



Increasing Equitable Access to Rehabilitation

Frequently Asked Questions (FAQ)

Keeping people healthier, especially in an aging society, managing the increasing prevalence and impact of chronic conditions, providing continuity of quality care and creating an integrated healthcare system are all fundamental goals of contemporary health system reform. Rehabilitation is a crucial component of the continuum of care for increasing numbers of people and can improve functionality, enhance coping and prevent or delay deterioration experienced by those living with chronic illness. Ensuring timely, equitable access to multidisciplinary rehabilitation services is an integral part of keeping people healthy. Improved access to community-based rehabilitation bridges gaps in the continuum of care reducing demand for hospital and other acute care services. Rehabilitation is an essential component of a high-performing health system.

What is driving the increased need for rehabilitation?

Medical advances have lengthened the lives of Canadians and transformed illnesses that were once imminently fatal into chronic, manageable conditions.¹ While these changes may rightly be deemed successes, they have also contributed to significant increases in the prevalence of chronic and/or episodic illness. It is estimated that as many as half of all adults live with some form of chronic illness,² whether it be arthritis, chronic obstructive pulmonary disease, hypertension, a mood disorder, multiple sclerosis, HIV or another persistent health issue. One out of every six Canadians over the age of 35 has been diagnosed with more than one chronic health condition.³ It is expected that these numbers will continue to grow as our population is aging at a rapid pace.⁴

How does high quality rehabilitative care improve the health of people living with chronic illness?

Chronic and/or episodic illnesses are often disabling. They can impair physical, emotional and/or cognitive functioning, reduce social participation for both individuals living with illness and their caregivers, impact quality of life and even result in premature death.^{1,5,6} Disability resulting from chronic disease may be continuous or intermittent/episodic⁷ and may be more severe among the growing number of Canadians living with multiple chronic illnesses,^{8,9} often called multi-morbidities.¹⁰

Evidence shows that rehabilitation services⁷ have both immediate and long-lasting^{14,15} positive effects on the well-being of people living with chronic illness, including:

- improving quality of life;^{11,12,13}
- decreasing the impact of the disease and/or secondary health issues,^{12,14} for example, work time lost;
- enhancing functioning and coping;^{12,13,15} and
- supporting therapeutic adherence.^{15,16}

When rehabilitation services are provided early, they may also prepare people living with chronic disease to cope with episodes of illness increasing their ability to engage in work and other productive activities more consistently.¹⁷



How does high quality rehabilitative care contribute to a high performing health system?

Equitable access to rehabilitation is a crucial component of the continuum of care, which ensures Canadians have access to the most appropriate health services, when and where they need them.¹⁸ High quality rehabilitation also contributes to overall system efficiency and sustainability by preventing or delaying deterioration and reducing the resulting demand for hospital and other acute health care services.^{19,20}

How can high quality rehabilitative care for people living with chronic illness be integrated into the system?

The skills and competencies of rehabilitation professionals make them value-added members of interdisciplinary primary health and community care teams. They are well positioned to contribute to the type of health care services which optimize the health of people living with chronic and/or episodic disease. These services are:

- provided by an interdisciplinary team;^{1,21,22}
- well-coordinated and easy to navigate;^{1,21,22}
- person-centred, responsive to individual needs and include supported self-management;^{1,21,22}
- holistic, and take into account a person's illness experience not only their disease;²³
- proactive rather than reactionary;^{1,21,22}
- adaptable, and prepared to address multi-morbidities;¹
- accessible during periods of ill health;**Error! Bookmark not defined.** and
- located in the domain of primary/community care.¹

Ideally, rehabilitation service providers would be located in many primary and community health setting and would work closely with physicians, nurses and other medical care providers to deliver insured, integrated health services to people living with chronic and/or episodic illnesses. For this to occur, rehabilitation services outside the hospital context must be publically funded or universally covered by provincial health insurance plans, and regional health authorities must work to integrate rehabilitation into emerging care strategies like primary care networks.

What are the current barriers to accessing rehabilitation services?

Inequitable access to rehabilitation services is a critical gap in health care in many regions. For most Canadians, rehabilitation services provided outside the hospital setting are not publically funded. For some, these services may be insured through their employee benefits plan, but for many, this coverage is not available or is inadequate. Lack of funding for and/or delisting of community-based rehabilitation services has resulted in inequitable access to rehabilitation and contributed to a fragmented continuum of care. Often individuals who are most likely to be affected by chronic illness, for example people with low socioeconomic status,²⁴ are disproportionately affected. Barriers to access include:

- cost of private provision;^{25,26}
- availability of services,^{26,27} which differs by geographical region, health and social status;
- strict eligibility criteria,^{26,28} both for insurance coverage and participation in services;
- wait lists for publically-funded care;^{27,29}
- lack of awareness of the full potential of rehabilitation services among health practitioners and individuals living with chronic and/or episodic illness,²⁸ and
- a health system-wide orientation toward acute, reactive care rather than prevention and the proactive development of self-management and coping strategies.²²



