Welcome to the PHC webinar series. My name is Beatrice Bernescut. I’m the communications focal point for the PHC team here at WHO. And I would like to introduce our first speaker this afternoon on our topic of quality and primary health care. Dr. Shams Syed, who coordinates WHO’s Quality Systems and Resilience unit, which sits within the UHC and Life-course division here at headquarters in Geneva. Doctor Syed did his studies in London at the University of St. George’s or University of London, rather, and was a GP in the UK for a number of years before coming to continuing his training at Johns Hopkins University. And he is a fellow of the American College of Preventive medicine. He’s currently directs the WHO National Quality Policy and Strategy Initiative, and I will let him introduce the topic of quality and primary health care. Thank you.

Thank you very much, Beatrice. And greetings to you all from across the world. It’s a real privilege to be part of this webinar series from the PHC colleagues. Today, I have 15 minutes to give you a little bit of an overview of what we’re thinking related to quality in primary health care. And one of the things that I’d like to do to start off with is to really move ourselves back to last year, actually, where three seminal publications were put forward on affirming quality essential to universal health coverage.
I think it is important to emphasize that this linkage has been increasingly recognized, and affirmed that quality clearly is central to UHC. And of course, access means very little if services lack quality. Each of these publications emphasize the central role of quality in PHC. And, of course, also highlighted key actions that have been proposed to improve quality with PHC as a key driver. And just also, perhaps, as a point of emphasis, to really highlight that all of these publications emphasized a health systems lens, and poor quality as a result of health system failures, as opposed to the fault of individual providers. And also the universality of the quality agenda. That it’s not something that is only important in rich countries, or countries that are finding their trajectory on universal health coverage.

But it really is a universal concept. And failure to build quality into health systems from the start, or in the process of reform and redesign, is really an important point of emphasis. Let me come to then the thinking related to why quality might be important for us to consider. I think most of the colleagues across the world that are joining today will understand and recognize this. But one point of emphasis from the Lancet Global Health Commission that you may have heard previously, and I certainly refer to it regularly, is this rather staggering figure of 8.6 million deaths per year in 137 low- and middle-income countries being due to inadequate access to quality of care. Now, let’s just imagine that the figures are not correct, let’s just imagine that the figures are an overestimate, even then we are really astounded by a figure of millions of deaths attributable to poor quality across the world.

And importantly, and as you’ll see in the very simple pie chart on the right, of these 8.6 million deaths, 3.6 million deaths of people who do not have access to health system, and 5 million are indicated to been from those who sought care, but received poor-quality care. Importantly, and then moving into the action phase of this, is that high-quality health systems could prevent an estimated 2.5 million deaths from cardiovascular disease, 1 million newborn deaths, 900,000 deaths from tuberculosis or all half of all maternal deaths each year. Each one of those data points refer to millions of human beings. And I think that’s an important emphasis point, again.

PHC central to this in terms of the potential to really unlock this prevention that could
take place if we had a focused effort on quality at all levels. But let's then think a little bit about what quality health services are. This will not be new to most of you. But it's important ground to cover. Quality health services have been defined in various ways across over the years. But it’s clear that while those domains have evolved over time, there is a growing acknowledgement that quality of health services need to focus in on the three domains of effectiveness, safety, and people-centredness with very strong attention to timeliness, equity, integration and efficiency. And this is really clearly laid out in the WHO/World Bank/ OECD reports that was part of the of the triad of reports that came out last year.

Dr Shams Syed 05:51
Just in this slide, just really emphasizing that PHC and UHC are, of course, mutually reinforcing. And they are really focusing in on the journey towards health for all, emphasizing target 3.8 on universal health coverage, with its clear focus on access, quality and financial protection. And, in fact, all of the SDG3 targets, which are all impacted by a focus on quality. Now, let's also emphasize - and this again, for those in the primary health care world - will not be any news. But the three interdependent pillars really give us a compass to think about and I’ll come to that just now. But it is important to emphasize that PHC has been shown to drive effectiveness and people-centredness, thus enabling quality within UHC.

Dr Shams Syed 06:46
I'm going to spend a little bit of time on this slide here. Just to unpack some of the thinking that was put forward within a technical paper which was part of the technical series that was used in the Astana conference. The technical series are related to quality in primary health care. Now the three interdependent and complementary domains of empowered people and communities, multisectoral policy and action, integrated health services, prioritizing essential public health functions and primary care, all three of those well-established domains and interrelated pillars have a clear linkage with quality.

