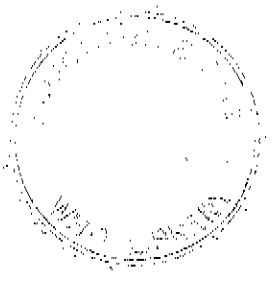
Standardization in measurement of impairment, disability and handicap, as consequence of disease

Report of a Working Group



Voorburg, Netherlands
11–14 October 1983

organized by the World Health Organization, Regional Office for Europe
in collaboration with the Government of Netherlands

Reprinted from Monthly Bulletin of Health Statistics
Netherlands Central Bureau of Statistics, vol 3, no. 2, Feb. 1984

standardization in measurement of impairment, disability and handicap, as consequence of disease

report of a working group

voorburg, netherlands
11–14 october 1983

ICP/HST 010 (1)
0399d
english only

1983

Note

Contents

1. Introduction

The World Health Organization, Regional Office for Europe, in cooperation with the Government of the Netherlands, organized a Working Group on Standardization in Measurement of Impairment, Disability and Handicap, as Consequence of Disease, in Voorburg from 11 to 14 October 1983.

The meeting was called following a recommendation of a joint ECE/WHO Meeting on Health Statistics in Geneva in February 1982. Its purpose was to share experiences in the area of classification relating to the consequences of disease, discuss the problems arising, define areas in which research and development is required and consider the coordination of future activities so as to ensure the widest possible adoption and use of a workable classification.

The meeting was attended by temporary advisers from Canada, Czechoslovakia, France, Federal Republic of Germany, German Democratic Republic, Netherlands, Norway, Switzerland, United Kingdom and USA. Representatives from the Council of Europe, Commission of the European Communities and International Social Security Association were also present. Observers from the Netherlands attended specific sessions. The list of participants can be found in Annex 1, and the list of documents discussed by the Working Group in Annex 2.

Dr J.P. Jardel, Secretary of the Working Group welcomed the participants on behalf of Dr L.A. Kaprio, Director of the WHO Regional Office for Europe. He gave an overview of the previous activities in WHO and other organizations, outlined the scope and purpose of the meeting, and thanked Dr Van Londen, Director-General of the Ministry of Welfare, Health and Cultural Affairs, and Professor Begeer, Director-General of the Central Bureau of Statistics, for their hospitality and their support to the organization of the Working Group, in which the Bureau for Classifications and Coding Systems in Health Services was also involved.

Opening the meeting Dr Van Londen described the long historical connexion of the Netherlands with the development of classifications in the field of health. The Netherlands was one of the first countries to take an interest in classifications of impairment, disability and handicap including classification of aids for the handicapped. Underlining the national and international importance of classification and standardization he stressed the need for international cooperation in this field.

The meeting elected Professor H.H.W. Hogerzeil (the Netherlands) as Chairman. Dr D. Robinson (WHO headquarters) was nominated as rapporteur.

2. The need for classification of impairments, disabilities and handicaps

The rational management of services depends on the availability of data which can be used to describe the need for the use and effect of those services. The medical model upon which health information systems are most often based, while being suitable for the care of those with acute health problems or problems amenable to medical or health service intervention is not so appropriate for information describing the consequences of such health problems. This is particularly so because the care of such individuals includes a large component which although health related is in fact more in the sphere of social policy and action than medical services.

Until 1975 classifications suitable for data referring to such individuals were fragmented. The International Classification of Diseases, until the last revisions, included supplementary classifications for impairments (see for example codes Y50 to Y88 in the seventh revision). Disability was seen as a separate issue and handled with separate classifications. Handicap was considered conceptually inseparable from disability or was not codified. The development of classifications of functional capacity for specific diseases to some extent filled these gaps.

The conceptualisation of disablement as three dimensional, having facets amenable to care in three different but related spheres gives those working in the field of disablement the opportunity to examine the individuals and populations in their care in a more complete light. It also allows those working in this field to see more clearly the relationship of the work of each to the others.

This concept, although inevitably complex, has implications for the development of health and social services and the information required for their support in countries at all stages of development. It is partly for this reason that the World Health Assembly saw fit to pass a resolution to develop and publish the ICIDH for trial purposes[1].

