

PRIMARY HEALTH CARE SERVICES IN MALTA: PROVISION, UTILISATION AND REFORM

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FAMILY DOCTOR

INTRODUCTION

The Alma-Ata Declaration defines **primary health care** as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.” The declaration goes on to specify that “it is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (Declaration of Alma-Ata, 1978).

HISTORY

The origin of primary health care in Malta has been traced back to the 16th century when the Order of St John set up a system of prescription and provision of financial relief, food and free medicines for poor and needy sick women in the main towns. Then, under British rule, Physicians for the Poor were appointed with clinical, administrative and sanitary responsibilities; the first government dispensary in fact was opened in 1832, followed by others usually attached to the local police station. The physicians later were incorporated into the Executive Police, becoming known as Police Physicians until 1879, when they were made accountable to the Department of Charitable Institutions as District Medical Officers. The DMO system remained till the late 1970's, responsible for treating patients in their district who qualified for a Medical Aids Grant based upon income thresholds. Today's state primary health care system developed from a free emergency polyclinic service that was introduced in 1980 by the government during the ten-year doctors' dispute which had commenced 3 years earlier (Azzopardi Muscat, 1999).

CURRENT ORGANISATION AND SERVICES PROVIDED

Primary Health Care in Malta is provided by the state and the private sector as shown in Table 1:

for 1 to 3 hours, once to five times a week, on weekdays only. These clinics also provide a postal service of free medicines to those entitled to such.

Besides the GP Service, most

Primary Health Care	
State	Private
<ul style="list-style-type: none"> • Health Centres <ul style="list-style-type: none"> General Practitioner Service (also in Local Clinics) Specialist & Paramedical Services Investigative Services Preventive Services • Community <ul style="list-style-type: none"> Domiciliary Nursing School Health Services 	<ul style="list-style-type: none"> • Solo General Practitioners • Company Doctor Groups • Nursing and other Health Care Professional Services

State Primary Health Care Services

The backbone of the State Primary Care Service is the **General Practitioner Service**, which is available on a 24-hour basis in five of nine **health centres** in Malta and Gozo. Due to a shortage of doctors, Cospicua, Qormi and Rabat Health Centres only provide a GP service between 8 a.m. and 5 p.m. on Monday to Friday, and 8 a.m. to 1 p.m. on Saturday, while B'kara Health Centre provides just a local clinic service. A GP and nurse also attend **local clinics** in some 40 localities - these open

health centres also provide **Specialist and Paramedical Services** during office hours as follows:

- Acupuncture Clinic (Floriana Health Centre only)
- Dental Surgeon Clinic
- Dental Hygienist Clinic
- Diabetes Clinic
- Gynaecology Clinic
- Medical Consultant Clinic
- Mental Out-Patients Clinic
- Nursing Treatment Service (24 hours)
- Ophthalmic Clinic
- Pharmacy Service
- Physiotherapy Clinic
- Podology Clinic

- Psychology Clinic (Qormi Health Centre only)
- Schedule Five Clinic
- Speech Language Pathology Clinic

These services are complemented by **Investigative Services**, which include:

- ECG Service
- Laboratory Investigations Service (through the St Luke's Hospital Laboratory)
- Pregnancy tests (within the Gynaecology Clinic)
- X-ray Service

Preventive Services too are available in the major health centres, as follows:

- Ante-Natal Clinic
- Cervical Smear Screening Service as part of the Gynaecology Clinic
- Glaucoma Screening Clinic
- Immunisation Service
- Smoking Cessation Clinic
- Weight Reducing Clinic
- Well-Baby Clinic

Community Services include a **Domiciliary Nursing Service**, which is contracted out by the state to a private company (the MMDNA - Malta Memorial District Nursing Association), and **School Health Services**, both medical and dental (Dipartimento tal-Kura Primarja, 1997).

