

Assessment of the impact of family physicians in the district health system of the Western Cape, South Africa

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Declaration:

I, the undersigned, hereby declare that the work contained in this assignment is my original work and that I have not previously submitted it, in its entirety or in part, at any university for a degree. I also declare that ethical approval for the study was obtained from the Health Research Ethics Committee of Stellenbosch University (Reference number: N11/10/012)

Signature:..... Date:.....Place:.....

Introduction

The implementation of primary health care has been a global undertaking, as health systems founded on this approach have been shown to improve the overall health of communities.(1,2,3,4) South Africa has also committed itself to improving primary health care and the district health system.(5) The Department of Health is especially looking at improving the outcomes for HIV/AIDS, TB, maternal and child health; as these are part of the Millennium Development Goals.(6) In their quest to do this the Department is exploring what specialists are needed in the district. The re-engineering of Primary Health Care focuses on three streams:(7)

1. Establishing District Clinical Specialist Teams, which include a gynaecologist, paediatrician, anaesthetist, family physician, advanced midwife and a primary health care nurse; with a focus on improving maternal and child health.
2. Strengthening School Health Services
3. Implementing Ward Based Outreach Teams that offer an integrated primary health care service in the community at household and individual levels.

The speciality of Family Medicine is a young one, having only been recognised by the Health Professions Council of South Africa in 2007. Since then, eight training programmes nationwide started training family physicians according to nationally agreed unit standards that aim to promote high quality training.(8,9) The family physicians being trained in the new programmes started graduating in 2011 and will hopefully be employed in those sub-districts where there are no family physicians currently. In essence the family physician is an expert generalist with a scope of practice designed to meet the needs of the South African district health system.

There are many expectations of the new family physicians, including: clinical care at the district hospital, outreach to or support of primary care teams, mentoring and training of staff, clinical leadership and governance, promotion of community-orientated primary care and supervision of younger doctors or students.(10) About 40 family physicians have been employed in the Western Cape to date and the general impression amongst district managers and policy makers alike, has been that they are having a positive impact on the health system and health outcomes.(3,11,12) The Western Cape is unique in terms of its commitment to placing family physicians in district hospitals and health centres throughout the province. Other provinces have only employed small numbers of family physicians at sub-district, district or even regional hospital levels. Evaluation of the model implemented in the Western Cape will assist policy makers and district managers throughout the country in terms of understanding the contribution that family physicians can make to the health system.(13,14)

The National Research Foundation has therefore funded a study to evaluate the initial impact of family physicians in the Western Cape. This study has several components which include an analysis of district health information to look for any correlation between improved indicators and the numbers of family physicians per 10,000 population, development of a 360 degree family physician impact assessment tool and lastly annual interviews with district managers over a period of 3-years.

The first round of interviews with district managers was conducted in 2012 and perceived that there was a positive impact on clinical processes for HIV/AIDS, TB, trauma, non-communicable chronic diseases, mental health, maternal and child health.(12) It was also perceived that health system performance was positively impacted in terms of access, coordination, comprehensiveness and efficiency. There was also the perception that the positive impact attributed to family physicians was in the early stages of development and that they are likely to have a positive impact on health outcomes in the longer run.

This study repeated the interviews with district managers a year later to explore how perceptions might have changed as newly appointed managers found their feet, the number of family physicians increased and the existing family physicians become more established in the health system.

Although similar research has been done in other continents the need to evaluate the impact of family physicians in an African context still exists.(11) This research should be valuable to the Department of Health as they are trying to re-vitalise primary health care and are planning for National Health Insurance.

This study aims to explore the perceived impact that family physicians have had on the performance of the health system, the quality of clinical processes and health outcomes from the perspective of the district or sub-district managers.

Not only will this information be helpful in a South African context, but also in an African context as many countries are in the process of reform and planning with regards to primary and district health care. Academic institutions and governments who are planning to move towards the training of family physicians may also find this research helpful.

