

## ISPRM DISCUSSION PAPER

### CHAPTER 6: THE POLICY AGENDA OF ISPRM

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#### SUMMARY

*This paper suggests a comprehensive policy agenda and first steps to be undertaken by the International Society of Physical and Rehabilitation Medicine (ISPRM) in order to realize its humanitarian, professional and scientific mandates. The general aims of ISPRM, as formulated in its guiding documents, the relations with the World Health Organization (WHO) and the United Nations system, and demands of ISPRM's constituency herein form the basis of this policy agenda. Agenda items encompass contributions to the establishment of rehabilitation services worldwide and the development of rapid rehabilitation disaster response, the enhancement of research capacity in Physical and Rehabilitation Medicine (PRM), and the development of PRM societies. ISPRM's possible input in general curricula in disability and rehabilitation, and in fighting discrimination against people experiencing disability are discussed. Moreover, the implementation of the International Classification of Functioning, Disability and Health (ICF) in medicine, contributions to WHO guidelines relevant to disability and rehabilitation, the provision of a conceptual description of the rehabilitation strategy and the outline of a rehabilitation services matrix are seen as important agenda items of ISPRM's external policy. With regard to its constituency and internal policy, a definition of the field of competence and a conceptual description of PRM, as well as the development of a consistent and comprehensive congress topic list and congress structure appear to be crucial items. The proposed agenda items serve as a basis for future discussions.*

#### INTRODUCTION

The basis for the International Society of Physical and Rehabilitation Medicine's (ISPRM) international role in Physical and Rehabilitation Medicine (PRM) and rehabilitation is a comprehensive internal policy agenda in relation to its constituency, and an external policy agenda in relation to international institutions including the World Health Organization (WHO),

the United Nations (UN) and other non-governmental organizations (NGOs) in official relation with WHO (1–3). Both sets of policies may be influenced from the outside as well as from the inside of the organization (1). They differ analytically, but in practice are often intertwined.

ISPRM's guiding documents, the By-laws (4), the Policy and Procedures (5) and the WHO/ISPRM collaboration plan (6) serve as a framework for the development of the policy agenda. They are aligned with the guiding documents of the Disability and Rehabilitation (DAR) team at WHO and DAR's Action Plan (7) and priorities (8), since ISPRM is an NGO in official relation with WHO (1, 9, 10). Beyond that, the main anchor point for ISPRM's policy agenda is the UN. In other chapters of this special issue on international perspectives in rehabilitation (1, 3, 9, 10) we have described basic features of the world societal environment within which ISPRM operates, policy processes and tools at the disposal of ISPRM, and organizational structures suited to ISPRM's evolving role.

The objective of this chapter is to describe ISPRM's current and emerging internal and external policy agenda. The specific aims are to describe the rationale of each agenda item, to outline the current status of ISPRM activity, and to discuss the next steps ISPRM can take to reach its policy objectives.

#### EXTERNAL POLICY AGENDA

A distinction is made between agenda items set by the UN system or from the outside and agenda items set by ISPRM itself or from the inside.

From the outside ISPRM's external policy agenda is currently driven by 3 developments in the UN and WHO context: (i) the implementation process of the UN Convention on the Rights of Persons with Disabilities (in the following called UN Convention (11)); (ii) the call by the World Health Assembly (WHA) Resolution on Disability and Rehabilitation (in the

following called WHA Resolution) to expand rehabilitation capacity (12); and (iii) the implementation of the International Classification of Functioning, Disability and Health (ICF) (13) into medicine and, more specifically, into rehabilitation (14–17).

From the inside ISPRM's external policy agenda is driven by the need: (i) to conceptualize rehabilitation as a health strategy based on the ICF and relevant to all health professions; and (ii) to develop an internationally shared understanding of the principles of rehabilitation services provision along the continuum of care and within the broader perspective of health services and care delivery.

#### *Supporting the establishment of rehabilitation services worldwide*

*Rationale of agenda item.* The WHA Resolution stresses “that 80% of people with disabilities, particularly in the child population, live in low-income countries and that poverty further limits access to [...] rehabilitation services [...]” (12). The WHA resolution thus requests the Director General of WHO “[...] to provide support to Member States in strengthening national rehabilitation programmes [...]”, and urges member states “[...] to promote [...] full physical, informational, and economic accessibility [...] to health and rehabilitation services [...]”. By the same token, the UN Convention recognizes “[...] the importance of accessibility [...] to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms [...]”, and requests that states parties “shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services” (11). The UN convention also recognizes “the importance of international cooperation for improving the living conditions of persons with disabilities in every country, particularly in developing countries [...]” (11). ISPRM, as an NGO in official relation with WHO, is therefore requested to address these issues.

