Annual National Report 2010

Pensions, Health and Long-term Care

Malta

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1 Executive Summary

The economic and financial crisis in Malta has been less felt on the financial side, and more from the economic perspective. Export-related economic activity, including the all-important tourism industry, has seen a strong and worrying decline. A strong and sound regulatory framework and prudent lending policies have however safeguarded the banking system, removing the need for (and the costs connected with) government intervention in this respect.

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 gradual parametric shift, the full impact of this policy will only become clear by the year 2026.

Where the first pillar pension scheme is therefore being overhauled, promised initiatives to build a system of second and third pillar provisions have so far not seen execution. This is likely to create some unrest, as worried citizens at present have no alternative strategy than to make private provisions on an underperforming private market.

In health care, the further extension of secondary and tertiary provisions has received much attention over the past years. Now, it is time to tackle the problems in primary care provisions. These problems boil down to a lack of coordination and synergy between the different levels of health care, resulting in an overburdening of hospitals and emergency services and related problems that ring through throughout the system. Plans to mobilise the private health care sector as the gatekeeper to the state-funded provisions have been laid out and are open for consultation. The final conclusions of the debate are not yet known.

Long-term care has benefitted from an expansion of residential care places. The problems in the sector of long-term care are however also closely linked to the problems concerning the allocation of health care resources and the efficiency gains yet to be realised there.

In summary, Malta seems to plan recovery from the economic situation through stimulus measures, an integration of policy-making competence, further implementation of previous decisions (pensions) and efficiency and effectiveness reforms. No cuts seem to have been made that would affect the level of social protection, and announced investments in health, education and social protection expenditure will maintain or even increase the level of social protection offered to the Maltese citizens.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year

2.1 Old-age pensions

2.1.1 Old-age pensions: system characteristics and reforms

The pension system in Malta operates on a pay-as-you-go basis, and provides for old-age (retirement) pensions, survivor's pensions and invalidity pensions.

The **first pillar** 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 income for self-employed (with minimum and maximum contributions).[1] The government-ran "Consolidated Fund" adds 50% of the contributions paid for each individual to the system.

The pension benefit is said to be a "two-thirds" pension, as it aims to provide for a replacement rate of two-thirds of the average earnings of insured persons. Entitlement is based on a minimum number of contribution periods upon reaching a statutory retirement age, for which certain periods of inactivity (sickness, unemployment, invalidity etc.) are equally taken into account. Calculation of benefits is based on the average income before retirement.

For those who would otherwise only receive a minimal benefit, a minimum pension guarantee exists, expressed as a percentage of the national minimum wage.

Complementing the contributory scheme is a system of non-contributory benefits. Where the basic requirement for entitlement to the former is that contribution conditions have been satisfied, the latter is means-tested.

The provision of guaranteed income to the elderly in the form of various pension types (contributory or non-contributory benefits) is one of the key elements underpinning the social security system in Malta. The recent 2007 and 2008 national budgets have further enhanced the "value" of these pensions to citizens whereby pensioners now receive a 100% cost of living increase as distinct from 66% previously, and as retirees can now earn an unlimited amount of income without any reductions in their pensions. These two improvements alone indicate the priority given to maintaining pensions at a sufficient level in relation to overall national income levels. The current management and administration of the pension system is highly regarded by a good majority of the citizens and the rates of pension payments are seen as reasonably generous.

2006 Pension Reform

The parameters used in the implementation of the first pillar pension scheme underwent important changes from 2007 onwards, following a comprehensive pension reform. Work on

[1] The Maltese system considers those who are neither employed or gainfully occupied as being self-employed, which means that the concept of self-employment includes persons who would in other systems be considered as "non-employed": "employed" are those who are bound by a service or employment contract (including civil servants); "self-occupied" are those who are self-employed and gain a set minimum amount of earnings; "self-employed" are those who are not employed and do not gain enough income to be considered self-occupied. The distinction made in Maltese legislation is important when analysing official reports and communications. The terms "self-occupied" and "self-employed" are therefore not interchangeable and do not necessarily coincide with concepts found elsewhere.

the reform started in June 2004, with the establishment of a Pensions Working Group which was to analyse all previous work and debate, and which was asked to formulate recommendations on the way forward. Following extensive national consultation and discussion, the Working Group presented a final report in June 2005.[2] This report provides a comprehensive and detailed analysis of how the system would evolve in the absence of reforms and contains recommendations for change taking into account long-term fiscal sustainability. Legislative changes were announced in March 2006 and finally enacted in December of that year.[3]

The most important changes can be summarised as follows:

1. The statutory retirement age is gradually increased, from 60 for women and 61 for men prior to the reform, to 65 for both 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. 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.

