

5.5. Workshop: Health-related functioning in terms of the International Classification of Functioning, Disability, and Health

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Compared with people without chronic diseases, those with chronic diseases report poorer self-rated health and functioning and more disability. However, results from similar studies using diverse concepts of functioning and disability are often incomparable. Not only to overcome such problems and to establish a common language for describing health and health-related states but also to permit comparisons of health data across populations, the World Health Organization (WHO) introduced the International Classification of Functioning, Disability, and Health (ICF). The workshop describes recent and upcoming developments and public health study findings regarding ICF classifications, concepts, and components.

The objectives of the workshop are 3-fold: (i) to inform on the latest developments in the ICF and give recent examples of its use, (ii) to illustrate the prevalence and changes therein over time of ICF components in patient and general populations, and (iii) to raise awareness about health disparities in terms of ethnic differences in ICF components.

After an introductory presentation on recent ICF developments, three ICF related topics will be presented. The first illustrates the development and validation process of an assessment tool for people with multiple sclerosis. The second topic demonstrates ethnic differences in the prevalence of functional limitations of coronary heart disease patients, as well as in its determinants. The third topic illustrates the trend in activity limitations in the Netherlands in the period 1990–2007. An audience discussion focusing on the use of the ICF in everyday practice concludes the workshop.

The international classification of functioning, disability, and health: work in progress

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The World Health Organization (WHO) launched the International Classification of Functioning, Disability and Health (ICF) in 2001. The ICF is the result of the revision of the International Classification of Impairments, Disabilities and Handicaps (ICIDH), published by WHO in 1980. Extensive use of the ICIDH in rehabilitation and allied health-related practices raised comments, which led to the start of the revision process. The ICF is now in use worldwide in different settings, for different purposes, and is being applied at national and international level.

Typical differences between ICIDH and ICF are: (i) negative terminology in ICIDH versus neutral terminology in ICF, (ii) causal relationship in ICIDH versus multi-direction relationships between components in ICF, and (iii) addition of environmental factors as an important component (classification) in ICF and recognition of the role of personal factors (not as classification) in ICF.

In 2007, WHO issued the ICF Children and Youth version (ICF-CY) as the first derived version of the ICF and is considered the first structural contribution to an ICF updating process. The ICF-CY is designed to record the characteristics of the developing child and the influence of its surrounding environment. The differences between ICF and ICF-CY are: (i) modifications or expanded descriptions in ICF-CY, (ii) modifications of inclusions and exclusions in ICF-CY,

(iii) new classes in ICF-CY, and (4) expansion of qualifiers to include developmental aspects.

Nowadays, the WHO is (i) supporting the implementation of ICF by creating a database with information regarding use of ICF and ICF related materials, (ii) developing educational materials including webbased ICF training, (iii) evaluating the use of ICF, e.g. the kind of use of the Activities and Participation list (ICF annex 3), and (iv) developing regular ICF updating procedures.

Integrated and patient-centered care using the international classification of functioning, disability and health

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Background

The health care system organization is shifting from being fragmented and service-centered to being an integrated, patient-centred system. Consequently, there is a growing need for tools to (i) facilitate integrated assessment for multidisciplinary care, and (ii) give patients the opportunity to play an active role in the assessment process. Using the International Classification of Functioning, Disability and Health (ICF), we developed the Multiple Sclerosis Impact Profile (MSIP). Our objective was to describe the process of development and validation of this assessment tool for people with multiple sclerosis (MS).

Methods

First, relevant items were selected from the complete ICF during a Delphi-study using 98 experts: patients, caregivers, medical and non-medical health care professionals. Selected items were operationalized using ICF-features. Next, data were obtained with the initial version of the MSIP from a postal survey among 530 MS patients for item reduction, scale construction and psychometric evaluation. A pilot study was performed to test the feasibility of use of the MSIP in integrated and patient-centred care in six regional MS centres with seven nurse specialists and 107 MS patients.

Results

The MSIP is a valid and reliable self-report measure with 36 ICF items reflecting a broad scope of disabilities and the perception of these disabilities. In clinical practice the MSIP seems to have added value in the enhancement of the role and influence of people with MS during a consultation whilst nurse specialists reported that patients were better prepared and having clearer insight into patients' health problems.

