1. **Introduction and Scope of Work**

   **a) Scope of Work**

Rehabilitation care models are a foundation strategy of universal health care.\(^1\) Incorporating rehabilitation care into the Vietnam Law on Examination and Treatment (LET) offers strong evidence of Vietnam’s commitment to progressive realization of the UN Sustainable Development Goals (SDG) through continued development of its universal health care delivery system.\(^2\) But a sustainable universal health care system also contributes significantly to other SDG development such as education, gender equality, decent work and economic growth, reducing inequalities, and working to create sustainable cities and communities.\(^3\) For purposes of this project, the focus will be to review comparable international laws and practices that define or provide guidance on rehabilitation care within a universal health care model. As requested, this review and approach will include: 1) workforce development, 2) the range of facility models capable to provide rehabilitation care; and 3) offer guidance in the evolution of treatment services. These models are conducive to maximize recovery treatment and offers potential cost efficiencies within rehabilitation care.

A further review of practices and laws from various countries in the Asia Pacific region and developed western countries with defined universal health care systems, clearly indicate that a structured legal framework which includes: workforce development, facilities re-structure to include home-based care models and rehabilitation services available throughout the continuum of care, helps to define the necessary components of an integrated universal health system. Revising the law provides institutionalized guidance and clarity. It is the opportunity to not only unite the various policies and regulations, but strategically define the minimum standards for workforce development, structural system development, and treatment services development for a modernly dynamic, flexible and sustainable health system.

2. **Fundamental Misperceptions of Rehabilitation Care**

There are many misperceptions of rehabilitation care. Primarily, rehabilitation care is not seen as recovery treatment for many health conditions. Further, rehabilitation care isn’t truly considered as a therapeutic treatment to a health condition, but more as fall back strategy when clinical methods fail.\(^4\) This misperception; however, undermines the very premise of Universal

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\(^1\) WHO Rehabilitation Framework March 2019

\(^2\) UN Sustainable Development Goals #3, Good Health and Well-Being.

\(^3\) UN Sustainable Development Goals: #4 Quality Education; #5 Gender Equality; #8 Decent work and economic growth; #10 Reduced Inequalities; #11 Sustainable Cities and Communities.

\(^4\) Access to Rehabilitation in Primary Care: an ongoing challenge (working draft) World Health Organization 2018.

“Across countries, especially low- and middle-income countries, rehabilitation is viewed as a fallback strategy when preventive or curative interventions fail.”
Health Care (UHC). WHO recognizes that the following dimensions are attributes of a universal health care model that ensures access to: 1) prevention, 2) promotion, 3) treatment, 4) rehabilitation and 5) palliation. Rehabilitation care is an integral phase, or connective tissue, of the health care continuum.

The focus of “rehabilitation care” has been traditionally categorized within a field of silos, each with its own separate disability designation. Each disability silo has been based on defined permanent disabilities such as physical (loss of limb) or sensory (sight or hearing). These silos have also worked to misrepresent rehab care as a clinical model in the context of handicap mobility service delivery only that concentrates on physiotherapy or orthotic/prosthetic devices such as wheel chairs and replacement limbs. The practice of placing disability in silos has only served to diminish the comprehensive capacity of rehabilitation care as a recovery service to all.

3. Vietnam’s Rehabilitation System Structure
Currently, the framework for Vietnam’s rehabilitation network is a highly institutionalized and centralized model. There are aspects of a Community Based Model (CBR) at the commune/station level; however, it can still be classified as a modified institutionalized model as many of the actual services and therapies are based out of facilities such as the Day Centers, Commune Health Station, District or Province level facilities.

- Currently, there are 63 rehabilitation hospitals/centers, including 38 rehabilitation hospitals/centers managed by the health sector, 25 rehabilitation hospitals/centers managed by other related sectors.
- 100% of general hospitals and specialized hospitals at central level have their own rehabilitation departments.
- 90% of general hospitals and 40% of specialized hospitals at provincial level have their own rehabilitation departments/divisions.

