

Accessing Rehabilitation Services: A Challenge To Overcome

Removing financial barriers towards universal health coverage

Rehabilitation is essential, yet not affordable

Rehabilitation is a core health strategy, along with promotion, prevention, treatment, and palliative care. The World Health Organization (WHO) defines rehabilitation as 'a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain **optimal functioning in interaction with their environments**'.⁽ⁱ⁾ Rehabilitation is beneficial to many people with a wide range of health conditions at various stages of their lives, as well as to many persons with disabilities.

Anyone may need rehabilitation at some point during their lives. Between 110 million and 190 million adults have significant difficulties in functioning⁽ⁱⁱ⁾ and 92% of global diseases are related to causes that require health professionals who are specialised in rehabilitation.⁽ⁱⁱⁱ⁾ Due to demographic changes, including an ageing population, increasing prevalence of non-communicable diseases and injuries, **the need for rehabilitation is growing.** Yet, rehabilitation services are often under-resourced, undeveloped,^(iv) and their financial coverage is highly variable or absent in most low-income countries.

Financial barriers remain key reasons for not seeking or receiving healthcare – including rehabilitation – for many people. Consequently,

an extensive need – as high as 50% of total need in some countries – remains unmet. While many people attempting to access rehabilitation services encounter significant barriers, **certain populations, including persons with disabilities, are at higher risk of being left behind.**⁽¹⁾

While the general health needs of persons with disabilities are the same as everyone else and can often be met by primary healthcare services, some may also have additional health needs related to specific impairments or health conditions.^(v) Despite the higher need, persons with disabilities often encounter greater barriers to accessing health services, including physical, communication, attitudinal and financial barriers. 50% of persons with disabilities cannot afford healthcare,

1. 'Leave no one behind' is a core principle enshrined in the 2030 Agenda for Sustainable Development adopted in 2015, and requires all actors involved in the implementation of the Sustainable Development Goals to address the inequalities affecting vulnerable people, including persons with disabilities.

facing a 50% higher risk of facing 'catastrophic healthcare costs',⁽²⁾ compared to persons without disabilities.^(vi) These costs can be related to general health-related household expenses, but may also be associated with costs of rehabilitation and assistive devices^(vii) (such as wheelchairs, prosthesis, visual supports).

The enjoyment of the highest attainable standard of health is one of the fundamental rights. Therefore, **financial cost should never be a barrier to access an essential health service such as rehabilitation.** Specific measures, with adequate budget, should be adopted to guarantee that everyone can receive, without financial hardship, effective and quality health services, including rehabilitation, according to their needs.

Article 26 of the Convention on the Rights of Persons with Disabilities requires States Parties to organize, strengthen and extend comprehensive habitation and rehabilitation services and programmes. Sustainable Development Goal target 3.8 sets the commitment, by 2030, to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

Therefore all policies and programmes designed to achieve universal health coverage should cover rehabilitation services and assistive devices.

Key findings from 9 country-level studies: high barriers, limited coverage

The iFAR Studies on the affordability of rehabilitation

Humanity & Inclusion (HI) is an independent and impartial aid organisation working alongside persons with disabilities and vulnerable populations in situations of poverty and exclusion, conflict and disaster. HI has a long and rich history and experience in rehabilitation; it is now implementing rehabilitation projects in 40 low- and middle-income countries.

HI has developed and conducted **iFAR studies (improve Financial Access to Rehabilitation services)** in several of the countries in which it operates, under the coordination of the HI Rehabilitation Direction.

An iFAR study is an economic analysis of access to physical and functional rehabilitation in low- and middle-income countries. Its main objective is to identify the financial barriers to access rehabilitation services and opportunities in the sector that minimise the risk of impoverishment of individuals due to their rehabilitation expenditure. iFAR studies contain information on the average costs of access (travel, accommodation and session fees) to physical and functional rehabilitation (therefore not capturing mental health difficulties or visual and hearing impairments) and compare this to national levels of Catastrophic Health Expenditure. Data are collected through desk review, key informant interviews, focus group discussions and a standardised survey.

This factsheet uses evidence from the fully-completed and most robust iFAR studies, which were conducted between 2015 and 2018 in Afghanistan, Laos, Vietnam, Cambodia, Madagascar, Rwanda, Burkina Faso, Haiti, with some additional information from the iFAR conducted in Bolivia.

2. According to WHO, catastrophic health expenditure is defined as direct payments that are greater than 40% of households' ability to pay.



"I am 22 years old and mom of an 11-month-old boy who lives with a physical impairment. To pay for membership in the rehabilitation center, I sold my furniture. I live 30 minutes' walk from the centre, but I come by tuk-tuk for 4 000 AR round trip. I spend about 37 000 AR a month, which corresponds to 20 kilos of rice."

Julia N., Madagascar, May 2018.

