University of Ostrava

Faculty of Social Studies

Coordinated Rehabilitation 1

Assoc. Prof. Lenka Krhutová, Ph.D.

Translated by Lucie Návratová

Ostrava 2017

Reviewed by Assoc. Prof. Martin Kaleja, Ph.D.
Study material was created as part the Institutional Development Project entitled "The Innovation of Existing Subjects for Health Social Care and Social Policy and Social Work Degree Programs in the Context of Internationalisation".
Translated by Lucie Návratová from the Czech original Koordinovaná rehabilitace 1,
Publisher University of Ostrava, First Issue, 2017
ISBN 978-80-7464-972-1

Contents

Introduction

Usually we only come to realize the full value of our health when we come to lack it. In 'lighter', less severe cases, we are only temporarily limited in completing our everyday activities (a cold, the flu, a simple fracture, etc.); in the case of more serious, long-term or permanent health problems, we usually alter our existing habits, routines and ways of performing ordinary activities (time and space management, alternative procedures, etc.). All our activities usually take place in a particular state of health (health, illness, disability), in a particular environment (natural, physical, informational, attitudinal, cultural, etc.), with particular people (relatives, friends, acquaintances, employers, strangers) and under certain conditions that vary according to the environment, time, culture, economy and politics in which we were born or in which we live. The above noted, and other aspects of life, have an impact on the manner and quality of life, which individuals, families and society possess as a whole.

The concept of coordinated rehabilitation is one of the modern trends in addressing people's health-related life situations. Although it was created as a direct link to the world war conflicts of the first half of the 20th century, its application extended beyond the rehabilitation of war veterans. Currently, its focus meets current demands regarding the shift from narrowly specialized solutions towards inter-disciplinarity, multi-disciplinarity, and trans-disiplinarity.

The study text of *Coordinated Rehabilitation 1* is the first part of a two-part university textbook[1] that is primarily intended for the study needs of the follow-up Master's degree students in the study field *Coordination of Rehabilitation and Long-term Health and Social Care* under the *Health Care – Social Work* degree program accredited at the University of Ostrava (UO) in 2014. Part 2 will detail individual tools (components) of coordinated rehabilitation and selected procedures used in the processes of coordinated rehabilitation.

The concept of coordinated rehabilitation (hereinafter referred to as "COR") is viewed in this text through the optics of integrated health and social work and also the ecological and social concept of health. The first part of the textbook deals with the theoretical and empirical conceptual grounds, which have been only partially (or for the purposes of Master's studies)

[1] Pursuant to the Rector's Directive No. 208/2014 on UO Publishing Activities, Article 2.6.2: Type of textbook publishing – texts with a simple typographic adaptation intended for the study needs of UO.

insufficiently elaborated in the Czech professional environment. The focus, structure and content of this text is based on the belief that in the context of the Master's study, the *theoretical knowledge of concepts* is essential both for deeper understanding of individual concepts and for the output *application skills* of graduates in independent professional work including research.

Note to the List of Utilized References:

The study text is based primarily on the author's own work supplemented with relevant references to the primary references in these author’s works, as well as with the new authors' texts and other references; please see the list of utilized references.

1 Theoretical and Empirical Grounds for Coordinated Rehabilitation

The system of coordinated rehabilitation represents the timely, combined, interconnected, continuous, coordinated and collaborative set-up and use of medical, social, occupational, educational, technical, technological and other tools to maintain or enhance the quality of life of a person with a health problem.

The idea of coordinated rehabilitation is not new; it originated in Europe at the beginning of the 20th century. However, hand in hand with the progressive differentiation of individual disciplines, there is a growing volume of specialized knowledge, which we often do not seem to be able to connect and understand (both at the scientific and practical level). There is a fragmentation of knowledge, as emphasized by Stanislav Hubík, one of the leading Czech philosophers and sociologists:

> The specialization [...] benefiting the production and accumulation of capital has gradually transformed the knowledge of reality into a conglomerate of often unrelated specialized knowledge for which reality exists only as a very partial excerpt of reality, the *fragment*. It is therefore modern specialized knowledge that creates "little real reality" and very real risks. [...] At the present stage [...], the division of labour has advanced to the point that we can talk not of "specialization" but of "excessive specialization" or of "over-specialization." Due to the ruthless specialization process and the loss of communication between individual specialties, more and more things remain "between" and therefore "beyond" the visual field of knowledge. [...] Modern selection of knowledge necessarily means disregarding *other cognitive abilities* offered by *other people, groups, and cultures*. [...] The problem of postmodernism is the mastery of this pluralism, heterogeneity, and otherness. (Hubík 1999: 197-205)

The German sociologist Ulrich Beck also criticizes the differentiation and hyper-complexity of field specializations as an unintended consequence of the

differentiation of science where, according to the author, "there is an almost chaotic flood of conditional, certainty lacking, and incoherent detailed results. (Beck 2004: 259) In this sense, the author talks about the "competition of various experts," the "controversial multi-voice of scientific languages", and "highly specialized and contradictory claims of validity." They are also reflected at the "multi-voice of experts" level, where "together with the experts' increasing specialization, the probability of designing and implementing fragmentary solutions in practice, whose intended main effects are permanently overlapped by unintended side effects, also increases.

Excessive specialized practice is thus becoming some sort of 'classification yard' for problems and the costly treatment of their symptoms." (Beck 2004: 295) Beck sees the possibilities of resolving this fatal differentiation in that "the science that wants to break through this 'fate' has to specialize in the context using new forms (to learn how to do this)" (Beck 2004: 296). The main focus in such a specialized study of contexts could, based on the author, "concentrate, for example, on those 'classification yards' of problems (as is typical in confrontation with risks and environmental problems, but they also seem to predominate, for example, in many areas of social policy and health and social services), and on the search for principal developmental alternatives, as well as 'railroad switches' that either prevent uncertainty or increase it by contrast." (Beck 2004: 296)

The concept of coordinated rehabilitation responds to the need to interconnect "over-specialized" fragmentary knowledge/solutions and offers "context specialization". In order to do this, it is necessary not only to obtain basic orientation across different disciplines, including relevant theoretical and empirical tools, but also to cultivate and use common sense.

1.1 Historical Contexts of Coordinated Rehabilitation

In terms of practice, rehabilitation as a purposeful tool and the process of activation and re-acquisition of the physical, mental and social competences of a person with a health problem has been known from the early 20th century. In Europe, it was connected with the need to address the situation of a large number of WWI and WWII veterans, and in America with the political activation of the Vietnam War

veterans. The original mechanical concept of rehabilitation focused on the quantitative parameters of the functioning of a dysfunctional (unhealthy) individual gradually, hand in hand with the development of knowledge, transformed into the environmental concept of rehabilitation based on a holistic concept and oriented towards strengthening of the usable potential of functional health and creating an accessible environment for all.

In countries such as France, Germany, Austria, the Netherlands, Sweden, Great Britain, USA, Canada and so on, the concept of rehabilitation viewed as interconnection and coordination of interdisciplinary measures has long been known and implemented.[2] These countries demonstrate in the form of systematically enforced national legislation and the concept of rehabilitation funding (separate rehabilitation laws) that it is more effective for the state and more beneficial for an individual, provided that formal and factual conditions have been formed, to help this person, wherever possible, integrate (re-integrate) into the work process (in cooperation with the departments of health, education, labour and social affairs, as well as the departments of infrastructure, information technology, etc.) and thus contributing into the system of public finances part of one's revenues, which are retrospectively used for partial coverage of the costs associated with an active employment policy and other support systems. It is a principle, which is based, in addition to the primary economic effect, on the respect and confidence in abilities and competences of a person who although temporarily or permanently having lost (or never had) part of his/her health, did not lose the potential of living a dignified life. The application of these principles is common for all age categories, each of which follows upon partly identical and partly different ways.

Coordinated Rehabilitation in the Czech Republic

Contrary to the above listed countries, economically and otherwise inefficient procedures with the preference of passive social systems prior to the rehabilitation procedures are systematically applied in the Czech Republic at the moment. An example is the situation of a person at a productive age for whom the state provides disability pension and other social welfare and social protection benefits and

[2] The first system steps are dated back to the first half of the 20th century; development occurs especially in the 1960's and 1970's.

services without having drawn upon and *exhausted* all the possibilities of rehabilitation interventions. The implementation of social measures is in fact perceived, or officially declared, a "solution" to his/her situation. From a macroeconomic point of view, however, as a rule, it is a rather ineffective "solution" that, as a consequence, uncontrollably exhausts the state of public finances and – in the view of the beneficiary – in many cases encourages an individual's sense of social isolation, helplessness, and dependence on the outer environment. Efforts to re-empower a person should be primarily and unambiguously guided in the line of rehabilitation – protection systems, and not vice versa.

In the Czech Republic, for more than twenty years there have been efforts made to promote a modern concept of rehabilitation. The interconnection and inter-coordination of the relevant measures in the Czech Republic is still lacking primarily because of their interdepartmental character, the absence of their system interconnection and financing and, last but not least, because of the fact that their scope in the Czech Republic currently does not fully integrate into any educational curriculum of any professional expertise studies. As a result, the coordination of rehabilitation in the Czech Republic has not yet found its anchoring, and therefore the various measures in various departments remain fragmented, duplicated, and uncoordinated, resulting in some needs of the clients being met in several places, while other needs are disregarded. From a level of practice, the need for coordination of interdisciplinary solutions to the consequences of changes in a state of health is evident, and is, in isolated cases, spontaneously and asymmetrically implemented, usually at a local level. However, to change the current, rather inefficient state, there is currently no legal support from national legislation.

Over the past decades, professional public sessions have been repeatedly initiated in the Czech Republic, which aimed, together with the Ministry of Labour and Social Affairs, the Ministry of Health, the Ministry of Education and other institutions, to prepare a so-called comprehensive rehabilitation law. Already in 1999, the then Minister of Labour and Social Affairs, Vladimír Špidla, established a department team for the preparation of this bill, however, this or a similar legal bill still awaits to be adopted in the Czech Republic. The European Union has urged its member countries to make coordinated rehabilitation a part of their state policy. However, the Czech Republic still belongs to the countries where this issue has been addressed only marginally and fragmentarily. Occupational rehabilitation is partially included in

the Employment Act, and social rehabilitation is regulated only in a narrow sense in the Act on Social Services. The rehabilitation in a legal sense - and also health care services - is exclusively focused on medical rehabilitation tools, and the pedagogical and educational rehabilitation is regulated separately by the Education Act. The above laws do not connect with each other in any way; legal measures are duplicated in some processes (typically it is ergo therapy in the Law on Health Services and social rehabilitation in the Act on Social Services), while others are completely missing (typically aspects of the reform of psychiatric care).

Since 2009, the Czech Republic has been legally bound by the International Convention on the Rights of Persons with Disabilities (hereinafter referred to as "the Convention") and is obliged to incorporate its individual articles into its national legislation.[3] Under the influence of the Convention and other internationally binding legislation, the Czech Republic is currently preparing a draft bill for the so-called Act on Coordinated Rehabilitation, which should deal with both the procedures, processes, and competencies of individual components of rehabilitation (in the health, educational, and employment system, as well as in a social rehabilitation) and also the financial funding of its provision.

Krása describes the current state of rehabilitation in the Czech Republic as follows (2011):

- (Rehabilitation is) a continuing problem.
- Nobody knows what to do about it.
- Everyone imagines something different under the term.

Krása also states:

"Let's picture a simple case of a young manager after a car crash. In today's situation, if he has a supporting family and good luck, he will probably end up being unemployed but in a well-adapted environment with appropriate compensatory aids, living on annuity and disability pension, and still with a functioning family. – It is my dream that the above case is different. I wish this man had a full-time job, paid his taxes and insurance. I am convinced that this can only be achieved with the help of an institution that will want to profit from a person’s fastest possible return back to

[3] In this respect, two articles of the Convention – Article 25 Health and Article 26 Habilitation and Rehabilitation – are relevant.

work, so it needs to coordinate all individual rehabilitation instruments and also have some funds available." (ibid)

Such an institution is still missing in the Czech Republic.

1.2 The Theoretical Framework of Coordinated Rehabilitation

It makes sense in the introductory section of this subchapter to consider what theories are (or can be) good for. The practice without their knowledge and application is undoubtedly possible. The question remains how effective it is.

Theories may be useful, for example, for the following reasons:

- Explain different phenomena and predict them (we do not have to always undergo repeated experience)
- Compare cases and situations
- Explain one's own professional activities to other people and
- Provide space for their review
- Correct theory or modify one's own actions when something occurs that is in conflict with the theory
- Increase our sense of professional self-confidence
- Compare the exponential strength and usefulness of the theories between each other, etc. (Matoušek et al., 2013)

Subsequently, we will learn about some theories and concepts that can explain the background of the system of coordinated rehabilitation.

1.2.1 System Approaches

What we define as the system approach is usually a calculated way or method of thinking and solving problems (behaviour), while the investigated phenomena and processes are understood comprehensively in their internal and external contexts.

System approaches have seen a rise in the field of scientific research in connection with the increasing complexity (especially) of industrial processes at the time of the onset of modernity. From the aspect of theoretical discourse, especially since the 1940's, a whole series of "system theories" have been developed across a range of disciplines. In terms of its application, the system approaches are applied in many areas of human activities such as law, economics, management, cybernetics, pedagogy, social work, etc.

Ludwig von Bertalanffy (1901-1972), an Austrian biologist, is known as the founder of the general system theory. He initially studied biological objects and based his concept on integrity, structural differentiation and integration, regulation, and dynamics of relationships within and outside the system. The application of general systems theory to social sciences is linked, among other things, with the names of an American sociologist, Talcott Parsons, and his disciple, a German sociologist, Niklas Luhmann, who have influenced many other scholars.

System interpretations are characterized by the fact that they look at things, structures, and problems in terms of dynamics, that they are trying to encompass a huge array of different elements and processes, and to select important elements and bonds from them, while preserving the integrity and functionality of the system. (Šubrt 2007, Šubrt, Balon 2010)

One of the key concepts of system approach is the concept of "system." In technical literature, the system is often defined in many different manners. However, all these definitions have the following key points in common:

- The system is a complex of dependent elements.
- With its surroundings the system forms a special functional unity.
- The system can be an element of both higher and lower order.
- The system contains a certain element of effective self-regulation.

Another important concept of system approaches is the "system surroundings." The surroundings of the system consists of objects that are outside of a given system, which by changing their properties affect the system, or that are dependent on the system's behaviour. (Surroundings of the system is formed by the elements and systems that are not part of the system but have certain bonds to it.)

One important property of the system is its "structure" – in other words, how the system is composed of individual parts. The structure of the system means the sum of the elements and relationships which determines a function between them – the system behaviour. The function is understood either in terms of teleology (calculated) or mathematics (the type of relationship).

The system has its arrangement characterized by an input, process (or a series of process cells), output and feedback mechanism ensuring a system lifetime in integration with its environment.

The relationship between the system and its surroundings is defined by inputs and outputs. By means of the inputs the surroundings affects the system and vice versa, by means of the outputs, the system affects its surroundings. A system without any links to the environment is called a closed system. For coordinated rehabilitation, however, the more important systems are the open ones, i.e. the systems with inputs and outputs. The system approach itself covers multiple disciplines and links between them. For the formulation of principles of general systems theory, there is a typical interdisciplinary approach, study of the complexity, and the relationship between the whole and its parts (a holistic approach).