The health care services and delivery models found in modern universal health care systems in developed countries have restructured to focus more on de-centralized delivery models. This includes supported discharge and more home-based care as possible. At the forefront of this restructure are the benefits of a flexible and well trained, para-professional workforce, or practitioners other than doctors. From a range of physician assistants, nurse practitioners, to a

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6 Historically, rehabilitation has been a low priority for many governments, especially those with limited health investment, which has resulted in underdeveloped, poorly coordinated services/“ Rehabilitation in Health Systems, World Health Organization (2017), pg 1,
7 Presentation: Rehabilitation - Current Situation and Priorities for the 2018- 2021, Presented by MSc. Le Tuan Dong Bureau of Medical Administration – Ministry of Health
8 UK Universal Health Care
group known as Allied Health Practitioners (AHP) and assistants. This health care workforce has been key to development of a sustainable universal health system in developed countries and will be key to UHC development within Vietnam over the next 10 years.

4. **Rationale: Rehabilitation Care Model Serves as Recovery Services for All within a Universal Health Care System.**

   a) **Non-Communicable Diseases are the next wave of health conditions to increase disability and mortality related conditions**

   Not all health conditions lead to permanent disabilities or mortality; however, a health condition may cause significant temporary disability. The rising health conditions contributing to mortality and disability are known as Non-Communicable diseases (NCD). NCD’s are credited as the next phase of conditions responsible for the greatest global burden and increase in mortality factors. NCD’s include conditions such as neurological injuries, stroke, cardiac events (i.e., heart attacks); hypertension (high blood pressure) and diabetes. Rehabilitation planning and development will be a vital role in preventing or limiting the disabilities associated with these NCDs.

5. **4 Pillars of Rehabilitation Care as a Foundational Strategy for a Universal Health System**

   a. **The World Health Organization (WHO) Model for Rehabilitation Care**

   It is well understood that development of Rehabilitation Care is most effective when those services are part of an overall health system strategy. Rehabilitation care is deemed as an integral component of any health system that directly affects aspects of society: burden of care as it affects a reduction in workforce and the economic diminishment of communities, families as well as limitations of the affected individual. Rehabilitation care is the connective tissue in the continuum of care that leads to an individual’s attainment of the highest attainable health.

   In April 2019, WHO published a 4 Pillar approach to incorporate rehabilitation care as part of an overall universal health system development. The 4 Pillars are:

   i) Availability and Quality
   ii) Governance and Finance
   iii) Health Care Workforce
   iv) Rehabilitation Data and Research

   As Vietnam continues to develop its model of UHC, the direction of its treatment law (LET) focus is on workforce development; facilities and services applicable to rehabilitation care. WHO has identified that new approaches to NCD’s will be needed to meet these demands as the focus

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9 pg 15, Law to advance right to health, WHO 2017
10 Western Pacific Regional Framework on Rehabilitation, Western Pacific Region WHO 2019
11 Ibid pg 11
12 UN General Comment 14 on Right to Health, ICESCR

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turns from institutional care to integrated aspects of primary health, community based care and educating patients as drivers to an integrated health system. The scope of disabilities and mortality identified to grow over the next 10 years, requires Vietnam to identify and legislate flexible, sustainable mechanisms in rehabilitation care.

6. Health Care Workforce Development Recognized by WHO and ILO

   a. ILO: Health Professionals, Associate Professionals, and Other Health Assistants as Workforce: Other Health Professionals also known as Allied Health Professionals:

The health workforce of a sustainable UHC will need to be diverse and flexible. The development of AHP’s are deemed critical to meet the growing demand on the health care continuum. Health care demands are due to aging population as well as a surge in chronic and complex disease. Countries in the APAC region such as Singapore and Australia have national legislation that defines “Allied Health practitioners” (AHP’s) as legal and regulated professions. Australia legally recognizes 15 National Boards by Allied Health Profession including Traditional Chinese Medicine; Occupational Therapists, and Physiotherapists as examples. Speech Pathology is self regulated under its own professional Board. Singapore recognizes 10 Allied Health Professions and regulates five. In 2018, UK, AHP’s are the third largest health care workforce. Through its National Health Service (one of the oldest universal health systems), the NHS recognizes 14 Allied Health professions. The UK even recognizes Drama Therapist and Music Therapist in its titles. Allied Health Professionals are listed as “relevant professions” required to be registered under the NHS. Malaysia recognizes 23 AHP to include hearing specialists, nutritionists, as well as Environmental Health, Forensic Science, and Medical Social Officer positions.