Private Primary Health Care Services

With the exception of just a couple of group practices, private **general practitioners** work on a solo basis from rooms in pharmacies or from specific clinics. Besides, a number of **groups of company doctors** provide a service of verification of sick leave for local companies. There are also **nurses** and **other health care professionals** (dentists, dental hygienists, physiotherapists, podologists, psychologists, speech language pathologists, etc.) who provide their services on a private basis, either individually or in groups.

Customers and Methods of Payment

As health-care providers in health centres are civil servants paid by salary, the state primary care service is offered free-of-charge at the point of use to all types of customers, direct or indirect (patients and relatives), and also potential (the whole population), be they Maltese citizens, refugees or tourists (the latter for emergencies only). However, clients must buy prescribed treatment from private pharmacies against out-of-pocket payment. The only exceptions are medicines on the Schedule Five list of chronic diseases (which are provided free from government pharmacies), and drugs, glasses, hearing-aids and dental services for Pink Card holders who fall below a certain income.

On the other hand, all private GPs (and other professionals working individually) operate on a fee-for-service basis, while the main groups of company doctors (and nurses) are paid by capitation. As such, services in the private sector are open to all those who can afford to pay the fees, and also to a growing sector of the population which has private health insurance.

UTILISATION OF PRIMARY HEALTH CARE SERVICES

Utilisation of primary health care services is reflected by the level of activity of such health

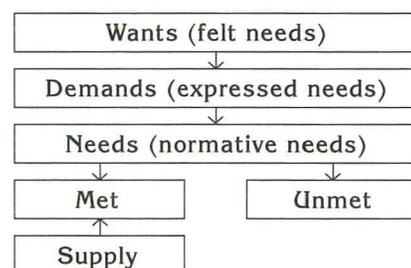


Figure 1: Different aspects of needs (Wright et al, 1998)

services. Such activity results from a process through which need becomes demand and then supply: this process is illustrated in Figure 1. Therefore, just as a doctor systematically assesses the needs of a patient before prescribing the effective treatment, the optimal utilisation of the resources of primary services depends on a systematic assessment of the healthcare needs of the population (Wright et al, 1998). Only then can inequalities in health and service-access be identified, following which priorities may be set for resources to be utilised effectively.

An effective and efficient health service should have as large an overlap as possible between need, demand and supply: see Figure 2, the original

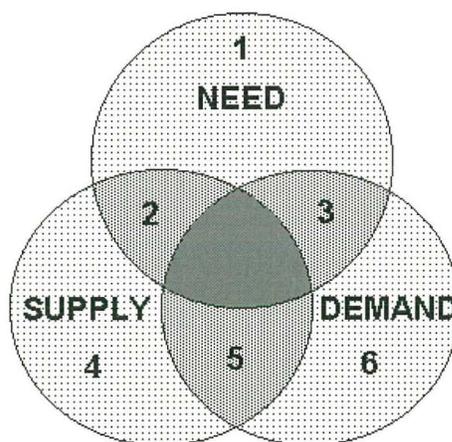


Figure 2: Relation between need, supply and demand: overlapping central area shows ideal relation (Wright et al, 1998)

Examples:

1. Treatment of child abusers
2. Health promotion; some screening; psychiatric treatment
3. Abortion; waiting lists
4. Hysterectomy
5. Vitamins; over-the-counter antibiotics
6. Cosmetic surgery in the public system

version of which was adapted by Wright et al (1998) from Stevens and Raferty (1992). The latter have defined **need** as the capacity to benefit from an intervention. There are a number of factors that affect the development of an *unfelt need*, through a *felt but unexpressed need*, to an *expressed need* or **demand** for a primary care service. These factors pertain to illness behaviour.

Illness behaviour of client

Mechanic (1978) defined illness behaviour as "the ways in which given symptoms may be differentially perceived, evaluated and acted upon (or not acted upon) by different kinds of person". Consciously or unconsciously, a patient would in fact ask a number of questions and consider different alternatives before seeing a doctor or another health care professional in primary care:

- *Are symptoms normal or abnormal?*

A client would consider prevalence ("there's a lot of it about at this time"), normalisation (a headache arising out of tension), and earlier events (a bruise after a fall) to decide whether a symptom is serious or not.

