

THE ASSESSMENT OF INVALIDITY IN THE CASE OF ONCOLOGICAL PATIENTS

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Submitted: 2010-10-31

Accepted: 2010-06-25

Published online: 2010-12-27

Abstract

This article concerns itself with the new view of the assessment of the state of health, the extent of the reduction of the work capacity and the invalidity of oncological patients which is included in Regulation 359/2009 Coll., which sets out the percentile extent of the reduction in work capacity and the prerequisites of the invalidity assessment and regulates the assessment of the work capacity for the purposes of invalidity upon the basis of the results of cooperation between the Ministry of Labour and Social Affairs and the J. E. Purkyně Czech Medical Society. Assessment of the extent of the reduction of the work capacity implied from Annex no. 2 of Regulation 284/1995 Coll. till the end of 2009 through which Pension Insurance Act has been carried out as amended. Annex no. 2 did not contain chapter of cancerous growths. Cancerous growths were not listed according to organ localization and that made difficulties in the process of assessment. Reaching stabilization of the state of health was mostly defined by period of two years after the treatment had been terminated which seems to be too long period according to the most modern treatment progress. Authors compare invalidity assessment of oncological patients according to Regulation 284/1995 Coll. and according to Regulation 359/2009 Coll. To show the difference they present assessment of oncological patients according to the old and to the new legal regulation. New conception of the state of health and work capacity of oncological patients assessment should contribute not only to creation of an independent chapter Cancerous growths in the new regulation, but moreover it should bring criteria for functional damage assessment of oncological patients based on the International Classification of Functional Abilities WHO. In conclusion the authors emphasize that the new way of assessment according to modern legal regulation will enable to assess useful profile of functional abilities of an individual, his/her health incapacity and to compensate reduction of work capacity in a targeted way.

Key words: cancerous growths – oncology – the assessment of the state of health – work capacity

INTRODUCTION

The method of assessment and the percentile extent of the reduction in work capacity for systematic gainful activities are set out in the implementing regulation to the Pension Insurance Act. Up to 31.

12. 2009, this implementing regulation is the Ministry of Labour and Social Affairs Regulation 284/1995 Coll. which implements the Pension Insurance Act, as amended (Vyhláška č. 284/1995 Sb., Zákon č. 155/1995 Sb.). From 1. 1. 2010, the assessment of the facts which are

decisive for the acknowledgement of invalidity and the definition of invalidity will change and a new three-level system of invalidity and invalidity pensions will be introduced upon the basis of Act 306/2008 Coll. which has amended the existing Pension Insurance Act 155/1995 Coll., as amended, from 1. 1. 2010 (Zákon č. 155/1995 Sb., Vyhláška č. 359/2009 Sb.). Before the amendment of Act 155/1995 Coll., invalidity was defined as full and partial invalidity (Kahoun 2007).

Section § 39 subsection 1 of Pension Insurance Act defines when the insuree is an invalid. Insuree is invalid if the reduction of his/her work capacity was at least 35% due to his/her long term disfavourable state of health.

Insuree is an invalid if his/her work capacity was reduced:

- a) at least by 35%, but the most by 49%, it is invalidity of first level;
- b) at least by 50%, but the most by 69%, it is invalidity of second level;
- c) at least by 70%, it is invalidity of third level (Kahoun and Šimák 2008, Kahoun 2009).

Regulation 359/2009 Coll., which determines percentile rate of work capacity reduction and assessments prerequisites of invalidity and adjusts assessment of work capacity for the purpose of invalidity (regulation of invalidity assessment) is based on Section § 39 subsection 1 to 8 of 306/2008 Act; Coll. These changes are a part of parametric changes of now happening first period of pension reform which by the way brings later retirement. According to this prognosis set rules for admission pension benefits will be unbearable for the pension

system in the future (Šimák 2010). New conception of the state of health and work capacity of oncological patients assessment should contribute not only to creation of an independent chapter Cancerous growths in the new regulation, but moreover it should bring criteria for functional damage assessment of oncological patients based on the International Classification of Functional Abilities WHO (Čevela et al. 2009a). Aim of this work is to compare assessment of work capacity reduction according to Regulation 284/1995 Coll. and according to regulation 359/2009 Coll. There are some case reports used as examples.

