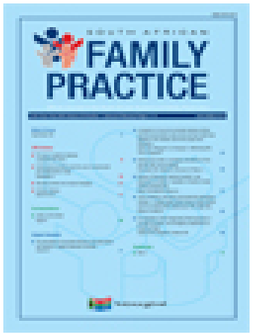

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RESEARCH

Strengthening primary health care through primary care doctors: the design of a new national Postgraduate Diploma in Family Medicine

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Strengthening primary health care is a national priority in South Africa, in order to improve quality of care and health outcomes, reduce inequity and to pave the way for National Health Insurance. The World Health Organization and World Health Assembly both recommend the inclusion of a primary care doctor with postgraduate training in Family Medicine in the primary healthcare team. Currently, medical practitioners without postgraduate training, and those who may need re-orientating and upskilling for the future re-engineered primary care system, are the largest pool of doctors in South Africa. Most of these doctors are of an age and at a stage in their careers where it is unlikely that they will train to be a family physician.

This article reports on a national process to design a Postgraduate Diploma in Family Medicine which will meet the learning needs of primary care doctors in both the public and private sectors as they prepare for the future.

A year-long process included two national stakeholder workshops, a survey of learning needs and two additional expert workshops before consensus could be reached on the design of the new diploma programme.

The future roles and competencies required of primary care doctors, learning outcomes congruent with these roles, and an educational design, which could be delivered at scale commensurate with the national need by all of the relevant higher education institutions, were envisaged during this process.

The design of this diploma, presented here, will now be developed into a revised or new programme by the higher education institutions, and implemented from 2016 onwards.

Keywords: family physicians, general practitioners, graduate medical education, physician's role, primary care doctors, primary health care

Introduction

Primary health care has been the cornerstone of health policy in South Africa since the end of apartheid 20 years ago.[1] Since then, considerable progress has been made in integrating the health services which were racially and geographically fragmented, and in implementing a district health system. The emerging primary healthcare system has been seriously challenged by the emergence of the human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) epidemic, and associated tuberculosis, as well as the quadruple burden of disease, which apart from HIV/AIDS, includes violence and injuries, maternal and child mortality, and chronic non-communicable diseases (NCDs).[2]

First-contact primary care is mainly offered by nurses in 80% of all consultations in the public sector.[3] Primary care practice is characterised by undifferentiated illness, uncertainty and bio-psycho-social complexity which is challenging, even for family physicians with several years of postgraduate training.[4] HIV/AIDS and tuberculosis have largely been addressed through vertical programmes with additional resources, and training and quality assurance. As a result, ambulatory primary care is dominated by chronic NCDs, with hypertension being the most common condition seen.[3] There is evidence that nurses struggle to function as medical generalists as very few psycho-social problems are identified.[3] For example, depression and anxiety are rarely diagnosed. In addition, the system does not support continuity of care and patients often complain that health workers are not empathic or caring.[5]

General practitioners in the private sector offer first-contact primary care to those with insurance or to those who can pay for out-of-pocket expenses; approximately 16–20% of the population.[6] General practitioners are not required to undergo any postgraduate training, and may vary considerably in their expertise and scope of practice.

The long-term goal of the government is to introduce National Health Insurance (NHI), with the intention of improving equity and access to quality health care for all South Africans.[6] One of the key prerequisites for this goal is the re-engineering of primary health care.[7] A number of initiatives have been introduced in an attempt to improve the quality of primary care. A list of national norms and standards are being driven by the Ideal Clinic Project, which should improve the infrastructure and patient experience.[7] District clinical specialist teams have been focusing on improving maternal and child health care.[7] School health services have been re-introduced to promote health and prevent disease in children and adolescents.[7] Community-orientated primary care, based on a Brazilian-style model, has also been implemented in some districts.[8] According to this model, teams of community health workers, supported by nurses, take responsibility for addressing health needs in a designated group of households.

