

Health and Justice: Value of Rehabilitation and Scope of Liability of Rehabilitation Workers*

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Rehabilitation is now covering a wider perspective to include any visceral disabilities which would include chronic illnesses including mental health, not only restricted to physical injuries. Rehabilitation can now be regarded as tertiary prevention, prevention of complications and further deterioration of existing chronic condition and restoration of usual functional capacity as far as possible; and quaternary prevention, prevention of complications of medical interventions. The scope of rehabilitative services is not only in the hands of particular specialties and healthcare professionals, to allow wider accessibility and affordability in achieving equity in health. Self-management and self-care, and patient empowerment programmes now also play an important part in rehabilitation, and the providers would go beyond the main stream healthcare professionals, such as physicians, nurses, physical therapists, and medical social workers. Introducing the concept of community health practitioners with basic training in health would play a critical role in supporting self-management, self-care, and empowerment which would be very time-consuming and costly if only relied on the main stream healthcare professionals. Revisitation of the concept of duty of care and definition of reasonable standard of care is warranted for the community health practitioners, so they have better understanding their scope of liability. As rehabilitation is a long term process, it is more than the physical process of treatment. Psychosocial rehabilitation is very much needed to support the patients and care-givers to manage the chronic conditions in community setting. This paper will discuss the credentials of community health practitioners and the issue of liability involved in rehabilitation particularly in community setting. This would enable them to play a greater role to fill in the gaps of services which might not be fully covered by the main stream healthcare professionals. Chronic illnesses now pose greatest health burden globally and the value of rehabilitation should cover wider perspective of health to address the needs of care in community. Universal health coverage should include community-based rehabilitation to focus on addressing the psychosocial perception and self-efficacy in chronic disease management in achieving justice and equity in health.

Keywords: community-based rehabilitation, health equity, health justice, community health practitioners, standard of care, liability

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Introduction

The context of health care has changed and a systematic review in 2001 estimated that 45% of global mortality and 36% of global disease burden were attributable to the joint hazardous effects of the 19 risk factors studied that were related to lifestyle and living environment (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). Systematic analysis of the Global Burden of Disease in 188 countries during the period 1990-2013 also identified behavioural, environmental and occupational, and metabolic risks accounting for half of global mortality and more than one-third of global daily average life years (DALYs) (GBD 2013 Risk Factors Collaborators, 2015). The International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12 provides that “The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (UN General Assembly, 1966). The Committee on CESCR General Comment 14 explains that “right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life extending to the underlying determinants of health” and CESCR describes the determinants of health including (not limited to):

- Adequate supply of safe food and nutrition;
- Housing;
- Access to safe and portable water and adequate sanitation;
- Safe and healthy working conditions;
- Healthy occupational and environmental conditions;
- Access to health-related education and information.

Maximizing health requires contributions from many sectors of society to tackle the determinants of health as described above. The health pyramid described by Frieden (2015) has shown improvement at the base of the pyramid generally improving health for more people at lower unit cost (see Figure 1). At the base of the pyramid are socio-economic factors, such as income, education, housing, and race and immediately above are traditional public health interventions changing the context to make default decisions the healthy choices (e.g., access to health related education and information, raising health literacy). Therefore, public health needs to focus on denominators to have higher proportion of people obtaining benefit from health intervention. Analysis of ecology of healthcare by Green, Fryer, Yawn, Lanier, and Dovey (2001) has reviewed that hospital care including the specialist out-patient clinics is only the tip of iceberg covering much less than 10% of population. Future ecology of health care should focus on self-management making default decision being healthy and healthcare provision should be close within the context of daily living of people with long-term and continuing care to allow co-ordination of care addressing socio-economic factors, enabling healthy decision-making and long-lasting protection (Lee, 2020).

Tertiary prevention is prevention of further deterioration of health condition and restores usual functional capacity as far as possible. Rehabilitation is to assist individuals experiencing or likely to experience disability, to achieve and maintain optimum functioning in interaction with their environments (World Health Organization [WHO] & World Bank, 2011). Rehabilitation should cover a wider perspective to include any visceral disabilities including chronic health conditions also mental health, not only restricted to physical injuries, so it should include empowerment for self-care and self-management.