Invalidity due to cancerous illnesses

The share of cancerous illnesses in the total number of invalid pensions in the Czech Republic is approximately 18% and it has increased slightly in recent years. This trend is apparently caused by the increasing incidence of cancerous illnesses in the gainfully employed population and also by the improved prognoses with regard to a number of cancer diagnoses thanks to advances in treatment (Čevela et al. 2009b, c). The development of invalidity due to cancerous illnesses in 2007 and 2008 is set out in Table 1, which includes the numbers of newly acknowledged cases of full and partial invalidity in comparison with the total number of cases of invalidity for all other illnesses. The most frequent oncological illnesses, for which partial invalidity was acknowledged in 2007–2008, are set out in Table 2. The most frequent oncological illnesses, for which full invalidity was acknowledged in 2007–2008, are set out in Table 3.

Table 1. The number of oncological illnesses, for which partial or full invalidity was acknowledged in 2007 and 2008

Invalidity	2007		2008	
	Total illnesses	Oncological illnesses	Total illnesses	Oncological illnesses
Partial invalidity	26,932	2,089 (7.76%)	25,847	2,119 (8.2%)
Full invalidity	23,354	4,656 (19.94%)	21,780	4,461 (20.48%)

(Source: Czech Social Security Administration Statistics 2009).

Table 2. The most common oncological illnesses, for which partial invalidity was acknowledged in 2007 and 2008

Type of tumor	2007		2008
Breast cancer	628	Breast cancer	672
Kidney cancer	115	Kidney cancer	124
Testicular cancer	108	Testicular cancer	100
Bowel cancer	104	Bowel cancer	89
Hodgkin's disease	104	Cancer of the cervix	88
Total	1059	Total	1028

(Source: Czech Social Security Administration Statistics 2009).

Table 3. The most common oncological diagnoses, for which full invalidity was acknowledged in 2007 and 2008

Type of tumor	2007		2008
Breast cancer	904	Breast cancer	909
Bronchial cancer	311	Bronchial cancer	348
Bowel cancer	272	Bowel cancer	283
Colon cancer	235	Colon cancer	254
Kidney cancer	198	Prostate cancer	178
Total	1920	Total	1972

(Source: Czech Social Security Administration Statistics 2009).

The cooperation between the Ministry of Labour and Social Affairs and the J. E. Purkyně Czech Medical Society

In 2007–2008, the J. E. Purkyně Czech Medical Society (JEP CMS) carried out a project announced by the Ministry of Labour and Social Affairs concerning the projection of the advances in medical science into the functional evaluation of the state of health and work capacity of individuals in relation to the International Classification of Diseases, while taking into account the International Classification of Functioning. The aim of the project was to prepare an expert medical basis for the evaluation of the consequences of a health problem in relation to work capacity and invalidity from the point of view of the five most frequent causes of invalidity. The completed chapters (circulatory system dysfunction, oncological illnesses, mental and behavioural disorders, movement system dysfunction and neurological dysfunction) concern themselves with the points at

issue from the point of view of the clinical picture, the diagnostic criteria, the course of the illness and its treatment and define the general assessment principles for assessing the individual types of health afflictions (Kol. autorů 2008, Čeledová and Čevela 2009).

In the interests of completeness, we would add that the further information required for the completion of the regulation was also acquired thanks to the cooperation between the Ministry of Labour and the J. E. Purkyně Czech Medical Society. Each prepared chapter of the ICD-10 is dedicated to the area from the point of view of the clinical picture, the diagnostic criteria, the course of the illness and its treatment and defines the general assessment principles for assessing the individual types of health afflictions (Kol. autorů 2009).

We consider the evaluation to be significant from the point of view of the impact of the affliction on the quality of life, the ability to undertake regular activities

and the ability to work. The principles of the International Classification of Functioning, Disabilities and Health, which we consider to be especially important, have been projected into the solution. The expert information from the J. E. Purkyně Czech Medical Society (JEP CMS) was transformed into the draft regulation, by means of which the percentile extent of the reduction in work capacity and the prerequisites for the assessment of invalidity would be designated and the assessment of work capacity for the purposes of invalidity would be regulated. The JEP CMS also commented on the prepared draft regulation concerning the assessment of invalidity and expressed its agreement with the submitted solution. From a material and legal point of view, the regulation is based on the provisions of section 39, subsections 1 to 8 of Act no. 306/2008 Coll. which amended the Pension Insurance Act effective as of 1. 1. 2010 and regulates the procedure when assessing invalidity, as well as on the existing provisions of section 39, subsection 2 of Pension Insurance Act 155/1995 Coll., as amended, and the provisions of section 6 of Regulation 284/1995 Coll., as amended. The draft regulation was expanded to include the method of evaluation, the use of the preserved work capacity in the case of level one and level two invalidity, the definition of any exceptional conditions and the prerequisites of the invalidity assessment (Čevela et al. 2009d, 2010a).

