

The perspectives of WHO on country indicators

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Health information is a pre-requisite for the analysis, interpretation, development and comparison of health systems. Depending on the users, the information must be analysed and presented in a valid, usable and understandable way. It is a longstanding policy of the WHO Regional Office for Europe to provide indicator-based information for all 53 European member states. This is in part achieved by the maintenance of databases which also comprise health system indicators. One of the main focuses of the WHO European Office with respect to health information is to strengthen the data quality of all databases and the further sophistication of databases to enable more in-depth analysis. This applies to the standardization of data collection, the evaluation of reporting biases and finally the validation of submitted data. In addition to the European Health for All database (HFA-DB), the product range has been broadened recently. To give users access to more detailed

mortality data by cause of death, age and sex, two separate versions of the mortality database have been developed, each offering data at a different level of aggregation. A new source of information is also the European hospital morbidity database (HMBD) containing hospital discharge data, all accessible via www.who.euro.int.

In line with WHO's normative function, initiatives and continuous efforts are being made towards development of international definitions, standards and data collection instruments, which are essential pre-requisites for improving international comparability of health and health systems indicators. WHO has worked closely with EUROSTAT and OECD on the harmonization of health system parameters and will continue to support any efforts to produce valid inter-country comparisons. One of the future priorities will be to foster the harmonized development of health and health system indicators in close cooperation with EUROSTAT and OECD. The challenge, however, is to cover and include in this process also other WHO European Member States, which are not members of the EU or OECD.

3.10. Workshop: The implementation of the 'International Classification of Functioning, Disability and Health' (ICF) in disability assessment

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Sickness absence and disability pension run high in many countries and health care/physicians have a key role in assessing level of work incapacity that can legitimate benefits. However, criteria and procedures for the evaluation of the level of disability and work incapacity substantially differ among European countries. This poses a major difficulty for comparative analyses and data exchange. In 2001, the WHO adopted the International Classification of Functioning, Disability, and Health (ICF). The ICF introduces both a universal conceptual framework and a detailed classification system. This means that the ICF also holds the possibility of becoming an interesting and useful tool in the field of social security and disability evaluation.

First, the fundamental concepts of the ICF will be discussed with their implications for disability assessment. Secondly, since the detailed classification system of the ICF is too inconvenient for use in daily practice, core sets are proposed as a practical alternative. An adjusted method to develop core sets will be presented. Thirdly, the results of a European core for the assessment of long-term disability are presented. The final contribution discusses the need and the methodology for the validation of core sets in practice.

The framework and the concepts of the ICF and their implications for disability assessment

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Issue

The International Classification of Functioning, Disability and Health (ICF) is a new WHO classification. It proposes a uniform language to describe health impairments and their repercussion on the functioning of a person in his environment.

ICF is organised in two parts: functioning and participation (with its social dimensions) and the contextual factors including personal and environmental factors. The categories (description units) are organized on four levels. Each category describes the level of disability by means of ordinal qualifiers (five levels).

Description of the problem

ICF proposes four levels of complexity. The first level contains 30 categories, the second level 362 categories and the third and fourth levels 1424 categories. Each level contains the lower levels like Russian dolls. The first level is too simple to describe a social functioning with enough details and the third and fourth levels are too complex. However, if the second level seems to be a good compromise, it still remains quite complex to use.

Lessons learned

ICF introduces new concepts that differ from the traditional biomedical framework. Training is necessary to understand the concepts and to use the classification. Environmental factors should be used to assess the impact of the environment on the personal functioning.

ICF is theoretically useful in medical assessment of social repercussions of impairments. However, ICF is too complex to be used in routine and a solution is to build core sets suitable to describe each different problem to be assessed e.g. incapacity to work or need of assistance from a third person.

Conclusion

ICF can help to improve the quality of communication between the different professionals involved in medico- social assessment and can be useful to allow communication between professionals of different countries. Core sets must be built to make the classification more convivial and suitable for a routine use.

Development of ICF core set for disability evaluation in social security - methodological aspects

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Background

An ICF Core Set is a selection of items of the International Classification of Functioning, Disability and Health that are relevant for persons with a specific condition or in a specific setting. An adapted methodology for the development of a core set for disability evaluation was worked out and used by a working group of the European Union of Medicine in Assurance and Social Security (EUMASS).

