South-African Family Practice: reflections from an "outsider".

During the last months I had the privilege to be able to follow most interesting discussions about content and position of family medicine in South-Africa. A first reflection is that the discussion is also most important and relevant for other countries e.g. in Western Europe. The discussion reflects the tension between the intrinsic characteristics of family medicine: first contact with health care system, longitudinal relationship with patients, comprehensive and holistic approach, generalism, integration of curative, preventive, palliative, rehabilitative interventions on the one hand and the question how to implement this in a concrete context of a society on the other hand.[1] In Flanders we actually live a very quick transition from a situation where 75% of the family physicians work in single-handed practices in the private sector towards a more community based and organised model of implementation of family medicine. Less than 3% of our actual graduates in family medicine still opt for the model of a single-handed practice. And the reasons are exactly those that are referred to in the South-African context: organisational problems with continuity, not enough time for meetings, too much orientation towards curative medicine, etc.

It is clear that historically the concepts of family medicine have developed in South Africa in private practice. The huge demand in the public sector did not allow ideas of holistic and comprehensive approach and patient centrism to develop. But the side effect was that family medicine became something "elitist".

A fundamental misconception in a lot of third world countries was that "poor people" were not in need of a personalised individual approach as far as their health care was concerned. For a long time it was believed that the "vertical approaches" (programmes on STD, mother- and childcare, TB, AIDS, …) was sufficient to cover the needs. So, it happened that in one health center, one patient could have five different records according to five different "vertical programmes" without any form of integration. It is now clear that this vertical approach failed to give an answer to the needs of the individuals, their families and communities. Family medicine is exactly the discipline that has the potential to integrate the horizontal, personalised approach to health needs of individuals and families with the need for a more population oriented approach. Therefore, I think it is worthwhile to look at the opportunities of bringing together the family medicine approach with the "COPC" Community Oriented Primary Care approach [2,3]. In Flanders, we have been successful in this integration especially in tackling the health problems of people in social disadvantaged areas.

Another important issue is the "fit" of "demand" and "offer". This is a key-element in the discussion. Also in Belgium we have the huge problem of inadequate "utilisation" of health care services. Emergency departments are over-utilised for self-limiting conditions. To tackle this problem, a multi axial strategy is needed: information and education of the population, strengthen the community based clinics and health centers, stimulation of the most cost-effective use of health care services, optimisation of supply of medicines at "peripheral points of distribution", and de-mystification of the impact of technology in medicine.

How to position family medicine in this? Looking at the international context, the position of the family physician is predominantly outside the hospital, in the community. This does not mean that family physicians cannot be active in hospitals, and they should in order to fill in the needs, but I would strongly emphasize the need to introduce the principle of subsidiarity. If there is a skilled MO that performs adequately the surgical procedures in the district hospital, the family physician should not do that. The international experience shows that in those countries where the family physician has limited his activities to the OPD of the hospital, family medicine has not developed well (e.g. the United States). In the community, our position should be supportive to the primary health care nurses in the clinics. Looking at the very interesting debate on the creation of "intermediate" health care workers, I think that actually it is better to invest in the optimisation of the functioning of primary health care nurses rather than to create new disciplines. In the United States they have created "nurse practitioners" and "advanced nurse practitioners" in ambulatory care, because the family physicians are not active in the community. Anyway, the concrete implementation of family medicine will be very context-specific[4]: "context helps to define identity", especially with respect to rural medicine.

In South-Africa, there is a need to create trust between the public and private sector. The problem is to find an adequate organisational structure. This structure should allow enough "entrepreneurship" to stimulate a flexible response to changing needs of the deserved population, but should in the meantime be publicly and socially "accountable". Maybe a model could be created where different "primary care groups" (PCG) contract with the local health authorities to achieve the goals that have been set, with special emphasis on "accessibility", "quality" and "equity". In such a primary care group, clinics, health centers and district hospitals could have a place. The primary care groups should be responsible for the "horizontal approach" towards the health needs of individuals, their families and communities and for the implementation and integration of "vertical programme". Within such a primary care group, a strategy could be set out to optimise health care utilisation with participation of the local population.

So far some reflections from an outsider. They may be completely wrong, but it was the way I perceived the discussion.

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References:

1. Starfield B. Is primary care essential? The Lancet 1994;344:1129-1133.
2. Community Oriented Primary Care: Health Care for the 21st century. Edited by Robert Rhyne, M.D. Richard Bogue, Ph.D., Gary Kukulka, Ph.D., Hugh Fulmer, M.D. American Public Health Association, 1015 Fifteenth Street, NW, Washington, DC 20005
3. De Maeseneer J, Derese A. Community Oriented Primary Care. European Journal of General Practice 1998; 4:49-50.
4. De Maeseneer JM, van Driel ML, Geen LA, Van Weel C. Translating research into practice: the need for research in primary care. The Lancet 2003;362:1314-1319.