EUMASS - UEMASS

European Union of Medicine in Assurance and Social Security
Union Européene de Médecine d'Assurance et de Sécurité Sociale

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WORKSHOP SUMMARIES

1. The use of ICIDH in social security medicine

2. Justice and concepts of objectivity and sickness in social insurance medicine

3. Professional Contract and its consequences for quality management

1. The use of ICIDH in social security medicine

Chairman: Doz. Dr. med. Klaus Leistner

- Summary -

In 1980 in World Health Organization (WHO) published the first version of the International Classification of Impairments, Disabilities and Handicaps (ICIDH-1) as a classification of the consequences of diseases.

The ICIDH is a multipurpose classification designed to serve different sectors. (epidemiology, health care planning, health economy, welfare provision services, rehabilitative medicine etc.) It provides a common framework for the dimension of "functioning" at three different levels:

- Body (Impairments)
- Person (Activity or disabilities as negative aspect)
- Society (Participation or handicaps as negative aspect)

The application of the ICIDH-1 in diverse fields of cure and care in numerous countries all over the world has revealed some shortages and weakness in terms of methodology and suitability of this concept; first and foremost the neglect of role of contextual factors for the unfolding of activity limitations (disabilities) and participations restrictions (handicaps). For that reason, after two decades of the use of ICIDH-1, this classification system required revision. The outcome of the world-wide revision process will be an improved second version (ICIDH-2). A WHO-authorized English version of the ICIDH-2 has been announced for 2001.

Unfortunately, the revision process has been delayed by very complicate and complex problems in the translation from English into vernacular languages. To find out congenial vernacular terms for the English expressions is a demanding and time consuming task owing to the diversity of highly different socio-cultural conditions in the user-countries.
Leaving aside the recognized weakness of ICIDH, there is striking evidence for the utility of this classification system in the field of social security medicine, ICIDH appears to be highly useful

- to give a comprehensive description of the patient's disablement status
- to specify the individual needs for cure and care of the disabled people
- to decide upon intervention and outcome evaluation programmes to control disablement
- to provide a common language for the description of disease consequences.

Furthermore, a review of the literature concerning the ICIDH application perspective comes to the conclusion that this classification system is an excellent aid for rehabilitative medicine. In this connection it must be emphasized that the ICIDH complements the International Classification of Diseases (ICD), but it cannot replace it.

Despite of all these obvious advantages, there is an intolerable backlog in the use of ICIDH in social security medicine so far. The workshop sessions and an enquête among the EUMASS council members of eight European countries prior to the workshop have shown that some progress has been made in the use of ICIDH-1 in the field of social security medicine in Germany, Ireland, Italy and United Kingdom, but only in a very limited scale. On the whole, the process of recognition of the utility of the ICIDH for the field of social security medicine and of its implementation into the practice of social security medicine in European countries is in an initial state.

What is sorely needed is a well conceived and carefully designed strategy for the above-mentioned process. This strategy has to cope with such prejudices and unjustified arguments like

- ICIDH is not comprehensive, it is too complicate
- ICIDH is reasonable but not practicable.

Some sort of evangelist propensity is needed for the national protagonists of the ICIDH implementation in social security medicine to defeat the "heresy" of scepticism. Obviously, there is an urgent need to tackle the problems of the use of the ICIDH in a more systematic and goal-oriented manner at the European level. The formation of a standing committee being composed of the national protagonists might be a promising option in this respect.

In addition, it is highly advisable to resume the discussion on the utility and implementation problems of ICIDH initiated at the EUMASS congress in Gent in the forthcoming congress.

On the question: How the proceed further with the ICIDH? - a decided answer can be given by invoking the devise of Gent's genius loci, Charles V: "Plus-oultre"

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2. Justice and concepts of objectivity and sickness in social insurance medicine

Chairman: Dr Hans Magnus Solli

In our work as experts and consultants in social security we are faced with ethical dilemmas. The workshop addressed the fundamental question: how should benefits be distributed equally without favouring certain groups? It invited, as a starting point, the participants to reflect on the present paradigm of distributive principles in European social insurance medicine. This paradigm seems to be based on German social insurance laws from the end of the 19th century, requiring objective findings of sickness in claimants.

However, development in modern medical science, epidemiology, philosophy and also public opinion has challenged this paradigm. Chronic fatigue syndrome is an example of a condition that rarely presents objective findings. Claimants with this condition are handled in widely divergent manners throughout Europe. In some countries, the condition is accepted as a fact, while others appear to deny its existence.

With a philosophical approach, this ethical dilemma can be better understood. The criterion of objectivity, as used in Bismarck's laws, can be seen as an exponent of an *ontological* concept of objectivity. In more recent medical science, on the other hand, an *epistemological* concept of objectivity is used, basing objectivity on consensus among observers.

In the workshop, the ethical consequences of these two concepts were discussed. The present paradigm usually gives more clear-cut criteria for distributing benefits. On the other hand, a consensus-based paradigm could account for conditions that are becoming overwhelmingly frequent and problematic in social security, such as chronic pain states, low back pain and fibromyalgia.

Neither of these two concepts, however, genuinely appreciates the claimant's personal, and subjective experience of disability. A third concept of objectivity, a *phenomenological*, was presented. This is based on a qualitative approach, and permits personal experience to be taken into consideration in a structured and scientific manner.

The workshop was well attended, and we aim at a continuation at the EUMASS congress in 2002.