The assessment of the health state and capacity to carry out systematic gainful activities is also based on the evaluation of the insured individual's state of health upon the basis of the results of the functional examinations and the ascertainment of the functional impact of the health affliction on the individual's physical, sensory and mental abilities. At the same time, the ability of the individual to make use of his/her achieved education, experience and knowledge to carry out his/her previous gainful activities, the individual's ability to undergo re-qualification, the assessment of the stabilisation of the individual's state of health, the individual's adaptation to his/her health affliction, the ability to make use of the preserved work capacity and possibly the assessment of the ability to work under exceptional conditions (Čeledová and Zvoníková 2010).

The evaluation of the ability to carry out systematic gainful activities in the case of oncology patients

The assessment of the reduction in the ability to systematically carry out gainful activities (invalidity) is based on Annex no. 2 of Ministry of Labour and Social Affairs Regulation 284/1995 Coll., which implements the Pension Insurance Act, as amended, up to the end of 2009. At present, fourteen years after the creation of the cited Regulation 284/1995 Coll., it is not possible to take into account the advances in medical science which have been achieved in recent years during the assessment of the state of health. Annex no. 2 does not contain a chapter on cancerous growths and it therefore does not take into account the increasing trend in the occurrence of cancerous illnesses. Tumours are stated according to their organ localisation which gives rise to a certain break-up of the assessment's points of view. Therefore, the new concept for assessing the ability to carry out systematic gainful activities in patients with cancerous growths, part of which includes the newly created chapter on cancerous growths in the regulation on the assessment of invalidity, will contribute to the creation of uniform criteria for the assessment of dysfunction in the case of patients with cancerous growths on the basis of the WHO's International Classification of Functioning. At the same time, this will also lead to an improvement in the identification of the target groups of patients with tumours, who can potentially achieve a return to the work process. Prospectively, it may also lead to the interconnection of the database of acknowledged invalid's benefits with the database of the National Oncological Register. The Cancerous Growths Chapter is unique within the framework of the regulation in that it does not involve an illness of a specific organ or system. Oncological illnesses deserve their own chapter with regard to the specific nature of their etiology, pathogenesis, development, therapy and prognosis. Despite the fact that tumours arising from various cells will differ significantly from the point of view of therapy and prognosis, the cellular origins of the tumour are of little significance from the point of view of the functional affliction of the patient. In oncology, the functional affliction is invoked both by the tumour and by the

oncological therapy. In the case of the early stages of cancerous illnesses, the role of the therapy may be predominant as a cause of the functional affliction.

The affliction of the individual organs and systems by the cancerous illness and its complications, including therapy complications, can be described using the WHO International Classification of Functioning (Čevela et al. 2010b). The actual cancerous illness constitutes an impingement on the patient's functional abilities as a result of its presence and especially during the oncological therapy and for a certain period after its completion, because it gives rise to significant potential for life-threatening complications. This reduction of functional ability upon the basis of an increased potential due to serious complications cannot be scored according to the current version of the WHO International Classification of Functioning, but it is dominant in the case of a significant number of oncological patients.

For this reason, the draft system for assessing functional ability in oncological patients is based on three levels of evaluation (Vorlíček et al. 2008).

- 1: Curability
- 2: Ongoing oncological treatment
- 3: The consequences of the tumour or the therapy

1. Curability

The basis for the evaluation of the stage of the tumour is the TNM system. Regularly reviewed recommendations, which are specific for the diagnosis of the individual tumours, exist for the designation of the stage. According to the TNM stages, it is possible to divide tumours into localised (stages I, II and III) and generalised (stage IV). Some haematological malignities (acute and chronic leukaemia, myelodysplastic syndrome, myeloproliferative dysfunction, multiple myelomas) are viewed as being primarily disseminated.