2. 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.

3. The way the pension amount is calculated is also amended. 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.

   Table 1: New pension amount calculation

Date of birth	**Retirement age (Men, Women)**		**Takes effect in**	**Contribution period**	**Calculation basis**
Before 1952	61	60	(2007)	30 years	Best 3 years within last 10 (employees) or last 10 (self-employed)
1952-1955	62	62	2013	35 years	
1956-1958	63	63	2018	35 years	
1959-1961	64	64	2022	35 years	
After 1961	65	65	2026	40 years	Best 10 years within the last 40

Source: Pensions Working Group, Final Report, 2005

4. Concerning adequacy and the concern to safeguard purchasing power, the adjustment of pension benefits will, from 2014, be calculated in such a way that the amount keeps track of increases in national average wages and inflation.

[2] The final report is available via http://www.mfss.gov.mt/pensions/documents/frpensions.pdf.

[3] The pension scheme is enacted in chapter 318 of the Social Security Act. In March 2006, the Prime Minister announced a series of changes to the current Pension System. Act No. XIX of 2006 (“Social Security (Amendment) (No. 2) Act, 2006”) was published in the Supplement to the Government Gazette on 7 December 2006, after it was formally adopted by the House of Representatives.

5. 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 reforms therefore amount to more than purely cost-cutting measures, and include measures to improve the replacement rate. Some changes will indeed represent an increase in expenditures.

It was also agreed to elaborate five-yearly reports on the results of the changes. The first of these reports, which is also expected to contain recommendations concerning adaptations and ameliorations, is due in the course of 2010. Some preliminary impact *projections* are however already available.[4]

Second and third pillar pensions

At present, Malta still lacks organised second and third pillar pension provisions. Occupational pension schemes (**second pillar**) and voluntary individual provisions (**third pillar**) are still in the initial stages of development, but can be expected to emerge soon. Indeed, the 2006 pension reform has also introduced the necessary legal framework for such provisions, but has however not detailed their regulation. Instead, the Minister in charge of the Department of Social Security, in concurrence with the Minister of Finance, is explicitly empowered to create regulations in this field (limited, however, in field of application to those individuals who have not yet reached the pension age). It is anticipated that the first five-yearly report will specify proposals as to the contribution rates and modalities of a second pillar scheme,[5] and will outline the details of a favourable tax regime for private (third pillar) provisions.

2.1.2 Old-age pensions: debates and political discourse

The slow pace of pension reform in Malta, where it concerns the second and third pillar pension provisions, gives rise to a certain degree of anxiety and voiced criticism. A number of commentators in the Maltese written media regularly highlight what one of them calls the "pension Black Hole"- pointing at the ever-increasing cost of the system.

Alfred Mifsud, a commentator for the Maltese Independent, described in an article of on 17 April 2009 in graphic detail the dilemma facing the Maltese pension system if it is not reformed and overhauled very quickly. George Mangion in an article as far back as July 2004 commented that Malta was "now at a crossroads" and that the pension system needed "radical reform" and more participation of women in the workforce.

These media commentators seem to be at the front line of the publication of material showing the absolute need for immediate and short-term action in the area of pension reform in Malta.

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[4] See the final report of the Pensions Working Group; see also the Update of the Convergence Programme 2006-2009 ("The impact of the pension Reform on Long-Term Pension Projections"), submitted by the Ministry of Finance in December 2006 (http://finance.gov.mt/image.aspx?site=MFIN&ref=convergence005).

[5] IOPS, the International Organisation of Pension Supervisers, reports on concrete plans for a new-to-be-implemented occupational pension scheme, in which contributions would initially amount to 1% for the individual plus 1% for the employer and would be increased to 5% by 2020. Government would participate not by adding contributions, but through exempting the contributions from taxation and through levying a fixed tax percentage at maturity. No citiation is given for these plans. See http://www.iopsweb.org/dataoecd/26/15/43469300.pdf.

