

Healthcare and the Biopsychosocial Model:
understand to act*O Cuidado em Saúde e o Modelo
Biopsicossocial: apreender para agir*

Healthcare involves a combination of personal decisions for human resources in health with the choice of Health Technologies (hard, light-hard, and light)⁽¹⁾. This choice should be as appropriate as possible to meet the actual needs of each patient. With an ever-increasing flow of health information, choosing cost-effective technologies from so many possibilities has been a challenge not only by human resources in health but also by managers.

Advances resulting from the relationship of proximity constructed between science and health, and also materialized in a “massive” contingent of technologies, have obviously brought unprecedented benefits to the population. These benefits are characterized and widely discussed in the theories of demographic and epidemiological transitions. However, regarding multidimensional matters such as Functioning, the understanding from purely biomedical knowledge has not been sufficient to meet health demands - characteristics of post-modern societies⁽²⁾.

In view of the exhaustion of the Biomedical Model - to meet a new demand that seeks not only to treat diseases but also to ensure higher health levels - there has been growing interest in the measurement and approach of Functioning over the past few years. There is a perception of the imminent need to complete information, widely-consolidated on biomedical rationality, about health conditions, including data that involve experiences regarding Body Functions and Structures, Activities, Participation, and Environmental and Personal Factors⁽³⁾. The theoretical framework of the “not so new” praxis is strongly portrayed in the Biopsychosocial Model.

If there is, currently, a group of health demands by patients, consequently there is a group of practices and knowledge that human resources in health articulate to meet these demands. Healthcare emerges in this summation of specific actions, which are at the same time interconnected with the different types of services. Humanized and comprehensive **Healthcare** are foreseen based on the Biopsychosocial Model focused on the real needs of patients, on the identification of the technologies available at each point of the assistance of the Lines of Care, as well as on the planned and agreed combination between those responsible for providing these resources. It is worth noting that the incorporation of Care Technology by the Biopsychosocial Model provides for solution of persistent deadlocks, such as the overuse of hard technologies; underutilization of light technologies and poor performance for inter-professional health work.

There is a growing interest in human resources in health in discussing the theme of the Biopsychosocial Model and its advantages⁽⁴⁾. It is opportune to go a step further and

Correspondence address:

Luciana Castaneda
Rede Brasileira de Pesquisa em
Funcionalidade, Instituto Federal de
Educação, Ciência e Tecnologia do Rio
de Janeiro – IFRJ
Rua Professor Carlos Wenceslau, 343,
Realengo, Rio de Janeiro (RJ), Brasil,
CEP: 21715-000.
E-mail: luciana.ribeiro@ifrj.edu.br

Received: December 17, 2018

Accepted: January 31, 2019

Study conducted at Instituto Federal de Educação, Ciência e Tecnologia do Rio de Janeiro – IFRJ - Rio de Janeiro (RJ), Brasil.

¹ Rede Brasileira de Pesquisa em Funcionalidade, Instituto Federal de Educação, Ciência e Tecnologia do Rio de Janeiro – IFRJ - Rio de Janeiro (RJ), Brasil.

Financial support: National Council for Scientific and Technological Development.

Conflict of interests: nothing to declare.



This is an Open Access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

materialize the discourse of the insufficiency and exhaustion of the Biomedical Model in professional practice and exercise-oriented to this overcoming. However, the literature has shown that there is a “gap” between the recognition of the importance of the Biopsychosocial Model and its effective incorporation⁽⁵⁾. It is only natural to imagine that an innovative paradigm shift will encounter difficulties and mishaps. The research questions that emerged in this essay were *How can the Biopsychosocial Model be operationalized?; How to withdraw from the “commonplace” associated only with recognition of the Biomedical Model exhaustion?*

The International Classification of Functioning, Disability, and Health (ICF) is a strong candidate to take the lead in providing a theoretical/practical framework that supports the construction of the paradigm shift. The possibilities of using the ICF converge to a homogeneous language about health information⁽⁶⁾, to a transformative orientation model for therapeutic planning⁽⁷⁾ and to a robust Functioning, Disability and Handicap information system⁽⁸⁾. This is an internationally accepted starting point and one that is strongly associated with the effort to create health systems aimed at reducing inequalities and at the perspective of providing comprehensive care.

