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Review

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Improving Rehabilitation Access in the Dominican Republic: A Bridge to the World Health Organization's Rehabilitation 2030 Initiative

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Abstract

Objectives: Despite a high prevalence of individuals living with disabilities in the Dominican Republic (DR), the availability of rehabilitation services remains critically low. The World Health Organization's (WHO) Rehabilitation 2030 initiative highlights the importance of strengthening global healthcare systems to provide essential rehabilitation services. In this article, we describe the current healthcare system in the DR and the need for a country-wide rehabilitation plan, guided by WHO's Rehabilitation 2030.

Materials and methods: A systematic search was conducted using a combination of controlled vocabulary and natural language keywords across electronic databases to identify relevant peer-reviewed studies. Data extraction from eligible studies was then performed to summarize and organize findings according to the topic. We also examined the most recent country-wide population/census data for relevant information.

Results: A 2021 population survey in the DR revealed that 7.3% of the population over the age of five lived with some type of disability. The leading causes of death and disability combined in the DR include ischemic heart disease, stroke and road injuries.

Conclusion: Globally, there is a significant need for rehabilitation to meet the needs of those living with disabilities in communities where these services are scarce or non-existent. The WHO Rehabilitation 2030 initiative emphasizes three missives as an approach to global rehabilitation which can be systematically applied to address rehabilitation gaps in the healthcare system of the DR.

Keywords: Access, global health, rehabilitation.

The World Health Organization (WHO) defines disability as *"part of being human and ... integral to the human experience. It results from the interaction between health conditions ... and a range of environmental and personal factors."*[1] Furthermore, the WHO defines rehabilitation as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment."[2] In their publication examining global estimates of the need for rehabilitation, Cieza et al.[3] estimated 2.41 billion individuals

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globally had conditions that would benefit from rehabilitation: an increase of 63% from 1990. Given this context, it is vital that improved rehabilitation practices be integrated into healthcare systems with strong embedded collaborations across communities, primary care services, and country-wide healthcare systems.[4] However, there remains an unmet need for rehabilitation services on a global level.[4] The need for increased and improved rehabilitation services is particularly prevalent in low-and middle-income countries, some of which are unable to provide rehabilitation services for more than half of the population that requires them.[5] In this article, we describe the need for sustainable, culturally appropriate rehabilitation in the Dominican Republic's (DR) healthcare system using the WHO's Rehabilitation 2030 as guidelines for improvement.[6]

The WHO's Rehabilitation 2030 Initiative

The WHO Pan American Health Organization (PAHO) estimated 366 million individuals in the Americas and the Caribbean had health conditions that would benefit from rehabilitation medicine: a 58% increase from 231 million in 1990.[2] As of 2020, all countries in the PAHO region, including the DR, ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[7] The CRPD was developed as an instrument for human rights, reaffirming that individuals with disabilities are entitled to human rights and fundamental freedoms.[7]

In 2017, the WHO launched the Rehabilitation 2030 initiative emphasizing the global unmet need for rehabilitation and underscored the importance of strengthening healthcare systems to provide rehabilitation services.[6] The initiative supports a new strategic approach with its three missives: (1) rehabilitation should be available for all the population and through all stages of the life course; (2) efforts to strengthen rehabilitation should be directed towards supporting the health system and integrating rehabilitation into all levels of healthcare; and (3) rehabilitation is considered an essential healthcare service by the WHO, and crucial for achieving universal health coverage.[6]

The healthcare system of the DR

Located in the northern Caribbean region of the Americas, the DR and Haiti form the island of Hispaniola. The DR is divided into 31 provinces and the National District (Distrito Nacional), where the capital Santo Domingo lies (Figure 1). According to the World Population Dashboard, the DR has a population of 11.4 million, an increase of 0.85% from 2023.[8] The DR is considered an upper-middle income country with 42% of the population living below the poverty line-with one-third of those living in extreme poverty.[9] Despite remarkable economic growth, urbanization, and expansion of the middle class over the past two decades, significant inequities based on sex, income, and immigration status still exist in the DR.[9-11]