This criticism may seem surprising, given the fact that the reform of the first pillar pension system is rather extensive, and has taken place on the basis of extensive societal debate. To the expert, this amounts to good news, and an accomplishment that seems still to be elusive in other countries. However, the unease can be explained by the apparent lack of initiatives in the second and third pillar pension schemes, leaving the first pillar – and state finances – to currently provide for everything and worried citizens no other option than to invest in a depressively underperforming private market. It remains to be seen if government initiative in this respect will be regarded as just and sufficient.

2.1.3 Old-age pensions: overview of published impact assessments

As a member of the euro zone, Malta is required to submit a stability programme to the European Union. The updated stability programme of Malta for 2009-2012 contains projections on the impact of ageing and the influence of the recent pension reforms[6] using models provided by the World Bank. Age-related public spending is projected to increase by 10.2% of GDP over the period 2007-2060.

To come to this figure, a rise of 6.2% of GDP is accounted to the contributory pension system (which includes old-age (retirement) pensions, survivor's pensions and invalidity pensions but not the non-contributory means-tested scheme). 3.3% is related to health care, and 1.6% to long-term care. Offsetting the balance are unemployment benefits (projected to remain largely stable) and a 1% decrease in spending on education.

A more thorough review of the pension system in terms of adequacy, social solidarity and sustainability is expected during the course of 2010, as part of the review mechanism that is agreed upon as part of the pension reform. The planned introduction of funded second and third pension provisions is seen as an answer to the question of sustainability and adequacy. Work on establishing these pillars (through the re-convened Pension Working Group) is still underway.

2.1.4 Old-age pensions: critical assessment of reforms, discussions and carried out research

The window of opportunity for the Maltese Government to fast track the development of a second pillar pension scheme and to actively encourage the participation in third pillar schemes is closing. The overall population continues to age (the share of persons aged over 64 is projected to rise from 13.8% in 2007 to 25.0% in 2050), and individuals are rightfully worried by the capacity of the first pillar system to cover the associated costs. At the same time, because of the ongoing decline in birth rates, the working-age population will certainly drop from its present level. According to these demographic projections, the support ratio – the number of persons of working age related to the dependent population – is set to fall from just under four at present, to slightly above two, by 2020.

Because government-supported second and third pillar systems are still lacking, individuals have no other alternatives than making provisions through private savings which, given the current economic and financial climate, is a rather unattractive prospect.

The reform of the first pillar pension scheme was necessary and seems to be adequate. It can

[6] Ministry of Finance, the Economy and Investment, "Malta: Update of Stability Programme 2009-2012", February 2010 (http://ec.europa.eu).

however not suffice in itself. Swift and decisive action to establish and implement second and third pillar systems is urgently needed, and cannot be delayed because of worries over the short-term fiscal cost.

2.2 Health care

2.2.1 Health care: system characteristics and reforms

Health care in Malta is provided under a universal system, covering all residents and offering services that are free at the point of use. Amongst others, provisions include free medical services at Health Centres (*Centri tas-Sacca*) and free hospitalisation.

Primary health care is at present organised through seven Health Centres, where government-employed professionals offer a full range of preventive, curative and rehabilitative services. General practitioners are available on a 24/7 basis, and their services are supplemented by various specialised services.

Secondary care and tertiary care are provided through public hospitals. There are currently eight public hospitals in Malta, the most important being the Mater Dei hospital in Msida, which opened its door in June 2007.

The public system is financed through general taxation, with out-of-pocket payments complementing funding. These out-of-pocket payments mainly exist for out-patient pharmaceuticals, which patients in principle have to pay for themselves. Two exceptions exists to protect the most vulnerable groups: persons with low income and passing a means test are entitled to receive free medicines from a restricted list of essential drugs; persons suffering from certain chronic diseases are entitled to the free provision of medication in relation to that particular medical condition (independent of financial means).

Dental treatment is provided on a means-tested basis and is free for certain categories of patients and population groups. Others are only covered for full dental examination, investigations, preventive treatment, emergency treatment, and surgery requiring general anaesthesia.

The general administration of health care (and long-term care) was recently restructured, resulting in better coordination and synergy between all strands of care. Where different administrations managed health care and long-term care for the elderly, and a separate ministry was responsible for the administration of social care for certain groups of non-elderly persons, all policy-making and management is now centralised.

