Malta

Health Care & Long-Term Care Systems

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Health care systems

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2.19. MALTA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2017, the GDP at market prices in PPS per capita stood at 28,700, which is below the EU average of 29,900. Population was estimated at 0.5 million in 2017. It is expected to stay within half a million in the coming decades, with the fastest expansion occurring in the next years.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (9.8% in 2014) has increased over the last decade (from 9.0% in 2005) and is below the EU average of 10.2% in 2015. Throughout the last decade, total public expenditure has first decreased then increased as a share of GDP: from 5.2% in 2005 down to 4.5% in 2010, and then up to 6.4% of GDP in 2014 (EU: 8.0% in 2015). Looking at health care without long-term care ([264]) reveals a similar picture with public spending below the EU average (MT: 5.6% in 2014 vs. EU: 6.8% in 2015). When expressed in per capita terms, also total spending on health at 2,566 PPS in 2014 was below the EU average of 2,975 in 2014. So was public spending on health care: 1,675 PPS in 2014 vs. an average of 2,324 PPS in 2014 ([265]).

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by a considerable 2.7 pps of GDP between 2016-2070, high above the average growth expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario". When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 4.3 pps of GDP from now until 2070 (EU: 1.6 pps) ([266]).

Medium fiscal sustainability risks appear for Malta over the long run. These risks are primarily related to the strong projected impact of age-related public spending (notably pensions, healthcare and long-term care) ([267]).

Health status

Life expectancy at birth, 84.0 years for women and 79.7 years for men, is above the respective EU averages of 83.3 and 77.9 years in 2015. Healthy life year expectancy is very high with 74.6 years for women and 72.6 for men in Malta versus 63.3 and 62.6 in 2015 in the EU ([268]). The infant mortality rate of 5.8‰ is above the EU average of 3.6‰ in 2015, having remained relatively consistent throughout the last decade, however caution needs to be exercised when interpreting such figures in view of the fact that termination of pregnancy is illegal in Malta.

As for the lifestyle of the Maltese population, the data indicates a proportion of regular smokers of 18.9% in 2014, being below the EU average of 20.9%. The proportion of the obese population is far above EU level. In 2014, one in four adults (25% of the population) were reported as being obese, in comparison with EU average of 15.4%, rising marginally from 23% in 2009 (EU average 15.5%). Overweight and obesity rates among 15-year old children has increased by 36% since 2001, and currently stand at 30% which is more than one and a half times the EU average. There are differences in obesity rates between girls and boys, these being 26% and 34% respectively ([269]). The alcohol consumption is below the EU level.

([264]) To derive this figure, the SHA aggregate HC.3 for LTC (health) is subtracted from total health spending.

([265]) Note that these PPS figures reflect current plus capital health expenditure in contrast to EUROSTAT data series, which reflect current expenditure only.

([266]) The 2018 Ageing Report, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([267]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([268]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

([269]) Health at a Glance: Europe 2016. State of Health in the EU cycle, OECD.

System characteristics

Overall description of the system

A National Health Service (NHS), managed by the Ministry of Health and funded through taxation, provides coverage for a comprehensive range of services (preventive, curative and rehabilitative care).

Coverage

The Maltese health care system is based on the principle of equity and solidarity with universal coverage. The public healthcare system provides a comprehensive basket of services to all persons residing in Malta who are covered by the Maltese social security legislation and also provides necessary care to groups such as irregular immigrants and foreign workers who have valid work permits. There are no user charges or co-payments for health services. The private sector acts as a complementary mechanism for healthcare coverage and service delivery.

Administrative organisation and revenue collection mechanism

The budget for the public health sector is defined annually in Parliament when the general budget is approved. A specific unit for financial management and control at the Ministry of Health monitors and controls the financial management of the public health system.

Role of private insurance and out of pocket co-payments

Private expenditure constituted a relatively high share, with 34.7%, of total health expenditure in 2014, which is above the EU average of 23.5% in 2015. A large part of private expenditure is out-of-pocket expenditure (28.9% of total health expenditure in 2014 and much higher than the respective EU average of 15.9% in 2015). Authorities ensure means-tested entitlement (for people with low incomes) to pharmaceuticals, dental and optometric care, i.e. benefits mostly excluded from the free public healthcare basket. The remainder is left to private health insurance whose share of private expenditure has remained steady over the last few years. The chronically ill are provided with free medicines according to their condition in a system which is separate from the one mentioned above.

Types of providers, referral systems and patient choice

The public healthcare system is the key provider of health services. The private sector complements the provision of health services, in particular in the area of primary health care. In 2016, a public-private partnership agreement was signed between the Maltese government and a private international health care provider to operate three hospitals in the Maltese islands. In addition, some services, especially for long-term and chronic care, are also provided by the private sector, the Church and other voluntary organisations.

