Annual National Report 2011

Pensions, Health Care and Long-term Care

Malta

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1 Executive Summary

Due to prudent, internally-oriented, financial activity the Maltese economy was not affected by a credit crunch – tourism and manufacturing were affected by the secondary effects of the crisis which were in any case replaced by new sectors and through training schemes to absorb the temporary drop in demand by certain sectors. Thus, no austerity packages were required resulting in no cuts to social protection expenditure in Malta.

In Malta, the public pension system operates exclusively 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. Reform initiatives to address long term concerns in pensions and health care in Malta are of paramount importance.

In the field of pensions, reform initiatives that started taking effect from 2007 onwards are being seen through. Changes are most apparent in the first pillar pension system. Being a gradual parametric shift, the full impact of this policy will only become clear by the year 2026, when the retirement age reached the age of 65. In the reporting period, a report with recommendations for the second phase of the reform was presented, and a consultation process is currently underway.

The emphasis in the reporting period has been on the potential reform in primary health care. Plans to mobilise the private health care sector as the gatekeeper to the state-funded provisions have however been put on hold due to the different roles and interests of health care providers. Notwithstanding, an incremental, consensual approach is being used to introduce certain measures. A number of developments covering the benefit package were recorded in the reporting period, namely the published package of health care services that are publicly available through the Ministry of Health, Elderly and Community Care; the continuing rolling out of the Pharmacies of your Choice Scheme[1]; a continuous increase in the number of medicines that are being provided; the introduction of new services; the launch of the National Cancer Plan and public private initiatives in certain areas.

Long-term care has benefitted from an expansion of residential care places within the public and private sector over the last few years. Quality of long-term care services has gained importance in the reporting period and a policy is currently being developed to establish standards within this sector. Improvements to accessibility within the public system are being improved as capacity is being increased through PPP initiatives and the purchase of beds within the private sector.

Within a local perspective, pension policy is debated extensively however this is more limited in the field of health care and long-term care, most notably the latter which is still not being given due consideration from the policy perspective.

[1] 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.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

A number of developments in social protection were undertaken in the reporting period. General developments in the area of pensions include the five year review of the pension system whereby 45 recommendations to ensure pension sustainability and adequacy were presented by the Pensions Working Group[2] to pave the way for the second phase of the reform. A number of recommendations presented include the following:

- Government should not consider to rectify today the projection outcomes as they appear in 2060 but should continue to adopt a calibrated reform of the pensions system over a five year period as is now mandated by the Social Security Act and in doing so adopt incremental measures that will have a long term impact towards the adequacy, sustainability and solidarity of the pension system;
- An increase in credits for child rearing biasing towards families with more children, child rearing credits for the transitional group and the establishment of a pro-natal commission;
- The introduction of a retirement longevity-index;
- Government should continue to strengthen community care support infrastructure for the sick, disabled and elderly persons so as to alleviate the pressure on individuals, particularly females, from the responsibility of care and, consequently, enables them to take on paid employment;
- Government should, as a further phase of the reform of the invalidity and disability pension system, give serious consideration to transform the paradigm from one that bases invalidity as a result of a condition of the said disability to one that determines the degree of the invalidity to the person’s ability to function; together with the holistic underlying support (re-skilling, psychological support, etc) required to achieve such a paradigm shift;
- Flexible work practices, child care centres and after school support to increase the female participation rate in the labour market together with on-going assessments;
- Measures to incentivise workers to emerge into the formal economy;
- Government is to assume an active affirmative policy to retain beyond the official retirement age employees who can add value;
- A reform of the provisions in the Social Security Act to remove discrimination against part-time and atypical work;
- Investment in education and consideration of a targeted immigration policy to narrow skills deficits and insufficiencies in labour supply;
- Allowance to persons to fill gaps in contributions due to lifelong learning;
- Study the possibility of placing the PAYG system on a Notional Defined Contribution framework;

[2] https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/strat_rev_pensions.aspx.

- The possible introduction of a second pillar in the form of housing equity release schemes, to allow people, should they wish, to leverage their home ownership investment into income during the retirement phase of their life cycle. (It must however be highlighted that in the light of recent experience[3], the extent of opinion in favour of this approach is however weakening considerably.)

A number of changes that were legislated for the pension system in 2006 have occurred within the reporting period whilst others most notably those concerning 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 the reporting period[4]. Within the field of long-term care, recent increases in the number of long-term care beds within institutional settings continued to increase together with the conversion and expansion of long-term care facilities for mental health, the development of nursing homes in the community based on the public private partnership (PPP) model and the purchasing of beds within the private sector.

Due to the fact that it was **only secondary effects of the economic and financial crisis** that hit Malta, firms managed to overcome the temporary drop in activity by reverting to EU support through ESF projects, coordinated by the Employment Training Corporation which enabled workers in distressed sectors to remain in employment.

The **onset of the recent crisis did not alter social protection policy approaches in Malta** due to prudent, internally-oriented, financial activity. Thus, no exit strategies were required, and budgetary allocations in the field of pensions, health care and long-term care remain unchanged.