The International Labor Organization (ILO) recognized in it its updated International Standard Classification of Occupations (ISCO-08) that many health care workers are of a professional level

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13 Supra pg 20, Everybody’s business
14 Allied Health assistants and what they do: A systematic review of the literature. Published 2010 Aug 19 JMDH
15 Allied Health Professions Act, Chapter 6B, First Schedule as revised 30 November 2013, Singapore
16 Health Practitioner National Regulatory Law, Victoria, Australia
18 Allied Health Professions Act, Chapter 6B, First Schedule as revised 30 November 2013, Singapore
19 Leadership of allied healthprofessions in trusts: whatevsexists and what matters, An evaluation summary and self-assessment for trust boards; NHS Improvement, page 2, June 2018
20 National Health Service Reform and Health Care Professions Act 2002, UK
21 National Health Service (NHS) [https://www.england.nhs.uk/ahp/role/](https://www.england.nhs.uk/ahp/role/)
22 Schedule 3 Interpretation; “relevant professions” means arts therapists; chiropodists; clinical scientists; dietitians; medical laboratory technicians; occupational therapists; orthoptists; paramedics; physiotherapists; prosthetists and orthotists; radiographers; and speech and language therapists; Health Care and Associated Professions Act 2001 as amended 2002 UK: [https://www.legislation.gov.uk/uksi/2002/254/pdfs/uksi_20020254_en.pdf](https://www.legislation.gov.uk/uksi/2002/254/pdfs/uksi_20020254_en.pdf)
and can perform work either autonomously or under supervision.\(^{24}\) Health Professional Classifications incorporate the levels anticipated in a rehabilitation care environment and defined by scope of practice. While classifications exist separately for medical doctors, nurses and midwives by their own different levels of practice, other health professionals such as those recognized as Allied Health Professionals and Assistants are directly related to the LET revisions. The hierarchy established in the IOSC-08 delineates from top to bottom: medical professional (Medical Doctors and Specialists); Para-medical professionals (i.e. Advanced levels of education and training, but not Doctors); nurses (advanced to low level of education and training); midwives (advanced levels to assistants) and Other Health Professionals (OHP), and Other Health Associate Professionals (OHAP).

Other Health Professionals are described and given a scope of practice definition describing the tasks under which these professionals operate.\(^{25}\) Many of the AHP’s such as physiotherapists, speech pathologists and occupational therapists are listed as OHP’s due to their scope of practice. The scope of practice for AHP’s within the ISOC-08, is defined as tasks performed such as assessments, developing and implementing treatment plans, evaluation and documentation of patient’s progress, diagnosing and treating diseases, injuries, malformations and referring clients to other health professionals or associates professionals if required.\(^{26}\) These are autonomous or semi-autonomous health care practice, not merely technician or assistant level. A technician scope is defined as an OHAP, or assistant to one of the above professions.\(^{27}\) Assistants have a defined scope of practice to provide technical or practical tasks to support diagnosis of treatment, illness, disease, injuries and impairments and to support implementation of health care, treatment and referral plans, but they do not conduct assessments, diagnosis, treatment planning nor do they work autonomously. OHAP’s must work at the direction of others. To note, medical prosthetic technicians who assist with design, fit, service and repair of medical devices and appliances following a prescription are defined under the OHAP or assistant classification\(^{28}\) and not as an AHP as these are not an autonomous practice. This distinction is relevant to the proposed classifications under the revised LET and should be reflected in a legislative guideline such as the LET.

\[b. \ The \ Role \ of \ Therapy \ Assistants \ or \ Technicians: \]

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\(^{25}\) ILO, ISOC-08, Vol 1, Group 22, page 125
\(^{26}\) ILO, ISOC-08, Vol 1, Minor Group 226, Other Health Professionals, page 132.
\(^{27}\) ILO, ISOC-08, Vol 1, Group 325 (specifically Minor Sub-Group 3253 Community Health Worker, 3255 Physiotherapy and Occupational Therapy Assistant, 3256 medical assistants, and 3259 Health Associate Professional non-classified))
\(^{28}\) Unit Group 3214 Medical and Dental Prosthetic Technician, ILO ISOC-08, page 186
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With a defined scope of practice and in alliance with allied health professionals, therapy assistants and aides offer true flexibility to create innovative models of direct patient focused care. Therapy assistants who provided direct assistance to allied health professionals were involved with program delivery such as individual therapy, group therapy, administration duties and health promotion.\(^{29}\) Therapy assistants are flexible to accommodate various multidisciplinary structures, focus and processes within which the team operated.\(^{30}\) Acknowledging the abilities and contributions of therapy aids and assistants into LET will provide the foundation and road map to cultivate direct patient care models that provide individualized care on a consistent basis. Again, better patient outcomes, less burden on families, communities and contributes to economic development.

