakeholders have utilised the guidance which a normative approach would bring, without interpreting them as rigid norms. As the stakeholders used language like 'central concepts' and 'starting points' it is clear they depart from certain principles from but as the KNMP articulates they are open to a "meaning and interpretation" suitable for the future (KNMP, 2013). Lastly, the analysis made it clear that often no one specific approach is adhered to but instead in some cases multiple approaches are used within one prospect.

4.4 Research Question 4: Uncertainty

Research question 4: Given that uncertainty about the future is inevitable, how do the stakeholders address uncertainty about the future in their prospects?

The answer to this question departs from the assumption that uncertainty about future states is inevitable since the future is open and unknown. Contrary to a futures study, which aims to minimise uncertainty and to give an accurate depiction of the future, a prospect has more leeway for subjectivity. This extra room for interpretation can be filled with statements that convey a great amount of certainty, or leave room for questions.

The following sections discuss the way uncertainty has been accounted for by the different stakeholders. Conceptualisations of different kinds of uncertainty show how, or in what way uncertainty appeared in the prospects. The sections below also discuss what the consequences are of presenting uncertainty in one way or the other. Have stakeholders tried to curb or acknowledge uncertainty in their prospect?

4.4.1 Uncertainty in the prospects

Research question three showed that the stakeholders aimed at creating a prospect that conveys certainty. Certainty is expressed in the prospects through confident expectations for the future. On the whole, most of the prospects pay little attention to uncertainties regarding future circumstances. The analysis points out that the stakeholders have not discussed normative uncertainties. According to the WRR normative uncertainty refers to the interests, preferences and values of (future) stakeholders and who those future stakeholders will be. Normative uncertainty is considered to be of relevance when stakeholders have different interests and when a distribution of shared resources and public interests are at stake. Following this understanding the stakeholders would have been wise to discuss their vision on normative differences within society or even within their own ranks. That relevant differences exist is shown by the results that the NPCF advocates a market based approach for care at home while for example the LHV/NHG opposes further marketization.

In spite of the aim to provide a certain view on the future, elements of cognitive uncertainty can still be found in the prospects. Cognitive uncertainty was identified when a lack of knowledge existed that would enable to make a judgement. An example, which conveys both certainty and cognitive uncertainty, is the following statement of the KNMP. In its prospect the KNMP states that “the patient receives health care (as much as possible) in his/her residence. Therefore the patient’s own pharmacist works closely together with other health care professionals, like the GP and the local nurse” (KNMP, 2013, p. 20). The use of the present tense “the patient receives” strengthens the impression of certainty. If this would have been phrased as ‘the patient may receive’ or the “patient could receive’ it would have come across as less certain. However, by adding “(as much as possible)” the KNMP adds uncertainty as this shows uncertainty exists to what will be deemed possible in the future.

The analysis shows that most of the uncertainty that was detected relates to the expectations regarding future circumstances. How will society or the economy develop; what will the preferences of patients be at that time? What new medical innovations will occur? In other words the circumstances in which the health care professional of the future will operate. Circumstantial uncertainty is most clearly presented when it is explicitly brought forward by the stakeholders. If this is not the case uncertainty could be found in the language used. Words like ‘could’ or ‘possible’ indicate that the topic is surrounded by uncertainty. For example in the introduction, the young professionals discuss the expected growth of health care expenditure as part of GDP “In case the increase continues, this percentage is expected to increase to 22 per cent in 2040” (Werkgroep Zorg 2025, 2013, p. 4). In this example cognitive uncertainty is shown by firstly stating ‘in case’ and then adding ‘is expected’. Meaning that, only when the increase continues – which is uncertain – , the share of GDP spend on health care is expected to increase to 22 per cent – the magnitude of the increase is

thus also uncertain. As they cite the SCP it would also have been acceptable if they would state 'Based on projections of the SCP, health care expenditure will constitute 22% of GDP in 2040' or if they would have stated 'with current trends in 2040 22% of GDP will be spent on health care'. These statements convey more certainty.

The NPCF, KNMG and the LHV/NHG further include some references to the fact that they are dependent on what circumstances will be like in the future. "Thereby, besides demographic developments other factors play a role" (NPCF & STOOM, 2010, p. 9); "The demand for care determines the nature and capacity of professions and education in care." (KNMG, 2011, p. 2); "Together with their team, GPs apply the three core values – generalist, person oriented and continuity – according to the demands and possibilities of society in 2022." (LHV/NHG, 2012, p. 13).. Unfortunately, they did not further elaborate on these statements, which would have provided the reader with a deeper understanding of the expectations of the respective stakeholder.

4.4.2 Processing uncertainty

Based on the assumption that uncertainties regarding the future cannot be avoided the stakeholder has several options to deal with uncertainties. The analysis shows that the cognitive uncertainty can be ignored, acknowledged, minimised or exploited. If uncertainty is ignored a certain statement about a potentially uncertain circumstance is given. When uncertainty is acknowledged the stakeholder describes the circumstance as being uncertain. Consequently the stakeholder could aim to minimise the uncertainty by for example providing evidence to support their statement. Alternatively, stakeholders could utilise the uncertainty and present more than one option on how the circumstance may develop. In the prospects that were studied here, the stakeholders mostly aimed to reduce cognitive uncertainties.

