

# Solidarity in healthcare – seven questions and answers

By Valerie Zaslowski

1. How did the principle of solidarity become established in the Swiss healthcare system?

Healthcare costs in Switzerland rose from CHF 2,083 million in the 1960s to CHF 28,151 million in the 1990s, which greatly increased the pressure for reform. Consequently, the four Swiss Federal Council parties – FDP, CVP, SVP and SP – had to agree on a compromise. After several unsuccessful attempts, a compulsory basic health insurance scheme for all Swiss residents and a financing system based on per capita premiums were launched in 1996. Since then, per capita premiums have remained the same for men and women across the age groups. The exceptions are lower premiums for children and young adults. There are also regional differences.<sup>1</sup>

Solidarity between the healthy and the sick is thus enshrined in the Federal Health Insurance Act (KVG/HIA)<sup>2</sup>. Redistribution is therefore one of the core functions of health insurance. In practice, this also results in solidarity between young and old, because young people on average have little need of medical care, but the risk of illness increases with age<sup>3</sup>. Uniform premiums also mean that under the HIA there is solidarity between men and women, as the latter generally claim more medical benefits due to pregnancies and

1: Differenzierung privater Krankenversicherungstarife nach Geschlecht: Bestandsaufnahme, Probleme, Optionen, Prof. Dr. Heinz Rothgang und Prof. Dr. Gerd Glaeske, 2005: <https://www.bmfsfj.de/blob/84280/4a18b7b416f5efbae139fc23e856c968/gutachten-krankenversicherung-gen-geschlecht-data.pdf>

2: Bundesgesetz über die Krankenversicherung: <https://www.admin.ch/opc/de/classified-compilation/19940073/201801010000/832.10.pdf>

3: Das Solidarprinzip in der gesetzlichen Krankenversicherung, Wolfram Burkhardt, 2013: <https://www.bpb.de/politik/innenpolitik/gesundheitspolitik/72358/solidarprinzip?p=all>

births and longer life expectancy. Last but not least, premium reductions also create solidarity between lower and higher earners, as these reductions are funded by way of progressive taxation.

People subject to compulsory insurance may choose freely between 51 federally approved health insurers. Insurance companies, on the other hand, are legally obliged to accept applicants regardless of their state of health on the basis of the admission obligation. A risk equalisation mechanism is in place to prevent risk selection between insurers – a further feature of solidarity. Insurers who have fewer people with an elevated risk of illness in their customer base than the average of all insurers must pay levies. A compensation office is responsible for ensuring the balance of risks between insurance companies.

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## 2. How do voluntary supplementary insurance plans differ from compulsory basic insurance?

Compulsory basic insurance ensures that all insured persons resident in Switzerland have access to the same basic healthcare benefits. The extra benefits offered by voluntary supplementary insurance plans, by contrast, have to be paid for separately and are therefore only affordable for higher earners. Supplementary insurance plans are subject to the Insurance Policies Act (VVG/IPA)<sup>4</sup>, and general contractual conditions apply. This means that insurance companies can theoretically limit the duration of contracts and terminate contracts in the event of a claim, although private health insurers generally waive this right in their insurance conditions. The amount of premium to be paid also varies depending on the individual insurance risk assumed by the company if it insures the person. A high risk exists when a person is very likely to incur high healthcare costs<sup>5</sup>. This is the case, for example, if a person already has illnesses when seeking to take out insurance. In contrast to basic insurance, insurers are not obliged to admit applicants to supplementary insurance, which means they are free to reject people with pre-existing conditions. The same applies to older people seeking to take out supplementary insurance: older people pose a higher insurance risk as the need for medical care increases with age. In practice, supplementary insurance premiums are primarily calculated according to age<sup>6</sup>. Supplementary insurance premiums may also differ by gender. Finally, supplementary insurance are not adjusted for income inequalities.