The distinctive feature of open systems is that they interact with each other and interact with other systems in their environment. This influence has two components – inputs, i.e. everything that enters the system from the environment, and outputs – everything that leaves the system. To be able to discuss the inside and outside of the system, we must be able to distinguish between the system itself and its environment. The system and environment are generally divided by borders.[4] So the system output is generally either a direct or an indirect result of certain inputs.

What comes out must first be accepted. However, the output is generally quite different from the input: the system is not only a passive tube, but also an active element that processes its inputs.[5] This transformation of inputs to outputs by the system is usually called the transformation function.

[4] For example, for a living system, the skin is the outermost boundary.
[5] For example, food, drinks, and oxygen as inputs for the living system are transformed and subsequently excreted as urine, excrements, and carbon dioxide.

If we look at the system surroundings in more detail, we find that it consists of other systems interacting with their environment.[6] If we now think of a set of such systems that interact with each other, we can again consider such a set the system.[7] The mutual interaction of system components combines these components into one. If the individual parts did not affect each other, then the whole would be nothing but the sum of individual parts. However, thanks to a mutual interaction, there is something extra here. With regard to the whole, individual parts are perceived as subsystems. And with regard to the parts, the whole is seen as a supersystem. If we look at the supersystem as a whole, we do not need to be aware of all its parts. We can just look again at all of its inputs and an overall output without looking into which inputs go into which subsystem.[8] This view is viewed by the system as a black box – something that absorbs (consumes) inputs and produces outputs without us being able to see what is going on in between (the opposite is a system where internal processes can be seen – we can call it a white box). Although the view of a system similar to a black box may not be sufficient, in many cases, this is the best we can get.[9]

The system means order and logic; it expresses an overall rather than a partial view of reality. The system's behaviour is in contrast to chaos and entropy. The system concept is not just about describing and interpreting the structure and function, but also about the dynamics characterized by constant changes. A particular reality can be characterized by a variety of systems. What is important is what the subject of interest is, what phenomena and relationships can be considered important.

The system can also be considered as a relatively simple dynamic model in which, by changing certain characteristics, we can estimate how the structure or function of the system changes. However, it is important that the functions of social systems do

[6] For example, a person's surroundings are again created by other people.
[7] For example, a group of interacting people can form a family, a company, or a city.
[8] For example, if we think in terms of a city, we can monitor the total amount of fuel the city *consumes* (input) and a total amount of pollution (output) without knowing who was responsible for which part of the pollution.
[9] For example, we do not know anything about most of the processes in our body. Physicians can see that if they administer a certain drug to a patient (input), the patient will react in a certain way (output) e.g. he'll urinate more. In any case, in most cases, the doctors have little awareness of the particular mechanism leading to this effect. The drug may trigger a complex chain of mutually linked reactions involving various organs and parts of the body, however, the only thing that can be ensured, is the end result.

not change automatically, but are managed and implemented by people who act both from objective and subjective motives.

The entire social reality is permeated by systems of different type and level. Each of us is a member of various social systems. There are the family, political, interest, professional, religious, formal and informal systems and, of course, the healthcare system. Within the healthcare system, we can distinguish between different subsystems: hospital, outpatient, administrative, laboratory, pharmaceutical, information, etc.

1.2.2 The Socio-ecological Concept of Health

It is clear that health is dependent on the natural and social environment and that it would be a mistake to separate it from the specific people in the fullness of their lives, including their personalities, work, family relationships, emotions, feelings, opinions, and social roles.[10] Perception and coping with health problems is to a large extent conditioned by cultural, economic, and political circumstances.

In the socio-ecological model of health, the health of an individual remains in the centre of attention, but at the same time it understands and emphasizes that a number of measures implemented at the population level can have a positive or, possibly, negative impact on human health.

Problems should, if possible, be dealt with in terms of the mechanisms by which they arise. For example if there is, as a result of an increase of cars, imperfect legislation, and inadequate road maintenance, an increase in road accidents, it cannot suffice to simply construct new traumatological centres linked to prompt medical assistance. Legislative adjustments, improvements in the condition of roads and means of transport, the professional training of drivers and their behaviour on roads, the style and effectiveness of the traffic police, the education of children, etc. should not be overlooked ... Somebody could argue that, for example, the technical

[10] The subchapter is compiled due to shortening and adjusting of the reference *Health 21*

condition of roads is not a medical issue. This is, of course, true, but the health of people does not only concern health professionals.

One of the benefits of this model is the broad understanding of the health determinants and the emphasis on their positive influence by using all appropriate means. The main characteristics of the socio-ecological model of health are as follows:

- Focus on the whole personality of an individual as a member of a family and of a society belonging to a certain culture and fulfilling corresponding civic and social roles
- Interest in social characteristics of health, e.g. the level of health depending on income, gender, age, education, etc.
- Efforts to understand cultural, social, and individual values and to assess their relationship to health.[11]
- Attention paid to the subjective aspect of health and to the role of personal feelings and emotions in relation to health. It is about the perception of both positive health and health disorders and, last but not least, about a subjective relationship to individual determinants of health.
- Efforts to understand health-related behaviour in the context of everyday life. People as the members of society are not just "smokers," "alcoholics," or "disabled persons." They are primarily people who are exposed to many other conditions and circumstances, joys and hardships in everyday life. Social life and its conditions represent an important complex of determinants of health.
- Health is conceived in its entirety, knowing that the resulting state of health is not only a result of a doctor's and patient's relationship, but is largely the result of activities of the individual himself, social groups and institutions as well as society as a whole.

[11] People do not generally consider health to be their main life objective. Health often opposes other important interests, values, and life goals such as being happy, experiencing adventure, breaking through in society, living a colourful or, on the contrary, a peaceful life, etc. There are a number of customs in certain cultures and social groups; common types of behaviour can vary significantly between different areas or groups of people, both in healthy and in sick individuals. Many of these differences document the social and cultural condition of the state of health, as well as the different types of behaviours strengthening or threatening health.

- Efforts to awaken and cultivate consciousness of one’s own dignity. Taking care of oneself is a necessary basic condition and the first form of care, which is followed upon by other medical services.
- Awareness that there is a wide range of care, treatment, and recovery methods.

The socio-ecological model of health does not seek to separate treatment, prevention and civic activities. It strives for their balance, complementary action and the maximum effectiveness. However, it must be emphasized that the socio-ecological model of health is definitely not the opposite of the biomedical approach but is rather its important expansion.

In the context of the increasing importance of citizens' participation in the care of their own health, the health models based on a general understanding of health connected with consequent health care, in particular self-care, are developed.

The socio-ecological model exists in a number of modifications. E.g. the health in its entirety seeks to adopt *a holistic model of health*. It draws attention to the fact that people not only study, protect, and restore their health, but also experience it; health is thus one of the characteristics of life in its fullness.

The *population health model* is similarly oriented. It is based on the following principles:

- People's health is influenced by social, cultural, and economic circumstances, both at the individual and the collective level.
- These circumstances are independent of the amount of funds spent on healthcare services.
- A society, the wealth of which is distributed relatively fairly, enjoys a higher level of health.
- As far as the individual level of health is concerned, it is conditioned by both the economic and social environment, and also by the individual's ability to cope with existing problems.

When pondering about health, and new characteristics and aspects of health, such as *hardiness* as a successful coping mechanism with the difficulties of life, or adaptability, maturity (in a developmental sense), spontaneity and creativity,

subjective self-perception (such as self-respect, self-reliance, high self-esteem, self-efficiency, etc.) are often mentioned in this model.

No matter what health model we apply, we should realize that it is always a partial simplification. From complicated and intertwined reality, we try to choose the essential phenomena and relationships in an effort to get to know them in more detail and, if possible, to influence them.
It is obvious that the perception of health is constantly evolving, and nobody can expect even current approaches to be definitive. The broadest concept of health and healthcare seems to be the most promising, taking into account both the individual and the social level. Such an approach is typical of WHO work and finds its expression in the Health 21 Program.

At first glance this concept may seem logical and quite obvious. In fact, it is about the bridging of a traditional dual perception of the world, and about crossing many existing institutional boundaries as well as about the transfer of the focal point of healthcare from highly prestigious clinics (where one's health is being "repaired") to families, schools and workplaces where health should be protected and purposefully developed.

Health is an important characteristic of the existence of individuals and social groups, dynamically evolving and changing from one’s conception to death; it forms a continuous scale of diseases from the state of complete health in the sense of the traditional WHO definition to the state of death. Health is conditioned by many circumstances and, to a certain extent, can be protected, developed and restored.

In order for the efforts to achieve the best possible health of people to be successful, it makes no sense to put some traditional concepts such as prevention and therapy, individual and social, health and illness/disease, particular disease management, and continuous (lifelong) health, medical and social care in opposition. It is important to ask what is useful for people’s health and try to help it through a wide range of medical, political, organizational, economical approaches and other measures.

We may be expecting a major transformation of healthcare, which is going to be thoroughly based on the health needs of citizens and the entire community and is going to be aimed at human health. Such transformation has gradually been taking

place in developed countries since the late 1970's. It is not about individual measures but about a rather complicated program process, the basic elements of which are equity (social justice, decency), efficiency (medical, economic, and social), and quality (including the meeting of professional standards and the satisfaction of citizens with healthcare). The whole process is characterized by a broad understanding of health and the inter-ministerial concept of healthcare, a significant share of research in the preparation and validation of intended measures, a solid level of conceptual thinking based on the use of modern findings in the field of management and informatics, human and democratic orientation, a relatively high culture of management and administration, and broad international cooperation.

The experience from many countries shows that it is useful if health becomes the subject of interest and the responsibility of individuals and social groups and if this interest is accompanied by adequate economic opportunities. Sometimes it is remembered that the question is not how much money a state can afford to pay for healthcare, but rather how long, or at what risk, the state and its citizens can afford not to provide at least as much money for healthcare as is absolutely necessary.

Health and health care is a basic human right. This was already taken into account by the WHO Constitution fifty years ago. Health is also a basic human need. When taking into consideration our share of civic responsibility for our destiny and, to a certain extent, also for the state and development of the society in which we live, we should ask ourselves both about our share in the care of our own health and about our role in the broadly defined system of healthcare. In this sense, *the healthcare strategy in Europe* is becoming a subject of both the public interest and the motive for cultivating and fulfilling our own specific personal responsibility.

1.2.3 The Concept of Social Functioning

The term "social" (from a Latin orig. *socialis* – social, allied, sociable) has lots of meanings. It relates to the meanings on an individual level (social contacts, inter-individual social communication) and on a social level (social security, social care services and allowances/benefits) and many other levels (welfare state – politics, sanitary facilities – toilets, etc.)

Social functioning is a concept with different meanings. The common conceptual basis of disparate versions of this concept is the interactions that take place between the environmental requirements and people. The core industry anchor of the concept is in social work.

Social functioning means, according to Barker (see cit. Navrátil 2001: 12):
"The fulfilment of the roles of man in society, in relation to people in the immediate social surroundings and in relation to oneself. This functioning involves the satisfaction of both basic needs and those on which an individual's use in society depends. Human needs include physical aspects (food, shelter, safety, healthcare and protection), personal satisfaction (education, rest, values, aesthetics, religion, achievement), emotional needs (a sense of belonging, mutual care, community) and adequate self-definition (self-confidence, self-esteem, and personal identity)."

Navrátil and Musil (2000) introduced the concept of social functioning into the Czech environment of social work. They use the concept of social functioning to refer to the complex of following facts:

- People and the environment are in a perpetual interaction with each other.
- The environment puts certain requirements on a person (it formulates expectations, defines social roles) and a man is forced to respond to them.
- There is usually a balance between environmental requirements and a man. If people do not sufficiently manage to deal with environmental requirements, the balance is distorted and a problem arises.
- Some people are able to cope with the problem and rebalance themselves; others do not have that ability, meaning that they cannot cope with the problem situation.
- The reason for the problems or the failure in coping with them can be both the lack of client skills and the inadequacy of a given environment's requirements when set against a client.
- The subject of a social worker's intervention is the interaction between the client's coping capacity and the environmental expectations from that client. A social worker aims to promote the social functioning of a client by helping to restore or maintain a balance between a more or less sufficient coping capacity.

Navrátil (2003) defines another factor, which has been lacking in the concept of "social functioning" and "life situations" thus far. According to him, not only does the social environment define its expectations and demands towards an individual or a group. What is important is that an individual and/or a group and other social entities also have their own expectations towards their environment. Given this fact, social functioning can be defined as the "relationship between the expectations of an individual and the social environment. If these mutual expectations are in harmony (complementary), interactions take place harmoniously; if they are not, difficulties arise in the interaction." (Navrátil, 2003: 87)

1.2.4 Empowerment

For the English word "empowerment" there is no suitable Czech equivalent. Its basis is the word *power*. The whole concept defines the process of acquiring power and the ability to make decisions about oneself and about one's life. The concept is translated into Czech as "making a person more powerful."

The empowerment concept is wide and flexible in terms of its meaning. According to Gojová (2012: 120, with references to relevant authors), "empowerment can be conceived of as a process, or a method, but also as a result. [...] The concept of empowerment as a result means that an individual or a group becomes independent and self-sufficient in solving their problems and in making decisions. [...] Empowerment is typically understood as a process by which people reduce their helplessness and alienation and gain more control over […] the aspects of their lives and their social surroundings. [...] In terms of the method, empowerment can be defined as the tools by which individuals, groups or communities become capable of taking control over the circumstances of their own lives, thus becoming able to direct their efforts to help others and maximize the quality of their lives."

The ability to independently solve their own problems, to make independent decisions, and to gain greater control over their lives requires, in addition to the common partial skills necessary for life, also the ability to have a critical view and self-reflection, a sense of responsibility towards both oneself and others, and the ability to take an action in a particular situation.

Empowerment is associated with the following characteristics:

- Self-awareness in time and space
- The ability to recognize and define one's own limits
- Self-control
- Self-esteem – the ability to accept oneself with one's pros and cons
- The ability to make decisions about the direction of one's life – the awareness of values and one's priorities
- The ability to evaluate, have a control over and regulate internal and external conditions of one's life – to change conditions and adapt to ever-changing conditions.

The force of empowerment is related to the process of mental maturing, but not exclusively to a physical age – some young people are mentally more mature than other people who are older.

1.2.5 Universal Design – DfA

One of the conditions for the social functioning of each person is mobility, freedom of movement and freedom to remain, the possibility to use public services such as transport, health, education, social, banking and other services and access to cultural heritage. If, due to a serious health problem, a reduction in the possibilities of movement and orientation occurs, one is excluded from the physical and therefore also from the social space by the existence of barriers. Physical barriers are usually primarily associated with people temporarily or permanently using a wheelchair or having another "typical" disability. A less well-known fact is that pregnant women (stairways without any railing), people transporting infants (high curbs, missing lifts), young children and senior citizens – can commonly encounter reduced velocity in response to stimuli, fatigue, reduced orientation and mobility during old age, as a result of involutionary changes in the body, are also limited by physical barriers.

Universal design (from an English original "Design for All" – DfA) is a philosophical and pragmatic approach to designing things, buildings, technologies, and so on, of elements or systems in the environment, which gradually evolved from a barrier-free

design in the late 1980's and 1990's. It is directed to all people regardless of their age, health, physical ability, nationality, and cultural, religious or social background.

Universal design fulfils the requirements of human diversity and social equality. It is a holistic way of thinking and design. It is necessary to identify the needs, abilities and specifics of various user groups and to include them as much as possible in the designs. This approach assumes, to a great extent, considerable interdisciplinary cooperation and continuity.