4.4.2.1 Reducing Uncertainty

The results show that the stakeholders frequently aimed to reduce uncertainty as is common with forecasts. However, the stakeholders have not done this in the way described by (de Vries, et al., 2011) and (van der Sluijs, et al., 2003). De Vries et al. (2011) recommend defining uncertainties as risk problems and van de Sluijs et al. (2003) recommend describing and analysing the dimensions of the uncertainty presented. The results show that the stakeholders do not explicitly mention uncertainties themselves. Instead they take them as given and focus on the implication of the possible trend or event. It reveals they aim to reduce uncertainty in such a way it would not harm the story line of the prospect. Lengthy description or calculations of uncertain elements would have done so.

A common method of reducing uncertainty that surrounds a certain statement was supporting the statement with scientific evidence. The KNMP for example supports its statement on

patient involvement by referring to Cochrane meta-analysis: “Scientific evidence, de renowned ‘Cochrane reviews’, shows that involving patients in decision making results in increased compliance and health gains” (KNMP, 2013, p. 15). The NVZ states that “Scientific research has shown that with increasing volume of treatment, the quality of care generally increases as well” (NVZ, 2013, p. 6). It is remarkable though; that both stakeholders did not refer to any sources in particular where this ‘scientific information’ originates from. This reduces the reliability of their argument, but for the sake of readability this approach suffices. The Order of Medical specialists also use research to support their argument but do name the organisations who conducted the research in text.

The LHV/NHG takes a different approach. In their prospect the organisations express their expectations with great certainty, but without referring to any sources to support their argument. After the prospect the publication is followed by a section with background information. This section provides information on the major themes of the prospect from organisations like the Council for Public Health and Health Care (RVZ), (TNS NIPO). This expansive background section could be an explanation for the ‘certain’ attitude of (LHV/NHG, 2012).

To reduce uncertainties regarding their radical proposals, nurses and care givers sought legal expert advice which concludes that the act on professions in individual health care (BIG) would need to be amended (V&V2020, 2012). The results show that by letting an expert draw the conclusion V&V increase the credibility of their prospect.

Another method applied to reduce uncertainty is to refer to experience others have had in a similar situation. The Order of Medical Specialists for example refers several times to the potential of benchmark data. They support their argument by referring to successful experiences Sweden has had with quality measurement. This argument is then further supported by citing the Boston Consulting Group which reported the Swedish experiences (OMS, 2012).

The last two methods to reduce uncertainty do not rely on bringing in information which actually reduces the ontological uncertainty but they work by making statement appear more certain. The first way to do so is used by ZN by applying back casting. They state that “in 2020 studies will have shown that eHealth is efficient” (ZN, 2011, p. 4). In this case the uncertainty – whether eHealth is efficient, and one could also question whether that will have been proven by 2020- is merely presented as a certainty.

The last method much relies on the stakeholder presenting conditions or circumstances in which their statement would hold – without providing information from an additional source to support the statement. The OMS for example states that “in any plausible scenario for economic growth, health care expenditure will tend to grow faster than the gross national product” (OMS, 2012, p. 43). This statement conveys a great amount of certainty because by explicitly addressing uncertainty it is reduced to almost nothing – “in any plausible scenario”.

4.4.2.2 Acknowledging uncertainty

The results further show that the stakeholders acknowledge uncertainty in some cases. Moreover, acknowledging uncertainty allows the stakeholders to account for future uncertainty and in some cases to formulate a possible solution.

Firstly, the publication of the Order of Medical Specialists provides clear examples where the OMS explicitly acknowledges uncertainty. “According to some, a well-informed patient will often waive treatment. However, this is not always the case. Patients often insist on referrals.” (OMS, 2012, p. 19). Here, the OMS acknowledges that two different views on the expectation of the wishes of well-informed patients exist. Another clear example where the OMS acknowledges circumstantial uncertainty is when they discuss their proposals for clinical registrations and state “whether this plan of action is feasible depends partly on the developments surrounding the implementation of the electronic patient record” (OMS, 2012).

Next, some of the stakeholders shown to embrace more general uncertainty about future circumstances, for example with regard to demand for care. The working group of young professionals repeatedly emphasises the need for a flexible system or flexibility among all stakeholders to achieve high quality and affordable care in the future (Werkgroep Zorg 2025, 2013). Additionally, some stakeholders make clear statements while at the same time leave details open to be filled in later. They mainly do so by stating that future demand should be the determining factor in. The KNMG also uses this method but describes demand as driving force “demand for care determines the nature and capacity of professions and education in care” (KNMG, 2011, p. 2). Additionally, the LHV/NHG applies this methodology in the same way the KNMG does : “Depending on the needs of patients and GPs the regional GP network takes care of: deals with health insurers, facility support (administration, human resources, accommodation, IT), a consistent quality policy, peer examination and a cooperation with local authorities, GGD, GGZ and ambulance services” (LHV/NHG, 2012, p. 11). However, in this example it is striking that the first words of the sentence indicate that the options are still very much open, but the LHV/NHG was still tempted and provided very detailed suggestions on what the tasks of the GP network should be.

Acknowledging uncertainty has also shown to be an opportunity for a solution. Firstly, the OMS does so in this example: “We note that the discussion on cost-effectiveness will be on the agenda in the coming years. Therefore, we propose to establish a working group with the OMS and scientific organisations” (OMS, 2012, p. 46). The OMS here emphasises that there still is uncertainty around cost-effectiveness and provides a solution to reduce the uncertainty in the future. The word “discussion” shows that there is no uniform opinion on cost-effectiveness but this topic will be important in the coming years.