- ¹ Canadian Academy of Health Sciences' (CAHS), 2010: [Transforming Care for Canadians with Chronic Health Conditions: Put People First, Expect the Best, Manage for Results](#)
- ² Advisory Committee on Population Health, 2002 & CIHI, 2009 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.11 and p.13
- ³ Bennett, T-L. (2012) [An Unequal Burden: The Prevalence and Distribution of Chronic Disease Multimorbidity in Canada](#)
- ⁴ Statistics Canada, 2010 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.14
- ⁵ Grumbach, 2003 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.12
- ⁶ Coleman, Austin, Brach & Wagner, 2009; Daar et al., 2007; Ebrahim, 2008 & Yach, Hawkes, Gould & Hofman, 2004 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.15
- ⁷ See the Canadian Working Group on HIV and Rehabilitation (CWGHR) website for information on episodic disabilities and a list of rehabilitation services
- ⁸ Van Weel & Hartman, 2009 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.12
- ⁹ Walker, 2007 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.14
- ¹⁰ Justice & Braithwaite. (2012). Lessons learned from the first wave of aging with HIV. *AIDS*, 26(1), S11-S18.
- ¹¹ Canadian Thoracic Society, 2012: Canadian Respiratory Guidelines: [Pulmonary Rehabilitation Fact Sheet](#)
- ¹² Canadian Physiotherapy Association, 2012: [The Value of Physiotherapy](#)
- ¹³ Hand, Law & McColl. (2011). Occupational therapy interventions for chronic diseases: a scoping review. *American Journal of Occupational Therapy*, 65(4), 428-436.
- ¹⁴ Ravesloot, Seekins & White. (2005). Living Well with a Disability health promotion intervention: Improved health status for consumers and lower costs for health care policymakers. *Rehabilitation Psychology*, 50(3), 239-245.
- ¹⁵ Scholten, Brodowicz, Graninger, Gardavsky, Pils, Pesau et al. (1999). Persistent functional and social benefit 5 years after a multidisciplinary arthritis training program. *Archives of Physical Medicine Rehabilitation*, 80, 1282-1287.
- ¹⁶ Touchard & Berthelot. (1999). Collaborative home practice: Nursing and occupational therapy ensure appropriate medication administration. *Home Healthcare Nurse*, 17 (1), 45-51
- ¹⁷ Roessler, Fitzgerald, Rumrill & Koch. (2001). Determinants of employment status among people with multiple sclerosis. *Rehabilitation Counselling Bulletin*, 45(1), 31-39.
- ¹⁸ Identified as a priority in the Ontario Ministry of Health and Long-term Care's 2012 [Ontario's Action Plan for Health Care](#)
- ¹⁹ Efficiency and financial sustainability are identified as two objectives for health systems policy shared across Canadian provinces and territories according to the Canadian Health Services Research Foundation's 2011 report: [Provincial and Territorial Health System Priorities: An Environmental Scan](#)
- ²⁰ Singh, 2005 as cited in Ontario Ministry of Health and Long-term Care, 2007: [Preventing and Managing Chronic Disease: Ontario's Framework](#), p.11
- ²¹ Nolte & McKee, 2008 as cited in CAHS, 2010 : [Transforming Care for Canadians with Chronic Health Conditions](#), p.12
- ²² Ontario Ministry of Health and Long-term Care, 2007: [Preventing and Managing Chronic Disease: Ontario's Framework](#)
- ²³ Stewart et al., 2003 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.24
- ²⁴ Community Social Planning Council of Toronto, University of Toronto Social Assistance in the New Economy Project & Wellesley Institute, 2009 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.14
- ²⁵ CWGHR, 2010, Collaborating for Integrative Rehabilitation : Effective, Equitable, Sustainable, presentation to Ontario MOHLTC (unpublished) as cited in Canadian Working Group on HIV and Rehabilitation & Wellesley Institute, 2012: [Equitable Access to Rehabilitation: Realizing Potential, Promising Practices, and Policy Directions](#), p.12
- ²⁶ Bell, Griller, Lawson & Lovren, 2010 and Schoen & Doty, 2004 as cited in CAHS, 2010: [Transforming Care for Canadians with Chronic Health Conditions](#), p.18
- ²⁷ Landry et al., 2009, [Availability and access to rehabilitation services along Ontario's continuum of care](#). This report is available on the [CWGHR website](#).
- ²⁸ Canadian Working Group on HIV and Rehabilitation & Wellesley Institute, 2012: [Equitable Access to Rehabilitation: Realizing Potential, Promising Practices, and Policy Directions](#)
- ²⁹ Passalent. (2010). Exploring wait list prioritization and management strategies for publicly funded ambulatory rehabilitation services in Ontario, Canada: Further evidence of barriers to access for people with chronic disease. *Healthcare Policy*, 5(4), 3139-e156.