The role of universal design is to develop a theory, principles and solutions that enable everyone to use the same physical solutions under the same conditions to the greatest possible extent, whether it concerns the buildings, public spaces, communications and communication technologies, transport, means of transport or, for example, household appliances. While in the second half of the 20th century (and somewhere up to now) accessibility experts had focused on simple functionality, i.e. physical accessibility, universal design nowadays also focuses on psychological and social aspects that is on the issue of the equal status of people.

In the concept of universal design, special solutions and additional adjustments to the environment are something that excludes and stigmatizes people. There is a significant difference between "adapting the environment for all" and "building the environment for all." In the process of adapting the environment (for all), *additional measures* are being taken to supplement the already existing (e.g. building) solutions, in the process of building the environment (for all) everything is planned from the beginning so that additional solutions are no longer needed. *Understanding the differences* between both approaches is *a key element* to implementing the concept of an *"accessible environment for all.*" Differences of approaches are described by Aragall (in ECA 2003: 38):

"In creating an actual environment, we assume the existence of an 'average person.' In the past, we perceived this accessibility issue as an individual's deviation from a 'norm.' The person concerned was 'an exception,' and thus also a 'problem.' After changing the approach to the issue, the most common solution is to add special equipment to existing buildings, such as ramps or door extensions. Such solutions, however, support the idea that certain individuals are an 'exception to the rule.' These solutions stigmatize people with disabilities by making them use, for example, separate entrances that are often located at the back of the building. Additionally,

these modifications are complementary equipment, arising from a secondary idea, not as a result of planning during the design stage. The aim of the new integrated approach, including the concept of universal design, is to solve each individual's problem with the same consistency. We should extend the "normality" criteria to make environmental construction function in line with the principles of universal design. We should all be able to visit and enjoy all the spaces of the constructed environment *independently and naturally* as much as possible."

If it is necessary to rule out some solution or a group, it should be done consciously and on the basis of firm arguments. Equal status, equal treatment, and equal quality are the key concepts of universal design.

The concept of equality in the context of universal design then forces us to think in greater contexts, to see territorial, economic and social planning in coherence. The design of buildings and products, or town planning with regard to social aspects of life was called "Inclusive Design" by Jim Sandhu, an English architect of Indian origin, in 1995. An example of this is the construction of dwellings that will serve the residents well throughout their lives, from youth to old age, tailored to all the specifics of aging, without the need for special and often costly adjustments.

Universal design also has an impact on other aspects of life that are reflected in the psychological aspects of individuals and the economic sphere of society. Inaccessible public spaces, inaccessible public transport and transport infrastructure, inaccessible public services (health, education, banking, insurance, etc.), and inaccessible housing are directly related to the self-sufficiency of an individual and the use of social services. If people have barrier-free housing available, they can go shopping or see a doctor independently, thus using fewer social services. And despite the fact that the existence of a completely barrier-free environment is considered to be utopian, the concept of universal design has just that significant psychological and economic effect – it reduces the need for technical, financial and human assistance for many (not only disabled) people.[12]

[12] The head of the authority, who was responsible for ensuring the mandatory share of employees with disabilities (then with so-called changed working capacity), was surprised that there is no interest in vacancies from people with disabilities: "Why don't people with disabilities apply for jobs when we have a barrier-free office?"... The answer is multi-layered, to some extent forms a closed circle, and might sound like this: They do not apply because they are usually missing the required qualifications. ↔ They do not qualify because they do not usually have the required education. ↔ As a rule, they are missing the needed education because barrier-free schools are still not a matter of course. ... Even twelve steps can be a real cut off of the possibility of attending a selected

2 A Terminology Framework

In a natural language, we use words in their "common" meanings. Professional terminology is usually based on "common" language, however, in the quest to refine its meanings it deviates more or less from it. Many professional terms or concepts, through which different professions communicate with each other (both within the profession and interdisciplinary), do not occur in common language. What can lead to a problem then is the "distance" or "tension" that arises when the difference between the natural and the professional term is too great rather than the actual content of a professional term.

The aim of this chapter is not to provide a systematic overview and analysis of definitions relevant to coordinated rehabilitation, but to create a certain conceptual awareness, and to provide a basic terminological background for a deeper understanding of the concept of coordinated rehabilitation.

2.1 Health, State of Health, and Well-being

Health

The term 'health' refers to a broadly defined life condition of people, and also to all phenomena and events that influence and accompany health. Health has many aspects, the importance of which changes in different historical periods, during people's lives, depending on culture, economy, the development of medicine and of all other widespread health care, and as a consequence of many other circumstances. It is generally accepted that it is difficult to define and measure health (it is easier in the case of illnesses). It can be concluded that health is a

---

school... If there is a principal who creates the conditions for accessing the school to pupils/students with severe health problems, he/she usually encounters psychological barriers in the form of the reluctance of teachers (or parents of "healthy" children, or the school principal himself/herself, provided that an initiator is a class teacher) to accept such a child/student. If a principal manages to overcome these barriers (i.e. provides teachers, consultations, teacher assistants, etc.), an almost insoluble barrier infrastructure problem will emerge. ↔ Inaccessible routes to school and inaccessible transportation to school usually require high individual deployment of parents and complications in their employment. (Not every employer will, or can, permanently accept the day-to-day pick-up and transport of a child/student to school.) The circle closes: the student chooses a school that does not meet the needs, interests and abilities of a prospective employee, but the one that is accessible. If such a school is far away and the student does not have good economic and/or family and other backgrounds, he/she resigns to education that would correspond to his/her real abilities, or resigns from education altogether. The consequences will then be reflected in his/her fall into the social benefits network. (Krhutová 2005: 70)

generally human and social concept rather than a unilaterally medical term, and that its determinants and possibilities of its protection, enhancement, and development go greatly beyond the traditional domain of health services.

Today, the classical "definition" of the World Health Organization (hereinafter “WHO”) from 1946 states that "health is a state of complete physical, mental, and social well-being, and not just the absence of disease/illness or defect." What brings along occasional embarrassment is the fact that it is not a definition in the true sense of definition. It is one of the paragraphs of the WHO Constitution, which was conceived at its inception as the WHO's intention of what to focus on. The above definition includes an element of the negative definition of health (the absence of disease/illness or defect) and also a positive definition element (a state of complete mental, physical, and social well-being). However, the definition does not say what is meant by well-being. Undoubtedly, a subjective sense of well-being will play a significant role here, but the concept of health cannot simply be reduced to it. It is clear that the "well-being" brought about by, for example, a drug does not correspond to the concept of health.

Although the current WHO definition is useful for general orientation, it can be considered idealistic – given that the core of the definition is "well being" as a very subjective and difficult to measure determinant – if we consistently applied it, the question arises as to how healthy the world population is ... And if there is also a conjunction "a" in the definition, then people, for example, with an amputated finger would not be considered healthy (according to this definition).

The vagueness of the above definition is a disadvantage for those who expect that such a comprehensive term/concept can be easily and accurately measured and that, on the basis of a specific definition, it is possible to select effective measures. However, the general definition can also be an advantage if we take it as the basis of the so-called broad concept of health and health care, with all the conditions, determinants, possibilities of influence, and their consequences. Such a concept is the basis of many activities (not only medical) that help protect, consolidate, develop, and restore health.

The definition of health has been refined and supplemented. In the WHO Health for All by 2000 Program, adopted in 1977, an additional profile of health emerged as an

ability to lead a socially and economically productive life. This definition meant that health ceased to be a goal in and of itself and has become a tool of implementing the harmonious development of man. Another shift is being made in the new WHO Health for All in the 21st Century Program, adopted in 1999, which provides a definition of health that, for practical reasons, defines health as "reducing mortality, sickness and disability due to identifiable diseases and disorders and the perceived increase levels of health." The document also talks about health potential as the highest level of health that an individual can achieve. The health potential of each person is determined by the ability to look after himself/herself and others, and his/her ability to make independent decisions and retain control over his/her own life. Society should create the conditions for people to use their health potential.

Health is therefore not only a characteristic of a biological organism (as a traditional medical object). It is also a significant human value, both individual and social. It is accompanied by many social, legal, political, economic, cultural, and other aspects. Depending on the different frames of reference (physical health, psychological health, etc.), different understandings of the concept of health can be expected, while certain differences may not be an obstacle to working together. Therefore, there is no need to promote only one definition of health. Although we can expect different approaches to health care, it is desirable that the concepts of health and the subsequent activities are viewed and implemented in a complementary manner, that is, everyone contributes to the common intent according to their own possibilities.

Understanding the concept of health can be easier with the remark that the word "health" is, in terms of linguistics, close to the concept of "whole." For example, the English term *health* has been derived from an Old English word *hale* having a direct relationship to the word *whole* (whole, healthy); similarly German *heil* means *whole* and *to cure*. In Slavic languages, the expressions of *to cure* (zdravit in Czech) and *to heal* (celovat in Czech) have already separated, but for example, when the wound heals, we say that it is *closing up* or *healing up* (zacelovat in Czech) (cf. holistic approaches.)

Given the problems with a definition of health, the so-called *operational definitions of health,* which are oriented towards those characteristics of health, or diseases that

are related to the goal of the particular study/research, are often created for scientific purposes.

State of Health

State of health can be characterized as a *neutral* term for a certain level of health.
An individual state of health is influenced by the following factors:

1. Personal factors (individual characteristics, behaviour, inheritance, lifestyle, etc.)
2. Social factors (economic, political, cultural, etc.)
3. Physical environment factors

These factors interact with each other and are sometimes referred to as *health (or also disease) determinants*.

The population's state of health

Even in the 1970's, there was a belief that the state of health of the population was, to the largest extent, a reflection of the level of health care. However, the state of health of the population is the result of a wide range of determinants of different nature and different origin. The main determinants of population health are as follows:

1. Lifestyle (one's way of life) – e.g. living standards, social factors, unemployment, work mode/method, stress, level of education, diet, physical activity, alcohol or drug abuse, smoking, approach toward and care of one's own health, personal hygiene, sexual behaviour, consumer behaviour.
2. Living and working environment (air, water, soil, noise, electromagnetic radiation, climatic conditions, food chain, production technologies, working environment, objects of daily use, housing, services, transport, town planning).
3. Health care and health services (development of medicine and medical equipment, health policy, availability of health care, health care systems, a level of health services, organization of financing and management of health services).
4. Biological (genetic) basis (congenital malformations, disposition to disease, a level of intellectual abilities, differences in male and female health).

In the expanded concept, the following further determinants were specified:

5. The social determinants of health that are represented by

a) Socio-economic factors of the environment – characteristics of the place where people live and the communities to which they belong – e.g. poverty, education, social exclusion, poor housing, social security, etc. These factors correlate with the state of health, affect the basic determinants of health, form a certain "cause of health and disease" and contribute to inequalities in health.

b) Psycho-social determinants of health – behavioural factors included in lifestyle (behaviour), and other psychological and social factors (personality type, stress management, psychological resistance, social support, etc.)

Well-being

The above and other characteristics can be summarized under the umbrella term "health-related circumstances." They affect the sense of well-being in a variety of ways. It's known in the professional literature as "well-being" (welfare, a state of ease, life satisfaction). This term covers the entire universe of domains of human life that make up what can be called a "good life".

Well-being is not just about subjective satisfaction (cf. the concept of quality of life); it includes deeper aspects of *well-lived life*. The concept of well-being captures important aspects of how people feel and experience their everyday lives – thus not being limited to physical or mental health, economic indicators, and prosperity.

The key elements of well-being are:

1. Purpose – we need to do something meaningful in life, what makes us feel happy and content, optimally every day. It does not matter whether it is an area of work, school, family, or leisure time; the essential thing is that we perceive a purpose in such activity and we are motivated to achieve our goals.
2. Social relationships – the quality of our relationships is very important for our health and well-being. Good and healthy relationships reduce stress and increase the feeling of well-being.

3. Financial – managing ones' own economic situation (employment or other income), financial stability and an individually perceived desirable amount of finances enabling us to do what we wish every day.
4. Health (physical) – The overall mental and physical health (vision, speech, movement, memory, etc.) and the amount of energy that is needed to complete daily tasks.
5. Community – A sense of belonging and involvement in life in the environment in which we spend time (upbringing, education, care for others, donations, volunteering, etc.) fills a person with positive emotions and satisfies the need for belonging.

An expanded concept of health, which (besides the physical dimension of life) also includes other vital aspects that are important for a sense of well-being, is shown in the table below:

Dimension	**Dimension content**
Physical	Anatomical parts of the body – body structures/organs, physical functions, including psychological, physical pain, sleep quality, appetite, etc.
Activities	What and how a person acts – the way he/she learns, communicates, moves, stands, sits, looks after himself, does household chores, looks after others (people, animals), goes shopping, completes phone calls, reads, writes, counts, draws, paints, cuts, sows, etc.
Personal	Individual psychological experiences, emotions, inner life, sense of purpose, existential questions, spiritual life, spirituality, experience, character, temperament, relationship to self, mental pain, feeling of well-being, feeling of security, personal value system, adaptation potential, etc.
Social	How a person engages in different life situations – social life, social networks, roles, behaviour and actions, relationships, upbringing, work, employment, community, interests and hobbies, holidays, travelling, participation in civic life, volunteering, sexual life, etc.
Environment	Natural environment, artificially created environment, products and technologies, support from the environment, attitudes of the surroundings, services, political, economic, geographic, cultural, and legal systems, organizations, institutions, a state of environment, material conditions, hygienic conditions, nutrition, financial income, housing, etc.

Source: Author's own table with the use of ICF and HRQoL[13]

[13] International Classification of Functioning, Disability and Health (ICF) and the concept of Health-related quality of life (HRQoL)

2.2 Health Problems, Injury, Illness/Disease, Infliction, Disability

Health Problems

When we think of health problems, we should not just refer to a rate of sickness. Rather, they are complexes of phenomena, conditions, determinants, and events, context and consequences which have a wide range of social, cultural, economic and other aspects and *mastery of which are not manageable by one field of science or in the possibilities of one area of human activity.*

However, the narrow definition of the term *health problem*, which is based solely on health disorders, is defined by the International Classification of Functioning, Disability, and Health, according to which a health problem is the "umbrella term for illness (acute or chronic), disability, accident or injury. [...] It may also occur as part of other circumstances such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition." (ICF 2008: 220)

Injury

An injury is characterized as a health disorder usually caused by sudden and external causes. The approximate medical synonym is the term "trauma." The most frequent causes of injuries include: falls, impacts, injuries by sharp or blunt objects or parts of machines, gunshot wounds, lacerated wounds, burns, fractures, amputations, brain concussion, electric shock, assault, torture and abuse, rape, a suicide attempt, a car crash, etc. More severe injuries can be fatal or can have other permanent consequences. In similar contexts, the terms "injury," "trauma," or "health injury" are used (the latter term is used mainly in insurance and criminal law).

Illness/Disease

The definition of "illness" can be seen from many frames of reference. From the pathological aspect, it is the loss of the whole (integrated, harmonic) organization of the organism. The resistance of the organism to disease is determined by the phylogenetic development (acquired resistance), plus the ability of adaptive mechanisms (adapting to various environmental influences). Using adaptive

mechanisms, an individual can cope with harmful factors, or – if the effectiveness of harmful stimuli exceeds the possibility of adaptation of the human organism – there is a loss of a typical organism structure leading to an onset of illness. The onset of further illness is also affected by the factors of the individual's current state (nutrition, fitness, aerobic capacity, blood circulation system, mental well-being, stress...). An important role in the constitution and course of the illness is played by human consciousness.

