NEW PROPOSALS for FAMILY DOCTOR SCHEME

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Table of Contents

1. EXECUTIVE SUMMARY

GENERAL FEATURES

Health care provision in developing countries is evolving in the direction of more investment in the Primary Health Care field. The development of Primary Health Care is indeed seen by the World Health Organization as the only means to ensure 'Health for All by the year 2000'. The move towards Primary Health Care can be seen in both the industrialized and developing countries and at the hub of this lies general practice. It is through this discipline that most health care systems deliver their care.

In Malta general practice has served the medical needs of the community for many years. Social and political events over the recent years have influenced the pattern of the delivery of such care, such that today it is fragmented and certainly not comprehensive enough, nor organized in a manner, that make it suitable for the effective delivery of Primary Health Care. The effective delivery of such care depends, to a large extent, on the role played by the family doctors, who in addition to their role of providers of medical care, become advisors, counsellors, educators and coordinators for those activities that will encourage people to adopt lifestyles that are conducive to better health and better quality of life.

As has happened in most other countries, the Government has taken upon itself the responsibility of introducing a system of health care to optimize the health of its people. The new system, to be called The Family Doctor Scheme, is a Primary Health Care plan which while remaining sensitive to doctors' legitimate rights and aspirations, is user orientated and integrates and interfaces well with existing hospital and other community care services, and indeed forms one of the basic elements in the global reform of the Health Services in Malta.

The Family Doctor Scheme will be run by an autonomous body to be called the Family Doctor Scheme Council which will be responsible for engaging doctors to provide health care to the population. Doctors working within the Scheme will still retain their self-employed status, assuring their professional liberty and enabling them to develop their own styles of practice. Doctors will be at liberty to join the Scheme and will work on a contract basis. The Scheme will ensure the availability, for all Maltese citizens, of a family doctor with whom they can consult on any health related issue. At the same time it will provide for the formation of relatively stable practice populations, each under the care of a doctor, which would allow for a well organized and therefore more effective health care delivery.

The doctors' practices would tend to become more effectively managed, as their role within the Scheme matures. It is envisaged that doctors would find more job satisfaction since they can then devote more time to their patients, and to their professional development without necessarily working harder and without the preoccupation of their need to see a large number of patients to ensure a good income. The Scheme proposes guidelines for the optimum number of patients that a single doctor will be expected to look after, and proposes in its regulations, a time scale over which such number can eventually be introduced. It also provides for the possibility of doctors taking on associates to help them with their work, as well as for doctors to join into group practices.

Doctors working in the Scheme will be paid on the basis of a mixture of capitation fees, item of service payments, and a number of other allowances. These allowances are geared toward stimulating doctors to provide good effective primary health care, as well as keeping themselves abreast with recent advances in their medical discipline. The scheme also provides for the reimbursement of wages (within defined limits) for the employment of ancillary staff to help doctors in their work; this will serve as a first step towards the development of Primary Health Care Teams. Other benefits are intended to help doctors improve existing consulting room facilities, to support doctors in times of sickness and to ensure the reward to doctors for any academic input.

OUTLINE

The Family Doctor Scheme Council

The Family Doctor Scheme Council shall be a body, within the Department of Primary Care, constituted by appropriate legislation which will be responsible and accountable for the overall management of the Scheme. It will be the body in charge for contracting and paying doctors, for ensuring the provision of health care to the public, for monitoring the quality of such care and for making any appropriate changes in the running of the Scheme, it deems necessary, within the limits established by the appropriate legislation. The F.D.S.C. will be responsible for responding to queries and complaints made by both the general public and the doctors.

Registration of Patients

Registration will constitute a formal undertaking by the doctor to look after the patient who has expressed the wish to join that doctor's list, during the time for which the doctor is contracted to provide a service. On the patients' part this means that the patient will have a doctor, who will come to know them well and with whom they can confer in time of illness or for any other matters related to health. On the doctors' part, registration will provide them with a known practice population, for whose health care they will be responsible; this defined population will form their target for the implementation of any primary health care interventions.

To provide comprehensive primary health care services for the whole population, the Scheme will ensure that there will be a family doctor assigned to each individual through a registration process, whereby, all persons will choose their own doctor. If by the start of the Scheme some persons will not have exercised the right of this choice, the Council shall find a doctor located near their residence, who agrees to accept them. The Council will inform such persons of this decision, give them the doctors' names and how and where to contact them in case of need.

Eligibility of Doctors

All doctors registered with the Medical Council of Malta can apply to join the Scheme. Certain categories of doctors, such as those holding full-time posts within the Department of Health, as well as those working in a specialist capacity in the private sector, shall not be eligible to enter the Scheme. The number of eligible doctors that will be able to work within the Scheme shall be open at all times. Initially the age of a practitioner shall not constitute a determining factor for eligibility, though it is envisaged that as the Scheme matures, a compulsory retirement age for doctors working in the Scheme will be introduced.

Training in Family Medicine

Ideally doctors engaged in the Scheme should be medical practitioners with appropriate training in family medicine. To date such specific training has not been available in Malta. While it has to be recognised that our medical school has produced some of the finest doctors, many of whom are currently in general practice, it has to be appreciated that the undergraduate training of doctors does not provide them with sufficient orientation and knowledge on matters that relate to primary health care. Recent developments in this field have been so vast and widespread, attitudes, beliefs and expectations have changed so radically, that orientation and specific training in the field is considered essential for a doctor to perform more efficiently and effectively in family practice. In order to ensure an opportunity for doctors already in practice to upgrade their knowledge and skills, they will be advised to take an appropriate refresher/orientation course within two years of joining the Scheme -such course to be organised by an appropriate academic body recognized by the Family Doctor Scheme Council.

Doctors Employed Full Time with other Agencies.

Doctors having full time employment with the Government or other companies who want to continue to do General Practice within the Scheme, shall be able to do so as long as they will be able to fulfil the conditions of the contract and satisfy the Council on adequate coverage of their practice. Because of time

constraints and other obligations, Government deems it reasonable that these doctors should limit their list of registered patients. In order to ensure a smooth transition, doctors presently holding a full-time post with Government or any other agency will be able to join the Scheme as principals, but will have to give up one of their appointments within a period of time as defined in the regulations.

Terms of Engagement

The relationship between doctors in the Scheme and the Family Doctor Scheme Council shall be a contractual one and therefore the status of the doctors within the Scheme will be deemed to be that of self-employed persons. On contracting to work in the Scheme doctors shall be considered to have accepted to provide continuing primary health care to the population of patients registered with them between the hours of 8am and 8pm on weekdays and between 8am and 1pm on Saturdays. They shall be considered to have agreed to render to all their patients, all necessary and appropriate personal services of the type usually provided by general practitioners; they shall also do so at his practice premises or at the patient's home if the condition of the patient so requires. The doctor shall act as a source for health education, health promotion and other preventive measures for all matters that relate to health. During the contracted hours, doctors will have to make themselves available to their registered patients for a minimum number of hours during the day and the week.

It shall be the duty of doctors working within the Scheme to keep proper records of all consultations with patients. These records are to be kept on special forms as supplied by the Council, shall follow the patients in the event that they decide to change their doctor and shall at all times remain the property of the Council.

Finally, doctors shall not accept any payment from individuals who are registered on their list, for any services rendered during the contracted hours.

The Doctors' Workload

The Government, through the F.D.S.C. has the responsibility of assuring a high quality of health care delivery to all registered persons. In considering the Doctors' workload, the Scheme ensures that solo general practitioners, who can provide optimal care to a list not greater than a certain size, will be adequately remunerated. It is possible for doctors, with a list larger than this size, to provide optimal care to their patients if they engage the service of an associate to help them with their workload. The Scheme encourages group practice formation and provides inducements to facilitate this kind of practice. At the start of the Scheme there will be no limit to the size of practice an individual doctor can have, though the Scheme proposes measures that to induce the transformation of large practices into more manageable ones.

Doctor - Patient Encounter Forms

The importance of obtaining good data on doctor-patient encounters and comprehensive health profiles on Maltese citizens is well recognized. Doctor-patient contacts within the Scheme will be documented on specifically designed forms supplied by the Council. For administrative purposes, the Council will need to be informed of these encounters and provisions will be taken to remunerate the doctors for this extra effort. The information collated centrally will also be useful epidemiologically, for the compilation of a national morbidity database and the overall management, evaluation and future planning of the Scheme. Every conceivable measure will be taken to ensure that the confidentiality of any medical information received by the Council will be preserved.

System of Remuneration

The system by which doctors engaged in the Scheme will be remunerated will be based on a formula of capitation, item of service and other allowances. The reason for choosing this mixture is based on an attempt to try and be as fair as possible to doctors so that their income does not only reflect the extent of their responsibility but also be equated to the volume and quality of their work.

Basic Capitation Fee - a retainer for future services to be given to patients and includes in its calculation factors such as administrative and other overhead expenses, that may be incurred by doctors in the carrying out of their duties.

Item of Service Payment gives an additional income to the doctors, which is directly related to the volume and type of their work. The workload is dependant on the size and demography of the doctor's list, but at the same time, it can be determined by the initiative and commitment to patient care by the doctor. Items of Service payments will include:

Encounter Form Fees will be given to doctors for filling in the encounter forms. This fee is given as a partial compensation in recognition of the extra time involved to complete it and is aimed to encourage the accurate and faithful reporting of encounter data.

Fee for Minor Surgery will be made to doctors for carrying out minor surgical interventions on patients registered with them.

A series of **Allowances,** forming the third component of the doctors' remuneration will include:

Good Practice Allowance will be paid to those doctors who on assessment by the Council will be found to be practising in a manner that is considered to have reached the required standard.

Continuing Medical Education Allowance will be paid to doctors who can show that they have regularly attended for programmes of continuing education organized by the relevant academic organisations.

Seniority Allowance: There is no doubt that although adequate knowledge, willingness to work, appropriate training, and the right orientation are all basic essentials doctors should have to perform their duties properly, it is the experience in the field which comes on with time that gels these factors together. It is therefore felt that this experience in the field of primary care should be reflected in the remuneration in the form this allowance.

Group Practice Allowance. In many countries the trend in primary health care today is for doctors to join up in groups. Working within a group, creates an opportunity to form a health care team approach in patient management; and generates the type of working environment conducive to good standards of patient care. It is because of this, and in an attempt to act as an incentive to form such groups, that such an allowance will be paid to doctors as part of their total remuneration. Only group practices of three or more doctors shall be eligible for this allowance.

Undergraduate Training Allowance - for the Scheme to be successful there is a need to have appropriately trained personnel working within it. At present, the medical school has already taken the first, albeit small, step in orientating the undergraduates to family medicine by attaching them to a family doctor for a period of four weeks. It is felt that the effort of these practitioners should be remunerated.

Practice Premises Allowance - In order to assure good standards of practice and suitability of the premises, the Council will reimburse part of the expenses incurred in the running of the doctors' clinics. The Council will, in pursuance of this aim, commence a program of inspection and approval of the premises. Following this inspection, doctors will receive a reimbursement to cover part of the expenses incurred in the payment of telephone, rent and electricity bills accrued in the process of providing service to patients registered in the Scheme.

The payment of the aforementioned fees and allowances, due to medical practitioners engaged in the Scheme, shall be effected by the Family Doctor Scheme Council, in accordance with such rates and subject to such conditions as the Council, after approval of the Minister responsible for Health may, from time to time, determine. Proposals for any changes in the rates and conditions of payment will be determined by the Minister, after consultation with organisations recognised as representing doctors providing medical services within the Scheme.

Partnership Association

It may at times be necessary, or indeed desirable, for a single-handed solo practitioner to join with an other doctor. Any two or more doctors working as solo practitioners, will be able to form a partnership. Once a partnership is formed, patients registered with the doctors within that partnership, can see any one of the doctors if they so wish, though it would be advisable for patients to keep to the same doctor. Any payments due to the doctors in respect of any patients registered within a partnership shall be forwarded by the Family Doctor Scheme Council in the name of the partnership.

Employment of an Associate

A solo practitioner, or a group of doctors, may at some stage want to engage the services of an associate to help out with the work in the practice. Such an associate will work part time within the Scheme up to a maximum number of hours per week, such hours to be regular and fixed and to be approved by the Family Doctor Scheme Council.

Only doctors with large enough list sizes of patients, will be allowed to engage an associate. The engagement of an associate, will allow the engaging doctors to increase his list to beyond what they are considered to be able to manage on their own. The terms of engagement will also provide, that within a reasonable period of time, associates are given the opportunity to become partners, if they so wish.

Use of Deputies

While it has been stated that doctors engaged in the Scheme shall be contracted to provide cover for a stipulated number of hours, it has equally been accepted that it will be most unreasonable to expect the doctor to be physically available to his registered patients throughout all these hours. It may at times therefore be necessary, for doctors to enter into a rota arrangement with colleagues, to provide cover for such periods during which the doctors will not be able to provide the service. Each doctor will, however, be expected to personally provide coverage outside normal office hours for a minimum period of time as specified in the regulations.

Concessionary Payment for Sickness

It shall be in a doctor's interest to make arrangements for cover with a colleague for any periods of absence he may have to take in case of illness, vacation and other emergency situations. In situations where through illness, a doctor is absent from his practice for a period of time exceeding two weeks, the Scheme shall provide a **locum allowance** for up to twelve weeks to help the family doctor meet any expenses that may be incurred in employing a locum during this period.

Employment of Ancillary Staff

The aims of the Scheme are to promote primary health care delivery and as stated earlier in the document the primary health care team is the medium through which this care can be effectively delivered. It is with this in mind, that the Scheme shall provide for the payment for the employment of limited ancillary staff (nurse and\or secretary\receptionist) to help the family doctors in carrying out their role. Through the Scheme, Government shall re-imburse payments made by family doctors, for the employment of nurses and secretarial/reception staff.

Diagnostic Backup Facilities

Within the Scheme, doctors will have access to a considerable number and type of diagnostic facilities. The list of diagnostic facilities that shall be available to Scheme doctors is to be worked out by the Family Doctor Scheme Council and the Department of Health.

The Role of Health Centres

The Family Doctor Scheme will integrate with existing community care services currently available from the health centres. The role of these health centres will inevitably change. The general practitioner service as it is known today will stop. The health centres will in future provide cover for accident and emergency situations and will very much function as regional units for such cases. In addition, an emergency general practitioner service will be provided during those hours which family doctors working in the scheme are not contracted to cover. Some of the major health centres will be open twenty four hours a day, while others will close during the night. The medical services from within the health centres, will be provided by doctors employed on a sessional basis. The diagnostic facilities presently existing will remain and these will be made available to all doctors working within the Scheme. The specialist sessions will continue and there will be scope for these to be expanded. The provision of supporting services, such as physiotherapy, speech therapy,and podology, shall continue to be provided from the health centres. The health centres will also provide the venue for activities related to health promotion and health education.

Integration with Hospital Services

The Family Doctor Scheme will also integrate with the hospital services. Since each hospital patient will be identified with a doctor, there will be more scope for the management of chronic problems within the community by having closer liaison between patient, family doctor and specialist. One would like to see better co-operation between the hospital specialists and the family doctor to

the maximum benefit of the patient. Apart from the personal contact between the hospital specialist and the family doctor, there will also be a need to improve communication between the two through other means. The better availability of the family doctor together with the more personalized and comprehensive care given, will not only benefit the patient but will also cut down on the utilization of hospital resources especially in the out-patient and accident and emergency departments.

2. PRIMARY HEALTH CARE-REAPPRAISAL

Until the nineteenth century, medical measures were essentially limited to the service of doctors to sick patients. Even today when there has been more than a hundred years' experience of preventive medicine, the original concept is still deeply rooted in public and professional consciousness as an essential medical role. However this traditional concept is beginning to be re-examined, and the nature of the medical task is beginning to be seen in a different perspective.

In affluent industrialised societies the attitudes of built-in obsolescence have spilled into the realm of personal health. People have come to assume that they can abuse their bodies as much as they want and the medical service will repair the damage. People's pursuit of the advantages that the new drug and technology revolution can offer has produced the most amazing effects on the type of service obtained from the medical profession. On its part the profession too has tacitly, albeit inadvertently, connived with the development of this attitude, with the effect that today too many people assume that health means cure and that the only person who can achieve that cure is the doctor.

