

# Uk dms military amputee rehabilitation strategy



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## Introduction

The previous chapter provided information regarding the context and background to the study, the research aim and objectives, the statement of the problem, the scope and limitations of the study, and the study structure.

Globally, the availability of rehabilitative staff and for that matter health workers in general has become a cause for concern. WHO (2006) commented that the world faces a shortage of 4.2 million health workers. Experts have warned that the number of health workers being trained domestically in many countries is threatened by the strain on public finances inflicted by the ongoing economic crisis. The EU could face a shortage of 1 million health professionals by 2020 – or 2 million if long-term care and auxiliary professions are also taken into account (Jensen, 2013). To combat these shortages, the UK and USA recruit staff on an industrial and international scale (Eckenwiler, 2009).

This chapter will review the UK DMS military amputee rehabilitation strategy. Comparing the UK with US, it will review the global rehabilitation situation, discussing a number of issues affecting service provision, and rehabilitation staff availability. Additionally, the chapter will review some of the current evidence supporting the impact relocation has on the retention of civilian rehabilitation staff, and review perspectives underlying staffs willingness to stay with health organisations.

## UK Military Rehabilitation Strategy

The principal aim of the UK DMS Rehabilitation Strategy (the Defence Military Rehabilitation Programme) is to return service personnel to operational levels of fitness as soon as possible – the “fitter quicker” principle. Where this is not achievable e. g. military amputee patients ‘the aim is to attain the maximal level of physical, psychological and social health possible’ (MOD, 2010, p. 1).

The Defence Military Rehabilitation Strategy (the Defence Medical Rehabilitation Programme) currently encompasses two distinct capabilities; the DMRC (Defence Medical Rehabilitation Centre) and the DMRS (Defence Medical Rehabilitation Service). The DMRC is the foremost Defence rehabilitation centre where service personnel can receive rehabilitation for neurological, complex trauma (polytrauma) or “force generation” musculoskeletal conditions. The DMRS (MOD, 2016) is provided through a tiered network of rehabilitation facilities including 152 Primary Care Rehabilitation Facilities (PCRF) and 15 Regional Rehabilitation Units (RRU) across the UK and Germany. The PCRFs are Unit/Station based rehabilitation departments offering physiotherapy and exercise therapy on an outpatient basis. Patients with injuries that cannot be resolved at this level are referred to RRUs who provide rapid access to imaging services, podiatry and residential rehabilitation.

The Defence Military Rehabilitation Programme is also supported by PRCs (Personnel Recovery Centres). They are residential facilities situated in or near garrisons and are available to all members of the Armed Forces during their recovery from sickness or injury. They aim to assist personnel back to either military service or a second career in a civilian occupation.

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## US Military Rehabilitation Strategy

United States Military Rehabilitation Strategy recognised the need for an overhaul of rehabilitation services during the War in Afghanistan. Seven years after US troops entered the Afghanistan conflict, Congress passed the Defence Authorization Act of 2008, which reflected legal and healthcare workers concerns about the quality and availability of medical care services (Lister, Panangala, and Scott, 2008). Accordingly, today's casualties receive an effective and expansive set of rehabilitative services that are akin to those seen in the in the United Kingdom.

US rehabilitative care is provided by Tricare (a health care program of the United States Department of Defense Military Health System) and the Veterans' Association (VA)<sup>2</sup>.

## Global Rehabilitation Issues – Amputee Services

Amputee rehabilitation services in high income countries are usually centrally funded and provide effective support. Amputee rehabilitation in low and middle income countries depends on their nation's stage of development. In areas beset by war (for example Cambodia, Vietnam, Angola, Mozambique and Uganda), the greatest number of amputations (Staats, 1996) results from conflict and landmine explosions. As war drags on, the number of amputees increases and becomes an economic burden. In some countries the number of amputees is so great it is considered an ecological as well as economic disaster; this is the " amputee volume imperative". In these regions amputee rehabilitation in any form is a luxury, if it is available at all.

## Global Rehabilitation Issues – Population Effects

When delivered at its best, rehabilitation provides people with the tools they need to attain maximal health, function, independence and self-determination (WHO, 2002). The World Health Organization (WHO) and the World Bank estimate that people with disabilities constitute at least 15% of the world's population, with the majority in low and middle-income countries (WHO, 2011; Pryor and Boggs, 2012). Despite the continued increase in rehabilitation cases worldwide, prioritizing and monitoring of progress to improve health services for people with disabilities remains inadequate (Tomlinson et al., 2009). International evidence shows that people with disabilities have many unmet health and rehabilitation needs, face barriers in accessing mainstream health-care services, and consequently have poor health.

