The International Classification of Functioning Disability and Health: its development process and content validity

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The World Health Organization's International Classification of Functioning, Disability and Health (ICF) has provided a new foundation for our understanding of health, functioning, and disability. However, different challenges have to be addressed during its implementation process. The objective of this paper is to address two of these challenges, namely, the study of the content validity of the ICF and its relationship to other health-related concepts such as well-being, Quality of Life (QoL) and Health-Related Quality of Life (HRQoL). Ongoing validation studies confirm that the ICF is an exhaustive classification, i.e. it covers most of the health and health-related domains that make up the human experience of functioning and disability, and the most environmental factors that influence that experience of functioning and disability. The ICF also contributes to the understanding of health on a continuum ranging from a body-centred view (“the bodily experience of health”), to a more comprehensive perspective (“the entire human experience”), and finally, to an overarching view (“the human experience”) which sees health as part of the human condition. The ICF allows the operationalization of health as part of the human experience on this continuum as health from a narrow perspective to the broad perspective of functioning. The ICF with its categories can also serve as starting point for the operationalization of objective well-being. Since HRQoL can be defined as an individual’s perceptions of health and health-related domains of well-being, the ICF categories encompassed in the ICF concept of functioning can also serve as the basis for the operationalization of HRQoL.

KEY WORDS: Quality of life - Health-status - Disability

The World Health Organization’s International Classification of Functioning, Disability and Health (ICF) has provided a new foundation for our understanding of health, functioning, and disability. Avoiding both sociological and biomedical reductionism, the ICF provides a starting point for a comprehensive and integrative understanding of the universal human experiences of functioning and disability, where body, personal action and the overall physical, social and attitudinal environment in which the person lives and acts are inextricably intertwined.

The ICF mirrors an important shift in the priorities by the World Health Organization (WHO). While WHO has traditionally focused on infection control and mortality reduction WHO now increasingly recognizes the importance of reducing the burden associated with health conditions throughout the world. The importance of reducing the burden associated with health conditions is also reflected by the United...
Nations Convention on the Rights of Persons with Disabilities which also draws the attention of governments to the relevance of functioning and disability in society.

At the time of the endorsement of the ICF by the 54th World Health Assembly in 2001, it was anticipated that its uses would be broad and various: a statistic tool for population studies and information management; a research tool for outcome measurement and Quality of Life; a clinical tool for treatment planning, assessment and evaluation; an educational tool for curriculum design and awareness raising; and a social policy tool for all aspects of health and disability policy, design, implementation and monitoring. Since then, the ICF has indeed been used in all of these areas, and more besides.4

The ICF, similar to other classifications belonging to the Family of International Classifications (FIC) of the World Health Organization (WHO), will undergo updates and ultimately a revision process. One can even say that the ICF is an ongoing development in which all the evidence gathered during its implementation will be integrated.

However, different challenges have to be addressed during its implementation process. Two most important challenges refer to the study of its content validity and to its usefulness as a platform for the elucidation of health-related concepts.

The objective of this paper is to address these challenges. In the first part, we will introduce the ICF and its development process. In the second part, we will concentrate in its content validity and its relationship to other health-related concepts such as well-being, Quality of Life (QoL) and Health-Related Quality of Life (HRQoL).

The International Classification of Functioning Disability and Health (ICF)

The ICF in the historical perspective

Clinicians have relied on classifications for the diagnosis of health conditions for over 100 years.5 6 The international classification of diseases was first published as a classification of causes of death in 1898.7 In the meantime the International Classification of Diseases (ICD) is undergoing its 11th revision. The ICD was initially used for actuarial reasons to document death. It was later adopted for epidemiology and by public health to monitor health and interventions. Lately it was used for clinical purposes mainly driven be the need to classify diagnoses in the context of reimbursement systems including diagnostic related groups.

By contrast, the first classification of disability, the International Classification of Impairment, Disabilities and Handicaps (ICIDH) 8 was published and released in 1980 for trial purposes only. The ICIDH together with models of the Institute of Medicine 9, 10 which are based on Nagi’s model 11, 12 and the Quebec model 13 have provided the bases for definitions of rehabilitiation,14 the development of rehabilitation practice and research,14 and legislation and policy-making.5 10 The ICIDH model represented a real breakthrough in that the WHO recognized that the medical model and its associated International Classification of Diseases 6 did not address non-fatal health outcomes. Particularly in Europe, there was considerable interest in the application of the ICIDH as a unifying framework for classifying the consequences of disease during the last 20 years of the 20th century. E.g. the Council of Europe launched its Recommendation No. R (92) 6 on “a coherent policy for people with disabilities” based on the ICIDH and the Quebec model.15

However, the ICIDH, which was never approved by the World Health Assembly as an official WHO classification, did not find worldwide acceptance.1, 14 It was criticized by the disability community over time for the use of negative terminology, such as handicap, and for not explicitly recognizing the role of the environment in its model. In the publication of the second edition of the ICIDH in 1993, WHO thus expressed its intention to embark in the development of a successor classification.

