POLISH HYPERBARIC RESEARCH 4(77)2021
Journal of Polish Hyperbaric Medicine and Technology Society

IMPLEMENTATION OF SELF-GOVERNMENT TASKS IN THE FIELD OF SOCIAL AND VOCATIONAL REHABILITATION OF DISABLED PEOPLE IN THE LUBELSKIE VOIVODESHIP IN 2008-2017

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ABSTRACT

Disability is an interdisciplinary-medical, social and professional phenomenon. The goal of medical professionals is to treat a person and restore his or her fitness. The group of disabled people in Poland is characterized by a lower level of education than among non-disabled people and high unemployment. The purpose of vocational rehabilitation is to make it easier for a disabled person to obtain and maintain appropriate employment and career advancement. Social rehabilitation is defined as an activity aimed at enabling a disabled person to fully participate in social life. The tasks of the local government addressed to disabled people include conducting occupational therapy workshops (WTZ), occupational activity establishments (ZAZ), community self-help homes (ŚDS) and social welfare homes (DPS).

The aim of the study was to analyze the implementation of self-government tasks in the field of social and vocational rehabilitation of disabled people, with particular emphasis on ZAZ in the Lubelskie Voivodeship in 2008-2017.

The work uses data collected in 2008-2017 by the Regional Center for Social Policy (ROPS) in Lublin. In addition, in December 2017, they were sent by e-mail to ROPS and Marshal's Offices in voivodship cities in Poland, inquiries about tasks and ways of implementing these tasks in the field of social and vocational rehabilitation of disabled people in 2008-2017. The available data on expenditure from the State Fund for Rehabilitation of the Disabled (PFRON) was collected. The research material was statistically developed using the IBM SPSS Statistics (v. 25) and Statistica (v. 13) statistical packages.

In the years 2008-2017 in the Lubelskie Voivodeship, PLN 75,529,959 was allocated for vocational and social rehabilitation of people with disabilities, the most (PLN 9,158,243) in 2016. In the same year, the largest number of people used the ZAZ. In 2008-2017, the average annual amount of expenditure on social and vocational rehabilitation of disabled people in all Polish provinces was PLN 7 576 718.9. In the discussed period, the highest amounts from PFRON were allocated to the rehabilitation of disabled people in the Śląskie Voivodeship, and the lowest in Lubuskie, while Lubelskie received average amounts.

In Poland, in the field of social and vocational rehabilitation and employment of disabled people, solutions similar to those already developed are applied in the countries of Western Europe. The costs of financing vocational rehabilitation, understood as financing the functioning of the ZAZ by voivodship self-governments, are constantly growing. The growing expenses incurred on the activities of the ZAZ do not significantly improve the situation related to vocational rehabilitation and employment of disabled people. Improving the operation of the system of vocational and social rehabilitation of people with disabilities should not only consist in increasing the funds spent under the current inefficient system, but should be preceded by a thorough analysis of the current state and the development of extensive organizational changes.

Keywords: a disabled person; social rehabilitation; vocational rehabilitation.

ARTICLE INFO

PolHypRes 2021 Vol. 77 Issue 4 pp. 89 – 102
ISSN: 1734-7009 **eISSN:** 2084-0535
DOI: 10.2478/phr-2021-0024
Pages: 14, figures: 1, tables: 3
page www of the periodical: www.phr.net.pl

Publisher
Polish Hyperbaric Medicine and Technology Society

Original article

Submission date: 29.06.2021 r.
Acceptance for print: 14.10.2021 r.

INTRODUCTION

Disability is an interdisciplinary phenomenon [1]. The concept of disability is closely related to the concept of health. The 1946 Constitution of the World Health Organization (WHO) defined health as the full physical, mental and social well-being of a person, not merely the absence of disease or disability. As it was written in the original text of the constitution adopted by the Polish authorities: "Health is a state of complete physical, mental and social well-being, and not only the absence of disease or disability" [2]. This definition is both established and open, which is reflected in the current expansion of it to include spiritual and sexual health.

