SOUTH AFRICAN ACADEMY OF FAMILY PHYSICIANS

Unabridged Position Statement July 2025

Contribution of Specialist Family Physicians to the Private Sector of South Africa: A Position Statement

Abstract:

Background: Primary health care is the best way to provide care to most populations. In the private sector of SA, primary health care is either provided by General Practitioners who possess the basic medical degree of MBBCH, or Specialist Family Physicians (SFP) who possess MBBCH, and the Fellowship of the College of Family Physicians (FCFP) degree (a four-year specialist training in Family Medicine is just like the other subject specialities in SA). However, SFPs in private practice are not remunerated accordingly, have limited rights to order investigations needed to treat their patients, and are sometimes denied hospital admission privileges.

Aim: This position statement clarifies the role of SFPs, their scope of practice, the added value that they bring to Primary Health Care and the problems SFPs in private practice experience with health funders, other regulating bodies, and subject specialists.

Method: This position statement emanates from the on-site experience of SFPs in private practice in SA. SFPs experiences were collated from Specialist Family Physicians in Private (SFPP) member interactions with health funders, subject to specialists and private hospital administrators during the discharge of their duties. Literature reviews were conducted for the role of SFPs in SA, other African countries and globally. Case studies were used where appropriate.

Conclusion: SFPs make an invaluable and unique contribution to primary health care; providing patient-centred care at both generalist and specialist levels. SFPs in private practice bring about cost reduction, improved patient outcomes and better clinical governance; health funders and administrators need to adjust applicable tariffs and benefits for SFPs in keeping with their peers in other specialities.

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1. Introduction

This position statement is endorsed by the South African Academy of Family Physicians (SAAFP). Its purpose is to clarify the contribution of Specialist Family Physicians (SFPs) to the private sector and to advocate for recognition and appropriate remuneration of SFPs to the public sector in SA (16).

What is Family Medicine?
The first point of contact for many people in SA seeking care for a medical problem is a 'generalist' (8). Family Medicine is a field of medicine that allows for patients with undifferentiated symptoms to be skilfully assessed and competently managed at a primary care level. SFPs are trained to provide specialist comprehensive care for most medical conditions for all ages. SFPs are qualified to treat the persons holistically, unlike subject specialists who focus on a particular patient group, organ, or disease. Beyond conventional specialities, SFPs seamlessly integrate Palliative Care, Lifestyle and Preventative Medicine into their practices, adapting to the dynamic landscape of modern medicine (2).

Family Medicine emerged in the 1940's and was approved as a medical speciality in the USA in 1969 (17). Tertiary institutions globally provide training in the discipline, with the first Department of Family Medicine in SA established at the University of Pretoria in 1967 (4). The South African Academy of Family Physicians (SAAFP) established in 1980, is a legally constituted body which provides advocacy, education, and training support for SFPs working in the public, private and academic sectors.

In 2001, the World Health Organisation (WHO) proposed a global goal of achieving universal primary care in the six domains established by the 1978 Alma-Ata Declaration (these domains are first contact, longitudinal, comprehensiveness, coordination, person or family-centredness and community orientation) (6). The World Health Assembly regards SFPs as essential members of the Primary Health Care (PHC) team, with the most effective health systems including SFPs, given the breadth of knowledge required at this level of care.

Specialist Family Physicians as Specialists in South Africa:
The qualification and skills set of an SFP is recognised by the Health Professions Council of South Africa (HPCSA) and was gazetted as a specialist qualification in 2007, and promulgated into law. Since 2007, SFPs have trained as 'specialist generalists' to strengthen primary health care and district health services in registrar posts within the public sector. By 2019, there were 969 SFPs on the HPCSA register, with an estimated 71% (688) in the private sector (26).

Family Medicine in the Public Sector of South Africa:
In the South Africa public sector, many people access primary care through nurses at PHC clinics, with those needing additional care referred to medical officers, and then upwards to further specialised practitioners. The SFP in the public sector is described as a competent clinician, consultant to the healthcare team, capacity builder, clinical trainer, and leader who ensures clinical governance to improve quality of care and patient satisfaction. In line with the PHC approach, they are also trained to implement community-oriented primary care and to work at the district hospital level (1, 15).