2. Ongoing oncological treatment

Oncological therapy may result in a long-term functional affliction as a consequence of organ and tissue toxicity. The contents of the evaluation include, however, the reduction in functional ability during the application of the therapy due to undesirable side effects and the creation of potential life-threatening

complications. The functional affliction may also be long-term due to the fact that chemotherapy, biological therapy and hormone therapy can be applied for a period longer than 6 months. We distinctively state the conditions after the allogeneic transplantation of blood-forming cells, because this highly toxic therapeutic modality is associated with a life-long affliction of functional ability. Surgical treatment is the most frequently used modality of oncological therapy, but its long-term functional consequences are not able to be generalised and is necessary to follow the functional affliction of the organs or the physical systems in a given patient (Vorlíček et al. 2008).

3. Functional affliction as a consequence of a malignant disease or the undesirable side effects of oncological therapy

The most frequent direct and indirect long-term effects of cancerous illnesses and the consequences characteristic for oncological patients: mental changes, chronic tiredness, musculoskeletal changes, aesthetic damage, cytopenia and immunity disorders, urostomy, nephrostomy, colostomy, ileostomy, a breach in the mobility of the limbs and lymphedema and chronic morbidity after breast operations excluding lymphedema (Vorlíček et al. 2008).

Regulation 359/2009 Coll. which designates the percentile degree of the reduction in work capacity and the prerequisites for the invalidity assessment and regulates the assessment of work capacity for the purposes of invalidity

In the new Invalidity Assessment regulation, Chapter II: Cancerous Growths is divided into two independent sections. Section A includes malignant cancerous growths.

When assessing the degree of the reduction of the work capacity in the case of malignant cancerous growths, the assessment is based on the functional affliction, to which both the cancerous illness and the oncological therapy contribute. At the same time, the overall condition, the affliction of the organ functions or the body systems, any long-term or permanent affliction caused as a result of chemotherapy, radiotherapy, hormone therapy or biological treatment, afflictions

after allogeneic transplants of blood-forming cells, the scope of the preserved functional ability (functional staging according to the World Health Organisation – the WHO) and the ability to carry out daily activities are also evaluated. Daily activities are considered to be the activities according to the International Classification of Functioning, Disability and Health (according to the WHO). Not only functional afflictions resulting from malign diseases have an impact on work capacity, but also the undesirable side effects of oncological therapy. The most frequent long-term results of oncological afflictions are chronic pain, mental changes, chronic tiredness, breathlessness, musculoskeletal changes, breaches in the functioning of the limbs, lymphedemae, cytopenia, immunity disorders, bleeding, neuropathy, the extent of the surgical procedure, including significant aesthetic afflictions, speech disorders, the intake of foodstuffs, digestion, urination, defecation and a breach in overall mobility. When assessing a reduction in work capacity, an insured individual with a localised tumour (stage I, II and III) is viewed as being potentially curable and the evaluation of the degree of the reduction in the work capacity is derived from the result of the treatment, the clinical picture and the extent and the weight of the functional affliction. In the case of disseminated tumours (i.e. in stage IV), which can be considered to be an especially heavy affliction, the affliction may be potentially reversible in the case of treatable tumours. Table no. 4 depicts Section A – Malignant cancerous growths, Chapter II Cancerous Growths, Annex no. 1 of Regulation 359/2009 Coll.

Section B of the regulation sets out non-malignant cancerous growths. In the cases when the functioning of an organ or a system is reduced or lost as a consequence of a non-malignant tumour, the degree of the reduction in work capacity is designated comparably according to the scope and affliction of the functioning of the given organ or system or any unfavourable side effects and the limitation of overall efficiency and the performance of daily activities.

Case histories

We have included the following case histories in order to show a comparison of the assess-

ment of oncological patients according to Regulation 284/1995 Coll., which implements the Pension Insurance Act, as amended and Regulation 359/2009 Coll., which sets out the percentile extent of the reduction of the work capacity and the prerequisites for the invalidity assessment and regulates the work capacity for the purposes of invalidity (Interní materiály MPSV 2009).