- **In 6 out of the 9 examined countries⁽³⁾ rehabilitation services represent catastrophic health expenditure.** The cost of assistive technology and devices can be particularly high in certain countries, especially where products are imported.⁽⁴⁾ In addition to fees for rehabilitation services, the cost of travel and stay in the area where rehabilitation services are provided are key financial barriers to accessing rehabilitation. Users are likely to require a carer to attend rehabilitation appointments, which significantly exacerbates out-of-pocket expenses.⁽⁵⁾



In Burkina Faso, the average cost for a set of rehabilitation sessions is 3 times bigger than the amount representing catastrophic health expenditures. Accommodation costs increase by an additional 41% the overall costs.



In Madagascar, the cost of lower leg prosthesis represents 23% of the average annual per capita income; crutches are the only assistive device that patients may usually afford.

- **Health financing schemes, in particular private insurances, often exclude rehabilitation services and/or devices from the covered packages of care.** These existing health financing schemes are far from providing universal health coverage. They rarely prevent users from incurring catastrophic health expenditures, as they cover only part of the population, and do not provide sufficient direct financial support to households. Specific protection schemes for persons with disabilities already exist in many countries,⁽⁶⁾ yet not all persons with disabilities benefit from them.



In Vietnam, although nearly 4 million persons with disabilities are covered under the social health insurance scheme, more than 3 million others have to pay insurance fees out-of-pocket.



In Laos, not even a quarter of the population is enrolled in public insurance schemes. The Health Equity Fund, one of the existing schemes covering 9.2% of the population, does not include rehabilitation.

3. Rehabilitation cares represent catastrophic health expenditures in Afghanistan, Burkina Faso, Cambodia, Haiti, Madagascar and Rwanda.

4. For children, who need to change or adapt their assistive devices more frequently as they grow, costs can be even higher.

5. Women and girls, who are often the primary caregivers, are likely to abandon their own opportunities so to dedicate time to assisting the member of their family in need; this results in loss of income for the entire household.


6. Across the countries examined, protection schemes for persons with disabilities were found in Bolivia, Burkina Faso, Cambodia, Haiti, Rwanda and Vietnam.




© Adrienne Surprenant/HI


- There is significant **shortage of rehabilitation workforce** that impedes adequate response to the needs of the population. The lack of professionals is often combined with limited or poor-quality educational and training opportunities, as well as challenges in retaining trained rehabilitation professionals.⁽⁷⁾

 An estimated 231,684 physiotherapists and 666 prosthetist-orthotists are missing across eight countries: Afghanistan, Burkina Faso, Cambodia, Haiti, Laos, Madagascar, Rwanda and Vietnam.⁽⁸⁾

 In Lao, only around 200 out of the 1,072 total qualified physiotherapists currently practice their profession.

- In all examined countries, **geographical inequalities are severe**: services and professionals are concentrated in cities, meaning that people living in rural areas face significant challenges accessing rehabilitation services. The limited availability of rehabilitation in primary healthcare necessitates travelling long distances, thus generating high transport and accommodation costs that prevent many people from seeking the care they need.


 90% of Afghan population lives at more than 100km from a rehabilitation centre.


 In Vietnam, 6 provinces with the highest numbers of persons with disabilities do not have a single rehabilitation hospital or centre.


7. Community-based-rehabilitation (CBR) workers should be recognised for their crucial role in improving the effectiveness of service delivery, especially in rural areas. Recognising the status of CBR workers and promoting their career and skills-development can ensure higher retention rates and maximise the impact of their work on individuals and communities.

8. In order to calculate the number of missing prosthetists and orthotists, we used the international standard of 5 professionals for 1,000,000 inhabitants. In order to calculate the number of missing physiotherapists, and in absence of international standards for this profession, we used the indicative standard proposed by Humanity & Inclusion of 1,000 physiotherapists for 1,000,000 inhabitants.


- **The level of investment in rehabilitation services is inadequate** to meet the constantly-increasing needs of the population, either because too few resources are allocated or because, in some cases, part of the available budget remains unspent.⁽⁹⁾


 Across the 9 countries, the health budget represents an average of 10% of the total public expenditure. None of the African countries examined met the requirement of the Abuja Declaration^(viii) of dedicating 15% of the total public expenditure to health.

 In Haiti, for example, the investment need to train an adequate number of prosthetist-orthotists is estimated as 0.54% of the Health Ministry's budget.


 In Afghanistan, only 1% of the Ministry of Public Health's budget was allocated to disability, mental health and drug demand reduction combined.


- **Quality of rehabilitation services is variable and often inadequate** in terms of availability of equipment, general level of equipment provided, and implementation of quality protocols.

 In Laos, 11 out of the 13 establishments examined, which provide physiotherapy services, have an insufficient or an average quality level.⁽¹⁰⁾







 In Cambodia, 33% of the surveyed persons with disabilities consider the perceived poor quality of services as a major barrier to access rehabilitation.