Secondly, the analysis found another example where uncertainty is acknowledged. When discussing future frameworks for funding the NVZ makes the proposal to adjust funding of care to the

local situation but states this should be determined “via experiments” first (NVZ, 2013). This example shows that acknowledging uncertainty actually helps the stakeholder to come across as strong as it shows that the NVZ has prepared certain actions to deal with future challenges. The NVZ has successfully managed the uncertainty by presenting a clear plan for the future, i.e. holding experiments, while still leaving room for flexibility in the future (NVZ, 2013).

Finally, the OMS has used uncertainty to conclude its prospects by noting that that the prospect “merely considers the first paradigms that will be further developed in the coming months” (OMS, 2012, p. 55). They continue by adding questions that should guide future development: “leading questions for organisation-innovation should continue to be: how can we it best be achieved that the interests of medical specialists and (other) hospital directors are in line with each other? What form of organisation promotes the development of care around patient groups and conditions? What form of organisation is most suitable for establishing regional networks? Etc.” (OMS, 2012, p. 55). Interestingly, this example shows that the stakeholders are aware that the future is ‘open but not empty’.

4.4.3 Conclusion

Uncertainty presented itself in the prospects either by the authors explicitly referring to cognitive uncertainty surrounding a certain topic, or through of subtle wording which indicates that the topic is surrounded by a certain margin of uncertainty. The analysis also pointed out that normative uncertainty was not discussed by the stakeholders. As described before the prospects have all taken forecasting as method to describe the future and to have a strong forecast it is important to reduce cognitive uncertainty. This is also what is seen in the prospects. For the larger part, the stakeholders have tried to reduce cognitive uncertainties. However, from the grounded theory analysis it also became clear that stakeholders have acknowledged cognitive uncertainty. Even though uncertainty is deemed undesirable within forecasts, the results here show that acknowledging uncertainty actually has a positive impact on the strength of a prospect. Prospects are not only read for information about a possible subjective future. The relevance of a stakeholder prospects comes from the combination of the particular stakeholder expressing the particular content. Therefore, as the results have shown, acknowledging uncertainty is strength of the stakeholder itself and revealing its resilience.

Chapter 5 Discussion

This study focuses on stakeholders in the Dutch health care sector and explores their visions on the future of the national health care in the period 2015-2025. Four questions regarding public values, the roles of stakeholders, futures studies' methodology and uncertainty, frame the grounded theory analysis. As the results chapter already directly discussed the findings of the study, this chapter deals with external implications of the results. Firstly the theoretical and practical implications of the finding will be discussed, followed by limitations to the study and concludes with recommendations for further research.

5.1 Theoretical implications

The results of this analysis highlighted the strong intent and commitment of the stakeholders towards long term support of public values. Further implications can be found with regard to the two propositions expressed in the theoretical background section concerning a) influences on the values and b) ambiguity in the interpretation of the values. The first question is related to the comments of Maarse (2012) who describes that values are transient and depending on time and culture. The findings established here are both in congruence with Maarse's comments but also challenge them. Namely, the findings opposes Maarse's statement as they show that 50 year old values which undoubtedly have been influential for a longer period remain the leading values, even for the future. In fact, the results even show that with the current budget and demand pressures on health care the values are still highly relevant. Instead, the results rather support the second proposition concerning the statement of Maarse (2012) which stated that values are characterised by abstractedness and ambiguity and can hence be translated into a variety of (behavioural) norms. This is supported here by the wide range of proposals introduced by the stakeholders to uphold values to which they aspire in the future. Interestingly, we see two stakeholders – the NPCF and the LHV/NHG, which have committed to the same values for the future, however, have very different plans for their achievement due to their conflicting views on the benefit of market forces in health care. In this sense it could be stated that the interpretation of the values are more influenced by the stakeholder's individual perspective than time and culture since all stakeholders share these.

Next, the results of this analysis do not provide a clear answer to the question whether the public values should be defined as public values or goals. In this study 'value' was chosen as it reflects the a-priori importance which the four public values seem to embody for the stakeholders. The stakeholders have mostly expressed the public values as a non-negotiable prerequisite for care rather than a goal which is aimed at. However, following the interpretation of Hadorn (1991) it could

also be argued that the stakeholder's values act as goals in the sense that they represent preferred outcomes of health care. In Hadorn's understanding it is likely that not all stakeholders will share the same preferences and that some stakeholder's preferences will be met by policies whereas others will not. The findings of this study also support this understanding. Namely, the findings have shown that preferences differ between stakeholders. Furthermore, the findings point out that the values are not as non-negotiable as they are led to believe in international treaty law. In fact, stakeholders have stated that the values are under threat of being compromised. In practice, this would mean that the stakeholders may have to engage in negotiations as to which values are most important. The prospects have further shown that the values are also interrelated, for example when increasing demand affects affordability of a health care system, which in turn can be mediated by limiting accessibility.

