

SOLIDARITY, HEALTH AND SOCIAL CARE IN EUROPE INTRODUCTION TO THE VOLUME

1. SETTING THE SCENE: THE ISSUE OF SOLIDARITY IN MODERN SOCIETY

When people in Europe are interviewed about the values, which they consider fundamental for the design of their health and social care systems, they often refer to the values of equity and solidarity. While equity may be a term for which most people have a quite similar and clear-cut understanding, solidarity is a less familiar notion that is subject to divergent interpretations and reflections. In general, the idea of solidarity is associated with mutual respect, personal support and commitment to a common cause. These interpretations come to the fore when Europeans in large-scale surveys are questioned about their understandings of this idea of solidarity. Their verbal answers to these kind of questions reflect notions as 'belonging together', 'mutual understanding', 'support of the weak and needy (benevolence)', 'shared responsibility' and commitment to the common good. To explain these notions, solidarity is often juxtaposed against individualistic and even egoistic behaviour or contrasted with the alleged self-centred individualism that is often superficially associated with the cultural habits, societal norms and liberal values of the United States. For example, the plain evidence that forty-five millions of inhabitants of the United States lack any sort of health care insurance is for many Europeans, especially on the leftist stance, writing on the wall. In contrast to the alleged irresponsibility and lack of concern that is generally associated with this kind of individualism, Europeans proudly refer to the notion of solidarity and how it shaped their national health and social care systems. How ill-defined solidarity often is, the basic understanding is that everyone is assumed to make a fair financial contribution to a collectively organised insurance system that guarantees equal access to health and social care for all members of society. This equally applies to other systems of social protection, which are operating in Europeans welfare states, such as social insurance systems covering the financial risks of unemployment and work related illness and disability, as well as old age insurance systems and pension schemes.

While European are boosting their safety net for the risks of bad health and forced idleness, however, there is increasing uncertainty about whether solidarity still is or can be a guiding principle in the shaping of care

arrangements within welfare states in the decades to come. This uncertainty is particularly slumbering in the area of health care and social policy, in which solidarity has acquired a particular meaning that goes beyond solely transferring income or in kind benefits to protect the vulnerable and needy in society. In the domain of health and social care, solidarity is first and foremost understood as a moral value and social attitude regarding those in need of support. Solidarity with vulnerable groups in modern societies, in particular the chronically ill, the handicapped, the political refugees and the frail elderly, is taken as an expression of personal concern and responsibility by the care giver, no matter whether she or he is a professional care-worker, a relative or a friend. The wider support for solidarity on the level of informal care practices may explain the extraordinary position of the care system within European welfare states. While protection systems of social and economic kind have been put increasingly under pressure, health care has not to the same extent been subject to such strains. However, there are concerns that health care systems may share the same fate as such protection systems. Its development into encompassing systems of universal coverage has put into question the acceptability and sustainability of nowadays configurations of care arrangements in society especially with a view to the increasing demands for expensive treatments, due to the ageing of the population and the changing and more demanding attitudes of the clients. Such concerns are therefore footed in societal developments, each potentially threatening solidarity.

2. CONCERNS FOR CARE PUT SOLIDARITY UNDER STRAIN

First of all, there is the worrying issue of the widening gap between expectations of and demands on the health care system on the one hand and the limited and bounded supply on the other. The ageing of the population of the European societies has resulted in a change of morbidity patterns and gave rise to an increased demand for care services, particularly in the field of long-term care. This process, which can be observed in most parts of the Western world, is reinforced by a change in attitudes among patients toward more self-awareness and self-assertiveness with respect to the demand for high-quality health care services. Instead of the humble, authority-sensitive attitude of patients in the past, the modern patient considers him or herself to be a client who is very well informed about the treatment opportunities and the types of advanced services that are available. This 'consumerism', reinforced by the growing popularity and spread of the Internet, is becoming more current among the next elder generations who are expected to claim a higher quality of services than in the past, particularly in the field of diagnostics. Moreover, as medical knowledge and technological opportunities are rising, the costs of medical interventions that are based on high-cost medical technologies will increasingly put pressure on the health care budget.

While the demand for care is increasing, national governments are under increased pressure to preserve or even downturn the level of public expenditures. One reason for this pressure emanates from the creation of the European Monetary Union, which has forced national governments to comply with strict measures regarding the level of public funding, the government deficit and public expenditures. The gap between the demand and supply of care, partly caused by these unification measures, has resulted in an increasing shortage of care services in all European countries, particularly in the public health care system. The shortage of services is particularly notable in the area of long-term care and care services for the elderly. The (relative) scarcity of health care services is putting solidarity within society under heavy strains. For example in the Netherlands, the willingness to pay higher insurance premiums to meet the costs of expensive treatments is decreasing, as can be shown by the results of opinion polls (See the chapter by Van der Made, Ter Meulen & Van der Burg in Part 1 of this Volume). An increasing part of the Dutch population shares the opinion that not everyone should be entitled to the same medical treatments, particularly if these treatments are extremely expensive.

The scarcity of resources puts strains in particular on the solidarity between generations, that is the willingness of the younger age groups to contribute to the expenditures required to meet the needs of the older generations. The ageing of the population and the concomitant increasing burden of disease will lead to high costs for the financing of health care and social care provisions for elderly persons. To the extent that the costs of care provisions cannot be covered from the collective premiums and additional contributions (co-payments) an additional burden must be levied on the shoulders of current generations of young workers. Since the number of elderly is growing fast in the next decades and the number of young workers is rapidly declining, the burden of health care insurance premiums and taxes levied on wages will strongly increase, endangering intergenerational solidarity. Will the younger generations continue to be prepared to transfer a large share of their income to the elder generations, while it is rather uncertain that they will equally benefit from such care services themselves when their turn comes?

