This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

EDITORIAL

EUR J PHYS REHABIL MED 2012;48:179-88

Disability and human rights: The World Report on Disability as a unique opportunity to review and enrich European Health Policy

A. GIUSTINI [1], P. M. VON GROOTE [1], N. CHRISTODOULOU [2], X. MICHAIL [3], G. VANDERSTRAETEN [4]

[1]ISPRM WRD Implementation Committee
[2]President of the UEMS Section of Physical and Rehabilitation Medicine
[3]President of the European Society of Physical and Rehabilitation Medicine
[4]President of the European Academy of Rehabilitation Medicine

MINERVA MEDICA COPYRIGHT®

The World Report on Disability assembles the best available scientific information on disability to improve the lives of people with disabilities and facilitate implementation of the Convention of Rights for Persons with Disabilities.

It aims to:

— provide governments and civil society with a comprehensive analysis of the importance of disability and the responses provided, based on the best available evidence;

— recommend and support many national and international positive actions.

The moral compass and the theoretical framework

1) The United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, aims to "*promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity*".

It reflects the major shift in global understanding and responses towards disability and can in itself constitute an agenda toward full inclusion of people with disabilities in society

In any country and after adoption of this Convention , these contents, aims and indications are basis for laws and rules for financial and management decisions to make the rights of disabled people, including those of educational, social and rehabilitative interventions, concrete.

Corresponding author: A. Giustini, Rehabilitation Hospital S. Pancrazio, Arco (Trento), Italy. E-mail: alessandro.giustini@ntc.it

2) The International Classification of Functioning, Disability and Health (ICF) (39), adopted as the conceptual framework for this Report, defines disability as an umbrella term for impairments, activity limitations, and participation restrictions.

Disability refers to the negative aspects of the interaction between individuals with a health condition (such as cerebral palsy, spinal cord injury, depression) and personal and environmental factors (such as negative attitudes, inaccessible transportation systems and public buildings, and limited social supports).

The CRPD shows how its two central themes, disability and rights, are intimately interlaced: On one hand disability is a condition of life that is either permanent or temporary for millions of people [1-40] and on the other hand people with disabilities must be empowered and granted access to essential resources to be able to lead optimal lives.[8, 14-16] This moral and in the case of signatory countries to the Convention legal concreteness of this groundbreaking document is now becoming even more visible in both high resourced countries where the demand of rehabilitation, technologies, and advanced and in-

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

novative care has to adhere to criteria of scientific evidence base, sustainability and efficacy as well as in low and medium resourced countries where deep rooted and systemic interventions to construct simple services for health, prevention and rehabilitation are urgently needed.

The Report promotes different approaches to meeting these challenges. It hereby links the rights based approach to disability with two fundamental components behind successful inclusion and participation - the community and empowerment. This notion has been a long standing tradition in developmental studies and has been previously included in the concept of Community Based Rehabilitation.[41-44] Both components, community [36] and empowerment, essentially capture from the very distinct individual perspective and broader life areas every aspect of a person's own resources within the family and community in interplay with the social, culture and economic context, and the disability. Rehabilitation of the individual and more specifically the Physical Rehabilitation Medicine [5, 37] is impossible or completely ineffective without a prominent role of the community in any of its aspects - a fact the discipline has always recognized and reiterated recently.[7, 42]

Empowerment as the second component is both a state and process as it constitutes the enrichment and, continuous reinforcement of a person's evaluation and decisional capability as a precondition for his or her autonomy in relation to the health problem, the suggested intervention and beyond in the life course. .

It is an intrinsic part of PRM to look beyond the clinical setting and to see the whole person in interaction with the environment.[6, 20-22] PRM and its actors are thus in the unique position to pursue their scientific, political [1, 9, 10, 13, 31] and humanitarian mandates in taking an active role in promoting the central aspects of the report.[17, 43]

The report hereby advocates a valuable tool in describing disability in its multifaceted contexts. The International Classification of Functioning, Disability and Health (ICF) can serve as an evaluation and analysis tool of both the individual health condition and the interaction with the environment.[24, 27, 28, 34, 39] It offers the chance to observe, integrate and understand all elements that make up the person whilst at the same time and in one classification to describe the environment in which we live and how participatory elements play out their facilitating or inhibiting facet's. The ICF can therefore guarantee the necessary common framework for individual and community perspectives to be now directly linked to the human rights perspective. Moreover, the ICF can describe the socioeconomical,[14-16] scientific and clinically systematic approach to rehabilitation in any given country.[27, 28] Modern European societies founded their institutions and laws governing their affairs on human rights and principles now engraved in human rights charters and conventions. The principles and more specifically the WDR recommendations to adhere to these as are institutionally speaking laid out on common ground and should hence be completely applicable in the European health political context.

