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Ability-based notions of health and disease in the Norwegian social security system

PERSPECTIVES

HANS MAGNUS SOLLI

Hans Magnus Solli (b. 1948)
is a physician with PhD working as a researcher in Vestfold Mental Health Care Trust , Tønsberg, and as a Consultant Senior Physician in the Norwegian Labour and Welfare Administration Telemark County. He has previously worked as a general practitioner.
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Email: hmsolli@online.no
Research Unit
Vestfold Mental Health Care Trust

In medicine, there are value-neutral scientific as well as value-laden relational notions of disease. This chronicle will discuss the practical use of value-laden notions of health and disease within the system of the Norwegian Labour and Welfare Administration (NLWA). I will use the health philosophy of the Swedish philosopher Lennart Nordenfelt, who focuses on human abilities. Ability-based notions of health and disease help establish a space for professional and ethical reflection in the encounter between users/patients and NLWA professionals.

As pointed out in the medical *Consensus Report to the National Insurance Court* in 1994, medical science has two basic and distinctive notions of disease. One is a value-neutral and strictly scientific notion, the other is a value-laden and relational one. Disease is perceived as negative and evil. Health can be defined in terms of the absence of disease, or in terms of a good process for the body and the mind (1, 2).

Around 1990, Norwegian authorities used the value-neutral notion of disease to restrict access to social benefits. In 1994, however, in its so-called «fibromyalgia verdict», the National Insurance Court drew on the consensus report referred to above to argue against the value-neutral and in favour of the value-laden notion of disease with regard to assessments of disability (1, 3). The authorities responded by giving equal weight to disease with objective findings and disease without such findings (2). In addition, section 12, subsection 6 of the National Insurance Act requires that the applied notion of disease should be «scientifically based and commonly recognized in medical practice» (4). Chronic pain, chronic fatigue and minor mental disorders can be regarded as disease, for example (5).

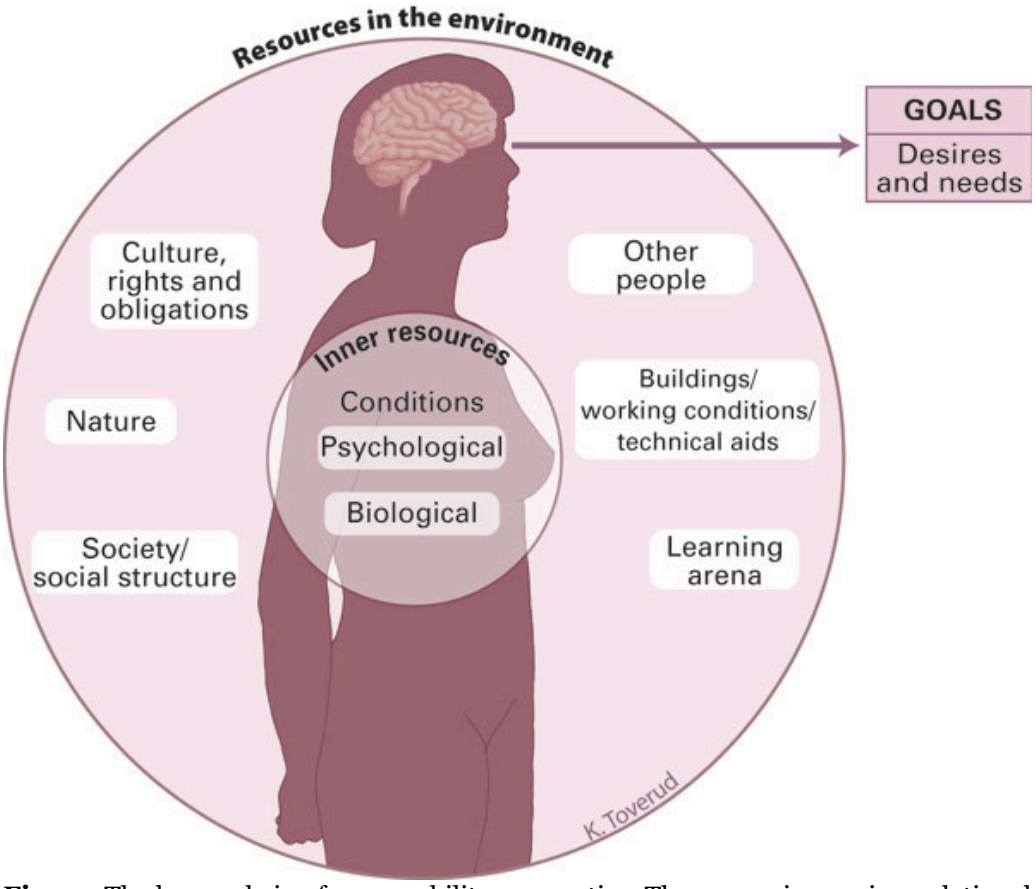
During the approximately 15 years that have passed since the fibromyalgia verdict, notions of disease have been little discussed in the former National Insurance Service and the present NLWA. This chronicle discusses the practical use of value-laden and relational notions of health and disease in the NLWA system. The term «the NLWA system» refers to the local NLWA offices, their superior governmental and municipal authorities and key collaborators such as the labour market, the health services and the sheltered workshops.

