Rev Bras Cineantropom Hum

point of view

DOI: http://dx.doi.org/10.5007/1980-0037.2018v20n2p229

International Classification of Functioning, Disability and Health (ICF) – way to Health Promotion

A Classificação Internacional de Funcionalidade, Incapacidade e Saúde (CIF) – um caminho para a Promoção da Saúde

Luciana Castaneda[1]

Abstract – The International Classification of Functioning, Disability and Health (ICF) is a classification of the World Health Organization (WHO). It is a reference document for the description of phenomena related to functioning and disability. The aim of the present study is to assess the relationship between the theoretical assumptions of ICF and the field of Health Promotion. The dissemination of ICF has been widely documented in literature over the last few years, however, there is a large gap between enthusiasm with the paradigm change that the classification proposes and its effective incorporation in the different environments of health care. This study presents an example of ICF operationalization. The biopsychosocial evaluation model of ICF presented is a strategy of light technology in health that advances towards the proposals of the field of Health Promotion.

Key words: Decision making; Disability and health; Health promotion; International classification of functioning.

Resumo – *A Classificação Internacional de Funcionalidade, Incapacidade e Saúde (CIF) é uma classificação da Organização Mundial de Saúde (OMS). É um documento de referência para a descrição de fenômenos relacionados a funcionalidade e incapacidade. O objetivo do presente trabalho é traçar uma relação entre os pressupostos teóricos da CIF com o campo da Promoção da Saúde. A disseminação da CIF tem sido amplamente documentada na literatura ao longo dos últimos anos, no entanto, há uma grande lacuna entre o entusiasmo com a mudança de paradigma que a classificação propõe e sua efetiva incorporação nos diferentes ambientes do cuidado em saúde. O presente ponto de vista apresenta um exemplo de operacionalização da CIF. O modelo de avaliação biopsicossocial da CIF apresentado é uma estratégia de tecnologia leve em saúde que caminha para o avanço das propostas do campo da Promoção da Saúde.*

Palavras-chave: *Classificação internacional de funcionalidade; Incapacidade e saúde; Promoção da saúde; Tomada de decisões.*

1 Federal Institute of Education, Science and Technology. Rio de Janeiro - RJ. Brazil.

Received: October 23, 2017
Accepted: March 08, 2018

INTRODUCTION

The phenomena of population aging and the high prevalence of chronic diseases present enormous challenges for health systems. The current health profile of the population requires a long follow-up time of individuals and a costly and complex intervention planning[1].

The identification of these needs has already been a concern of the World Health Organization (WHO) for some decades, which has been working to build and improve a health information documentation system with the Family of International Health Classifications[2]. More than a decade ago, in 2001, WHO published the International Classification of Functioning, Disability and Health (ICF)[3]. The International Classification of Diseases (ICD) together with ICF is the two main classifications of WHO's Family of Classifications. They present totally different objectives, but their use must be made in a complementary way[4]. Over the last decade, there has been a great deal of scientific activity on ICF. However, there is still a great heterogeneity regarding the understanding of components and language of ICF[5]. In this sense, the aim of this study is to point out the relevance of ICF in the field of Health Promotion, exemplifying a form of application.

THE USE OF A UNIVERSAL LANGUAGE AS A WAY TO PROMOTE HEALTH

ICF provides a system and a language proposal that describes functioning and disability related to health conditions, reflecting the approach that shifts the focus of disease consequences to also highlight functioning as a component of fundamental health. One of the ICF aims is to propose a functional approach that is not only restricted to the disease approach (biological approach), but that advances to the biopsychosocial approach[6]. Another equally important aim of ICF is to serve as a tool for language unification so that information about the phenomena of functioning and disability can be described in a universal perspective[7].