There are hereby many important steps to be taken that can support this process. For example, in the health sciences it needs to be demonstrated and actively advertised in how far the ICF contents is able in its detail and granularity to depict concrete and real life situations in their multidimensionality, including the human rights perspective. The ICF can thus connect the "traditional" scientific and medical approaches to health with the human right dimension

In particular for PRM the different anatomic-biological, functional and relational elements that were already known and are being dealt with, must and can be combined with the elements of context, personality and individuality of the subject, of his/her personal and medical story, as they contribute to defining the total prognosis of recovery (intrinsic and extrinsic) of a person's health condition. This would supersedea simple diagnosis [6, 19, 30] of the illness and a simple definition of disability as an impairment:

— disabily and participation restrictions_are visible and concrete demands for us and for the Community;

— science (research, evidence, efficacy, education...) [23, 27] is absolutely necessary but not sufficient to promote interventions;

— rights on the contrary are the indispensable motive power and the justifications for increasing investments.

The ICF can also be instrumental in creating effective, operational methodologies, combining the

MINERVA MEDICA COPYRIGHT®

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

expertise of health professionals, systems and service developers and managers and health policy decision makers that have to involved in implementing the report's recommendations. It already does so by presenting a framework which incorporates shared rehabilitative concerns that up till now have often been only seemingly divided into political, cultural, religious and economic expressions of disability and human rights.

Finally, it is of utmost importance that all relevant parties understand how problems related to disability are essentially problems of every citizen and society as a whole. Whether an underlying temporary or lasting health condition, across the lifespan, and independent of other concomitant societal influences, excluding disabled citizens has direct negative effects on the economic and financial productivity [2, 3, 32] and cultural, ethical, and unitarian components that make up successfully adapting and consequently demographically and ethnically evolving, prospering nations.[41] PRM specialists can offer their existing professional duty, knowledge and experience in helping people back into participating in society, empowering them by communicating problems and prospects and guiding other relevant partners throughout society in their efforts in implementing disabled people's rights.

World Report on Disability Launch in New York, 2011, June 2006.

"More than one billion people in the world live with some form of disability, of whom nearly 200 million experience considerable difficulties in functioning. In the years ahead, disability will be an even greater concern because its prevalence is on the rise. This is due to ageing populations and the higher risk of disability in older people as well as the global increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders. Across the world, people with disabilities have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities. This is partly because people with disabilities experience barriers in accessing services that many of us have long taken for granted, including health, education, employment, and transport as well as information. These difficulties are exacerbated in less advantaged communities.

To achieve the long-lasting, vastly better development prospects that lie at the heart of the 2015 Millennium Development Goals and beyond, we must empower people living with disabilities and remove the barriers which prevent them participating in their communities; getting a quality education, finding decent work, and having their voices heard. As a result, the World Health Organization and the World Bank Group have jointly produced this World Report on Disability to provide the evidence for progressive policies and programmes that can improve the lives of people with disabilities, and facilitate implementation of the United Nations Convention on the Rights of Persons with Disabilities, which came into force in May 2008.

This landmark international treaty reinforced our understanding of disability as a human rights and development priority. The World Report on Disability suggests steps for all stakeholders – including governments, civil society organizations and disabled people's organizations – to create enabling environments, develop rehabilitation and support services, ensure adequate social protection, create inclusive policies and programmes, and enforce new and existing standards and legislation, to the benefit of people with disabilities and the wider community.

People with disabilities should be central to these endeavours. Our driving vision is of an inclusive world in which we are all able to live a life of health, com-fort, and dignity. We invite you to use the evidence in this report to help this vision become a reality."

Mr Robert B Zoellick President World Bank Group
Dr Margaret Chan Director-General World Health Organization

"I welcome this first World Report on disability.

This report makes a major contribution to our understanding of disability and its impact on individuals and society. It highlights the different barriers that people with disabilities face – attitudinal, physical, and financial. Addressing these barriers is within our reach.

In fact we have a moral duty to remove the barriers to participation, and to invest sufficient funding and expertise to unlock the vast potential of people with disabilities. Governments throughout the world can no longer overlook the hundreds of millions of people with disabilities who are denied access to health, rehabilitation, support, education and employment, and never get the chance to shine.

The report makes recommendations for action at the local, national and international levels.

It will thus be an invaluable tool for policy-makers, researchers, practitioners, advocates and volunteers involved in disability. It is my hope that, beginning with the Convention on the Rights of Persons with Disabilities, and now with the publication of the World report on disability, this century will mark a turning point for inclusion of people with disabilities in the lives of their societies."

