STRENGTHENING PRIMARY HEALTH CARE THROUGH PRIMARY CARE DOCTORS AND FAMILY PHYSICIANS
PRIMARY HEALTH CARE
PHC Service Delivery Reforms

Comprehensive services, patient education, food security and nutrition, water and sanitation, maternal and child health, family planning, immunisation, endemic and common diseases, injuries, essential drugs, co-ordinated, prioritise local health needs, suitably trained health workers working in a team.
WORLD HEALTH REPORT 2008

Primary Health Care

Now More Than Ever

WORLD HEALTH ORGANIZATION

UNIVERSAL COVERAGE REFORMS
to improve health equity

SERVICE DELIVERY REFORMS
to make health systems people-centred

LEADERSHIP REFORMS
to make health authorities more reliable

PUBLIC POLICY REFORMS
to promote and protect the health of communities
World Health Organization

“Primary care has been defined, described and studied extensively in well-resourced contexts, often with reference to physicians with a specialization in family medicine or general practice. These descriptions provide a far more ambitious agenda than the unacceptably restrictive and off-putting primary-care recipes that have been touted for low-income countries.”

World Health Assembly

“[We need] to train and retain adequate numbers of health workers, with appropriate skill-mix, including primary health care nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people’s health needs.”
GLOBAL STATUS FAMILY MEDICINE TRAINING

1. Does the country have an active postgraduate training program?
2. Does the country’s health system (Ministry of Health or health governing body) recognize FM/GP training?
3. Is there a FM/GP Professional Society present in the country?

Dr John Parks johnticeparks@gmail.com
BRAZIL, INDIA, CHINA AND SOUTH AFRICA: BACKGROUND

## POPULATION AND ECONOMY

<table>
<thead>
<tr>
<th>Country</th>
<th>Population (millions)</th>
<th>% rural population</th>
<th>Number of provinces or states</th>
<th>% population using private health care</th>
<th>% GDP on health</th>
<th>% GDP spent in public sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>53</td>
<td>36</td>
<td>9</td>
<td>16</td>
<td>8.9</td>
<td>4.3</td>
</tr>
<tr>
<td>China</td>
<td>1357</td>
<td>47</td>
<td>34</td>
<td>8</td>
<td>5.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Brazil</td>
<td>200</td>
<td>15</td>
<td>22</td>
<td>25</td>
<td>9.7</td>
<td>4.7</td>
</tr>
<tr>
<td>India</td>
<td>1252</td>
<td>68</td>
<td>29</td>
<td>71</td>
<td>3.8</td>
<td>1.3</td>
</tr>
</tbody>
</table>

GDP=Gross Domestic Product
Under 5 mortality (per 1000) Goal: 2/3 reduction

Source: http://mdgs.un.org/
Maternal Mortality (per 100000) Goal: \( \frac{3}{4} \) reduction

Source: http://mdgs.un.org/
<table>
<thead>
<tr>
<th></th>
<th>Number of medical schools (Population in millions per medical school)</th>
<th>Outputs (new doctors/year)</th>
<th>Medical Practitioners* /10000 population</th>
<th>Family Physicians/ 10000 population</th>
<th>Nurses and midwives /10000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>9 (5.9)</td>
<td>1300</td>
<td>3.7</td>
<td>0.1</td>
<td>51</td>
</tr>
<tr>
<td>Brazil</td>
<td>242 (0.8)</td>
<td>21395</td>
<td>19</td>
<td>0.2</td>
<td>76</td>
</tr>
<tr>
<td>India</td>
<td>398 (3.1)</td>
<td>52305</td>
<td>7</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>China</td>
<td>980 (1.4)</td>
<td>192344</td>
<td>14</td>
<td>1.2</td>
<td>51</td>
</tr>
</tbody>
</table>

* Not specialists
UNIVERSAL COVERAGE AND HEALTH INSURANCE

India
NHI policy commitment 2011, plans to implement at hospital level

South Africa
NHI policy commitment 2011, NHI pilot districts

China
Social insurance law 2011, implemented, variety of schemes

Brazil
NHI policy implemented with public and private insurance 1988
COST AT POINT OF SERVICE TO PATIENT

India
Weak coverage, mostly out of pocket private sector

South Africa
Free primary care for low income

China
Free if insured, but limited scope and gaps.