The state health service and private general practitioners (GPs) provide primary health-care services. Increasing the effectiveness and consolidation of the position of the primary health care system is the cornerstone of the National health care system. To this effect a number of actions have been implemented to strengthen quality and efficiency of services such as new referral systems in liaison with the private family doctor. Private family doctors are empowered to directly refer patients with musculoskeletal problems for physiotherapy services in primary health care settings. Both public and private doctors also refer their patients for bone densitometry and X-rays. A number of public health centres are equipped with digital X-ray facilities, enabling X-rays to be taken on site and accessed remotely by hospital specialists in secondary care.

Secondary and tertiary care is mainly provided by specialised public hospitals of varying sizes. Hospital care is mostly delivered in NHS hospitals. The main acute general services are provided by one teaching hospital (Mater Dei hospital) incorporating specialised, ambulatory, inpatient care and intensive care services. There has been a significant amount of investment in public-private partnerships, in order to improve the capacity in terms of surgical operations as well as diagnostic and emergency services. Some minor procedures have recently been partly relocated to primary health centres to alleviate the burden on the main hospital. Anticoagulation monitoring services have also been partly devolved to health centres.

Under the NHS, primary care is delivered through a network of public health centres, provided by general practitioners (GPs), nurses and some specialists. NHS outpatient specialist care is centred in the hospitals outpatient departments, in which most of the specialists work, with a number of ambulatory specialist clinics being held in primary health centres.

In addition to NHS provision, there is also private outpatient primary care and specialist care practice, given mostly from the private doctor's office, for private patients. Doctors are allowed part-time after-hours private clinics when in public employment. This applies mostly to specialities other than family medicine, where there seems to be a better uptake of the option that the public sector offers for a better paid, exclusive contract, which bars private practice.

There is a compulsory referral system from primary care to specialist doctors. GPs act like gatekeepers to specialist and hospital care. However, this system is very often bypassed by patients attending specialist health care directly in the private sector. One reason is the degree of choice of GP, or specialist, in the private sector and the other is that in certain specialist areas there are still relatively long waiting times for outpatient appointments in the busier specialities.

As a rule, patients consult more frequently GPs in the private sector than GPs in the public sector, mostly due to the continuity of care that the same GP in the private sector can provide, as opposed to the GP on call in the public sector. However, not all GPs in the private sector are well-equipped to deal with any sort of emergency, especially those requiring urgent investigations such as specific blood tests and radiography.

Some of the health centres are equipped to deal with minor emergencies for 24 hours and 7 days a week. The Accident and Emergency department at Mater Dei Hospital is equipped to deal with more serious emergencies. The Maltese tend to make unnecessary use of hospital emergency care, particularly since they would not want to risk that they might need specialised investigations or admission to hospital, for which the public GP would refer them to A&E. This peaks in weekends when private practitioners tend to have their days off.

A number of initiatives are being adopted in Malta to help alleviate this problem. European investment is being sought to create a major primary care hub (to become operational in 2023) which should alleviate the congestion at the hospital. Indeed, according to this plan, a number of services, particularly those that are ambulatory, elective in nature, and not dependent on other hospital infrastructure, would be moved towards the primary care hub, in addition to other primary care functions. It would be desirable that this would be accompanied by a cultural shift within the population to visit the primary care facilities for emergency care, encouraged by a clear-cut organisational and financial regulation aiming at avoiding duplication of emergency services between the hospitals and the primary health hub.. Further investment is being sought for setting up of an integrated IT infrastructure which would bridge between primary and secondary care, together with public and private care. This should also significantly increase continuity of care and, consequently, one hopes, the increased engagement of the public with primary care services.

The density of physicians in Malta is slightly above the average density in the EU. In 2015, there were 379 practising physicians per 100,000 inhabitants, compared to 344 in EU. The number of general practitioners is also slightly above the EU average (81 per 100,000 inhabitants vs. 78 in the EU). The number of nurses per 100,000 inhabitants (794 in 2015) is slightly below the EU average of 833.

In 2015, the number of acute care beds was relatively low with 324 compared to 402 per 100,000 inhabitants in the EU. With this capacity Malta achieves discharge rates of 15.3 per 100 inhabitants (EU: 16.2).

Treatment options, covered health services

The public healthcare system offers primary, secondary and tertiary health care services. The private sector acts as a complementary mechanism for health care coverage and is now also involved in a number of public-private partnerships related to healthcare provision.

The state health service and private general practitioners comprise primary health care in

Malta. However, the two systems of primary care practice function independently of one another and the latter account for two-thirds of the workload. Secondary and tertiary care is mainly provided by specialised public hospitals of varying size and function. The main acute general services are provided by one main teaching hospital incorporating specialised, ambulatory, inpatient care and intensive care services. A new oncology hospital was opened in September 2015 providing oncology and haematology care ([270]). Malta has become almost self-sufficient in terms of providing most tertiary care. When it comes to the provision of highly specialised care, there are cases where this is provided by visiting consultants from specialised centres abroad who periodically attend local hospitals for outpatient consultations and/or perform operations. For certain conditions patients are sent overseas because it would neither be cost-effective nor feasible to conduct such treatments locally.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

GPs and specialists are paid on a salary basis when working for the NHS, while they receive a fee-for-service in the private sector. The collective agreement with the Medical Association of Malta, concluded by the Government in 2007, includes job plans for doctors in senior posts resulting in better pay per performance. The possibility of exclusivity contracts with the NHS has been introduced, remunerated at a higher rate. Such job plans and exclusivity contracts have also been extended to various levels within the general practice profession with the revision of the said collective agreement in 2013, and to resident specialists in the 2017 agreement.