National debates regarding the future developments of social protection focus mainly on reconciling institutional interventions with client demands to ensure more appropriate and sustainable approaches that sufficiently correct or compensate against social imbalances and inequalities within an overall sustainable public budgeting process.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The public pension system operates exclusively on a first pillar pay-as-you-go (PAYG) basis and provides for old-age (retirement) pensions, survivor's pensions and invalidity pensions. Concerns impinging on the PAYG system include population ageing[5], low employment rates of older workers and early exit from the labour market. Thus, age-related expenditure on pensions and health care can pose significant challenges to the long-term sustainability of public finances in Malta, as acknowledged in the NRP for Malta under the EU 2020 Strategy.

The first pillar, PAYG system is funded through contributions by employers and employees, which are partially matched by the state. Contributions are calculated per week, and amount to 10% of weekly wages for employers and employees, and 15% of annual net earnings or

[3] 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.

[4] 2011 Annual Report, Ministry of Health, Elderly & Community Care.

[5] The proportion of persons aged 65 or over expected to double between 2010 and 2020 to over 9%.

income for self-employed (with minimum and maximum contributions). The government-ran "Consolidated Fund" adds 50% of the contributions paid for each individual to the system. The main pension benefit is contributory and provides a two-thirds replacement ratio which is wage-indexed, subject to a nominal ceiling. Thus, the system features 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 due to 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.

Parametric changes to the PAYG were introduced by law in 2006[6]. Changes include:

- A gradual increase in retirement ages for females and males from the current 61 years (in 2011), to 65 years of age by 2026. The implementation of this measure is formulated in such a way that the individual retirement age is calculated on the basis of the age on 1 January 2007, as shown in Table 1. Those who reached the age of 55 before that date are not affected, and the retirement age of 65 will take full effect only for those born after 31 December 1961.

Table 1: Amendments to the Retirement age

Age at 1 January 2007	Retirement Age
55 yrs of age and over	no change
51 – 54 yrs of age	62 years
48 – 50 yrs of age	63 years
46 – 47 yrs of age	64 years
45 yrs and below	65 years

Source: Annual National Report 2009: Pensions, Health and Long-term Care

- Parallel to the increase in the statutory retirement age, the required contribution period to be entitled to the full two-thirds pension is gradually lengthened, to reach 40 years by 2026 as opposed to the current 30 years.

- Prior to the reform, the amount was determined on the basis of the yearly average of the basic wage during the best three years within the last ten years of employment. For self-occupied persons, the best ten years were taken into account. Following the reform, the calculation base will be the yearly average income during the best ten years within the last 40 years, and will be the same for all born after 1961.

- The guaranteed national minimum pension, now based on the national minimum wage, will be calculated at a rate of 60% of the national median wage, representing a higher rate than presently and offering a minimum that is more in line with the overall level of wages. The maximum pension income is to increase to € 20,970 by 2014. Pension benefits are to be calculated in a way that keeps track of increases in national average wages and inflation at 30% and 70%, respectively.

Five yearly reports were also scheduled to elaborate on results obtained by the system. The first of these reports, to contain recommendations concerning adaptations and ameliorations, was scheduled for 2010.

6 https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/final_report_white_paper.aspx.

Changes in the pension system, legislated in 2006 have occurred within the reporting period, although parametric reforms, namely an increase in the retirement age will take effect in 2014. Work on the pension reform within the reporting period was undertaken in terms of the recommendations that were presented by the Pensions Working Group in December 2010. (as outlined above).

In general terms, the economic and financial crisis did not lead to a re-orientation of social protection policies, and hence, **it did not impact national budget consolidation programmes**. In 2009, social protection expenditure amounted to 19.8%[7] of GDP in 2009 up from 17.9% in 2008.

2.2.2 Debates and political discourse

The recommendations put forward by the Working Group in 2010 are open for consultation until the end of May. Government has made it clear that it has a "strong interest" in listening to the opinion of all citizens, including young people, as well as social partners before it takes a position on the full 45 recommendations put forward in the report.

Over the reporting period, a number of newspaper releases[8] have highlighted the fact that the time is not right for a mandatory second pillar pension, which would raise labour costs for employers and eat away at workers' disposable income as it is not "socially or economically feasible" to start building this fund now. The National Association of Pensioners believes the introduction of the second pillar now would be "ill-timed". The association was instead in favour of having another fund to complement the state pension, with guarantees that the capital being invested by people is actually guaranteed and state-governed. The General Workers Union fear that a second pillar pension may not be afforded by workers, especially since families are heavily burdened by the high cost of living and the high prices of utilities.

Since the longevity of the population is expected to continue to rise, the pensions working group has recommended that the government should establish a retirement-age longevity **indexation mechanism** which would raise the retirement age every time there is an increase in the longevity index. It is debated that though life expectancy may result in healthy living the fact remains that there will continue to be occupations which cannot be carried out post 61 years of age.

Debate regarding a guaranteed minimum pension in Malta is concerned with adequacy of income in retirement to cope with living costs.

Conclusions made by the EU Pensions Working Group with regards to Malta's long term GDP growth stand at 1.7%. This estimate is on the relatively low side and is viewed to threaten the future of the first pillar in Malta. **Academic debates** in this regard highlight the risks and possible shocks to the pension system in a micro-state with positive and negative risks that may affect an exclusive first pillar approach.