Aims and objectives

The main aim was to explore the perceptions of rural district and metropolitan sub-structure managers on the impact of family physicians on the district health services. There were three main objectives:

- To explore the perceived effect of Family Physicians on the health system performance (e.g. access to care, continuity of care, comprehensiveness of care, co-ordination of care)(27)

- To explore the perceived effect of the Family Physicians on clinical processes (e.g. quality of care for HIV/AIDS, TB, maternal and child healthcare, non-communicable diseases, trauma)
- To explore the perceived effect of Family Physicians on health outcomes (e.g. facility level mortality)

Methods

Study design

This was a qualitative study using in-depth interviews.

Setting

The Western Cape district health system consists of four metropolitan substructures and five rural districts. As shown in the map (Figure 1) the five rural districts consist of the West Coast, Eden, Cape Winelands, Overberg and Central Karoo. The four metropolitan substructures consist of Klipfontein and Mitchell's Plain, Northern and Tygerberg, Western and Southern, and Khayelitsha and Eastern substructures. Each of the rural districts has a manager, except for Central Karoo that currently falls under the management of Eden. All the rural districts fall under the Chief Director for the Rural DHS. Each of the Metropolitan sub-structures has a manager, and falls under the Chief Director for the Metro DHS. Family Physicians were employed in all of the rural districts and Metro sub-structures, except for the Central Karoo.

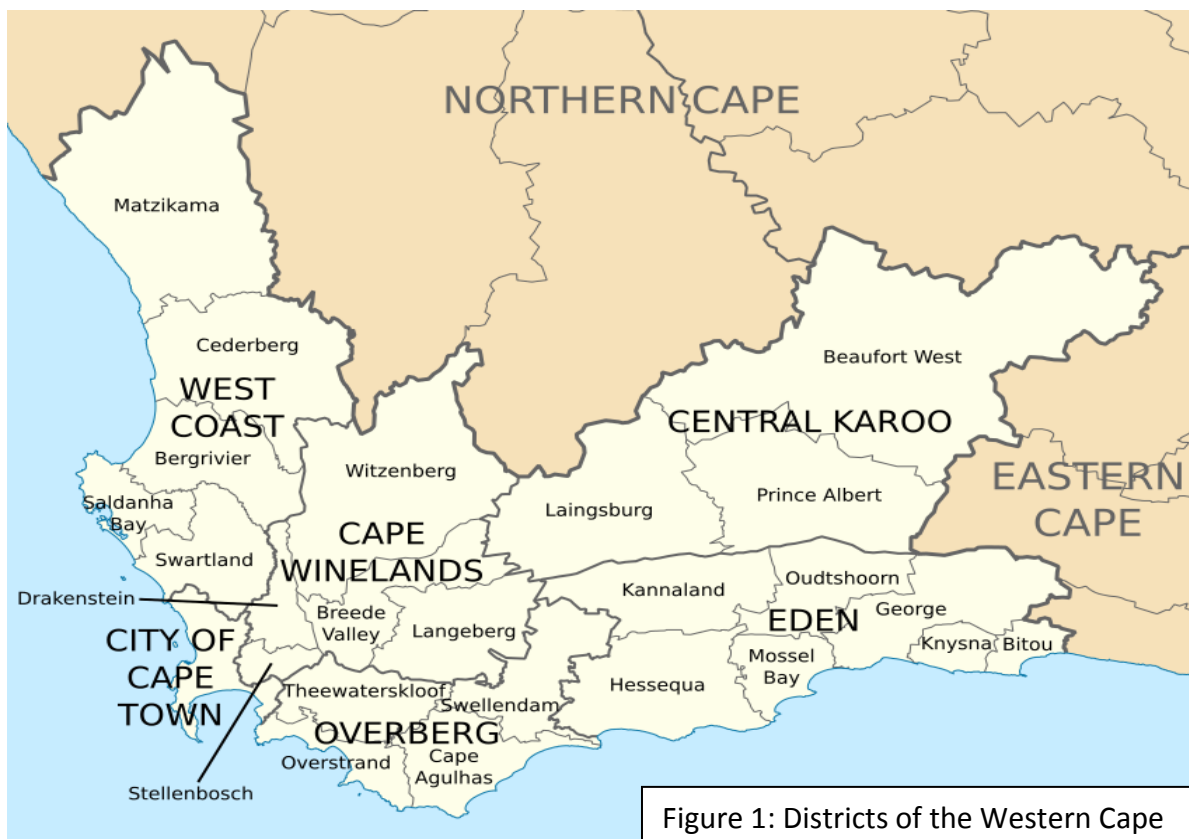


Figure 1: Districts of the Western Cape

I am a registrar in family medicine and was in my second year of study during the time of the interviews. I have been working at a district level hospital for the past five years, from which I developed my interest in the district health system. I became aware of this research in my first year as a registrar, and was immediately drawn to the value it could add not only to the development of family medicine as a speciality, but also to the growth of the district health system and overall health of the people we serve.

