Malta

Health Care & Long-Term Care Systems

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Malta

Health care systems

1.19. MALTA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita is currently below EU average with 21,620 PPS in 2013 (EU: 27,900). The population was estimated at 0.4 million in 2013. It is expected to stay within half a million in the coming decades, with the fastest expansion occurring in the next years. The total population is projected to grow from 421,364 in 2013 to around 476,000 by 2060.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (8.7% in 2013) has increased over the last decade (from 8.2% in 2003) and is below the EU average of 10.1% in 2013. Throughout the last decade, public expenditure has first increased then decreased as share of GDP: from 5.7% in 2003 up to 6.3% in 2006, and then down to 5.8% of GDP in 2013 (EU: 7.8% in 2013).When expressed in per capita terms, also total spending on health at 2,171 PPS in 2013 was below the EU average of 2,988 in 2013. So was public spending on health care: 1,435 PPS vs. an average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by a considerable 2.1 pps of GDP between 2013- 2060, 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 3.0 pps of GDP from now until 2060 (EU: 1.6) ([198]).

Medium 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) ([199]).

Health status

Life expectancy at birth, 84.0 years for women and 79.6 years for men, is above the respective EU averages of 83.1 and 77.6 years in 2013. Healthy life year expectancy is very high with 72.7 years for women and 71.6 for men in Malta versus 61.8 and 61.6 in 2013 in the EU ([200]). The infant mortality rate of 6.7‰ is above the EU average of 3.9‰ in 2013, 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 19.2% in 2008, being below the EU average of 22%. The proportion of the obese population is far above EU level at 23% in 2009 (EU: 15.5%), while the alcohol consumption is below the EU level.

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, where a comprehensive basket of services is offered free at the point of use to all entitled persons. The system also provides coverage for vulnerable population groups such as illegal migrants.

([198]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([199]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

([200]) 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.

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 has been set up to monitor and control 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 33.9%, of total health expenditure in 2013, which is above the EU average of 22.6%. A large part of private expenditure is out-of-pocket expenditure (31.5% of total health expenditure in 2013 and much higher than the respective EU average of 14.1%), showing an increase since 2003 (29%). Authorities ensure means-tested entitlement (for people with low incomes) to pharmaceuticals, dental and optical 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 health-care 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 addition some services, especially for long-term and chronic care, are also provided by the private sector, the Church and other voluntary organisations.

The public health-care 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 for all 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 health-care coverage and service delivery.

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 setting. Both Public and Private Doctors also refer their patients for Bone Densitometry and X-Rays.

Secondary and tertiary care is mainly provided by specialised public hospitals of varying sizes. The main acute general services are provided by one teaching hospital incorporating all 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.

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. Hospital care is mostly delivered in NHS hospitals. In addition to NHS provision, there is also private outpatient primary care and basic specialist care practice, given mostly from the private doctor’s office, for private patients, though often conducted by the same doctors that work for the NHS.

To emphasise primary care use there is a compulsory referral system from primary care to specialist doctors and 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 relatively long waiting times.

Some of the health centres are equipped to deal with minor emergencies for 24 hours and 7 days a week. Nevertheless, the mainstay amongst the Maltese public for treatment for emergencies, minor or major tends to be directly at the accident and emergency department at Mater Dei Hospital. 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. Furthermore, shortages of GPs in the NHS still result in waiting times for primary care, which, combined with high patient expectations, has led to some excess and unnecessary use of NHS specialist and hospital emergency care or patients searching for private care. 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. There has been active engagement of the ministry responsible for health with financial authorities as the setting up of group medical practices was being hindered by some regulatory barriers in the legislation on the setting up of partnerships or companies. In addition, European investment is being sought to create a major primary care hub 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, increasing their likelihood to visit the primary care facilities for emergency care. 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 at the average density in the EU. In 2013, there were 346 practising physicians per 100 000 inhabitants, compared to 344 in EU. The number of general practitioners is slightly above the EU average (80 per 100 000 inhabitants vs. 78 in the EU). The number of nurses per 100 000 inhabitants (702 in 2011) is below the EU average of 837.