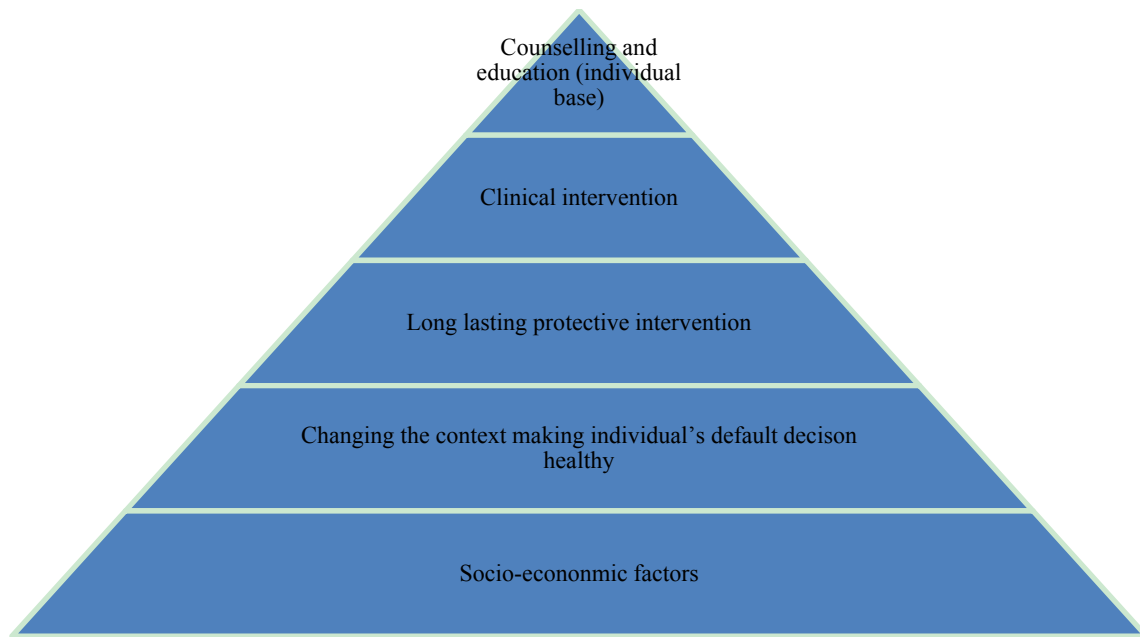


Figure 1. Health pyramid (Source: Frieden, 2015).

Governments should strengthen or create a legal framework, such as a constitutional or statutory right to health, to ensure rights-based universal health coverage on the basis of principles of equity and non-discrimination for rehabilitation services. This includes affordability, financial protection, transparency, accountability, participation, privacy, and sustainable financing. Taken reference from Almost All Questions Answered (AAQA) Framework (Global Health Workforce Alliance [GHWA] and WHO, 2014), the essential elements should consist of 5As:

- Availability—public health and basic healthcare facilities, goods, services and programmes.
- Accessibility—non-discriminative, without barrier, right to seek, and receive health information.
- Affordability (economic accessibility).
- Acceptability—sensitive to culture, gender, and life-cycle requirements.
- Assurance of quality—skilled healthcare personnel, quality healthcare facilities, evidence-based healthcare practice, safety.

Chronic illness is major global health burden (GBD 2013 Risk Factors Collaborators, 2015; Hajat & Kishore, 2018; Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). Multimorbidity, the presence of two or more non-communicable diseases (NCD), is a costly and complex challenge for health systems globally and it is important to recognise the need for better equity and financial protection as well as pattern of service delivery (Sum, Hone, Atun, Millett, Suhrcke, Mahal, Koh, & Lee, 2018). To ensure their rights to access rehabilitation services for better management of their chronic health conditions, it is important to come up with a model for cost effective delivery of the services including the rational deployment of different levels of healthcare workers to maximise the resources and assurance of quality of care.