- *Should a doctor be visited?*

This decision depends on a sufficient number of social triggers (Zola, 1973). These include the perception of interference with a vocational or physical activity (a painful knee for a professional soccer player) or with social or personal relations (pressure by relatives to see the doctor); the occurrence of a personal crisis (family bereavement); and temporising of symptomatology ("it will soon pass") or sanctioning (a hangover after too much to drink).

- *What are the alternatives?*

Any alternatives to seeing the doctor could also be considered, such as ignoring the

symptoms (if previous episodes settled on their own), self care (analgesics for aches and pains), lay referral (taking the advice of a neighbour), or visiting an alternative health practitioner (an aromatherapist for eczema).

- *What are the costs/benefits of seeing the doctor?*

Finally, the patient would also weigh the benefits versus the costs of seeking a doctor's advice. Thus the benefits could be therapeutic (the prescription of treatment to cure an illness), the legitimisation of the sick role (the issue of a sick-leave cer-

The unfortunate truth is that in Malta clients abuse the state primary care system by attending health centres at all hours for minor ailments (two out of three GP encounters between 8 p.m. and 8 a.m. are for non-urgent cases - see Table 2) and by calling out the doctor for unwarranted house calls (as much as one in six of all calls are performed between 8 p.m. and 8 a.m. - see Table 3) (Department of Primary Health Care, 2000). This has affected clinicians' attitudes, and consequently staff resources, as described in the next section.

Night-time (8 p.m. - 8 a.m.) GP encounters during Jan-Sep 2000	Non-urgent (seen in GP Clinic)	Urgent (seen in Treatment Room)	Total
Number	35166	18094	53260
Percentage	66.0%	34.0%	100%

Table 2: GP encounters between 8 p.m. and 8 a.m. in health centres in Malta during January-September 2000 (Department of Primary Health Care, 2000)

House calls done during Jan-Sep 2000	Day-time (between 8 a.m. and 8 p.m.)	Night-time (between 8 p.m. and 8 a.m.)	Total
Number	22531	4387	26928
Percentage	83.7%	16.3%	100%

Table 3: House calls performed from health centres in Malta during January-September 2000 (Department of Primary Health Care, 2000)

tificate), or simply a dose of the doctor (where the doctor-patient relationship is strong enough for just a talk with the doctor making the patient feel better). The costs of visiting the doctor could include payment (unless use is made of the state services), time off from work (a self-employed person depends on his work to survive), travel (if the doctor's clinic is a long distance away - unless a house-call is requested), commitments (need to find someone to look after the children), the doctor's approachability (depending on his character and availability), trusting an outsider (with problems of a personal nature), fear (of the diagnosis of a serious disease) and pain (from surgery).

Clinicians' attitudes and resources

Once the illness behaviour of a client allows a need to be transformed into a demand, two categories of factors determine the **supply** of the necessary health care: clinicians' attitudes and resources. In spite of the state service in Malta being free, it has been estimated that two-thirds of primary health care is provided by private GPs. Although it has been said that the availability of good medical care tends to vary inversely with the need for it in the population served (Tudor Hart, 1971), this private-public disparity in utilisation in Malta may be due to different reasons.

Resources

Although there are adequate *facilities* (health centres, clinics and equipment), there is a lack of GP *staff* (in November 2000 standing at only two-thirds of the complement) working in the state primary care services due to poor employment conditions. As a result of this, doctors in health centres have to see a disproportionately large amount of clients, and often can only dedicate the minimum time necessary to see to a client's complaints. Moreover, health centre doctors are disheartened by the poor *conditions of work* and their low *income*, with a yearly basic salary during 1999 starting from Lm 4640, which is not even double that year's national income per head of Lm 2596 (Central Office of Statistics, 2000). This unfortunately has resulted in the development of a 'laissez-faire' attitude among a few doctors. Others are making the decision to switch to private practice when their income from the latter reaches a sufficient level, with the shortage of doctors thus being exacerbated further.

