

Seize the Moment! Establishing Vision-Related Rehabilitation and Access in the Nation's Public Health Policy Agenda

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Abstract: The potential benefits to the vision rehabilitation field and the people it serves of an ongoing collaboration with public health are highlighted. This article focuses on the current phase of the long-term federal Healthy People initiative, and suggests that the inclusion in Healthy People 2010 of a section devoted to people with disabilities and another that specifically targets vision and hearing loss make this an especially propitious time for an alliance between fields that have historically operated on separate tracks. Formation of such an alliance faces a number of obstacles, however, and action on the part of those working in vision rehabilitation and special education is called for, lest they lose a significant opportunity to enlist professionals in public health in the cause of people with visual impairments.

A variety of circumstances have recently come together to raise awareness in the public health sector about vision loss as a condition deserving concerted attention by policy makers and practitioners. This moment of public health interest in vision loss may be fleeting, however, and it is up to those working in the field of visual impairment to seize the moment and act to make rehabilitation objectives part of the public health agenda.

If those of us working in the public health field aim to collaborate with those working in the area of visual impairment, it is important to understand the relevant aspects of public health structure and culture. This article begins by reviewing the separate histories of the vision rehabilitation and public health fields to suggest

why vision loss has not been part of the public health agenda before now. Next, it examines in detail a major approach to public health policy—Healthy People 2010—that may be strategically useful in focusing the public health field's attention on vision rehabilitation.

In its discussion of health issues, this article focuses on the health of people who are already visually impaired or blind (those for whom further medical or surgical treatment will not improve visual capacity). The part of the field that, broadly speaking, deals with rehabilitation and environmental access will be referred to here as the vision rehabilitation field, to designate a) processes by which blind and visually impaired people acquire skills and attitudes enabling them to use alternative

means of reading, mobility, etc., and b) activities to create and provide accessible materials and settings.

Historical background

First in the United Kingdom and then in the United States, public health as an identifiable field emerged in the nineteenth century around tracking, treating, and controlling infectious diseases. This focus called for assuring availability of medical acute care to individuals, and environmental control of infectious agents, such as bacteria that caused typhoid fever, in the community. The public health approach was strikingly successful, leading to longer average life expectancy in the population. In time, as chronic diseases and associated disabilities overtook infectious diseases as the main causes of the public's health problems, the attention of public health analysts shifted more toward the challenge of health promotion and disease prevention. A major public health agency of the United States, the Centers for Disease Control (CDC), formally added prevention to its mandate in 1992, becoming the Centers for Disease Control and Prevention. Although education is the main tool for achieving public health prevention goals, as it is for rehabilitation, these two efforts have historically been divided by prevention's focus on healthy, nondisabled people.

Thus, the model of "disease control and prevention" dominates CDC's structure and functions in such a way that "disability" represents a negative endpoint to be avoided. That emphasis on prevention of disability has been at the expense of attention to rehabilitation for people *with* disabilities, although the two aims need not be mutually exclusive. Furthermore,

the notion of promoting health and preventing illness in people with disabilities has seemed incongruous to many. For example, Pope and Tarlov in 1991 referred to the "medical model" of disability and explained that, under the influence of that view, "health and social agencies provide a mix of services that for the most part categorize affected individuals [that is, individuals with disabilities] as permanently ill and incapable of meeting their own needs" (Pope & Tarlov, 1991, p. 244).

During a similar period starting in the early nineteenth century, the vision rehabilitation field moved along its separate track. The seminal specialized services that emerged in the 1800s were in the education of blind children, setting an educational rather than a health-oriented basis for the field (Koestler, 1976). Much later, "independent living" services for adults emerged in a social work model of home-based services, often provided by blind women to others like them, and called "home teaching" (Ponchillia & Ponchillia, 1996). That term was changed to "rehabilitation teaching" when formal education became standard for training in that occupation (Commission on Standards and Accreditation for the Blind, 1966). Very recently, the professionals in that specialty have been renamed "vision rehabilitation therapists," signaling a shift toward highlighting the health-related aspects of their services.

Although orientation and mobility services initially developed as a professional specialty in the context of the Veterans Administration medical system, they matured apart from the medical profession's aegis. The direction that orientation and mobility took appears to have been influenced by C. Warren Bledsoe, whose

own early experience was shaped by his father's role in directing a residential school for the blind (Bledsoe, 1997).

