

第4回 社会保障審議会統計分科会
生活機能分類専門委員会

平成 19 年 12 月 14 日(金)
14 時 ～ 16 時
三田 共用会議所
第2特別会議室

議 事 次 第

○ 議 事

- 1 WHO-F I C トリエステ会議の報告について
- 2 国際生活機能分類－小児青少年版について
- 3 その他

〔配布資料〕

- 資料1-1 WHO-F I C トリエステ会議について
- 資料1-2 WHO-F I C トリエステ会議を踏まえた「国際生活機能分類」の
現状
- 資料2 国際生活機能分類－小児青少年版（仮称）について
- 参考資料1 WHO記者発表資料
- 参考資料2 I C F ビギナーズガイド（仮称）（英文）

WHO-FIC トリエステ会議について

主 催： WHO、WHO-FIC イタリア協力センター共催
開催期間： 平成 19 年 10 月 28 日(日)～11 月 3 日(土)
会 場： イタリア国フリウーリ＝ヴェネツィア・ジュリア州トリエステ市
Plalazzo dei Congressi (議会堂)
参 加 者： WHO、協力センター10カ所、厚生、統計関係部局、オブザーバー等 27 カ国
168 名が参加

主な議題について：

(1) ICD-11 改訂及び改訂運営会議(RSG)からの進捗状況報告

- * ICD revision の方向性及び最終イメージについて RSG シュート議長より提示
- * 各 TAG のチェアより改訂の現状報告
 - ・ 精神(2007 年 1 月に第一回会合を開催。改訂に関するペーパーを準備中。)
 - ・ 希な疾患(Orphanet のデータベースと ICD をリンク。第 17 章を担当。)
 - ・ 外因(ICECI 等の分類との整合性を図る。改訂に関するペーパーを作成。)
 - ・ 内科(WG を組織化。)
 - ・ 腫瘍(IARC 等と協調。ICD-O 等の既存の分類の考え方を導入。)
 - ・ その他(感染症、歯科、眼科、産科、小児科領域等の専門家とコンタクト。)

(2) ICF 活用の新しい展開についての報告

- * ICF-CY に関するベニス会議の報告
- * ICF におけるターミノロジーの開発など

(3) 各種委員会報告

● 企画実行委員会(Planning Committee)

1)planning committee から council(仮称)へ組織が変更(詳細未定)

- * council のメンバーは以下のとおり
 - ・WHO 担当官(地域事務局を含む)

- ・各委員会及びレファレンスグループのチェア(RSGのチェアを含む)
- ・協力センター長(申請中も含む)

- * 初代 council(仮称)のチェアを選出(任期2年)
- ・マハティ・ベトナム氏(ノルディックセンター長)
- ・マージョリー・グリーンバーグ女史(北米センター長)

2) annual meeting(年次会議)から assembly(仮称)へ組織を変更(詳細未定)

- * assembly(仮称)の参加資格(WHO 担当官以外)
 - ・協力センターからの代表
 - ・WHO と公式な関係を有する NGO からの代表
 - ・WHO 本部が参加を認めた WHO 加盟国からの代表(日本はここに該当することになる)

● 普及委員会(Implementation Committee(IC))

- * 第2回アジア・パシフィックネットワーク京都会議について報告
- * アジア・パシフィック地域以外の地域の情報の共有化、連携の可能性についての検討

● 分類改正改訂委員会(Updating and Revision Committee (URC))

- * ICDの改正について125議題について審議;
- ・89提案受け入れ

● 教育委員会(Education Committee(EC))

- * 死因コーディング認定プログラムの完成
- * 疾病コーディング認定プログラム作業の開発

● 電子媒体委員会(Electronic Tools Committee(ETC))

- * ICDメンテナンスツールの改訂作業
- * ICD-11改訂作業ツールの開発

● 国際分類ファミリー拡張委員会(Family Development Committee(FDC))

- * 看護の国際分類(International Classification of Nursing Practice(ICNP))(仮称)の国際分類ファミリーへの加入(関連分類)を勧告
- * 伝統医学(Traditional Medicine)の国際分類ファミリーへの加入(関連分類)を検討

- 死因分類改正グループ(Mortality Reference Group (MRG))
 - * 死因分類に関する 50 議題を議論;
 - ・15 合意(URC へ提出)
 - ・ 5 要点合意(修正ののち URC へ提出)
 - * RSG への参加(共同議長のオブザーバー参加を提案)

- 疾病分類グループ(Morbidity Reference Group (MbRG))
 - * 疾病分類について 12 提案を URC へ提出
 - * 共同議長の交代(R.マッデン氏から K.アイネス氏へ)

- ターミノロジーグループ(Terminology Reference Group (TRG))
 - * WHO-FIC と IHTSDO の連携について議論
 - * 分類とのマッピング作業を検討

- 生活機能分類グループ(Functioning and Disability Reference Group (FDRG))

(基準、改正、ICD との調和、測定と活用、教育、倫理、環境因子、ターミノロジーに関する 8 つのプログラムにより構成)

 - * 改正のサイクルを提案
 - * オントロジーの作成を検討

- URC、MRG、MbRG 合同会議
 - * 大改正(Major update)は、当初予定の 2009 年から 2010 年に延期。小改正(Minor update)は 2012 年まで実施
 - * MRG の共同議長が、RSG にオブザーバー参加することを WHO 事務局に提案

次年度開催予定:平成 20 年 10 月 26 日(日)~11 月 1 日(土)インド

WHO-FICTリエステ会議を踏まえた「国際生活機能分類」の現状

(1) 分類そのものとしての進展

開催前の状況 ICFは、平成13年のWHO総会で採択されて分類としては完成しており、日本では翻訳版である「国際生活機能分類」を平成14年に発行した。

年次会議での進展 今次年次会議では、ICDと同様に、URC(改正改訂委員会)による改正・改訂の段階に入る方針が示された。さしあたり改訂は行わず改正のみ行われる予定で、ICDと同様、インターネット上のユーザ階層ごとのアクセス許可による「プラットフォーム形式」で意見集約、議決、改正のサイクルを行うことが提案された。

(2) 各分類項目における評価基準の設定

開催前の状況 第3回生活機能分類専門委員会において、分類項目の要素が「活動」または「参加」であるものについてWHOでの議論に先駆けて評価点基準(案)の作成を行った。

年次会議での進展 今次年次会議では、今後、WHOにおいても、「コーディング基準」を作成していくことについて言及されたが、詳細については今後FDRG(生活機能分類グループ)で議論される予定である。