A study on 'Social Policies in Malta'[9] covers the evolving political thought and tendencies over the past four decades that have tended to shape policy orientations towards the welfare system. A paper entitled 'Catholic Social Teaching, Economic Thought and Four Hundred Thousand Maltese'[10], mentions the fact that the up-coming elderly register higher expectations than their predecessors. They are more socially and politically interactive than in

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[7] Social Protection: Malta and the EU 2010, National Statistics Office.
[8] https://secure2.gov.mt/socialpolicy/socprot/social_benefits/pensions_reform/releases.aspx.
[9] http://publications.thecommonwealth.org/social-policies-in-malta-863-p.aspx.
[10] http://www.apsbank.com.mt/filebank/documents/OccPaper9.pdf.

the past with the result that their consumption expenditure per period varies directly with age; the older the elderly the lower is the direct expenditure outlay per week. The paper also mentions that the extension of the official retiring age limit is bound to bring about several implications not only for the would-be elderly themselves but also for all others with whom they come in touch, namely their next-of kin who seek their assistance or from whom they themselves ask for support; and their would-be competitors in the labour market who are affected by the legal entitlement for a person up to 65 years to continue working.

Another study, entitled 'Personal well being, social values and economic policy'[11] shows that social measures are generally very complex; they develop piece-meal over time, often without taking stock of the changing outside environment and in relation to the whole corpus of measures in place. The result is usually disillusionment for many, the generation of unwanted and undesirable social structures that produce the same results that the measures were meant to address. Societies end up with heavy bills to pay in tax and interest payments on public debts, disillusioned and unsatisfied families and individuals, complex bureaucratic set ups, and an unsure way forward especially in the context of a rapidly ageing society. This seems to be the present situation in Malta's social welfare programme.

A study on Gender Equality in Maltese Social Policy[12] 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.

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.

2.2.3 Impact of EU social policies on the national level

The **Green paper** addresses the key challenges facing pension systems and how the EU can support Member State efforts to deliver adequate and sustainable policies. It recognises the links and synergies between pensions and the overall Europe 2020 Strategy for smart, sustainable and inclusive growth. There has been some discussion in national conferences involving the principal stakeholders on the Green Paper following its launch. For example, the Malta Chamber of Commerce[13] stated that the EU Green Paper on Pensions has sought to find long term solutions for the structural problems which will hinder Europe in the coming decade and its main aims includes ensuring transparency, safeguarding pensions and achieve the right balance between work and retirement. Furthermore, the main thrust of the Green Paper is pursued at the policy level through recommendations put forward by the Pensions Working Group. Overall, 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.

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

[11] http://www.apsbank.com.mt/filebank/documents/OccPaper8.pdf.
[12] http://www.millermalta.com/gender-equality-in-maltese-social-policy/.
[13] http://www.maltachamber.org.mt/content.aspx?id=216282.

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, include 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 EU2020 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 also reflect the EU 2020 strategy. As highlighted previously, debates on the adequacy of pension income in retirement is an issue in Malta, in the light of possible restrained living standards of pensioners.

With reference to the objectives specified in the **Annual Growth Survey**, the NRP states that parametric reforms to the PAYG were introduced by law in 2006. One of these reforms is the gradual increase and convergence of retirement ages for men and women to 65 years of age. To date, the linking of the retirement age with life expectancy has not been included in the first phase of the reform. There are no plans as yet however one of the recommendations put forward by the Pensions Working Group is to introduce a longevity index as part of the second phase of the reform.

The **NRP** mentions the reduction of early retirement is incentivised through the encouragement of older workers to continue working. 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.

The NRP mentions a number of targeted incentives have 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).

The promotion of lifelong learning is mentioned in the NRP. Measures cover Life-Long Learning into the Community through a Pilot Out-Reach Programme, Introducing New Possibilities and Modalities of Learning in Higher Education and the Training Aid Framework. However, no direct reference is made on the promotion of lifelong learning due to longer working lives.

The development of complementary private savings to enhance retirement incomes is addressed in the NRP. This measure states that the introduction of second and third pillars (mandatory and voluntary funded schemes) was perceived as a more structural type of reform that requires further discussion and this part was postponed until the second phase of reform can take place. At present, the discussion concerning the funded component is open for consultation.

There is recognition within the NRP that Malta faces challenges in terms of sustainability of public finances due to an ageing population. In this context, and in view of the requirements of the Stability and Growth Pact, and the obligations outlined in the Treaty on the Functioning of the European Union, fiscal consolidation is a top priority of the Maltese Government. This is specified in the NRP. In addition, the NRP highlights that Pension Reform aims to address the long-term sustainability and adequacy of the Pensions system in Malta.

The NRP reflects other pension issues. These include the low employment rate of older workers, together with a number of bottlenecks to employment. Bottlenecks include: an ageing population, a tradition where women, particularly those having young children, generally opt not to work and remain at home to look after their children due to a weak uptake of work-life balance measures, older workers that are less receptive to incentives to join the labour market and people continuing to resort to undeclared work in spite of actions being taken to cut down on such abuse and encourage them to regularise their position.

Other initiatives that commence in 2011 are mentioned. These include the support to persons with a disability to actively participate in the labour market, the integration of vulnerable people into the labour market and the pro-rata contribution to be extended to the self-employed including students and pensioners.

To date, no activities are being planned for **2012 as the year of active ageing** by the Ministry for Social Policy, as the main policy thrust on this issue is being carried forward by the Ministry of Health, as described further on.