I had never formally met any of the interviewees prior to these interviews.

Selection of participants

All managers of the metropolitan sub-structures and rural districts, as well as the chief directors of the metropole (4 sub-structures) and rural areas (5 districts) were selected for in-depth interviews. They were selected because they have a unique overview of their district/sub-structure, and would have useful knowledge of the impact made by family physicians.

Data collection

In-depth interviews were performed on a face to face basis. The interviews were conducted in the interviewees' language of choice, either Afrikaans or English, and lasted 45-60 minutes. All the interviews were audio taped.

Before starting the formal interviews I had a brief introduction to qualitative interviewing by a lecturer at the University of Stellenbosch. I read extensively on the subject of qualitative interviewing including various articles and applicable chapters out of relevant textbooks. I did a mock interview with one of the local senior family physicians. My supervisor felt that it was satisfactory and that I could go ahead with the formal interviews.

An interview guide was used to ensure that all points of relevance were explored (see Appendix 1). The interviews were completely open in nature, ensuring that the interviewee's perspective was fully explored and captured. Summarizing and reflective listening were used to help facilitate the communication. The first question was open in nature, asking about the interviewee's experience of the family physicians working in their district so far. The key areas that were explored included the perceived impact of the family physicians on the quality of clinical care, performance of the health system or facilities and health outcomes (morbidity and mortality). The extent to which the family physician's predicted roles had been seen in practice was also explored as well as any unanticipated effects or roles.

Data analysis

All the interviews were transcribed in the language of the interview. All the transcripts were checked by the researcher to ensure accuracy and any corrections made against the original tapes. The framework method was then used to analyse the data. This approach includes the following steps: Familiarisation with the raw data, creating a thematic index of codes and categories arising from the raw data, annotating transcripts with the codes from the index, creating charts that brought together all data on the same codes and category, using the charts to interpret the data and derive the key themes inductively. Interpretation looked at the range of opinions and experiences, paid attention to any deviant viewpoints, and looked for any associations or relationships between the emerging themes. The ATLAS.ti computer software programme was used to help with the data analysis.

Results

Seven interviews were conducted that included both the chief directors of the metropolitan and the rural district health system, three rural district managers as well as two urban sub-structure managers .

General impressions

Perceptions of the impact of the family physicians according to district managers were very varied and ranged from very positive, to sceptical, but optimistic, to downright bleak. The overall sentiment seemed to be that the family physicians had mostly had a positive impact within the Metro, but were not as convincing in the Rural DHS:

“My experience has generally been a good one. I’m mainly related to the recent graduates of the new four year programme.”

“If you can get a family physician that can base himself at a specific hospital, that comes with the right skills, it might make a big difference.”

“I am saying there are red lights going on. Maybe we are training the wrong people, or we are training them wrong, or maybe our expectations are wrong.”

“So unfortunately I must tell you that I formed a bit of a negative view point regarding specific areas.”

It seems like the presence of family physicians brought a seniority and level of clinical skills to the service delivery platform that gave the rest of the clinical team, including medical officers and clinical nurse practitioners, more confidence. They knew that if there was a big problem, they could call on the family physician to come and sort it out:

“The confidence among medical officers and clinical nurse practitioners have improved because they know there are somebody you can depend on if things go wrong.”

The new family physicians came with enthusiasm, energy and a vision of how they wanted to change the system to make it better for the client. They came with a client centred approach:

“I think the most pleasing part of it has been a group of people that have been very enthusiastic, that really came out with a lot of energy and a lot of vision to make the system work. So I think that is an understanding how the system work and how they fit into this account system and really embracing it to actually take on the system to make things better for the patient. So it has been a relatively good experience with most of them in terms of that.”