Scope of Rehabilitative Services

Rehabilitation should not only be regarded as tertiary prevention, but also quandary prevention, prevention

of complications of medical interventions; and secondary prevention identifying those with chronic illnesses at risk of hospital admission as well as primary prevention empowering the population health. In a book review by Rosenbaum (2019) on the book *Restoring Voice to People With Cognitive Disability: Realising the Right to Equal Recognition Before the Law* by Anna Arstein-Kerslake (2017), it has highlighted that social model of disability has supplanted the outdated medical model but it does not deny the medical treatment or interaction with medical professionals. One should view disability as caused by society and environment that creates barriers, rather than by a physical or mental impairment that needs to be treated, cured, or rehabilitated. The book provides a discussion of the importance of decision-making and the ways in which it is currently denied to people with cognitive disability and it identifies the human right to equal recognition before the law as the key to ensuring the equal right to decision-making of people with cognitive disabilities (Arstein-Kerslake, 2017). Looking to the future, it also provides a roadmap to achieving such equality.

Rehabilitation for patients with chronic illnesses often involve multiple health problems and the complexity of multi-morbidity requires more than an “*assess-and advise*” model of care as those patients will need to have professional inputs from different disciplines according to their needs and clinical circumstances (Lee, 2020). It is not the question which specialists the patients need, and it should be comprehensive and holistic care with good co-ordination is essential to help patients navigating complexity. Patient-centred care is needed to support patients adopting behaviours across a wide range of lifestyle factors for management of their underlying conditions, but there is little guidance as to how to achieve these recommendations. Greene and Yedidia (2005) had outlined the key elements for patients to manage their chronic health conditions:

- Offer them understandable explanations;
- Respect what patients say;
- Involve them in making care plan;
- Given them choices;
- Help them to solve problems occurring in caring their illness;
- Encourage them to learn about illness;
- Helping them to make changes in lifestyles;
- Spend sufficient time during consultation;
- Available during an urgent episode;
- Help them to feel able to take care of themselves.

Raising self-efficacy is important for adoption of health behaviours, in the change of detrimental habits, and in the maintenance of change (Bandura, 1992). An Australian qualitative study has suggested that patients of chronic illnesses construct their own individual self-management and self-care programme springing from an important emotional base (Furler, Walker, Blackberry, Dunning, Sulaiman, Dunbar, Best, & Young, 2008). Patient’s inability to adhere to the treatment regime is grounded in psychological and motivational rather than education factors (Minet, Møller, Vach, Wagner, & Henriksen, 2010). Self-management programmes need to grasp the psychosocial and emotional needs involved in making a meaningful life with chronic illness (Roger, 2006; Walker, Peterson, & Millen, 2003), and this might explain the small improvement in health outcomes of many lay or peer-led programmes in the past (Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001) and calling for a new approach with deeper engagement of patients and peer led support.

Raising self-efficacy and enhancing skills for self-care and self-management are important components for rehabilitation of patients with chronic illnesses. For effective delivery of services for rehabilitation, empowerment of patients and care-givers in community setting is very much needed. Study has shown that those patients with relatively good self-management behaviour and ability in self-care would benefit from patient empowerment programme for chronic disease management (Cheung, Chan, Hung, Leung, Lee, Chan, Chung, Poon & Chan, 2017). The study has also identified that enhancing risk perception would facilitate the uptake of patient empowerment programme. The Stanford Model of Chronic Disease Self-Management Programme (CDSMP) is developed by Dr. Kate Korig and colleagues at Stanford University Patient Education Research Centre with the contents and structural design from patients' perspectives shifting the focus of outcomes from predominately bio-medical markers, such as HbA1c for diabetic patients to provision of help to patients in day to day living with chronic conditions, e.g., choosing healthy food, managing pain (Lorig, Holman, Sobel, Laurent, González, & Minor, 2012). Community-based rehabilitation (CBR) would be the way forward for rehabilitation and it should focus on addressing the psychosocial perception and self-efficacy in chronic disease management. CBR needs to be better defined and the manpower involved should be studied for large scale implementation.