*Status of ISPRM activities.* In the past, ISPRM has contributed to WHO DAR's Community Based Rehabilitation (CBR) guidelines, the WHO Violence and Injury Prevention trauma guidelines, and the World Report on Disability and Rehabilitation (2). Also, ISPRM is contributing to a WHO report on “International Perspectives in Spinal Cord Injury” (IPSCI) (18) which reviews the current situation of spinal cord injury rehabilitation and beyond.

A set of activities is evolving in the context of the newly established network of professional organizations in official relation with WHO's DAR team. In a meeting of the DAR professional organizations network during the 61<sup>st</sup> WHA assembly in 2008, in which ISPRM participated, the need to develop a document outlining the minimum requirements to build a national rehabilitation programme covering all specializations (Physical Therapy, Occupational Therapy, PRM, etc)” was recognized. A “needs assessment for physical rehabilitation services in developing countries” was called upon, as well as

the development of “guidelines for service provision”, and guidelines for people with disabilities “and their role in their own care, in line with CRPD (Convention on the Rights of Persons with Disabilities; the authors (11)) Article 26” (19). A meeting to build consensus on the next steps was envisioned. Furthermore, “educational programs so that services are available in rural districts” are planned and the development of consulting capacity of policy makers in rural areas and outreach support were seen as targets of joint activities (19).

*Next steps.* In addition to the described and ongoing activities in collaboration with DAR and its professional organizations network, ISPRM may commission a discussion paper on the agenda item. The paper could review the current situation of PRM in the provision of rehabilitation services in low resourced settings and discuss how ISPRM can support the work of PRM physicians in these areas. The paper could also explore possible collaborations with other organizations involved in fostering rehabilitation services provision in low resource countries, such as the International Society of Prosthetics and Orthotics (ISPO) and the International Rehabilitation Forum (20). Considering the importance of the issue, ISPRM may consider the formation of a committee.

#### *Developing rapid rehabilitation response to natural and man-made disasters*

*Rationale for agenda item.* War, terrorism, civil unrest, epidemics, earthquakes, flooding and storms may result in a sudden onslaught of huge numbers of catastrophic and disabling injuries. National governments, NGOs, and the UN develop sophisticated plans to respond to disasters. Rapid rehabilitation response and specific strategies to protect and evacuate people with disabilities are important elements of complete disaster response programmes. Governmental plans seldom recognize the acuity of medical rehabilitation. The responses to recent disasters ranging from the Indonesian tsunami (21, 22) to the wars in Iraq and Afghanistan (23–25) involved limited efforts to provide acute medical rehabilitation for the local populations. Conversely, in the earthquake in China in May 2008 the rehabilitation perspective was considered from the first day, and PRM physicians including members of ISPRM were involved in the planning and execution of the rescue effort.

*Status of ISPRM activities.* In the WHO DAR professional organizations meeting this agenda item has been identified as an important issue. The World Federation of Occupational Therapists reported on ongoing activities (19).

*Next steps.* In addition to the ongoing activities in collaboration with DAR and its professional organizations network ISPRM may commission a discussion paper on the agenda item. The paper could review PRM's role in rehabilitation service provision in recent disasters, discuss lessons learned and outline how the rehabilitation perspective can be enhanced in organizations involved in disaster response. Such a paper could serve as input from PRM's perspective for the respective ongoing DAR activity.

*Enhancement of research capacity*

*Rationale for agenda item.* The WHA resolution urges member states to “develop their knowledge base” and particularly highlights the “importance of reliable information on various aspects of disability prevention, rehabilitation and care” (12). In this it is clearly recognized that “today’s investments in rehabilitation research are investments in improved rehabilitation care in the future” (26).

The challenges to build research capacity have been summarized in 2 recent initiatives, the Rehabilitation Summit in the USA (27) and an initiative by the *Journal of Rehabilitation Medicine* (JRM) to conceptualize, organize and develop human functioning and rehabilitation research based on the ICF as a unifying model (28, 29). The latter is in line with the notion by WHO’s DAR team that the “ICF should be used to put order into research” (19).

*Status of ISPRM activities.* ISPRM is currently addressing this agenda item through its contribution to the DAR professional organizations network where this agenda item is being explored.