In a medical (in general health care) environment, where illness is central to the field interest, synonyms such as the terms "disease," "morbidity," (from a Latin orig. morphus, from a Greek orig. "nosos," "patos") are used. From the point of view of this terminology, it is a condition in which the function of one or more organs is altered or impaired as a result of internal or external circumstances. The typology of the disease/illness ranges from the body's response beyond the physiological response – "a pathological response," through a temporary disorder of one or more essential functions in the body – a "pathological process" to a prolonged change in the body - a "pathological condition." The term "disease/illness" is usually referred to a disease/illness within a defined time period. The term "nosological unit" is understood to be a disease/illness that can be clearly defined in relation to other diseases/illnesses.

The progress of the disease/illness in the sense of deterioration is called "progression" (from a Latin original *prógredi* – move forward), in the sense of improvement it is "regression" (from a Latin original *regredī* – to return). Spread of the disease is referred to as "propagation" (*propāgāre* – to spread). There may be periods without any symptoms, which are called a "remission," or repetitive deterioration of the patient's state – "relapse." If the disease displays a fluctuating course, the periods of improvement – "compensation" (from a Latin original *compēnsāre* – to balance) and the periods of deterioration – "decompensation," alternate. The disease ends with recovery, stabilization, or death of a patient.

An illness/disease can have the following time course:

1. Acute course – severely developing, suddenly and rapidly emerging. It lasts several days or weeks.

2. Chronic course – long-term illness/disease caused by a recurrent cause of illness/disease, a permanent cause, or insufficient adaptation. It lasts several months or years.
3. Relative health – such a condition is achieved when the body under constant conditions appears to be healthy. The disorder is compensated and a patient feels well (e.g. a person with cardiac problems has difficulty only when being exposed to a higher functional stress).
4. Progressive course – a patient's condition is becoming progressively worse and in case of impairment of vital organs ends in death.
5. Subacute, subchronic course – indicating a course that is not clearly acute or clearly chronic.

The death of a patient can occur at any stage of the disease/illness. Acute illnesses generally lead to complete recovery, but may end in death, or there may be recovery with consequences – so-called partial health.

From the point of view of medical terminology, the nature of the disease/illness is divided into organic – "somatic" (the "*sōma*" – body), mental –"psychic" (from a Greek orig. *psychē*), mental on the organic basis – "somatopsychic," or organic on the psychic basis – "psychosomatic." A person suffering from a variety of conditions is referred to as a "polymorbid patient;" this state is referred to as "multimorbidity." In these patients, the most principal disease is referred to as "dominant," the other diseases as associated – "comorbidity." A patient who has been experiencing a very severe form of the disease is called a "moribund patient" in medical terminology.

To classify diseases we use the 10th revision of International Classification of Diseases and Related Health Problems (ICD-10). Disease classification systems are based on symptomatology and a diagnostic principle.

ICD-10 codifies the system for the labelling and classification of human diseases, disorders, health problems, and other related health and illness symptoms, situations, or circumstances. One of the purposes of ICD is the possibility of international comparison of health information. The ICD codification enables communication between healthcare professionals across the world, regardless of their national languages.

Infliction

An infliction resulting of health damage does not amount to a disease. However, an infliction is often confused with it just as people with some type of impairment are often perceived as being ill. Although an illness or other health disorder is the requirement (it must always be the case) in order to be able to talk about a "health" infliction, not every ill person is inflicted by the ill health at the same time.

For the purposes of coordinated rehabilitation interventions, an infliction can be defined as a long-term or permanent state of health different from a common age-appropriate health condition that *is manifested* by a change in the *functioning* of a person at the following levels:

1. Physical, i.e. somatic level – hearing, vision, mobility, mental functions, etc. (impairment)
2. Performing of acts, tasks, actions, activities by an individual (activities)
3. Participation in social events, involvement in life situations (participation)

Causes of infliction include: diseases/illnesses, injuries, heredity, drug abuse, smoking, and certain medication during pregnancy, birth complications, etc. People with inflictions are a differentiated non-homogeneous group not only in the following terms:

1. Type of infliction – people with physical disabilities, sensory impairments, mental retardation, mental illness, combined disabilities, etc.
2. Period of infliction development – congenital or early age, or acquired at a later age
3. Degree (intensity, depth) of infliction – light, medium, severe, very severe

One of the main features of an infliction is its variability – the causes, manifestations and consequences of an infliction in persons with the same type and degree of infliction are individually very diverse. Two people with the same illness and/or impairment may be on a different level of functioning level while two people with the same level of functioning may not necessarily suffer from the same health problems. Individual impacts of an infliction on the functioning of a person with some impairment depend on environmental factors (i.e. in the particular physical, social, attitudinal, cultural, political, and economic environment in which people live) rather

than on personal factors (age, gender, duration of handicap, life experience, social status, personality characteristics, relationship to self, etc.)

Older definitions of an infliction and definitions of the concept of *handicapped people* are primarily focused on defects, deficiencies, and inabilities; they place the problem onto a disabled person's side in terms of failing to deal with situations where the cause of an individual's worsened functioning is not primarily in a body impairment or personal dispositions, but in *environmental barriers*. The definition of terms depends on the type and purpose of definitions and also on the micro-meso-macro level of their definition. The definitions of an infliction can be divided into several types:

1. Clinical
2. Legislative and administrative
3. Research and development

For purposes of practice, particular definitions vary according to the focus of support systems, or depending on which manifestations and consequences of an infliction are monitored and dealt with in practice. Different definitions apply to the implementation of social policy measures (e.g. the definition of eligible social service users, recipients of social benefits, social care benefits, or pension benefits), and another in the area of health care (the categories of persons in terms of their functional diagnostics, assessment medicine), or school practice (establishing a range of eligible beneficiaries of special pedagogical support) and in some other areas. The form of these particular definitions is further affected by the historical, socio-cultural, psychosocial, economical, political, environmental and other aspects.

The definition of an infliction and the content of handicapped people concept differs not only according to the scientific discipline or the field of practice within which they are defined (in addition to traditional social, medical, and pedagogical approaches, e.g. social constructivist, gender, anthropological and political theories, or art theories, etc.), they also differ territorially, that is, at the level of states and continents.

Synonyms of the term frequently include *people with a health disadvantage, the handicapped, the disabled, people with special or specific learning needs, etc.* A historical, terminologically outdated and no longer used term is *an invalid* – currently

it even has a pejorative connotation. The core of the term *handicap* (in connection with disability) is in the social dimension – it refers to limited participation of people with impairment in social life (without distinction of the cause of this limitation).

Disability

The Czech language currently does not have an adequate expression for simple description of the "disability" construct. The term is quite often mistaken for a "handicap." However, these are completely different concepts.

In older concepts, "disability" is defined as *a reduction in performance* from the level of one's *own* abilities – in the sense of an individual's non-ability. Currently, this view has been overcome. Following socio-ecological approaches, the concept has been redefined as an interaction between the individual and their environment: *Disability arises when an individual, with his/her health condition, comes across barriers in the environment*. It has changed its original connotation (incompetence, inability of an individual) to a new meaning of the "barrier," which can be the result of not only internal but also external conditions independent of a particular person (co-acting factors). At the same time, the term disability means "different ability", "different capacity", "diversity".

A person in a certain health condition in a particular current situation finds himself in a disabling situation and vice versa, in a different situation, despite the fact that his health condition has not changed, he is not in a disabling situation. A disabling situation can be explained using the example of a blind man: if he is able to make a phone call (finds the phone, dials the number on a display, talks, ends a call, or sends an SMS), he is not in a disabling situation. If the same blind person ends up, in what is for him a totally unfamiliar physical environment, (but he is orientated, knows where he is and how he gets to where he needs to go), he is not in a disabling situation. But if he finds himself in a completely unknown environment where he has never been and no guide is available to him, he finds himself in a disabling situation. Thus, if perception of *a barrier* is not under certain *circumstances* present, a person is not in a disabling situation even though his health condition "does not meet the normal health standard." Also, a person with no disabilities may find himself/herself in a disabling situation – typically, for example, if we break a leg and live in a home with no lift. A disabling situation (and also disability) can also

affect pregnant women or seniors who are not physically handicapped but have certain health problems that are aggravated by interaction with environmental barriers (see the following subchapter for more detail).

2.3 Impairment, Activities, Participation

The terms "impairment," "activities," and "participation" have spread in professional terminology at the turn of the millennium in connection with the development of a new WHO classification system, namely the International Classification of Functioning, Disability and Health (ICF). ICF belongs to the "family" of the WHO classification systems and is complementary to ICD-10.

In the mid-1970's, WHO started developing an information system to complement the International Classification of Diseases (ICD). ICD as a standardized diagnostic tool with multiple axes (aetiology, anatomy, pathology, etc.) was not able to capture and describe *the functioning of a person* affected by a health problem. According to WHO, the changes in health care during the twentieth century, ranging from the treatment of acute conditions to a chronic stage of the illness/disease, required attention to be paid to consequences of a disease rather than to the actual disease. It has become necessary to adopt a new paradigm. While in the case of short-term (infectious) diseases a diagnostic approach and short-term treatment were usually sufficient, with an increase in chronic (non-infectious) diseases, along with aging of the population, the importance of "consequences of the disease" has grown so much that they have become a very serious problem. Apart from traditional "recovery," the arrangement and organization of living conditions in which a person dwells is at the forefront. ICD cannot answer these questions because it cannot be deduced from the diagnosis itself.

In 1972, WHO created a preliminary scheme related to functional and social consequences of disease. Gradually, it was developed in 1980 to a classification system known as the *International Classification of Impairments, Disabilities and Handicaps* (ICIDH).[14] It was based on an expert need to identify, describe, and determine the degree of "disease consequences" at an individual level and at a societal level that could not be captured by disease codes. ICIDH has been a

[14] In Czech translation known as *Mezinárodní klasifikace poruch, disaptibility a handicapů*.

progressive act in the context of time. By introducing "disease" and "consequences of disease" as separate categories, it allowed for a systematic description of individually different impacts of "identical diagnoses" on the personal and social life of different people.

On an international scale, this was an important shift and a qualitative change.[15] In a very simple way, until the development of ICIDH, the health problem was equal to the diagnosis. ICIDH brought a concept of a dimensional model viewing a health problem from three levels:

1. From the perspective of the body as an organism (the problem develops at the body's level, body organs, and/or their functions)
2. From the perspective of everyday activities that an individual completes
3. From the perspective of an individual's involvement in social life

The World Health Organisation designated the above levels by the following terms: Impairment (no. 1), Disability (no. 2), and Handicap (no. 3), and defined the precise content for each of them. WHO explained their inter-constellation in the manner and scheme below:

Something abnormal manifests in a person
Pathological changes are manifested
(symptoms and findings)
A HEALTH PROBLEM

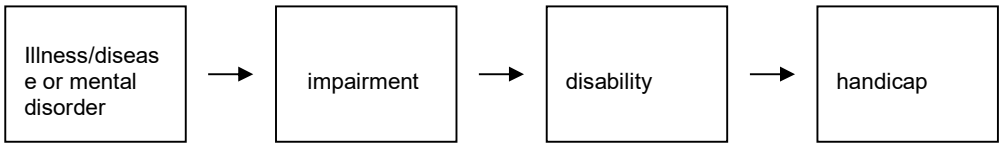
Someone notices this fact
Symptoms can be diagnosed (a disease starts being clinically visible/detectable)
IMPAIRMENT / at the level of a body
(of an organ or a system)

Performance of person's activities can
Performance can worsen, lower, is measurable
To change the disease symptoms (they are objectified)
(disease-related behaviour)
DISABILITY / at the level of an individual

A person gets in a disadvantageous position compared to others
society's reaction to a person
(limited participation in social events)
HANDICAP / the level of society

[15] In the Czech Republic, this shift occurred much later, when the flat-rate assessment of, for example, entitlement to allowances and aids according to a scheme was abandoned – all those who had a leg amputated above the knee would receive an identical amount of financial compensation.

The graphic scheme of 1980 ICIDH



The definition of disability was defined in ICIDH as follows (WHO-beta 1997: 143)

Definition	In the context of health, disability means any limitation or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range that is considered normal for a human being.
Characteristics	Disability is characterized by deviations or deficiencies that are usually expected in performance of activities and functioning and which may be temporary or permanent, reversible or irreversible, progressive or regressive. Disability can be developed as a direct consequence of impairment or as an individual's reaction, especially psychological, to physical, sensorial, or other impairment. Disability represents the objectification of impairment and as such reflects an individual level disorder. Disability refers to the inability to perform complex activities and actions that are generally understood to be basic components of everyday life. Examples include behavioural disorders, personal care (personal hygiene, eating, defecation) and other activities of everyday life as well as physical activity (such as the ability to walk).

This definition, as well as the entire ICIDH classification concept, have been criticized for their bias, focus on pathology, and attention solely to "what does not work" and "what works poorly." Critical voices pointed out that directionality of the arrows induces the causal model interpretation that is decisive for changes occurring over time when damage-impairment leads (only!) to negative deviations from performance standards and to inability-disability that trigger the process of exclusion-handicap and that one-way nature of arrows does not allow any movement from handicap and disability to impairment meaning that the model does not sufficiently reflect the effects of social and physical environment on the individual's situation.

Although ICIDH's original text has already claimed that circumstances are more complex than just a simple timeframe, WHO has acknowledged that this statement has to be articulated much more clearly and that the arrows in the graphical representation should only be understood as "can possibly lead to...".

Another critical point of the concept was that the social dimension of a health problem, the social handicap of a person was perceived as a direct individual consequence of a health disorder. This was reflected in the definitions of handicap not only in our country. For example, according to Vysokajová: a handicap may not always manifest. It depends on the cultural and social standards that surround the disabled person, because a handicap is basically a disharmony between the state or *the performance of a person* and the community expectations where he or she belongs. Many authors, on the other hand, defined a handicap as a function of the relationship of a person in an environment that systemically puts him/her at a disadvantage due to the fact that it does not count on people who do not fit in in terms of health normality. Environmental factors (physical, informational, attitudinal, etc.) according to them either allow or do not allow, or make it difficult for a person to participate in social life.

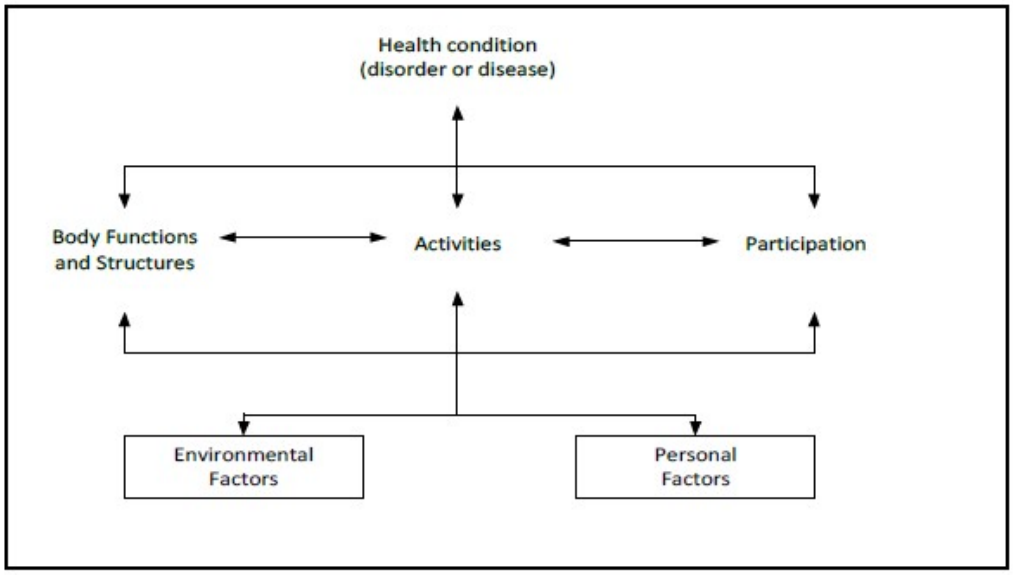
The WHO classification of ICIDH was published in 1980 with the assumption of 10 years of trial operation. However, the process of adopting it in line with the international standard was extended to eighteen years. In response to criticism and in the context of overall societal changes, environmental factors were newly integrated into the classification system, and personal factors and conceptual pillars were fundamentally redefined. The terms "impairment – disability – handicap" have been replaced with the terms "impairment – activity – participation," the concept of handicap has been completely abandoned, and the concept of disability has acquired a completely different content and meaning in terms of its connotations. The classification was given the new name *International Classification of Functioning, Disability and Health* (ICF)[16] and in 2001 was officially approved by all WHO Member States as an international standard for the description and measurement of both individual and societal health and disability.

