

Emerging role of family medicine in South Africa

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The 2016 United Nations-led High-Level Commission on Health Employment and Economic Growth found a nine-dollar return to a one-dollar investment in health, with opportunity for gains across several Sustainable Development Goals.¹ The Primary Health Care Performance Initiative, launched in 2015 by the Bill and Melinda Gates Foundation, World Bank and WHO, highlighted the need for primary care that provides first contact care that is comprehensive, coordinated, continuous, people-centred and accessible.² WHO suggests five interdependent strategies to achieve ‘integrated, people-centred health services’, one of which is re-orienting the model of care, with strong primary care-based systems providing continuity and coordination. It highlights family medicine as a mechanism to achieve this.³

There is a move from the traditional model of general practice, defined principally by the individual doctor–patient interaction, towards a population-oriented model of family medicine, which embraces coordinated multidisciplinary teamwork, appropriate referral pathways, integrated hospital-based health services, and empowered and accountable community health care.^{4–9} This evolution makes it well placed to provide comprehensive, coordinated and continuous, first contact primary health care, which can help achieve universal health coverage in all countries of the world.

Africa is expected to be a land of economic opportunity by 2060, with an increasingly sophisticated and demanding population.¹⁰ However, it is currently struggling with inefficient primary healthcare systems; inappropriate prioritisation of selective vertical programmes, hospitals and subspecialisation, human resource shortages and inadequate policy responses. This is impairing the establishment of good-quality, comprehensive, primary healthcare services that

Summary box

- ▶ Global health organisations increasingly prioritise integrated, people-centred primary health care as a route to universal health coverage.
- ▶ Despite the role that family physicians can play as key members of primary care teams, they are absent from policy documents in Africa.
- ▶ South African National Health Insurance plans for capitation contracting of private general practitioners may allow decentralised practice-based teamwork to deliver people-centred primary health care.
- ▶ However, private general practitioners need up-skilling in order to achieve cost-effective health care for larger practice panels.
- ▶ African policy-makers should invest in appropriately trained, family doctor-led primary health-care teams in order to achieve universal health coverage.

are integrated around individuals and their community.^{11 12}

Family physicians in various African countries have been advocating for stronger primary care systems that support teamwork and include family physicians with a community orientation.¹³ However, policy on primary health care in most African countries is silent on the role of family physicians. The focus of policy, in the light of shortages of doctors, is on task-shifting as the only solution to improving (mostly medical) healthcare access for all people.^{9 12 14–16} Yet, this is arguably short sighted. Senior African government officials and academics engaged in a recent study on family medicine in Africa see a strong leadership role for family physicians in primary health care, although principally based at district hospitals.^{17–19} Their leadership is expected mainly through managing clinical referrals from juniors and clinical governance (including training and supporting the primary healthcare team in the district, including clinics).^{17–19} These stakeholders suggest a team-based approach, which

includes family physicians, to proactively care for defined communities, as primary care practices, in the long term, but stakeholders in South Africa appear hesitant for family physicians to take a leadership role in current nurse-driven primary healthcare clinic systems.^{17–19}

The expansion of family physicians in South Africa has focused on district hospitals (especially rurally) as a gap in service. This has shaped the 4 years of full-time postgraduate training, which is currently required to become a family physician in South Africa.¹³ This has established family medicine as a respected ‘specialist’ discipline within the current specialist culture of South African health care. However, this growth has not been without some disquiet around the hospital locus of the generalism of family physicians, especially with the lack of visible family medicine practice in public services at community level.^{20–22} Advocacy by South African family physicians for a greater presence within primary health care has had little effect, with the National Department of Health currently only recognising family physicians in policy as one of four specialists per health district providing clinical governance. The other specialists are obstetrician, paediatrician and anaesthetist.²³