Family Medicine in the Private Sector of South Africa:
In SA, there are two groups of doctors practicing at the primary care level in the private sector:

1. General Practitioners (GP), with an MBBCh degree and no specialist training in Family Medicine; they are often referred to as family practitioners.
2. Specialist Family Physicians (SFPs), with a four-year postgraduate training leading to a Master's Degree in Family Medicine (MMed Family Medicine), and a Fellowship (FCFP) awarded by the College of Medicine South Africa (CMSA), leading to registration as a specialist with the HPCSA.

SFPs are often confused with GPs, with most SFPs compelled to work as GPs because they are wrongly remunerated according to medical scheme tariffs as GPs and are not afforded meaningful recognition as specialists. SFPs cannot order certain investigations, imaging and medications appropriate to their specialist training.in contrast, in the public sector, the salaries of SFPs are on par with other specialists and are employed as consultants in Family Medicine. This imbalance in remuneration for private SFPs reflects the lack of distinction between GPs and SFPs by funders.

Health funders have not acknowledged the legal standing of SFPs as specialists and the important role and expertise SFPs bring to primary care. This has had detrimental effects on attracting younger graduates to the specialist of Family Medicine. This has also resulted in a lack of collegial and institutional recognition for SFPs (11, 13, 23, 26).

Furthermore, some private hospital groups and funders deny SFPs hospital admission privileges, limiting their ability to function as specialists in private hospital settings. In contrast to the experiences of South African based SFPs in the private sector, in African countries such as Kenya and Botswana, SFPs can and do work in hospital settings and the surrounding primary care platforms (25).

Although most doctors in district and private hospitals in Nigeria do not have specialist training in Family Medicine, local governments and private hospitals across the country are increasingly seeing the need to employ SFPs in these hospitals. Wherever available, SFPs in these hospitals render highly specialised, cost-effective, integrated, coordinated and comprehensive care (inpatient, outpatient and surgeries) to patients irrespective of their disease presentation. This results in enormous cost saving for the institution (30).

2. The Roles of Specialist Family Physicians in the Private Sector

The SFP is guided by the principles of Family Medicine, which include an open-ended commitment to patients; an understanding of the context of illness; the use of all visits for preventative purposes; the view of the practice as a population at risk; the use of a community-wide network of supports; sharing the same habitat as their patients; the care of patients in office, home and hospital; a recognition of the subjective aspects of medicine; and an awareness of the need to manage patient's resources (7).

Family Medicine is an approach to delivering health care to individuals, families, groups or communities. Its principles apply wherever and whenever people receive care and advice about their health. At the community level, the SFP uses a Community-Oriented Approach to Primary Health Care (COPC) to manage prevailing and priority health problems impacting communities they practice in, in partnership with the community.

In the private sector, the role of the SPF focuses on the core functions of high-quality primary care, these being:

- First contact access
- Comprehensiveness
- Person-centredness
- Continuity and coordination
- Enhanced chronic care services

As holistic care specialists, SFPs are trained to treat different medical conditions and identify areas that need referral to subject specialists. The SFP therefore leads the drive to improve competence in primary care and reduce hospitalisation and the associated costs like investigating and performing procedures in the outpatient setting where appropriate.

SFPs are equipped to lead quality improvement and patient safety initiatives; for example, managing casualty waiting times, developing triage systems, improving patient communication and streamlining COVID outpatient management. The SFP's generalist approach enables team-based care. They also understand their patient's context

and personal factors contributing to their health and highlight this when collaborating with other specialists in caring for patients needing referral or admission.

In any health system, high-quality primary heath care is the most important component that improves people's health status while reducing costs, with SFPs playing a central role in minimising costs (25). By focusing on the core functions of primary care SFPs can improve health systems effectiveness and efficiencies.