2.2.4 Impact assessment

Following the reform in January 2008, which enables a person to earn the full retirement pension and remain active in the labour market, an increase of 341[14] persons (aged 62-64 years) remained in employment in 2008 on 2007 and in 2009 an increase on 2008 of 370 persons. The **rate of participation in the labour market** of persons who are 65+ years of age is very low – although this has marginally increased between Q1 2005 and Q1 2010. With regards to males this has increased from 0.6% to 1.50% and with regards to females from 0% to 0.70%. Whilst this increase indicates that a shift, albeit a very marginal one, is occurring with regards to retaining persons in employment beyond retirement age, the fact remains Malta is not actively tapping into the valuable experience of elderly people who can still play an active role in the labour market.

A policy measure that emanated following this impact assessment is that that Government should assume the leading role of maintaining in employment 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. As the nation’s largest employer, the Government’s adoption of an affirmative measure in this regard would strongly signal the importance of this policy measure as well as to induce a shift in the nation’s milieu in this regard. This is in fact one of the recommendations that is being put forward by the Pensions Working Group.

[14] https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/strat_rev_pensions.aspx .

There are **no main findings with regards to updated assessments due to the economic and financial crisis**. Currently, the system features a generous benefit to contribution ratio however 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.

In 2009, the people at risk of **poverty** or exclusion (65+)[15] in Malta decreased to 21.8% from 24% in 2005. This indicator compares well with that of the EU-27 average. (EU-27: 26% in 2005 to 21.7% in 2009). The Aggregate replacement ratio, (2009 - MT 0.47 and EU 0.51) is indicative of the fact that pension income especially for the older cohorts is falling in relative terms compared to wage income, mainly due to the economic growth in recent years. The Median relative income of elderly people, (2009 – MT 0.78 and EU 0.86) corroborates the previous point. The change in theoretical replacement rates between 2006 and 2046 is a negative 7.5 percentage points on a gross basis and a negative 9.1 percentage points on a net basis[16]. This indicates that the pension system will in future result in a continued reduction in income replacement, in part due to the ceiling on maximum pensions and the less than complete indexation to wages. It is also the case that the tax system would further accelerate the drop in replacement rates from a net viewpoint.

In this regard, an improved safety net will be achieved through the measures that enhance adequacy to the first pillar system namely amendments that have been made to indexation and minimum pensionable income.

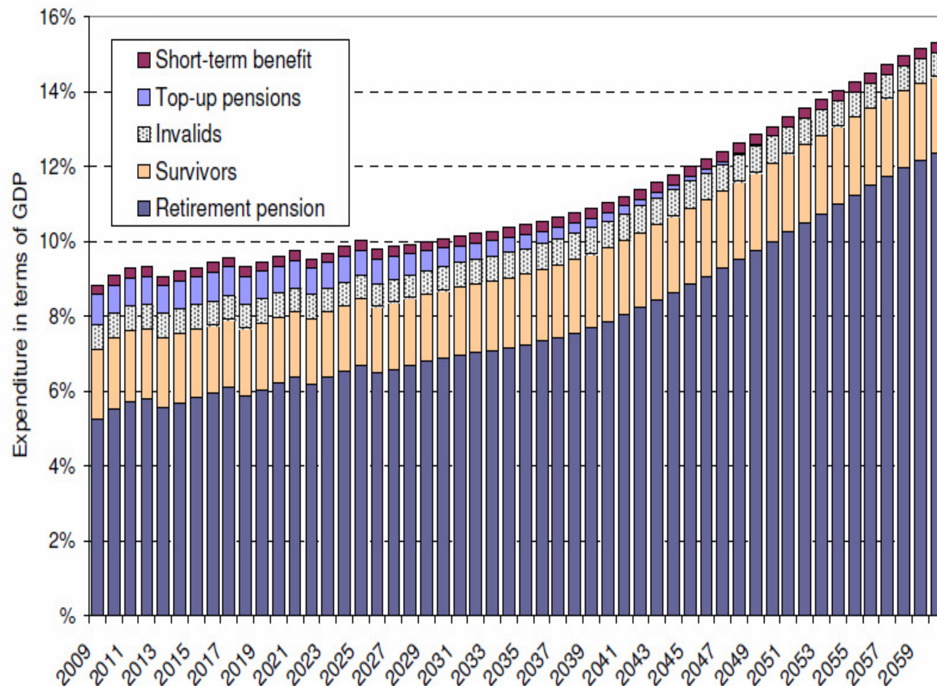
Career breaks impact on the number of missing contributions which affect pension entitlements through the pension formula. – the crediting of contributions for child rearing are being introduced for this purpose.

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.

[15] This indicator summarises number of people who are either at risk-of-poverty and/or materially deprived. No data is available for Malta for 2000.

[16] Source: UPDATES OF CURRENT AND PROSPECTIVE THEORETICAL PENSION REPLACEMENT RATES 2006-2046.

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



Source: Pensions in Malta: Acturial 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.

2.2.5 Critical Assessment of reforms, discussions and research carried out

Adequate and accessible retirement incomes for all must be obtained through methods that increase the resilience of the first pillar system through increased flexibility in the retirement age (to cater for demographic developments) and in replacement and contribution rates (mainly in consideration of economic factors), within the context of measures that enhance and lengthen the productive life of workers of different categories. Malta has taken a positive approach by reviewing pensions every five years. This is conducive towards the achievement of the objectives agreed to in the OMC are achieved.