It seems that family medicine as a speciality is a respected one. If you look at the number of applications that were received to join the programme, it is unparalleled:

“Which other speciality in this province has gone from zero registrars to a commitment of seventy to eighty registrars in a space of four years? There is no other.”

Roles of the Family Physicians

There was a general feeling that the family physicians should not only be the clinical governors, but also competent clinicians and leaders of their clinical teams:

“You should know from a very young age when you start that you are going to be called upon to be the leader of a clinical team.”

This was indeed the case in the Metro where family physicians stepped up and used their seniority and superior clinical skills to take the lead in difficult clinical situations, and they were the last port of call before referral. Being consultants themselves also made the referral process easier as they could communicate with confidence with other consultants at the referral centres, and get more respect from junior doctors:

“The relationship between primary care and tertiary hospitals has improved, because when the guy says I’m a family physician, the intern will keep quiet for once...”

The family physicians brought a holistic approach, respect for patients and promoted good communication within a multidisciplinary team. Because of their seniority, calling meetings regarding clinical governance was made much easier. Other senior staff members seemed to listen, and the junior doctors would respond better to feedback coming from a consultant rather than a medical officer:

“So something as simple as managing to get senior nurses and doctors together once a month to look at perinatal and infant and child mortality and morbidity statistics intelligently, and interrogate them, and actually work out what went wrong, and draw conclusions, and come up with a battle plan. It is a small example, but actually it’s made a big impact.”

Clinical audits were done by the family physicians for chronic diseases. They also ran morbidity and mortality meetings for all disciplines. They did outreach to the clinics where they provided support to the medical officers, and also looked at clinical governance at the clinics. They acted as mentors for the clinical nurse practitioners to help make sure they were up to date, which in turn strengthened the multidisciplinary team leading to more effective clinical care for patients:

“She ensures that protocols are being followed out there, she looks at documentation and the quality of note keeping, and the medical officers’ note keeping has definitely improved. They are looking at patients more holistically now.”

It was the general viewpoint in the past year that family physicians in the rural districts mainly worked in primary health care, and did not take the lead in the hospital, as was expected. As nineteen of the twenty four family physicians in the rural districts were in hospital posts, this was a surprising finding that raised some questions. Despite the placement of these family physicians the interviewees still perceived a need for family physicians to focus more on the procedural skills required in hospitals and not only the primary health care setting:

“In a district hospital, especially in a rural area, we want doctors that can give an anaesthetic and do surgery. We are not necessarily getting that. That is why I am saying that the family physicians lean towards primary health care, chronic disease management; it is almost as if it is a safer environment, but never the less an important one.”

The family physicians also played a pivotal role in the co-ordination of teaching. They provided help with the teaching of 4th 5th and 6th year undergraduate students from the University. They also organised in-service training of staff, and co-ordinated other teaching opportunities. The co-ordination or training of the family medicine registrars in some districts was also their responsibility:

“She is the training co-ordinator for the registrars in that complex... she organises training for the staff to get them up to date as this is also a responsibility that befalls her...she started a small training programme where she went and did training even out of her jurisdiction.”

Clinical processes

The family physicians were particularly seen to impact the quality of care for chronic diseases such as non-communicable diseases, HIV and TB:

“So I can see that there are quite a lot of family physicians that actually look at the integration of non-communicable diseases with HIV/TB and improving the quality in accordance to that.”

Numerous projects and programmes were started in different districts that are all family physician driven. The quality of clinical expertise and support they brought to the primary health care team was thought to be a big advantage. For example a family physician developed new elements of the medical records that are now used widely throughout Eden and the Central Karoo, and which are anticipated to have a significant effect. Eye care in the West Coast was transformed with an initiative from a family physician. A register was started following up patients over the long run, ensuring compliance and better clinical outcomes:

“It is really nice, she started a register, and she has made a data sheet with which we are working now. Now we can look at this at the end of the year, or end March, and we can look at the data and analyse it together with her.”

In many of the districts there was a belief that mental health was one of the disciplines where there was a lack of expertise and structure. In many of these districts there were no permanent medical officers in psychiatry, and no visiting psychiatrists. Therefore the family physician was required to develop this area:

“I think the family physicians had to step up to the plate you know, in each of the district hospitals there’s had to be a family physician who’s taken on mental health, maybe they like mental health, but maybe they didn’t, so that was unanticipated for some of them, and certainly for us.”