Community-Based Rehabilitation

The Hong Kong Society of Rehabilitation developed Community Rehabilitation Network (CRN) to pilot CBR. The aim is to enhance patients' capacity for active involvement in the rehabilitation process and promoting self-help and an inclusive society (Poon, So, & Loong, 2014). The services of CRN then became a sub-vented programme by the Social Welfare Department as a regular social service provision leading to a big step to facilitate patients managing their chronic health conditions in a community setting. It is in line with the guidelines of CBR programmes of WHO as the aims are to enhance the quality of life for people with disabilities and their families to meet the basic needs and ensure inclusion and participation (WHO, 2008). The services of CRN in delivering CBR have been shown to be effective and meeting the needs of people with chronic illnesses (Lee et al., 1999). CBR is using community resources to enhance the quality of life of chronically ill patients and their families through the following approaches (Poon, So & Loong, 2014; Lee, 2014a; 2014b):

- Chronic care model being patient-centered based on individual needs (physical and psychosocial and environmental) and intensive co-ordination of care to ensure care across the continuum, secondary (identification patients at risk of re-admission) and tertiary prevention (prevention of complications).
- Promotion of self-help and mutual support, self-care-the people with chronic conditions experience to take up the peer worker role in chronic disease self-management.
- Patient empowerment—healthcare, semi-healthcare, social care professionals to be further equipped to be health educator and coach role, self-efficacy (Lee et al., 2011).

Psychosocial rehabilitative services designed for emotional well-being and support to promote patient self-help group emphasizing collaborative effort can help patients and their carers to acquire the knowledge, skills, and confidence in managing their conditions (Bodenheimer, Lorig, Holman, & Grumbach, 2002). The concept of patient-centred medical homes, which are redesigned primary care practices, can focus more on preventive care, patient education, and care coordination between different healthcare providers (Calsyn & Lee, 2012). It is time to revisit those who are the healthcare providers for patient-centred particularly for raising

self-efficacy, self-management, empowerment of patients and carers and psychosocial rehabilitation. It would escalate the health care expenditure if different healthcare professionals are involved. It should adopt case management approach that the supportive services can be delivered by another tier of health care practitioner, “community health practitioners” (CHP) with post-secondary education in health study not reaching the level of nursing and allied health professionals. Jesus, Landry, Dussault, and Fronteira (2017) had revealed the needs-based shortages and lack of access to rehabilitation workers, particularly in lower income countries and in rural/remote areas. The paper also suggests to ensure the study of a whole rehabilitation workforce (i.e., not focused on single professions), including across service levels. This would enable community approach for service delivery to people with multiple needs associated with disability through case management (Lou, 2014).

From static perspectives, case management is process of co-ordination and management of care across different systems both formal and informal (Lee et al., 1999). The dynamic process will include assessment, individual care plan, care plan implementation, evaluation and monitoring, re-planning, and re-adjustment of care delivery (Lou, 2014). Changes can be induced by changing conditions of patients, changing environment, changing of family circumstances. Both formal and informal systems are needed in case management. Formal system includes co-ordination with main stream healthcare professionals and other related professionals from health care system, such as doctors, nurses, allied health professionals, health administrators, etc., and social care system, such as social workers, social security officers, housing department officials, rehabilitation service providers, volunteer services, emotional support services, etc. The informal system covers family members, domestic helpers, neighbours, etc. It is important to think seriously to enhance the role CHPs to bridge the formal and informal systems for holistic and continuing care for patients with chronic illnesses.

The Role of Community Health Practitioners as Frontline Rehabilitation Workers in Case Management

Case management is closely related to manage resources. Most of the service provision team has fixed manpower, so care and resource management needs to be achieved within a whole team. Case mix at particular time will determine how much care can be allocated to each case within a service team, e.g., cases discharged from hospital would need more intensive care with heavier load to the team. Community health practitioners (CHP) again play an important role in managing those stable cases to allow professional staff to focus on new cases just discharged from hospital.

One of the key reasons for the high level of health care spending and its rate of growth is the predominance of the fee-for-service payment system, which rewards quantity over quality, especially for high-cost, high-margin services as the system does not encourage low-cost, high-value services, such as preventive care or patient education even though they could significantly improve patients’ health and lower health care costs throughout the system (Calsyn & Lee, 2012). The cost of CBR will be very high if it only relies on main stream healthcare professional services, such as physicians, nurses, physiotherapists (PT), occupational therapists (OT), and medical social workers (MSW). Many patients with poorly controlled chronic health conditions, such as diabetes or heart failure could be managed with better preventive disease management, which would eliminate the need for costly hospital stays.