Dr Shams Syed 07:33
But let's come to the the foundation there. And you can see on the left and on the right, when we've just articulated the domains of quality. When we look at the high-performing primary care, we can see - and this again will not be news to many of you - but people’s first contact, comprehensiveness, coordination, people-centredness, continuity, accessibility - all of these things that are usually spoken about when we talk about a high-performing primary care system are incredibly complementary to the domains that we
just articulated in relationship to quality.

Dr Shams Syed 08:09
And here you can see that clear linkage between many of the attributes of a high-performing primary care and quality care. But we shouldn’t underemphasize the linkage also that quality plays with empowered people and communities, and multisectoral policy and action. So the conceptual linkage is there, and it is clear. But it is also important to emphasize that quality doesn’t occur spontaneously, and one has to organize one’s thinking around quality. And that will be what I turn to next.

Dr Shams Syed 08:51
There are many interventions to think through and again, the time that we have will not allow us to go into this in any level of detail. But I did want to introduce some thinking related to how to organize thinking around quality interventions. And often this can provide a reasonable starting point for consideration. This organization of quality interventions is seen within the WHO/World Bank/OECD reports, and also is taken up by the WHO Initiative or National Quality Policy and Strategy.

Dr Shams Syed 09:27
Now just to unpack some of these pieces...bringing forward the system environment on any quality issue is key. So the types of things that we’re talking about there are interventions such as is focused on external evaluation and accreditation; clinical governance; public reporting' and comparative benchmarking; performance-based financing; and training and supervision of the workforce. These are just a select number of interventions that can be considered from a systems environment perspective. And then we then need to consider how each of these interventions overlay within the primary health care context.

Dr Shams Syed 10:08
When we think about reducing harm, there are lots of different interventions that can be taken on board such as safety protocols, safety checklist, adverse event reporting, and inspection of institutions for minimum safety standards. Clearly a hugely important agenda that’s also gaining global momentum. The third block of interventions really focus in on improvement in clinical care. And of course, this is a highly complex arena, but the types of quality interventions that one could imagine are clinical decision support tools; clinical standards, pathways and protocols; clinical audits and feedback; morbidity, and
Now, each of those types of interventions have their own nuances and differences when applied in the primary health care context. And that is what we need to then consider. And the final fourth block is an important and often-neglected area within the quality work. And that's the block related to patient family, community engagement and empowerment. And there were a range of interventions that one could think through. Example such as: focusing in on shared decision-making; peer support; and expert patient groups; patient experiences of care’ and patient self-management tools. Now, each one of those and again, it's just to emphasize that each of these interventions could be a subject of a webinar in its own right. But I'm trying my best to give you an orientation around how to think through these quality interventions as a potential starting point for consideration. Certainly not complete, but at least a starting point.

And national health systems would really need to pay particular attention to all of these interventions and carefully select a practical set of interventions in a clearly articulated national direction on quality, with primary health care at its core. So with all of that, I mean, let's just come right back to the patient and really thinking through a person - and perhaps the word person is better than patient - but person with diabetes. Many of the colleagues on the call today, this will not come as any news. But essentially, there are so many attributes to the care that's required for a person with diabetes. And you can see that for yourself. Long-term medication use; self-management; preventive measures; the secondary and tertiary care management issues; the measures to adopt a secondary disability; and of course, the linkage with management of social impact. These are multiple and complex health needs within a service. And of course, there's a heightened potential for worsened health outcomes due to poor quality.

Going back to my initial focus on the preventable deaths, you can see how closely linked that unpacking of the prevention potential would be with primary health care, but primary health care being uniquely placed, if quality is placed within the patient journey, and there are many, many entry points. So all of the interventions that I was mentioning earlier, have its own place within this soup. So it could be a focus on individualized prevention, promotion and treatment. It could be the coordination and gatekeeping role. And, of course, the role of all primary health care to complex medical and social...
So let me turn now to perhaps a few of the challenges that we face, in the remainder of my time. There are a number of key challenges that are articulated in this paper on quality in primary health care that I alluded to, and I wanted to just to touch on each of them. So there is this often misunderstanding on the meaning of quality PHC. That’s really now moving into a phase of conceptual clarity. And that’s actually really important to emphasize. And hopefully some of the resources that I’ve just mentioned are a part of that armour, for that conceptual clarity that’s required. And then of course, nothing succeeds as a concept, but it’s the action that is the necessary action from that concept. And this conceptual clarity, of course, evolves and has a different nuanced meaning in the different systems that we work in.