The family physicians took the lead with mental health and started working on programmes to get teaching going in the communities at the local primary health care clinics, organising visiting psychiatric registrars at the clinics and visiting consultants at the district hospitals. There is still a long way to go, but at least someone has taken on the responsibility of improving mental health care at a district level.

There was a problem with infant mortality in a specific sub-district, especially during the diarrhoeal season. A team was put together by a family physician. They went around to the various primary health care facilities and provided training to the staff in setting up intravenous-lines, intra-osseous lines and all the essential clinical skills needed to treat

critically ill infants with acute gastroenteritis. It is believed that this had a significant positive impact on the morbidity and mortality of that specific district:

“It has resulted in I think quite a dramatic decrease in the number of deaths from diarrhoeal disease and children admitted with severe dehydrating diarrhoea. So diarrhoeal deaths have come down from in the hundreds last year to about seventy for the whole of the Metro.”

In the hospitals where there were no obstetricians, the family physicians took the lead in maternal health, in some areas transforming the system with only positive feedback:

“Phenomenal stuff in just the way obstetrics is handled in Khayelitsha hospital. He single handedly put systems into place to improve obstetric care in Khayelitsha.”

Systems improvement

If you look at the four key areas as described in the conceptual model of the larger study; access, co-ordination, comprehensiveness and efficiency, it is perceived that the family physicians impacted positively on all of these areas:

“So I think we are lacking in actually defining an appropriate strategy for improving health system performance and we are lacking in defining exactly what the role of the various players would be in doing that. Having said all of that I can think of one or two or three family physicians that has embraced it and in their own way have led to improvement of things, without necessarily having the framework, a clear strategy and clearly define the roles of doing it. So I can think of one or two people which have actually played an important role in access, continuity, coordination and comprehensiveness, in the way that they do their ordinary business.”

Respondents gave several examples of how family physicians have impacted the performance of the health service.

Access

In one of the rural districts a new system was initiated where doctors and nurses in the district hospitals were trained to follow up patients that went to referral centres for certain procedures. Now they could be followed up locally, and did not have to travel long distances to the site where they had the procedure done. As transport from very rural districts to the bigger referral centres is a big problem, this intervention definitely improved access to care.

In most districts the family physician has an outreach clinic in the community where they see referrals from the primary health care nurses and the medical officers, giving the patients access to a higher level of clinical care in their own community:

“People living in Khayelitsha now, in theory, have access to highly qualified specialist clinicians, which they probably didn’t have before, and those could be family physicians at PHC level or at Hospital level...they don’t have to travel thirty kilometres, they can actually see a specialist right on their doorstep. So I think that has made a big difference, and it is in line with that whole philosophy of taking the service to the people.”

Co-ordination

Another family physician helped to develop a local protocol on referrals which clearly stipulated who needed to be seen where and how to prioritise the different problems. The new system introduced standardised referral letters for common problems and provided contact details for specialised clinics at tertiary and secondary hospitals to streamline the referral process and save time. The system prevented the wrong patient from ending up at the wrong clinic, wasting both time and resources for the patient and health system alike. The family physician also acted as the link between the referral centres and the district health system. The family physician can build personal relationships with the specialists in their area, and they can then be informed of inappropriate referrals received from their district. In this way problem areas can be identified and improved, again leading to better co-ordination of care and better efficiency:

“She is the middleman between the medical officers and the specialists...she makes sure a specific patient is a good candidate for the orthopaedic surgeon, gynaecologist, paediatrician or psychiatrist, whatever is needed, there she also fulfils her role as a consultant.”

Comprehensiveness

Another area where the family physicians had a significant impact was on the psychiatric services. It is a known fact that mental health services are poor and a neglected field in the district health system. One of the family physicians in the rural districts started a screening programme, aiming for a preventative approach. She tried to identify high risk patients by means of a standardised questionnaire the primary health care nurse could use. This was used in high risk patients such as diabetics, patients on TB treatment and new mothers:

“I have seen family physicians actually take the lead in the co-ordination of mental health care provision across the care continuum, because community based and primary care is the important base where mental health should fit itself in.”