3. Available approaches

Although there is a wide variety of classifications available for use in specific conditions of disablement, the only widely used international approach to classification of disablement is the OECD one. The ICIDH, although not yet fully established for international use, has the potential to meet the classification needs of a wide spectrum of care for the disabled. The two classifications have approached the problem from opposite angles: the OECD tried to arrive at a synthesis starting from measurable characteristics of the individuals, while the ICIDH started from general concepts and attempted to arrive at a workable classification.

---

[1] Resolution WHO 29.35.

3.1 International classification of impairments, disabilities and handicaps

The ICIDH was developed as a classification for trial purposes. Its aims were to improve the assessment of disablement and to open the way to the collection and use of data relating to the consequences of disease. It considers those consequences in the three dimensions of impairment, disability and handicap, which correspond approximately with the areas of influence and action of medical care, rehabilitation and social policy respectively.

The classification is designed to assist in the identification of impairments and disabilities without assuming that the individuals in whom these are present have some handicap. The presence of impairments and disabilities may not necessarily, depending on the social and economic environment of the individual, manifest themselves as handicap. Nor are specific impairments and disabilities necessarily linked to specific handicaps.

The classification is seen as having three functions.

1. The production of statistics on the consequences of disease.
2. The collection of statistics relevant to the utilization of services.
3. The assessment of disablement of individuals, leading to improved indexing and case record retrieval.

It should be noted that these functions are appropriate only where the information needs are perceived in this form. Thus for ICIDH to have any practical value, those responsible for policy and action must be thinking in the terms expressed by the concepts of ICIDH.

The development of the ICIDH was intended as a stimulus to those involved with disablement to broaden their thinking to embrace the concepts it advances, and it has certainly provided such a challenge.

The implication of a classification carrying the title 'international' is that comparability of national data is intended. Although this has to be considered as a secondary aim, of greater importance is the use of the classification to stimulate action in the field and to push those responsible into examining their needs for information and the means for obtaining it. In some groups of countries there is a real need for comparable information. This is particularly so in Europe where the Council of Europe recommended that comparability of data on impaired, disabled and handicapped people be achieved both at the domestic and international level[2]. Even in those parts of the world where this does not apply, comparable conceptual frameworks for policies will make for easier discussion and exchange of information on the management of disabilities in different centres.

For a number of reasons, the ICIDH has not been widely tested in the three-year since its publication. These reasons include difficulty experienced by national authorities in fully grasping the concept, the amount of work involved in developing the necessary instruments, the difficulty experienced in obtaining copies of the classification, and problems in translation into languages other than English.

Translations, published or otherwise, are now in existence in French, Dutch, German, Spanish, Russian and Italian. Others are in preparation. These translations, to be successful, must be interpretations of concepts rather than word for word translations. Where the concept has been fully understood, the translation has proceeded smoothly. Where there have been problems in adopting the concepts in the contexts of the national culture, the language translation has proved difficult.

3.2 OECD indicator

The indicator was developed within the framework of the OECD Social Indicator Programme which started in 1976, as a common development effort attempting to recommend disability indicators under the social concern 'Healthfulness of Life'. This work resulted in a recommendation for a short-term (time-based) disability indicator and a long-term disability indicator[3].

Especially the latter had the attention of the Working Group since it was developed according to the basic concepts of a draft ICIDH. However, the OECD indicator focuses mainly on the disruption of normal social activity resulting in a definition: 'the consequence of the effect of ill-health on activities essential to daily living'. This was operationalized in a questionnaire of 16 items for each of which there is a sceling of severity in four categories. The 16 items represent disability in three broad types: mobility, communication and self-care. The indicator was tested in several countries[4] and proved to be a practical tool in (health) interview surveys although it tends to be more sensitive to severe levels of disability and hence more applicable to the elderly. The indicator has the advantage that it allows for internationally comparable data, at short notice, which are to a substantial degree not biased by differences in social medical systems.

---

[2] Council of Europe; Partial agreement in the Social and Public Health Field, Resolution AP (81)8 on information systems on impaired, disabled and handicapped people.