Brazil
Free for all people
India: Upgraded 8250 primary health care facilities and 2313 facilities for first referral.

South Africa: Policy on PHC re-engineering and Ideal Clinic.


Brazil: Family Health Strategy with 62% coverage 2014.
## DELIVERY OF PHC

<table>
<thead>
<tr>
<th></th>
<th>China</th>
<th>India</th>
<th>South Africa</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(first contact)</td>
<td>--</td>
<td>Accredited Social Health</td>
<td>Ward based outreach teams</td>
<td>Family health care teams and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Activist</td>
<td></td>
<td>Basic Health Units</td>
</tr>
<tr>
<td><strong>Primary level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(first contact)</td>
<td>Village health</td>
<td>Sub-centres and primary</td>
<td>Clinics or community health</td>
<td>Basic health units</td>
</tr>
<tr>
<td></td>
<td>posts, rural</td>
<td>health centres</td>
<td>centres</td>
<td>and emergency units</td>
</tr>
<tr>
<td></td>
<td>township</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>centres, village</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>clinics and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>urban community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>healthcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>centres (CHCs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>District level</strong></td>
<td>Level 1</td>
<td>Community health centres and</td>
<td>District hospitals</td>
<td>District hospitals</td>
</tr>
<tr>
<td>(generalist</td>
<td>hospitals (care</td>
<td>sub-divisional hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital care)</td>
<td>offered by</td>
<td>(posts for specialists)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>specialists)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Secondary and</td>
<td>Level 2 and 3</td>
<td>District hospitals and</td>
<td>Regional, tertiary and</td>
<td>Regional, tertiary and medical</td>
</tr>
<tr>
<td>tertiary level</td>
<td>hospitals</td>
<td>medical college hospitals</td>
<td>central hospitals</td>
<td>college hospitals</td>
</tr>
<tr>
<td>(specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DELIVERY OF PRIMARY HEALTH CARE

India
Variety of options (GPs, doctors, AYUSH, nurses, ASHA, registered medical practitioners)

South Africa
Nurse-led primary care, access to doctor

China
General practitioner-led primary care (re-directed hospital specialists)

Brazil
Family health care team (doctor, nurse, nurse assistant and 4-6 community health workers)
India
One of many options (GPs, doctors, AYUSH, nurses, ASHA, registered medical practitioners)

South Africa
Outreach from district hospitals and community health centres

China
General practitioner-led primary care (re-directed hospital specialists and public health specialists)

Brazil
Member of family health care team – primary care, home visits.
<table>
<thead>
<tr>
<th>Country</th>
<th>Training Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>Only undergraduate public health exposure, a few postgraduate 3-year training programmes (200 places)</td>
</tr>
<tr>
<td>South Africa</td>
<td>Undergraduate primary care exposure, internship, 4-year MMed for family physician</td>
</tr>
<tr>
<td>China</td>
<td>Little/no undergraduate primary care exposure, postgraduate 3-years, on-the-job training for specialists, re-training for rural</td>
</tr>
<tr>
<td>Brazil</td>
<td>Undergraduate primary care exposure, 2-year residency training</td>
</tr>
</tbody>
</table>
REFLECTIONS ON THE PRIMARY CARE DOCTOR

- Primary care doctor needed as part of the PHC team
- Task shifting a clear strategy
- Roles fluid and defined by functional needs of team and health needs
- Role of the doctor more than just clinical competence
- Postgraduate training recognised, but underdeveloped and not at scale
- Re-orientate and up-skill existing doctors
- Not a popular career choice
- Develop curriculum to focus on local health needs
- Need for more evidence on value of investing in family physicians in LMIC
- Tension between community or hospital orientation
FUTURE DIRECTIONS IN SOUTH AFRICAN CONTEXT
ROLE OF THE FAMILY PHYSICIAN

**Care-provider** – able to work independently at all facilities in the district

**Consultant** – to the primary care services

**Capacity-builder** – teaches, mentors, supports, develops other practitioners

**Supervisor** – of registrars, interns, medical students, clinical associates

**Leader** of clinical governance

**Champion of COPC** – engages with the community served

Leadership is not another role but "authentic self-expression that adds value" in all roles.