Next to the prospects' contents, this study set out to explore the methodology of futures studies in the new field of prospects by means of the third research question. The analysis showed that prospects are comparable to futures studies in terms of construction. It revealed that the forecast approach was chosen by all stakeholders. This is expected as forecasts enable the stakeholders to channel their vision for the future into a convincing message. However, the findings also show that prospects differ from futures studies in other respects. In contrast to futures studies, prospects are characterised by subjectivity associated with the author. The results showed that the forecasts are accompanied by normative statements that express preferences for the future health care system and society. Additionally, while the prospects are dominated by forecasting the stakeholders have used the freedom they have to mix forecasting with foresight and back casting. Even though the use of this was limited it showed that the rigid frameworks of forecasting can be left behind, giving the author freedom to construct the prospect. The findings show that this enabled the stakeholders to distinguish between different messages in their prospect. For example, the nurses and caregivers first expressed their vision through forecasting and concluded their prospect with a back cast which included the steps that have to be taken next. Hereby, V&V were able to distinguish between their short and long term visions. The results further indicate that the stakeholders also moved away from the requirements of forecast by allowing for 'room for variation' in their prospects. This tendency was also described by van Asselt, et al. (2010b) as 'introducing a bandwidth'. Where a bandwidth refers rather to numerical variation as a result of uncertainty, the results here show that the stakeholders tend to leave room for future variation by not providing detailed descriptions on the implementation of their prospects. In summary, the application of forecasting in these stakeholders prospects could be defined as 'subjective forecasts with room for future uncertainties'.

With regard to future uncertainty the findings point out that the stakeholders attempted to reduce mainly cognitive uncertainties. This could be expected as it is in line with the core purpose of forecasts. However, none of the stakeholders has used the 'taming' approaches (e.g. examining

dimensions, quantification into 'risk problem') that focus on increasing tangibility as advocated by van der Sluijs, et al. (2003), van Asselt, et al. (2010a) and de Vries, et al. (2011). Instead the results show that the approach employed by some prospects has been simply to acknowledge uncertainty rather than trying to explain it. Even though this means that the stakeholders have sacrificed deeper understanding of the uncertain issue, they were wise to do so. Namely, using the advocated approaches would have turned the prospects into technical documents. This would have harmed the textual flow which is essential in the prospects that often rely on a story line. Hereby this study shows that the approaches to reduce uncertainty used for futures studies are not appropriate for prospects.

Moreover, by acknowledging uncertain circumstances in the future the stakeholder shows their expectations of the future are appropriate and trustworthy. This allows the stakeholder to address the uncertainty and provide different options of dealing with it. Thus, where uncertainties are to be minimised in forecasts, this study found that acknowledging and addressing them actually strengthens prospects.

[illegible]

5.2 Practical implications

As this study analyses prospects for the future of health care in the Netherlands there are several practical and policy implication that can be derived from the results.

Firstly, the results point out that the stakeholders share important grounds concerning the major developments of the coming years, including: quality of life orientation, increased participation and responsibility for patients, task redistribution to lower levels, multi-disciplinary and integral care provision, the shift to a more coaching oriented role for health care providers, and all providers treasure the four public values. This means that politicians and government policy makers can assume relative homogeneity amongst the stakeholders when it comes to broader, macro level developments. This will facilitate legislation and policy implementation.

However, an outlier seems to be found in the NPCF which has a clear preference for a marked based system, where the other stakeholders do not express such a preference. Based on the results, in which the NPCF foresees a society of 'rights and duties', it is fair to speculate that the results imply that the NPCF will be in support of the cabinet's aim to create the 'participatory society'.

Next, while the results showed shared visions in relation to macro level developments, that challenges may appear during the implementation phase at the organisational level. Particularly the redistribution of tasks may prove to be difficult as the results have shown that consensus on this topic is lacking. In general agreement upon roles and responsibilities is crucial because of the profound integration of care provision. Besides, several stakeholders envision taking on the role of coordinator. As suggested by van Asselt et al (2010a) this could be the phase where the difficulties arise if issues around consensus between stakeholders have previously been overlooked. Moreover, the lack of exploration of normative consensus – or ambiguity – could lead to difficulties between the patients and providers, particularly when looking at cooperation and shared understanding of patient responsibilities and self-determination. For example, the findings indicate that the OMS may have difficulties handing over decision power to the patient and taking on a coaching role.

Lastly, to maximise the potential of increased self-security and patient participation, the government will need to provide accurate policies and legal provisions that will allow people to take up these roles. The results point out that the stakeholders, who agree on this, only see it becoming successful if policies that allow people to combine informal care, work and family are implemented. On the supply side of health care this means that health care providers and their organisations and institutions will have to put great effort into increasing cooperation with each other and informal care givers to build an integral care network that can provide the care that is needed. Where the stakeholders who describe informal care have a positive outlook concerning this challenge, the V&V does not have faith in the ability of people to provide enough informal care.

5.3 Limitations

The grounded theory approach proved itself to be essential in the aim to stay close to the raw data. However, the approach also led to some limitations to the study.

Firstly, a drawback was the loss of contextual information, which occurred as a result of using the grounded theory approach. As (Mortelmans, 2011) describes grounded theory works through 'breaking up' the text in little blocks (codes) and later 'rebuilding' the story through establishing networks. When integrating the codes and networks to answer the research questions it appeared that codes were not easy to place as the labelling in a short code led to loss of contextual information. Additionally, because much of the analysis is focussed on the meaning of the codes, grounded theory makes the analysis vulnerable to losing overview. As the analysis was focussed on a particular dimension of the prospect (e.g. the role of the health care professional) the statements referring not to any of the sensitising concepts were left out of sight. When the aim is to stay true to the original data, it is not only important to find the right code and the right translation but it is also important to understand the wider perspective of the stakeholder which ensures the right interpretation of the codes and relations. If such difficulties presented themselves they could be solved by going back to the original text and getting back to the original meaning.