Next to the public system, there is an important private system. There, patients pay for services themselves, but often cover these costs through private insurance (especially for hospital and specialist care under the private system). Private financing on health care in Malta therefore not only points to out-of-pocket payments made by patients who make use of the public system, but also of those turning to the private sector, or taking out private insurance.

Persons enjoying private insurance or choosing to pay for services in the private system themselves can however not opt out of the public system.

2.2.2 Health care: debates and political discourse

Debate in 2009 mainly revolved around government plans to re-organise policy concerning the provision of primary health care. Following the construction of the Mater Dei hospital, Malta has an ample and modern hospital infrastructure. Problems with overcrowding and inefficiency however remain. These problems are thought to be connected mainly to the absence of a clear division and task-sharing between the different layers of health care provision.

To increase coordination and efficiency and to rationalise the use of secondary and tertiary health care provisions, the government proposed plans for a Primary Health Care Reform at the end of 2009.[7] The proposals aim to create a system in which general practitioners would act as gatekeepers to secondary and tertiary care and would be the first point of contact before any patient can gain access to specialist care, thus relieving the stress on the other levels of health care. Based on the current Maltese context where most individuals visit general practitioners in the private system and where the (public) health centres are today equipped to provide for more than primary care, the plans call for a shift of primary care functions from these health centres to the *private* family doctors, while the former would focus on the delivery of secondary care and would no longer be allowed to act as gatekeepers for further specialist care.

While the urgent need for change is widely recognised and the core of the plans itself is not widely contested, criticism is voiced over the shift of the financial burden from the state to the patient. Indeed, where a Maltese resident can now receive primary health care free of charge at a Health Centre, full implementation of the proposals would require patients to see private family doctors who work for a fee. Mitigation of the cost for low-income patients would be provided through a system of vouchers, and the current use of private doctors suggest that the practical implications of this change for the patients would not be dramatic; still this element of the plan has inspired many remarks.

Other concerns revolve around the possibility to motivate private doctors to provide the 24/7 access to services which is now provided by the Health Centres, the registration of patients with a particular family doctor, and the necessary emergence of a system of (electronic) central patient files.

Based on this debate, and following political hurdles encountered by the proposal, the plans are currently being adapted.

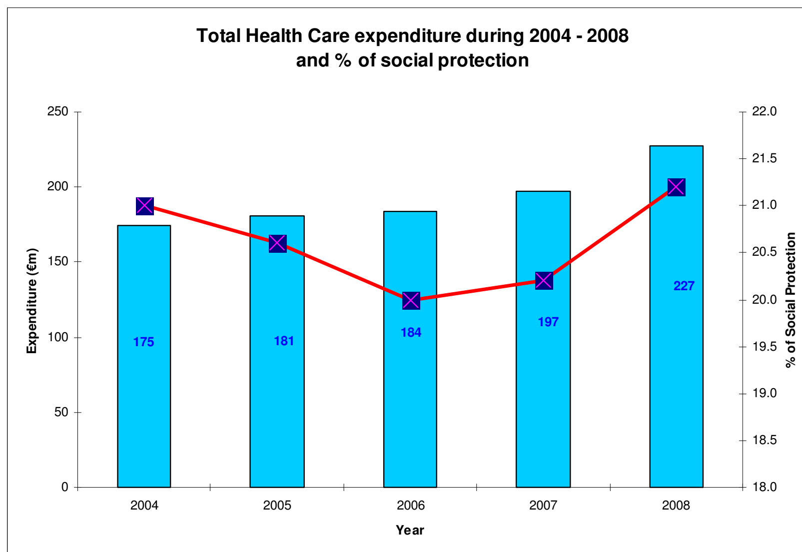
2.2.3 Health care: overview of published impact assessments

Expenditure

Expenditure on hospitals and other health care facilities was on the rise in recent years, with an increase from EUR 197.3 million in 2007 to EUR 227.5 million in 2008. Two-thirds of this rise can be accounted to higher recurrent expenditure incurred in the human resources needed for the running of Mater Dei Hospital

[7] The proposals, in the form of a White Paper, can be consulted on https://opm.gov.mt/file.aspx?f=2121.

Figure 1: Total health care expenditure 2004-2008



Source: National Statistic Office (NSO) – Social Protection – Malta & the EU 2009

Access

Malta's health sector continues to operate in a health care environment that is becoming increasingly demographically, financially, and technologically more complex, and the necessity to quickly encompass change is becoming ever more essential. The Ministry of Health is responsible for the financing and provision of publicly funded health care services, and health care in the public sector is highly centralised and tightly regulated. In effect, the Government combines the roles of both service purchaser and service provider. In contrast, private health care practice is not formally regulated.