Today, there are two models of disability: medical and social. The medical model dictates the definition of disability in the context of the fitness or inability of the human body. Disability is a direct result of disease or damage to the body. The social model of disability recognizes the existence of external barriers limiting people with disabilities from the full use of goods available to non-disabled people [3]. Medical and social models of disability are defined in the WHO International Classification of Functioning Disability and Health (ICF). This study, as a feature of the medical model of disability, emphasizes its individual and personal character that affects a specific person. The goal of professionals is to treat a person and restore his fitness. The tool here is the healthcare system. The social model emphasizes the causes of disability that are external to a specific person. Such causes may be architectural barriers, communication barriers, organizational barriers or discriminatory practices existing in society. The tool of change are social activities, carried out not only by a narrow group of medical professionals, but in a much wider dimension, i.e. social, political and legal. ICF combines these two models, taking into account the biological, psychological and social conditions of the functioning of people with disabilities [4]. The social model of disability is also expressed directly by the Convention on the Rights of Persons with Disabilities adopted by the United Nations General Assembly in 2006, which states that disabled persons include persons with reduced physical, mental, intellectual or sensory fitness, which in interaction with various barriers may have limited participation in society on an equal basis with other citizens. This definition shows disability as a problem caused by factors external to the person (barriers) and emphasizes the equality of citizens in social life, therefore it is also anti-discriminatory [5].

The group of disabled people in Poland is characterized by, on average, a lower level of education than among non-disabled people, high unemployment, a significant level of professional inactivity and living on invalidity pension. In 2014, only 9% of the disabled had higher education, in the group of non-disabled people this percentage was 22%. 30% of disabled people and 33% of non-disabled people had secondary education. In the category of lower secondary and vocational education, the percentage of disabled people is 30% and 31%, respectively, and 24% and 21% of non-disabled people. Relatively low education and the level of professional qualifications to some extent translate into an unfavorable situation on the labor market. The environment of people with disabilities is characterized by a high level of professional inactivity. Almost 81% of disabled people are economically inactive, while in the group of non-disabled people this percentage is approximately 41%. Even greater disproportions occur in the group of working people. Only 16% of disabled people are employed, compared to 52% of working non-disabled people. These data concern the general population of people with disabilities. In the case of people of working age, the economic activity rate is 29% (working and jobseekers), while the employment rate is 26%. The employment rate directly depends on the degree of disability. Most often, people with mild (24%) and moderate (18.3%) disabilities work, while only 5% of people with a severe degree of disability remain in employment. However, the registered unemployment rate of people with disabilities is relatively low and amounts to 10%. This is due to the fact that disabled people do not register as unemployed for fear of losing their disability benefits [6]. These factors contribute to the significant risk of poverty and permanent poverty of families. This results in a low social status, a threat of deepening social exclusion and a generally low quality of life. The inconveniences resulting from disability also influence the consolidation of negative social attitudes, including the low level of trust of people with disabilities in the society and its institutions [7]. Disability has numerous negative social effects.

The issue of rehabilitation has been the subject of numerous studies and implementation of practical solutions. The Polish rehabilitation school developed by Professor Wiktor Dega assumed the joint medical, social and psychological rehabilitation. Effective rehabilitation should be characterized by early onset, commonness and continuity and comprehensiveness. This model, developed in the 1970s, is up-to-date and can be effectively extended to the sphere of social and vocational rehabilitation [8]. The definition of rehabilitation referring to the principles developed by Dega is included in the Act on Vocational and Social Rehabilitation and Employment of Disabled Persons. In the light of this act, rehabilitation is a set of organizational, therapeutic, psychological, technical, training, educational and social activities. The aim of the activities is for a disabled person to achieve the highest possible level of their functioning, quality of life and social integration. The need for active participation of a disabled person in the rehabilitation process is emphasized here. The Act distinguishes and defines vocational and social rehabilitation. The purpose of vocational rehabilitation is to make it easier for a disabled person to obtain and maintain appropriate employment and career advancement. The goals of vocational rehabilitation are achieved through counseling, training and job placement. The process of vocational rehabilitation should include: work ability assessment, counseling aimed at choosing the optimal employment and training methods, vocational training, preparation of an appropriate workplace, equipping a disabled person with technical means enabling them to perform work [9]. Social rehabilitation is defined as an activity aimed at enabling a disabled person to fully participate in social life. Among the tasks of the local government addressed directly to the disabled is running occupational therapy workshops (WTZ), occupational activity establishments (ZAZ), community self-help homes (ŚDS) and social welfare homes (DPS). WTZ and ZAZ are social and vocational rehabilitation centers.

