Health Care Analysis **8:** 65–75, 2000.

Lifestyle Solidarity in the Healthcare System

MARGO TRAPPENBURG
Department of Political Science, PO box 9555, 2300 RB Leiden, The Netherlands;
E-mail: trappenb@fsw.LeidenUniv.nl

Abstract. Encompassing health care systems in modern welfare states embody several forms of solidarity: between the sick and the healthy, the old and the young and between those who take good care of their health on the one hand and fellow citizens who choose to risk their lives by smoking or unsafe sex on the other. The latter form is called lifestyle solidarity. In the Netherlands this type of solidarity has become the object of a debate between medical ethicists. Most medical ethicist seem to want to uphold lifestyle solidarity. Most Dutch citizens agree with them. The Dutch government, however, embarked on a project to change the health care system by transferring state responsibilities to other actors (employers, insurers, individuals). This changing policy may diminish or destroy lifestyle solidarity despite the fact that no one intended this to happen.

Key words: risky behaviour, responsibility, health care system

Introduction

Several forms of solidarity come together in the healthcare system. An encompassing healthcare system entails solidarity between the sick and the healthy, the rich and the poor, the old and the young, and between employers, employees and the unemployed. Following the crisis of the welfare state in Western European countries, all these forms of solidarity within the healthcare system are being questioned. In several countries private hospitals offer their services to the rich who can afford them, thus diminishing the solidarity between the rich and the poor. In various countries patients have to contribute to doctors' fees or medication costs, which can be interpreted as an infringement on the solidarity between the sick and the healthy. In the Netherlands many employers advocate a healthcare system in which their employees would not have to queue on a hospital waiting list, so as to enable them to get back to work as soon as possible. This will undoubtedly change our views on solidarity between employers, employees and the unemployed. Policy makers in different countries worry about the effects of an ageing population on health care costs. Will we be able to look after the medical needs of the elderly thirty years from now, when they will make up one quarter of the population?

There is another form of solidarity in the healthcare system which used to be hidden in the past. We might call this lifestyle solidarity. Lifestyle solidarity refers to solidarity between smokers and non-smokers, between the fat and the skinny, between teetotallers, moderate drinkers and alcoholics, between hamburger-lovers and strict vegetarians. Lifestyle solidarity has never been an explicit choice in healthcare systems. When the systems were designed this kind of solidarity was not an issue. This has changed gradually during the last ten or twenty years. There is an increasing amount of information about the relation between health and lifestyle. Various scientists have pointed out that, at least in rich, western countries, one's health is partly determined by one's way of life: what one eats, how much one drinks, whether one smokes, how hard one works, whether one indulges in risky sexual behaviour, etcetera. It is, moreover, assumed that at least some of these statistical or causal relations are common knowledge. Everybody ought to know by now that smoking can damage your health as can excessive drinking, risky sexual behavior, or going without fruit and vegetables.

A growing awareness that "many medical needs are foreseeable and avoidable consequences of individual actions"[1] combined with an increasing pressure on the health care budget has raised a number of questions concerning lifestyle solidarity. Medical ethicists have thought up intriguing moral dilemmas and fascinating analogies; suppose a drunken driver hits a tree and is subsequently carried into the operating room. In the next hospital ward an old lady is waiting for surgery, which is scheduled at the same time that the drunken driver was brought in. Should her operation be postponed in order to save the drunken driver's life? Even if this would cause her considerable stress which might further endanger her health?[2] Or take this analogy. Suppose someone needs champagne to get to work in the morning, just like other people need coffee. No one will maintain that the champagne lover must be subsidized because of his expensive tastes. Why should this be different with people whose expensive lifestyles will lead to large medical expenses? Yet our health care system is such that the average tax or premium payer implicitly subsidizes fellow citizens with expensive lifestyles. Shouldn't we change the health care system and make room for some kind of 'fault' or 'just desert' principle?[3] According to proponents of a just desert principle in health care, things are very simple. One knows what to do in order to live healthily. If one nevertheless chooses to risk one's health, one cannot expect society to pay for that decision.