Malta may consider implementing an automatic adjustment to increase the statutory retirement age to move in line with increases in life expectancy. This may lead to a more sustainable balance between time spent in work and in retirement and is consistent with the EU 2020 strategy target for reaching the 75% employment rate target. Of great importance is lifelong learning, which will enable workers to maintain their employability throughout their working lives.

The integration of pension funds with housing equity schemes may introduce elements of risk associated with fluctuations in property prices, actually deepening the exposure of household wealth and incomes to this factor, within an environment where housing wealth already constitutes a significant element of total wealth (estimated at 79%). In circumstances where population ageing has already advanced to a significant degree and the window for opportunity to create pension funds is rapidly being narrowed, it may be preferable to focus

on a restructuring of the PAYG system so as to render it more sustainable in the light of developments in economic activity, while implementing supply-side reforms to enhance labour employability and productivity.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The public health care system is provided under a universal system, financed out of general taxation. It covers all residents and offers primary, secondary and tertiary health care services that are free at the point of use. 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. The private sector acts as a complementary mechanism for health care coverage, with out of pocket payments and private health insurance.

During the reporting period, **no changes were made through legislation with regards population coverage**. Coverage 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 work permits. On-going reviews are being carried out to determine whether persons with permanent residence have a right to free health care in Malta.

Changes made to the benefit package in the reporting period[17] 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[18] with an additional 46 pharmacies included since 2010;
3. A continuous increase in the number of medicines that are being provided. In the reporting period, this amounted to an increase of 16 medicines, 11 of which are related to cancer care.
4. 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;
5. The launch of National Cancer Plan in February 2011 covers prevention, screening and quality of care. The introduction of PET scanning services is being offered in conjunction with the private sector. Breast screening continued in 2010 with 67% of those invited attending, which is slightly below the 70% target. 11 new medicines specifically for the cure of cancer have been approved in the reporting period. In 2010, this has increased by € 2,582,981 over the previous year.

[17] 2011 Annual Report, Ministry of Health, Elderly & Community Care.

[18] 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.

6. The launch of the Sexual Health Policy which will pave the way for the Strategy, was launched in 2011, a long-awaited policy for the last ten years.
7. 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 the primary health care by giving GPs greater access to patient information in the public system are on hold, mainly due to concerns by specialist providers regarding data confidentiality. A balance between the roles and interests of health care providers including GP's and specialists is currently being sought. Notwithstanding, incremental measures are being phased slowly based on a consensual approach. One of the first steps includes the ordering of blood tests private GP's in public health care centres and the introduction of IT in primary care.

According to the Health Interview Survey of 2008[19], GP consultations within the private sector are still prevalent with almost 23% of respondents attending private GP consultations and almost 9% attend a public GP consultation, in the four week period prior to the interview. No change resulted from 2002 for private GP's but an increase of 1.4% was registered for public GP's. As age increases, the probability of a person attending a private GP consultation decreases. While those between 15 and 24 years are three times more likely to attend a private GP consultation, those aged between 65 and 74 years are two times more likely to choose a private GP. Lower income groups and pensioners report higher percentages of public GP consultations than private GP consultations. Same trends follow for Medical and Surgical Specialist Consultations; however private specialist consultations show a drop from 9.2% of respondents in 2002 to 6.5% in 2008. Rates of public specialist consultations remain unchanged from 2002 to 2008 at 5.2%.

Secondary and tertiary care is mainly provided by specialised public hospitals of varying size and function. The main acute general services are provided by one new main teaching hospital incorporating all specialised, ambulatory, inpatient care and intensive care services. Over the reporting period, it was noted that hospital care is shifting from the private to the public sector. One case in point is the obstetrics field. This shift has led to the closure of private hospitals.

With regards to health insurance coverage, the rate within the survey population is 21.5%, similar to that in 2002. However, as private insurance coverage is becoming more unaffordable and public hospital care is now provided through a new hospital, fewer people are seeking coverage, especially in the light of a shift between private to public health care. In the Patient Experience Survey, 97% of patients were satisfied with the general ambience of the new public hospital whilst 95% stated that they had full trust in the medical staff.

As indicated previously, 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[20] for recurrent expenditure within the Ministry of Health, Elderly and Community care stood at € 289,065,000 in 2010 which is comparable to that spent in 2009. In 2009, health care expenditure amounted to 23% of total social protection expenditure increasing slightly from 21% recorded for the previous year.

Collective agreements were not affected and capital developments, such as the development of the Oncolgy Centre at Mater Dei is on-going. It could be stated that the recession hit Malta in a favourable manner when it came to the purchasing of new medicines, whereby a fixed