OBJECTIVE

The aim of the study was to analyze the implementation of local government tasks in the field of social and vocational rehabilitation of people with disabilities in the Lubelskie Voivodeship in 2008-2017.

MATERIALS AND METHODS

The work uses data collected in 2008-2017 by the Regional Center for Social Policy (ROPS) in Lublin. In addition, in December 2017, they were sent by e-mail to ROPS and Marshal's Offices

in voivodship cities in Poland, inquiries about tasks and ways of implementing these tasks in the field of social and vocational rehabilitation of disabled people in 2008-2017. The available data on expenditure from the State Fund for Rehabilitation of the Disabled (PFRON) was collected. The research material was statistically developed using the IBM SPSS Statistics (v. 25) and Statistica (v. 13) statistical packages.

RESULTS

The tasks in the field of social and vocational rehabilitation of the disabled are implemented by ROPS in Lublin in the Lubelskie Voivodeship. Table 1 (Tab. 1) presents a summary of expenditure on social and vocational rehabilitation of the disabled of the self-government of the Lubelskie Voivodeship in 2008-2017. The expenditure on social and vocational rehabilitation of disabled people from all Polish voivodships in 2008-2017 is presented in Table 2 (Table 2). Expenditure from PFRON on social and vocational rehabilitation in 16 voivodeships of Poland in 2008-2017 is presented in Figure 1. (Figure 1.). Table 3 (Tab. 3) presents the expenditures on all voivodship tasks related to the rehabilitation of disabled people in 2008-2017.

Tab. 1

Summary of expenditure on social and vocational rehabilitation of the disabled (ON) of the self-government of the Lubelskie Voivodeship in 2008-2017.

Years	Means (PLN))	Expenses on functioning of ZAZ (PLN)	Number of ON in a ZAZ	Expenses on investments (PLN)	Number of investments	'Soft'projects (PLN)	Number of contracts
2008	6 590 826.00	1 274 672.00	69.00	4 607 937.00	9	708 216.00	29
2009	5 304 157.00	2 681 068.00	145.00	2 183 089.00	7	440 000.00	41
2010	5 250 376.00	3 200 500.00	173.00	1 449 876.00	5	600 000.00	45
2011	8 982 419.00	4 389 256.00	174.00	2 212 021.00	6	2 381 142.00	117
2012	6 027 030.00	3 808 569.00	176.00	1 490 479.00	5	726 982.00	70
2013	8 280 294.00	3 256 000.00	176.00	3 259 592.00	12	1 764 703.00	158
2014	8 400 586.00	3 256 000.00	176.00	4 584 121.00	11	560 465.00	53
2015	8 740 412.00	3 922 000.00	212.00	1 919 006.00	10	2 899 406.00	141
2016	9 158 243.00	4 624 500.00	237.00	967 600.00	5	3 566 143.00	153
2017	8 795 616.00	4 727 150.00	247.00	2 834 983.00	8	1 233 483.00	56
TOTAL	75 529 959.00	35 139 715.00		25 508 704.00	78	14 880 540.00	863

Tab. 2.

Summary of expenditure on social and vocational rehabilitation of the disabled people from all voivodship self-goverments in 2008-2017.