Lots of counterarguments have been launched to attack this position. Proponents of lifestyle solidarity point out that many people do not consciously choose an unhealthy lifestyle. When you have been raised in a lower class family where disease used to be seen as a blow of fate, you may grow

into an unhealthy lifestyle without ever having chosen it.[4] And even if you grew up in a health-loving family you might still end up with an unhealthy lifestyle that was not a real choice. You may have been struck by disaster such as divorce, the death of a loved one or dismissal at work. It seems unfair to punish people for being weak, or for no longer caring about their own health in such a situation. Proponents of lifestyle solidarity further argue that it will be simply impossible to punish all sorts of risky lifestyles. Smokers and rock climbers are much more easily caught than burnt out workaholics. Thus, any form of just desert policy in health care is bound to be arbitrary. Some advocates of lifestyle solidarity feel that introducing a fault principle in the health care system would transform doctors into judges, which they consider a bad thing. Others argue that it would not necessarily be a bad thing, but that it would entail a much bigger change of hospital practice than proponents of a fault principle realize. The hospital would have to be transformed into a courtroom where people ought to be allowed to plead their case. (‘Yes, your honor, I admit that I have not been taking good care of my body. But I was unhappy and sad. In the last few months my life has changed, though. I have got a new girlfriend, we are going to have a baby and I found a real nice job. I really intend to change my ways.’) Some medical ethicists argue that repentant sinners ought to be given a chance to better their lives.[5] In this article I do not intend to discuss the merits of these moral arguments. Instead I want to review certain developments in the Dutch health care system and debates about the health care system. I want to show what each of these developments will do to lifestyle solidarity. Although the article is about the Dutch health care system in particular the concepts discussed may be useful to analyse developments in other countries as well.

Changing Policies

Recent developments in the Dutch healthcare system can be described using the following table.

Table 1. Changing the health care system

	lifestyle solidarity +	lifestyle solidarity –
individual choice –	STATE	EMPLOYER
individual choice +	INDIVIDUAL PRIVATE INSURER	COMMUNITY

The upper left cell of the table represents the traditional welfare state where the citizen's health is for a large part assumed to be the state's responsibility. There is a broad standard package of medical treatment that is collectively financed. The contents of this package are determined by the state, usually in consultation with the medical profession. In the upper left cell the health care system is part of a balanced overall picture. The dominant actor (the state) has to take a variety of conflicting and competing interests into account. From the perspective of lifestyle solidarity, this is a reassuring idea. Of course, it is to a certain degree in the state's interest that people live healthily and die of old age. Thus, the state will no doubt provide some kind of information about health promoting behavior (it may organize vaccination programmes for young children, produce leaflets with warnings against the dangers of smoking, print similar messages on cigarette packages, organize campaigns concerning the risks of certain kinds of foods, distribute leaflets on the dangers of drug use during pregnancy etcetera). However, promoting citizens' health is but one of the state's many interests. Reducing unemployment is also in the state's interest. The state can hardly afford to have a perfectly consistent anti-smoking policy when this will cost thousands of jobs (tobacco companies, retailers, advertising agencies). In a similar way the state has to balance its citizens' health against the economic interests of liquor stores, fish and chips shops and perhaps even nurses and medical doctors. The state would appreciate it if we ate wholesome food and drank healthy beverages, but the state will never distort its policy to fulfill these wishes. There is always also the gross national product to consider, the balance of payments, the number of welfare recipients and quite a number of equally important matters. Moreover: it is not really in the state's interest that all its citizens live to a ripe old age and die of Alzheimer's disease. On the contrary: the growing percentage of elderly citizens is a reason for concern. Thus, it seems safe to assume that the state will never go overboard when implementing public health programmes. From a narrow public health perspective this may seem inadequate, but from a plain citizen's perspective this seems very reassuring. In the upper left cell of the matrix I do not have much of a say in what happens (after all, it is the state that determines the contents of my health care package and it is likewise the state that will balance my interests against those of my fellow citizens), but I can be fairly sure that nothing really drastic will ever happen. The traditional welfare state provides the citizen with a stable societal context in which he can live and breathe and do his own thing. Such were things in the traditional welfare state, in the golden days. However, following the crisis of the welfare state, politicians and health care policy makers decided that things could not go on that way. There were too many rules and regulations, too many taxes and social insurances, too little

room for market forces, too little room for citizens' manoevering. Citizens had been pampered and smothered. The economy seemed to collapse under the weight of the welfare state, in short: it was time for a change.

