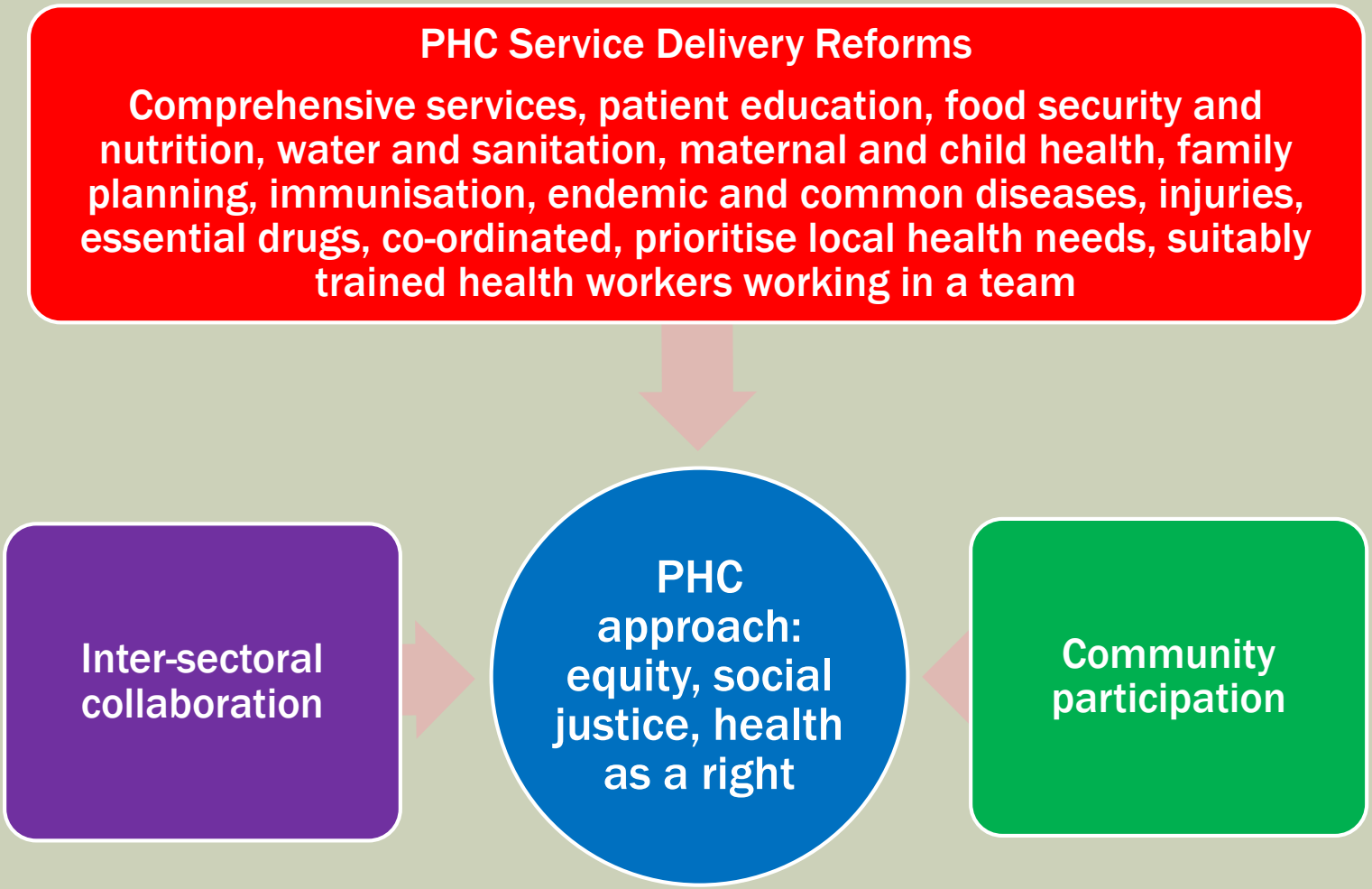
STRENGTHENING PRIMARY HEALTH CARE THROUGH PRIMARY CARE DOCTORS AND FAMILY PHYSICIANS

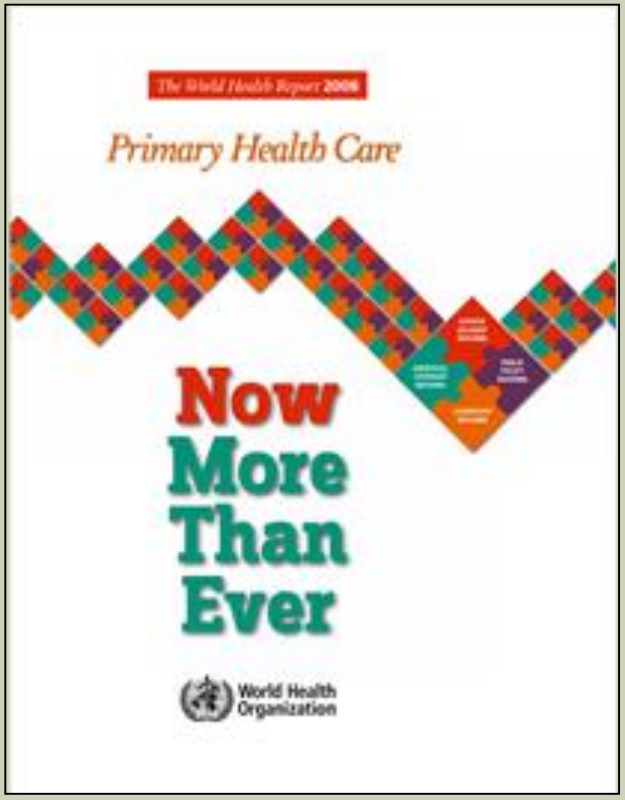
Prof Bob Mash
Family Medicine and Primary Care
Stellenbosch University

PRIMARY HEALTH CARE

ALMA ATA 1978



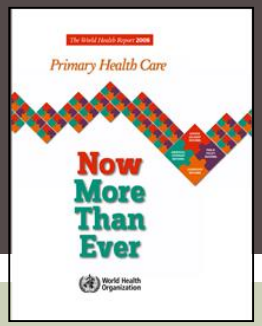
WORLD HEALTH REPORT 2008



CORE DIMENSIONS OF PRIMARY CARE SYSTEMS

STRUCTURE	PROCESS	OUTCOMES
Governance	Access	Quality
Economics	Continuity	Efficiency
Workforce development	Co-ordination	Equity
	Comprehensiveness	

Kringos, D.S., Boerma, W.G., Hutchinson, A., van der Zee, J. & Groenewegen, P.P. 2010, "The breadth of primary care: a systematic literature review of its core dimensions", *BMC health services research,* vol. 10, pp. 65.