During the history of medicine, hospital medical care has been by far the most important approach to providing health services. Where primary care services are inadequate, hospital services tend to be used as costly and inappropriate substitutes. Hospitals have been seen as the providers of life blood for all the health services, such services, supposedly reaching everyone. It is now becoming apparent, that hospitals cannot provide that kind of comprehensive service and, in fact, are responsible for only a sector of health services. There is no doubt that most countries have become more aware of apparent deficiencies in their health care systems, and are beginning to invest more in primary health care systems.

In the declaration made by the International Conference on Primary Health Care organised by the World Health Organisation at Alma Ata in September 1978, primary health care is defined 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 and in the spirit of self reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of

the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the 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 process.". This definition includes several worthwhile ideals which are undoubtedly hard to attain, even assuming every effort to do so.

The role to be played by family doctors in the formidable effort to achieve the above ideals is seen to be central, and indeed crucial. Far from seeing family doctors as the sole agents for carrying out these tasks, the Alma Ata declaration, envisages them joining other health professionals in the formation of a health care team, backed by referral to specialist service; the declaration also refers to patient participation both as individuals and in groups. The challenge that primary health care puts to family doctors, is for them to abandon their solitary role and accept less familiar roles as organisers, co-ordinators and educators of the health care system, without abandoning the essentials of personal doctoring - broad scope, ready access and continuity of care.

Accepting the challenge proposed by the Alma Ata declaration will necessitate a change in those attitudes and expectations discussed earlier, of both the profession and the people. People should involve themselves more in looking after their health, and regard the doctor, not as the provider of the `cure' to their problem, but as the person who can guide and help them in finding a solution to their problem. These changes are hard to achieve, and will certainly not take place overnight; education and reorientation of both the public and the profession are certainly two basic essentials for this attitudinal metamorphosis.

3. THE HEALTH CARE SYSTEM IN MALTA

Up to some years ago Malta's primary health care services were offered by private medical practitioners who, in the vast majority, worked from solo practices. These were complemented by a number of Government employed district medical officers who offered services to people, who on means testing, were considered unable to afford to pay for private medical care. This system for the provision of primary medical services was disrupted as a result of the medical dispute of 1977.

In 1979 Government opened the first of the existing health centres, then known as polyclinics, and through them, offered free medical care to all those who sought it. Over the years, more health centres were developed and to date, there are eight such health centres situated in Floriana, Mosta, Paola, Gzira, Qormi, Rabat, Cospicua, and Gozo with a ninth being built in Birkirkara. The role of these health centres broadened with time, and today, in addition to providing general practitioner services, they serve as a base for the provision of Government-run primary health care programmes such as immunisation, ante-natal, well-baby, family welfare and other screening clinics. Within these centres one also finds specialist clinics, as well as the provision of other supporting facilities such as physiotherapy, podology and speech therapy. There are also radiological and laboratory diagnostic facilities to back up the provision of these services. In addition to the above, there are numerous small clinics in most towns and villages where there is a doctor in attendance for specific periods of time on set days in the week.

There is currently a complement of ninety five doctors working in these health centres who attend to patients that turn up at the health centres, as well as those who request a home visit. These doctors work on a roster basis. Because of this set up, as well as the fact that doctors have no obligation to look after specific groups of patients, there is very little room for the establishment of any sound doctor-patient relationships or the development of any continuity of care, with the result that the quality of care given is very impersonal and at times superficial. This was a contributing factor to a reduction in the interest and enthusiasm of the doctors working in such centres, and has also led to people utilising the medical services offered, for episodic illnesses and emergencies.

The provision of primary care by private practitioners continues to exist, and it is to these practitioners, that most people resort for the more chronic and serious complaints. But even this set up, provides room for improvement in the quality of family practice.

Over the past few years there was a marked increase in the number of doctors graduating from the Medical School of the University. The large majority of these doctors are employed by the State, and presently work in the health centres and as junior doctors in the hospital wards; many of them working in private general practice in their time off, in an attempt to boost their income. In Malta, there are around seven hundred doctors, of whom, over one hundred possess a specialist degree. Most of these specialists, too, are in Government employ and, like their non-specialist counterparts, work in private practice. Few are those specialists that work solely in private practice, with no access to hospital beds. A number of specialists also engage in private general practice.

One other feature of the present health service which is conspicuous by its absence, is the lack of effective communication that exists between the primary and secondary care physicians, and indeed between the State-employed and the private primary care physicians. Record keeping by most primary care physicians is very scanty, if at all existent. This is the prevailing situation both in private practice as well as in the State-run health centres. An attempt to improve this has been made in the past, with the introduction of computer data entry points within the consulting rooms at the Floriana health centre; however this project had to be abandoned for a number of reasons..

From the above, it can be seen that the provision of primary care in Malta today is fragmented, and there is general consensus that its structure needs to be reformed to meet present and future needs. The present set up is not conducive to the provision of effective primary health care to the population, and it is felt that appropriate steps need to be taken to ameliorate the situation. In most of the industrialised countries, the Government has taken the responsibility of introducing a system of health care to optimise the health of its citizens. As has become obvious, it is most efficient, both financially and health-wise, to intervene by preventive measures and public education to anticipate illness and disability, rather than to apply a cure after the disease had struck. The medical model has been costly both in terms of suffering and economics. The primary health care model, is a comprehensive approach on the rational utilisation of the resources of the country, to involve both the public and the health care professionals in the well-being of the general population. It is only with the

intervention of Government action, that such changes can be achieved, and it is therefore the intention of Government, in line with its electoral promise, to introduce a system which ensures the provision of such care, to the maximum satisfaction of both the consumer and the provider.

4. A PRIMARY HEALTH CARE PLAN FOR MALTA

When one considers the prevailing situation in Malta today, and compares it with the ideals and goals set by the World Health Organisation in its Alma Ata Declaration, one readily appreciates that the current set up of general practice in Malta is not structured, integrated and co-ordinated enough to ensure the desired amelioration of the service. Family medicine forms the hub around which primary health care revolves, and it is exactly this hub, that Government intends to strengthen by the introduction of the Family Doctor Scheme. It is this resolve that has spurred Government to propose an important reform in Malta's health services which, in turn, are expected to bring about a gradual evolution in the perception of the role and function of the family doctor by both the public and the profession. The Family Doctor Scheme, will undoubtedly bring about a better understanding of family practice and an amelioration in the physical, psycholoical and social well-being for both the consumers and the providers of health care.

The role of the family doctor within the Scheme will no longer be that of a provider of medical care to people at times of illness, but it will also evolve into that of an adviser, a counsellor, an educator and a co-ordinator for all such activities that will help people adopt lifestyles conducive to better health and better quality of life. With the introduction of the Scheme, the public will learn to assume responsibilities and generate new attitudes to the question of health, as also to perceive the new role of their family doctor as a leader in the health care team. Thus the individual is to be educated to make proper use of the services, and to maximise the supporting care given by the other members of the primary health care team. The Scheme will provide for the development of a sound, continuing and lasting patient-doctor relationship, that will generate an atmosphere of mutual trust, respect and friendship conducive to an open discussion of problems and factors that relate to health.

It is equally envisaged that public attitudes to health and health care delivery will change. The appropriate utilisation of the doctor's time will ensure that, the doctor will have enough time to dedicate to the other roles of the family doctor. It is important for the public to come to appreciate that, it is to their advantage to consult only the one doctor for all matters that concern health; this doctor should invariably be the family doctor. This will ensure the development of that continuing relationship so essential to good health care delivery. The public will also come to learn the working patterns of doctors and their teams, their normal working hours, and, while conforming to such patterns of practice,

they will acknowledge and respect the doctors' right to their rest and family and social life.

The Scheme that is being proposed is patient-oriented. It not only offers individuals the facility to choose their preferred doctor, but will also stimulate them to learn how to maximise the benefits to their health, from their contacts with the health care team. It is also a Scheme that respects doctors' rights, needs and legitimate aspirations for freedom of practice and professional independence. It is finally a Scheme that, while ensuring a holistic approach to patient care, integrates well with existing hospital and other community care services, and will form an essential component of other reforms in health services in Malta.

It is the State's obligation to ensure the availability for its people of the best possible health care services, designed to secure improvement in their physical, mental and social health and in the prevention, diagnosis and treatment of illness, given the economic constraints of the country. In the light of this commitment, Government is introducing a Scheme which is designed to procure the services of a family doctor to each individual through a system of registration. This will assure the provision of such care to all, thus making the Scheme a truly comprehensive primary health care system.

The proposed new primary health care plan shall be referred to as the Family Doctor Scheme. It is envisaged that this Scheme will be run and administered by a body within the Department of Primary Health Care, to be known as the Family Doctor Scheme Council (F.D.S.C.), whose powers and responsibilities will be determined by appropriate legislation. The F.D.S.C. will arrange with medical practitioners to offer personal primary health care services to all residents. It shall work independently of the Department of Primary Health Care, though in close liaison with it, and shall be accountable to the Minister responsible for Health.

The proposed Scheme, not only does not exclude the possibility of other private primary health care schemes providing a similar service, but itself provides the framework within which family practitioner services can be delivered and essentially managed in an autonomous manner by the doctor and other health care providers themselves. The proposals included in this document are not to be regarded as the final answer to the achievement of all the principles declared at Alma Ata, they are to be considered as an initial step toward the achievement of such objectives.

Although the Scheme envisages the registration within it of all residents, it does not, in any way, restrict the individual's right of seeking private medical care outside the Scheme. Government recognises the contribution made by the private sector towards the health care of the population. An awareness is, however, felt of the need for the development of guidelines that will help enhance the quality of care provided by this sector.

To preserve the concept of pluralism and freedom of choice in primary health care delivery, it is agreed that any approved alternative Scheme undertaking to provide primary health care, of a standard at least equal to that provided by the Family Doctor Scheme, will be positively encouraged by appropriate legislation.

As the Scheme matures, it is evident that there will be a need for an evaluation of its operation. As more details of the rates and patterns of health care services utilisation are available, legislation will provide for the possibility, for persons so desiring, of opting out of the Family Doctor Scheme, and registering within an approved alternative scheme operating along the guidelines referred to above.

For this purpose, as part of the evaluation process, the Family Doctor Scheme Council will, within one year of the effective date of the coming into operation of the Scheme, set up an appropriate working party, including a representative of the doctors' union, to evolve and submit the relevant proposals and guidelines, which after approval by the Family Doctor Scheme Council, would be proposed for legislation.

The working party is to submit its report to the Family Doctor Scheme Council, and render it public, not later than six months from its appointment, so however that the legislation referred to above can be presented to parliament within not more than two years of the effective date of the coming into operation of the Scheme.

All doctors who fulfil the criteria for eligibility will be able to work in the Scheme. Those doctors joining the Scheme will not be employed by the Council, but shall be engaged with the Council on a contract basis for a five year period, automatically renewed, unless there is an explicit written notice to the contrary and without prejudice to the health care providers' right to claim review of remuneration in the interim period. It is felt that this independent contractor status of the family doctor, will afford practitioners a free hand in the running of

neir practice, as long as they conform with the terms and conditions of the igned contract. This free hand, will not only give the doctor professional liberty, ut will also give patients a choice of style of practice, in addition to the choice of doctor.

Doctors engaged in the Scheme will be appropriately and justly remunerated, given the economic constraints of the country. The method of payment shall be on the basis of a mixture of capitation fees, item of service payments, and other allowances. This system not only ensures a guaranteed income for family doctors related to the number of patients for whom they are responsible, but also reflects the amount of work performed. In addition, doctors will be entitled to receive allowances related to experience, participation in educational activities, quality of care provided and group practice formation. Incentives will be given for the running, maintenance and improvement of practice premises and for the employment of ancillary staff.

All persons, on registering within the Scheme, will choose a family doctor from a list of eligible medical practitioners, subject to acceptance by the doctor. Initially solo practitioners will be able to accept any number of patients who request to register with them. At a later stage, regulations bearing on the doctors' list size and workload will come into operation.

Much of primary care, especially in the management of people with chronic illness and in prevention, requires a co-ordinated approach with a multidisciplinary team of health professionals. The concept of the primary health care team is currently gaining ground in many other countries as it is regarded an essential nucleus in the provision of primary health care. For this reason the Scheme being proposed has in-built incentives for promoting the beginning of the formation of such teams.

The success or otherwise of a primary health care team depends on the attitudes of the individual members. Team members need to have a good understanding of, and respect for, the skills which others can contribute and also have an appreciation of the outside pressures which impinge upon them. To date in Malta professionals in the various disciplines have worked in isolation and every effort should be made to alter this trend. One should take cognisance of the fact that good, effective primary care can only be provided with the help and support of other allied professions. There is a need to further develop the role of nurses in primary care, and efforts should be made to orientate groups of nurses interested in this field by providing the appropriate training courses.

The introduction of the new Scheme may give rise to a lot of questions and fears. The main concern of the public is centred around the fear that once doctors will no longer be paid directly by the patient for any services rendered, any such service provided by that same doctor will be of inferior quality. The Scheme has in built measures to safeguard and reward good quality care provided by the doctors and because the income of the doctors will be related to the number of patients registered with them, it will be in their interest to provide the best possible care.

Some of the major fears expressed by the profession include medical unemployment, inappropriate use of resources, unlimited accessibility to the physician, unreasonable demands on the doctors' time, and lack of appreciation of the services offered when these are provided at no apparent direct cost to the patient. Some of these fears and problems are to be expected and anticipated, though the concept of registration with one doctor will by itself introduce a type of relationship and respect that will reduce any tendency for abuse. The doctors themselves will have more time to spend with the patient, and in their role as health educators, they will teach and show their patients how to make the best use of the available resources. Indeed the educational campaign that will accompany the launch of the Scheme will also bear on this.

It has already been highlighted, that the introduction of the Scheme will bring about significant changes in the general practitioner system as it has existed for many years. The effect this may have on both the provider and the consumer has also been referred to earlier. It is therefore important that such changes be introduced gradually in order to allow sufficient time for the parties concerned to get acclimatised to the new system. In order to ensure that the transition from the existing set up, to the new set up within the Scheme, will be as smooth as possible, it is proposed that initially, doctors working in the Scheme, will only be contracted to carry out work between the hours of 8am and 8pm on weekdays and 8am and 1pm on Saturdays; the remaining times will continue to be covered by doctors working in the health centres. It is estimated that 95% - 98% of all general practitioner contacts take place during these times, and therefore such an initial measure will not have any major deleterious effect on the continuity of care which the Scheme proposes to promote. Moreover, measures will be taken to ensure the effective communication to the doctors in the Scheme, of any services rendered to patients on their lists, by the health centre doctors outside these contractual hours. The net effect of this introductory measure on effective patient care will be closely monitored by the Council.

The introduction of a Voucher System as part of the Scheme has been put forward as a practical solution to the problem of indiscriminate use of the Scheme facilities. Such a proposal has been thoroughly considered and its advantages very carefully weighed against its disadvantages. Apart from their use to collect the relevant data on the various patient-doctor contacts, the only remaining role of the vouchers is that of controlling access to the system, thus eliminating the risk of abuse on the part of the consumer. It is anticipated that for the majority of doctors, their practice population will consist of people they are caring for under the present system and it is most unlikely that these will abuse the system because of the respect already generated through an established patient-doctor relationship. It will only be in a minority of cases where new relationships shall have to be established. Of these, only a few patients may be expected to be abusers. What is termed abuse is, in most cases, no more than lack of education in health matters and in the utilisation of the service. The responsibility for this education is shared by both the Government, health care provider and consumer. After deep consideration, it has been decided that the introduction of such a system of vouchers will create such complex administrative problems for the health care administrator, provider and user alike, that its introduction as a means of deterring such a small minority is not justified. It is hoped that the wisdom and maturity of all parties concerned will make them appreciate and utilise wisely what their tax is supporting and providing.

