THE LEGITIMACY OF INCLUDING THE SOCIAL PARAMETERS IN EVALUATING THE HEALTH STATUS IN THE SOCIAL ASSURANCE SYSTEM

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Abstract
The social state crisis encouraged a reductionist tendency which had recently developed in the evaluations of the health status in the social assurance system. A holistic, psycho-medical approach, which took in consideration the implications of the social factors regarding disability, was confronted with a strictly medical model, in which the illness is exclusively considered a person's problem; therefore, the references towards the „social" are irrelevant. In this context, the present paper states the question of the legitimacy of using some sociological concepts, in medical expertise, considered relevant in this area, such as: „occupational access" or the „social functioning of the person". The present study doesn't stop at offering as arguments of legitimacy the authority of some recommendations regarding the use of the social-medical model, including the evaluation of the health status, recommendations received from the behalf of OMS and the European Council (see CIF). The paper presents the construction of specific evaluation instruments and tries to identify the sense in which using the references regarding the „social" could influence the pressures in the social assurance system.

Keywords: *social parameters, health status*

I. Introduction

In this paper we attempt to find an answer to the issue regarding the inclusion of certain social components in the health assessments that are applied in the social security system.

Clarifying the chosen subject is particularly important now since – considering the existing crisis that affects the "welfare state" – there is a more and more frequent tendency towards understanding and assessing "illness" from a strictly medical perspective. The reason for narrowing the perspective on illness, which means giving up the complex biological, psychological and social factors it involves, lies in the fear that such a complex approach would lead to the appearance of "medically illegitimate cases".

There are at least 3 sources on which we rely to prove the legitimacy of connecting social parameters for assessing health in the social security system:

- Scientific
- Normative
- Praxiological.

The present study doesn't stop at offering as arguments of legitimacy the authority of some recommendations regarding the use of the social-medical model, including the evaluation of the health status, recommendations received from the behalf of OMS and the European Council (see CIF). The paper presents the construction of specific evaluation instruments and tries to identify the sense in which using the references regarding the „social" could influence the pressures in the social assurance system.

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II. Paper content

Scientific legitimacy

The increase of life expectancy in the countries which have seriously developed from an economic and social point of view during the last 200 years has led to successive changes in the health evaluative concepts and indices. Thus, specific indices – such as the "surviving" ones, i.e. morbidity or mortality, as well as the rigid nosological categories – have been replaced by assessments of the individual's daily life performances so that today there is a dynamic and holistic approach which insists on the individual's "welfare" and "quality of life".

By following this tendency we shall be able to find in special literature several paradigms which explain and define health and illness. Some of the best known are: the medical pattern and the medical-social pattern.

According to the "medical pattern", illness is strictly a problem of the individual. His life context, no matter how pathogenous or obstructive it is, appears as irrelevant and is ignored. Individual healthcare is the only subject for curing or treating the illness.

Morbidity and mortality indices are specific to this pattern (these indices do not measure the health state, but the bad health state, which is a negative measurement), alongside with the division in nosological categories and clinical assessments which do not involve any reference to the individual's current life environment.

On the other hand, the medical-social pattern makes use not only of strictly medical information regarding the existing health problem, but also of information regarding the functioning of the individual.

The definition for health given by World Health Organization – as "the complete physical, mental and social welfare, and not just as the absence of an illness or impairment" – has led to introducing positive health indices referring to the three dimensions: physical, mental and social.

We shall briefly present the assessment types accomplished in conformity with the medical-social paradigm for the period of 1950-2000.

Besides the scale types used for measuring physical impairment, such as the PULSES profile, one can state that the first scales used for assessing individual state of health were the ADL scales (Activities of Daily Living)[1]. Using the concept of functional liability, one has tried to answer to the question: which are the normal limits of individual functioning when the latter takes care of the daily activities? From this perspective, **an individual is healthy only if he is physically and mentally able to do the things he wants and needs to do**.

ADL indices have been developed by Sydney Katz starting with 1959 and they basically refer to the patient's capacity to deal with his basic hygiene, the ability to take care of oneself, as well as the patient's mobility abilities. These indices can be expressed as an **impairment index**. Katz used the functional level as a marker that indicates the existence, the severity and impact of the illness; this level makes it possible for the measurement to be made even if, sometimes, nothing is known about the etiology of the illness. So, ADL scales measure the patient's degree of independence in performing activities such as: getting dressed and undressed, washing, using the toilet, personal care, mobility and eating.

Especially after 1970, the ADL scale has been applied to persons living in a community (family, work) – within which they perform different roles. This scale has been named IADL (Instrumental Activity of Daily Living). IALD methods include indices which bring into evidence an enlargement of the impairment issues with reference to the elements specific to a largely used concept – at least up to the year 2000 – i.e. the concept of handicap. More and more extensive scales have been created to record the factors that can explain different levels of handicap, for one kind of

[1] Ian Mc Dowell, Claire Newell, *Measuring Health*, Oxford: Oxford University Press, 1987, pp 5-22;

impairment or another, e.g.: the type of work performed by the subject, his house etc. This extension will lead to creating indices known as "social and emotional functionality indices."