4: Bundesgesetz über den Versicherungsvertrag: <https://www.admin.ch/opc/de/classified-compilation/19080008/index.html>

5: Das Solidarprinzip in der gesetzlichen Krankenversicherung, Wolfram Burkhardt, 2013: <http://www.bpb.de/politik/innenpolitik/gesundheitspolitik/72358/solidarprinzip?p=all>

6: Differenzierung privater Krankenversicherungstarife nach Geschlecht: Bestandsaufnahme, Probleme, Optionen, Prof. Dr. Heinz Rothgang und Prof. Dr. Gerd Glaeske, 2005: <https://www.bmfsfj.de/blob/84280/4a18b7b416f5efbae139fc23e856c968/gutachten-krankenversicherung-gen-geschlecht-data.pdf>

### 3. Why are we even prepared to show solidarity when it comes to healthcare?

The story of Saint Martin is often cited as a prime example of solidarity<sup>7</sup>. He is said to have spontaneously given half of his cloak to a beggar. Why do people do such things? There are different explanations for this good deed: Brain researchers relate it to activity of the frontal lobe, a region of the brain that reacts particularly strongly to socially motivated sensations. Psychologists, on the other hand, think that Saint Martin was hoping for something in return, while philosophers believe that sharing is a kind of deposit into a “feel-good bank” – made in the hope of getting everything back with interest<sup>8</sup>. And business ethicists say that a better way for Saint Martin to show his solidarity would have been to open a coat factory to get the beggars off the streets. Christians see it as an act of charity.

Solidarity in healthcare is primarily driven by the realisation that we will most likely one day ourselves be dependent on the solidarity of others. So, drawing parallels with Saint Martin’s story, solidarity in healthcare can best be compared with the philosophical deposit into a “feel-good bank”. Insureds receive interest back in the form of medical care. Whether you pay in or get back usually depends on your age. During the course of your life you shift from one status to the other<sup>9</sup>. Of course, young people can also get sick and old people can stay healthy right to the end of their life. But this self-interest with regard to solidarity in healthcare has nothing to do with people’s level of income<sup>10</sup>. Upper income groups also have a major vested interest in having comprehensive cover in the event of illness. Premium reductions for lower-income citizens are financed through progressive taxation, which means that high earners (always) pay more.

### 4. So was there no solidarity in the Swiss healthcare system before 1996?

There was. After all, solidarity isn’t an overarching design principle<sup>11</sup> that was decided at some point in time with the aim of implementing and maintaining this system as systematically as possible. However, the aim at the start of the 1990s was to create a system based on solidarity that was also financial-

7: Wie viel Solidarität steckt im Menschen? Christoph Pagel, 2010: <https://www.zeit.de/wirtschaft/2010-07/solidaritaet-forschung/seite-2>

8: Solidarität in der Krise: Zusammenleben in Zeiten von Selfies und Singles, Katharina Finger und Nicole Schleider 2015: <http://www.3sat.de/page/?source=/wissenschaftsdoku/sendungen/181189/index.html>

9: Das Solidarprinzip in der gesetzlichen Krankenversicherung, Wolfram Burkhardt, 2013: <http://www.bpb.de/politik/innenpolitik/gesundheitspolitik/72358/solidarprinzip?p=all>

10: Sinkt das Vertrauen in Gesundheitssysteme? Eine vergleichende Analyse europäischer Länder, Claus Wendt, 2007: [https://www.boeckler.de/wsimit\\_2007\\_07\\_wendt.pdf](https://www.boeckler.de/wsimit_2007_07_wendt.pdf)Eine vergleichende Analyse europäischer Länder, Claus Wendt, 2007: [https://www.boeckler.de/wsimit\\_2007\\_07\\_wendt.pdf](https://www.boeckler.de/wsimit_2007_07_wendt.pdf)

11: Einer für alle, alle für einen – Das Solidarprinzip in der gesetzlichen Krankenversicherung, Wolfram Burkhardt, 2013: <http://www.bpb.de/politik/innenpolitik/gesundheitspolitik/72358/solidarprinzip>

ly viable and of high quality. Solidarity is more of a characteristic that could be used to describe various existing arrangements. This applies to both the time before and after 1996, i.e. after the implementation of compulsory basic insurance. The principle of solidarity is subject to change: Before industrialisation, the family was primarily responsible for caring for the sick and infirm. In the event of serious illness, local communities sometimes provided the necessary support. The church offered assistance as an act of charity.