(3) 実用的なユーザインターフェイスの工夫

開催前の状況 ICFのすべての分類項目(約1,500項目)を評価することは困難であるので、今後実用に供する段階では、用途に応じて、標準的なセット分類項目を抽出する等の工夫をする必要がある。

年次会議での進展 今次年次会議では、このような用途別の分類項目のセットの今後の開発の可能性について、汎用的ICFコアセット(Generic ICF Core Set)と、状況・状態別ICFコアセット(Condition and/or context oriented ICF Core Sets)の開発について提案された。また、一例としてコンピュータ・ソフトウェアを使用した測定評価結果入力ツールを紹介する中でもユーザインターフェイスの工夫について言及された。

(4) 簡単で容易に利用可能な普及資料の開発

開催前の状況 国内におけるICFの正しい普及・啓発を図る手引きとして本年3月に「生活機能分類の活用に向けて—ICF(国際生活機能分類):活動と参加の基準(暫定案)—」が出版された。

年次会議での進展 このような普及資料として、「ビギナーズ・ガイド」に加え、今年年次会議では、コーダーの教育等に用いられる「カリキュラム」や「トレーニング用入門教材」、多目的の使用に資する「ガイドライン」等について言及された。

(5) 実地活用について

開催前の状況 評価対象者本人を含めたさまざまな利用者間の共通言語としての理念的位置付けや、多方面での汎用性の高い利活用を現実化していくため、具体的な活用方策の検討が求められている。

年次会議での進展 今年年次会議では、保健サービスでの測定尺度としての利用や統計分野、社会政策等での活用について、有効利活用を促す議論がなされた。

(6) ICF-CYの進捗

開催前の状況 確定版は出ていなかったが、草案や概要、対象や基本方針等が示されていた。

年次会議での進展 確定版が発表された。ICF-CYでは、例えば「d816:Preschool life and related activities(就学前の生活と関連活動)」等の項目がICFに追加されており、より小児・青少年の健康と生活機能の特徴を踏まえたものになっている。

(7) ICFとICF-CYに係るWHO-FIC組織体制

開催前の状況 FDRGとその下に8つのプログラムが組織されていた。

年次会議での進展 ICFに関する組織体系に変更はなかったが、EC(教育委員会)とFDRG等、関連組織間の連携が進んだ。

国際生活機能分類－小児青少年版（仮称）について

1. 国際生活機能分類－小児青少年版（仮称）（ICF-CY）の勧告と今後の動向

- (1) 国際生活機能分類－小児青少年版（仮称）(International Classification of Functioning, Disability and Health - version for Children & Youth) (ICF-CY) は、小児青少年期における生活機能の特性に鑑み、国際分類ファミリーの中心分類である国際生活機能分類(ICF)を補完する目的で、派生分類として開発された。
- (2) 2006年WHO-FICチュニス会議において正式に承認され、2007年WHO-FICトリエステ会議の直前、10月25日～26日イタリア、ベニスにおいて正式に発表され刊行物が配布された。
- (3) ICF-CYの普及及び改善等については、チュニス会議において発足した生活機能分類グループ(FDRG)等で検討が進められることとされ、ICF本体と連動して、改正を行う予定である。

2. 国際生活機能分類－小児青少年版（仮称）（ICF-CY）の主な内容

- (1) ICF-CYはICFの派生分類であり、18歳未満の新生児・乳幼児・児童・青少年を対象とする。（ICF-CYの対象は、国連「児童の権利条約」にのべられている18歳未満のすべての者をいう）
- (2) ICF本体との関係：派生分類としてICF本体から由来し、それと完全な整合性をもち、分類構造、カテゴリーを同じにする。
ICF本体は本来総合的なものであったが、成長・発達期の特徴を記録する用途としては、改善点も指摘されていたため、それを補うものである。
- (3) ICF-CYはWHO-FICの一つであり、児童・青少年期の保健領域及び保健関連領域の情報についてICD-10と他の派生分類・関連分類と共に用いるべきものである。

- (4) ICF-CY と ICF 本体との違いは次の 4 点である。
- (a) 記述内容の修正と拡張
 - (b) 新しい項目を未使用コード番号に割り振る
 - (c) 「含まれるもの」「除かれるもの」の規定の修正
 - (d) 評価点を拡張して発達の側面を含める
- (5) 追加、修正された主な項目
- 第 1 レベル（章立てレベル）での両者の違いはないが、それ以下のレベルでの追加がみられる。
 - <心身機能> 第 1、4～7 章に一部追加
 - <身体構造> 第 1、3、7、8 章に一部追加
 - <活動と参加>
 - ・第 1 章から第 9 章までの各章で追加がみられる
 - ・とくに第 1 章「学習と知識の応用」第 2 章「一般的な課題と要求」第 8 章「主要な生活領域」に集中している。
 - <環境因子> 第 1、5 章に一部追加
 - 児童・青少年記に特有な項目が追加されている。
 - ・「d 3 3 1 Pre-talking」
 - ・「d 8 1 6 Preschool life and related activities」
 - ・「s 3 2 0 0 0 Primary dentition」等
 - 既存の項目が一部修正され、例示の部分が変更されているものがある。
 - ・「d 5 1 0 6 Regurgitation and vomiting」→「「d 5 1 0 6 Vomiting」
Functions of moving food or liquid in the reverse direction to ingestion, from stomach to oesophagus to mouth and out, such as in gastroesophageal reflux, recurrent vomiting, pyloric stenosis. 等

3. 国際生活機能分類—小児青少年版（仮称）ICF-CY の国内への適用について

国内への適用に向けた今後の対応（案）

- ICF-CY のプレス発表について社会保障審議会統計分科会へ報告。

- 専門性の高い個別具体的な審議内容であることから
 - ・ 検討体制については、小児青少年領域の専門家の意見を反映するための体制の構築を行う。
 - ・ 検討内容を関係省庁、関係部局、関係団体等に送付し意見聴取を行う。
 - ・ 集約した意見を取りまとめ委員会において検討する。

- ICF 専門委員会における検討結果を統計分科会に報告。

- 「国際生活機能分類－小児青少年版（仮称）（ICF-CY）日本語版」の刊行。



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News Release WHO/59
24 October 2007

WHO PUBLISHES NEW STANDARD FOR DOCUMENTING THE HEALTH OF CHILDREN AND YOUTH

24 October 2007 GENEVA/VENICE -- WHO publishes the first internationally agreed upon classification code for assessing the health of children and youth in the context of their stages of development and the environments in which they live.