While the Caribbean is widely known for popular tourism destinations, local healthcare systems are often overburdened, making it challenging to deliver care to those living outside of metropolitan areas.[12,13] The structure and function of the healthcare system in the DR continues to change as the country works toward the UN's 2030 Sustainable Development Goals (SDGs) and has gone through significant changes in pursuit of these.[14] In 2001, the DRs government approved a new legal framework for healthcare which resulted in the structure of the country's current healthcare delivery system: The National Health System (NHA) and the Dominican Social Security System.[15] This framework functions to hold the government accountable for guaranteeing the health of the entire population and carrying out public health interventions.[15]

The Ministry of Public Health and Social Assistance (Ministerio de Salud Pública y Asistencia Social) is the highest national health authority the DR.[13,16] It is comprised of many offices and councils including the National Health Service (Servicio Nacional de Salud, SNS) and National Health Plan/Seguro Nacional de Salud (SENASA).[17,18] The SNS was created in 2015 to function alongside the Ministry of Public Health and Social Assistance.[18] Within SNS exists the Regional Health Services (Servicios Regionales de Salud) network which provides healthcare services to the country's population based upon their geographical distribution and three levels of care (Figure 2).[15]

The SENASA is a government-subsidized health insurance which primarily insures

Figure 1. Map of Provinces in Dominican Republic.

low-income households.[18] Approximately 52% of the residents are covered by SENASA, however, this percentage varies greatly within regions.[18,19] In general, the more under-resourced a region is, the higher percentage of individuals with SENASA coverage. To illustrate, SENASA covers 80% of individuals in region IV and 77% in region VI (lesser-resourced and poorer areas), compared with only 33% and 37% in regions II and V (urban, higher resourced areas), respectively.[19] One key tenet of the DR healthcare system and SENASA is the decentralization of its health sector, granting more autonomy to the regional and provincial levels of healthcare.[15]

Those under the SENASA coverage can only access providers in the public network, unless a service is unavailable in the public network. Those under the Contributory Regime can utilize public, private, or self-managed Health Risk Administrators (Administradores de Riesgos de Salud, ARS) and are, thus, able to access private providers (Figure 3).[17] Outside of the scope of Social Security, private healthcare services are financed through private insurance premiums, or out-of-pocket payments (Figure 3).[17,18]

MATERIALS AND METHODS

A systematic search was conducted using a combination of controlled vocabulary and natural language keywords in Spanish and English across electronic databases to identify relevant peer-reviewed studies encompassing the concepts of disability, healthcare services, rehabilitation, and healthcare structure in the DR. Data extraction from eligible studies were then performed to summarize and organize findings about disability and healthcare in the DR. In addition, the research team examined the most recent country-wide population/census data for relevant information.

