REHABILITATION

PREAMBLE

Rehabilitation is a process which addresses impairments, activity limitations and participation restrictions, as well as personal and environmental factors (including assistive technology) that impact on functioning. Rehabilitation is a highly person-centred health strategy, with interventions focusing on the function and capacities of an individual as well as the goals and preferences of the user.[1]

There is convincing evidence that early, intensive and co-ordinated multi-disciplinary rehabilitation significantly reduces the impact of a broad range of health conditions and thus disability.

The *World Report on Disability* published by the World Health Organisation in 2019[2] however informs that data from four Southern African countries found that only 26–55% of people received the medical rehabilitation they needed; 17–37% received the assistive devices they needed; 5–23% received the vocational training they needed; and 5–24% received the welfare services they needed.

The *World Report on Disability* (2011)[3] summarises well that "Unmet rehabilitation needs can delay discharge, limit activities, restrict participation, cause deterioration in health, increase dependency on others for assistance, and decrease quality of life.

Our own experience points to inadequate rehabilitation contributing to:

- Optimal functional recovery not being attained.
- Loss of means of generating an income (particularly considering that the majority of poor people rely on their physical capabilities to generate any form of income);
- Perpetuation of unnecessary hardship and suffering;
- Additional (avoidable) emotional difficulties in some cases.

These negative outcomes have broad social and financial implications for individuals, families, and communities - and indeed for the country.

Of significant concern is the fact that, in many instances, the Road Accident Fund is paying out large sums in compensation due to inadequate rehabilitation.

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[1] https://www.who.int/publications/i/item/access-to-rehabilitation-in-primary-health-care

[2] https://apps.who.int/iris/bitstream/handle/10665/70670/WHO_NMH_VIP_11.01_eng.pdf;jsessionid=37619DA2D932AB81FA972B226EA9D42A?sequence=1

[3] https://www.who.int/disabilities/world_report/2011/report.pdf?ua=1

RECOMMENDATIONS IN RESPECT OF REHABILITATION OF MOTOR ACCIDENT VICTIMS - viewed in the light of issues of concern in this regard

1. State rehabilitation policy and services

Issue 1.1:

Rehabilitation remains excluded and poorly understood in many health care systems around the world.

The WHO states that: Rehabilitation regularly lacks strong leadership and planning within health systems, and there is correspondingly limited championing of rehabilitation within primary health care. Health ministries have commonly prioritized preventive and curative care with focus on mortality. Failure to recognize the contribution of rehabilitation to population health and the lack of advocacy for rehabilitation have meant that rehabilitation is often excluded from health financing and planning processes, such as health care packages for primary health care.[4]

Despite the fact that the Department of Health has adopted a Framework and Strategy for Disability and Rehabilitation Services in South Africa (2015 - 2020)[5]*, little has changed if the importance – and indeed funding – afforded to acute medical intervention vs rehabilitation services is analysed. Such analysis reveals a fundamentally flawed view of what is needed to facilitate recovery from injury and reintegration into a full and meaningful life following such injury.*

Recommendation 1:

There is an urgent need for discussions between the RAF and the Department of Health regarding inadequate rehabilitation services / facilities in the public sector. The re-prioritisation of rehabilitation - as envisaged in the *Framework and Strategy for Disability and Rehabilitation Services in South Africa (2015 - 2020)* - would significantly reduce the impact of traffic accidents on victims thereof (while also impacting positively the provision of services to the general population of our country).

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[4] https://www.who.int/publications/i/item/access-to-rehabilitation-in-primary-health-care

[5] http://www.health.gov.za/index.php/2014-08-15-12-54-26/category/266-2016-str?download=1569:framework-and-strategy-final-print-ready-2016#:~:text=This%20Policy%20Framework%20and%20Strategy,all%20levels%20of%20health%20care.

Issue 1.2:

Regional / community rehabilitation services - which are responsible for injured persons in the post-acute phase i.e. following discharge from hospital - are particularly inadequate.

- *Relatively few positions exist for rehabilitation therapists of different disciplines.*
- *Many staff providing these services are inexperienced and ill-prepared for the job which they must do.*
- *Staff serve large geographical areas and the patient load which they carry is simply overwhelming.*
- *Resources available to staff are restricted.*

Recommendation 2:

The RAF should negotiate with the Department of Health for the urgent expansion of regional, community and primary health rehabilitation services.

This will reduce the prevalence of preventable disabilities, delayed recovery and delayed return to work.

Recommendation 3:

The RAF should also engage with private rehabilitation services / facilities in order to:

- Negotiate mutually beneficial public / private partnerships.
- Ensure access to these facilities for injured individuals with certain conditions / categories of impairment.