The importance of obtaining good data on patient-doctor encounters and comprehensive health profiles on Maltese citizens is well recognised. Malta's geographical size and captive population provide an ideal situation for centrally collecting health and other medical data for various clinical and epidemiological studies, for studying outcome of interventions and for planning future directions in health care provision. We are at a time when technologies in data collection are in a state of rapid advancement, and advantages should be taken of the most recent technologies in introducing the Family Doctor Scheme, with the belief that efficiencies and economies in compiling valid and reliable health information will be the wisest strategy in the long run.

In order to ensure the collection of the information about the various patient-doctor contacts that will take place once the Scheme is in operation, the Council will remunerate doctors for reporting information on such contacts. The Council will supply doctors with Encounter Data Forms, which they will fill and return to the Council. There will be two types of such encounter forms, the first to be used on the doctor's initial encounter with the patient and the second to be

used for reporting on subsequent encounters. This reporting will not only ensure the compilation of a national morbidity register, and an index of the state of health of the population at the time of effective introduction of the Scheme, but will also give the Council and the profession information about the patterns of utilisation of the service. This information will constitute essential operational data that will help evaluate the Scheme and bear influence on any decisions taken about future planning. In addition this centrally collected data will benefit the individual doctors by providing them with information about their own practice; doctors will be able to receive information about their workload and its content making it possible for them to monitor any observed trends and compare them with national figures as compiled by the F.D.S.C. The Council will be able to respond with customised reports to queries from individual doctors with special interest in some aspect of their practice.

Measures, including legislative, will be taken to preserve the confidentiality of the data received by the Council in the interest of both the public and the profession.

As stated previously the new Scheme will integrate with the other levels of the health services, in particular with the existing community care services currently available from the health centres. The role of these health centres will inevitably change. The health centre based general practitioner service as it is known today will stop. The major health centres will in future provide daily cover for accident and emergency situations during the hours of 8am to 8pm from Mondays to Fridays and 8am to 1 pm on Saturdays. Outside these hours, apart from covering for such situations, the health centres will also provide cover for any other services that patients may require. Provisions will be made such that these emergency services from the health centres will be given by Government employed doctors, who will have specific instructions to deal only with emergencies and to direct persons, attending the health centre for other ailments, to their family doctor if they present with these ailments during the Scheme contractual hours . Doctors working in the health centres will be engaged on a sessional basis. Those doctors who are engaged in the Scheme will not be allowed to work in the health centres during their contractual hours in the Scheme.

The diagnostic facilities and personal health services presently provided from the health centres will continue to be run by the Department of Health and they will be made available to the doctors working within the Scheme. The specialist sessions will continue and there will be scope for these to be

expanded. Another function of the health centres could be their utilisation for any screening programmes run by the Department of Health. The centres could also be used for the launching of health education drives (e.g. nutrition). The education facilities could eventually be expanded to include undergraduate and postgraduate training programmes for members of the primary health care team. They could also serve as a venue for programmes of continuing professional development of medical and allied health workers.

The Family Doctor Scheme will also integrate with existing hospital services. With the introduction of the Scheme the management of chronic problems within the community will be more comprehensive, as the patient will have an identifiable family doctor to follow up the patient's care on release from the hospital or specialist clinic. Family doctors will be encouraged to visit their patients while they are in hospital, and without involving themselves in the management of the patient, they can work in close liaison with their hospital colleagues by providing background medical and social information. Family doctors will be of great assistance, by their participation in conferences held on the management of problem cases. Apart from this personal contact between the hospital specialist and the family doctor, there will also be a need to improve communication between the two through other means. The better availability of the family doctor, together with the more personalised and comprehensive care given, will not only benefit the patient, but will also cut down on the utilisation of hospital resources.

5. THE FAMILY DOCTOR SCHEME

1. The Family Doctor Scheme Council

The Family Doctor Scheme Council shall be the body within the Department of Primary Health Care, constituted by appropriate legislation, responsible for the overall management of the Scheme. It shall be accountable to the Minister responsible for Health. It will be the body responsible for ensuring the provision of primary health care to the public along the lines defined in section III of this document, for contracting and paying doctors, for monitoring the quality of care and for making any appropriate changes in the running of the Scheme it deems fit and necessary within the parameters of the relative legislation. Just as the planning of the Scheme has involved a long process of dialogue and mutual understanding between Government and the profession, it is imperative for the successful development of the Scheme, that any changes that may need to be made, are implemented in the same spirit of dialogue.

The Council will be constituted as follows:

- The Director of Primary Health Care who will ex officio be the executive chairperson.
- The Manager Nursing Services will be an ex officio member
- one person to be elected by and from amongst the doctors working in the Scheme,
- one person nominated by the Malta College of Family Doctors,
- one other person coming from the ranks of the consumers, nominated by the persons mentioned above on the principle of consensus.

Members elected and appointed on the Family Doctor Scheme Council must :

- be citizens of Malta;
- be of good moral character;
- be persons who have not contested a general election as a member of any Political Party;
- be persons who do not hold any official position in any Political Party;
- be persons who do not hold any official position in any Trade Union.

The Board shall be responsible for the general implementation, management and development of the Scheme. Amongst other functions, it shall:

- establish and maintain relationships and work in close association with Government Departments and other institutions, through the Department of Primary Health Care,
- prepare budgetary estimates,
- ensure the appropriate use of allocated funds,
- recommend changes in the terms and regulations of the Scheme,
- ensure the proper collection, utilisation and safeguarding of all data,
- ensure the carrying out of the necessary medical audit*, quality control and research activities as it deems necessary,
- with the concurrence of the Minister employ executive, administrative as well as supporting staff to manage the Scheme.

** In the case of medical audit it will be assured that the relative judgement and evaluation is made by members of the medical profession.*

The Complaints Board

The Council shall set up a Complaints Board to deal with any complaints from the public or the doctors. The Board shall consist of a chairperson, who shall be a person having the warrant to exercise the medical profession, one other person representing on the one hand the doctors working in the Scheme and two other persons representing on the other hand the public at large. The Complaints Board shall investigate and adjudicate complaints referred to it. Where the complaint refers to a matter relating to professional competence, the Complaints Board will report the matter to the Scheme Council. The Council may either take cognisance of the case, investigate and adjudicate; or, it may not take cognisance of the case and refer it to the Medical Council of Malta. In matters of professional competence referred by the Complaints Board to the Scheme Council, it shall be the professional members of the Council who will be responsible for the adjudication of the case. Any appeals to decisions of the Complaints Board shall be referred to the Scheme Council, such appeal to be filed within 28 days of the decision of the Complaints Board.

The Appeals Tribunal

There shall also be a Tribunal, appointed by The President of Malta, to hear appeals from decisions of the Scheme Council. An appeal is to be filed within 28 days of the date of the decision of the Scheme Council. The Tribunal shall be chaired by a person chosen from amongst retired judges or magistrates or from amongst persons who have had the warrant to exercise the legal profession for at least seven years. The chairperson shall be assisted by another two persons, one of whom shall be chosen from a panel of professionals nominated by the associations recognised by the Council as representing the professions working in the Scheme, and the other chosen from a panel of persons nominated by the Council. Decisions of the Tribunal shall be final and binding.

2. Registration of Patients

The concept of registration encourages the development of that bond between the doctor and the patient that is so necessary to effective primary health care; ideally this bond develops not only between the doctor and the individual patient but also between the doctor and that patient's family and it would therefore be desirable if household members register with the same doctor.

Registration will constitute a formal undertaking by the doctors to look after the patient who has registered or been registered with them. On the patients' part this means that they will have a doctor who will come to know them well, and with whom they can confer in time of illness or for any other matters that relate to health. On the doctors' part registration will provide them with a known practice population for whose health care they will be responsible; this defined population will form their target for the implementation of any primary health care interventions. This registration implies a mutual relationship, between the doctor and the patient, based on reciprocal trust, rights and obligations.

To provide comprehensive primary health care services for the whole population, the Scheme will ensure that there will be a family doctor responsible for the health care of each individual. This will be done through a registration process whereby each person will be invited to select a family doctor from a list of eligible doctors who will have expressed the desire to engage in the Scheme.

If after a reasonable period of time a person has not yet registered with a doctor, the Council shall find a doctor to take on the responsibility for the care of that person in accordance with criteria defined hereunder.

While it is desirable that patients consult the same doctor for all matters that relate to health, it shall be possible for patients to change their doctor within the Scheme without undue difficulty.

Regulations

2.1 Every member of the public shall be invited to register with a doctor of their choice in the Family Doctor Scheme provided that:

i. The name of the doctor with whom the patient registers appears on the Family Doctor List of the Family Doctor Scheme Council.

ii. The person's registration is accepted by the doctor with whom that person wishes to register.

2.2. At a date determined by the Council, registration forms will be sent to all members of households, to be filled in and signed by each person, countersigned by the doctor and returned to the offices of the Council within three weeks from the date of such countersignature.

i. The head of the household shall complete the registration form for members of the family aged less than 16 years.

ii. The head of the household shall be responsible to register a new-born child with a doctor within six weeks of the birth of the child.

iii. In the case of a death, the person reporting the death shall hand in the deceased's F.D.S.C. Health Document to the officer registering the death, who shall in turn pass on such card to the Council. The Council will then inform the doctor of the removal of such person from the practice list.

2.3. Initially the effective date of registration will be the effective date of operation of the Scheme as determined by the Council; thereafter the date on which the doctor signs for the acceptance of a person, shall be deemed to be the effective date of registration.

2.4. Any persons who by the closing date for registration as determined by the Council will not have registered with a doctor, will be reminded by the Council and will be given a further period of three weeks in which to register with a doctor of their choice.

i. If after the extended period defined in paragraph 2.4, such persons will still not have registered with a doctor, the Council shall allocate such persons to a doctor's list as provided in paragraphs 2.9. and 2.10. below.

2.5. All persons, once registered with a doctor will receive from the Council an F.D.S.C. Health Document detailing their name, registered address and Scheme Number as well as the name of the doctor with whom they are registered.

2.6. Persons who no longer wish to continue to avail themselves of the services of the doctor with whom they are registered, may change their doctor at any time provided that:

i. They fill in an appropriate form, have the form countersigned by the new doctor of their choice and return the form together with their Health Document to the Council;

ii. The person has been registered with the first doctor for a period of at least three months unless:

a. The change is required because of a change in the area of residence; or

b. Special permission has been obtained from the Council;

iii. The effective date of transfer shall be the day on which the person is accepted on to the practice list of the new doctor.

2.7. No person shall be allowed to change their doctor more than two times in any twelve month period unless special permission is obtained from the Council.

2.8. Doctors may have any person removed from their list by informing that person or requesting the Council to do so. The removal shall take effect on the date of registration with another doctor or on the eighth day after the Council receives the request for removal whichever occurs first.

i. If the doctor is at the date when requesting the removal treating the person at intervals of less than seven days, the doctor shall be obliged to inform the Council of such fact. The removal shall take effect on the eighth day after the Council receives notification from the doctor that the patient no longer needs such treatment or upon acceptance by another doctor, whichever occurs first.

ii. Doctors may not request to have any person removed from their list within three months of the date of acceptance or allocation of such patient on to their list, unless special permission is granted by the Council.

2.9. The Council will allocate a doctor to any person who is not on the practice list of any Scheme doctor having regard to:

i. The distance between the person's residence and the practice premises in the area;

ii. Whether within the previous six months the person had been removed from the list of any doctor in the area at the request of the doctor;

iii. Such other circumstances, including those concerning the doctors in the area and their practices as the Council thinks relevant;

iv. The opinion of the doctor to whom the patient is to be assigned.

2.10. The Council shall have the power to assign a person to a doctor in the rare situation where every eligible doctor refuses such person, provided that every effort shall have been made to resolve the situation by a process of dialogue with the doctors.

i. The Council shall have power to exempt from the liability to have persons assigned to them under this regulation any doctors who apply to the Council for that purpose and in considering such an application shall have regard to the doctors' age, state of health and the number of persons on their list.

3. Eligibility of Doctors

All doctors registered with the Medical Council of Malta shall be eligible to join the Scheme with the exception of those holding certain high positions within the Department of Health, those holding specialist posts within the Department of Health or those working in a specialist capacity in the private sector[1]. For this purpose, those falling within this accepted category, will have to declare to the F.D.S.C. whether they opt to dedicate themselves exclusively either to their speciality or to family practice. Amendments to existing legislation will be enacted to provide for a Specialist Register.

Ideally doctors engaged in the Scheme should be medical practitioners with appropriate training in Family Medicine. To date such specific training has not been available in Malta. While it has to be recognised that our medical school has produced some of the finest doctors, many of whom are currently in general practice, it has to be appreciated that the undergraduate training of doctors does not provide them with sufficient orientation and knowledge on matters that relate to primary health care to make them adequately prepared for

[1] vide Appendix 1

work in general practice. Recent developments in this field have been so vast and widespread, attitudes and beliefs have changed so radically, that orientation and specific training in the field is considered essential. Steps in this direction have already started within the University with the introduction of a general practice module within the undergraduate curriculum and the running, in conjunction with the University of Toronto, of a postgraduate programme for a small group of doctors in 1987/88. It is hoped that this movement is continued. Meanwhile, in order to ensure that doctors who are already in practice have upgraded their knowledge and skills, the F.D.S.C. will advise them to take an appropriate refresher/orientation course within two years of joining the Scheme; such course to be organised by an academic body recognised by the Family Doctor Scheme Council.

Every effort shall be made such that new graduates from our medical school have the orientation referred to above and also that appropriate postgraduate training courses shall be developed such that in the future all doctors will only be eligible to join the Scheme if they have completed such training. The need for the continuing upgrading of knowledge, skills and attitudes is also considered to be of paramount importance and special considerations are made to this fact within the Scheme.

The number of doctors that shall be eligible for work within the Scheme shall be open at all times. Initially the age of a practitioner shall not constitute a determining factor for eligibility, though it is envisaged that as the Scheme matures an age limit of 65 years shall be introduced for doctors working within the Scheme.

Regulations

3.1. Doctors, to be eligible to engage in the Scheme, shall have to be licensed to practice medicine in Malta.

3.2. Doctors shall be accepted on the Family Doctor List to be held by the Council and deemed to be eligible for work within the Scheme provided that they:

i. are in a position to complete within two years of joining the Scheme an appropriate refresher/orientation course organised by a recognised academic institution;

ii. do not practice medicine in a specialist or consultant capacity.

iii. are not in full-time employment with the Department of Health in certain grades or positions

iv. are in a position to fulfil the terms and regulations of the Scheme.

3.3. Following such closing date as may be determined by the Council for the initial enrolment of doctors, doctors over the age of sixty five years shall not be eligible.

3.4. At such time when specific postgraduate training in general practice is available, only doctors who have satisfied the Council that they have completed such training will be eligible to join the Scheme; the date on which this provision becomes effective to be determined by the Council in consultation with the medical academic institutions.

3.5. Doctors engaged in the Scheme will continue to be eligible for work in the Scheme as long as they:

i. fulfil their obligations in terms of the conditions of service as determined on the day of initial engagement within the Scheme or as subsequently amended;

ii. maintain full registration with the Medical Council of Malta;

a. Any practitioner working in the Scheme who ceases to be a registered medical practitioner shall ipso facto cease to be eligible for work within the Scheme and where at any time any practitioner's registration with the said Council is suspended, that practitioner's eligibility for work within the Scheme shall likewise be suspended.

b. When a practitioner's registration is suspended, the Council shall take action in terms of paragraph 3.6 and when it is restored in terms of paragraph 3.7 of these regulations.

iii. fulfil such criteria related to postgraduate continuing medical education as the Council in consultation with the relevant academic bodies shall from time to time determine;

iv. fall within the age limits as follows:

a. doctors who on the date of initial engagement at the launch of the Scheme are aged 60 years or more, shall be eligible for work within the Scheme for a maximum period of five years from the date of engagement;

b. doctors who on the date of initial engagement at the launch of the Scheme are aged less than 60 years as well as doctors who engage within the Scheme at a date subsequent to the date of launch of the

Scheme, irrespective of their age at joining, shall be eligible for work within the Scheme until their 65th birth-day.

3.6. When the Council is satisfied that a doctor on the Family Doctor List has been suspended by the Medical Council of Malta, it shall:

i. remove the doctor's name from the Family Doctor List,

ii. make arrangements for securing the treatment of persons on the practice list of that doctor; and/or

iii. give notice to the persons on the practice list of the doctor, that the doctor is for the time being unable to carry out those obligations under the terms of service.

