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The study "rehabilitation services"

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Abstract. Rehabilitation of the patient's social environment is being developed internationally as the best way to meet the needs of a large number of people with disabilities. The goal of rehabilitation in the patient's social environment is to combine the medical and social models of disability.

Introduction

Rehabilitation of the patient's social environment, the introduction and development as "early realized strategy" (Edmonds and Peat, 1997), in order to promote the transformation of health and social services, is the reflection of changes in social processes of rehabilitation as well as in the attitude towards disability and the development of society, that have occurred over the last thirty years.

Rehabilitation of the patient's social environment is being developed internationally as the best way to meet the needs of a large number of people with disabilities in developing countries, as well as developed societies (Peat, 1997).

Rehabilitation of the patient's social environment is considered as a "primary candidate for searching practical and successful ways and means to ensure appropriate health care to a higher percentage of the people with disability" (Peat, 1997).

In many ways the goal of rehabilitation in the patient's social environment is to combine the medical and social models of disability. The supporters of rehabilitation in the patient's social environment consider that its central tasks are:

1. To offer the client tools, skills and support in a way that they could formulate their own definition of health and be able to make deliberate decisions regarding their needs and care. (Hahn, 1991; Wallerstein, 1992).
2. To change the attitude of all interest groups towards societies where the people with disabilities can access structures, organizations, services and policies, in which they can fit in and participate. (McConkey and O'Toole, 1998: Peat, 1997).
3. To encourage the initiative of people with special needs, which emerge from their goals, strategies and systems of support and evaluation. (Boyce and Ballantyne, 2000; Lang, 1999; McConkey and O'Toole, 1998; Peat 1997; Twible and Hanley, 1993).

The study "Rehabilitation services" is devoted to the problem of accessibility of rehabilitation services for people in rural areas.

"In Latvia "rural area" has been defined only in law of Agriculture and Rural Development, which states that rural area is the whole territory of Latvia, except the major cities and district centers".

The focus is on accessibility of services, rehabilitation services, as well as on customers' ability to reach them. Not all the services have been studied, only rehabilitation.

The concept of rehabilitation, concept "rural area", "availability" and the concept of service quality have been defined in theoretical grounds of the research. In theoretical grounds, acts of legislation in provision of rehabilitation services are also examined.

The aim of the study

To analyse the availability of rehabilitation services from different aspects – defined in legislation and physically accessible, leaving aside the aspect of material accessibility.

Methods used in the study

1. Interviewing specialists/physiotherapist, ergo-therapist, speech therapist, social worker and doctors who are involved in the process.
2. Interviewing clients and their family members, who are involved in the rehabilitation process.
3. Legislation studies that determine patients' rights for rehabilitation.

The main question of the research

Are the rehabilitation services accessible for clients living in rural areas, is there a sufficient legislation base, as well as can the client, who is living in the rural area, access the rehabilitation service provider.

Legislation on rehabilitation

Regulations on a person from the state budget and their own duties (patient's contribution, co-payment), other health care regulatory laws, and to what extent they are provided:

"6.10. rehabilitation after the treatment phase in the hospital, which provides 24-hour emergency care and urgent assistance or medical rehabilitation dynamic observation" (Health Care Organization and Financing, 2006).

What is the quality of social work?

Service availability is one of the quality components of the service.

Here we could mention a number of points that were common to all the researchers.

The first one – a client and their family must be involved in the work and in the research of quality.

The second one – the feedback from client and his family has to be obtained on a regular basis, as well as the feedback from direct service provider about the service quality.

During interviews, questionnaires, observations a common time cycle should be kept.

A very important component is customer's level of satisfaction after receiving services.

Some attention should be paid to the level of complaints, as well as if there are no complaints at all, in this situation an audit should be carried out as well as observations about complaints (Šiļņeva, 2004).

In their work J. Laškova and I. Gutjare (J. Laškova and I. Gutjare, 2003) state that compared to other European countries, Latvia does not have common standards for the realization of social services, and recommend to make a service manual for each service provider, a care plan for each customer, more serious criteria for health care, adoption of standards in individual life stages, such as "Death and Dying", complaint and proposal processing procedures by staff and continuity of educational standards.

Social workers Dervinika, N. Pujate and V. Runča in their article have discussed such specific issue as home care in rural areas (A. Dervinika, N. Pujate, V. Runča, 2003).