Recommendation 4:

In order to ensure that there is equality in services provided to all road traffic victims, the RAF is encouraged to provide training on the claims process and service provision to all health care practitioners who provide medical and rehabilitation services to these victims. This would be beneficial in terms of their understanding of the system, but also enable them to inform road accident victims accordingly. The latter is seen as a responsibility of case managers / medical / other healthcare personnel.

This would be most efficient if presented in the form of an on-line training tool (for which CPD points could be accrued).

Recommendation 5:

Health education is required so that accident victims are informed on the benefits of early rehabilitation, their rights to medical / rehabilitation services and the pathway to accessing these services.

An adjunct to the report compiled when the accident victim is discharged from hospital should include the information provided **to** the accident victim regarding rehabilitation.
This information should also be held with the medical report.

2. Access to / quality of rehabilitation services

Issue 2:

Access to rehabilitation services in South Africa is severely limited and quality of service provision is not uniform.

- *Facilities with rehabilitation services are usually located in larger hospitals which are not easily accessible to all .*
- *Availability of rehabilitation services to individuals with certain health conditions is far more limited than for other health conditions.*
  Traumatic brain injuries and mental health conditions are but two examples.
- *Accessing rehabilitation services is particularly problematic for poor people – not least because of difficulties travelling to / from sites where such services are offered.*
- *Access to rehabilitation services for those living in rural areas is extremely limited, if such services are available at all.*
  Sherry informs that barriers to accessing health care … are "compounded in rural districts where travel times and costs may already be much higher, education and information poorer and health services more scant and poorly resourced."[6]
- *There is inequality regarding access to rehabilitation services in general **and** between those who have private health insurance and those who do not.*
  That having been said, having private health insurance does not necessarily guarantee access to well co-ordinated and comprehensive rehabilitation.

Recommendation 6:

The RAF, in addition to recommendations 1, 2 and 3, should specifically liaise with the Department of Health to expand services in regard to access to suitable rehabilitation services by injured persons who:

- Have sustained moderate and severe head injuries.
- Live in rural areas.
  Use of community rehabilitation workers, who should eventually be attached to local clinics, will contribute in this regard.

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[6] Sherry, K. *Disability and rehabilitation: Essential considerations for equitable, accessible and poverty-reducing health care in South Africa.*
South African Health Review, Volume 2014/2015 Number 1.

Recommendation 7:
Guidelines should be developed for the rehabilitation / management of all injuries, i.e. non-serious (e.g. soft tissue injuries) and serious injuries, (e.g. paraplegia) – during both the pre- and post-settlement phase.
Such guidelines should include the recommended minimum rehabilitation intervention (disciplines involved and number of sessions indicated) which must be prescribed for a particular condition.

While such guidelines would be very helpful in many cases, it must always be borne in mind that there are many factors which can influence the extent to which guidelines are suitable for a particular individual e.g. age; psychological adaptation; socio-economic circumstances, pre-existing health conditions. A personalised approach is required when considering guidelines, with opportunity to extend rehabilitation for deserving cases.

Recommendation 8:

People who do not have necessary funds to get to and from rehabilitation facilities / services must be identified early and transport / funds made available.

Recommendation 9:

The development of self-management tools, such as digital technologies, should be investigated as a means to increase self-management by victims, to access rehabilitation support and services, and for follow-up purposes.

3. Case Management

Issue 3.1:

Case Managers are not regularly used in the acute or post-acute / rehabilitation phases of intervention following road traffic accidents.

Recommendation 10:

Case Managers should be viewed as a **critical** requirement for a variety of road traffic victims (including those detailed in recommendations 11, 13 and 21). Appointment of Case Managers will facilitate greatly improved service to traffic victims, particularly those who are vulnerable for whatever reason.

Issue 3.2:

Case Managers who are appointed by the RAF often do not have the requisite knowledge or experience in relation to rehabilitation and their duties are not clearly defined..

Recommendation 11:

Case Managers, appointed by the RAF, should be experienced in rehabilitation, including:

- Its fundamental principles
- Rehabilitation needs for the various types of injuries / impairments which result from motor vehicles accidents.
- Facilities available in both public and private sectors.
- Sources of goods and services.

It is then the responsibility of each case manager to ensure that the individual is referred to a relevant facility / practice for the necessary intervention - be it treatment, rehabilitation, securing of suitable assistive devices / prosthesis / care.

4. Acute vs post-acute intervention

Issue 4.1:

While some accident victims receive physiotherapy (and other interventions) in hospital, hospitalisation is always very brief.
Some are referred to community-based facilities (clinics, day hospitals) and see a therapist once every 3 / 4 weeks for a couple of months. In these instances, it is common that advice (you should avoid …; lifting should be done like this ….) and / or a home program (a list of recommended exercises) is provided.
There is seldom adequate follow-up to ensure that the home program is being properly applied, to identify subsequent sequelae of the injuries or to inform the person regarding resumption of a "normal" range of daily activities.