[3] John R. McWhinnie. Measuring disability, the OECD Social Indicator Development Programme. Special Study No 5, OECD, Paris, 1982.

[4] Results of such tests have been published in Revue d'épidémiologie et de santé publique, 1981, 29, pp 413–475.

The Working Group noted that the indicator may not appear to be fully compatible with ICIDH, e.g. according to the OECD list a person who can perform activities normally but with aids has no disability whereas according to the conceptual framework of the ICIDH he has a disability. Its specific relation with the D classification of ICIDH was also discussed particularly in view of the paper presented by J. van den Berg and J. Van Sonsbeek about the preliminary findings of the use of the OECD list in the Dutch health interview survey in 1983, and in proxy interviews, and the intentions to examine the possibilities of developing it as a tool to measure disability according to the D classification.

4. Work on classifications reported to the meeting

The meeting was presented with a review of the utilization of ICIDH in household surveys and registration schemes, particularly in the European Region. To an enquiry made in relation with the present meeting, nine countries of the Region reported that they have conducted interview surveys about health and/or health care consumption in the framework of national statistics after 1980. For at least seven of those, it is known that such surveys are performed at regular intervals. Four countries reported that more detailed data about handicapped people are or will be collected by means of interview surveys. In general, the questionnaires used cover only parts of the IDH classification. They do not always make a clear distinction between the concepts of impairment, disability and handicap. They seem to focus more on information about disabilities which apparently can better be obtained by means of interviews than can information on impairments and handicaps. The questions in interview surveys allow at best for a broad classification and are not fully compatible with ICIDH definitions. In conclusion, there is a general tendency in countries to measure in interview surveys a range of variables which can be classified as disabilities. The situation seems to be much more confusing for impairments and handicaps, for which data collection and use of the ICIDH seem to have created difficulties. Several countries report the existence of ad hoc surveys and specific applications which may contribute substantially to the development of common measurement instruments in the field of disablement. Participants in the meeting reported experiences in recording impairments, disabilities and handicaps. These experiences are summarized below.

4.1 General review

4.2 Household surveys

The Netherlands

The OECD disability indicator list has been included, in modified or unmodified form, in the Netherlands Life Situation Survey since 1979.

The instruments for this survey have been examined for their appropriateness and ease of administration. The results obtained are seen as valuable for the management of services for disablement, although they may unduly emphasize more severe disability and disability in the elderly. The OECD list used in this way has shown itself to be a useful tool which can provide internationally comparable data of limited sophistication at short notice, even if it does not take sufficiently into account the culturally determined response to disability upon which social policy may depend.

An examination was made of the compatibility of this list with the disability list of the ICIDH. Although the developers of the OECD list took into account the concepts defined in a preliminary revision (1975) of the ICIDH, there are difficulties in direct comparison. The users in the Netherlands did not attempt to produce an instrument based on the disability list.

France

The ICIDH has been translated into French. According to the first evaluations, there appears to be a consensus of approval concerning the concepts. There are, however, little effective experimental applications of the classification. Besides translation problems, it was stressed that ICIDH in its present form is considered by several potential users in France as too complex, it is also regretted that it does not include indicators of environmental conditions. The classification has never been used directly in its present form, but numerous questionnaires for population surveys have been developed according to the concepts of impairment, disability and handicap, particularly in recent gerontology surveys, in a rheumatological survey and in one regional extension of the French health survey in order to test this approach.

In the light of these experiences, several suggestions for further improvement of this instrument have been made:

a a clear definition of the purpose of a classification of consequences of diseases is needed;
b in French, the term 'handicap' may be confusing as it is traditionally used both in relation to impairment and to disadvantage. It would be better to use 'social disadvantage' or 'disadvantage' where the term handicap is used in isolation, and to consider as an impairment any handicap qualified by an indication of organic lesion (visual handicap, motor handicap);
c the equivalence between social disadvantage and need should be precisely defined;
d a common set of dimensions should be used by different countries to assess disadvantage, even though thresholds of perception of social disadvantage may be different. Proposed dimensions are physical mobility, activities of daily living, occupation, social integration, and economic self-sufficiency;
e the measurement of environmental conditions should be developed;
f an inventory of indicators currently in use would facilitate the standardization of measurement tools;
g the classification of impairments should be linked with the ICD.