In 2013, the number of acute care beds was low 256 compared to 356 per 100 000 inhabitants in the EU. With this capacity Malta achieves discharge rates of 14.0 per 100 inhabitants (EU: 16.5).

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.

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 as 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 new main teaching hospital incorporating all specialised, ambulatory, inpatient care and intensive care services. Malta has become almost self-sufficient in terms of providing most tertiary care. When it comes to the provision of highly specialised care for the treatment of rare diseases or specialised interventions 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 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.

Hospital remuneration is 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 include 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 authorises 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). The existing national eHealth platform lacks certain essential components needed to provide cost-effective, cost-efficient and sustainable health services on a national scale. A gap analysis and a needs analysis were carried out, and a number of work packages have been designed to address the situation, with the help of ERDF funds. To this effect, the eHealth Project aims to develop a comprehensive national eHealth infrastructure and integrated portfolio of eHealth systems, in support of improvement of Malta's health and increased efficiency and sustainability of Malta's healthcare system. The deliverables of the Project are important for the cost-effective and sustainable use of available resources and to meet strategic objectives such as the strengthening of primary care, as envisaged in the NHSS.

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 curbing smoking and alcohol consumption and the reduction of obesity through a national platform that promotes healthy diet and exercise. Authorities also see the education 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, non-communicable disease and sexual health, among others.

Recently legislated and/or planned policy reforms

Recent policy response

A landmark Health Act was approved by the Maltese Parliament in 2013, repealing the old Department of Health Constitution Ordinance and creating a modern framework separating policy from regulation and operations.

This Act also enshrined patient rights into a legal instrument for the first time.

The implementation of the new Mental Health Act (MHA), which fully entered into force in October 2014, brought patients' rights to the forefront of service delivery. Patient consent to treatment, the

use of the least restrictive types of treatment, respect for patient autonomy, patient empowerment and the offering of treatment in the community where possible, have all contributed to a gradual reorientation in service provision.

The Act also established a Commissioner for the Promotion of Rights of Persons with Mental Disorders. Government Mental Health Services and the Office of the Commissioner have worked closely to ensure that the rights of persons suffering from mental disorders are safeguarded.

Another major milestone in shaping health services provision is the Human Organs, Tissues and Cells Donation Bill which is being discussed in Parliament and underwent the second reading on the 8th March, 2016.

With respect to major policy reforms noteworthy is the finalisation and launch of the National Health Systems Strategy (NHSS) in 2014. Sustainable high quality healthcare is the focal point of the NHSS. In order to put this into action a detailed Action Plan (AP) and a Cost-Benefit Analysis (CBA) were completed by January 2015.

The Health Systems Performance Assessment (HSPA) was also completed during 2015. The HSPA collates the indicators that were selected following an extensive and rigorous process to monitor the implementation of the NHSS. The HSPA 2015 demonstrates the baseline results and interpretation of these indicators and will be repeated every two years.

The Steering Committee tasked with overseeing the implementation of the NHSS was enacted. It includes the most senior members of the Department of Health.

A number of concrete measures to increase the effectiveness and consolidation of the position of the primary health care system is the cornerstone of the NHSS. A number of actions implemented to strengthen quality and efficiency of services include:

- strengthening of prevention and screening strategies - breast, colorectal and cervical; Preventive strategies – introduction of 'Lifestyle Clinics', strengthening of immunisation services;
- introduction of innovative services – anticoagulant clinics, chronic disease management clinics, backslap plaster services, conduct of minor surgery, setting up of outreach clinics, provision of services by social worker;
- strengthening of existing services – extending opening hours, orthopaedic outreach clinics have increased in frequency, increased involvement of private family doctor, provision of scoliosis screening programmes in schools;
- provision of latest technology equipment in health centres;
- upgrading of the present infrastructure.