Case history no. 1 – Thyroid cancer

A 48-year-old woman – a high school graduate – was found to have a micro-carcinoma of the thyroid gland (pT1N0M0) in 2006 as an accidental finding discovered during a standard operation for goitre which did not initially indicate an oncological basis. The thyroid gland was removed and this was followed by treatment with radioiodine.

In 2008, i.e. more than 2 years after the completion of the treatment, the condition was stabilised from an oncological point of view, no recidivism or progression of the illness was discovered. From an endocrinological point of view, however, it was not possible to achieve the required reduction of the thyroxin stimulating hormone by means of targeted and maximum substitution therapy. Tiredness and joint pain continued subjectively. Objectively, no severe organ complications were discovered.

According to Annex no. 2 of regulation 284/1995 Coll., in the wording valid up to 31. 12. 2009, the health affliction was assessed according to Chapter IV, entry 9.3, letter b) which states “A malignant tumour of the thyroid gland after the achievement of the stabilisation of the state of health (usually after two years from the end of the treatment) with slight dysfunction”. The upper limit of 40% was selected from the appropriate percentile range (30–40%) for the reduction of the capacity for the realisation of systematic gainful activities and the assessed patient was awarded a partial invalid’s benefit. The reason was the stabilised condition after two years from the end of the oncological treatment and the as yet incomplete hormonal substitution and the coexistence of other illnesses such as stabilised asthma and hydronephrosis of the kidneys without a breach of renal function. There was no reason for the assessment of full invalidity, because this did not involve a condition during ongoing oncological treatment or a progressing or recidivate form of the illness.

Table 4. Annex no. 1 to Regulation 359/2009 Coll. – Chapter II Cancerous Growths, Section A – Malignant Cancerous Growths

Entry	Type of health affliction	Degree of reduction in work capacity in 0%
1	<p>Cancerous growths The assessment standpoint: When designating the degree of the reduction of work capacity, it is necessary to evaluate the functional ability from the point of view of the curability, the ongoing oncological treatment in relation to the defined period and the consequences of the tumour or therapy and to also focus on reversible healthcare problems or on those which can be controlled with treatment.</p>	
1a	minimum affliction, asymptomatic states, minimum functional affliction or states after the treatment of surface skin and mucous membrane tumours (primary loco-regional treatment), tumours in situ or tumours which do not require adjuvant oncological treatment, states where no oncological stabilisation is necessary or smaller scale surgical operations with a minimal functional impact, states without the limitation of the realisation of the individual's daily activities	5–10
1b	slight affliction, states in complete remission, usually after 6 months from the end of the active oncological treatment, stabilised or smaller scale operations due to a malignant cancerous growth, external resection or amputation which is not directly visible, the amputation of parts where a prosthetic replacement is possible (for example, a mastectomy, the partial amputation of limbs, the resection of part of the bowels, hysterectomies, the enucleation of the eyeball given the good function of one eye) or states with slight functional afflictions to some organs or systems, the performance of some daily activities with difficulties or using compensating mechanisms and tools	15–25
1c	medium affliction, states in complete remission, usually after 6 months from the end of the active oncological treatment, stabilised, where the dysfunction has an extent reaching half of the scale of a full breach of functional ability, for example, stomie, penectomies, colectomies or the enucleation of the eyeball given reduced vision in the seeing eye or a loss of a limb at the forearm or in the shank or a partial laryngectomy or stabilisation after an allogeneic transplantation or states during the application of biological treatment, undesirable and long-term serious functional afflictions as a consequence of long-term hormone therapy or biological treatment, the performance of some daily activities is limited	35–45
1d	severe affliction, states in complete remission, after the completion of active oncological treatment, stabilised, where the dysfunction has an extent reaching more than half of the scale of a full breach of functional ability, for example, a total laryngectomy or resections in the area of the head or neck with mutilating consequences or a loss of a limb at the thigh or in the arm or any of the types of disseminated tumours (i.e. in stage IV), reversible, treated, after the achievement of the stabilisation of the condition, the performance of some daily activities substantially limited	50–65
1e	very severe affliction, malign tumours localised (stages I, II, III) during oncological treatment and usually within 6 months of its completion, if the complete remission remains or generalised malign tumours (stage IV), primarily disseminated tumours, usually within one year of the completion of the oncological treatment, if complete remission remains or states with persistent or progressive tumours or states within 6 months of the completion of radiotherapy of the cranium or nephrostomy, the combination of a colostomy or ileostomy or a urostomy or the full loss of a lower limb or an upper limb or with a relatively short stump, elephantiasis of the limbs, the mutilating growth of the tumour or states during transplantation treatment (the transplantation of blood-forming cells) and usually within 6 months of its completion or chronic graft versus host disease (GvHD) manifesting itself as a multi-organ autoimmune affliction or severe cytopenia, severe immune disorders with manifestations of opportune infections or septic states, severe bleeding or states with food ingestion dysfunction, incontinence, severe limitation of movement (functionally comparable with severe paresis of the limbs) or states involving the failure of any organ or system, the performance of the daily activities is severely limited	70–80