The second major challenge is often that when setting national quality directions - and I’ve alluded to the necessity for each country to really focus in on a clearly articulated national direction - that linkage and connection to local PHC environments is really important and often is a major challenge. Because frontline realities faced by PHC teams can sometimes be ignored when setting national directions. And that’s an area that really requires very strong attention.

The third area, again, not perhaps news to anybody, but important to emphasize, is that PHC measurement can be disconnected from improvement efforts. An example of how to tackle that is is the very interesting Primary Health Care Performance Initiative, which is really looking at unpacking the linkages between the measurement dimension and the improvement dimension, with a strong focus on engagement. So that’s clearly an area where primary health care practitioners, when they’re asked to measure, really deserve the support to also improve. And this is where the concept of no measurement without improvement comes in.

The fourth point, and the fourth major challenge to highlight, is often the lack of integration between the efforts at the primary care level with districts and hospitals and here, the critical importance of an integrated people-centred health service approach,
which is something that WHO has really been pushing forward with, and that’s a clearly important area that requires further unpacking. And, essentially, primary health care provides an opportunity to bring that cohesiveness and integration that is required.

Dr Shams Syed 17:19
The fifth one is a particularly taxing one – it’s that quality initiatives often can be seen as time-bound projects. And this is true for various settings. But particularly in the development arena, sometimes there can be a multitude of quality initiatives, and they can be considered as time-bound. And this is where the sustainability issue comes in. And for a point of emphasis, here is a clear role of the stewardship function of Ministries of Health to allow that clear national direction on quality to be able to provide that overall direction on where primary health care quality is placed within an overall national direction on quality.

Dr Shams Syed 18:14
The sixth and final challenge that I’d like to highlight is the contextual relevance of many of the interventions, even, of course, the ones that I mentioned previously. These are the areas that we need to focus on, on how do we create the local adaptation and the learning that comes from that, and feeds in to global learning on the subject. And this is exactly where the work that WHO and others are doing in relationship to the learning agenda at the global level.

Dr Shams Syed 18:51
So my final slide is a question mark, because this is also, again, a highly complex arena, but primary health care and health emergencies - now we recognize that nearly 2 billion people will be living in settings of fragility conflict or vulnerability. And of course, PHC is, again, the driving force for the solutions that are required in these settings. The reason I placed a question mark on this is that we really do need to think this through carefully. A starting point. Again, an assistant technical document for the technical series for Asana was this paper on primary health care and health emergencies, and placing that for consideration, because it is something that we really need to think through together. And that’s a little bit of a whistlestop tour of a few of the reflections that I wanted to provide related to quality and primary health care. And I’m going to now thank Beatrice to continue. Thank you.
Thank you very much Dr Syed. Joining us also to speak on this highly important topic is Dr. Kamaliah Noh, who’s joining us today from Malaysia, where she has spent more than 35 years at various levels of the public health delivery system in that country. And she retired from the public health system as the Deputy Director for Primary Health Care in the Family Health Development Division. She’s currently an associate professor on the Faculty of Medicine at Cyberjaya University College of Medical Sciences. Dr. Noh, over to you.

Dr Kamaliah Noh 20:43
Thank you, Beatrice. And thank you Shams, for giving that overview. And I guess for me now, it is to relate what is happening at the country level when it comes to quality initiatives. I guess the first question that comes to mind is: as clinicians, what would be the impact of quality on our day-to-day efforts in our primary health care practice? And I think, for us, we tend to be more comfortable with patient care. And we may define “quality” as patients receiving effective, evidence-based care, and what is this? Which is related to our clinical practice guidelines that’s available in our countries.

Dr Kamaliah Noh 21:38
But as clinicians, we need to be reminded that how we manage our facilities will also impact on the quality of services delivered, because increasingly, we are in teams, working in teams. And we need to ensure that all members of our primary health care team who are treating patients, they are professionally trained, they continue their professional development, so that they’ll be able to have the knowledge, as well as the skills, to perform specific procedures. And, more importantly, they will implement this knowledge and skills.