There have also been efforts to develop more community-based services for long-term and mental health care. Other health reforms that have taken place in recent years include use of health technology assessment to define the public benefits package and the introduction of the Pharmacy of Your Choice scheme to provide more equitable access to medicines.

The focus on prevention and community services has led to progress in areas such as cancer prevention with the development of cancer screening programmes. Since 2009, a number of national plans and strategies have been launched to address major public health issues, mainly cancer, obesity, sexual health and non-communicable diseases. The National Breastfeeding Policy and Action Plan 2015-2020, launched in July 2015, seeks to increase the initiation of breastfeeding rates and support the family of the breastfed child.

Policy changes under preparation/adoption

Demographic projections are showing that the drive for the attainment of better efficiency within the sector needs to be strengthened. Pursuing healthcare reforms to increase cost-effectiveness of the public health sector is therefore a priority for the government. The following are the key thrusts of the reform Malta is undertaking.

- Improving governance: the government continues investing in the overall governance of the public health services. The focus is on

ensuring better leadership, oversight, management and co-ordination of policy, services, supplies and resources. Measures include:

- the launch in 2014 of the National Health Systems Strategy (NHSS) for the period 2014 to 2020; the first Health System Performance Assessment Report has been completed;

- curtailment and containment of costs through the introduction of various internal control mechanisms and monitoring of operational costs: measures include the implementation of financial governance models which have led to restructuring, increased efficiency of service delivery, containment of indirect administrative costs and deterrence of abuse and misuse of resources. Improved financial control through the recruitment of financial and audit expertise has also reaped benefits, particularly through the enforcement and monitoring of financial and procurement protocols;

- centralisation of procurement services to increase gains from economies of scale, whilst instilling accountability by making each entity responsible for its own purchasing;

- emphasis on health promotion and disease prevention: the growing burden of chronic disease represents a major challenge for health systems and economic and social development across Europe. The government continues working on ensuring that people adopt healthy lifestyles that are conducive to healthy ageing with the aim of increasing the long term sustainability of the health system. Work on the implementation of policy and strategy document issued in the past years such as the National Cancer Plan 2011-2015; A Strategy for the Prevention and Control of Non-Communicable Disease in Malta (2010); A Healthy Weight for Life: A National Strategy for Malta 2012-2020 will continue.

- New measures in the area of health promotion and disease prevention are mainly focused on tackling obesity and diabetes which are both identified as national health challenges. Other measures include: the Food and Nutrition Policy and Action Plan was published in 2014. The Health Behaviour in School Children study was completed and international report published in March 2016. Fieldwork for the European Health Interview Survey has been completed and the National Food Consumption Survey is ongoing. The National Breastfeeding Policy and Action Plan 2015-2020 was published in 2015. ([201]) The Diabetes Strategy was published in December 2015. The Communicable Disease Strategy was published in 2013. It is Government's aim to publish a specific strategy on HIV in 2016;

- strengthening primary health care to reduce acute hospital costs: Initiatives under this measure are aimed at alleviating the pressure from more costly acute care provision and increasing the interaction between public and private primary care provision with the aim of enhancing access. Particular focus is on those services related to chronic disease management and this will be made possible through better resource utilisation, simplification of processes and empowering the private sector;

- increasing the range of services offered at primary level – new services planned include the introduction of chronic disease management clinics and devolution of anticoagulant clinics from the acute to the primary sector;

- upgrading of current primary healthcare facilities – a programme of upgrading and refurbishment of the Gozo General Hospital and Health Centres/peripheral clinics is currently underway;

- opening of new regional centres co-financed by the EU including the building of a Primary Care Regional Hub that will provide a whole myriad of services closer to the community;

- training of healthcare professionals for integrating acute and community care.

([201]) http://health.gov.mt/en/Pages/National-Strategies/NHS.aspx

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, in particular with regard to monitoring the quality of care.