INTERNATIONAL

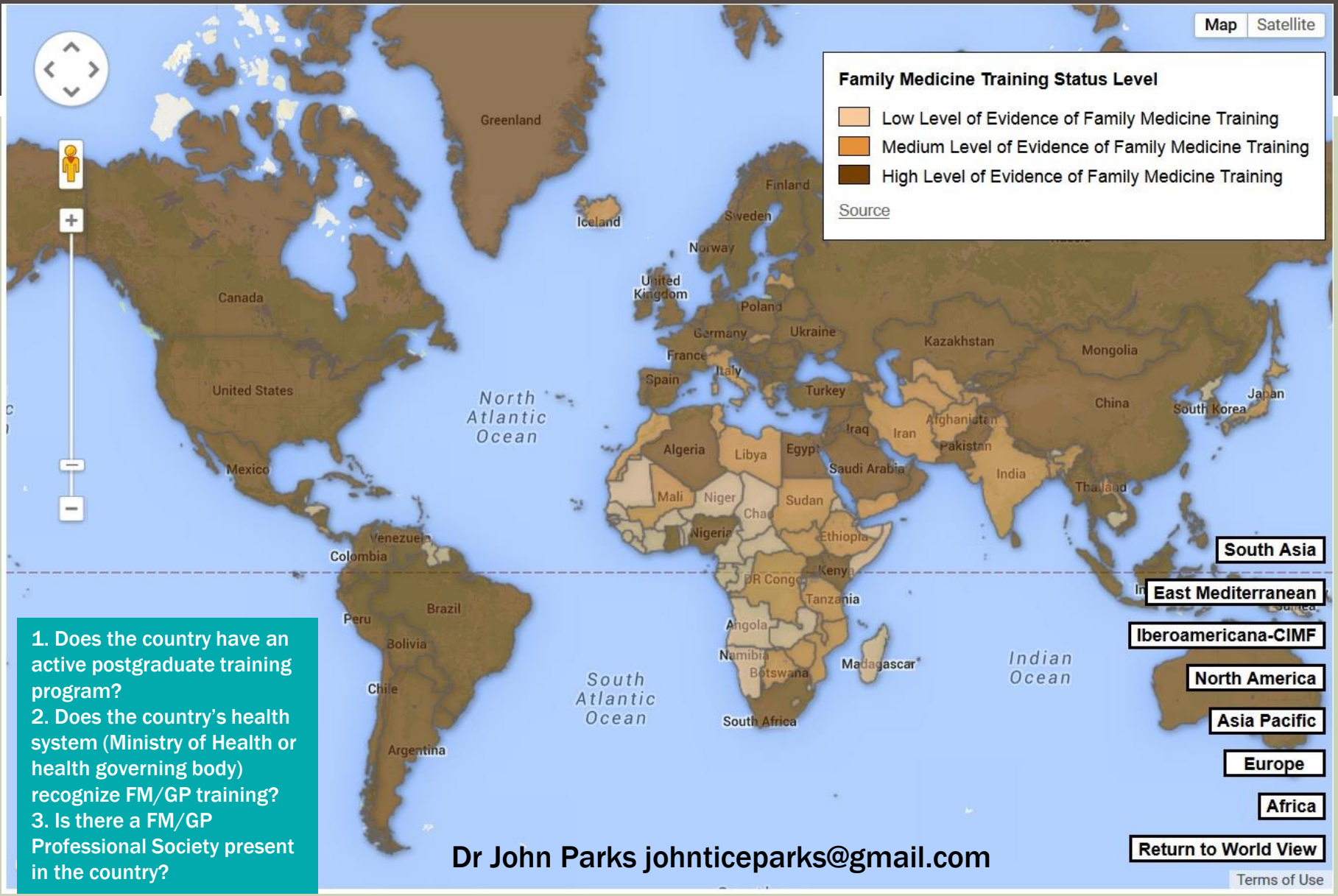
World Health Organization

"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?

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AFRICA STATUS FAMILY MEDICINE TRAINING

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BRAZIL, INDIA, CHINA AND SOUTH AFRICA: BACKGROUND

Mash R, Almeida M, Wong W, Kumar R, Von Pressentin K. The roles and training of primary care doctors: China, India, Brazil and South Africa. Presentations at The Network: Towards Unity For Health, Fortaleza, Brazil, 2014. Submitted Human Resources For Health.