Current research in France focuses on the development of health indices, the validation of indicators currently used in surveys, the development of simplified indicators, and the design of simplified questionnaires on disability.

United Kingdom
Experience of the problem of collecting disablement data shows that there is a need to develop instruments based on the IDH concepts and classification which at the same time pay attention to operational reality. Nevertheless, a national survey which took place in the late 1960 recognized the distinction between impairments and other planes of disablement. The work carried out at Canterbury in the early seventies showed that one household survey is much more effective in identifying disabled persons than were all registers combined.

4.3 Rehabilitation

Czechoslovakia
The ICIDH translation into Czech will be published in 1984. The classification has been applied on a small sample of disabled young people for functional evaluation with a view to their better adaptation to work. From this experience, changes in the ICIDH have been suggested particularly in order to facilitate its practical use.

Federal Republic of Germany
In an industrial rehabilitation scheme in Cologne it was seen to be necessary to define the capacity and handicap of workers suffering disablement following illness or accident. The method developed was a detailed coding of the three dimensions of the disablement, but especially the disability code, using the ICIDH as the basis for the instrument. Disability and demand profiles have been used sucessfully, and the method is being promoted for use in other industrial settings. In different projects, the H code has been used as a screening tool.

The Netherlands
The Rehabilitation Institute of the Erasmus University (Rotterdam) has applied in its medical records the impairment list and a selected number of disabilities, derived from the preliminary version (1975) of ICIDH.

Norway
The ICIDH has not yet been used in Norway, with a few exceptions. It is seen as somewhat complex and incomplete and probably not necessary to the services as they stand. The survey of handicap is seen as presenting the risk of raising expectation unless the information sought is directly needed for management purposes. The major development of classification relevant to disablement in Norway has been a classification of aids which should permit comparison of the aspect of services for disablement in the Nordic countries.

4.4 Routine registration and recording

German Democratic Republic
The Disability code of the ICIDH has been applied in a registration project for children and adolescents from 10–18 years of age. It proved to be well suited for controlling the course of impairments and disabilities in children of this age. Epidemiological problems will arise from possible combinations of disabilities. Distinction must be made between long-term and short-term disability in the context of special surveys and registration schemes.

The Netherlands
In 1983 a registration was started by the teams for early detection of handicapping conditions in young children. Part of the registration-items can be traced back to the ICIDH. In the same year, the EEC pilot study on home accidents started also in the Netherlands. A list of impairments is incorporated in the registration form.

The rehabilitation institutions prepare the introduction of a routine registration, starting in 1984. The impairment and disability lists will be used in this computerized information system.

Parts of the disability list are used in the national routine registration of nursing homes.

4.5 Health insurance

The Netherlands
In connexion with the enactment of the Disablement Insurance Act and the General Disablement Act, which entitle all inhabitants of the Netherlands to cash benefit in case of loss of earning capacity as a consequence of disease or deficiency, a system for assessing the degree of disablement – understood as occupational incapacity – has been set up by the Social Security. A pattern of functional limitations was developed in the early seventies. It is used to determine the profile of the individual and compare it to the profile of his or her last job. Attempts to apply the ICIDH led to some disappointment, as it was found to be too 'institution-oriented'. It would be useful to improve it by defining a set of basic skills substituting the manifold and situationally-defined activities that presuppose the possession of such skills. A list of impairments has been set up on the basis of ICIDH and tested with good results. It was not possible to do the same work with disabilities and handicaps, due to the existence of contextual and situational dependencies, and to some difficulties in distinguishing between the two concepts.

The discussion focussed on the apparent conflict between the subjective perception by an individual of his disablement, and the need of an objective measurement of it for decision on eligibility to compensation. It was recommended to promote more debate with decision makers and lawyers in order to find alternative means of deciding on eligibility, in an equitable way.

Switzerland

The disablement insurance system is one of the few health-related systems in Switzerland which is countrywide. The characteristics of the individuals receiving benefits are coded according to a classification developed for the purpose. These files are little used as sources of basic data.