The following tables based on Maltese Ministry of Health published information compare the resource provision of Malta with a basket average of 15 EU states. In general terms, Malta has fewer doctors, dentists and nurses than the average for the EU-15, by around 315 fewer doctors, 37.5% fewer dentists, 18% fewer nurses, but only a quarter of the European average numbers 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 average	611

Source: Ministry of Health

Because of its relative size it may not be economically viable to maintain advanced medical institutions or research centres to promote medical staff skills and experience. Therefore, there is an issue of migration of medical staff. Migration abroad of newly qualified Malta doctors (approximately 80%) to further their studies in the UK has been highlighted in the local media, and continues to be a problem. Plans are in place to enable medical personnel to complete equivalent and UK-recognised post-graduate qualifications in Malta.

It is generally accepted throughout Europe that if a country aims to reform its health processes to deliver the enhancement of patient-centred access it should be considering the following aspects of service: safety, effectiveness, patient-centeredness, timeliness, efficiency and equitability. In practical terms then, health systems need to provide their services to patients in faster, more flexible, more effective and less bureaucratic ways. This means the right kind of care, delivered by the right people, in the right place – localising services where possible and centralising only where necessary.

The management of waiting lists and target setting to monitor performance management have been well documented elsewhere recently in the EU, and particularly in the UK NHS which has close links with the Maltese Health Service. There will be many issues that the Maltese sector will have to address in a climate of stringent financing while facing continuing increasing expectation and demand, but a critical one will be how to mitigate the impact on the patient who finds him/herself on a waiting list.

An IT-based centralised patient waiting system is being introduced and a pilot exercise has seen a reduction in orthopaedic waiting lists simply by the validation of patient names on the waiting list. It does not provide an instant fix to waiting lists; it is the clinical staff who after all have to deal with the patients, and mention has already been made above of the relative shortage of doctors in Malta. In addition to the normal methods of dealing with waiting lists, better use of operating theatre time, more procedures carried out on a day clinic basis, or better bed management; one key device in the reduction of waiting lists and waiting times (de facto barriers to access to health care) in other Member States has been the advances in accurate, timely information that allows performance management of the system by the commissioners and the provider organisations, and also provides useful information for the use of patients and their relatives. This relies on robust information systems at all levels.

There is anticipation that analysis of information already held on systems will allow the Government to develop ‘maximum acceptable waiting times’. Elsewhere in the EU Member States, governments have approached the ‘acceptability’ issue from a policy point of view: setting access targets which become increasingly more challenging over time and using the health information systems to manage the performance of the secondary and tertiary care providers.

Quality of health care – perception by the population

Despite the constraints referred to above, the population enjoys high standards of health care, resulting in a longer life expectancy and recognition by the World Health Organisation which has described Malta's health care as one of the best and most cost-effective health systems in the world. For a small population such as Malta, with a population akin to a medium-sized European city, and the limited information analysis systems capacity of the health service, there is no further subjective, objective or comparative additional local information that can be reliably used.

2.2.4 Health care: critical assessment of reforms, discussions and carried out research

The absence of a gate keeping system promotes an over-use of the secondary and tertiary care system. Collaboration between the private and public service providers is limited, and the private sector is still largely unregulated. The decision to build the Mater Dei hospital, made in the early 1990's, has meant that attention and funds have been diverted away from a development of other aspects of health care strategy, most notably of that of efficient first-tier primary care provisions. As a result, too many patients are now receiving services in hospitals, without the existence of an objective need.

The development of a primary care strategy is high on the agenda, but the outlined policy has been criticised for not answering concerns about the level of service provision, and for shifting the financial burden from the state to individual patients through the strong emphasis on private physicians as the gatekeepers of the system and by taking away the competence of referral of the doctors employed by the state in the Health Centres.

Waiting times remain a concern in Malta, in big part because the emphasis on the development of capacity for acute care leaves a shortage of long-term care facilities and because the absence of an effective gatekeeper system induces over-use of emergency care facilities. As a result, access is proving to be a major concern in Malta; one that is being recognised by the authorities and for which several action plans exist. In the following years, measures are planned to improve information provision, consultation on new policy, study (and lessen) waiting times, prevention, and access to new treatments.