	Total (16 voivodships)					
Years 2008-2017	N	M	SD	Min	Max	Suma
Means	160	7576718.9	3806435.6	1307923.0	17571852.0	1212275030.0
Investments [PLN]	160	2751896.7	1949152.3	0.0	9731660.0	440303468.0
Investmemnts- numer of constructions	160	10.3	6.8	0.0	38.0	1655.0
Investmemnts in ZAZ [PLN]	160	319511.5	759848.0	0.0	3988027.0	51121837.0
Investments in ZAZ – numer of ZAZ	160	0.4	0.7	0.0	4.0	64.0
Functioning of ZAZ [PLN]]	160	3519533.8	2525121.5	0.0	10970548.0	563125405.0
NGO [PLN]	144	843404.1	924599.7	0.0	5420402.0	121450193.0
NGO-number of contracts	143	43.7	38.6	0.0	223.0	6248.0

N- numer of years analyzed x 16 (liczba województw); M – mean, SD – standard deviation; Min – minimum; Max – maximum.

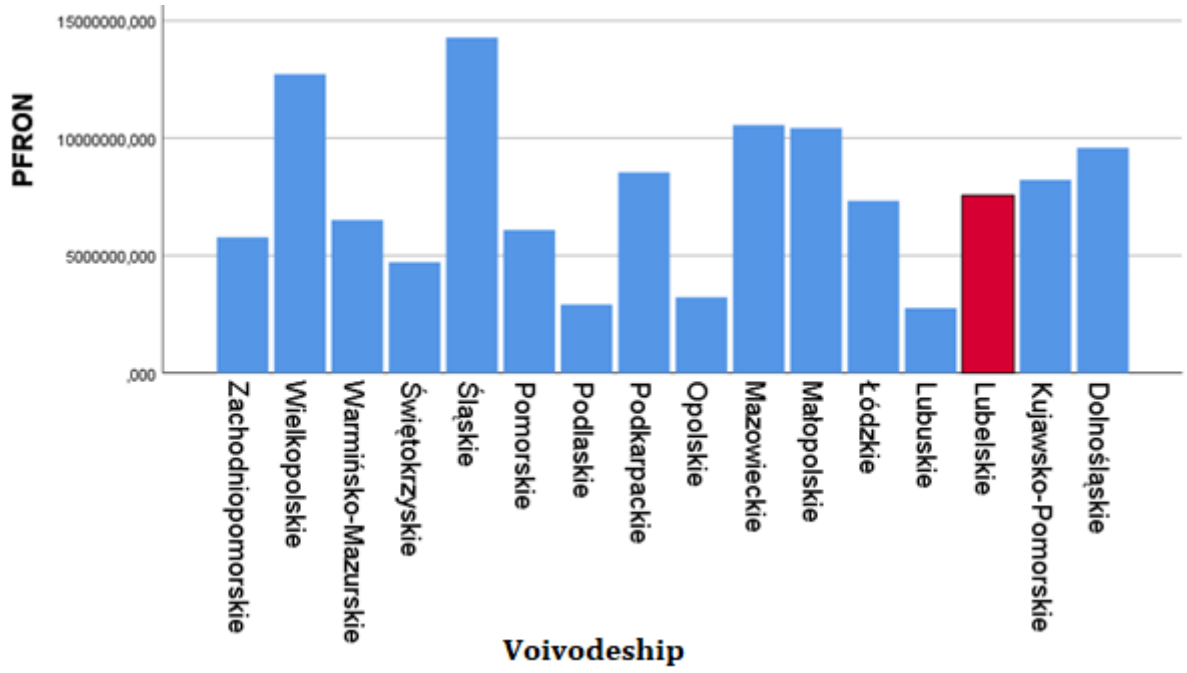

Fig. 1. Expenditure from PFRON on social and vocational rehabilitation in 16 voivodeships of Poland in 2008-2017.

Tab. 3

List of expenditure on all tasks related to the rehabilitation of disabled people (ON) in 16 voivodships in 2008-2017[%].

