Access to rehabilitation in primary health care: an ongoing challenge

Working draft
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Acknowledgements

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Introduction

At the heart of the 1978 Declaration of Alma-Ata\(^1\) was the recognition that primary health care\(^2\) (PHC) forms an integral part of every country's health system. PHC brings health care to people where they live and work, and it constitutes the opening element of a continuing health care process. The declaration made it clear that, to address the main health needs of the community, PHC must provide promotive, preventive, curative, rehabilitative and palliative services in accordance with those needs (1). In this paper, rehabilitation services are recognized as a core component of the health care continuum, as necessary in primary care – at the gateway to service delivery – as they are in secondary or tertiary care settings (see Box 1 for an outline of what rehabilitation comprises).

Box 1. What is rehabilitation?

Rehabilitation is a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions, in interaction with their environment. Health conditions include disease (acute or chronic), disorders, injuries or trauma. A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly or genetic predisposition.

Rehabilitation may be needed by anyone with a health condition who experiences difficulties in, for example, mobility, vision or cognition. It addresses impairments, activity limitations and participation restrictions, as well as personal and environmental factors (including assistive technology) that affect functioning. Rehabilitation is a highly person-centred health strategy, with treatment catering to the underlying health condition(s) as well as the goals and preferences of the user.

Rehabilitation services referred to in health systems include those provided by rehabilitation professionals such as physiotherapists, occupational therapists, speech and language therapists, and orthotic and prosthetic technicians. Rehabilitation interventions may be also provided by psychologists, social workers, audiologists and community-based rehabilitation workers. Where integrated into PHC, rehabilitation services may be provided by primary care workers such as general practitioners (GPs), primary care nurses or community health workers (CHWs) (2).

The Declaration of Alma-Ata's recognition of rehabilitation was significant, because it helped to promote a political commitment to improving access to rehabilitation services for people in their communities. It did so by encouraging:

- the transfer of basic rehabilitation skills from rehabilitation professionals to PHC workers and less-specialized practitioners; and
- the streamlining of referrals to more specialized rehabilitation services external to the community.

Since the signing of the declaration, countries have followed different approaches to integrate rehabilitation into primary health care, depending on their available resources and health infrastructure.

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\(^1\) A declaration on the need for urgent action by all governments, health and development workers, and the world community to protect and promote the health of all people, signed at the International Conference on Primary Health Care in Alma-Ata, 12 September 1978.

\(^2\) PHC is a whole-of-society approach to maximizing the level and distribution of health and well-being by acting simultaneously on three components: primary care and essential public health functions as the core of integrated health services; multisectoral policy and action; and empowering people and communities. PHC is the most equitable, effective or and cost-effective way to enhance the health of populations.
Alma-Ata at 40: taking stock and looking ahead

Where the rehabilitation workforce capacity is strong, rehabilitation specialists may be accessible at the primary care level, especially for addressing the needs of people with highly prevalent conditions, such as back pain or postpartum complications. Where the rehabilitation workforce capacity is less developed, rehabilitation interventions may be delivered by generalist providers with limited rehabilitation training, more appropriate to their general role. In all instances, the PHC workforce – GPs, primary care nurses or community health workers (CHWs) – should be trained to identify and assess the rehabilitation needs of their patients, and either provide basic rehabilitation interventions or refer them to rehabilitation services (3, 4). The three case studies in this paper demonstrate various pathways that countries may take in ensuring that rehabilitation plays a key role in primary health care (see Boxes 4–6).

As we approach the 40th anniversary of the Declaration of Alma-Ata, it is important to be realistic about the actual progress countries have made in both recognizing the vital importance of rehabilitation and the need to integrate rehabilitation in primary care. Despite the declaration, and the existence of successful models of integration, in most health systems (especially in low- and middle-income countries), rehabilitation has not been fully or effectively integrated into primary care. Data collected by the World Health Organization (WHO) Regional Office for the Western Pacific, for example, found that only 25% of countries in the region have well-established and sustainable rehabilitation in primary care (5).

