

Health system dialogues

Strengthening primary healthcare: A cross country dialogue

Centre for Social and Economic Progress (CSEP)
CSEP Research Foundation

6, Dr Jose P Rizal Marg, Chanakyapuri, New Delhi 110021, India

Ph: 011 2415 7600

CSEP Research Foundation

Regd. Off: Second floor, 6, Dr Jose P Rizal Marg
Chanakyapuri, New Delhi 110 021 India
T: +91 11 2415 7600 E: info@csep.org W: www.csep.org

Speaker(s)

Vinod Paul

Member, Health, NITI Aayog

Sujatha Rao

Former Secretary, Ministry of Health and Family Welfare

Rifat Atun

Professor of Global Health Systems, Harvard University

Erno Harzheim

Former Secretary of Primary Health Care, Government of Brazil

Moderator(s)

Sandhya Venkateswaran

Senior Fellow

Know More Details: <https://csep.org/JWOSKf0>

Watch the full event video here: <https://youtu.be/tK4AKsw-J8o>

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Sandhya Venkateshwaran:

CSEP is a public policy think tank with research focused on a range of issues including growth finance and development, energy and climate change and foreign policy. Recently CSEP initiated a work program on human development with a specific focus on health policy. The program aims at analysing health policy and systems from the perspective of improved health outcomes as also reduce financial risk associated with accessing healthcare. As part of this work in the last few months we have been engaged in distilling insights from the design and implementation of health systems across countries with a view to understanding how different mechanisms of governance, financing, organisation contributes to building resilient health systems. The papers on six country's systems which we have been looking at will be on our website soon. So do look out for that space. Based on this analytical work we have now initiated a dialogue series which is basically focussing on different aspects of the health eco system and discussing that across different countries and today our dialogue is focused on primary healthcare. In case anybody is asking why primary healthcare, there is a global consensus now that universal health coverage can only be achieved on the foundation of a strong primary care system. And the last two and half years or a little more have underscored that. The pandemic made very clear the importance of building a strong primary healthcare system. I will talk a little bit about India and where we are on primary healthcare. India has for long underscored the criticality of primary care. It is not something that the country is waking up to now. If we look at the architects of NRHM, which is the National Rural Health Mission, as far back as 2005, even then primary care was the centre of India's health initiatives through NRHM. In fact the link between the health system and communities was recognised through the Asha model. Today India has a very elaborate network of government primary healthcare facilities both in rural and urban areas. But they have for long delivered on a narrow range of services. And for that reason have been somewhat underutilised. But that has been recognised and if I can call it that, a sort of second wave of primary care reforms were initiated in the country in the last few years. The vision for these reforms is very holistic. It does focus on expanding preventive and promotive services in addition to the curative services which are already there. There has been a change in the approach to service delivery moving from mainly routine curative care to more of community engagement and leveraging a variety of other cadre of providers. The reforms move away from a medicalised workforce to community health officers. In fact this approach has been made institutional through their legal status which is included in the national medical commission act. The act in fact empowers non-physician providers to prescribe a limited range of medicines. At the same time there are states such as Assam and Chhattisgarh which have actually adopted innovative approaches of leveraging a range of providers to work in primary care. Part of the vision has also been in bridging digital health and technology enabled family healthcare, digitisation of records, all of this has been started. Of course infrastructure is being expanded through India's health infrastructure mission. So the point is that there has been enormous movements in India as well as in multiple other countries. And so it seems like a very opportune time to discuss the insights that are emerging from all of these experiences. The dialogue today is a sharing of experiences across countries focused on three key aspects. We will look at organising primary care, we will look at financing care and we will look at the tricky issue of human resources. The focus of today's dialogue is on three countries. Brazil, Turkey and India. However that should not stop our

speakers from actually referring to insights from other countries as well. Now, we are honoured to have a stellar panel with us for this dialogue. First the event is chaired by Dr Vinod Paul, a globally respected medical scientist and member NITI Aayog, leading on health, nutrition and education. Dr Paul has played a pivotal role in the design of several key reforms in the country including those aimed at primary care. And of course he has led numerous committees and task forces. Our discussants today for country insight include Ms Sujata Rao, who is former secretary health, government of India. She spent 20 years in health during her professional career with the government both at the state and national level. She has represented India on numerous global boards and has been a founding member of key institutions. Professor Rifat Atun is professor global health systems at Harvard School of public health and the director of health systems innovations lab. His work spans multiple countries. And in addition to a large body of research he has advised numerous countries on health system. Professor Erno Harzheim has been secretary primary health for the government of Brazil. In this role he led the primary care reforms in Brazil. He is currently professor at the medical school at Federal University of Rio Grande Do Sul and also has a large body of research. We will now welcome all of you and thank you once again for taking the time out to be part of this dialogue. We will start with the chair's opening remarks and we will then have three rounds of discussions focusing on three issues or questions, whatever we want to call them followed by questions from the audience. With that I would request Dr Paul to share his opening remarks. Dr Paul, thank you once again for joining us and over to you.

Dr Vinod Paul:

Thank you very much Sandhya. Good evening, good afternoon, respected Madam Sujatha Rao, Rifat Atun sir, Dr Erno Harzheim and the participants of today's discussion. I am grateful to Sandhya for providing me this opportunity to be able to listen to stalwarts, to listen to experts, world leaders in the sphere of health sector in general but even more so in the very important core area of primary healthcare. Thank you for the opportunity. You have already set the stage by articulating some initiatives. The key initiatives taken by the government of India in catapulting primary healthcare to the very next level. Primary care has been focused ever since India gained independence. The early focus was on diseases such as smallpox, shall we say, the other communicable diseases like cholera, family planning came up as a very important area in the 60s and so on. Then slowly but surely the scope of primary healthcare improved with more focus on children with diarrheal disease, immunisation programs, pneumonia and so on and of course on antenatal checks and maternal care, postpartum care and so on. But I think the current commitment to primary healthcare is remarkable and this, the origin of the current initiatives goes back to the exercise undertaken in 2015, 2016 in articulating the national health policy. Ultimately the national health policy document was released in 2017, but a lot of discussion took place after the new government came in 2014 under the leadership of the Honourable Prime Minister Modi. During those discussions and the churning that took place at the point of time the strategic shift from limited primary healthcare to comprehensive primary healthcare emerged, that contours emerged and at that time a lot of listening in regard to the models in other countries apart from our own experience and NGO experience was all put together and it came together. I may also mention that the high level expert group 2011 report by the planning commission, the predecessor organisation where I am sitting here, also helped sharpening the debate around the emerging contours and the paradigm of primary healthcare. So come 2017 we have a national health policy which lays a very sharp focus on

