Heeding a global call to action on rehabilitation

By Wesley Pryor and Alexandra Lewis-Gargett
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The evolution of rehabilitation in health and development is a case study in re-thinking policies, and the international cooperation necessary to implement reforms.

The Sustainable Development Goals and Universal Health Coverage (UHC) targets compel efforts to get the right healthcare to people at an affordable price. For more people than ever, the right healthcare includes rehabilitation. Broadly defined, rehabilitation is about gaining or recovering optimum function and self-sufficiency, which can be a cost effective and cost-saving measure in an aging population with a growing burden of non-communicable diseases.

Long-term needs associated with infectious disease are often ignored, too – and illustrate the neglect of rehabilitation. Recent disease outbreaks like Ebola and Zika will leave a legacy of long-term, complex health needs. Rehabilitation centres in Brazil are overflowing, and turning away children affected by Zika. With better treatment for HIV, more people survive, but live with musculoskeletal and neurological disorders.

More people are affected by, but surviving, large-scale disasters like earthquakes, floods and conflict. People are living longer, but with ongoing health issues that make it harder to socialise, be active and independent. Psychosocial disability and mental ill-health account for more morbidity than any other family of health conditions, but holistic, multidisciplinary health services for people with those conditions are rarely prioritised.

This mix of conditions requires re-evaluating the position of rehabilitation in health and social services, and is an opportunity for intervention across multiple sectors to address challenges at the nexus of ageing, non-communicable diseases, mental health, and disability.

That's why in early February this year, the World Health Organization (WHO) released a *Call for Action* on rehabilitation, describing the current unmet need as 'profound'.

This repositioning of rehabilitation on the global health agenda was urgently needed, and long overdue. But why did we need it at all? Rehabilitation is hardly new: it has always been part of the dominant definition of Primary Health Care since the 1978 Declaration of Alma

Ata.

But for most of the four decades since, rehabilitation has taken a back seat to interventions targeted at reducing mortality. Fair enough, you might say. Resource limitations require tough decisions. Controversy was never far away.

The consequence has been de-prioritisation of attention and financing for rehabilitation. In many places, rehabilitation has been cleaved entirely from national health strategies. Globally, we don't have enough rehabilitation professionals to provide services.

At the time of Alma Ata, the WHO acknowledged the overwhelming undersupply of qualified rehabilitation professionals and specialist rehabilitation services, and introduced Community-Based Rehabilitation (CBR) as a primary health model for providing basic health-related rehabilitation services in the community.

CBR has now evolved into a community development approach for the social inclusion of people with disability. In this 'new' model, CBR practitioners require a suite of skills from other sectors and are guided by social development principles; it is no longer 'rehabilitation lite', but a sophisticated approach to social inclusion. Where national economies are constrained, CBR will be as relevant as ever, but needs ongoing support to scale and link with the emergence of new health-related rehabilitation models.

This history has resulted in rehabilitation and disability being bundled together in aid and development. There are some advantages of this, but it is often a problem for both the rehabilitation services sector and the disability movement, because not everyone with disability wants or needs rehabilitation, and most people who might need rehabilitation do not identify as a person with disability.

So, redressing the neglect of rehabilitation cannot be framed only as a disability inclusion challenge. Ageing populations and changing health trends require cohesive responses across multiple policy and practice dimensions, spanning boundaries of health, disability, assistive products, ageing, social services, and other sectors.

As such, it will be complex to monitor global investment and actions on the WHO's 'Call to Action'. If our investments in health do not consider the long-term care outside of the acute hospital setting, we're not meeting the moral, clinical or policy imperatives to do so.

A key step in our region might be analysis of current national and aid investments, and the programs under which rehabilitation has been funded. Has it been included in health investments, or is it only embedded in disability programs?

The need for a massive scale-up of rehabilitation in our region

The burden of non-communicable disease on populations in the Pacific islands is profound, and the need for better responses is urgent. Populations are ageing faster in East Asia and the Pacific than anywhere else on earth.

In the Pacific islands, rehabilitation is provided by a small number of committed rehabilitation professionals who are mostly working in urban based hospitals, and equally committed NGOs who are scattered across the region. As is the case around the world, services often rely on international funding and visiting specialists or volunteers, and continuity of care is challenging.

Yet in many Pacific island countries, nascent referral pathways for rehabilitation in the health system already exist. In Fiji and Solomon Islands, for example, rehabilitation professionals are employed within the health system and working in hospitals and community rehabilitation programs managed by the Ministry of Health. Both countries have courses in rehabilitation, and are working with the Western Pacific Regional Office of the WHO to build rehabilitation workforces in their health systems.

The conditions for the overdue scale-up are in place if we get development strategies right, not least by ensuring that UHC reforms consider rehabilitation.

Strengthening rehabilitation in health systems

The Rehabilitation 2030 Call for Action outlines strategies for addressing the current paucity of rehabilitation in health systems.

Through strengthening leadership and governance, 'champions' and skilled practitioners can ensure long term stewardship of the sector. Our institutions, and many like them, are supporting these reforms with good evidence like population surveys, better health and disability questions in national censuses, and better consideration of chronic health problems in health information systems as they evolve. New techniques to classify, measure, critique and plan better rehabilitation services are available.

From prosthetics and orthotics in Kiribati, Samoan diabetic footcare, the DFAT-supported *Disability Rights Initiative Cambodia* programme to population surveys to determine unmet need for services including rehabilitation and assistive products – and countless others – there are examples in our region to learn from and scale.

To heed a call to action and overcome four decades of inertia, a whole-of-sector approach is needed, to build on the strengths of both disability inclusion and health reforms. This will require international cooperation, national 'champions' and leadership, and a unified voice of consumers, industry, government and civil society.

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