Hospital budgets are defined by the government on a prospective global budget basis, but managers' decision-making autonomy assists in increasing hospital efficiency.

The market for pharmaceutical products

While there is no direct product price regulation, there is a tendering system to control the prices of NHS covered medicines and a cost/benefit analysis is conducted prior to the inclusion of a medicine in the Government Formulary List. Authorities promote the rational prescribing of physicians through treatment guidelines. Education and information campaigns on the prescription and use of medicines are also organised from time to time. Within the NHS prescribing is done by active ingredient and pharmacists dispense the products procured by the public system which may include generics. For private patients generic substitution is voluntary.

Use of Health Technology Assessments and cost-benefit analysis

The use of health technology assessment (HTA) for decision-making purposes is increasing (including the development of treatment guidelines or for defining the benefit package or medicines). Since HTA requires scientific know-how and administrative capacity which for a small country may represent a significant cost, local authorities are engaging with initiatives such as EUnetHTA. Authorities are encouraging providers to set up patient care protocols to enhance safety and clinical outcomes.

eHealth, Electronic Health Record

eHealth and electronic hospital records empower patients by introducing access to their medical data. While hospital activity data is available in certain detail, even from parts of the private sector, there are still information gaps in a number of areas (e.g. providers' clinical outcomes, appropriateness of processes, outputs, patient experiences and satisfaction). Malta's National Health System Strategy gives particular attention to the use of information technology and the creation of a healthcare information system. The roll out of *myHealth service* since 2012 allows patients and doctors to access electronic medical records through a nominated doctor of their choice and an eID, thus strengthening continuity of care for patients. Developments are continuously being deployed on this platform connecting more and more services over time. A number of eHealth initiatives are currently underway with procurement procedures already in place.

([270]) Azzopardi-Muscat N, Buttigieg S, Calleja N, Merkur S (2017). Malta: Health system review. Health Systems in Transition, 2017; 19(1):1–137.

Health promotion and disease prevention policies

The central government has set a number of relevant public health objectives strongly associated with the risk factors and pattern of mortality and disease. Priorities include the prevention and control of obesity and diabetes through a national platform that promotes healthy diet and exercise, decrease smoking and alcohol use. Authorities also see the education and sports sector as an important partner through the inclusion of health promotion and disease prevention in school curricula and the training of health staff. Such public health objectives are clearly defined in strategy and policy documents published over the past five years, including obesity, diabetes, non-communicable disease, cancer and sexual health, among others.

Recently legislated and/or planned policy reforms

Recent policy response

Health promotion and disease prevention

The National Health System Strategy (NHSS) recognised that health promotion and disease prevention initiatives are key to improving population health and maintaining the sustainability of the health care system in the long term. A number of sectoral strategies have been launched since 2014, including:

- a new National Cancer Plan (2017-2021) that builds on a previous National Cancer Plan (2011-2015);
- a Diabetes strategy (2015-2020);
- a Hepatitis strategy (2018-2025);
- a national Breastfeeding Policy (2015-2020);
- a Food and Nutrition Policy and Action Plan (2015-2020);
- a Healthy Lifestyle in Schools: Healthy Eating and Physical Activity Policy (2015).

Other strategies are at an advanced stage of development, including those related to Mental Health; Food reformulation; Tobacco; Food Safety; Health Enhancing Physical Activity (*HEPA*); Antimicrobial Resistance and Medical Genetics services. Additionally, a consultation document on a Transgender Healthcare Strategy for Malta was launched in April 2018. At the same time, there is ongoing implementation and evaluation of earlier strategies that are approaching the end of their lifespan in 2020, including the Healthy Weight for Life, Non-communicable Disease, Tuberculosis Communicable Disease and Sexual Health strategies.

In 2018, a Social Determinants Unit within the Superintendence of Public Health was set up following the award of a large European Social Funds project. The work carried out by the unit will include research, training and policy implementation, recognising the profound impact of social determinants on health.

Healthcare services

Since the launch of the NHSS, new healthcare services have been introduced, whereas established services which have been operating successfully have been expanded.

Screening: Since 2014 there has been a gradual expansion of the National Cancer Screening Programmes.

Primary care: The relocation of services from hospital to primary care is key to long-term sustainability of the health care system. This is being supported by investment in various ongoing infrastructural projects. These capital projects are being accompanied by a restructuring of elective care services away from the acute hospital, with the aim of placing more of these interventions within the community setting. The paradigm shift in care from one of hospital medical professionals' dominance to the inclusion of highly qualified health care professionals across disciplines in primary and chronic care settings has been evidenced in diabetes care in Malta, as well as other aspects of chronic illness. A range of

specialist clinics are now organised through the primary health care centres ([271]).