Leading complexity

- Implicit purpose
- Few simple rules
- Defined boundaries
- Explicit objectives
- Freedom to act
- Unambiguous feedback
- Ambiguity tolerance
- People's skill & will
LEADERSHIP

"It"
Understanding the context of the health system

"We"
Building relationships with the team and the organisational values, vision, purpose

"I"
Knowing one's own personal values, vision, purpose and congruent leadership behaviour

Family physician leads the whole team to take responsibility for clinical governance

Clinical governance should take a comprehensive approach

Clinical governance requires a supportive organisational culture

Competencies in guideline development and implementation, quality improvement cycles, risk management, reflection on routine data, critical appraisal of evidence, training.
Corporate governance refers to the traditional managerial tasks – finance, human resources, supply chain, infrastructure.

Family physicians should be “consciously incompetent”.

Principles apply equally to public and private sectors.
The contribution of family physicians to district health services:

a national position paper for South Africa

Fabius “G” Epiphane, "J" Makoza, "D" Fakatzeni

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President, South African Academy of Family Physicians, and College of Family Physicians of South Africa
Head, Department of Family Medicine, University of KwaZulu-Natal Medical School
Professor, Division of Family Medicine, University of Cape Town Medical School
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Abstract

This position paper on Family Medicine in South Africa was written for the National Department of Health in 2014 for the purpose of delivering a comprehensive assessment of the contribution that family physicians could make to the health system and the issues that need to be addressed in order to realize this contribution. The paper family physicians in the public sector. It identifies the roles of family physicians in the public sector, the role of family physicians in the public sector, and the roles of family physicians in the public sector. It also highlights the need for family physicians in the public sector to be involved in policy development and implementation in order to provide effective and efficient health care.

Keywords: family physicians, district health services, position papers, National Department of Health, South Africa

Introduction

This document was prepared for the National Department of Health at the request of Dr. Terence Carter and his team. Following a series of meetings between them and the team, it was agreed that the reliance on family physicians in the public sector should be strengthened.

Policy context

Introduction

The World Health Organization (WHO) has recommended that primary care in Family Medicine (FM) should be provided by family physicians, who are trained in all areas of health care, including primary care, surgery, pediatrics, and family planning.

The National Developing World has specifically recognized the importance of family physicians in primary care, and is improving the quality of health care services. Therefore, the need for family physicians in the public sector is increased in order to provide effective and efficient health care.

National

The National Developing World has specifically recognized the importance of family physicians in primary care, and is improving the quality of health care services. Therefore, the need for family physicians in the public sector is increased in order to provide effective and efficient health care.

The African Region of the World Health Organization (WHO) has published a consensus statement on the contribution of Family Medicine service of family physicians in the African context.
- We should have a short-term goal as a country of having initially one family physician employed per sub-district and one per district hospital.
- We should ensure that the regulatory environment in the private sector fully recognises family physicians as an important component of health care provision.
- We should ensure that family physicians working in accredited training sites have sufficient capacity to provide quality training through additional family physician posts and joint staff positions.
- We should ensure sufficient registrar posts are available for each training programme and that the finances for these posts are secured on an on-going basis.

An initial cohort of 34 family medicine trainers attended two 5-day courses: August 2014 and February 2015

Further courses 2015 and 2016

Ongoing collaboration with RCGP to develop SA version of the course

Development of workplace based assessment of training and accreditation of trainers

SA society of clinical trainers of family medicine
Three 1-day courses at FCFP(SA) examinations:
May 2014, October 2014, May 2015

Further courses 2015 and 2016
Focus on training of examiners and improvement of national exit examination:
- OSCE station writing
- MCQ writing
- Standard setting
- Clinical assessment in workplace and examination
Positive impact on the quality of clinical processes with specific examples given for HIV/AIDS, TB, maternal and child health, non-communicable diseases and mental health.

Some impact on health services performance in terms of improved access to care, better co-ordination, more comprehensive and efficient services.

Anticipate impact on health outcomes but early days.