The current concept of disability in the context of ICF is presented by WHO as holistic with reference to the bio-psycho-social model of health. The term "disability" is explained in ICF as "the umbrella concept for all three views – the body, individual

[16] Translators of an original English version of ICF to Czech (published in the Czech Republic in 2008), Prof. MUDr. Jan Pfeiffer, DrSc. and doc. MUDr. Olga Švestková, Ph.D. had to deal with many difficulties (Švestková 2013). For the umbrella English term "disability", they suggested using the Czech term "handicap" (Pfeiffer, Švestková 2008: 219) and use both terms, with several exceptions, as mutually interchangeable. They decided to translate the term "functioning" in the classification title as "functional abilities." However, this Czech expression can again refer to the evaluation conceptions from the constructivist approach – he/she is able/is not able – in terms of value categories.

and society" (International 2008: 219) and defined as an umbrella term for impairment, activity boundaries and reduced participation. It denotes *the negative aspects* of the interaction between the individual (with a health problem) and the co-acting factors of a noted person (environmental factors and personal factors). The current concept of health/disability is illustrated in the graphical diagram below.

The graphic scheme of ICF 2001 – a contemporary concept of health/disability



Source: WHO 2013

While ICD-10 provides an etiological framework of health problems, it is possible to diagnose and describe the nature and extent of organ failures and/or of their function, because ICD provides information on the functioning of an individual in everyday life. The great philosophical shift of this classification is that ICD *does not classify individuals but describes and classifies each person's situations* in a number of health-related circumstances, that is, the situation of an individual interacting with different life situations and environments. It can be used both in the context of health problems and in a healthy population.

ICD is or can be one of the tools for optimal *teamwork and communication between health professionals* from different areas related to health (in a broader sense). It classifies and measures health conditions and health-related circumstances at an individual and societal level.

The International Classification of Diseases may be

1. A tool to describe one’s state of health (continuous and uniform assessment, a uniform language), especially for the purpose of assessing one's degree of disability, assessing one's health fitness for work (provided a person is disabled), assessing one’s special needs in education, prescribing and reimbursement of medical aids; it is also a tool for health insurance companies, for determining one’s state of health as a basis for granting different benefits and social security and employment services, for assessing one's long-term adverse health status in order to deal with social security and employment matters, and for statistical purposes when assessing one's state of health.
2. A clinical tool to compare the effectiveness of treatment and rehabilitation procedures, functional diagnostics, and planning of intervention
3. A tool for measuring quality of life
4. A statistical tool for one's planning in health systems and social security systems
5. A tool for the removal of architectural barriers, etc.

2.4 Long-term Illness, Long-term Adverse Health Status, Disablement

The term "long-term illness" is often confused with the term "health infliction" but also with the term "long-term adverse health status," therefore it is necessary to clarify their different grounds and contents.

Long-term Illness

The term "long-term illness" is most commonly used in the Czech Republic in the context of long-term care (LTC). This term's equivalent is a "chronic illness," which is a long-term illness, usually lasting longer than a few months (a prolonged illness), or a permanent disease – e.g. cardiovascular disease, chronic respiratory diseases such as bronchial asthma or chronic obstructive pulmonary disease, epilepsy, metabolic diseases such as diabetes, obesity, dementia - such as dementia in Alzheimer's disease - etc.). There are usually changes in the body that may not be reversible (they are so-called "irreversible") present. Therefore, such illnesses are more difficult to cure, or we may not be able to cure them completely without consequences. Depending on the severity of the diagnosis, a long-term illness can lead to a disability and disablement.

Long-term Adverse Health Status

"Long-term Adverse Health Status" (LAHS) is the term used in the Czech Republic in social security systems and is the subject of an assessment activity under the auspices of the District Social Security Administration.

To claim some social welfare a person must satisfy a condition of having their health impaired. While, for example, in the case of health insurance claims, the short-term health disorder is already of significance; receiving benefits or another type of support from other social systems is usually conditioned by a longer-term health disorder, which is referred to as a long-term adverse health status.

One's actual long-term adverse health status does not constitute any social security claims, however, it is a basic prerequisite for such a claim. Legislation requires, in addition to LAHS, some of its specific consequences, which differ from one social system to another depending on the nature and purpose of each system. When fulfilling these consequences, it is possible to accept the corresponding category (e.g. disablement of a certain grade) that characterizes the health condition of entitlement to a specific social benefit (e.g. to a disability pension), or with which some benefits are associated (a disabled person in the employment system).

Legally Significant Consequences of LAHS:

1. In the system of benefits for persons with disabilities, such disabilities constitute a significant functional impairment of mobility or orientation (medium severe, severe, particularly severe, or complete), severe defects in the supporting or musculoskeletal system, and also severe hearing or visual impairment, or else severe mental retardation.

2. In retirement insurance, the most significant consequence of LAHS is the qualified percentage of one's decline in working capacity. Depending on its percentage, it can meet characteristics of a first-degree disability provided it has reached at least 35% and not more than 49%, the second-degree disability provided it has reached at least 50% and not more than 69%, and the third-degree disability if it has reached at least 70% of a decline in working capacity.

3. In the employment system, the most important consequence of LAHS is the substantial reduction in the ability of a person to be or stay involved in an employment process, to continue working in an existing profession, or to utilize the previous qualification (or gain some qualification), while retaining the ability to maintain a consistent employment or other gainful activity – these are characteristics of the disabled person category.

4. In the social services system, the most important consequence of LAHS is the inability to manage the basic necessities of life – mobility, orientation, communication, nourishment, dressing and putting on shoes, body hygiene, physiological needs, care of one’s health, personal activities and housekeeping. This inability fulfils the characteristics of dependence on the assistance of another person. The dependence may be classified as light (Grade I), moderate (Grade II), heavy (Grade III) or full (Grade IV).

In all social systems, the character of a starting point in LAHS on the one hand means that without its existence, the corresponding category cannot be recognized, even if the other specified assessment criteria were met in a specific case. On the other hand, it also means that the existence of LAHS itself does not fulfil the conditions for recognition of the relevant category.

2.5 Rehabilitation and Coordinated Rehabilitation

Rehabilitation is one of the systemic, internationally recognized concepts of "returning to health" and/or of improving the quality of life of people with a long-term or permanent change in health status. The term "rehabilitation" is derived from a Latin term "habilis" (able/capable) and a prefix "re" meaning re-occurrence. The meaning of the term "rehabilitation" differs beyond the Czech Republic's borders from the narrow definition and use of the concept in the Czech Republic – this term is improperly attributed to the content of former physical, nowadays physiotherapeutic activities. However, the concept of rehabilitation goes far beyond the rehabilitation framework in the healthcare system (also called medical rehabilitation).

When it comes to children and adolescents, we use the term "habilitation," in the case of working-age adults and the elderly the term "rehabilitation" is used. Older alternative names are "complex rehabilitation," "comprehensive rehabilitation," "complete rehabilitation," which appear in parallel in professional terminology, especially in the fields of special pedagogy. The term "coordinated" plus "rehabilitation" takes into account the current lay person's connotations of rehabilitation, which in the Czech Republic continues to be used (out of habit), and it is therefore necessary to find another designation for psychological reasons. In many countries outside of the Czech Republic (Great Britain, Sweden, USA, Australia, etc.) this term is not used, re/habilitation is automatically perceived in the original meaning of complexity as a multidisciplinary inter-professional discipline, which has no exclusive link to medical rehabilitation in the Czech republic.

3 Definitions and Models of Coordinated Rehabilitation (COR)

3.1 Definition of COR

The myth: Rehabilitation is a domain of disability.

The various definitions of coordinated rehabilitation (hereinafter referred to as "rehabilitation") capture the gradual terminological and empirical development of the concept.

The 1947 WHO Definition
Rehabilitation is the combined and coordinated use of a variety of therapeutic, social, educational, and occupational measures for training or re-training of an individual to the highest attainable level of functional ability.

The 1993 UN Definition
Rehabilitation is a process aimed at enabling people with a handicap (disability) to achieve and maintain the optimal physical, sensory, intellectual, psychological, and social level of their functions and to provide them with the means to change their lives to achieve a higher level of independence. Rehabilitation may include measures to ensure and restore functions or measures compensating for the loss or absence of function, or functional limitation.

The 2001 WHO Definition
Rehabilitation is the restoration of independent and full physical and mental life of persons after injury, illness, or mitigation of the permanent consequences of illness or injury to improve the life and work of an affected person.

Rehabilitation in the context of the UN Convention on the Rights of Persons with Disabilities from 2008
In 2008, the UN Convention on the Rights of Persons with Disabilities entered into force and became part of the Czech legal order in 2010. The Convention has the character of transnational law (the Member States have to implement the individual articles of the Convention into their national legislation) and obliges the Member States to promote, protect, and ensure the full and equal enactment of all human rights and fundamental freedoms by all people with disabilities and to promote respect for their natural dignity. Article 26 of the Convention specifically addresses habilitation and rehabilitation:

1. State Parties agreeing to this Convention shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, State Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programs, particularly in the areas of health, employment, education and social services, in such a way that these services and programs:
   (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
   (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.
2. State Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
3. State Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Another important article of the Convention, which also concerns the rehabilitation concept by emphasizing independence, is Article 19, Living independently and being included in the community:

State Parties agreeing to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

The shift in defining the concept of rehabilitation and its aims from the initial "training to functional ability" through the emphasis on independence and community life (i.e. outside of an institutional facility) to respect for dignity and personal autonomy is obvious.

The Concept of Long-term Care

Both the concept of rehabilitation and the concept of long-term care have a number of common elements and practices; often they are linked to each other, but they differ in their basic focus and manner of implementation.

Long-term care (LTC) is usually understood as a set of in-home services and/or services provided in institutions needed by people with a long-term limitation on self-sufficiency, where the cause of this limitation lies primarily (but not exclusively) in chronic illness or disability. This is usually such a state of health, which is stabilized, however, which does not allow for complete independent functioning. Long-term care is understood to be a set of services to ensure completion of activities of daily living (ADL), especially in basal areas (assistance with personal hygiene, dressing, meal preparation and food intake, mobility, etc.), while it is often combined with the provision of basic medical services (assistance with wound dressing, medicine administration, pain relief, monitoring of health condition), and instrumental areas (such as assistance with shopping, housekeeping, finances, etc.). In long-term care, it is primarily a combination of health and social services that people who depend on the help of another person, because of their long-term adverse health condition. The long-term care system should allow people to remain in their natural environment while making sure they have a dignified life and create suitable conditions for their family members.

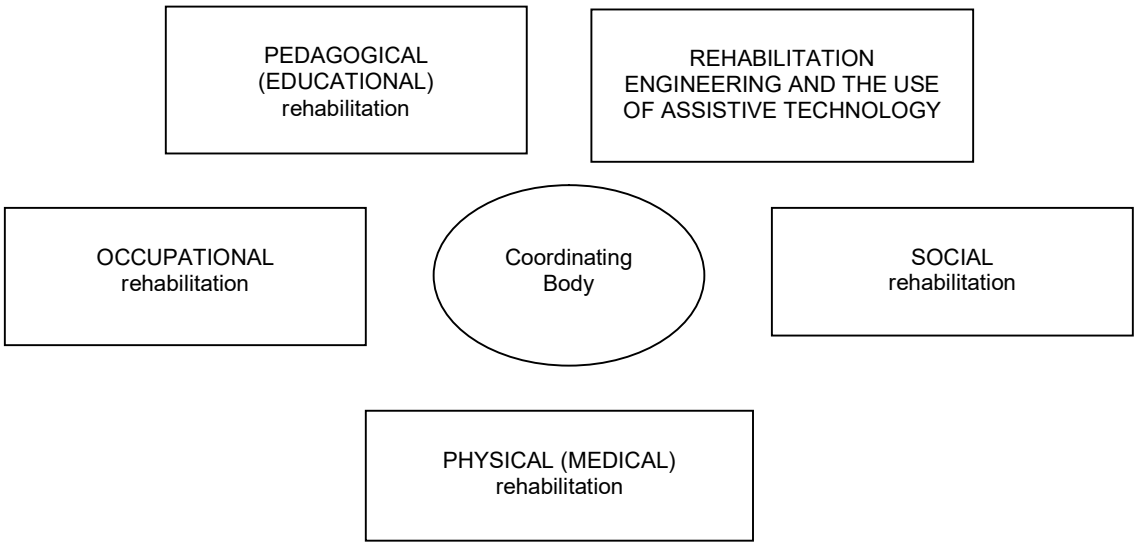
In practice, these services are offered in several forms, that is, as residential (institutional) (provided by, for example, long-term care hospitals, hospices, specialist therapeutic institutes, nursing homes in hospitals and aftercare, institutional social care facilities, etc.), outpatient (rehabilitation care centres, day or night care centres, etc.), and field or outreach (health and social in-home services and field services) support. An integral and essential part is taken by informal long-term care in-home providers, support of which the future reforms of the long-term care system should be focused on. Some authors divide the forms of long-term care into professional and family (also informal) care. However, the Czech Republic has already been experiencing attempts to promote the professionalization of family care for

people with long-term illness (people with long-term adverse health status) as one of the ways of developing and innovating the concept of long-term care.

3.2 System, Measures / Components of COR

The system of coordinated rehabilitation represents the timely, combined, interconnected, smooth, coordinated, and collaborative establishment and use of health, social, occupational, educational, technical, technological and other measures to maintain or enhance the quality of life of a person with a health problem. The purpose of the COR system is to acquire/re-acquire the skills important for an individual's functioning in areas that are affected by his/her temporary or long-term adverse health status. COR simultaneously focuses on stabilizing health, mitigating the risk of progression, and preventing the consequences of illness or injury, or secondary disability.

The Scheme of Coordinated Rehabilitation



Different authors state the scheme and components of the COR using different nomenclatures and structures. Basic components include the physical (medical), social, occupational, and pedagogical-educational rehabilitation components.

