Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

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1 Executive Summary

In Malta, the public pension system operates primarily on a first pillar pay-as-you-go (PAYG) basis whilst the public health care system offers a comprehensive basket of services, free at the point of use to all the population, financed out of general taxation. Debate on and implementation of reforms to address long term concerns associated with adequacy and sustainability are ongoing.

In the field of pensions, reform initiatives that started taking effect from 2007 onwards are being seen through. The consultation process following the launch of the 2010 report of the Pensions Working Group (presenting a number of recommendations for further reform) continued in the reporting period.

Within health care, an electronic system was implemented giving GPs in primary health care greater access to patient data residing within the public health system. The benefits provided continued to increase, including a geographical extension of the Pharmacies of your Choice Scheme; increasing the number of medicines and services provided both in Malta and for Maltese patients requiring care in the UK and the launch of National Cancer Plan 2011-2015. There was also an organisational re-structuring at the top echelons in the Ministry.

Long-term care has benefitted from an expansion of community-based services and residential care places. Accessibility within the public system is being improved through PPP (public private partnerships) arrangements and the purchase of beds within the private sector. Policy sought to help elderly people continue to reside in their own homes through the introduction in the 2012 fiscal budget, of a EUR 300 annual grant awarded to every elderly person over 80 living in their own home or with their family. This initiative will cost EUR 3.5 million, and will benefit nearly 12,000 elderly persons[1] (3% of the total population).

No austerity measures were required in Malta such that social protection was not affected by any such considerations. It is however to be noted that fiscal expenditure in 2013 is to be reduced by EUR 40 million following a review of the budget for the year by the European Commission. Government indicated that this would affect its operational expenditure. Thus, while not influencing transfer payments such as welfare benefits, this could have an impact on services provided in kind, such as those related to health and long-term care.

[1] Budget Speech 2012, page 88.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The consultation process following the launch of the 2010 report of the Pensions Working Group which aims for a second reform, continued in the reporting period. A number of changes that were legislated in the pension system in 2006 have occurred within the reporting period whilst others, most notably the increase in retirement age, will take effect in 2014.

Within the field of health care, no changes were made through legislation with regards population coverage. However, a number of changes occurred with regards to the benefit package.

In long-term care, policy focused to provide support to enable dependent persons to remain in society and lead, as far as possible, an **independent life**. Notwithstanding, State community based services have been extended as they continue to be increasingly demanded whilst within the institutional care setting, the purchasing of beds within the private sector continued.

As reported in last year's annual report, the **onset of the recent crisis did not require any alteration of social protection policy approaches in Malta**. Thus, no exit strategies were required, and budgetary allocations in the field of pensions, health care and long-term care remain unchanged. In 2013, the provision of services in kind may to some extent be affected by a reduction in government operational expenditure, as compared to that provided for in the fiscal budget for the year, following a review of the same budget by the European Commission.

National debates regarding the future developments of social protection focused mainly on obvious tensions between client demands and fiscal sustainability, within growing concerns of a deteriorating international economic environment and sovereign debt downgrades which affected Malta as well. At the present stage, there seems to be no clear outcome from this debate, other than a general recognition of increasing demands for services, areas of stresses in the provision for particular areas, and the potential challenges posed by the economic situation. In the area of health care in particular, a longer term strategy for quality provision and sustainability has not been articulated.

2.2 Pensions

2.2.1 The system's characteristics and reforms

In Malta, public **pension provision** consists of a mandatory earnings-related pension scheme, financed on pay-as-you-go (PAYG) basis, which provides old-age pensions, survivor's benefits and invalidity pensions. The scheme is supported by a means-tested (non-contributory) welfare programme. The entire population is covered under either contributory or non-contributory pension scheme. Occupational pension schemes and personal pension provisions are still in a very nascent stage of development in Malta although occupational schemes did exist before 1979. Occupational service pensions continue to apply for civil servants employed before that year and for specific occupational categories including military and police workers, but these are a relatively minor element within the overall system.

The contributory public pension system is classified as an unfunded, defined-benefit scheme. The system operates exclusively on a first pillar PAYG basis. Currently, the **statutory**

retirement age is 61 years of age for both males and females whilst the average exit age lies at 60.3 years[2] One of the parametric changes to the PAYG introduced by law in 2006[3] is that of increasing the retirement age incrementally to 62 years of age as from 2014, reaching 65 years of age by the year 2026.

In the case of employees, employees and employers each pay a contribution of 10% of the basic weekly wage. This is matched by the State contributions equivalent to 50% of the total amount paid by both employee and employer. Contributions are payable by all persons between age 16 and 65[4]. Persons over 65 years who decide to continue working are not liable to pay contributions[5]. In the case of self-employed persons, the worker pays a contribution based on total net income, with a maximum rate of 15%. Contributions may be credited without payment under certain circumstances, such as during sickness, unemployment, widowhood and invalidity. Amendments were made to the "contributions credit system" in the 2006 reform by introducing credits for parents with career breaks for a period up to two years for every child, together with provisions encouraging work beyond the new statutory retirement age (to curb early exit from the labour market).

The **benefit formula** is calculated as two-thirds of the average income of the best three consecutive years during the last ten years prior to retirement, after a contribution period of 30 years. For self-employed people, the income averaging period is extended to the last ten years. The required contribution period to be entitled to the full two-thirds pension will be gradually increased in a staggered manner to 35 years for those retiring in 2014, reaching 40 years for those retiring in 2026. Gradual changes have also been made to the calculation base to take effect as from 2014. The pensionable income will be calculated on the basis of the best three consecutive years in the last eleven years of their working lives while for self-employed persons it will be calculated on the average of ten consecutive years in the last eleven years prior to retirement. The pensionable income will continue to be calculated in the same manner but will increase gradually to the last 13 years of their working lives. By 2026, the calculation base will be the yearly average income during the best ten years within the last 40 years, and there will no longer be a distinction between employed and self-employed persons.

The guaranteed national minimum pension, currently based on the national minimum wage, will be calculated at a higher rate of 60% of the national median wage. The maximum pension income is to increase from EUR 16,424 in 2010 to EUR 20,970 by 2014. The increase will occur in three steps between 2011 up to 2014. Pension benefits are to be indexed with increases in the average wage and inflation, with weights of 30% and 70% respectively.

The system provides a generous benefit to contribution ratio offering a theoretical 66% replacement rate out of a 20% contribution rate. Higher income levels are excluded from this system by means of ceilings, expressed in absolute terms, on contribution and pension levels. These offer better replacement rates to lower income earners while containing the financial cost of the system. In the past two decades, however, the ceilings have restrained the living standards of pensioners while not fending off excessive pressures on its cost. This reflected population ageing and relatively, low employment rates of older workers, also because of early exit from the labour market.

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2 Eurostat, LFS main indicators.

3 Enacted Pensions Reform Changes document accessed on 13th February 2012 at: https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/documents_archive.aspx.

4 Persons opting to continue working from age 61 to 65 can enjoy their pension's rights without paying further contributions subject to a minimum wage ceiling.

5 After the age of 65, the minimum wage ceiling is removed and no contributions are due.

Early retirement opt outs remain commonly available in Malta, though less than in past. Layoffs resulting from privatisation of public entities and redundancies in private business, as well as abuse in invalidity pension claims contribute to an early exit age which weakens the sustainability of the first pillar. On the other hand, the reform in the social security legislation to allow for retired persons to continue working without forfeiting their pensions has incentivised thousands of pensioners to continue working beyond retirement. The application of flexicurity measures to the elderly segment of the labour force has recently started to produce positive results.

One of the measures of the 2006 reform includes the preparation, every five years, of a report to elaborate on the performance of the system. The first of these reports entitled "Strategic Review on the Adequacy, Sustainability & Social Solidarity of the Pensions System" includes 45 additional recommendations so as to pave the way for a second reform. These were presented by the Pensions Working Group in December 2010[6]. To date, these recommendations have not yet been legislated. As reported in the annual report for 2011, these recommendations inter alia include:

- An increase in credits for child rearing biasing towards families with more children and allowances given to persons to fill gaps in contributions due to lifelong learning;
- The introduction of a retirement longevity-index;
- The appointment of a working group to assess the possibility of transforming the first pillar two-third pension into a notional defined contribution so as to award higher replacement rates for persons who remain active in the labour market;
- The possible introduction of a mandatory second pillar;
- The introduction of a voluntary third pillar with a EET fiscal incentive framework; and
- The possible consideration of a housing equity release scheme, to allow retirees to leverage their home ownership investment into income during retirement. (It must however be highlighted that in the light of recent experiences[7], the extent of opinion in favour of this approach is weakening considerably.)

In general terms, the economic and financial crisis did not impact pension policy in Malta since **it did not impact national budget consolidation programmes**. In 2009, social protection expenditure amounted to 19.8%[8] of GDP in 2009 up from 17.9% in 2008. In 2009, expenditure on pensions, health care and long-term care amounted to 9.7%, 4.4% and 0.72% of GDP, respectively[9].