Secondary and tertiary care: Several initiatives in the area of secondary and tertiary care implemented since 2014 include improvement the patient care experience.

New model for capital investment in hospitals: A public-private partnership between the public healthcare sector and an international provider was announced in 2016.

Equitable access and patient rights: Patient rights and responsibilities have been enshrined in a National Patients' Charter, launched in 2016, which sets out key rights and responsibilities of people receiving care within the Maltese health system and provides information that underpins their right to safe and high-quality care. Several initiatives to enhance provision of equitable access to healthcare have been implemented. The rights of marginalised groups and minorities were also given specific attention.

Ensuring quality of care: Concern about excessive waiting time for outpatient appointments or inpatient (e.g. elective surgical) care – which may negatively impact patient health – has led to initiatives aimed at reducing waiting lists, including a 'fast tracking' system (guided by the newly established position of 'fast-track nurse') for colonoscopy patients. Other initiatives have also contributed to a reduction in waiting list times for various services, especially for surgery. There was also an increase in acute care hospital beds from 255 per 100,000 in 2013 to 324 per 100,000 in 2015 ([272]). There are also agreements for specific surgical procedures with the private sector to increase surgical capacity and bring waiting times in line with the requirements of the Charter of Patient Rights. The efficient sourcing and supply of medicines is a particular concern for the health system. Business process re-engineering and new IT infrastructure has enabled the eradication of out-of-stock situations on a number of medicines.

Health workforce recruitment, training and specialisation: Efforts at healthcare workforce capacity building have been largely successful, with the number of physicians increasing from 346 per 100,000 in 2013 to 382 per 100,000 in 2015; and the number of nurses increasing from 744 per 100,000 in 2013 to 840 per 100,000 in 2015 ([273]).

IT systems: EU and national investment in IT and e-health infrastructures within the healthcare system have increased in recent years. The national e-health programme includes various projects planned for the period 2017– 2021, such as a 'converge' project, that aims to establish a unified e-health infrastructure, pulling together existing vertical systems, thus facilitating a national electronic health record and better intelligence for informing policy decisions; introduction of electronic card scheme and electronic prescriptions (currently being piloted) to manage patients' medicines entitlement; a revised Digital Health strategy is currently at an advanced stage of development.

Challenges

The analysis shows that a number of reforms have been implemented in recent years notably to reduce waiting times for elective surgery and to establish public health priorities. The main challenges for the Maltese health care system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades. To evaluate whether the ongoing strategy of health system reform is sufficient to cope with the challenge of future spending growth.
- To monitor health systems performance and enhance its functioning as needed.
- To continue to include more elements of activity-related payment in primary care and specialist outpatient care.
- To continue to enhance primary care provision. To make the referral system more effective and improve care coordination.

([271]) Source: https://deputyprimeminister.gov.mt/en/phc/Pages/Home.asp.
([272]) Malta HSPA 2018.
([273]) Malta HSPA; data from Eurostat.

- To investigate if additional measures regarding price regulation, expenditure control, and good prescribing practices are needed to ensure a more cost-effective use of medicines.

- To improve data collection on primary and outpatient care utilisation. To continue efforts to improve the IT infrastructure and sustain the use of health technology assessment in decision-making.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school).

- To ensure acceptable standards in public-private partnership hospitals. A robust legislative and governance framework is needed to ensure careful monitoring and evaluation of this new arrangement. This would allow the regulator to assess the quality of care and value for money being provided to the population.