AHP’s and their Assistants, within the context of a UHC and rehabilitation care model are critical aspects to a care team under a UHC or Rehabilitation component. A flexible, but defined workforce structure of AHP’s can readily demonstrate the commitment and development guideline of a universal health care system. Alternatively, the current LET does not provide for the development of an AHP strategy even thought there has been a vigorous development of the AHP workforce here in Vietnam.\(^{31}\)

c. **Global Strategy on Human Resources for Health: Workforce 2030:**
Multi-Disciplinary teams of health care workers are critical to face the challenges of disability as well as disability and mortalities caused by NCD’s.\(^{32}\) But cost efficiencies are also necessary to meet the demands of a sustainable UHC. Under Section 3.1, WHO has recognized that the need for cost effective measures relies on the expansion of the health resource.\(^{33}\) In this case, to recognize AHP’s in the legislative strategy to revise the LET, is directly responsive to three of the WHO objectives toward health workforce. The recognition would 1) optimize performance along the continuum of care model; 2) align investment with current and future needs; and 3) build capacity at subnational and regional levels. AHP’s are in a position to bridge gaps throughout

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\(^{29}\) Supra pg 146

\(^{30}\) Supra pg 146

\(^{31}\) See MCVN Occupational Therapy Bachelor level program at UMP HCMC began in 2017:

Trinh Foundation development of speech pathology programs in HCMC and Da Nang began in March 2019 accessed 8 July 2019: https://trinhfoundation.org/masters-and-bachelors-commencing-this-year/

\(^{32}\) Health Workforce Education and Training website; “Scaling up educational programmes to produce multi-disciplinary service delivery teams - which include a carefully balanced mix of clinicians, community health workers and health managers - is clearly urgent and essential. Accessed 26 Jun3 2019:
https://www.who.int/hrh/education/en/

\(^{33}\) Para. 31 Page 26, WHO Global Strategy on Human Resources for Health: Workforce 2030, 2016
the continuum of care. This includes cost efficiencies and relief of overcrowding such as reduced hospital length of stays, reduced hospital re-admissions.\textsuperscript{34}

The health care environment in Vietnam has changed dramatically since 2009 when the original LET was passed. AHP’s were not reflected outside of the term “technician” in the current LET. However, as a workforce, AHP’s drive better patient outcomes and deliver cost efficiencies. More importantly, AHP’s can be trained at various levels (to include assistants) to put additional workforce in the field of direct patient care much more quickly than physicians. It is well known that hospitals in Vietnam are over-crowded, clinics and commune stations are understaffed. A range of AHP’s, when part of a rehabilitation team environment throughout the continuum of care, accelerates positive outcomes to patients. This in turn, greatly diminishes the burden of care to individuals, communities and health care delivery systems.\textsuperscript{35} AHP’s are in a position to bridge gaps throughout the continuum of care. This includes cost efficiencies and relief of overcrowding such as reduced hospital length of stays, reduced hospital re-admissions,\textsuperscript{36} and offers affordable support opportunities to develop community and home based care models.

7. Facilities and Services within the Continuum of Care models.

\textit{a. Comparative International Practices Continuum of Care for Facilities, Community Based Care to Home Based Care Teams}

Rehabilitation Services can be provided in a large range of post acute care or other non-institutionalized settings. The phrase “From Hospital to Home” describes the continuum of care necessary for an individual’s optimum recovery; however it also evidences cost efficiencies by reducing health care cost. Optimum recovery means reduced hospital overcrowding, cost efficiencies to the health system due to less acute episodes or re-admissions and workforce flexibility while developing a health care workforce. There are even models for “hospital at home” care designed for certain conditions with monitoring and visits to be fully conducted at a patient’s home. For cost efficiencies, workforce distribution and reduction in the cost of hospital services, more home-based care models work to help create sustainability in a UHC.