Attitudes

Another factor in the disparity of utilisation is the poor continuity of care provided by the state GP service. As there is no patient registration in Malta, a client can walk into a health centre at any time to see the doctor who happens to be on duty, this resulting in a poor doctor-patient relationship. Moreover, as most clients attend for trivial reasons, entries are hardly ever made in the health centre files that were introduced in 1997.

On the other hand, while medical-record keeping in private practice cannot be said to be optimal and formal registration is non-existent, private GPs still have a core of patients who consult them most of the time

for all their health needs, with satisfactory continuity of care and doctor-patient relationships. In private practice, the item-of-service system of payment also acts as an *incentive*, as opposed to the salaried system in the state service. Clinicians' continuing medical *knowledge* and *fashions* of care are only minor factors in the private-public equation.

As a result, it has become the *culture* for a typical client to attend a health centre doctor for trivial and run-of-the-mill complaints (e.g. colds, BP checks, repeat prescriptions, sickness certificates), but to then seek his private GP's advice regarding more serious medical problems.

REFORM FOR QUALITY CONTROL IN PRIMARY HEALTH CARE

Quality is the degree or grade of excellence. **Quality control** involves the supervision and control of all operations involved in a process, usually involving sampling and inspection, in order to detect and correct systematic or excessively random variations in quality. Quality control was introduced in the health care sector in order to make better use of resources and improve the overall quality of care (WONCA, 1995).

Health **policy** may be defined as a series of activities with their intended and unintended consequences on health. In some languages, there is actually no difference between the words 'policy' and 'politics'! Walt (1994) has described a framework for health policy analysis, with **actors** of a health policy in the centre of a triangle made up of the content, **context** and process of such policy.

Context

The political system in Malta is democratic, with general elec-

tions where the people's representatives are elected to parliament. The latter is led by a cabinet of ministers from the main political party in government, which takes liberal and egalitarian decisions based on the recommendations of permanent secretaries and directors made through their respective ministers.

Such decisions should normally be based on societal values, with cognisance being given to technological factors, environmental and international influences, and within the constraints of the legal system. However, the overriding factor that affects all decisions is the difficult economic situation in which the country finds itself today. There is no better example of this than the proposed reform for quality in primary health care: the efforts of the various actors towards this goal are described below.

Actors

The importance of the provision of quality in primary health care, both academically and organisationally, was first highlighted in the late 1980's. Regarding the academic aspect, a 9-month intensive course for family physicians was conducted in 1987-88 by Prof. D Johnson of the University of Toronto, under the auspices of the **University of Malta** and with the support of the **Ministry of Health**. As declared by a former Dean of the Faculty of Medicine and Surgery, it is a pity that the competent authorities at the time did not respond to a detailed report on the development of family medicine in Malta left for them by Prof. Johnson (Grech, 1998). However, as an indirect result of such course, the **Malta College of Family Doctors (MCFD)** was founded in 1989, with an emphasis in its statute on the College's primary responsibility 'to encourage, foster and maintain the highest

possible standards in family medicine in Malta' (Malta College of Family Doctors, 1990, 1996).

As regards the organisational quality of primary care, in August 1988 the **Minister of Social Policy** (then responsible for Health) wrote to the two doctors' unions at the time, the **Medical Association of Malta** (MAM) and the now-defunct **Union of Government Medical Doctors**, announcing that "this administration intends to provide a truly comprehensive national health scheme, in which a key factor is that of the right choice of the patient to his own general practitioner", and inviting them to make submissions in this regard (Galea, 1988). Here, as described in the WHO publication 'Health Care Systems in Transition - Malta' (Azzopardi Muscat, 1999), 'a major change to the (primary care) system was attempted. The government at that time wanted to introduce a scheme whereby patients would be registered with a GP of their own choice. GPs were to be remunerated on a capitation basis and allowances. The scheme was to be voluntary, (and) not all GPs would be obliged to join.' However by 1991, as the report continues, 'due to a series of problems, the initiative never materialized, the project was abandoned and an opportunity to make a difference to the primary health care service was lost.'