Primary care doctors (18000)

Revitalised primary care

Universal coverage

National health insurance

Family physicians (500)
PG DIPLOMA IN FAMILY MEDICINE

New nationally designed Postgraduate Diploma in Family Medicine
PG Dip (Fam Med)

The new diploma has been designed nationally through a process driven by the South African Academy of Family Physicians. It is aimed at existing primary care doctors, from either the private or public sector, as a powerful tool to expand their knowledge and skills in areas relevant to primary care. The programme aims to enhance the quality of general practice by equipping primary care doctors to take their role as competent clinician, change agent, collaborator, practitioner, capability builder, critical thinker and community advocate in the future South African primary health care system.

Course Content and Duration
This is a two-year programme, with a modular curriculum (4-6 modules) and a blended approach which will combine online-based teaching, web-based teaching and mentored peer learning. During the course of the programme the learner must work in a clinical setting appropriate to the practice and training of family medicine. For instance a general practice, community health service, rural or district hospital.

Admission Requirements
For admission to the Postgraduate Diploma in Family Medicine programme a student must hold a MBChB, BCh degree, or equivalent qualification deemed to be of an adequate standard, and must be registered with the Health Professions Council of South Africa or with an equivalent learning body in the country where he/she is practicing.

Application forms can be downloaded from the relevant universities. See contact details below:

The development of a new national postgraduate Diploma in Family Medicine is a part of the broader transformation of primary care through primary care doctors enabled by the Department of Health, the National Department of Basic Education, the National Council of Provinces, and the South African Medical Association. The course is offered by several universities, and will undergo an accreditation process as per the provisions of the European Union.
WHAT ABOUT BOTSWANA?
STAGES OF CHANGE MODEL

- Pre-contemplation
- Contemplation
- Action
- Maintenance
- Relapse
- Permanent change
<table>
<thead>
<tr>
<th>STAGES APPLIED TO FAMILY MEDICINE EDUCATION IN AFRICA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-contemplation</strong></td>
</tr>
<tr>
<td>Key stakeholders are not considering family medicine training</td>
</tr>
<tr>
<td>Share information and raise awareness of need for family medicine training</td>
</tr>
<tr>
<td><strong>Contemplation</strong></td>
</tr>
<tr>
<td>Key stakeholders are exploring the idea, but remain ambivalent</td>
</tr>
<tr>
<td>Resolve ambivalence as part of new medical schools, local champions, start informal training, professional bodies</td>
</tr>
<tr>
<td><strong>Action</strong></td>
</tr>
<tr>
<td>Key stakeholders implement family medicine training</td>
</tr>
<tr>
<td>Develop curriculum, develop training sites, identify support from established programmes, recruit faculty, included in policy, registrar posts, register for FPs</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
</tr>
<tr>
<td>Family physicians enter the health system</td>
</tr>
<tr>
<td>Agree on the role of the FP in the health system, alignment with HR policy, creation posts, going to scale, managing tensions and change, build research capacity</td>
</tr>
<tr>
<td><strong>Relapse</strong></td>
</tr>
<tr>
<td>Family medicine training is aborted after initial attempt</td>
</tr>
<tr>
<td>Reflect on lessons learnt and reasons for relapse, re-enter at contemplation phase</td>
</tr>
</tbody>
</table>

## STAGES APPLIED TO FAMILY MEDICINE EDUCATION IN AFRICA

<table>
<thead>
<tr>
<th>Pre-contemplation</th>
<th>Contemplation</th>
<th>Action</th>
<th>Maintenance</th>
<th>Relapse</th>
</tr>
</thead>
</table>
| Key stakeholders are not considering family medicine training | Key stakeholders are exploring the idea, but remain ambivalent | Key stakeholders implement family medicine training | Family physicians enter the health system | Relapse  
Family medicine training is aborted after initial attempt |
| Share information and raise awareness of need for family medicine training | Resolve ambivalence as part of new medical schools, local champions, start informal training, professional bodies | Develop curriculum, develop training sites, identify support from established programmes, recruit faculty, included in policy, registrar posts, register for FPs | Agree on the role of the FP in the health system, alignment with HR policy, creation posts, going to scale, managing tensions and change, build research capacity | Reflect on lessons learnt and reasons for relapse, re-enter at contemplation phase |