*Next steps.* In addition to the ongoing activities in collaboration with DAR and its professional organizations network, ISPRM may commission a discussion paper on how to develop rehabilitation research capacity from the perspective of PRM. This paper could build on the 2 mentioned initiatives. Beyond the issues discussed in these initiatives it should explore how an NGO such as ISPRM can contribute to building research capacity internationally and particularly in low resourced countries (1). For this, one could draw on relevant experiences including the European School Marseilles, France, the Euro-Mediterranean Rehabilitation PRM School in Syracuse, Italy and the work by the American Austrian Foundation (AAF). The paper could serve as input from PRM’s perspective for the ongoing DAR activity.

ISPRM may also explore how it could contribute to a more widespread use of the ICF to enhance the relevance and comparability of disability statistics worldwide and the consideration of disability in addition to mortality in international health policy.

*Development of PRM societies for low resource settings*

*Rationale for agenda item.* The development of PRM societies in low resourced settings is an important means to achieve the goals of the UN Convention and WHA Resolution. It is a highly desirable condition for building sustainable medical rehabilitation service provision. There are regions where no PRM societies, and even no PRM, exist. It has, for instance, been reported that in Sub-Saharan Africa, only 6 PRM doctors serve 750 million Africans (30).

*Status of ISPRM activities.* Based on a list of PRM societies, ISPRM has identified the countries that currently do not have a PRM society (1).

*Next steps.* It is envisioned that ISPRM commissions a discussion paper on how to facilitate the development of PRM

societies. The paper could review the state of rehabilitation and PRM within the countries that do not have a PRM society (1, 30). The latter task will, in part, be covered by the WHO’s World Report on Disability and Rehabilitation (31), to which individual ISPRM members as well as the organization as a whole are providing input. The paper could also discuss how to involve PRM physicians from developing regions, such as Sub-Saharan Africa (30) in ISPRM’s policy processes, e.g. through an observer status in the Board of Governors.

*General curricula in disability and rehabilitation*

*Rationale for agenda item.* All medical doctors and allied health professions are confronted with issues related to functioning and disability. Besides the education of PRM doctors and academic researchers in PRM, all medical students, health professionals and medical researchers should therefore receive basic training in disability and rehabilitation. Unfortunately, many respective curricula currently do not include appropriate modules in functioning, disability and PRM.

*Status of ISPRM activities.* ISPRM is contributing to the plan of WHO’s DAR team to design curricula “on disability and rehabilitation for schools of public health, medical schools, and other institutions training personnel for work in broader public services” (7). In this context ISPRM has contributed to a review of curricula on violence and injury prevention and disability called TEACH VIP.

*Next steps.* As the only physician organization in official relation with DAR, ISPRM could facilitate the work of WHO’s DAR team by commissioning a discussion paper that specifically addresses how functioning and disability could best be included in curricula for medical doctors.

*Fighting discrimination and promoting comprehensive views of disability*

*Rationale for agenda item.* According to the UN Convention, discrimination against people with disabilities is a worldwide major political issue. This discrimination may be a product of the medical model of disability in conjunction with cultural ideas about personal guilt and punishment (32). Also, the view that disabled people are of no value to, and need to be cared for by, society because they are no longer productive in economic terms, still prevails in some countries.

*Status of ISPRM activities.* ISPRM may contribute to changing underlying attitudes towards the recognition “that people with disabilities are important contributors to society and that allocating resources to their rehabilitation is an investment [...]” (12). Towards this goal ISPRM has an important role in promoting and disseminating the comprehensive ICF model of disability which is reconciling the social and the medical model. In particular, the social aspects need to be highlighted, i.e. that it may be the environment that causes the disability and not only impairments. Indeed, blaming the environment including health and social services is a strategy of keeping the person from being discriminated against.

*Next steps.* The strategic pathway regarding ISPRM's contribution to fighting the global discrimination against people with disabilities may entail the publication of a discussion paper elaborating, for example, the anti-discriminative potential of the ICF.

#### *Implementation of the icf in medicine*

*Rationale for agenda item.* The ICF is becoming the unifying and universal model for rehabilitation practice (15, 16, 33–35) and research (28, 29). In addition, the ICF is instrumental for comparable and meaningful disability statistics and the fighting of discrimination and the promotion of comprehensive views on disability, as outlined in previous sections of this paper. While the ICF is now widely accepted as the unifying and universal conceptual model for rehabilitation and PRM, it is not yet widely implemented in clinical practice (34).