Voivodship	Co-financing of construction works in rehabilitation facilities in%	Co-financing of the costs of ZAZ [%]	Co-financing of the operating costs of ZAZ [%]	Tasks in the field of vocational rehabilitation and social and social activities, ON commissioned to foundations and non-governmental organizations [%]
Zachodniopomorskie	38.4%	1.7%	52.6%	5.5%
Wielkopolskie	13.7%	3.3%	64.1%	15.7%
Warmińsko-Mazurskie	47%	2.8%	46.4%	2.9%
Świętokorzyskie	27.7%	1.1%	53.3%	11.4%
Śląskie	44.1%	5.9%	49.9%	0%
Pomorskie	51.6%	0%	34.8%	12.2%
Podlskie	66.6%	1.4%	20.6%	9.8%
Podkarpackie	21.7%	1.5%	70.2%	4.5%
Opolskie	10.5%	0%	59.5%	28.9%
Mazowieckie	36.6%	1.1%	35.0%	19.2%
Małopolskie	53.3%	0.9%	36.0%	8.2%
Łódzkie	49.0%	0.4%	30.4%	10.7%
Lubuskie	67.3%	8.7%	1.5%	22.2%
Lubelskie	**23.8%**	**7.3%**	**47.9%**	**17.7%**
Kujawsko-Pomorskie	18.5%	21.8%	55.9%	3.8%
Dolnośląskie	41.2%	5.4%	40.2%	8.3%

DISCUSSION

Rehabilitation is a set of organizational, therapeutic, psychological, technical, training, educational and social activities. The aim of the activities is for a disabled person to achieve the highest possible level of their functioning, quality of life and social integration. In the process of rehabilitation, especially vocational, the need for active participation of a disabled person is emphasized [9]. Historically, rehabilitation was originally about soldiers wounded in armed conflicts to restore them to society and increase the number of men fit for work. It happened for centuries when epidemics of infectious diseases and wars systematically reduced the number of citizens in many countries. As early as 1919, The New England Journal of Medicine wrote about the need not only to heal wounds inflicted on soldiers, but also about the need to teach them a new profession after returning home, in which, despite their disability, they would be able to earn a decent living [10].

In 1917, it was founded in New York under the patronage of the Red Cross Institute for Crippled and Disabled Men. From the very beginning of the institution's existence, the need to teach a new profession not only to crippled war veterans, but also to men who suffered accidents while performing other industrial jobs was noticed. At that time, it was estimated that 80,000 men in the United States of America suffered accidents at work each year [10]. While the first hospitals were funded by wealthy donors and maintained thanks to social fundraising and the work of volunteers and non-profit organizations, with time purely commercial activities entered the health care system, including rehabilitation. Each procedure now comes at a cost. The persons performing these procedures are responsible for them and expect payment for this. Nobody provides pro bono medical / rehabilitation services, or only a few. Carrying out activities involves considerable responsibility and personal risk. In the United States of America, 75% of physicians are sued at least once in their careers due to suspected malpractice [11]. Thus, the costs of medical procedures and insurance costs are rising. And people with disabilities are convinced that these procedures are due to them. This is driving a spiral of economic dependence. Since there are no more rich sponsors, the health care system has to budget for these procedures.

In 1980, Relman noticed the increasing commercialization of the medical sector and the drive towards expensive technologies and expensive drugs that people with disabilities could not afford and the uninsured [12]. In 1990, the president of the United States of America, George Bush, signed The Americans with Disabilities Act. In 2015, The New England Journal of Medicine published a summary of the 25-year operation of this document, the assumptions of which were: equal access, full participation in social life, independent housing and economic self-sufficiency of people with disabilities. The authors of the report note that crossings have appeared in the public space with low curbs for wheelchair users, sound signals in addition to light signals for the visually impaired, numerous architectural barriers in public buildings were eliminated, but all four postulates of the act could not be implemented. Currently, 56.7 million Americans live with disabilities (8.4% of children under the age of 15 and as much as 70.5% of those aged 80 and over). The percentage of the disabled is more than twice as high among the unemployed than among the employed (33.5% vs 12.6%). Significantly more women than men live with disabilities (24.4% vs 19.8%). The severity of the phenomenon of disability in these social groups is also observed in Europe and Poland. The authors see the causes of this condition in the prevalence of chronic diseases (diabetes, arthrosis) and in modern medical interventions that support the life of premature babies and children born with serious malformations (spina bifida, congenital heart defects) [13]. The authors note that people with disabilities have difficulties in carrying out tests resulting from common prevention programs: mammography and cytology in the case of women, annual visits to

the dentist, smoke tobacco more often, are obese, have hypertension and emotional problems more often than people without disabilities [13]. The USA, despite the world's highest expenditures on medical and rehabilitation procedures, has not achieved the highest quality of life indicators or the longest survival time among developed countries. It is related to inequalities in access to medical procedures and insufficient expenditure on prevention compared to healing.