Change took place in three different directions, to the three other cells in the table.

Diminishing Lifestyle Solidarity

The move to the upper right cell of the table was preceded by the realization that the welfare state consisted of a strange and at times perverse system of carrots and sticks. For example. Employers who wanted to sack certain employees (either because they did not function properly or because of economic malaise) could very easily take the so-called disability route.[6] They made their (elderly) employees go to a friendly doctor who would say that those employees were no longer capable of lifting heavy packages or staring at a computer screen. The employees would then get a state financed allowance that was so generous that the unions did not dare to object to this kind of redundancy policy. There was no reason whatsoever to improve working conditions or to try to employ less healthy employees somewhere else in the workplace. Neither unions, nor employers, nor employees would come up with objections against the disability route. The sticks and carrots were all pointed in the wrong direction. This strange social policy was not just a Dutch phenomenon. Similar policy schemes existed in other Western European countries, notably in France and Germany.[7] The Dutch government decided that this should change. Henceforth employers would have to pay for sickness and disability allowances. This would no doubt induce them to improve working conditions. It would make them take responsibility for their employees' health. At first sight, this seems a change for the better. After all lots of people get work related diseases at one point or another. They suffer from too much or too little responsibility, have to work in sick buildings, have to breathe toxic substances and so on. It sounds eminently reasonable to give employers a financial incentive to change all that.

However, the move to the upper right cell has not just been a change for the better. Employers do not operate in a system of competing claims and conflicting interests, like the state used to do. Within the new incentive structure, their interest is plain and simple. Employees are to be as healthy as possible. Thus, employers want to hire healthy employees. The new laws on sickness and disability came into force between 1992 and 1994. Already research has shown that many employers have become risk averse when it comes to hiring older employees, employees with chronic conditions or people with unhealthy lifestyles.[8] In the United States, where health

insurances are often tied to employment, “lifestyle choices have become a precondition for gaining and retaining employment”; some companies do not hire smokers or charge overweight employees increased health insurance copayments.[9] It may seem far fetched to assume that the situation in the Netherlands will be like that in a couple of years, but things certainly seem to develop in that direction.

Once they are hired, employers want to keep their employees healthy, so as to save money. In the Netherlands employers sometimes want to make deals with hospitals and insurers in order to make sure that their employees who need medical assistance will be up and about as soon as possible. One can easily see what this development will do to lifestyle solidarity in the long run. Already a working life sometimes leads to speedy treatment in the hospital; housewives, children and pensioners do not have an employer who can strike deals for them.

One can imagine future employers providing their personnel with exercise rooms and work out equipment, encouraging them to keep fit. Already some employers have introduced an anti smoking policy that requires smokers to work over time, in order to make up for all the lost minutes they used having a quick smoke outside the building or in a special smoking zone. Healthy behavior may gradually transform. It used to be anybody’s free choice, but it may turn into a duty toward one’s employer, all part of the job, or even: a precondition to ever get a job.[10] If good and speedy healthcare services become in one way or another a privilege of those who work, and work becomes a good that is only available to the healthy who actively strive to remain healthy, lifestyle solidarity may disappear even though no one really agrees with the arguments against it. For, after all, the change from the upper left to the upper right cell was never made in order to abolish lifestyle solidarity. It was a change toward a more efficient incentive structure that seemed to make sense in the beginning. Still, from the perspective of lifestyle solidarity, making citizens’ health their employers’ concern is the worst that could happen.