Efficiency

One family physician looked at the way patients flow in the hospital, they improved systems to decrease waiting times and getting patients to the right clinics thereby decreasing the

total time spent in the hospital. The clinical expertise and seniority of the family physicians also led to more effective in-hospital management and shorter in-patient stays:

“There’s this belief that if you work at a regular hospital you automatically know more than somebody at primary level and so forth, so the interns will listen, the community service doctors will listen. So that relationship has improved and that has impact on the clinical output because patients no longer stay around for so long and then they end up where they are supposed to be quicker.”

Health Outcomes

The subjective feeling across the board was that the family physicians were having a positive impact on health outcomes, both rurally and in the metropole:

“Subjectively I think there is probably, because again I can think of the pockets. There are probably better health outcomes, which are not being proven. It can be attributed to interventions associated with specific family physicians.”

The impact on health outcomes is obviously multifactorial, but the presence of the family physicians seems to have a positive impact even though it is in the very early stages:

“I think it is too short, you know there are so many factors that have an influence, to actually at the end of the day see the impact on wellness. It is very difficult to say we are now so many years down the line but I see no impact. I think it is unfair, unrealistic to have that expectation.”

Unanticipated effects

In the smaller hospitals with less experienced medical officers a lot was expected of the family physicians, as it should be, but in some instances the extent of what was expected might have been unanticipated:

“The go-to guy is the family physician, because they’ve got all this broad range of skills you know. So we don’t have a psychiatrist, your family physician will sort it out. You don’t have an emergency medicine physician; the family physician will sort it out. So it’s not entirely unexpected, but I think that the magnitude maybe was unexpected.”

In some districts the family physician was pulled into the district office to help with the programme development and management. For instance; eye care services, chronic disease services, mental health services. Their medical knowledge helped the managers plan targeted interventions and gave another perspective to policy planning. Their initiatives were used to give the services higher quality through collection of data in the field. The family physician came up with simple and innovative ideas to gather information that can

later be used to better plan for the future regarding understanding of disease patterns and trends:

“The input she gives here at the district office where we plan the programmes are priceless. That we have her, her medical knowledge and we can pull her in, it helps us tremendously.”

Opinions differed from district to district, but it was felt that the family physicians did not primarily belong in the management meetings, but should rather work at the clinical level. They shouldn't be invited to sit around tables; they belong in operational clinical services:

“In my eyes, if you train a clinical specialist, the aim is get a clinician, not a manager. We can hire managers for managerial posts. We cannot use our clinical posts for that.”

There seemed to have been some confusion of specifically what the family physicians role was, as some family physicians came with different expectations, and only wanted to fulfil a consulting/managerial role. They were not prepared to take the lead clinically, refusing to give anaesthesia and do surgical lists. They only wanted to consult on a certain amount of difficult patients as they had administrative duties that also needed their attention. The managers felt that it was a luxury that could not be afforded in a rural hospital. If they were going to spend the amount of money needed to employ a family physician, they wanted them to fulfil mainly a clinical role that catered to the specific district's needs. If that need couldn't be met they would rather employ a medical officer and a clinical nurse practitioner for the same amount of money:

“My point of view is, if I pay that amount of money for a clinical specialist, then I expect that he will do eighty to ninety percent clinical work. Not sitting in a meeting somewhere, not holding someone's hand, he must walk in the front of the clinical team, and if he cannot do that, then we cannot call him a specialist.”

This mismatch of expectations caused some animosity between management and the family physicians, even though it was only isolated family physicians that were perceived to have come with unreasonable expectations. In the districts where the intended roles were clearly understood by the family physician applying for the post, the positive impact of the family physicians was much more recognised, as they delivered what management was expecting:

“We went into one meeting and he (FP) told us senior managers, my job is not to come into these meetings, because I should be out there improving quality of care and supporting my staff. I mean that was so... I felt so good. And he has all these ideas how things should be run and I think, I call him the role model of family medicine, he has brought credibility to the discipline of family medicine.”