In the case of social benefits, the reduction in the overall budgetary expenditure for 2013 following the Commission review of the fiscal forecasts is not expected to impact on social security benefits.

2.2.2 Debates and political discourse

The **consultation process** following the 2010 strategic review report of the Pensions Working Group continued throughout 2011. This involved a number of meetings with social partners together with a number of public consolations. Formal submissions and questions could also be

6 https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/strat_rev_pensions.aspx, accessed on 13th February 2012.

7 Housing prices have internationally proved to be volatile to economic and financial market fluctuations. Although these pressures were contained in Malta, the risks to downward pressures on property prices exist mainly due to a significant over supply therefore exposure of pension funds to the real estate sector may introduce an element of risk.

8 Social Protection: Malta and the EU 2010, National Statistics Office.

9 The residual amounting to 4.9% of GDP includes 'other social protection expenditure'.

sent via email. Formal feedback received from stakeholders[10] together with other related documentation can be found in the pension reform section on the website[11] of the Ministry of Employment, Education and the Family.

The opposition party believes that the PAYG method is not a sustainable way to provide adequate pensions, however in the light of this reality, people's purchasing power and economic developments must also be kept in mind as people are struggling with day-to-day living costs, possibly due to inflation[12]. In 2011, Malta's annual inflation rate was recorded at 2.4%, whilst the inflation rate of the EU stood at 3.1%. Compared to the EU average, inflation in Malta tends to be somewhat volatile and sensitive to developments in food and utility prices. The latest SILC reveals that in 2010, both the average gross household income and disposable income fell by 1% when compared to the previous year.

There are various positions held by different stakeholders regarding the extension of working lives and increasing the retirement age. In general, there is agreement that there should be no financial disincentives in place for those who wish to work beyond retirement age. There is however concern regarding the automatic linking of the retirement age to longevity beyond 65 years of age. In particular, the General Workers Union refer to the 'undesirability and impracticality' of having certain categories of workers still working beyond a particular age. MCCEI and MHRA state that 'one must look at the long term effects of indexing retirement age with life expectancy. The latest statistics are showing that in general the Maltese population is living up to the age of 79.' The Green Party states that 'an independent commission should consider whether a different age for pension eligibility should be set for physically or mentally demanding jobs'. The National Council of Women believe in 'parallel initiatives' which must accompany longer working lives, particularly lifelong learning.

The Malta – 2012 Article IV Concluding Statement of the IMF Mission (23rd January 2012)[13] mentions that 'Building on progress already made, further pensions reform will contribute to resolving anticipated long term fiscal imbalances and support medium-term growth....we support the main recommendations of the Pensions Working Group, notably: indexing retirement age to longevity and introducing a mandatory privately funded second pillar and voluntary third pillar. Consideration should also be given to introducing a notional defined contribution first pension and to accelerating the planned gradual retirement age to 65.'

Discussions regarding a guaranteed minimum pension in Malta are concerned with adequacy of income in retirement to cope with living costs. The guaranteed national minimum pension has been addressed in the 2006 reform as the guaranteed national minimum pension will be equivalent to 60% of the national median income and will come into force in 2026. There is an on-going debate regarding adequacy prior to that date for current and future pensioners[14]. The

[10] https://secure2.gov.mt/socialpolicy/socprot/social_benefits/pensions_reform/written_feedback_received.aspx, accessed on 13th February 2012.
Written Feedback was received from: the Alliance of Pensioners' Org., Alternattiva Demokratika, Forum of Maltese Unions, General Workers Union (GWU), Malta Employers Association, Malta Federation of Professional Associations, Malta Institute of Taxation, Malta Insurance Association, MSV Life p.l.c., National Commission for the Promotion of Equality (NCPE), National Council of Women, National Council for the Elderly, The Malta Chamber of Commerce, Enterprise and Industry (MCCEI) and MHRA, The Malta Institute of Accountants and the Union Haddiema Maghqudin (UHM).

[11] https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/pens_adeq_sust.aspx, accessed on 13th February 2012.

[12] http://www.timesofmalta.com/articles/view/20110414/local/-Pension-structure-should-embrace-the-economic-and-education-systems-.360191.

[13] http://www.imf.org/external/np/ms/2012/012312.htm.

[14] This has been brought up by UHM and the National Alliance of Pensioners.

Pensioners' Alliance is calling for an immediate implementation of the revised national minimum pension.

At present there are no second or third pillar pension schemes. There are a number of voluntary long term savings products (that do not provide fiscal incentives to save); however the latter are not pension products. There has been considerable debate regarding the important role of **private/funded pensions** to complement the PAYG system in Malta.

The Malta Insurance Association argues in favour of the introduction without any further delay of voluntary third pillar pensions, suitably incentivised with fiscal instruments, followed by the establishment of mandatory second pillar pensions. The role of the first pillar is more or less seen to serve as a safety net in those cases where there are no savings. Private financial savings, with adequate regulatory safeguards are seen as consumption-smoothing instruments that ensure adequacy in old age. The benefits derived do not only include the increase in income of individuals in old age but also the stimulation of private financial savings[15] and the creation of business activity in the financial services sector. On the other hand, there are a number of stakeholders which have a number of reservations regarding the implementation of mandatory second pillar pensions due to their impact on low-income earners.

A study entitled **Pensions: What fiscal incentives can Malta implement?** (Debono, 2010) highlights that there is a case in favour of adequate fiscal incentives in Malta due to the lack of incentives for employers and employees. A Table with a list of possible incentives is presented, starting from the least expensive incentive to the most expensive one, so as to make the pension system more adequate and sustainable. These range from allowing benefits to be taken as income free of tax, to the removal of taxes on funds saved for retirement planning.

A study on **Gender Equality in Maltese Social Policy**[16] published in 2011 examines women's experiences of gender equality in terms of key elements of gender models covering paid work and income and care work. The study mentions that the promotion of gender equality is weak, whilst parental leave and care benefits that exclude entitlement to national insurance contributions and which offer no compensation for loss of earning, discourage men's share in time-to-care benefits, and perpetuate women's traditional role and dependence on men.

An analysis of the pension system in Malta reveals that a point of concern is that many women who are separated from their husbands often face problems in receiving the pension cheque to which they are entitled. Entitlement to the woman is not automatically sent by Government, since a woman who has never worked in formal employment has no accrued pension rights.

Within the PAYG system itself, there are no significant **gender pension gaps** in the statutory retirement age since men and women retire at the same age. Shorter lengths of service due to career breaks do not provide different replacement rates when compared to complete working lives with no career breaks, within the current system. Current pensioners would have accrued full replacement rate at 30 years of service. Women who continued working after having children would be likely to have accumulated this number of years of service. The bulk of the other women would have typically accumulated no pension rights at all, as they would have left the labour market relatively early in their working lives. There are gender pension gaps when it comes to pension levels due to different wage levels between men and women. The average pension paid to male beneficiaries is probably higher than that paid to females due to

[15] Housing and financial wealth in Malta are unevenly distributed at 79% and 21%, respectively. This is not the case for the Euro area as housing and financial wealth is evenly distributed at 49% and 51%, respectively[15]. Thus, it can be concluded that Maltese households hold a low proportion of their wealth in the form of financial assets when compared to countries in the Euro area. Source: http://www.ecb.int/pub/pdf/other/mb200901_pp59-71en.pdf, accessed on 13th February 2012.

[16] http://www.millermalta.com/gender-equality-in-maltese-social-policy/, accessed on 13th February 2012.

substantial difference between genders in pay received during the working life of current pensioners.

In future, as more women will continue to participate in the labour market after childbearing and caring, together with the extension of the contribution period to 40 years, there may result a lower average replacement rate for women. This may be tempered by the crediting of contributions for women absent from the labour market due to child responsibilities for a maximum period of 2 years per child. Gender pay gaps are likely to narrow as more skilled women will be present in the labour market.

It is also interesting to note the results of the **Euro Barometer Survey** on Active Ageing held between September – November 2011. This provides an understanding of European citizens' views and attitudes towards older people, the contribution of older people in the workplace and society, and how best to promote an active role of older people in society. Respondents from Malta thought being "young" stopped at 36.7 years, in comparison to 41.8 years in the EU-27. Maltese respondents were very positive about the contribution of old people in society, scoring at an average of 78%, in comparison to 70% in the rest of the EU-27. Most people in Malta (75%) believe that people should be allowed to continue working once they have reached the statutory retirement age, in comparison to 61% of respondents in the EU-27. This may be partly reflected by the fact that Malta has lower unemployment rates when compared to the rest of the EU. There is thus no strong perception of a possible danger of longer working lives curtailing employment prospects for younger workers.

2.2.3 Impact of EU social policies on the national level

EU support through ESF projects, coordinated by the Employment Training Corporation in the course of the financial crisis, enabled workers in distressed sectors to remain in employment. This assisted firms to overcome the temporary drop in activity.

