

The ICF twenty years later

Patrick Millet

Twenty years ago, on May 22, the fifty-fourth World Assembly approved the adoption of the International Classification of Functioning, Disability and Health (ICF) [1] to replace the 1980 International Classification of Impairments, Disabilities and Handicaps [2]. Thus setting the stage for a new era concerning the classification of individual functioning, and at the same time strengthening the already existing assumption that disability is a multifactorial concept [3, 4]. One might point out that perceiving disability as multifactorial had already been given credence by the WHO in their 1948 definition of health, which challenged the perception of health as entirely based on medical factors, and incorporated both social and contextual factors. This original widening of the concept of health is suggested here as still today a basic and essential prerequisite for the continued progress and development of all rehabilitation processes.

Another critical development was the proposal by Engel [5] that the biopsychosocial model should replace the biomedical model for use in medical education and clinical procedures. Engel's biopsychosocial model can therefore be seen as underlining and reinforcing the widening of the concept of health. Since 1977, Engel's biopsychosocial model has been further developed by various others, for example, [6]. Notably, however, the biopsychosocial models have not replaced the biomedical model in medicine [6].

Nevertheless, the idea of a more inclusive definition of health that integrates biological, individual, and social aspects was now firmly in place to bolster the further understanding and development of the fields of functioning, disability, and rehabilitation; and here, the biopsychosocial model was critical and is so to this day. Not only does it form the basis of the ICF, but also is used in many other areas relating to health [7].

What is the ICF? Its underlying principle is simply human functioning, divided into two main areas on a spectrum from proper functioning to major disability, related to an individual's activities and participation, and influenced by environmental factors, health conditions, and personal factors [1]. Importantly, the ICF at its conception was assumed to have the potential to improve the perception of functioning and disability and to further the scope and depth of research within said fields. Additionally, due to its universality and standardization, it provided for the possibility of increased incorporation and communication between various professionals and researchers the world over [3, 8].

But if the primary goal is to understand and appreciate the ICF, a distinction must be made between medical rehabilitation and vocational rehabilitation (VR), as they have very different primary goals. With VR, the return to work is the primary intention, whereas with medical rehabilitation the restoring of functions and ability is primary, such generally taking place prior to any VR process.

The interpretation here is that the ICF's main focus was medical rehabilitation, something that in any evaluation needs to be kept in mind, and meaning that the ICF's highlighting of an individual's activities and participation, influenced by environmental factors, health conditions, and personal factors, would most likely introduce new ways of thinking about defining functions and disabilities.

This having been said, the assumption was that most medical professionals and indeed even other professionals such as VR counselors would reap benefits from the ICF, as it offers a structure for analyzing, planning, and pursuing an effective rehabilitation process [3, 9].

Thus, the VR field received a boost to continue its challenge to the medical paradigm in pursuing models and methods that considered various factors outside of that paradigm, such as the continued shift away from a focus on diagnoses, eventual problems, dependence, and disabilities toward a holistic perspective on health and independence.

One important "outside" factor was empowerment [3]. Empowerment, placed in the context of rehabilitation and/or VR processes, is suggested by many researchers [10, 11] to be central to any successful result. However, let it be noted that all the ideas presented above existed

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years before the ICF. For example, the inclusion of factors outside the medical paradigm in various rehabilitation processes has been in practice for years. Models of Case Management and other models used in psychiatric rehabilitation programs, such as The Boston Model and Supported Employed, all existed before 2001. These models acknowledged the importance of empowerment both from the contextual and from the individual perspective (psychological empowerment) and were an integral part of both the theory and the application of these models. Thus, the question then arises; what contributions have the ICF provided for the field of vocational rehabilitation?

A review of the research literature shows that the field of rehabilitation has indeed been influenced by the ICF, particularly medical rehabilitation. Madden and Bundy [12] have identified areas of influence and development introduced by the ICF. They argue that researchers' and professionals' reasoning has evolved when working with statistics and information related to functioning, disabilities, and health. They point to evaluations and discussions that now are more comprehensive, including environmental factors, activities, participation, and even personal factors.