With an ever-increasing incidence and prevalence of chronic disabling non-communicable diseases (Boutayeb and Boutayeb, 2005) and a global health refocus on reducing mortality, the world is experiencing a growing demand for rehabilitation services. Generally however, physical and functional rehabilitation is not emphasized in global health discourse (Pryor and Boggs, 2012), despite many recent documents, including various national and international policy instruments and the World Report on Disability (2011) that stressed that physical rehabilitation services are a necessary element of a comprehensive system. The WHO Global Disability Action Plan 2014-2021 (2015) includes the strengthening of rehabilitation services as a key objective. To achieve this objective, it provides capacity building actions (to meet this objective) for member states, national and international partners.

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Currently however, rehabilitation services, particularly in low and middle-income countries, do not have the capacity to adequately address the needs of their populations.

#### Global Rehabilitation Issues – Finance and Resources

UK and US military rehabilitation strategies are able to provide tiered and specialist services as they are centrally funded. Specialised amputee services in high income countries can also attract charitable donations in order to achieve the best care solution.

Where rehabilitation is adequately financed, national rehabilitation strategies (NRH, 2009) dictate that care should be delivered from 3 perspectives: general rehabilitation; specialist rehabilitation; and a complex specialised rehabilitation service (C-SRS). In high income countries (UK, US, Australia, New Zealand, Norway, Sweden) rehabilitation is integrated in health care and financed under the national health system (Lilja et al., 2009; WHO, 2004). In other countries responsibilities are divided between different ministries. This stymies rehabilitation services at regional and local level; they are often poorly coordinated and not integrated into the overall system (OECD, 2008).

The cost of rehabilitation can be a barrier for people with disabilities in high-income as well as low-income countries. Rehabilitation is problematic even where central funding from government, insurers, or NGOs is available, as it may not cover enough of the costs to make it affordable (Bijelow et al., 2004). Deficits in the New Zealand rehabilitation infrastructure and workforce already severely compromise access to and provision of

rehabilitation services (New Zealand Rehabilitation Association, 2014).

Australia (the sixth largest country in the world) is a high-income country, ranked 19th in terms of per capita GDP. The development of health services in Australia has mainly been focused on metropolitan and regional areas, with both on-site and outreach locations. A review of 30 years of development in rehabilitation, clinical services, and education reforms in Victoria (Pryor and Boggs, 2012), indicates that progress has been indifferent with mistakes, dead ends and successes along the way.

Financing strategies can improve the provision, access, and coverage of rehabilitation services, particularly in low-income and middle-income countries. Whilst it can be assumed that any new strategy should be carefully evaluated for its applicability and cost-effectiveness before being implemented, the reality is that rapid implementation negates strategic review. In low and middle income countries, physical and functional rehabilitation is particularly challenging, given human resource shortages and inadequate funding of health care. In these situations, rehabilitation services have evolved in unique ways. They are often strongly linked to humanitarian responses and wider disability actions, and are less connected with mainstream health care than in other settings. Aid agencies from Australia, Germany, Italy, Japan, New Zealand, Norway, Sweden, the United Kingdom, and the United States have supported such activities (Dolea, 2010).

The rehabilitation sector is frequently disconnected from the health sector and is closely linked with poverty reduction strategies. Limited resources and health infrastructure in developing countries, and in rural and remote

communities in developed countries, can reduce access to rehabilitation and quality of services (World Bank, 2009). In a survey of the reasons for not using health facilities in two Indian states, 52.3% of respondents indicated that no healthcare facility in the area was available (World Bank, 2009). Other countries lack rehabilitation services that have proven effective at reducing long-term costs, such as early intervention for children under the age of five (Stucki et al., 2005; Rimmer, 2006; Storbeck and Pittman, 2008). A study of users of community-based rehabilitation (CBR) in Ghana, Guyana, and Nepal showed limited impact on physical well-being because CBR workers had difficulties providing physical rehabilitation (Stucki et al., 2005). A 2005 global survey (SNCDD, 2006) of the implementation of the nonbinding, United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities found that: in 48 of 114 (42%) countries that responded to the survey, rehabilitation policies were not adopted; in 57 (50%) countries legislation on rehabilitation for people with disabilities was not passed; in 46 (40%) countries rehabilitation programmes were not established.