- To continue to include more elements of activity related payment in primary care and specialist outpatient care to induce a higher number of consultations.

- To continue to enhance primary care provision by increasing the numbers and spatial distribution of GPs and nurses possibly by using private provision for the benefit of all NHS patients. To make the referral system more effective and improve care coordination.

- 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 in some crucial areas such as expenditure, resources and care utilisation and improve the monitoring of activity in the sector. This should also include efforts to assess and publish evaluations of the quality of care provided and to increase 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).

Table 1.19.1: **Statistical Annex – Malta**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	5	5	5	5	6	6	6	7	7	7	8	9289	9800	9934
GDP per capita PPS (thousands)	21.2	21.3	21.8	21.7	22.2	22.3	21.2	21.8	21.4	21.5	21.6	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	0.1	-0.9	2.9	2.2	3.7	3.2	-3.5	3.8	1.0	0.3	1.9	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	5.5	2.2	9.9	3.1	-3.8	-0.5	-1.7	3.6	15.9	-8.3	2.0	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	8.2	8.5	9.1	9.1	8.5	8.2	8.3	8.3	9.5	8.7	8.7	10.4	10.1	10.1
Total current as % of GDP	6.5	7.1	7.3	7.5	7.2	7.7	7.9	8.0	9.0	8.3	8.2	9.8	9.6	9.7
Total capital investment as % of GDP	1.7	1.4	1.8	1.6	1.3	0.5	0.5	0.4	0.5	0.5	0.5	0.6	0.5	0.5
Total per capita PPS	1339	1409	1586	1664	1648	1683	1703	1813	2167	2067	2171	2828	2911	2995
Public as % of GDP	5.7	5.9	6.3	6.3	5.7	5.3	5.4	5.3	6.6	5.7	5.8	8.1	7.8	7.8
Public current as % of GDP	4.6	5.0	5.0	5.2	4.8	5.0	5.1	5.1	6.3	5.4	5.4	7.9	7.7	7.7
Public per capita PPS	933	979	1094	1139	1100	1090	1106	1163	1510	1352	1435	2079	2218	2208
Public capital investment as % of GDP	1.2	0.9	1.2	1.1	0.9	0.3	0.3	0.2	0.3	0.3	0.4	0.2	0.2	0.1
Public as % total expenditure on health	69.7	69.5	69.0	68.5	66.7	64.8	64.9	64.2	69.7	65.4	66.1	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	12.5	13.5	14.4	14.6	13.6	12.5	12.5	13.1	13.3	13.5	:	14.8	14.9	:
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	100.0	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	28.7	28.2	28.9	29.6	31.2	33.0	32.5	33.3	30.3	32.2	31.5	14.1	14.4	14.1