\textbf{Continuum of Care (CoC) Clinical/Medical Definition:}

Based on a context of a clinical setting, the concept of a “Continuum of Care” (CoC) relates to the steps to appropriate care within a disease, injury or health system services to optimize the care or recovery of a patient. In the US, one definition of CoC as it relates to cancer treatment is described as” the delivery of health care over a period of time. In patients with a disease, this

\textsuperscript{34} HAIVN 18 month study of clinical internships,

\textsuperscript{35} Global Strategy on Human Resources for Health: Workforce 2030

\textsuperscript{36} HAIVN 18 month study of clinical internships,
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covers all phases of illness from diagnosis to the end of life. The Israeli Ministry of Health incorporates the concepts of “recovery process and necessary medical treatment post acute.” The Israeli MOH definition further involves the transition of patient information amongst caregivers and institutions in order to ensure delivery of appropriate care. Within the Rehabilitation Care context, it is a matter of appropriate location and services necessary to optimize the individual’s recovery process or to maintain or reduce limitations of disability. Rehabilitation care has historically taken place in locations such as hospitals, specialty departments, clinics, community based rehabilitation (CBR) programs or Local Commune Stations in Vietnam.

However, where delivery of rehabilitation services occur has changed dramatically in many developed countries. Large, institutionalized locations are only good for the providers and revenue generation which can create cost inefficiencies and a false environment to learn or re-learn skills for daily living. Clients and patients find it a hardship to continue rehabilitation services when they need it most, such as after an acute in-patient episode. Many CBR programs that were designed for mobility impairments are now incorporating outbound or mobile teams to include various rehabilitation modalities for NCD’s as well as aging population. The various CBR versions are now based on community need and access to a flexible, yet trained workforce of AHP team members.

WHO Community Based Rehabilitation

According to WHO, Community Based Rehabilitation (CBR)are programs that support people with disabilities in attaining their highest possible level of health, working across five key areas: Health promotion; Prevention; Medical Care; Rehabilitation and Assistive Devices. While many early models were facility based, more are now “home” based care or mobile team care models and the care provided is expanding to include NCD’s, aged care and other health conditions when a patient cannot access a facility. Examples of expanded definitions for CBR to home based models include: Thailand, Fiji, US, Singapore, Australia and UK as example or restructured care models.

38 State of Israel, Ministry of Health website accessed 14 June 2019: “Keeping the recovery process and necessary medical treatment post acute Maintaining the continuity of the medical care delivered to the patient, especially when switching between caregivers or care institutions is optimum. Medical care is characterized by multiple caregivers and care institutions, and there is a vital need to document up-to-date information and to communicate it among the different caregivers in order to assure delivery of appropriate, high quality medical care https://www.health.gov.il/English/Topics/Quality_Assurance/Patient_Safety/Pages/continuity.aspx
39 WHO Community Based Rehabilitation: CBR Guidelines, 2010
Examples of Re-Structured Rehabilitation Models Integrating Rehabilitation Care in Primary Health, CBR and Home-based models:

**Thailand**

A CBR Team added to Primary Care Units located in rural areas. The team made “doorsteps” as part of the home health-care scheme whereby the team including physician, pharmacist, nurses and health workers (rehab workers), conducted home visits on a regular basis. A protocol was established for home based rehab care. Local volunteers and family members were taught daily living skills training. (see handout) ⁴⁰

**Fiji**

Mobile Rehabilitation Outreach program. A team of health professionals come to peoples homes or provides transport to a local facility. The service allows health practitioners understand nature of living situation and how to best support the individual within their own settings rather than clinical settings whenever possible. Health team may include a physician, nurse practitioner, nurse, physiotherapist, occupational therapist, speech therapist, village health worker and/or assistant based on community need.

**Examples of Hospital to Home Continuum:**

**Singapore:**

*Hospital to Home Continuum:Acute Care to Home-Based Care*

The Singapore continuum drives service delivery as quickly as possible to a process of step down facilities with an emphasis towards home care as possible. The community hospitals are the base of sub-acute or the next level of care post hospitalization. The aim of their community hospital system is to provide a “short period of continuation care” after an acute episode. ⁴¹ Service across the community hospitals are similar with some specializing in specific care needs such as hip replacement for older adults, brain injuries, neurological (stroke) or cardiovascular events post acute care recovery to name a few.