Two years later, the **Medical Association of Malta** (1993) took the initiative in organising a conference entitled "Quality of Health Care in Malta - the Way Ahead", and the following were the main consensus points following the session on Family Practice:

- Continuity of care needs to be restored so that a doctor or more likely a small group of doctors are identified as the patient's carers.
- Immediate consideration is

given to the formulation of an adequate medical record in the health centres.

- The time has come to institute specific training for Family Medicine ... and CME should be actively promoted.
- Peer review: one of the possible steps could be the formulation of sets of clinical guidelines for common conditions seen in general practice.
- Pathology practice - a quality assurance programme should be made available for anyone performing laboratory tests outside hospital.

Then, in 1995, the **Department of Health Policy and Planning** (1995) of the Health Division published 'Health Vision 2000: A National Health Policy'. This recommended that 'the Primary Health Care Services will need to be strengthened in ways that will allow for the development of sound doctor-patient relationships and continuity of care, and will evolve from one exclusively providing medical care to clients at time of illness to one of advising, counselling, educating and coordinating all such activities that will help people adopt lifestyles conducive to better health and better quality of life'.

In May 1998, the **Malta College of Family Doctors** (1998 [1]) approved its 'Policy Document on Family Medicine in Malta', drawn up in line with recommendations from the World Health Organisation (WHO) (1998), and presented it to the Minister of Health in the Labour government then in power. In July 1998, the College sent the Policy Document with a Memo to Political Parties entitled 'Recommendations for the Future Development of Primary Care in Malta' (Malta College of Family Doctors, 1998 [2]). The memo concluded that "any future changes in the primary health care field should include these priorities:

- The homogenization of private and state-provided primary care services;
- Full professional autonomy of family doctors;
- The establishment of a chair in Primary Care within the Faculty of Medicine;
- Vocational training, ongoing education and specialization opportunities for family doctors."

'The betterment of primary health care in the community' is the title of section 161 of the 1998 Electoral Manifesto of the **Nationalist Party** (1998), which states: 'We commit ourselves to the betterment of primary health care in the community. This means the service provided by family doctors, health centres, pharmacists, nurses and paramedics, team-working at the local level. Reform here is essential. The biggest setback is that patients do not always meet the same doctor when visiting healthcare centres, and so continuity and the personal touch are lost. We will work at finding ways of promoting cooperation between the private health sector and that of the state, to the greater satisfaction of doctors and patients.'

In November 1998, following the election of the Nationalist Party to government, the **Malta College of Family Doctors** (1998 [3]) wrote to the Prime Minister (in reference to the Nationalist Manifesto) as follows:

- Organisational improvement of structural conditions

"The College agrees that continuity of care and teamwork are two of a number of cardinal characteristics of Family Medicine, together with systematic record-keeping and a cost-effective referral system, working within well-organised practices. International experience consistently shows that those health systems with a comprehensive and strong general practice set-up go hand in hand with relatively low national spending on

health care (ref. World Bank Report, 1990). Unfortunately, while huge financial resources are allocated for the development of secondary/tertiary care in Malta, primary care remains the Cinderella of medicine and is afforded scant and insignificant attention”.

- *Professional development*

“The College believes that education of the family doctor should be reviewed, both at undergraduate level (which at present is practically non-existent), and at postgraduate level through the introduction of vocational and specialist training (in addition to continuing medical education presently provided by the College). Such activities can only be maintained by an Academic Department of Family Practice within the Faculty of Medicine and Surgery at the University of Malta. In fact, this ties up with Malta’s aspirations to become a member of the European Union, where specialist training in Family Medicine is a requirement for family practice by doctors qualifying after EU accession (ref. EC Council Directive 93/16/EEC of 5 April 1993)”.