The Value Offering of Specialist Family Physicians (The 5 core functions of Specialist Family Physicians):

SFPs are first contact physicians that provide comprehensive person-centred care and facilitate the coordination of the multi-disciplinary team in patient care, SFPs ensure continuity of care by follow-up to prevent health pluralism, and provide on-going chronic disease management leading to cost reduction and prevention of complications and disabilities.

1. ***First Contact:***
   SFPs are trained to assess and manage the undifferentiated patient with broad knowledge and pattern recognition. Their skill set includes building rapport, excellent patient communication, clinical competence, surgical skill, motivational interviewing and psychological assessment. These are critical tools in extracting relevant and accurate history that enables the clinician to focus their examination, direct investigations and comprehensively manage a definitive condition or a dynamic, evolving health problems.

2. ***Comprehensive Person-Centred Care:***
   SFPs are competent to manage conditions in primary care practice, across all age groups and multiple disciplines, including Paediatrics, Obstetrics and Gynaecology, Orthopaedics, Internal Medicine, Emergency Medicine, Surgery, Anaesthetics, Palliative Care, ENT, Ophthalmology, Dermatology and Psychiatry. Their training enables them to manage complicated patients and those with multiple morbidities without referring them to Hospital-based specialists (Box 1: Case Study of Miss N). The SFP care can therefore be more effective and efficient for the patient and health system, with improved rational use of resources (15, 16).

Box 1: Comprehensive Person-Centred Care:

Case Study 1 of Miss N

Miss N is a 24-year-old supermarket cashier, visited the rooms of an SFP, with a history of headaches, fatigue and insomnia for the past 10 months. During this time, she had visited her local GP on more than three occasions, but did not get better.

On each occasion she was prescribed analgesics, which included codeine-containing painkillers, and benzodiazepines, and on the last visit the doctor suggested a referral to the local health centre for a possible CT scan.

On further questioning, Miss N described the headaches as a tightness across her head with associated neck muscle tension. She also mentioned that she was experiencing fatigue, a change in her appetite, and early morning awakening. On further questioning she stated that she has lost her drive and motivation, and had a low mood for months now. When she sleeps, she experiences flashbacks and nightmares.

She traced the origins of her symptoms to an incident that took place 18 months prior, when she was sexually assaulted after an evening out. She subsequently contracted HIV as a result of the sexual assault. She was put on ARVs, but stopped treatment due to psychological distress and denial of her condition.

In summary, Miss N, a 24-year-old lady who visited her GP on numerous occasions for a headache then visited an SFP that saw her over an extended consultation and made a diagnosis of Post-Traumatic Stress Disorder with Major Depression, codeine and benzodiazepine dependency, and HIV treatment interruption.

The SFP proceeded to coordinate care by referring Miss N for assessment. A psychologist and a social worker were brought in to assess the social dynamics. She was started on an SSRI and medication to improve her sleep. Her HIV treatment management was evaluated and reinstated. All the relevant inputs were integrated and she was followed up by the SFP.

Six months later, the blood tests revealed a suppressed viral load, indicating adherence to medication. Her headaches had abated; mood had improved and there were significant improvements in functioning.

The comprehensive diagnosis and coordination of care for Miss N was as a result of the specialist training of the SFP who was able to delve deeper into the patient's complaints, make deeper diagnoses and manager her comprehensively.

Miss N (Box 1) received holistic specialist care from only one physician. Several procedures and costs were avoided, including imaging and laboratory tests, admission to a psychiatric ward or hospital, and prescriptions of unnecessary medications. This would result in significant savings for the medical funder and the patient. It also allows comorbid conditions to be managed at one time with reduced risk of polypharmacy and drug-to-drug interactions.
The SFP focuses on health promotion, disease prevention and palliative care, with the potential for a reduction in the incidence of several preventable diseases and the need for hospitalisation, leading to better healthcare resource utilisation (15). Their expertise in whole-person medicine and the bio-psycho-social approach gives them a full perspective and context of the patient, their family and the community.

