EUMASS
European Union of Medicine in Assurance and Social Security

Medical assessments in social security in Europe

As it is stated on the EUMASS website about 500 million people in Europe are affected by social insurance schemes funded or endorsed through society as a collective social security. Decisions on entitlement to benefit are usually based on medical assessments which in turn are based on European insurance medical knowledge and common methods.

However, insurance medicine does not exist in Europe as such. The assessments are often carried out in the own national way, without European coordination or consensus.

During European meetings and congresses, in which scientific developments and practical experiences in the domain of insurance medicine are exchanged, we noticed that although medical assessments are carried out in the context of social security in all European countries, insurance medicine has only in a few countries developed into a medical specialty.

There is still a lack of clarity about the medical assessments in social security in Europe and about the education and training of doctors working in this field, while the outcome of such assessments has far-reaching consequences for both individuals and society. It was therefore important to gain insight into the situation that has arisen in the field of insurance medicine.

Since the aim of EUMASS/UEMASS is to provide a platform to exchange experiences within the field of Insurance Medicine between various insurance-related organisations in Europe, mainly focusing on public social security, I have spent the last years, with the help of EUMASS Council members researching the necessary knowledge, skills and competencies for those medical assessments in insurance medicine in Europe.

How did the current social security situation in the different European countries come about and what does it mean for daily practice of medical assessments in the social security context? Who are the doctors who carry out such assessments? What tasks do they perform and how are they educated and trained? Questions that aroused our interest, but to which we initially found no answers because European research within social security has generally compared the systems with each other and in particular emphasized the differences between those systems. Hardly any consideration was given to the role of doctors within these systems and to their (required) education and training.
Therefore, our research goal was to develop a European core set of tasks as well as of education and training, in order to harmonise as much as possible, both insurance medical practise and the required education and training.

Several studies were carried out with the help of EUMASS, for which I am grateful. They have given us the necessary insights into the insurance medical work in European social security, on the basis of which we have been able to make various European comparisons and it has enabled us to develop a European core-set of tasks, knowledge and competencies required to execute those tasks.

A number of comments and considerations can be made on the basis of the results:

Within the social security systems, physicians are mainly deployed for the assessments of absenteeism and disability or incapacity for work. This puts them, and the associated insurance medicine in a special position because, unlike other physicians, they seem not to fulfill the role of healthcare provider, but rather of loss adjuster, who checks possible health damage against the policy conditions of a public or private disability insurance. As a result, insurance medicine is not regarded as curative medicine and is therefore generally not taught as such within the undergraduate curriculum which is dominated by disease and curation.

With the exception of only a few countries, this also applies to the postgraduate training, in which insurance medical topics are taught fragmentarily, usually concerning the claim assessment schemes and then often from a historical and national perspective which has created major differences in the education and training situation of physicians working in the insurance medical field in Europe.

Besides, this apparent failure to fulfill the role of healthcare provider has consequences for the position of the physicians working in social security and the associated insurance medicine. In fact, a work disability assessment should be part of a treatment that, after all, also aims to restore functioning at work and all the more so because work is often involved in the onset and course of the disease. Unfortunately, however, in practice, such an explicit work-oriented treatment objective is often not the case.
Conversely, an insurance physician will have to form an opinion about the remaining chances of recovery, whether or not with the aid of an efficient intervention, so there should be, or is indeed a link between curative and insurance medicine.

But this link also seems to be missing in quality developments. All kinds of efforts are made within medicine to bring the medical practice in line with the state of scientific knowledge and to keep it up to date. The development and implementation of guidelines, the introduction of new interventions, instruments and procedures and training should contribute to this. However, these efforts are usually only curative. Whereas the scope of medicine ought to be broader as physical, mental and social system levels are intertwined. Attention to the consequences of the disease for the functioning of the individual in his/her social context, including the patient's work situation, is for the most part limited though. Because developments in medical knowledge regarding aetiology, diagnostics, prognosis and treatment usually do not include insurance medical elements they often bypass the insurance medical domain.
On the other hand, improving the quality of work disability assessments generally focuses only on the interpretation of disability legislation and on implementation procedures, rather than on the quality of the assessment as such, which in insurance medicine, is not just about the medical assessment of the patient, as in the curative sector, but about the broad assessment of the claimant in his/her psychosocial context and the use of efficient interventions.

Insurance medicine thus operates within a legal framework at the intersection of health(care), society and economy.
An insurance medical advice or decision also unites various interests: primarily those of the individual, the claimant, but also those of the collective, the insurance company and society. The latter is to guarantee the affordability of social insurances and provisions.

Social security systems, like healthcare systems are usually funded by a system of premiums and taxes.

Both systems are under pressure not only from rising expenditure, but also from economic and social changes.
For example, disorders are becoming more chronic, multimorbidity is increasing and socio-cultural developments are leading to patients/claimants becoming more assertive and generally getting older, which means that they will have to work longer, whereby lifestyle becomes more important too. As a consequence, the emphasis is more on maintaining functioning and self-reliance than on healing. As a result, not only the demand for healthcare, but also for socio-medical services is increasing while there is a shortage of healthcare personnel in general and physicians working in social security in particular. Hence, not only expenditure is jeopardising affordability, both individual and collective, and thus also accessibility and quality of the services, but the shortage of physicians has negative consequences for quality, accessibility and affordability as well.

So, following the curative sector, task transfer is also increasingly being introduced within social security. However, here too, due to the lack of a clear insurance medical identity, we see that this introduction takes place differently within Europe.

In view of the above considerations, insurance medicine occupies a special position on all sides. Given this special position one would then actually expect it to be an independent medical specialty. After all, a medical specialty is generally defined as a subfield of medicine that requires specific expertise for which specification and enhancement of competencies acquired in the graduate programme are required for deepening of that specific subfield.
The additional education and training must be described in a competency-based manner in accordance with the European Standards in Medical Training, set by the European Union of Medical Specialists (UEMS) and there must be a training structure with the associated

safeguarding mechanisms. This means that the training besides the general competencies of the specialist has to include further developed specific competencies. In addition, continuous medical education must be provided. Then there are also requirements for the training institutions and the guarantees for an optimal training climate must be laid down. Furthermore, the specialty must have its own scientific domain.

Given the huge differences in the current training situation, ranging from no additional training/education at all to a 4-5 years postgraduate training and education programme, it is not realistic to introduce and require a four-year insurance medical training in all European countries at the moment. An initial European basic education and training programme in insurance medicine though, based on the core competencies, knowledge and skills on which there is consensus could be a first step towards harmonisation of training. This modular education and training programme can then be gradually developed into a full insurance medical curriculum over time.

There still seems to be a long way to go, but hopefully EUMASS is going to have a long and bright future, in which it can play a role in the introduction and implementation in the various countries, sometimes against the historical and national customs.

Not intending to supersede the competence of the national authorities with regard to postgraduate training, but rather to complement, if necessary, and harmonize the content of national education and training programmes, so that insurance medicine eventually becomes a European recognised medical specialty.

Long live insurance medicine!

Long live EUMASS!