Table 2.19.1: **Statistical Annex – Malta**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	5	5	6	6	6	7	7	7	8	8	9	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	21.9	21.7	22.5	22.1	20.6	21.3	21.1	21.3	21.5	22.5	24.2	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	3.1	1.5	3.6	2.7	-3.2	3.0	0.9	1.7	3.2	5.9	7.3	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	2.8	-3.6	-1.3	-1.1	2.6	16.7	5.4	2.6	4.4	:	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	9.0	9.1	8.5	8.2	8.3	8.3	9.6	10.0	9.9	9.8	:	10.2	10.1	10.1	10.2
Total current as % of GDP	7.1	7.4	7.1	7.6	7.9	7.9	9.1	9.4	9.3	9.1	:	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	1.9	1.8	1.4	0.5	0.5	0.4	0.5	0.5	0.6	0.7	:	0.9	0.6	0.2	0.3
Total per capita PPS	1,537	1,621	1,609	1,637	1,663	1,768	2,114	2,282	2,391	2,566	:	2,745	2,895	2,975	3,305
Public total as % of GDP	5.2	5.3	4.7	4.5	4.5	4.5	5.2	5.4	5.5	6.4	:	8.0	7.8	7.8	8.0
Public current as % of GDP	3.4	3.5	3.4	4.0	4.2	4.3	4.9	5.1	5.0	5.8	:	7.7	7.6	7.6	7.8
Public total per capita PPS	895	941	900	896	899	968	1,141	1,243	1,320	1,675	:	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	1.89	1.76	1.38	0.45	0.32	0.27	0.30	0.37	0.46	-0.20	:	0.2	0.2	0.2	0.2
Public as % total expenditure on health	58.2	58.1	56.0	54.8	54.1	54.8	54.0	54.5	55.2	57.5	:	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	15.0	13.9	13.6	12.1	13.5	13.6	14.0	14.2	15.1	13.8	14.1	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	:	:	100.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	28.8	29.6	31.1	32.8	31.9	32.9	30.2	29.9	30.3	28.9	:	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	502.1	503.0	505.2	508.5
Life expectancy at birth for females	81.4	82.0	82.2	82.3	82.7	83.6	83.0	83.0	84.0	84.2	84.0	82.6	83.1	83.3	83.3
Life expectancy at birth for males	77.3	77.0	77.5	77.1	77.9	79.3	78.6	78.6	79.6	79.8	79.7	76.6	77.3	77.7	77.9
Healthy life years at birth females	70.4	69.5	71.1	72.1	71.0	71.3	70.7	72.2	72.7	74.3	74.6	62.0	62.1	61.5	63.3
Healthy life years at birth males	68.6	68.3	69.2	68.8	69.4	70.1	69.9	71.5	71.6	72.3	72.6	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	78	80	76	70	72	56	158	151	125	123	110	64	138	131	127
Infant mortality rate per 1 000 live births	5.4	3.7	6.6	8.5	5.5	5.6	6.5	5.3	6.7	5.0	5.8	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.3	1.4	1.4	1.4	1.5	1.5	1.9	1.8	1.8	1.6	:	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.3	0.3	0.4	0.4
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	0.3	0.2	0.3	0.3
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	1.8	:	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	0.2	:	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	0.7	:	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.4	0.4	0.4	0.4	0.4	0.4	0.5	0.4	0.4	0.4	:	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	0.4	:	0.1	0.1	0.2	0.2
Prevention and public health services	:	:	:	:	:	:	:	:	:	0.2	:	0.2	0.2	0.2	0.3
Health administration and health insurance	:	:	:	:	:	:	:	:	:	0.8	:	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.19.2: **Statistical Annex - continued – Malta**

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	18.1%	19.0%	19.3%	18.7%	18.7%	18.9%	20.4%	18.9%	19.2%	18.2%	:	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	31.5%	:	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	2.9%	:	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	11.9%	:	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	10.5%	11.2%	10.8%	9.9%	10.0%	9.1%	9.7%	7.3%	7.6%	6.1%	:	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	7.1%	:	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	:	:	:	:	:	:	:	:	:	2.6%	:	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	13.6%	:	4.1%	4.0%	3.6%	3.4%

Expenditure drivers (technology, life style)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
MRI units per 100 000 inhabitants	:	0.74	0.73	0.73	0.72	0.72	0.48	0.72	0.94	1.17	1.16	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	:	0.5	0.7	1.0	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	:	2.5	2.7	3.2	3.1	3.1	2.9	2.9	1.9	2.1	1.9	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	:	0.0	0.0	0.0	0.2	0.2	0.2	0.2	0.5	0.5	0.5	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	:	:	22.9	:	:	:	:	:	25.2	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	:	:	19.2	:	:	:	:	:	18.9	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	6.4	8.8	7.5	7.1	7.4	7.9	6.9	7.7	8.6	8.5	:	10.4	10.3	10.1	10.2

Providers	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Practising physicians per 100 000 inhabitants	:	:	:	:	304	308	317	329	346	366	379	324	330	338	344
Practising nurses per 100 000 inhabitants	550	561	584	643	618	647	669	669	702	798	794	837	835	825	833
General practitioners per 100 000 inhabitants	:	:	:	72	66	67	76	80	80	81	81	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Doctors consultations per capita	2.6	3.6	2.6	2.4	2.5	:	:	:	:	:	:	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	8	8	7	9	11	12	14	14	14	15	15	17	16	16	16
Day cases discharges per 100 000 inhabitants	3,461	3,458	3,427	3,578	3,957	6,759	7,145	7,639	7,763	8,454	8,612	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	87.5	89.6	80.4	78.0	82.3	81.5	83.2	83.2	80.7	81.8	81.7	77.1	76.4	76.5	76.8
Hospital average length of stay	4.7	5.3	4.8	4.9	6.6	6.8	7.6	7.8	8.6	7.9	8.0	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	30.5	:	31.8	27.4	26.6	35.4	34.4	35.2	35.7	36.6	37.6	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps. Malta	EU
AWG reference scenario	5.6	6.0	6.4	6.8	7.1	7.3	7.4	7.5	7.7	7.8	8.1	8.3	2.7	0.9
AWG risk scenario	5.6	6.2	6.9	7.5	8.1	8.5	8.7	8.9	9.1	9.3	9.6	9.9	4.3	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in % Malta	EU
Population projections until 2070 (millions)	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	19.9	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Malta

Long-term care systems

3.19. MALTA

General context: Expenditure, fiscal sustainability and demographic trends

In 2015, the GDP at market prices in PPS per capita stood at 24,200, which is below the EU average of 29,600. Population was estimated by Eurostat at 0.4 million in 2016 and it is expected to reach half a million by 2070 with the fastest expansion occurring in the next years.