The Flagship Initiative in the **EU 2020 strategy** "European Platform against Poverty" calls upon Member States to promote shared collective and individual responsibility in combating poverty and social exclusion; fully deploy their social security and pension systems to ensure adequate income support and access to health care; and to define and implement measures addressing the specific circumstances of groups at particular risk such as elderly women.

The NRP under the Europe 2020 strategy for Malta acknowledges challenges in terms of pension sustainability and adequacy, including demographic ageing and bottlenecks to labour market participation. It describes parametric reforms that have been undertaken and proposes recommendations for the second phase of the pension reform. Recommendations for the second phase of the reform reflect the EU 2020 flagship requirement for a fight against poverty through an improvement in the minimum pension income and indexation within the parametric reform to the PAYG; a paradigm shift for disabled persons to enter employment and urging informal economy workers to enter the formal economy, including atypical workers.

Pension reform debates locally reflect the EU 2020 strategy and the NRP, as discussed in the previous section.

With reference to the objectives specified in the **Annual Growth Survey**, there has been progress to retain older workers in employment. New legislation was introduced in 2008 through which persons of pensionable age under the age of 65 are now able to work without losing their pension entitlements, irrespective of the amount of earnings and irrespective of their age. The new legislation requires that such persons contribute by means of a social security contribution from their employment. Therefore, there is now no longer a limit on the amount of earnings from gainful activity (i.e. a capping of earnings) in order to qualify for a

retirement pension prior to age 65. It is to be noted that prior to this legislative measure, persons under 65 years of age had to forfeit their pension if gainfully occupied and earning more than the Maltese National Minimum wage. The said measure is expected to continue contributing towards more active participation of older people in the labour market.

Government is already maintaining in employment, on a selective basis according to the needs of the service, persons beyond their official retirement age. As a small nation, positive practices introduced by Government normally have a 'pull' effect on the rest of society. Efforts towards a comprehensive active ageing strategy to accompany increases in retirement ages are however lacking.

A number of targeted incentives have however been put in place to employ older workers. The Employment Aid Programme contributes towards the integration of disadvantaged persons in the labour market, according to pre-specified target groups. It facilitates access to employment through financial assistance and upgrades skills through work experience. Employers will receive a public grant equivalent to 50% of the wage costs i.e. half the actual wage plus half the employer's national insurance. One of these pre-specified target groups are persons older than 50 who do not have a job or who are losing their job (i.e. has been served with a redundancy notice of termination of employment/applied for a voluntary redundancy scheme). In total, 2025 persons within all pre-specified categories, or 1.2% of the employed population, who were given work experience through the Employment Aid Programme, were subsequently engaged full time by the companies which offered them the experience[17]. The scheme registered an 85% success rate.

The promotion of lifelong learning in Malta is on the increase but there must be more emphasis on conveying the importance of this with employers and workers alike.

According to the **Country specific recommendations[18]of the Commission** published in June/July 2011, 'the risks with regard to long-term sustainability of public finances appear to be high as the long-term budgetary impact of ageing, including pensions, is significantly higher in Malta than the EU average. Moreover, the labour market participation of older workers is very low, due to a still relatively low retirement age, frequent recourse to early retirement schemes and the very low participation of older women'. As highlighted in Section 2.2.2, these considerations have featured in national debates, and were reinforced by the IMF report of January 2010.

Fostering participation of women in the labour market is another major challenge for Malta, given that its female employment rate is the lowest in the EU. A substantial number of initiatives targeting female workers have been implemented in the reporting period including the extension of childcare centres, after school hours programmes, media campaigns to attract women to enter the labour market, and the extension of maternity leave. The budget for 2012 furthermore introduced favourable taxation arrangements for working couples with children.

The Open Method of Coordination is of a relatively minor importance in the context of social dialogue concerning pensions in Malta. There is very much the perception that the method is a matter of the Government and the Commission, with little or no involvement by other stakeholders. Over this reporting period, at local level, stakeholders were involved by providing their feedback concerning pension policy documentation.

[17] http://www.timesofmalta.com/articles/view/20120228/local/high-success-rate-for-etc-s-employment-aid-programme.408927.

[18] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:215:0010:0012:EN:PDF.

2.2.4 Impact assessment

One indicator of the effects of policies is the fact that **labour market participation of the elderly** has increased over the last three years due to the removal of disincentives to work longer, as explained in Section 2.2.1. In December 2011, there were a total number of 10,304 persons who remained in employment after retirement age, from 8,156 in December 2008[19].

In terms of **adequacy,** Maltese males have a much higher 'at risk of poverty or exclusion'[20] when compared with European counterparts (Males, 65+ & 75+ in 2010 MT: 22.7%, 23.3% EU-27: 16.2%, 17.6%). This stems from the 'at risk of poverty indicator' (ARPR) since material deprivation indicators fare well with the rest of the EU. The typically lower female participation rate in the labour market corresponding to this age cohort results in one earnings related pension that has to be shared between both married persons[21]. Due to the higher life expectancy amongst females relative to that of males, at the risk of poverty rate diminishes substantially for women within the 75+ age cohort, since widows typically continue to receive five-sixths of their husband's pension. This makes widows financially better off compared to married retired couples on a per capita basis. Therefore, counter to the tendency in the EU, Maltese females aged 65+ are in a better financial position than males, markedly in the 75+ category.

An income earner with a career break is expected to have a lower pension entitlement than that for an average income earner working for a full 40 year career, in the future. This is not the case at present since 30 years of contributions may still be achieved with a ten year career break given that people start working at a young age. A different set of results is however expected for 2050 due to the reform measure that will require a 40 year contribution period for a full pension rather than the current 30 coupled by the fact that an increasingly larger proportion of young persons further post secondary and tertiary education and start working later.

T**he** economic **and financial crisis** did not impact upon this assessment of the system, for reasons described earlier on.

Medium and long-term forecasts, derived by the World Bank are reproduced in Figure 1. Total benefit payments will stand at 10% of GDP in 2030 and 15% of GDP in 2060 from the current 9%, reflecting demographic change and a relatively low GDP growth scenario.

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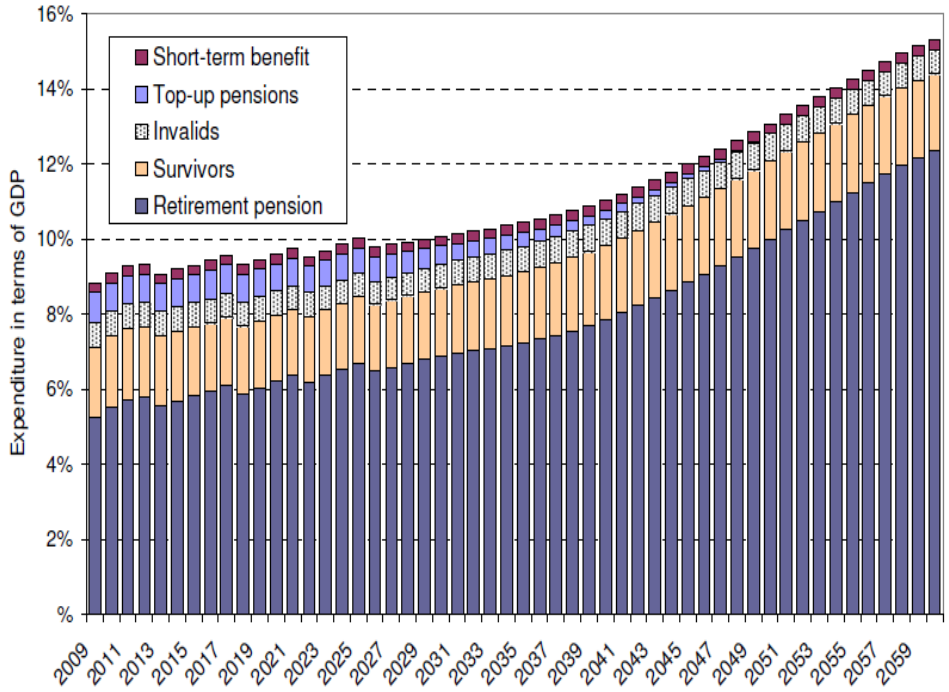
19 http://finance.gov.mt/image.aspx?site=MFIN&ref=2012_Budget%20Speech%20English.

20 The **Europe 2020 strategy** promotes social inclusion, in particular through the reduction of poverty, by aiming to lift at least 20 million people out of the risk of poverty and social exclusion. **This indicator corresponds to the sum of persons who are: at risk of poverty or severely materially deprived or living in households with very low work intensity**. Persons are only counted once even if they are present in several sub-indicators. At risk-of-poverty are persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income (after social transfers). Material deprivation covers indicators relating to economic strain and durables. Severely materially deprived persons have living conditions severely constrained by a lack of resources, they experience at least four out of nine following deprivations items: cannot afford i) to pay rent or utility bills, ii) keep home adequately warm, iii) face unexpected expenses, iv) eat meat, fish or a protein equivalent every second day, v) a week holiday away from home, vi) a car, vii) a washing machine, viii) a colour TV, or ix) a telephone. People living in households with very low work intensity are those aged 0-59 living in households where the adults (aged 18-59) work less than 20% of their total work potential during the past year.