Finally, much remains to be done where it concerns measuring and guaranteeing the quality of health care. While the system is generally perceived as adequate and satisfactory, standards and procedures seem to be lacking. Solutions here are of course tied in with the development of a clear task-sharing between the different levels of health care, and with the ability to deploy comprehensive and encompassing policy.

2.3 Long-term care

Long-term care in Malta is provided by the government, by the family of the person in need, and by 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. While local councils have no policy-making powers, they do play a role in monitoring the provision and quality of services for the elderly.

Services at home

Nursing services at home are provided free of charge by the state, through a network of community nurses.

Non-medical care, personal assistance and help with light domestic work to persons over the age of 60 is provided by the homecare help service, against a nominal fee. The capacity of this system is however limited and priority is given to persons over the age of 85 and those with special needs or in particular situations.

Cheap home-delivered meals are provided by non-governmental organisations in cooperation with the state authorities. The staff of these services is trained to observe the person's home environment and report back when anything is out of the usual.

The government, in cooperation with a telephone operator, also runs a tele-alarm system known as "Telecare".[8] Subscribers receive a personal alarm device through which they can alert a control centre. The control centre keeps lists of who to contact, and is aware of the medical situation of the subscriber.

Care in institutions

Elderly persons living by themselves, or at risk of otherwise being alone all day, can make use of day care services provided in day centres throughout the country. These centres offer physical education and social and creative activities. They operate during the day, five days a week, and require only a nominal contribution from individuals. Day-care centres are often organised and managed by local councils.

Long-term residential care is provided by the government in Government Community Homes intended for physically independent elderly people who require sheltered accommodation, and in long-stay facilities for those who have more nursing needs. State-ran long-term care is however not free. Patients are required to provide co-financing in the form of a percentage of their income (60% in Community Homes and 80% in long-stay facilities).

Capacity for long-term residential care is increasing, with 144 extra beds created in 2009. A further extension is planned. The issue ties in with plans that aim to focus the work of hospitals to secondary and tertiary acute care, and to further develop the provision of primary health care services.

Most long-term care is however provided within the family circle and through the involvement of non-governmental and charitable organisations. Indeed, care for a needy person is, according to the Maltese Civil Code, the responsibility of the spouse and, where there is no spouse, the children or other descendants. State care is therefore in the first place geared towards unmarried persons or widow(er)s without children.

Churches also provide for residential care, both for dependent and independent residents. Church-provided services are popular, and places are hard to come by. In addition, private care-homes step in to meet increasing demands.

Other provisions

Persons taking care of a family member in need of assistance can receive a Carer's Pension. The benefit is however only granted to unmarried relatives of the needy individual, who share his or her residence and provide care on a full-time basis. The benefit is also means-tested, as the financial means of the care-receiver are taken into account when applications are assessed.

[8] See https://ehealth.gov.mt/healthportal/elderly/telecare_page.aspx.

3 Impact of the Financial and Economic Crisis on Social Protection

The main sectors that suffered from the financial and economic crisis are the tourism industry and the export of manufactured goods. The key issue is one of "demand" – both domestic and foreign. An example of this external demand relates to tourism, with Malta having suffered a drop in tourist numbers particularly from the "traditional" countries such as the UK. The strength of the Euro against the UK Pound means that UK tourists' costs have risen sharply. On the other hand, the Malta National Statistical Office has reported in April 2010 that tourist numbers for March 2010 had risen for the fourth month in a row. While these increases are referenced against 2009 figures and may not reflect a benchmark against for example 2006 or 2007, the outlook seems positive.

Another key success area for the Maltese economy is its financial sector. The Ministry of Finance works closely together with the Maltese Central Bank and the Maltese Financial Services Authority to ensure that the banking system in Malta remains on solid ground. Maltese banks were not exposed to the financial storm that hit those in some other EU Member States. The Governor of the Central Bank, Mr. Bonello, reiterated this point strongly in a recent speech when he said "our (Maltese) banks start from a relatively strong position since their fundamentals have not been weakened by the financial crisis. The existence of a sound regulatory system, effective risk management practices, and prudent lending policies have combined to minimise the banks' exposure to bad or dubiously-valued assets".