Conclusions

The MSIP can be applied in outcome and epidemiological studies. On individual level the MSIP can be applied in clinical practice to enhance the patient role, and as a basis for integrated care planning. The ICF turned out to be a useful classification as a basis for the development of a valid and reliable assessment tool.

The role of ethnicity in functional limitations among Slovak coronary patients: a matched study

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Background

Roma have been shown to have an adverse socio-economic position and unfavourable health compared with the majority of the population. We assessed whether the level of functioning in terms of the International Classification of Functioning, Disability and Health differs significantly between non-Roma and Roma coronary patients.

Method

Out of 399 patients that were referred for coronary-angiography in the East Slovakian Institute for Cardiac and Vascular Disease 114 patients were selected for the purposes of this study. Due to a relatively small number of Roma patients ($n=38$) and possible confounding effects of the socio-economic status (SES), patients were divided into three groups: 1 = Roma patients (with low SES income and education), 2 = matched non-Roma patients with low SES, 3 = matched non-Roma patients with high SES. Logistic regression controlled for age and gender was used to analyse data. Functional status was measured by ejection fraction (EF) and the physical component summary of SF 36 was used as subjective report of limitations in everyday life.

Results

Non-Roma with high SES were less likely to have systolic dysfunction (EF lower than 40%) compared with Roma (OR, 0.22; 95% CI, 0.05–0.92), but non-Roma with low SES and Roma did not differ (OR, 1.21; 95% CI, 0.41–3.60). Both groups of non-Roma patients (with low and with high SES) were less likely to report perceived functional limitations compared with Roma (OR, 0.30; 95% CI, 0.10–0.83, OR, 0.18; 95% CI, 0.06–0.54).

Conclusion

Ethnicity has been found to be a factor significantly influencing the subjective perception of the functional limitations level among patients with coronary heart disease, even after controlling for the effect of the socio-economic status. However, with regard to objective measure (EF), no ethnic differences were found. The perception of adverse functional status of Roma coronary patients may warrant additional care since this is expected to have adverse effects on quality of life of these patients as well.

Time trends in late-life activity limitations

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Background

This study sought to give the best estimate of the time trend in the level of functioning in terms of the International Classification of Functioning, Disability and Health among the Dutch older population between 1990 and 2007, based on several datasets using a meta-analytic approach.

Methods

Data from two repeated cross-sectional surveys and three prospective surveys among non-institutionalized inhabitants of the Netherlands aged 55–84 years were used to examine study-specific and overall time trends of self-reported activity limitations based on ADL and SF-36 items.

Results

Taking all activity limitations together there are no large changes over time. Looking at separate activities, the risk of limitations in climbing stairs based on ADL items is increasing approximately 4% per year (99% CI, 1.01–1.07) and the risk of limitations in getting dressed based on ADL items is increasing approximately 5% per year (95% CI, 1.00–1.08), whereas trends in activity limitations based on SF-36 items were mainly stable.

Conclusions

The above results are relevant in the anticipation of care needs of the ageing population. Conflicting developments in underlying determinants of both activity limitations as well as chronic disease will be highlighted in regard of the results.

5.6. Sickness absence and mental health

Workplace health promotion and absence culture are more important than structural factors as determinants of the staff sickness absence level in Swedish municipal social care

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Background

In Sweden, there are large unexplained differences in sickness absence between regions as well as between employers within the same trade. The aim was to study sickness absence differences between municipalities in their social care sector in relation to internal workplace factors and external structural factors in the local society.

Method

A questionnaire with focus on perceived organizational climate, health, absence culture and workplace health promotion (WHP) was sent out to 15 871 social care employees in a random sample of 60 out of Sweden's 290 municipalities.

The response rate was 58%. A database of the 60 municipalities was constructed with aggregated data from the questionnaire and official registers.

Results

A lower sickness absence level was related to internal factors (better self-rated health, access to and utilization of a broader repertory of WHP measures, a more restrictive absence culture and a lower number of staff per older inhabitant) as well as external structural factors (lower rates of sickness and disability compensation, unemployment and mortality in the population). Multivariate analyses indicate that unemployment rate was the main external predictor, but the internal parameters WHP measures and absence culture were the most important overall predictors of the sickness absence level. A higher WHP level was only related to internal factors reflecting a better organizational climate. A more restrictive absence culture, on the other hand, was only related to external structural factors such as a more favourable situation concerning prosperity and labour market as well as age distribution and standardized mortality rate in the local society.