primary healthcare. We have committed to provide two thirds of the government health budget to primary healthcare. We move from what we have been seeing as a limited primary healthcare to comprehensive primary healthcare. When we say limited, what we meant was that it was focused on maternal child health and new born health, some communicable diseases. It was evident that it must enlarge fully to encompass non-communicable diseases, care of the elderly, mental health, eye care, ENT. Huge unmet agenda, palliative care and so on and so forth. So at least this was all put on the table. So we need to move in that direction and we need to find the ways and means to do so. Our report which was connected to the exercise of developing the policy was very useful. Extremely useful. And to me this set the stage for them pushing for action based on very important thoughts that came around from the comprehensive primary healthcare report plus also the HLEG report I was referring to. From 2014 onwards there is a transformation. Our existing systems in the rural areas to be specific is to have a sub centre or sub health centre covering about 5000 to 6000 population and primary health centre covering about 30000 population and then so on. What was then designed, the upgraded design encompassed that the sub centre will now be called as the sub centre but the health and wellness centre. And add sub centre. And the primary health centre will also be called a health and wellness centre in bracket primary health centre. The thinking was that it should be now the platform for targeting all the primary care needs, primary care services step by step and also then to have outreach hub from here reaching out into the community for say public health action and disease prevention action and disease control action with these health and wellness centres serving as the nodes and the hubs and the nodal centres. In 2018 a decision was taken in the broad rubric of universal health coverage to launch two interlined missions. This is early 2018. And these two missions were under the overarching name of Ayushman Bharat. That means long live India. It had two pillars to begin with. It had a pillar of comprehensive primary healthcare through these health and wellness centres. So it was health and wellness centre and loaded on to this is the paradigm of comprehensive primary healthcare. The other pillar was the Ayushman Bharat Pradhan Mantri Jana Roga Yojna. The health assurance scheme for secondary and tertiary care for half a billion people. Later to this family of Ayushman Bharat we have added digital mission and health infrastructure mission and so on. But at that time these were the two missions launched in April, the primary healthcare mission and in September the health insurance mission. So a big change happened starting 2018. Vision for comprehensive primary healthcare was that we shall transform 150,000 sub centres or primary health centres, obviously many more sub centres into health and wellness centres. And Sandhya referred to the human resources for the health and wellness centre which at the sub centre level will now be manned by a new health worker, new provider. And this is a very fundamental shift because such a provider did not exist. We had the Asha workers or community workers or community mobilisers and we had auxiliary nurse midwives primarily focused on maternal and childhood. Come this proposal or come this model, and we have what she referred to as a community health officer who today typically is a graduate, well trained registered nurse. So India has now put close to 94,000 or almost a 100,000 nurses in the rural heartland of India and we are building the urban component of this also and I will come to that very briefly toward the end. So a new worker but with that come the idea of more expanded comprehensive primary healthcare in which apart from the child care and communicable disease which was going on in family planning have now been strengthened, I added the strengthened component of non-communicable disease, treatment of hypertension, screening and treatment of diabetes and then screening for cancer. I will come to the numbers in a very short while. Then moving on to

perhaps other communicable, non-communicable diseases such as detecting the non-alcoholic fatty liver as a precursor of cirrhosis for example. What we have not done so far is to add additional components such as mental health. We have to be adding at some point of time care of the elderly. We have to be also looking eye care and ENT care. Those components will be now layered one by one on this platform that has been developed. It doesn't mean all those have to be delivered by the same person. For example for dental check there could be a periodic visit by a dentist, for eye check there could be a periodic visit. But those services will get layered. Today as we stand we have completed the task of operationalising 120,000 of the 150,000 that we have targeted for these health and wellness centres are functional. End of this year the target of 150,000 health and wellness centres upgradation, functional transformation will be completed and we are on track. I am happy to add here that one billion footfalls have been recorded in the last 4 years and three to four months in all the established health and wellness centres. Total hypertension screenings are 230 million and those who have hypertension are put on treatment, I will come to that in a minute. The total diabetes screened is 186 million, total oral cancer screening 124 million. Each health and wellness centre at the sub central level provides 105 free drugs. Each health and wellness centre at primary health centre provides 172 free drugs. Sub centre and health and wellness centres provide 14 diagnostic tests. And the PSC 1 provides 63 diagnostic tests. So it is comprehensive in terms of the free drugs supply as well as the diagnostics and more of this could come. As I said the new worker has been put in place, there is also the digital family... shall we say folder or digital health records, this will be entry for digital health records also. When you go to these places, these are of course additional services but they are also new buildings and a new paradigm where yoga exercises and wellness activities also happen. So there is a transformation in the making in a very big way. We are extending this to urban areas. It is a bit slow but then in this part of our journey this will gain acceleration. A special budget apart from the normal budget of the 15th finance commission which has also provided additional budget to the third layer of our local self-bodies, the panchayat raj system, both in urban have provided injection of huge resource, something to the tune of 10 billion dollars equivalent over 5 year to strengthen the primary healthcare in the urban and rural areas. A clear proud moment and a proud scheme that the government has been implementing and we believe this will in a very big way be a precursor for change. Ultimate vision would be perhaps a family health doctor sitting in these health and wellness centres tomorrow, if there is need for additional workers to take care of additional responsibilities that would also happen. But in consonance with this I also want to make one last point. There are other initiatives on promoting health. Primary healthcare also emphasises health promotion. And there let us not forget that India has built 110 million toilets in rural areas. 110 million toilets since 2014. India has provided 94 million cooking gas connections to rural households. India is now in a mission of providing safe quality water to rural households. Today 52.5% of rural households which accounts to 100 million rural households have potable water in their homes. This mission was started only in 2019 when this proportion was 17%. It has now moved to 52.5% and in this period you can see a tremendous increase in water supply. So water, sanitation, toilets, clean air cooking environment for the family at least three major examples where life in terms of prevention of disease and wellness would improve. Just to also add there is a very major community led movement for promoting yog in our day to day life. I will stop here. Will be happy to take the discussion forward. But just to say in conclusion that India's commitment to taking primary health to have a very solid comprehensive resilient sustained primary healthcare is a dharma. It is a given. We are committed to strengthen it, we

have made very major progress in the last four years. But that is only the beginning. So much more needs to be done. We have seen, last but not the least, that the pandemic response and vaccination coverage what we achieved was through the primary healthcare workers, the grassroots workers and the system that is now getting strengthened by the day. I will stop here Sandhya. We will pick up threads as the discussion picks up. Thank you very much for the opportunity.