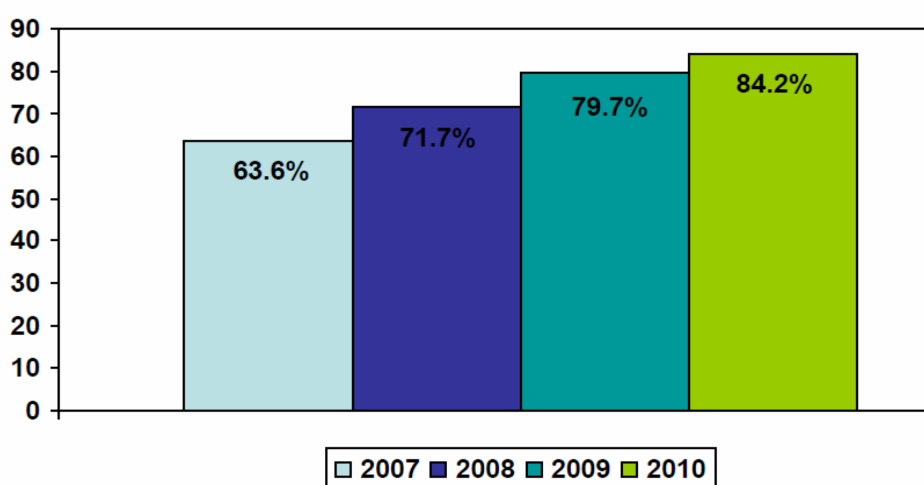
[19] https://ehealth.gov.mt/HealthPortal/strategy_policy/healthinfor_research/surveys/european_health_interview_survey_2008.aspx.
[20] Financial Estimates 2012: http://finance.gov.mt/page.aspx?site=MFIN&page=estimates&year=2009.

price is agreed on the point of introduction as part of the reform on the procurement of medicines. At the point, a national max reference price is plugged in and any tenders must come in below that maximum. Thus, overall a general slight decline in the prices of medicines was recorded in 2010, due to the impact of the recession. A higher number of undergraduate students were attracted to the medical field during the reporting period, since the field of health care is seen to provide a safe job during recessionary periods.

2.3.2 Debates and political discourse

The human workforce is an important pillar to the sustainability of the health and long-term care system in Malta, ranging from low to high skilled personnel. To improve retention of qualified staff, particularly doctors, efforts at developing local post-graduate specialist programmes have been undertaken in the reporting period. In 2010, the first year of the Malta Foundation Programme course was completed, led by the Malta Foundation School in collaboration with the UK Foundation Programme. The number of doctors within this programme increased by 23%, from 83 in academic year 2009-2010 to 102 in academic year 2010-2011. Figure 2 depicts an increase of newly qualified doctors that have chosen to remain in Malta and form part of the Foundation Course. 36% of doctors that qualified in 2007 left Malta, whilst the remaining 63.6% remained in Malta. On the other hand, in 2010, 15.8% left whilst 84.2% remained, with the latter increasing by 20.6% over three years.

Figure 2: Share of newly qualified doctors that have remained in Malta



Source: Annual Report 2011, Ministry of Health, Elderly & Community Care

To this end, 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.

There is still a shortage in the nursing field, however, we are in a relatively good situation since Government is pursuing a policy of active sourcing and recruitment of suitably qualified nurses from overseas. In the meantime, 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.

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. There were some allegations that carers are not being paid their minimum dues by the private contracting company.

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.

2.3.3 Impact of EU social policies on the national level

In the past year, the debate at European level with respect to the **Open Method of Coordination** and Social Policy Council focused increasingly on labour market policy rather than health care. The last NSR cycle which covered health closed in the period 2008-2010. Placing social policy and health together is causing the health aspect to be side-lined.

The **EU 2020 strategy** has not impacted on health reform debates at local level. One of the pillars of the EU 2020 strategy is to decrease poverty. The flagship initiative "European platform against poverty" ensures that social and territorial cohesion such that the benefits of growth and jobs are widely shared and people experiencing poverty and social exclusion are enabled to live in dignity and take an active part in society. In itself, this initiative focuses more on labour market policy rather than health policy. The EU 2020 Strategy did not impact health reform debates in Malta. This could be due to the fact that provision of free health is universal whilst overlooking the challenge of long waiting times in the public health system which may cause problems with access to health care. Furthermore, there is the exclusion problem within private insurance for older age groups which may affect the material deprivation indicator. In addition, the improvement in the poverty indicator in recent years may indicate that the relatively younger people among the 65+ age cohort tend to be better off. This may be masking an incidence of poverty and deprivation among the old-old.

Policies in the area of **health care and long-term care** 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 or the wider challenges faced by the health care system in general, including quality, access and pressures for widening of services offered.

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 shall serve 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.

2.3.4 Impact assessment

Main indicators of impact assessment include access to and quality of services provided, following reform processes.

With respect to health outcomes, Malta has fewer doctors, dentists and nurses than the average for the EU-15, as shown in Table 2. On average, Malta has 315 fewer doctors per 100,000 inhabitants, 240 fewer dentists, 120 fewer nurses, but only a quarter of the European average number of qualified pharmacists.

Table 2: Health professionals, per 100,000 population

	Malta	**EU-15 average**
Doctors	260	380
Dentists	400	640
Nurses	550	670
Pharmacists	200	790

Source: Ministry of Health

Table 3: Hospital beds, per 100,000 population

Malta	496
EU-15	611

Source: Ministry of Health

Increasing levels of education lower inequalities within the health care sector. A positive correlation exists between low education achievement and a low uptake/reluctance to health prevention activities such as routine tests, smoking and obesity.

With regards to gender impact, changes in the reporting period were slightly more biased towards females with the launch of the Breast Screening Programme, which is targeted towards females.

Austerity and retrenchment following the recent crisis are not affecting access to and provision of health care services. However, long term concerns regarding the financing of health care in the face of increasing demands on access the system, including those associated with population ageing, and limited resources remain an important consideration for social policy in Malta. These may become even more of a concern if the fiscal rules of the Stability and Growth Pact are tightened in the medium term.