- **Rehabilitation services rely to a significant extent on the technical and financial external aid** provided by donors, international institutions and non-governmental organisations in the countries studied. In fragile countries, the role of external aid in rehabilitation care is particularly prominent. Depending on the country, external aid actors intervene by supporting existing health infrastructure and promoting referrals for services, on delivering rehabilitation services themselves, or through financing rehabilitation services.

 In Haiti, non-governmental organisations run 28% of total rehabilitation centres, and all structures surveyed in the iFAR study relied upon external aid.

 In Cambodia, International NGOs personnel comprise 18% of the human resources in rehabilitation.

Common factors found in countries where rehabilitation is affordable (Bolivia, Cambodia, Laos)

-  Better health status and economic development
-  Policy frameworks for rehabilitation and disability
-  Social protection mechanisms for the most vulnerable
-  Investments in the rehabilitation workforce
-  Dynamic organisations of persons with disabilities
-  Rehabilitation services at all levels of health systems

**Rehabilitation
does not represent
catastrophic health
expenditures**

9. Unspent health budget corresponds to 17% in Cambodia (2016) and 8.2% in Madagascar (2017).

10. In iFAR studies, technical level of rehabilitation facilities visited during surveys is evaluated based on: availability of equipment; general level of equipment; and existence of and compliance with protocols. Facilities are scored out of 100 and are classified in 3 categories: A (75-100), B (50-75) & C (0-50).



Recommendations for policy-makers in low- and middle-income countries and donors

- **Adopt and/or reform rehabilitation policies, laws, and delivery systems** to fulfil the right to health for everyone and ensure compliance with the United Nations Convention on the Rights of Persons with Disabilities (particularly with reference to Article 26 on “habilitation and rehabilitation”).
- **Ensure that rehabilitation is included in health-financing solutions and other UHC relating policies and programmes**, like health insurance schemes, health package financing, special funds, etc. Population groups at risk of poverty and exclusion, including persons from lower socio-economic background, persons with long-term and ongoing health conditions, and persons with disabilities, should be prioritised in social protection schemes. Coverage of travel and accommodation costs should be further developed within health-financing mechanisms.
- **Increase financial resources dedicated to rehabilitation and assistive devices.** The allocation of resources to rehabilitation should be considered as an investment, rather than a cost: rehabilitation helps reduce the time spent in hospital and prevents readmission; it also generates further economic benefits as it helps rehab patients resume income generating activities.
- **Integrate rehabilitation services and assistive devices into health systems at all levels** (from community, to primary care, to specialised services) and in particular expand rehabilitation in primary healthcare, in order to maximise access, including for people living in marginalised communities and in rural areas.
- **Strengthen human resources for rehabilitation**, by addressing the workforce shortage, expanding high-quality training opportunities, increasing recognition and retention of personnel.



© Jaweed Tanveer

- **Invest in initiatives to raise the quality of rehabilitation services**, by deploying well-trained rehabilitation personnel, implementing and monitoring clinical standards and protocols of care, and planning for quality improvement across the entire rehabilitation management system.
- **Ensure the meaningful participation of users, persons with disabilities**, and their representative organisations in the design, implementation, monitoring and evaluation of health financing, UHC and social protection policies.
- **Prioritise rehabilitation in external aid**, with a view to supporting national health system strengthening and increasing their capacity to deliver rehabilitation services.
- **Harness investments in research and testing for innovative solutions**, which have the potential to increase accessibility and affordability of rehabilitation and assistive devices for those in need.

References

- (i) WHO and World Bank, 'World Report on Disability', 2011.
- (ii) WHO, 'Disability and Health Factsheet', 2018
- (iii) Gupta N., Castillo-Laborde C. and Landry M.D., 'Health-related rehabilitation services: assessing the global supply of and need for human resources', 2011.
- (iv) Krug E. and Cieza A., 'Strengthening health systems to provide rehabilitation services', 2017
- (v) WHO, 'Disability and Health Factsheet', 2018.
- (vi) Mitra, Posarac, Vick, 'Disability and poverty in developing countries: A multidimensional study', 2013.
- (vii) Mitra et al, 'Extra costs of living with a disability: A review and agenda for research', 2017.
- (viii) WHO, "The Abuja Declaration: Ten Years On", 2011.



© ISNA Agency/HI

The implementation of the study was financially supported by the Ministry of Foreign Affairs of Luxembourg.



First published in November 2019, © Humanity & Inclusion - Website: <http://www.hi.org> - Blog: <http://blog.hi.org>

HI is registered in France under the following references: N° SIRET: 519 655 997 00038 - Code APE: 9499Z.

This publication is copyrighted, but may be reproduced by any method without fees or prior permission for teaching purposes, but not for resale. For copying under any other circumstances, prior written permission must be obtained from the publisher, and a fee may be payable. Layout: <http://www.atelier-volant.fr>