Areas of expertise and skills needed for successful teams in managing serious illnesses include pain and

symptom management, expert communication capabilities, and assessment and remediation of the social contributors to ill health and suffering (such as food insecurity), and teams should be about self-care, resilience, and learning from each other to enhance skills and improve the team's long-term capacity to provide support to seriously ill people (Cohn et al., 2017). The team requires an interdisciplinary team to include persons apart from physicians, nurses, social workers, rehabilitation specialists, such as chaplains, home health aides, community health workers, and others. The team should be intentional about self-care, resilience, and learning from each other to enhance skills to provide support to seriously ill people.

Kendall, Muenchberger, and Catalano (2011) identified 10 competencies as highly important to community rehabilitation (CR) practice which would be reference for CHP. Three competencies were rated as being the most important to CR practice, namely consumer engagement (i.e., understanding consumer preferences, enabling consumer control over their rehabilitation, and engaging consumers in the process); reflective practice (i.e., understanding the role of the CR practitioner in the rehabilitation process, highlighting the need to be creative in the use of resources, planning and prioritizing using local solutions, and adopting a flexible approach to problems); and a holistic focus (i.e., recognizing that consumer needs extend beyond immediate physical health issues, and incorporating social and emotional health in any response). Practitioners rated themselves as being competent in these "important" areas but less competent in areas, such as service continuity, systems advocacy, frameworks for understanding, or community engagement.

The core competencies for all healthcare professionals as described by the Institute of Medicine (IOM, 2003) include: patient-centred care, teamwork and collaboration, evidence-based practice, quality improvement, and informatics. The role of CHP is mainly on helping patients during the recovery phrase of chronic disease management. Taken reference from IOM (2003), study by Kendall et al. (2011) and areas of expertise and skills by Cohn et al. (2017), Table 1 summarises the credentials of CHP.

Table 1

Credentials of Community Health Practitioners

1. Acquiring skills to empower respective clients in self-management of common chronic conditions, performing health assessment and interpreting basic findings, and relieving their stress or anxiety due to chronic conditions. 2. Supporting patients to follow and maintain health advice and instruction given by healthcare professionals by overcoming their difficulties in home environment, to ensure prescribed advice or treatment regime is properly executed and CHPs do not provide new health advice and instruction. 3. Referring the patients back to healthcare professionals for consultation in case of doubt or changes of conditions. 4. Knowledge enrichment to identify cases with medical emergency and cases requiring further medical investigation or intervention so that CHPs can act as co-ordinator in maintenance care, assisting cases to get appropriate support to achieve quality maintenance care in the community.

CHPs are more involved in engaging the users (patients and care-givers) in self-care and building resiliency to solve their problems, mobilising resources and creating innovative and flexible approaches, providing psychosocial care and patient-centred approach, and engagement in team work. The capability of CHPs is more than health volunteers and possesses basic health knowledge and health management skills (see Table 2). CHPs would facilitate the affordability, availability, accessibility, and acceptability if they possess the credentials as described early on. CHPs can be regarded as junior level of healthcare professionals especially in CBR. They fulfil most of the components of AAQA Framework (GHWA and WHO, 2014) and 5As. The next question will be on quality assurance and implication of clinical liability upon them.

Table 2

Differences Between CHE and Ordinary Volunteer in Supporting Patients

Capability and background	CHE	Ordinary volunteer
1. Nominated by NGO with strong commitment to serve patients	Yes	Not known
2. Equipping with skills for effective patient communication	Yes	Not known
3. Conducting simple health assessments and measurements	Yes	Not known
4. Mobilising other community resources to support patients	Yes	Not known
5. Interpreting basic medical findings	Yes	No
6. Supporting patients adhere to health advices prescribed by professionals	Yes	No
7. Identifying conditions requiring further medical consultation	Yes	No
8. Referring patient to appropriate health professionals when necessary	Yes	No

Liability of Community Health Practitioner in Community-Based Rehabilitation

In delivery of healthcare services to users, clinical liability will be imposed and the practitioners will be alleged to be negligent in their practice if not meeting the standard required. For main stream healthcare professionals, like physicians, nurses, OTs, PTs, and MSWs, they have established professional standards and code of practice. Code of practice and credentialing can be established for CHPs, so quality assurance and risk management should be taken into account.