The *International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY)* confirms the importance of precise descriptions of children's health status through a methodology that has long been standard for adults. Viewing children and youth within the context of their environment and development continuum, the ICF-CY applies classification codes to hundreds of bodily functions and structures, activities and participation, and various environmental factors that restrict or allow young people to function in an array of every day activities.

The rapid growth and changes that occur in first two decades of life were not sufficiently captured in the *International Classification of Functioning, Disability and Health (ICF)*, the precursor to the ICF-CY. The launch of the ICF-CY addresses this important developmental period with greater detail. Its new standardized coding system will assist clinicians, educators, researchers, administrators, policy makers and parents to document and measure the important growth, health and development characteristics of children and youth.

Children who are chronically hungry, thirsty or insecure, for example, are often not healthy and have trouble learning and developing normally. This classification provides a way to capture the impacts of the physical and social environment so that these can be addressed through social policy, health care and education systems to improve children's well-being.

"The ICF-CY will help us get past simple diagnostic labels. It will ground the picture of children and youth functioning and disability on a continuum within the context of their everyday life and activities. In this way it enables the accurate and constructive description of children's health and identifies the areas where care, assistance and policy change are most needed," said Ros Madden, Australian Commission on Safety and Quality in Health Care, and, Chair of the Functioning and Disability Reference Group of the WHO Family of International Classifications (WHO-FIC) Network.

The ICF-CY has important implications globally for research, standard setting and mobilizing resources. "For the first time, we now have a tool that enables us to track and compare the health of children and youth between countries and over time," said Nenad Kostanjsek of WHO's Measurement and Health Information team. "The ICF-CY will allow countries and the international community to take informed action to improve children's health, education and rights, by treating their health as a function of the environment that adults provide."

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The classification also covers developmental delay. Children who achieve certain milestones later than their peers may be at increased risk of disability. Using this classification, health practitioners, parents and teachers can describe these delays precisely in order to plan for health and educational needs and frame policy debates.

The children and youth version of the *International Classification of Functioning, Disability and Health (ICF-CY)* is launched today in Venice, with international praise:

— "The publication of the ICF-CY by the WHO provides, for the first time, a standard language to unify health, education and social services for children," said Dr. Margaret Giannini, Director of the Office of Disability, U.S. Department of Health and Human Services.

— "This approach offers a scientific basis for describing each child's functional abilities using a shared language. Further, the ICF-CY has important implications for educational policy, research, and service designs for children and youth with disabilities," said Mary Ruth Coleman Ph.D., President Council for Exceptional Children (2007).

— "The ICF-CY is a tool that can be shared by clinical services as well as by schools, community agencies and government entities. Further, with the visibility of an international WHO standard, the ICF-CY can serve to affirm the universal needs and rights of children," said Rune J. Simeonsson, Chair, WHO Work group on ICF-CY Children and Youth; University of North Carolina.

— "The approach of focusing on how children and youth function physically, socially and mentally within the context of their development and environment has important implications for special education," said Yutaka Oda, President, National Institute of Special Education, Japan.

For further information, please contact:

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Lina Reinders, Communications Officer, WHO, Geneva. Telephone: +41 22 791 1828; Fax: +41 22 791 1967; E-mail: reindersl@who.int.

All WHO Press Releases, Fact Sheets and Features as well as other health information can be obtained on the WHO home page <http://www.who.int/>.

International Classification of Functioning, Disability and Health: Children and Youth Version (ICF-CY) is currently available in English through: WHO Press, 1211 Geneva 27, Switzerland, Tel +41 22 791 24 76, Fax +41 22 791 48 57, E-mail: bookorders@who.ch. Publication in other languages and in a multilingual CD-ROM version are upcoming. Order forms are available at: www.who.int/bookorders/en.

All press releases, fact sheets and other WHO media material may be found at www.who.int.

世界保健機関

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プレスリリース WHO/59

2007年10月24日

WHOが小児・青少年の健康の記録を目的とした新しい標準を発表

2007年10月24日 ジュネーブ/ベネチア-WHOは、小児・青少年の発達段階および彼らが置かれている環境に照らして彼らの健康を評価するため、初の国際的な合意に基づく分類コードを発表する。

国際生活機能分類-小児青少年版 (ICF-CY) は、長らく成人のための標準であった方法論により、小児の健康状態を正確に記述することの重要性を再確認するものである。小児・青少年を彼らの置かれた連続的な環境と発達という文脈のなかでとらえつつ、ICF-CYは、何百もの心身機能・身体構造、活動、参加、そして日々の一連の活動において若者の機能を妨げあるいは許容するさまざまな環境因子に分類コードを適用している。

人生の最初の20年間におこる急激な成長と変化は、ICF-CYの前駆的分類である国際生活機能分類 (ICF) においては十分に把握されていなかった。ICF-CYの発表により、この重要な発達時期に対するよりきめ細やかな対応が可能になる。ICF-CYにおける標準化された新コーディングシステムは、臨床家・教育者・研究者・管理者・政策決定者、そして親が、小児・青少年の健康と生活機能の特徴を記録することを支援する。

例えば、慢性的に空腹・喉の渇きがあり、不安を感じている小児は健康でない場合が多く、正常な学習・発達が困難である。この分類は物理的・社会的環境の影響を把握する方法を提供し、社会政策、医療および教育システムを通じてそれらに取り組むことで小児の安寧を促進するものである。

世界保健機関国際分類ファミリー (WHO-FIC) ネットワーク生活機能分類グループ議長である Australian Commission on Safety and Quality in Health CareのRos Maddenは「ICF-CYは我々が単純な診断名から卒業する手助けになろう。それは日々の生活および活動という文脈の中で継続的に小児・青少年の生活機能の実態を示すだろう。ICF-CYにより小児の健康を正確かつ建設的に記述できるようになり、ケア、支援、政策変更が必要とされる分野を特定することができる。」と述べている。

ICF-CYは、研究、標準化、リソース動員に対して世界的に重要な示唆を与える。WHO 測定・健康情報チーム (WHO's Measurement and Health Information team) のNenad Kostanjsekは「我々は、異なる国々における小児・青少年の健康を経時的に追跡・比較することができるツールを今はじめて手にしたのである。ICF-CYによって、国々および国際社会が、大人が提供する環境を変数として小児の健康は規定されるものととらえることにより、小児の健康・教育・権利を向上させるために情報に基づいた行動をおこすことができるようになる。」と述べている。