*Status of ISPRM activities.* To facilitate the implementation of the ICF in medicine and rehabilitation in particular, practical tools such as the ICF Checklist and the ICF Core Sets have been developed (34). ISPRM is spearheading the development of the ICF Core Sets in close collaboration with other international organizations, WHO and the ICF Research Branch of the German WHO Family of International Classification (DIMDI) ([www.icf-research-branch.org](http://www.icf-research-branch.org)). ICF Core Sets have been developed along the continuum of care and across a wide spectrum of health conditions (34, 36, 37). Currently, a Generic ICF Core Set which serves as general reference is underway (38).

While the development of the ICF Core Sets has been conducted under the auspice of WHO's Classification, Terminology and Standards (CTS) team, the implementation of the ICF and ICF Core Sets in rehabilitation is under the auspice of WHO's DAR team, with which ISPRM is in official relation.

*Next steps.* The first 2 steps along the strategic pathway towards implementing the ICF in PRM are the adoption of the ICF and the endorsement of the WHO ICF Core Sets by the ISPRM board. The third step is the ratification through the national societies in a process outlined in another article in this special issue (9).

To facilitate the implementation based on the scientific literature (15, 16, 34, 35) ISPRM may consider the development of manuals on using the ICF in clinical practice and on translating values obtained with specific measurement instruments such as the Functional Independence Measure (FIM) into the ICF and vice versa (34).

In addition, ISPRM may consider the development of web-based training tools, or facilitate the link to existing training tools, such as the ICF Case Studies ([www.icf-casestudies.org](http://www.icf-casestudies.org)).

A special issue featuring studies on the implementation of the ICF in concrete clinical settings inviting authors from different world regions and implementing the ICF along the continuum of care could enhance the implementation process.

Finally, and most importantly, ISPRM may want to collaborate with WHO's DAR team, which is leading the implementation of the ICF within WHO and worldwide in the development

of a WHO Technical Guideline for the Implementation of the ICF in Rehabilitation Practice. In this case, and considering both the importance of the ICF agenda item and the wide range of activities, the formation of an ICF Implementation Committee seems advisable.

#### *WHO guidelines and glossary on terminology relevant to disability and rehabilitation*

*Rationale for agenda item.* It is almost a normative expectation that an international medical society such as ISPRM is involved in the production and publication of guidelines on health intervention standards and procedures. Guidelines are of utmost value to clinical practice, since they provide the basis for the development of more or less flexible routines (39) that are informed by the current state of evidence and expert opinion. A guideline can be understood as a document containing recommendations about health interventions, whether they are clinical, public health or policy. One may, for example, differentiate between emergency, standard, and management guidelines. Prerequisite for guidelines that can be applied globally is a unified terminology in disability and rehabilitation.

According to the WHO DAR Action Plan 2006–2011 (7), a number of guidelines relevant to PRM have recently been published, are currently being compiled or are planned.

In collaboration with the Measurements and Health Information Systems (MHI), the UN Statistics Division and the Washington Group on Disability Statistics, guidelines on appropriate data collection methods addressing the need for disaggregated gender-specific disability statistics at the country level are envisioned. Likewise, guidelines on strengthening medical rehabilitation services are currently being developed. Furthermore, guidelines on the provision of manual wheelchairs in less-resourced settings (40) have been published. Guidelines for training personnel in developing countries for prosthetics and orthotics services (41), as well as guidelines for CBR are in preparation (18). Another important item of the WHO DAR Action Plan is a glossary on terminology relevant to disability and rehabilitation.

*Status of ISPRM activities.* ISPRM has already contributed to the review of, and as advisors for, a WHO guideline on CBR, which will be published in 2009. Collaboration in the compilation of a position paper for medical rehabilitation is provided according to ISPRM's work plan with WHO: "ISPRM will continue to be actively involved and to contribute to the revised position paper on strengthening medical rehabilitation and any other activities in relation to this; by attending informal and formal meetings and the submission of written reports and by commenting on revised versions. The new position paper on strengthening medical rehabilitation will include and comprehensively cover aspects brought in by the expertise from ISPRM" (6). ISPRM's collaboration with regard to the glossary that is going to be included in the WHO World Report on Disability and Rehabilitation (31) encompasses reviews by ISPRM representatives and ISPRM's representation on the advisory committee.



*Next steps.* ISPRM may review already published guidelines and, if applicable, adopt them by a vote of ISPRM's Board of Governors or Assembly of Delegates. Beyond adoption, ISPRM may develop a ratification process for guidelines by ISPRM member countries following the procedures outlined in another chapter of this special issue (9).