Code of Practice and Credentialing for CHP With Regard to Duty of Care

For successful action in negligence, the claimant must establish (Jones, Dugdale, & Simpson, 2017):

- The existence of a duty of care situation;
- Breach of that duty;
- Causal connection between the defendant's careless conduct and the damage;
- That the damage was not so unforeseeable as to be too remote.

The existence of duty of care requires special relationship and the requirements for special relationship are (*Hedley Byrne & Co Ltd v Hellers & Partners Ltd* [1964] AC465):

- A reliance by the plaintiff on the defendant's special skill and judgment;
- Knowledge, or reasonable expectation of knowledge on the part of the defendant, that the plaintiff was relying on the statement;
- It was reasonable in the circumstances for the plaintiff to rely on the defendant.

The three-pronged test determining duty of care will be (*Caparo Industries Plc v Dickman* [1990] 2 AC 605):

- Whether the damage was reasonably foreseeable;
- Whether the relationship between the plaintiff and the defendant could be characterised as one of "proximity" or "neighbourhood";
- Whether the situation was one in which the court considers it fair, just and reasonable to impose a duty of the given scope upon the defendant.

Consideration of the three requirements involved value judgments and it was necessary to take a holistic view of foreseeability, proximity and the need to be satisfied that it would be fair, just, and reasonable to impose a duty of care. Tables 1 and 2 have provided descriptions of the roles and duties of CHPs. As junior level of

healthcare practitioners, they are mainly involved in helping patients to maintain health advice given by senior health professionals, such as physicians, nurses, OTs, PTs and MSWs and empowering patients and family members in self-care and self-management. They are involved in simple assessment of patients and interpretation of basic medical findings. They are only expected to have basic knowledge and skills in first aid to identify patients at risk for consultation with senior healthcare professionals. CHPs are more engaged in communicating with patients to identify their needs, mobilising community resources to support them in community and providing psychosocial support. CHPs will not be involved in diagnosis and initiate management plan for patients. Their respective clients should be well informed the roles and duties of CHPs and should rely on them to play supportive role and as anchor persons to healthcare professionals rather than relying on them to provide diagnosis and treatment.

The previous sections have highlighted the gaps in CBR and we need to have additional manpower resources to fulfil the AAQA framework (GHW and WHO, 2014) for better care in community for patients with chronic illnesses. Introducing the concept of CHPs would help to fill in the service gaps meeting the needs of population at the bottom of health pyramid (Frieden, 2015) delivering low-cost and high-value services. The senior healthcare professionals would mainly deliver services on the top level of health pyramid, such as clinical intervention and individualised counselling and management (Frieden, 2015). There are concerns of the liability of CHPs in delivering services to their respective clients. However, their duty of care is mainly confined to raising their clients' self-efficacy, enhancing their knowledge and skills in self-care and self-management by reinforcing the management plan and advice by senior healthcare professionals, and providing them psychosocial support including resource mobilisation, and facilitating those at risk to senior healthcare professionals. Therefore, CHPs will not be engaged in clinical decision with immediate and direct risk to their respective clients. Although CHPs have special relationship with their clients, it lacks the proximity for any damage due to their acts with their roles and duties. CHPs assess whether the self-management skills have been transferred to patients and not the assessment of severity of illnesses and initiate treatment. It is not fair, justifiable and reasonable to impose duty upon CHPs for damage if they are not directly accountable for the clinical decision. The standard of care of CHPs should be confined to their roles and duties according to their credentials.

Standard of Care for CHPs: Quality Assurance and Risk Management

The orthodox approach to the standard of care at common law was “*Bolam* test” stating that

a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of a medical men skilled in that particular art.... merely because there is a body of opinion that would take a contrary view. (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 586)

The *Bolam* test defines standard of care as medical judgement and might not be applicable to define standard of care for CHPs. In Australia, the common law test takes reference from *Rogers v Whitaker* (1992) 175 CLR 497 at 487,

...standard of care to be observed by a person with some special skill or competence is that ordinary skilled person exercising and professing to have that skill.... But, that standard is not determined solely or even primarily by reference to the practice followed and supported by a responsible body of opinion in the relevant to the practice followed or supported by a responsible body of opinion in the relevant profession or trade....