The role of the doctor is often marginal in many of these public sector initiatives, partly because of the scarcity of experienced doctors. According to the ideal clinic project, it is recognised that a future goal is that every clinic must have access to a doctor. Contracting private general practitioners to support the clinics on a sessional basis is one initiative to realise this goal in the NHI pilot districts. While there have been programmes to orientate these doctors, there has not been any structured mechanism to support any upskilling which they may need in order to cope with the modified scope of practice. The World Health Report on primary

health care supports the view that successful systems include doctors with postgraduate training in Family Medicine or general practice.[9] Such postgraduate training was formalised in 2007 in South Africa. Various programmes are used to train family physicians in all of the medical schools. The World Health Assembly has also recommended that primary healthcare teams should include a family physician.[10] However, the number of family physicians remains low, currently 570 on the Health Professions Council of South Africa (HPCSA) register. The short-term goal is for there to be one family physician for each subdistrict, community health centre and district hospital.[11]

However, the HPCSA register includes approximately 18 000 medical practitioners who are not registered as specialists. Many of these are established practitioners, working as primary care doctors in either the private or public sectors. Most of these established practitioners are unlikely to return and take a registrar post to train as a family physician, although a few may have studied for a postgraduate diploma in Family Medicine. Nevertheless, over the next decade they represent the largest group of doctors who are available to strengthen the primary healthcare system. In order to make a significant contribution, these doctors need to be re-orientated and upskilled for their role in the future re-engineered primary healthcare system.

The aim of creating a new national postgraduate diploma in Family Medicine was to provide training to these primary care doctors so that they can fulfil the roles and competencies required in the emerging primary healthcare system.

Design process

The design process began with key stakeholders meeting to define the future roles and competencies of the primary care doctor. Key stakeholders included the universities currently offering postgraduate diplomas in Family Medicine (Cape Town, Stellenbosch, Pretoria and KwaZulu-Natal), as well as other universities which could potentially offer the programme (Free State, Witwatersrand, Limpopo, Walter Sisulu and Sefako Makgatho); the Foundation for Professional Development which offers a postgraduate diploma in General Practice; and the College of Family Physicians, which recently introduced an examination for a Higher Diploma in Family Medicine. It was recognised that the current postgraduate diplomas varied considerably in their learning outcomes and relevance to the new directions in primary health care. One of the goals of this process was to align all of the postgraduate diplomas with one set of national learning outcomes, and therefore ensure that relevant training could be offered at scale commensurate with the national need in the country.

Other key stakeholders included the National Department of Health, the district health services, independent practitioner associations and organisations, nurse practitioners, and the South African Academy of Family Physicians.

Once the roles and competencies had been defined by this large group of stakeholders, exit-level learning outcomes were developed by a workshop with the National Education and Training Committee of the South African Academy of Family Physicians, which is responsible for coordinating specialist Family Medicine training between different higher education institutions. The members of this group also reached agreement on key educational principles required for the approach to teaching and assessment in the new postgraduate diploma.

A national survey of the learning needs of primary care doctors in both the private and public sectors was also conducted during this period and used to inform the design process.[12]

Once the roles, competencies, learning outcomes and educational principles had been defined, a further meeting was held with key people coordinating the existing postgraduate diploma courses. The purpose of this meeting was to explore in detail how these curricula needed to be revised in order to align with the new postgraduate diploma learning outcomes.

Following this, a workshop was held with all the role players offering, or who could potentially offer, the postgraduate diploma, in order to reach consensus and explore how to assist these institutions to accredit and develop their own postgraduate diploma programmes.

A final workshop was then held to provide feedback on the whole design process to the larger group of stakeholders, and to plan the way forward in terms of developing and implementing the postgraduate diploma further.

Roles, competencies and learning outcomes

Six broad roles and competencies with associated learning outcomes were developed. These roles are shown in Figure 1. The details are given in Table 1.

Approach to teaching and learning

The postgraduate diploma was conceptualised as a two-year modularised curriculum, typically comprising 4–6 modules, with a blended approach to teaching and learning involving campus-based teaching, web-based teaching, and workplace-based team and peer learning.

Overall, the design will support adult, self-directed and team and peer learning, as the participants are expected to be established practitioners. This means, for example, that learners will identify the clinical areas in which they need to improve in order to achieve the learning outcomes, and focus on meeting their learning needs in these areas by using the resources provided in the programme, as well as the strengths and abilities of other members of the healthcare team at their places of work.

