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ORIGINAL ARTICLE

The concept of disease in the Norwegian National Insurance Court

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Abstract

Aims: The National Insurance Act administrates an important part of the welfare system in Norway by entitlements to benefits. Disease is an absolute requirement for many benefits, but the Act does not provide any definition of disease. The National Insurance Court is the normative body in management of the Act. In 1994, a consensus report was written on the concept of disease on behalf of the National Insurance Court, which subsequently became a guideline in the management of decisions. This study examined how the concept of disease has been interpretated in recent decisions in the National Insurance Court compared to the interpretation in the consensus report. *Methods:* The material consisted of anonymous decisions from the National Insurance Court in the period from September 2018 to August 2019. It was analysed by systematic text condensation and compared to the consensus report by a theory-driven content analysis. *Results:* The consensus report described disease as a value-laden condition with personal resources and external environment as decisive context, while the decisions express disease as a process with causal relationship to personal resources and external environment. ***Conclusions:*** **The analysis of recent decisions showed that the interpretation of the concept of disease has moved in a value-neutral direction compared to the consensus report.**

Keywords: *Concept of disease, disability benefit, National Insurance Court, National Insurance Act, insurance medicine, social medicine*

Introduction

The National Insurance Act manages several important welfare schemes in Norway. Disease is an absolute conditional for many of these benefits, such as disability benefits [1]. The understanding of the concept of disease has major consequences for patients, medical doctors, welfare administration and health policymaking. Classification systems of diagnosis are important for administrational and statistical use, as they code conditions, but they do not define disease. The most widely used classification system worldwide is the International Classification of Diseases by the World Health Organization [2]. Further, advanced theories of the concept of disease have been proposed. However, despite extensive classification systems and advanced theories of disease, there is no agreement on a universal definition of the concept of disease [3].

The National Insurance Act in Norway has no definition of disease. Every day, however, decisions are made based on the concept of disease. In case of doubt, the National Insurance Court is an advisory body where decisions are normative for the management of the National Insurance Act [4]. Disability benefit is one of more benefits in the National Insurance Act where disease is an absolute conditional.

Until 1994, the management of the concept of disease in the National Insurance Act was considered to be objectively determined [5]. Disease was considered to be independent of preferences and values of individuals or professionals, or by society. The concept of disease was expected to be defined and described by medical science. This is often referred to as a naturalistic concept of disease [6]. Christopher Boorse [7,8], a prominent representative for the naturalistic view,

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defined disease as a type of internal state that impairs normal functions, thus reducing the possibility of survival and reproduction. Accordingly, disease is supposed to be a value-neutral concept [5].

The year 1994 was a turning point for the understanding of the concept of disease in the National Insurance Court in Norway. A consensus report commissioned by the National Insurance Court to clarify the concept of disease was published. This report stated that historically, there were mainly two groups of theories: value-neutral and value-laden concepts of disease.

A value-laden concept of disease, in contrast to a value-neutral concept of disease, understands disease as something relational, determined in the relationship between medical science, ailments, personal resources and the expectations of society [5]. In common with the corresponding value-laden theories, also named normative theories, is that disease is largely defined by norms and values [6]. The theories of Sedgwick might illustrate normative theories, as he defines disease as a deviation from a condition that is considered more desirable [9,10]. Another normative representative, Engelhardt, believes that disease must involve some judgement of what a member of a species should be able to do, esteeming a particular type of function [11].

In addition, it might be added, there are several hybrid theories that combine the perspectives from both the value-neutral and value-laden theories. For example, disease is defined as a harmful dysfunction in the theories of the American philosopher Jerome Wakefield [12]. The American Association Council uses the following criteria of disease: (a) an impairment of the normal function of some aspects of the body, (b) characteristic signs and symptoms and (c) harm and morbidity [13].

In contrast to the prevailing value-neutral concept of disease before 1994 in the management of the National Insurance Act, the consensus report expressed a value-laden concept, as can be seen in the conclusion of the report [4]:

> When a person is identified to be sick, it will often be necessary to include conditions outside the field of medical science . . . patients' perceptions, concerns and expectations are important and complementary to the traditional approach of medical doctors . . . We will conclude that it is difficult to operate with a scientific concept of disease, in the sense that the medical science decides who is sick decided by an objective definable condition of the individual. When deciding whether a person is sick or not, it is necessary to consider the function level of the individual in relation to its environment and its personal resources. A person might then be sick in one context, but not in another.

Subsequently, that same year, the consensus report became guidance for the important 'fibromyalgia decision' in the National Insurance Court [14]. The principal importance of this case was shown by using a jury of seven compared to a normal jury of two to three members. Fibromyalgia had previously not been accepted as a disease qualifying for disability benefit due to the lack of objective signs. This decision considered fibromyalgia as a disease on the basis that the subjective symptoms were equally accepted as the objective signs on the basis of the value-laden concept of disease from the consensus report. This decision made the value-laden concept of disease from the consensus report a precedent for the management of the National Insurance Act. The specific case became normative well beyond the diagnosis of fibromyalgia.