3.7. In order to rescind any arrangements made under 3.6 above, doctors have to submit to the Council a report confirming their re-inclusion in the register of the Medical Council of Malta.

3.8. The Council may deduct from the doctor's remuneration in part or in whole the cost of any arrangements made under paragraphs 3.6 and 3.7.

4. Doctors in Full-Time Employment

Ideally doctors who work as principals in the Scheme will not hold other full-time positions as it is not considered possible for these doctors to fully satisfy their obligations in the Scheme and the terms of service of their other employment concurrently. It is appreciated that to impose this from the start of the Scheme would create a significant problem for those doctors presently holding a full-time post with Government or any other agency, as many will not want to give up the security of their present job for a less known future within the Scheme. It is therefore the intention of Government to make an allowance in this regard in order to ensure the smoothest transition from the present set up. To start with in order to help the doctors decide whether to join the Scheme and resign their full-time post, there will be a time interval between the enrolment of doctors, the registration of patients, and the actual onset of the Scheme such that these doctors will know the number of patients intending to join their list and thereby make projections as to their prospects within the Scheme. Moreover doctors presently holding a full-time post with Government or any other agency will benefit from a transitory clause enabling them to join the Scheme as principals, solo or in partnership, as long as they opt to do so *at the start of the Scheme*. Such doctors will be expected to make a definite decision, within a

period of time, as to whether they want to dedicate themselves fully to work within the Scheme or with Government. These doctors will be allowed to have a limited number of patients registered with them, as described in the regulations. They will have to satisfy the F.D.S.C. that adequate arrangements have been made for the care of their patients during those times that they are away from their practice. These doctors will also have to satisfy the Council that they are personally available to their patients for a minimum number of hours per week as defined in the regulations. It has to be understood that, in the case of these doctors, their joining the Scheme must in no way prejudice the discharge of their contractual obligations and duties in the Government service.

After the closing date for initial registration of doctors, doctors in full-time employment with Government or any other agency will only be able to work in the Scheme in association with other principals. These doctors will only be allowed a maximum of 600 patients and will also have to devote a minimum number of hours to the care of their patients. They too, will be expected to make a definite decision as to whether they want to dedicate themselves fully to work within the Scheme or work with Government within a period to be agreed upon.

Regulations

4.1. Any eligible doctors joining the Scheme at its beginning, who concurrently hold a full time position with Government or any other agency, shall be able to hold both positions as for the time interval as follows:

i. any eligible doctors having a list size of less than 600 people shall be able to hold both positions for a maximum period of three and a half years, when they shall have to decide whether they want to dedicate their whole time for work within the Scheme or to continue full time with Government or any other agency.

ii. any doctors who for an aggregate period of six months have a list size greater than 600 but less than 900 people, shall be able to hold both positions for a maximum period of two and a half years, when they shall have to decide whether they want to dedicate their whole time for work within the Scheme or to continue full time with Government or any other agency.

4.2. Any eligible doctors, who have a full-time appointment with Government or any other agency, joining the Scheme after the closing date for initial registration of doctors, shall be able to hold both positions for a maximum

period of two years, as long as their practice list size within the Scheme does not exceed 600 people for an aggregate period of more than six months.

4.3. In all the above cases, doctors must give a six months' notice, in advance, of their decision to opt out of their full-time employment with Government or any other agency.

5. Enrolment of Doctors

Regulations

5.1. All doctors in general practice will be invited to indicate their intent to join the Scheme such that their name can be entered into the Family Doctor List to be established by the Family Doctor Scheme Council.

5.2. Any doctors eligible to enter the Scheme in accordance with the provisions set out above will apply in writing to the Council and fill in all the details in an application form that the Council may provide.

5.3. The doctors will be informed by the Council with respect to their inclusion on to the Family Doctor List held by the Council.

6. Terms of Engagement

The relationship between doctors in the Scheme and the Family Doctor Scheme Council shall be a contractual one. Such contract shall be for a five year period automatically renewed unless there is an explicit written notice to the contrary and without prejudice to the health care providers' right to claim review of remuneration in the interim period. It has to be stated that the Family Doctor Scheme Council will need to have a clear, just and sufficient reason to terminate the contract, while no such reason has to be given by the doctor concerned.

On contracting to work in the Scheme doctors will take on the responsibility for providing continuing primary health care to all the patients registered with them. They will agree to render to all their patients, all necessary and appropriate personal medical services of the type usually provided by general medical practitioners; they shall do so at their practice premises or at the patient's home if the condition of the patient so requires. They shall also act

as a source for health education, health promotion and other preventive measures for all matters that relate to health. Family doctors working in the Scheme shall make themselves physically available to provide care to their patients for a reasonable minimum number of hours during the day and the week as defined in the regulations. In addition to this, doctors shall be responsible for ensuring the provision of adequate medical coverage for their patients at other times when they shall not be personally available.

It shall be the duty of doctors working within the Scheme to keep proper records of all consultations with patients. These records are to be kept on special forms as supplied by the Council, follow the patient in the event that the patient decides to change doctor and shall at all times remain the property of the Council.

Finally doctors shall not accept any payment for services, covered by the Scheme, rendered to individuals who are registered as patients on their list.

Regulations

6.1. Where a decision whether any and if so what, action is to be taken under these terms of service requires the exercise of professional judgement, a doctor in reaching that decision shall not be expected to exercise a higher degree of skill, knowledge and care than family doctors as a class may reasonably be expected to exercise.

6.2. A doctor's patients shall be defined as:

i. persons who have applied and are recorded by the Council as being registered on that doctor's list;

ii. persons who have been assigned to that doctor's practice list under regulations 2.9., and 2.10. above;

iii.persons in relation to whom the doctor is acting as deputy of an other doctor under these regulations.

6.3. Doctors shall not otherwise than by virtue of the provisions of these regulations, demand or accept a fee or other remuneration for any treatment under these terms of service, which they give to the person for whose treatment they are responsible under paragraph 6.2 except:

i. from any statutory body for services rendered for the purpose of that body's statutory functions;

ii. from any body or employer for a routine medical examination of persons for the purpose of advising the body or employer of any administrative action they might take;

iii. when doctors treat a patient under paragraph 6.4, in which case, doctors shall be entitled to demand and accept a reasonable fee (recoverable under paragraph 6.5) for any treatment given provided they give the patient a receipt;

iv. for issuing any certificate other than those listed in paragraph 6.19.

v. for services given to patients on their list when such services are requested and given outside the contractual hours;

vi. for services given to patients on their list or that of a partner, when such services are given to the patient at a place more than three miles away from the patient's registered address;

vii. for services given to patients not on their list or that of a partner

6.4. If a person applies to a doctor for treatment and claims to be on the doctor's list but fails to produce the medical registration document and the doctor has reasonable doubts about that person's claim, the doctor shall give any necessary treatment and shall be entitled to demand and accept a fee under paragraph 6.3.iii.

6.5. If a person from whom a doctor received a fee under paragraph 6.4 applies to the Council for a refund within 14 days of payment of the fee and the Council is satisfied that the patient was on the doctor's list, the Council may recover the fee from the doctor by deduction from the doctor's remuneration or otherwise and shall repay it to the patient. The doctor shall be informed of any action to be taken by the Council.

6.6. Doctors shall, unless prevented by an emergency, attend and treat any patient who attends for the purpose at the places and during the hours for the time being approved by the Council under paragraph 6.9. Doctors may defer a patient's request for a consultation provided that the patient's health would not thereby be jeopardised and the patient is offered an opportunity for such consultation within a reasonable time having regard to all the circumstances. Doctors shall take all reasonable steps to ensure that a consultation is not so deferred without their knowledge.

i. Any consultation so deferred shall be considered to be covered by these terms of service, irrespective of the time at which it is carried out, in which case the provisions of paragraph 6.3 shall apply.

ii. Doctors shall be held liable to a charge, equivalent to 25% of the basic capitation fee payable in respect of that patient, if any consultation so deferred shall have to be covered by the extra-contractual cover provided by Government through the health centres.

6.7. A doctor is responsible for ensuring the continuous provision for the patients, of the services referred to above throughout the period during which the doctor's name is included in the Council's Family Doctor List.

i. The times during which doctors are expected to provide cover for their patients shall be between 08.00 hrs and 20.00 hrs from Monday to Friday and 08.00hrs and 13.00 hrs on Saturday, or any other times as may be agreed between the Council and the medical association.

6.8. Doctors whose name is included in the Council's Family Doctor List shall:

i. normally be available at such times and places as shall have been approved by the Council;

ii. obtain the approval of the Council to the places where and the times during which they are available for consultation and to any changes in them;

iii. inform their patients about their availability by displaying a notice at their practice premises or sending notices to them, about the times and places at which they are available.

6.9. The Council shall not approve any application submitted by doctors in relation to the times they are to be available unless it is satisfied that the times proposed by a doctor with an average list size, are such that:

i. Doctors will as a minimum normally be personally available to their patients for consulting:-

a. in 46 weeks in any period of twelve months;

b. on 5 days in any such week.

c. for a minimum of 50 hours in any such week; such hours to include time spent in office/clinic consultations, home visits and, in hours of coverage for their patients during those times as specified in paragraph 6.7.i or as may be amended.

ii. The hours for which doctors will normally be available in any one week are to be allocated between the days on which they will normally be

available in that week in such a manner as is likely to be convenient to their patients.

6.10. Exemption may be made to paragraph 6.9 after application by the doctor to the Council. Such exemption:

i. shall not be given unless the doctor gives adequate reasons (e.g. small list size) for wanting this relief;

ii. shall not be given unless the doctor has been able to make satisfactory arrangements with another doctor or doctors for the treatment of patients during those times;

iii. shall not affect a doctor's responsibility for treatment requested but not given during the period when the doctor is responsible for service.

iv. shall not exceed half the minimum number of hours specified in paragraph 6.9 of these regulations.

6.11. The responsibility of doctors who are standing in for another doctor shall extend to the patients on the list of the doctor for whom they are deputising and shall include the duty to inform that doctor of any services which they have given to that doctor's patients.

6.12. Doctors shall take reasonable steps to ensure that a doctor, whom they propose to engage to carry out duties on their behalf, fulfils the eligibility criteria for working in the Scheme, and shall retain overall responsibility for the provision of service under the Scheme by the doctor acting as their deputy. However, doctors whose name is included on the Council's Family Doctor List, when acting as deputies to other doctors whose name is also included on the list, shall be responsible for their own acts and omissions in relation to the obligations under these terms of service and for the acts and omissions of any person employed by them or acting on their behalf.

6.13. Doctors shall inform the Council, in advance, of any deputising arrangements, unless exceptional circumstance arise.

6.14. When doctors propose to be absent from their practice for more than a week, they shall inform the Council, whenever possible in advance, of the name of the doctor or doctors responsible for their practice during their absence.

6.15. Doctors acting as a deputy may treat patients at places and at times other than those arranged by the doctor for whom they are acting, but due regard shall be had for the convenience of the patients. It shall be the duty of the

deputising doctor to inform the patient's regular doctor of the relevant clinical details arising from such consultations.

6.16 A doctor intending to engage in partnership/group practice with another doctor shall inform the Council of such intention within two months in advance of the date on which the partnership/group practice arrangement is to take effect.

i. The Council shall inform all persons on the practice lists of the doctors intending to engage in such arrangement giving notice of any changes in the times and places at which the doctors shall be available for consultation as well as the date on which the new arrangements are to take effect.

ii. The notice under the preceding paragraph shall also state that the person to whom it is given, shall be deemed to have remained on the practice list of the doctors specified in the notice as from the date so specified, unless not later than 14 days after that date, the person has chosen another doctor or given notice in writing to the Council not to be so included.

6.17. Doctors shall provide proper and sufficient accommodation at their practice premises having regard to the circumstances of their practice, and shall, on receipt of a written request from the Council, allow inspection of those premises at a reasonable time by a member or officer of the Council authorised by the Council for the purpose.

6.18. Doctors shall:

i. keep adequate records of any consultations they have with their patients on forms supplied to them for the purpose by the Council;

ii. as soon as possible on request, forward such records in a sealed envelope, to the Council, in the case of retirement, resignation or withdrawal, for whatever reason, of the doctor from the Scheme, or in the case where the individual decides to change doctor.

iii. within 14 days of being informed by the Council of the death of a person on their list and in any case not later than 28 days of otherwise learning of such a death, forward the records relating to that person to the Council, in a likewise sealed envelope.

iv. The Council is to take all the necessary measures to ensure confidentiality of these records.

6.19. Doctors shall issue for their patients free of charge the following certificates:

a. to support a claim or obtain payment either personally or by proxy under the Social Security Act,

b. to enable proxy to draw benefits under the Social Security Act,

c. to prove inability to work or incapacity for self support for the purposes of the Social Security Act,

d. to establish pregnancy for the purpose of obtaining welfare benefits,

e. to establish fitness to receive anaesthesia,

f. to establish unfitness to attend for examination by a medical board,

g. to support late application for or notification of non-availability to take up employment owing to sickness,

h. to support application for school entry, and in respect of absence from school due to illness,

i. to certify immunisations carried out by them in terms of the conditions set out in the Prevention of Disease Ordinance,

j. notifications to Government required in terms of health legislation.

6.20. Doctors shall order by issuing a prescription on a form provided by the Council, order any medication that is needed for the patient's treatment. They shall also issue any prescriptions that may be necessary for the procurement of free drugs. The doctors shall themselves sign the prescription form in ink in their own handwriting and not by means of a stamp, and shall so sign only after particulars of the order have been inserted in the prescription form. Doctors shall only use such form in the course of treating persons to whom they are providing treatment under these terms of service.

6.21. Where it appears to the Council that doctors are incapable of carrying out their obligations under these regulations because of a chronic incapacitating physical or mental disability, the Council may require a medical report by a suitably qualified doctor as to such aspects of the incapacitated doctors' health as the Council may specify. The Council shall then appoint a medical board to advise it on a decision.

6.22. Where the Council is satisfied after receiving the advice of the medical board that because of such physical or mental disability a doctor's obligations under these regulations are not being adequately carried out shall:

i. remove the doctor's name from the Family Doctors List held by the Council;

ii. make arrangements for securing the treatment of persons on the list of that doctor and inform them accordingly.

6.23. In order to rescind any arrangements made under 6.22 above, doctors may be required by the Council to submit a report by a suitably qualified doctor as to such aspects of their health as the Council may specify.

6.24. The Council may deduct from the doctor's remuneration in part or in whole the cost of any arrangement made under paragraph 6.22.

6.25. Where doctors, for any reason, intend to retire from the Scheme, they shall inform the Council of such intention by not later than six months before such retirement date is to take effect.

6.26. The F.D.S.C. shall, on the death or on the removal from the Family Doctor List of a doctor, give to the persons on the practice list of the doctor, notice of their right to apply to another doctor on the Family Doctor List for acceptance.

6.27. Where a successor is appointed to a practice, the F.D.S.C. shall notify to the persons on the practice list of the doctor who last carried on that practice, the name and address of the successor, and the names and addresses of any partners.

i. When the doctor retiring from the Scheme forms part of a group practice or partnership, the partner or partners of the out-going doctor shall be deemed to be the successor or successors to the practice list, and the persons on the practice list of the retiring doctor shall be accordingly notified.

6.28. The notice under the preceding paragraph shall also state that the person to whom it is given shall be deemed to be on the practice list of the successor specified in the notice, as from a date so specified, unless not later than 14 days after that date, that person has chosen another doctor or given notice in writing to the Council not to be so included.

7. THE DOCTORS' WORKLOAD

The size of doctors' lists is a conditioning factor to their ability to deliver satisfactory care and at the same time fulfil their role as a healer, counsellor and teacher in the primary health care field. It is the design of the Scheme not only to

provide the people with high quality primary health care but also to allow doctors sufficient time off their practice, such that they can further their education and spend more time with their families thereby improving their professional abilities and their quality of life. It is for all these reasons that the Scheme envisages the phased introduction of appropriate limits to the size of a practice as basic and accepted criteria to achieve good quality care. On the basis of this, family doctors will be requested to comply with regulations by joining a group, or by engaging the services of an associate.