As far as the guidelines currently under development are concerned, ISPRM may consider enhancing its input and could, accordingly, evolve its activities in the next work plan with WHO's DAR team.

#### *Conceptual description of the rehabilitation strategy*

*Rationale for agenda item.* As outlined in another article in this special issue, conceptual descriptions and definitions are powerful tools influencing the perception of real world problems by internal and external players (9). A conceptual description and derived definitions of rehabilitation are thus instrumental in achieving the goals outlined in the UN Convention (11) and the WHA resolution (12). More specifically, they facilitate the development of a common understanding within the rehabilitation professions in order to act in concert to enhance rehabilitation capacity worldwide. By the same token, they are essential for the successful development of the professional discipline of PRM (42).

When describing and defining rehabilitation, it is useful and necessary to distinguish between different understandings or applications. From a public health perspective, rehabilitation can be understood and described as a strategy in healthcare. Other strategies include prevention, cure and support. From the perspective of care provision, the rehabilitation strategy is instrumental for the understanding and definition of professional disciplines including the medical specialty PRM (42). From a primarily scientific perspective, the rehabilitation strategy serves as a basis for the understanding and description of distinct scientific fields, including integrative rehabilitation sciences or biomedical rehabilitation sciences and engineering (43–45).

There is no single appropriate definition of rehabilitation understood as a health strategy. For example, a legal definition may differ from definitions suitable for the perspective of service providers and payers, policy-makers, advocacy groups or scientists. In addition, depending on the purpose, one may, for example, wish to use a comprehensive or a brief definition.

To facilitate purpose-tailored, but consistent, definitions of rehabilitation, the development of a conceptual description that can serve as reference seems most useful. Considering the ICF as an emerging unifying model for functioning and rehabilitation a conceptual description should be based on the ICF and use its taxonomy.

An ICF-based conceptual description can overcome the limitations of past definitions of rehabilitation that have been criticized for their narrow perspective based on the biomedical model. They include the WHO's definition of rehabilitation from 1981 (46) and the UN standard rules from 1993 (47). Whilst the biomedical perspective is essential in enabling people to achieve optimal physical capacity, other approaches are equally important. They include approaches that focus on the

factual performance of individuals in their concrete life situation, which aim at the empowerment of proxies and caregivers of the person, and which create a facilitating environment by, for instance, removing environmental barriers.

*Status of ISPRM activities.* Towards a globally accepted ICF-based conceptual description of the rehabilitation strategy (Table I), JRM has recently published a discussion paper and subsequent letters to the editor (48). A derived short definition describes rehabilitation as the health strategy applied by PRM and professionals in the health sector and across other sectors that aims to enable people with health conditions experiencing or likely to experience disability to achieve and maintain optimal functioning in interaction with the environment (48).

*Next steps.* Considering the importance of a conceptual description and derived definitions of the rehabilitation strategy, ISPRM may prioritize this agenda item in its work with WHO's DAR team. As a first step towards a globally accepted and ICF-based conceptual description of the rehabilitation strategy ISPRM thus brought the agenda item to the attention of DAR and its professional organizations network during the meeting held during the 61<sup>st</sup> WHA in 2008. In the envisioned process towards a universally accepted conceptual description, ISPRM may consider the development of a position statement based on the JRM discussion paper.

Table I. *ICF-based conceptual description of rehabilitation strategy (48) (ICF terms in the proposed ICF-based conceptual description are marked in bold)*

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*Rehabilitation is the health strategy which*  
based on WHO's **integrative model of human functioning and disability**  
applies and integrates

- ⇒ biomedical and engineering approaches to optimize a **person's capacity**
- ⇒ approaches which build on and strengthen the resources of the **person**
- ⇒ approaches which provide a **facilitating environment**
- ⇒ approaches which develop a **person's performance** in the interaction with the **environment** over the course of a **health condition**;  
along and across the continuum of care,
- ⇒ ranging from the acute hospital to rehabilitation facilities and the community;  
and across sectors
- ⇒ including health, education, labor and social affairs with the goal
- ⇒ to enable people with **health conditions** experiencing or likely to experience **disability** to achieve and maintain optimal **functioning**

*Rehabilitation is*

- ⇒ the core strategy for the medical specialty PRM,
- ⇒ a major strategy for rehabilitation professions,
- ⇒ a relevant strategy for other medical specialties and health professions, service providers and payers in the health sector,
- ⇒ and a relevant strategy for professionals and service providers across sectors caring for or interacting with people with **health conditions** experiencing or likely to experience **disability**.