Patients prefer to receive care in their community, as they are more likely to retain support from family and friends and feel more comfortable and less isolated in familiar surroundings. For example, the involvement of SFPs in palliative care has reduced healthcare costs, as patients are more likely to receive care in their community and less likely to be admitted to the hospital (29). SFPs provide high-quality palliative care for people with Cancer at home, including holistic pain and symptom management, emotional support, and end-of-life planning that involves honest discussion.

3. *Coordination of Care*

Patients with multiple morbidities seldom benefit from fragmented and super-specialised care, as each specialist prescribes medication and manages their condition in isolation. This type of fragmented care requires increased clinic visits with increased costs to the patient and results in a loss of oversight of the patient (10). This type of care is also more likely to result in other specialist referrals (a physician who is unable to manage mental health matters is more likely to refer to a specialist psychiatrist than to a generalist).

This highlights why SFPs maintain a holistic perspective in their patient's care packages and needs, and should be integrally involved in coordinating the multiple specialists and health professionals that patients might be referred to. During hospital stays, SFPs play a primary role in communicating with family and medical aid and facilitating multi-disciplinary team discussions, treatment planning and advocating for the patient.

Higgins et al, demonstrated in their 2018 study how SFPs used innovative pain management programs for chronic pain syndrome (8). Coordination of care by SFPs via multi-disciplinary team resulted in a 26% reduction in healthcare costs over 6 months. This was largely due to bringing the needed expertise into the primary care environment and reducing the need for emergency room visits and hospital admissions.

SFPs also play an important tole for their patients and families, who may not be familiar with the clinical environment and appreciate the support of someone who can act on their behalf and advocate for their holistic care. Having an SFP who can give patients clarity when subject specialists fail, reassure the patients, and reduces unnecessary investigations of symptoms arising from the individual and psychosocial context of the patients. SFPS reassure their patients that someone is listening to them and will act on their behalf, taking the pressure off them as they engage with various subject specialists.

For example, care coordination by an SFP for patients with congestive heart failure can reduce hospital admissions, reduce visits to the emergency room centre, and reduce mortality and costs (27). Patients with chronic conditions are often seen by multiple specialists and various health professionals who seldom coordinate their different inputs. The SFP, with their commitment to primary care and whole-person medicine, coordinates care around the patient's needs (Box 2: Case Study for Mrs A for example).

Box 2: Specialist Family Physician Role in Integration of Healthcare

Case Study 2 of Mrs A

Mrs A is a 55-year-old female with a history of hypertension, hyperlipidaemia, and Type 2 diabetes. She has been seeing an SFP, Dr B, to optimise and attain holistic management of her chronic conditions with inputs from the cariologist and endocrinologist.

Mrs A has been experiencing symptoms of fatigue, shortness of breath, and chest pain for several weeks. She called Dr B's office and was able to schedule an appointment the same day. Dr B conducted a thorough physical examination and ordered an electrocardiogram (ECG) in the office. The ECG revealed changes consistent with a myocardial infarction.

Dr B immediately called the local hospital and arranged for Mrs A to be transferred to the emergency department.

Upon arrival at the hospital, Mrs A was taken to the cardiac catheterisation lab where she underwent an emergency angiogram. The angiogram revealed a blocked coronary artery, which was immediately treated with angioplasty and placement of a stent. Mrs A was admitted to the hospital for observation and further treatment.

Dr B coordinated with the hospital team to ensure that Mrs A received appropriate care while in the hospital and that her other chronic medications were consistently provided. He also commented with her other specialists to update them on her condition and to ensure that her care was well-coordinated.

After Mrs A was discharged from the hospital, Dr B followed up with her in his office and adjusted her medications as needed. He also referred her to a cardiac rehabilitation program to help her recover from her heart attack.

This case study demonstrates the value of a coordinated care model for patients with cardiovascular disease, and the important role that SFPs can play in leading such efforts. By working closely with other healthcare providers and providing comprehensive care and previous medical history, SFPs can help reduce downstream costs and improve outcomes for patients with chronic conditions.