Doctors will be initially allowed to enrol all individuals who express the desire to join their list. However, patients will learn to appreciate that the busiest doctors, unless adequately supported, may not be able to offer them the comprehensive care planned by the Scheme. In such cases, patients may, of their own accord, eventually move to smaller practices.

Although doctors can join the Scheme with any number of patients, they will be required to accrue a list of not less than three hundred patients to be accorded the status of principal.

Regulations

7.1. Doctors who join the Scheme on the day of its launch will have no upper limit to the number of persons whose health care needs they can look after except for as provided below:

i. by the end of the first year of operation of the Scheme, those doctors wanting to look after more than 3,000 persons, will be able to do so provided they engage the services of another doctor to help them out with their workload;

ii. by the end of the second year of operation of the Scheme, those doctors wanting to look after more than 2,500 persons, will be able to do so provided they engage the services of another doctor to help them out with their workload;

iii. by the end of the third year of operation of the Scheme, those doctors wanting to look after more than 1,700 persons, will be able to do so provided they engage the services of another doctor to help them out with their workload.

iv. doctors who are in continuous full-time employment with Government at the start of the Scheme will only be allowed to look after a

maximum of 900 persons or less for the time interval as determined by paragraph 4 of this document.

7.2. In the event of principals finding themselves looking after more persons than allowed by 7.1 above, they will have to take on the services of an associate, engage a partner or shed the excess patients.

7.3. Doctors who join the Scheme subsequent to the closing date for initial application to participate in the Scheme, will be able to offer services to more than 1,700 persons, provided they engage the services of another doctor to help them out with their workload.

7.4. Doctors who on the closing date for initial registration of persons within the Scheme are looking after less than 1,700 persons, will be able to offer services to more than 1,700 persons, provided they engage the services of another doctor to help them out with their workload.

7.5. Doctors referred to in 7.1., 7.3. and 7.4. above will not need to engage the services of another doctor to help them with their workload, if the increase in their practice list size is due to:

i. children born to parents registered within the practice;

ii. where one member of a family is registered outside the practice, transfer of registration of such member on to the saturated practice list such that the whole family becomes registered within the same practice, will be permissible after written approval from the Council, such approval not to be unreasonably withheld.

7.6. Doctors who join together to form a group practice shall be allowed to look after a number of patients equal to a multiple of the number of doctors by the maximum list size permissible at the time.

7.7. Doctors who engage the service of an associate to help them out with their workload, will be allowed to look after 40 people more than stipulated in the above regulations for every hour of work performed by the associate.

7.8. Doctors who do not follow the guidelines detailed in the above regulations will have the payments due, in respect of the excess number of persons on their practice list, stopped if they do not remedy the situation within three months of being notified by the Council of such excess.

7.9. The size of a doctor's practice list shall remain confidential at all times.

8. PARTNERSHIP FORMATION

It may at times be necessary for single-handed solo practitioners to join with another doctor either because they are looking after more patients than allowed by paragraph 7 above, or, it may indeed be the case that two doctors join forces in order to reap the benefits of working as a team. It is outside the scope of this document to go into the possible terms of engagement between the two doctors, though no doctor will be able to form a partnership unless such partnership is approved by the Family Doctor Scheme Council; approval shall be granted as long as the following guidelines are followed.

Regulations.

8.1 Doctors joining a partnership shall have to be enrolled as a principal within the Scheme.

8.2. Any two or more doctors working as solo practitioners with a practice list size of at least 300 persons each, shall be able to form a partnership.

8.3 Doctors whose list size is above the maximum permissible number, as defined in paragraph 7, shall be able to take on a partner as long as the average number of persons the partnership will be looking after does not exceed the number permissible for a solo practitioner.

8.4. In situations where there is a large discrepancy in the list sizes of partners, it would be desirable if any new persons wanting to register within such partnership were registered with the doctor having the smaller list.

8.5. Once a partnership is formed, persons registered with the doctors within that partnership, can see any one of the doctors if they so wish, though it would be advisable for people to keep to the same doctor.

8.6 Any payments due to the doctors in respect of any persons registered within a partnership shall be forwarded by the Family Doctor Scheme Council in the name of the partnership.

8.7. The Family Doctor Scheme Council shall have no business to interfere in the financial arrangements made between the partners.

9. EMPLOYMENT OF AN ASSOCIATE

All principals within the Scheme shall be able to employ associates, though the number of hours the associate will be allowed to work for, will be related to the size of practice of the employing doctor. For those doctors who are looking after more patients than permitted by paragraph 7 above, employing an associate will allow them to have a list size greater than the maximum permissible number by forty persons for every hour of work performed per week by the associate.

Associates shall not be considered to be principals in the Scheme, though they will be allowed to register persons with them. Once they become personally responsible for the care of 300 persons, they will then be accorded the status of principal, giving them the right to negotiate a partnership agreement with the employing doctor.

The associate will be expected to undertake the normal range of duties in the practice usually undertaken by the employing doctor; however, the employing doctor will remain responsible for the actions and breaches in the terms of service of the associate doctor.

It shall be for the doctors between themselves to determine the terms of engagement, though any such agreement shall have to ensure:

i. minimum levels of remuneration as from time to time stipulated by the Family Doctor Scheme Council,

ii. a right for the associates to register persons in their own name during the period of employment,

iii. a provision enabling the associates to negotiate a partnership, once they have been accorded the status of principal.

The associate will have effective access to the Family Doctor Scheme Council for redress, should the conditions of employment, as stipulated in the agreement signed by the principal and the associate, fail to be honoured by the principal.

10. USE OF DEPUTIES

While it has been stated that doctors engaged in the Scheme shall be contracted to provide cover for their patients as stipulated in paragraph 6.7, it has equally been accepted that it will be most unreasonable to expect doctors to be physically available to their registered patients at all times. It shall therefore be necessary for doctors to engage the services of a deputy at times when they are not able to provide such cover for their patients, though they will be expected to do so for a specified period of time as detailed in paragraph 6.9 above. Such cover can readily be provided by mutual arrangements between doctors working in the Scheme. It shall also be necessary for the doctors to give details to the Council of any deputising arrangements they make, such arrangements to be made with a doctor eligible to work in the Scheme. No one doctor shall be responsible for the cover of more than 5,000 patients at any one time.

11. DOCTOR-PATIENT ENCOUNTER DATA

As described earlier patient-doctor contacts within the Scheme will be documented and reported on specifically designed forms supplied by the Council. The first type of such encounter forms will be known as the Patient Health Profile Form which will record all the patient details including past history, family history, social history as well as any current medication and allergies. This sheet will be filled in duplicate, one copy going to the Council for the compilation of a national morbidity database and the other copy will serve as a clinical database to be kept in the patient's medical record held by the doctor.

For any patient-doctor contact subsequent to the initial consultation, doctors, who so wish, will be asked to fill in a monthly encounter data sheet which will be known as the Monthly Encounter Form. On this form doctors will enter such details as the daily number of consultations, the daily number of home visits, and the disposition of the patient. The information collated centrally will form a database of utilisation statistics which will be of great help for evaluating the Scheme.

Measures, including legislative, will be taken to ensure the confidentiality of any medical information received by the Council.

It is appreciated that filling in these encounter forms will involve an extra degree of time and effort on the part of the doctors. Doctors will be compensated on an item of service basis for this work.

Regulations

11.1. Upon receipt of a person's registration form countersigned by the doctor of that person's choice, the Council will send to the doctor a set of records which will include in it the Patient Health Profile Form. This is to be filled in by the doctor and sent to the Council within one week of the patient's first visit to the doctor. At the start of the Scheme, Health Profile forms should reach the Council within three months of the date of onset of the Scheme.

i. Such encounter forms will only be issued on the initial registration of persons within the Scheme.

11.2. At the date of joining the Scheme, or at any subsequent date, doctors may inform the Council of their intent to submit the monthly encounter data forms.

i. Doctors who opt to submit this information to Council will be expected to do so within ten days of the end of the particular month and in any case not after two weeks from such date.

ii. Doctors who, after agreeing to submit such information, decide they no longer wish to do it, can stop submitting the information after giving Council notice in writing, three months in advance of the date they intend to stop.

11.3. Doctors will be paid for both the Patient Profile Forms and the Monthly Encounter Data Forms received by the Council; such payment to be made monthly except for those that are received later than the time stipulated in paragraphs 11.1 and 11.2 above.

11.4. No payment will be made for any forms that are inappropriately or illegibly filled in by the doctor. Such forms will be returned to the doctor concerned for the necessary corrections.

11.5. The authenticity of all Forms received will be the subject of checks by the Council.

12. EMPLOYMENT OF ANCILLARY STAFF

The aims of the Scheme are to promote primary health care delivery and as stated earlier in the document the primary health care team is the medium through which this care can be delivered effectively. It is with this in mind that the Scheme shall provide for the payment of ancillary staff to help the family doctors in carrying out their role. Through the Scheme, Government shall re-imburse any payment made by the family doctors for the employment of nurses and secretarial/reception staff. Of course resources are limited and while it would be ideal not to impose any limit to the amount of staff doctors can add to their teams, it is both the economic as well as the trained human resource constraints that necessitate this.

It is felt that all principals working in the Scheme should have the opportunity of eventually forming their own primary health care team, the size of this team being of course determined by the number of patients registered with the individual practitioner. Principal family doctors working in the Scheme will therefore be re-imbursed the expenses incurred in the employment of one person acting as a nurse and/or secretary/receptionist in their practice at the rate of one work-hour per week for every two hundred patients on their list.

The formation of group practices is another aim of the Scheme. In the case of group practices, the reimbursement of expenses will therefore be worked out at the rate of one work-hour per week for every hundred patients on the practice list, the practice list being taken to mean the sum total of the individual lists of the principals in the group. Moreover, such practices will be entitled for the reimbursement of any wages paid to both a secretary/receptionist as well as a nurse employed, provided that the group qualifies for the payment of the group practice allowance. Consideration will be given by the Council for the reimbursement of more staff in the case of large group practices (more than three partners).

The repayment scheme is not intended as an alternative to close working arrangement between family doctors and community nurses, midwives and other staff presently engaged with the Department of Health. It is hoped that such arrangement will be developed to the fullest possible extent and it is not expected that practitioners will engage staff to duplicate these services.

It is hoped that with the evolution of the Scheme, community nursing services currently being provided through the M.M.D.N.A. could be integrated

with the Scheme. This can take the form of nurse attachments to a family doctor or group of doctors working in a particular area. Although the nurses would still be employed with the M.M.D.N.A., their services would be related to the needs of the patients registered with the doctor/s they are attached to. Thus they too will come to form part of the health care team, their role being quite distinct from that of the practice nurse referred to above.

Regulations

12.1. This scheme provides for the direct reimbursement of expenses incurred in employing paid ancillary help to improve the overall running of the practice and thereby improving the quality of care given to patients.

12.2. The scheme applies only to staff directly employed and paid by the doctor or group. Payments will be made in respect of an appropriately trained employee, directly employed and paid by the doctor on a regular basis to carry out

i. nursing duties and/or
ii. secretarial / receptionist duties.

12.3. In the case of a single handed principal, payments will be made in respect of 12.2,i up to a maximum of 1 hour nurse-time per 200 patients registered with the doctor or in respect of 12.2,ii up to a maximum of 1 hour secretary/receptionist-time per 200 patients registered with the doctor.

12.4. In the case of a group practice, payments will be made in respect of both 12.2,i and 12.2,ii, up to a maximum of 1 hour of nurse/secretary/receptionist time per 100 patients registered with the doctors in the group, provided that the group is in receipt of the group practice allowance.

12.5. Payment under the scheme shall comprise reimbursement to cover:

i. the gross basic pay paid to the employee before deduction of income tax or national insurance contributions, if any, such pay not to exceed that determined by the F.D.S.C. on a basis of comparability to similar grades in the public sector;

ii. the gross national insurance contributions, if any, payable by the employer in respect of staff employed.

iii. the payment of any statutory bonuses or proportion thereof

iv. the pro-rata payment of any wage increases introduced by the Government

12.6. Before being entitled to a reimbursement of the said payments, a doctor must apply to the Council for the approval of the proposed appointment. Any such application must include:

i. the number of hours it is proposed that the employee will work,

ii. a copy of the proposed terms of employment between the doctor and the employee concerned,

iii. an authenticated copy of the employee's workbook.

12.7. In all cases, applications must reach the Council no later than fourteen days prior to the commencement of such employment. Likewise the Council is to be notified of any changes in the hours of work of the employee, any change of post holder or any proposed termination in the employment, no later than 14 days before the proposed changes are due to take effect; but in any case within 14 days of the occurrence of such event.

12.8. Following approval by the Council, claims for such reimbursement should be submitted quarterly within 10 days of the end of the quarter and will be payable at the beginning of the following quarter. Claims submitted later than within ten days of the end of a quarter will not be paid until the beginning of the next following quarter.

13. SICKNESS LOCUM ALLOWANCE

Family doctors like all other workers are entitled to vacation leave and are also likely to have periods of illness. As is the case with all other self-employed individuals, the independent contractor status that family doctors will enjoy does not entitle them to any allowances for vacation or sick leave. It shall therefore be necessary for doctors to make arrangements with colleagues for any such periods of absence. In situations of prolonged periods of absence, it may at times be necessary to employ a locum to look after the patients. Doctors will be well advised to make these arrangements with colleagues as part of a standing agreement between them, such that no difficulties will be encountered in periods of unforeseen urgent absence.

In situations of prolonged illness, the Scheme shall provide a sickness locum allowance in order to ensure the best possible care to patients during those periods when the family doctor is absent because of prolonged illness.

Regulations

13.1. Principals who are absent from their practice on account of sickness will receive their normal remuneration but in addition, and subject to the other provisions of this paragraph, they will be eligible to receive a special payment known as a Sickness Locum Allowance.

13.2. All principals working within the Scheme will be eligible for receipt of such payment.

13.3. The scale of payments will be that of twelve weeks' full payment with a possibility of a further twelve weeks' payment, if so decided by the Council, in any one calendar year.

13.4. No payment shall be made if the period of continuous incapacity does not exceed two weeks; in other cases payment will be made from the date on which the locum takes up duty.

13.5. Payment of such benefit will only be made where locums from outside the practice are actually and necessarily engaged.

13.6. It will normally be accepted that single handed principals will need to engage a locum whenever they are incapacitated; in these cases payment will normally be made for a locum outside the practice as follows:

i. payment for a Type I locum if the number of patients on the list of the incapacitated practitioner is 1,700 patients or more;

ii. payment for a Type II locum if the number of patients on the list of the incapacitated practitioner is 900 patients but less than 1,700 patients;

iii. payment for a Type III locum if the number of patients on the list of the incapacitated practitioner is less than 900 patients.

13.7. Doctors working in groups will be expected to stand in for each other as far as possible and payment will normally be made for a locum from outside the practice only where the incapacity of one partner leaves each of the others with an average number of patients as follows:

i. payment for a Type I locum will be made if the resulting average number of patients on the remaining partners' list is 2,300 or more patients each;

ii. payment for a Type II locum will be made if the resulting average number of patients on the remaining partners' list is 2,000 or more patients each;

iii. payment for a Type III locum will be made if the resulting average number of patients on the remaining partners' list is 1,700 or more patients each;

iv. no payment will be made if the resulting average number of patients on the remaining partners' list is less than 1,700 patients each.

13.8. Payments of any benefit will be subject to the submission of medical certificates to the Council, covering the period from the first day of absence and on the understanding that practitioners will not engage in conduct which is prejudicial to their recovery or which is contradictory to their state of ill-health.

13.9. Payment will also be subject to the condition that doctors agree, if requested by the Council, to submit themselves to examination by a doctor nominated by the Council for that purpose, and agree to the opinion of the examining doctor being conveyed to the Council.

13.10. Locums will be expected to assume all the responsibilities of the doctor they are replacing in terms of these regulations.