In 2011. WHO and the World Bank have published a report on disability in the world. It emphasized that there are huge differences in access to rehabilitation between developed and developing countries [14]. It was also noticed that not all procedures called rehabilitation are confirmed in evidence-based medicine, i.e. that there are no randomized studies confirming their effectiveness, as is the case when new drugs are introduced to the market or surgical procedures are introduced into medical practice. The Physiotherapy Evidence Database contains the results of nearly 20,000 clinical trials, most of which are inappropriately designed, covered very few groups of patients and did not provide evidence of their effectiveness [15].

The New England Journal of Medicine in 2013 published a report on injuries and their consequences around the world. In 2010, it was reported that 5.1 million people worldwide died as a result of injuries. This means that 10% of deaths worldwide were caused by injuries. This number is greater than the sum of deaths from the most serious infectious diseases (HIV-AIDs, tuberculosis and malaria taken together) that contributed to 3.8 million deaths worldwide during this time. Another important fact was also noted: in developed countries, where there are high expenditures on rescue, treatment and rehabilitation, death as a result of injuries affects 6% of victims, and in developing countries, with low expenditures on rescue, treatment and rehabilitation, as many as 89% of people, who were injured died. It was emphasized that as a result of injuries and subsequent disability, the economic and social cost of injuries increases, which is expressed, inter alia, as Disability-Adjusted Life-Years (DALY). Men are more likely to be injured, especially between the ages of 10 and 24.

Sustained injuries dominate among unintentional injuries in traffic accidents (and there are more of them, the poorer the country, worse roads, worse

quality cars), and among self-harm there are suicides and suicide attempts (which are the highest in developed countries) [16]. No wonder that the Ministry of Loneliness was established in 2017 in the UK. If this avoids the depressive disorder of citizens and their most severe form of suicide attempts, it will be an idea to follow in other countries. Today, more than half of the world's population lives in cities. A high rate of urbanization increases the risk of depressive disorders and a sense of isolation among citizens, as well as stratification into poor and rich about unequal access to medical procedures. All civilized countries are trying to ensure access to treatment and rehabilitation for their citizens with disabilities. Its costs are increasing and even the richest countries are not always doing well with meeting the needs of citizens in this respect. In the United States of America, it is estimated that health care spending will increase from 18% to 25% of gross domestic product by 2037 [11].

Polish works in the field of therapeutic, but also professional and social rehabilitation have placed our country among developed countries for a long time. This applies to both the scientific, practical and legal spheres. The Polish rehabilitation school (the Polish model of rehabilitation) created by the Poznań orthopedist, Professor Wiktor Dega, grew out of the need for rehabilitation of victims of the Second World War, also known in other countries. In addition to innovative medical aspects, the tan model assumed a broad approach to rehabilitation, also in the psychological sphere of the patient and in the professional sphere. The influences of the previously mentioned American thought regarding the rehabilitation of war veterans developed in the USA by Dr. Howard Ruska. In Poland, professor Dega encountered much more serious challenges, as statistically many more people, including mainly civilians, including children, were affected by the problem of disability caused by hostilities than in other countries. The consequences of the war were felt long after its end, e.g. due to numerous explosions of war remains - mines, misfires and unexploded bombs [17].