The state also decided to shift some of its burden of responsibility to the lower left cell in the matrix, to the individual. The argument behind the change in this direction seemed to be as follows. Citizens, especially those who are socially insured for healthcare expenses (about 65% of the Dutch population), do not feel responsible for their own health and their medical bills. In fact, many patients never even see a medical bill. If they were more aware of health care costs, if they would have to bear part of their medical expenses themselves, they might become more sensible consumers. Thus, there should be much more consumer freedom, consumer choice, private insurance, market incentives, competition between insurers and other market elements. Now, what will this development do to the solidarity structure in

the healthcare system? Will it be as bad as the change to the upper right cell? Imagine you are a private health insurer competing with other health insurers. What kind of clients do you want to have and what kind of clients would you rather do without? You do not want to accept clients who already have a serious disease, or who will undoubtedly suffer from a serious disease in the near future. You do not want cancer patients or HIV positive clients and you would rather not have clients over 75 because you can be sure that they are going to cost you dearly. It is your natural inclination to avert those clients or, if you are not allowed to refuse them because of legal obstacles, to charge them as much as possible. In other words: if the state shifts responsibility for its citizens' health to the citizen and his private insurer, this will (if nothing be done to prevent it) lead to a diminution of solidarity between the sick and the healthy as well as the old and the young.

Will it also decrease lifestyle solidarity? Not necessarily and certainly not immediately. A health insurer can be pretty sure that all of his clients will get sick in the long run. There is no financial reason to prefer a non-smoker who will live and pay premiums till a ripe old age before dying of senile dementia after ten years with high medical bills over a heavy smoker, who pays his insurance premiums up till the age of 58 and then dies of lung cancer. In fact: research has shown that the smoker will probably cost less.[11] Investing quite a lot in preventive medicine or lifestyle education is not rational from the private insurers' point of view. In the words of Van der Maas who did extensive empirical research in this area: "[I]n health insurance, as opposed to all other insurances, the more the insurer invests in repairing the damage, the higher the costs he will incur in the future. (. . .) Nearly all effective interventions, be it primary prevention, secondary prevention or therapy, will, irrespective whether they will result in life prolongation, result in increased lifetime healthcare expenditures."[12]

The incentive structure will not induce private insurers to diminish lifestyle solidarity. The market might accomplish this nevertheless. With regard to lifestyle solidarity, health insurers will probably sell whatever clients are inclined to buy. If it turns out to be highly profitable to sell low premium packages to non smokers, who contractually agree to pay a certain percentage of their medical costs themselves, then there will be insurers who will sell this kind of non smokers insurance. The same goes for total keep fit packages (you have to pay a large part of your medical bills, but you can enter our special fitness and exercise schools for free). If consumers are not interested in this kind of offer, because they feel that health insurance is not an instrument to remain healthy, but a solidarity system to help those who fall ill, then insurers will not force them upon us. There is no pure financial incentive for them to do so.

It seems to be up to ‘us’ to determine what will happen in the lower left cell. There is more room for individual choice. However, we have to understand the nature of this type of choice. Private insurers do not approach individuals as citizens, they address them as prospective buyers or rational consumers and being addressed as such may well make them behave as such. It is possible that people who would immediately agree with all arguments in favour of lifestyle solidarity (opinion surveys have shown that the Dutch do not approve of the introduction of some sort of fault principle in the health care system),[13] would nevertheless buy themselves a special health insurance offer for non smokers, because this seems the right thing to do when they are approached as consumers. If this happens often, we may still end up in a society without lifestyle solidarity, albeit less quickly than in the upper right cell. And partly it will be our own doing.

Now and again, ambitious policy makers also consider a move to the lower right cell. They worry about the ever rising health care budget. They argue that it is time for difficult choices in health care. Citizens ought to decide what kind of health care is necessary in society and what health care can be considered luxurious, unnecessary, too expensive or any combination of these three qualifications. Thus, in the Netherlands a committee was installed which had to reflect on choices in health care. They produced a report in which they advocated (among many other things) a so-called community approach in health care.[14] The community ought to pay for those health care services (and only those) which are necessary in order to function as a member of our community. Hence, the community should discuss and decide what kind of health care services could be qualified as such. Is physiotherapy necessary in order to function normally in our society? Can citizens with a persistent back ache function without it? Is in vitro fertilization necessary for proper functioning in our society? Cannot people function without biological offspring? Etcetera. The choices in health care committee argued that citizens should engage in public debates about this kind of questions.