Spending on rehabilitation services is difficult to determine because it generally is not disaggregated from other health care expenditure. Many countries – particularly low and middle income countries – struggle to finance rehabilitation, but rehabilitation is a good investment because it builds human capital (Haig et al., 2009). Health care funding often provides selective coverage for rehabilitation services, for example, by restricting the number or type of assistive devices, the number of therapy visits over a specific time, or the maximum cost (Dejong, Palsbo, and Beatty, 2002), in



order to control cost. Governments in 41 of 114 countries did not provide funding for assistive devices in 2005 (SNCCDD, 2006). In Haiti, before the 2010 earthquake, an estimated three quarters of amputees received prosthetic management due to the lack of availability of services (Bijelow et al., 2004). Poor access to prosthetic services that were available was attributed partially to users being unable to pay (Bijelow et al., 2004). Rehabilitation national survey in India, found two thirds of the assistive technology users reported having paid for their devices themselves (World Bank, 2009).

Whilst global strategy recognised the need for appropriate resourcing, very few countries recognised the impact of disability on income. People with disabilities have lower incomes and are often unemployed, so are less likely to be covered by employer-sponsored health plans or private voluntary health insurance. If they have limited finances and inadequate public health coverage, access to rehabilitation may also be limited, compromising activity and participation in society (Crowley, 2003).

#### Global Rehabilitation Issues – Availability of Services and Staff

National rehabilitation strategies require competent professional staff in great numbers; the global availability however of qualified /experienced rehabilitation professionals is on the decline (Chen, 2006). Not only do the settings for rehabilitation vary greatly from country to country, the availability of rehabilitation services in different settings varies within and across nations and regions (WHO, 2004; Haig, 2007; Tinney et al., 2007; Buntin, 2007; Ottenbacher and Graham, 2007). Haig et al (2009) flippantly

concluded that the chance of a person with a disability in sub-Saharan Africa meeting a physician with specialist skills is about the same as that for an Antarctic penguin.

Continuous WHO research has revealed wide cross-national disparities in the supply of rehabilitation health professionals. Lower income countries tend to have the lowest densities with less than 0.5 workers per 10,000 inhabitants in many countries of sub-Saharan Africa but also in several across Asia (Bangladesh, Nepal, Pakistan, Myanmar, India) and the Eastern Mediterranean (Iran, Yemen). Many high income countries – including Finland, Japan, the United States, the United Kingdom and Canada – have workforce densities several times higher (De Savigny and Adam, 2009). This finding is not surprising: large differences across countries and critical shortages of highly skilled professionals in low-income countries have been well documented (Chen, 2006).

Building a cadre of trained amputee rehabilitation personnel is a goal of many organisations and governments. Dunleavy (2007) suggests that the quality of the rehabilitation workforce in low-income countries is both disturbing and dangerous. A recent comprehensive survey of rehabilitation in Ghana identified no rehabilitation doctor or occupational therapist in the country, resulting in very limited access to therapy and assistive technologies (Tinney, 2007). An extensive survey of rehabilitation doctors in sub-Saharan Africa identified only six, all in South Africa, for more than 780 million people, while Europe has more than 10,000 and the United States more than 7,000 (Haig et al., 2009). Discrepancies are also large for other rehabilitation professions (Saxena et al., 2007).

Many developing countries do not have educational programmes for rehabilitation professionals. According to the 2005 global survey, 37 countries had not taken action to train rehabilitation personnel and 56 had not updated medical knowledge of health-care providers on disability (SNCDD, 2006). Despite a huge need for rehabilitation services in both urban and rural Cambodia, for example, hospitals could not afford to hire rehabilitation professionals (Dunleavy, 2007).

### Global Rehabilitation Issues – Communication and Strategy

Inadequate health information systems and communication strategies can contribute to low rates of participation in rehabilitation. Barriers to rehabilitation include poor communication across the health care sector and between providers (notably between primary and secondary care), inconsistent and insufficient data collection processes, multiple clinical information systems, and incompatible technologies (DiGiacomo, 2010). Poor communication can result in ineffective coordination of responsibilities among providers (Kroll and Neri, 2003). Complex referral systems can limit access. Where access to rehabilitation services is controlled by doctors (Dejong, Palsbo, and Beatty, 2002), medical rules or attitudes of primary physicians can obstruct individuals with disabilities from obtaining services (Hilberink, 2007). People are sometimes not referred, or inappropriately referred, or unnecessary medical consultations may increase their costs (Eldar, 2000; Holdsworth et al., 2006). The 2005 global survey (SNCDD, 2006) of 114 countries, revealed 57 did not consult with families of persons with disabilities about design, implementation, and evaluation of rehabilitation programmes. This directly challenged McColl and Boyce's

supposition (2003) that the development, implementation, and monitoring of strategy and policy should always include users.