With the expansion of wage labour in the mid-19th century, relief funds were set up in many places based on the principle of mutual solidarity. The idea was that workers would receive financial support in case of illness. First they were compensated for loss of wages, and later they were reimbursed for treatment costs. In return, insureds had to pay regular contributions.<sup>12</sup> The fund system continued to develop, with some cantons and cities implementing compulsory insurance schemes. In the past, insurance companies had greater freedom in defining premiums, but according to the Federal Office of Public Health, even back then individual risks were balanced between the various insureds. However, solidarity by way of premium reductions did not yet exist. It took several attempts before solidarity was enshrined in law at the national level, as there were major federalist and financial reservations about expanding centralist institutions.

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#### 5. How much solidarity is there within the Swiss healthcare system by international standards?

To compare the solidarity of the Swiss system to international models, you first have to differentiate between the characteristics of the various health systems. The literature distinguishes between three different healthcare models<sup>13</sup>: the social security model, the tax-financed model and the market economy model. Social security models are found in Switzerland, Germany, the Netherlands, France, Austria and Belgium. They are based on the concept of solidarity in the form of mutual support between the healthy and the sick. There are three systems within this category<sup>14</sup>: a structured system with free choice of insurer and competition between health insurers (Switzerland, Germany and the Netherlands), central universal healthcare (France) and professional and regional compulsory insurance (Austria and Belgium). Social security models are funded by contributions. Unlike the tax-financed model, employers tend to be involved in financing the scheme (although this

12: Geschichte der sozialen Sicherheit, Bundesamt für Sozialversicherungen, 2018: <https://www.geschichtedersozialensicherheit.ch/risikogeschichte/krankheit/>

13: Gesundheitssysteme und Rehabilitation im Internationalen Vergleich, Dr. med. Harald Berger, 2017: <http://www.psychotherapie.uni-wuerzburg.de/termine/dateien/Berger-2017-06-07-InternationaleGesundheitssysteme.pdf>

14: Gesundheitssysteme, AOK Bundesverband, 2016: [https://aok-bv.de/lexikon/g/index\\_00368.html](https://aok-bv.de/lexikon/g/index_00368.html)

does not apply to Switzerland). The state, on the other hand, has only an indirect steering function in the social security model.

Tax-financed healthcare systems that include the whole population in their coverage exist in the UK, Italy, Portugal, Spain, Sweden, Denmark and Norway. Finally, there is the American model, which is based on the logic of a market economy. In the USA, despite Obamacare and the associated “compulsory insurance” introduced for the first time in 2010, a large proportion of the population is still not covered by health insurance<sup>15</sup>. Anyone not insured has to pay for their own medical care in case of illness, which is why many people get into debt. In an international comparison, the Swiss health system displays greater solidarity than the US health system, for example<sup>16</sup>. However, it is also more liberal than the German health system, where health insurance premiums depend on a person’s income. It is also more liberal than the health systems in France or the UK, which rely more on fiscal contributions from the state. However, whether “more liberal” is always synonymous with “less solidarity” is another matter. In other words, do state healthcare systems necessarily display greater solidarity? This is doubtful, because state healthcare systems financed by taxes are also forced to compensate for dwindling tax revenues, for example, by increasing deductibles, which reduces the solidarity between insureds in different income brackets.

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6. Would the introduction of the Electronic Patient Record (EPR) have an impact on the principle of solidarity in the Swiss healthcare system?