Adverse drug reaction related deaths are on the rise globally and annually (14). SFPs are custodians of their patient records including medical history, drugs, past procedures, and laboratory investigations. Patients are reassured when their SFP acts as their advocate, looking out for possible drug interactions and monitoring

any complications between drugs prescribed by different specialists (12). Having an SFP who understands the patient's co-morbidities and conducts a rational review of medications to ensure that there are no duplication, adverse drug interactions or polypharmacy, is integral to the care of chronic patients.
SFPs practice person-centred care, using bio-psycho-social and holistic approaches aimed at uncovering deeper or masked diagnoses that may be missed by subject specialists. These hidden diagnoses may not respond well to traditional pharmacological therapy and may impact a patient's acceptance, adherence and response to treatment. SFPs are trained to understand the person and the disease, unlike subject specialists who are trained to treat diseases.

4. ***Continuity of Care***

SFPs are committed to continuity of care over time as well as during a specific illness episode, which reduces the need for after-hour care, acute hospitalisation and reduces premature mortality (22). For patients in private care, SFPs have an overview and a longitudinal perspective of the care received and needed. They are in a position to prevent duplication of procedures and treatment while rationalising costs.

SFPs have intimate knowledge of a patient's context, including affordability and an understanding of medical aid funding allocation. Managing patients in primary care is more cost-effective than hospital-based care. Continuity of care prevents unnecessary and repeat investigations, and ensures that chronic diseases do not lead to complications, organ impairments or disabilities. (Box 3: Case study of Mrs M)

Box 3: Specialist Family Physician's Role in Continuity of Care

Case Study 3 of Mrs M

We report a case of a 54-year-old female presenting with persistent abdominal pain lasting over 6 months, associated with bloating, fatigue, and episodic share epigastric pain. Despite multiple prior consultations with other doctors, symptoms persisted and escalated in frequency.

Dietary history revealed excessive caffeine intake, frequent consumption of sweets, carbohydrates, and spicy foods. Psychiatric assessment diagnosed previously unrecognised adult ADHD, with associated anxiety and binge-eating tendencies.

Clinical examination noted upper abdominal tenderness and significant costochondral junction sensitivity. Investigations showed elevated HbAlc, cholesterol, liver enzymes, and hepatic steatosis; H. Pylori was negative. Upper GI endoscopy revealed chronic gastritis.

The patient received intensive counselling and psychotherapy prior to commencement on proton pump inhibitor therapy, dietary modifications, and pharmacologic ADHD treatment. Within one month, she reported complete symptom resolution, mood stabilisation, cessation of binge eating, and a 9kg weight loss. The index patient's diagnosis of ADHD inspired the assessment of her son and his subsequent diagnosis of ADHD.

This case highlights the complex interplay between gastrointestinal symptoms, dietary habits, and undiagnosed neuropsychiatric conditions which SFPs are uniquely trained to manage.

SPF-led continuity of care for people with chronic conditions adds value to several components of primary care (1). Evidence-based treatment, and patient education and counselling by SFPs, not only improved diabetic control but also reduced healthcare costs by over 6% over 2 years due to reduced hospital admissions and emergency department visits (22).

Costs that could potentially have been avoided had Mrs M seen an SFP earlier:

1. Cost of doctors consulted and other medical interventions, and unnecessary expenditure on medications used with no symptom relief or behaviour changes over a 6-month period.

Cost benefits of Mrs M seeing an SFP for extended specialist consultations:

2. Psychiatry assessment by an SFP during medical visits compared to separate psychiatrist consultation fees.
3. Preventative cost of addressing hyperlipidaemia, impending diabetes and alcohol abuse due to binge eating and drinking from undiagnosed ADHD.
4. Preventative cost of avoiding in-patient mental health admission for mood issues relating to undiagnosed ADHD, which was addressed during her gastritis investigations.
5. Proactive benefit for the family as mum's ADHD diagnosis initiated neurodiversity assessment and management of son, who has been sub0optimally managed for his mental health issues with numerous psychiatry admissions.