Training sites

The postgraduate diploma should enable as many primary care doctors as possible to enrol. Therefore, broad criteria were

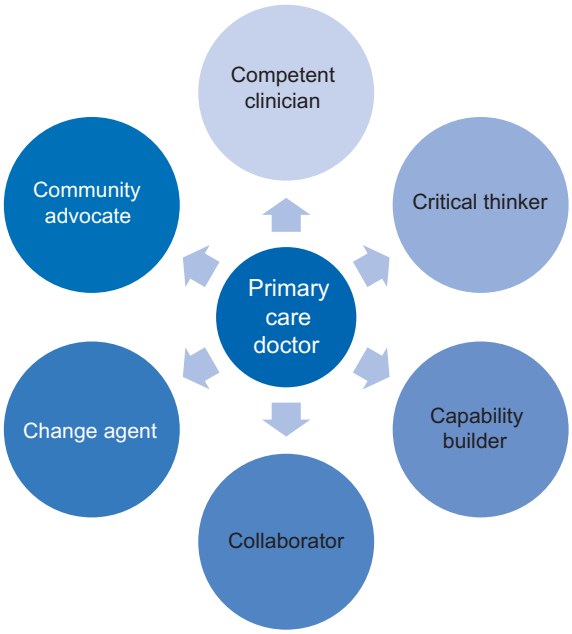

Figure 1: The roles of the future primary care doctor

Table 1: Roles, competencies and learning outcomes

Roles and competencies	Learning outcomes
Competent clinician	
• The primary care doctor should be able to practice competently across the whole quadruple burden of disease • They should have the clinical and procedural skills to fulfil this role in primary care. • They should be a role model for holistic patient-centred care with the accompanying communication and counselling skills. • They should be able to offer care to the more complicated patients that primary care nurses refer to them. • They should support continuity of care, integration of care and a family–orientated approach. • They should be able to offer or support appropriate health promotion and disease prevention activities in primary care. • They may need to assist with clinically related administration e.g. occupational health issues, medical record keeping, medico-legal forms	• Manage patients with undifferentiated problems in primary care • Respond effectively to the quadruple burden of disease • Provide ethical, legal, professional, and scientifically sound healthcare • Perform appropriate clinical, communication, and procedural skills • Provide comprehensive, co-ordinated and continuing care (preventative, promotive, curative, rehabilitative, palliative) • Manage resources within the context of the multi-disciplinary team and the referral system towards optimal clinical care • Use evidence and guidelines to reflect on practice • Assist with clinically related administration
Capability builder	
• The primary care doctor should be able to engage in learning conversations with other primary care providers to mentor them and build their capability. • They should be able to offer or support continuing professional development activities. • They should help to foster a culture of inter-professional learning in the work-place. • As part of a culture of learning they should attend to their own learning and development.	• Facilitate and support inter-professional learning activities. • Guide a primary health care provider / colleague to identify and address their own professional learning needs. • Reflect on their own professional learning needs, and design and implement an appropriate learning plan.
Critical thinker	
• The primary care doctor is one of the most highly educated/trained members of the primary care team and as such should be able to offer a level of critical thinking to the team that also sees the bigger picture. • They should be able to help the team analyse and interpret data or evidence that has been collected from the community, facility or derived from research projects. • They should be able to help the team with rational planning and action. • They should have IT and data management skills and the ability to make use of basic statistics.	• Evaluate and assess the system and individual clinical processes within the team. • Teach and support the team to interpret and use local data and health information • Offer recommendations on adjusting and adapting the health service provision of the local team in the light of the national context
Community advocate	
• The primary care doctor should exhibit a community-orientated mind-set that supports the ward-based outreach teams, understands the community's health needs and social determinants of health in the community and thinks about equity and the population at risk. • They should be able to perform home visits in the community when necessary.	• Support patients and communities in engaging with their health rights and responsibilities • Coordinate the holistic care of patients with healthcare providers and facilities in their community/geographic service area • Assess and respond to the social determinants of health within a particular community
Change agent	
• The primary care doctor should be a champion for improving quality of care and performance of the local health system in line with policy and guidelines. • They should be a role model for change – people need to see change in action. • They should know how to conduct a quality improvement cycle and partake in other clinical governance activities. • They should provide vision, leadership, innovation and critical thinking. • They may need to support some aspects of corporate governance.	• Facilitate a quality improvement cycle with the primary health care team on aspect(s) of clinical care, clinical performance, patient experience or community orientated care • Reflect on and develop his/her leadership capability in order to be a change agent for a specific facility or service • Use behaviour change counselling as it applies to patients and colleagues • Align professional values and behaviour as a role model for change • Support relevant aspects of corporate governance
Collaborator	
• The primary care doctor should champion collaborative practice and teamwork. • The primary care doctor should use their credibility and authority to assist the team with solving problems across levels of care (referrals up and down) or within the community network of resources and organisations. • They should help develop a network of stakeholders and resources within the community.	• Facilitate functional health teams • Facilitate cooperation amongst stakeholders (intra-sectoral / inter-sectoral) in addressing health needs of patients and communities

Note: AIDS: acquired immune deficiency syndrome, HIV: human immunodeficiency virus, NCDs: non-communicable diseases.

developed to guide whether or not the doctor was working in a suitable setting in order to meet the objectives of the postgraduate diploma. The doctor needed to be:

- Consulting ambulatory patients.
- Providing some first-contact medical care.
- Working as a medical generalist.