On this point of professional development, the **University of Malta** finally re-entered the field in February 1999. During a meeting that month with the Prime Minister, the President of the Malta College of Family Doctors (1999 [1]) announced that the setting-up of a long-overdue University Department of Family Medicine had been included in the Faculty of Medicine & Surgery’s Strategic Plan for 1998-2000. In fact, in May 1999, the Faculty Board of Medicine and Surgery unanimously approved the setting up of a **Department of Family Medicine**, and this was subsequently confirmed by the University Senate in November 1999, and by the University Council in February 2000 (Malta College of Family Doctors, 2000). However, GPs re-

plying to a call for applications for Academic Part-time Posts (T2) in Family Medicine issued on 26th April 2000 (University of Malta, 2000) had yet to be interviewed by November 2000.

During the above-mentioned meeting with the Prime Minister in February 1999, the College President also urged that the Cabinet favourably considers a report outlining ‘Proposals for Reform in the Primary Health Care Services’ prepared by the College with the Department of Primary Health Care and the Medical Association of Malta (Department of Primary Health Care et al, 1999). This report was finalised in January 1999 by the Working Group set up on the initiative of the **Ministry of Health** through the **Department of Primary Health Care**, and called for a realistically planned and costed comprehensive primary care scheme. As described in the World Health Organisation report ‘Health Care Systems in Transition – Malta’ (Azzopardi Muscat, 1999), these proposals ‘seek to address the rift that exists between the public and private systems of health care provision and take Malta’s historical, cultural, social and economic context into account. The principles underlying the reform will be similar to those proposed in 1991, but the details differ having learned from previous experience’. This WHO report agreed that ‘the present system of primary care is inefficient and reforms in this sector are urgently required. These must occur in the wider context of health care reform with particular attention to community support services and an emphasis on health promotion and disease prevention.’

Unfortunately, in May 1999, the **MAM** and the **MCFD** were given the disappointing news that the **Cabinet** had sent back the above recommendations to the Working Group with the message ‘think again’, apparently due to

the country’s financial constraints. In reply, both organisations reconfirmed their “readiness to participate in discussions leading to a reform in primary health care ... but requested that the Cabinet provides the Working Group with an indication of the financial resources that would be available for any proposals made.” (Malta College of Family Doctors, 1999 [2]). To date, no answer has been forthcoming to such offer and request.

The Maltese health care system was critically analysed in February 2000 during a three-day consensus conference entitled ‘A National Agenda for sustainable Health Care’ organised by the **Foundation of Medical Sciences and the Forum Group**. Prime Minister Dr E Fenech Adami, who opened the conference, outlined three priorities for discussion, the first of which being the need to decentralise care from the hospitals to the community care system (Fenech Adami, 2000). Moreover, in the conference’s concluding report entitled ‘Getting it all together’, Jonsson and Bannister (2000) emphasised resource allocation as a priority, pin-pointing primary health care as the sector which needed to be given adequate resources.

Therefore, despite:

- initiatives from professional interest groups (the Malta College of Family Doctors, the Medical Association of Malta and the Forum Group) on the
 - recommendations of international organisations (the World Health Organisation, the European Union and the World Bank), and the
 - provision of the necessary support from government and non-government organisations (the Health Division, the Ministry of Health, the University of Malta, and the Foundation for Medical Services),
- the cabinet of the present gov-

ernment has so far failed inexplicably to implement its own recommendations made when still a political party in opposition. In October 2000, however, it was revealed that an ad-hoc committee set up by Health Division was examining proposals made by three private entities interested in the running of the general practitioner service from the health centres (Deguara, 2000 [1]).

CONCLUSION: DEEDS NOT WORDS!