21 According to the SILC, in 2009 there were a total of 3,850 households (with 2 or more persons aged 65+) with a total household income ranging between EUR 5,001 and EUR 10,000.

Figure 1 - Benefit payments in terms of GDP, 2009-2060



Source: Pensions in Malta: Actuarial Analysis and Options for a Second Generation Reform, World Bank

Regarding revenue, the more stable evolution of contributors (given population and employment trends) results in a relatively constant trend for projected resources around 10% of GDP for the medium and short term period.

A brief assessment of **international comparative indicators** in the field of pensions reveals that the median relative income ratio of older people (60+)[22] in Malta fares worse than that of the EU-27 reflecting a lower overall income situation of older people relative to the active population (MT: 0.83, EU-27: 0.92, 2010). Malta's aggregate replacement ratio[23] is lower than that of the EU 27 (MT: 0.46, EU-27: 0.53, 2010) whilst the at-risk of poverty rate[24] for the 65+ category is relatively higher than that of the EU 27 (MT: 18.8%, EU-27: 15.9%, 2010). These indicators possibly reflect adequacy issues of the PAYG system and the lack of financial savings during one's lifetime (within the context of non-existing second pillar and third pillar elements).

2.2.5 Critical assessment of reforms, discussions and research carried out

In relation to the OMC and the Europe 2020 framework, an **innovative policy approach** includes the introduction of the flexicurity measure which allows retired persons to continue working without forfeiting their pensions.

It is the **opinion** of the authors that the general thrust of programmes and reforms being contemplated is in the **right direction**. However, in an economic environment which may be difficult in the short- to medium-term, and within the context of the inescapable challenges of

[22] The indicator is defined as the ratio of the median equivalised disposable income of persons aged 60 and over to the median equivalised disposable income of persons aged between 0 and 59.

[23] The indicator is defined as the ratio of the median individual gross pensions of 65-74 age category relative to median individual gross earnings of 50-59 age category, excluding other social benefits.

[24] Share of population aged 65 or over with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income after social transfers.

population ageing, it is here argued that a more vigorous approach to such reforms may be required, with priorities as follows.

Recommended short term priorities that address pension adequacy and sustainability include:

- The implementation of re-training opportunities targeted specifically to older workers to support longer working lives;
- Necessary measures must be undertaken to make pension benefits received by married persons in the name of both spouses as a default unless requested otherwise by the two spouses or a court of law;
- Incentivising work effort and productivity through support structures to increase female employment (child care and after school hours), family friendly measures at the workplace, lifelong learning amongst the working age population and the removal of social security benefits which disincentives work in the formal economy;

Recommended policy priorities that address medium to long-term issues include the:

- Automatic adjustment that increases the statutory retirement age in line with future gains in life expectancy. This would meet risks associated with an unexpected rise in life expectancy. It is fair that higher life expectancy would be met with a longer working life whilst offering sufficient flexibility to optimise individual decisions with respect to retirement;
- Increased access to supplementary pension schemes namely the introduction of funded pillar pensions to complement the PAYG pension system so as to improve the adequacy of pensions. The implementation of the voluntary private pension system must provide adequate incentives to allow individuals to save for retirement. This is to be complemented by a national financial education and long term saving promotion.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The public health care system in Malta is **funded** through taxation and national insurance and operates through public hospitals and health care centres. It covers all residents and offers primary, secondary and tertiary health care services that are free of charge at the point of use. Rehabilitation services have been undergoing a process of consolidation[25].

Provisions include free medical services at Health Centres and free hospitalisation. **No user charges or co-payments apply. There are a few services that are provided subject to means testing**. These include dental treatment that is also free for certain categories of patients and population groups, optical services and certain formulary medicines. Patients are sent overseas for highly specialised care required for rare diseases[26]. The private sector acts as a

[25] The scope of the Rehabilitation Hospital Karen Grech is to provide assessment and post-acute care and rehabilitation to a wide range of persons including younger adult patients (16-60 years of age) and the elderly (≥60 years) with the ultimate goal being that of encouraging patients to remain living within the community. In April 2011, the Neuro-rehabilitation unit which was housed in Sir Paul Boffa Hospital was transferred to Rehabilitation Hospital Karen Grech (RHKG). During the year 2010, the main focus of the Rehabilitation services was on the migration of Zammit Clapp Hospital services to RHKG. (Source: annual report 2010 & Ministry of Health, Elderly and Community Care).

[26] An agreement with ISMETT (Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione) for lung and liver transplants has been signed in November 2011.

complementary mechanism for health care coverage, funded by out of pocket payments and private health insurance.

During the reporting period, **no changes were made through legislation with regards population coverage**.

Changes made to the **benefit package** in the reporting period[27] include:

1. The published package of health care services that are publicly available through the Ministry of Health, Elderly and Community Care;
2. The continuing rolling out of the Pharmacies of your Choice Scheme. The Pharmacies of your Choice Scheme[28] covers 160 community pharmacies out of the current 208, and is spread within 59 localities in Malta and Gozo. Gozo has been covered by the POYC scheme in *toto* since July 2010. The number of patients benefitting the Scheme to-date amount to 72,741. It is targeted that the POYC scheme will be spread nationwide by end December 2012;
3. A continuous increase in the number of medicines that are being provided. In 2012, the new list of conditions, covered in Schedule V of the Social Security Act, has been updated to cover 79 chronic illnesses instead of the previous 38[29].
4. In the reporting period, this amounted to an increase of 19 medicines, four of which are related to cancer care.
5. The introduction of new services, which were only offered till recently in the UK and an increase in the number of specialties and visits, covered by foreign consultants at Mater Dei; In addition, new services in the UK have now been added to the list of services which are received in UK.
6. The launch of National Cancer Plan 2011-2015 was launched in February 2011, covering prevention, screening and quality of care. A Steering Committee was created to oversee its implementation. The introduction of PET scanning services is being offered in conjunction with the private sector. Government is also in the process of purchasing a PET scanner to be installed in the public sector. Breast screening continued in 2011 with 61% of those invited, accepting their invitation. In line with Government's National Cancer Plan, planning is currently underway for a national colorectal cancer screening programme to be rolled out in the last quarter of 2012. This will initially target males and females age 60-64 over a two year cycle. Two new medicines specifically for the cure of cancer have been officially introduced in the Government Formulary List in the reporting period. The Sexual Health Policy was launched in November 2010. The national Sexual Health Strategy was subsequently published in November 2011 with a programme of actions that will be implanted over the coming years.

Within the health care sector, there is a current political controversy on the lack of information regarding the extent to which the reduction in government operational expenditure will impact on health expenditure.

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[27] Ministry of Health, Elderly and Community Care.

[28] The 'Pharmacy of your Choice' scheme (operative in 113 localities to date, covering a total of 51,500 patients) has enhanced access to medicines within the community through improved convenience and proximity for the patient, longer opening hours and a closer relationship with dispensing pharmacists.

[29] http://www.timesofmalta.com/articles/view/20120130/local/More-free-medicines-as-list-of-eligible-diseases-grows.404448, accessed on 13th February 2012.

With regards to **health management,** during 2011, there was an organisational re-structuring of the top posts in the Ministry[30].

Primary health care in Malta is offered by the **public and private systems**. Currently, the two systems of primary care practice function independently of one another. Efforts to reform primary health care by giving GPs greater access to patient information in the public system have resulted in the implementation of the myHealth system, which is designed to provide family doctors with direct, secure access to their patients' data residing in the public health system (hospital discharge letters, lab results, medical image reports, current medicines entitlement, and appointments). This functionality started to be phased in from the end of January 2012.

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 all specialised, ambulatory, inpatient care and intensive care services. As private insurance coverage is becoming more unaffordable due to spiralling health care costs and public hospital care has in the past few years been upgraded also in terms of hotel services, relatively fewer people are seeking full insurance coverage. In the Patient Experience Survey, 97% of patients were satisfied with the general ambience of the main public hospital whilst 95% stated that they had full trust in the medical staff.

As reported in the last annual report, these trends are resulting in hospital care shifting from the private to the public sector, which was particularly pronounced in the obstetrics field. This has led to the closure of some private hospitals.

The private health insurance coverage rate lies at approximately 21% of the population, similar to that in 2002. It is also worth noting that only 10% of the population, or 41,000 people benefit from an extensive refund plan. The rest subscribe to policies for very limited refunds. Those covered by basic plans find their policy useful when paying for low-valued medical consultations but private hospitalisation will greatly exceed their benefit limits. This is another reason why people end up resorting to public health care in spite of the insurance cover available. In addition, patients with a full refund scheme choose to use public hospitals because of the more intensive or sophisticated treatment offered there.