Outside the vision rehabilitation field, the larger rehabilitation specialty professions, notably occupational therapy and physical therapy, emerged within the medical domain and gained in status by operating under the direction of physicians (Institute of Medicine, 1989; Moffat, 2004). In a seminal edited volume on sociology and rehabilitation (Sussman, 1965), still unsurpassed in exploring the sociological path of blindness services separately from services for other impairments, Bloom (1965) offered an explanation. He suggested that onset of blindness typically is gradual and progresses outside the usual medical institutional basis for rehabilitation. By contrast, occupational and physical therapists characteristically work with people who have been impaired abruptly by stroke or injuries, and whose rehabilitation begins in a hospital setting under the direction of physicians (Bloom, 1965).

DISPARATE APPROACHES

In an extension of their historically divergent development, the fields of vision rehabilitation and public health have continued to operate on separate tracks due in part to the nature of vision services and in part to the general separation of rehabilitation from the health field. Vision services have not typically been seen as a public health issue because vision problems are at once too common and too rare. Typical vision care for correctable vision problems—services such as refraction and prescription of ordinary corrective lenses—have generally been excluded from health-insurance payment

plans, no doubt because of the extremely high prevalence of need for eyeglasses. In addition, the widespread belief that age-related vision loss is simply part of “normal aging” implies that it is not a health problem. Because financing and delivery of health services occupy a substantial span in the scope of public health policy making, the exclusion of vision services from the financing mix tends to keep vision-related issues below the radar of public health analysts.

At the other end of the spectrum, blindness and low vision (severe vision loss that cannot be corrected medically or with ordinary lenses) are conditions that, because of their low prevalence, are also excluded from most third-party payment plans; they are typically not in the service repertoire, or even the referral repertoire, of many eye-care specialists. Blindness is conventionally considered a catastrophic disability (in the Rehabilitation Act, “legal blindness” is “a severe disability”; in the Social Security Act, it is the only impairment that automatically qualifies as preventing employment). Many ophthalmologists are reputed to view individuals who are blind or have low vision as representing a failure of their services; these patients often are told that “nothing more can be done” for them.

Despite these paradoxical reasons for vision loss being effectively excluded from attention in the public health arena, the interest of public health and eye care practitioners is likely to increase if current efforts to include vision rehabilitation in Medicare (Medicare Low Vision Rehabilitation Demonstration, 2004) are successful, after decades of poor showings for such initiatives (Kirchner, 1988; Massof, 2001).

As for the “rehabilitation” aspect of the field’s designation, rehabilitation (regardless of the type of impairment) has only relatively recently drawn concentrated attention in the federal health establishment. One marker is the 1990 founding of the National Center for Medical Rehabilitation Research within one of the National Institutes of Health (National Institute of Child Health and Development, n.d.). Another is the establishment in 1988 of an Office of Disability and Health within CDC, to promote techniques of rehabilitation toward the goal of “healthy people with disabilities.” (At federal and state levels, rehabilitation has been linked mainly to the education and labor sectors, rather than to health services. Notably, the federal Rehabilitation Act, including the National Institute on Disability and Rehabilitation Research, is administered by the Department of Education, not the Department of Health and Human Services.)

A FRAGILE FOUNDATION FOR COOPERATION

Thus, with the emergence of the vision rehabilitation therapist and a tentative toehold in obtaining Medicare coverage for vision-related services, on the one hand, and the establishment of an Office of Disability and Health within CDC on the other, there appear to be conditions in place to support the emerging public health interest in vision loss from a rehabilitative perspective. But how stable are these current conditions likely to be? There are a number of developments that provide a basis for believing the interest will be sustained, but that also underscore the fragility of these positive trends.

First, low vision rehabilitation is becoming institutionalized as a specialty

within the eye-care professions (American Academy of Optometry, n.d.). Thus, there is a growing nucleus of eye-care practitioners who promote and even provide vision-related rehabilitation services, rather than avoiding further involvement with patients who are blind or have low vision. However, third-party coverage, whether under Medicare, Medicaid, or private insurance plans, is still limited and still constrains this development (Agency for Healthcare Research and Quality, 2002; Kirchner, 1988; Massof & Lidoff, 2001).

Second, the National Eye Institute, which has for several decades provided a relatively small funding stream to support research in low vision rehabilitation, has more recently added funding for health services research in eye care and low vision services. Cumulatively, those programs are building the still-rudimentary “evidence-based” body of knowledge that will help substantiate the field as meriting public health attention.