Professor Stephen W. Hawking

World Health Organisation, World Bank. World Report on Disability. Geneva. WHO; 2011.[45]

MINERVA MEDICA COPYRIGHT®

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

WRD indications in detail in 9 Recommendations

The evidence in this Report suggests that many of the barriers people with disabilities face are avoidable and that the disadvantages associated with disability can be overcome. The following nine recommendations for action are cross-cutting, guided by the more specific recommendations at the end of each chapter.

Implementing them requires involving different sectors – health, education, social protection, labour, transport, housing – and different actors – governments, civil society organizations (including disabled persons organizations), professionals, the private sector, disabled individuals and their families, the general public, the private sector, and media.

It is essential that countries tailor their actions to their specific contexts. Where countries are limited by resource constraints, some of the priority actions, particularly those requiring technical assistance and capacity building, can be included within the framework of international cooperation.

1. — Enable access to all mainstream systems and services.

People with disabilities have ordinary needs – for health and well-being, for economic and social security, to learn and develop skills. These needs can and should be met through mainstream programmes and services addressing the barriers that exclude persons with disabilities from participating equally with others in any activity and service intended for the general public, such as education, health, employment, and social services.

Mainstreaming also requires effective planning, adequate human resources, and sufficient financial investment – accompanied by specific measures such as targeted programmes and services .

2. — Invest in specific programmes and services for people with disabilities .

In addition to mainstream services, some people with disabilities may require access to specific measures, such as rehabilitation, support services, or training. Rehabilitation, including assistive technologies,vocational rehabilitation and training for work, improves functioning and independence

There is a need for more and better, more accessible, flexible, integrated and well coordinated,reviewed on effectiveness and efficiency , locally tested, multidisciplinary services,

3. — Adopt a national disability strategy and plan of action.

A national disability strategy sets out a consolidated and comprehensive long-term vision for improving the well-being of persons with disabilities and should cover both mainstream policy and programme areas and specific services for persons with disabilities. The development, implementation, and monitoring of a national strategy, even in the short and medium term should bring together the full range of sectors and stakeholders.

4. — Involve people with disabilities .

People with disabilities are entitled to control over their lives and therefore need to be consulted on issues that concern them directly – whether in health, education, rehabilitation, or community living. Supported decision-making may be necessary to enable some individuals to communicate their needs and choices. Disabled people's organizations may need capacity building and support to empower people with disabilities and advocate for their needs.

5. — Improve human resource capacity.

Human resource capacity can be improved through effective education, training, and recruitment. A review of the knowledge and competencies of staff in relevant areas can provide a starting point for developing appropriate measures to improve them. Relevant training on disability, which incorporates human rights principles, should be integrated into current curricula and accreditation programmes for current practitioners, strengthening the capacity of primary healthcare workers, and ensuring availability of specialist staff where required.

6. — Provide adequate funding and improve affordability.

Adequate and sustainable funding of publicly provided services is needed to ensure that they reach all targeted beneficiaries and that good quality services are provided. Contracting out service provision, fostering public-private partnerships, and devolving budgets to persons with disabilities for consumer-directed care can contribute to better service provision.

7. — Increase public awareness and understanding.

Mutual respect and understanding contribute to an inclusive society. Therefore it is vital to improve public understanding of disability, confront negative perceptions, and represent disability fairly. Collecting information on knowledge, beliefs, and attitudes about disability can help identify gaps in public understanding that can be bridged through education and public information involving the media together Governments, voluntary organizations and professional associations

8. — Improve disability data collection.

Internationally, methodologies for collecting data on people with disabilities need to be developed, tested cross-culturally, and applied consistently to enrich the benchmark and monitor progress on disability policies for the implementation of the CRPD nationally and internationally.

Nationally, disability should be included in data collection. Uniform definitions of disability, based on the ICF, can allow for internationally comparable data. Dedicated disability surveys can also gain more comprehensive information on disability characteristics, such as prevalence, health conditions associated with disability, use of and need for services, quality of life, opportunities, and rehabilitation needs.

9. — Strengthen and support research on disability.

Research is essential for increasing public understanding about disability issues, informing disability policy and programmes, and efficiently allocating resources. This Report recommends areas for research on disability including the

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

impact of environmental factors (policies, physical environment, attitudes) on disability and how to measure it; the quality of life and well-being of people with disabilities; what works in overcoming barriers in different contexts; and the effectiveness and outcomes of services and programmes for persons with disabilities. A critical mass of trained researchers on disability needs to be built.