In these debates the issue of lifestyle solidarity might pop up as well. Citizens might decide to restrict certain kinds of treatments (such as liver transplants or open heart surgery) for deserving patients only. We might come up with interesting judgements on individual responsibility and decide that our community ought to encourage healthy lifestyles and condemn unhealthy ones, perhaps even for paternalistic reasons, because that would be best for our fellow citizens. What could be wrong with moving to the lower right cell? If this would lead to diminuation of solidarity (lifestyle solidarity or other) it would be because this was our democratic choice, that is, society’s considered judgement.

I think that we could question this development in spite of its seemingly democratic image. What policymakers intend to do when they want to move to the lower right cell is not necessarily just have a public debate and then implement whatever values citizens claim to profess. They want to organize and orchestrate public debate, they want to make their citizens aware of certain developments in the health care system and then force them to make choices. They do not want citizens to say that they are willing to spend an extra 25 guilders a month or so in order to keep the present system in shape (whereas actually opinion surveys show that citizens are more than willing to do so, because they consider health to be of paramount value in life, both their own and others)[15] The Dutch committee on choices in health care described the object of the public discussion on choices in the Netherlands as follows: "The aim of this discussion is to introduce the public to the idea of the need for making choices. (. . .) The objectives are twofold: a. to make widely known that it is necessary and desirable to make choices and b. to make clear to people that they can themselves make choices, and to encourage them to do just that."[16] Robert Blank who wants to introduce a similar discussion in the United States is arguably even more explicitly undemocratic. He advocates a new health care system for the United States and wants to ground this new system in a public debate about lifestyle obligations and the desert principle: "Because the most difficult issues surrounding medical care are inextricably linked to broader social goals, all but the most technical decisions should be open to public dialogue and public control. The major issues discussed here center on values concerning health and medicine as well as individual rights and the common good. How we resolve the technical decisions largely reflects how we perceive these broader issues. There is, however, a paradox in arguing for more public involvement in health policy. Given the American value system and the strong belief of the public in the illusions of medicine, heightened public involvement might solidify support for the dominant medical model. (. . .) What is needed then is not simply a broadened debate but an enlightened one led by courageous leaders who are willing to fight for the necessary conceptual and practical changes. Health care reform appears to be one area where the value system effectively works against change that is critical to the public's health both literally and figuratively."[17]

This seems to have little to do with democratic enthusiasm. This sounds more like evangelical zeal. It seems obvious that neither Blank nor the Dutch committee on choices in health care intends to leave room for citizens coming up with proposals to spend whatever is necessary on health care and find the money somewhere else. Advocating democratisation but at the same time restricting the menu for choice to a few options that are all equally unattractive from a plain citizen's perspective seems rather hypocritical. In fact, it

seems sensible to mistrust every sort of democratisation that is forced upon us from above. Empirical research in Canada has shown that people do not really want to have much of a say in health care matters. They want to see a provider whenever they need one and they are willing to pay for it.[18] There is no reason to assume that people in Western Europe might be different in this respect. (It might be different in the United States where the system is in such a state that citizens might be eager to change it, and where neither the state, nor employers and insurers have done a good job so far.)

A foreign commentator once characterized recent developments in the Dutch health care system as "change without choice".[19] He is right when we look at the changes toward the upper right and the lower left cells. Moving toward the lower right cell should be democratically legitimated; change that is grounded in choice. However, it may turn out to be a forced choice which we would prefer not to make, between options created by others. In the end it might be better, from a democratic perspective, to be able to complain about choices made by policy makers than to be forced to choose yourself.

Conclusion

The debate about the introduction of a desert principle in health care among medical ethicists in the Netherlands seemed to be won by the proponents of lifestyle solidarity. The majority of the Dutch population also wants to uphold this type of solidarity. However, the government's decision to transfer some of its responsibility for citizens' health to employers, individuals and private insurers and to the community of citizens, a decision made for a variety of legitimate reasons, is bound to diminish lifestyle solidarity in fact.

Acknowledgement

This article was written as part of the BIOMED II project Communicable Diseases and Personal Responsibility. Ethics and Rights. The author wishes to thank the European Commission for its support.

Notes and References

1 Blank, R.H. (1997) *The Price of Life. The Future of American Health Care*, Columbia University Press, New York, p. 106.