This year, the world comes together at the Global Conference on Primary Health Care to endorse the Declaration of Astana, and to recommit to strengthening PHC to achieve universal health coverage (UHC) and the Sustainable Development Goals (SDGs). At this time, it is important that we reflect on the current and future rehabilitation needs of individuals and communities, and how these needs can be efficiently met in the context of PHC. It is also important to reflect on the current challenges we face when integrating rehabilitation in primary care and what concrete actions can be taken. The 40th anniversary of this global health milestone provides an opportunity to reaffirm the principles of the original declaration, and underline the importance of the integration of rehabilitation in PHC in order to achieve the collective health goals for the 21st century.
Rehabilitation in primary care: the need

Global demographic and health trends will probably increase the need for rehabilitation to be integrated into primary care. The world’s population is ageing, and the number of people living with noncommunicable diseases (NCDs) and the consequences of injuries are increasing (6–8). The population aged over 60 years is predicted to double by 2030, and the prevalence of noncommunicable diseases has already increased by 13.7% in the past 10 years (6, 9). Together, these trends bring a surge in the prevalence of disability, and will place new and major demands on health and social systems, affecting the delivery of primary care.

As the impact of NCDs and population ageing continues, the number of people who require rehabilitation services close to their homes will also increase. In addition, primary care will continue to be an especially critical platform for the identification and referral of children with developmental and other congenital conditions, because although these individuals may never enter the hospital system, they need long-term rehabilitation.
Rehabilitation in primary care: the benefits

Primary care is where the diagnosis of many health conditions, identification of problems in functioning, and referral to other service delivery platforms need to occur. It is also the care platform where adherence to treatment plans and the progress of such plans take place. Promoting all these functions of primary care insures that a life course and integrated perspective on care is achieved, which has a positive impact on functioning and quality of life.

In addition to health benefits, rehabilitation provided in primary care has broader social benefits (see Box 2 for examples). Early intervention can greatly reduce the prevalence and slow the onset of the disabling effects of chronic conditions among adults and children; for example, managing cognitive decline for individuals with dementia, maintaining movement for those with arthritis, and optimizing functioning and family support for children with cerebral palsy (10–12). Integrating rehabilitation into primary care can also optimize the outcomes of other kinds of health interventions (surgical or psychological) by facilitating continuity of care that supports full recovery (13, 14). Rehabilitation provided close to people’s homes enables them to remain in education and in the workforce, and to remain independent of care and financial supports for longer (15, 16). In addition, by helping to mitigate the risk of preventable complications and secondary conditions (17, 18), rehabilitation at the primary care level can help avoid costly hospitalizations and re-admissions (19–21).

Box 2. The wider benefits of rehabilitation

In Fiji, an elderly woman experienced a stroke and required full-time care. Following rehabilitation in her home, she learned to walk again and to independently carry out her self-care tasks. Now, using her orthoses and quad stick, she can go outside and tend to her garden. Her daughter has been able to return to work and improve their household income (22).

In Switzerland, a 49-year-old woman was involved in a bicycle accident, sustaining multiple injuries including a broken neck, crushed lower back and blocked arteries. She underwent many surgical procedures, and spent extensive time in hospital. When she was finally discharged, she continued rehabilitation with a community physiotherapist. Her rehabilitation has helped her to manage her chronic pain, and to improve her movement, strength and balance. It has also allowed her to return to work and light exercise. She states that rehabilitation gave her a “second life, a second life definitely worth living” (23).

The health needs of people with long-term and chronic-health conditions are unlikely to be effectively addressed without rehabilitation, leaving them at risk of being “left behind” unless rehabilitation interventions are made accessible at the primary care level. For this reason, essential rehabilitation interventions at primary care level is a key component of UHC (7, 24).
Strengthening rehabilitation in primary care: challenges and ways forward

Health systems do not naturally gravitate towards achieving the goal of health for all, and the same can be said for the health system objective of integrating rehabilitation into PHC. Many countries need to be persuaded of the value of rehabilitation through information about the effectiveness and cost–effectiveness of rehabilitation services, and many countries will need guidance about how best to integrate rehabilitation into PHC.

This section describes the common barriers and challenges encountered when integrating rehabilitation into PHC, along with some of the actions that can be taken to address those barriers and challenges.

Limited rehabilitation leadership, planning and prioritization

Rehabilitation often lacks strong leadership and planning within health systems (25), and there is correspondingly limited championing of rehabilitation within PHC. Health ministries have commonly prioritized preventive and curative care, and have focused on mortality (26). Failure to recognize the contribution of rehabilitation to population health and the lack of internal advocacy for rehabilitation have meant that rehabilitation is often excluded from health financing and planning processes, such as health care packages for primary care.

