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The documentation form to create a functioning profile mentioned in this manual is also available in an open access interactive web-based format www.icf-core-sets.org
Preface

Gerold Stucki

The diagnosis of health conditions and the assessment of an individual’s functioning are at the core of clinical practice. For the diagnosis and classification of health conditions, health professionals have relied for more than 100 years on the World Health Organization’s (WHO) International Classification of Diseases (ICD), whose 11th edition is currently under way. For the assessment and description of functioning, health professionals have been able to turn to the ICD’s companion volume, the International Classification of Functioning, Disability and Health (ICF) for the past 10 years. The ICD and the ICF are currently used for health statistics so that mortality, morbidity and disability data can be collected in a uniform and internationally comparable fashion. There are a variety of other uses for these classifications, such as programme eligibility and reimbursement. Most importantly, however, the ICF has great potential for enhancing clinical practice by providing a standardized description of functioning by means of ICF-based tools, such as those described here. This information is central for all features of clinical practice: these data structure the clinical assessment of functioning, the assignment to health services and health interventions and the management of services and interventions, including outcome evaluation. In this manual we focus on the description of functioning for which standardization is of crucial importance, both for consistent practice and for comparable health outcomes.

When the ICF was endorsed by the World Health Assembly in 2001, it represented the outcome of a unique international collaborative exercise that produced not only a paradigm shift in our understanding of functioning and disability, but also a complete classificatory tool that, for the first time, made health and disability information comparable around the globe. Yet, by constructing an exhaustive classification, it was clear that the ICF was not directly usable as a practical tool since, in daily practice, clinicians need only a fraction of the categories found in the ICF. Responding to the need for practical ICF-based tools for clinical practice, the ICF Core Set project was begun soon after in 2001.1–2

The ICF Core Sets provide health professionals with invaluable tools tailored for specific health care areas. In this manual, health professionals will find practical guidance on how to apply ICF Core Sets in their clinical practice in order to structure the clinical description and assessment of functioning. Although ICF Core Sets
are intended for all health practitioners, the emphasis in this manual is on the needs of health professionals who apply the ICF Core Sets in the context of rehabilitation. The manual is inherently multi-professional and may be used not only by practitioners working in different settings but also by students in the health professions, their teachers and their mentors.

To facilitate the use of the manual, each chapter can be read on its own. The manual starts with an introduction to the concept of functioning as the lived experience of health. It then provides an introduction to the ICF and the process and scope of the development of the ICF Core Sets. A theoretical chapter outlining the principals that govern the use of the ICF Core Sets in practice is followed by a series of use cases illustrating how to apply the ICF Core Sets in different contexts. To facilitate the use of the ICF Core Sets in clinical practice, the manual also includes a CD containing over 1,400 pages of documentation forms.

The editors and authors of this manual are enthusiastic about the enormous potential that the implementation of the ICF and the ICF Core Sets has to better understand patients’ problems and how to best address their needs. We recognize that this manual would not have been possible without the outstanding effort of health professionals around the world and the excellent support provided by the Classification, Terminology and Standards Team at WHO, led by Dr. Bedirhan Üstün and coordinated by Nenad Kostanjsek. We wish to commend everyone who has contributed to this outstanding and valuable practical tool.

The ICF and the ICF Core Sets are still new and their use in clinical practice is still challenging. We would therefore like to encourage users of this manual to become involved in the further development of the ICF and the ICF Core Sets by collaborating with the ICF Research Branch in cooperation with the WHO Collaboration Centre for the Family of International Classifications in Germany (at DIMDI), www.icf-research-branch.org. Let’s learn from each other!
Everyone knows what health is, although we are all a bit vague about it. A researcher who had spent years defining health gave up saying that “it seems to be impossible to devise a concept of health which is rich enough to be nutritious and yet not so rich as to be indigestible”. Although the World Health Organization’s definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” is famous, when it comes to collecting information about people’s health, assessing patients, planning health interventions and describing the outcomes we want, no one actually uses this definition. To be practical about health information, we need a more concrete notion of “health”. We need to focus on what matters about one’s health. Longevity certainly matters, but for most of us, our health is more about what we can do or not do in our lives. Health, in short, is about how we function in our day to day lives. In order to denote this positive and practical aspect of health, WHO used the term “functioning”, which is the foundation for the International Classification of Functioning, Disability and Health (ICF).

What does the WHO mean by functioning? Firstly, the WHO notion is both narrower and broader than the ordinary English term “functioning”. It is narrower because it only applies to humans, but far broader because it captures all body functions and body structures and everything that people do (actions, tasks, skills) as well as all the things they are or aspire to be (parents, workers, voters). In the following chapters, the specific details of how the WHO concept of functioning operates in the ICF will be carefully set out, since these details are crucial for
understanding the ICF Core Sets and their application. Here we look only at how WHO intends the concept of functioning to be used.

For the WHO, functioning is a set of specific domains of human functioning – once again, body functions and body structures and the things people do and the things people are or aspire to be. These domains of functioning are the categories that are the items in the ICF classification. Secondly, the WHO understands functioning to be a continuous concept, that is, a concept of “more or less”, measurable along a continuum from complete (or total) functioning to complete absence of (or no) functioning. In other words, when people experience difficulties in functioning the result is disability, in the WHO sense of that word. The word “disability” has suffered the plight of being defined in countless different ways, by people concerned about theory as well as people concerned about practice. Even within the health professions, there is really no consensus about what disability means. It was for that reason that the WHO outlined its notion of disability defining disability in terms of functioning; in particular, as that level of functioning that is below a determined threshold along a continuum, for each domain, between completely present and completely absent.

Where that threshold is placed is not the WHO’s decision, but is a matter for science and practice, epidemiology and population-based norms. It is also, it must be said, an economic and political judgment. It is clear, though, that where the threshold for disability lies is not the WHO’s decision but has been left to each country to determine and justify to the community of health professionals and practitioners. Obviously, the complete absence of functioning is disability, so drawing no threshold at all would be impossible to justify. Putting the threshold close to complete functioning, would also be impossible to justify. So, the threshold is somewhere in the middle of the continuum, most likely closer to the “complete” absence end. Figure 1 is a graphical depiction, along a continuum, of the relationship between the WHO’s conception of functioning and disability.

![Functioning and disability in the ICF](image-url)
Why should the notion of functioning matter to health professionals? First and foremost, functioning is what matters to the health professionals’ patients. Patients are not so much concerned to know medical facts; they want to know if they will be able to walk or see their friends across the street or get a job. All of us think of health as important because of how our health affects everything that we do in our lives. Secondly, there is no better description of outcomes of health interventions than improvements in functioning. Finally, we know that problems in functioning can predict both the objective need for health services and the subjective desire for these services. Administratively, therefore, health-system planning depends on good information about functioning.

In actual clinical and public health, uses of the WHO notion of functioning meet the challenges of descriptive data collection and analysis. At both the individual and the population levels, functioning describes the outcome of the four main public health strategies: prevention, cure, rehabilitation and support. We seek to improve functioning, either as a primary outcome (cure and rehabilitation) or as a related outcome (prevention and support). Functioning is also valuable for the clinical assessment of individuals. As we shall show in the following chapters, the ICF functioning framework offers a common terminology and conceptual model for the improvement of clinical and patient-oriented assessment instruments. Thus, for example, the international network OMERACT (Outcome Measures in Rheumatology) has adopted the ICF as the reference model to understand what to measure when thinking about the lived experience of rheumatoid arthritis. The ICF is also the basis for the ICF Core Sets for which this manual provides guidance for use in practice.