Rehabilitation: quantity and quality will count

Cardiac rehabilitation has historically been an underdeveloped service in the UK. It is now recognised as an essential component in the management of heart disease and will shortly encompass those at risk of developing cardiovascular disorders. This development may necessitate a change in ethos, as well as a change in name for many organisations involved in this aspect of healthcare. This has been exemplified by the inclusion of 'prevention' in the title of the main European clinical journal of the specialty.

Rehabilitation programmes are essentially structured around exercise classes, although multidisciplinary interventions, from dietary instruction, relaxation therapy and educational sessions, are an inherent part of the accepted process of rehabilitation. Rehabilitation can improve cardiovascular outcomes following acute infarction and revascularisation, with improvements in mortality that approximate those that can be achieved with traditional pharmacological treatments, such as aspirin and beta-blockade. This data has been accepted widely and justifiably used to promote universal expansion of rehabilitation to all areas where patients with cardiovascular disease are diagnosed and, by extension, to include provisions for individuals detected to be at risk of developing heart disease. It is important to note, however, that a large proportion of programmes are very unlikely to reach the frequency of exercise sessions, the intensity of training or the duration of rehabilitation treatment that was characteristic of the studies which contributed to the meta-analyses that demonstrate the much quoted > 20% mortality reduction.

Rehabilitation in primary prevention

The interventions that we believe to be effective in rehabilitation and secondary prevention are largely applicable to the area of primary prevention. There is therefore an attractive rationale behind combining services. There may be some pitfalls, which will require care to avoid. Services based around hospitals arose by necessity to cater for the original, rather narrow, application of exercise-based rehabilitation to patients after myocardial infarction. Extending the remit of rehabilitation to all patients with step changes in their coronary disease, to patients after revascularisation, to heart failure, and to congenital heart disease will produce a potentially huge pressure on existing programmes.

> ***'Cardiac rehabilitation will shortly encompass those at risk of developing cardiovascular disorders'***
>
> ***Malcolm Walker***
> ***President, BACR***

Commissioners of services are also aware that most programmes reach only a small proportion of patients who might benefit from attendance. It is inconceivable that another large group of patients populating a new waiting list (for rehabilitation) will be allowed to develop, with all the criticism and political pressure that would follow. A schism between what can and should be offered by the hospital sector versus what is best to be undertaken in primary care and the community must not be allowed to develop.

The requirement is for individualised programmes closely tailored to needs, since the evidence would support this as being the most likely way that long-term changes in behaviour will be achieved. The evidence is also that this will save lives in certain subgroups of patients, when intensive supervised multi-disciplinary programmes are begun in the hospital setting. Seamlessly progressing from one programme to another in the community and primary care would be the ideal for most patients. Some with milder manifestations of disease or recently documented high risk might be better served by directly accessing a local community ser-

vice. Thus close co-operation between the sectors is required, recognising that the same goal is being addressed by all.

The risk is that a limited budget for rehabilitation will be spread too thinly. Existing functional and successful programmes might be sacrificed in favour of less intensive community services perceived to be more inclusive and possibly less costly, particularly if provision becomes a divided responsibility between health services providers and local authorities. Those areas where hospital-based programmes are appropriate and successful need to examine their methods of access and any tendencies to exclusivity should be minimised; to do this barriers to referral will have to be addressed. It should be possible for primary care clinicians to refer directly into programmes for suitable patients, as much as it is expected that some secondary care patients should bypass hospital-based programmes to be referred directly for primary care and community rehabilitation. Successful models of care have been developed in several parts of the UK, where integration of provision and blurring of boundaries is being achieved, but they have in common dedicated professionals in rehabilitation leading the service and have been the beneficiaries of considerable investment to achieve their success.

Having succeeded in promoting rehabilitation and prevention away from the sidelines to the UK cardiovascular main stage, important challenges are presenting themselves. Existing services need the support of clinicians to ensure the interventions are sufficient and appropriate. Coordinating the many disciplines involved can be difficult but the potential benefits for our patients and for the population in general are huge and there for the taking.

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Br J Cardiol 2003;**10**:424–5