World Health Organisation, World Bank. World Report on Disability. Geneva. WHO; 2011.[45]

Each of these recommendations can be directly related to a process of enriching the horizon of both the systems level of for instance European health services and the community, of living together in equality.[1, 12] Equally glaring challenges appear in terms of addressing financial requirements to bolster efforts in mainstreaming, investing and strengthening systems and services. Years of economic crisis tear down budgets and force governments to prioritize In addition demographic and epidemiological changes and increasing incidence of disability as a whole pose financial constraints on old systems. Investments in times of crisis even more request to well defined efficacy and effectiveness of services and interventions in any given field and not only in Health. Here research and years of experience offer [6, 23, 38] strong arguments to create and present evidence to policy makers not only on medical interventional aspects but much more regarding participation and related aspects for the person and for the community.

Discussion

What we have done what we can do

The Report makes detailed suggestions of the most important steps and tools to be applied in addressing disabling barriers (to rehabilitation, education ,employment...) and consequently inequalities faced by people with disabilities. Explanations on how much these are necessary and useful speak a clear language that is comprehensible and applicable worldwide and especially in Europe in regard to the structure of Community, of social and institutional organization.

For physical and rehabilitation professionals and PRM specialists it should immediately be clear how all of these aspects relate to their role in the ICF based vision for PRM - a specific and active role, applying the new perspectives for our tasks [17, 18, 25, 26, 29, 35, 43] of PRM in the Community, combining our scientific, clinical and management role in Health Services and in social integration. This role enables the translation of the WRD recommendations to the European contexts and the facilitation of their implementation. The WRD is mainly directed at Governments, but at the same time to the different institutional sectors and social, cultural, medical-scientific, religious, formative, sanitary, social organisations, both public and private, and to the voluntary service and to people with or without disabilities and their families. Involving multiple actors in joint action will help meet multifaceted challenges.

Understanding the diversity of European countries and of the starting conditions for life and rehabilitation for people with disabilities, the aim needs to be to build and lead a broad campaign which can progressively enable everyone to a level of autonomy and social and private participation satisfactory to the person and the CRDP's legal requirements.

Scientific evidence of every social-medical and economic intervention needs to be collected and serviced to be up to date, in order to describe every disability in terms of prevention and rehabilitation and provide valid information to policy maker, systems administrators and providers.

Another qualifying point is when the Report states that investing in Rehabilitation, making conditions for and improving autonomy and participation for all the people with a disabilities, creates wealth for the community and for the countries who do so: the World Bank for Development states it as a growth indicator for all countries, even the poorest ones.

The most significant problem remains that of awareness: in the poorest countries that have parallel sanitary systems less advanced and less developed on the scientific, formative and operative level, there is the tendency to use the scarce resources to give "stopgap solutions" to the worse disability conditions, without the aim to substantially modify the disability itself and the real conditions of people's life. Contributions, assistance, services such as telephone, transports, aids, are given without being included in a real rehabilitation program often with financial and logistical support by no-governmental and aid organizations.

Awareness raising must aim to influence govern-

MINERVA MEDICA COPYRIGHT®

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

ments decisions recognizing that comprehensive rehabilitative interventions are part of the core and primary rights of citizens and that they have to be considered a community and government's priority. A national rehabilitation plan is then the most important prerequisite to effectively and efficiently implement these rights by means of planned, monitored and evaluated interventions.[41, 43]

This fundamental, universal goal and global vision places special attention on European Countries already marked by expectations for full compliance with the CRPD by deliberate implementation of the WRD's recommendations: in this region there are strong historical rehabilitation foundations based on scientific, sociocultural and ethical experience; there is also a developing and sometimes well routed awareness of and common understanding of the responsibilities derived from disabled people`s rights; the lived experience of people with disabilities of full participation in the Community light the way and the systems, services and health professional knowledge of supports and interventions to establish successful reintegration already exist; and the understanding of the need for sufficient economical investments and the financial advantage of these investments for society as a whole is being increasingly heard.

In addition, the education of professionals [5, 11, 27, 37] in any given field needed (health , social, cultural, school, mobility and work) that the WRD recommends is already established and increasing efforts in funding, disability mainstreaming and revising curricula in light of the CRPD can be directly implemented into existing educational systems and environments.

Moreover, in Europe Disabled Peoples Organisations (DPO), as essential partners of any efforts to implement the CRPD, have a long standing history of challenging established barriers and successfully advocating for change.