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ICF: International Classification of Functioning, Disability and Health; PRM: Physical and Rehabilitation Medicine; WHO: World Health Organization.

*Rehabilitation services within health services matrix*

*Rationale for agenda item.* According to the WHO DAR action plan (7), “the number of people with disabilities is increasing due to population growth, ageing, emergence of chronic diseases and medical advances that preserve and prolong life. [...] These trends are creating overwhelming demands for health and rehabilitation services”.

A prerequisite to meet these demands is an internationally shared understanding of the principles of rehabilitation services provision within the broader perspective of health services and care delivery. Recognizing the large international variation in the types of services provided and their financing, basic principles guiding rehabilitation services provision along the continuum of care, for varying health conditions, and involving different levels of care in varying environments may be identified. An envisioned matrix of rehabilitation within the broader context of health services and care provision may facilitate the specification of services tailored to a specific context and hence foster an effective and efficient service provision.

*Status of ISPRM activities.* ISPRM has brought the agenda item to the attention of the DAR meeting with the professional organizations network during the WHA in 2008. During this meeting it was emphasized that the ICF should serve as reference for a matrix with regard to intervention goals. The matrix should further “cover different time frames: acute, post acute, maintenance or habilitation” (19). The matrix should also “be applicable across different care settings (tertiary, secondary, primary – community and family) and highlight the need for a continuum of care” (19). It was decided that “WHO will develop an outline of the objectives of the matrix and process for development for feedback by the professional organizations” (19).

*Next steps.* Next steps on the strategic pathway towards the development of a rehabilitation services matrix include a review and discussion of the draft proposal within ISPRM’s executive board and the publication of a discussion paper in order to prepare for further discussions within DAR’s professional organizations network.

## INTERNAL POLICY AGENDA

ISPRM’s internal policy agenda is driven by activities perceived by its members to be of value to them. The agenda is limited by the resources available to achieve all of interest to the members.

From a policy perspective, a re-emerging current topic is the definition of the “field of competence” of PRM. Examples are an initiative of the professional practice committee of the European Union of Medical Specialists (UEMS), which aims to specify PRM’s “field of competence” (49, 50).

The key difficulty in defining the field of competence of PRM physicians may lie in the fact that PRM is not defined by a disease or organ system, but rather by limitations of functioning associated with health conditions in interaction

with personal and environment factors. As a result of this complexity, PRM is a highly interdisciplinary area in both practice and research.

The discussion regarding the field of competence of PRM is timely since we can now build on the ICF as a unifying model for PRM allowing to conceptualize PRM as the “medicine of functioning” (33, 42, 51, 52) or to identify a comprehensive set of topics relevant for PRM congresses (53).

*Conceptual description of PRM*

*Rationale for agenda item.* An essential element for the definition of the field of competence of PRM is a respective conceptual description. A conceptual description can serve as basis for derived definitions suited for specified purposes and audiences (42). A conceptual description and derived definitions of PRM are likely to foster a common identity of PRM physicians and make the field more attractive for medical students and other physicians.

Both the scientific basis of functioning and the conceptual issues, such as the definition of the field of competence, are of importance to develop a rehabilitation strategy. Thus cooperation both with scientific and professional organizations is important, for instance in Europe these are the European Society of PRM (ESPRM) and UEMS PRM-Section and Board. The Professional Practice Committee has already started a process to define the field of competence of PRM as well as the relations with other health professionals, in a series of statements and position papers.

*Status of ISPRM activities.* A discussion paper providing a first version of an ICF-based conceptual description of PRM has been published in JRM (42). A modified version of the suggested conceptual description of PRM is reprinted in Table II.

*Next steps.* The basis for the development of an ICF-based conceptual description and derived definitions of PRM is the adoption of the ICF as the unifying framework for PRM by ISPRM’s Board of Governors, as mentioned under the respective agenda item.

Next steps could include the review of a proposed conceptual description and definitions and related letters to the editor published in JRM within ISPRM’s governing bodies. A position paper could then be drafted by an author team commissioned by ISPRM’s executive committee. After voting on the draft and possible amendments, an ISPRM position paper could be published.

A brief definition derived from the conceptual description may then be included into an envisioned revised ISPRM constitution (Bylaws and Policy Principles (4)). Finally, a ratification process by national societies along the lines described in another article in this special issue (9) is conceivable.