Areas of action to counter limited rehabilitation leadership, planning and prioritization include the following:

- Creating and strengthening leadership and political support for rehabilitation at subnational and national levels, and developing and implementing strategic plans and monitoring frameworks for rehabilitation, using the WHO Rehabilitation Support Package (27).
- Ensuring that rehabilitation is integrated into health planning and financing processes, and into countries’ efforts to achieve UHC through the inclusion of essential care packages. A preliminary version of an “essential package of rehabilitation interventions” suitable for community settings has already been proposed and can be used for this purpose (28).
- Mobilizing civil society to advocate for rehabilitation in PHC by promoting campaigns that emphasize the personal, social and economic impact of rehabilitation, so that the need for rehabilitation resonates with decision-makers and budget holders.
Misconceptions about rehabilitation

Several misconceptions have undermined the prominence of rehabilitation in primary care (and in the health system more broadly). Across countries, especially low- and middle-income countries, rehabilitation is viewed as a fallback strategy when preventive or curative interventions fail. In fact, rehabilitation interventions are a complementary component of care, and they should be delivered alongside preventive and curative interventions in order to optimize outcomes.

A second misconception is that rehabilitation is a “luxury” or optional health service for those that can afford it. In reality, given the impact of rehabilitation interventions on people’s lives, it is an essential service that should be available to everyone. A third misconception is that rehabilitation is only relevant for people with disabilities, when in fact rehabilitation is a core service for population-wide health.

Areas of action to counter misconceptions about rehabilitation include the following:

- Raising awareness of the added value of rehabilitation across a wide range of health conditions, through compiling evidence of both the effectiveness of rehabilitation interventions and their cost-effectiveness.
- Engaging in and disseminating economic studies the return on investment of rehabilitation interventions across society.
Limited workforce capacity for rehabilitation

Access to rehabilitation is dependent on there being enough appropriately trained personnel to meet population needs, particularly in primary care. In higher-resource settings, the rehabilitation workforce in primary care is considered to be comprised of personnel with extensive training in rehabilitation, such as physiotherapists, occupational therapists, speech-language therapists and rehabilitation doctors. Especially in primary care, however, it is also fundamental that other health workers such as (e.g. GPs, primary care nurses and are trained in assessing rehabilitation needs and in the delivery of rehabilitation interventions that address common health problems, such as back pain, chronic obstructive pulmonary disease and cardiac disease (29–31).

Areas of action include the following ones.

- Increasing the number of rehabilitation personnel in primary care through greater investment in education and training programmes, and through incentives for practice in the community. For example, including degree programmes for rehabilitation disciplines in universities, or establishing student exchange arrangements with international training programmes; ensuring rehabilitation personnel are paid competitive salaries; and that there are opportunities for career progression.

- Using innovative workforce modelling to more efficiently and effectively distribute rehabilitation competencies among the workforce in accordance with population needs and country resources (32, 33). For example, re-evaluate traditional curricula and explore options for new cadres, such as rehabilitation assistants, or dual disciplines.

- Increasing the capacity of GPs to deliver rehabilitation interventions by integrating rehabilitation competencies into their training and certification, in accordance with the needs of the population. For example, ensuring that GPs can provide first-level rehabilitation interventions for highly prevalent conditions such as back pain.

- Increasing the capacity of CHWs to deliver rehabilitation interventions through the integration of training in the provision of protocol-directed care for prevalent rehabilitation needs. For example, training CHWs in how to deliver exercises after a stroke, and how to educate those with pulmonary and other chronic conditions in energy conservation and self-management.

- Optimizing rehabilitation workforce performance and retention by investing in supportive practice environments, such as sound supervisory structures, professional development opportunities and active professional associations.
Poor referral systems for rehabilitation

Several studies have shown that, among GPs and other members of primary care teams, under-referral for rehabilitation is a major hindrance, even in high-income settings (see Box 3).

In many cases, GPs lack knowledge of rehabilitation needs for their patients, even for conditions such as rheumatoid arthritis, for which rehabilitation should be an obvious option (3, 12, 34). Other factors that influence referral rates include availability of rehabilitation services (with particular challenges in rural areas and smaller communities), whether the referring service is public or private, co-location of services, the individual’s burden of illness, the socioeconomic status of patients, and staff attitudes towards rehabilitation (35).