Ability theory

Lennart Nordenfelt has launched an action theory for ability, and defines health and disease accordingly (6) – (8). The concept of ability is a relational one. Three conditions must be fulfilled if we are to speak appropriately of a person's ability to act. There must be:

- A person with bodily and mental capability
- A natural, social and cultural environment
- Goals that the person needs or wishes to achieve (6)

Nordenfelt defines *ability* as that which the inner resources of this person allow this person to perform in terms of actions. Inner resources refer to the biochemical, physiological and psychological conditions within the person. Such abilities are referred to as *first-order* ability. However, ability alone is insufficient to act. There must also be opportunities, i.e. resources in the environment (fig. 1). When speaking of ability and opportunity jointly, we can use the concept *practical resources for action* (or possibility for action) (box 1) (7). One example can elucidate the use of this concept: A woman has developed chronic muscular pain syndrome. Her life situation has entailed new pains that restrict her ability to undertake manual work. An NLWA advisor speaks with her and assesses her functional capacity (9). Together, they draw up a plan to improve her inner resources with the aid of treatment, education and occupational therapy. The plan also states how she can improve her opportunities with the aid of measures such as practical and organizational facilitation and individual follow-up at work. In this manner, the woman will be able to improve her practical resources for action.



Figur 1 The human being from an ability perspective. The person is seen in a relational interplay between the body, mental capabilities and internal resources, goals that the person strives to accomplish and resources in the environment.

Box 1

Practical resource for action

Practical resource for action = internal resource (or ability) + resource in the environment (or opportunity) for action

An assessment of a person's abilities requires that the assessment be made based on a notion of what is to be regarded as a standard (or a reasonable) environment. If the working conditions are far too complicated, no person will be able to perform a particular job. There are no absolute abilities that are independent of the environmental conditions. Neither the ability nor the opportunity to work can be seen separately from the other. Both concepts are relative (8).

Nordenfelt also uses what he refers to as a «second-order» notion of ability, for example to point out the importance of learning or training to develop abilities. A second-order ability is thereby a general ability to develop first-order abilities through learning or training (8). A person who is able to use a computer after having taken a computer course has a second-order ability to use a PC.

Relational and value-laden notions of health

Using the notion of ability as his point of departure, Nordenfelt defines health at various levels of use. For everyday use, health is defined as the ability to cope with daily life or as the ability to fulfil needs (8). Biologically, health is defined as the organism's basis for executive ability (8). In other words, health is the ability to perform, endure, implement decisions and execute skills. A general definition of health uses the second-order notion of ability (defined above), and thereby puts the emphasis on the ability to learn: «*A* is completely healthy, if and only if *A* is in a bodily and mental state such that *A* has the second-order ability, given an accepted set of circumstances *C*, to realize all her vital goals» (6, p. 162). Realization of vital goals implies that the person can cope with daily life, maintain close relationships with family and friends and participate in society, usually in the labour market. The definition indicates that a person with poor health has problems with his or her bodily or mental state, so that the second-order ability to realize one or several vital goals cannot be fulfilled, given a standard environment. I have reviewed a selection of documents without having seen that the NLWA has defined its notion of health (5, 9) – (11). The new formulation of section 11, subsection 5, of the National Insurance Act stipulates that health should be included as one of several factors in the assessment of reduced ability to work (4). However, the preparatory works of the Act fail to define the notion of health (10). The NLWA's assessments of ability to work must include appraisals of health as one of six aspects of the individual in the context of his or her environment, but the concept is not defined (9, 11). If we use Nordenfelt's general definition of health as described above, this would mean that the ability to learn should be given weight. A discussion of what this definition would add to an assessment of functional capacity, an endeavour which is already quite complex, is beyond the scope of this chronicle.