*Congress topic list and congress structure*

*Rationale for agenda item.* Scientific conferences are instrumental in the development of scientific fields or “fields of competence”. Conferences bring scientists together and

Table II. *ICF-based conceptual description of the medical specialty Physical and Rehabilitation Medicine (PRM) (42) (ICF terms in the proposed description are marked in bold)*

PRM is the medical specialty which based on

- the diagnosis and treatment of **health conditions**,
- WHO's integrative model of human **functioning**,
- and rehabilitation as its core health strategy.
- assesses functioning in relation to health conditions, personal and environmental factors
- performs or applies biomedical and engineering interventions to optimize capacity

suitable to:

- ⇒ stabilize, improve or restore **impaired body functions and structures**,
- ⇒ prevent **impairments**, medical complications and risks
- ⇒ compensate for the absence or loss of **body functions and structures**
- leads and coordinates intervention programmes to optimize performance
  - ⇒ in a multi-disciplinary iterative problem-solving process
  - ⇒ performing, applying and integrating a wide range of biomedical, psychological and social interventions
- provides advice to patients and their immediate **environment**, service providers and payers
  - ⇒ over the course of a **health condition**
  - ⇒ along and across the continuum of care from the acute hospital to rehabilitation facilities and the community
  - ⇒ and across sectors from health, education, labor to social affairs
- manages rehabilitation, health and multi-sectorial services
- informs and advises the public and decision makers about suitable policies and programmes in the health sector and across the other sectors which
  - ⇒ provide a **facilitating** larger **physical and social environment**;
  - ⇒ ensure access to rehabilitation services as a human right;
  - ⇒ and empower practitioners to provide timely and effective PRM care with the goal
- to enable people experiencing or likely to experience **disability** to achieve and maintain optimal **functioning** in the interaction with the **environment**

ICF: International Classification of Functioning, Disability and Health; WHO: World Health Organization.

foster the exchange of ideas as well as the formation of a common identity. Against this background, continuity of topics discussed at scientific conferences in a field of competence is essential to develop both, science and clinical practice. A list of topics to which participants can refer when submitting abstracts and presentations defines the field on the one hand, and encourages researchers interested in these topics to attend a conference on the other.

For scientific societies that are organizing congresses, it is therefore worthwhile to carefully define the topic list for the free submission of abstracts (either for poster sessions or presentations). In the case of conferences in PRM, topics need to be related to PRM practice, but should also be attractive for PhD researchers working in such diverse fields as biology and sociology and focusing on the understanding of human functioning from the cell to society.

Until now topics of international PRM congresses, including the ISPRM world congress (3), have varied widely, leading to

varying coverage of issues relevant to PRM and limited continuity and institutional memory. Appendix II of the ISPRM Policies and Procedures (5) provides only general guidance regarding the topics to be provided at World Congresses.

*Status of ISPRM activities.* To foster a shared understanding of the field of PRM, the ESPRM has initiated the discussion towards the development of a topic list (53) and a minimal structure for international PRM congresses (54).

*Next steps.* ISPRM may consider the development of a topic list (53) and a minimal structure for international PRM congresses (54) in close collaboration with the large regional societies, including Asia-Oceanian Society of Physical and Rehabilitation Medicine (AOSPRM), European Society of Physical and Rehabilitation Medicine (ESPRM) and Asociación Médica Latinoamericana de Rehabilitación (AMLAR). This would facilitate envisioned joint congresses of ISPRM in collaboration with regional societies (3). When developing a topic list for abstract submission it should provide orientation, but should also allow flexibility. Topics thus need to be broadly defined, providing leeway for innovation and specific focus.

As a final step ISPRM may endorse a topic list in concert with the regional societies and set a date for revision. The topic list could then become binding for abstract submissions to future congresses.

## DISCUSSION

This paper has described the main current policy agenda items focusing on external policies (see Table III). Some agenda items are quite clearly contoured; others are complex and need long-term development and more extensive discussion within ISPRM's governing bodies, with other rehabilitation professions, disabled persons organizations and so forth. Also, there are a range of additional items that will require attention in the future. These include clinical curricula and clinical guidelines.