5. ***Enhanced Chronic Care Management:***
   SFPs play a role in coordinating chronic care and prescriptions for better outcomes and patient satisfaction. Chronic conditions have a significant impact on the families of those affected and afflicted by these conditions. An example is HIV care, where an entire family may be affected by and or infected with the virus. Chronic care can be provided by a single practitioner at a single visit for multiple family members and multiple conditions.

   The SFPs have a contextual understanding of the quality of life psychosocial issues, adherence matters and impacts of disease on all other members. They are able to synchronise scripts, blood tests, and physical exams so that the family can receive care at the same time reducing the frequency of visits for individual family members.

   The SFP uses every visit as an opportunity for health promotion and to be cognisant of all individual's agendas (for example, taking the shared decision to put a couple in the same HIV medication may improve support for each other and overall adherence). The normalisation of chronic illness can also improve adherence and understanding (for example, children living with HIV who witness their parents actively take responsibility for their chronic condition, are likely to do the same) leading to several economic and health benefits.

3. Economic Benefits of Specialist Family Physician Management of Chronic Diseases

SFPs can bring about several economic benefits for patients, health funders and the state:

1. ***Preventative Care:***
   A focus on preventative care reduces the need for expensive treatments by identifying health issues early, which saves costs associated with advanced medical care (17). SFPs are trained to view their practice as a population at risk and to use motivational interviewing and the behaviour change model to mitigate risk (for example; smoking cessation, excessive alcohol use, obesity, risky sexual practices).

2. ***Reduced Hospitalisations and Emergency Room Visits:***
   Regular check-ups and early intervention algorithms (enabled by the ongoing relationship a patient has with their SFP) can prevent health conditions from escalating, thereby decreasing healthcare expenses and reducing hospitalisations (25).

3. ***Lower Overall Health Costs:***
   Managing chronic conditions effectively prevents complications, hospital visits, the need for costly procedures, and leads to improved outcomes and reduced overall healthcare spending (3).

4. ***Cost Effectiveness:***
   SFPs are gatekeepers to advanced healthcare (they ensure that patients receive appropriate and cost-effective care, and reduce referrals and unnecessary visits to subject specialists and emergency rooms)(5).

5. ***Improved Medication Adherence:***
   The continuous and trusting relationships developed by SFPs lead to higher patient satisfaction and adherence to treatment regimens, which can lower costs associated with non-compliance. (20).

6. ***Efficient Resource Utilisation:***
   Understanding a patient's medical history streamlines their care, and reduces duplication of tests, unnecessary procedures, and administrative expenses within the healthcare system (21). SFPs provide holistic care that addresses multiple health issues in one visit, reducing the need for several specialist consultations.

4. Recommendations: Challenges of Specialist Family Physicians in the Private Sector and Restorative Solutions

Although SFPs have a specialist practice number issued by the Board of Healthcare Funders (BHF), are registered as Specialists in Family Medicine by the HPCSA, and practices are paid as specialists in the public sector (Department of Health). However, in the private sector, they continue to report various problems. This position statement enumerates some of these problems and makes recommendations on how best these can be tackled.

Problem 1: Inadequate Medical Scheme Recognition
SFP qualifications are not recognised by all medical schemes, despite being HPCSA approved and recognised in the public sector. This means that SFPs are constrained to provide services as a GP with their scope of practice limited to that of GPs. The current approach to remunerating the Family Medicine speciality exposes the shortcomings of a reimbursement model that focuses on the quantity of care and not the quality of care.

Solution:
SFPs need clear recognition and distinction as a specialist group with remuneration tariffs in keeping with the complexity of managing multiple conditions.

Problem 2: Poor Communication Between Subject Specialists and SFPs
This is a pervasive problem that occurs in inpatient and outpatient settings. Despite playing an important coordinating role and promoting teamwork amongst health workers, SFPs are frequently not informed about their patients. This occurs particularly when patients are referred to subject specialists about a specific aspect of care of a patient and the SFP is excluded from the ongoing care plan and decision-making, even on discharge from the subject specialist care. This creates a disabling environment where SFPs are unable to practice on the level of their expert training. This also frequently leads to acts of supersession by subject specialists (for example, a physician asks an ENT to see a patient with chronic sinusitis and postnasal drip instead of involving the SFP to manage this and up refer if necessary).