POPULATION AND ECONOMY

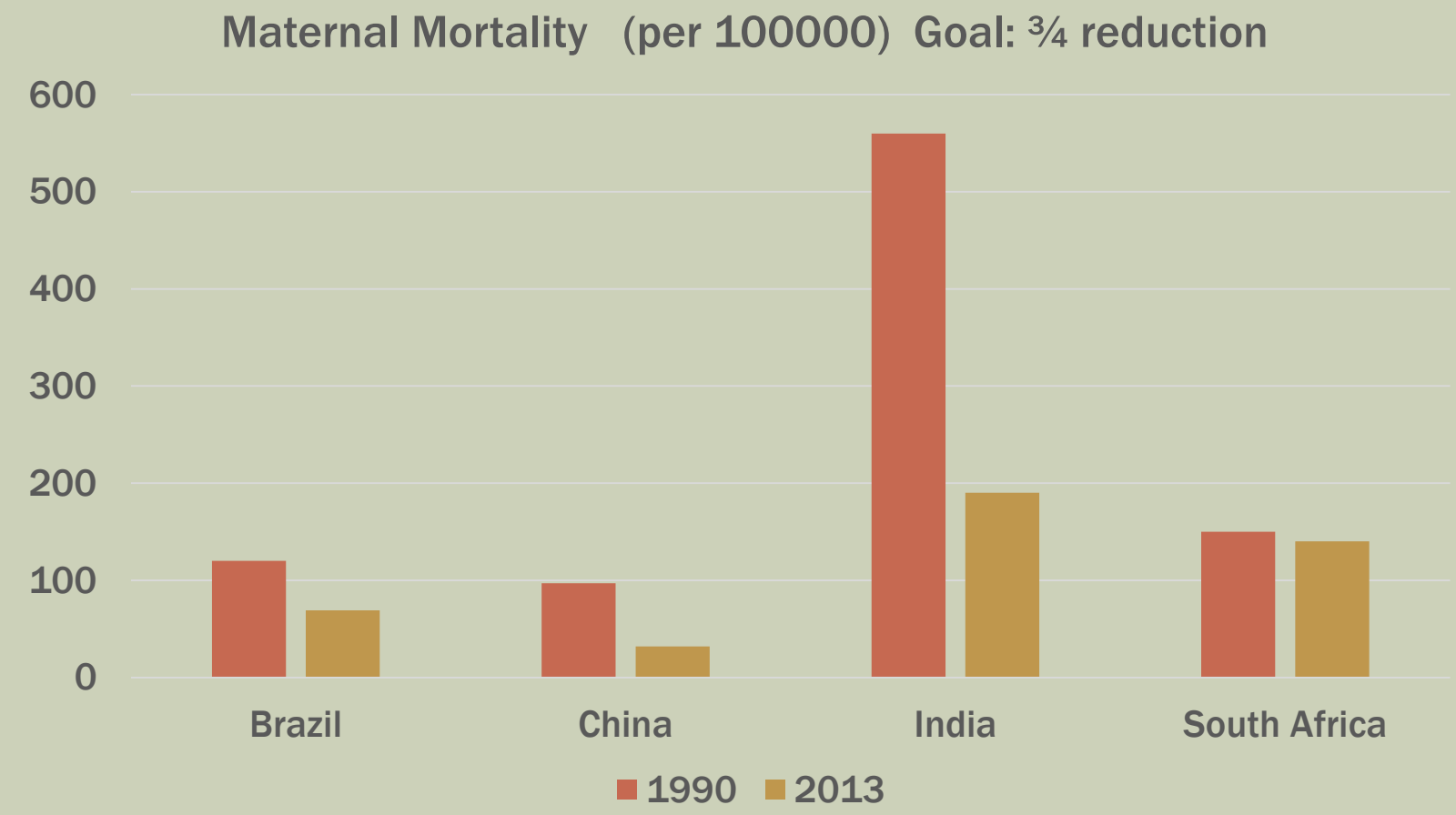
Country	Population (millions)	% rural population	Number of provinces or states	% population using private health care	% GDP on health	% GDP spent in public sector
South Africa	53	36	9	16	8.9	4.3
China	1357	47	34	8	5.6	3.1
Brazil	200	15	22	25	9.7	4.7
India	1252	68	29	71	3.8	1.3

GDP=Gross Domestic Product

HEALTH OUTCOMES MDGS

Source: http://mdgs.un.org/

HEALTH OUTCOMES MDGS



Source: http://mdgs.un.org/

NUMBER OF DOCTORS

	Number of medical schools (Population in millions per medical school)	Outputs (new doctors/year)	Medical Practitioners* /10000 population	Family Physicians/ 10000 population	Nurses and midwives /10000 population
South Africa	9 (5.9)	1300	3.7	0.1	51
Brazil	242 (0.8)	21395	19	0.2	76
India	398 (3.1)	52305	7	-	17
China	980 (1.4)	192344	14	1.2	51

*** 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

STRENGTHENING PRIMARY HEALTH CARE

India

Upgraded 8250 primary health care facilities and 2313 facilities for first referral

South Africa

Policy on PHC re-engineering and Ideal Clinic

China

Expansion of PHC facilities – village health posts, health centres. Essential medicines.

Brazil

Family Health Strategy with 62% coverage 2014

DELIVERY OF PHC

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

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)

ROLE OF PRIMARY CARE DOCTORS

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.

TRAINING OF PRIMARY CARE DOCTORS

India

Only undergraduate public health exposure, a few postgraduate 3-year training programmes (200 places)

South Africa

Undergraduate primary care exposure, internship, 4-year MMed for family physician

China

Little/no undergraduate primary care exposure, postgraduate 3-years, on-the-job training for specialists, re-training for rural

Brazil

Undergraduate primary care exposure, 2-year residency training

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

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

Consultant – to the primary care services

Leader of clinical governance

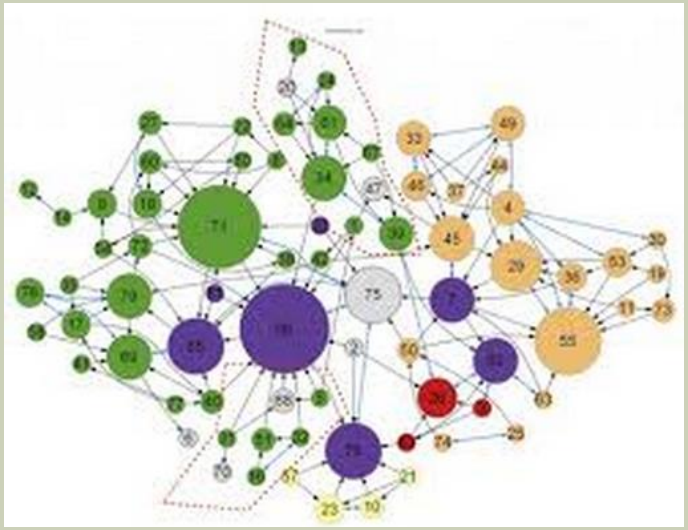
Capacity-builder – teaches, mentors, supports, develops other practitioners