The **onset of the recent crisis** did not alter policy approaches with respect to health. Budgetary allocations remained stable in absolute or relative terms. The approved estimate[31] for recurrent expenditure within the Ministry of Health, Elderly and Community care stood at EUR 302,147,000 in 2011, which is comparable to that spent in 2010. Collective agreements were not affected and capital developments, such as the development of the Oncology Centre at Mater Dei are on-going. It could be stated that the recession affected the health system in a positive manner, due to a reduction in medicine prices and the attraction of students to a purportedly more professionally stable medical career.

[30] The post of Chief Medical Officer (CMO) was re-established and it incorporated the previous functions of DG Strategy and Sustainability and DG Health Care Services. On the other hand, the DG Public Health Regulation was re-named Superintendent for Public Health (SOPH). A new DG Financial services was also created. The top most post was unchanged and is occupied by the Permanent Secretary. The CMO department is responsible for the following areas: Office of the CMO, Directorate for Policy Development, EU and International Affairs, Directorate for Health Information and Research, Directorate for Pharmacy Affairs, Directorate for Nursing Services, Directorate for allied Health care Professions, Treatment Abroad Unit, Entitlement Unit & Health Care Services: Hospital, Primary Health Care, Elderly and Community Care. The SOPH department is responsible for the following: Office of the SOPH, Directorate for Health care Standards, Directorate for Health Promotion and Disease Prevention, Directorate for Environmental Health, Occupational Health and Safety Authority, and Health care Professions Regulatory Councils.

[31] Ministry of Finance, the Economy and Investment, Financial Estimates 2012.

2.3.2 Debates and political discourse

Human resources are central to all public health systems and a considerable share of resources allocated to public health goes towards them. Partnerships with other EU countries are being sought to create and maintain an exchange of specialist trainees thereby providing our local trainees with international exposure and conversely, foreign trainees with opportunities to use Maltese facilities for their training programmes.

In order to improve retention of qualified staff, particularly doctors, efforts at developing local post-graduate specialist programmes have continued in the reporting period. Retention of Medical Graduates into the Maltese Health Care System through the Foundation Programme was of 88% in 2011, 4 percentage points more than in 2010. The trend is a very positive one for the health service as supply is increasing at Basic Specialist Trainee level with quality trained medical doctors. At Postgraduate specialised level, training programmes set in motion in the various specialities are being coordinated through an internal system and administrative support and facilitation is provided through the Postgraduate Medical Training Centre which was set up in 2008. This ensures quality of training and may assist in retention of doctors even at higher levels.

There is still a shortage in the nursing field (circa 10% of the current nursing posts are still vacant). Government is recruiting suitably qualified nurses from overseas as an interim measure. Government has taken other initiatives to encourage young people to join the nursing profession and in 2012 Malta will be seeing the largest ever number of nursing graduates in a single year, amounting to around 200. Students will continue to be encouraged to take up health care professions, particularly nursing. In 2010, a number of orientation visits and Job Exposure Programmes were carried out at Mater Dei hospital to encourage students within compulsory education to pursue studies at further and higher education within this field of study. Another initiative was the possibility for nurses to work beyond their age of retirement.

The Budget Speech for 2012 mentions a number of **initiatives that aim to increase the number of graduates in the medical field** namely science popularisation by investing in an interactive science centre together with work on the *BioMalta Campus* - an industrial park which will provide the necessary infrastructure for research and industrial innovation in the pharmaceutical and life sciences industry[32].

An important point to note is that all the new collective agreements that have been signed with major groups of health professionals will also help address the challenges with regard to human resources in the health and long-term care sectors. A positive development is the Continuous Professional Development (CPD) component that is an integral part of all agreements.

Government is relying on contracting out for non-health care professional grades, so as to focus on its key HR functions. This was also the case for the long-term care sector, whereby Government has opted to contract out the services of careers through private companies.

Inequalities in health care exist and important issues and causes were identified in the focus groups that were organised in the compilation of the National Strategic Report for 2008-2010 for health and long-term care. These included the importance of equitable access to information, education and preventive care and community based services, the influence of socio economic status, policies and legislation and the progression towards a more person–centred approach.

In Malta, health care expenditure is regressive since lower income households spend a larger proportion of their income on health. According to the Household Budgetary Survey for 2008,

[32] Budget Speech 2012, page 11.

6.4% of total expenditure by households, (irrespective of income), is on health related expenditure. Lower income households spend a larger proportion of their income on health than higher income counterparts at 9% and 5%, respectively.

Waiting lists are an issue in the Maltese public health system which to a certain extent, make the public system inaccessible. The **debate regarding a more important role of private health care as a complement to the public health system** has brought up by various stakeholders in the reporting period. The Malta Insurance Association believes that access can be improved through private insurance since this can "contribute to a win-win situation with benefits for government and privately insured patients. Government benefits through a reduction in waiting lists and possibly costs. Private patients win through wider choice and more convenient and timely health care"[33]

2.3.3 Impact of EU social policies on the national level

The inclusion of health with social policy in the last NSR cycle, as well as the shifting focus of the Open Method of Coordination on labour market policy at the EU level did not prevent from health care issues being at the forefront of policy attention and public and political debate at the national level.

The **EU 2020 strategy** has **not directly impacted** on health reform debates at local level. However, national initiatives towards health reform can be viewed to contribute to the EU 2020 strategy, namely the introduction of electronic patient records, to the Digital Agenda flagship. Political debate and action is strongly focused on the continued provision of health care services in the public system. This can be viewed as a major contributor to the EU 2020 strategy pillar aimed at poverty reduction. On the other hand, the challenge of long waiting times in the public health system which may cause access problems within the health care sector is significant, which is denting from the attainment of this goal.

Policies in the area of **health care and ageing** services are not extensively addressed in the NRP. Section 2.2.1 of the NRP refers to the importance of the financial sustainability of the health system without any direct reference to long-term care, which is becoming increasingly important with an increasingly ageing population ages. EU policy fails to address **health policy with respect to ageing**. The elderly are excluded from health policy at EU and local level. Under the current scenario, utilisation of EU funds is problematic since output indicators are linked to employment. One exception is policy in the area of health promotion for dementia patients, notably through a dementia clinic and an activity centre.

In the context of the year 2012 as the **Year of Active Ageing**, the Ministry of Health, the elderly and community care has set up a National Committee on Active Ageing. In the performance of its duties, the committee serves as a forum to discuss with stakeholders and civil society; identify ideas and initiatives that promote active ageing; facilitate implementation of ideas, initiatives and projects; assist and advice the national coordinator for the European Year for Active Ageing 2012; monitor progress and implementation; highlight problems and issues encountered in the implementation of actions whilst attempting to identify solutions or provide mitigation measures; encourage and promote best practices; monitor the implementation of actions/initiatives; monitor financial aspects and requirements and carry out other functions as necessary.

[33] http://www.timesofmalta.com/articles/view/20110911/letters/Private-sector-s-role-in-national-health care.384211, accessed on 13th February 2012.

The four thematic areas adopted within the Maltese programme on Active Ageing include the inclusion of older persons participating in formal employment, active ageing by means of health literacy and healthy ageing initiatives, and older persons participating in volunteering and solidarity between generations. A number of upcoming initiatives[34] will be revealed in an upcoming work programme. In addition, the European Association of Homes and Services for the Ageing (EAHSA) will be organising a Conference entitled "Active Ageing - The Challenge for Providers" in Malta, in September 2012, dealing with best practices and innovations in housing, services and care.

The link between **health and poverty** is very important. One of the key actions under the flagship initiative "European platform against poverty" includes the improved access to work, social security, essential services (health care, housing, etc.) and education. As mentioned previously, since health care is free for all, the accessibility issue in Malta may be overlooked. The severe material deprivation for Malta is positively affected by free health care because it addresses one of the nine deprivations (unexpected expenses) and leaves more disposable income to eliminate other deprivations.

In 2010, the people at 'risk of poverty or exclusion' (EU 2020)[35] in Malta stood at 20.6%. This indicator compares well with that of the EU-27 average (EU-27: 25.3%). As outlined in Section 2.2, within the 65+ age cohort, males have a much higher 'at risk of poverty or exclusion' when compared with European counterparts (Males, 65+ & 75+ in 2010 MT: 22.7%, 23.3% EU-27: 16.2%, 17.6%). The typically lower female participation rate in the labour market corresponding to the 65+ age cohort results in one earnings related pension that has to be shared between both married persons. Due to the higher life expectancy amongst females relative to that of males, the at risk of poverty rate diminishes substantially for women within the 75+ age cohort, since widows typically continue to receive five-sixths of their husband's pension. This makes widows financially better off compared to married retired couples on a per capita basis. However, this may no longer be the case if the life expectancy for males increases with advancements in the medical field.

