

Policy brief

Family physicians strengthen district health services

Executive summary

South Africa has an urgent need to improve the quality of district health services. Following the creation of the new speciality of family medicine in 2007, the introduction of family physicians to the district health services was an important intervention. A body of research now exists on the initial impact of family physicians on the district health services.

“Family physicians were found to have a substantial impact”

Family physicians have had an impact through their six roles: clinicians, consultants, capacity builders, leaders of clinical governance, supporters of community-orientated primary care and clinical trainers. Their impact in these roles is seen as substantial, significantly greater than medical officers and similar in both district hospitals and primary care as well

as rural and metropolitan areas. They have improved access to and the comprehensiveness of care at the community level. They have also had an impact on clinical processes for chronic diseases, maternal and child health as well as emergency care. Their impact on district and national health indicators is not yet visible due to the small numbers currently available (0.03 per 10,000 population in public sector).

The health services need to employ family physicians at district hospitals and community health centres or sub-districts. The supply of family physicians needs to be increased by doubling the number of registrar posts from an average of 5 per year per training programme to 10 per year per training programme.

Introduction

South Africa is looking for ways to strengthen district health services in order to improve people’s health and the quality of health care. Health reforms have included the introduction of district clinical specialist teams, promotion of the ideal clinic, introduction of ward based outreach teams and improved school health services. There is also an urgency to deliver on the promise of universal health coverage through national health insurance and to meet demands for service delivery.

Another health reform has been the introduction of family physicians to the district health services. Since the creation of this new speciality in 2007 the country has had a supply of specialists in family medicine and many have been employed within the district health services. A body of research has now been completed that evaluates their initial impact in terms of health system performance, clinical processes and health outcomes. This policy brief shows that family physicians are an effective intervention who also enhance the success of other health reforms.

Approach and results

Family physicians are different from general practitioners and medical officers in that they have completed 4-years of postgraduate training to become specialists in family medicine. Training prepares family physicians to work in district hospitals and primary health care settings.

Four inter-related studies investigated the initial impact of family physicians across seven provinces by:

- Asking the health care team members to score the impact of family physicians relative to medical officers in a national survey¹
- Interviewing district managers on how family physicians had contributed to strengthening services²
- Comparing the performance of district hospitals and community health centres with and without family physicians³
- Correlating district health indicators with the supply of family physicians⁴

Impact on health system performance

Family physicians were found to have a substantial impact in all of their six roles (Figure 1). This impact was significantly greater than medical

officers in all six roles (Figure 2). Their impact was similar in primary care and district hospital as well as in rural and metropolitan settings. The six roles are (Figure 3):

1. **Clinician:** They are trained as expert generalists in 211 clinical skills across clinical domains (e.g. medicine, surgery, obstetrics, anaesthetics, paediatrics, emergencies, orthopaedic) relevant to all problems seen at district hospitals and primary care. They are trained to be patient-centred and to also address health promotion, disease prevention, palliation and rehabilitative care issues.
2. **Consultant:** They are the most highly trained member of the clinical health care team and act as a consultant to clinical nurse practitioners and junior medical officers. They focus on seeing more complicated patients within a multidisciplinary team approach.
3. **Capacity-builder:** They are trained in the educational skills necessary to improve the capability of the other health care team members through mentoring, clinical training and teaching.
4. **Clinical governance:** They take the lead in clinical governance activities to improve the quality of care.
5. **Community-orientated primary care:** Their training includes an approach to integrating public health and primary care perspectives and supporting the development of community based services such as ward-based outreach teams.
6. **Clinical trainer:** Many family physicians will also be responsible for the training of medical students, clinical associates or registrars in family medicine.

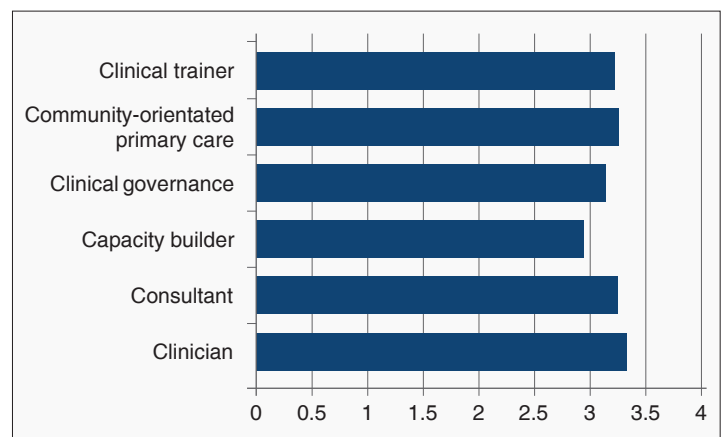


Figure 1: Impact of family physicians on scale from 0-4.