The preparatory documents for the Act, referred to above, clearly state that «health problems» refer to problems caused by disease (or injury/disability) (10, p. 19). Here, it appears as though the legislator employs a purely scientific notion of disease and health. Nordenfelt's definition of reduced health includes not only disease, but also a number of other aspects that can cause a person's health to deteriorate.

A pragmatic and a theoretical notion of disease

Nordenfelt introduces a useful distinction between pragmatic and theoretical notions of disease. A pragmatic notion of disease defines disease as a diagnosis in accordance with professional literature and diagnostic criteria. NLWA requires that diagnoses must be coded using ICD-10 or ICPC-2. The NLWA system needs a pragmatic notion of disease in their busy daily activity.

However, it is crucial to be aware that this notion of disease contains no elements that enable it to be used to assess the disease of a person in relation to his/her environment and goals.

Nordenfelt's theoretical notion of disease is value-laden and relational. Disease is defined as «a bodily or mental process which is such that it tends to reduce the health of its bearer.» (6, p. 162). The notions of health invoked here are ability-based. Reduced health is the basis for the doctor's assessment. Accordingly, the patient gives an account of his or her reduced health (health problems). In typical cases, the patient will have difficulty in coping with daily life, close relationships may have become strained and problems may have occurred with regard to participation in work or in society in general. Against this background, the doctor investigates whether a disease can be detected and interpreted as a cause of the reduced health (fig. 2). The medical issue is whether a cause of the reduced health can be found, a cause which has also been found in others with similarly reduced health (8). The above definition of disease is open with regard to the professional framework applied to describe the cause. It could include biomedical descriptions of patho-physiological conditions, psychological or psychiatric descriptions of mental processes, or more comprehensive systemic processes (such as chronic muscular pain syndrome).

Figure 2 An ability-based notion of disease. On the basis of the health dimension, ranging from poor to good, disease is defined as a process within the person, of a nature that tends to reduce the bearer's health.

Many who suffer from disease have reduced health, but not necessarily all. In some cases, a person can be in good health even though a disease has been detected (8). Minor cases of psoriasis are an example. Reduced health could also constitute a future statistical possibility. This notion of disease is relational. It means that a person's disease depends on several interacting conditions: the person's bodily and mental state in general, the scope and course of the inner process, the nature of the environment and the vital goals that the person has defined.

Ability-based notions of health and disease as tools for reflection

The notions of health and disease defined by Nordenfelt can serve as useful tools for reflection in the NLWA system, for several reasons. They supplement the pragmatic notion of disease in gainful ways.

- The user or the patient is regarded as an acting person who seeks to satisfy needs and realize vital goals in interaction with his or her natural, social and cultural environment within a given social structure. The concepts are conducive to regarding the person in a relational framework comprising the body, mental resources, opportunities in the environment and the goals that he/she has set for him-/herself (fig. 1). The dynamic notions of reality inherent in this view are a fruitful basis for understanding individual needs and for working with an interdisciplinary approach in the NLWA system. For example, by using the concept of practical resources for action (box 1), the NLWA advisor, the user (the patient) and the doctor can jointly discuss the following: What kind of resources does the user have, that can be combined with adaptation or facilitation of the environment to improve the resources for action and thereby for functional capacity?

- Nordenfelt's notion of health is learning-centred. This notion of health is useful for the health services, which are increasingly offering education to patients with chronic diseases to help them cope with the disease.