Champion of COPC– engages with the community served

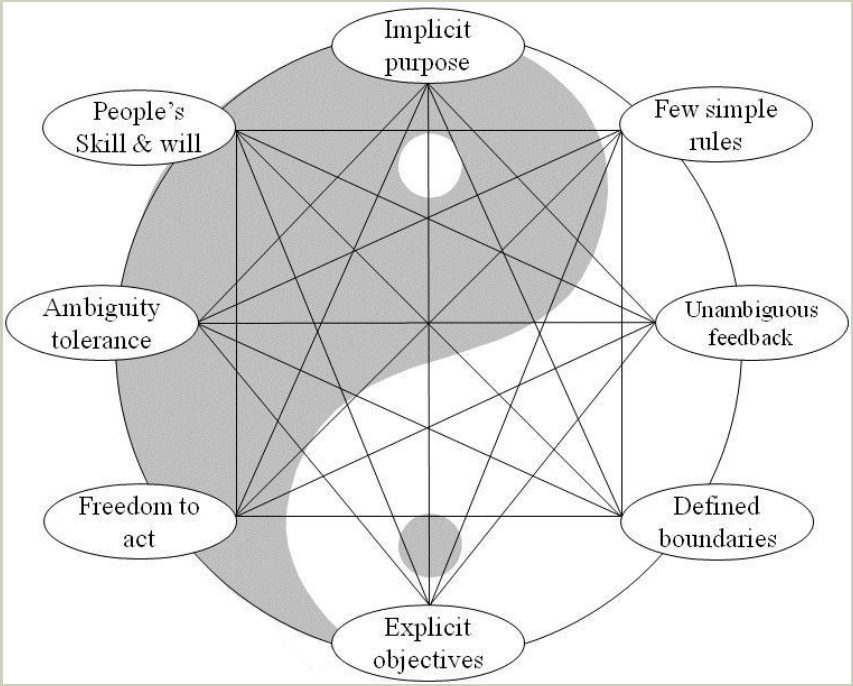
Mash R, Downing R, Moosa S, de Maeseneer J. Exploring the key principles of Family Medicine in sub-Saharan Africa: international Delphi consensus process. SA Fam Pract 2008;50(3):60-65

LEADERSHIP

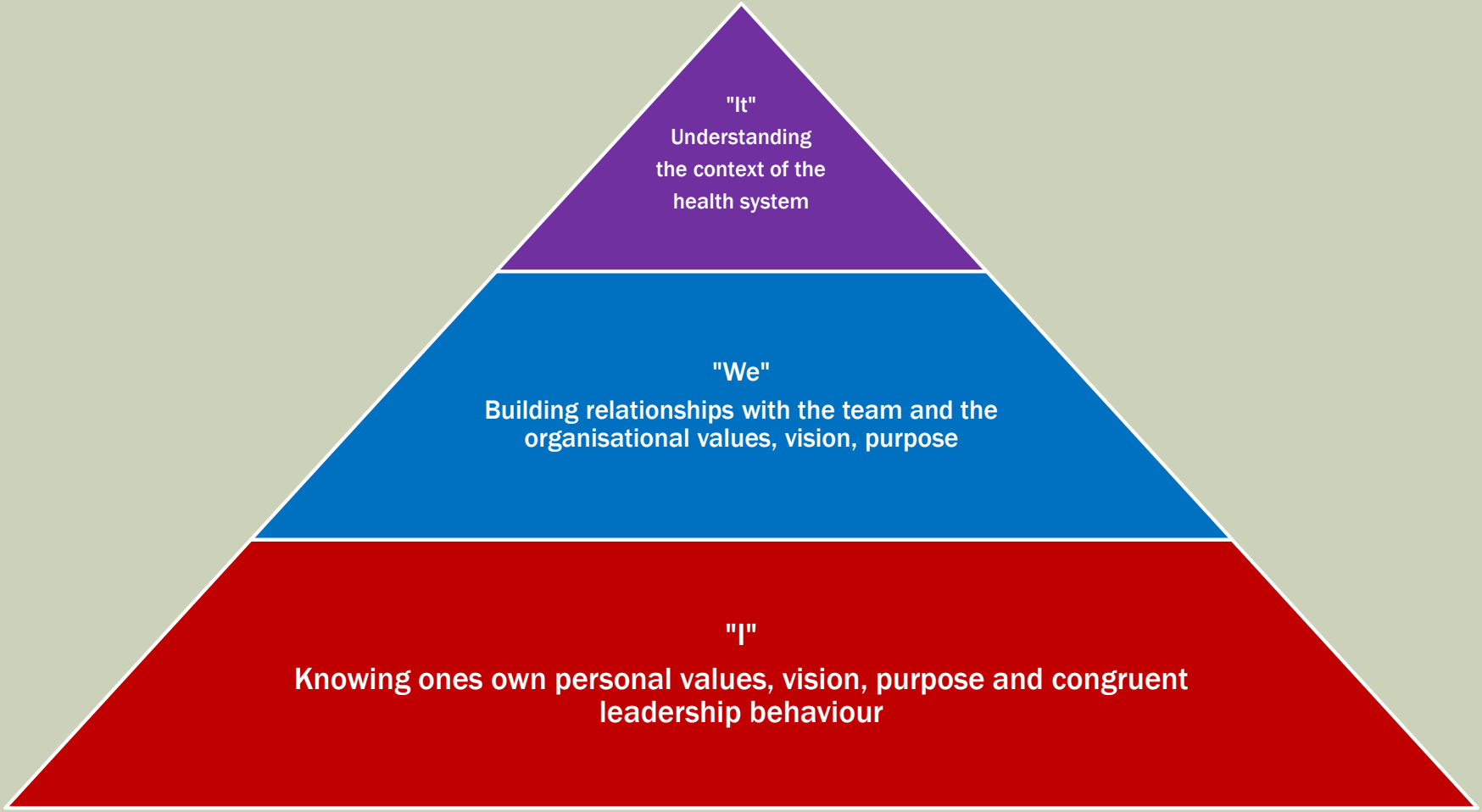
- Leadership is not another role but "authentic self-expression that adds value" in all roles