Dr Kamaliah Noh 22:20
And in primary health care, Dr. Shams has alluded to these core dimensions of primary health care in terms of access to comprehensive services, with continuity of care and coordination of care, which is very important nowadays, because of the high burden of non-communicable diseases. And if we want to ensure that these are achieved, we need to look at the whole spectrum of care, starting from the community level, as well as making sure that we are linked to the hospitals that we refer to whenever we are measuring our quality initiatives.

Dr Kamaliah Noh 23:03
And this is important because we are not only interested in the patient, but we are also
interested in population health outcomes when we are the primary health care level. So this needs a culture of quality in our environment. And we need to make sure that there’s incentives for this, there’s technology which can enable this, so that our staff, and we also will not be overwhelmed by the process of quality performance measurements, and forget that link to improvement that is so necessary after the measurement.

Dr Kamaliah Noh 23:48
So if I can go to the next slide, Dr. Shams has also alluded to this that we need to take a systems approach, and because how we practice is also dependent on our system inputs, and therefore the entire health system should be coordinated. And therefore we have so many competing priorities. And which one do you focus on first? Depends on your health system goals. And the context of your health system functions. Because this determines the capacity, and to be able to focus on certain areas that you you need to address first. In order to do this, there are already many frameworks that are available. And Dr Shams has mentioned the PHCPI. And I was involved in the development of this framework, as well as the looking at the feasibility of using the indicators that were developed in this work for Malaysia. And why do we need to use frameworks? Because it articulates knowledge and priorities and how qualities defined, it guides measurement - what to measure, what not to measure - and this common language for improvement. And, as mentioned just now, quality is a journey. The goalposts are always shifting. It's an improvement cycle, and we need to review our strategy and measures periodically. And in order to do this, there are many measurement tools, and the indicators that you choose will depend on your health system goals.

Dr Kamaliah Noh 25:39
And for my last slide, I’d like to share a little bit about the Malaysian journey. When it comes to quality, all of us in all our countries, we’re not starting from zero baseline. You know, we have quality initiatives, whether it’s audits, whether it’s our CPG, whether it’s our licensing procedures. And therefore the first step is actually to assess the measurement system in our country. For Malaysia, we introduced our quality assurance program in 1985. After 25 years, reviewed our QAP, and it has taken us five years to review our strategic plan. And right now, we are currently engaging with the stakeholders to develop a national policy for quality in health care.

Dr Kamaliah Noh 26:33
So with this assessment, then you’ll be able to identify gaps in the quality measurement by applying the measurement tools. And I have put on this slide, a link that you can go to
where you can assess the toolkit produced as part of the PHCPI work. And it looks at the various indicators, whether it is technical quality, experiential quality...this is because we are more familiar with client satisfaction. But we are now going into patient experience, as well as community engagement, which, for Malaysia, that was a weak area that we found.

Dr Kamaliah Noh 27:15
We found that our measurements were unbalanced. We were overemphasizing on effectiveness of prevention and cure, whereas we needed more indicators addressing safety and patient centredness as well as quality of long-term care. The other weakness that we found was that it was strong in the public sector, but for the private sector, it was not as strong. And after our assessment, no wonder our staff were complaining at the ground, because we found we had too many indicators. And we have managed to pare it down now to about 70-75 indicators. So for alignment, we attempted to start with a broad goals of our system, because the goals have changed, you know.

Dr Kamaliah Noh 28:09
And we wanted to be able to measure variability across indicators and equity. We added timeliness as a service quality. We were also looking at outcomes, rather than intermediate outcomes. It was good that Dr Shams showed you the journey of the diabetic patient, so we found that we were measuring more of diabetes control. What is the HbA1C, but actually, we needed to focus more on prevention of complications, for example. And we also used this assessment to set our priority conditions, based on high burden of disease and costs. And we wanted to create measures which could cut across disciplines. For example, all the surgical disciplines, they measure infection. So ultimately, all this assessment, you get some data, and this data should be used for decision-making so that you can improve the services. So with that, I end my short presentation and back to you, Beatrice.

Beatrice Bernescut 29:23
Thank you very much Dr Noh for that excellent outline of your of the example from Malaysia. I would like to offer our participants the opportunity to send in their questions. And I'm going to start with the first question which we've received, which is, what role can PHC play to reduce those projected TB deaths that were mentioned earlier? Who would like to take that question? Dr Syed?