Guidelines detailed in recommendation 7 above are important in this regard.

Issue 4.2

*Several studies have shown that among general practitioners and other members of primary health care teams, **under-referral** for rehabilitation is a major hindrance, even in high-income settings.*[7]

It is further important to note that, while rehabilitation may be necessary at various stages of the affected individual's life, it is typically a once-off event.

It is our experience that the majority of medical practitioners consider the job done once they have completed their medical / surgical treatment and do not refer their patients for rehabilitation when they should.

Recommendation 12:

Further to recommendations 4 and 5, systems should be developed to ensure early detection of road accident victims, ensuring that all beneficiaries have access to recommended treatment guidelines and that all victims are followed up at regular intervals until MMI (expanded definition) is achieved.

[7] https://www.who.int/publications/i/item/access-to-rehabilitation-in-primary-health-care

Issue 4.3
Early rehabilitation of persons with multiple or more severe injuries is often inadequate.

- *Hospital stay is, as already stated, typically brief and post-acute intervention is absent or just skims the surface.*
- *This situation is compounded by a lack of communication and coordination of services between tertiary, secondary and primary levels of care.*
- *Assistive devices / prostheses are not provided or, if issued, are often unsuitable amongst other things for the conditions to which the individual is being discharged.*
  The WHO informs that access to assistive products is commonly lacking in primary health care and, where it may exist, affordability and quality are often a challenge. It is estimated that only one in ten people globally have the assistive products they need.[8]

Recommendation 13:

More severely disabled road traffic victims - where long-term / disabling sequelae can be predicted with reasonable accuracy - should be identified early and referred to a case manager.

The case manager should:

- Facilitate early authorisation for referral to a suitable rehabilitation facility;
- Secure early authorisation for and provision of necessary assistive devices / prostheses / alterations to residence / necessary care;
- Be responsible for routine follow up - after discharge / on an ongoing basis - to identify / prevent deterioration and to address changes as the injured person ages.

Recommendation 14:

Necessary **and** appropriate assistive devices / prostheses / equipment must be provided as early as possible.

[8] https://www.who.int/publications/i/item/access-to-rehabilitation-in-primary-health-care

5. Functional outcomes

***Issue 5**:*

*The AMA Guides (Sixth Edition) define MMI (Maximum Medical Improvement) as "a status where patients are as good as they are going to be from the **medical and surgical** treatment available to them. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected change."*

It is our experience that MMI is currently understood / applied / considered only in terms of strict medical / surgical treatment i.e. little heed is paid to the achievement of MFI - maximal functional improvement - and the need for further rehabilitative intervention.

Many people who have sustained relatively minor injuries – simple fractures, dislocations, soft tissue injuries – for which adequate medical / surgical intervention has been provided in the acute stage, are not referred for any form of rehabilitative intervention.
As a result, functional outcomes following injury are often not optimal.

Achieving optimal functional outcomes is critical if the individual is to resume an active life – and indeed return to work – following injury.

Recommendation 15:

A revised definition of MMI should be adopted and stressed i.e.
MMI is the point at which an injured person's medical condition has stabilized **and further functional improvement is unlikely, despite continued medical treatment or rehabilitation.**

6. Longer term needs e.g. for assistive devices / prostheses / alterations to residence / care are not promptly identified or provided.

Issue 6.1:

Many severely disabled people:

- *Are discharged from hospital / rehabilitation facilities before necessary and suitable assistive devices / prostheses have been authorised.*
- *Are provided with unsuitable / inadequate assistive devices / prostheses while waiting for interim funding to be provided / cases to be settled.*
- *Wait years to access suitable assistive devices / prostheses / care / necessary changes to accommodation - typically until post-settlement.*

As a consequence of the above, many develop complications, such as more severe deformities, and regress in functional terms.

See recommendation 13

Issue 6.2:

The strong relationship between poverty and disability is well documented.[9]

Many road accident victims are discharged from hospital / rehabilitation facilities before application for a Disability Grant has been made or such Grant facilitated (even if only needed on a temporary basis) with associated hardship for the individual and his / her family.

Recommendation 16:

Case managers should assist with applications for Disability Grants for those injured individuals whose treatment / rehabilitation is likely to be protracted - or ensure referral to a social worker - so that they and their families have some form of income prior to settlement of their claims.

[9] Banks L, Kuper H, Polack S. (2018) Poverty and disability in low- and middle-income countries: A systematic review. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0189996

7. Return to work

Issue 7.1:

Many road traffic victims who have the potential to return to work do not do so - for a variety of reasons.