The research question of this study was to examine the interpretation of the concept of disease expressed in recent decisions on disability benefits in the National Insurance Court. This understanding was then compared to the understanding of the concept of disease in the consensus report as it emerges from the conclusion on page 8 of the report.

Methods

Materials

This study was based on decisions on disability benefits in the National Insurance Court in the period from 1 September 2018 to 31 August 2019 [15], and the conclusion on page 8 of the consensus report.

To be eligible to receive disability benefit in Norway, three requirements are medically conditional. First, disease has to be present. Further, the loss of function has to be caused by this disease. Subsequently, the reduced possibility of income has to be caused by this loss of function. The latter two might be considered as ability to work. This study was limited to the first requirement of the presence of disease in the decisions.

Disability benefits were chosen on the basis that the cause of the impairment of the ability to work had to be clarified. In comparison, the National Insurance Act allows some doubt for sickness benefit and work assessment allowance (AAP). When granting these benefits, the applicant might undergo a clinical examination to determine the cause of the impaired ability to work. Disability benefit, on the other hand, is a permanent benefit where it is expected that the disease status is clear, and that disease is the cause of the impaired ability to work. There was no limitation in the selection of decisions concerning diagnosis.

It is stated in the National Insurance Act that the concept of disease should be based on science and

generally recognised in medical practice. The number of decisions were then limited to decisions with a minimum of one medical member in the court in order to assure medical competency. The selection criterion provided material from 55 decisions.

Each decision was structured in approximately the same way. A decision has essentially five parts: (a) overview of court members, case numbers and parties; (b) statement of the background of the case; (c) the parties' allegations; (d) the remarks of the court; and (e) legal costs. In this examination, it was the remarks of the court that were of interest.

The consensus report was written in 1994 by an expert panel of five medical doctors and one philosopher commissioned by the National Insurance Court to clarify the concept of disease. The text serves the purpose of answering questions raised by the National Insurance Court to develop new input in the management of the National Insurance Act in Norway.

Methods

The material was analysed by using systematic text condensation in four analytical steps [16]. The chosen method is a cross-case qualitative text analysis that searches for characteristics of the phenomenon being studied. The method is well suited for the analysis of concepts.

In the first analytical step, we became familiar with the material. Previous understanding and theories were put aside. Preliminary themes were set up based on the impression of the text. In the second analytical step, the meaningful units were identified, coded and collected on the basis of similar properties. In the third analytical step, the meaningful units were extracted from each code group and sorted into subgroups by content. Condensates were further made from the subgroups. In the fourth analytical step, the condensates were synthesised from subgroups and code groups into analytical text organised as result categories. The findings were then evaluated against the original text for validity.

Next, findings were compared with the conclusion in the consensus report by a theory-driven content analysis [17]. The theories for the value-laden and value-neutral concepts were used as described in the consensus report. The findings from the systematic text condensation and the theory-driven comparison with the consensus report were synthesised into an analytic text.

The consensus report classified theories of the concept of disease into value-laden and value-neutral theories. There are many alternative ways to classify theories of the concept of disease. In this study, we used the same method of classification as the consensus report for ease of comparison.

Ethics

Since 2003, the National Insurance Court has published its decisions, including their justification, anonymously. These anonymous decisions were the material of this study. Hence, it was not necessary to obtain ethical permission or pay special attention to privacy.

Results

Function, external environment, personal resources and symptoms were recurring related topics in the question of the presence of disease in the decisions.

Findings examining the decisions of the National Insurance Court

Function. Physical and psychological function was central to the interpretation of the concept of disease. Impaired function was discussed in terms of being a part of the concept of disease if it was a result of a process of a certain origin. The properties or severity of the impaired function were not decisive. It was the origin of the process leading to the impairment which was decisive. If the impairment of function was caused by processes originating from social reasons, it was not part of the concept of disease.

> . . .social causes including language skills lead to reduced ability to work. The court therefor agrees with the appellant counterpart that social reasons seem to be the main reason for the reduced ability to work. (Decision 17/3129)

External environment

In the decisions, it was noted that physical and psychological function could be altered in relation to the external environment. This relational change of function was not seen as a part of the concept of disease. The external environment, on the other hand, could be a direct or contributing cause in the development of disease, which could then lead to dysfunction. A major physical or mental trauma caused by the external environment, as well as repeatedly physical or negative social life events over time, could cause disease.

> . . .the appellant has with high degree of probability been exposed to life events of a kind or nature that can cause serious injuries or dysfunction at an early stage in life. (Decisions 17/3831)

Personal resources. The decisions focused on personal resources as traits in respect of ability to work, but not necessarily as a part of the concept of disease. Lack of personal resources was considered as a vulnerability which could manifest as a contributing cause to the development of disease. A vulnerability could also worsen the course of the disease but without being the cause. It was then not included in the concept of disease. The lack of personal resources was connected to genetic inheritance, poor conditions when growing up and unfavourable living conditions.