A study of rehabilitation medicine related to physical impairments in five central and eastern European countries suggested that the lack of strategic planning for services had resulted in an uneven distribution of service capacity and infrastructure (Eldar et al., 2008). Strategy and planning needs to be based on analysis of the current situation, and consider the main aspects of rehabilitation provision – leadership, financing, information, service delivery, products and technologies, and the rehabilitation workforce (De Savigny and Adam, 2009), defining priorities based on local need. Many countries have good legislation and related policies on rehabilitation, but the implementation of these policies, and the development and delivery of regional and local rehabilitation services, have lagged.

#### Retention of Rehabilitation Staff

Like other health staff, retaining rehabilitation professionals is affected by poor working conditions, safety concerns, poor management, conflict, inadequate training, lack of career development and continuing education opportunities (Crouch 2001; Tinney, 2007; Lehmann, Dieleman, and Martineau, 2008; Tran et al., 2008; Dolea, 2010). High income countries do not suffer from this scarcity, as their economies regularly attract healthcare workers from low-income countries (Landry, Rickets, and Verrier, 2007; Mock et al., 2007; Lehmann, Dieleman, and Martineau, 2008; Willis-Shattuck, 2008; Magnusson and Ramstrand, 2009).

Retaining professional workers is especially important as professional workers may have stronger professional than organisational identification reasons for staying (Robertson and Hammersley, 2000). Retention can prove difficult however as turnover tends to be growing rapidly across many industries (Si, Wei and Li, 2008). More importantly, when employees leave they take their know-how with them and thus an organisation risks a potential loss of experience and expertise (Walker, 2001; Frank, Finnegan and Taylor, 2004).

Employers invest a lot in recruiting and selecting employees and then invest even more in training and developing them over time. The development of these assets is an important task for human-resource managers (Sutherland, Torricelli, & Karg, 2002). Moncarz, Zhao and Kay (2009) found that professional growth is an important retention factor and that 'in organisations where employees receive the proper training needed to assume greater responsibilities, turnover rates are generally lower' (p. 441).

### Why Staff Stay With Organisations

The learning and development of employees is an important retention-supporting strategy (Horwitz, Heng, and Quazi, 2003; Kyndt et al., 2009). Tymon, Stumpf and Smith (2011) note how retaining the best professional talent is of great practical significance to organisations as it eliminates the recruiting, selection and on-boarding costs of their replacement, maintains continuity in their areas of expertise, and supports a culture in which merit can be rewarded (p. 293). Advancement opportunities appear to motivate

high-performer retention more so than other employees (Hausknecht, Rodda, and Howard, 2009).

The role of management as a key factor in the retention of professional workers has been cited by several studies. Andrews and Wan (2009) link improved nurse retention to manager behaviour (p. 342) and Snyder and Lopez (2002) emphasize the role of leaders in an organisation in encouraging the “talent of the organisation” to stay.

Research has shown that as long as employees feel that they are learning and growing, they will be less inclined to leave. On the other hand, once employees feel they are no longer growing, they begin to look externally for new job opportunities (Rodriguez, 2008). Factors influencing retention appear to be the existence of challenging and meaningful work, opportunities for advancement, positive relationships with colleagues, empowerment, responsibility, recognition of capabilities and performance contributions, rewards, good work-life balance, good communication within the organisation, managerial integrity and quality, and new opportunities/challenges (Arnold 2005; Herman 2005; Pitts, Marvel, and Fernandez, 2011; Allen and Shanock, 2013). The role of management as a key factor in the retention of professional workers has been cited by several studies. Andrews and Wan (2009) link improved nurse retention to manager behaviour (p. 342) and Snyder and Lopez (2002) emphasize the role of leaders in an organisation in encouraging the talent of the organisation to stay. There appears to be two aspects of management that are particularly important in retention these being the adoption of an appropriate style of

leadership (Spence Laschinger et al., 2009) and perceived management support (Paillé, 2013).