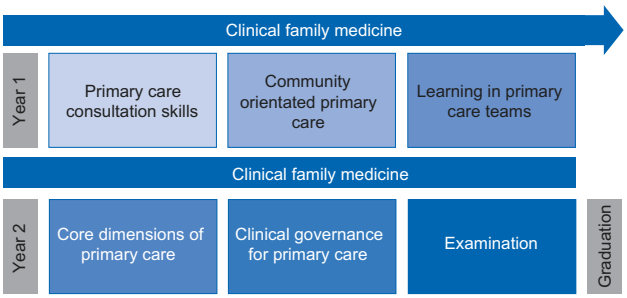

Figure 2: An example of the academic programme

Doctors working in district hospitals usually meet these criteria as they provide outreach services to the primary care platform, see ambulatory patients in the hospital and work as generalists across all parts of the hospital, especially after hours. Of course, doctors working in clinics, health centres and private general practice meet these criteria. Therefore, doctors can be in the public or private sector, and study for the postgraduate diploma in their practice setting.

Academic programme

A programme coordinator will be responsible for the programme at each training institution, and will be assisted by other tutors in overseeing learning and the application of the course content. Assessment during the programme will focus on the modules and workplace-based learning. The modular structure of one of the revised programmes is given as an illustration of what the postgraduate diploma might look like (Figure 2). However, each institution's programme will meet the learning outcomes in its own unique way.

Workplace-based learning and assessment

Learning in the workplace will be driven by peer learning, and documented by means of an electronic portfolio of learning. Peers might be family physicians, other doctors with a postgraduate diploma in Family Medicine, studying the postgraduate diploma course, or any other experienced member of the healthcare team at that workplace. The portfolio of learning would need to include:

- Evidence of self-directed learning by means of six-monthly learning plans, with an assessment of and reflection on, the extent to which they were achieved.
- Evidence of learning, by means of at least 10 observations per year of their performance in the workplace in relation to one of the key roles, with feedback being given on their competence and learning needs. Typically, this would be observations of consultations or clinical procedures, or mentoring others, using standardised tools, such as the Mini-CEX® or direct observation of procedural skills.
- Evidence of learning clinical skills with the use of a logbook to reflect on the performance of key skills, competency and learning needs.
- An annual assessment of the learning documented in the portfolio by the training institution.

Final assessment

One national exit examination for the country is needed. Ideally, this should be offered by the College of Family Physicians of South Africa. Entry to this examination should be based on adequate performance up to that point, as evidenced by a satisfactory portfolio assessment. The assessment must align with the programme's teaching methods and learning outcomes.

Quality assurance

Quality assurance for the postgraduate diploma programmes will be ensured by the National Education and Training Committee of the South African Academy of Family Physicians, which facilitates coordination and collaboration between the programmes. The Colleges of Medicine of South Africa will be responsible for quality assurance of the national examination as the final assessment. Each institution follows its own internal quality assurance processes for postgraduate diplomas. Thus, ultimately the programme coordinator and tutors will be responsible for the quality of modular content and teaching, workplace-based learning (peer learning and portfolio of learning) and assessment.

Incentives and going to scale

If all of the potential institutions offer the postgraduate diploma at a scale commensurate with the national need, then the stakeholders also need to incentivise doctors to study for the postgraduate diploma. This might mean:

- Incorporating the postgraduate diploma into the ongoing development and support of private general practitioners who contract with the public sector to work in the clinics.
- Making the postgraduate diploma one of the accreditation criteria for doctors being employed through the NHI.
- Making the postgraduate diploma a criterion for accelerated notch progression, bonuses or rank progression for medical officers in the public sector, and offering a bonus to those who obtain the postgraduate diploma.
- Making the postgraduate diploma a criterion for preferred status or accreditation by the medical schemes.
- Making the postgraduate diploma a prerequisite to work or continue to work in private healthcare provider networks.
- Providing bursaries to postgraduate diploma students.
- Allowing community service doctors to enrol for the postgraduate diploma.