Dr Shams Syed 29:58
Sure. Thanks for that. And it’s a really important question. So one of the things that I might want to highlight there is the important role that disease-focused programs have in catalyzing action on quality health services, and particularly with a PHC-driven approach. So TB, HIV, malaria all have a quite a deep experience in quality initiatives and quality endeavors. One of the things that we feel might need to be strengthened is the interlinkage between these disease-focused areas. Of course, the linkage is very obvious related to TB and HIV from a clinical perspective, but it is also important to emphasize that taking a holistic and integrated approach to improving quality of health services for the entire population - while recognizing the importance of focusing in on specific population groups, and specific disease entities - is critical in order to have the synergy that’s required, and ultimately to unlock the potential for preventing the deaths that we articulated earlier on.

Dr Shams Syed 31:29
So, in summary, one is really focusing and on the integration of the efforts on quality at the PHC level between different disease-focused entry points. And secondly, to really emphasize the importance of a clearly articulated national direction on quality that Dr. Kamaliah really highlighted from the Malaysian side. And then the third and fourth final piece in this is to always emphasize the clinical entry point, but always ringing in the population side as well. So you’ve got a very clearly important individual element to this. Of course, that’s the heart of primary care, but at the same time, taking a population-based approach. And that’s where the linkage between primary care and the central public health functions comes in. Thanks, Beatrice.

Beatrice Bernescut 32:33
Dr Noh, would you like to add to this question about PHC playing a role on TB?

Dr Kamaliah Noh 32:40
I guess maybe I can just give an example. So for primary health care practitioners, when we’re working in our clinics, we realize that we are actually the coordinators of care, we are the hub of coordination for each patient. And why I say this is because when it comes to TB, that’s not only because of quality of care, it is influenced by social aspects as well. And therefore you have patients who are unable to come for treatment. And therefore if you do not take into account these social aspects of your patients, by referring them to welfare aid, for example, or providing transportation costs, then the quality of care by the clinician will be affected. And at the same time, when it comes to TB, I think we have to focus on prevention as well. And that’s where the placement of our primary health care
practitioners closest to the community is really appreciated, because our engagement with the community is really what sets us apart from our secondary care colleagues who are in the hospital. So I think more of a practical point when it comes to how PHC can reduce not only TB deaths, but any other deaths, for example, whether it's infectious or non-infectious.

Beatrice Bernescut 34:17
Thank you very much. That plug for PHC care in the community is key. Correct? Another question we have received is we are being asked, do we need advocacy tools for primary health care quality? And if so, what would you suggest? Dr. Syed?

Dr Shams Syed 34:40
That's also a very interesting question. So the question just to understand would be, do we need advocacy tools for quality in primary health care? Yes, in summary, but also, the point of emphasis that I might make is that we don't want a silo around quality. Quality as a concept should be embedded within the primary health care approach. And we should have a very strong advocacy effort on the critical importance of quality as integral and as part of the fabric of primary health care. And just building on Dr. Kamaliah's point - for sure, we are talking about all the way from promotion to palliation. And we need to advocate for high-quality health promotion, disease prevention, cure, rehabilitation and palliation. So this is a big order, a tall order for us. But the advocacy that's required should be able to empower the local most primary health care team taking both an individual and population-based approach.

Beatrice Bernescut 35:58
If I may speak to that...This is Beatrice Bernescut. Again, one of the three components of primary health care, as you know, is empowering people and communities. So advocacy works both...it works in a number of different directions. But it starts with people in the community advocating to their caregivers. Caregivers need to know what people need, want and are looking for. Advocacy is also from caregivers to government and policy-makers. For example, we recently talked on this series about climate change and primary health care. Health care professionals have a role to advocate to government for policies that will support better health. So yes, there’s definitely a role for advocacy. Dr. Noh, would you like to speak to this...

Dr Kamaliah Noh 36:48
If I may add to that...the tool that I, that is on the slide here, which is measuring the performance of primary health care toolkit, it’s very interesting when we worked on this because we wanted a practical tool. And we realized that, you know, the quality improvement cycle is not only about measurements, having lots of data, but you need to be able to present that data in a form that’s easily understood, depending on who is your target. And in this tool, you will find how to approach the different stakeholders when it comes to primary health care, whether it is the providers, the other providers, or whether it’s the community, or whether it is the politicians who are the policy-makers and who make all the decisions regarding resource allocation, for example. And therefore I urge you to read this toolkit so that you can have some practical experience from other countries which I shared in this toolkit. Over to you, Beatrice.