As in developed countries, also in Poland the causes of disability are changing. Civilization diseases, traffic accidents and work accidents are becoming a serious problem, and paradoxically, advances in medicine, which increase the survival rate of people after injuries and newborns coming into the world with serious deficits. The sphere of financing medical services, related to medical and social rehabilitation and occupational problems of people with disabilities is an issue where we observe significant weaknesses of the Polish system. Expenditures in this area in Poland are much lower than the average in the European Union (EU) countries. This applies to both strictly medical expenses and and non-medical services belonging to the social sphere provided by the welfare state. It is closely related to the level of economic development of countries, the higher the gross domestic product, the greater the medical and social expenses [18]. Medical procedures, including therapeutic rehabilitation, are only a starting point for restoring a disabled person to the highest possible quality of life, which includes health, family, social, professional and emotional aspects, the possibility of fulfilling personal aspirations and eliminating barriers that make it difficult. The next steps of rehabilitation are social rehabilitation and vocational rehabilitation being the last stage of rehabilitation procedures [17].

In the 1970s and 1980s, when Poland was implementing the utopian program of 'full employment', including people with disabilities, and in Great Britain, a policy of pushing people with disabilities out of the labor market was being pursued more or less on purpose, in Germany completely different means. The 1970s were a period of crisis in the employment of disabled people in Germany. Since then, German social policy has been based on the idea of full participation of disabled people in social life, including professional life. Therefore, in the first place, activating activities are carried out there. Passive, benefit or disability activities are implemented in the second place, only when planned and the implemented rehabilitation does not bring any positive effects. The basic form of activation is vocational rehabilitation, carried out in various practical forms. The main forms of rehabilitation are Supported Employment, Workshops and Workshops. In the case of people using these forms of rehabilitation, its effectiveness, measured by entering the labor market, is 70% [19].

Rehabilitation costs are understood not only as the necessity to pay financial benefits and provide services to disabled people, but also costs consisting in the loss of benefits resulting from social and professional inactivity of disabled people and their families. The aim of all the systems under discussion is to introduce and maintain disabled people to the labor market, and to achieve maximum independence and relieving families and savings in social systems. Interestingly, some Polish institutions (ZAZ) were almost 100% copied from German patterns. Therefore, the question remains why similar institutions in Germany can boast that 70% of rehabilitated disabled people find employment, while in Polish conditions this ratio is close to zero.

The tasks of the voivodeship self-government performed in the field of rehabilitation include:

- development and implementation of voivodship programs on equalizing opportunities for disabled people and counteracting their social exclusion, as well as helping in the implementation of tasks for the employment of disabled people;
- preparing and presenting information about the conducted activity to the Government Plenipotentiary for Disabled People;
- co-financing of construction works of rehabilitation facilities, in connection with the needs of the disabled;
- co-financing the costs of creating and operating the ZAZ;
- cooperation with government administration bodies as well as poviats and communes in the implementation of tasks under the Act;
- cooperation with non-governmental organizations and foundations acting for the benefit of the disabled;
- issuing opinions on the application for entry in the register of centers accepting groups of rehabilitation camps, kept by the locally competent voivode;
- subsidizing tasks carried out by non-governmental organizations (soft projects).

ROPS in Lublin carries out about 150 projects annually, the value of which ranges from several thousand to one million zlotys. The analysis of almost a thousand projects shows that the activity of local governments and non-governmental organizations from individual counties varies greatly.In all areas, there are

clear leaders in project implementation, as well as poviats in which the activity of administration and non-governmental organizations is close to zero or does not occur. The city of Lublin (local government and non-governmental organizations) shows the greatest dynamics in obtaining funds and carrying out tasks in the entire Lubelskie Voivodeship.

CONCLUSIONS

- In Poland, in the field of social and vocational rehabilitation and employment of disabled people, solutions similar to those already developed are applied in the countries of Western Europe.
- The costs of financing vocational rehabilitation, understood as financing the operation of vocational activity establishments by voivodship self-governments, are constantly growing.
- The growing expenses incurred on the operation of vocational activity establishments do not significantly improve the situation related to vocational rehabilitation and employment of disabled people.
- Improving the operation of the system of vocational and social rehabilitation of disabled people should not only consist in increasing the financial resources spent under the current inefficient system, but should be preceded by a thorough analysis of the current state and the development of extensive organizational changes.

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