While it may be perceived as less tangible than congresses and clinical guidelines, ISPRM's members will probably benefit from the development of ISPRM's external policy agenda. This includes an increased recognition of the specialty by the WHO and the UN, as well as other medical disciplines and health professions, disabled persons organizations and the general public, including people with disabilities. Efforts to increase rehabilitation capacity worldwide will enhance the opportunities of PRM physicians to provide services and care to people in need of rehabilitation. A central challenge hereby is funding, an issue that has been addressed in some detail in another chapter in this volume (3, 9). The authors wish to invite ISPRM members and the wider constituency to participate in an open debate on the suggested policy agenda. It must be emphasized that this paper discusses only selected policy agenda items. A broad discussion will need to introduce new and worthwhile aspects of future political engagement.

Table III. Overview of selected items of ISPRM's policy agenda

Agenda item/strategic goal	Internal/ External	Status of ISPRM activity	Type of mandate	Policy process stages*	Next steps	Relation to UN system
Supporting the establishment of rehabilitation services worldwide	External	Envisioned; Ongoing activities of complementary organizations	Humanitarian; Professional; Scientific	Agenda setting	Discussion paper	UN Convention, WHA Resolution, Reduction of Poverty WHO-DAR professional organizations initiative
Developing rapid rehabilitation response to natural and man-made disaster	External	Envisioned	Humanitarian	Agenda setting	Discussion paper	UN Convention, WHA Resolution, WHO-DAR professional organizations initiative WFOT (ongoing activities)
Enhancement of research capacity	External	Envisioned	Scientific	Agenda setting	Discussion paper	WHA Resolution, WHO-DAR professional organizations initiative
Development of PRM societies in low resource settings	External and Internal	Envisioned; Identification of white spots	Professional; Humanitarian	Agenda setting	Discussion paper	Implementation of UN Convention, WHA Resolution
General curricula in disability and rehabilitation	External	Envisioned; Contribution to review	Professional	Agenda setting	Discussion paper	WHO-DAR Action Plan, WHO-DAR professional organizations initiative
Fighting discrimination	External	Envisioned	Humanitarian	Agenda setting	Discussion paper	UN Convention
Implementation of the ICF in Internal medicine	External and Internal	Envisioned ICF Core Sets; ICF tools	Professional; Scientific	Implementation	1. Adoption of ICF 2. Endorsement of the WHO ICF Core Sets 3. Ratification by the national societies 4. Development of manuals on ICF implementation with WHO and other rehabilitation professions including relation of ICF Core Sets and existing functional status measures 5. Development of web-based training tools or facilitate the link to existing training tools	ICF, WHO-FIC, WHO-FDRG, WHO-DAR professional organizations initiative
Contribution to WHO guidelines and glossary on terminology relevant to disability and rehabilitation	External	Work in progress; Envisioned	Professional; Scientific	Goal setting Implementation	1. Review of published guidelines 2. Adoption 3. Input to guidelines and glossary in development stage through DAR professional organizations initiative	WHO-DAR Action Plan WHO-DAR professional organizations initiative
Conceptual description of the rehabilitation strategy	External and Internal	Discussion paper	Professional; Scientific	Agenda setting	Position paper (with WHO-DAR, other rehabilitation professions)	WHO-DAR Action Plan WHO-DAR professional organizations initiative



Table III. *Contd.*

Agenda item/strategic goal	Internal/ External	Status of ISPRM activity	Type of mandate	Policy process stages*	Next steps	Relation to UN system
Rehabilitation services within health services matrix	External and Internal	Envisioned	Professional; Scientific; Humanitarian	Agenda setting	Discussion paper	UN Convention; WHA Resolution WHO-DAR professional organizations initiative
Conceptual description of PRM and the definition of the field of competence	Internal	Discussion paper; UEMS initiative	Professional	Agenda setting Implementation	1. Position paper 2. Integration into ISPRM constitution	
Congress topic list and congress structure	Internal	Discussion papers	Scientific; Professional	Implementation	1. Development of topic list 2. Endorsement of topic list	

\*The policy process stages refer to the policy cycle introduced in an accompanying paper (9). Goal setting is the process of defining and prioritizing goals. Agenda setting means the communication of an issue and related goals to specific audiences. Resource mobilization refers to fundraising and human engagement. Implementation means the realization of goals in real world settings. Evaluation refers to outcomes assessments.

DAR: Disability and Rehabilitation; FDRG: The Functioning and Disability Reference Group; FIC: Family of International Classification; ICF: International Classification of Functioning, Disability and Health; ISPRM: International Society of Physical and Rehabilitation Medicine; PRM: Physical and Rehabilitation Medicine; UEMS: European Union of Medical Specialists; UN: United Nations; WFOT: World Federation of Occupational Therapists; WHA: World Health Assembly; WHO: World Health Organization.

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