So far all are in line with the intentions of the ICF. Madden and Bundy [12] and other researchers [13–15] point to the ICF's furthering of work practices, such as intervention processes and methods. Other researchers show that progress has been made in improving the level and depth of cooperation and communication between various professionals and researchers. Research results show that progress has been made in strengthening universality and standardization of functions, disabilities, and health. Thus, all in all, the ICF has contributed much to medical rehabilitation, but has it therefore by extension even added to the general field of rehabilitation? A general review indicates that additional research and development is required if it is to be integrated into the various processes of vocational rehabilitation. One could say that there is a need for continuing evolution and application.

As stated earlier, the VR field had already questioned the medical paradigm, and the incorporation of environmental factors into models and methods was normalized before ICF. The major ICF contribution to VR is that it offers an excellent standard structure for analyzing, planning, and pursuing an effective rehabilitation process. Research, however, seems to show that the utilization of ICF in this setting by VR counselors is limited [16,17]. Why this is so is unclear at the present time. Do VR counselors have limited knowledge of the ICF and its eventual benefits? Or are they careful not to increase medical influence in VR?

To summarize, there is evidence that the ICF has indeed contributed to the field of rehabilitation, but mainly, however, to medical rehabilitation. For further development and application, there is a need for

cooperation between researchers and professionals in both medical and vocational rehabilitation, using the ICF as a platform.

Keywords: ICF, Medical rehabilitation, Vocational rehabilitation

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Patrick Millet – Conception of the work, Design of the work, Acquisition of data, Analysis of data, Interpretation of data, Drafting the work, Revising the work critically for important intellectual content, Final approval of the version to be published, Agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

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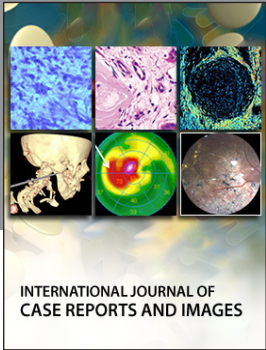
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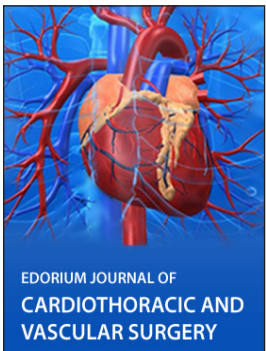


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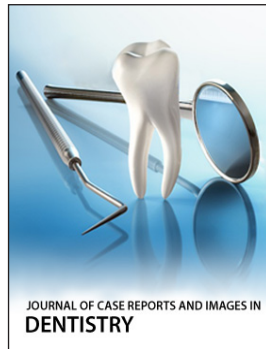
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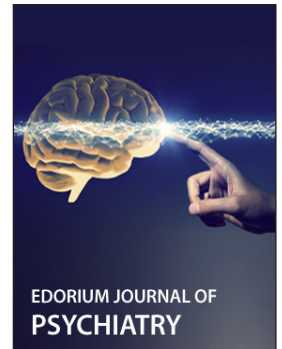
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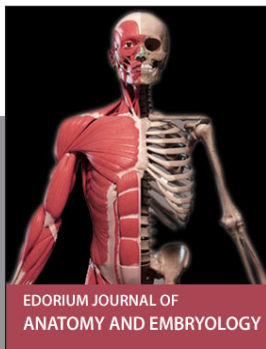
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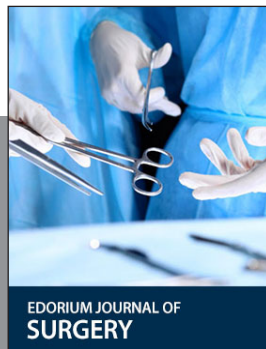
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