The ICF in the WHO and the UN perspective

Recognizing the importance of functioning and disability as a major public health issue both in the developed and in the developing world, WHO has developed the ICF to provide a unified, international and standardized language for describing and classifying health and health-related domains and hence to provide a common framework for health outcome measurement. The ICF thus complements indicators that have traditionally focused on deaths and diseases.6 To complement mortality or diagnostic data on morbidity and diseases is important since they alone do not adequately capture health outcomes of individuals and populations (e.g., diagnosis alone does not
explain what patients can do, what their prognosis is, what they need, and at what treatment costs.\textsuperscript{16, 17}

The ICF, which is now coordinated by WHO's Classification, Terminology and Standards (CTS) team serves as reference framework throughout WHO. Most importantly, the ICF is the reference framework of the Disabilities and Rehabilitation Team (DAR) under the Department of Violence and Injury Prevention and Disability. The WHA resolution 58.23 on “Disability, including prevention, management and rehabilitation” approved in May 2005 by the 58th World Health Assembly and coordinated by the DAR team thus recalls the ICF as its framework.\textsuperscript{14} As requested by the resolution, the WHO is currently developing a world report on disability and rehabilitation whose structure is based on the ICF framework. The International Society of Physical and Rehabilitation Medicine (ISPRM) which is the international Physical and Rehabilitation Medicine (PRM) organization in official relation with WHO, is represented on the advisory board of the report and is supporting the DAR team in this development.

While the ICF has been developed by WHO, the specialty agency responsible for health within the United Nations (UN) system, the ICF has been accepted as one of the UN social classifications.\textsuperscript{1} It thus now serves as reference framework for the UN and its other specialty agencies including the United Nations Statistics Division (UNSTAT), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the International Labour Organization (ILO).

Although the ICF is not explicitly mentioned, the understanding of functioning as a universal experience according to the ICF framework is the basis for the characterization of disability in the UN Convention on the Rights of Persons with Disabilities\textsuperscript{18} approved on 13 December 2006 at the UN Headquarters in New York. While the convention does not establish new human rights, it does define the obligations on states to promote, protect and ensure the rights of persons with disabilities. Most importantly, it sets out the many steps that states must take to create an enabling environment so that persons with disabilities can enjoy inclusion and equal participation in society.

\textit{Development of the ICF}

Coordinated by WHO’s secretariat for mental health and later by the secretariat responsible for classifications and terminology, the ICF was developed in a worldwide collaborative process through the network of collaboration centers for the family of international classifications, especially the North American Collaboration Center (NACCC). After three preliminary drafts and extensive international field testing including linguistic and cultural applicability research, the successor classification which was first tentatively named ICIDH-2, the ICF was finalized in 2000.\textsuperscript{1} The ICF for Children and Youth, the ICF-CY, was finalized and officially launched in 2007. Until March 2008 the ICF has been translated in several languages.

The ICF not only addresses Western concepts but has worldwide cultural applicability. The ICF follows the principle of a universal as opposed to a minority model. Accordingly, it covers the entire lifespan. It is integrative and not merely medical or social. Similarly, it addresses human functioning and not merely disability. It is multi-dimensional and interactive and rejects the linear linkage between health condition and functioning. It is also etiologically neutral which means functioning is understood descriptively and not caused by diagnosis. It adopts the parity approach which does not recognize an inherent distinction or asymmetry between mental and physical functioning.

These principles address many of the criticisms of previous conceptual frameworks and integrate concepts established during the development of the Nagi model\textsuperscript{11, 12} and the Institute of Medicine model of 1991.\textsuperscript{9, 10} Most importantly, the inclusion of environmental and personal factors together with the health condition reflects the integration of the two main conceptual paradigms that had been used previously to understand and explain functioning and disability, that is, the medical model and the social model.