Beatrice Bernescut 38:09
Thank you. Another question we’ve received is: how do you see the caregivers role - the primary health caregivers role - in standardizing clinical service and improving quality? So going beyond each individual’s actions to making sure that level is standardized across a system or a facility? What do you think Dr Syed?

Beatrice Bernescut 38:34
So what would be the role of the individual caregiver to help standardize clinical service and improve the quality of clinical service?

Dr Shams Syed 38:46
So I’m presuming...that’s a great question. But I’m just trying to clarify whether it’s the role of the individual caregiver. We’re talking about two types of caregivers. One is of course the professional caregiving, and then there is also the family and community-based caregiving that’s provided. So, for me, there’s nothing more important than extracting out the wisdom from those that are providing the care at the point of delivery. And so absolutely, there is a critical role of trying to harness the wisdom from that interaction, and allowing that to percolate any of the standards that are developed for quality primary health care delivery. That’s an easy one to say and incredibly difficult to do. But it is always important to have that input into standard development from those that are absolutely on the at the point of delivery. So, in summary, what I’m saying here is that playing close attention to informal caregivers, as well as those who are providing care from a professional perspective, is critically important when setting standards for care.
Okay, Dr. Noh, did you want to add anything to that?

Dr Kamaliah Noh

Yes. Just by sort of my observation in my long years of service... Twenty years ago, when clinical practice guidelines were developed, they were usually led by the secondary care doctors, doctors in the hospitals. But with the primary health care going stronger and stronger, you find that now, you will have a development of an integrated guideline, which starts from the primary health care, as well as the continuation into secondary care. So this is how primary health care caregivers, the professionals, can play a very important role in making sure that the clinical practice guidelines is an integrated one, which cuts across the care delivery system. Back to you, Beatrice.

Beatrice Bernescut

Thank you. We are receiving a question which is something that comes up fairly frequently in which I would like to address here, is inconsistencies in meaning and/or understanding of the different terms "primary health care" and "primary care". So "primary health care" is an approach; "primary care" refers to the set of services that happen at the first year interaction with the health care system. Could you expand a little bit on that for me, Dr Syed?

Dr Shams Syed

I think that all of the technical work that was done in the build up to Astana was really trying to unpack this issue. And, for sure, that was a hot topic of debate. But I think that the conceptual clarity that the person that’s posing this question is seeking has been achieved to a certain degree. And really, that focuses in on this triad. And I think it's an important triad to remind ourselves of, and making sure that we stay true to it. So, for us, I think the important piece that Beatrice you just highlighted is primary care, and essential public health functions being one of the three areas - empowered people and community - the second area, and then the multisectoral policy, and action, the third area. Now, of course, this builds on the original Alma-Ata declaration, but it also clearly articulates the critical importance of primary care within a broader and wider concept of primary health care.

Beatrice Bernescut
Thank you. We have had a request for your views, Dr. Syed and Dr. Noh on PHC and mental health care, mental care. Doctor Noh, would you like to go first this time?

Dr Kamaliah Noh 43:40
Yeah, sure. In our review of our health system in 2014-2015, mental health is one of the areas that we are not particularly strong at in our primary health care system. Right now, it’s mainly taking care of stable patients who have been discharged from the hospitals. But we’re going more into community-based care now when it comes to mental health. But when it comes to the clinic itself, we are more towards screening for mental health and detecting potential cases which need further management either by our family medicine specialist in our clinics, or to be referred to the psychiatrist in secondary care. So...but it does need resources in the sense that our primary health care’s tough, they are a multidisciplinary group, they are multitasking. And for them to be able to do mental health is an area that you need training in. As in post basic training in mental health. I think that the experience from Malaysia, it is an area which we are relatively weaker in, and we need to develop this area, because the burden of disease is high, and it’s a high cost. And we need to move not only look at the curative aspect, but we also need to look more on the preventive aspects. Over to you Beatrice.