13.11. Payments will only be made in respect of applications accepted by the Council. Accordingly when doctors wish to take advantage of this allowance, they should submit the necessary forms to the Council as soon as arrangements have been made for the engagement of a locum. The application must be covered by a medical certificate covering the period since the first day of absence from the practice. The Council will advise the doctors as soon as possible whether their application has been accepted. Where the application has been accepted, further certificates should be sent to the Council without delay. Where a practitioner is unable to submit an application personally, the Council may accept an application submitted on the doctor's behalf.

13.12. Claims for payment should be submitted on the appropriate form on resumption of duty or on the termination of engagement of the locum.

13.13. Doctors will lose their entitlement to the payment of this allowance if during the period of illness in question they engage in any other form of work.

14. SYSTEM OF REMUNERATION

As already described the system by which doctors engaged in the Scheme will be remunerated will be based on a formula of capitation, item of service and other allowances. The reason for choosing this mixture is based on an attempt to try and be as fair as possible to doctors, in such a way that their income shall reflect not only the extent of responsibility and the size of their patient list, but also the volume and quality of their work.

For each patient on their list, doctors will get a **basic capitation fee** which will be a retainer for future services to be given to patients and includes in its calculation factors such as administrative, transport and other overhead expenses that may be incurred by the doctor in the carrying out of his duties. The fixed basic capitation fee, which will vary with the age of the patient, guarantees the doctor a certain amount of income that is related to his responsibilities depending on the size and demography of his list; it also assures a steady income for the doctor and a fixed budget for the administration of the practice.

The **item of service payment** gives an additional income to the doctor which is directly related to the volume and type of his work. The workload is dependant on the size and demography of the doctor's list but at the same time can be determined by the initiative and commitment to patient care of the doctor. Payments for filling in the **Encounter Forms** will form part of the item of service fees.

It is thought pertinent to mention arrangements that have to be made for the treatment of temporary residents in Malta, not only because a substantial proportion of the population have a summer residence but also because of the high influx of tourists, a number of whom are entitled to free medical care under the terms of signed reciprocal agreements[2]. It is felt unfair to financially penalise the family doctor for any temporary movement his practice population makes in the summer months especially when he had been offering it a continuing service throughout the busier winter months. It would be highly desirable if for the sake of continuity of care these people shall continue to be looked after by the family doctor they are registered with. It is however unreasonable to oblige the family doctor to do this especially if the temporary residence is quite a distance away from the patient's normal place of residence. The onus should therefore fall on the individual himself who should at all times try to see his own family doctor for

2 vide Appendix 3

episodes of illness that occur while he is away from his normal place of residence. In the event that the patient is too ill to be able to go to see his doctor and a home visit is requested, while it will not be obligatory for the family doctor to respond to this request, this would be highly commendable. In this situation, the doctor will be allowed to charge the patient as fee according to a published schedule of fees payable for services rendered by private practitioners in conformity with the regulations stipulated in paragraph 6.3 above. If the patient's doctor or his deputy are unable to attend the patient, any local doctor can be called and he will be entitled to charge the patient an appropriate fee.

In the case of foreign patients, those of nationalities with whom Malta has no reciprocal agreement for health care, shall pay the doctor directly on a fee for service basis. In the case of tourists from the countries with whom such an agreement exists, they will be able to avail themselves of the emergency service that will be offered from the health centres. The Scheme doctors will be allowed to receive direct payment for services rendered; to any such patients who seek their professional advice. Foreigners who have the status of temporary or permanent residents will be treated like Maltese nationals.

In order to try and maximise total patient care by the family doctor as well as to reduce the workload on the hospital and therefore reduce patient waiting time, it is felt that certain minor surgical procedures can be done by the family doctor. The doctor on his part will be free to do or not do such procedures. The doctor will be able to charge the patient a fee for such a procedure. Half the fee paid by the patient will be reimbursed by the Council upon presentation of a receipt obtained from the doctor.

The third component of the doctors' remuneration will be made up of a series of allowances which are geared towards stimulating the doctor to provide good effective primary health care as well as keeping himself abreast with recent advances in his medical discipline. If the doctor can show that the quality of care he is giving his patients is of a sufficiently high standard, the doctor will be paid an additional amount of money in the form of a **Good Practice Allowance.**

The need for updating one's knowledge and keeping abreast with new developments in the field of medicine is also an important factor in determining the quality of care a doctor can offer his patients and for this reason a further allowance in the form of a **Continuing Medical Education Allowance** will be paid. Although adequate knowledge, willingness to work, appropriate training, and the right orientation are all basic essentials a doctor should have to perform

his duties properly, it is the experience in the field which comes on with time that gels these factors together. This experience will be reflected in the remuneration in the form of a **Seniority Allowance.** Experience and continuing education are complementary to each other in the formation of a good family doctor and therefore the payment of the seniority allowance will be dependant on the doctor qualifying for the continuing medical education allowance.

In many countries the trend in primary health care today is for doctors to join up in groups. Practical benefits of a group practice might include sharing the cost of premises and equipment and simplifying arrangements for daytime, night, week-end and holiday cover. However there are other benefits of group practice. Group practice allows the partners to develop special fields of interest, either in clinical areas or in education and research, and enables these new skills to be transmitted within the practice. In addition the easy accessibility to colleagues with whom to discuss personal and clinical problems, new techniques or methods of management is an important benefit. Working within a group creates an opportunity to form a health care team approach in patient management. The setting up of group practices is not only appealing to doctors; it generates the type of working environment conducive to good standards of patient care and it is because of this latter effect that a **Group Practice Allowance** will be paid to doctors who join up to work in group practices.

Group practices can take various forms ranging from a loose arrangement between a number of doctors and a fully established partnership where doctors do not only practice from a common centre but also share the profits and losses of the partnership. Before joining into a group/partnership the Family Doctor Scheme Council has to be informed of such intent such that the patients of the respective doctors can be informed. Once a group practice is established, the registration of patients shall remain with the individual doctor who is responsible for the primary health care of the patient. Doctors within the group will be able to see their partners' patients in acute illness, emergency situations and when the patient's doctor is busy or otherwise unavailable.

As has been highlighted before, for the Scheme to be successful there is a need to have appropriately trained personnel working within it. At present the medical school has already taken the first, albeit small, step in orienting the undergraduates to family medicine by attaching them to a family doctor for a period of four weeks. It is felt that the effort of these practitioners in the form of an **Undergraduate Training Allowance**. When in the future, specific training in family medicine at the postgraduate level becomes available, those practices

that qualify as a teaching practice and have a trainee attached to them, will similarly qualify for a **Postgraduate Training Allowance.**

One of the objectives of the Scheme is to improve the standard of premises in which family doctors work. The provision of care as contemplated by the Scheme is dependant on adequate premises from which such care can be delivered. One must however be realistic, and it is not to be expected that such changes will take place in a short time. Traditions are hard to break, the availability of suitable premises is scarce and building new, or upgrading existing, premises to be ready for the start of the Scheme, would involve an expense that economic constraints do not permit.

Premises that are to be used as a main office must ideally have the following features:

- ease of access to premises and ease of movement within them;
- a properly equipped consulting room for use by the doctor and also where appropriate by nurses and other members of the primary health care team;
- a properly equipped treatment room where provided;
- adequate lavatory and washing facilities, including a wash-hand basin in the consulting room;
- the premises, fittings and fixtures are to be kept clean and well maintained, with adequate lighting and ventilation;
- adequate security for records, drugs and other documents;
- adequate equipment for carrying out consultations and other procedures.

Although a number of these features can be found in a number of existing premises, it is only a small minority of doctors who have premises that possess all these features. As a first step, in an attempt to help doctors in this direction, the Scheme shall provide incentives in the form of a **Practice Premises Allowance** aimed at substantially reimbursing the expenses incurred in running and maintaining premises. In the future, once a clearer picture of the type and standard of existing premises emerges, due consideration will be given to a greater financial investment in this regard, and to the possibility of the introduction of a system of grants or soft loans for those doctors wanting to improve their premises. The possibility of renting, to doctors in the Scheme, any suitable Government owned premises will also be looked into.

It is fair to say that the expenses incurred in running and maintaining practice premises vary with the type, size, location of the premises and facilities offered, as well as with the size of practice list. These variables will form the basis for the calculation of the Practice Premises Allowance that each doctor will receive. The Family Doctor Scheme Council shall be responsible for the inspection and assessment of the adequacy of premises, and for determining the value of the allowance to be paid; its evaluation and decision being final.

It is reasonable to take also into consideration the fact that, in order to provide the services envisaged by the Scheme, doctors will also incur a recurrent expense in running and maintaining a car. For this reason principals working in the Scheme will also be paid a **Car Allowance** which will be divided into a fixed allowance, to cover some of the expenses incurred in maintaining a car, and a variable allowance which will be related to the number of patients on the doctor's list.

The payment of the aforementioned fees and allowances due to medical practitioners engaged in the Scheme shall be effected by the Family Doctor Scheme Council in accordance with such rates and subject to such conditions as the Council after approval of the Minister responsible for Health may determine. Proposals for any changes in the conditions and rates of payment shall be submitted by the Council for approval by the Minister. The nature and quality of such proposals shall be determined after consultation with such organisations recognised as representing doctors providing medical services within the Scheme.

Regulations

Capitation Fees

14.1. Doctors engaged in the Scheme shall be entitled to receive a basic annual capitation fee for each patient registered with them in accordance with the limits outlined in paragraph 7 of these regulations.

14.2. The value of the fee payable in respect of each patient will vary with the age of the patient.

14.3. As soon as possible after the beginning of each quarter, the Council will send to all medical practitioners on its list a statement showing:

i. the number of patients included on the first day of the quarter on their list, in each of the age groups in accordance with the capitation fee they attract;

ii. the number of patients added or subtracted from the practitioner's list in each of the age groups together with the reason for each addition and subtraction.

14.4. If the Council is satisfied, that a patient whose notice of acceptance by doctor which is received by the Council within two days of the start of the quarter was so accepted on or before the first day of that quarter, it will treat the patient as having been included in the list of the doctor, and removed from that of any other doctor, on the first day of the quarter.

14.5. Unless within ten days of receipt of the statement referred to in 14.3, doctors notify the Council that they dispute its correctness, the statement will be regarded as agreed by them and it will not be open for them subsequently to raise any objection to it or to any payment based upon it. If doctors do dispute the correctness of the statement, they will be required to submit to the Council any evidence that may reasonably be required to settle the dispute.

14.6. If a person chooses to leave a doctor's list in order to join another doctor's list at any time other than that defined in paragraph 14.4, the payment of the fee due for that quarter will be split pro-rata between the two doctors.

14.7. Basic capitation fees will be paid quarterly at 25% of the annual rates in respect of the patients included on the doctor's list on the first day of the quarter subject to the conditions defined in regulations 7.5 and 7.6.

14.8. The sum payable for each quarter may be subject to adjustment in respect of payments after due consideration is given to changes made in terms of 14.6 above.

Fee for Minor Surgery

14.9. A fee for minor surgery will be payable by the patient to doctor on the Family Doctor List of the Council who carry out a minor surgical procedure for any patient on their personal list or the personal list of their partners within a group practice.

14.10 Doctors will be obliged to supply the patient with a receipt for any payments made, such payment to be partly re-imbursed to the patient at the rate of 50% of the total amount paid to the doctor, on presentation of such receipt to the Council.

14.11 The following procedures will count towards eligibility for part re-imbursement of the fee payable to the doctor:

intra-articular injection
peri-articular injection
aspiration of joints
aspiration of cyst
aspiration of bursae
aspiration of hydrocele
incision of abscess
incision of cyst
incision of thrombosed pile
excision sebaceous cyst
excision of lipoma
excision of skin lesions
removal of toe nails
cautery of warts and verrucae
removal of foreign body (not eye)
suturing of wounds.

14.12. The authenticity of claims will be the subject of checks by the Council with patients.

Good Practice Allowance

14.13. Any doctor working within the Scheme who has a practice list size of not less than 600 patients and not exceeding the maximum permissible number of patients may apply to the Council for consideration for receipt of this allowance.

14.14. The value for this allowance shall only be payable to those doctors who, after having their practice assessed by an accreditation panel, are certified as being so eligible. The accreditation panel shall be composed of a member of

the Council, a representative of the Malta College of Family Doctors and a representative of the Institute of Health Care of the University.

14.15. The allowance will be payable annually subject to certification.

14.16. Certification by the accreditation panel referred to in paragraph 14.14. shall be valid for a period of no longer than two years, after which time re-certification will be necessary to establish the doctor's continued eligibility for the allowance.

14.17. In order to qualify for eligibility, doctors who apply to be considered shall have to show that:

i. they are in receipt of the Continuing Medical Education allowance;

ii. they have not over the preceding two years been found guilty of a breach of their terms of service;

iii. they have strived to maintain a relatively static practice population;

iv. they have maintained a good standard of record keeping;

v. they are working within a framework of a primary health care team approach to patient care;

vi. they make appropriate use of back-up facilities and referral to secondary care;

vii. they communicate well with and maintain a good relationship with other professional colleagues and patients;

viii. they have a good administrative set-up within their practice.

14.18. In the case of a group practice, each doctor within the group shall be eligible for this allowance, as long as each doctor applies for accreditation and the practice is in receipt of a group practice allowance. In relation to paragraph 14.13., for doctors within a group practice to qualify, the average number of patients within the group shall have to be no less than 600 and no more than the maximum permissible number of patients.

<u>Continuing Medical Education Allowance</u>

14.19. Medical practitioners will be paid an allowance if they can satisfy the Council that they have attended at least 25 hours of accredited postgraduate education spread reasonably over a period of twelve months from the start of the Scheme and an equal period thereafter.

i. The refresher/orientation course referred to in paragraph 3.2,i shall be equivalent to 10 hours accredited education for the purposes of eligibility for the allowance.

14.20. Courses will be considered accredited if so approved by the Council acting upon the advice of the Malta College of Family Doctors and the Postgraduate Medical Committee of the Faculty of Medicine at the University.

14.21. Unpaid individual clinical attachments under consultant supervision and supernumerary to establishment may be accredited by the Council to count towards the allowance.

14.22. Claims for such an allowance can be made on special forms obtainable from the Council and are to be accompanied by documentary proof of attendance.

14.23. Claims may be made at any date following fulfilment of the conditions described in 14.19. above and the allowance will be paid for the following twelve month period.

Seniority Allowance

14.24. In the first two years of operation of the Scheme, payment of this allowance will be made to each doctor working in the Scheme. After two years from the onset of the Scheme, this allowance will only be payable to doctors with practice list sizes exceeding 300 patients.

14.25. Only doctors in receipt of the Continuing Medical Education Allowance will be eligible for the payment. This shall not apply in the first twelve month period following the launch of the Scheme.

14.26. The payment shall be related to the number years of registration with the Medical Council of Malta up to a maximum of twenty years, at which time the payments shall cease to increase.

14.27. For the purpose of determining the number of years a doctor has been registered the following provisions shall apply:

i. Registration by the Medical Council of Malta will count from the date of registration as shown in the Register of the said Council.

ii. The F.D.S.C. may allow a doctor to count registration from the date of full registration by an overseas authority by virtue of any qualification recognised or accepted by the Medical Council of Malta. A practitioner wishing to count from the date of registration overseas will be asked to produce documentary evidence of the overseas registration, and of having been granted registration by the Medical Council of Malta on the basis of the qualification by the virtue of which he obtained the overseas registration.

iii. a period during which for disciplinary reasons a doctor's name has been erased or has been suspended from the Register of the Medical Council of Malta or of any other authority with whom registration has been accepted by the F.D.S.C. for seniority purposes shall not be counted as a period of registration, but periods of registration immediately before and after the period of erasure or suspension may be aggregated.

14.28. Applications for the payment of such an allowance should be made annually to the Council on the special forms supplied for the purpose and shall be paid in four equal instalments at the beginning of each quarter.

Group Practice Allowance

14.29 Doctors practising as members of a group shall be eligible for the payment of this allowance if the group they belong to fulfils the following criteria:

i. except for as provided in 14.30., a group must consist of no fewer than three family doctors practising within the Scheme who are in partnership and whose average list size is not less than 600 patients per practitioner;

ii. except for as provided in 14.31., all members of the group must work in close association from a main office even if they sometimes also work at branch offices

iii. a group must provide adequate off-duty and holiday relief for each member;

iv. a group must employ help, to the extent of at least the equivalent of one full time person on secretarial or receptionist duties; full time employment being taken to mean a minimum of 40 hours a week. They must also employ a nurse for a number of hours in proportion to the aggregate list size.