Despite the crisis, there are no plans to cut back on spending social protection or in health related areas. Expenditure on social security benefits rose by 10.5% during the first three months of 2009.[9] The total expenditure on social security benefits amounted to EUR 192.3 million during the first three months of 2009, which is an increase of EUR 18.3 million over the corresponding period last year. This increase was mainly a result of an increase in payments of contributory benefits amounting to EUR 17.2 million. The increase in contributory benefits was the result of a growth of more than EUR 10 million growth in pension in respect of retirement, which amounted to EUR 93.5 million for the first quarter of 2009. This increase was mainly a result of expenditure on the "two-thirds" pension, which saw an increase of EUR 8.0 million, reflecting a higher number of beneficiaries.

When presenting the 2010 budget, the Minister for Finance announced a number of incentives for the Island's main industry, tourism. For example, the 2010 budget allocated EUR 31 million to the Malta Tourism Authority to promote the Island and included an extra EUR 2 to EUR 5 million to specifically address the crisis in the tourism industry.

Further, in order to counter rising unemployment the Government introduced a number of pro-employment measures including significant budgetary increases to the Employment and Training Corporation to launch a number of new pro-employment initiatives.

Spending is also planned on initiatives that favour the creation of jobs and economic development, for example EUR 80 million in incentives, EUR 228 million in the country's physical infrastructure and EUR 1.3 billion, in health, education, and social protection expenditure.

The health service in Malta draws heavily on the principles and structures of the UK service, particularly the principle of a service free at point of use. The financial crisis has had no

[9] Maltese NSO, Press release 11 May 2009, Expenditure of social security benefits.

impact on that principle either in Malta, or the UK.

Comparing these principles with data from a survey conducted by The Gallup Organisation, Hungary, upon the request of the Directorate General Employment, Social Affairs and Equal Opportunities ("Monitoring the social impact of the crisis: public perceptions in the European Union, Wave 2")[10] it becomes clear that a sizeable percentage of the population of Malta like their neighbours across Europe, no changes were noticed in the areas of childcare as well as health and long term care.

The data and analysis from that survey indicate that Malta has not been adversely affected in health and long-term care terms by the financial crisis:

Perceived changes in the ability to afford health care for the family

Over the six months of the survey period, 10% of people interviewed thought things had become somewhat easier, 36% perceived no change while 16% thought that health care had become more difficult to afford.

Perceived changes in the ability to afford long-term care for the family

Things were slightly worse in this sector: 7% of people interviewed felt things were improving, 22% perceived no change, while 24% felt they had somewhat more difficulty, and 13% much more difficulty in affording long term care. These data could well change in the next 'Wave' of surveys since the Maltese Government have plans to increase long-term care capacity on the island.

EU citizens' perceptions about the affordability of health care – a comparison between July and December 2009

At the EU level, according to the survey referred to above, no differences were observed between the July 2009 and December 2009 results in terms of EU citizens' perceptions about changes in health care and social care affordability in the past six months. There was, however, no overall pattern: in some Member States, perceptions were unchanged, while in others, examples of both positive (i.e. easier to afford services) and negative (i.e. more difficult to afford services) trends emerged. Spontaneous or 'knee jerk' change over a short period in Malta, with the population of a medium-sized European city, would be unlikely in a well respected health care sector.

As countries start to emerge from the financial crisis, it may be that an in-depth analytical survey carried out in five years time might reveal interesting developments in health and long term care as a result of the crisis; at this stage in mid-2010 it is probably too early to draw specific conclusions.

[10] Flash Eurobarometer Series No. 286, "Monitoring the social impact of the crisis: public perceptions in the European Union, Wave 2", The Gallup Organization, 2010.

4 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
- [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] Malta National Statistics Office**,** Social Protection: Malta And The EU, 2009, Publishing Date: January 2010, retrieved from: http://www.nso.gov.mt/statdoc

This report by the Maltese NSO consists of mainly tables and charts which cover a broad range of statistical data, both numeric and financial covering the period 2004-2008. The first three chapters deal with social benefits, health and social welfare respectively, while Chapter 5 deals with work-related issues such as training. The statistical data provided is very relevant in that it covers a four-year period from 2004 - when Malta acceded to the EU - and the end of 2008. The NSO has produced in this report 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.