Specifically, the Cochrane Collaboration (n.d.), an international effort to compile research evidence in the biomedical fields, has added an “eyes and vision” group, aimed at promoting “systematic reviews of interventions to treat or prevent eye diseases or visual impairment” (Cochrane Eyes and Vision Group, n.d.). More pertinent here, a subtopic is devoted to “Vision Impairment and Rehabilitation.” A leader in that effort (Wormald, 2004) has concluded that “there is growing awareness among participants in this area of research that the evidence base is poor and steps are now being taken to remedy the situation” (p. 12). As of July 2006, only two reviews are listed, one on community screening for vision

impairment, leaving only one on a *bona fide* rehabilitation topic (orientation and mobility training).

Separate from its research funding, the National Eye Institute's public education arm has taken a strong role in promoting services in the area of low vision, thereby bringing a community-based, public-health-oriented component into the traditionally basic-science and disease-based treatment emphases of the Institute (emphases that, quite appropriately, are likely to endure). (See the Janiszewski article in this issue.)

Some vision rehabilitation professionals now disavow a widespread view that has limited the field's focus on health issues (Massof & Lidoff, 2001). The stereotype has been that working closely with health care professionals would countenance the "medical model" of blindness and low vision that is antithetical to the educational approach of rehabilitation. Further, many policy analysts in the disability field dismiss the medical model as "blaming the victim" by viewing the social problems related to blindness (or other impairments) as inherent to the individual rather than as products of a discriminatory and inaccessible environment. More recently, however, some leaders in the public health field, as well as some working in vision-related rehabilitation and access, have begun to acknowledge that their aims are essentially the same (Mulhorn, 2004) (see also the introduction by Crews, Kirchner, and Lollar in this issue). They may emphasize different intermediate outcomes—improved health on the one hand, improved functioning in daily living on the other—but their common long-range goal is the full participation in society of people with disabilities.

That goal, it is worth noting, corresponds to the mission of the Americans with Disabilities Act (ADA, 1990), which states that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." Because the ADA expresses the nation's current disability policy rationale, it further justifies and supports the aim of bridging public health and vision rehabilitation.

The ADA can also be viewed as a policy tool for helping to achieve health goals. For example, Title II, which covers state and local government services, aims to assure people with vision loss equitable access to health information and health care, and Title I, which covers employment, assures them the opportunity to work in health-related occupations. The latter is an indirect but powerful way to achieve better understanding of visually impaired patients' needs in health care encounters (Basnett, 2001). Unfortunately, however, references to and reliance on the ADA also invoke a substantial measure of pessimism. As of this writing, with the ADA having been in effect for more than 16 years, people with disabilities have realized limited progress in general social participation, and specifically in health care (Iezzoni & O'Day, 2006).

The stimulus to the health sector's interest in vision rehabilitation that could result from gaining Medicare payment for services is considered by some to be on shaky ground. A congressionally mandated five-year demonstration project in four states and two cities (Centers for Medicare and Medicaid Services, 2006), launched as the basis for deciding on Medicare coverage, seems seriously limited in the duration of

services it authorizes (nine hours). If the demonstration fails to engage the participation of professionals and patients, or if it does not achieve convincing benefits (which requires sufficient inputs and still-lacking measuring tools), the continued interest of the public health community could be significantly undermined. Indeed, the fragile reed of the Medicare demonstration may jeopardize the very existence of nonvocational vision-related rehabilitation services within a few years (Yablonski, 2006).

There seems to be a steep uphill challenge within the public health domain to establishing the status of rehabilitation generally. Currently, rehabilitation of people whose disabilities persist, although their functioning is improved as a positive approach to promoting the nation's health, is not well-established in the institutional centers of public health. To illustrate that point, consider curricula in the nation's 38 accredited schools of public health. CDC's Office on Disability and Health recently funded curriculum grants to address the virtual absence of courses that focus on environmental access and rehabilitation approaches to removing health disparities between people with and without disabilities. In response, Oregon Health Sciences University developed a two-credit course on disability and public health, expanded in 2006 to three credits (Rehabilitation Research and Training Center, n.d.). Boston University School of Public Health (n.d.) developed modules on disability and health for use in existing courses, such as health policy or administration). To date, however, there is no evidence of broad receptivity to building such modules into public health

training. If those who work in the public health field—practitioners, researchers, policy analysts, administrators—are not exposed to that perspective in their education, we should not be surprised that it holds so little sway throughout the larger public health structure. (see Fall 2004 issue of *Disability Studies Quarterly* on public health and other health professionals' education).