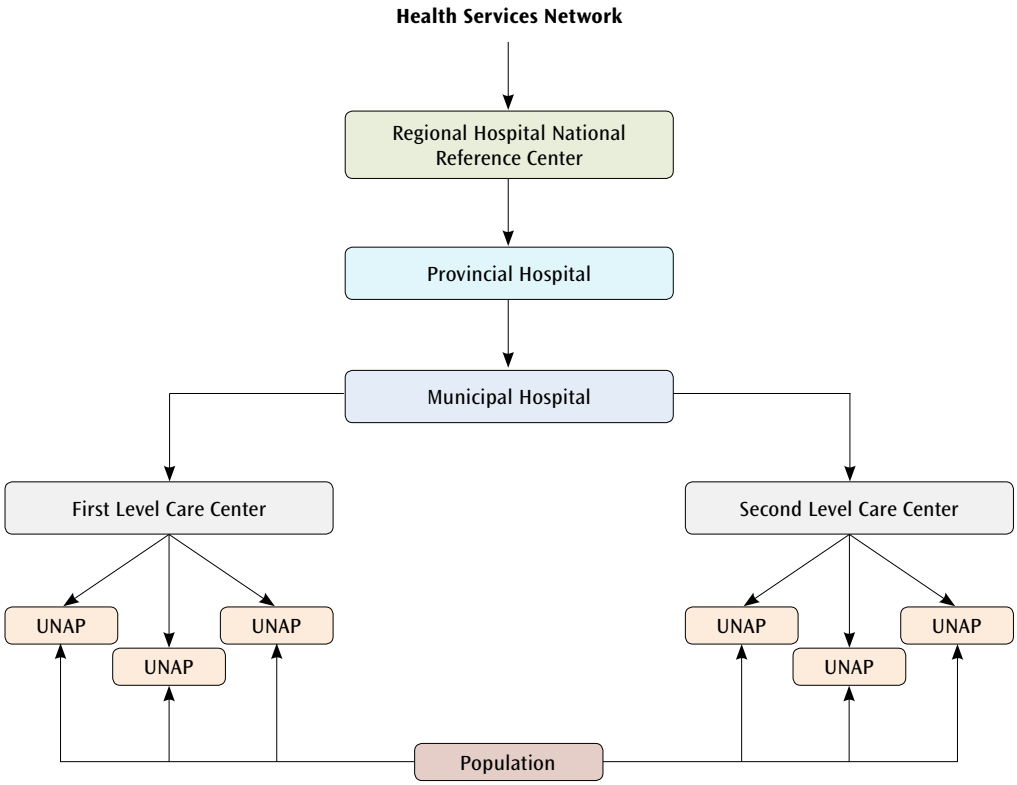

Figure 2. Health Networks in the Dominican Republic.
UNAP: Primary Care Unit.

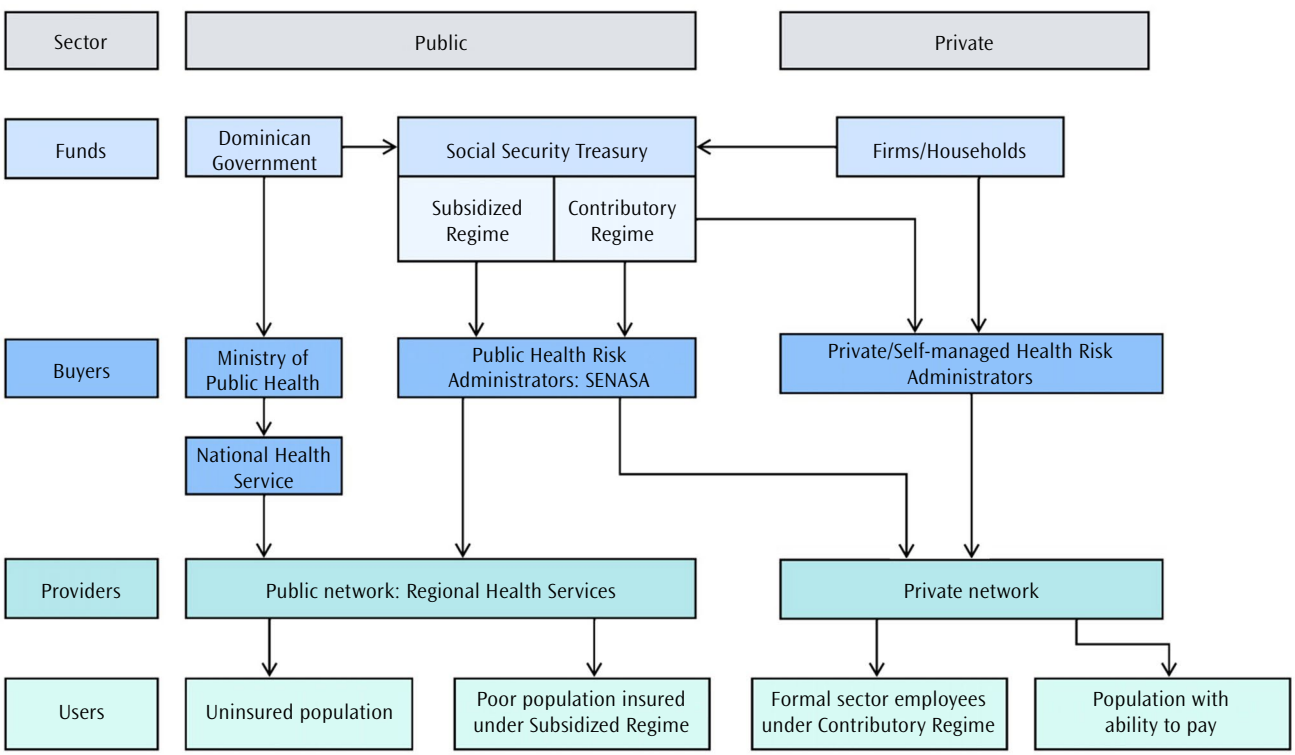

Figure 3. Public *vs.* Private Health Networks.

Keywords in both Spanish and English were also taken from the WHO's Rehabilitation 2030 Initiative, including "universal health coverage," "service delivery models," "rehabilitation financing," "rehabilitation services," and "public health."