2.3.4 Impact assessment

For a small population such as Malta, impact assessment studies are somewhat limited. Nonetheless, the Maltese population enjoys high standards of health care, resulting in a longer life expectancy and recognition by the World Health Organisation[36] which has described Malta's health care as the 5th best out of 190 countries, in the year 2000[37].

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[34] Initiatives undertaken to date may be viewed at: https://ehealth.gov.mt/HealthPortal/elderly/european_year_2012/initiatives/lifelong_learning.aspx.

[35] The Europe 2020 strategy promotes social inclusion, in particular through the reduction of poverty, by aiming to lift at least 20 million people out of the risk of poverty and social exclusion. This indicator corresponds to the sum of persons who are: at risk of poverty or severely materially deprived or living in households with very low work intensity. Persons are only counted once even if they are present in several sub-indicators. At risk-of-poverty are persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers). Material deprivation covers indicators relating to economic strain and durables. Severely materially deprived persons have living conditions severely constrained by a lack of resources, they experience at least four out of nine following deprivations items: cannot afford i) to pay rent or utility bills, ii) keep home adequately warm, iii) face unexpected expenses, iv) eat meat, fish or a protein equivalent every second day, v) a week holiday away from home, vi) a car, vii) a washing machine, viii) a colour TV, or ix) a telephone. People living in households with very low work intensity are those aged 0-59 living in households where the adults (aged 18-59) work less than 20% of their total work potential during the past year

[36] http://www.photius.com/rankings/healthranks.html, accessed on 13th February 2012

[37] The World Health Organisation's ranking of the world's health systems was last produced in 2000, and the WHO no longer produces such a ranking table, because of the complexity of the task.

The self-reported unmet need for medical examination or treatment, by income quintile indicator reveals that low income earning individuals have a higher perceived unmet need for medical examination or treatment in Malta. Possible reasons include affordability issues for private sector medical examinations or treatment due to long waiting lists within the public health care system. In addition, the lack of information of any good doctor or specialist by lower income individuals may cause them to have a higher perceived unmet need for medical care. For each respective income quintile, Malta records lower rates, possibly due to free medical health care and proximity due to smallness.

Table 1 presents indicators for health outcomes for Malta in 2010. Life expectancy for the Maltese population at birth is higher than the EU-27 average for both males and females (EU-27: Males – 76 yrs, Females - 82 yrs, WHO). There are fewer acute hospital beds[38] and physicians in Malta in relation to the population when compared to the EU 27 (372 acute hospital beds, 330 physicians, 2009, WHO). This reflects the small size of the territory and the high population density of the country, which leads to more intensive use of the beds available.

Table 1 - Health Outcomes (Malta, 2010)

Indicator	**Value**
Life expectancy at birth, female	84 years
Life expectancy at birth, male	79 years
Physicians per 100,000	307
Dentists per 100,000	44
Pharmacists per 100,000	72
Nurses per 100,000	645
Acute care hospital beds per 100,000	269

Source: WHO database

With regards to **gender impact**, recent changes in the benefit package were slightly more biased towards females with the launch of the breast screening programme. In addition, within primary health, gender differences are found for private GP consultations[39], possibly as women are more health-conscious than men.

Austerity and retrenchment following the recent crisis are not affecting access to and provision of health care services.

Coverage within the health care system includes all persons residing in Malta who are covered by the Maltese social security legislation. It also provides for all necessary care to special groups such as irregular immigrants in accordance to the Legal Notice on subsidiary protection, foreigners with reciprocal agreements such as UK citizens and foreign workers who have valid

[38] Acute hospital beds is being used rather than hospital beds for the purposes of cross country comparisons due to differences in the definition.

[39] 77.1% of females reported having had a private GP consultation less than 12 months ago as opposed to 71.5% of males. Further to this 25.7% of males reported having had their last consultation 12 months ago or longer as opposed to 20.3% of females.

work permits[40]. For medical emergency care that requires admission to government hospitals for services, such as inpatient care, day care services, diagnostic services or outpatient visits, patients will not be charged if they present proof of EU nationality and a valid EHIC. The cost of all prosthesis and medication prescribed for follow-up care after hospital inpatient treatment or as part of day care or outpatient care shall be borne in full by the person concerned.

2.3.5 Critical assessment of reforms, discussions and research carried out

Within the area of health care in Malta, there are a number of **best practice examples**. This includes free access to health care, reciprocal agreements with other countries for specialised health care and the implementation of the myHealth system that is designed to provide family doctors with direct, secure access to their patients' data residing in the public health system. Another best practice example includes the initiatives taken to avoid staff shortages such as the retention of nurses beyond retirement age.

Long term concerns regarding the financing of health care in the face of increasing demands on the system, including those associated with population ageing, and limited resources remain an important consideration for social policy in Malta. Health care reform proposals in Malta are well focused on sustainability and quality issues. However, the reform implementation is slow due to administrative, political and cultural obstacles, as well as inertia from certain stakeholders.

The expansion and modernisation of the provision of primary and community care will reduce the need and demand for expensive institutional health and long-term care while managing the individual's care from an early stage, bringing care closer to patients and their families. Thus, efforts to reform primary health care must be further pursued. However, the effective reform may require changes to the way in which private sector provision operates, and how it integrates with the public health system. Resistance to change in this regard is being encountered from certain categories of providers.

Waiting lists for public hospital care continue to remain an issue. Increased private sector collaboration to support the public health system was evident in the reporting period. Efforts must continue to exploit private sector hospital capacity to meet the increasing demand which will provide win-win situations – a reduction in waiting times and a source of revenue to the private sector.

The 'Pharmacy of your Choice' scheme has continued to enhance access to medicines within the community through improved convenience and proximity for the patient, longer opening hours and a closer relationship with dispensing pharmacists. The improved access to medicines must be complemented by an educational campaign to bring about a culture change. Patients must understand that even though they may be entitled to free medication, there should be discretion in taking medicines in excess of that required just for the sake of doing so since this comes at a cost, borne by taxpayers. Generic medical products play an important role in Malta. Doctors are encouraged to prescribe medical products by chemical name rather than by trade name. This is strongly promoted within Government procurement practises.

[40] TCNs are covered through Social Security legislation. Besides having a work permit one must be regularly be paying N.I in the case of workers given that there are other categories of TCNs that are covered such as dependants.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care in the Maltese context relates essentially to 'dependent persons' and is provided by the Government, by the family of the person in need, by the church, the voluntary sector and local councils (municipalities). The priority within the long-term care sector is to provide all the support required so that dependent persons remain in society and lead, as far as possible, an independent life. This avenue is of paramount importance to ensure the financial sustainability of the LTC system. In order to help elderly people live independent lives in their own homes, a new measure was introduced in the 2012 Budget Speech whereby a new EUR 300 annual grant will be awarded to every elderly person over 80 living in their own home or with their family. This initiative will cost EUR 3.5 million, and will benefit nearly 12,000 elderly persons, or 3% of the total population[41]. Another measure introduced in the Budget Speech 2012 includes the removal of VAT on private nursing and home help offered by the private sector to the elderly in their private homes that will become effective as from the 1st January 2012.

The Department of the Care of the Elderly provides a number of facilities, including residential homes (where patients pay a proportion of their costs), geriatric hospital beds, and a home help service. Additionally the church provides free residential care for disabled people.

State-organised community care encompasses services with the aim to enable elderly people and those with special needs to remain within the community for as long as possible. Services at home cover nursing services through the MMDNA, Community Care Outreach Programme, non-medical assistance such as home help, subsidised home-delivered meals, incontinence service, telecare, handyman service, day centres, night shelters, respite service and activity centre for persons with dementia. The Community Care Outreach Programme was initiated in 2010 as a pilot project in the Msida locality. This service consists of a six week service delivered by a multidisciplinary team where the main focus is to enable informal carers and support them in the care of dependent persons, thus enabling them to continue living in the community. During 2011, this project was extended to include other localities and further expansion is planned for 2012.

Other services which continued to expand are the day centres which now have reached a total of 18. Night shelters are a recent addition to the package of support services for those persons living in the community. Discussions are currently being held with church entities and Local Councils with the aim of extending night shelters in various localities.

Use of community care services is highest amongst the 85+ age category, at 24% as opposed to 7.4% in the 60-74 category[42]. Table 2 presents the total number of beneficiaries for different community services within the reporting period.

[41] Budget Speech 2012, page 88. Almost 12,000 of around 13,600 persons aged 80+ in Malta live in the community rather than in institutions.

[42] Health Interview Survey 2008.