It is highly probable that in the longer term, additional sources of tax funding for health will have to be identified, without however resorting to user fees. It is also probable that private sector hospital capacity will be needed to be utilised by the public system to meet the increasing demand. Another important issue will be the extent to which local citizens will be utilising public health care systems elsewhere in the EU to avoid waiting times, putting an additional financial burden on the finances of the Maltese public health system.

The health care system is sustainable in terms of health care personnel. Emigration of highly skilled newly qualified doctors is being contained as shown in Figure 2 further above. Shortages in lower skilled medical staff personnel are being filled by the engagement of foreign workers.

With regards to **groups not covered by the health system**, exemptions or reduced rates are available for United Kingdom and Australian citizens falling within the parameters of bilateral agreements between Malta and these countries. All other foreigners pay full charges except for refugees whose fees have traditionally been waived by the Minister for Health. There are no special population groups that have their own parallel health care system. **De facto access** is not an issue for Malta, due to smallness and proximity of service provision.

During the reporting period, there was no recent analysis with regard to **inequalities in health**. Inequalities in health care definitely 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.

As highlighted previously, waiting lists are an issue in the Maltese public health system which to a certain extent, make the public system inaccessible. Formal and informal payments do not limit access to services. 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, 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 that higher income counterparts at 9% and 5%, respectively. Access to health care in urban/rural areas is not applicable for Malta due to smallness and proximity of service provision, through local health centres.

2.3.5 Critical assessment of reforms, discussions and research carried out

National debates on the future developments of social protection systems include: long term concerns regarding the sustainability of the public hospital system in the face of increasing demand, associated with population ageing; the need to reduce waiting lists for public hospital care and the need to meet ever increasing demands for quality health services.

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, whilst bringing care closer to patients and their families. Thus, efforts to reform primary health care must be further pursued.

The focus on a preventive approach to health that characterises changes in the reporting period is an essential prerequisite for the country’s social and economic development. This is also borne by the inclusion of health as one of the pillars in the Vision 2015 policy document.

Increased private sector collaboration to support the public health system was evident in the reporting period. 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. Private sector hospital capacity must be further exploited 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.

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' as defined by the Ministry of Health, which affirms that they should be given all the support they require to remain in society and lead, as far as possible, an independent life. 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. Thus, long-term care in Malta is provided by the government, by the family of the person in need, by the church, the voluntary sector and local councils.

State-organised long-term 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, non-medical assistance such as home help, cheap home-delivered meals, Telecare, Handyman Service and Day Centres. According to the Health Interview Survey 2008[21], overall reported care service use is low within the elderly population. 11% of respondents reported making use of at least one community care service in the 12 months prior to the interview. Use of community care services is highest amongst the 85+ age category, at 24% as opposed to 7.4% in the 60-74 category. The community care service used most overall within all age groups is home help whilst the least used is home delivered meals.

However, in order to secure a balanced continuum of care, long-term stay residential care facilities 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 seven State-owned community hostels which along with St Vincent de Paul Residence provide institutional 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 4 depicts that there were a total of 29 church and private homes for older persons operating in Malta and Gozo in 2009.

Table 4: Number of licensed church and private homes in 2009

	Number of homes	**Number of licensed beds**
Church	17	733
Private	12	993
Total	29	1,726

Source: Department of Health Services Standards, Annual Report 2009

[21] https://ehealth.gov.mt/HealthPortal/strategy_policy/healthinfor_research/surveys/european_health_interview_survey_2008.aspx

Table 5 depicts the increase in the number of licensed beds over the two year period 2007-2009.

Table 5: Increase in the number of licensed beds for older people (2007-2009)

2007	1,650
2008	2,612
2009	4,193

Source: Department of Health Services Standards, Annual Report 2009

With a total of 2,467 beds for older persons, the Government has the majority of the market share with 60% of the caring beds, followed by the private sector with 23% and the church run homes occupying the remaining 17%.

One of the major problems that the new acute hospital is facing is the congestion of beds caused primarily by elderly patients who cannot be discharged back to the community for various reasons. This situation is being balanced out by **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, developing nursing homes in the community based on the PPP model as is the case of the new residence in Mellieha and the purchasing of beds within the private sector.

With regards to **funding**, there is a system of co-financing in the form of a percentage of their pensionable income (60% in Community Homes and 80% in long-stay facilities). With regards to the role of **private insurance schemes or contracts**, one of the proposals of the second phase of the pension reform is housing equity release schemes.

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.

With regards to service provision and organisation, long-term care in the community may be improved, especially nursing services provided at home whilst take up of community care services must be improved. Few efforts are in place to support and coordinated church and voluntary initiatives. Private providers are being integrated in ongoing reforms through the purchasing of beds for long-term care within the private sector.

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. Other important discussion points were concerned with the need of education to carers especially on how 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.

2.4.2 Debates and political discourse

No major changes have taken place with respect to the public debate on long-term care organisation in Malta. Public awareness with regard to the evolution of long-term care in the future is weak. This was also noted within the context of the NRP where no reference was made to long-term care.

With respect to **access** and **quality** to long-term care in Malta involves 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. 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.