- There are various forms of reduced health that are unrelated to disease. Arduous family responsibilities, domestic or workplace conflicts may have a considerable negative impact on health. Negative life experiences can give the individual a pessimistic view of him-/herself or of the things that he/she might accomplish in life. Key goals are set low, and the ability to cope is reduced. An ability-based set of concepts will be suitable for assessments of various explanations of reduced health and functional capacity.

- According to the National Insurance Act, a disease must be sufficiently grave to have caused a significantly reduced functional capacity in order to give rise to an entitlement to sickness benefit, rehabilitation benefit or disability benefit (4). Along with other professionals in the NLWA system, the doctor must assess the correlation between the disease and the reduced functional capacity. In the context of sick leave, the theoretical, ability-based notion of disease is suitable for assessing the patient's situation specifically and individually. If the person's health is not sufficiently reduced to give grounds for full sick leave, the doctor should discuss this with the patient and think through which aspects of the working conditions might have an impact on the disease. Some job tasks may be performed even in the face of reduced health, whereas others may not. The need for facilitation can be raised with the patient and the manager. A part-time sick leave may be appropriate. In case of long-term sick leave, the doctor should remain open to discussions with the patient regarding experiences and goals that the patient needs to clarify in order to keep working full-time or part-time.

Discussion

Ability-based notions of health and disease encourage dialogue, reflection and deliberate interpretations when a person's functional capacity is assessed. Some doctors may feel that value-laden and relational notions of health and

disease appear alien, even as tools for reflection. The definition of disease may appear vague. A purely scientific notion of disease may appear to have a higher level of precision. Many doctors would agree, however, that «sick leave and sickness absence are complicated social processes» (12). Given this complex reality I claim that applying an ability-based set of concepts in the NLWA system could work well – it could spark a debate on how concepts of disease are used among doctors. Furthermore, parts of the health services often employ a bio-psycho-social medical model, for example in primary health care, in psychiatry and in physical medicine and rehabilitation. In my opinion, there is a good conceptual coherence between the bio-psycho-social model and the ability-based notions of health and disease discussed here.

A value-laden notion of disease is unlikely to present any particular legal problems; as mentioned above, the National Insurance Court has endorsed it (3). In legal practice, it is crucial to establish the facts of the matter. A value-laden notion of disease implies that a medical description for purposes of assessing an entitlement to a benefit remains a neutral description of what are recognized as the medical facts (including the relevant social conditions of the patient, the patient history, treatment, medical status, reduced functional capacity and likely prognosis) as well as what could conceivably increase the patient's functional capacity. Most often, the value component will not be explicitly articulated; it constitutes the backdrop for the assessment. For example, the doctor should be empathic and try to see the matter from the patient's point of view. As long as the doctor strives to remain objective and impartial in his/her assessments, the use of a value-laden notion of health will be unlikely to generate any negative consequences from a legal point of view (2, p. 391 – 403).

It may seem obvious to ask whether ability-based notions of health and disease will inevitably lead to liberalization in the use of disease-based social benefits. I disagree with this claim. Being value-laden, the concepts open up to a discussion of the values that the NLWA should uphold in a welfare state based on solidarity. On the one hand there are key values, such as the idea that work is important for human dignity. Being able to provide for oneself is a good thing, and for most people, working is conducive to their health. Keeping a job is often positive in itself, even though accompanied by some pain and discomfort. On the other hand there are other important values, such as the conviction that people who have suffered bodily and mental damage to an extent that significantly reduces their functional capacity should have the right to fulfil their need for financial security from communal sources. Between these values a balance must be struck. In my opinion, this balance can best be promoted by engaging in a continuous reflection on values, within the NLWA system as well as in society as a whole. The existence of NLWA is based on fundamental humanistic values with roots going back to the care that monasteries and guilds in European medieval society provided to the poor and needy (2). However, it is a task for contemporary democratic social debate to clarify the values that will define whether citizens should be granted social benefits or not. Potential value conflicts call for the development of an *NLWA*

code of ethics. Some of these value reflections ought to conclude with guidelines to help medical practitioners in their assessments of the functional capacity of those suffering from disease and reduced health.

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