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3. Professional contract and its consequences for quality management

Chairman: Dr Bernard Starink

<u>Introduction</u>

After the 1996 UEMASS congress in Veldhoven, hosted by NVVG, development of a professional contract in insurance medicine was undertaken. This basic professional contract formed the starting point for adaptation to the specific situation that exists within the disability assessment system in The Netherlands.

On September 30th, 1999, two important documents for insurance physicians were issued: the professional contract and the report on quality care.
Both are the result of the so-called "Convenant", agreed upon on May 28th, 1998 between the insurance physicians working in the implementing agencies for social security (i.e. their representatives: VHP, LAD, NVVG and VesUVIus) and general management of these agencies. In this convention agreement a professional contract is realised in close co-operation between employers and employees.

For this purpose the steering committee Professional Contract was instituted. At the same time a working group further explored the criteria for quality management concerning case-management in insurance medicine.

The first result consisted of the Professional Contract itself.
The second result consisted of a set of minimum requirements concerning the conditions for the professional case-management in social security medicine.
The most essential elements are:

- sufficient available time to perform a proper assessment
- realisation of conditions in the field of:
  - administrative and professional support
  - training facilities
  - accommodation for clinics
- institution of quality assessment, mainly based upon statistical parameters and combined with peer reviews
- focusing of management upon the steering and securing of professional processes
- stimulation and support of scientific research

In the workshop the "sweeping" statements of the agreement itself were be presented and explained. To the attendants the floor was open for discussion of selected elements into some depth.

Presentation sheets in the workshops The professional contract and its consequences for quality management .

Participating parties

1 - Employer **Managing directors of implementing agencies**

2 - "Medical" Union **Association of executive personnel**

3 - Professionals **N.V.V.G. & medical associations in each implementing agency / LAD**

Documents & progress

- **1996 - UEMASS Veldhoven**
- **28-5-1998 - "Convenant"**
- **Sept. 1998 - Professional contract**
- **1-1-1999 - Implementing study**
- **30-9-1999 - Ratification**
- **since - Implementation**
- **1-9-2000 - Evaluation & update (yearly)**

Mission & objectives

- **Describe the minimal conditions, that implementing agencies shall meet, in order to sufficiently guarantee independent disability assessment of a high professional standard**

1 - Effectiveness

- **Disability assessing doctors are multi-taskable in all domains of insurance medicine. Their specification of duties has to meet this demand.**

2 - Expertise

- **All doctors shall be qualified specialists in insurance medicine**
- **All doctors shall maintain their proficiency; employers shall provide necessary facilities and financial means**
- **Recruitment shall meet specific demands of proficiency**

3 - Training

- **Three training levels**
  - **Basic training**
  - **Specialist training**
  - **Refreshment training**
- **Conditions imposed by SGRC (Registration Committee) are leading and shall be met**
- **Employers shall cover time and costs**

4 - Standards & implementation

- **Standards need development in accordance with and approval from the professional association**
- **Employers shall check feasibility before implementation of standards**
- **Results of this check are discussed with the assigning and controlling office**

5 - Access to knowledge

- **Sufficient documentation shall be available to the doctor, regarding the job as well as the profession**
- **Supervisors shall be easily accessible as source of information**

6 - Medical facilities

- **Doctors shall have at their disposal well-equipped clinical facilities with sufficient privacy for the client**
- **Every clinic shall have a representative waiting-room**
- **Every clinic shall have an adequate safety plan**

7 - Support

- **Adequate ICT-facilities and supportive personnel shall be at the disposal of the doctors**
- **Consultation of labour experts and adjudication officers shall be possible**
- **Doctors may have available information on input, work at hand and output**

8 - Capacity-planning

- **Professional quality depends largely upon the availability of sufficient time for assessing cases**
- **Capacity-planning will be based upon explicit professional premises:**
  - **defined work-processes**
  - **prescribed quality demands**
  - **fixed timing and frequency of actions**

9 - Medical records & secrecy

- **Medical records shall be stored separately from benefit records**
- **Medical records shall be accessible to doctors only, as well as to qualified medical supervisors**
- **Implementing agencies shall provide sufficient means**

10 - Quality assessment

- **The protocol for social medical activities shall be followed, including system-audit and file-reviews**
- **Reviews shall be performed exclusively by qualified professionals in insurance medicine**
- **Management shall abide to these medical rulings in case of differences**

11 - Inter-collegial reviews

- **Yearly at least 30 hours shall be made available for inter-collegial reviews**
- **ICR is the full responsibility of the professional group**
- **Employers shall facilitate ICR**
- **ICR-groups are self-steering**

12 - Non-qualified doctors

- **Every doctor shall certify as a specialist in insurance medicine**
- **Non-certified doctors shall hold limited authority, they shall undergo supervision**
- **Qualified supervisors determine the work-package of individual non-qualified doctors**

13 - Locum doctors

- **Only limited use shall be made of locum doctors**
- **Locum doctors shall have undergone basic training**
- **All locum doctors, the qualified ones as well, shall work supervised only**

14 - Supervisors

- **Supervising doctors are highly qualified in insurance medicine**
- **Their span of control will be no more than 16 doctors**
- **Supervisors shall undergo their own ICR**

15 - Research & development

- **Research is considered essential for the functioning of implementing agencies**
- **Implementing agencies shall facilitate professional research and development**
- **Implementing agencies shall support the institution of an independent scientific institute for problems regarding disability**

Results (as of today)

- **GAK Working groups are well under way**
- **Cadans Hesitant, due to capacity-problems**

- **USZO On-going discussion**
- **SFB Mostly implemented on forehand**
- **GUO Hesitant, due to capacity-problems**