Table 2 – Beneficiaries in 2011

Service	**Total Beneficiaries**	
Day Centres	1,327 Members	
Telecare	9,103 participants	
Incontinence	1,119 Scheme A	
	2,524 Scheme B	
Handyman	1,734 jobs	
Home Care Help	3,661 beneficiaries	2,702 Households
CommCare	6,225 requests	
MMDNA	481,315 General Care	
Meals on Wheels	1,480	85,305 meals
Night Shelters	12 Residents	

Source: Department of Elderly Care

In order to secure a balanced continuum of care, **long-term stay residential care facilities** are still required for those older adults who despite support in the community would still find it difficult to cope in their own home. This care aspect is provided by eight State-owned community residential care homes which along with St Vincent de Paul Residence and a number of additional long-term care facilities provide residential care to persons having varying degrees of dependence. The growing number and proportion of older citizens and persons with disabilities have increased whilst the quality of life of these people is constantly ensured together with the ongoing monitoring and effective management of resources.

Institutional service settings have flourished rapidly over the past few years within the private sector. Table 3 depicts that there were a total of 31 church and private homes for older persons operating in Malta and Gozo in 2011.

Table 3 - Number of licensed church and private homes in 2011 (including number of licensed beds)

Homes for Older Persons	**Number of Homes**	**Number of Licensed Beds**
Church Homes	16	728
Private Homes	15	1223
TOTAL	31	1951

Source: Department of Health Care Standards

As shown in Table 4, with a total of 2500 beds, the Government has the majority of the market share of licensed beds in homes and long term nursing care facilities during 2011.

Table 4 - Number of homes in 2011 held by Government (including number of licensed beds)

Government Home or Long-term care Facilities	**Number of Homes/Long-term care facilities**	**Number of Licensed Beds**
Government Homes	8	782
Government Long-term care facilities including St Vincent de Paule Residence	6	1718
TOTAL	14	2500

Source: Department of Health Care Standards

Table 5 depicts the increase in the number of licensed beds for older people over the period 2007-2011.

Table 5 - Increase in the number of licensed beds for older people (2007-2011)

2007	1,650
2008	2,612
2009	4,193
2010	4,411
2011	4,451

Source: Department of Health Care Standards

The demand for more accommodation is continuously increasing in the area of the care of the elderly. There have been recent increases in the number of beds at the St. Vincent de Paule Residence, conversion and expansion of long-term care facilities at Mount Carmel Hospital, the development of nursing homes in the community based on the PPP model as is the case of the new residence in the North of the Main Island and the purchasing of beds within the private sector. Government has also earmarked land in the centre of the Main Island for the construction of a new residence for the elderly.

Over the last two years an increasing number of long-term care beds have been purchased as a partnership with private homes for the elderly. By the end of 2011 these reached a total of 370 beds. Another initiative is the opening of another long-term care facility, Zammit Clapp Hospital Residential Home, which will cater for the needs of 96 long-term care residents.

Maltese lifestyles have gone through many changes in the past few years which have had, and will continue to have, an increasingly big effect on the capability to provide this **informal type** of care. Informal carers in Malta find difficulties in identifying contact points when support is needed by these carers and also physical, financial and psychological support. An important development in the reporting period is the development of the Community Care Outreach Programme which provides carers with guidance to help the patient regain and retain his/her independence as much as possible.

Informal care will increasingly become an issue in the future as the population is ageing rapidly, with the proportion of persons aged 65 or over expected to double between 2010 and 2020 to over 9%, coupled by an increase in the female employment rate amongst the younger generation of females, with the challenges work-life responsibilities in the care of their children and their elderly parents (the so-called "sandwich generation"). Thus, new and different needs for long-term care services have consequently emerged. Besides homes for those who do not have the possibility to be cared for by families or for those persons whose requirements are such that they become too hard to handle by relatives, there is the need for more formal community-based care services.

As stated previously, long-term care arrangements were not impacted by austerity programmes in Malta. As highlighted previously, budgets allocated to health care and long-term care remained stable as that for the previous year, during the period under consideration.

2.4.2 Debates and political discourse

Within the **context of the NRP**, no reference is made to long-term care. More awareness regarding the evolution of long-term care in the context of service provision is becoming increasingly important in the light of ever increasing costs related to long-term care services.

With respect to **access** and **quality** to long-term care in Malta, there are a number of criteria for admission into state institutional facilities, which favours those that have low income levels.

Capacity for long-term care has been increased to cater for the increasing demand, in collaboration with the private sector. Access to church-provided services is hard to come by due to the limited number of places available. In addition, private care-homes step in to meet increasing demands. It is often debated that increased collaboration between the private and the public sector is discouraging groups of the elderly population to enter nursing homes on their own personal initiative, due to the PPP arrangements and the purchasing of beds by Government in the private sector. In addition, more information regarding the availability and quality of long-term care services is also debated. Transparent admission criteria together with quality standards are to be made available and better enforced. The Health Care Standards Directorate has developed a policy document addressing standards in long-term care. This document is currently in advanced draft form and is being consulted upon internally. As reported in the 2011 report, when the policy document was being developed, inspections of Government homes and long-term care facilities for the elderly are to be coordinated by the Health Care Standards Directorate. Improving the quality of care in government residential homes is being considered as a first step in the conversion of these homes into nursing homes. This will include increased emphasis on care standards, more medical care and increasing availability of paramedical services.

A study on the organisation of dementia care by families in Malta[43] discusses the need to enhance formal support mechanisms for dementia patients and their families emphasising the role of better integration of patients within community life.

2.4.3 Impact of EU social policies on the national level

As reported within Section 2.3.3., the focus of the Open Method of Coordination has shifted more on labour market policy at the EU level.

The **EU 2020 strategy** has **not directly impacted** on long-term health care reform debates at local level. However, the provision of long-term health care services can be viewed as a major contributor to the EU 2020 strategy pillar aimed at poverty reduction. Access to state institutional long-term care favours those at the lower end of the income scale, but may not be sufficient for others who are close to risk of poverty. The elderly are excluded from health policy at EU and local level causing the utilisation of EU funds to be problematic since output indicators are linked to employment. One exception is policy in the area of health promotion for dementia patients, where further development of dementia services and the refurbishment of a unit at St. Vincent de Paule Residence for these particular patients. Access to public long-term care institutions is favourable towards those with low means however issues of long-term care and poverty may impact the old-old group, who decide to remain at home not to opt for institutional care, especially females.

With regards to disability, a shortcoming is that the NRP focuses on the integration of the disabled in the labour market however it fails to address groups with a higher level of disability who are wholly dependent on others to care for them.

[43] http://dem.sagepub.com/content/early/2011/03/11/1471301211398988.abstract?rss=1, accessed on 13th February 2012.

2.4.4 Impact assessment

In Malta, access to and the provision of long-term care services was not impacted by the financial crisis.

Long-term care however faces **shortages** in the field of carers, which is currently being fulfilled by a pool of foreign workers. The increase in bed capacity must be accompanied by a concomitant expansion in skilled human resources, particularly carers.

Of relevance to the demand for long-term care is the fact that due to the existence of a free health care system, the severe material deprivation indicator for older people is lower for Malta when compared to the EU-27. An important point to note is that **males** within the 75+ category are recorded to have a very low rate of material deprivation at 1.9%. This is due to the fact that the SILC[44] is under-representing males within this category, since typically widowed males leave the household and move on to live within nursing homes receiving institutionalised long-term care.

Information gaps with regard to future policy development include the concept of fragility in old age, the needs and aspirations of the elderly population, catering for dementia and the concept of delaying the need for institutional care by strengthening community services.

Malta's NSR indicates that between 2010 and 2050, the share of health care costs within GDP is expected to rise by 1.8 percentage points, from 4.5% of GDP to 6.1% of GDP. As a percentage of GDP, health expenditure in Malta is relatively low compared to other EU countries. Health expenditure per capita[45] in Malta is lower than that for the EU at EUR 513 compared to EUR 1,731. This partly reflects the fact that we have fewer acute hospital beds and fewer physicians per 1000 of the population, within one centralised system in a small jurisdiction which is densely populated.

Table 6 - Projections in health and long-term care expenditure

	Projected spending as % of GDP				Change	Difference as % of GDP compared to pure ageing scenario		
	2004	2010	2030	2050	2004-2050	2010	2030	2050
Health								
Malta	4.2	4.5	5.5	6.1	1.8	0	0	-0.1
EU15	6.4	6.7	7.5	8.1	1.6	0	-0.1	-0.1
EU25	6.4	6.6	7.4	7.9	1.6	0	0	-0.1
Long-term care								
Malta	0.9	0.9	1	1.1	0.2	Na	Na	Na
EU15	Na	Na	Na	Na	Na	Na	Na	Na
EU25	0.9	0.9	1.1	1.5	0.6	Na	Na	Na

Source: Health Data July 2008 – Supporting data for National Reports (received 28 June 2008). Data taken from DG ECFIN calculations; reproduced in NSR.

2.4.5 Critical assessment of reforms, discussions and research carried out

Within the area of long-term care in Malta, there are a number of **best practice examples**. These include the initiatives taken to encourage independent living such as the new annual grant to elderly persons over 80 living in their own home and the removal of VAT on private nursing and home help, PPP arrangements for community based nursing homes, the purchasing

[44] Statistics on Income and Living Conditions.
[45] Author's estimates using Eurostat data since data is not readily available.

of beds by Government in the private sector and the initiative taken to avoid staff shortages namely the retention of nurses beyond retirement age.