Solution:
Undergraduate medical training programs should adjust emphasis and increase the exposure to the generalist speciality of Family Medicine. In practice, the SFP should be recognised as the central and primary coordinator of care for a patient. SFPs should be appointed by patients into multi-disciplinary teams and a cooperative working

environment should be established. It should become standard practice for the SFP to be central in any decisions to refer to other specialists.

All decisions should be made in cooperation with the coordinating SFP. The referral process should be viewed an incomplete if the subject specialist does not refer the patient back to the SFP. Artificial Intelligence systems could easily be established so SFPs are copied on investigations (imaging, laboratory tests and procedures). For example, a patient admitted for oncology care should have the SFP copied on any blood tests, scans, and treatment plans.

Problem 3: Poorly Defined Roles

The managed care organisations and medical aids do not recognise the value SFPs offer in coordination across multiple levels of care (for example, the ability to provide care in the hospital as well as in step-down units, rehab settings, outpatient settings, hospital at home and palliative care settings). Even with the current proposed National Health Insurance, there is no designated role for SFPs and they remain undifferentiated from GPs. In fact, SFPs are not mentioned once in the entire policy document (31).

Solution:

The contribution of SFPs to patient satisfaction; communication with family and patient; continued management of chronic conditions other than the admission-related complaint; collaboration with allied health providers; and bridging the inpatient and outpatient care continuum should be recognised (19).

SFPs should be central in coordinating multi-morbid care and involved in care as inpatient and outpatient. Medical Aids, other funders, hospitals, and the NHI should include SFPs in their specialist staffing and encourage multi-disciplinary team formation (with SFPs in a coordinating role). SFPs are uniquely equipped to provide a diverse range of skilled services at multiple levels of care and offer capacity as specialist generalists and care coordinators in the proposed NHI program.

Problem 4: Inadequate Remuneration

No appropriate tariff structure has been developed by stakeholders, funders and administrators to remunerate SFPs as specialists, as have been done for other disciplines.

Solution:

SFPs conduct consultations at a specialist level that are enhanced by their training in psychosocial, therapeutic and clinical care (all of which add time to a consultation). This needs to be recognised and remunerated appropriately. A tiered billing system to allow for differing lengths and complexity of patient consultation is necessary.

SFPs are uniquely positioned to offer procedures, interventions, and investigations (at lower costs) in the rooms/outpatient setting/day hospitals/day theatres/hospital at home; these ordinarily would have required subject specialist referral at a hospital level. These services and procedures in the room should be recognised and reimbursed accordingly, for example, minor surgical procedures, ultrasound, stress ECGs and IV infusions.

Problem 5: Restricted Access to Specialist Privileges

SFPs are limited in their authorisation to order advanced testing and imaging in line with other specialities. As a result, patients may be referred to subject specialists because the SFP cannot order the necessary imaging or testing using their practice number/ SFPs cannot practice to the full potential of their speciality because they are limited by the system and classified as GPs (a disabling work environment). In addition, certain hospital groups do not grant admitting privileges to SFPs.

Solution:

SFPs should be given access and authority to order appropriate investigations or medications to enable more comprehensive and specialised care in the inpatient and outpatient sectors (9).

5. Conclusion

SFPs are recognised and registered as specialists by the HPCSA and CMSA. SFPs provide comprehensive and coordinated patient care; they improve clinical governance and continuity of care. SFPs reduce health pluralism, poly-pharmacy, unnecessary investigations and hospital admissions; these lead to reduced healthcare costs and better patient outcomes.
SFPs in private practice, therefore, need to be remunerated and afforded the same recognition as their peers in other specialities (32).

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Appendices: Legal Opinion on Specialist Family Physicians Position Statement; FCFP (SA) EPortfolio (Training Programme)

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