- Leading complexity



LEADERSHIP



Flaherty J. Coaching: Evoking excellence in others. Routledge, 2011

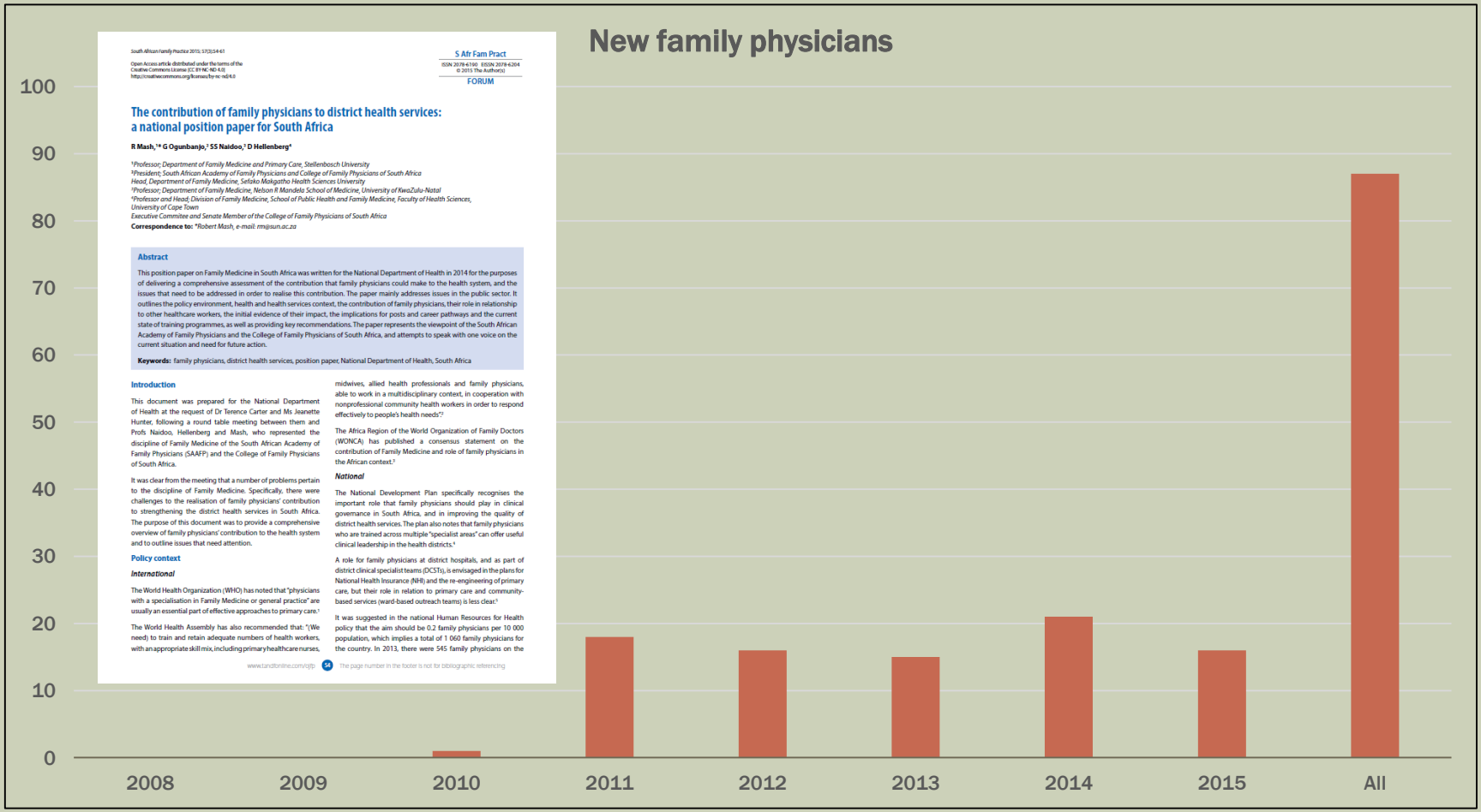
CLINICAL GOVERNANCE

- 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

- 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

NATIONAL POSITION PAPER



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FORUM

The contribution of family physicians to district health services: a national position paper for South Africa

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Head, Department of Family Medicine, Sefako Makgatho Health Sciences University
[3]Professor, Department of Family Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal
[4]Professor and Head, Division of Family Medicine, School of Public Health and Family Medicine, Faculty of Health Sciences, University of Cape Town
Executive Committee and Senate Member of the College of Family Physicians of South Africa
Correspondence to: *Robert Mash, e-mail: rm@sun.ac.za

Abstract

This position paper on Family Medicine in South Africa was written for the National Department of Health in 2014 for the purposes 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 realise this contribution. The paper mainly addresses issues in the public sector. It outlines the policy environment, health and health services context, the contribution of family physicians, their role in relationship to other healthcare workers, the initial evidence of their impact, the implications for posts and career pathways and the current state of training programmes, as well as providing key recommendations. The paper represents the viewpoint of the South African Academy of Family Physicians and the College of Family Physicians of South Africa, and attempts to speak with one voice on the current situation and need for future action.

Keywords: family physicians, district health services, position paper, 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 Ms Jeanette Hunter, following a round table meeting between them and Profs Naidoo, Hellenberg and Mash, who represented the discipline of Family Medicine of the South African Academy of Family Physicians (SAAFP) and the College of Family Physicians of South Africa.

It was clear from the meeting that a number of problems pertain to the discipline of Family Medicine. Specifically, there were challenges to the realisation of family physicians' contribution to strengthening the district health services in South Africa. The purpose of this document was to provide a comprehensive overview of family physicians' contribution to the health system and to outline issues that need attention.