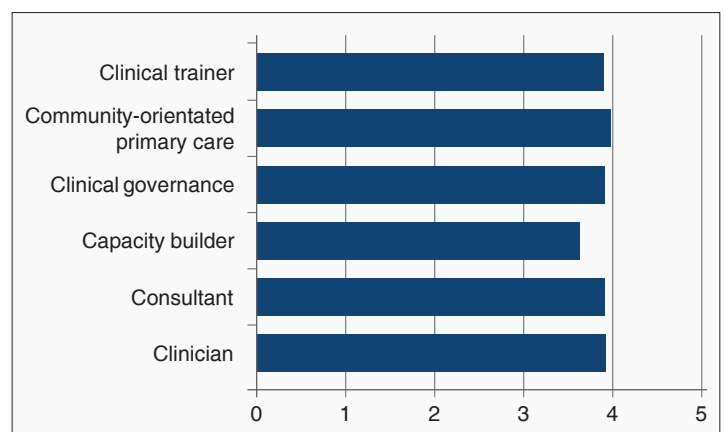


Figure 2: Impact of family physicians relative to medical officers on scale from 0-5.



Figure 3: Six roles of the family physician.

District managers reported that family physicians improved access to a more comprehensive package of care that was closer to the community. They reduced referrals to regional and tertiary hospitals by managing more complicated patients, filling gaps in the clinical skills available as well as by improving the capability of other health care workers. Within facilities they improved the organisation of patient flow and access to care. In some provinces they supported the implementation of ward-based outreach teams. District hospitals with family physicians performed better than those without, particularly in relation to paediatric care.

The impact was enhanced by having a sufficient skills-mix in the team. Family physicians were seen as clinicians and not managers, and functioned better when managers took responsibility for corporate governance and developed a collegial and collaborative working relationship with the family physician. Clinical governance was enabled by supportive managers and sufficient resources to improve quality of care.

Impact on clinical processes

District managers reported that family physicians had an impact on the quality of care for chronic diseases, particularly HIV, TB, mental health and non-communicable diseases, as well as on maternal, child and emergency care. Their impact appeared to be mediated by direct clinical care, capacity building and clinical governance activities. Managers reported that care offered by nurses, doctors, registrars and community health workers was improved by input from a family physician. Managers

also reported engagement of family physicians with implementation of guidelines, protocols or standard operating procedures as well as quality improvement cycles, review of adverse events and learning from routine data.

Impact on health outcomes

District managers felt it was too early to detect an effect on health outcomes, although this might be seen over time and with the deployment of family physicians at scale (current rates in the public sector 0.03 per 10,000 population). This viewpoint was confirmed by an ecological study that did not find any correlation between family physician supply and district health indicators across the country. An observational study found that in-hospital rates for child, neonatal and perinatal mortality were better in facilities with a family physician and

the number of modifiable risk factors associated with these deaths was significantly improved.

Conclusion

Family physicians are an effective health intervention in both district hospitals and primary health care teams. The small numbers currently employed in the public sector are already having an impact on health system performance and clinical processes through the six roles of the family physician. Family physicians can also strengthen the success of other health reforms such as ward-based outreach teams, district clinical specialist teams and the ideal clinic.

Implications and recommendations

Provinces should employ family physicians at district hospitals and community health centres or sub-districts as part of the health care team.

If one family physician was initially employed in this way we would need approximately 700 to achieve this goal.⁵ Since the new speciality was created the nine training programmes have only graduated 158 family physicians and the national register has 1064. The register includes family physicians out of the country, in private practice, in other positions in the public sector and from less standardised training programmes.

The supply of family physicians needs to be increased to achieve this goal by ensuring a sufficient number and fair distribution of registrar posts as well as a gradually increasing number of family physician posts. The mean number of registrar posts per programme should be at least 10 per year to give a national intake of 90 per year. The current mean is 5 per year and in 2017 intake varied between programmes from 0 to 12 per programme.

The roles and contribution of family physicians to district health services needs to be consistently described in government policy. Current policies are sometimes confused or contradictory on how the family physician should be deployed.

District managers should enable the contribution of the family physician by promoting collegial and collaborative relationships with managers, avoiding the use of family physicians as facility managers, providing an adequate skills-mix in the team and ensuring support for clinical governance activities.

References

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