It is worth mentioning the importance of keeping the language of ICF as proposed in its official version. One of the major obstacles in the field of rehabilitation sciences concerns the polysemy of terms to describe the objects of action, such as the phenomenon of disability or the opposite, of functioning. Expressions such as functional limitation, functional disability and functional capacity are ambiguous terms according to ICF definitions. As pointed out by Souza et al.[8], the use of ICF may be a way to unify the language used by the health care multiprofessional team. However, as pointed out by the authors, the quality of life questionnaire scores can be related to the structure of ICF qualifiers. It is worth mentioning that the concept of quality of life is a personal and subjective concept[9] and differs from the concept of Functioning proposed by ICF. They are, therefore, two distinct concepts and their comparison in the same structure must

be done with caution. Still on the same work[8], the authors state that the "ICF has scale ranging from 0 to 4, where 4 is the worst level". On this statement, it is valid to add the information that the ICF primary qualifiers are proposed on a scale from 0 to 4, where 0 refers to no problem and 4 to a complete problem. However, when we are dealing with the codification of environmental factors of the facilitator type, this metric is inverted, and 0 refers to no facilitation and 4 to a complete facilitation[3]. Finally, supplementing the authors' information, "summary lists are usually structured in a questionnaire model that contains information about the functioning of a group of subjects with similar functioning profile (Checklist) or with the same disease (core sets), It is worth discussing that summarized lists are not really questionnaires, since these documents propose what to evaluate and not how to evaluate[5].

ICF AS A TOOL FOR HEALTH PROMOTION

Considering the specific objectives of the National Policy for Health Promotion (PNPS)[10]: 1) to increase the autonomy and co-responsibility of individuals and collectivities; and 2) to promote the understanding of the broader conception of health among health workers, both in the middle and end activities, ICF can be considered as a guiding tool for the achievement of these two specific objectives of this policy.

Figure 1 presents the interaction model of concepts proposed by ICF. This conceptual model represents the biopsychosocial view of WHO and can be used to organize data and information on human functioning and disability. The information needed to fill out the model is usually collected in assessments carried out at the different levels of health care.

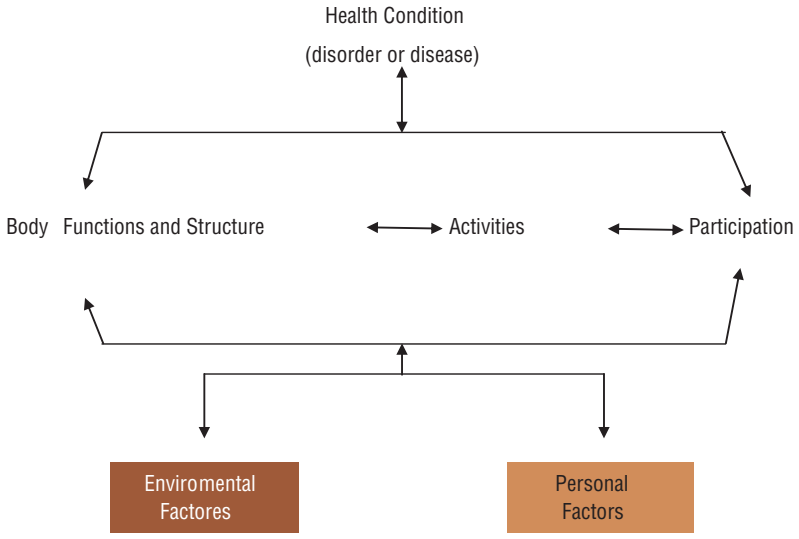

Figure 1. Model of Interactions between the ICF components.
Fonte: WHO[3].

The use of the model proposed above has the capacity to assist professionals in making decisions about the interventions most appropriate to

each component. It is well known that although the health condition of individuals may remain the same over time, the experience with regard to functioning and disability invariably changes, which is the basis of any and every proposal of health care. It is an attempt to improve functioning and reduce disability. The use of measurement instruments with a biopsychosocial approach to observe the impact of interventions is fundamental[12]. The filling of the interaction model of concepts by professionals or interprofessional teams, describing the associations observed can also be used to develop preventive strategies, which again corroborates the specific objectives of PNPS. We propose the qualitative use of ICF as a tool for guiding health care, incorporating the biopsychosocial perspective for the holistic view of individuals.

The qualitative use of ICF as a biopsychosocial assessment tool should take into account the subjects' perception (especially for the components of activities and participation and environmental factors). This subjective production, which does not restrict the evaluation of structured instruments that lead to purely numerical expressions, is also in accordance with the proposals of PNPS, which is the participation and involvement of subjects in order to increase autonomy and co-responsibility. I stress that in the scope of evaluation processes, the subjective and objective dimensions do not necessarily assume dichotomous positions, but rather complementary. Both plans reproduce dimensions inherent to complex social phenomena such as functioning, disability, and health. The central idea is not to exclude one of the polarities, nor to defend the predominance of one over the other, but to suggest an expanded conception of the processes of evaluation and construction of therapeutic plans[13].