Sandhya Venkateshwaran:

Thank you Dr Paul. That was amazing. Thanks you for framing the discussion. And sharing with all our participants all that India has done and the commitment and the distance it has travelled. Both in terms of the thinking and the action. I think India's vision is very, very holistic and like I said at the risk of repeating myself this is an opportune time for different countries to come together and discuss their experiences. So let's jump into the discussion now. The first sort of question or area of discussion is around organisation and governance. Everybody knows that an effective preventive, promotive and curative system has to go beyond sporadic engagement with citizens. And the system has to take responsibility for promotion of population health. In fact Dr Paul's last point refer to population health and from primary care we see very often what falls through the cracks is the preventive and the promotive aspect of it. In a sense this means that the system needs to cater to those who are not on their own attending health facilities. My question therefore is what the feasibility is and what is the approach of transitioning a system from a reactive to a proactive one. By reactive I mean people coming to a health facility when they are sick. By proactive I mean citizens actually taking responsibility for the health of the community whether they are sick or not. Implicit in this question is also what is the pathway, what are some of the path dependencies in moving from a reactive to a proactive one. I would like to start with a note. If you could talk about Brazil's experience. Brazil has empanelled community groups and there is a sense that empanelling community groups is a key element of being to address population health. So my question to you is how critical is that from Brazil's experience? And also if you could talk about the role of decentralisation, Brazil is a much decentralised system. So what role has that played in terms of addressing population health and what were the enablers for empanelment? Over to you Erno.

Erno Harzheim:

Good evening and good morning for everybody. I would like to begin by thanking Sandhya and the centre for social and economic progress for this invitation. I am very proud to talk to you about the Brazilian experiences on primary care. Before starting I think it is important to briefly describe the Brazilian health system. Very briefly. Brazil has 210 million inhabitants in the tax funded universal healthcare system. About 30 million people also have private out of pocket health coverage but with some degree of public tax incentives. For about 180 million people the SUS is the only health system and SUS is the name of our national health system. It has the fundamental principles of universality, comprehensiveness and equity. And these three principles should be in equilibrium and it is not a very easy task to equilibrate these three sometimes contradictory principles. SUS is organised on a municipal basis. Municipalities are responsible for providing health services from primary care to hospital care. Obviously not all municipalities offer all services. But inter-municipal arrangements are agreed to the role of the 27 states we have in Brazil and the federal government to make the flow of the people seeking

care from primary care to hospital care easier. It is the obligation of all municipalities however to provide primary healthcare services. This is offered in Brazil through the family health teams. A family health team is composed of a doctor, a nurse, a nursing technician and community health workers and sometimes other health professionals in a variable composition. Each team is responsible for the health of two to four thousand people depending on the socio-economic status of the population. The more vulnerable the population, the smaller the number of individuals under the care of a family health team. In 2019 there was a major reform of the financing and organisation of the Brazilian primary care called **Prevenir** Brazil which transformed the financing that was previously mainly based on the provision of services in the offer of services into a mixed system of capitation, payment for performance and incentives for specific actions such as the use of electronic health records by the health teams, training of health human resources inside these family health teams and expansion of the opening hours of the primary care clinics. After this very brief introduction I will answer your questions India formulated before. In order to have an efficient health system for the challenges of the 21st century it is essential to start from a known population denominator, a panel of people very well defined not only in quantitative terms but also in the identification of each subject, each person, both population agent, mental health, the epidemic of chronic disease, the re-emerging new challenge of infectious disease, then final agenda of maternal and child conditions, the external causes and incorporation of preventive and healthcare technologies. Among other aspects required by the health systems starts from a panel of citizens in which we have their demographic and epidemiological information like risk factors, life habits and present illnesses and besides these a very well defined personalised form of contact with each person of our country. Mainly the cell phone numbers of the people. Here in Brazil almost 9% of the population has a smart phone and could be reached by information technology. It is not enough to create a face to face and virtual care network for people if we need to and we want to create a universal health system. We need to have disease risk identification systems that allow systematic proactive actions in order to reach levels of quality of care close to the potential of each healthcare technology we have in our hands. Tracking chronic disease such as cervical and breast cancer for example, identifying symptomatic people or symptomatic contacts in times of pandemics as another example, are fundamental actions for the health systems to be effective and efficient. This is impossible to do in the absence of a detailed panel of people and the use of information technology. In 2018 before the primary care reform there were 74 million Brazilians registered in the primary care digital panel at the ministry of health. 29 million of this 74 million were vulnerable people. And now after the reform we have 162 million people in this digital panel with address, with cell phone numbers, with demographic aspects, with some risk factors, with some measures of lab exams. Inside this 162 million people 62 million are very vulnerable people. The number of linked people more than doubled from 2018 to the beginning of 2022. Thanks to the capitation model. The change of financials from offer of service to capitation model makes the possibility to put inside the system almost 100 million people. We had in 2018 45000 primary care teams. And now we have 55000 family health teams. The number of diabetes and hypertension consultations were under 3 million by the year 2018. And now in this year it will be more than 4 million diabetes and hypertension consultations to this population. I think these numbers can show the importance of our capitation model and importance of the panel of people we have who are very well described and digitised. Thank you.

Sandhya Venkateshwaran:

Thank you Erno. Thank you for describing the Brazil system and talking about empanelment. I would like to move to Rifat to talk about Turkey because Turkey has also looked at an outreach system, has also empanelled communities Rifat. What would you say some of the path dependencies in this journey and a second question that I would love for you to comment on is when we are talking of population health, when we are talking of prevention etc. how does a system managed performance accountability?