Yet, challenges still remain and are now becoming ever more evident in light of the WRDs analysis and recommendations for action. The main shortcomings are the limited or even lack of sufficient resources involved in the rehabilitation activities in many countries. Even in the most technically advanced and rich countries these are not always suitable to the real needs and to the potentialities of recovery and autonomy of persons with disabilities. However, and maybe the worst and most important shortcoming is the awareness of how much rehabilitative intervention can modify health and disability conditions that are on the contrary unfortunately still often considered as something unchangeable, like a scar.

European Countries should therefore be able to show how they intend to fill the gaps the Report highlights and how the recommendations can be addressed. Any country, how resourced they may be, should be able to progressively and effectively change the situation on the ground. Europe however cannot draw back from the table whilst having the best possible hand in the game.

The goals cannot forgotten if they are pursued by governments, involving people with disabilities, monitored by independent institutions, consulting relevant partners and experts like PRM specialists and investing in education, services and systems and research. The WRD consequently calls upon governments to take action and for instance establish national rehabilitation plans. An essential role in Europe and in joint forces with the other health professionals, policy makers, systems and services developers and provides hereby lies with PRM as the Report acknowledges.[41, 43] In defining PRM as being "concerned with improving functioning through the diagnosis and treatment of health conditions, reducing impairment and preventing or treating complications" the report highlights the comprehensive role of PRM in enhancing the participation of people with disabilities.[41, 43]

Given the global lack of rehabilitation professionals, more training capacity is needed. Coordination is required to ensure quality and continuity of care, especially when more than one provider is involved in rehabilitation. More research on rehabilitation in different context are needed.

Research on rehabilitation has several characteristic that differ fundamentally from biomedical research: for example it is difficult to measure the global outcome rehabilitation , as much as it tends to evaluate behaviour and not a single biological parameter.

In this sense, research in rehabilitative medicine does not focus only on the organ damage, but on the reduction of the disability, which is obtained both through direct intervention on the function or structure, as well as through suitable strategies to reduce the limitations and restrictions in participation, obtained even and above all by addressing interac-

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

tion between the person and his context, placing the person at the centre of action. (Italian National Rehabilitation Plan – EJPRM 2012, in press).

Hopefully, and Europe has a specific responsibility, an interdisciplinary research activity with the objective of contributing to the following aspects must be implemented and promoted:

— defining instruments of measurement according to the "International Classification of Functioning of the WHO, which are essential in the construction of specific indicators for rehabilitation;

— identifying valid protocols of inclusion and reintroduction of the patient in his family and social environment;

— identifying strategies and methodologies of evaluation of the adaptation and inclusion/reintroduction in the work or scholastic environment;

— developing new organisational models for the integration of the various resources (internal and external to the public and private health system), in order to guarantee efficiency within the system;

— identifying and validating criteria of appropriateness of the rehabilitation itineraries and indicators of effectiveness and efficiency of the process.

European National Health Services, together European Union Research Authorities can promote a large project to improve these aims in research to solve this problems, according the evidence-based rules but covering the specific and wide rehabilitation field.

It is also indispensable in terms of "demand" in Europe, be able to offer suitable, effectiveness and sustainable solutions to the people actually and in the future.

Moreover, given the fact that rehabilitation intervention aims to involve the entire person in his globality, the evaluation of indicators of the outcome is particularly difficult. This situation is further aggravated by the complexity of every individual case, which makes it problematic to apply methodologies of research that are normally used in other disciplines; this has given rise to the possible use of the "case by case" methodology, providing the scientific method is used.

It has therefore become essential to enhance "research capabilities" in rehabilitation, understood as the process of individual and institutional development leading to a higher level of knowledge and greater ability in conducting profitable research.

As the Report and scientific research demonstrates, the investment in rehabilitative services, in aids and other technologies for integration autonomy has to grow. Research ultimately has shown the benefits of PRM.[41] Much needed further investment into rehabilitation research will give answers to pressing questions of diverse and aging societies.[41] Finally, evidence of effective interventions has to be presented in a way policy makers can use to take necessary steps.[43, 45]

Goals for our activities regarding different responsibilities in Europe

National Governments and EU Commission can:

— Review and revise existing legislation and policies for consistency with the CRPD; review and revise compliance and enforcement mechanisms.

— Review mainstream and disability-specific policies, systems, and services to identify gaps and barriers and to plan actions to overcome them.

— Develop a national disability strategy and action plan, establishing clear lines of responsibility and mechanisms for coordination, monitoring, and reporting across sectors.

— Regulate service provision by introducing service standards and by monitoring and enforcing compliance.

— Allocate adequate resources to existing publicly funded services and appropriately fund the implementation of the national disability strategy and plan of action.

— Adopt national accessibility standards and ensure compliance in new buildings, in transport, and in information and communication.