This article examines problems with the administration of services within a small rural municipality where the funds do not meet the amount and quality of service provision. The biggest problem is regular transport, which is needed in order to serve customers that are living far away from service provider.

Accessibility of services

In her work "Accessibility of Health Care Services" Vera Boronenko points out that:

"Inaccessibility of health care services is a serious problem because one third of patients recently had to give up some of the health care services" (Vera Boronenko, 2003).

The accessibility of services can be divided in different stages.

The first is the availability from legislative view. The law stipulates the need for service, customer groups, funding, service standards or quality of certain criteria, and requirements for a service provider and service operator.

The second is the physical capability to get the customer to the provider or the service provider to the customer.

The third is how expensive is the service, who pays for it and, if the client is the one paying, can the client's income cover the costs of the service.

Fourth – the availability of information, whether the customer knows that he has the access to such services and where he can access them.

The fifth stage is motivating – whether the customer and his family understand that the service is needed and how it will improve client's health and social status.

The research process

In interviews with 40 rehabilitation out-patients, they point out:

- Services are difficult to access because of the lack of information about their existence. Doctors give no information or not enough information to their patients about rehabilitation options. Information is only on the Internet, or is found in conversations between patients. There is a lack of brochures and other informative materials.
- The options for accessing rehabilitation services are uncertain. It is unclear which doctor and when they can send the patient to rehabilitation. It seems that doctors have no clarity about this issue, because their answers to this question are conflicting.
- For customers living in rural areas, services are not available due to lack of transport. Public transport runs not frequently enough, and it is not available for people with disabilities. Social services in rural areas may not always be provided with special transport for people sitting in wheelchair or in a recumbent position. Buying this service from NGOs or individuals is expensive and the customer's cannot afford it.
- Customers do not read the legislation, so they are not familiar with their rights.
- Customers have to be on the waiting list for two years to get such technical aids as wheelchairs.
- State-line for rehabilitation services is very long, everything depends on budget funding.

The state is not interested, at least not at a practical level, in customer's rehabilitation and returning in the labor market. In the Disability Law the section of predictable disability in practical environment is not working.

There are no funded rehabilitation centers, which could quickly perform arrangements needed for rehabilitation, and the waiting list for this rehabilitation is very long.

There are rehabilitation centers in Vaivari, Līgatne, Tērvete and Jaunķemeri. Centers have developed rehabilitation services, but the price for services is often not available to the client due to lack of funds.

In rural areas the average pension is 160–180 LVL per month, while the average wage is around 300 LVL. The daily charge in rehabilitation centres ranges from 22 to 40 LVL.

The stage – predictable disability, is often missed, in our survey 80% of patients have already become disabled by the time they are sent to the State Medical Commission for the Assessment of Health Condition and Working Ability.

In the interviews with ten family doctors and rehabilitation specialists it has been found out that the rehabilitation services are dilatory, and usually after treatment the client becomes disabled and unable to work, although if the rehabilitation had been started in time, the client could recover and keep to possibility of self-care and even partial working ability.

Conclusions

1. In legislation the rehabilitation service is provided as successive acute treatment.
2. There is a lack of information that can reach the customer who is in need for rehabilitation.
3. Family doctors do not have enough information about different rehabilitation services. Part of family doctors is not trained to evaluate client's care and functional ability.
4. During treatment hospitals give their patients information about rehabilitation, but the awareness is selective.
5. The insufficient amount of technical aids in the country creates unsurpassable obstacles for client to access rehabilitation services.
6. The lack of social and public transport creates unsurpassable obstacles for clients from rural areas to access rehabilitation services.
7. Social services in municipalities are not provided with special transport for clients in recumbent position or for clients with movement disorder.
8. If the client's material capabilities to access rehabilitation services would be included in the study (have not been included due to the lack of time, but will be included later), another obstacle for reaching the rehabilitation services would be well-founded.

Innovation methods for development of rehabilitation services

1. Move the rehabilitation services closer to receiver and create rehabilitation departments in communities next to the social services. There is an experience in this field. If it was possible to finance day-care centres and halfway home service creation in the initial period of the state, then it would be also possible to finance this activity.
2. The big municipalities – districts were created to improve social services, moving medical services closer to client so that social worker and medical workers could access the client in his home.
3. To open social service points in the former locations of municipality boards of administration, locating there the social worker not only for distributing benefits, but also as the service provider and coordinator of social work, who is provided with transport and could drive the client to the place where he could get the needed services.

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