(Source: Regulation 359/2009 Coll.).

According to the Annex to Regulation 359/2009 Coll., as amended, the aforementioned patient would be assessed as having a long-term unfavourable condition from 1. 1. 2010. The health affliction would be assessed according to Chapter II, "Oncology", Section A "Malignant Tumours", entry 1b) "Cancerous Growths – slight affliction". The upper limit of the appropriate 15–25% reduction in work capacity would have been selected with regard to the endocrine dysfunction. There would not, however, have been seen to be any reason for the overall increase by 10 percentage points in accordance with section 3, subsection 1 (the cause of the long-term unfavourable state of health did not involve several health afflictions, as a consequence of which the reduction in work capacity would have been greater than the upper level of the percentile range) and subsection 2 (the long-term unfavourable state of health did not have such an influence on the use of her secondary school education or the use of her knowledge and experience so that the reduction in the work capacity would have been greater than the upper level of the percentile range). There would have been no reason for the evaluation according to entry 1c) and there would furthermore have been no reason with regard to the non-existence of a medium severe affliction with dysfunction at the extent of up to half of the scale for a full breach of functional ability. During an assessment according to the new regulation, this would not involve level one, two or three invalidity.

Case history no. 2 – Bowel cancer

A 31-year old apprenticed man without a high school diploma carrying out highly physically demanding work underwent a bowel operation in 2002. This involved a right-hand hemicolectomy for a malignant tumour of the appendix with medium histological differentiation and with infiltration into the nodes (pT3N2Mx, stage IIIC). No Stomie was undertaken and the assessed patient underwent 12 cycles of cytostatic treatment.

In 2008, he was awarded a partial invalid's benefit according to Annex no. 2 to Regulation no. 284/1995 Coll., as amended, in the wording valid up to 31. 12. 2009, according to Chapter X, Section C, entry 4, letter e) which states "A malignant tumour of the small and large intestine, the rectum after the achievement

the stabilisation of the state of health (usually after two years from the end of the treatment), without stomie, with slight dysfunction" At that time, 4 years had passed from the end of the treatment, the assessed patient was still in the dispensary care of the Oncology Ward, an entire range of examinations were undertaken at regular intervals (colonoscopy, sonograph of the abdomen, laboratory examinations, lung X-rays, clinical examinations). All of the examinations of the assessed patient showed a stabilised condition, without any signs of regression or recidivism, there were no signs of malnutrition. Dysplastic adenomas were preventatively removed. A genetic examination proved Lynch syndrome, i.e. the syndrome of family carcinomas. Of the patient's subjective problems, only the more frequent stool remained.

According to the appropriate legislation, the assessment selected the upper level of the percentile range (30–40%) and this was increased to a total of 50% due to the worker's qualification as per section 6, subsection 4 of the same regulation. The assessment of full invalidity was not relevant, because the assessed patient no longer had any ongoing oncological treatment, this did not involve a state with stomie with any stomie dysfunction and no unfavourable, progressive or recidivate form of the illness was found.

According to the annex to Regulation 359/2009 Coll., valid from 1. 1. 2010, the assessed patient's condition would have involved a long-term unfavourable state of health which would have been evaluated according to Chapter II, Section A, entry 1b) which states "Cancerous Growths – light affliction". The upper limit would be chosen from the appropriate 15–25% percentile range for the reduction of the work capacity and then increased by 10% to a total of 35% according to section 3, subsection 2 due to the patient's inability to carry out his original physically demanding, unqualified manual work and due to the problematic option of acquiring qualifications. The evaluation according to entry 1c) would not be relevant, because this did not involve a medium severe affliction with dysfunction at the extent of up to half of the scale for a full breach of functional ability. The assessed patient would thus have reached level-one invalidity according to the new regulation.

