interventions. The extension of the Finnish Diabetes Prevention Study suggests that the benefits of intensive lifestyle intervention are sustained for many years after the intervention period (unpublished data).[13]

Overall, despite the impressive risk reduction for progression to diabetes, the lack of data on long-term benefits and side-effects, and the high cost of therapy, mean that health-care funders are unlikely to see rosiglitazone as an appropriate agent for individuals with impaired glucose regulation but low absolute cardiovascular risk. Unfortunately, the greater benefits in higher risk individuals would have to be balanced against the likely increased risk of heart failure. Given the prolonged benefits and demonstrable cost effectiveness of intensive lifestyle intervention for people at high risk of diabetes, such interventions should remain the mainstay for the prevention of type 2 diabetes.

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The definition of disability: what is in a name?

The definition of the word disability has been debated for the UN Convention on the Rights of Persons with Disabilities, and the final draft will soon be submitted to the UN General Assembly for approval.[1] WHO has been mandated to produce a world report on disability and rehabilitation by 2009 to collate the best evidence about the prevalence, distribution, and trends of disability and recommend action.[2]

In many countries, the 2010 census round will probably include questions about disability, as recommended by the UN Population Division. In the next few years, countries around the globe will begin to implement national health and disability surveys. Such data, coupled with global demographic changes, will mean increased attention to non-fatal health outcomes, such as the disability associated with ageing. Therefore, we believe that a common agreement on the meaning of disability is urgently needed.

To be able to stand up to scrutiny, a definition of disability should be: applicable to all people, without segregation into groups such as "the visually impaired" or "wheelchair users" or those with a chronic illness,[3] and be able to describe the experience of disability across many areas of functioning. The definition should allow comparison of severity across different types of disability, be flexible enough for different applications (eg, statistical or clinical use), be able to describe all types of disability, and recognise the effects of the environment on a person's disability.[4] Finally, the definition should not include stipulations about the causes of any disability.

Only when disability is accurately defined can the many issues in health and social policy be tackled

Panel: ICF definition of disability

The negative aspects of the interaction* between an individual (with a health condition) and that individual's contextual factors (personal and environmental factors).[5]

Current UN Convention definition of people with disabilities

Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[7]

Proposed definition of disability

Disability is a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors.

*Impairments are interactions affecting the body; activity limitations are interactions affecting individual's actions or behaviour; participation restrictions are interactions affecting person's experience of life.

and appropriate studies designed to assess which interventions have the best health and health-related outcomes to improve the life and wellbeing of all people living with disability.

WHO's international classification of functioning, disability, and health (ICF) provides a consistent and complete conceptualisation of disability.[5,6] ICF was the result of nearly a decade of substantial collaboration and field testing and has been endorsed by all member states.

The ICF definition of disability (panel) does not restrict disability to any previously defined threshold of functioning. Such a threshold depends on the purpose of the description (eg, to assess research enrolment or eligibility for benefits). Nor does the ICF definition stipulate that disability has a specific cause. Disability is defined within the context of health; however, a person's experience of disability is also a function of features of the environment in which they live. This definition avoids the fallacies that disability is either only a medical problem or is completely socially created.

The current draft of the UN Convention does not define disability but rather people with disabilities (panel).[7] Unfortunately, this definition fails to acknowledge that disability is a central health issue that plays out in all areas of individual and social life. The definition in the Convention of people with disabilities is solely medical and restricts the concept of disability to only those with long-term impairments irrespective of their level of participation. And by insisting that impairment must be "long term", the definition also excludes a vast array of short-term, fluctuating, or episodic impairments.

Disability is a state of decreased functioning associated with disease, disorder, injury, or other health conditions, which in the context of one's environment is experienced as an impairment, activity limitation, or participation restriction. Understanding both the health and the environmental aspects of disability allows for the examination of health interventions that improve functioning as well as interventions to change the environment to improve participation of people with disabilities.[4]

However, when defining disability we should be careful to distinguish objective descriptions of the disability experience from an individual's satisfaction with that experience. Although equally significant, data about disability are objective descriptions that differ from subjective appraisals. Data about quality of life, wellbeing, and personal satisfaction with life are useful for health and policy planning; but these data are not necessarily predicted by the presence or extent of disability.

In view of these considerations and the urgent need for clarity in the definition of disability, our proposed definition (panel) is based on the ICF conceptualisation. We believe this definition includes all aspects of disability, highlights the interactive dynamic nature of disability, and acknowledges the equally important roles of the person's state of health and environmental factors in the production and mediation of the disability experience.

Our ICF-based definition brings us closer to the goal of equal rights, opportunities, and participation in society. Inequality can only be identified by comparison of people who benefit from the way society is organised with those who do not benefit. If there is no agreement about how to identify those who are disadvantaged by the experience of disability, comparison cannot be made, and inequality can neither be identified, measured, nor remedied.[8]

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Rising to the global challenge of the chronic disease epidemic

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Last year, a study published in *The Lancet* showed how a global goal of reducing deaths from chronic disease by 2% a year, a target already attained in many wealthy countries, would avert 36 million deaths by 2015.[1] Most of the deaths averted would be in the developing world and just under half would be in people aged under 70 years. The journal's editor commented: "There is an unusual opportunity before us to act now to prevent the needless deaths of millions."[2] An attempt is now being made to grasp that opportunity.

Of the 58 million deaths in the world in 2005, some 35 million were from heart disease, stroke, cancer, chronic respiratory disease, and other chronic conditions. Chronic disease accounted for almost three-quarters of the burden of disease (measured in disability-adjusted life-years) in those aged 30 years or over. By 2015, deaths from chronic disease will be the commonest cause of death even in the poorest countries.

Despite this burden of chronic diseases, there is no Millennium Development Goal to address them.[3,4] Currently, infectious diseases, perinatal conditions, and nutritional disorders are the major killers of the very poorest people, and that is why so much emphasis has rightly been concentrated on these problems—but we should not neglect chronic disease. Various myths have probably led to their neglect. Many still believe that these are diseases of affluence and are self-inflicted through indulgence in unhealthy lifestyles. In fact, chronic disease is a bigger problem in poor people because they do not have the resources to pursue healthy choices. Another myth is that little can be done about chronic disease, but deaths from heart disease have fallen by up to 70% in the past three decades in Australia, Canada, Japan, the UK, and the USA. About 50% of deaths from chronic disease are attributable to modifiable risks, including tobacco use, raised blood pressure, and poor diet. Raising tobacco taxes and treating people who have had a cardiac event are among the most cost-effective interventions for those in developing countries.[5]

The current Millennium Development Goals are appropriate for the poorest billion people in the world, but action is needed to better manage chronic disease for the 4 billion people living in China, India, Brazil, Egypt, South Africa, Poland, and other low-to-middle