Tenable Solidarity in the Health Care System

Solidarity in the health care system is a great good, as it helps to make the system open to everyone. The main topic of this report is how the arrangements for solidarity and the transfers involved have developed, and whether they remain 'tenable' in the more distant future.

The insurance system ensures that there is 100% risk solidarity and that there is income solidarity under the Compulsory Health Insurance and the Exceptional Medical Expenses schemes. This solidarity has remained more or less intact over the years, on top of which our health care system provides a high degree of solidarity once you are inside, i.e. treatment is based on medical urgency.

The financial transfers associated with these solidarities have increased sharply, owing mainly to risk solidarity and a real increase in health care costs. In 1999 the most expensive 10% of insured persons accounted for 70% of total curative costs, and the percentage is even higher if we include costs under the Exceptional Medical Expenses scheme. If policy remains unchanged, risk solidarity transfers will continue to increase until 2020, owing mainly to the rising incidence of diseases of old age (intergenerational solidarity).

Solidarity transfers are also increasing as a result of rising health care expenditure. The increase is being paid for, in effect, out of growth in gross domestic product, making it increasingly difficult to fund other spending (on education, social security and real improvements in purchasing power) from this. Computations show that the pressure on the budget can only increase, creating an ever-growing issue of distribution.

Real income growth will stagnate, compared with the situation in the past. The sharp rise in wealth in the 1990s has mainly benefited the baby boomers' generation; the youth of the future will not be able to benefit from economic growth to the same extent.

At the same time society is in a state of flux. The main social and cultural trends point to an increasingly differentiated and individualized society with different value systems, and this in turn points to a redefinition of the present collective solidarity arrangements. More and more, people are looking for health care outside these publicly-funded arrangements, and it is becoming increasingly clear that one of the main factors in the success of health care in the future will be the 'behaviour' of patients and the public. This is bringing the customary norms and ethical views into question.

A policy of more 'conditional solidarity transfers' could help to solve these problems. Of necessity, the first step will have to be a broad-based public debate, for which the Council, based on its analysis, has drawn up a number of 'propositions for debate'.

1. The basic cover should be evidence-based: any care that is not evidence-based should not be included in the basic cover. Similarly, a minimum acceptable level of quality could be applied in relation to the Exceptional Medical Expenses scheme.
2. Behaviour is an important precondition for the effectiveness of health care, so it is permissible to reward people for healthy behaviour (Condition 2a) and appropriate patienthood (Condition 2b). Insurers may therefore apply differential contributions and require patients to pay part of the cost out of their own pockets, up to a specified maximum.

3. The options for differential contributions must not be based only on reducing the cost of collective contracts; considerations of desirable solidarity and public health must also be included. This means that, on top of the differentiation in proposition 2, differential contributions based on age should be reconsidered.
4. The government should encourage the prudent use of health care, with patients paying for part of the cost out of their own pockets, subject to the condition that individuals have real influence.
5. There should be a more rigid separation between services and care. As a rule all services (permanent/temporary accommodation, hotel expenses) should be paid for by the user.
6. The care provided should also activate people to return to the labour market. Employers and employees should have real prospects of good work-related health care from the system (Condition 6a). Personal prevention and healthy behaviour should be strongly encouraged (Condition 6b).
7. The funding should be supplemented by individual options for limited forms of capital cover. Personal savings are not a wholesale alternative to health insurance, however. A budget-neutral savings scheme could be introduced by converting the current Save As You Earn scheme into a health care savings scheme.
8. The government should encourage those who, by virtue of their remit or mission, make a contribution to general solidarity and safety net functions in the health care system. These incentives should be available not only to professional carers (Condition 8a) but also to ordinary people looking after one another (Condition 8b). Where forms of solidarity are provided by the private sector (supplementary insurance), the government should ensure that these operate in the interests of consumers (Condition 8c).

The purpose of this report is to spark off a debate. The Council's aim is to make the first move, and it invites everyone concerned to join in the debate, as our society needs a form of solidarity in the health care system that enjoys a broad base of support and is tenable in the longer term.