This paper provides an introduction to the central concepts of the World Health Organization’s (WHO’s) new classification, the International Classification of Functioning, Disability and Health (ICF) (1) and discusses the prospects and dilemmas that the ICF presents in practical rehabilitation work, based on initial experiences in Denmark and the other Nordic countries.

The potential of the ICF theoretical framework seems promising and a large number of countries have expressed interest in the need for such a framework and its relevance to the professional areas of rehabilitation and public health. There is emerging interest in the different aspects of functioning and it seems that the ICF may also support the documentation and evaluation of quality services in rehabilitation. During the past two years a number of papers have been published in which the authors express their interest in the ICF as a common framework for clinical work and for research in rehabilitation (2–6). The framework was developed over a period of time, commencing with the work of Nagi in the 1960s, further conceptualized in the “Disability model” by Verbrugge & Jette (7), and, also of great importance, the work by Fougeryrollas, addressing the importance of the environment as a major determinant to what Fougeryrollas terms the “Handicap Creation Process” (8).

To my mind, the WHO’s approval of the ICF will not only have an impact in the theoretical uniformity of the concepts, but also, and more importantly, may guide member states in their future work in the health sector of population needs in functioning and disability.

The ICF is the result of a revision process based on the ICIDH (9), and has been ongoing during the last decade. “Revision” may not be the right word, as it is actually a new classification, which stands on a different theoretical framework than that of the ICIDH from 1980. The WHO’s new classification was approved by the World Health Assembly, as an official member of the WHO Family of Classifications, in May 2001. The “Family of Classifications” launched contains both the ICD and the ICF as the main international classifications of health. From a recent international meeting, held by the WHO in Trieste, Italy in April 2002, the WHO’s director general, Dr Gro Harlem Brundtland, likened the ICF to the Swiss army knife, with many tools and possible uses1.

Since the release of the ICIDH by WHO in 1980, to be used in field trials, there has been continuous discussion between researchers, professional clinicians and the disability movement on both the theoretical conceptualization and the use of the ICIDH. Although the ICIDH was not recognized as an official classification, it has had an impact on development in research and education. The literature on this topic amounts more than 1500 references which can be classified into two main categories: On the one hand, references which are using ICIDH as a theoretical framework in different studies, and on the other hand, references of papers, criticizing the idea and concepts of ICIDH, and pointing out the shortcomings of adopting a medical-biological view on disability. Recently, Pfeiffer has debated the need for a classification as such (10, 11). Pfeiffer’s view seems to capture the major criticism from people with disabilities, as similar views have been expressed by e.g. European Disability Forum. Pfeiffer emphasize that as long as the conceptual basis of ICF is a medical model, disability issues are getting medicalized. According to Pfeiffer this may be the
Disability must also be seen in the societal context, and can sometimes be described according to existing laws and regulations within the given society.

This issue is far more complicated than a straightforward dichotomous distinction between having a disability or not. This must also be taken into account when scientists try to conceptualize and quantify the malfunctioning, disability or impairment in populations (12, 13).

**FROM ICIDH TO ICF**

Even if the ICIDH has described the components of disability on a linear, progressive scale, the understanding of disability is relativistic and multifactorial in its nature. This was not captured by the first version of the ICIDH from 1980, and this issue was a central aspect in the discussions during the 1980s.

The WHO did take this into account during the revision, and has conceptualized the framework of the ICF in line with modern understanding of disability, containing both a medical perspective and a social perspective. As presented in Fig. 1, the framework of functioning is related to aspects of health. The framework is introduced as a bio-psycho-social approach to disability, including contextual factors: environmental factors and personal factors.

Since the first release of the ICIDH, it has been emphasized that disability has to be understood within a social and environmental contextual framework. Studies have been performed in Quebec, Canada, based on the Quebec Classification and the framework “Handicap Creation Process” (8, 14). This work has contributed to the current conceptualization of the environmental impact on actual functioning at the individual level. This conceptualization puts the ICF in line with modern understanding of “disability” and “functioning”; disability not only is a consequence of a health condition, but is also determined by the physical environment, the services available in the society, attitudes and legislation, which are environmental factors in this respect.

The overall term in the framework is functioning, which covers the components body functions, body structures, activity and participation. Functioning is used as the positive or neutral wording and the negative aspect is called disability. Disability

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**Table I. Concepts and terminology of the ICF related to components**

<table>
<thead>
<tr>
<th>Component</th>
<th>Definition</th>
<th>Activity</th>
<th>Participation</th>
<th>Environmental factors</th>
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<tbody>
<tr>
<td><strong>Body functions</strong></td>
<td><em>Body functions</em> are the physiological functions of body systems (including psychological functions). Body Structures are anatomical parts of the body, such as organs, limbs and their components.</td>
<td><em>Activity</em> is the execution of a task or action by an individual.</td>
<td><em>Participation</em> is involvement in a life situation.</td>
<td>Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.</td>
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<tr>
<td><strong>Body structures</strong></td>
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<td><strong>Activity</strong></td>
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<td><strong>Participation</strong></td>
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<td><strong>Environment</strong></td>
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2 The Dutch WHO Collaborating Center has an extensive database on ICIDH literature.
has changed meaning from ICIDH to ICF, from being an individual’s attribute of limited activities to currently being the negative aspect of functioning. It is not only one dimension of functioning, but is part of the overall concept.