The classification in current use is divided into three fields: nature of disablement (i); nature of the functional disorder (f); and nature of benefits (p). Although there is not a one to one correlation, the i, f and p codes can be translated into the I and D codes of the ICIDH, as shown by a preliminary study. It is unlikely that the H code could be used for existing data.

It is intended to explore the possibility of modifying the existing instruments in order to take advantage of the ICIDH.

4.6 Mental health

The Working Group was informed about WHO activities in the field of disablement related to mental disorders, and in particular, the WHO collaborative study on the Assessment and Reduction of Psychiatric Disability, initiated in 1976, and involving research centres in seven countries. The concepts and instruments developed for this study were taken into account for the development of the ICIDH. The assessment instruments included psychiatric history and socio-demographic description, present state examination, psychological impairment rating schedule – PIRS (assumed to be related to disability according to ICIDH concept), disability assessment schedule – DAS (assumed to be related to handicap according to ICIDH concept) and diagnostic and prognostic assessment.

The DAS included as areas of social functioning sections related to individual behaviour, and a section dealing with modifying factors (assets, liabilities, home atmosphere and outside support).

Detailed questionnaires and instructions have been devised, as well as selection criteria, and training material. At least three successive assessments have been performed on each individual. Analysis of data has been performed in order to reduce the number of variables and to establish proper scaling and scoring systems. Results are used to analyse the structure of disablement, the effects of different types of intervention, the possible predictors for individual patients and groups. Preliminary results are encouraging and show that a well standardized approach can be used in different socio-cultural environments. Furthermore, the instruments developed for the study are adaptable to conditions other than psychiatric. It was stressed that the sections of ICIDH related to mental disorders would benefit from a revision in the light of the results of the study.

5. Conclusions and recommendations

5.1 The Working Group recognized that, with ageing populations and an increase in the prevalence of chronic disease and its consequences, Member States are confronted by pressing problems. The latter include:

- how many people are affected by illness-related problems of more than brief duration?
- to what degree (or severity) are they affected?
- what help or compensation should be offered to those affected?

The Group agreed that, in trying to solve these problems related to the consequences of disease, distinction between different qualities of experience such as is represented by the separate notions of impairment, disability, and handicap, makes an important contribution and further agreed that dissemination of this approach to appreciation of the problems should be undertaken. It was regretted that insufficient efforts have been made so far to promote the dissemination of these concepts.

Recommendation

1) Educational material should be developed in order to facilitate dissemination of the concepts of impairment, disability and handicap to health professionals, researchers, administrators, planners and others.

5.2 The Group recognized that, in seeking answers to these questions, it was necessary to develop screening instruments to detect those affected, methods for assessing the severity of affection, and indicators of the needs revealed by such assessments. This is in line with the recommendations of the Council of Europe[5] on information systems on impaired, disabled and handicapped people. In this regard the Working Group agreed that the principles of the approach followed in the ICIDH made an important contribution to answering the questions, and especially by projection of the rehabilitation process from the clinic to the community. It was recognized that clarification and modification of both definitions and specific categories in the ICIDH would be needed, to proceed hand in hand with further development of the classification itself and extended experience and testing of its application.

Suggestions for consideration when reviewing the ICIDH were made by several participants of the Working Group. They are indicated below as elements for further discussion:

[5] Resolution AP (81)8.

a. Impairment component
   - There is a need to link the impairment code with the ICD.

b. Disability component
   - Clarification is required for some categories, especially those related to mental, behavioural, and personal care disabilities.
   - Duration scales would be usefully associated with certain types of disability.
   - Consideration should be given to the mutual exclusivity of the dimensions. This would facilitate multiple coding of individual's disablement.
   - The operational definitions of disability indicators used in surveys should be compared with the dimensions of disability in ICIDH.
   - The supplementary grading for assessment of outlook should be given emphasis in applying the D code to individuals, as this element serves as a link with subsequent assessment along the dimension of handicap.

c. Handicap component
   - The elements of orientation, physical independence and mobility could be reassessed to clarify whether or not they are more appropriate to the determination of disability status than handicap.
   - The element of social integration requires further specification, perhaps using what is presently under 'disabilities in relation'.
   - More consideration should be given in the H code to the subjective perception of quality of life.
   - It could be useful to consider the introduction of elements concerning the assets and liabilities having an impact on the individual's ability to function and adapt to the social environment.