Assessment scales mentioned in specialized literature have made use of a large range of indices: psychological, social, life quality etc., which are often vaguely defined and difficult to be applied: "welfare state", "welfare", "life quality" etc.[2] Despite of several imprecise definitions, the use of the mentioned concepts has made it possible to create measurement instrument, which can point out not only the illness symptoms, but also positive states that are specific to the illness.

A remarkable valorization of the medico-social pattern was accomplished in the book: The International Classification of Functioning, Disability and Health (ICF)[3].

Far from being a simple catalogue for classifying and codifying illnesses, ICF is a real paradigm on health and people with health problems, while offering the conceptual frame and the necessary operational definitions. ICF requires the development of research activity for improving "assessment procedures", appreciating that "empirical research will lead to … a clearer operationalization of the notions."

A fundamental concept in the medical-social paradigm used for explaining the illness (in ICF) is the bipolar concept of functioning-disability.

Disability (term opposed to functioning) is understood not only as an impairment of the whole functional body integrity, but also as activity limitation and a participation restriction to daily activities.

Disability (fig. 1) is a general term for *impairments, activity limitations and participation restrictions*. It denotes the negative aspects concerning the interaction between *the individual (who has a health problem) and the contextual factors (environmental and personal factors)*.[4]

This concept juxtaposes social disfunctionality and body disfunctionality and it also establishes a connection between them. Consequently, the definition given to disability makes reference to the daily consequences of the impairments, consequences that are expressed as activity limitations and participation restrictions. Moreover, the consequences cannot be mechanically deduced from "body impairments", because the **functioning/disability** of a person is seen as a dynamic interaction between health problems (illnesses, disorder, lesions, traumas etc.) and the existing contextual factors.

ICF pays maximum attention to context in assessing the individual health state. Contextual factors are, in ICF, "the basis on which health states are founded."[5]

Now we could conclude that the difference between the two paradigms – the medical pattern and the medical-social pattern – relies on two key words: "**illness**" and "**disability**".

While the "ill person" is "seen" and his/her state of health is evaluated in the clinic and the lab, the "person with disabilities" is "seen" and evaluated taking into consideration his/her life style, the social "current environment", because his/her way of expressing himself/herself, as well as his/her abilities, are due both to his/her impairment and to his/her life conditions. "Two persons with the same illness (serious illness, author's note) may function differently, exactly as two persons who function in the same way must not necessarily have the same state of health".[6]

By means of these theoretical clarifications – brought by ICF– and also by means of the constructs conceived before ICF, as well as after the publication of this paper. I have conceived two

[2] Mihai Nedelcu, *O paradigmă a cunoaşterii calităţii vieţii – rezumatul tezei de doctorat*, Bucureşti: Editura Universităţii din Bucureşti, 1996;

[3] Clasificarea internaţională a funcţionării dizabilităţii si sănătăţii – Organizaţia internaţională a sănătăţii, Bucureşti: Editura Marlink, Bucureşti, 2004;

[4] Idem, p. 217

[5] Clasificarea internaţională a funcţionării dizabilităţii si sănătăţii – Organizaţia internaţională a sănătăţii, Bucureşti: Editura Marlink, Bucureşti, 2004, p. 218;

[6] Idem p. 4;

questionnaires that are basically meant for documentation and specific assessments in the social security system.

I refer to *The Social-Professional Assessment Instrument (S-PAI)* and *The Social Functioning Assessment Instrument (SFAI)*.

a) ***S-PAI*** combines qualitative and quantitative information. Thus, we accomplish a presentation of the subject's social situation: occupational status, professional career, family, living conditions, living standard and an evaluation made according to the concept of "*occupational access"*.

"*Occupational access***"** is not mentioned as such in ICF, but it is rather considered as a synthetic, "resumative" indicator[7], which joins variables from different categories, such as: environment and social factors, as well as "activities and participation" factors.[8]

We have showed that contextual factors (environment and personal factors) are an essential ICF component. They interact with the other "functionality-disability" components and they *facilitate* or *block* the impact of the physical and social world, as well as people's behavior.

The expertise of the work capacity consists in wholly evaluating a person's health state in order to establish if and to what extent this person is compatible with one or another kind of activity, as well as with taking up an occupation (workplace).

But, access to a workplace of persons with medical problems does not depend either on that person's medical status, on the diagnosis, on the impairment itself or on that person's "availability" to work. In many cases non-medical factor – contextual factors – are involved. According to the above presented theory, these factors can reduce or increase the disability, facilitate or block access to work.

The complex, evaluating concept "occupational access" – presented in S-PAI – includes the following variables: age, duration of unemployment, household activities, occupational trust-mistrust in relation to the economic characteristics of the residential area, availability to work.

The "Occupational access" indicator and its variables are congruent with the medical-social paradigm of functioning-disability.

b) ***IEFS*** is a social assessment instrument. Its role is to bring into evidence and in a quantifiable form the activity limitations and participation restrictions that may appear in different life areas, while indicating the most important limitations, the situations in which the person with disabilities needs support from other persons. The necessary social services are evaluated taking into consideration the degree to which the disabled person depends on help from someone else.