Areas of action to counter poor referral systems for rehabilitation include the following:

- Building smooth and effective rehabilitation referral processes, located inside and outside primary care. Ensuring referral mechanisms “keep up” with services, especially in high-income countries where complexity and fragmentation is often a feature of health services (36).

- Raising awareness and educating the primary care workforce of the benefits of rehabilitation across a wide range of health conditions, and the importance of early referral to rehabilitation. This may include in-house education sessions, adaptations to existing practice protocols, or setting up visual cues in the workplace to prompt staff to discuss rehabilitation options with their patients (3, 37).

- Increasing opportunities for collaboration between rehabilitation providers and other primary care workers. For example, co-location of services, team meetings and interprofessional models of service delivery can increase opportunities for understanding and trust among the primary care workforce, and can positively influence rehabilitation referral rates (33).

Box 3. Scoping review

WHO conducted a scoping review on rehabilitation and PHC using the PubMed database. The search string rehabilitation [Title/Abstract] AND “primary health care” OR “primary care” [Title/Abstract] was used, including studies published in English between 2008 and 2018. Of the 530 abstracts that were examined, 246 were excluded. A further 78 were excluded following full text review, resulting in 212 included in the final analysis.

Key findings

Most of the literature reviewed (89%) came from high-income settings. Thematical, 64% of analysed studies mentioned referral to rehabilitation by the primary care workforce, while others referenced rehabilitation carried out in a primary care setting (25%), or explored the idea of rehabilitation in the primary care context (11%).

One key issue repeatedly mentioned in the literature was under-referral to rehabilitation by the primary care workforce. For example, several studies focused on the under-utilization of pulmonary rehabilitation for COPD, despite overwhelming evidence of its benefits for all symptomatic COPD patients (31, 38–41). A systematic review of surveys and audits found that only 3–16% of eligible COPD patients were referred to pulmonary rehabilitation (42). Reasons for under-referral include lack of knowledge about pulmonary rehabilitation, particularly among GPs, and insufficient resources (3, 43).
Limited access to assistive products

Assistive products (e.g. walking aids, toilet and shower chairs) or simple time-management devices should be an essential component of rehabilitation and primary care. A range of basic products can be provided with minimum training and can have a significant effect on a person’s functioning; such products are needed by an increasing number of people, and should be available close to the person’s home.

In spite of the advantages, access to assistive products is commonly lacking in primary care and, where access does exist, affordability and quality are often a challenge. It is estimated that only one in 10 people globally have the assistive products they need.

Areas of action to counter limited access to assistive products includes the following:

- Creating and strengthening leadership and political support for the provision of assistive products in primary care, and building this provision into strategic plans and monitoring frameworks for health care.

- Ensuring that the provision of assistive products is integrated into health planning and financing processes, and into countries’ efforts to achieve UHC through the inclusion of a “priority assistive products list”. WHO has developed a model list of priority assistive products that can be adapted according to subnational or national needs.

- Ensuring that procurement systems are in place with a sustainable supply of high-quality assistive products that are appropriate for the local environment in which they will be delivered.

- Equipping primary care personnel with the knowledge and skills needed to provide a range of basic assistive products, with inclusion of the following steps: assessment and selection, fitting, user training and follow-up, including maintenance and repairs.

Assistive products are any external product (including devices, equipment, instruments and software), especially produced or generally available, the primary purpose of which is to maintain or improve an individual’s functioning and independence, and thereby promote their well-being. Assistive products are also used to prevent impairments and secondary health conditions (43).
Limited primary care data on rehabilitation

Robust and effective data on rehabilitation is lacking in most countries; in particular, on rehabilitation in primary care. Hence, policy-makers lack the information they need to identify the population’s needs, and to allocate resources effectively; planners lack the necessary information to design more effective primary care services; managers lack the necessary information to monitor and evaluate these services; and primary care professionals lack the necessary information to provide high-quality and evidence-based care.

Including information on rehabilitation needs and rehabilitation interventions in primary care as part of countries’ broader health information systems is essential for strengthening rehabilitation in primary care. In addition, systems-level information about all aspects of the delivery and financing of rehabilitation services is needed. This includes information on inputs for rehabilitation (e.g. policy, financing, human resources and infrastructure); outputs from rehabilitation services (e.g. service availability and quality); and rehabilitation outcomes (e.g. service coverage and use).