Health status

Life expectancy at birth with 84.0 years for women and 79.7 years for men is above the respective EU averages of 83.3 and 77.9 years in 2015. Healthy life year expectancy is very high with 74.6 years for women and 72.6 for men in Malta versus 63.3 and 62.6 in 2015 in the EU. The percentage of the population in 2015 having a long-standing illness or other health problem is lower than in the Union (29.2% in Malta against 34.2% in the EU). The percentage of the population indicating a self-perceived severe limitation in daily activities stands at 2.5%, which is considerably lower than the EU-average (8.1%).

Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase significantly over the coming 60 years. In 2016, the number of dependent people stood at 17,000 and is projected to increase by 108% to 37,000 by 2070. That is a steeper increase than in the EU as a whole (25%). Also, as a share of the population, the dependents are becoming a bigger group, from 3.5% to 6.2%, an increase of 74%. This is much more than the EU-average increase of 21%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 1.4 pps of GDP by 2070 (EU: 1.2 pps) ([543]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.3 pps of GDP by 2070 (EU: 2.7 pps).

Medium fiscal sustainability risks appear for Malta over the long-run. These risks are entirely related to the strong projected impact of age-related public spending (notably pensions, healthcare and long-term care) ([544]).

System Characteristics

Public provision of LTC is provided at both central and regional levels. In addition, there are also private residential homes and several day centres for the elderly and persons with disabilities. There has also been an expansion in the provision of community-based services and residential care places. In 2013, the number of licensed beds in LTC institutions amounted to more than 4,000.

Public spending on LTC ([545]) reached 0.9% of GDP in 2015 in Malta, below the EU average of 1.6% of GDP. 0.7% of GDP was spent on in-kind benefits (EU: 1.4%), while 0.2% of GDP were provided as cash-benefits (EU: 0.2%). It is not clear which role private co-payments for formal in-kind LTC play in the financing of LTC services.

Types of care

The expenditure for institutional (in-kind) services makes up 85% of public expenditure (EU: 56%), 15% being spent for LTC services provided at home (EU: 28%). Institutional care is relatively costly, Member States with high shares of spending in institutional care may benefit from efficiency gains by shifting some coverage (and

([543]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([544]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([545]) Long-term care benefits can be disaggregated into health-related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

thus expenditure) from institutional to other types of care.

Eligibility criteria and user choices: dependency, care needs, income

Eligibility for long-term care in state-run institutions that cater for permanent residents is granted to persons over 60 years and/or those with a disability that leaves them unable to cope with living within their own home. For all cases, eligibility is determined by a multi-disciplinary evaluation. Cash and in-kind benefits are partly means-tested and others are needs-based, with the majority being of a needs-based type.

Prevention and rehabilitation measures

Acknowledging the importance of preventive strategies that target the elderly, a vast range of community care services exist in Malta, which are intended to enable the elderly to continue living at home and/or in his community. Amongst such services, one can cite as examples: (a) the *Telecare Plus Service* which allows the subscriber to call for assistance when required; (b) the *Meals on Wheels*, which supports elderly persons and others who are still living in their own home but who are unable to prepare a decent meal. The system was successfully overhauled in 2016, which in turn resulted in the introduction of menus which are sensitive to client needs and demands, and the elimination of a significant waiting list which existed prior to the reform; (c) a *Handyman Service* that helps older adults and persons with special needs to continue living as independently as possible in their own home by offering a wide range of repair jobs; (d) a *Home Help Service* which offers non-clinical, personal help and light domestic work to older adults.

The past years saw the consolidation of a number of traditional services and the introduction of a series of new ones to meet the emergent client needs. Improvement in operations resulted in service user gains in *Home Help, Handyman, Night Shelters and Continence service*, while technological improvements made it possible to develop *Telecare* (where beneficiaries approximate 9,000 persons).

Dementia has been put on the national agenda by launching the National Dementia Strategy (2015-2023). Implementation of this strategy saw appointment of a *Dementia Care Coordinator* and the setting up of *Dementia Intervention Teams*, multi-disciplinary team specialising in Dementia Care and support for families caring for older persons with Dementia.

"Dementia Day Centres" provide specialised day care for persons with dementia and offer respite to carers who have family members. Options are being considered to open similar facilities in different parts of the island. "*Memory Cafés*" were introduced in 2017 as an innovative concept where informal carers are provided with informal support from professionals and other people going through the same experience.