The financing of care provisions and the pressure on intergenerational solidarity becomes even more problematic in view of other demographic and sociological processes, like decreasing fertility rates and dwindling family networks, inducing a diminished supply of informal care that has to be compensated for by the supply of professional care. It is not a viable option to levy the additional costs for care on the shoulders of the elderly themselves as this would lead to extremely high premiums, while the demand for care is the highest among elderly persons with low incomes. For this reason younger generations have to pay a solidarity premium to finance the care for the elderly, which can attain very high levels. The increasing demand for care by the elderly is putting a heavy claim not only on the social resources for health care, but also on the willingness of the younger generations to care for their

dependent parents. Though many of them, particularly the daughters, are willing to supply such care, there are limits to their physical and emotional possibilities. While most of them want to support their parents, they do have their own life plans and their own children to care for. Individualisation patterns (like for example self-realisation in work and family life) are putting limits to solidarity with elderly dependent parents. As institutional care and home care are put under strain, families are increasingly burdened with the care for their elderly and needy family members.

A second potentially threatening development is the shift from collective responsibility towards an increased emphasis on individual responsibility with regard to the financing of health care insurance and personal health care services. One of the policy options to cope with the scarcity of resources is to increase the financial responsibility of the users for the utilisation of health care services, for example by co-payments and contributing to the costs. The idea underlying this policy is to make the individual familiar with and aware of the costs of health care, and thus to promote the cost consciousness and responsible behaviour with respect to medical consumption. Increased financial contributions are believed to have an inhibiting effect on the demand for care. It is evident that this policy affects solidarity; direct non-income related payments to insurers or care providers are irrefutably a greater burden for lower incomes group than for higher incomes.

The shift towards more private financial responsibility is reinforced by the changing role of the state in the organising of the welfare and health care arrangements. In most European countries the state is retreating to a less prominent role in the health care system. While the state keeps its responsibility in regard with the access to and the quality of health care services, health care providers and health care insurers are getting a greater freedom in the organisation and delivery of health care services. At the same time, room is created for flexibility to accommodate individual preferences. On the one hand this development may create opportunities for more tailored health care services and new types of personal solidarity, for example in the area of informal care. On the other hand, more room for the market and for individual financial contributions to care provision will lower the solidarity with the lower income groups and with persons with chronic diseases (which are difficult to insure). The retreat of the Welfare State will give way to two-tier systems of health care, that will enable individuals to buy privately luxury care or other care services that are not part of the basic package. The changing nature of state responsibility in various areas of society will affect the structure of solidarity as well as the egalitarian character of health care.

A third development that may present a threat to solidarity is the so-called *individualisation* of society. In the sociological literature individualisation is conceived as a long-term social process, a trend extending over several centuries. From its beginnings in the 19th century

sociology has been concerned with the transition from 'traditional' to 'modern' society, and the dissolution of traditional bonds and groups that tied people together was seen as part of this transition. During the last decades, however, specific social changes in Western society have given the concept a new significance. In order to clarify the concept of individualisation, Wilterdink (1995: 7) has distinguished three aspects of the individualisation trend that took place since the 1960s. They represent both a partial continuity and partial discontinuity with respect to preceding developments. The three aspects are the following.

1. In a relational sense, individualisation refers to an increasing instability or changeability of personal, intimate social relations. In earlier periods we have witnessed the erosion of local communities and extended family networks. Today we see the penetration of individualisation into the last bastion of traditional society, the nuclear family. Although the nuclear family is still the ideal of many, it is no longer the necessity of yesterday. The individualisation process has not only led to an increasing number of different household types, but also an increase in divorces and the breaking up of other intimate relations.
2. As a situational development, individualisation refers to a process by which the range of behavioural options for individuals inherent in the social situation becomes enlarged. The emancipation of women has led to an increasing participation of women in advanced and higher education and the labour force. As more married women have paid jobs, they become less dependent on their husbands, lead more their own lives, and are less exclusively oriented to the household and the upbringing of children. The tendency that the range of options for individuals becomes enlarged is, however, not confined to women. More basically, the alternatives, which are important in the individual's life course, tend to increase with respect to education, work, residence, friends and partners. Individuals get more freedom to decide for themselves, but also increasingly feel the burden of making the right decision.
3. As a normative process, individualisation refers to a change in norms and values implying an increasing stress on the moral significance of individual autonomy. Because the individuals have escaped the strict surveillance of their spiritual leaders and the interference of their snooping peers, the individual freedom attained is by many considered to be a gain. There is, however, also a shaded side to it as far as individualisation can be held responsible for rising criminality, political apathy, lack of responsibility, hedonism and moral obtrusion.

Wilterdink argues that the above mentioned processes are strongly interconnected: when social relations become more changeable, the individuals involved have more options; when individuals have more options, this change in 'objective' conditions will give rise to legitimating normative ideas. Hence, in turn, when norms stress individual autonomy,

Solidarity in Health and Social Care in Europe

Editor-in-chief: ter Meulen, R. - Arts, W.; Muffels, R.
(Eds.)

2001, XXII, 506 p., Hardcover

ISBN: 978-1-4020-0164-2