A study on the organisation of dementia care by families in Malta[22] 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 previously, in the past year, the debate at European level with respect to the **Open Method of Coordination** and Social Policy Council focused increasingly on labour market policy rather than long term health care. The last NSR cycle which covered health closed in the period 2008-2010. Placing social policy and health together is causing the long term health care aspect to be side-lined. Policies in the area of long-term care services are not extensively addressed in the **NRP**, which make it increasingly difficult to benefit from structural funds within the area of long-term care for the elderly.

The **EU 2020 strategy** has not impacted on long term health reform debates at local level. Access to state institutional long-term care favours those at the lower end of the income scale thus exclusion may not be seen to lead to poverty in this regard at local level. One problem that is being overlooked is the disparities that exist between the young-old and the old-old. Due to the relatively strong pace of economic restructuring and growth over the past years, people who have retired on incomes over ten years ago may have living standards within their home which are quite different from those of the recently-retired. This issue is likely to persist in future, as the economic dynamics continue and life expectancy increases. Social dynamics, and smaller family sizes are also reducing the extent to which the old-old especially are being cared for by their own families.

As highlighted previously, EU policy fails to address **long term health policy with respect to ageing and poverty**. 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, where further development of the dementia services and the refurbishment of a unit

[22] http://dem.sagepub.com/content/early/2011/03/11/1471301211398988.abstract?rss=1.

at St. Vincent de Paule Residence for these particular patients. As highlighted above, access to public long-term care institutions is favourable towards those with low means however issues of long-term care and poverty may impact who old-old group, who decide to remain at home not to opt for institutional care. 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.

2.4.4 Impact assessment

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

With respect to **quality** of long-term care, a policy document to address standards is currently being developed whereby inspections of Government homes and long-term care facilities for the elderly, coordinated by the Department of Health Care Services Standards, will be undertaken as in the private sector. 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.

Long-term care faces **shortages** in the field of carers, which is currently being fulfilled by a pool of foreign workers. This was explained previously in the health care section. Multidisciplinary teams composed of professionals such as nurses, psychologists, occupational therapists and physiotherapists are planned for home outreach services so that community care is prolonged as much as possible whilst institutional care is prolonged. Almost 6%[23] of the elderly population (aged 60+) were living within institutions in 2008, with the rate of those living in institutions increasing with age. Thus a significant proportion of the elderly population will increasingly demand community care services.

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.

A plan is currently being drawn up by the Ministry for long-term care needs over the coming years. This plan will incorporate both the structures and the human resource needs that are required. The increase in bed capacity must be accompanied by a concomitant expansion in skilled human resources, particularly carers.

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. As a percentage of GDP, health expenditure in Malta is relatively low compared to other EU countries.

[23] https://ehealth.gov.mt/HealthPortal/strategy_policy/healthinfor_research/surveys/european_health_interview_survey_2008.aspx .

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

						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

Overall, long term health policy must focus on the concept of strengthening community support in order to delay institutional care. Quality of long-term care both within community care and within institutional settings must be ensured and standards must be implemented for both settings and within the private and public providers.

Access to institutional care must continue to 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 in the case of disability.

At policy level, long-term care as a concept must be further developed in Malta to reflect the ever increasing needs of an ageing population. At EU level, long-term care policy must take a more pro-active role since employment objectives tend to side-line this sector.

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World Bank, Pensions in Malta: Acturial Analysis and Options for a Second Generation Reform, 2010 – retrieved on 1 May 2011 - https://secure2.gov.mt/socialpolicy/SocProt/social_benefits/pensions_reform/final_report_white_paper.aspx/

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; H ; L] APS BANK, Catholic Social Teaching, Economic Thought and Four Hundred Thousand Maltese, 2010, Delia – retrieved from:

http://www.apsbank.com.mt/filebank/documents/OccPaper9.pdf

This publication brings together the three main areas involved in the subject, namely, Catholic social teaching, economic thought and the particular characteristics that make up the present Maltese economy and society, and, also the envisaged changes in such a community. These three 'components' have to be addressed together in order to appreciate the relationships between principles and applications, and the interaction of these and particular political and economic situations. Principles remain always basic points of departure. The challenge lies in their implementation in specific contexts at particular points in time.

[R; H; L] AZZOPARDI, Rose Marie, Social Policies in Malta, March 2011, London

This paper examines the economic, political and social development of the island, particularly since independence, highlighting the successes and failures of the social development strategies adopted and suggesting how these lessons can inform future policy decisions.

[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.

R; H; L] Malta National Statistics Office**,** Social Protection: Malta and the EU, 2010,

Publishing Date: 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.

[H; L] MINISTRY FOR SOCIAL POLICY, Annual Report, DHCSS 2009, 2010, retrieved from:

https://ehealth.gov.mt/HealthPortal/public_health/healthcare_serv_standards/reports_pub_resources.aspx

This report has been drawn up by the Department of Health Care Services Standards (DHCSS). It contains information on the licensing of Private and Church Homes for Older Persons as well as Private Clinics and Hospitals.

4 List of Important Institutions

Ministry of 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 social benefits, social housing, disability, equality, industrial employment, children, family and pensions. Under the ministry's responsibility fall also the fields of employment and training.

Ministry of Health, the Elderly and Community Care

Address: Palazzo Castellania, 15, Merchant's Street, Valletta, VLT 2000, Malta
Webpage: http://www.sahha.gov.mt/

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.

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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

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

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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.

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(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