"Respite in care homes" is a highly demanded community service. The number of beds available for this service has nearly doubled over the past year such that 30 respite beds are available in eight care homes to meet clients' needs and requests. "*Respite at Home"* was launched in May 2017, where the family is provided with a qualified carer to provide respite in their own home. Different modes of service provision are offered to suit family needs.

The *"Carer at Home Scheme"* was launched in 2016 to reimburse families who employ a qualified carer to care for an older person within a community setup. The range of domiciliary care services was extended in 2016-2017 through the introduction of physiotherapy, occupational therapy, podiatry and a geriatrician service for home-bound persons. A total of 1,700 new referrals were received and followed until October 2017 (a total of 1450 in 2016).

Efforts are ongoing to make effective use of community based services. This achieved through policies and procedures, professional assessment, follow-up and communication, which control abuse without limiting access for persons who genuinely require domiciliary care.

Rehabilitation services are key to reduce pressure on acute care services while delaying institutionalisation and securing the availability of beds allocated for long-term nursing care. Older patients admitted to Mater Dei Hospital are referred and considered for transfer and further management as necessary. The aim is to continue

their medical and nursing care, promote mobilisation and help regain functional independence. An interdisciplinary team approach helps provide holistic care and enable reintegration into the community.

Formal/informal care-giving

Informal care plays an important role in Maltese society, due to the strong traditional role of the family. Support measures offered to informal carers in Malta include a combination of cash benefits and care leave. Respite and support for informal carers is provided through benefits in-kind via community services and the "*Commcare*" unit, which provides assessment and case management services via a team of nurses, allied health professionals, social workers and carers who provide services to clients that are house-bound.

Recently legislated and/or planned policy reforms

Malta is in the process of implementing a National Strategic Policy for Active Ageing (2014-2020), namely within three distinct pillars: active participation in the labour market; social participation; and independent living.

With regards to the first pillar, the policy supports employers to assist the ageing workforce to remain active and productive within the labour market. It also supports the ageing employees to continue to develop their skills in order to meet the changing needs of the work organisation. The second pillar focuses on financial security in old age, encouraging active participation in society, which includes volunteering, grandparenthood, and involvement in civic engagement. The policy promotes lifelong learning and offers support to informal carers and inter-generational solidarity. The third pillar promotes independent living and addresses health prevention and promotion within the community sector. It links acute and geriatric rehabilitation, psychiatric mental health and well-being with community care services. It further promotes age-friendly communities to support good quality of life for older people within society. It finally looks at issues on abuse and end-of-life care.

Several initiatives and programs within this National Strategic Policy have been implemented, or are in the process of being, implemented.

Amongst the initiatives which support participation in the labour market, a seminar was held in collaboration with the Occupational Health and Safety Authority to promote occupational health and safety principles that foster the employability of older and age workers up, and even subsequent, to statutory retirement age. Pre-retirement programs were held with different entities to assist in the smooth transition to retirement. Several initiatives were held to encourage social participation by older adults. Associations of members of day centres and associations of residents in residential homes have been set up to strengthen the voice of vulnerable groups. Active ageing centres have been piloted and set up on a permanent basis and are now being transformed into lifelong learning hubs and collaboration with local councils is ongoing to set up new Active Ageing hubs which provide informal learning opportunities to older adults. Similar sessions are also being held in residential homes for the elderly.

Collaboration with the Malta Communications Authority is ongoing and several information and communication training programs are held based on best practice models so as to support digital inclusion. Older adults are encouraged to lead an independent and active life while support is provided to those who are frailer. Information sessions for informal carers of older persons and information sessions for informal carers of persons with dementia were held. Community services, including respite service, are being reinforced to support older adults to continue living in their own homes. Innovative financial support models for personal care at home have been introduced. Several intergenerational programs are held including programs with Malta College of Arts, Science and Technology (MCAST), main stream and special schools, and with Eko Skola (Eco-Schools). "*Mill-Anzjan ghall-Anzjan*" (from Elderly to Elderly) is a pilot project which was designed and launched with the aim of encouraging older citizens in to care for and assist older persons who live with the same community where they live. The outcome of this project is being evaluated.

With regards to the second and third pillars, the government has also undertaken various measures to enhance long-term care and services for the elderly. These measures include: (a) National minimum standards for residential homes to ensure adequate environment and care of residents; (b) the upgrading of the national *"Telecare"* service to *"Telecare Plus"*, which now offers valuable add-ons and also the upgrading of the pendant to a 'smart accessory'; (c) a 'carer at home' programme that provides older persons with full-time carers to support them to live in the community. Besides, the government also offers a number of respite beds at various care homes to alleviate the responsibilities of informal carers towards their elder relatives. *"Respite at Home"* was launched in May 2017, where the family is provided with a qualified carer to provide respite in their own home. Different modes of service provision are offered to suit family needs. Moreover, the majority of care homes were upgraded to nursing homes and have also undergone refurbishment and have been upgraded with wi-fi facilities.