The aforementioned forms of use of the ICF Biopsychosocial Model should not be considered exclusionary, but complementary. They depend not only on the use of human resources in health in “core activities”, but also on the support of managers and incorporation of Health Policies at the macro level. Driven by Functioning, Healthcare innovation strongly predicts the inclusion of cost-effective technologies, and this innovation is a central theme of national and international social security agencies. Nevertheless, as pointed out by Ayres⁽⁹⁾, Healthcare through the Biopsychosocial Model should be based on technologies, but never be controlled by them.

In spite of the endless possibilities of health technologies, “glaring” inequality gaps persist across and within countries, underscoring the collective failure to share health advances equitably. The incorporation of a look and the documentary record of the impact of health conditions on Functioning are increasingly fundamental for supply planning and achievement of Social Welfare, which ensures opportunities for positive experiences with the Functioning framework. Strategies for using the Biopsychosocial Model and Language to guide Functioning, without the need for initial and joint incorporation of the ICF codes, maybe a way to narrow the gap between the popularity and incorporation of this classification.

REFERENCES

1. Merhy E. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, editores. *Agir em saúde: um desafio para o público*. São Paulo: Hucitec; 1997.
2. Stucki G, Zampolini M, Jucevicius A, Negrini S, Christodoulou N. Practice, science and governance in interaction: European effort for the system-wide implementation of the International Classification of Functioning, Disability and Health (ICF) in Physical and Rehabilitation Medicine. *Eur J Phys Rehabil Med*. 2017;53(2):299-307. PMID:27882907.
3. Talo SA, Rytökoski UM. BPS-ICF model, a tool to measure biopsychosocial functioning and disability within ICF concepts: theory and practice updated. *Int J Rehabil Res*. 2016;39(1):1-10. <http://dx.doi.org/10.1097/MRR.000000000000151>. PMID:26756850.
4. Gonçalves AV, Jácome CIO, Demain SH, Hunt KJ, Marques ASPD. Burden of treatment in the light of the international classification of functioning, disability and health: a “best fit” framework synthesis. *Disabil Rehabil*. 2017;39(13):1253-61. <http://dx.doi.org/10.1080/09638288.2016.1194898>. PMID:27374769.
5. Stephenson R, Richardson B. Building an interprofessional curriculum framework for health: a paradigm for health function. *Adv Health Sci Educ Theory Pract*. 2008;13(4):547-57. <http://dx.doi.org/10.1007/s10459-006-9042-2>. PMID:17068658.
6. Madden RH, Glozier N, Fortune N, Dyson M, Gilroy J, Bundy A, et al. In search of an integrative measure of functioning. *Int J Environ Res Public Health*. 2015;12(6):5815-32. <http://dx.doi.org/10.3390/ijerph120605815>. PMID:26016438.
7. Harty M, Griesel M, Van der Merwe A. The ICF as a common language for rehabilitation goal-setting: comparing client and professional priorities. *Health Qual Life Outcomes*. 2011;9(1):87. <http://dx.doi.org/10.1186/1477-7525-9-87>. PMID:21978385.
8. Stucki G, Bickenbach J. Functioning: the third health indicator in the health system and the key indicator for rehabilitation. *Eur J Phys Rehabil Med*. 2017;53(1):134-8. PMID:28118696.
9. Ayres JR. Cuidado: tecnologia ou sabedoria prática? *Interface: Comunic, Saúde, Educ*. 2000;4(6):117-20. <http://dx.doi.org/10.1590/S1414-32832000000100010>.