For patients who no longer require acute or community hospital care, the next level is the Day Rehabilitation Centre or Home Care Services. While the Day Rehabilitation Centers are usually run out of the community hospitals as separate centers, ⁴² there is a system of private care rehabilitation service contractors. These service providers are licensed facilities under the Ministry of S however, they are contracted to ensure minimal staffing mechanisms are maintained as well as other safety and reporting mechanisms in order to be paid by the social

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⁴⁰ Supra, Box 1 page 6

⁴¹ Community Hospital Care, Handbook for Patients page 1; Singapore Ministry of Health 2017.

⁴² Community Hospital Care, Handbook for Patients page 9; Singapore Ministry of Health 2017.
health insurance. The private contractors primarily offer home-based care such as rehabilitation (Sp, OT, PT), nursing or home medical services. The home care services are specifically designed for either home based care or requires the contractor to provide transportation services to the centre for therapy care. Many caregivers are also offered training through the home-based care providers to assist their loved one with activities of daily living. Private providers are managed by the Agency for Integrated Care, a division under MOH.

**Singapore’s Approach to Care in Community Rehabilitation Centers:**

Singapore MOH sets out expectations of CBR service providers. Contractors are required to follow a multi-disciplinary and holistic person centered approach as part of the contract to provide services payable under the social insurance system. It is the Contractor who coordinates the AHP aspects of care (Sp, PT, OT) and includes orthotic/prosthetic technicians, dieticians, social workers, case managers as part of the continuum when appropriate. All AHP’s are required to be registered with the AHP Council. Regular case management discussions amongst the care providers and may be conducted via phone, written reports or on-site discussions. Reports and audits of compliance are required to be submitted by Contractor to the AIC as often as quarterly to conduct oversight of operations and patient quality of care.

**UK Community Rehabilitation Care through National Health Service (NHS)**

The National Health System (NHS) began an overhaul of its health care delivery services for primary and acute care services. The impetus for the overhaul was a fundamental acknowledgement that the NHS as envisioned in the beginning was not equipped to face the challenges of an aging population, disabilities, and rising rates of long-term health conditions such as NCD’s. Since 2016, the NHS has piloted several new fully integrated service models whereby a full continuum of health care services are contracted through a single entity to include General Physicians on to Acute care hospitals. This not only improved proactive support models, but moved health care delivery out of hospitals as appropriately possible. The central part of the design is based upon a multi-disciplinary approach utilizing teams of health and social care, working with a cluster of general practitioners whereby each team and cluster may be cover a population from 30,000-50,000 people. The models are designed to have a flexible physician, nurse and AHP workforce with a wide range of service approaches and interventions

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43 Community Hospital Care, Handbook for Patients page 10; Singapore Ministry of Health 2017.
44 Community Hospital Care, Handbook for Patients page 11; Singapore Ministry of Health 2017
45 Chris Naylor and Anna Charles, The King’s Trust, April 2018; “Developing New Models of Care in the PACS Vanguards, a New National Approach to Large Scale Change?", page 7

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for their respective population.\textsuperscript{46} It has been noted that these models are in effect, able to appease the demand for hospital services in a way that reflects the “aggregation of moderate gains” in only 3 years\textsuperscript{47} and hospital emergency activity has a tangible reduction in these areas.\textsuperscript{48}The teams recognized that the freedom to innovate within their local areas and led them to discover ways to shift from a centralized episodic hospital treatment model to one of long term individual support.\textsuperscript{49}

Back in 2010, the Royal College of Physicians in a joint paper, clearly understood that outpatient or home-based models with multi-disciplinary teams were the future of de-centralized, patient/centered rehabilitation services. More so than many specialties, Rehabilitation medicine and treatment modalities have the flexibility to fashion innovative responses to care delivery.\textsuperscript{50}Outpatient and home-care based services better serves the patient’s recovery as these services can focus on the impact of disabling conditions in their own real life home or work environments.\textsuperscript{51}Multi-disciplinary teams were also noted to be a constructive element in both an institutional setting, outpatient setting and a home-based setting and may even follow the patient into throughout the continuum to receive care in the most appropriate and cost effective setting.\textsuperscript{52}