Secondly, as all coding and processing into networks was done manually this was very time consuming and complex. Especially the construction of the networks was very complex as all codes had to be typed separately into the boxes and all stakeholder labels had to be attached individually to the codes as to ensure that in the analysis phase the belonging stakeholder could be derived. Furthermore, even though manual coding did not affect the quality of the results, the use of a coding programme would have allowed for more quantitative analysis. This would have allowed including more information about the frequency with which stakeholders referred to certain topics. Lastly, as the study is written in English and the prospects are written in Dutch it could not be avoided that some of the meaning of the original text has been lost due to translation. When focussing intensively on the meaning behind discourse, and the exact meaning of a word comes so close, not being able to use the original word leads to a loss of meaning. For example, a lot of the stakeholders have used the word 'doelmatigheid', which is commonly translated as efficiency and also in this study. However, this translation is compromised as in Dutch also the word 'efficiëntie' is used. Why have the stakeholders used 'doelmatigheid' and not used 'efficiëntie'? None of the stakeholders provided an explanation about their choice of discourse, or provided any reason to suspect dissimilarity between the two words. Moreover, a new translation, for example into 'goal orientation' was not possible as this is an existing concept in the English language referring to a personality trait.

5.4 Implications for further research

Further research is recommended to focus on the use and construction of prospects and on normative uncertainties. Firstly, further research into the construction of prospects is welcomed. This is motivated by the similarities but also notable differences between futures studies and prospects established by this study and given that the involvement of stakeholders is crucial in policy making and implementation in the Netherlands. Further research should not be explorative of nature, but focus on establishing recommendations for innovative construction of prospects which combines the elements of 'neutral' forecasting and 'subjective' normative perspectives and uncertainty is embraced.

Secondly, based on the lack of results with regard to normative uncertainties and the statement of van Asselt, et al. (2010a) that normative uncertainties often are a blind spot and that questions about variety of values, perspectives and interests are not sufficiently asked, it is recommended that future research focuses itself on the presence of such differences in the health care sector and the possible implications of those for policy making and policy implementation. If even the statement of van Asselt, et al. (2010a) describes problems arising because of this blind spot, the urgency for further research is eminent with regard to prospects as even more than 'neutral' forecasts, prospects should pay attention to normative uncertainties.

Chapter 6 Conclusion

Pressures in health care spurred stakeholders in the Dutch health care sector to share their perspective on the future. Commonly, policy makers turn to futures studies for future policy options. However, the policy landscape of the Netherlands is characterised by extensive stakeholder influence. Previously, the perspectives of these stakeholders have not received much attention. It is in this light that this study examines prospects published by stakeholders. This study set out to provide insight in the prospects through grounded theory analysis, staying close to the stakeholders' original meaning. The analysis was framed by the four public values (i.e. quality, availability, accessibility and affordability); the future roles the stakeholders see themselves to fulfil; by the application of methods for futures studies and by how uncertainties about the future were dealt with.

Firstly, the results showed that the four public values remain leading values for the stakeholders. Yet, the stakeholders differ in opinion as to which measures will uphold the values, which reveals differences in interpretation. Only the NPCF and the NVZ showed a preference for market based home care. The different proposals further show that the values are interconnected.

Quality of care is generally regarded as very high but also as under pressure. Interestingly, some stakeholders emphasised that quality is related to the act of providing care, while others emphasise the result. This result is increasingly seen as the quality of life the patient experiences, rather than medical outcomes. In the future the stakeholders not only perceive quality as an end, but also use transparency to further raise quality levels. The results show that great variety exists among the proposals on how to improve quality.

With regard to the public goal of availability, some stakeholders are concerned about the availability of resources and personnel due to increasing demand for health care. Only the NPCF expects that improvements in health status will prevent shortages of personnel regarding home care. Informal care is discussed as potential solution, but ambiguity remains to what extent informal care will be reliable. Most stakeholders are optimistic about the potential of informal care, but the V&V is of the opinion that informal care givers lack time and skills. Availability was also discussed in relation to innovation, largely focussing on specific techniques or tools, most commonly eHealth.

Next, the stakeholders mostly discussed accessibility in terms of spatial proximity of care. Accessibility of care is set to change as a consequence of dispersion and concentration of health care; concentrating complex care while basic should remain within easy reach of patients. New forms of care like eHealth and tele-consultation are expected to increase access by some stakeholders.

Lastly, affordability was foreseen to be under pressure in the future due to increased demand for care in general and especially for hospital care. A wide range of suggestions for cost containment and efficiency gains were provided, but differences exist regarding the question where to place responsibility, with the patient, physician or the government?

With regard to the stakeholders' future roles, three developments can be highlighted: the enlarged role of the independent patient, task redistribution and integral care provision. As a result, the future health care provider is expected to shift to a role of 'health (care) coach'. However, stakeholders hold different views to what extent patients will be able to direct care, to what extent informal care is available and to what extent professionals need to complement the patient's efforts. The potential of informal care givers is doubted by some stakeholders and seen as depending on policies that facilitate informal care giving. The role of the nurses and care givers is also expected to grow in scope as a consequence of task redistribution to the lower levels. The last major influence is the transition to integral care supply. Henceforth, the role of the health care professional will be characterised by intensive cooperation.

Next, the third research question moved the focus from the content of the proposal to its construction. It showed that in order to establish their visions on the future the stakeholders primarily made use of the method of forecasting, enabling authors to convey a convincing message. The forecasts are largely influenced by trend extrapolations and by to a smaller extent by normative influences derived from principles or 'starting points'. The prospects can be characterised as 'subjective forecasts with room for future uncertainties'.