Areas of action to counter limited primary care data on rehabilitation include the following:

- Ensuring that information on rehabilitation needs and interventions is integrated into primary care information management systems, such as district health information software.
- Ensuring that system-level information about all aspects of the delivery and financing of rehabilitation services in primary care is collected and used, alongside information on population needs for health system planning.
- Equipping statistical departments of ministries of health with the knowledge and skills needed to collect, analyse and use data for policy decisions.
The Declaration of Astana and integration of rehabilitation in PHC

Despite its poor integration to date, rehabilitation exemplifies the basic properties and virtues of PHC. It provides a comprehensive and integrated response to the needs and challenges associated with numerous underlying health conditions, addresses broader determinants of health through multisectoral coordination that improves accessibility for people with rehabilitative needs, and empowers people to care for their health and function. Overcoming the challenges and obstacles to placing rehabilitation higher up the PHC agenda in all countries – regardless of their resource level – is now urgent. Ageing populations and the rise of NCDs and chronic health conditions will increase the prevalence of disability worldwide and dramatically increase the need for rehabilitation. This rising need must be addressed across the health system, but mostly within the context of PHC.

Early rehabilitation interventions optimize outcomes, mitigate disability and improve people's ability to live independent lives. They are also the most cost-effective use of these services (see Boxes 4–6 for examples of this). WHO's emphasis on UHC and its recent launch of the Rehabilitation 2030 Call for Action are encouraging steps towards the goal of strengthening rehabilitation within the health system (2, 23), particularly in PHC. Rehabilitation 2030 was a commitment to key actions to strengthen rehabilitation services by Member States, international and professional organizations, nongovernmental organizations, rehabilitation experts issued in 2017. As we move forward towards the Declaration of Astana, designing and implementing concrete steps to bring rehabilitation fully within the PHC agenda and fulfil the promise of Alma-Ata will demand ingenuity, energy and strong commitment from all stakeholders.
Box 4. Example from Chile

In Chile, primary care is of paramount importance for the development of rehabilitation. Rehabilitation services available in primary care have increased over the past decade. A survey based on the International Classification of Functioning, Disability and Health (ICF) (45), was conducted in 2004 to measure disability in the population. Among other outcomes, the survey findings highlighted the need for improved rehabilitation services in the country. In 2007, the Programa de Rehabilitación Integral en la Atención Primaria de Salud (Integral Programme of Rehabilitation in Primary Care of the Public Assistance Network) was initiated in order to:

- optimize the functioning and independence of individuals with permanent or temporary health conditions, bringing rehabilitation to the community;
- increase the provision of assistive products;
- facilitate intersectoral work; and
- promote community participation.

How was rehabilitation integrated into primary care?

The Integral Programme of Rehabilitation in Primary Care is funded by the MoH. The initiative involved significant enhancement of PHC infrastructure, with 243 new facilities being built across the country, equipped with relevant rehabilitation equipment and resources. Rehabilitation services in the new facilities were prioritized for individuals with acute and chronic musculoskeletal, respiratory and neurological conditions.

The programme also saw a boost in the rehabilitation workforce, with an increase in kinesiology and occupational therapy staff. Rural rehabilitation teams were formed to increase access to rehabilitation services in remote rural areas.

What was the impact?

The MoH has developed a rehabilitation network at the primary care level that covers an important part of the rehabilitation needs of the population, particularly for individuals with musculoskeletal, respiratory and chronic neurological conditions. This has made it possible for hospitals to focus their rehabilitation resources on more complex and specialized services, with an emphasis on early rehabilitation, in the acute and subacute phase of the pathologies. It has also increased the quality of care for patients needing ambulatory or close-to-home rehabilitation, with the outcome of reducing recovery, preventing or improving disability (or both) (46).
Box 5. Example from Fiji

A Mobile Rehabilitation Service was set up in Fiji in 2013 to provide multidisciplinary rehabilitation services at the primary care level. This government-led outreach rehabilitation service provides a decentralized approach to rehabilitation service provision, complementing other rehabilitation services available at tertiary level, and ensuring that rehabilitation reaches those living in rural and remote locations.