Policy context

International

The World Health Organization (WHO) has noted that "physicians with a specialisation in Family Medicine or general practice" are usually an essential part of effective approaches to primary care.[1]

The World Health Assembly has also recommended that: "(We need) to train and retain adequate numbers of health workers, with an appropriate skill mix, including primary healthcare nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with nonprofessional community health workers in order to respond effectively to people's health needs".[2]

The Africa Region of the World Organization of Family Doctors (WONCA) has published a consensus statement on the contribution of Family Medicine and role of family physicians in the African context.[3]

National

The National Development Plan specifically recognises the important role that family physicians should play in clinical governance in South Africa, and in improving the quality of district health services. The plan also notes that family physicians who are trained across multiple "specialist areas" can offer useful clinical leadership in the health districts.[4]

A role for family physicians at district hospitals, and as part of district clinical specialist teams (DCSTs), is envisaged in the plans for National Health Insurance (NHI) and the re-engineering of primary care, but their role in relation to primary care and community-based services (ward-based outreach teams) is less clear.[5]

It was suggested in the national Human Resources for Health policy that the aim should be 0.2 family physicians per 10 000 population, which implies a total of 1 060 family physicians for the country. In 2013, there were 545 family physicians on the

NATIONAL POSITION PAPER

- 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.

http://www.saafp.org/index.php/news/48-national-position-paper-on-family-medicine

TRAINING OF FP CLINICAL TRAINERS

- 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

TRAINING OF FM EXAMINERS

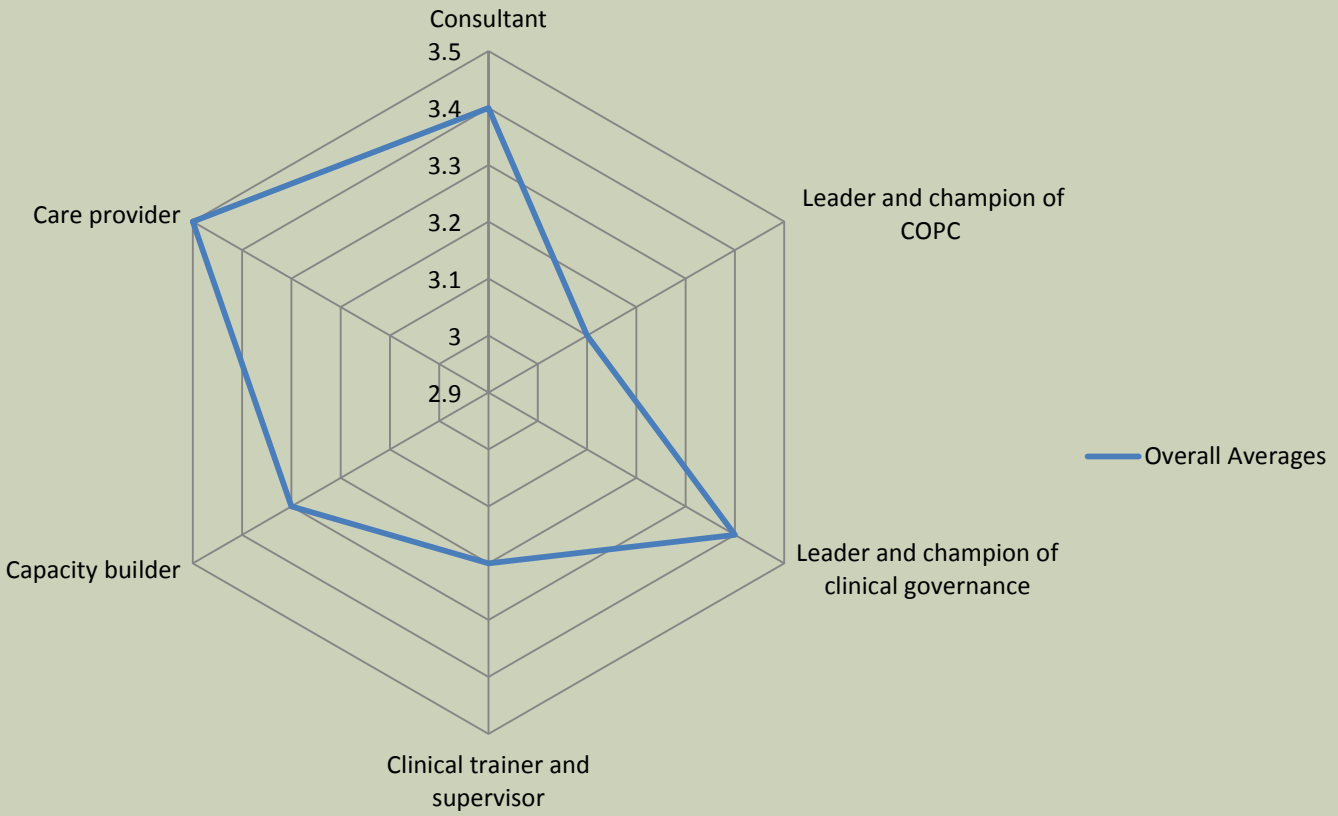
- Three 1-day courses at FCFP(SA) examinations:
  May 2014, October 2014, May 2015
- Further courses 2015 and 2016
- Focus on training of examiners and improvement of national exit examination:
  - OSCE station writing
  - MCQ writing
  - Standard setting
  - Clinical assessment in workplace and examination