Table I provides a basic overview of the definitions of the components of ICF as a framework. It should be observed that this is not the structure of the classification. Body functions, body structures, activity and participation constitute one part of the classification and the other part is made up by contextual factors, both environmental factors and personal factors, although the personal factors are not classified, but are part of the conceptual framework.

The components of ICF are structured in domains and categories. Table II gives an overview of the domains within the components. Additionally it is possible to detail the categories, and all are included to the second level, as from the domains, and for body functions especially, there are categories on third level, as from component level.

As the conceptual framework is meant to be understood in a dynamic and not a linear way, the concept has changed as from a causal linear relation between the components to a dynamic, interactive framework, wherein all components are related and influence one another (15) (see Fig. 1).

In the introduction of the ICF, the use and meaning of qualifiers are introduced. The central message is that one generic, ordinal scale with five steps is suggested as being applicable to all categories in the classification. In addition to the five steps, it is possible to register information as “unspecified” and “not applicable”. Through field trials in Denmark, practitioners have identified problems with use of the qualifiers suggested in the ICF, as the generic scale cannot be applied in all categories (Dahl, unpublished observations). This may originate in the obvious statement that the categories are of different character and nature and, as a consequence, may need different types of rating scales for measures. This issue needs further study and development in the coming years, as well as studies mapping existing instruments into ICF categories.

ADVANCES, LIMITATIONS AND SHORTCOMINGS

“The title International Classification of Functioning, Disability and Health is confusing. One may think that we have to classify Functioning and Disability and thereafter classify health. Health is one of the terms added recently by the WHO, and it has caused much confusion and a lot of reactions from those involved in the process. Preferably, the title should state the scope of the classification and thereby avoid misunderstandings, as to the content. In most theories of health and ill health, functioning and disability are central ingredients of health and should not be disentangled.”

This statement by Dr Nordenfelt, seems, to my mind, to
capture the central problem with the title of the published classification.

Late in the revision process Activity (A) and Participation (P) were put into a joint list, as they are the same component, and in the annexes to the classification, several suggestions are made for use of A and P. Several coding guidelines are also suggested in the annexes. If different coding strategies are used in national data sets, there is no possibility for comparing data across countries. Uniform coding conventions are an important prerequisite for maintaining high data quality. This is seen as a major problem, which should be addressed in further studies, in addition to the question as to whether the use of different coding guidelines gives the same output in statistics and records.

There is no agreement among users whether the domains in the component Activity and Participation, are either activity or participation or activity and participation. As a result of this, some countries are developing their own distinctions of Activity and Participation (16).

The conceptual framework of the ICF identifies that a majority of outcome measures, used in clinical rehabilitation and research reflect body functions, body structures, and activity, as these components often are major areas in medical rehabilitation. The Quebec User Evaluation of Environmental Factors measures the impact of the environment. Measuring participation may be a challenging task, and the WHO have developed WHO-DAS II, which will be released in 2002. WHO-DAS II is a measure of aspects of functioning, and the conceptual background is the ICF.4

From my own experiences with the Danish field studies and discussions with Nordic colleagues there seems to be a strong consensus on the suggested conceptual framework among professionals working in the field of rehabilitation, in the health sector as well as in the social sector. To my mind still more studies need to be done in order to make the ICF operational for practical use.

POTENTIAL IMPACT FOR FUTURE REHABILITATION SERVICES AND RESEARCH

From personal experience in discussions, teaching and ongoing studies, it seems that the theoretical framework makes sense for both professionals and disabled people. The discrepancies in views between professionals and people from the disability movement are similar to those expressed by Pfeiffer (11). In the Nordic countries there are several studies underway, either implementing the framework in rehabilitation settings, or doing research with the ICF as the theoretical framework. Wade may be right when he states that the major advances in rehabilitation are on the conceptual level, rather than in improving quality of interventions (6). The conceptualization can be seen as the first step in improving the quality of rehabilitation. The use of common terms within the team allows the formulation of goals for rehabilitation, which are identifiable and meaningful to all involved, and enables professionals to record interventions and outcomes in a standardized professional language within a uniform framework.

Different areas of rehabilitation will certainly have different needs for documentation and assessment, and it is likely that special versions of the ICF will be developed for use in specific areas.

CONCLUSION

The WHO has provided a classification on functioning, which is strongly needed for many purposes within the health area. For the first time, a classification has been officially launched and recommended for official use in the UN member states. The framework of functioning is seen to be a great leap forward, compared with the original ICDIH classification. However, some central aspects of the classification still need further development and research, especially those qualifiers suggested here. The ICF is seen as a promising input for the future development of rehabilitation services and research.

REFERENCES


4Information on WHO-DAS II can be obtained at www.who.int/classification/icf.