14.30. In the case of some areas, where the potential number of patients does not support more than two doctors, the Council may decide for the payment of the allowance.

14.31. Until such time as group practices establish themselves into premises large enough to be adequate for the needs of a group practice , the allowance shall still be payable as long as the Council is satisfied that the members of the group are actively seeking to remedy the situation.

14.32 Where members of a group in receipt of the allowance, cease to fulfil the conditions for payment because one or more members leaves the group, payment of the allowance to the other members will be continued for a period of 6 months from the date on which they cease to fulfil the conditions, provided that the Council is satisfied that the remaining members are actively seeking to remedy the situation.

14.33. Claims for the allowance should be made to the Council on the appropriate form supplied by the Council. Payment of the allowance will be made in four equal instalment at the beginning of each quarter.

Undergraduate Training Allowance

14.34 Any practitioners who assist the University in the teaching of undergraduate medical students by giving them experience of general practice in their own practice, will be eligible for a fee based on the number of students involved and the time they spend in the practice provided that:

i. the medical school has arranged with the practitioner for the training;

ii. the University confirms that the training has taken place

14.35. Practitioners who satisfy the conditions set in 14.34. above may claim a fee for each student for each period of attachment to the practice. The time spent attached to the practice will mean, time spent in the practice in education or training in the provision of primary health care services, including where possible observation and instruction in the work done by the members of the practice team.

14.36. A period of attachment shall consist of at least two weeks of such activities. No more than two periods per student can be claimed in respect of a twelve month period.

14.37. Only one practitioner can claim in respect of any time spent by a student in a group practice and this should normally be the practitioner with whom the medical school has arranged the attachment.

14.38. Claims for the allowance should be submitted on the special form provided by the Council. The claim should be accompanied by written confirmation from the University that the students were in fact attached for the period specified in the claim. The practitioner will be responsible for obtaining this written confirmation.

14.39 Payment of the allowance shall be made at the beginning of the quarter immediately following the receipt of the claim form.

Practice Premises Allowance

14.40. All principals will be eligible to receive payment under this paragraph

14.41. The premises may constitute a separate unit, or form part of a residence or pharmacy, and may be rented, or owned by the doctor or a close relative of the doctor.

i. In all cases where the premises are rented or owned by a close relative of the doctor, they will be treated for the purposes of this paragraph as if they were rented or owned by the doctor himself.

ii. For the purpose of this paragraph, separate premises will be taken to be self-contained premises used only for practice purposes.

iii. The provisions of this paragraph will apply to the main practice premises shown, in the medical list held by the Council, to be those at which advertised consulting sessions are held; premises used for the occasional consultation will not be accepted.

14.42. Where the freehold of separate premises is owned by the doctor, a notional rent equivalent to the current market rent as assessed by the F.D.S.C. is to be paid.

14.43. Where practice accommodation forms part of a residence rented or owned by the doctor, the value of the rent or notional rent, taken into account in computing the value of the allowance, will be related solely to that part of the residence used regularly and substantially for practice purposes, such apportionment to be determined by the F.D.S.C.

14.44. The accommodation to be taken into account for the purposes of this paragraph will exclude any part of the premises which is not directly used for practice purposes.

14.45. Where the practice accommodation is subject to a lease, or is included within premises which are the subject of a rental agreement, the Council may wish to see a copy of the lease or rental agreement.

14.46. Where private income is derived from work conducted at or associated with premises accepted for the purposes of this paragraph, the payments otherwise due to be made in respect of the premises, will be abated proportionately if such gross receipts account for 10% or more of the total gross receipts of the practice.

14.47. The value of the allowance to be paid to each doctor will be determined on an individual basis for each doctor; the determination of such value being effected after inspection of the premises by the Council, or any other person or body acting on its behalf.

14.48. In determining the value of the allowance, the Council will take the following criteria into consideration:

i. Type of Premises:	Room in Pharmacy
	Part of other accommodation
	Separate Premises
ii. Size :	Consulting Room + Examination Room
	Consulting Room
	Examination Room
	Treatment Room
	Waiting Area
	Toilet for Patients
	Reception/Record Storage
iii. Facilities:	Fully Equipped Consulting Room
	Fully Equipped Treatment Room
iv. Decor of Premises :	Decoration
	Comfort
	Cleanliness
	Lighting
	Heating/cooling

v. Location: The rent payable on premises is related to the location in which it is situated. It is difficult and unfair to set up rate bands related to locality. The payment of this part of the allowance will therefore be paid in proportion to the rent payable on the premises.

vi. Telephone Charges: The amount payable will be related to the size of the doctor's practice list.

14.49. Once the value of the allowance has been worked out by the Council, the doctor will be notified of its value; such notification to include a breakdown of the value's determination. The decision of the Council will be final.

14.50. Payments under this paragraph will normally be made quarterly in arrears.

15. DIAGNOSTIC BACKUP FACILITIES

Family doctors today have two levels of access to diagnostic backup facilities provided by the various departments at the hospital. Doctors working in the health centres have access to virtually all facilities while those working outside the health centres have access to a very limited number of tests. Within the Scheme, doctors will have access to a number of diagnostic facilities to be worked out by the Family Doctor Scheme Council and the Department of Health[3].

Diagnostic facilities shall be available at the various health centres and at the various departments in the hospital. Doctors will be encouraged to perform their own simple diagnostic tests such as urine testing and blood sugar estimation. To reduce the cost of such tests, arrangements will be made such that the requisite reagents could be purchased at a reduced price from the Department of Health's stores. It need hardly be mentioned that any such expenses borne by the family doctor in providing a service to patients registered within the Scheme shall be considered as a practice expense and therefore tax deductible. In additions, doctors who decide to perform their own diagnostic tests will have to participate in a National quality assurance programme run by the Department of Pathology.

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[3] vide Appendix 2

6. REMUNERATION

1.Basic Capitation Fee:

Age:	00 - 05	LM 4.50
	05 - 14	LM 3.50
	15 - 44	LM 3.00
	45 - 64	LM 4.50
	65 -	LM 7.00

2. Value of Encounter Forms

The Initial Registration Encounter Form	LM 0.25
Monthly Encounter Data Form	LM 2.00

3. Fee for Minor Surgery

The payment for each surgical procedure shall be LM 7.50

4. Good Practice Allowance

The value of this allowance will depend on list size as it is felt that the larger the list size the more difficult it will be to fulfil the criteria and the less time will be available to keep practice affairs in order.

For doctors with list sizes	900 <	LM 500
For doctors with list sizes	900 - 600	LM 350
For doctors with list sizes	600 - 300	LM 200

5. Seniority Allowance

Doctors will be paid per year of registration a sum of LM 25

6. Continuing Medical Education Allowance

This allowance too has a variable value depending on list size for the same reasons given above.

For doctors with list sizes	900 <	LM 500
For doctors with list sizes	900 - 600	LM 350
For doctors with list sizes	600 - 300	LM 200

7. Group Practice Allowance

Doctors in a group practice will each be paid LM 500

8. Undergraduate Training Allowance

The value per student per session will be LM 50

9. Concessionary Payment for Sickness

Payment for a Type I locum shall be	LM 100
Payment for a Type II locum shall be	LM 75
Payment for a Type III locum shall be	LM 50

10. Practice Premises Allowance

Type of Premises:	Room in Pharmacy	LM 20.00
	Part of other accommodation	LM 50.00
	Separate Premises	LM100.00
Size : Consulting Room + Examination Room :	>120 sq feet	LM 100.00
	100 - 119 sq feet	LM 80.00
	80 - 99 sq feet	LM 50.00
	< 80sq feet	LM 25.00
Consulting Room:	>100 sq feet	LM 80.00
	80 - 99 sq feet	LM 60.00
	65 - 79 sq feet	LM 30.00
	< 65 sq feet	LM 00.00

Examination Room:	>50 sq feet	LM 40.00
	40 - 49 sq feet	LM 30.00
	30 - 39 sq feet	LM 15.00
	< 30 sq feet	LM 00.00
Treatment Room:	>190 sq feet	LM 100.00
	170 - 189 sq feet	LM 90.00
	150 - 169 sq feet	LM 80.00
	130 - 149 sq feet	LM 70.00
	100 - 129 sq feet	LM 50.00
	< 100 sq feet	LM 00.00
Waiting Area:	> 50 sq feet/cons room	LM 60.00
	40 sq feet/cons room	LM 40.00
	<40 sq feet	LM 00.00
Toilet for Patients:		LM 30.00
Reception:	>40 sq feet	LM 80.00
	30 - 39 sq feet	LM 50.00
	20 - 29 sq feet	LM 25.00

Facilities:	Fully Equipped Consulting Room	M 80.00 max
	Fully Equipped Treatment Room	LM 100.00 max
Decor of Premises :	Decoration	LM 20.00 max
	Comfort	LM 20.00 max
	Cleanliness	LM 20.00 max
	Lighting	LM 20.00 max
	Heating/cooling	LM 20.00 max

Location:	Rent paid per annum	> LM 400	LM 150.00
		LM 300 - LM 399	LM 120.00
		LM 200 - LM 299	LM 90.00
		LM 100 - LM 199	LM 60.00
		<LM 100	LM 30.00

Telephone Charges:	List Size:	300 - 500	LM 35
		501 - 700	LM 50
		701 - 900	LM 65
		901 - 1100	LM 80
		1101 - 1300	LM 95
		1301 - 1500	LM 110
		1501 - 1700	LM 125
		1701 - 2000*	LM 140
		2000 - 2500*	LM 160
		>2500*	LM 180

* only payable in the first three years of operation of the Scheme.

11. Car Allowance

Fixed Car allowance		LM 400.00
Variable Car Allowance	LM	0.25 per patient

7. PREMISES AND PERSONNEL REQUIREMENTS

The Family Doctor Scheme Council will be a body constituted within the Department of Primary Care by the appropriate legislation. It will have a Board of directors which will have as executive chairman the Director of Primary care. Other members on the Board will be the Manager Nursing Services, a representative of the Malta College of Family Doctors, a member elected by the doctors working in the Scheme, and a member coming from among the ranks of the consumers, nominated by the persons mentioned above on the principle of consensus. All the members of the board of directors will not be entitled to any payment for services rendered .

In addition to the Board of Directors, the Council will need an administrative structure to operate the Scheme. Since the Council will function within the Department of Primary Care, the administrative backup can be shared with that of this Department. This should not create any administrative problems since both the council and the department will be under the same Director. It is therefore proposed that all administrative work for the council will be carried out by employees of the Department of Primary Care. This structure will reduce the administrative costs of the Scheme, not only because staff will be shared, but also it will obviate the need for the establishment of separate premises for the Scheme Council.

Premises Requirements

If the above proposal is implemented, there will certainly be no need for new premises to launch the Scheme. The Department of Primary Care has recently moved into new premises and will be in a position, albeit with some difficulty and crowding, to house all the additional personnel needed for the Scheme. This will entail the removal of the existing Board room, which presently serves Boffa Hospital, as well as the refurbishment of the new premises, in the ground floor of the building, to house the Health Promotion Department, which is presently housed within the Department of Primary Care. At a later stage it may be possible to occupy the space presently housing the Port Health Office, especially if the latter can be moved into alternative accommodation.

Personnel Requirements

For the Department of Primary Care to be in a position to effectively manage the needs of the Scheme, it will need to have the following additional staff:

Departmental Manager
Information Systems Manager
4 Administrative Officers: Patient and Doctor Registration,
Administration/Personnel
Finances (2)
4 Executive Officers Council Inspector
Public Relations
Council Investigations
Stores
6 Clerks
5 Data Entry Operators
2 Messenger Driver
2 Cleaners

In addition to the above, the Department will need to have two vehicle for its use.

Finances

Personnel	Number	Salary	Bonus	Total
Assistant Head	1	4461	210	Lm4671
Administrative Officer	5	4196	210	Lm22030
Executive Officer	4	3517	210	Lm14908
Clerk	6	3125	210	Lm20010
Data Entry Operator	5	3316	210	Lm17630
Messenger/Driver	2	2775	210	Lm5970
Cleaner	2	2480	210	Lm5380
Cars	2	3500	0	Lm7000
				Lm97599

The above estimate include only the personal emoluments due to the prospective employees of the Scheme. It is impossible at this stage to make an accurate estimate of the recurrent operation and maintenance expenditure that will be incurred. A rough estimate of Lm 150, 000 is being proposed.

8. THE ROLE OF HEALTH CENTRES

As already mentioned, with the introduction of the Scheme, the role of the Health Centres will change. Apart from supplementing the general practitioner service in a manner referred to earlier, such a change in role will need to reflect the total reform in the primary health care services. The health centres, born as polyclinics, were initially set up to cater for an emergency general practitioner service. They have grown and developed into providers of a substantial proportion of medical care in Malta, as well as offering a range of preventive services and backup facilities. However, overall it can be said, that the quality of the output from such centres is primarily based on a medical model, and does not reflect the true concept of health as understood in the principles outlined by Alma Ata.

The need for change in the quality of care provided from the existing centres has been felt for a long time. Although several attempts at change have been made in the past, none have left any real impact. In spite of extending further the services being offered through these centres, and in spite of changing the conditions of work of all employees, the work ethos of the service has not changed. The reason for this may be explained on the basis of the fact that, such changes did not have at their base the radical reform, as reflected by the changes proposed in this document, that primary health care in Malta has for so long needed.

At the beginning of the reform process, the general practitioner service currently being provided from the health centres will stop, apart from the provision of the necessary backup service for the Family Doctor Scheme, It is hoped that this will immediately change the public's perception of the role of health centres, which to date, has been that of providing free medical care. This will create the much needed physical as well as ideological space, so far unavailable, for the creation of a different perception and role of such centres.

It is envisaged that the primary role of the health centres will be that of providing a venue for all activities related to health promotion and health education. Clinics, along the lines of smoking cessation clinics currently held in the health centres, will be established to cover national priority areas in health. The first of such clinics will include those aimed at helping people lose weight, and those aimed at offering basic family counselling covering areas like marriage counselling, family planning and psycho-social problems. In addition,

the health centres will serve as the base for the allied health professionals, in the development and expansion of their role within an extended primary health care team.

The overall policy in relation to health care is geared towards more care of the individual at the community level. The general aim is to reduce the load from the hospital and cater for their needs at a community level. It is therefore proposed that more out patient care, currently being carried out at the hospital, will in future be carried out at the health centres. Moreover, it may indeed be possible for general practitioners, referring patients for specialist opinions , to join the specialist at the initial appointment. This will not only mitigate for true continuity of care, but will be of extreme usefulness for the continuing professional development of the general practitioner.

Health Centre Back up for the Family Doctor Scheme

Doctors working in the Scheme will be contracted to provide services between the hours of 8am and 8pm during weekdays and between 8am and 1pm on Saturdays. It is proposed that during these contractual hours, there will be medical cover in the health centres which will serve as an emergency outpost, catering for accident and emergency work that may arise during these contractual hours. During the remaining non-contractual hours, routine general practitioner that may arise and be requested by the public, will continue to be provided by doctors working from within the health centres.

Doctors working in the health centres will no longer be employed on a whole time basis, they will be employed on a fixed sessional basis. This will have many advantages as it will not only guarantee a better work output of the doctors concerned, but it will also create working space for those medically qualified individuals who are not in a position to afford a full-time commitment. Moreover, it will allow for those doctors working in the Scheme and not having a large list, the facility to boost their income. It also allows doctors to choose the time they prefer to work, thus increasing their commitment and dedication to their job.

All the existing health centres will open from 8am till 8pm while it will only be the major health centres that will be open round the clock. Thus while the

health centres in Floriana, Paola, Mosta and Qormi will be open on a 24 hour basis, the other health centres will only open during day-time hours.