The Ipp Report (2002) Recommendation 4 has stated: “reasonably be expected of a person professing that skills with regard to relevant circumstances at that time”. Further clarification in Ipp Report (2002) Recommendation 3 clarified: “a profession does not incur a liability in negligence arising from the provision of a professional service if it was widely held by a significant number of respected practitioners in the field, unless the court considers irrational”. The Recommendation 3 of the Ipp Report has been enacted in similar although not identical in all Australian States except Northern or Australian Capital Territory, the *Civil Liability Act* 2002 (NSW) s5O(1)(2). Under s5O(3)(4) states: “Different widely accepted peer professional opinions does not prevent any one or more or all being relied on and peer professional opinion does not have to be universally accepted to be considered widely accepted”.

In *Hope v Hunter and New England Areas Health Services* [2009] NSWDC 307, irrational should be focused on practical nature of risk and referring to reasons being illogical, unreasonable and based on irrelevant considerations.

...[I] do not construe *irrational* to mean without reasons.... Rather I construe it to refer to reasons that are illogical, unreasonable or based on irrelevant considerations.... The focus should be on the practical nature of the risk that attracted the duty of care and consideration of patient safety...concern potential intra-operative harm if reasonable precautions against the foreseeable risk of harm are not reasonable taken.

CHPs should be not asked to perform the duties that should be performed by more senior health professionals as stated in *Civil Liability Act NSW* 2002 s 5Q(1).

The extent of liability in tort of a person (*the defendant*) for breach of a non-delegable duty to ensure that reasonable care is taken by a person in the carrying out of any work or task delegated or otherwise entrusted to the person by the defendant is to be determined as if the liability were the vicarious liability of the defendant for the negligence of the person in connection with the performance of the work or task.

Proper delegation of duties to CHPs would minimise liability imposed on them. In *Shakoor v Situ* [2001] 1 WLR 410 has stated that an alternative practitioner prescribing remedy ought to take steps to satisfy no adverse report. As long as the CHPs do not deviate from the advice and management plan by the senior healthcare professionals, they have provided reasonable care.

Healthcare providers can organise how they deliver the services to meet the basic needs of patients. Patients cannot always expect care to be delivered by senior healthcare professionals although they are entitled to receive basic care not falling below minimum standard. In *Bull v Devon AHA* [1969] 1 QB 428, court attempted to draw a distinction between the hospital's duty to provide minimally required adequate treatment for which it could be liable in negligence, and its freedom to choose how to organise its services within the limited resources. Mrs. Bull was not entitled to expert obstetrician to be immediate available but waiting for an hour falling below minimum standard. If the registrar (specialist in training) had arrived within 10 minutes, the claim would have probably failed.

The whole healthcare delivery should be managing what is foreseeable. In *Gracia v St Mary's NHS Trust* [1993] Med LR 117 (CA), it had taken 30 minutes for the on-call cardio-thorax registrar to arrive at Mr. Gracia's bedside after losing conscious following cardiac surgery and delay was not held to be negligent.

The whole system has to be framed to deal with which is reasonable foreseeable. I do not take the view that the whole system has to be framed to deal with possibility that a rare occurrence will happen...the duty to Mr. Gracia co-exists with a number of duties....

As long as CHPs are involved in supporting the patients and care-givers to follow the health management plans, they have fulfilled their duty of care and met the standard expected. They should not be held liable for occurrence of unexpected events that are not foreseeable. Healthcare providers should develop rational deployment of manpower resources to meet the required needs but cannot guarantee always accessible to senior health professionals. This would pose the issues of availability and affordability and care would not be accessible at the end. Even though the services of senior healthcare professionals are available and accessible, the cost cannot allow unlimited services in terms of time and depth of the services and it raises the issues of acceptability and quality. It would serve better interest of patients if the services of CHPs can be readily available and accessible so patients would receive minimal required services rather than NO services.

