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LETTER TO THE EDITOR

RE: ISPRM DISCUSSION PAPER: PROPOSING DIMENSIONS FOR AN INTERNATIONAL CLASSIFICATION SYSTEM FOR SERVICE ORGANIZATION IN HEALTH-RELATED REHABILITATION

Since rehabilitation is perceived as one of the 4 main health strategies it has become one of the most important tools for overcoming disability in persons with health conditions (1). Healthcare delivery is confronted with the emerging problem of chronic conditions, with a growing group of patients with multi-morbidity, and an increasing social gradient in health (2). We acknowledge, with great respect, the discussion paper by Gutenbrunner et al. (3), and wish to thank the authors and expert groups for developing this classification system. The discussion paper meets the growing demand for a clear system to classify rehabilitation services worldwide. It creates opportunities for rehabilitation settings to describe their services based on a list of dimensions and categories. At the same time it fulfils the need of different rehabilitation services to explore their true identity.

We do not question the value and the importance of this classification system, but request that the authors consider an additional category for the provider dimension: *"Rehabilitation competences"*, ranging from expert skills in the treatment of short-term biomedical issues to expert skills in coaching towards adaptation and self-management in dealing with long-term psychosocial issues. The rationale for proposing this additional category is based on the result of a study of the experiences of patients regarding their rehabilitation process, in which the patients acknowledge both sets of competences to be of great value, but only when the professional is able to make a flexible shift from one role to the other and at the time the patient is ready for it (4). Patients expect an authority with regard to short-term issues and a partner or coach with regard to long-term issues. Adding the category of *"rehabilitation competences"* could help in determining what specific type of professional is needed for service delivery; an authority with regard to biomedical issues or more of a partner when it comes to psychosocial issues. In addition, there would be a strong impetus for educational programmes in rehabilitation sciences to focus on this 2-body practice and prepare future rehabilitation professionals in both sets of competences. Rather, the discussion remains that these 2 sets of competences are fundamentally different and that it might be difficult to be an expert in both. In rhetoric, rehabilitation professionals should be masters of both sets of competences, but, in reality, professionals tend towards one side in most situations. Thus, it might be difficult to combine the authority role and the coach role, and it remains unclear whether these 2 sets of competences should be combined in a single professional or should be embodied by 2 different professionals. However, at the same time, this stresses the importance of adding it as a separate category. The main reason for adding this extra category lies in the importance of acknowledging the 2-body practice described above, emphasizing the urgency of training rehabilitation professionals accordingly. Adding this category strengthens the other categories described in the domain of service delivery: rehabilitation strategy, the service goals and the aspect of time, in which there is a strong correlation with the required competences. Thus the biopsychosocial paradigm, upon which the International Classification of Functioning, Disability and Health (ICF) is built, is emphasized more strongly in the rationale of this classification system.

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