New problems identified

Mainly referring to the rural districts, there was a general concern regarding mostly the clinical skills, especially surgery and anaesthetics, and leadership skills the new family physicians emerged with. There were many different ideas of what the cause could be. Many were worried that young doctors straight out of community service did not yet have enough experience to make a good family physician in four years' time, that they were not yet sure of what they wanted from their career. It was felt that many of the skills you need to be a good family physician come with years of experience, and is something that cannot be taught. Young newly qualified family physicians, who are appointed in specialist posts, also experienced friction with older and more experienced career medical officers, particularly in terms of leadership within the facility. Therefore they felt that candidates straight out of community service should not be considered for registrar posts:

"The guys coming into the registrar posts are too inexperienced...The guys with more experience turns out to be the better family physicians."

The rural hospitals have a need for family physicians that can give anaesthetics and do surgery, and they were under the impression that is what the new family physicians will bring to the table. In more than one instance they were left wanting, not receiving the clinical skills they felt was promised to them:

"Our need is for a hands on clinician, if we cannot get that out of a family physician, I can tell you, I will never hire a family physician again, as that is what we need from them. Then I would rather take a medical officer, look after him nicely till he is where we need him, able to do everything and is worth it to us."

It then raised the question of where the problem lies. Was it with what was taught in the new programme, or where it was taught, and by whom? Was it that the wrong candidates were picked for the programme, or is it about having the wrong expectations?

"The programme in my eyes is busy going back to what the previous family physicians were. They do not get trained in regional hospitals; they sit in the district hospitals. You cannot learn all you need in a district hospital. So I think we are busy shooting ourselves in the foot through the system we are busy developing with the training."

Another main concern was that the new family physicians were not willing to do overtime, something that is essential to the functioning of many of the rural hospitals. It resulted in the need to reject some of the applications received:

"My concerns are that we are not getting anaesthetics, surgery, the after hour's commitment and leadership qualities that we want in these people."

Discussion

Summary of the key findings

The general sense was that the family physicians were having a positive impact on improving the performance of the health system and the quality of clinical processes, especially in the Metropole. Respondents gave examples of how family physicians had improved access, co-ordination, comprehensiveness and efficiency of care. Respondents also highlighted examples of how family physicians had impacted on clinical processes for HIV/AIDS, TB, mental health, child health, non-communicable diseases, eye care and maternity. The perceived impact on health outcomes was also positive, although it cannot be statistically proven in this type of study.

A few new concerns were raised from the Rural DHS regarding their performance in district hospitals, particularly in relation to surgical and anaesthetic skills, overtime, managerial engagement and sharing the clinical load. These concerns were related to specific individuals and not necessarily all family physicians. The perception, that despite the presence of a family physician, the scope of surgery and anaesthetics was still too limited led to questions regarding the training programme. In recent years registrars were located more in district hospitals and were rotated to regional hospitals for specific skills training, as opposed to spending a block of 2-years at a regional hospital. This may have led to concerns that the training programme was not focusing enough on these procedural skills. The scope of practice in terms of surgery and anaesthetics at district hospitals is however a systemic issue and may also be limited by the availability of other staff, especially after hours, the proximity of the referral centre, infrastructure and other resources.

Differing conceptualisations of the roles and competencies required of the family physician between managers and family physicians may also lead to a mismatch of expectations. There is clearly a need to ensure that all stakeholders share a common understanding and to improve communication on such issues between the university and managers at all levels in the DHS. Local circumstances and requirements also need to be taken into account when employing family physicians.

Many of the positive influences continued to grow from the previous year. The impact on clinical processes and the health system seemed to be more prevalent as time goes by. Some new difficulties regarding the clinical competencies the new family physicians emerged with were identified that were not evident in the previous year. These details regarding the clinical competencies painted a clearer picture of what needed to be looked at to potentially increase the positive impact the family physicians have on the district health system. Their role in clinical training did emerge even more, and was perceived to be a

positive one. Community orientated primary care still remained an area that was not much discussed, and should be explored further during the future interviews. Although questions were asked and some alarm bells sounded, all of the interviewees felt that they would definitely employ more family physicians should the posts become available, and everyone was optimistic about what the future holds for family medicine as a speciality and the promising impact it could have on the district health system.