In the 1980s, a few constituents of the 50,000-member American Public Health Association (APHA) initiated a special interest group, Disability Forum, which has not yet reached the 300-member level required for full "Section" status. Its uphill struggle and mixed reception can be illustrated by disparate events since then: in 1999, Disability Forum threatened an ADA suit against the parent association because of severe access barriers at the its annual convention; four years later, the member who led the suit was placed on a distinguished plenary session panel at the association's 2003 annual convention.

The vision field is represented in APHA by the Vision Care section, founded in 1979, with close to 400 members, primarily optometrists. Its program at the annual conventions and its policy resolutions have focused on vision screening and access to eye care, but it has also promoted vision-related rehabilitation. In 2003, it submitted a resolution that urged "all health care providers to make appropriate and prompt referrals for vision rehabilitation services for people with visual impairments" (APHA, 2003).

In summary, it appears that the beginnings of an infrastructure exist upon which to build a strong partnership between public health and the vision

rehabilitation field. But unless there is concerted attention, in the areas of policy development and program planning, to strengthening this somewhat fragile foundation, the potential could crumble. There is, however, a major public health policy resource that could be used to strengthen the focus on vision-related rehabilitation.

A vehicle for policy development

Policy development for the vision rehabilitation field requires that the issues first become a part of the nation's public health agenda. In many domains, policy agenda is a somewhat amorphous concept, one that generally does not refer to a specific mission statement or set of written goals. In the public health arena, however, a document has been developed since the 1980s that itemizes the nation's health priorities for the ensuing decade—the Healthy People series. We are now past the midpoint in the current plan, Healthy People 2010.

Healthy People 2010 refers to a document, but beyond that signifies an elaborate process and structure within the Department of Health and Human Services. The plan involves CDC and many other public (federal, state, local) and private-sector agencies, either as “lead agencies” in specific areas, or as “partners” with informal agreements to collaborate. It is that complex totality of the Healthy People 2010 plan that offers what may be a sturdy vehicle for people in vision rehabilitation to climb aboard, moving toward their policy objectives.

Nevertheless, there are concerns. For one, the Healthy People 2010 plan may be weakened by the inevitable emergence of competing priorities (emergency pre-

paredness, for example, has demanded special attention since September 11, 2001 [see the Sapolin article in this issue]), and further undermined by its own breadth: however worthy, an initiative with more than 400 objectives across 28 focus areas may be just a bit too ambitious. Notwithstanding these concerns, participants in public health policy should be prepared to use Healthy People 2010 as strategically as possible. To this end, the National Eye Institute has created and supports a derivative program, Healthy Vision 2010, to focus on and foster the vision objectives in Healthy People 2010 (Healthy People 2010, n.d.).

VISION REHABILITATION IN HEALTHY PEOPLE 2010

Healthy People 2010 consists of 28 chapters, each with an overall goal and several objectives; these have baseline indicator measures at or near the start of the decade and targets for 2010. A requirement for adopting each objective was that data exist to allow before-and-after measures. If no data source existed before Healthy People 2010 launched in 2000, the objective was called “developmental”; if no measure was available by the decade's midpoint, the objective would be dropped.

Two chapters are of primary interest here, neither of which had existed in HP2000, thus underlining the recent opportunities in these areas. Chapter 6, on “Disability and secondary conditions,” expresses the newly meaningful concept of “healthy people with disabilities,” suggesting that disability is not just a negative outcome of illness nor a lack of access to or effectiveness of health services. Rather, in whatever way the disability

occurred, disability can be viewed for its potential relation to fitness and health. The chapter's overall goal is to "Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population." This is an ambitious statement that at one time would have been unthinkable. The chapter designates co-leader agencies, CDC and National Institute on Disability and Rehabilitation Research, bridging the federal health and education agency structures.

The chapter on disability does not highlight visual impairment, nor, for that matter, any specific impairment. Rather, its objectives apply to people who are visually impaired insofar as they apply to people with any impairments. The chapter specifies 13 objectives; three were originally developmental, but data sources have been identified.

The other chapter of interest is Healthy People 2010's concluding chapter, focused on "Vision and hearing." Its overarching goal is to "Improve the visual and hearing health of the Nation through prevention, early detection, treatment and rehabilitation." When the chapter was created, nine of the vision section's ten objectives were "developmental"; all have identified a data source.