This indicator is based on the functioning-disability bipolar concept. The result may be presented as a general score, a sum of several sectorial scores.

Normative legitimacy

In the last 50 years, as a consequence of the tendency manifested by the World Health Organization to define and evaluate health state, one has noticed a move from the static approach to the individual (who was placed in a nosological category) towards a more dynamic one (which places the individual within the context of his/her daily capacities and functional performances).

Since this tendency became prominent, in May 2001, at the 54th session, the World Health Organization approved the International Classification of Functioning, Disability and Health[9] and recommended the member states to use ICF "in research, surveillance and reporting…"

Romania has been a WHO member since 1948.

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[7] Idem p. 172;

[8] Idem p. 124;

[9] Clasificarea internațională a funcționării dizabilității si sănătății – Organizația internațională a sănătății, Bucureşti: Editura Marlink, Bucureşti, 2004, pag. 25;

EU Directives – e.g. Directive 2000/78 in favor of equal job opportunities – set forth the main concepts and the objectives of the Sectorial Operational Programs, on the basis of which EU allots structural and cohesion Funds for: social economy development, development of programs for reintegrating persons with disabilities, supporting the creation of new workplaces in factories, improving access and participation of vulnerable groups. All these programs are elaborated in the spirit of the medical-social pattern, whose conceptualization and operationalization have been significantly improved by ICF.

The above mentioned terms and objectives do not fit within the strict limits of the medical pattern.

Romania has been a EU member state since 2007.

Praxiological legitimacy

The term "disability" is a generic one. It might replace the notions of handicap and invalidity, which are regarded as being "pejorative" by ICF. Thus, the significance and implications of the concept of disability are not only semantic or ethical, but they can also influence organization, social policy, legislation and the financial sector.

Undoubtedly, there are cases in which participation limitations are due not only to the incapacity caused by the illness/impairment, but also to the environment, including the social restrictive attitudes. However, the major role of the social enterprise is not to replace medical criteria or to eliminate them, but to provide information that might help conceive solid and functional social medical policies.

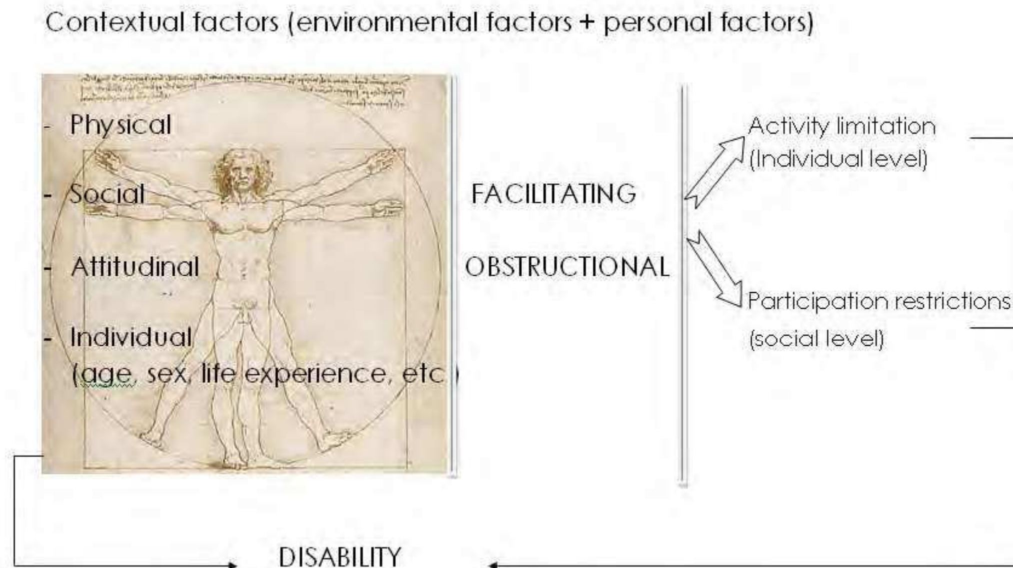
Introducing or accepting social references are meant to complete medical information which will be useful and adequate to a large number of applications including for the social security system. ICF offers the information conceptual frame that can be applied to personal health problems, including for preventing illnesses, promoting health, improving participation (by elimination or diminishing obstacles and by offering support as a facilitation factor or social level).

The aim of this activity is to reduce disability, impose social and professional participation and inclusion, finally to reduce the financial assistance expenses.

III. Conclusions.

Since the medico-social paradigm is recommended by the WHO in an official document (ICF), it results that it is legitimate according to the international scientific community and it is fully compatible with the EU values; at the same time, the Romanian present norms regarding the granting of medical pensions is tributary to a medical federalist model in which connections between "the biological" and "the social" are annihilated."

The fear that this connection might lead to an increase in the number of persons retired on medical grounds is not justified because this scientifically and normatively legitimate type of documentation and evaluations is crucial for conceiving authentic social medical policies. It is this type of solutions that can "reduce the pressure" existing on the security system.



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