Rifat Atun:

Thank you Sandhya. Thank you and the CSEP for inviting me for this excellent panel. And very inspiring presentation by Dr Vinod Paul and also by Erno Harzheim. So Turkey — dependency is very important. Turkey has a strong tradition of public health. When the health transformation program was introduced in 2003 subsequently that strong public health base was quite important in the way primary healthcare developed and evolved. So primary healthcare is very much centred in the new model around family health teams, in family medicine centres and the core nucleus of the team includes a family physician, nurse, midwives and health assistants. In order to scale up very rapidly, because there was no traditional of family medicine, although there was a small residency program, after an initial pilot Turkey introduced retraining of general practitioners, doctors who are not hospital specialists or neuro specialists and internal physicians to transition to be certified as family physicians. So that enabled rapid scale up of the family medicine model provided through the family medicine centres. And comprehensiveness was one of the initial objectives of the system but with a strong focus initially to improve outcomes in relation to maternal and child health. So the payment model was designed to attract teams into family medicine and rather than just the salary based system a per capita payment model was introduced. With some waiting and adjustments for rurality and also for socioeconomic vulnerability with higher payments for the population that was vulnerable. So the family health centres are remunerated according to the number of people they cater for and this is typically between 1000 to 4000 on an average. Each family health centre is around 3000 persons that they cater for with adjustments that I talked about. But there is also performance related pay. Focus is very much on the initial targets, antenatal care, and immunisation. So there are negative incentives. There are certain targets have got to be met in relation to antenatal care coverage but also in relation to immunisation coverage and if these are not met then there is a clawback from the payment. There is also contributions to the payment based on the average cost of a family healthcare centre but also if other additional services are provided. For example mobile health services as well as consumables. What was very interesting early on in the turkey short reform was that gate keeping was initially introduced but then withdrawn because there was push back from the citizens. So individuals are able to access primary healthcare but they can also directly access hospitals both the ministry of health hospitals or university hospitals directly. Although this so called gate keeping does not exist, primary care utilisation increased initially according to the studies that were done, because of improved access and accessibility because family medicine centres were rolled out throughout the country. But later on increase in utilisation was because the service quality improved. And increased responsiveness to individuals improved. So this is very interesting. So gatekeeping is quite a negative term and I think what is important is really providing high quality person centred care that is comprehensive, that is well coordinated that empowers individuals and really levels up the effectiveness and efficiency of services through their involvement at primary and community care level. Of course primary care needs to play

an important coordination role. Maybe a better term would be coordination rather than gatekeeping in that journey. But engagement of individuals in the care process and across the whole care continuum is very important. So the care should not be episodic and reactive. It should be very much focused on individual needs and managing the whole care continuum from health education, to health promotion, to disease prevention as well as management of the care process when there is an episode or when there is a need for providing continuing care for chronic diseases but also palliative care. Dr Paul mentioned mental illness and cancer. Again these are critically important. So one should think about the management of the whole care continuum rather than episodes of care. In Turkey what is interesting is that, again based on the earlier approach to providing primary care was that in addition to family medical centres there are also community centres. Community health centres. These are based in the district, they deliver community and public health services. For example environmental health, reproductive health, child health and adolescent health services as well as they are involved in cancer screening. So they work very much in conjunction with family medicine centres that are focused both at the individual and population level care where as the community health centre is based on the traditional structures provide public healthcare. But more recently Turkey has introduced healthy living centres. Again this is transitioning from managing episodic care for acute events or disease management actually emphasising healthy living. And this is again multidisciplinary services that provides guidance in relation to management of non-communicable diseases instead of proactive management of NCDs with the screening for priority NCD conditions to ensure that there is a population that will approach with the focus on early management and management of risk factors. Not just management of disease as in when it develops. Now I could go on. But I am conscious of the time. I will stop here. But maybe just one important point not just in relation to Turkey but generally. In 2018 I was asked to develop a report for the Alma Ata conference fourth year anniversary. I undertook a very comprehensive analysis of the way primary healthcare had evolved in the WHO European region. Turkey is also in the WHO European region that includes 52 countries. And the number of important principles emerged from the primary care models that were being developed. And each country has a slightly different flavour of primary healthcare. And there were ten important principles that characterise primary care models that have emerged in the European region. The first was people centeredness. Holistic services emphasising individuals rather than focusing on disease and episodes of care. Secondly integration. Integrated care, integrated provision of person centred, continued care. Continuing care for individual health services but also public health. So this dichotomy between individual services and public health should no longer exist. We should try and integrate both. They are part and parcel of the same thing. Third was important coordination role for primary healthcare. Both management coordination of the care process within the primary care setting but also across levels. Fourth was comprehensiveness that both Dr Vinod Paul and Erno Harzheim also alluded to. Comprehensive for the course of intervention across the care continuum. Fifth and very important, the continuity of care. So it is not just episodes of care and fragmented care. Sixth is focus on not just individual but also the population with a sense of responsibility for health and wellbeing of the population including social determinants of health. Very important. I think Brazil has done that quite well. Seventh is participation, engagement of communities and individuals in the design, planning, implementation and process. That is the only way to improve social determinants. Eighth is accountability. Ensure that the services provided are effective, evidence based, efficient, equitable and responsive to needs of users and the changing

context. Ninth is solid evidence base for the intervention and also the services that are being delivered and finally integration of technology. All of this underpinned by use of technology to enable provision of highly targeted precision public health and precision health services for individuals.

Sandhya Venkateshwaran:

Thank you Rifat. That was really a very comprehensive outline and much appreciated. I have a question on incentivising performance. But I will come back to that later. Right now, Sujatha, everybody talked about the importance of the people centred system. So my question is that in India and elsewhere actually for that matter, can population health be managed without the system or model of empanelment. And in India specifically empanelling community groups? In India specifically, how can that happen, just given how large our population is etc. and then the second what I asked Rifat again, what type of performance management mechanisms would be most effective?

Sujatha Rao:

Thank you Sandhya for having me this evening. Both the previous speakers have really laid down the principles of primary healthcare, particularly Rifat has gone through the whole comprehensive definition of it by WHO. So now your question for me is very specifically oriented to community engagement. In that sense, is that what, have I got you right? You want to know people's participation, how do we do that? And what could be the performance measurements for that. You know in the context of primary care. One of the articles of faith in the WHO definition concept of Alma Ata and now again as Rifat has said is that primary healthcare can only be effective if it is people centred. And what they mean by that is just not having a committee where people representatives are members of it. But it is based on the concept that the accountability of the primary healthcare system is to the people. Now in India what had really happened as Dr Vinod Paul has traced us very rapidly through the history of primary healthcare in India, as you call it was a very static, passive system of primary care. And that was suitable for the communicable diseases that we had, the disease burden we had which was episodic. So whether it is malaria, whether it is a pregnancy, whether it is HIV, whether it is TB, whether it is leprosy, these are all episodic events that happen and therefore the primary healthcare system was really addressing that. It was only in HIV that is a little bit of the community engagement from the key populations was required because it was a chronic disease and it also required a lot of behavioural change. That then brought in the whole focus on how we make the primary healthcare centres much more responsive to the people. That can only come when the primary healthcare teams know what the people need. In India we are a very diverse population. The state of Bihar cannot be Kerala. Kerala's model cannot be cut pasted and put there. Government of India can only lay down broad principles, can lay down what is the broad vision. But ultimately it has to be decentralised to district and below, looking at evidence and data. Beyond which we don't have that kind of systems here in our country because even today the disease burden estimates are state level. We don't have it district level. Every district will have a different disease burden in our country. And therefore the system has to be designed in accordance with what the disease burden is which reflects in a kind what people need from the health system. So if you go to Assam or Bihar where people are desperate for reproductive healthcare or desperate for family planning, unmet needs and so on and you go with saying I will do mental health which may not be the highest priority, which could be a

high priority for Kerala, then your health system is not responding to people's needs and people don't respond to you either. So the first step for me to say when you say people's engagement it is to have what Turkey has done, as Brazil has done. To have population, demographic, and health surveys to predicate any designing of the primary healthcare system in that district to say what should be my primary healthcare system be doing in addressing these disease burdens that this particular disease has. So that becomes __ the accountability which is very necessary and it is only in such a framework can all those terms and concepts and principles that Rifat has laid out, continuity of care, comprehensiveness of care, need based care, all this comes in when the team leader, when the family health team is given a dedicated population that he is accountable for and is able to say in my group of dedicated population that could be in India's context maybe 2000 families, ten thousand population or as in Brazil concept about 5000 people which is a thousand families, they know that there are so many elderly people, so many who have required reproductive needs, so many hypertensive, so many are diabetic and this then becomes the target, the performance, by which you assess the family health, whether they are really addressing the people's needs and bringing them to a level where they are healthy and well. So what I see is India's history if you really look at it and take a snapshot of 75 years, today what India is struggling with is making this transition from a very passive episodic health system to a system which can give you that continuity of care, can do chronic management, diabetes and hypertension is not an episodic event. It is a lifelong event. So this health system has to have that ability, the family health teams have to have the resilience, the primary healthcare has to be oriented to follow up the diabetic case day after day, week after week, month after month, talking to them, going to their home, bringing in that behaviour change in them. There is no point giving them a drug if that guy continues to eat irresponsibly and not do exercise. So the lifestyle changes, that behaviour changes have to be brought in. And __ has to be pursued. A hypertensive gets heart ailment or something, you do post hospitalisation care. So this kind of continuity of care which means the whole mind set has to be changed of our personnel who are working in the primary healthcare system. This requires new skills and competencies is one aspect, but massively training of our people to say that you are accountable to the patient, you are accountable to the people. So population health in terms of behaviour change for healthy life, I am not saying yoga is one aspect but more importantly look at the diets that we have. How much of rice we eat? So, our eating habits, our exercise habits, bringing changes in the laws of making available... like Chandigarh I would say is a healthy city. Those kind of environments have to be created and to that extent the toilet program, the water sanitation initiatives are bound to have a massive impact on our diarrheal cases and infants dying of diarrhoea. But this beyond social determinants at the individual family level we need to do a lot more counselling on behaviour change and that becomes people centred because the health team takes accountability for that particular family under his charge. Over a period of time. And that is easier said than done. This requires a long term vision, it requires very systematic and property sequenced reforms. It doesn't mean just planting somebody here or putting two doctors or three doctors that doesn't help. Each team unit, the ability to work in teams which also means that you have to probably change your medical education. Bringing in the kind of change that was envisioned a few years ago to say who wants to do clinical medicine, who wants to go into community and public health. So these kind of specialisations will need to be thought of today. So you know whether it is a family medicine, whether it is public health, so these disciplines need to be brought into the primary healthcare space. So I say when people engagement, people get automatically engaged if they find that particular

health centre, whether it is a sub centre or a primary healthcare centre responding to their needs. You can actually see the difference of this approach when applied in Kerala. Few years ago Kerala had barely one patient coming to the primary healthcare centre. Even I as a secretary when I visited Kerala many times, I used to think maybe the sub centre and the PHCs in Kerala setting is a waste of money. Because everybody in Kerala goes to a hospital. They all want to go to the district hospital. They are not interested in your sub centre or PHC. But I was wrong. Now they have implemented the family health centres as they call them, 550 of them, where they can even get nebulisers and asthma drugs. It is the amount of intensive training of the existing teams with changes in functions and responsibilities have been changed and with that you should see the footfalls today. It's massively increased very substantially. Now Tamil Nadu is also doing this population demographic and disease burden surveys. I think that's the way to go. I think we need to look at India not as one homogenous unit. We need to look at north very differently to the south. We cannot ask any state to say, please wait till the other state catches up with you. Because for a state like Kerala diabetes and mental health and hypertension are very critical. RCH is not so. Whereas for a UP or a Bihar RCH still continues to be a very critical need. They are two epidemiological worlds and the health system has to be addressed to reflect that. So I really look forward to furthering the reform process which Dr Vinod Paul has so nicely laid out to say let the next stage be towards decentralisation, towards gathering more district level data, preparing teams to work on evidence and tuning their own health systems at the district level and I believe Sandhya very strongly that one feeling. I felt it even when I was in service that we have no patience. We don't have the patience to do piloting. But I have seen the efficacy of pilots both in the HIV program where DFID supported us immensely on pilots which then as you know Gates foundation came with big money and NACO also scaled up with a huge amount of money, we were able to scale up those initiatives. Kerala also did that quietly for 2014 to 2016. For two years they worked this model only in three PHCs. And now despite covid they have been able to upscale it from three PHCs to 550 PHCs. So this kind of modelling has to be done at the micro level because that is where it counts. The broad vision at the national level cannot ever be replacing the local skills and the local solutions that the teams at the local levels can bring in. I am not sure if I answered your question on people centred. But I do believe that the people centeredness comes in only when the health system recognises them as important key stakeholders.