EVIDENCE OF IMPACT

- 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

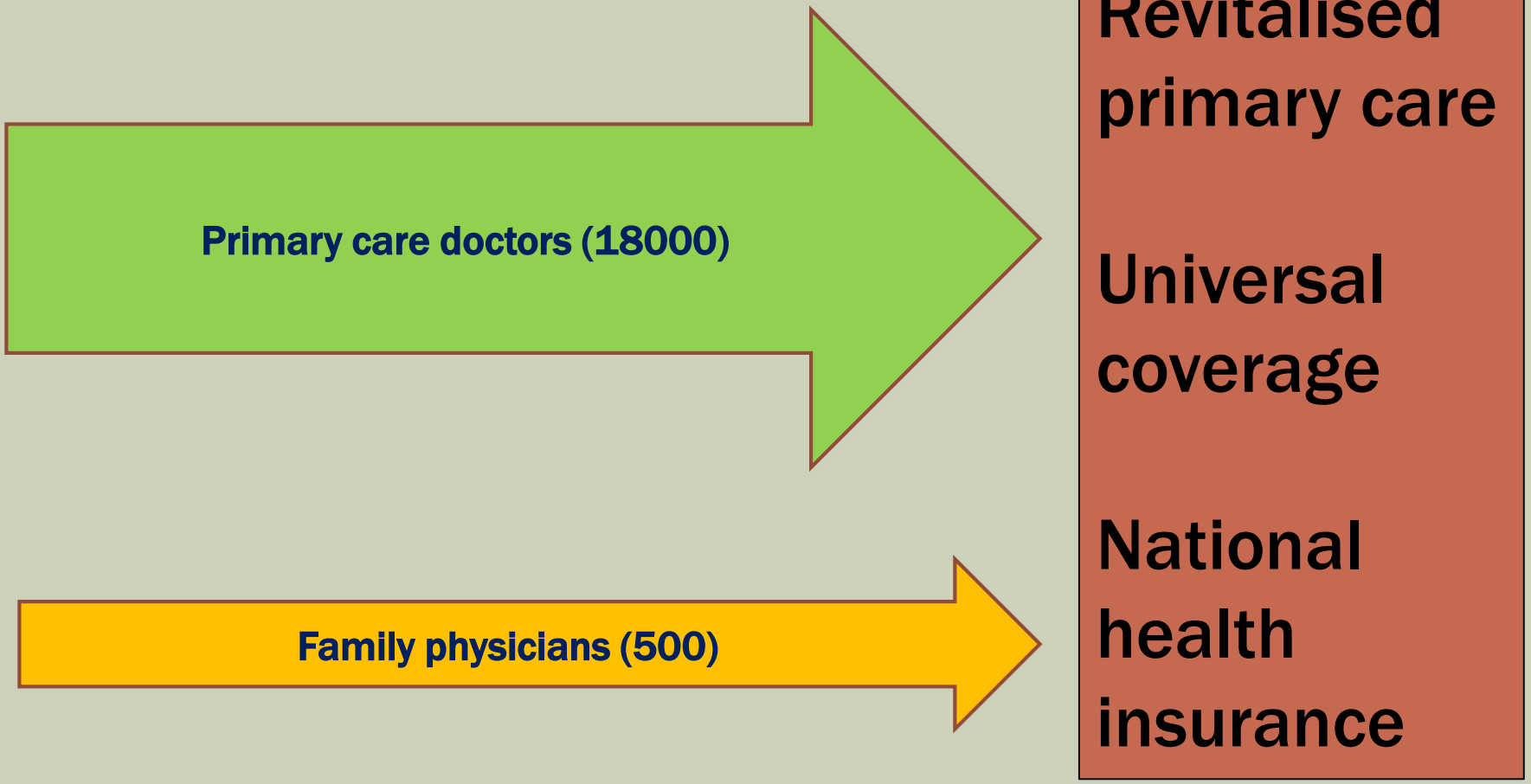
Swanepoel M, Mash B, Naledi T. Assessment of the impact of family physicians in the district health system of the Western Cape, South Africa. Afr J Prm Health Care Fam Med. 2014;6(1), Art. #695, 8 pages. http://dx.doi.org/10.4102/ phcfm.v6i1.695

EVIDENCE OF IMPACT

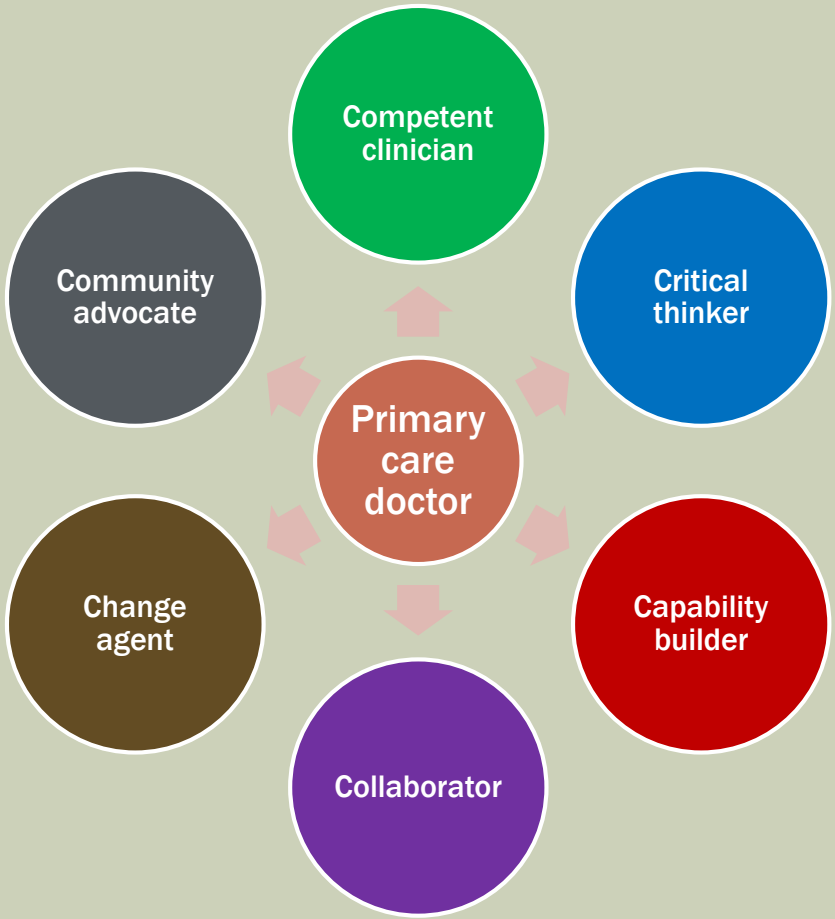


Pasio K, Mash R, Naledi T. Development of a family physician impact assessment tool in the district health system of the Western Cape Province, South Africa. BMC Family Practice 2014, 15:204. http://www.biomedcentral.com/1471-2296/15/204

PRIMARY CARE DOCTORS



PG DIPLOMA IN FAMILY MEDICINE



New nationally designed Postgraduate Diploma in Family Medicine

POSTGRADUATE DIPLOMA IN FAMILY MEDICINE
PG Dip (Fam Med)

The new diploma has been designed nationally through a process overseen by the South African Academy of Family Physicians. It is aimed at existing primary care doctors, from either the private or public sector, to enable them to expand their knowledge and skills in areas relevant to primary care. The programme aims to enhance the quality of general practice by capacitating primary care doctors to fulfil their roles as competent clinicians, change agents, collaborative practitioners, capability builders, critical thinkers and community advocates in the future South African primary health care system.