— Introduce measures to ensure that people with disabilities are protected from poverty and benefit adequately from mainstream poverty alleviation programmes.

— Include disability in national data collection systems and provide disability-disaggregated data wherever possible.

— Implement communication campaigns to increase public knowledge and understanding of disability.

— Establish channels for people with disabilities and third parties to lodge complaints on human rights issues and laws that are not implemented or enforced.

United Nations agencies and development organizations can:

— Include disability in development aid programmes, using the twin-track approach.

— Exchange information and coordinate actions – to agree on priorities for initiatives, to learn lessons and to reduce duplication of effort.

— Provide technical assistance to countries to build capacity and strengthen existing policies, systems and services – for example, by sharing good and promising practices.

MINERVA MEDICA COPYRIGHT®

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

— Contribute to the development of internationally comparable research methodologies.
— Regularly include relevant disability data into statistical publications.

Disabled people's Organizations can:

— Support people with disabilities to become aware of their rights, to live independently, and to develop their skills.
— Support children with disabilities and their families to ensure inclusion in education.
— Represent the views of their constituency to international, national, and local decision-makers and service providers, and advocate for their rights.
— Contribute to the evaluation and monitoring of services, and collaborate with researchers to support applied research that can contribute to service development.
— Promote public awareness and understanding about the rights of persons with disabilities – for example, through campaigning and disability-equality training.
— Conduct audits of environments, transport, and other systems and services to promote barrier removal.

Service providers can:

— Carry out access audits, in partnership with local disability groups, to identify physical and information barriers that may exclude persons with disabilities.
— Ensure that staff are adequately trained in disability, implementing training as required and including service users in developing and delivering training.
— Develop individual service plans in consultation with disabled people, and their families where necessary.
— Introduce case management, referral systems, and electronic record-keeping to coordinate and integrate service provision.
— Ensure that people with disabilities are informed of their rights and the mechanisms for complaints.

Academic institutions can:

— Remove barriers to the recruitment and participation of students and staff with disabilities.
— Ensure that professional training courses include adequate information about disability, based on human rights principles.
— Conduct research on the lives of persons with disabilities and on disabling barriers, in consultation with disabled people's organizations.

The private sector can:

— Facilitate employment of persons with disabilities, ensuring that recruitment is equitable, that reasonable accommodations are provided, and that employees who become disabled are supported to return to work.
— Remove barriers of access to microfinance, so that persons with disabilities can develop their own businesses.
— Develop a range of quality support services for persons with disabilities and their families at different stages of the life cycle.
— Ensure that construction projects, such as public accommodations, offices and housing include adequate access for persons with disabilities.
— Ensure that information and communication technology products, systems, and services are accessible to persons with disabilities.

Communities can:

— Challenge and improve their own beliefs and attitudes.
— Promote the inclusion and participation of disabled people in their community.
— Ensure that community environments are accessible for people with disabilities, including schools, recreational areas, and cultural facilities.
— Challenge violence against and bullying of people with disabilities.

People with disabilities and their families can:

— Support other people with disabilities through peer support, training, information, and advice.
— Promote the rights of persons with disabilities within their local communities.
— Become involved in awareness-raising and social marketing campaigns.
— Participate in forums (international, national, local) to determine priorities for change, to influence policy, and to shape service delivery.
— Participate in research projects.

World Health Organisation, World Bank. World Report on Disability. Geneva. WHO; 2011.[45]

Conclusions

PRM specialists, together with other professionals (in health, social services, education, mobility, employment and work, etc.), with DPOs and other civil societal organizations have the responsibility to help reach these goals as soon as possible. Their professional role is of key importance; their professional field can be actively involved in this positive development in any European country. In particular European PRM Societies are called upon to proactively lead efforts in the coming years in: educating coming PRM generations with disability mainstreamed curricula; advocating and forming CRPD based national rehabilitation plans by consulting governments, services and systems developers and providers; reaching out

MINERVA MEDICA COPYRIGHT®

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

to communities in caring for people with disabilities (social services, civil society organizations); strengthening collaborations and exchange with the other health professional organizations in coordinating efforts (WCPR, WFOT, ISCPO and their European corresponding associations); and including people with disabilities in planning steps to fulfilling their rights as set out in the CRPD by implementing the recommendations made by the WRD.

Epub ahead of print on April 17, 2012.