Recommendations

2) Initiatives at national level should be encouraged to reconcile the sometimes conflicting needs of different classes of users such as survey workers, clinical assessors, eligibility assessors, etc.
3) A working group should be convened to consider the various deliberations conducted at national level and to seek an agreed basis for further international development of a common basis for assessment of disablement.
4) The overall responsibility for promoting and coordinating this effort should remain with those WHO units directly concerned with the development of the ICIDH system. Apart from the Division of Health Situation and Trends Assessment, with whom the responsibility is lodged, the technical units responsible for rehabilitation, care of the elderly, accident prevention and mental health should play an important part.

5.3 In acknowledgement of the WHO goal of health for all by the year 2000, and of the contribution to this goal to be made by primary health care and community participation, the Working Group agreed that collaboration between interested rehabilitation facilities in different countries should be encouraged, so as to provide a nucleus for development of applications of the ICIDH in more clinical situations and their extension to the community.

Recommendation

5) An initiative should be taken, at the international level, to facilitate collaboration between interested rehabilitation facilities. This might include the designation, in collaboration with Member States, of national centres with appropriate knowlegde and resources, as coordinating units for identifying and cataloguing instruments in use in their particular areas of expertise. Such centres could organize workshops for clarifying the relationship between operational instruments and the IDH conceptual framework, and disseminate information about the development and use of such instruments.

5.4 The Group was aware of problems concerning the comparability of available data within and among countries, and between surveys and registration schemes, and of how these problems contributed to uncertainty about the frequency and magnitude of disablement. These difficulties are particularly evident in pursuing population-related enquiries, such as health interview surveys.

There is a need to identify and catalogue the instruments currently available and under development for use in the classification of IDH. To facilitate the compilation of these instruments and of the information that has been collected with their use, the following categorization of tools is suggested:

1. Screening tools
   single or multi-purpose instruments
2. Assessment tools
   to serve especially the purposes of individual case management and rehabilitation
3. Epidemiological survey tools
   concerned primarily with determining the magnitude of the problem or undertaking analytical investigation.

Special consideration should be given to the following aspects of instrument identification and application. This is particularly relevant for instruments designed for surveys.

a. In addition to the core part of each instrument, there should also be special modules developed to meet the specific problems of assessing disablement of persons with mental retardation, psychiatric, sensory and physical impairments.

b. At the impairment level, instruments designed for collecting data on categories of impairments should allow for grouping of such impairments into large categories of disabled persons.
c. Tools should be identified for collecting information on the subjective perception of quality of life.

Recommendations

6) Existing material from disability surveys conducted in the past should be reappraised, so as to indicate if any tested instruments relevant to the problem could be applied in future work.
7) On this basis, and augmented by further pilot studies, it is necessary to establish a glossary of categories to be considered and an enumeration of criteria to be fulfilled for assignment to these categories (cf. WHO mental health studies).
8) The above-mentioned work should give consideration to the level of the classification at which comparability is considered desirable and possible for comparison within and among countries and between surveys and registration schemes.
9) European intergovernmental organizations should promote and facilitate intercountry collaboration in the conduct of pilot studies and the application of their results to further large scale trial surveys.

5.5 The Working Group recognized the existence of overlap between the 9th revision of ICD and ICIDH, and that this leads to confusion in application.

Recommendation

10) Activities related to the development of ICD-10 should seek to eliminate needless and confusing duplication between ICD and ICIDH, and to ensure that the concepts and form of the ICIDH are taken into consideration in the revision of ICD.

5.6 The Group recognized that the ICIDH scheme is likely to be appropriate for only certain purposes, and that various problems, such as indicators of need, are not coped with in the classification. Some of the difficulties encountered result from failure to identify clearly for what purpose it is wished to apply ICIDH.

Recommendation

11) A mechanism should be established by WHO, in collaboration with other agencies, to consider areas of disablement which require classification but are not covered by the ICIDH.