Discussion of the findings in relation to the literature:

The findings are in line with the latest health policy of the country, and the rest of the world, that family physicians are an important part of the health care team to improve the performance of the health system and the quality of clinical processes.(1,11,27) It is also congruent with new research that family physicians can have a significant impact on clinical governance and the quality of clinical care.(12,28) The ambivalence about their management role and concern about the amount of time spent on administrative tasks as mentioned in a recent study were also identified in this study.(29) The lack of evidence of an impact in community orientated primary care was corroborated by the other components of the larger study.(12,28) The questions raised about the skills required from a family physician in rural areas seems to be a topic that is much discussed, especially in the rural areas of South Africa.(29) In many countries, including the USA, Brazil and Australia the importance of the family physician's role is well established, not only in clinical care, but in the performance of the district health system.(29,30,31) The findings are also congruent with what is found in the 2008 World Health Report (27), that family physicians play a pivotal role in effective primary health care and the overall wellness of the community.

Limitations of the study methods

All of the sub-structure managers could not be reached for interviews, but both the chief directors took part in the interviews. Their overview included all of the sub-structure managers that could not take part. It is felt that the information received from the chief directors were representative of those sub-structures as well, and that they would probably not have added any new information to the study.

The views represented in this study are based on the perceptions of the interviewees, which makes it entirely qualitative in nature. It will form part of a bigger study where quantitative data will also be analysed, which can be triangulated with the findings here.

Although the researcher was a family medicine registrar, which could potentially lead to the interviewees not wanting to express their real feelings, all the interviewees were very professional and honest with the information they provided, and all negative impacts were discussed and explored thoroughly.

Implications or recommendations of the study for policy makers or future researchers

The positive impact of family physicians in the district health system is clearly supported by the study findings. Employment of increased numbers of newly qualified family physicians will most likely lead to better quality patient care and an overall improvement of the functioning of the health system. The findings therefore support the employment of family physicians in the DHS in South Africa and could be transferred to similar settings in other African countries.

The training programmes and the DHS need to ensure that they share the same conceptualisation of the roles and competencies required of family physicians, especially as these requirements may shift in the context of a health system that is evolving in line with provincial and national policy. This requires on-going open communication and opportunities for honest feedback and reflection.

As the study continues with more interviews in the year to come, researchers will gain more insight about the impact as more time have passed and the family physicians will be more settled in their posts and there would hopefully be larger numbers of family physicians employed in the different districts.

The findings of this study should be looked at together with the larger study which will include quantitative data to triangulate with the findings of this study.

Conclusion

It was perceived that family physicians were fulfilling the role of competent clinician, consultant and leader of clinical governance well. Their role as a champion of community orientated primary care and as a clinical teacher was much less developed. They seemed to have a positive impact on the clinical processes for non-communicable chronic diseases, HIV and TB, mental health, eye care, child health and obstetrics. A few concerns were expressed about their skills in anaesthetics and surgery at rural hospitals. Access, co-ordination, comprehensiveness and efficiency of the health system were positively impacted. It was anticipated that in the long run health outcomes will be positively impacted.

Acknowledgements

I would like to thank the two chief directors of the metro and rural DHS, the three district managers as part of the rural DHS and the two sub-structure managers of the Metro are mentioned with great appreciation for agreeing to be part of this study and taking the time for the interview. The information received was of the highest quality and contributed to the success of this study.

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Appendix 1:

Interview Guide

Assessment of the impact of family physicians in the district health system, Western Cape.

1. What has been your experience of family physicians in your district/subdistrict so far?
2. What effect, if any, do you think your family physicians have had on the quality of clinical care (HIV/AIDS, TB, STIs, NCDs, Maternal, Child, Injury, Trauma, Mental)?
3. What effect, if any, do you think your family physicians have had on the performance of the health system or facilities (Access, Continuity, Coordination, Comprehensiveness, Other)?
4. Do you think that your family physicians are having any impact on health outcomes in your subdistrict/district (Mortality)?
5. Over the last year what other new policy initiatives, projects or programmes are likely to have impacted on the quality of clinical care or performance of the health system (Policy, Generic or Targeted Interventions
6. To what extent have the predicted roles of the family physician been seen in practice (care provider, consultant, mentor, supervisor, manager, community orientated leader)?
7. Have there been any unanticipated effects or roles?