References

1. A coherent policy for people with disabilities. Recommendation R (92) 6. Council of Europe. Strasbourg; 1992.
2. Canberra, Australian Bureau of Statistics, 2004 Disability, ageing and carers: summary of findings, 2003 (No. 4430.0) [Internet]. Available at http://tinyurl.com/ydr4pbh [cited 2009, Dec 9].
3. Disability supports in Canada, 2001: participation and activity limitation survey. Ottawa, Statistics Canada, 2001. [Internet]. Available at http://www.statcan.ca/english/freepub/89-580-XIE/help.htm [cited 2007, Aug 30].
4. Haualand H, Allen C. Deaf people and human rights. Helsinki, World Federation of the Deaf and Swedish National Association of the Deaf, 2009. Core Sets. J Rehabil Med 2004;4(Suppl):7-8.
5. Giustini A. From acute intervention to domiciliary and social integration: research to build Community-Based Rehabilitation (CBR) on effectiveness". Int J Rehab Res 2004;27(Suppl. 1):44-5.
6. Giustini A. Certainties and prospects in PRM. EuraMedicoPhys 2005;41:215-9.
7. Gutenbrunner C, Meyer T, Melvin J, Stucki G. A conceptual description of Physical and Rehabilitation Medicine – Towards an internationally accepted conceptual description of Physical and Rehabilitation Medicine. J Rehabil Med 2011;43:760-4.
8. Living with disability in New Zealand: a descriptive analysis of results from the 2001 Household Disability Survey and the 2001 Disability Survey of Residential Facilities. Wellington, New Zealand Ministry of Health; 2004
9. Kennedy J. Unmet and under met need for activities of daily living and instruental activities of daily living assistance among adults with disabilities: estimates from the 1994 and 1995 disability follow-back surveys. Medical Care 2001;39:1305-12.
10. Krauth C, Hessel F, Klingelhöfer HE, Schwelkert B, Hansmeier T, Wasem J. [Health Economic Evaluation of Rehabilitation Programmes in the "Rehabilitation Science" Research Funding Programme in Germany]. Rehabilitation (Stuttg) 2005;44:297-306.
11. McFarlane L, McLean J. Education and training for direct care workers. Social Work Education 2003,22:385-99.
12. Michailakis D. Government action on disability policy: a global survey. Stockholm, Institute on Independent Living, 1997 [Internet]. Available at (http://www.independentliving.org/standardrules/UN_Answers/ UN.pdf [cited 2010, Feb 9].
13. Rehabilitation and integration of people with disabilities: policy and integration. Strasbourg: Council of Europe Publishing, 7th edition: 2003; p 369.
14. Regional report of the Americas 2004. Chicago, IL, International Disability Rights Monitor, 2004. [Internet]. Available at (http://www.idrmnet.org/content.cfm?id=5E5A75andm=3 [cited 2010, Feb 9].
15. Regional report of Asia 2005. Chicago, IL, International Disability Rights Monitor, 2005. [Internet]. Available at http://www.idrmnet.org/content.cfm?id=5E5A75andm=3 [cited 2010, Feb 9].
16. Regional report of Europe 2007. Chicago, IL, International Disability Rights Monitor, 2007. [Internet]. Available at http://www.idrmnet.org/content.cfm?id=5E5A75andm=3 accessed 9 February 2010.
17. Reinhardt JD, von Groote PM, DeLisa JA, Melvin JL, Bickenbach. JE, Li LSW, et al. Chapter 3: International non-governmental organizations in the emerging world society: The example of ISPRM. J Rehabil Med 2009; 41: 810–822.
18. Reinhardt JD, von Groote PM, DeLisa JA, Melvin JL, Bickenbach. JE, Stucki G. Chapter 4: A policy process and policy tools for international non-governmental organizations in the health sector using ISPRM as a case in point. J Rehabil Med 2009; 41: 823–832.
19. Sickness, disability and work: breaking the barriers. A synthesis of findings across OECD countries. Paris, Organisation for Economic Co-operation and Development, 2010.
20. Steiner WA, Ryser L, Huber E, Uebelhart D, Aeschlimann A, Stucki G. Use of the ICF model as a clinical problem-solving tool in physical therapy and rehabilitation medicine. Phys Ther 2002;82:1098-107.
21. Stucki G, Ewert T, Cieza A. Value and application of the ICFin rehabilitation medicine. Disabil Rehabil 2002;24:932-8.
22. Stucki G, Kroeling P. Principles of rehabilitation. In: Hochberg MC, Silman AJ, Smolen JS, Weinblatt ME, Weisman M H, editors. Rheumatology. 3rd edition. Vol. 1. Edinburgh: Mosby; 2003. p. 517-30.
23. Stuki G, Giustini A. European PMR journals in concert. Eur J Ohys Rehabil Med 2008;3:229-37.
24. Stucki G, Grimby G. Applying the ICF in medicine. J Rehabil Med 2004;44(Suppl):5-6.
25. Stucki G, Reinhardt JD, von Groote PM, DeLisa JA, Imamura M, Melvin JL. Chapter 2: ISPRM's way forward. J Rehabil Med 2009;41:798-809.
26. Stucki G, Reinhardt JD, Imamura M, Li J, De Lisa JA. Developing. the International Society of Physical and Rehabilitation Medicine (ISPRM): Following through. J Rehabil Med 2011;43:1-7.
27. Stucki G, Reinhardt JD, Grimby G, Melvin J. Developing "human functioning and rehabilitation research" from the comprehensive perspective. J Rehabil Med 2007;39:665-71.
28. Stucki G, Cieza A, Melvin J. The International Classification of Functioning, Disability and Health: a unifying Model for the Conceptual Description of the Rehabilitation Strategy. J Rehabil Med 2007;39:279-85.
29. Stucki G, von Groote PM, DeLisa JA, Imamura M, Melvin JL, Haig AJ *et al.* Chapter 6 : The policy agenda of ISPRM. J Rehabil Med 2009;41:843-52.
30. Supports and services for adults and children aged 5–14 with disabilities in Canada: an analysis of data on needs and gaps. Ottawa, Canadian Council on Social Development, 2004. [Internet]. Available at http://www.socialun-ion.ca/pwd/title.html [cited 2007, Aug 30].
31. Testing a disability question for the census. Canberra, Family and Community Statistics Section, Australian Bureau of Statistics; 2003.
32. The global burden of disease: 2004 update. Geneva, World Health Organization; 2008.
33. Understanding the health-care needs and experiences of people with disabilities. Menlo Park, CA, Kaiser Family Foundation, 2003 United Nations Children's Fund, University of Wisconsin.
34. Ustun B, Chatterji S, Kostanjsek N. Comments from WHO for the Journal of Rehabilitation Medicine Special Supplement on ICF.
35. Von Groote PM, Reinhardt JD, Gutenbrunner C, DeLisa JA, Mel-