プレスリリース WHO/59

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またこの分類は発達遅延もその対象としている。同年代の小児よりも遅れて一定の発達段階に到達した小児は障害のリスクが高い場合がある。この分類を使用することで、医療関係者・親・教師はそれらの遅延を正確に記載することができ、健康・教育上のニーズについて計画を立て、政策に関する議論の枠組みを提供することができる。

国際生活機能分類—小児青少年版 (ICF-CY) は本日ベネチアにおいて発表され、国際的に高い評価を得ている：

— 「WHOがICF-CY を発表したことで、小児のための健康・教育・社会福祉を一元化するための共通言語がもたらされた。」と米国・保健福祉省 障害者部門長 (Director of the Office of Disability) のDr.Margaret Giannini は述べている。

— 「このアプローチは、共通言語を使用して個々の小児の機能的能力を記述するための科学的根拠を提供している。さらにICF-CYは障害を持つ小児・青少年のための教育政策・研究・サービス設計に重要な示唆を与える。」と特殊教育評議会 (Council for Exceptional Children) 理事のMary Ruth Coleman Ph.D.は述べている (2007)。

— 「ICF-CYは学校、地域機関、政府機関はもとより臨床サービスでも共有することができるツールである。またWHOの標準として国際的に認知されるため、ICF-CYは小児の普遍的なニーズおよび権利を再確認する役目を果たすことができる。」とICF-CY小児・青少年版のWHOワークグループ議長でノースカロライナ大学のRune J. Simeonssonは述べている。

— 「小児・青少年の身体的・社会的・精神的な機能について、彼らの発達・環境という文脈の中で重点的に取り組むというアプローチは特殊教育に重要な示唆を与える。」と日本の国立特別支援教育総合研究所 理事長の小田豊は述べている。

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**Towards
a
Common Language
for
Functioning, Disability and Health
ICF**



World Health Organization
Geneva
2002

**Towards a
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for
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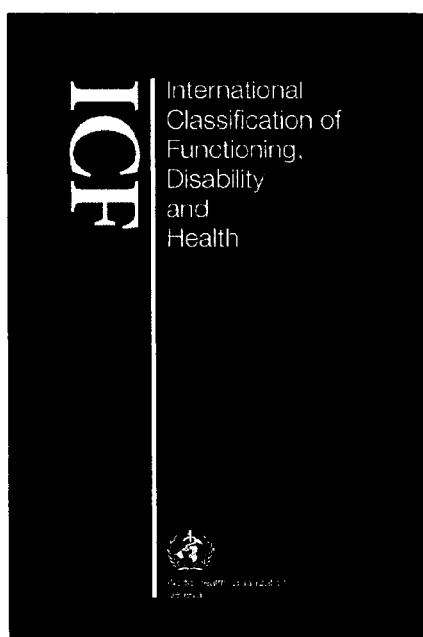
ICF

**The International Classification
of Functioning, Disability and Health**

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INTRODUCTION

The *International Classification of Functioning, Disability and Health*, known more commonly as ICF, provides a standard language and framework for the description of health and health-related states. Like the first version published by the World Health Organization for trial purposes in 1980, ICF is a multi-purpose classification intended for a wide range of uses in different sectors. It is a classification of health and health-related domains -- domains that help us to describe changes in body function and structure, what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance). These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. In ICF, the term *functioning* refers to all body functions, activities and participation, while *disability* is similarly an umbrella term for impairments, activity limitations and participation restrictions. ICF also lists environmental factors that interact with all these components.



ICF is WHO's framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. It is a universal classification of disability *and* health for use in health and health-related sectors. ICF therefore looks like a simple health classification, but it can be used for a number of purposes. The most important is as a planning and policy tool for decision-makers.

ICF is named as it is because of its stress is on health and functioning , rather than on disability. Previously, disability began where health ended; once you were disabled, you where in a separate category. We want to get away from this kind of thinking. We want to make ICF a tool for measuring functioning in society, no matter what the reason for one's impairments. So it becomes a much more versatile tool with a much broader area of use than a traditional classification of health and disability.

This is a radical shift. From emphasizing people's disabilities, we now focus on their level of health.

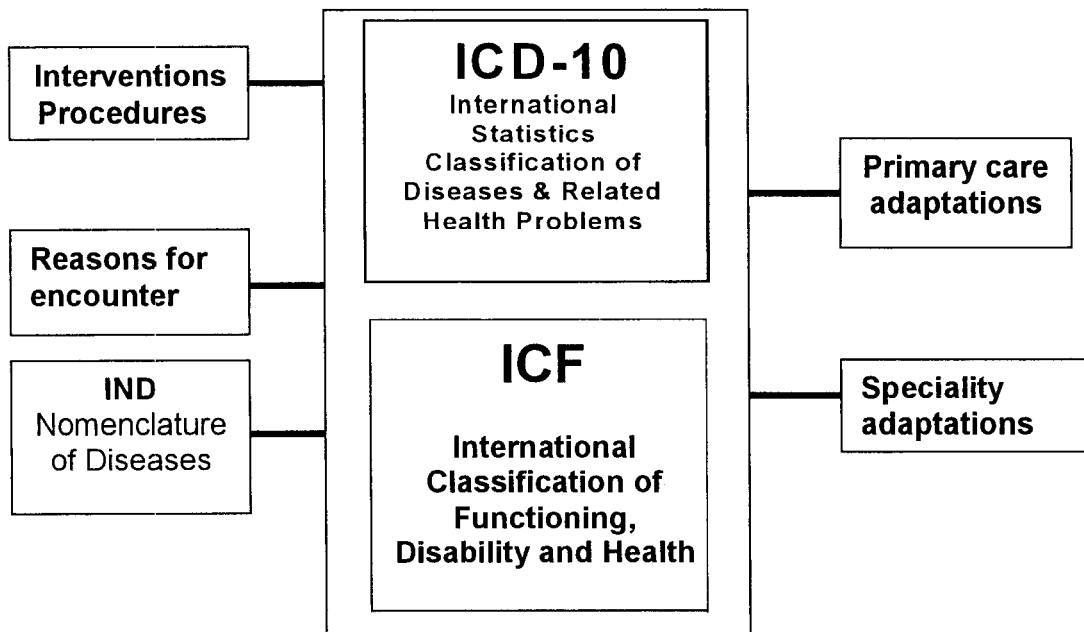
ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some disability. This is not something that happens to only a minority of humanity. ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability.

