Chapter 9

Conclusion of thesis

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The 2008 World Health Report on Primary Health Care "*Primary Health Care: Now More Than Ever"* recommends four reforms for primary health care: universal coverage; service delivery; public health in all policies; and government leadership. Service delivery reform requires a shift from verticalised to integrated primary health care, with people as the organising principle [1]. Integrated first contact care, that is comprehensive, coordinated and continuous, produces quality and improves health [2,3].

Africa is struggling with health systems built around vertical programmes, hospitals and specialists; human resource shortages and inadequate policy responses, especially for establishing integrated primary health care at district level [1,4]. On the other hand Africa is expected to be a land of opportunity by 2060, with an increasingly sophisticated and demanding population [5]. South Africa is in a space where the population are demanding better cheaper care, between the costly private sector and the poor quality public sector. The South African government is implementing National Health Insurance for universal health coverage and has made primary health care re-engineering core to it, including capitation contracting with private general practitioners [6,7].

Global family medicine is grappling with a changing world and embracing stronger teamwork, integrating personal, procedural-hospital-referral and community health care to improve access in the midst of resource constraints [8–12]. Family medicine has been active in advocating for greater community orientation amongst family physicians and against fragmented verticalised healthcare, especially in Africa [8,13]. African policy on primary health care is mostly silent on the role of family physicians.

Several studies were undertaken to understand the emergence of family medicine in Africa: how stakeholders (leaders in sub-Saharan and South Africa and providers at the coalface in Johannesburg, South Africa) view family medicine and the human resource issues; why emigrant healthcare professionals did not take up primary health care posts in Africa; and the

views of private general practitioners in groups on engaging National Health Insurance in South Africa.

Key stakeholders interviewed in Africa and South Africa (including university deans, heads of departments of health, health workers etc.) see a strong leadership role for family physicians in the district health service and a strong overlap between family medicine and primary health care [14–16]. This triangulates with growing international recognition of family medicine [17]. These African stakeholders see family physicians role as dealing with referrals and clinical governance (including training and supporting the primary health care team), based at district hospitals. Despite this specialist- and hospital-based approach to family medicine these African stakeholders see a role for family physicians in the community. This is in line with aspirations of family physicians in Africa [18]. The perceived health care pressures appear applicable globally: responding to a changing patient, using a team approach, focusing on priority programmes whilst extending care into the community and hospital [19].

Task shifting is considered an effective strategy for addressing human resources for health in primary health care [20] but primary health care should not be dangerously oversimplified in resource-constrained circumstances [1]. The right mix of staff needs to be in number, diversity and competency. The focus in task shifting needs to shift from a narrow mix of staff types (where the grouping of skills is often arbitrary) to skills management in a decentralised organization where human resources are optimised responsively [21,22]. These stakeholders in Africa suggested organisational development strategies for primary health care, using a team-based approach including family physicians to progress to care for defined populations as family practices. There is a need to develop a professional model of organisation for primary health care in Africa. This needs to occur with greater decentralization, democratization, holistic health care, viable finances and a strong regulatory framework [23,24]. This needs a paradigm shift from reductionist command-and-control approaches to a systems thinking approach for health in Africa, which allows for health units, as part of complex adaptive systems, to develop emergent

ways of working to achieve integrated health care. The ‘health vortex’ can be driven by ‘attractors’ like patient-centred care, strengthened by well-structured contractual arrangements [25–28].

This reshaping in organization (developing a team-based approach and health promotion focus) may happen spontaneously, as private general practitioners responded to proposed National Health Insurance contracting in South Africa, producing cost-effective models of primary health care [29]. Decentralised primary health care teamwork can be capacitated operationally to address the poor working environment and the contextual challenges in PHC to maintain long-term sustainability in terms of human resources, as has been done in Chiawelo Community Practice [30–32]. Chiawelo Community Practice, as an attempt at community-oriented primary care led by a family physician, provides a useful example of managing these pressures, developing strong teamwork including community health workers, engaging community and developing a robust health promotion programme. Extrapolation of the model suggests that it is not only possible considering human resource shortages but also more cost-effective than current primary health care, not only in South Africa but many parts of Africa [32].

There is an inverse primary care law evident in Africa [30]. Seminal documents in Africa fail to clearly delineate human resources for primary health care, and do not mention family physicians [4,33,34]. National Health Insurance in South Africa, with primary health care re-engineering, is seen an opportunity for family physicians [15,35,36]. Private general practitioners could be an important and cost-effective resource for National Health Insurance plans [29]. This value is applicable to large parts of Africa, provided there is adequate funding for primary health care and human resource policy for integrated primary health care, including family physicians and community health workers. Human resource policy needs to prioritise specialist training opportunities in family medicine, compensation and working conditions [30,31,37]. Family physicians must build social accountability and multi-disciplinary training in undergraduate educational reform. Decentralised training and sub-

specialisation, e.g. in rural health, may improve retention in rural areas and reduce pressures on family physicians to be based at district hospitals.

Despite the high expectations of family physicians playing strong leadership roles in Africa and South Africa there are concerns about team conflict in primary health care, especially with poor understanding of family medicine and the dominant nurse - medical specialist paradigm in Africa [16,37]. Change management of the legacies of colonialism-apartheid, the current state bureaucracy and the distrust of private general practitioners needs sensitive leadership by family physicians [38–40]. There are opportunities to develop contracting models for private general practitioners in a strong professional accountability framework in primary health care under universal health coverage [41]. Policy engagement should be astute, including building on successful implementation of family medicine with engagement of local stakeholders [42–44]. Family physicians need to become social activists, advocating for peoples health, more than the profession. The path is open for family physicians in Africa: to innovate, extrapolate, evaluate and advocate. A wider range of stakeholders in Africa needs to be engaged.

Whilst critics and Afro-sceptics may term the propositions in this thesis as ‘wishful thinking’ the possibilities and arguments offer a refreshing input into an otherwise gloomy discussion around human resources for health in Africa and deserves more scrutiny.

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