Since learning and development opportunities appear crucial for the retention of talented employees (Arnold, 2005; Echols, 2007; Rodriguez, 2008; Kroon and Freese, 2013) an organisation must establish a supportive learning and working climate. This makes development and learning critical for attracting and retaining employees, because ‘ talented people are inclined to leave if they feel they are not growing and stretching’ (Michaels, Handfield-Jones, and Axelrod, 2001, p. 14).

### Relocation and Strategy

Relocation is among one of the most radical strategic decisions a firm can make (Isabella 1990). Relocation is essentially a form of organisational change, which, in its simplest form, can be defined as ‘ a difference between new and old settings’ (Weber and Manning, 2001, p. 229). Even when completed within the same vicinity, it is a complex and unsystematic process involving several stakeholders, phases and decisions (O’Mara, 1999). Whilst relocation can be perceptualised as a “ golden” opportunity, with organisations using change as a catalyst to introduce elements of organisational change (Inalhan, 2009), it can have a significant impact on real estate costs, productivity, efficiency, workforce satisfaction, and meeting the overall business objectives (Morgan and Anthony, 2008; Christersson and Rothe, 2013). For employees, the combination of workplace redesign and relocation can be challenging. Not only are they facing a change in their workspace, they also lose the organisational patterns and

roles that were a part of the old premises (Milligan, 2003). Additionally, the way the change is delivered can also impact on how the change is received (Bull and Brown, 2011; Vischer, 2011).

At an organisational level, many positive effects of relocation have been identified; positive changes in employee behaviour: enhanced employee satisfaction and productivity: improved decision-making, collaboration and cross-selling: improved retention and recruitment: reduced churn costs: and positive client feedback (Morgan and Anthony, 2008). On the other hand, relocation can also be risk-laden (Rasila and Nenonen, 2008). People form emotional links to physical environments, called “ place attachment” (Milligan, 2003; Inalhan, 2009), and a relocation inevitably causes a disruption in this relationship to the old premises with some employees experiencing loss and grieving (Inalhan, 2009) or even a form of organisational death (Milligan, 2003).

Early employee involvement and empowerment to participate in decision-making should be a part of projects where workplace change is significant and a part of a cultural transformation. Effective managerial communication in an organisation helps to connect with employees, build positive relationships and frame attitudes and behaviours of employees in the workplace and numerous studies state that communication plays an important role in the change process (Elving, 2005; Hayes, 2007) and some even claim that employee communication can mean its success or failure (Barrett, 2002). Communication of the reason and impact of the workplace change is significant in influencing the participants to accept change, and it is suggested to be even more important than the frequency or amount of

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information supplied (Bull and Brown, 2011). Despite this, employee experiences of the relocation process have not been widely addressed, with the exception of needs and experiences of employees in long-distance relocations, where organisations move to a new geographical area and the employees will have to move to a new home to stay with the company (Rabianski, 2007). Studies conducted within a relocated setting, often focus on comparing employees' experiences of the old office with the new one (Brennan, Chugh, and Kline, 2002; Brown et al., 2010), but do not give attention to how employees experience the change in location.

## Conclusion

The current economic situation has severely impacted global rehabilitation services. In low and middle income countries, inadequate resourcing combined with an ineffectual health infrastructure and consistent neglect of rehabilitation services, leaves patients facing lifelong disability. Some countries are barely able to provide a single rehabilitation practitioner. Beset by the net effects of an ever increasing population, the increasing health burden will continue to destabilize and overwhelm the most basic rehabilitation services. Even affluent countries (UK and USA) struggle to retain or recruit personnel, depending on industrial-scale immigration of qualified rehabilitation staff from countries who can barely afford their release.

Nations (and naturally organisations, the DMS and MOD) recognise the qualities an experienced workforce can deliver. With the prospect of relocation, retaining these workforces can be difficult. Thus, the availability

and maintenance of personal and professional development are key retention strategies. Relocation however, can have diverse results. On the one hand it can result in positive changes in employee behaviour, enhanced employee satisfaction and productivity; on the other it can result in a significant impact on the workforce, leading to the loss of staff with a resulting shortfall in experience and expertise.

Though there are a number of researchers that have investigated healthcare workers perspectives of relocation and retention, this literature review has revealed a lack of any available UK military associated research of its military or civilian staff. The next chapter will attempt to address the DMRC civilian rehabilitation workforce's retention and relocation perspectives through a research methodology that will encompass a qualitative focus group and cross-sectional quantitative investigation.