The use of the concept interaction model to achieve some of the PNPS objectives has Integrality[14] and Humanization[15] as its conceptual and theoretical basis. The first refers to the expanded view on the subject and the second refers to the incorporation of light technologies in professional health practices. The proposal does not presuppose leaving aside the traditional and already consolidated practices of evaluation and therapeutic planning, but rather walking in the exercise of biopsychosocial thinking.

FINAL COMMENTS

In the scope of health care, ICF has become the reference tool for describing and approaching the phenomena of Functioning and Disability. The biopsychosocial view encompasses the health condition and the components of body functions and structures, activities and participation, and the interaction with contextual factors. The structure and language of ICF and its qualitative use with the concept interaction model can be used as a low-cost and long-range strategy, aiming to consolidate the autonomy and co-responsibility of individuals and collectivities and to understand the expanded conception of health.

REFERENCES

1. Leite Ida C, Valente JG, Schramm JM, Daumas RP, Rodrigues Rdo N, Santos M, et al. Burden of disease in Brazil and its regions, 2008. Cad Saude Publica 2015;31(7):1551-64.
2. Buchalla CM, Laurenti R. A família de classificações internacionais da Organização Mundial de Saúde. Cienc Saude Colet 2010; 18(1): 55-61.
3. World Health Organization. International Classification of functioning, disability and health: ICF. World Health Organization; 2001.
4. Di Nubila H, Buchalla CM. O papel das Classificações da OMS - CID e CIF nas definições de deficiência e incapacidade. Rev Bras Epidemiol 2008;11(2):324-35.
5. Castaneda L, Bergmann A, Bahia L. A Classificação Internacional de Funcionalidade, Incapacidade e Saúde: uma revisão sistemática de estudos observacionais. Rev Bras Epidemiol 2014; 17(2):437-51.
6. Stucki G, Bickenbach J. Functioning: the third health indicator in the health system and the key indicator for rehabilitation. Eur J Phys Rehabil Med 2017; 53(1):134-8.
7. Stucki G. International Classification of Functioning, Disability, and Health (ICF): a promising framework and classification for rehabilitation medicine. Am J Phys Med Rehabil 2005; 84(10):733.
8. Souza E, Neto J, Grigoletto M. Functional training and international classification of functioning: an approach. Rev Bras Cineantropom Desempenho Hum 2016;18(4):493-7.
9. Minayo MC, Hartz Z, Buss PM. Qualidade de vida e saúde: um debate necessário. Cien Saúde Coletiva 2000;5(1):7-18.
10. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde/Ministério da Saúde, Secretaria de Vigilância em Saúde, Secretaria de Atenção à Saúde. 3. ed. Brasília : Ministério da Saúde, 2010.
11. Stucki G, Bickenbach J. Functioning information in the learning health system. Eur J Phys Rehabil Med 2017; 53(1):139-43
12. Stucki G, Bickenbach J, Gutenbrunner C, Melvin J. Rehabilitation: The health strategy of the 21st century. J Rehabil Med in press.
13. Castaneda L, Guimarães F, Castro SS. O panorama de utilização da Classificação Internacional de Funcionalidade, Incapacidade e Saúde (CIF) no contexto da reabilitação e do cuidado em saúde – Onde estamos? In: Araujo E, Biz C. Implantando a CIF - o que acontece na prática? São Paulo: Wak, 2017. pp. 208.
14. Pinheiro, R. Integralidade. In: Dicionário da Educação Profissional em Saúde. Disponível em: <http://www.epsjv.fiocruz.br/dicionario/verbetes/intsau.html>.
15. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Clínica ampliada, equipe de referência e projeto terapêutico singular. 2007. 1-60 p.

CORRESPONDING AUTHOR

Luciana Castaneda
Rua Professor Carlos Wenceslau, 343
Realengo, Rio de Janeiro, Brasil
CEP: 21710-240
E-mail: luciana.ribeiro@ifrj.edu.br