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												**2009**	**2011**	**2013**
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	504.5	506.6
Life expectancy at birth for females	80.8	81.2	81.4	82.0	82.2	82.3	82.7	83.6	83.0	83.0	84.0	82.6	83.1	83.3
Life expectancy at birth for males	76.4	77.4	77.3	77.0	77.5	77.1	77.9	79.3	78.6	78.6	79.6	76.6	77.3	77.8
Healthy life years at birth females	:	:	70.4	69.5	71.1	72.1	71.0	71.3	70.7	72.2	72.7	:	62.1	61.5
Healthy life years at birth males	:	:	68.6	68.3	69.2	68.8	69.4	70.1	69.9	71.5	71.6	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	84	80	78	80	76	70	72	56	147	129	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	5.7	5.7	5.4	3.7	6.6	8.5	5.5	5.6	6.5	5.3	6.7	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.86	1.19	1.32	1.43	1.39	1.44	1.47	1.50	1.85	1.57	1.60	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.31	0.31	0.32
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	0.25	0.25	0.24
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.74	0.33	0.36	0.41	0.37	0.40	0.42	0.39	0.47	0.32	0.34	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.13	0.12	0.13
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	0.25	0.20	0.19
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.19.2: **Statistical Annex - continued – Malta**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	28.4%	16.7%	18.1%	19.0%	19.3%	18.7%	18.7%	18.9%	20.5%	19.0%	19.5%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	3.2%	3.3%	3.3%
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	2.6%	2.6%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	16.2%	6.6%	7.2%	7.9%	7.6%	8.1%	8.2%	7.7%	7.5%	6.0%	6.3%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	:	:	:	:	:	:	:	:	:	:	:	3.2%	2.7%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	:	:	:	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	:	:	:	0.74	0.73	0.73	0.72	0.72	0.48	0.72	0.94	1.0	1.1	1.0
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	0.8
CTS per 100 000 inhabitants	:	:	:	2.5	2.7	3.2	3.1	3.1	2.9	2.9	1.9	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	0.0	0.0	0.0	0.2	0.2	0.2	0.2	0.5	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	:	22.9	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	:	:	:	:	19.2	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	6.3	6.3	6.3	6.7	7.6	7.8	7.2	7.6	7.8	:	:	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	:	:	:	:	:	:	304	308	317	329	346	329	335	344
Practising nurses per 100 000 inhabitants	519	532	550	561	584	643	618	647	669	669	702	840	812	837
General practitioners per 100 000 inhabitants	:	:	:	:	:	72	69	67	76	80	80	:	78	78.3
Acute hospital beds per 100 000 inhabitants	340	299	280	284	269	277	271	270	241	250	255	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	2.3	2.4	2.6	3.6	2.6	2.4	2.5	:	:	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	6.9	7.9	7.8	7.3	9.5	10.9	12.3	13.6	14.1	14.0	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	3,509	3,461	3,458	3,427	3,578	3,957	6,759	7,145	7,639	7,763	6368	6530	7031
Acute care bed occupancy rates	83.4	85.4	87.5	89.6	80.4	78.0	82.3	81.5	83.2	83.2	:	72.0	73.1	70.2
Hospital curative average length of stay	4.6	4.6	4.7	5.3	4.8	4.9	5.0	5.0	5.3	5.3	5.3	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	33.8	30.5	:	31.8	27.4	26.6	35.4	34.4	35.2	35.7	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	5.7	6.3	7.0	7.5	7.6	7.8	2.1	0.9
AWG risk scenario	5.7	6.4	7.4	8.2	8.4	8.7	3.0	1.6

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

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	0.4	0.4	0.5	0.5	0.5	0.5	12.7	3.1

Sources: EUROSTAT, OECD and WHO

Malta

Long-term care systems

2.19. MALTA

General context: Expenditure, fiscal sustainability and demographic trends

In 2013, the GDP at market prices in PPS per capita stood at 21,600, which is below the EU average of 27,900. Population was estimated at 421,364 in 2013. It is expected to stay within half a million in the coming decades with the fastest expansion occurring in the next years. Total population is projected to grow from 421,364 in 2013 to around 476,000 million by 2060.

Health status

Life expectancy at birth (84.0 years for women and 79.6 years for men) are above the EU averages of 83.1 and 77.6 years in 2013. Healthy life year expectancy is very high with 72.7 years for women and 71.6 for men in Malta versus 61.8 and 61.6 in 2013 in the EU. The percentage of the population in 2012 having a long-standing illness or other health problem is slightly lower than in the Union (29.5% in Malta against 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in daily activities stands at 3.2%, which is considerably lower than the EU-average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 15 thousand residents living with strong limitations due to health problems in 2013, an increase of 82% is envisaged until 2060 to slightly more less 30 thousand. That is a steeper increase than in the EU as a whole (40%). Also, as a share of the population, the dependents are becoming a bigger group, from 3.5% to 5.7%, an increase of 61%. This is much more than the EU-average increase of 36%.

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 1.2 pps of GDP by 2060 ([419]). 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 2.2 pps of GDP by 2060.