In order to raise more awareness, two seminars were held, one on end-of-life care and the other to raise recognition of elder abuse and neglect. Leaflets have been distributed to the general public. Lectures on crime prevention related to older persons are being provided with the cooperation of the Malta Police Force.

In relation to dementia, the measures undertaken include: (a) the setting up of a dementia intervention team to further support persons with dementia in the community; (b) the opening of a dementia day activity centre at St Vincent de Paule Residence for the elderly and a dementia centre in Gozo, the second largest island of the Maltese archipelago; and (c) the introduction of a 24/7 dementia helpline service (d) establishing a National Commission on Dementia. Moreover, a pilot programme on dementia friendly communities has been running since January to December 2016 while booklets on dementia were published targeting both the general public as well as informal carers.

In addition to pursuing a policy of active ageing, other policy initiatives are being pursued in order to further improve the provisions of long-term care and services offered in the country. Some of the new policy initiatives are hereby reported.

After the publication of the White Paper on National Minimum Standards for care homes for older people, the standards have been published. Enforcing legislation has also been drafted and is being vetted prior to presentation to Cabinet of Ministers.

The National Dementia Strategy has been published and is already being implemented (see measures above). As part of a comprehensive strategy for elderly care, Malta is also embarking on a new service dealing with geriatric mental health rehabilitation. Policy guidelines have been recently adopted at the state run St. Vincent de Paul Residence for the elderly, which caters for long term residential and nursing care. The intention is to have these policy guidelines adopted by other government residential and nursing homes.

Challenges

The main challenges of the system appear to be:

- **Improving the governance framework:** to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers.

- **Improving financing arrangements:** to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool.

- **Encouraging home care:** to develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation

controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care.

- **Encouraging independent living:** to explore alternative services which encourage independent living, provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** to establish better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.19.1: **Statistical Annex – Malta**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	5	5	6	6	6	7	7	7	8	8	9	12,451	13,213	13,559	14,447
GDP per capita, PPS	21.9	21.7	22.5	22.1	20.6	21.3	21.1	21.3	21.5	22.5	24.2	26.8	28.1	28.0	29.6
Population, in millions	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	:	:	:	:	:	:	:	:	:	0.8	:	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	:	:	192.9	:	264.1	283.2	352.1	373.6
As % of total government expenditure	:	:	:	:	:	:	:	:	:	1.9	:	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	81.4	82.0	82.2	82.3	82.7	83.6	83.0	83.0	84.0	84.2	84.0	82.6	83.1	83.3	83.3
Life expectancy at birth for males	77.3	77.0	77.5	77.1	77.9	79.3	78.6	78.6	79.6	79.8	79.7	76.6	77.3	77.7	77.9
Healthy life years at birth for females	70.4	69.5	71.1	72.1	71.0	71.3	70.7	72.2	72.7	74.3	74.6	62.0	62.1	61.5	63.3
Healthy life years at birth for males	68.6	68.3	69.2	68.8	69.4	70.1	69.9	71.5	71.6	72.3	72.6	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	20.3	24.9	24.7	27.5	28.5	30.4	30.5	29.5	28.2	29.2	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	4.0	3.3	2.6	3.7	3.9	4.0	3.1	3.2	2.8	2.5	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	2	5	7	10	10	10	1	1	1	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	9	7	5	4	4	4	8	8	9	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	2.7	2.9	3.1	3.3	3.3	3.4	2.2	2.2	2.3	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.19.2: **Statistical Annex - continued – Malta**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	0.4	0.5	0.5	0.5	0.5	0.5	0.5	19%	2%
Dependency									
Number of dependents in millions	0.02	0.02	0.02	0.03	0.03	0.03	0.03	108%	25%
Share of dependents, in %	3.5	3.8	4.7	5.3	5.4	5.6	6.2	74%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.9	1.0	1.3	1.6	1.8	2.0	2.3	154%	73%
AWG risk scenario	0.9	1.0	1.4	1.9	2.4	3.0	4.2	364%	170%
Coverage									
Number of people receiving care in an institution	3,973	4,725	7,126	9,314	9,942	10,678	12,529	215%	72%
Number of people receiving care at home	8,092	9,353	13,021	15,591	16,419	17,528	19,601	142%	86%
Number of people receiving cash benefits	4,679	4,818	5,634	5,596	5,482	5,350	5,224	12%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.8	4.2	5.3	6.0	6.2	6.5	7.2	87%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	:	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	80.0	81.4	84.8	88.0	89.2	90.7	92.3	15%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	20.0	18.6	15.2	12.0	10.8	9.3	7.7	-61%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	85.0	85.3	86.0	86.8	86.8	86.9	87.2	3%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	15.0	14.7	14.0	13.2	13.2	13.1	12.8	-15%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	67.3	64.8	66.5	67.8	70.2	74.8	76.5	14%	10%
Unit costs of home care per recipient, as % of GDP per capita	5.8	5.7	5.9	6.2	6.4	6.9	7.2	23%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	16.8	17.0	17.5	17.7	17.8	17.6	17.6	5%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).