At policy level, long-term care as a concept needs to continue to reflect the ever increasing needs of an ageing population, primarily within formal community based services to support independent living.

Quality of long-term care must be ensured within private and public provision. Access to instructional care must ensure that those with the lowest means are not excluded whilst church and voluntary organisations must be supported both in the field of elderly long-term care and disability.

2.5 The Role of Social Protection in Promoting Active Ageing

2.5.1 Employment

The employment of the elderly is **promoted** by the social protection system in Malta. As highlighted earlier in this document, recent changes were made to the legislation. The Maltese Government has adopted a policy to incentivise active participation in all sectors of society. Elderly persons may remain in employment after retirement age without losing their pension benefits. NI contributions must still be paid up to 65 years of age, without resulting in any increase in future pension benefits, thus reducing the incentives for longer working lives.

The current **mandatory retirement age** is 61 years of age in Malta to increase to 65 years of age in 2026. The increase in retirement ages is to be implemented in a phased manner increasing to 62 years of age in 2015, reaching 65 years of age in 2026 for both genders. Various models were considered, however the model which has been implemented is considered to be the one with the least negative social impact due to its gradual implementation. Within the framework of an increased retirement age, working conditions for certain categories of workers remain a challenge. This becomes increasingly challenging if Malta were to adopt the Pensions Working Group recommendation to further increase retirement ages beyond 65 years of age, to reflect increases in life expectancy. A mandatory retirement age is **stipulated by labour law** allowing employers to dismiss workers beyond retirement age (Employment and Industrial Relations Act, Article 36 (14)).

2.5.2 Participation in society

Volunteer work abroad is promoted by the social protection system. Citizens of Malta (who have not yet reached retirement) who go abroad as volunteer workers on projects in the areas of human welfare and development and environmental protection (which are recognised as such by the Minister in advance), are entitled to **credited contributions**. The period during which volunteer work is carried out is covered as long as any such number of credited contributions shall in no case exceed an aggregate of 260 in any period of 10 years.

2.5.3 Healthy and autonomous living

The promotion of **autonomous living** is incentivised by the social protection system. Elderly persons who live within Government Community Homes and long-stay facilities have to co-finance their stay in the form of a percentage of their pensionable income (60% in Community Homes and 80% in long-stay facilities). This is further reinforced in the Budget Speech 2012, which provides for a EUR 300 annual grant provided to every elderly person over 80 living in their own home or with their family and the removal of VAT on private nursing to the elderly.

There is a political priority in Malta to provide support for home care as opposed to institutional care. The scope of all home care support services for the elderly persons and others

is to support independent living. For example, home care help[46] at very affordable rates[47] applies to persons aged sixty years and over whereby persons over eighty-five years and those with special needs are given priority. As highlighted in Section 2.4.1, home helpers and support at home are included in the long-term care benefit basket with the number of beneficiaries for such services increasing over the years.

Within the **health care sector**, the Government is shifting its emphasis to **preventive** services. A Strategy for the Prevention and Control of Non Communicable Diseases has been published by the Department of Health Promotion and Disease Prevention within the Ministry in April 2010[48]. This is a concrete step on the path to an increased emphasis on preventive services. Non communicable diseases (NCD) such as coronary heart disease, stroke and diabetes are responsible for about 82% of deaths in Malta. They are also responsible for a similar amount of disability in the form of pain and suffering, reduced mobility and loss of independence. The overall goal of the NCD strategy is to develop a multifactorial approach to NCD prevention through tackling common risk factors targeting both at a population level, and also high-risk groups. Thus, the strategy dealing with the prevention and control of non-communicable diseases marks the start of a journey to prevent of delay the dependency of care.

[46] The home care help service offers non nursing, personal help and light domestic work to older adults or persons with special needs. The aim of such service is to allow the recipients of such service to continue living in their community as independently as possible. It also aims to provide respite and support for informal carers. Ultimately, the home care help services helps to avert or delay the demand for long-stay residential care by providing the required support in the client's own home.

[47] There is a nominal fee of EUR 2.33 per week for a single person, and EUR 3.49 in the case of more than one person benefiting from the service.

[48] https://ehealth.gov.mt/HealthPortal/public_health/non_comm_disease_prev_unit/introduction.aspx, accessed on 13th February 2012.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R] BORG.,CAMILLERI-CASSAR F., Gender equality in Maltese social policy, 2005, retrieved from:
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The study asks about women's experience of gender quality policy in Malta. It provides a number of interviews with Maltese women who give us unprecedented insight into women's experience of Maltese culture and social policy. Based on original data collected from a sample of graduate women who are experiencing this tension in their work and family lives, the study presents a fine example of the relevance of social science to understanding the significance of the European project for Malta.

[R] DEBONO GRECH S, What fiscal incentives can Malta implement?, 2010, retrieved from:
https://secure2.gov.mt/socialpolicy/socprot/social_benefits/pensions_reform/written_feedback_received.aspx

The main aim of this study was to examine which fiscal (tax) incentives could be introduced for pension plans in Malta and which would seem most appropriate, considering the local and international pension arenas. A necessary objective of this dissertation was to evaluate the fiscal incentives applied by other European countries in order to consider which principles the local Government and financial institutions could apply.

[H] Health care

[H; R; L] Malta National Statistics Office**,** Social Protection: Malta and the EU, 2010, February 2011, retrieved from:
http://www.nso.gov.mt/statdoc/document_view.aspx?id=2888&backurl=/themes/theme_page.aspx

This report by the Maltese NSO consists of mainly tables and charts which cover a broad range of statistical data, covering up to the period 2009. The first three chapters deal with social benefits, health and social welfare. A series of easily understandable statistical tables which also includes a comparative analysis of the various Maltese social protection benefits and schemes vis a vis other EU Member States' statistical data is included.

[L] Long-term care

[L] INNES, Anthea, ABELA, Stephen, SCERRI, Charles, A study on the organisation of dementia care by families in Malta: the experiences of family care givers,

May 2011, retrieved from:
http://dem.sagepub.com/content/early/2011/03/11/1471301211398988.abstract?rss=1

This paper discusses the experiences of dementia family caregivers in Malta. The study design was essentially exploratory as this is the first funded social research on dementia in the island of Malta. A thematic analysis was guided by the questions: What are the experiences of family care giving in Malta? And what impact does care giving have for individual/family life? Three key findings are discussed, namely: the organisation of family care in Malta; the use of formal services; and the dislocation of dementia care giving experiences from wider community life. This paper raises questions about support mechanisms currently available in Malta while presenting cross-national learning opportunities to apply established knowledge to the Maltese context.

4 List of Important Institutions

Malta National Statistics Office

Address: Lascaris Valletta VLT 2000 Malta
Phone: +356 2599 7000
Fax: +356 2599 7205
Email: nso@gov.mt
Webpage: http://www.nso.gov.mt/site/page.aspx

Mission Statement: To produce efficiently and with minimum burden on respondents high quality statistics that are relevant, reliable and comparable, and to disseminate them in an impartial, independent and timely manner, making them available simultaneously to all users.

Ministry of Justice, Dialogue and the Family (previously the Ministry for Education, Employment and the Family)

Address: Palazzo Ferreria, 310 Republic Street, Valletta VLT 2000, Malta
Phone: 2590 3100
Fax: 2590 3216
Webpage: https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions/contri_pen/info_retire.aspx

The ministry's services contain inter alia issues like Courts of Justice, Attorney General's Office, Data Protection, Social Policy, Family Policy, Child Policy, Social Security Solidarity Services, Social Housing, Equality, Industrial and Employment Relations, Malta Council for Economic and Social Development and EU Information (MEUSAC).

Ministry of Health, the Elderly and Community Care

Address: Palazzo Castellania, 15, Merchant's Street, Valletta, VLT 2000, Malta
Webpage: https://ehealth.gov.mt/HealthPortal/default.aspx

Divisions:

- *Health care Services*
- *Public Health Regulation*
- *Resources & Support*
- *Strategy & Sustainability*

Departments:
Elderly Care, E.U. Health care Entitlement Unit, Environmental Health, Government Health Procurement Services, Health Care Services Standards, Health Information & Research, Health Promotion & Disease Prevention, Human Resources, Information Management Unit, Nursing Services Standards, Pharmaceutical Policy and Monitoring, Policy Development and EU Affairs, Primary Health Care, Programme Implementation Monitoring.

University of Malta - Faculty of Economics, Management and Accountancy and Faculty of Sociology

Address: University of Malta, Msida MSD 2080, MALTA
Webpage: http://www.um.edu.mt/fema; http://www.um.edu.mt/arts/sociology/

There are few social protection-related activities at the University of Malta, mainly within the Faculty of Economics, Management and Accountancy and the Faculty of Sociology.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en