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EDITORIAL

Rehabilitation Services at the Primary Healthcare Level

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Rehabilitation is a pivotal health strategy. It not only optimizes functioning but also reduces disability across the life course. Functioning is heavily influenced by health conditions, but environmental, social, and personal factors also significantly impact it.

Rehabilitation spans a continuum of care. At the primary care level, it is function-focused, preventive, and people-centered. It can maintain or restore everyday performance and participation at home and in the community. Services such as physiotherapy, occupational therapy, and community-based efforts are integrated. The emphasis is on early identification of functional limitations, management of chronic conditions, and improvement in the standard of living. Tertiary rehabilitation is disease specific. It is delivered by specialist multidisciplinary teams in hospitals or rehabilitation centers for patients who are recovering from complex or high-risk conditions such as major surgery, severe trauma, neurological injury, or advanced cancer. Evidence has shown that rehabilitation services based solely in secondary or tertiary care fail to meet the population needs. This is particularly true for individuals who live with chronic conditions and may require long-term support.

A review rehabilitation services across primary, secondary, and tertiary levels in low- and middle-income countries found that most of these rehabilitation services were concentrated in higher levels of care. They had limited functional integration into PHC settings, even in the presence of clear policy intent. It underlined how weak referral systems, workforce shortages, and a lack of coordination undermine the continuity of rehabilitation. As a consequence, PHC is becoming underutilized as a platform for long-term functional support. Evidence from Chile showed a positive trend that must be considered. It shows how the enmeshment of rehabilitation within PHC can significantly improve coverage and equity. The national implementation of the Comprehensive Rehabilitation in Primary Health Care Program expanded rehabilitation delivery. It allowed services to reach the underserved populations closer to their homes.

In order to design effective services, there is a need to understand how individuals interact with PHC before and after rehabilitation. A longitudinal cohort study examined primary care use in the context of specialized rehabilitation. It showed that visits to the general practitioner and physiotherapist were more frequent in the years before rehabilitation and declined afterward. It was shown that individuals with musculoskeletal disorders had consistently higher diagnosis-related primary care use, while those with cardiovascular conditions showed increased diagnosis-related follow-up after rehabilitation rather than before. The authors concluded that factors such as self-management capacity, daily functioning, and contextual supports likely influence long-term outcomes.

A scoping review of occupational therapy services in primary care identified a plethora of assessments and interventions. These interventions included chronic disease self-management, falls prevention, health

promotion, functional assessment, and the distribution of community resources. The review explored how occupational therapy interventions in PHC are conventionally structured around a person-environment-occupation framework. This helps people translate their rehabilitation gains into meaningful daily activities. Occupational therapy has long-term benefits that cannot be achieved through medical follow-up alone. These findings substantiated the evidence that claimed that rehabilitation outcomes depend on more than health service frequency and require customized approaches that could work within everyday life contexts. A systematic review examining strategies to improve access to primary health care services identified several approaches that are directly relevant to rehabilitation delivery. These included outreach services and mobile clinics, community-directed health programs, telemedicine, and collaboration with non-governmental and non-profit organizations. Outreach and mobile service models were praiseworthy solutions, as they reduced geographic barriers by making health services, including rehabilitation, accessible to communities. Telemedicine further improved the health outcomes by enabling follow-up, monitoring, and education where in-person access was limited to none.

Evidence from Pakistan explains why PHC-based rehabilitation is difficult without broader PHC strengthening. A mixed-methods study from Khyber Pakhtunkhwa found that PHC needs remained unmet even in service use. This was because of the high costs across the care-seeking pathway. The study also showed weak outreach and awareness, inconsistent availability of medicines and diagnostics, and how the patients faced difficulties navigating and adhering to care. These barriers are directly relevant to rehabilitation, which often requires repeated follow-up, continuity of diagnostics and medications, and sustained engagement. A Pakistan-focused PHC systemic review similarly underlined persistent challenges to the system. These were fragmentation, limitations to the workforce, and uneven quality of care in both the public and private sectors. Strengthening PHC rehabilitation in Pakistan, therefore, requires rehabilitation workforce planning alongside improvements in affordability, service quality, communication, outreach, and continuity mechanisms.

This combined evidence shows us how rehabilitation services are most effective when they are integrated into PHC systems that put a sustained emphasis on the continuity, functionality, and accessibility of such services. Specialized rehabilitation remains important. But long-term outcomes depend on structured follow-ups of the patients, functional goal setting for progress, and community-based support that improve their health outcomes. Health systems that fail to integrate rehabilitation into PHC increase the risk for perpetuating access inequities and fragmented care pathways. Occupational therapy is a perfect paradigm of how rehabilitation can be operationalized within PHC through interventions that are focused on function and context responsive. When these are combined with strategies such as outreach services and telehealth, PHC rehabilitation can not only manage functional needs but also break structural barriers. To combat the growing burden of chronic conditions and functional limitations, rehabilitation services at the primary health care level must be considered.

In Pakistan, affordability constraints, inconsistent availability, limited outreach, and difficulties engaging with care demonstrate that rehabilitation integration must occur alongside broader PHC strengthening for meaningful functional outcomes. Strengthening rehabilitation within PHC would require considerable changes. These can range from coordinated system-level integration and functional and person-centered interventions to targeted strategies that overcome all barriers to accessing the required services. This will play a life-changing role in improving population health and equity.