Sandhya Venkateshwaran:

You have Sujatha. Thank you so much. I am going to take off from your focus on teams that in order for a system to be people centred the teams that are working on the ground have to have a variety of skills because they are there for the long haul. It is not that sporadic engagement. So they are really in many ways the fulcrum of an effective primary care system. So I am now going to ask a question on the workforce. I had a question on workforce and one on financing. But I am going to mix them up if you don't mind. I am going to Rifat and ask, so Turkey has multidisciplinary teams. And as all of you have said that it is very important to have teams which can do both outreach and curative tasks and on a variety of issues, communicable, non-communicable, population health etc. The key element of something like this is skilling, training these things. Rifat would you talk about Turkey's journey in terms of skilling. Because I am just thinking again of large countries like India and others that often becomes a bit of a bottle neck. How do you actually manage effective skilling? Of course the numbers are a big problem as well but since we are not necessarily talking of medicalised teams, let us assume

for a minute that numbers are not such a challenge. So Rifat would you talk about training and skilling within about five minutes.

Rifat Atun:

Absolutely. That is a really critical question. I think there are two important dimensions to that. So the one is the temporal dimension and the second is sort of the scope and scale of the skills. Now temporal dimension is important because in any reform program one has to scale up rapidly to introduce nationwide changes. Of course very important to pilot to understand what a model might look like. And I would even go beyond calling these pilots. I would call them demonstration programs to show what the new would look like. Because what is on paper when it hits the ground is going to be very different. So one can spend years designing the perfect solution informed by technical evidence. But actually when this solution on paper hits the ground it is going to be very different. So it is very important to demonstrate what could work and then scale up rapidly. Sujatha used a very important word. The sequencing and staging is very important. It would be very important to have a core set of skills and competencies for the team that enables a rapid scale up. Because one has to show results to show impact of these interventions to get buy in, to get legitimacy. Because one is introducing a new model. And with anything new there will be push backs. Because people will not want to change what they are doing. So that deciding what are the initial core set of skills and competencies for the primary healthcare team is a very important exercise. And then thinking about looking at the available workforce which would be different from state to state, municipality to municipality who needs to be trained so that everyone is levelled up to have this core set. So that is the temporal dimension. Then the second element of temporal dimension is over the longer term what kind of skills and competencies need to be in place, what is the scope of these skills and what is the scale of these skills to enable a country to develop a larger set of services. In Turkey there was an emphasis initially to rapidly scale up skills of doctors and nurses to enable them to become members of the family health team. And this included short course training over three months. Initial discourses were piloted and it was shown that the training program was successful. I was actually involved in the design and in the evaluation of these and then from three provinces the program was rolled out to 81 provinces very rapidly. That was instrumental in demonstrating that the new model would work and actually achieve results. Which then gave the ministry of health and the government the legitimacy to continue with the changes. And the initial emphasis was on developing this nucleus of family physicians, family health nurses, midwives, as well as assistants. But of course as I said earlier there has been an expansion of what is provided in healthcare by extending population level public health intervention through community health centres and not through health living centres. So I would work backwards and say where do you want to be in ten year time? My vision of primary care is that primary healthcare should be providing 95 to 98% of all healthcare related episodes. We cannot solve health problems in hospitals. That is just not possible or feasible. We are very fortunate to have technology in terms of diagnostics, remote care, in terms of treatments and health technologies that will enable us to provide really high quality and comprehensive care at primary care level. And the skills and competencies should be coupled with that vision. Primary care shouldn't be the weak basic care that has characterised primary care. It should be the core of the health system providing the best services and attracting the best members of health professionals. I think investing in nursing and other cadres are actually the really wise decision because chronic disease management has to be managed not just by doctors but actually by nurses and other

healthcare professionals. So work backwards from what is the vision in ten year time. This is an ongoing process, the changing process. And then gradually build these skills and competencies. But think of the temporal issue. Rapid scale up with a core set of skills. So everywhere we have these services provided and we have the platforms to build upon.

Sandhya Venkateshwaran:

Thank you Rifat. I am tempted to move on to financing and Erno, you had talked about Brazil being a decentralised system and how the municipalities control large part of the resources. Could you talk about Brazil's experience in how did the decentralised process impact delivery of primary care? And also I am tempted to say more importantly what the politics around that was. Around being able to decentralise resources.

Erno Harzheim:

As I told you, the municipalities are responsible to provide primary care in Brazil. They receive the money, they receive orientation about the composition of the team, which is not the best way to do it. But they receive from the ministry of health a list of activities, a very comprehensive activities, actions they have to hold on to maintain and turn better the health of the population. It is very important to talk about the nature of the reform of the financing of the primary care in Brazil. I think one of the first things to talk about is not about the nature of the provider. I agree a lot with Prof Rifat Atun that we need to look for the needs of the population. And the list of activities the team will hold on with the people will change over the years. And primary care has to be a very technological health services. With this increasing information technology and other technologies of healthcare, we have to put technology in the healthcare primary care teams. For that many times you need to take help from the private providers of health in each country. I think the nature of this provider, if the provider is public or private, it doesn't matter. What really matters is the quality and the nature of the contract the government have with each provider and the method of payment between the government and the provider. OECD has established that the best model for pay for primary care is a mixed model in which 50% is capitation and the rest is divided between incentives, a little bit of fee for service and pay for performance. Capitation has to look into equity... that is capitation should pay more money for each individual who has the greatest needs and the pay for performance must be based on the great indicators inspired by the value based healthcare with indicator representing health and not only illness. As we have talked a little bit more, now here in Brazil we established that we will have 21 health indicators for the pay for performance in our reforms. Four of these 21 indicators are health indicators. They are the resolutivity of the doctors, the scores in primary care assessment tools, an instrument developed by Barbara Starfield who measures the quality and the presence of the attributes of primary care. PDRQ9 an instrument developed in Holland that measures the strength of the doctor patient relationship and net promoter score, a very useful marketing indicator of compliance between people and services. The other 17 indicators are directed to illnesses that are important here in Brazil at this moment. Diabetes, mental health, hypertension, immunisation, mother and child care, HIV, Tuberculosis and they try to move from structure and process indicators to result indicators. But the challenge in this changing process to achieve these better result indicators is the information we have to measure it. In Brazil at this moment we put more or less 4 billion dollars annually from the federal budget into primary care. This represents 17% of the federal budget for health. It is decentralised through the municipalities. But the municipalities put out of their pockets more