This literature review also included information directly from DR governmental websites, SENASA and Sistema Único de Beneficiarios - Unified Beneficiary Identification System (SIUBEN).[20-22] The SIUBEN is an institution of the DRs government and attached to the Cabinet of Coordination of Social Policies. The role of SIUBEN is to identify and prioritize families in need of social assistance to ensure their access to the programs and monetary subsidies according to their socioeconomic status.[20]

Finally, the authors utilized Google Translate to translate articles and websites from Spanish into English which were then verified by the Spanish speaking lead author. Websites, articles, census data, and other sources of information were prioritized if they were from within the past five years in order to make sure the information was timely and accurate.

RESULTS

In 2022, SIUBEN released results of a major population survey from 2018 revealing that 7.3% of the population surveyed over the age of five lived with some type of disability.[20] Of those surveyed, 7.1% self-reported having a severe disability, 23.8% reported a moderate disability, and 69.1% reported having a mild disability (Table 1).[20] Among those with disabilities, 50.8% were unable to walk, 40.1% could not perform personal activities, and 25.7% were unable to speak.[21] The leading cause of disability included ischemic heart disease, stroke, diabetes, and road injuries (Table 2).[23]

The Quality-of-Life Index (QLI) revealed 56.2% of individuals living in extremely or moderately poor households had a family member with a severe disability.[21] Additionally, 66.9% of individuals with disabilities were unable to work, with 42.5% lacking access to public transportation, and 33.5% facing barriers to healthcare services.[21]

Table 1. Disability by severity

Distribution of respondents, according to severity of disability		
Severity of disability	People (n = 464,795)	%
Mild	321,173	69.1
Moderate	110,621	23.8
Severe	33,001	7.1
Total	464,795	100

Table 2. Leading causes of disability[23]

Rank	Causes of DALYs	% Increase 2011-2021
2	Ischemic heart disease	+ 40.2
3	Stroke	+ 28.1
4	Diabetes	+ 53.7
6	Road enjury	+ 2.88

DALYs: Disability-adjusted life years.

DISCUSSION

Our findings highlight both national trends and the urgent need to strengthen rehabilitation services within the DR's healthcare system. A significant proportion of households reported at least one family member living with decreased mobility, personal care limitations, and/or speech impairments.[21] The leading causes of disability, ischemic heart disease, stroke, diabetes, and road injuries, underscore the growing burden of non-communicable diseases (NCDs) and preventable diseases.[23] Key risk factors such as malnutrition, hypertension, high glucose levels, and obesity, further emphasize the need for early intervention and long-term rehabilitative care.

The national data from SIUBEN identified significant economic barriers to healthcare and support services, particularly for families living in poverty. Many households struggle to meet basic food needs and require social protections, while high transportation costs and geographic limitations further restrict their ability to seek necessary care. These barriers disproportionately affect individuals with disabilities, with 85.5% of individuals with physical or motor impairments reporting unemployment, compared to only 30% of those without disabilities.[22] This exclusion from the work force, combined with the increased expenses associated with disability, exacerbates financial strain and limits access to essential rehabilitation services.

Table 3. Recommendations for rehabilitation using rehabilitation 2030's strategic

Rehabilitation 2030 Strategic Approach[7]	Recommendation/PGC
1. Rehabilitation should be available for all the population and through all stages of the life course	The PGC posits "guarantee[ing] care, rehabilitation, prevention and promotion services that achieve the reduction of morbidity and lethality, pregnancies in adolescent population, maternal and infant mortality, mortality and consequences of traffic accidents." In addition, they state the need for prioritizing employment for the disabled and regulating inclusion in payrolls, which would provide more people with disabilities access to health insurance through their occupations and throughout the lifespan.[22] Given the robust community health clinic (UNAP) presence in the DR, community-based initiatives to promote rehabilitation could be utilized to improve public knowledge and access.
2. Efforts to strengthen rehabilitation should be directed towards supporting the health system and integrating rehabilitation into all levels of health care	Given this structural framework of national healthcare under SRS that has been successfully implemented in the DR, the inclusion of rehabilitation medicine addition to the SRS could be implemented at all levels with great potential for improved health outcomes. This could include multi-disciplinary teams as both a part of the care team and in making appropriate referrals to rehabilitation and to address the complex and diverse needs of patients throughout their recovery. The authors suggest the following additions to the current SRS structure (Table 4).
3. Rehabilitation is an essential health service and crucial for achieving universal health coverage.	Within healthcare, it states the need for universal health coverage as described in the National Development Strategy 2030's objective to "guarantee a universal, unique and sustainable Social Security system against the risks of old age, disability and survival, integrating and making transparent the existing segmented regimes" (translated).[22]

PGC: Programa de Gobierno del Cambio.