Recommendation 17:

Data available in the RAF system in respect of loss of employment should be analysed to determine the extent of this issue and the cost of compensation paid by the RAF.

Such analysis would support the notion that early rehabilitation - including vocational rehabilitation - is critical.

Issue 7.2:

Many road traffic victims who were employed at the time of the accident event lose their jobs as a result of:

- *Absence from work – while in hospital and recovering*
- *Lack of / inadequate liaison with employers regarding:*
  - *Anticipated length of absence from work;*
  - *Anticipated outcome of treatment / rehabilitation*
  - *Adaptations in the workplace which could facilitate return to work – including consideration of alternative jobs available*
- *Road traffic victims not knowing their rights e.g. in respect of the employer's duty to attempt to accommodate an injured employee.*

This is especially important for poorly educated individuals who are only eligible for unskilled work – where reliance on physical abilities is critical.

Recommendation 18:

Road traffic victims who were permanently employed at the time of the accident and sustain relatively minor injuries should be identified early to determine potential to return to work **and** should be referred for intensive post-acute rehabilitation,

Recommendation 19:

Contact should be made with the employer of each road accident victim who is **permanently employed** at the time of the accident - in order to ensure that:

- Employers are well informed regarding treatment and anticipated recovery times.
- Anticipated outcomes of treatment are shared.
- Employers are well informed in respect of their responsibility to accommodate injured / disabled employees as mandated in The Constitution of the Republic of South Africa, 1996, the Employment Equity Act, 55 of 1998 and the Code of Good Practice on the Employment of People with Disabilities[10].
- Work visits are undertaken, where indicated, to consider how a workplace can be adapted or an alternative job identified to facilitate return to work.
- The employer is informed when the accident victim is ready to return to work (albeit with reasonable accommodations e.g. in a different capacity / reduced hours).
- Interventions can be undertaken in the workplace, if indicated.

Issue 7.3:

Vocational rehabilitation is virtually non-existent.

Recommendation 20:

Vocational rehabilitation must be expanded urgently and substantially - both in respect of the appointment of suitably experienced practitioners and provision of suitable facilities.

[10] https://www.gov.za/documents/employment-equity-act-code-good-practice-key-aspects-employment-people-disabilities

8. Navigation of the health system

Iss*ue 8:*

Many road traffic victims do not have the ability to navigate the health system without support. Due to illiteracy, lack of knowledge and insufficient statutory provision, a common feature of the recovery pathway includes poor compliance, delayed surgery and poor management of complications, resulting in preventable disabilities.

Those who claim directly from the RAF are considered potentially particularly vulnerable in this regard.

Recommendation 21:

Traffic victims who do not have the ability to navigate the health system – and all direct claimants – should be identified early and referred to case managers in order to ensure that such individuals comply with / are able to access recommended intervention

9. Rehabilitation team

Issue 9.1:

While it is known that the knowledge, skills and expertise of several categories of healthcare and other professionals may be required – simultaneously or at different times:

- *Certain categories of health care practitioners e.g. speech therapists, neuro-psychologists are rarely available.*
- *Communication and collaboration between professionals is often lacking (for various reasons).*

Recommendation 22:

Expert practitioner in each of the following disciplines should be available at RAF regional offices as a resource to medical and other health care practitioners, as well as case managers - to educate / advise / monitor as necessary:

- Clinical psychology
- Neuro-psychology
- Occupational therapy
- Orthotics and Prosthetics
- Physiotherapy
- Audiology / Speech and language therapy.
- Biokinetics

Issue 9.2:

Rehabilitation reaches beyond the health sector, encompassing and including the involvement of many other sectors such as education, transportation, social services, labour and housing. This seldom occurs.

Recommendation 23:

A database should be developed at each regional office with details of NGO's / DPO's / other public sector departments and individuals (e.g. builders) who / which can contribute re-integration of disabled persons in society.

Recommendation 24:

The RAF should forge ties with individuals / organisations / other public sector departments which could assist in facilitating independent living of road accident victims e.g.

- Municipal housing departments so that a policy is developed in regard to provision of suitable housing on a priority basis for severely disabled traffic victims.
- Organisation providing residential care for severely disabled individuals.
- Municipal transport departments so that suitably accessible public transport becomes a priority.
- Nursing agencies which provide home-based care.

Recommendation 25:

The RAF, Department of Health, Department of Education and Department of Social Development should work together in facilitating academic and vocational placements / support for victims within:

- Mainstream schools;
- Special (ELSEN) schools;
- Sheltered and protected workshops;
- Community based projects;
- Vocational skills workshops.

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