than double or one and half times of that. Like 6 billion dollars annually is put in primary care from the pocket of the municipalities. We have a ten billion dollar budget to primary care in Brazil to this 150 million people representing more or less 50 dollar per capita a year and 40% of this is from federal government and 60% of this is from the municipalities. So each city, each municipality has some orientations from the federal government but they have a lot of autonomy in looking after the needs of their population and try to conform and offer primary care teams to resolve these problems. The problem of this radical decentralisation is that we have more or less one thousand cities, very small with less than 5000 people living there and this is more serious. They face some very huge weaknesses in maintaining governance in health. So we need a role of the provinces of the states to give a hand in these small cities and make possible to have better primary care. As a national health system there are no formal out of pocket costs for the citizens in Brazil. But some of the research and World Bank showed in a recent study that about 12% of the household budget is directed for healthcare here in Brazil. And in the poorest level of income in Brazil this 12%, 4 to 8% is spent on medicines. And we have a free medicine program offered from the municipalities and from the federal government. It shows Sandhya that we have a national health system. But with a lot of challenges that you have to work till it becomes better. Brazil spends about 9.5% of GDP on health. On the whole of GDP 4 to 4.5% is through the public system. And 5% of the GDP finance the private sector. The private system has already some incentives, tax incentives in the order of 3.5 billion dollars a year. So we are at an equilibrium in the financials of the private and public sector in Brazil. And a lot of space for additional reforms. I think it is important to talk to you some of the main lessons we learned in the primary healthcare reform in Brazil. This goes in three directions. First it is only possible to reform financial if the proposed reform meets some of the provider expectations. Mainly in the absolute increase in the value in the amount of money we are transferring into the municipalities. We spend more than 10% of primary care budget in the first year of the reform. Second the reform has to be widely discussed with the providers. And undergo changes in response to their demands as long as this change does not mischaracterise the nature of the reform. And have to present very clear transition rules. Radical reforms is impossible to make it without transition rules. And third to be carried out and achieve stability. A reform in the financial primary care should be made with a lot of transparency and accountability. All of you were talking about accountability. Inclusive to produce a healthcare system more accountable and more responsible with the public budgets.

Sandhya Venkateshwaran:

Thank you Erno. That was a really interesting and useful outline of many of the financing elements. In fact as you were speaking I had so many questions. But we are so behind time that I think we will have to have a follow up discussion on this. I am going to ask one last question to Sujatha. If you could just take five minutes. Many countries like India have a very large private sector. Erno talked about the importance of contracting and whether that be the private or the public, it doesn't matter. My question to you is can the government or how can the government shape the private sector through contracting mechanisms in the context of primary care specifically?

Sujatha Rao:

To begin with I think as a nation and as a policy we must admit to ourselves that of the three sectors of tertiary, secondary and primary, primary care is something that cannot be left to the

private sector. It has to be done by the government. And what do I mean by that? That is that government alone need not be providing the services. Government can also take private sector people to provide the services, but then like... I really have a lot of confidence in the way in which UK has done its GP system and as you know, all the GPs there are private people. But they are very tightly bound by the government both in terms of they cannot earn a pound more than what the government gives them. And they are accountable and answerable to the government for the services that for which they are being paid. If we can have a private sector provider who is paid and allowed to do or is asked to do this package of service delivery and is fully paid for and doesn't have his own side business of any kind that is okay. That is fine. But in our country because of lack of... the proliferation of the private sector has been so mismanaged if I may say so, that on the same street you will have a Jola fellow, you will have a RMP, unqualified quack, it is a lot of holes in the bucket which becomes very difficult for the government to plug and have a neat system to say for these three thousand population Mr so and so, you are going to be with your team, the responsible and I contract you for that person. For that service delivery to be done to these three thousand people. The primary healthcare scene in India is very complex, very multi-variegated, and very competitive and it is very difficult for government to be finding space and providing the delivery of services on its own. This is the reason why contracting in the primary healthcare system is becoming very difficult because accountability and performance of the private sector to the contracts that they have agreed to is very complex and difficult. So this is where I think the redesigning has to be done. For example, if we can restrict the private contracting only to say missionary hospitals and not for profit. What do I mean by that? In a tribal area, the government may not be the strongest actor to provide services in their remote and tribal settings. Maybe there is already missionary hospital. Like in Barasat there is a Ramakrishan mission which is the only source of providing services to that lot of people. There is no harm in government getting into a contract with them saying, these are all the services. We give you money, we also give you the drugs that are required for you to give under the national health programs. But we will extend the contract severely on a third party evaluation, that you have really immunized 100% of the immunization, 100% antenatal care, whatever the contract lays down in terms of services. But this much we should go step by step. Can the government say identify where its source of strength is, where are its strong sense, where they can provide the private sector the primary health services through its own centers. And where do we need to co-opt or partner with a not for profit charitable missionary, whatever, charitable organizations that don't do for profit, but then make them strictly accountable to have the team that we specify, providing the services that we laid out and have a system of evaluations concurrently, frequently to see that they are giving the quality of care that we want to give. I know Rifat should have mentioned. He knows that to arrest the reproductive healthcare they had a whole lot of these nurses, midwives in every village who couldn't charge the patients but they were giving safe and good quality reproductive healthcare in that particular locality. So you can experiment with all that. The payment system has to be public. And for that we need to increase our budgets and since this is the last question Sandhya, I would only like to say, no matter what vision we have, what concepts and principles we may adhere to, the overall budget has to increase. In fact the economic advisory council of the Prime Minister set up a task force in 2019 and they made a report of what is required for primary care. And that itself came up that just for infrastructure strengthening as per the IPH standards of 2012, not 2022 which are way beyond our capacity for the next 50 years, 2012 IPH standards, they need 1% of GDP and human resources requires

another 1% of GDP. Now 2012 IPH standards are very modest and even to achieve that modest standards we need a 2% GDP to be dedicated to the primary healthcare system. So these are complex issues. Ultimately what we need is a step up of public investment and if we can focus it on primary healthcare, public, private I don't care who the provider is, but the quality, the service delivery, the evaluation system and ability to not allow it to get politicized and really have an evidence based driven system, that will help. But then that requires a very solid regulatory system in our own country. So it is a very interlinked, mixed up set of issues that we need to deal and layer by layer tease out and sort out to achieve that end.

Sandhya Venkateshwaran:

Thank you Sujatha. That is very well put, the need to increase budgets, the importance of government being responsible, and the provider could be public or private, but figuring out how to tackle out very heterogeneous non-government provider landscape. Whether it be for profit or not for profit but as you said it is a very heterogeneous landscape. There it is important to leverage them somehow. But not entirely clear how.