Medium 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) ([420]).

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 reached 1.1% of GDP in 2013 in Malta, below the EU average of 1.6% of GDP. 0.8% of GDP was spent on in-kind benefits (EU: 1.3%), while 0.3% of GDP were provided as cash-benefits (EU: 0.3%). 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 75% of public expenditure (EU: 80%), 25% being spent for LTC services provided at home (EU: 20%). 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 thus expenditure) from institutional to other types of care.

([419]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.
([420]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

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 medical evaluation. Cash and in-kind benefits are partly means tested and others are needs-based.

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 Maltese Cross Corps (a non-governmental organisation) in collaboration with the Department for the Elderly and Community Care provide these individuals with a cooked meal); (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 Care Help Service which offers non-nursing, personal help and light domestic work to older adults.

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. Rehabilitation services for older people in Malta are provided by the Department of Geriatrics at the Rehabilitation Hospital Karin Grech. 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 "Community Care Unit". The latter consists of nurses, physiotherapists, occupational therapists, 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) and with Eko Skola (Eco-Schools).

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 'live-in carer' 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. Several of these care homes 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. 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 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 2.19.1: **Statistical Annex – Malta**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	5	5	5	5	6	6	6	7	7	7	8	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	21.2	21.3	21.8	21.7	22.2	22.3	21.2	21.8	21.4	21.5	21.6	26.8	27.6	28.0	28.1	27.9
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	504	506	507
Public expenditure on long-term care																
As % of GDP	:	:	:	:	:	:	:	:	:	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	:	:	:	:	:	:	:	:	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	:	:	:	:	:	:	:	:	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.8	81.2	81.4	82.0	82.2	82.3	82.7	83.6	83.0	83.0	84.0	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	76.4	77.4	77.3	77.0	77.5	77.1	77.9	79.3	78.6	78.6	79.6	76.6	76.9	77.3	77.4	77.8
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	:	62.6	62.1	62.1	61.5
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	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	20.1	20.3	24.9	24.7	27.5	28.5	30.4	30.5	29.5	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	3.9	4.0	3.3	2.6	3.7	3.9	4.0	3.1	3.2	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	2	5	7	10	10	10	1	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	9	7	5	4	4	4	8	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	2.7	2.9	3.1	3.3	3.3	3.4	2.2	2.0	2.2	2.2	2.3	2.1
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 2.19.2: **Statistical Annex - continued – Malta**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	0.4	0.4	0.5	0.5	0.5	0.5	13%	3%
Dependency								
Number of dependents in millions	0.01	0.02	0.02	0.02	0.03	0.03	82%	40%
Share of dependents, in %	3.5	4.1	4.8	5.3	5.4	5.7	61%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	1.1	1.3	1.6	2.0	2.1	2.3	104%	40%
AWG risk scenario	1.1	1.3	1.9	2.6	3.0	3.7	229%	149%
Coverage								
Number of people receiving care in an institution	1,197	1,547	2,201	2,788	2,892	3,075	157%	79%
Number of people receiving care at home	8,103	10,296	14,254	16,667	16,769	18,175	124%	78%
Number of people receiving cash benefits	3,290	3,342	3,184	3,136	3,058	2,926	-11%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.0	3.5	4.3	4.9	4.8	5.1	70%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	84.5	84.9	88.7	91.8	89.8	89.3	6%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	82.2	84.6	89.1	91.4	92.1	93.1	13%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	17.8	15.4	10.9	8.6	7.9	6.9	-61%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	75.0	75.0	75.0	76.0	76.5	76.1	2%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	25.0	25.0	25.0	24.0	23.5	23.9	-5%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	242.9	228.7	228.3	234.1	241.4	249.8	3%	-2%
Unit costs of home care per recipient, as % of GDP per capita	12.0	11.5	11.8	12.4	12.8	13.2	11%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	25.6	25.7	25.6	25.6	25.8	25.7	1%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".