5.7 The need for a central coordination of the international effort towards the standardization of measurement of disablement was obvious to the participants. Since it is within the functions of WHO to establish and revise classifications and promote standardization in the field of health, it was felt that the responsibility for such central coordination should naturally be vested with WHO, at either regional or global level, or both. Furthermore, it is essential to secure adequate financial support for such a coordinating role.

Recommendations

12) Consideration should be given to the establishment of a mechanism to ensure the continuity of coordinated efforts towards the development and application of the ICIDH in different contexts. Such a mechanism could involve the convening of working groups, the establishment of a permanent steering group, and/or the formulation of a special programme at global or European level.
13) In order to secure adequate financial support of the above-mentioned coordinating role, voluntary contributions designated for work related to the ICIDH, might be elicited from interested governments.

Annex 1
List of participants
Temporary advisers

Mr J.T.P. Bonte[6]
Head, Department of Health Statistics
Central Bureau of Statistics
428 Prinses Beatrixlaan
2270 AZ Voorburg
Netherlands

Dr A. Colvez
Epidémiologiste chargé de recherche à l'Institut National de la Santé et de la Recherche Médicale (INSERM), Unité 164
44 Chemin de Ronde
78110 Le Vésinet
France

Dr M. de Kleijn-de Vrankrijker[6]
Ministry of Welfare, Health and Cultural Affairs
Postbus 439
2260 AK Leidschendam
Netherlands

[6] Participation expenses not paid by WHO.

Dr D. Duckworth
Research Fellow
Health Services Research Unit
University of Kent
Canterbury, Kent CT2 7NF
United Kingdom

Mr W.M. Hirs[6]
Bureau PCC van de Centrale Organisatie TNO
Prinses Beatrixlaan 428
2273 XZ Voorburg
Netherlands

Professor H.H.W. Hogerzeil[6]
RUG/Instituut voor Sociaal-Medische Wetenschap
Bloemsingel 1
9713 BZ Groningen
Netherlands

Mr G. Hunfeld[6]
Head, Staff Department for Research and Development
Joint Medical Service
P.O. Box 8071
1005 AB Amsterdam
Netherlands

Professor K. Jochheim
Deutsche Sporthochschule Köln
Rehabilitationszentrum der Universität zu Köln
Lindenburger-Allee 44
5000 Köln 41
Federal Republic of Germany

Mr O. Lorentsen
Head of Department, Central Institute for Industrial Research
Norwegian Council on Technical Aids for Handicapped Persons
P.O. Box 350
Blindern, Oslo 3
Norway

Mrs M. Muller[6]
Centre de réadaptation
Le Bouclier
37, sud Place Bourget
Joliette, Quebec, J6E 5G1
Canada

Dr F. Paccaud
Department of Health Statistics
Schwarztorstrasse 53
3003 Bern
Switzerland

Dr J. Pfeiffer
Charles University Prag CSSR
Chair of Medical Rehabilitation and Institute of Psychiatry and Balneology
Albertov 7
128 00 Praha 2
Czechoslovakia

Dr C. Seidel
Institut für Sozialhygiene und Organisation des Gesundheitsschutzes
Nöldnerstrasse 34–36
1134 Berlin
German Democratic Republic

Professor R.T. Smith
Department of Behavioural Sciences
School of Hygiene and Public Health
Johns Hopkins University
615 North Wolfe Street
Baltimore, Maryland 21205
USA

---

[6] Participation expenses not paid by WHO.

Professor C. Tilquin[6]
University of Montreal
E.R.O.S.
3535 Queen Mary Road No. 501
Montreal, Quebec H3V 1H8
Canada

Mr J. Van den Berg[6]
Collaborator of the Department for Health Statistics
Central Bureau of Statistics
Kloosterweg 1
6401 CZ Heerlen
Netherlands

Dr P.H.N. Wood
Director
ARC Epidemiology Research Unit
Stopford Building
University of Manchester
Oxford Road
Manchester M13 9PT
United Kingdom

Observers

Mr R. Pompe[6]
Department of Rehabilitation
University Hospital 'Dykzigt'
Rotterdam
Netherlands

Dr D. Wiersma, Sociologist[6]
Department of Social Psychiatry
(WHO Collaborating Centre)
Academisch Ziekenhuis
Postbus 30.001
97 RB Groningen
Netherlands