Method

A formal decision-making process was applied, inspired by the development of core sets for clinical, chronic conditions. The method was adapted to suit national differences in legislation. In a first step, national expert meetings in eight countries suggested functional categories both from ICF and others. They had uniform background material: a list of ICF two-level categories, the ICF checklist, the brief core sets for 12 chronic conditions, a Belgian proposal for core set and the Dutch functional capacity list. In the national meetings 191 different functional categories were suggested. The working group (20 physicians from 11 countries) discussed and selected a final list in two voting rounds. It was emphasized to keep the list short, and avoid inclusion of similar items. In the first voting round, categories with 80% vote or more were included; categories with 20% vote or less discarded and categories in between were set aside for a second voting round. In the second voting round, categories receiving at least 50% vote were included.

Conclusion

A formal decision-making process was designed to develop a core set for functional assessments in disability benefit claims. The core set is generic and is a list of categories that always should be assessed by the medical doctor. When the core set is used, one must compare the level of functioning with work demands of that person, within the framework of the national social insurance legislation.

The European core set for long-term disability assessment

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Background

We present a core set of relevant ICF categories for the assessment of long-term disability, developed by an expert group of the European Union of Medicine in Assurance and Social Security. This core set can be a useful tool for data exchange and comparative studies among European social insurance systems.

Methods

The methodology is described in the previous abstract.

Results

In total, 20 categories were selected for the core set.

Five categories from body function (higher-level cognitive function, sensation of pain; exercise tolerance functions; mobility of joint functions; muscle power functions) and 15 categories from activities and participation (four from the chapter learning and applying knowledge, two from general tasks and demands, one from communication, seven from

mobility and one from interpersonal interactions and relationships) were included in the core set.

All categories of body structures were voted out by the expert panel in the first round. The according category of body function was always considered more relevant. More amazingly, no category from environmental factors was included. None of the many suggestions reached the threshold for inclusion, possibly indicating that divergences are mostly situated in this chapter.

Conclusions

The task of the physician in the disability evaluation process is to evaluate restrictions in work participation in persons who have been unfit for work for long term, usually at least 6–12 months. The core set is a list of ICF categories that always and irrespective of diagnosis, should be assessed.

The low number of categories agreed on is an advantage as it can increase the usefulness of the core set. However, the usefulness of the ICF standards for the level of functioning in disability assessment has yet to be established. For use in national insurance schemes, it is possible that categories have to be added according to national standards and legislation.

Validation of ICF Core Sets

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Issue

The conceptual approach for the development of the ICF Core Sets derived from two different perspectives: the perspective of people experiencing an acute episode and the perspective of people with a chronic condition. For people after an acute episode, the Acute and Post-acute ICF Core Sets need to be useful in the acute hospital setting and post-acute rehabilitation. For chronic conditions, the ICF Core Sets for chronic conditions need to be useful in any care provider setting.

Description of the problem

Although the ICF Core Sets theoretically represent the most relevant aspects of functioning in specific situations and for specific health conditions, they are preliminary versions and they might be too comprehensive for clinical encounters. Thus, their validity has to be verified. The main goals of the testing and validation process are 1) to verify whether the ICF categories included in the ICF Core Sets really represent relevant aspects, 2) to identify whether there are relevant categories currently missing and 3) to verify sensitivity to change, construct validity and predictive value. All ICF Core Sets are now being tested and validated with a number of methodological approaches, including cross sectional and longitudinal empirical studies, focus groups with patients and Delphi exercises with different professional groups.

Lessons learned

The Core Set validation process provides the opportunity to develop comprehensive, brief and very brief ICF Core Sets by taking the client and consumer perspective. Since the ICF Core Sets only provide a standard for 'what to measure', but not for 'how to measure', the ICF Core Sets will need to be operationalized either by matching currently available measures or by the development of new measures.

Conclusion

We envision that the ICF and practical tools such as the ICF Core Sets will stimulate research for a better understanding of functioning, disability and health.