The medical model views disability as a problem of the person caused directly by the disease, trauma or other health conditions and calls for individual medical care provided by health professionals. The treatment and management of disability aim at cure and target aspects intrinsic to the person, \textit{i.e.} the body and its capacities, in order to achieve individual adjustment and behaviour change.\textsuperscript{19, 20}

By contrast, the social model views disability as the result of social, cultural, and environmental barriers that permeate society. Thus, the management of disability requires social action, since it is the collective responsibility of society at large to make the environmental modifications necessary for the full partici-
ipation of people with disabilities in all areas of social life.21–24 The ICF and its framework achieve a synthesis, thereby providing a coherent view if different perspectives of health.2

**Up-date and revision process**

The ICF published in 2001 is a first version. Similar to the ICD it will undergo up-dates and ultimately a revision process. The up-date is prepared by WHO’s CTS team in collaboration with the relevant committees and the Functioning and Disability Reference Group (FDRG) of the Network of the Collaboration Centers for the Family of International Classifications (WHO FIC CC Network).

The update will include information obtained in a wide range of testing and validation studies conducted in collaboration with FDRG and in the scientific community. Currently, FDRG is exploring the possibility and methodological approaches to develop a classification of personal factors. In the future the ICF may evolve in a classification which is based on an ontological approach similar to the approach taken by Systemized Nomenclature of Medicine (Snomed).25

**The Structure of the ICF**

As shown in Figure 1, the ICF consists of three key components. In short, the first component, body functions and structures, refers to physiologic functions and anatomic parts, respectively; loss or deviations from normal body functions and structures are referred to as impairments. The second component, activity, refers to task execution by the individual. “Activity limitations” are thus difficulties the individual may have in executing activities.3 The third component, participation, refers to involvement in life situations. “Participation restrictions” are thus problems the individual may experience with such involvement.3 These three components are summarized under the umbrella terms functioning and disability. They are related to and may interact with the health condition (e.g., disorder or disease) and personal and environmental factors.

![Figure 1](image1)

![Figure 2](image2)
The components of body functions and structures, activities and participation, and environmental factors are classified based on ICF categories. It is conceivable that a list of personal factors will be developed over the next years. The ICF contains a total of 1,424 meaningful and discrete or mutually exclusive categories. Taken together the ICF categories are cumulative exhaustive and hence cover the whole spectrum of the human experience. The categories are organized within a hierarchically nested structure with up to four different levels as shown in Figure 2. The ICF categories are denoted by unique alphanumeric codes with which it is possible to classify functioning and disability both on the individual and population level.

An example of the hierarchically nested structure is as follow: “b1 Mental functions” (first/chapter level); “b130 Energy and drive functions” (second level); and “b1301 Motivation” (third level). Based on the hierarchically nested structure of the ICF categories, a higher-level category shares the attributes of the lower-level categories to which it belongs. In our example the use of a higher-level category (b1301 Motivation) automatically implies that the lower-level category is applicable (b130 Energy and drive functions).

Because the ICF categories are always accompanied by a short definition and inclusions and exclusions the information on aspects of functioning can be reported unambiguously. Examples of ICF categories, with their definitions, inclusions and exclusions are shown in Table I.

**Validity of the ICF**

A wide range of studies across world regions and user perspectives have been examined and have pro-

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**Table I.—Examples of ICF categories with their corresponding code, title and definition.**

<table>
<thead>
<tr>
<th>Code* and title, definition, inclusions and exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>b130 Energy and drive functions</td>
</tr>
<tr>
<td>General mental functions of physiological and psychological mechanisms that cause the individual to move towards satisfying specific needs and goals in a persistent manner.</td>
</tr>
<tr>
<td>Inclusions: functions of energy level, motivation, appetite, craving (including craving for substances that can be abused), and impulse control.</td>
</tr>
<tr>
<td>Exclusions: consciousness functions (b110), temperament and personality functions (b126), sleep functions (b134), psychomotor functions (b147), and emotional functions (b152).</td>
</tr>
<tr>
<td>b280 Sensation of pain</td>
</tr>
<tr>
<td>Sensation of unpleasant feeling indicating potential or actual damage to some body structure.</td>
</tr>
<tr>
<td>Inclusions: sensations of generalized or localized pain, in one or more body part, pain in a dermatome, stabbing pain, burning pain, dull pain, aching pain, impairments such as myalgia, analgesia and hyperalgesia.</td>
</tr>
<tr>
<td>s730 Structure of upper extremity</td>
</tr>
<tr>
<td>d450 Walking</td>
</tr>
<tr>
<td>Moving along a surface on foot, step by step, so that one foot is always on the ground, such as when strolling, sauntering, walking forwards, backwards, or sideways.</td>
</tr>
<tr>
<td>Inclusions: walking short or long distances; walking on different surfaces; walking around obstacles.</td>
</tr>
<tr>
<td>Exclusions: transferring oneself (d420); moving around (d455).</td>
</tr>
<tr>
<td>d920 Recreation and leisure</td>
</tr>
<tr>
<td>Engaging in any form of play, recreational or leisure activity, such as informal or organized play and sports, programmes of physical fitness, relaxation, amusement or diversion, going to art galleries, museums, cinemas or theatres; engaging in crafts or hobbies, reading for enjoyment, playing musical instruments; sightseeing, tourism and traveling for pleasure.</td>
</tr>
<tr>
<td>Inclusions: playing, sports, arts and culture, crafts, hobbies and socializing.</td>
</tr>
<tr>
<td>Exclusions: riding animals for transportation (d480); remunerative and non-remunerative work (d850 and d855); religion and spirituality (d930); political life and citizenship (d950).</td>
</tr>
<tr>
<td>e1101 Drugs</td>
</tr>
<tr>
<td>Any natural or human-made object or substance gathered, processed or manufactured for medicinal purposes, such as allopathic and naturopathic medication.</td>
</tr>
</tbody>
</table>