The components of coordinated rehabilitation

Physical (Medical) rehabilitation	Invasive interventions – surgeries, procedures; non-invasive interventions – medication, physiotherapy, occupational therapy, clinical psychology, clinical speech therapy, visual therapy, etc.
Social rehabilitation*	Social services, social benefits, employment support, therapeutic workshops, housing, support of cultural and recreational activities, etc.
Occupational rehabilitation	Overlapping with pedagogical rehabilitation – qualification, retraining, overlapping to medical rehabilitation – ergodiagnostics, occupational therapy, ergonomics, and overlapping with social rehabilitation – sheltered employment, etc.
Pedagogical (Educational) rehabilitation	Education, pedagogical counselling, with an overlap to occupational rehabilitation – preparation for occupation, etc.
Rehabilitation engineering and use of assistive technology	Development and manufacture of compensatory aids (supportive devices), removal of informational, architectural, and transport barriers – means of transport, transport infrastructure, etc.
Economic rehabilitation	Overlapping with occupational and legal rehabilitation – state public finance policy (e.g. subsidies to create jobs, provision of social services, etc.)
Legal rehabilitation	Legislation to ensure equal living conditions

* The concept of social rehabilitation in the context of coordinated rehabilitation is different from the concept of "social rehabilitation" within the meaning of the Social Services Act[17]

3.3 The Principles of COR

The individual components of COR are usually presented (and implemented in the Czech Republic) as isolated components, however, the key feature of COR is that its processes and procedures overlap and follow upon each other. The key principles for planning and implementation of COR are:

Timeliness * Complexity, continuity, and coordination * Accessibility * Individual approaches * Multidisciplinary assessment * Efficiency

Timeliness

The timely commencement of rehabilitation in all its areas is a fundamental prerequisite for successful fulfilment of its purpose and leads to the much needed activation and motivation

[17] See Paragraph 70 of Act No. 108/2006 Coll., on Social Services, as amended

of a person with a serious health problem towards solving his/her situation, his/her social reintegration.

Complexity, continuity, and coordination

Complexity, continuity, and coordination are essential attributes of the effective functioning of the rehabilitation system. Absence of any of these may lead to a systemic malfunction and ineffective, or duplicate, spending of funds.

Accessibility

It is necessary to ensure not only the widest accessibility of information on rehabilitation, but also to mediate and provide it to the target population.

Individual approach

The implementation of rehabilitation, i.e. the implemented means, must correspond to the specific conditions and needs of a person with a serious health problem, which emphasizes the desirable straightforwardness of the proposed system.

Multidisciplinary assessment

In justified cases, an individual approach, especially in the case of individuals with a serious health problem, must be based on the outcome of a multidisciplinary assessment which is a significant basis for identifying the appropriate means of rehabilitation.

3.4 Objects and Subjects of Coordinated Rehabilitation

Objects of coordinated rehabilitation

Target groups of rehabilitation are individuals

- whose life situation is affected by a serious health problem (SHP),
- who perceive this situation as difficult and/or necessary to address,
- and/or which is difficult for their family members and friends and/or necessary to be addressed,
- and at the same time, they cannot solve it using their own internal resources

The target groups of rehabilitation are highly differentiated, both in terms of age, duration, type, course and severity of the health problem, and in terms of its manifestations and impacts on social functioning of a person in a life situation affected by a health problem.

The characteristics of the rehabilitation target groups mainly depend on the following factors:

1. Current age of the person with a serious health problem (SHP) – a child, an adolescent, an adult of working age, an elderly individual
2. Time of the SHP origin/development – congenital or acquired during life
3. Duration of the SHP – temporary (acute, gradual), long-term, permanent
4. Course of the SHP – stationary, progressive, fluctuating
5. Occurrence and type of pain in the SHP – with presence of pain, with absence of pain
6. Type of the SHP – a serious health problem in the area of sensory functions (vision, hearing), body functions (body movements, cardiovascular functions, metabolism, etc.), mental functions (thinking, memory, attention, learning, etc.)
7. Causes of the SHP – primary illness, injury, inadequate nutrition (anorexia, bulimia), disproportionate hygiene (social conditions of housing, homelessness), addictions (narcotics, alcohol)
8. Levels of the SHP impacts – at the body level (organ changes), at the level of completing activities of daily life (self-care, enduring other daily needs), at the level of involvement in life situations (relationships, public activities, etc.)
9. Severity of the SHP – light, more severe, totally problematic
10. Relationship to the SHP – primary (person himself has a serious health problem), secondary (a caregiver who is a family member or a friend)

Depending on the combination of various factors, COR clients are both the people who require short-term rehabilitation (e.g. people after uncomplicated physical and/or mental traumas) who will not have health problems after the medical (physical) rehabilitation and will not use other components of COR, and the people who require long-term and/or repeated rehabilitation intervention (e.g. after a limb amputation, after a spinal cord injury, people with long-term mental problems), involving more or all of the COR components.

Subjects of coordinated rehabilitation

The process of coordinated rehabilitation involves a variety of entities, at the micro-mezzo-macro-level of involvement.

Micro level – A person with a health problem (in the case of a child also his/her legal guardian), a contact worker (coordinator)
Mezzo level – Institutions of sectoral providers of individual components of the COR – medical (physical), social, educational, counselling and other services facilities, employment office, municipalities, etc.
Macro level – Ministries, government, insurance providers, legislative bodies, etc.

3.5 Expert-based coordinated rehabilitation

Expert based rehabilitation can be characterized as a process involving the cooperation of professionals (in particular) working in helping professions to address to the greatest possible extent all relevant aspects of solving a person's life situations associated with his/her serious long-term illness, the consequences of an injury/accident or disability. Expert based rehabilitation is mainly focused on inter-professional interventions with minimal involvement of the family and other non-formal support and care providers.

An example of expert based rehabilitation in the area of physical disability:
Medical specialists (orthopaedists, neurologists) carry out interventions to improve or stabilize an individual’s health status and treat accompanying symptoms of their illness or disability. Other experts include rehabilitation physicians, physiotherapists and occupational therapists who are involved in functional diagnostics and help to attain or recover and maintain mobility, including the maximum possible self-sufficiency and independence, and the ability to develop occupational skills and to be able to use compensatory aids. Rehabilitation engineering and assistive technology involves both manufacturers and development engineers of compensatory aids, as well as experts to create a complete barrier-free environment. The required rehabilitation and compensatory aids and devices are indicated and prescribed by doctors; the actual training in their use is carried out by occupational therapists and physiotherapists, visual therapists and others. Special teachers (physical therapists, speech therapists) participate and cooperate in coordinated rehabilitation, for example by increasing communication and social skills, developing and implementing an individual educational plan, occupational therapy plan and retraining. The psychologist's job is to diagnose potential psychological problems and to induce or increase the motivation of a person to overcome the obstacles associated with his or her health condition. A social worker helps a person to stabilize suitable living conditions, to obtain social security benefits, to ensure adequate housing, etc.

The rehabilitation of people with disabilities has been and often continues to be implemented in hospitals or specialized centres in the context of long-term institutional care, which often leads to isolation from community life and activities. In addition, the care provided using this method is very costly and cannot manage to fulfil some significant needs of both individuals and society.

3.6 Community based rehabilitation (CBR)[18]

The currently most used trend abroad is community based rehabilitation (CBR), which aims to provide rehabilitation support in the natural community of a person with disability.

Hillapsy, Rambarran, Harden et al. (2009) report that community based rehabilitation services are most frequently used by persons with some psychiatric illness, especially schizophrenia. However, they add that this group is not the main target group of community-based rehabilitation. According to Peat (1999), the CBR model is designed for people with physical disabilities across a different spectrum of diagnoses, for example, for people with physical impairments (amputation, reduced mobility), people after a stroke, people with mental disorders such as bipolar affective disorder or depression; the community based rehabilitation also focuses on people after brain injuries, people with neurological disease, cardiovascular disease, etc.

In 2003, the WCPT[19] defined the factors for which the concept of rehabilitation was historically considered with a low priority of all state policies. WCPT incorporates these factors:

- The cost-benefit ratio of service provision for people with disabilities
- Underestimating the potential of people with disabilities to achieve something
- Negative attitudes of society towards people with disabilities, discrimination
- Lack of urgency – rehabilitation tends to focus on chronic or non-transmissible diseases that are not threatening to others
- Doctors are more interested in drug development
- Insufficient participation of people with disabilities in public policy

[18] The subchapter is compiled by concision, stylistic and other augmentation of the Haunerová 2017 primary resource; for all references to primary authors and sources of the subchapter, see Haunerová 2017 - available in the DIPL2 Information System of the University of Ostrava.
[19] World Confederation for Physical Therapy

Community based rehabilitation is a strategy approved by WHO for rehabilitation, poverty reduction, equal opportunities and social inclusion of people with disabilities, and was intended as another possible rehabilitation concept, especially for low- and middle-income countries. According to WHO (2010), community based rehabilitation was initiated by the World Health Organization following the International Conference on Primary Health Care in 1978 and the resulting Declaration of Alma-Ata. In the 1970's, this decentralized and participatory approach to the planning and implementation of rehabilitation programs gained popularity in many countries and in many areas of health and social development.
WCPT (2003) defines community based rehabilitation cumulatively in various aspects as follows: *"It is a strategy within general community development for rehabilitation, equalization of opportunities and social inclusion of all people with disabilities"* (WCPT, 2003, p. 11). One of the most basic characteristics of CBR is that it is realized primarily through the joint efforts of disabled people themselves, their family and community, and adequate health, educational, professional and social services, while it is considered a low-cost service. Another CBR characteristic is, according to WCPT, a focus on the client.

Another definition of CBR is provided by Peat (1999), who considers community based rehabilitation as a comprehensive approach, including disability prevention, primary care rehabilitation, inclusion of children with disabilities into ordinary schools and, last but not least, the provision of employment opportunities for people with disabilities. CBR's main objective, according to the author, is to ensure that people with disabilities are able to maximize their physical and mental capabilities, have access to regularly provided services, and achieve complete social inclusion in their communities and societies. Also, a local community of people with disabilities should be actively involved in planning, deciding and evaluating of the CBR programs. Peat's approach emphasizes the role of the family, according to which family members are the best source for addressing the day-to-day needs of people with disabilities. Rehabilitation in the community is, according to Peat, a strategy for improving the lives of people with disabilities by providing them with more fair opportunities while protecting their human rights, with an ideology behind it based on which nationwide financial resources for rehabilitation are centrally planned and fairly distributed across the population.

According to Iemmi, Gibson, and Blanchet (2015), the CBR concept became a development strategy to support the inclusion of people with disabilities. *"Rehabilitation in the community is used to meet the basic needs of people with disabilities and their families to improve the quality of their lives."* (Iemmi, Gibson and Blanchett, 2015, p. 5).

The authors Mooney, Doig and Fleming (2009) see CBR's objectives in partial compensation of hospital service costs and in reducing the impacts of ongoing client problems, as well as in assisting the client to attain their maximum level of function, participation and quality of life in their home environment and community.

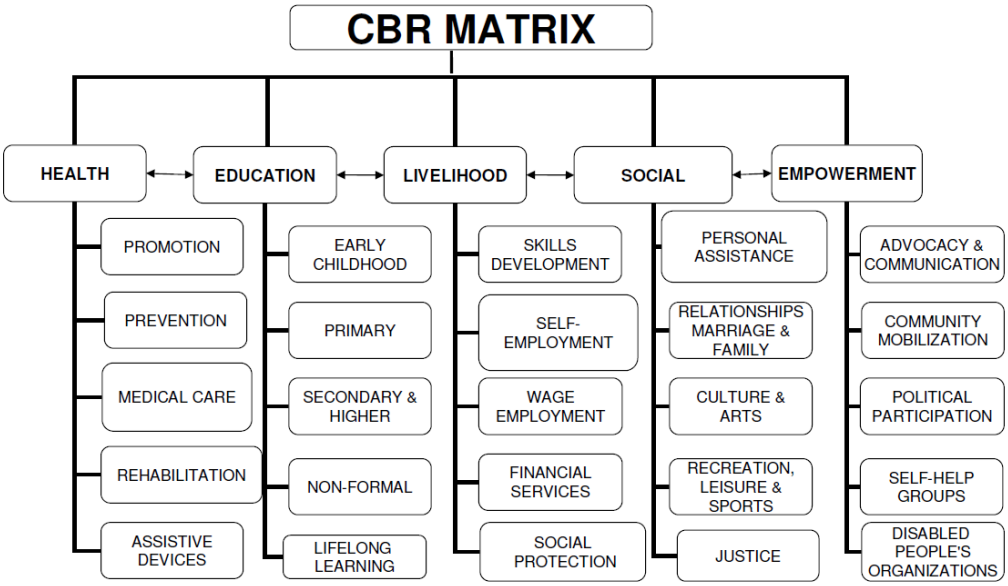
Another definition of CBR can be found in Cornielje, Velema and Finkenflugel (2008), according to whom the rehabilitation in the community has become, besides informal and routine care provided by family or neighbours, a focal point of efforts to address the needs and requirements of people with disabilities in low- and middle-income countries. The authors consider CBR to be a model of community support that takes into account the historical, social, economic, political, and cultural context.

The CBR matrix

In the theoretical concept of CBR, a matrix of the basic framework for community based rehabilitation programs, the so-called matrix, was developed. The CBR matrix (see the scheme below) contains five key components to be focused on by community based rehabilitation interventions. The key components are:

- Health
- Education
- Livelihood
- Social relationships
- Empowerment

Each of these components contains an additional five parts containing a different number of other sub-parts. Community based rehabilitation programs consist of one or more activities in one or more components. According to Peat (1999), the CBR matrix can serve both for efficient planning and provision of community based rehabilitation services, as well as serving as a tool for evaluation of the rehabilitation program. It is not expected that each CBR program will implement each component of the CBR matrix, but that it will vary depending on the specific needs of specific users, as a result of which, in practice, the CBR programs are very diverse. The CBR matrix is in line with the ICD concept, which contains similar components.



Source: WHO 2017

The Functions and Principles of CBR

It is clear that the definition of the CBR model and its use in practice will vary internationally due to differences in culture, environment, education, health and social systems, so there is no single explicit approach to CBR. Nevertheless, the CBR model is used in different countries and its concepts will be based on certain generally applicable principles and foundations.

According to WCPT (2003), the main functions of the Community Based Therapy include:

- Provision of functional rehabilitation services
- Formation of positive attitudes to and relationships with people who have disabilities
- Generation of micro- and macro-level revenues
- Provision of professional training and education, and last but not least,
- Prevention of disabilities

WCPT (2003) states the following principles, on which the CBR model is based:

- Partnerships of the community with people who have disabilities, their families and caregivers
- A holistic approach involving physical, social, occupational, educational, and economic needs, followed by promotion of social inclusion of people with disabilities in existing services

According to Peat (1999), CBR programs should try to change the attitudes and behaviour of the community towards people with disabilities, to empower them and to enable their functioning in society and their community. The author also emphasizes that the CBR model should be based on the active involvement of people with disabilities in the rehabilitation process.

The general principles on which the CBR model is based, according to Peat (1999), are as follows:

- Customer and community orientation
- Focus on prevention and timely intervention
- Cooperation with institutional care facilities
- Consistency and flexibility
- Coordination of a referral system
- Interdisciplinary and multi-sectoral approach
- Focus on sharing information
- Providing relevant knowledge to the community
- Establishment of agencies to select appropriate technologies to meet the needs of the community
- Providing full or part-time employment to professional or non-professional teams if necessary
- Increasing the level of knowledge of the contact persons
- Establishing partnerships in the development and implementation of rehabilitation programs

Peat (1999) outlines another principle of the CBR model, namely the cooperation of all stakeholders in a community rehabilitation and introduces eight main stakeholders:

- A disabled individual
- Family or caregivers of individuals with a disability
- Community
- Volunteers
- Community health care workers
- Rehabilitation professionals
- Non-governmental organizations
- Employers

According to Peat (1999), family members and/or caregivers are trained to provide simple rehabilitation services for people with disabilities and are encouraged to be creative in using simple assistive aids and devices to enable people with disabilities to function just like their family members.