\textit{UK NHS Outpatient and Home-Based Rehabilitation Services:}
Whether services can be transitioned to a non-institutionalized setting such as out-patient or a home-based model, it is fundamental that the structure include a multi-disciplinary team; ability for any relevant inter-agency teams to be accessible to other providers, to the patient and to carers or families.\textsuperscript{53} To that end it was recommended that the following services be made available as possible in outpatient or home-based care models:\textsuperscript{54}

\textsuperscript{46} Chris Naylor and Anna Charles, The King’s Trust, April 2018; “Developing New Models of Care in the PACS Vanguards, a New National Approach to Large Scale Change?, page 11. Models include a Primary and Acute Care (PACS); Multispecialty Community Providers (MCP)
\textsuperscript{47} Chris Naylor and Anna Charles, The King’s Trust, April 2018; “Developing New Models of Care in the PACS Vanguards, a New National Approach to Large Scale Change?, page 14
\textsuperscript{48} Chris Naylor and Anna Charles, The King’s Trust, April 2018; “Developing New Models of Care in the PACS Vanguards, a New National Approach to Large Scale Change?, page 15
\textsuperscript{49} Chris Naylor and Anna Charles, The King’s Trust, April 2018; “Developing New Models of Care in the PACS Vanguards, a New National Approach to Large Scale Change?, page 26
\textsuperscript{50} Page 45, Medical Rehabilitation in 2011 and Beyond, Report of a joint working party of the Royal College of Physicians and the British Society of Rehabilitation Medicine, Nov 2010; Royal College of Physicians
\textsuperscript{51} Page 45, Medical Rehabilitation in 2011 and Beyond, Report of a joint working party of the Royal College of Physicians and the British Society of Rehabilitation Medicine, Nov 2010; Royal College of Physicians
\textsuperscript{52} Page 49, Medical Rehabilitation in 2011 and Beyond, Report of a joint working party of the Royal College of Physicians and the British Society of Rehabilitation Medicine, Nov 2010; Royal College of Physicians
\textsuperscript{53} Page 45, Medical Rehabilitation in 2011 and Beyond, Report of a joint working party of the Royal College of Physicians and the British Society of Rehabilitation Medicine, Nov 2010; Royal College of Physicians
\textsuperscript{54} Page 53, Medical Rehabilitation in 2011 and Beyond, Report of a joint working party of the Royal College of Physicians and the British Society of Rehabilitation Medicine, Nov 2010; Royal College of Physicians 2010
Physiotherapy; gymnasium and hydrotherapy resources; occupational therapy facilities including a domestic environment and workshops; IT equipment and software for patient use orthotics and prosthetics; specialist wheelchairs and seating; electronic assistive technology; driving assessment and training services; local education and employment training services; vocational rehabilitation services; social services; counseling services

**Australia:**

Australia has legislated requirements for the development of a “flexible, responsive and sustainable health workforce” as well as “encourages innovation in education and service Delivery by health practitioners.” Flexible and innovative service delivery modalities are not possible without the AHP workforce. Many rehabilitation services are available as part of the National Disability Insurance Scheme through non-governmental providers. While the outpatient services are generally located at a licensed facility or institutional model, many rehabilitation services can be delivered via home based care. Australia offers more options for home based care as it has a highly developed health care workforce. Home-based services include the medical care visits from nursing to patients with various NCD’s, short term and long term disabilities that include respiratory care, neurological care and orthopedic conditions. Another focus has been on respite care for caregivers of those managing rehabilitation treatments. Respite care may be having another carer-assist or options for day services, such as a local recreation center for social interaction during the day. Private contractors are managed as members in the National Disability Scheme with minimum requirements for services, workforce and capabilities in line with the social insurance for payment.

**8. Recommendations:**

All countries reviewed, whether they be a developing low middle income country (LMIC) or a highly developed universal health care system has required its universal health system to step back and re-think its perception of workforce and delegation of care duties; facility based health care delivery compared to home-based care; the type of health services that can be provided through non-institutionalized care; a broader scope of facilities or even home-based services. The relationship amongst the three areas requires more of a helix inspired approach instead of a field of silos. There are multiple points of access whereby rehabilitation care will be a touch point for all aspects of recovery care.