Discussion

The design of a new national postgraduate diploma programme in Family Medicine, as presented here, is an exciting development with regard to the strengthening of primary health care in South Africa. All of the higher education institutions have participated in the process, and committed themselves to collaborating on the development and implementation phase. Stakeholders affirmed the following aspects of the design in the final workshop:

- That the design is a collaborative process which aligns all programmes with a national set of learning outcomes and assessment.
- That the design was based on research evidence and national guidelines.
- That the process has clarified the roles of the future primary care doctor.
- That the learning outcomes are applicable and relevant.
- That the design has the potential to expand to scale, is very inclusive and includes both public and private sectors.
- That the design includes important previously neglected roles of the primary care doctor.
- That the design allows for flexibility and self-directed learning.

- That the peer-learning approach in the workplace develops local communities of learners, and encourages the emergence of lifelong learning skills, as well as the development of learning organisations.
- That the postgraduate diploma demonstrates the contribution of Family Medicine to the national priorities.
- That the postgraduate diploma can contribute to the development of universal coverage and re-engineering of primary health care.

Despite these positive aspects, the stakeholders also had concerns regarding the realisation of the necessary incentives, and the long process that is required before the new programmes can be approved by the National Department of Higher Education and Training, Council for Higher Education and the South African Qualifications Authority. Institutions may also need additional capacity to tutor the postgraduate diploma programme. The dovetailing of the training programmes and the national exit examination must still be resolved in detail with the College of Family Physicians of South Africa.

The stakeholders also recommended that there should be further engagement with the medical schemes and with the Department of Health to align the postgraduate diploma with other policy and planning initiatives. The Department of Health could align its performance management framework and job description for primary care doctors with the six roles outlined in this document. Attention should be given to synergy between this postgraduate diploma and the training of clinical nurse practitioners and clinical associates.

Conclusion

A new national two-year postgraduate diploma in Family Medicine for the training of primary care doctors has been designed through a participatory process involving relevant higher education institutions and other stakeholders. The future roles and competences of primary care doctors have been conceptualised with the specific aim of strengthening primary health care for all South Africans. The teaching and learning philosophy which underpins the programme will have the potential to create a culture of learning involving the entire healthcare team at the training sites. The postgraduate diploma must now be fully developed and implemented. The institutions with existing postgraduate diploma programmes plan to revise them and offer the new national Postgraduate Diploma from 2016.

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References

1. Matsoso M, Fryatt R, Andrews G. The South African health reforms 2009–2014: moving towards universal coverage. Pretoria: Juta and Company; 2015.
2. Bradshaw D, Norman R, Schneider M. A clarion call for action based on refined DALY estimates for South Africa. S Afr Med J. 2007;97(6):438–40.
3. Mash B, Fairall L, Adejayan O, et al. A morbidity survey of South African primary care. Plos one. 2012;7(3):e32358.
4. Howe A. Medical generalism: why expertise in whole person medicine matters. London: RCGP; 2012 [cited 2013 Nov 5]. Available from: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Medical-Generalism-Why_expertise_in_whole_person_medicine_matters.ashx.
5. Joyner K, Shefer T, Smit E. Discourses and practices in institutionalised nursing in South Africa: challenges for care. S Afr Rev Sociol. 2014;45(3):34–52.
6. National Department of Health. National health insurance in South Africa: policy paper. Pretoria: NDoH; 2011.
7. Padarath A, English R, editors. SA Health Review 2013/14. Cape Town: Health Systems Trust; 2014.
8. Kinkel H, Marcus T, Memon S, et al. Community oriented primary care in Tshwane District, South Africa: assessing the first phase of implementation. Afr J Prm Health Care Fam Med. 2012;5(1):477. doi: 10.4102/phcfm.v5i1.477.
9. World Health Organization. The World Health Report 2008: primary health care—now more than ever. Geneva: WHO; 2008.
10. World Health Assembly. Resolution 62.12: primary health care, including health systems. Geneva: 62nd World Health Assembly; 2009 May 18–22.
11. South African Academy of Family Physicians. The contribution of family physicians to district health services: a position paper for the National Department of Health. 2014 [cited 2015 May 1]. Available from: http://www.saafp.org/index.php/news/48-national-positionpaper-on-family-medicine.
12. Malan Z, Cooke R, Mash R. The self-reported learning needs of primary care doctors in South Africa: a descriptive survey. South African Family Practice 2015;1(1):1–9. doi: 10.1080/20786190.2014.1002677.

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