> . . .the district psychiatric outpatient clinic writes that appellant is vulnerable to external stresses that could worsen her mental health. (Decision 18/219)

Symptoms. Some symptoms might be related to disease only as a subjective experience. According to the decisions, symptoms of somatic diseases had to be based on physical conditions. Physical symptoms associated with an area without a physical starting point were considered as somatisation of mental disease.

> The appellant's somatic ailments have not been explained with relevant somatic pathology and are probably based on somatisation and anxiety preparedness. (Decision 18/2488)

Comparison with the consensus report

There were clear differences in the interpretations of the concept of disease when comparing the decisions and the consensus report.

The decisions considered disease as a process, whereas the consensus report interpreted disease as a condition. In the consensus report, the concept of disease was a value-laden condition decided on the context of personal resources and the environment. The decisions, however, tried to explain the concept of disease through causality (causal factors). In the decisions, the lack of personal resources and the impact of the external environment were possible contributing factors to the development of a disease rather than a decisive value-laden context. The impairment of function was the effect of causality, where disease was the process leading to the effect.

The consensus report concluded that patients' perceptions, concerns and expectations are as important as the traditional approach of medical doctors. Subjective symptoms were recognised in the same way as objective signs of disease. The decisions recognised subjective symptoms as well, but the physical symptoms without physical pathology were explained as a somatisation of mental disease in the decisions. The consensus report did not try to explain the nature of these symptoms but rather used a value-laden concept of disease.

Discussion

Findings

We identified an overall change in the interpretation of the concept of disease in the decisions compared to the consensus report. The analysed decisions showed a more value-neutral understanding compared to the consensus report. The concept of disease in the decisions was based on causality, which goes hand-in-hand with scientific thinking, and on a value-neutral understanding of the concept of disease. Subjective physical symptoms without physical pathology were also explained by causality as a somatisation of mental disease.

The value-neutral aspirations in the decisions differ though from Boorse's theories that consider disease as a type of internal state with statistical deviations. Hybrid theories of Wakefield and the criteria of American Association Council also base their concept of disease on a state or condition. The decisions rather consider disease as a process focusing on the cause and effect of the process.

In the consensus report, the concept of disease was considered as a condition, where the environment and personal resources were the normative decisive context. The value-laden concept might be linked to the demand and expectation of society. This can be seen in comparison to the theories of Sedgwick, who considered disease as a deviation from a more desirable condition. In the management of the welfare system, there is an expectation of the ability to work set by society. This also corresponds to Engelhardt, who stated that the concept of health and disease was dependent on a normative assessment of the ability to function.

While a value-laden understanding of the concept of disease will change with the values in society, a concept of disease based on causality will to a greater extent be determined by science rather than being determined normatively. This indicates that the management of the concept of disease in the National Insurance Act in Norway has moved towards a more value-neutral concept. A change in the understanding of the concept of disease will presumably lead to a change in who could be entitled to receive the benefit. However, this study has not examined the implications of such change, but the result addresses a question for further research on this topic.

The National Insurance Act is a legislation adapted to Norway and therefore unique to Norway. It is important to be cautious with respect to drawing any international parallels from the findings of this study. The Act functions to manage several welfare schemes. This study examined disability benefit, and the findings are not directly applicable to other schemes in the Act. Nevertheless, the National Insurance Act states that the concept of disease must be a scientifically based and generally recognised in medical practice. Moreover, the same trends that govern the changes in Norway may very well be at play in other countries, as Norway is very much influenced by international development.

Strengths and weaknesses of the study

This study used the classification of theories based on value-laden and value-neutral concepts of disease as used in the consensus report. Of the six authors of the consensus report, five are medical doctors. Preferred terminology and classifications systems are likely to differ with respect to the background of the reader. For example, a sociologist may have a different approach to the terminology and classification system than a medical doctor. It is stated in the National Insurance Act that the concept of disease should be based on science and be recognised in medical practice. The choice of terminology in this study has therefore been chosen to reflect this perspective.

The material of the study was anonymised decisions that are freely available to the public. This was chosen instead of applying for access to the original documents. While this means that we lost some information, it makes the study easier for others to replicate. Moreover, the National Insurance Court posts the anonymous decisions publicly to help the managing of the Act and to give the public insight into the process. This study therefore used the decisions in the same form and format as the administration uses them as reference work for the standardisation of management of the Act. Additionally, personal information was considered to have little relevance for the understanding of the concept of disease.

This study compared a selection of recent decisions in the National Insurance Court to the content of a consensus report by an expert panel appointed by the National Insurance Court. This means the comparison was made from two different types of texts. Every decision in the National Insurance Court is normative to the management of the National Insurance Act. The consensus report was not written by the National Insurance Court, and therefore it was not normative in the same way. However, the consensus report was used as the basis for the fibromyalgia decision. As the report gives more information than a single case, the report makes a more relevant comparator.

Conclusions

A targeted selection of recent decisions of the National Insurance Court showed that the interpretation of the concept of disease has moved in a value-neutral direction compared to the consensus report of 1994. The most recent decisions expressed disease as a process decided by causality, where personal resources and the environment were possible contributing causes. The consensus report described disease as a value-laden condition, with personal resources and the environment as a normative decisive context.

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