Subsequently, the fourth research question discussed the issue of uncertainty. Uncertainty was found in the form of cognitive uncertainty. The prospects are characterised by aiming to reduce these cognitive uncertainties. Reduction was not achieved by increasing tangibility as is conventional with futures studies, but discretion that comes with a 'vision' was used to assume certainty. Unlike forecasts, the prospects distinguished themselves uncertainty was acknowledged as well. By embracing uncertainty and allowing 'room for variation' the stakeholders could accommodate for future uncertainties. This was found to strengthen the reliability of the prospects as the stakeholder he is prepared to deal with uncertain factors. The findings showed that normative uncertainties had not been discussed which leads to believe that normative consensus is assumed. However, normative ambiguity could be expected to arise due to the high likelihood of intra- and inter- stakeholder differences. These could be exacerbated in the future as a result of pressure on the four public values.

This study has provided insight in what the major stakeholders envision the future of the Dutch health care system to be like. On the whole the differences between the prospects of the stakeholders exist because of a difference in opinion but also to some extent because the prospects are limited to the occupation of the respective stakeholder. The majority of differences were not found in macro level views, but in the operationalisation. Future policy makers can expect challenges with regard to the redistribution of tasks and responsibilities as the findings show that stakeholders wish to take on particular roles. Moreover, it will be challenging for some providers to take on a more coaching role and hand over control to the patient.



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Appendix 1: Overview Stakeholder Organisations and Prospects

The information in the table below has been derived from the websites of the organisations.

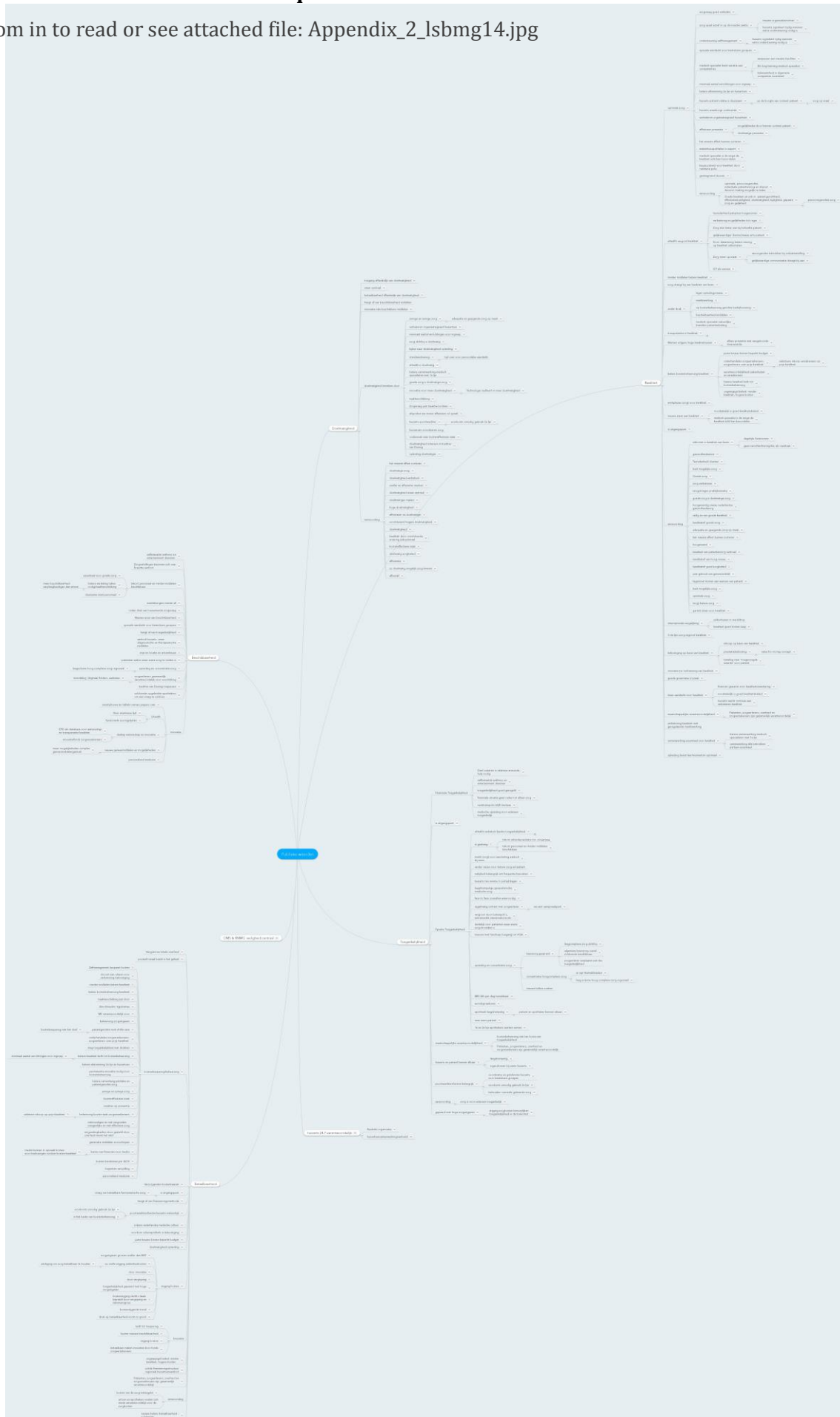
Organisation	Representing	Aim	Prospect
De Jonge Specialist (formerly know as: De Jonge Orde en de Landelijke Vereniging van Medisch Specialisten in Opleiding) www.dejongespecialist.nl	Trainee medical specialists	De Jonge Specialist stands for one unite voice of aspiring medical specialists on national level, a strong negotiation position for all aspiring medical specialists and initiating, coordinating and stimulating initiatives to safeguard and improve education.	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')
Juniorkamer van de Vereniging voor Sportgeneeskunde - VSG www.sportgeneeskunde.com	The VSG represents 417 members	The association's statutory aim is "to develop sports medicine in the broadest sense, to promote en safeguard the quality of the practice of sports medicine as well as advocating the interests of its members"	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')
KNMG - Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst www.knmg.nl	A federation of seven professional associations who together represent over 53.000 physicians and medicine students. (including the Landelijke Huisartsen Vereniging and the Orde van Medisch Specialisten).	KNMG, for responsible medical care. The KNMG promotes quality, safety, transparency and testability of medical act and supports physicians therein.	Memo – Visiedocument 'Zorg waar de KNMG-federatie voor staat.'- April 2011
KNMP – Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie www.knmp.nl	Over 90% of pharmacists in the Netherlands are a member of the KNMP. Most members work in community pharmacy. The remaining members work as pharmacists in a hospital, the industry or elsewhere.	The KNMP is the overarching professional and industry of pharmacists and represents the interests of its members as well as those of the pharmaceutical sector in general.	Contouren. Toekomstvisie Pharmaceutische Zorg 2020
Landelijk Overleg Sociaal-Geneskundigen In Opleiding – LOSGIO	Trainee medical specialists social medicine	Since 1983 the trainee physicians in social medicine and those recently finished are associated in the Landelijk Overleg Sociaal-Geneskundigen In Opleiding (LOSGIO). The goals of the LOSGIO are to promote and safeguard the quality of education for the two main tracks for 'physician society and health' and physician for 'labour and health'	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')