THE WHO FAMILY OF INTERNATIONAL CLASSIFICATIONS

ICF belongs to the WHO family of international classifications, the best known member of which is the ICD-10 (*the International Statistical Classification of Diseases and Related Health Problems*). ICD-10 gives users an etiological framework for the classification, by diagnosis, of diseases, disorders and other health conditions. By contrast, ICF classifies functioning and disability associated with health conditions. The ICD-10 and ICF are therefore complementary, and users are encouraged to use them together to create a broader and more meaningful picture of the experience of health of individuals and populations. Information on mortality (provided by ICD-10) and information about health and health-related outcomes (provided by ICF) can be combined in summary measures of population health.

In short, ICD-10 is mainly used to classify causes of death, but ICF classifies health.

WHO Family of International Classifications



THE NEED FOR ICF

Studies show that diagnosis alone does not predict service needs, length of hospitalization, level of care or functional outcomes. Nor is the presence of a disease or disorder an accurate predictor of receipt of disability benefits, work performance, return to work potential, or likelihood of social integration. This means that if we use a medical classification of diagnoses alone we will not have the information we need for health planning and management purposes. What we lack is data about levels of functioning and disability. ICF makes it possible to collect those vital data in a consistent and internationally comparable manner.

For basic public health purposes, including the determine the overall health of populations, the prevalence and incidence of non-fatal health outcomes, and to measure health care needs and the performance and effectiveness of health care systems, we need reliable and comparable data on the health of individuals and populations. ICF provides the framework and classification system for these purposes.

For some time, there has been a shift in the focus from hospital-based acute care to community-based long-term services for chronic conditions. Social welfare agencies have noticed a marked increased in demand for disability benefits. These trends have underscored the need for reliable and valid disability statistics. ICF provides the basis for identifying kinds and levels of disability which provides the foundations for country-level disability data to inform policy

development.

There is also an increased recognition among social planners and service agencies that reductions in the incidence and severity of disability in a population can be brought about both by enhancing the functional capacity of the person and by improving performance by modifying features of the social and physical environment. To analyze the impact of these different interventions, we need a way of classifying domains of areas of life as well as the environmental factors that improve performance. ICF allows us to record this information.

HOW WILL WHO USE ICF?

WHO must provide tools that our Member States can use to improve their health policies, achieve better health for their population and to ensure that their health systems are as cost effective and fair as possible. We provide tools that are based on the best science and which represent the basic core values on which the Organization bases its work: equity, inclusion and the aim of all to achieve a life where each person can exploit his or her opportunities to the fullest possible degree.

Last year, the 191 Member States of the World Health Organization agreed to adopt ICF as the basis for the scientific standardization of data on health and disability world-wide. ICF directly contributes to WHO's efforts to establish a comprehensive population health measurement framework. We would like to go beyond the old, traditional mortality and morbidity measures by including measures of functional domains of health.

WHO uses a multi-dimensional health measure as the basis for health systems performance assessment. The health goal of a health system is measured on the basis of ICF. In this way, WHO can assist Member States in enhancing the performance of their health systems. With better functioning health systems, health levels across the population are raised and everyone benefits.

The ICF is key example of such a tool. ICF is a scientific tool for consistent, internationally comparable information about the experience of health and disability. As such, it also provides the basis for WHO overall approach to health.

HOW CAN ICF BE USED?

Because of its flexible framework, the detail and completeness of its classifications and the fact that each domain is operationally defined, with inclusions and exclusions, it is expected that ICF, like its predecessor, will be

used for a myriad of uses to answer a wide range of questions involving clinical, research and policy development issues. (For specific examples of the uses of ICF in the area of service provision, and the kinds of practical issues that can be addressed, see the box below.)

ICF Applications Service Provision

At the individual level

- For the assessment of individuals: *What is the person's level of functioning?*
- For individual treatment planning: *What treatments or interventions can maximize functioning?*
- For the evaluation of treatment and other interventions: *What are the outcomes of the treatment? How useful were the interventions?*
- For communication among physicians, nurses, physiotherapists, occupational therapists and other health workers, social service workers and community agencies
- For self-evaluation by consumers: *How would I rate my capacity in mobility or communication?*

At the institutional level...

- For educational and training purposes
- For resource planning and development: *What health care and other services will be needed?*
- For quality improvement: *How well do we serve our clients? What basic indicators for quality assurance are valid and reliable?*
- For management and outcome evaluation: *How useful are the services we are providing?*
- For managed care models of health care delivery: *How cost-effective are the services we provide? How can the service be improved for better outcomes at a lower cost?*

At the social level...

- For eligibility criteria for state entitlements such as social security benefits, disability pensions, workers' compensation and insurance: *Are the criteria for eligibility for disability benefits evidence based, appropriate to social goals and justifiable?*
- For social policy development, including legislative reviews, model legislation, regulations and guidelines, and definitions for anti-discrimination legislation: *Will guaranteeing rights improve functioning at the societal level? Can we measure this improvement and adjust our policy and law accordingly?*
- For needs assessments: *What are the needs of persons with various levels of disability - impairments, activity limitations and participation restrictions?*
- For environmental assessment for universal design, implementation of mandated accessibility, identification of environmental facilitators and barriers, and changes to social policy: *How can we make the social and built environment more accessible for all persons, those with and those without disabilities? Can we assess and measure improvement?*

Among the other kinds of uses for ICF are these:

Policy development...

In both the health sectors and other sectors that need to take into account the functional status of people, such as social security, employment, education and transportation, there is an important role that ICF can play. It goes without saying that policy development in these sectors requires valid and reliable population data on functional status. Legislative and regulatory definitions of disability need to be consistent and grounded in a single coherent model of the disability creation process. Whether it is devising eligibility criteria for disability pensions, developing regulations for access to assistive technology, or mandating housing or transportation policy that accommodates individuals with mobility, sensory or intellectual disability, ICF can provide the framework for comprehensive and coherent disability-related social policy.

Economic analyses...

Most applications of ICF lend themselves to economic analyses. Determining whether resources are effectively used in health care and other social services requires a consistent and standard classification of health and health-related outcomes that can be costed and compared internationally. We need information on the disability burden of various diseases and health conditions. To ensure that society can effectively prevent limitations on activities and restrictions on participation, it needs to cost the economic impact of functional limitations as compared to the costs of modifying the built and social environment. ICF makes both of these tasks possible.

Research uses...

Generally, ICF assists in scientific research by providing a framework or structure for interdisciplinary research in disability and for making results of research comparable. Traditionally, scientists have measured the outcomes of health conditions by relying on mortality data. More recently, the international concern about health care outcomes has shifted to the assessment of functioning at the level of the whole human being, in day-to-day life. The need here is for universally applicable classification and assessment tools, both for activity levels and overall levels of participation, in basic areas and roles of social life. This is what ICF provides and makes possible.