Only one objective in the chapter deals broadly with issues affecting people who are blind or visually impaired; the others refer to prevention and treatment of specified eye diseases. Objective 28-10, the one devoted to vision rehabilitation, aims to "Increase the use of rehabilitation services [and] the use of visual and adaptive devices by persons with visual impairments." This objective, taken alone, may

have limited utility for policy to support the broad health and quality-of-life goals sought by those in the vision rehabilitation field. However, in conjunction with Chapter 6, which aims to assure equity in health for all people with disabilities, the components of Healthy People 2010 constitute an important first step, having placed vision rehabilitation on the nation's public health agenda.

Indeed, Healthy People 2010's Chapter 6 merits particular attention in this analysis, both because it offers a broad framework for considering public health aspects of vision rehabilitation, and because its potential seems to have been overlooked by the vision rehabilitation field. The National Eye Institute of the National Institutes of Health, the lead agency for Chapter 28's vision section, makes no reference to Chapter 6 in its extensive materials describing the Healthy Vision 2010 initiative (Healthy People 2010). (More comprehensive information on Chapter 6, including operational suggestions to achieve each objective, is available in a monograph on request from CDC [NCBDDD, 2001].) Every HP 2010 chapter highlights objectives in other chapters as pertinent links. Although all Chapter 6 objectives are relevant to promoting vision-related rehabilitation, only one (6-11, referring to assistive devices) is specified in Chapter 28.

AVENUES FOR INTERDISCIPLINARY EXCHANGE

Although recently reviewed as part of CDC's major institutional reorganization called the "Futures Initiative" (<www.cdc.gov/futures>), the mission statement of CDC is still "To promote health and quality of life by preventing and controlling

disease, injury, and disability.” Taken literally, that wording makes efforts to foster and enhance the health of people with disabilities seem incompatible with the mission. Fortunately, the explicit statement of intent in Healthy People 2010’s Chapter 6—to promote the health of people with disabilities—helps to correct that exclusionary impression. In fact, practitioners in the vision rehabilitation field may be surprised by how closely most of the objectives match their work, whether that work deals with clients’ vocational goals, skills for independent living, or emotional well-being, or involves environmental access via assistive technology or barrier removal. Box 1 lists the subset of the 13 objectives that best mirror the work of vision rehabilitation.

For example, Objective 6-8, dealing with employment opportunities, sparks a multitude of ideas ripe for exchange between workers in public health and vision rehabilitation. Such an alliance could infuse new resources into the respective professions, and lead to greater efficiencies on both sides. Working together, public health and vision rehabilitation professionals might at last shed light on the generally overlooked role of poor health in the low employment rates of those with visual impairments (Kirchner, Schmeidler, & Todorov, 1999). Along these lines, the service delivery expertise of public health analysts could help to address employers’ concerns about meeting health care needs of employees with disabilities. Similarly, research could be designed to document the health benefits of employment for individuals with vision loss, or to examine the effects on health of accessible, compared to inaccessible, work environments.

Rehabilitation-oriented objectives

- 6-2 Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.
- 6-3 Reduce the proportion of adults with disabilities who report feelings such as sadness, unhappiness, or depression that prevent them from being active.
- 6-4 Increase the proportion of adults with disabilities who participate in social activities.
- 6-5 Increase the proportion of adults with disabilities reporting sufficient emotional support.
- 6-6 Increase the proportion of adults with disabilities reporting satisfaction with life
- 6-8 Eliminate disparities in employment rates between working-aged adults with and without disabilities.
- 6-9 Increase the proportion of children and youth with disabilities who spend at least 80 percent of their time in regular education programs.
- 6-10 Increase the proportion of health and wellness and treatment programs and facilities that provide full access for people with disabilities.
- 6-11 Reduce the proportion of people with disabilities who report not having the assistive devices and technology needed.
- 6-12 Reduce the proportion of people with disabilities reporting environmental barriers to participation in home, school, work or community activities.

Box 1.

The Chapter 6 objective aimed at increasing the time students with disabilities spend in regular education programs (6-9) might be contentious for experts in habilitation of blind children, given the intensive specialized requirements for teaching braille or other “expanded core curriculum” skills (Corn, Hatlen, Huebner, Ryan, & Siller, 1995). But that possibility argues for more rather than less collaboration between public health workers and educators of visually impaired children. As noted earlier, including educational environments in an agenda for health promotion can open opportunities for interdisciplinary ideas and resources to achieve mutual objectives. Similar attention and analyses, undertaken jointly by public health and vision rehabilitation specialists, could be applied to each of the Chapter 6 objectives listed in Box 1, with a focus on the specific needs of people with visual impairments.