The emergence of National Health Insurance in South Africa is seen by some key stakeholders as an opportunity for family physicians to improve the delivery of community-oriented primary care.¹⁸ However, there are no more than 1000 family physicians in South Africa for its population of 55 million versus 17 000 general medical practitioners, 9000 of which are in the private sector as general practitioners and 8000 in the public service mostly in public hospitals, as per the Health Professions Council of South Africa. Therefore, as an alternative, South Africa is currently planning contracting general practitioners through capitation, who have until now largely worked as independent private providers. Yet, many have no postgraduate training or formal qualifications in family medicine.^{18 24} So while private general practitioners in South Africa responded promisingly in 2011 to a hypothetical National Health Insurance contract for a panel or practice population of 10 000 people per private general practitioner-led team, with teamwork including nurses and other healthcare workers, at a cost almost the same as public service expenditure at the time,²⁵ there are reservations about the ability of this workforce to deliver on aspirations.²⁶

In view of this, family physicians engaged with various stakeholders in South Africa, including the National Department of Health, and developed a 2-year practice-based, mostly online, diploma in family medicine as a route to up-skill the private general practitioner workforce. This diploma covers key training to become a family doctor: clinically competent as well as a change agent, capability builder, critical thinker, community advocate and collaborator.²⁷ It is now being offered at a number of universities with the aim that National Health Insurance contracting will be made subject to private general practitioners holding this diploma. Without these skills,

the contracting-out of services to private general practitioners’ risks failing to become truly community-oriented if the default behaviours are to the current fee-for-service culture of patient care, which is not focused to support community-level outcomes. The Chiawelo Community Practice (Box 1) is one example in South Africa successfully demonstrating community-oriented primary care and team-based care led by family doctors, which can be applied as a model for National Health Insurance capitation contracting.

National Health Insurance contracting of private general practitioners could create a paradigm shift from the current bureaucratic, command-and-control large organisational approaches that exist in South African public healthcare provision, towards smaller, nimbler, community-oriented models of organisation for primary health care. With up-skilling of this workforce, this would enable family doctors (general practitioners with relevant postgraduate training) to provide leadership to primary health teams (including clinical associates/physician assistants, nurses and community healthcare workers) caring for communities of around 10 000 people. A systems-thinking approach to health suggests that such decentralised contracted health units with operational and financial independence, alongside strong family doctor leadership, can develop emergent ways of working to achieve health care that is more integrated around the individual and the community. This decentralisation and independence can also allow teams to respond to poor working environments with appropriate use of resources and achieve long-term sustainability of human resources. Rural capitation payment adjustments

Chiawelo Community Practice

Chiawelo Community Practice (a section within Chiawelo Community Health Centre, Soweto) is an experiment in developing comprehensive community-oriented primary care in South Africa as a model for National Health Insurance capitation contracting. Chiawelo Community Practice is part of the public health service in South Africa and is led by a family physician working fairly independently. The Chiawelo Community Practice team includes two doctors, a clinical associate/physician assistant, a nurse and 22 community health workers (mostly deployed into defined streets of the community). The team of four clinicians provides comprehensive health care to this defined community of 18 124 people. Local community and government stakeholders are engaged, supporting a growing health promotion programme that is embraced by the community. The current team model is not optimal as more nurses are required in place of doctors. However, it has allowed family physicians to experiment with team configurations and a clear population in which to measure health process, outcomes and costs. The Chiawelo Community Practice model is influencing capitation contracting plans with private general practitioners as it is the only population-based source of integrated service data apart from national statistics. Chiawelo may be seen as an example of a living laboratory, which pilots an approach to delivering the health service of the future. Details are available online (www.AfroCP.org.za).

can help teams address the added contextual challenges of healthcare provision to rural communities.¹⁶ This can be driven by the government in the right direction by applying equitable, evidence-based and people-centred performance measures and payments captured in well-structured contractual arrangements and a strong regulatory framework.^{28–30}

The legacies of colonialism-apartheid, the current state bureaucracy under post-apartheid leadership and political distrust of the mostly white private general practitioners in South Africa^{25–31} require transformational leadership by policy-makers and family physicians. In helping shape the contracting framework for primary healthcare service delivery under National Health Insurance, family medicine and primary health care can be strengthened in South Africa. South African family doctors, as informed advocates for community needs and preferences, and as clinical team leaders in publicly regulated community practices across the country, are well placed to respond to their defined populations' healthcare needs. Successfully engaging just 5500 private general practitioners of the 9000 in practice would cover the entire South African population. Such a change in South Africa can be the catalyst for transformation in other African settings as the continent moves towards achieving universal health coverage.

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