*The letter b refers to body functions, s: to body structures, d: to activities and participation domains, and e: to environmental factors.*
vided empirical and theoretical evidence supporting different aspects of the validity of the ICF framework. They include exhaustiveness, or width, and precision, or depth, of the classification.

EXHAUSTIVENESS OR WIDTH

A classification needs to be exhaustive by its very nature. In relation to the ICF and its categories, exhaustiveness refers to the coverage of the complete spectrum of health and health-related domains that make up the human experience of functioning and disability, and the complete spectrum of environmental factors that influence that experience of functioning and disability. Exhaustiveness is thus closely related to the concept of width, which refers to the number of distinct health and health-related domains at the same level of specification included in the classification. Based on results of published studies, the ICF appears to fulfil the formal criteria of exhaustiveness, especially in relation to the bandwidth of covered domains. In this respect, the results of the studies conducted in the context of the ICF Core Set development can be considered “proof of concept”.

To the surprise of many clinicians and scientists involved, the ICF has been shown to be a highly comprehensive classification covering virtually all aspects of the patient experience. More specifically, the ICF has covered the spectrum of problems encountered in people with a wide range of conditions and along the continuum of care. Ongoing validation studies for the ICF Core Sets from the patient and health professional perspectives have shown that the ICF broadly covers patient problems and aspects of functioning treated by occupational therapists, physiotherapists and psychologists, e.g. in patients with rheumatoid arthritis. The results also show that health professionals from different professions differ greatly in their Intervention goals, reflecting the importance of validating the ICF from the perspective of many different health professions.

Further proof as to the comprehensiveness of the ICF is the finding that items of a wide range of measurement instruments can be mapped to the ICF. Most importantly, the ICF broadly represents the contents of Health-Related Quality of life measures.

PRECISION OR DEPTH

The second consideration for a classification is its depth, or precision. Depth, or precision, can be defined as the number of distinct levels of specification differentiated within a health or health-related domain. Ultimately, the proposal, as presented to the World Health Assembly in 2001, was arbitrary. However, there were guiding principles. Most importantly, the level of specification of ICF categories was established in relation to the human experience of people across a wide range of health conditions, along the continuum of care, along the life-span and across the WHO regions. Since the ICF categories are intended to be discrete and meaningful elements, they reflect the intuitive level or the level of informed “lay experts” but not the level of “professional experts” in a specific area.

Few studies have so far explicitly addressed this issue. A study that linked Health-Related Quality of Life measures to the ICF found that items with different content are linked to the same ICF category. This can be seen as an indication that the ICF does not differentiate these categories adequately. One example is the category b152, Emotional functions. In a review of the items of the SF-36 and the NHP, different items of these instruments were linked to the same ICF category b152, even though they referred to different emotions. Based on this and other results, the most common emotional functions that could be specified in a future version of the ICF are: sadness, happiness, anxiety, and anger.