-		(insurance-medicine and occupational health) including the preconditions.	
De Landelijke Organisatie van Aspirant Huisartsen. – LOVAH www.lovah.nl	Trainee general practitioners	De Landelijke Organisatie van Aspirant Huisartsen (LOVAH) exists since 1980 and has grown into the organisation which advocates the interests of general practitioners in training.	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')
Landelijke Huisartsen Vereniging- LHV www.lhv.nl	Advocate of nearly 11,000 general practitioners	"The core task of the LHV is strengthening of the position of the GP. The association can position itself as a wide front for material and non-material advocacy. Furthermore, support for practice is an important goal."	Toekomstvisie Huisartsen zorg 2022 – November 2012
Nederlandse Patienten Consumenten Federatie - NPCF www.npcf.nl	The patient federation (NPCF) is a partnership between patient and consumer organisations.	To realise demand based care for patients and consumers from a patient-perspective, reasoning from solidarity, freedom of choice and upholding personal autonomy	Toekomst Zorg Thuis – Nieuwe Trends Nieuwe Kansen (together with STOOM)
Nederlands Huisartsen Genootschap - NHG www.nhg.org	Scientific organisation of general practitioners. Over 10,000 members.	"The NHG aims to promote a scientifically sound professional practice. By translating science to the GP surgery the NHG contributes to professionalization of the profession.	Toekomstvisie Huisartsen zorg 2022
Nederlandse Vereniging van Ziekenhuizen - NVZ www.nvz-ziekenhuizen.nl	118 institutions are a member of the NVZ	"Our goal is to safeguard all preconditions which our members need to provide high quality and efficient specialist medical care to patients"	Zorg in de Toekomst- Standpunten 2013
Orde van Medisch Specialisten - OMS www.orde.nl	The Order of Medical Specialists (OMS) is the professional association for and by medical specialists. The OMS represents almost 11.000 medical specialists (to be).	The OMS supports, as representative party, medical specialists (to be) in such a way they, as experts, can achieve specialist medical care with all its facets.	Visie document: De Medisch Specialist 2015 (oktober 2012)
Stichting Onderzoek en Ontwikkeling Maatschappelijke gezondheidszorg - STOOM Merged with Stichting ELSE in 2012	-	"Stoom wants to develop new knowledge, care concepts and practice and promote modern homecare"	Toekomst Zorg Thuis – Nieuwe Trends Nieuwe Kansen ; mei 2010 (samen met NPCF)
Vereniging voor Aios Specialisme Ouderengeneeskunde Nederland	Trainee medical specialists gerontology	Vason goals: Advocating the interests of current and future trainee physicians gerontology. Maintaining and promoting the quality of the education. Promoting contact between trainee physicians gerontology.	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')