Table 4. Integrating rehabilitation into existing levels of healthcare

1	**First level:** Primary health centers (UNAPS) would include outpatient rehabilitation therapy services such as PT, OT and SLP and direct referrals to physiatrists at second level facilities.
2	**Second level:** Specialized facilities would include physiatrists for 1:1 patient consultation, following the team recommendations for inclusion of other specialized physicians (i.e. neurology, cardiology) as available. In addition, physiatry would be consulted for all cases requiring rehabilitation follow-up. Specialized care centers would include a rehabilitation space including PT, OT, and SLP.
3	**Third level:** Regional and specialized hospitals would include acute and in-patient rehabilitation services for cases of greater complexity.

PT, physical therapy; OT, occupational therapy; SLP, speech-language pathology.

The increasing disability-adjusted life years (DALYs) lost to NCDs and injuries further reinforce the necessity of a strong rehabilitation component within the healthcare system. A well-structured rehabilitation framework can help individuals maintain mobility, reduce impairment, and improve their overall quality of life. To address these challenges, the DR must prioritize rehabilitation as an essential healthcare service, ensuring equitable access to care and support for individuals with disabilities across all levels of the healthcare system.

The National Multi-Year Public Sector Plan (PNSP) was created as part of the DR's 2021 Government Change Program (Programa de Gobierno del Cambio/PGC) within the government's Department of Economy, Planning, and Development.[24] This plan provides objectives for improving a multitude of public services including water, electricity, access to justice, and healthcare.[24] This blueprint can be systematically applied to the three missives in the strategic approach listed in Rehabilitation 2030 to address both the DR's need for - and current healthcare system's potential to address - unmet rehabilitation needs in the country.

To effectively implement the WHOs Rehabilitation 2030 Initiative in the DR, strategic measures must be taken to integrate rehabilitation services into the national healthcare framework (Table 3). First, expanding access to rehabilitation by incorporating it into broader healthcare efforts, along with prioritizing employment and payroll inclusion for individuals with disabilities,

would improve long-term health and economic stability. Second, leveraging the existing structure of the SRS to integrate rehabilitation medicine at all levels - primary, secondary, and tertiary - would improve patient outcomes and accessibility (Table 4). Finally, ensuring universal health coverage for rehabilitation services within a unified and sustainable Social Security System would provide comprehensive protection for individuals facing disability, aging, and other long-term health conditions. By adopting these recommendations, the DR could strengthen its healthcare system and improve rehabilitation access.

In conclusion, the resolution of complex global health problems requires interdisciplinary, collaborative expertise and communication from governmental, non-governmental and educational agencies.[22] Rehabilitation is an increasingly important healthcare service considering aging populations and the rising prevalence of NCDs across the world. Rehabilitation is crucial in addressing only health, but also economic outcomes. Scarcity of rehabilitation from injuries or other catastrophic events lead to fewer people able to return - or return in their previous capacity - to work, resulting in individual, family and country-wide economic consequences.[25] Furthermore, as access to healthcare interventions expands, rehabilitation is needed to maximize their effectiveness and impact. Despite this, the need for rehabilitation greatly exceeds its availability in many countries. Due to current health trends and the widespread under-prioritization of rehabilitation globally, these unmet needs are likely to increase. Therefore, further prioritization of rehabilitation within the health sector is urgently needed to meet the needs of millions of people around the world.

Declaration of Conflicting Interests

The authors declare that there are no conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Author Contributions

S.P., R.B.: Idea/concept, design, control/supervision, critical review, references and fundings; S.P., R.B., S.T., I.M.: Data collection and/or processing, analysis and/or interpretation, literature review, writing the article, materials

Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

AI Disclosure

The authors declare that artificial intelligence (AI) tools were not used, or were used solely for language editing, and had no role in data analysis, interpretation, or the formulation of conclusions. All scientific content, data interpretation, and conclusions are the sole responsibility of the authors. The authors further confirm that AI tools were not used to generate, fabricate, or 'hallucinate' references, and that all references have been carefully verified for accuracy.

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