How was rehabilitation integrated into primary care?

Rehabilitation is well integrated in Fiji’s health system and is acknowledged in both the annual Corporate Plan and Strategic Plan. The Mobile Rehabilitation Service is aligned with the country’s national health priorities, and as such receives buy-in and financial support from the Ministry of Health and Medical Services (MHMS). The service sits within Fiji’s National Rehabilitation Hospital (NRH), and works in close partnership with other nongovernmental agencies. The activities of the service are overseen by the Acting Rehabilitation Consultant, who effectively coordinates the teams, plans upcoming outreach visits, manages the list of clients and coordinates with MHMS regarding the budget. The Ministry of Education and the Ministry of Social Welfare have also been engaged in aspects of the service, to facilitate referral pathways for children and to promote joint service provision.

The service requires only minimal resources to operate. Rehabilitation services, including provision of assistive devices, is provided free of charge for clients.

The Mobile Rehabilitation Service team is made up of staff from the NRH, including a rehabilitation consultant, prosthetist and orthoptist, nurse, technician, community rehabilitation assistant and a physiotherapist when available; it is committed to ongoing training of its experienced staff. The service has access to quality assistive devices and rehabilitation equipment, which are sourced and procured by local organizations.

Data collection related to clients and the provision of assistive devices is largely paper based. Discussions are underway to develop a standalone database or module within the MHMS patient information system, to improve visibility of service achievements and information handover between health services.

The Mobile Rehabilitation Service has well-established referral pathways, with community rehabilitation assistants playing a key role. The service ensures continued rehabilitation beyond hospital discharge; it also identifies new clients in the community, ensuring access for those who would otherwise not receive any services. The service consistently carries out follow-up visits with clients to monitor progress, and to ensure maintenance and training in use of assistive devices. Opportunities to further strengthen referral processes with other health services are being explored, and several strategies have already been implemented (including developing brochures, participating in a coordinating committee and attending meetings with relevant stakeholders).

Service coverage is an ongoing challenge. The Mobile Rehabilitation Service visits clients in the western and northern divisions of Fiji; however, there is still limited coverage in the outer islands because of the cost and time required to travel to these areas. There is also currently inequity in service provision for the different age groups, with adults receiving more services than children. This is probably due to the service’s focus on rehabilitation interventions for amputations and spinal cord injuries, which often present in adulthood.

What was the impact?

A recent evaluation of the Mobile Rehabilitation Service (22) found it to be an effective approach to rehabilitation service provision, having notable impact on the lives of service users. The success of the Mobile Rehabilitation Service service has informed policy development, including the draft National Disability Inclusive Health and Rehabilitation Action Plan 2017–2022.
Box 6: Case example from Canada

In 2003, the First Ministers of Canada committed to improving access to multidisciplinary primary care teams (33). This health reform prompted a number of initiatives that focused on integrating rehabilitation services in primary care, and has seen improvements in health care costs, individual outcomes and quality of care (47).

How was rehabilitation integrated in primary care?

Between 2009 and 2013, the Ontario government (Ministry of Health and Long-Term Care) allocated funding to expand the number of occupational therapy and physiotherapy positions within primary care (33, 47).

The additional rehabilitation workforce integrated into a variety of service delivery settings, from Family Health Teams (an interprofessional model of primary care), to aboriginal health centres, community health centres and nurse practitioner-led clinics (33, 47). The interdisciplinary workforce in these settings varies, but can include physiotherapists, occupational therapists, chiropodists, dietitians, psychologists, social workers, mental health workers, pharmacists, physicians, respiratory therapists, and nurses (33). Most of the workforce provides services for individuals across the lifespan and with a wide range of health conditions (33, 47).

A key challenge in the integration process was the lack of understanding among the primary care workforce regarding the role of a physiotherapist and occupational therapist (33, 47). Shared electronic medical records, as well as co-location of services and team meetings, were crucial in enabling formal and informal communication, and in increasing awareness among physicians and other interdisciplinary team members (33).

What was the impact?

Integration of rehabilitation within Ontario’s primary care services has seen significant overall improvements in patient functioning, mobility and quality of life, and improved access to services. Pain management services, for example, have seen a decrease in repeat visits, a reduction in medication prescription, improvements in self-management and patient satisfaction (47).
References