This document is protected by international copyright laws. No additional reproduction is authorized. It is permitted for personal use to download and save only one file and print only one copy of this Article. It is not permitted to make additional copies (either sporadically or systematically, either printed or electronic) of the Article for any purpose. It is not permitted to distribute the electronic copy of the article through online internet and/or intranet file sharing systems, electronic mailing or any other means which may allow access to the Article. The use of all or any part of the Article for any Commercial Use is not permitted. The creation of derivative works from the Article is not permitted. The production of reprints for personal or commercial use is not permitted. It is not permitted to remove, cover, overlay, obscure, block, or change any copyright notices or terms of use which the Publisher may post on the Article. It is not permitted to frame or use framing techniques to enclose any trademark, logo, or other proprietary information of the Publisher.

vin JL, Bickenbach JE *et al*. Chapter 5: Organizational structures suited to ISPRM's evolving role as an international non-governmental organization in official relation with the World Health Organization. J Rehabil Med 2009;41:833-42.
36. Wade DT. Community rehabilitation, or rehabilitation in the community? Disabil Rehabil 2003;25:875-81.
37. Wade DT. Investigating the effectiveness of rehabilitation professions—a misguided enterprise? Clin Rehabil 2005;19:1-3.
38. Ward AB. Physical and Rehabilitation Medicine in Europe. J Rehabil Med 2006;38:81-6.
39. World Health Organisation. International Classification of Functioning, Disability and Health: ICF: Geneva: WHO; 2001.
40. World Health Survey. Geneva, World Health Organization, 2002–2004 [Internet]- Available at http://www.who.int/healthinfo/survey/en/ [cited 2009, Dec 9].
41. World Health Organisation, World Bank. World Report on Disability. Geneva. WHO; 2011.
42. Meyer T, Gutenbrunner C, Bickenbach J, Cieza A, Melvin J, Stucki G. Towards a shared conceptual description of rehabilitation as a health strategy. J Rehabil Med 2011;43:765-9.
43. Von Groote PM, Bickenbach JE, Gutenbrunner C. The World Report on Disability – implications, perspectives and opportunities for physical and rehabilitation medicine (PRM). J Rehabil Med 2011;43:869-75.
44. World Health Organization, United Nations Educational, Scientific and Cultural Organization, International Labour Organization, International Disability and Development Consortium. Community-based rehabilitation: CBR guidelines. Geneva, World Health Organization, 2010.
45. World Health Organisation, World Bank. World Report on Disability. Geneva. WHO; 2011.
46. Lavis JN, Oxman AD, Lewin S, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP). Health Research Policy and Systems 2009;(Suppl 1):I1.

MINERVA MEDICA COPYRIGHT®