ICF FRAMEWORK

Jette has rightly argued that for “scientific investigation, a crucial aspect of any conceptual framework is its internal coherence and its ability to differentiate among concepts and categories within the framework. Without empirical differentiation, conceptual frameworks cannot be investigated and validated. One of the common criticisms of the original ICIDH was that it was difficult to ascertain the boundaries between the basic concepts, each lacked the clarity and distinctness necessary for useful empirical testing. Thus, for the ICF to be useful as a framework for research, it is critical that the classification be clear about the phenomena it classifies with distinct and measurable definitions of each dimension. Without distinct and measurable dimensions, researchers will have trouble using the ICF for hypothesis development, study design and measurement construction.”
Currently, only few published studies have empirically investigated the components of the ICF.39 A most important question with regard to the components of the ICF framework is the differentiation of activities and participation40, 41 and the differentiation between capacity and performance. In the development process of the ICF no clear distinction between the activities and participation component could be made in relation to specified sets of ICF categories. In the first version of the ICF, WHO thus suggested the further investigation of this issue and offers four possibilities to differentiate between these components. A first empirical study exploring the issue found, that there are distinct concepts conforming to the two ICF components activities and participation.39

Another approach to study the validity of the ICF framework is its reflection from the perspective of theoretical or professional models in relation to functioning. For example, occupational therapy models which focus on occupations and activities of daily living in the context of the environment can be expected to be closely related to the ICF. In a paper exploring the link of conceptual occupational therapy models to the ICF, the majority of the concepts from three conceptual occupational therapy models could be linked to the ICF.30, 42, 43 The ICF also proved to be useful as a framework for comparing the similarities and differences of the three conceptual occupational therapy models. The findings of the study also demonstrated that there are strong conceptual connections between the ICF and occupational therapy models, which encourage occupational therapists to use the ICF in their practice.42

### Functioning in the perspective of related concepts

To facilitate the acceptance and application of the ICF as universal framework and classification of functioning, disability and health, it is important to understand the relationship of the ICF with related concepts such as well-being, Quality of Life and Health-Related Quality of Life. The discussion of these relationships based on the ICF as a reference framework may contribute to the clarification of the often vague and varying uses of these concepts.44

The basis for the understanding of the ICF in relation to these concepts is the recognition of the varying understanding of health, the distinction between an objective versus an explicitly subjective perspective, and the distinction of health domains, health related domains and non-health domains. The authors recognize that the presented relationship of the ICF with those related concepts as summarized in Table II is a

<table>
<thead>
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<tr>
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<td>Health state</td>
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</tr>
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</tr>
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<td><strong>ICF Components/Aspects by type of domain</strong></td>
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<tr>
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<td>—</td>
<td>—</td>
</tr>
<tr>
<td>unrelated to health</td>
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<td>—</td>
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</table>
simplification. It does not address the issue of the understanding of personal factors in relation to health versus non-health domains and can be questioned from many perspectives, e.g. with regard to the separability thesis of health and non-health domains. Acknowledging the limitation of the presented simplification, it may contribute to the international discussion towards a common understanding of the discussed concepts in relation to the ICF.

**Understanding health on a continuum**

There is a wide range of concepts and definitions of health in the perspective of the human experience. With respect to the ICF one may understand health on a continuum ranging from a body-centred view (“the bodily experience of health”), to a more comprehensive perspective (“the entire health experience”), and finally, to an overarching view (“the human experience”) which sees health as part of the human condition Table II. The ICF allows the operationalization of health as part of the human experience on this continuum as health from a narrow perspective to the broad perspective of functioning.

**Objective versus subjective perspective**

While topic of wide ranging philosophical debates, a distinction between a more objective or descriptive versus a more subjective or appraising perspective of health is often made.

With respect to functioning the objective perspective would e.g. consider a limitation to use the telephone when calling friends. The subjective perspective would consider how somebody feels or how dissatisfied somebody is if he is limited to use the telephone to talk to friends.

On the continuum of health, the concepts from the objective perspective range from health to functioning and objective well-being. The concepts of the according subjective perspective range from the health component of well-being often also referred to as health-related quality to well-being or Quality of Life.

The ICF categories are the meaningful and discrete elements to classify functioning from the objective perspective. However, the same categories may serve as starting point for the operationalization and hence the assessment of the subjective perspective.

**Health, health-related and non-health construct**

The health construct refers to “under the skin” or “within skin” aspects that are intrinsic to the person as a physiological and psychological entity. Examples are mental and seeing functions. In the ICF, the health construct is addressed with the components body function and structures and the concept of capacity. In this context it is important to note that capacity is not defined by specified domains or ICF categories of the component activity/participation but the concept of an individual’s ability to execute a task or an action. Specified domains or ICF categories of the component activity/participation can thus be considered health or health-related depending on the concept – capacity versus performance – under which they are considered.