DISCUSSION

In 2003–2007, oncological illnesses ranked second in the list of the most frequent health causes of full invalidity and fourth among the causes of partial invalidity. When assessing the state of health and work capacity of oncological patients, the procedure up to the end of 2010 was undertaken according to Regulation 284/1995 Coll., which meant assessment according to the chapters of the regulation corresponding to the organ localisation of the tumour, because the regulation did not contain an independent chapter dedicated to cancerous illnesses. Given the growth in the numbers of full and partial invalidity due to oncological illnesses and taking into account the rapid development of the diagnostic therapy of oncological states, the structure of the regulation had ceased to correspond to reality. For this reason, an independent chapter dedicated to oncology has been created in the systemisation of Regulation 359/2009 Coll. with the aim of comprehensively covering the area of oncological states. Regulation 359/2009 Coll. is admittedly based on Regulation no. 284/1995 Coll. in a number of cases, but at the same time it also brings new procedures in the assessment of not only oncological patients. For example, it systematises the individual chapters of health afflictions in accordance with the International Classification of Diseases (ICD-10). It defines the method and use of the preserved work procedures in the case of level one and two invalidity and sets out the maximum extent of the reduction in work capacity in such a way so that these values are fully sufficient for the acknowledgement of level three invalidity and at the same time expresses the fact that even during very severe health afflictions an insured individual does not lose all the mental, sensory and physical abilities which are significant for work (Wernerová 2009). The annex to the regulation sets out in fifteen chapters the percentile extents of the reduction of work capacity for the individual groups of health afflictions and the most frequent types of health afflictions. This involves new evaluation criteria with regard to functional disorders and their impact on the quality of life (daily activities and the ability to participate) and these are based on the principles of the International

Classification of Functioning, Disability and Health (the ICF according to the WHO). Regulation 359/2009 Coll. also shortens the existing unjustifiably long deadlines for the stabilisation of the condition in the case of oncological afflictions. The examples of the comparison of the assessments according to Regulation 284/1995 Coll. and Regulation 359/2009 Coll. in the two stated case histories of oncological patients show that the new legal regulation at least represents a change in the approaches to the evaluation of functional ability and to the evaluation of the impact of dysfunction on work capacity and the ability to manage daily activities.

CONCLUSION

From the point of view of scientific advances, about one third of the expert, theoretical and practical knowledge in medicine is modified every five years and there are significant changes in diagnostics, treatment and the results of treatment. A number of illnesses can be diagnosed significantly earlier, in the early stages, and as such it is possible to achieve better treatment results, a number of states which were once untreatable or difficult to treat can now be successfully treated, cured or stabilised, it is possible to slow down regression or to attenuate unfavourable impacts, i.e. the scope and degree of any unfavourable accompanying effects or the results of the health affliction. These facts have a favourable influence on people with a healthcare affliction, because the aforementioned advances mean that the resulting functional state of the organism as a consequence of the health affliction is in many cases substantially better than that which was enabled by medicine at the time when Regulation 284/1995 Coll. was established. The aforementioned positive features of modern medicine naturally do not only have a positive impact in the state of health, but also on the quality of life and the ability of the individual to work. This should therefore be subsequently reflected in the development and symptoms of invalidation.

Regulation 359/2009 Coll. which sets out the percentile extent of the reduction in work capacity and the prerequisites for

the invalidity assessment and regulates the assessment of work capacity for the purposes of invalidity (concerning the assessment of invalidity) not only brings a new chapter on cancerous growths, which is in accordance with the development of medical knowledge in recent years, but also sets out uniform principles which ensure the individual and flexible assessment of the state of health. The systemisation of the arrangement of the regulations with the creation of an independent chapter dedicated to oncology has

enabled the area of oncological states to be comprehensively encompassed. The change in the perception of the need for the reduction in the period for stabilisation after the treatment of a tumour to 6 months confirmed by leading Czech oncologists is also significant. The new method of assessment thus enables the assessment of an effective profile of an individual's functional ability and health affliction and the provision of compensation for the reduction in the individual's work capacity in a targeted fashion.

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