Rifat Atun:

If I may Sandhya. I practiced as a family physician in the UK for many years. We are independent contractors... there was a service, we were contracted and we provided the service but we are part of the national health system. I think it is very important in this phase of reforms to use all the assets available and in terms of assets I mean the human resources available to scale up the reforms. Using contracting but very importantly having defined the skills and competences to have licensing and ongoing accreditation. And ongoing performance measurement. One should contract with public sector providers as well as private and not for profit to scale up or level up services across the country. Then build on using contracting as an instrument to expand the services and to introduce performance related pay.

Sandhya Venkateshwaran:

Absolutely.

Erno Harzheim:

It is the model we have to follow. We have to be worried about the nature of the services provided not the nature of the provider.

Rifat Atun:

Exactly. And focusing on the outcomes. Not just inputs.

Erno Harzheim:

Quality of the outcomes.

Sandhya Venkateshwaran:

So on that note I am going to now come to Dr. Vinod Paul. Because in fact Sujatha was speaking about the need to raise more resources, I thought that is a perfect point to actually pivot back to Dr. Paul. So having heard all of these insights and experiences Dr. Paul over to you just in terms of how you see some of what you heard.

Sujatha Rao:

Sandhya, just before Dr. Paul starts I would just like to say that in the scale where we are money is important. But I think more than the money... if the prime minister says Dr. Paul you want? Okay here, take 3% GDP. I think he will probably _____. Because first we have to get the design and the whole fit right. Which requires a lot of baby steps of reform and clarity of ideas. So then the money follows and you really scale it up. Sorry, I just wanted to say that. Because in our discourse in India is constantly badgering government for money. But money for what?

Sandhya Venkateshwaran:

Fair point. So Dr. Paul. Your thoughts now.

Dr Vinod Paul:

Thank you very much. Very illuminating discourse. Wonderful, insightful presentations and comments. And new information. So thank you so much Ma'am and Dr. Rifat and Erno, very grateful. Well I think the points that have been made and summed up in the last three four minutes with enthusiasm are absolutely valid. They provide in taking the discussion forward for the kind of work that policy enablers would do. So it is very insightful, it is refreshing because in covid several work, several missions had to wait and I am glad that we are reigniting our broad discussion around the health system. Having said that I think my one takeaway is the word continuity of care. I must say that we haven't used that very often. But that has come very strongly. Episodic care vs continuous care and therefore a responsibility of ensuring compliance and ensuring follow ups, ensuring outcomes and change in the status of health over and over again weeks and months. Something which is very well stated, extremely well stated. That also has become part of our training. Because often our training is a snapshot training. We don't follow enough in training. So that is something very refreshing. The second point is that we still are struggling with an optimum model or models for urban primary healthcare. And some of the insights that I heard today refreshingly as they are, they are reminders looking at doing urban healthcare. Urban primary healthcare somewhat differently from the rural. It is putting something that is very big issue into a very simple two sentences. But I think that is where there is a room for innovation, room for not simply to cut paste the rural model to say the least and because that work is still to unfold as we know. We do believe that we should give leadership to the local self-governments especially when the urban geography and population is say of size something like half a million, one million and in that range the rural model tends to then break down. Because there is too much of complexity around it. So one take home message is that surely for urban thinking about different models. The point about contracting, the very fundamental problem that we face at the moment is we don't have enough people to contract in. Who will go to... whom do we contract? Even if we wish to hand over services or geography to a private system but where are the private providers of the kind and mix that we would like to have? So that is a constraint that we have to live with for some time. But certainly in the urban space some leeway and some flexibility is available to us. My third point is technology that can leapfrog many steps. And gives us an opportunity. For India technology being relatively strong and rising and in being utilised as well in the health sector and several other sectors, there is a huge opportunity for us to tweak the approach using technology. So the core principle that you have all said remain the same. Rifat you highlighted them very clearly. But in order to reach and to embrace those principles and to practice those principles technology could come handy. I just want to add here that in the health and wellness

centres having telemedicine is a norm. Telemedicine has to be there using smart phones or using a static computer. It is a norm, period. I have a number here to just impress you. 46 million consultations through these emerging health and wellness centres till date. And that is being tracked. So technology and then as I mentioned to you the health accounts, on health ID and health digital records, some of those approaches could be taken forward and be leapfrogged using technology. That is an opportunity that we are looking forward to. Talking about data also it is possible for us to leapfrog in terms of local data and its utilisation using technology. So that gives them a huge opportunity. Your ideas on how technology can be leveraged for a situation like ours and Ma'am your thoughts connecting to practical domain Madam Sujatha would be very useful as we take this course forward. I think clearly primary healthcare must remain the most important component, foundation of India's health systems. There is absolutely no doubt. We wish to move in that direction. I think the quantum improvements that have been carried out since 2018 are one very major change and transformation. But lot more has to happen, must happen and particularly in the urban space I would say learning is still underway before we finally talk about one design or more than one design and how to go forward. But very kind of you to have me in this discussion and excellent learning. Thank you indeed.

Sandhya Venkateshwaran:

Thank you so much Dr Paul. Thank you for outlining some of the key elements that came out of this conversations, some that need attention as you said, Urban PHCs, continuity of care, etc. others that we know they are already under way and help leapfrog like technology, data

Dr Vinod Paul:

One question. One thing we are grappling with is the care of the elderly. So there ideas on how to orchestrate care of the elderly in the rural system, compatible with the rural imperatives. Those ideas will be very welcome. Researches, pilots, demonstrations, projects would be extremely useful from the global level.

Sandhya Venkateshwaran:

Absolutely. Thank you Dr Paul. So care of elderly, a learning eco system, focus on data, using technology to leapfrog, contracting but as you said where are the providers the kind we need, leadership to local self-government, urban PHCs, continuity of care, all key issues that need more and more attention. With that thanks to all of you. There are a bunch of questions but we are beyond time now and I know some of you need to leave because I have been getting messages. So I am not going to take questions. I am very sorry, my apologies to the audience I could take one or two but that is unfair. Either we take the bulk of them or none. We will see if there is a way to get responses to these questions from our speakers later. But my profuse apologies that time is not allowing us to take questions. But thank you so much on behalf of CSEP for this very rich and enlightening discussion. We hope to continue our work on these issues and to reach out to all of you again. Thank you Dr Paul, thank you Sujata, thank you Erno and thank you Rifat. Thank you very much. And thanks to all our participants who listened and contributed with their questions.