Iemmi, Gibson and Blachnet (2015) regard a multi-sectoral and bottom-up strategy to be one of the CBR principles, characterized by the use of predominantly local community resources to ensure appropriate and low-cost assistance. According to Mitchell (1999a), local community resources may include, depending on available conditions, a local supervisor, a family trainer, members of the extended family, people with disabilities, communities, while through the CBR optics it is expected that all listed participants are to be actively involved in the rehabilitation process.

CBR Planning

The planning of CBR programs was dealt with in detail by Peat (1999), particularly in the context of the political and managerial level. First of all, he has documented that one of the key features of CBR programs is decentralization, that is, the transfer of planning, management and decision-making to the local level. He defines such planning to be an essential feature and element in the implementation and organization of CBR, and it is the process of identifying the community fundamental values and their transfer to the priorities and objectives of the rehabilitation programs, defining fundamental structures for the rehabilitation programs and drawing up guidelines for the use of possible resources.

Peat sees the function of the planning process in identifying key factors such as the balance between the needs of an individual and a community, the role and relationship between institutional care and community care, the degree of integration and coordination with professional, social, legal, or educational services, as well as the number and distribution of human resources. *"Planning must be done in conjunction with a basic knowledge of the local community and should include key informants and stakeholders in this process."* (Peat, 1999, p. 73). The key informants and stakeholders are understood to be people with disabilities, their families, community leaders, teachers, religious institutions, and politicians. According to Peat, CBR program managers must communicate effectively with other community services within a particular locality to avoid the duplication of services.

Scobbie, Duncan, Brady and Wyke (2015), who carried out a study focused on the CBR planning in the UK for post-stroke patients, dealt with the determination of specific goals within the planning of rehabilitation. The outcome of this study is that most UK patients get to be involved in the goal-setting process, although patients themselves are unclear about their roles when setting goals and feel they have no control over the goals of rehabilitation. The authors add that some patients after a stroke suffer from cognitive and communication problems, so it would be advisable for these patients to always have a copy of their set goals with them. The researchers also point out that they most often focus on setting patient priorities and specific rehabilitation goals, reviewing patient progress, and providing feedback on CBR planning and service goals. The services are less often, according to the authors, focused on identifying obstacles to completing the plan, on planning a path to overcome an expected obstacle, or on assessing confidence in completing the plan.

The Stages of the CBR Process

Wade (2001) describes the stages of the community based rehabilitation process:

- Diagnostic stage (an initial stage)
- Planning stage (planning of rehabilitation objectives)
- Intervention stage
- Evaluation stage

According to the author, the initial stage is defined primarily by the required process of assessing the functioning and needs of a disabled person, usually in which many specialists participate; the “data collection” may take a long time and requires close and longer-term cooperation and development of a relationship between “the client and the expert”. Therefore, according to the author, the initial stage is complicated, long-lasting and involves many people outside the central team, such as a physical therapist, a social worker, a speech therapist, etc.

The planning stage is seen by the author as more costly for several reasons, such as the necessity to make different professionals agree with the client's goals - therefore the professionals must be very patient. Wade also adds that the planning stage is equally time-consuming in terms of the need for collaboration between professionals across different fields.

In the actual intervention stage, the author distinguishes between two types of rehabilitation care, namely primary intervention and secondary intervention. Primary intervention is,

according to the author, focused on different parts of the biopsychosocial concept of rehabilitation and includes, for example, the following activities: physical therapy, training in how to use compensatory aids, information assistance, etc. Contrary to this, secondary intervention in rehabilitation differs by its nature from primary intervention. Wade understands the key point of the intervention stage to be the formation of a team uniting specialists and the disabled person with his/her surroundings, and then considers the integration of the user with his/her surroundings to be the central process of rehabilitation. For the learning process is, according to the author, necessary for the user and his/her surroundings to want to learn, to attempt the learned things in practice and to receive feedback from it.

The evaluation stage is considered important by the author in the rehabilitation process as it evaluates whether a goal set in the planning stage has been achieved, or it may offer the user the chance to end the provided service and switch to another service or else continue using the service.

CBR Evaluation

The CBR evaluation allows for an assessment of the CBR program's impact on a target group, to determine the effectiveness of procedures and to make adjustments to improve it, to assess sustainability of the CBR program, to allow each employee to learn from others on the basis of their experience, to determine cost effectiveness, to determine whether the program can be implemented in later period, and to find out whether the program is consistent with an established policy. It also mentions the persons who should participate in the evaluation process. These include disabled persons, caregivers and the persons' families, community, employers, professional groups, governmental and political agencies. Last but not least, the author states what should be the focus of the evaluation: community needs and target groups, use of existing services and quality of care, administration and management functions, financial and physical resources, cost effectiveness, human resources, relevance, as well as the consequences of the CBR program.

The authors Cornielje, Velema and Finkenflugel (2008) state the following about the evaluation stage: *"Evaluation is indicative of why and how the goal was (or was not) achieved. It tries to solve the problems of causality. Evaluation is a learning and management tool: It is an assessment of what has occurred over a certain period of time and helps in planning and improving future activities."* (Cornielje, Velema and Finkenflugel, 2008, p. 40). The authors also add that the evaluation should be as objective and systemic as

possible, although it may be subjective and participatory, if necessary. Evaluation should provide important information and enable politicians and managers to make informed and more effective decisions.[20]

The Use of the International Classification of Diseases in the Evaluation of the CBR Model

According to Cornielje, Velema and Finkenflugel (2008), in order to evaluate the CBR model and its programs, we can use a variety of tools such as quality of life questionnaires for disabled people and their families, different classifications from the WHO classification family, etc. In the context of evaluation of the CBR model, ICD is frequently used.

The team of authors, Maddenn, Dune, Lukersmith et al. (2014), shows that ICD was identified as a highly relevant framework that serves as a tool for the monitoring and evaluation of CBR programs. According to the authors, it provides a framework for the systematic recording of information about functioning and disability. The authors carried out research, the results of which show that all ICD components are relevant for an evaluation of the CBR programs. The use of ICD in the CBR evaluation reflects the complexity and multi-dimensional nature of CBR, which is based primarily on a CBR matrix that is very similar to the structure and components of ICD. For this reason, the ICD application is one of the cornerstones for the CBR evaluation and monitoring. One of the results of the use of ICD in the CBR evaluation is that *"it can serve to provide an infrastructure for functioning and disability information to be delivered to physicians and to enable national and international comparisons."* (Madden, Dune, Lukersmith et al., 2014, p. 826).

Although ICD has been recognized as a suitable CBR assessment tool, for example the ICD-derived and internationally used questionnaire to identify the subjective experience of disability-related life situations, The World Health Organization Disability Assesment Schedule (WHODAS 2.0),[21] according to Kulnik and Nikoletou (2014), despite its use in community based rehabilitation, focuses on the medical interpretation of disability and is therefore not recommended by these authors for CBR evaluation. They refer to the results of

[20] The authors Turner-Stokes, Williams and Abraham (2001) elaborated clinical standards for specialized community rehabilitation services. The standards are detailed in the Haunerová 2017 primary resource annex.
[21] WHODAS 2.0, according to Kulnik and Nikoletou (2014) contains 36 items, grouped into six areas: cognition, mobility, self-attendance, human relations, life activities (household, work, school), and involvement in society with each item being ranked by respondents in terms of the level of its difficulty on a five-point scale ranging from "none" to "extreme/impossible to complete/do."

the research[22] conducted with ten users of community based rehabilitation using structured interviews.

Interdisciplinary CBR Teams

According to Wade (2001), the teams providing CBR generally consist of a physical therapist, an occupational therapist, a speech therapist, nurses, a psychologist, physicians, coordinators, and administrative workers (Wade 2001). On the contrary, Moran, Nancarrow, Enderby et al. (2012) focus on care and support assistants who are explicitly defined for the purpose of their work as employees working with professionally qualified specialists, and who, although they may have a medical or social training, do not have tertiary qualifications. Specifically, these are professional group assistants (incl. physical therapists, occupational therapists, social workers and nurses), generic employees working across different professions, technical instructors, health workers, home caregivers, and social service support staff. *"As part of community based rehabilitation, care and support assistance workers are perceived as a means of enabling the more efficient use of qualified therapists, allowing therapists to focus more on assessment, case management and comprehensive services by assigning the prescribed treatment plan to assistants."* (Moran, Nancarrow, Enderby et al., 2012, p. 538). This role of helping professionals has been approved by society as a means of increasing flexibility and efficiency in meeting each given patient's needs.

For a more detailed list of professions used in CBR see Moran, Nancarow, Freeman et al. (2009). The rehabilitation team working in the community can be composed, for example, of a physical therapist, an occupational therapist, a social worker, a geriatric consultant, a psychologist, community psychiatric nurses, general nurses, care assistants, administrative staff, a speech therapist, a dentist, a paediatrician, etc. The authors elaborate the profession of care assistants, such as a technical instructor, a rehabilitation assistant, a social worker assistant, a physical therapist, a rehabilitation technician, a psychologist, an occupational technician, a therapeutic assistant, etc. The rehabilitation care provided by the community may also involve a visual rehabilitation therapist, a coordinator/manager of care, a psychotherapist, a consultant, etc.

[22] KULNIK, Stefan T. a Dimitra NIKOLETOU. WHODAS 2.0 in community rehabilitation: a qualitative investigation into the validity of a generic patient-reported measure of disability*. *Disability* [online]. 2014, **36**(2), 146-154 [cit. 2016-09-28]. DOI: 10.3109/09638288.2013.782360. ISSN 09638288

Community Teams Involved in CBR

Wade (2001) identified 152 organizations in the UK providing community based rehabilitation services and subdivided them into the following typology:

Community rehabilitation teams, according to the author, are teams set up by the management structure and their aim is to cooperate and take responsibility for the assessment and rehabilitation of a wide range of clients, usually aged 16+.

Young disabled community teams aim to coordinate the assessment and treatment of people between 16-19 who have a large range of long-term physical disabilities. According to the author, this model is used primarily because it often helps the transition of young people from pediatric care to general health care.

Community rehabilitation teams for older clients are designed to coordinate the assessment and treatment of people with disabilities usually aged 65+ (in some cases, according to the author, the entry criteria is set at the age of 80). The author defines as the target group of these teams mainly disabled people with their disability being associated with a stroke, neurological disease, fractures, or other diseases of the mobility system.

Client group-specific community rehabilitation teams provide rehabilitation services only to a particular group of clients – patients with head injury, multiple sclerosis, or patients after a stroke.

All of the above CBR models and their teams offered these services: identifying and assessing the needs and functioning of a patient and his/her caregiver, specific treatment, support to and education of a patient and his/her family relatives, and training in the use of compensatory aids and devices.

Community therapy teams that the author thus called in response to the results of her research, where individual experts who were organized in separate professional communities (e.g. the private practice of a physical therapist, social services and an occupational therapist) collaborated with individual patients or groups of patients. They could be, according to the author, referred to as "informal community rehabilitation teams."

Rehabilitation coordinators are defined by the author as individuals employed to coordinate professionals working in existing but separate services. Their task was not to identify existing

workers as a team, but to merge existing resources into informal community rehabilitation teams and to be a key worker for individual patients or groups of patients.

Outreach teams are often located in emergency intervention facilities, with specific responsibility for community care, as well as in the emergency sector for specific groups of clients such as clients with head injury, a stroke or Parkinson's disease.

Afterword

The history of the establishment of the follow-up Master's study branch "Coordination of Rehabilitation and Long-term Health Social Care in the Degree Program of Health Social Care at the Faculty of Social Studies of the University of Ostrava

The Grounds for the Coordination of Rehabilitation and Long-term Health Social Care (CRLHSC) Study Branch

The accreditation of the Coordination of Rehabilitation and Long-term Health Social Care (CRLHSC) at the University of Ostrava (UO) was preceded by an analysis of the labour market and health and social policy needs in the Czech Republic which are explicitly and/or secondarily expressed in various national and draft documents concerning the population with health impairments. An example is the propositions of the draft law bills on coordinated rehabilitation (Proposition, undated), discussion materials on long-term care (Preliminary, 2005, Discussion, 2010 etc.), the National Action Plan Supporting Positive Aging 2013-2017 (National, 2013), the National Plan Supporting Equal Opportunities for Persons with Disabilities for 2015-2020, (National, 2015), the Strategy for the Reform of Psychiatric Care (Strategy, 2013), etc. From the above listed and other documents, it is obvious that there is a lack of experts in the Czech Republic who meet the demanding requirements of interdisciplinary health and social work in terms of their knowledge (theory) and skills (practice).

It can be argued that this deficit can be relatively efficiently solved by having an expert from originally one area (e.g. a health professional) expand his/her knowledge and skills from another area (e.g. social work) and vice versa. Yes, it is one of the models of personal saturation of health and social work. The benefits of this model are based on solid, generally deeper knowledge and skills of one profession, which are broadened by the fundamentals of the other profession. The disadvantage may be that the prevailing inclination of an expert will be to his/her original professional profile, and the adoption of paradigms and habits of the original (or main) profession. The so-called integrated professional model, which has also found an example in Czech educational practice in the form of a Bachelor's study branch Health-Social Worker, is often applied abroad. This model combines the health and social knowledge and skill set of both originally separate professions. The disadvantage of this model may be the smaller amount of knowledge and skills from an aspect of the individual occupational segments. The advantage is the joint professional optics in solving the difficult

life situation of a client (or an institution), which permits access to a bridge across the deeply rooted departmentalism in the Czech Republic.

CRLHSC consistently applies an integrated professional model. The graduates of Bachelor's degree programs of social work and special pedagogy, together with the graduates of non-medical health care Bachelor's study branches, are admitted to the study program. Already during theoretical studies, we create a prerequisite for a practical discussion of different angles of view and different approaches to solving a difficult life situation of a client in relation to health. In one study group, three different views – "social", "health" and "pedagogical" – are encountered and confronted in real time, and the result is that students learn to recognize, respect, and purposefully utilize the meaning and perceptions of people from "originally different fields" and learn to look for so-called “integrated solutions." [23]

The Preparation Process of CRLHSC

The establishment of the CRLHSC study branch at the University of Ostrava is not accidental. Twenty years ago at the former Medical-Social Faculty, University of Ostrava (1995-2013), the five-year Master's degree program Social Work with a Health Profile was accredited. Its birth is connected with Prof. Oldřich Chytil, Ph.D. Soon after, a Bachelor's degree, this time in Social and Health Care and Geriatric Care, was accredited at the same faculty from the initiative of Prof. Chytil. We have continuously followed upon this history and experience and, in the context of the Bologna Process (permeability of studies, recognition of education from abroad, etc.), we managed to accredit in 2011 the Bachelor's degree in Health Care and Social Work, in 2014 the follow-up Master's degree in CRLHSC. The study branch was first opened in September 2015, both in the full-time and combined form of study). This is a follow-up Master's degree in the Health and Social Care program which has not yet been accredited in the Czech Republic, and which draws with its philosophy and content from the experience of similar, already internationally accredited study branches, with its application to the Czech environment.