2 An example of Dupuis, H., discussed in De Beaufort, I.D. (1991) Eigen schuld, dikke bult: een pijnlijke kwestie? (It's Your Own Fault: a Painful Issue?), background study for the Committee on Choices in Health Care, SDU, Zoetermeer.

[3] An example of Van Asperen, G.M. discussed in De Beaufort (1991), see ref. 2.
[4] Cf. Stronks, K. (1997) *Socio-economic inequalities in Health: Individual Choice or Social Circumstances?* thesis Erasmus University, Rotterdam.
[5] Arguments for and against lifestyle solidarity are discussed in De Beaufort (1991), see ref. 2.
[6] Van der Veen, R.J. (1991) *De Sociale Grenzen van Beleid. Een Onderzoek naar de Uitvoering en Effecten van het Stelsel van Sociale Zekerheid* (The Social Boundaries of Policy. An Inquiry into the Implementation and Effects of the Social Security System), Stenfert Kroese, Leiden/Antwerpen; Trommel, W.A. (1996) *Korter Arbeidsleven. De Wording van een Rationele Mythe* (Early Retirement: the Birth of a Rational Myth), SDU, Den Haag.
[7] Kohli, M., Rein, M., Guillemard, A.-M. and Van Gunsteren, H. (Eds.) (1991) *Time for Retirement. Comparative Studies of Early Exit from the Labor Force*, Cambridge University Press, Cambridge.
[8] Andriessen, S., Veerman, T.J. and Vijgen, J. (1995) *Risicoselectie op de Nederlandse Arbeidsmarkt. Selectieve Aanstelling en Afvloeiing van Personeel op grond van (Vermeende) Risico's binnen de Ziektewet en WAO* (Risk selection on the Dutch labour market. Selective hiring and firing of workers based on (assumed) risks according to the laws on sickness and disability), CTSV, Zoetermeer.
[9] Leichter, H.M. (1997) Lifestyle correctness and the new secular morality. In *Morality and Health*, ed. by A.M. Brandt and P. Rozin, Routledge, New York/London, pp. 359–378, p. 362.
[10] Van Dartel, H. (1997) De wachtende werknemer: voor welke gezondheid kiest de gezondheidszorg? (The waiting worker: what kind of health does the health care system choose?). *Beleid en Maatschappij* **24**, 221–236.
[11] Van der Maas, P.J., Barendregt, J.J. and L. Bonneux (1996) The future of the health and health care of the Dutch. In Gunning-Schepers, L.J., Kronjee, G.J. and Spasoff, R.A. (Eds.), *Fundamental Questions about the Future of Health Care*, Preliminary and background studies, WRR Den Haag, pp. 23–40.
[12] See ref. 11, p. 36.
[13] Cf. e.g. NIPO (1999) *U over de gezondheidszorg. Nederland over de toegankelijkheid van de gezondheidszorg* (Your opinions about health care. The Netherlands on accessibility of the health care system). Onderzoek in opdracht van AGIS Groep Zorgverzekeraars, Agis Groep, Utrecht, p. 39.
[14] Dunning, A.J. (Chairman) (1991) *Kiezen en delen* (an English version entitled *Choices in Health Care* was published in 1992), SDU, Zoetermeer.
[15] Tijmstra, Tj. and Heinsbroek, N. (1998) Meningen over de zorgverlening in Nederland. Teruggang in tevredenheid geeft te denken (Opinions about health care in the Netherlands. Growing dissatisfaction food for thought). *Medisch Contact* **53**, 811–813.
[16] Dunning, A.J. (Chairman) (1992) *Choices in Health Care*, SDU, Zoetermeer, p. 145.
[17] See ref. 1, p. 177.
[18] Lomas, J. (1996) Reticent rationers: consumer input to health care priorities. In Gunning-Schepers, L.J., Kronjee, G.J. and Spasoff, R.A. (Eds.), *Fundamental Questions about the Future of Health Care*, Preliminary and background studies, WRR Den Haag, pp. 71–85.
[19] Marmor, Th. and Werner, F.J.M. (1996) Discussion. In Gunning-Schepers, L.J., Kronjee, G.J. and Spasoff, R.A. (Eds.), *Fundamental Questions about the Future of Health Care*, Preliminary and background studies, WRR Den Haag, pp. 71–85.