With the Electronic Patient Record EPR, the Swiss healthcare system is planning a major milestone in its digital transformation. Basel-Stadt was the first Swiss German canton to introduce the EPR in 2018 once the system had met the requirements of the applicable federal law<sup>17</sup>. The remaining cantons will soon have to follow suit, because the deadline for implementation is 2020 for all hospitals and 2022 for old people’s homes and maternity facilities. Electronic Patient Records allow patients and healthcare establishments to store personal health data centrally. Other practitioners can access EPRs any time, anywhere. A number of these can be put forward to anticipate how the EPR will affect solidarity if confidence in the systemic framework conditions and responsible actions of others is seen as a prerequisite for solidarity. If introducing EPR really does lead to the promised increase in efficiency and quality in healthcare by reducing redundancies for diagnoses

15: Krankenversicherung in den USA, The American Dream, Holger Zimmermann und Marcus Sieber: <https://www.info-usa.de/versicherung-usa/>

16: Der KVG-Kompromiss von 1994 zerbröselt, Dietmar Braun, 2007: <https://www.nzz.ch/articleF23ZA-1.137917>

17: Gesetzgebung Elektronisches Patientendossier (EPDG): <https://www.bag.admin.ch/bag/de/home/gesetze-und-bewilligungen/gesetzgebung/gesetzgebung-mensch-gesundheit/gesetzgebung-elektronisches-patientendossier.html>

and treatment, a stabilising effect on solidarity would be conceivable, because trust in doctors and the system could increase. If individual health literacy and personalised prevention were also to improve, confidence in the behaviour of fellow citizens – and thus in solidarity – could also grow.

However, there are also concerns regarding solidarity: Although patients are supposed to retain the greatest possible control over their sensitive health data, and insurers or employers are not supposed to have access to the data, there is still a risk of data theft and manipulation, as is the case with all digitally networked systems. The worst case scenario is that all sensitive health data could be made public. This would create a level of transparency that would remove the basis for any trust in the system and in others, and would cause lasting damage to social solidarity.

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7. What are the key issues around the future of the principle of solidarity in the Swiss healthcare system?

The most important question is whether the rise in healthcare costs can be controlled, because the growing costs are leading to a rise in premiums every year. And this increase in premiums is putting a strain on individuals' willingness to help cover the risks of other citizens without limitation. For example, SVP National Councillor Thomas de Courten<sup>18</sup>, who chairs the Health Commission, called in 2016 for the compulsory health insurance requirement to be relaxed. The call to increase deductibles by 50 Swiss francs for all insureds is a further sign that the boundaries of solidarity are shifting: If the sick had to pay more for their medical bills, this would primarily impact lower-income households.<sup>19</sup>

However, whether it's possible to get a grip on the costs doesn't depend solely on the raft of measures recently launched by the Federal Council<sup>20</sup>. It will be just as important to see whether digitalisation can be designed in such a way that it boosts confidence in the system.

Projects such as the EPR (Question 6) look promising, but they also highlight the limits of technology. It will also still be important to promote personal responsibility in the future, for example by encouraging the moderate use of medical services. In addition to the actual individual costs, trust in the per-

18: Prämienanstieg der obligatorischen Krankenversicherung stoppen! Ansatzpunkte und Lösungsvorschläge! Welche Rezepte hat der Bundesrat? Thomas de Courten, 2016: <https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20163919>

19: SVP kippt Franchisen-Erhöhung um 50 Franken in der Schlussabstimmung, Schweizer Depeschagentur, 2019: <https://www.aargauerzeitung.ch/schweiz/svp-kippt-franchisen-erhoehung-um-50-franken-in-der-schlussabstimmung-134241540>

20: Kostenbremse im Gesundheitswesen, Hansueli Schöchli, 2019: <https://www.nzz.ch/schweiz/globalbudget-im-gesundheitswesen-das-kleingedruckte-zaehlt-ld.1465901>

sonal responsibility of others is an important cornerstone of active solidarity. In theory, digital fitness and reward apps can encourage personal responsibility. However, use of these apps remains low and no long-term benefits have been proven. What's more, digital companions are always also a means for people to create distinctions and compare themselves with others. This can serve as motivation, but can also widen the gap between users and non-users, making solidarity more difficult overall. In addition to limiting individual costs, key factors in safeguarding solidarity in the healthcare system in the future will be preventing social exclusion and sustainably promoting personal responsibility.