Dr Shams Syed 45:46
Yeah, just to add on that point...It’s a really important question, another one. The huge burden of disease that’s attributable to mental health conditions. So maybe just using the example of schizophrenia, often the epidemiological nugget that’s often used is 1% prevalence across the globe. And we can see that what that means in terms of magnitude of the population that requires mental health services, but as Dr. Kamaliah highlighted, treatment and the services that are required for these concerns for schizophrenia is a highly specialized area. But having said that, the primary health care bedrock for mental health is exactly what is required to ensure that there’s a clearly integrated mechanism to providing the necessary services.

Dr Shams Syed 46:42
So if you if one thinks about the role of a, say, a general practitioner in the United Kingdom, it’s to be able to be the first point of contact, and in order to be able to take that person through a care pathway that is of high quality, and allows the district-based or county-based mental health teams to take over care of the severely mentally ill. But the majority, the majority of mental illness, of course, can be taken care of within a primary health care setting. Now just also highlighting what Dr. Kamaliah was mentioning,
this takes resources. And it also takes capacity building for primary health care teams to be equipped to be able to deal with mental health issues in all its guises, from the relatively mild but hugely significant to those conditions, which are less prevalent, but require urgent attention, and often require hospital care. And I suppose this is where the integration comes in. So the agenda related to suicide prevention, for example, has to go right into the heart of the community. And this is where, clearly, the interlinkages between primary health care, primary care, and the community engagement and empowerment comes in also in a very strong way. Back to you, Beatrice.

Beatrice Bernescut
Well, I'm afraid we have time for just one last question, a bit of a provocative one this time. What do the two of you think about privatizing health care in order to ensure quality? Dr. Noh, I'll let you answer first.

Dr Kamaliah Noh
OK. From the Malaysian experience, as I've said earlier...Actually, when we look at, when we assess the quality of care, the public sector seems to be pretty strong. Because we have the mechanism in place, we have the structure in place, we have the direction. But in the private sector, again, as in most of the countries as well, their business model is different. And what is stipulated or mandated by the law, that's the one that they will follow. After having said that, the trend in Malaysia it is changing, in the sense that they are now going more from solo practitioners, they're going more into network of practice, and this network of practice, do place some emphasis on some quality measurements for their members, and therefore, privatization....when it comes to primary health care, Malaysia has a dichotomous system. We have public providers, we have private providers. And there are pros and cons to it, in the sense that if I think if you have a strong enforcement, by regulations, as well as you have incentives for the private sector to do quality work, then it would be...I mean, whether it should be privatized or not. In the Malaysian experience, we have both already. We have privatized services. But this is actually balanced by our public system. And when it comes to quality right now, the public system actually is stronger because of the structure and the governance that's there. Over you, Beatrice.

Dr Shams Syed
Yeah, I love the provocative question. It's a good one. I would just echo what Dr. Kamaliah has highlighted - that we really shouldn't make any assumptions on quality related to whether the provision is from the private or public sector, as the example in Malaysia has
being put forward. The public sector provision can be of high, high quality and higher quality than the private sector. But at the same time, we absolutely cannot ignore the private sector, as the future health systems are being designed across the world. And that needs careful and considered interventions. So one of the things that just the last point that Dr. Kamaliah highlighted is the governance architecture. So with the provision from either private or public sector, there needs to be a clearly in my mind, a national direction on quality health services, that provides a clear pathway for the provision of care of high quality, and that allows the measurement of quality health services to be taken forward in a on an equal playing field, and also the setting of the key quality interventions within a primary health care setting. So that the question which is never going to be a clearly articulated answer for, on whether we go for public or private, is based on the information that is coming in, rather than any assumptions that are made. So that the final point here is that the standards and the interventions should be applied to both the public and private, and the iteration that’s required and the continuous adjustment of how PHC is rolled out, is dependent on the real information that’s coming in, rather than any assumptions related to the private and public sector.

Beatrice Bernescut  53:06
If I may, I think that this question speaks to a stereotype that - or prejudice if you will - that we have been fighting against in primary health care, this preconceived notion that primary health care is somehow cheap care for the poor, where we want to be at absolutely adamant that it is not. So and quality is not just dependent, because you pay for it through a private system, does not necessarily guarantee that it is better than what is provided elsewhere. So thank you very much. So thank you, everyone, for joining us this afternoon. I'm afraid we've run out of time, and I apologize that we were not able to get to everyone's questions today. As always, we will post in within short order a transcript and a recording of this session on the PHC website under www.who.int. And if you have any questions or comments, please send them to us at primaryhealthcare@who.int Thank you very much, and we'll see you next month.