Two of the Chapter 6 objectives (6-1 and 6-13) focus on the collection of data; their relationship to vision rehabilitation is indirect yet vital. Both deal with population-based data on health status and conditions. Generating such data is distinctive and fundamental to the public health approach, in contrast to patient- or client-based studies that are traditional in both the medical care and rehabilitation arenas.

Objective 6-1 (“Include in the core of all relevant Healthy People 2010 surveillance instruments a standardized set of questions that identify ‘people with disabilities.’”) is a potentially powerful policy tool. If achieved, standard questions to identify people with disabilities would be in studies measuring all Healthy People 2010 objectives (not just those in Chapter

6), allowing a test of whether Healthy People 2010 activities reduce health disparities between people with and without disabilities.

Setting aside the difficulty of that objective for disability in general, we must tackle the thorny issue of adopting the same objective for visual impairment. In fact, that aim may be desirable, but not feasible or wise, mainly because it implies that all impairments should be measured in every HP2010 surveillance study. Such a requirement would be unacceptably expensive and burdensome for respondents.

Working toward a standard disability indicator can benefit the vision rehabilitation field, and certainly merits the field’s efforts to collaborate. A general benefit for the vision field derives from the principle underlying Objective 6-1: “Disability is a demographic descriptor rather than a health outcome” (NCBDDD, 2001, p. 51). The statistical approach is another way of emphasizing that disability status should be a starting point in health promotion, rather than a negative endpoint. Furthermore, if disability were routinely measured, some of those surveillance studies could serve as efficient screeners and sampling frames for follow-up studies focusing on specific impairments and their health-related correlates. Special studies could test the conditions under which health-related trends observed using the general disability indicator can or cannot be used as reliable proxy measures for people with visual impairment. However, these possibilities can be realized only if the vision field works with researchers in the larger disability field.

Objective 6-13 (“Increase the number of Tribes, States and the District of Columbia that have public health surveillance and

health promotion programs for people with disabilities and caregivers.”) extends the previous objectives of Chapter 6 in two ways. First, it moves from the national to state and tribal levels; thus, it is an effort to harness the resources of the strong public health service delivery structure. Its surveillance focus involves placing measures into the Behavioral Risk Factors Surveillance Study, CDC’s ongoing state-based data-gathering effort (<www.cdc.gov/brfss>). Regarding tribes, the relevance for the vision field is highlighted in Topor’s article in this issue. The second focus of Objective 6-13, on the needs of caregivers, has been left in “developmental” status, lacking adequate data resources (NCBDDD, 2001).

Objective 6-7 (“Reduce the number of people with disabilities in congregate care facilities, consistent with permanency planning principles.”), although not as directly relevant to the vision field, is important nonetheless. The references to “congregate care facilities” and “permanency planning” primarily denote services for those with cognitive impairments, especially but not exclusively impairments acquired in childhood (developmental disabilities). The objective of drastically reducing the number of institutionalized people in favor of home- and community-based services is relevant for the vision field, given high rates of cognitive and other impairments among people with visual impairment, many in nursing homes (Tielsch, Javitt, Coleman, Katz, & Sommer, 1995).

Conclusion

The potential benefit to people who are blind or visually impaired from an emerging public health interest in vision loss is

unlikely to be realized unless more professionals and advocates in the vision-related fields of specialized education and rehabilitation take notice and act. Taking notice starts with understanding more about what public health is, how its services are funded and organized, and how public health policy is developed and implemented. One tool is the Healthy People 2010 document and process. Within the framework of Healthy People 2010, the vision field has gained a toehold and started to act by focusing on the explicit objective of increasing the target population’s use of rehabilitation services and visual and adaptive devices.

But it would be a mistake to stop there. The 13 objectives specified in Chapter 6 of Healthy People 2010 have the aim of eliminating disparities in health between people with and without disabilities. The vision field has an opportunity now to draw upon and actively support those objectives. Although promulgated for all people with disabilities, the objectives are essentially extensions of the vision rehabilitation field’s long-term priorities for people with visual impairment—efforts now recognized by the many disciplines encompassed in the public health arena to be essential in promoting health.

Whether this window of opportunity closes quickly is not entirely a matter of chance, although chance does play a part, as anyone who follows politics is well aware. The field’s stakeholders—service providers, consumers, educators, and administrators—could influence the outcome. They could put into place stronger assurances that vision-related rehabilitation access will not only remain on the public health agenda, but will become a touchstone for shaping a range of health

policy decisions. Working toward that goal requires, at a minimum, that participants become familiar with key resources for policy development in the public health sector.

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