Equity and Justice in Health for Chronic Care

The chronic care model should cover the different levels of intervention as described in health pyramid by Frieden (2015) in Figure 1. Most main stream health care professionals are trained in the acute medical model of care with doctor-centred approach and contribution from patient's perspectives is very little. They mainly cover the top levels of health pyramid which is the professional is to meet the medical agenda to improve specified outcomes (glycaemic control and blood pressure). Although technical targets are important, they are unlikely to be satisfied if psychosocial aspects are not addressed. Those with psychosocial problems, such as depression, anxiety, and social isolation as depression is commonly present in patients with coronary heart disease and is independently associated with increased cardiovascular morbidity and mortality (Lichtman et al., 2008). Davidson (2012) had revealed that depression diagnosed or simple self-reported, continues to mark very high risk for a recurrent acute coronary syndrome or for death in patients with coronary heart disease. Four common psychological conditions (depression, anxiety, stress, and insomnia) are also found to comorbid with coronary heart disease (Davidson, Alcántara, & Miller, 2018).

The "contract" between patient and carers in chronic disease management is markedly different from acute situations. It needs to be explicit, negotiated and modified in response to various life and disease events. The outcome measurement should include whether patients and/or family have mastered the skills in self-care. Evidence has shown if the professionals remain in control, the outcome are worse as substantial proportion of patients would still expect their health to be responsibility of medical team rather than their own control (Kaplan, Chadwick, & Schimmel, 1985). Admission to hospitals, exercise demands to review results of investigations would erode patient's feelings of self-control. Curative aspect of medicine cannot effectively tackle the health burden which requires rehabilitation, health promotion, and self-care.

The programmes for rehabilitation are designed and delivered by team of healthcare professionals from different disciplines. The trans-disciplinary approach would enable sharing and transfer of knowledge and skills across disciplinary boundaries with patient-centred approach. All relevant healthcare professionals are involved at initial stage delivering clinical interventions and counselling for individual needs, the top levels of health pyramid (see Figure 1).

Physiotherapists would design the content of physical therapy; the social workers would provide services on psychosocial perspectives, such as skills in management of stress and anxiety, positive thinking; occupational therapists would help patients to adopt to usual daily activities and back to work if possible; nurses would focus

on day to day care of the chronic conditions including self-monitoring of symptoms and signs; and dieticians would focus on nutrition. However, only few professional members would provide the service across the whole patient journey as they are only accountable for areas related to their disciplines. They are not directly involved in the bottom levels of health pyramid (see Figure 1), such as changing the context making individual's default decision healthy and supporting the patients and family members to address the socio-economic perspective for better management of their chronic conditions. The presence of CHPs would help to overcome the existing professional boundaries to meet the multi-faceted needs of patients and care-givers with holistic care having patients at the centre of the care team.

Gostin (2014) had outlined the key determinants of global health equity to include:

- Universal health system;
- Essential public health services;
- Good governance;
- Human rights;
- Social determinants of health.

Equitable services for chronic disease management require good rehabilitation services with focus on community-based rehabilitation. Successful CBR needs to have good system of governance to include both main stream healthcare professionals as well as CHPs at junior level. Raising self-efficacy, empowerment of self-management and self-care, preventive care, patient education and psychosocial rehabilitation are the essential components of CBR and also fundamental part of public health services. In conventional healthcare delivery model, the rights to those services are always accorded low priority. The health pyramid (see Figure 1) has pointed out the importance of addressing socio-economic factors for health, so CBR should have strong focus on social determinants of health by mobilisation of community resources. The value of rehabilitation to support chronic disease management should support equity and justice in health.

Conclusion

The key roles of doctors, nurses, and allied healthcare professionals are clinical decision-making and formulation of management plan as they possess the special skills or qualifications for management of cases with disabilities and comparable with reasonable person with the relevant skill or qualification, and *reasonably be expected of a person professing that skills with regard to relevant circumstances at that time*. However, they should also need to take into account of the social model of caring disabilities *empowering* and *engaging* them in *choices and decision-making*, and *understanding of their material risks*. Community health practitioners need to *enable* the cases to comply with professional advice on management plan and *enhance* and *empower* them the skills in self-management. They should also help the cases and family members to *explore* possible resources in community to help them *navigating* the patients' journey.

Universal health coverage should include community-based rehabilitation to focus on addressing the psychosocial perception and self-efficacy in chronic disease management in achieving justice and equity in health. The value of rehabilitation should cover wider perspective of health to fill in the gaps of services which might not be fully covered by the main stream healthcare professionals. The service providers need to ensure a

good system of governance to ensure safety and health for both clients and employees with adequate supervision and support, and process of monitoring and evaluation for quality assurance.

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