COURSE CONTENT AND DURATION

This is a 2-year programme with a modularised curriculum (4-6 modules) and a blended approach which will involve campus-based teaching, web-based teaching and work-place based peer learning. During the course of the programme the doctor must work in a clinical setting appropriate to the practice and learning of family medicine, for instance a general practice, community health centre, clinic or district hospital.

ADMISSION REQUIREMENTS

For admission to the Postgraduate Diploma in Family Medicine programme a student must hold a MB, ChB 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 licensing body in the country where s/he is practicing.

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

UP – Mr F Sekgwele
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Website: www.sun.ac.za/fammed

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Fax: +27 (0)21 406 6447
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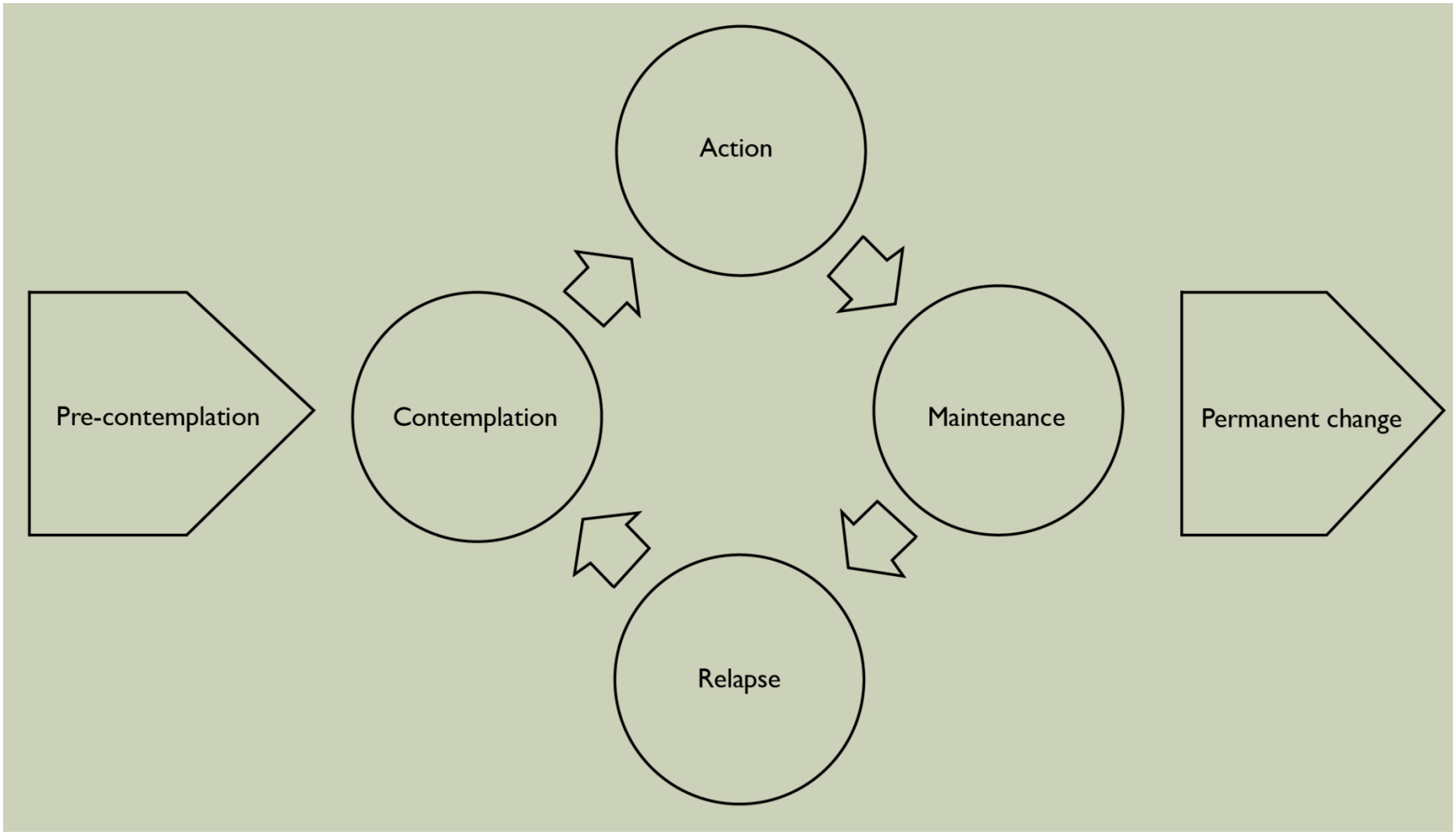
Website: www.familymedicine.ukzn.ac.za

The development of a new national postgraduate Diploma in Family Medicine is one of the goals of the project "Strengthening primary health care through primary care doctors and family physicians" that has been conducted with the financial assistance of the European Union. The contents of this document are the sole responsibility of the authors and can under no circumstances be regarded as reflecting the position of the European Union.

WHAT ABOUT BOTSWANA?

STAGES OF CHANGE MODEL



STAGES APPLIED TO FAMILY MEDICINE EDUCATION IN AFRICA

Pre-contemplation

Key stakeholders are not considering family medicine training

Share information and raise awareness of need for family medicine training

Contemplation

Key stakeholders are exploring the idea, but remain ambivalent

Resolve ambivalence as part of new medical schools, local champions, start informal training, professional bodies

Action

Key stakeholders implement family medicine training

Develop curriculum, develop training sites, identify support from established programmes, recruit faculty, included in policy, registrar posts, register for FPs

Maintenance

Family physicians enter the health system

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

Relapse

Family medicine training is aborted after initial attempt

Reflect on lessons learnt and reasons for relapse, re-enter at contemplation phase

Mash R, de Villiers M, Moodley K, Nachega J. Guiding the Development of Family Medicine Training in Africa through Collaboration in the Medical Education Partnership Initiative. Academic Medicine 2014; 89(8 Suppl):S73-7. doi: 10.1097/ACM.0000000000000328

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