In his closing address at the February 2000 conference 'A National Agenda for sustainable Health Care', the Minister of Health, Dr L Deguara, declared that "*the days when health policy is dictated by political gains are over. It is high time to practice what we preach if we truly believe that the welfare of our nation surpasses any partisan political scoring. We are at the crossroads. If we really want a better future, long-term solutions are a must, even at the expense of short-term pains*". (Deguara, 2000 [2]). Fine words indeed; but will they be followed by the promised deeds? In this country we seem to have great difficulty in converting words into deeds, as evidenced by the sequence of events (or lack of them) in the primary health care sector over the past ten years or so (Sammut, 2000). As asked by Fenech (2000) in the Sunday Times published a few days before the conference, "will our politicians act together now, forgoing narrow political interests in the defence of the sick and suffering, both present and future?" Only time will tell.

During a symposium organised by the Ministry for Social Policy (1991) entitled 'Reforming the Health Services', the Workshop on Primary Health Care concluded that the most important and urgent recommendation in this area was a comprehensive educational

campaign for the public to make effective use of primary care services while avoiding abuse. Nearly a decade later such educational campaign has still not materialised.

Perhaps the time has come for better use to be made of the media to inform the ordinary citizens of the dire needs of primary care in Malta, and persuade them to lobby their local parliamentary representatives on the matter, for the good of the country's health care system and, ultimately, that of the Maltese patient.

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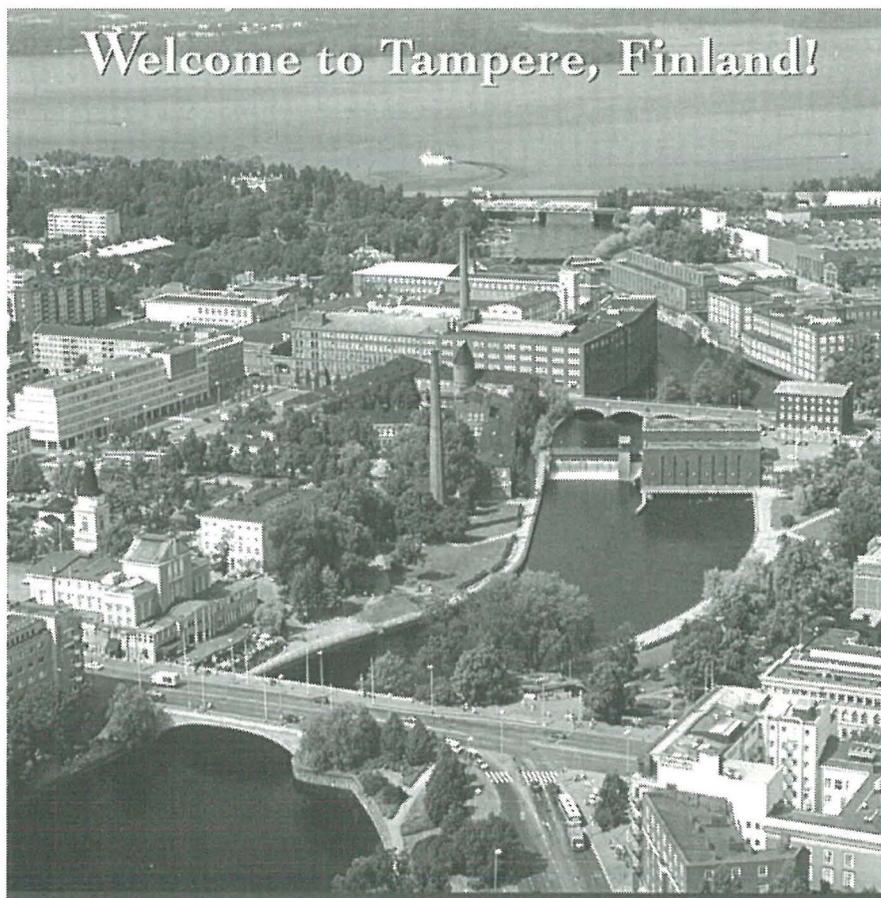
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