Intervention studies...

Of particular interest in research are intervention studies that compare the outcomes of interventions on similar populations. ICF can facilitate this kind of research by clearly distinguishing interventions – and coding outcomes – in light of the aspect of disability that the intervention addresses. Body level or impairment interventions are primarily medical or rehabilitative, and attempt to prevent or ameliorate limitations in person or societal level functioning by correcting or modifying intrinsic functions or structures of the body. Other rehabilitative treatment strategies and interventions are designed to increase capacity levels. Interventions that focus on the actual performance context of an individual may address either capacity-improvement or else seek environmental modification, either by eliminating environmental barriers or creating environmental facilitators for expanded performance of actions and tasks in daily living.

Uses of Environment Factors...

One of the major innovations in ICF is the presence of an environmental factor classification that makes it possible for the identification of environmental barriers and facilitators for both capacity and performance of actions and tasks in daily living. With this classification scheme, which can be used either on an individual basis or for population wide data collection, it may be possible to create instruments that assess environments in terms of their level of facilitation or barrier-creation for different kinds and levels of disability. With this information in hand, it will then be more practical to develop and implement guidelines for universal design and other environmental regulations that extend the functioning levels of persons with disabilities across the range of life activities.

THE MODEL OF ICF

Two major conceptual models of disability have been proposed. The *medical model* views disability as a feature of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. Disability, on this model, calls for medical or other treatment or intervention, to 'correct' the problem with the individual.

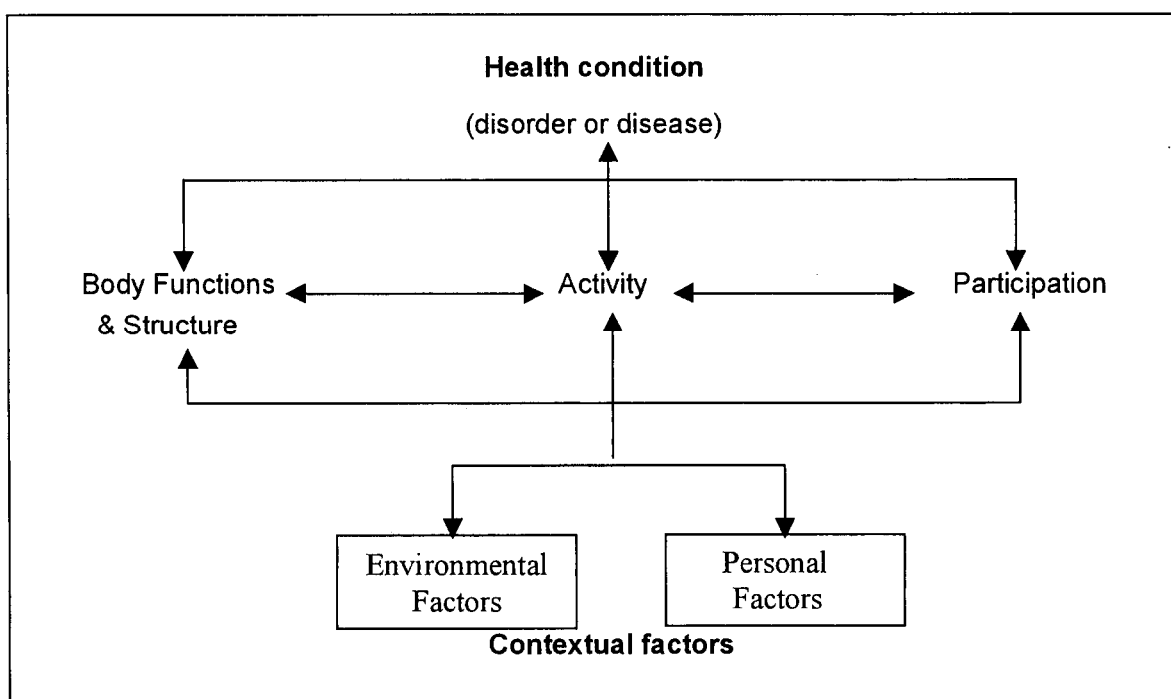
The *social model* of disability, on the other hand, sees disability as a socially-created problem and not at all an attribute of an individual. On the social model, disability demands a political response, since the problem is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment.

On their own, neither model is adequate, although both are partially valid. Disability is a complex phenomena that is both a problem at the level of a person's body, and a complex and primarily social phenomena. Disability is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of disability are almost entirely internal to the person, while another aspect is almost entirely external. In other words, both medical and social responses are appropriate to the problems associated with disability; we cannot wholly reject either kind of intervention.

A better model of disability, in short, is one that synthesizes what is true in the medical and social models, without making the mistake each makes in reducing the whole, complex notion of disability to one of its aspects.

This more useful model of disability might be called the *biopsychosocial model*. ICF is based on this model, an integration of medical and social. ICF provides, by this synthesis, a coherent view of different perspectives of health: biological, individual and social.

The following diagram is one representation of the model of disability that is the basis for ICF



Concepts of functioning and disability

As the diagram indicates, in ICF disability and functioning are viewed as outcomes of interactions between *health conditions* (diseases, disorders and injuries) and *contextual factors*.

Among contextual factors are external *environmental factors* (for example, social attitudes, architectural characteristics, legal and social structures, as well as climate, terrain and so forth); and internal *personal factors*, which include gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character and other factors that influence how disability is experienced by the individual.

The diagram identifies the three levels of human functioning classified by ICF: functioning at the level of body or body part, the whole person, and the whole person in a social context. Disability therefore involves dysfunctioning at one or more of these same levels: impairments, activity limitations and participation restrictions. The formal definitions of these components of ICF are provided in the box below.

Body Functions are physiological functions of body systems (including psychological functions).

Body Structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function or structure such as a significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity Limitations are difficulties an individual may have in executing activities.

Participation Restrictions are problems an individual may experience in involvement in life situations.

Environmental Factors make up the physical, social and attitudinal environment in which people live and conduct their lives..

The Qualifiers

The list of domains in ICF becomes a classification when qualifiers are used. Qualifiers record the presence and severity of a problem in functioning at the body, person and societal levels.

For the classifications of body function and structure, the primary qualifier indicates the presence of an impairment and, on a five point scale, the degree of the impairment of function or structure (no impairment, mild, moderate, severe and complete).

In the case of the Activity and Participation list of domains, two important qualifiers are provided. Together, these qualifiers enable the user to code essential information about disability and health.