What is fundamental to all of the models is development of enumerated legislation that is reflective; yet, acts as a guiding force to be innovative to Vietnam’s version of a UHC. This points to a development focus of multi-disciplinary and integrated models with a wide ranging AHP workforce; establishing rehabilitation access points within various forms of facility-based and non-facility based models; and with services delineated for the various delivery formats.

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55 Ibid 3(3)(f)

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Health Care Workforce Recommendations:

Practice Acts for Practitioners:
Practice Acts legislation describes mechanisms for creating a regulatory or self-regulatory council for Physicians, Nursing, or AHP protocols. Protocols include processes for credentialing, education and training as well as the delegation of authority to a ministry or subsidiary council for implementation and monitoring. As of 2016, the 37 countries recognized in the WHO Western Pacific region, there are only 5 Countries that do not indicate any legislation on Allied Health professionals including Viet Nam.\textsuperscript{56} Some countries such as Australia (14 AHP), New Zealand (16 AHP), Republic of Korea (21 AHP) and as of 2016, Malaysia will have the most going into force (23 AHP) in 2019. There are 17 Countries in the Western Pacific Region that demonstrated various enumerated legislation such as Medical Practice Acts, Allied Health Professional Practice Acts; and Nursing/Midwifery Acts as examples.

Recommendation to Regulate AHP or Create Methodology for the AHP resources to Self Regulate in LET:
The LET currently reflects only physicians, junior physicians, nurses, midwives, traditional medicine and technicians. There are revisions already suggested to revamp the licensing section that anticipates a medical council, a national test, eliminating junior doctors and utilizing only physician resident training; yet fails to clarify the distinctions for nurses, midwives or any other clinical pathways to credential AHP’s. As there are several bachelors level and a masters level training in process for addition of OT’s and SP therapists, there needs to be a mechanism to credential the AHP workforce as it grows. It is not enough to merely place a few AHP titles into the LET. As the education and training permits, there needs to be a mechanism to grow the AHP titles as necessary to meet demands of public health and Viet Nam’s universal health care system.

Recommendation for Health Services Acts that Includes specific UHC services related to Prevention, Promotion, Treatment, Rehabilitation and Palliative Care.
The Health Services or Medical Services acts describe mechanisms for resource allocation, facility types and approved services. The best example is the current NHS Service Act 2006, which authorizes and requires the obligations for the NHS to provide: Hospital accommodations, Medical, dental ophthalmic, nursing and ambulance services; care to pregnant women and young children; services to prevent illness, care for those suffering from illness, and after care of persons who have suffered illness; and such other services as required to diagnose and treat.\textsuperscript{57} The current LET specifies First Aid, Inpatient Care and

\textsuperscript{56} Health Workforce legislation in Western Pacific Region 2016, Annex 2, pg 36
\textsuperscript{57} National Health Services Act 2006; UK Public General Acts Chapter 41, Part 1 Section 3 (1a-e); accessed 2 July 2019: \url{http://www.legislation.gov.uk/ukpga/2006/41/section/3}
Outpatient care, but that is not adequately reflective of a UHC system. Providing the terminology for a UHC into the LET offers the opportunity for the legislation to guide the UCH growth to Viet Nam’s needs.

**Recommendations for Facilities and Services Models:**

Each modality in a UHC system is best reflected as an integrated support for the health conditions of the individual. From Institutionalized care to clinics, out-patient and home-based models require a review of the facility mechanism within the LET. Currently the LET organizes various medical establishments based upon the professional practice certificate and facility physical requirements. However, the national construction standards, examination and treatment establishment standards for practitioners, for grant of operation licenses based on type of facility do not appear to align with attributes necessary to recognize the advancement of AHP’s into the workforce, doesn’t allow a mechanisms for mobile teams or for home-based models and restricts CBR models to focus on disability services and not health conditions that can cause disability. Enumerating the flexibilities within establishment will offer overall guidance down the line from Hospital to Home care team models. For example, a rehabilitation outpatient or day rehab center within the continuum, does not need to provide for laboratory services, surgical services, food safety or dietary services, or other hospital defined services and should be separately licensed for such activities. However, if the Day Center is designed as a recreational social activity, then risk protocols for falls, safety, and food service may need to be considered. As the LET currently lists Hospitals, Departments of Hospitals, Centers, CBR’s, Commune Stations, and “other health establishment” would be more constructive for guidance if these modalities were better defined as to purpose than mere designation.