The health-related construct refers to “outside the skin” aspects. It is closely related to the health construct and is necessary for the description of a person’s lived or “entire experience of health”. Examples of health-related aspects are work, education, and social activities. In the ICF, health-related aspects are addressed with the concept of performance. Performance is defined as what an individual does in his or her current environment. As already mentioned for capacity, a specified domain or ICF category can in principle be considered or assessed both as capacity or performance.

Aspects of the non-health construct have been described as “criterial goods”. They include “autonomy and integrity” on the one hand and the “material conditions of life” on the other. One might also think of the famous French triad of liberté, égalité and fraternité – ultimate cultural and policy goals that constitute human goods. In the ICF non-health aspects relevant for health by influencing functioning as barriers or facilitators are addressed with the components environmental and personal factors. Non-health aspects without relevance for functioning are not classified in the ICF.

**Well-being and Quality of Life**

**Objective well-being** is the broadest concept in relation to health discussed here. It encompasses the whole universe of health, health-related and non-health aspects relevant for the human condition.
Figure 3 illustrates the universe of well-being with its internal differentiations of health, health-related and non-health aspects. Since the ICF encompasses non-health aspects described as environmental factors and personal factors in addition to the health and health-related aspects summarized as functioning, the ICF is closely related to the concept of well-being. Indeed, from an overarching view, health can be understood as major part of well-being.

The ICF with its discrete and meaningful categories can thus serve as a starting point for the operationalization of objective well-being. Since the ICF does per definition only include aspects relevant for health, there are non-health aspects which are part of the universe of well-being not covered in the ICF. Socio-economic factors have been specifically mentioned in this context. Another example is “egalité” which is, at least in the current version, not covered by the ICF. Since one may argue that “egalité”, as any other non-health domain can at least in principle influence or interact with health, one may ultimately come to an understanding of the ICF as a classification of objective well-being which encompasses all aspects of the human condition. In the future, the ICF may thus evolve from a classification of functioning and health for persons with a health condition to a general classification of health, functioning and objective well-being for all persons irrespective of the presence or absence of a health condition.

The relationship of the ICF with the concept of quality of life is similar to the relationship with objective well-being. Since Quality of Life can be defined as an individual’s perceptions of the domains of objective well-being, the ICF with its domains ranging from health to health related and non-health aspects can thus serve as the basis for an operationalization of Quality of Life.

Functioning and health-related quality of life

While objective well-being can be understood as the human experience, functioning can be understood as the entire health experience. Understanding humans as biological and societal entity, the human experience encompasses both, health and non-health aspects. In the ICF, health and health-related aspects are integrated under the more comprehensive notion of functioning, which is defined as the “umbrella term for body functions, body structures, activities and participation”.

Since Health-Related Quality of Life can be defined as an individual’s perceptions of health and health-related domains of well-being, the ICF categories encompassed in the ICF concept of functioning can serve as the basis for the operationalization of Health-Related Quality of Life.

The bodily experience of health

A still more focused understanding of health refers to the body and encompasses only health aspects. This perspective is in line with the more recent WHO focus on defining health for measurement purposes. It refers to an operational concept of health in terms of a set of health aspects and ‘under the skin’ capacities that are intrinsic to the individual person as a biological entity.

Similar to the distinction of objective well-being versus Quality of Life and functioning versus Health-Related Quality of Life a differentiation between “biological health” versus experienced or perceived health can be made. One may thus differentiate “biological health” from “subjective health” or “experienced health”.

Figure 3.—The universe of well-being and functioning based on the ICF.
**States versus status**

The ICF lends itself to clarify the measurement of variation in the discussed concepts. It has been suggested to use the term *state* for the reporting of *profiles* across ICF categories and to use the term *status* for the reporting of *indices* which aggregate or summarize information across specified ICF categories.44

In the outlined understanding of health on the continuum from health to functioning and well-being, one can clarify the terminology for states and status on the different levels. While health state and health status address health from the perspective of the body, functioning state and functioning status address health on the level of functioning.

**Conclusions**

The ICF contains most aspects of functioning disability and health that are important to patients and that are intervention targets of clinicians and health professionals. It also contain the content of items of a wide range of instruments to address functioning, disability and Health-Related Quality of Life measures.

The ICF has also a potential as a conceptual framework to clarify and organize an interrelated universe of health-related concepts, such as, well-being, health state, health status, Quality of Life and Health-Related Quality of Life. All these concepts can be elucidated based on the ICF. The result is a coherent framework of interrelated concepts that contributes to our understanding of human health and well-being.

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