The *Performance qualifier* describes what an individual does in his or her current environment. Since the current environment always includes the overall societal context, performance can also be understood as "involvement in a life situation" or "the lived experience" of people in their actual context. (The 'current environment' will be understood to include assistive devices or personal assistance, whenever the individual actually uses them to perform actions or tasks.)

The *Capacity qualifier* describes an individual's ability to execute a task or an action. This construct indicates the highest probable level of functioning of a person in a given domain at a given moment.

When a person has a capacity problem associated with a health condition, therefore, that incapacity is a part of their state of health. To assess the full ability of the individual, one would need to have a "*standardized environment*" to neutralize the varying impact of different environments on the ability of the individual. In practice, there are many possible environments that we could use for this purpose.

That is, a standardized environment might be: (a) an actual environment commonly used for capacity assessment in test settings; or (b) an assumed environment thought to have an uniform impact; or (c) an environment with precisely defined parameters based on extensive scientific research. Whatever it is in practice, this environment can be called 'uniform' or 'standard' environment. The capacity construct therefore reflects the environmentally-adjusted ability of the individual in a specified domain. The Capacity qualifier assumes a 'naked person' assessment, that is, the person's capacity without personal assistance or

the use of assistive devices. For assessment purposes, this environmental adjustment has to be the same for all persons in all countries to allow for international comparisons. For precision and international comparability, features of the uniform or standard environment can be coded using the Environmental Factors classification.

For a disability and health classification it is important that users be able to express these domains by means both of a performance and a capacity construct, even if, in particular cases for special uses only one of the two constructs are employed. ICF provides a single list of Activities and Participation which users can, for their needs and purposes, employ either by

A) designating some domains as Activities and others as Participation and *not allowing overlap*;

B) making this designation but *allowing overlap* in particular cases;

C) designating *detailed* (third- or fourth-level) categories within a domain as Activities and *broad* (second-level) categories in the domain as Participation;

D) *designating all domains* as potentially both Activity and Participation, and employing the qualifiers to distinguish the information that is required and collected.

(The approach described in D) is WHO's default approach and ICF country data submitted to WHO will be assumed to reflect this approach.)

Having access to both performance and capacity data enables ICF user to determine the 'gap' between capacity and performance. If capacity is less than performance, then the person's current environment has enabled him or her to perform better than what data about capacity would predict: the environment has facilitated performance. On the other hand, if capacity is greater than performance, then some aspect of the environment is a barrier to performance.

The distinction between environmental 'barriers' and 'facilitators', as well as the extent to which an environmental factor acts in one way or another, is captured by the qualifier for coding Environmental Factors.

Finally, an additional qualifier is available to supplement this information. Both the Capacity and Performance qualifiers can further be used with and without assistive devices or personal assistance. While neither devices nor personal assistance alter the impairments, they may remove limitations on functioning in

specific domains. This type of coding is particularly useful to identify how much the functioning of the individual would be limited without the assistive devices. The constructs and the operation of the qualifiers is set out in the next chart:

Construct	First qualifier	Second qualifier
Body Functions (b)	<p>Generic qualifier with the negative scale used to indicate the extent or magnitude of an impairment</p> <p><i>Example: b175.3 to indicate a severe impairment in specific mental functions of language</i></p>	None
Body Structure (s)	<p>Generic qualifier with the negative scale used to indicate the extent or magnitude of an impairment</p> <p><i>Example: s730.3 to indicate a severe impairment of the upper extremity</i></p>	<p>Used to indicate the nature of the change in the respective body structure</p> <p>0 no change in structure 1 total absence 2 partial absence 3 additional part 4 aberrant dimensions 5 discontinuity 6 deviating position 7 qualitative changes in structure, including accumulation of fluid 8 not specified 9 not applicable</p> <p><i>Example: s7300.32 to indicate the partial absence of the upper extremity</i></p>
Activity & Participation (d)	<p>PERFORMANCE</p> <p>Generic qualifier</p> <p><u>Problem in the person's current environment</u></p> <p><i>Example: a5101.1_ to indicate mild difficulty with bathing the whole body with the use of assistive devices that are available to the person in his or her current environment</i></p>	<p>CAPACITY</p> <p>Generic qualifier</p> <p><u>Limitation without assistance</u></p> <p><i>Example: a5101._2 to indicate moderate difficulty with bathing the whole body and implies that there is moderate difficulty without the use of assistive devices or personal help</i></p>
Environmental Factors (e)	<p>Generic qualifier, with negative and positive scale to denote extent of barriers and facilitators respectively</p> <p><i>Example: e145.2 to indicate that products for education are a moderate barrier. Conversely, e145+2 would indicate that products for education are a moderate facilitator</i></p>	None

Underlying principles of ICF

There are general principles that underlay the conception of ICF as a health classification of functioning and disability, and are closely linked to the biopsychosocial model of disability. These principles are essential components of

the model of ICF and guided the revision process.

UNIVERSALITY

A classification of functioning and disability should be applicable to all people irrespective of health condition. Therefore, ICF is about all people. It concerns everyone's functioning. Thus, it should not become a tool for labeling persons with disabilities as a separate group.

PARITY

There should not be, explicitly or implicitly, a distinction between different health conditions as 'mental' and 'physical' that affect the structure of content of a classification of functioning and disability. In other words, disability must not be differentiated by etiology.

NEUTRALITY

Wherever possible, domain names should be worded in neutral language so that the classification can express both positive and negative aspects of each aspect of functioning and disability.

ENVIRONMENTAL FACTORS

In order to complete the social model of disability, ICF includes Contextual Factors, in which environmental factors are listed. These factors range from physical factors such as climate and terrain, to social attitudes, institutions, and laws. Interaction with environmental factors is an essential aspect of the scientific understanding of the phenomena included under the umbrella terms 'functioning and disability'.