www.vason.nl			
Vereniging Apothekers in Opleiding tot Ziekenhuisapothekers- VAZA	Trainee hospital pharmacists	VAZA is an association by and for hospital pharmacists in training and other young pharmacists working in hospital pharmacy. VAZA aim for high quality education and a good future for young hospital pharmacists and their profession	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')
www.vaza.nu			
Vereniging Arts in opleiding tot Arts Verstandelijk Gehandicapten	Trainee medical specialists for intellectually disabled	The VAAVG is an association for and by trainee physicians for intellectually disabled (AIOS-AVG, meaning trainee physicians for intellectually disabled). The association was founded in April 2003 with the following aims: advocating the interests of the AIOS-AVG concerning education and work practices. Promoting and maintaining the quality of education for physician for intellectually disabled. Promoting the contacts between AIOS-AVG.	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')
www.vaavg.nl			
De Vereniging van Jonge Apothekers – VJA	Trainee community pharmacist	“The Association of Young Pharmacists advocates the interests of the starting community pharmacist and hence the future of the profession and service to patients. The VJA does this in several ways. The VJA supports young pharmacists in the first years of their careers. Members support each other in their pursuit for improvement of their own functioning as independent professional. This professionalisation is inextricably linked to optimising service to patients.	Coach, Cure & Care – 2025; 2013 Working group of young professionals ('the young professionals')
www.vja.nu			
V&V- Verpleegkundigen & Verzorgenden Nederland	Professional organisation with over 40.000 members	We are the professional association for and by nurses and care givers. Together we take make sure we can execute our profession well. But we also make sure we have fun in our work and we remain proud of our profession. Together we fight for everything which helps achieving this.	Verpleegkundigen en Verzorgenden 2020 – Leren van de Toekomst; Maart 2012
www.venvn.nl			
ZN- Zorgverzekeraars Nederland	The association of health insurers in the Netherlands	Good quality, affordable and accessible care for all insured, aimed at promoting health and quality of life: this is the mission of health insurers.	Precompetatieve samenwerking eHealth- April 2011
www.zn.nl			

Appendix 2: network results research question 1

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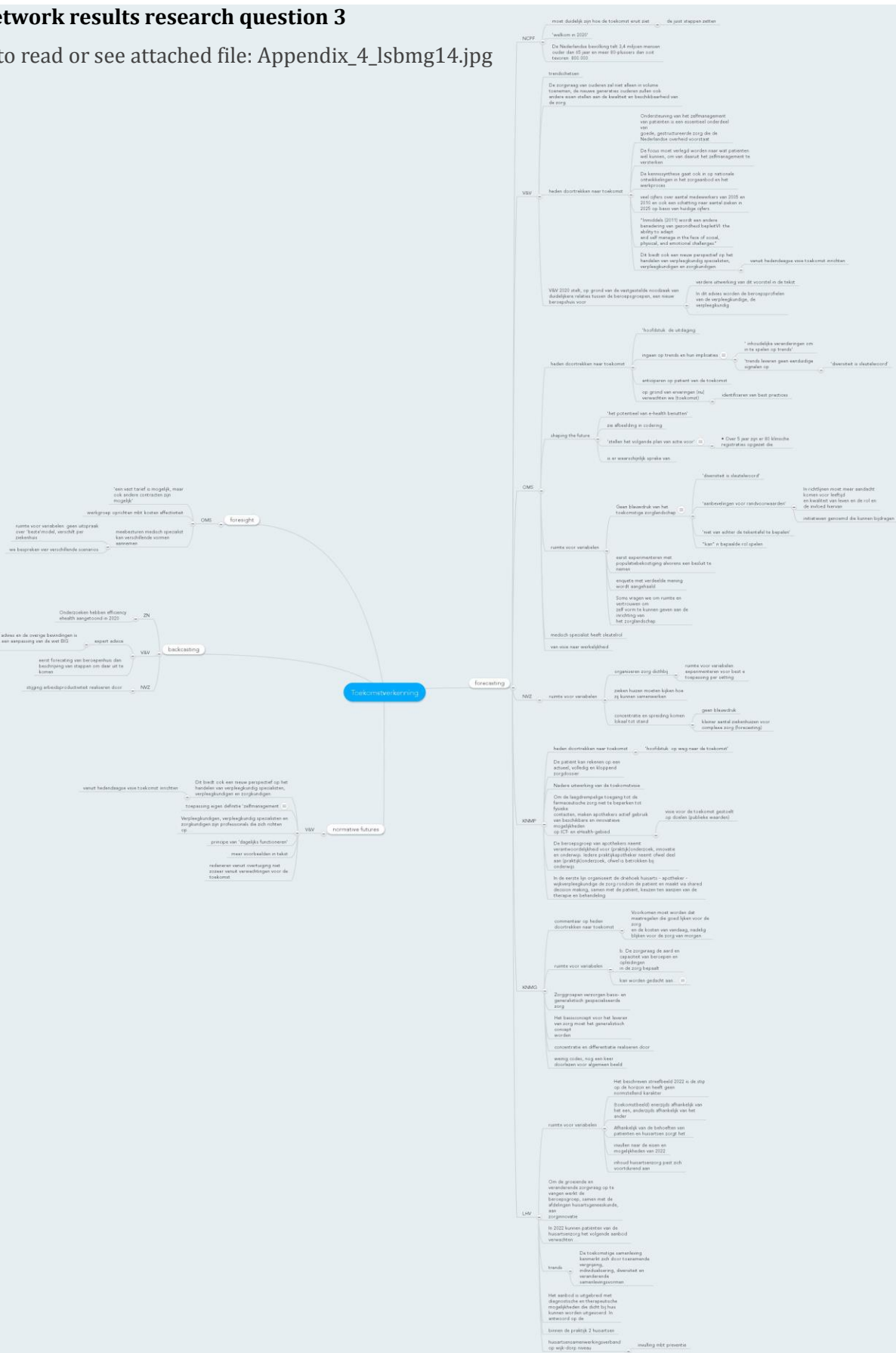
Appendix 3: network results research question 2

Please zoom in to read or see attached file: Appendix_3_lsbmg14.jpg

Appendix 4: network results research question 3

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