From the very beginning, already at the phase of the program accreditation (2012), a great emphasis was placed on the joint teamwork of the Faculty of Social Studies and the Faculty of Medicine. The team regularly met and debated the issues associated with the program

[23] CRLHSC claims to be an affiliate of the study branches with a highly practical professional profile. This does not question in any way the need or necessity of research (theoretical) work in the field, on the contrary. The ability to design, implement, and evaluate research is an integral part of a Master's degree study across different disciplines.

profile, curriculum, material and financial background, personnel, etc. An essential and integral part of the preparation of accreditations was structured consultations with people who are primarily concerned with the subject – people with health problems. We did not want to be those academics who "know best" what is "good" or even "the best" for people with health problems. An academic blindness lacking adequate reflection is a great danger and an obstacle to linking theory with practice just as much as a blindness of professionals from practice who see their work as "the only criterion of truth." From the very beginning, the study program was created in discussion with representatives of organizations of people with disabilities – especially with Jana Hrdá (in memoriam), Pavel Dušek (in memoriam) and Václav Krása. We asked experienced academics outside our university to participate in the consultation process – the concept and the content of the field have been consulted with Prof. Jan Pfeiffer, MD, and Assoc. Prof. Olga Švestková, MD (experts in the field of coordinated rehabilitation) and with Assoc. Prof. Iva Holmerová, MD (a long-term care expert). Incentives and critical feedback have also been drawn from colleagues at selected foreign universities where similar degree programs have been successfully running for years.

As has already been stated, the curriculum of the study branch is based on an analysis of labour market needs and their interdependence with learning outcomes. The creation of this study branch in the Czech Republic was supported by the President of the Union of Employers' Unions of the Czech Republic, Jiří Horecký. In the concept of the study branch, we place a great emphasis on linking theory and practice through cooperation and participation of professionals from practice in teaching. Of a total number of 30 lecturers at the Faculty of Social Studies and the Faculty of Medicine who teach individual subjects/courses, there are 8 external lecturers from the field of healthcare and social work services and 6 internal lecturers, who teach part-time at the university and work part-time in the field health, social or health-social practice. It means that almost half of the lecturers have a day-to-day uninterrupted contact with practice. The interconnection of theory and practice is ensured by CRLHSC students in the form of both continuous (interrupted, short-term) and uninterrupted practical training in the field with reflections in a case studies seminar.

The Characteristics of CRLHSC

The follow-up Master's degree program Coordination of Rehabilitation and Long-term Health Social Care prepares graduates to pursue professions in the interdisciplinary field of, in particular, health and social interventions at the macro-meso-micro level of societal practice. The grounds for the design of the study program is the discussion and the need for systemic

changes in the field of coordinated rehabilitation and in the social and health care system of long-term care, and also the increasing demand for services intended for people whose health condition is stabilized, however, they depend on the assistance of health and social services. The concept of the study program is based on the requirements of practice, i.e. inseparability, continuity, interconnection and coordination of medical, social, and other interventions to address the consequences of changes in health condition including the prevention of development or progression of these changes.

An interdisciplinary profile of a graduate of CRLHSC currently has no legal anchorage in the Czech Republic, however, the study program responds to a clearly identified absence and the need for qualified specialists with targeted interdisciplinary knowledge and competences, able to identify, analyse, conceive, negotiate, solve and evaluate the effectiveness of topic solutions with overlapping elements in both areas. Emphasis is placed on the mutual coordination and continuity of rehabilitation, long-term care and community services. The aim of the program is to prepare competent experts to coordinate and ensure the continuity of support, assistance and/or care for people with temporary or long-term illness, people after an accident, and people with permanent health impairment who, based on acquired knowledge and skills, will be able to solve the tasks in the health and social field which include, in particular (1) the bridging of existing barriers between health and social support, assistance and care systems, (2) the coordination of the system of professional services, (3) the coordination of professional and non-professional cooperation (multidisciplinary and inter-professional team assessment with the involvement of a person with poor health status, including his/her significant social surroundings), (4) support for the individualisation of rehabilitation and long-term care (a client-oriented approach), (5) ensuring continuity of services, the so-called discharge planning, discharge management, (6) and the promotion of a social debate on the creation of a system of rehabilitation and long-term care in the Czech Republic (Accreditation 2013).

About CRLHSC Terminology

As was already noted in the main body of text of this study material, knowledge of the meanings of terms "rehabilitation" and "long-term care" in the Czech Republic is still associated with some historical relics of the understanding of rehabilitation and long-term care in the 1950’s. Therefore, I consider it essential to clarify what is the meaning of these terms that are being used in connection with the name and curriculum of the CRLHSC program.

The modern concept of **"rehabilitation"** represents the concept and process of timely, continuous, smooth, combined, and coordinated use of health, social, occupational, pedagogical, technical, technological and other means in order to attain/recover the functional potential of a person who is temporarily, or permanently affected by a particular health condition. Rehabilitation in this approach is aimed at stabilizing health, focusing on mitigating the risks of progression and consequences of illnesses or injuries, and on preventing the development of secondary disability. It is a process of flexible interconnection of both professional and informal support tools aimed at improving the quality of life of a person with a health problem.

The set phrase "coordinated rehabilitation" (rehabilitation, RI) is subject to the Czech attitude towards the one-word concept of "rehabilitation". While abroad this term is commonly understood in the original word meaning of a complex interconnection of the system of interventions to achieve the goal of "being skilled, (being able again)" and has no exclusive, or primary relation to rehabilitation in the health care sector, in the Czech Republic it continues to be understood as “physical therapy," or general physical rehabilitation (also rehabilitation in health care system or medical rehabilitation). It is therefore necessary, for psychological reasons, at least temporarily, to name it in a different manner. Alternative Czech names for rehabilitation in the above-mentioned sense include the terminology known especially from (but not limited to) the terminology used by special pedagogy: "complex rehabilitation", "complete rehabilitation," or "comprehensive rehabilitation."

Long-term care (LTC) means both in-home care and institutional care. It is a complex of services that people with long-term limited self-attendance need, especially in basal areas (hygiene, dressing, meal preparation and intake, use of medicine, mobility problems) and instrumental areas (enabling people to live independently of their community, such as shopping, finance, common household chores, etc.). A condition causing long-term limited self-sufficiency is determined primarily by (not limited to) chronic illness or disability.

Together with the content of the concept of "rehabilitation", the term "long-term care" is subject to historical distortions in the Czech linguistic context, especially for its a priori association with long-term and long-term care institutions. However, long-term care can be understood both in the broader sense and in the narrow sense as the legislative, organizational and fiscal unification of elementary health-social support and care at the level of interpenetration of health and social services (for example, but not limited to – home and nursing care). In order to emphasize this connection, we use the term long-term health and social care in the name of the study program.

Last but not least, it makes sense to introduce the concept of health and social care. This concept can be understood as one of the segments of **health social work**.

When talking about health and social work, it is necessary to define what it means in a particular context. Sometimes we mean direct work with clients or work in organizations on the border of health and social services or institutions, or the actual profession of a social worker in the health care system. This segment is generally referred to as "practice." At other times, we talk about health and social work in the sense of educational or research activities – these segments are usually (each separately or together) grouped as a "theory." Commonly, we talk about "interconnecting theory and practice" in the sense of a "diverse" relationship and a degree of interconnection between these segments. It should be added, however, that it is not always clear what the nature of this relationship is or what "all" belongs to health and social work. The difference between different forms (but not the identical contents) of the terms – (a) health-social, (b) health and social, (3) socio-health, and (4) social and health – is not always reflected.

The National Strategy for the Development of Social Services for 2016-2025 sets objectives and measures in the Czech Republic in ten thematic areas. These include the "Socio-Health Border." In order to solve the problems of this segment, the Ministry of Labour and Social Affairs of the Czech Republic needs to cooperate with the Ministry of Health of the Czech Republic. These are more or less closely related to other thematic areas, but none of them is, in its objectives and measures, linked to so many different areas, such as the socio-health border.

***

The University of Ostrava, in cooperation with the Faculty of Social Studies and the Faculty of Medicine, responds to the clearly articulated need for the strengthening of the personnel capacities of integrated health social care in the Czech Republic by the development of the CRLHSC study branch and the Health Social Care degree program.

References

Accreditation 2013 – *Akreditační spis oboru Koordinace rehabilitace a dlouhodobé zdravotně sociální péče* v prezenční formě studia 2013. Ostrava: Ostravská univerzita v Ostravě. Nepublikováno.

ARAGALL, F. 2003. *Evropská koncepce přístupnosti*. Luxemburg: EuCAN.

BECK, Ulrich 2004. *Riziková společnost*. Praha: Sociologické nakladatelství.

Diskusní materiál k východiskům dlouhodobé péče v České republice. Praha: MPSV, 2010. (online) Available from: http://www.mpsv.cz/files/clanky/9597/dlouhodoba_pece_CR.pdf (cit. 2017-09-25)

GOJOVÁ, Alice 2012. *(Bez)mocná sociální práce?* Habilitační práce. Ostravská univerzita v Ostravě.

HAUNEROVÁ, Romana 2017. *Model Community Based Rehabilitation ve Spojeném království Velké Británie a Severního Irska*. Diplomová práce. Ostravská univerzita. Vedoucí práce doc. Mgr. Lenka Krhutová, Ph.D.

HOŘEJŠÍ, Jaroslav 1998. *Moc a nemoc medicíny.* Praha: Makropulos.

HUBÍK, Stanislav 1999. *Sociologie vědění*. Praha: Sociologické nakladatelství.

KRÁSA, Václav 2011. Moje představa o koordinované rehabilitaci. In *Koordinovaná rehabilitace. Sborník přednášek*. Praha: Výbor pro sociální politiku Poslanecké sněmovny Parlamentu České republiky. Praha: 2011.

KRHUTOVÁ, Lenka 2005. Přístupnost staveb a dopravy. In Krhutová, Lenka et. al. *Občané se zdravotním postižením a veřejná správa*. Olomouc: Univerzita Palackého Olomouc a Výzkumné centrum integrace zdravotně postižených. s. 66-71.

KRHUTOVÁ, Lenka 2010. Teorie a modely zdravotního postižení. In *Sociální práce/Sociálna práca*, 2010, 4. s. 49–59.

KRHUTOVÁ, Lenka 2011. Disability studies. In MICHALÍK, Jan et al. 2011. *Zdravotní postižení a pomáhající profese*. Praha: Portál. s. 27–29.

KRHUTOVÁ, Lenka 2013a. *Autonomie v kontextu zdravotního postižení*. Boskovice: Albert.

KRHUTOVÁ, Lenka 2013b. *Úvod do disability studies.* Ostrava: Ostravská univerzita

KRHUTOVÁ, Lenka 2015. *Nástroje identifikace disability*. Habilitační práce. Ostravská univerzita v Ostravě.

KRHUTOVÁ, Lenka a Jarmila KRISTINÍKOVÁ 2013. *Koordinovaná rehabilitace a dlouhodobá zdravotně sociální péče.* Ostravská univerzita v Ostravě.

KUZNÍKOVÁ, Iva et. al. 2011. *Sociální práce ve zdravotnictví*. Praha: Grada.

MATOUŠEK, Oldřich et al. 2013. *Encyklopedie sociální práce*. Praha: Portál.

Mezinárodní klasifikace funkčních schopností, disability a zdraví WHO. 2008. První české vydání překladu anglického vydání International Classification of Functioning, Disability and Health, World Health Organization, 2001. Přeložili Olga Švestková a Jan Pfeiffer. Praha: Grada.

Národní akční plán podporující pozitivní stárnutí. Praha: MPSV, 2013. (online) Available from: http://www.mpsv.cz/files/clanky/14540/III_vlada__Akcni_plan_staruti_.pdf (cit. 2017-09-25)

Národní plán podpory rovných příležitostí pro osoby se zdravotním postižením na období 2015-2020. Praha: Úřad vlády, 2015. (online) Available from: http://www.vlada.cz/cz/ppov/vvzpo/dokumenty/narodni-plan-podpory-rovnych-prilezitosti-pro-osoby-se-zdravotnim-postizenim-na-obdobi-2015-2020-130992/ (cit. 2017-09-25)

Národní strategie rozvoje sociálních služeb na období 2016–2025. Praha: MPSV, 2015. Dostupné z: http://www.mpsv.cz/files/clanky/29624/NSRSS.pdf (cit. 2017-09-25)

NAVRÁTIL, Pavel 2001. Vybrané teorie sociální práce. In MATOUŠEK, Oldřich et. al. *Základy sociální práce.* Praha: Portál. s. 183-267.

NAVRÁTIL, Pavel a Libor MUSIL 2000. Sociální práce s příslušníky menšinových skupin. *Sociální studia 5. Sborník prací FSS MU.* Brno: Masarykova univerzita.

NAVRÁTIL, Pavel 2003. *Romové v České společnosti.* Praha: Portál.

Předběžná národní zpráva o zdravotní a dlouhodobé péči v České republice. Praha: MPSV, 2005. (online) Available from: http://www.mpsv.cz/files/clanky/1342/zprava_zdravotni_pece.pdf (cit. 2017-09-25)

Strategie reformy psychiatrické péče. Praha: Ministerstvo zdravotnictví, 2013. (online) Available from: http://www.reformapsychiatrie.cz/wp-content/uploads/2013/10/SRPP_publikace_web_9-10-2013.pdf (cit.2017-09-25)

ŠUBRT, Jiří a Jan BALON 2010. *Soudobá sociologická teorie*. Praha: Grada.

ŠUBRT Jiří 2007. Niklas Luhmann: Komplexita, evoluce, kontingence. In ŠUBRT, Jiří et al. 2007. *Soudobá sociologie. Teoretické koncepce a jejich autoři*. Praha: Karolinum, s. 68–119.

Teze právní úpravy koordinace rehabilitace osob se zdravotním postižením. Praha: MPSV, nedatováno) (online) Available from: http://www.czepa.cz/news/teze-pravni-upravy-koordinovane-rehabilitace-osob-se-zdravotnim-postizenim/ (cit. 2017-09-25)

Úmluva o právech osob se zdravotním postižením 2009. Sbírka mezinárodních smluv, částka 4. s. 66–124.

Věcný záměr zákona o dlouhodobé zdravotně-sociální péči (návrh. Praha: MPSV, 2013. (online) Available from: http://www.mpsv.cz/files/clanky/13536/Navrh_vecneho_reseni_problematiky_LTC.pdf (cit. 2017-09-25)

WHO-Beta 1997. *International Classification of Impairments, Activities and Participation. A manual of Dimensions of Disablement and Functioning*. WHO: Geneva.

WHO 2013. How to use ICF. A Practical Manual for using the International Classification of Functioning, Disability and Health. Exposure Draft for comment October 2013. (online). Available from: http://www.who.int/classifications/drafticfpracticalmanual.pdf (cit. 2017-09-25)

WHO 2017. About the community-based rehabilitation (CBR) matrix. (online) Available from: http://www.who.int/disabilities/cbr/matrix/en/ (cit. 2017-09-25)

Zdraví 21, Výklad základních pojmů, Úvod do Evropské zdravotní strategie. Nedatováno. Available from: file:///C:/Users/Transformer/Desktop/04_PUBL_ME/0_2017/IRP_skripta_KAD1/Zdraví 21_Ekologicko-sociální%20koncept%20zdraví.ojmů: 25-29 (cit. 2017-09-25)

Publication:	COORDINATED REHABILITATION 1
Author:	Assoc. Prof. Lenka Krhutová, Ph.D.
Publisher:	University of Ostrava, Dvořákova 7, 701 03 Ostrava
Year of Publication:	2017
Translated by:	Lucie Návratová from the Czech original Koordinovaná rehabilitace 1, Publisher University of Ostrava, First Issue, 2017
ISBN:	978-80-7464-972-1