THE DOMAINS OF ICF

The domains of ICF are arranged in a hierarchy (Chapter, second, third and fourth level domains), which is reflected in the coding:

Level	Example	Coding
Chapter	Chapter 2: Sensory Functions and Pain	b2
Second level	Seeing Functions	b210
Third level	Quality of vision	b2102
Fourth level	Colour vision	b21021

The follow chart sets out the complete list of chapters in the ICF:

Body	
<p>Function:</p> <p>Mental Functions Sensory Functions and Pain Voice and Speech Functions Functions of the Cardiovascular, Haematological, Immunological and Respiratory Systems Functions of the Digestive, Metabolic, Endocrine Systems Genitourinary and Reproductive Functions Neuromusculoskeletal and Movement-Related Functions Functions of the Skin and Related Structures</p>	<p>Structure:</p> <p>Structure of the Nervous System The Eye, Ear and Related Structures Structures Involved in Voice and Speech Structure of the Cardiovascular, Immunological and Respiratory Systems Structures Related to the Digestive, Metabolic and Endocrine Systems Structure Related to Genitourinary and Reproductive Systems Structure Related to Movement Skin and Related Structures</p>
Activities and Participation	
<p>Learning and Applying Knowledge General Tasks and Demands Communication Mobility Self Care Domestic Life Interpersonal Interactions and Relationships Major Life Areas Community, Social and Civic Life</p>	
Environmental Factors	
<p>Products and Technology Natural Environment and Human-Made Changes to Environment Support and Relationships Attitudes Services, Systems and Policies</p>	

The following chart gives some possible examples of disabilities that may be associated with the three levels of functioning linked to a health condition.

HEALTH CONDITION	IMPAIRMENT	ACTIVITY LIMITATION	PARTICIPATION RESTRICTION
Leprosy	Loss of sensation of extremities	Difficulties in grasping objects	Stigma of leprosy leads to unemployment
Panic Disorder	Anxiety	Not capable of going out alone	People's reactions leads to no social relationships
Spinal Injury	Paralysis	Incapable of using public transportation	Lack of accommodations in public transportation leads to no participation in religious activities
Juvenile diabetes	Pancreatic dysfunction	None (impairment controlled by medication)	Does not go to school because of stereotypes about disease
Vitiligo	Facial disfigurement	None	No participation in social relations owing to fears of contagion
Person who formally had a mental health problem and was treated for a psychotic disorder	None	None	Denied employment because of employer's prejudice

The next chart indicates how the different levels of disability are linked to three different levels of intervention.

	Intervention	Prevention
HEALTH CONDITION	Medical treatment/care Medication	Health promotion Nutrition Immunization
IMPAIRMENT	Medical treatment/care Medication Surgery	Prevention of the development of further activity limitations
ACTIVITY LIMITATION	Assistive devices Personal assistance Rehabilitation therapy	Preventive rehabilitation Prevention of the development of participation restrictions
PARTICIPATION RESTRICTION	Accommodations Public education Anti-discrimination law Universal design	Environmental change Employment strategies Accessible services Universal design Lobbying for change

CONCLUSION

ICF offers an international, scientific tool for the paradigm shift from the purely medical model to an integrated biopsychosocial model of human functioning and disability. It is a valuable tool in research into disability, in all its dimensions -- impairments at the body and body part level, person level activity limitations, and societal level restrictions of participation. ICF also provides the conceptual model and classification required for instruments to assess the social and built environment.

ICF will be an essential basis for the standardization of data concerning all aspects of human functioning and disability around the world.

ICF will be used by persons with disabilities and professionals alike to evaluate health care settings that deal with chronic illness and disability, such as rehabilitation centres, nursing homes, psychiatric institutions, and community services.

ICF will be useful for persons with all forms of disabilities, not only for identifying their health care and rehabilitative needs, but also in identifying and measuring the effect of the physical and social environment on the disadvantages that they experience in their lives.

From the viewpoint of health economics, ICF will help monitor and explain health care and other disability costs. Measuring functioning and disabilities will make it possible to quantify the productivity loss and its impact on the lives of the people in each society. The classification will also be of great use in the evaluation of intervention programmes.

In some of the developed countries, ICF and its model of disability have been introduced into legislation and social policy, across sectors. It is expected that ICF will become the world standard for disability data and social policy modeling and will be introduced in the legislation of many more countries around the globe.

In sum, ICF is WHO's framework for health and disability. It is the conceptual basis for the definition, measurement and policy formulations for health and disability. It is a universal classification of disability *and* health for use in health and health-related sectors.

THE WORLD-WIDE ICF NETWORK

For further information about ICF, and its application to regions or countries, contact the following organizations, agencies, and NGOs who form part of ICF collaborating network.

Collaborating Centers:

Australia: Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, Australia
Contact: Ros Madden.

Canada: Canadian Institute for Health Information, 377 Dalhousie Street, Suite 200, Ottawa Ontario K1N9N8, Canada
Contact: Janice Miller.

France: Centre technique national d'Etudes et de Recherches sur les Handicaps et les Inadaptations (CTNERHI), 236 bis, rue de Tolbiac, 75013 Paris, France
Contact: Catherine Barral.

Japan: Japan College of Social Work, 3-1-30 Takeoka, Kiyosehi, Tokyo 204, Japan
Contact: Hisao Sato.

The Netherlands: Center for Standardization of Informatics in Health Care (CSIZ), Driebergseweg 3, 3708 JA Zeist, The Netherlands, Contacts: Willem Hirs and Marijke W. de Kleijn de Vrankrijker.

Nordic countries: Department of Public Health and Caring Sciences, Uppsala Science Park, SE Uppsala Sweden
Contact: Björn Smedby.

United Kingdom: NHS Information Authority, Coding and Classification, Woodgate, Loughborough, Leics LE11 2TG, United Kingdom. Contact: Ann Harding, Jane Millar

USA: National Center for Health Statistics, Room 850, 6525 Belcrest Road, Hyattsville MD 20782, USA
Contact: Paul Placek.

Networks:

La Red de Habla Hispana en Discapacidades (The Spanish Network). Co-ordinator: Jose Luis Vazquez-Barquero, Unidad de Investigacion en Psiquiatria Clinical y Social Hospital Universitario "Marques de Valdecilla", Avda. Valdecilla s/n, Santander 39008 Spain.

The Council of Europe Committee of Experts for the Application of ICIDH, Council of Europe, F-67075, Strasbourg, France. Contact: Lauri Sivonen.

Participating Non Governmental Organizations:

Disabled Peoples International, 11 Belgrave Road, London SW1V 1RB, United Kingdom. Contact: Rachel Hurst.

European Disability Forum, Square Ambiorix, 32 Bte 2/A, B-1000, Bruxelles, Belgium. Contact: Frank Mulcahy.

European Regional Council for the World Federation of Mental Health (ERCWFM), Blvd Clovis N.7, 1000 Brussels, Belgium. Contact: John Henderson.

Inclusion International, 13D Chemin de Levant, F-01210, Ferney-Voltaire, France. Contact: Nancy Breitenbach

Rehabilitation International, 25 E. 21st Street, New York, NY 10010, USA. Contact: Judith Hollenweger, Chairman RI Education Commission, Institute of Special Education, University of Zurich, Hirschengraben 48, 8001 Zurich, Switzerland.

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