Representatives of other organizations

Council of Europe (CE)
Mr H. Scicluna[6]
Principal Administrative Officer
Partial Agreement Division in the Social and Public Health Field
Council of Europe
B.P. 431 R6
67006 Strasbourg CEDEX
France

Commission of the European Communities (CEC)
Mr D.J. Sweet[6]
Statistical Office of the European Communities
Bâtiment Jean Monnet B2/038
Luxembourg

International Social Security Association (ISSA)
Mr J.W. Altena[6]
Head of the Statistical Development Department
Social Security Board
P.O. Box 100
2700 AA Zoetermeer
Netherlands

World Health Organization

Regional Office for Europe
Dr H. Hermanova
Regional Officer, Elderly, Disability and Rehabilitation
Dr J.P. Jardel
Regional Officer for Epidemiology and Information Support

Headquarters
Dr. A. Jablensky
Senior Medical Officer, Mental Health
Dr. D. Robinson
Medical Officer, Development of Epidemiology and Health Statistical Services

---

[6] Participation expenses not paid by WHO.

Annex 2
List of working papers and background material

Working papers

ICP/HST 010(1)/1 Rev. 1	Provisional list of working papers and background material
ICP/HST 010(1)/2	Scope and purpose
ICP/HST 010(1)/3	Provisional agenda
ICP/HST 010(1)/4 Rev. 1	Provisional programme
ICP/HST 010(1)/5	Provisional list of participants
ICP/HST 010(1)/6	Recent activity in the application of ICD in France, by A. Colvez
ICP/HST 010(1)/7	Some problems in using the ICIDH to obtain statistical data, by D. Duckworth
ICP/HST 010(1)/8	Indicators for accidents: measuring trauma and long-term consequences, by Richard T. Smith
ICP/HST 010(1)/9	The use of ICIDH at the Maxim Zetkin institute of social hygiene and organization of protection of health, by Christa Seidel
ICP/HST 010(1)/10	Note on the conversion of an administrative filing system into a code for the international classification of impairments, disabilities and handicaps, by F. Paccaud
ICP/HST 010(1)/11	Standardization in measurement of impairment, disability and handicap – the situation in Norway, by O. Lorentsen
ICP/HST 010(1)/12	Classification of young handicapped people in Czechoslovakia, by J. Pfeiffer
ICP/HST 010(1)/13	Use of the classification of impairments, disabilities and handicaps at the rehabilitation centre, Cologne, by K.-A. Jochheim
ICP/HST 010(1)/14	The background to the ICIDH, by P.H.N. Wood
ICP/HST 010(1)/15	Use of IDH for specific problems: mental health, by A. Jablensky
ICP/HST 010(1)/16	Current use of classifications related to impairments, disabilities and handicaps (IDH) in health information systems, by D. Robinson
ICP/HST 010(1)/17	The use of IDH-classifications in health interview surveys, by J.T.P. Bonte
ICP/HST 010(1)/18	Experiences with the OECD long-term disability indicator: use in field-work and coding in IDH-categories, by J. Van den Berg and J.L.A. Van Sonsbeek
ICP/HST 010(1)/19	Use of IDH-classification in registration schemes for purposes of social security systems, by G. Hunfeld
ICP/HST 010(1)/20	The classification development group on disablement, by W.M. Hirs
ICP/HST 010(1)/21	Using the ICIDH in interview surveys, by M. de Kleijn-de Vrankrijker

Background papers

Wood, P.H.N. & Badley, E.M. *People with disabilities*. New York, World Rehabilitation Fund, Inc., 1980 (Monograph number twelve).

McWhinnie, J.R. *Measuring Disability*. Paris OECD, 1982 (The OECD social indicator development programme, Special Study No. 5).

Health statistics, report of the third joint ECE/WHO meeting (selected parts). Geneva, Economic Commission for Europe, 1982 (unpublished document, CES/AC.36/25–EURO/ICP/HST 010/25).

Glossary of terms, extracted from: Wood, P.H.N. The language of disablement, a *glossary* relating to disease and its consequences. *International Rehabilitation Medicine*, 2: 86–92 (1980).

Colvez, A. Proposals related to the classification of consequences of disease (original: French).