There will be one doctor on duty in each of the health centres during the contractual hours of the Scheme, there will be a variable number of doctors working in the health centres during the nights and over the weekends, such number being calculated in relation to the population size in the respective catchment areas. The catchment areas will be as follows:

Floriana	2883	**Paola**	9522	**Mosta**	15401	**Qormi**	17958
Valletta	8090	Cospicua	6430	Naxxar	8445	St Vennera	6410
Hamrun	11653	Senglea	3599	Gharghur	1858	Luqa	5887
Marsa	5936	Vittoriosa	3122	Mgarr	2615	Lija	2294
Gzira	8032	Kalkara	2807	St Paul's Bay	6001	Balzan	3522
Sliema	13567	Safi	1575	Mellieha	5634	B'Kara	21456
Msida	6854	Kirkop	1885	Rabat	12613	Siggiewi	6826
Pieta	4142	Tarxien	7417	Dingli	2663	Zebbug	10248
St Julians	7012	St Lucia	3594	Attard	7799		
Ta' Xbiex	1783	Fgura	10676	Mdina	404		
Swieqi	5327	Zabbar	13622	San Gwann	10865		
Pembroke	1680	M'Scala	3799	Iklin	2807		
Qrendi	2345	Xghajra	677				
Mqabba	2486	Gudja	2781				
Zurrieq	8518	Ghaxaq	4029				
		B'Bugia	6805				
		M'Xlokk	2822				
		Zejtun	11411				
	90308		96573		77105		74601

Taking the actual number of house visits generated by these population catchments in the respective areas, based on figures for 1993, one will find that on a daily average, there were six, nine, four and two home visits requested between 8pm and 8am in the Floriana, Paola, Mosta and Qormi catchment areas respectively. The same averages are obtained when the number of home visits for the first quarter of 1994 are analysed.

From an analysis of the number of home visits taking place on Saturdays and Sundays in all the health centres during the first quarter of 1994, it has been calculated that the workload for home visits on these days will roughly be divided as follows:

Saturday	08.00 - 12.00	12.00 - 16.00	16.00 - 20.00	20.00 - 24.00	00.00 - 08.00
Floriana	16	6	12	6	3
Paola	25	8	16	8	3
Mosta	10	4	8	4	2
Qormi	10	3	6	3	1
Sunday					
Floriana	24	8	12	6	3
Paola	30	13	16	8	3
Mosta	15	5	8	4	3
Qormi	14	5	6	3	1

It is proposed that doctors working in health centres will work on a sessional basis, each session being four hours long. Given the workload, as estimated above, it is estimated that the number of doctors working in each sessional period should be as detailed in the table below.

Weekday	08.00 - 12.00	12.00 - 16.00	16.00 - 20.00	20.00 - 24.00	00.00 - 08.00
Floriana	1	1	1	2	2
Paola	1	1	1	3	2
Mosta	1	1	1	2	2
Qormi	1	1	1	2	2
Gzira	1	1	1	0	0
Rabat	1	1	1	0	0
Cospicua	1	1	1	0	0
B'Kara	1	1	1	0	0
Saturday					
Floriana	1	2	3	2	2
Paola	1	2	3	2	2
Mosta	1	2	2	2	2
Qormi	1	2	2	2	2
Gzira	1	1	1	0	0
Rabat	1	1	1	0	0
Cospicua	1	1	1	0	0
B'Kara	1	1	1	0	0
Sunday					
Floriana	5	3	4	2	2
Paola	6	4	4	2	2
Mosta	4	2	2	2	2
Qormi	4	2	2	2	2
Gzira	1	1	1	0	0
Rabat	1	1	1	0	0
Cospicua	1	1	1	0	0
B'Kara	1	1	1	0	0

This would give a weekly total of 371 sessional periods. If each sessional period is paid at the rate of Lm20.00, then the total cost for health centre cover would amount to LM385,840.

In addition to the above, doctors will have to be reimbursed for any expenses made in connection with using their car while carrying out home visits from the health centres. Taking the above calculations, it is estimated that the weekly average for home visits will be 446, giving an annual figure of 23,192 house visits. Assuming that on average 6 miles per visit, the total number of miles covered can be estimated at 139,152. It is proposed that doctors will be reimbursed at 13cents per mile. This would make the total cost equivalent to Lm 18,090

Thus the total cost for offering emergency cover and cover for the general practitioner services offered by the Scheme would amount to a total of **Lm403,930**

It is estimated that given the change in the function and opening hours of the health centres, there would be a reduction in the number of personnel presently employed in the health centres. It is estimated that this would lead to a reduction in present costs of about **LM 610,000**

9. Estimate of Income of General Practitioners

Maximum Income of G.P. with a Practice List of 1,700

Capitation Fees	Lm	6,890
Encounter Forms	Lm	24
Minor Surgery	Lm	255
Good Practice Allowance	Lm	500
Seniority Allowance	Lm	500
CME Allowance	Lm	500
Group Practice Allowance	Lm	500
U.G. Training Allowance	Lm	100
Car Allowance	Lm	825
Total	**Lm**	**10,094**

The above computation assumes:

2% of practice population has a minor surgical intervention
the doctor qualifies for all allowances
the doctors has at least 20 years of service
excludes the payment of the practice premises allowance which at a maximum would amount to Lm Lm 795
excludes the payment of the locum sickness allowance

Maximum Income of G.P. with a Practice List of 1,000

Capitation Fees	Lm 4,046
Encounter Forms	Lm 24
Minor Surgery	Lm 150
Good Practice Allowance	Lm 500
Seniority Allowance	Lm 375
CME Allowance	Lm 500
Group Practice Allowance	Lm 500
U.G. Training Allowance	Lm 100
Car Allowance	Lm 650
Total	**Lm 6,845**

The above computation assumes:

2% of practice population has a minor surgical intervention
the doctor qualifies for all allowances
the doctors has at least 25 years of service
excludes the payment of the practice premises allowance which at a maximum would amount to Lm 780
excludes the payment of the locum sickness allowance

Maximum Income of G.P. with a Practice List of 500

Capitation Fees	Lm 2,025
Encounter Forms	Lm 24
Minor Surgery	Lm 75
Good Practice Allowance	Lm 200
Seniority Allowance	Lm 250
CME Allowance	Lm 200
Group Practice Allowance	Lm 500
U.G. Training Allowance	Lm 50
Car Allowance	Lm 525
Total	**Lm 3,849**

The above computation assumes:

2% of practice population has a minor surgical intervention
the doctor qualifies for all allowances
the doctors has at least 10 years of service
excludes the payment of the practice premises allowance which at a maximum would amount to Lm Lm 690
excludes the payment of the locum sickness allowance

10. ESTIMATE OF TOTAL EXPENDITURE

Capitation Fees

Age	*Number*	*Rate Lm*	*Cost Lm*
00-04 yrs	25905	4.5	116572.5
05-14 yrs	54650	3.5	191275
15-44 yrs	161163	3	483489
45-64 yrs	85392	4.5	384264
65yrs +	41298	7	289086
Total	368408		

Encounter Forms

368408		0.25	92102
200	12	2	4800

Minor Surgery

368408	2%	7.5	55261.2

Good Practice Allowance

40		200	8000
40		350	14000
70		500	35000	57000

CME Allowance

60		200	12000
60		350	21000
120		500	60000	93000

Seniority Allowance

147200

Group Practice Allowance

30	500	15000

UG Training Allowance

50	2	50	5000

Locum Sickness Allowance

7	12	100	8400	
2	12	75	1800	
10	12	50	6000	16200

Car Allowance			
300	400	120000	
368408	0.25	92102	212102
Practice Premises Allowance			
			381,000
Total Remuneration to Doctors			**2543352**
Employment of Ancillary Staff			236,179
Coverage from Health Centres			403930
Family Doctor Scheme Council			97599
Running Costs			150,000
Total Cost of Scheme			**3431060**

11. APPENDICES

Appendix 1

Grades Ineligible to Work in the Scheme

i. Divisional Employees

a. Director General Health
b. Director Primary Care
c. Director Institutional Health
d. Director Public Health
e. Director Policy and Planning
f. Director Health promotion
g. Director Health Information
h. Medical Administrator -Hospital

ii Specialist Posts within the Department of Health

a. All doctors employed as Consultants within the Department of Health. This should include both those consultants in permanent posts as well as any consultants in employment on a contract basis. It, of course, includes the various Directors and Chairmen of Clinical Departments.

b. All doctors employed as Consultants/ Professional Medical Officer within the Department of Health as this post is regarded by the Department as a specialist post.

Those doctors occupying specialist posts, within the Department, in the field of general practice will be allowed to join the Scheme. It would be contradictory to exclude from the Scheme those people who are probably the better trained and qualified in family medicine. While eligibility to enter the Scheme will be allowed, the Department will have to ensure that such doctors will not, by joining the Scheme, jeopardise their commitment to their work within the Department. These doctors will have to comply with the regulations for "Doctors in full-Time Employment".

iii. Specialist Capacity in the Private Sector

Any doctor who has a postgraduate qualification, recognized as such by the Medical Council, can be regarded as a specialist. The introduction of Specialist Registers by the Medical Council, will simplify the identification of this group of professionals.

Appendix 2

Proposed List of Investigations:

Biochemistry:

Blood

Albumin
Alkaline Phosphatase
Bilirubin (Direct and Indirect)
Calcium
Chloride
Cholesterol
HDL-Cholesterol only if result of total cholesterol is high
Creatinine
Glucose
Glucose Tolerance Test only if fasting glucose indicates it
S.G.P.T.
S.G.O.T.
Gamma G.T.
Glycosylated Haemoglobin
Potassium
Total Proteins
Protein Electrophoresis only after consultation with Pathologist
Sodium
Triglycerides
Urea
Uric Acid
Ferritin
Vitamin B_{12} only if blood count shows macrocytosis
Folate only if blood count shows macrocytosis
Thyroid Function Tests

Urine

Bence Jones Proteins only after consultation with Pathologist
Calcium only after consultation with Pathologist
Chloride only after consultation with Pathologist
Microscopy
Potassium only after consultation with Pathologist
Sodium only after consultation with Pathologist
Urinalysis

Faeces

Occult Blood

Haematology:

Haemoglobin
Red Cell Count
White Cell Count with differential
Platelet Count
Packed Cell Volume
E.S.R.
Reticulocyte Count only after consultation with Pathologist

Microbiology:

Urine Culture
Sputum Culture
Pus Swabs
Vaginal Discharge
Throat Swabs

Cytology:

Aspirates
Sputum
Cervical

Histology:

Any specimen removed at minor operation

Toxicology:

Phenobarbitone levels only after discussion with toxicologist
Phenytoin levels only after discussion with toxicologist
Carbamazepine levels only after discussion with toxicologist
Valproate levels only after discussion with toxicologist
Digoxin levels only after discussion with toxicologist

Virology: Hepatitis
Infectious Mononucleosis
Rubella
HIV

Blood Transfusion:ABO Grouping
Rh Grouping

Radiology: Skeletal X-Rays
Chest X-Ray
Plain Abdominal X-Ray
K.U.B. X-Ray
U/S Scan Abdomen
Barium Meal only after discussion with radiologist
Barium Enema only after discussion with radiologist

Appendix 3

Reciprocal Health Agreements

Reciprocal Agreements providing for the "immediately necessary treatment" for conditions arising during the course of their stay of temporary visitors exist between Malta and the following countries:

- Australia
- Bulgaria
- Czechoslovakia
- Greece
- Hungary
- Turkey
- United Kingdom

The said agreements apply only to Government and public hospitals and other health care institutions and provide free medical assistance in emergencies.

12. INDEX

13 GLOSSARY OF TERMS

Accreditation - the process of evaluating the organisation and activity of a practice or programme in respect of meeting prescribed criteria and standards.

Allied Health Workers - see paramedical.

Ancillary Staff - non-professional personnel working in a practice.

Associate - a medical doctor having no list of his own employed by a principal or group practice with the F.D.S.C..

Capitation Fee - a retainer fee paid to each doctor contracted in the Scheme for every person registered with him.

Certification - documentary confirmation of successful accreditation.

Community Care Services - those services provided by health care workers, visitors, nurses working under the Department of Health.

Community Nurse - a nurse who provides health care in the patient's home.

Consultation - see contact.

Contact - an occasion on which a patient receives professional advice, help or treatment from the doctor.

C.M.E. - Continuing Medical Education; a process by which doctors keep abreast with advances in their medical discipline.

Deputy - a Scheme doctor who stands in for another Scheme doctor.

Disposition - a plan of action for the follow - up management of a patient's condition.

Doctor - a medical practitioner holding full registration with the Medical Council of Malta.

Doctor's List - a list of persons registered with a doctor for whom the doctor has undertaken to provide primary health care services.

Emergency Care - the care that needs to be given to patients suffering from such conditions that any delay in providing care will jeopardise the patients' health.

Emergency Unit - designated area within a health centre that provides emergency care.

Encounter - see contact

Episodic Care - the sporadic care given by a doctor to a patient presenting to him with an episode of acute illness.

Family Doctor - a medical practitioner working in a primary care setting who provides continuing health care to persons irrespective of age, sex or illness.

Family Medicine - an academic discipline whose main focus is that body of knowledge dealing with enhancing the quality of life and health of individuals in all social, psychological and medical aspects.

F.D.S.C. - Family Doctor Scheme Council.

General Practitioner - see family doctor.

Good Practice - the provision of effective and efficient primary health care.

Group Practice - a group of three or more doctors working together from common premises sharing practice facilities and ancillary staff.

Health Care Team - a group of health professionals (practice and community nurses, health visitors, midwives, social workers, psychologists, dietician, doctors, etc.) actively working together with the individual, to promote effective delivery of primary health care.

Health Education - the teaching by health care providers given to patients about their health problems and their management in order to achieve better compliance with and understanding of any treatment or advice given.

Health Prevention - an activity or behaviour adopted to avoid risk factors that can lead to ill-health.

Health Promotion - the attitude and activity whereby health care providers educate the people on how to adopt healthy lifestyles.

Item of Service - a special service provided by doctors that is covered by a separate fee.

Locum - a doctor employed by a Scheme doctor to look after the practice in his absence.

Malta College of Family Doctors - academic professional institution committed to encourage, foster and maintain the highest standards of Family Medicine in Malta.

Family Doctor List - a list of doctors eligible to provide primary health care services, held by the F.D.S.C..

Morbidity Register - an information base of patterns and characteristics of sickness provided by primary health care workers.

Normal Hours - the hours between 8 am and 8 pm on weekdays and 8 am and 1 pm on Saturdays.

Office Hours - the times the doctor has indicated to the F.D.S.C. that he will be available to see patients in his consulting office.

On Call - the ready availability of a doctor for receiving calls from patients over a stated number of hours.

Paramedical Workers - non medical health professionals.

Partner - a principal working with another principal on the basis of a partnership agreement approved by the F.D.S.C.

Periodic Care - the regular, ongoing care provided by a doctor to a patient with a chronic condition or prolonged period of illness.

Personal Health Services - the non medical services provided by primary health care workers.

Practice(Catchment) Area - the geographic area in which a doctor is under obligation to visit patients by virtue of his application for inclusion in the Family Doctor List of the F.D.S.C..

Practice Nurse - a nurse with specific training and experience in the field of family medicine.

Primary Health Care - front-line health care made universally accessible to all individuals and families in the community, providing health promotion, illness prevention, assessment and management of problems presenting to the doctor in his office, in special clinics, the individual's residence or place of work.

Principal - a doctor authorised by the F.D.S.C. to provide primary health care services within the Scheme

Registration - the formal documentation by the F.D.S.C. of the doctor's acceptance to provide primary health care services to those persons who have chosen him as their family doctor.

Secondary Health Care - care requiring attention of a special nature, usually more sophisticated and complicated than would be handled by the family doctor.

Scheme - the Family Doctor Scheme as proposed in this document.

Scheme Doctor - a doctor approved by the F.D.S.C. as eligible for work within the Scheme.

Temporary Patient - a person who receives one or more health care services from his doctor at a place other than his normal place of residence.
- a visitor who under bilateral reciprocal health agreements is eligible for treatment under the Scheme.

Triage - the initial assessment of a medical problem by a health professional to decide about the best course of action.

Urgent Care - the care that needs to be given to patients in as short a time as possible to prevent unnecessary suffering or complication.