[R4] BROWN, Maria; BRIGUGLIO, Michael, Discouragement Amongst Ageing Workers in Malta within an EU Context; Societies Without Borders, Volume 4, Number 1, 2009, pp. 45-60(16)

> *This paper investigates perceptions of unemployed ageing workers in Malta, in relation to disadvantages in the labour market and to discouragement with regard to chances of finding stable employment. The principal results are that educational level and number of breadwinners in one's household significantly affect perceptions; and that there are cases manifesting the 'discouraged worker effect', even though they are still registering to find employment. This challenges traditional views arguing that this effect is present only among individuals who already gave up the job search completely. This paper concludes that the struggle for productive employment requires mass representation of trade unions, which, in turn, require the construction of alliances to widen their appeal.*

[H] Health

[H2] Matthew Mifsud et al., Reproductive health in Malta, in: The European Journal of Contraception & Reproductive Health Care 14 (4), 2009, pp. 249-257, retrieved from: http://informahealthcare.com/doi/abs/10.1080/13625180903072047

> *The study confirms that sexual behaviour has changed. The educational support to deal with these altered practices is in place but still needs to be reinforced. The Maltese population traditionally harbours Roman Catholic beliefs that have been gradually secularised. The present study sets out to quantify the consequences of more liberal sexual attitudes in this community. The study reviewed the reproductive and sexual health indicators reported from Malta and from other selected European countries. It then analysed the findings of a questionnaire study which was carried out among 200 Maltese and 2200 other European individuals to investigate various aspects of their sexual history. A greater proportion of Maltese births occur in teenagers but the out-of-wedlock maternity rate in Malta appears to be the third lowest in Europe. However, the rate appears to have nearly trebled over seven years. Sexually transmitted infections rates in Maltese are either similar to or lower than those reported from the other European countries. The Maltese reported a higher mean age at first intercourse and a lower mean number of sexual partners mainly in women aged over 35 years. They received an earlier sexual education but they still predominantly resorted to unreliable contraception methods at their first sexual encounter.*

5 List of Important Institutions

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.

Ministry of Social Policy, Health, the Elderly and Community Care – MSOC

Address: Palazzo Ferreria, 310 Republic Street, Valletta VLT 2000, Malta
Phone: 2590 3100
Fax: 2590 3216
Email: john.dalli@gov.mt
Webpage: http://www.msp.gov.mt http://www.gov.mt

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.

Strategy and Sustainability Division Ministry of Social Policy, Health, the Elderly and Community Care – MSOC

Address: Palazzo Castellania, 15, Merchant's Street, Valletta, VLT 2000, Malta
Phone: +356 22992232
Fax: +356 22992663
Email: dgss.mhec@gov.mt
Webpage: http://www.sahha.gov.mt/pages.aspx?page=943

The Strategy and Sustainability Division is responsible for research and analysis, policy development, coordination of strategy planning, and EU affairs. It also develops proposals and gives direction on the sustainability of health services. In developing policy and strategy, the division is responsible for planning, leading and maintaining an ongoing process of consultation with stakeholders and user involvement.

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.

Main recurring publications:

Annual Reports, Statistics, Publications, Quality Service Charter,s Press Releases, Diet Sheets,

General Information Circulars, Forms, mediKURA.

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

Government Hospital Services in Malta

Webpage: http://www.health.gov.mt/health_services/hospitals/hosp.htm

Mater Dei Hospital
Tal-Qroqq, Msida
MSD 2090
MALTA
Webpage: https://ehealth.gov.mt/HealthPortal/
Chief Executive Officer: Ms Marion Rizzo

Mater Dei Hospital is an acute general teaching hospital offering a full range of hospital services. It also provides an extensive range of specialist services. Mater Dei aims to create a centre of excellence in the provision of effective and efficient, acute patient-centred quality care. It also aims to achieve high levels of patient and staff satisfaction and enhance teaching, research and innovation.

University of Malta, Institute of Health Care
Institute of Health Care, Mater Dei Hospital,
MSD 2080
Webpage: http://www.um.edu.mt/ihc

The Institute of Health Care provides the knowledge and skills for the professional career, so that s/he may contribute to effective decision making and policy setting. Besides the regular courses offered, the Institute of Health Care is also responsible for the running of continuing professional development courses for registered practitioners, ensuring that allied health professionals are kept abreast of the continuing advances in the medical field and related technologies.

Malta Health News
Website: http://health.einnews.com/malta/

An international news service for health professionals. Constantly updated news and information about Malta Health.

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