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Analytical support on social protection reforms and their socio-economic impact

Country Document 2013

Pensions, health and long-term care

Malta

November 2013

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On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
GVG

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1 Executive Summary

Within the context of a re-opening of the excessive deficit procedure for Malta, reform initiatives within the pensions, health care and long term care become increasingly important. Debate on and implementation of reforms under the new administration elected in March 2013 are ongoing to address long term concerns associated with the sustainability and adequacy of the social protection system.

In the field of pensions, reform initiatives that started taking effect from 2007 onwards are being seen through. A Post Consultation Final Report including details of the stakeholder consultations regarding the 2010 review was presented last year including also proposed next steps. Developments are underway with repect to a voluntary third pension pillar and the drawing up of an Active Ageing policy. In order to encourage longer working lives, provisions encouraging work beyond the new statutory retirement age have been introduced. Furthermore, the need for a holistic approach to extending working lives has become more apparent in the reporting report whereby policies must increasingly focus on the promotion of lifelong learning, healthy and active ageing.

Within the health care and long term care sector, PPP initiatives have been introduced to improve accessibility and reduce waiting times. The benefits provided continued to increase including a geographical extension of the Pharmacies of your Choice Scheme as well as the development of a new oncology centre, financed through ERDF funding which is a crucial element of the recently launched National Cancer Plan. A number of other projects within the health care sector have been financed through Cohesion Policy within the reporting period.

Health care sustainability remains a challenge within the context of ageing population, lax controls on the eligibility of free medicines as well as weak governance stuructures. Efforts to reform public primary health care must be further pursued, whereby the basis must be to improve doctor-patient relationships and continuity of care.

The promotion of independent living within the community for the elderly and persons with disability has been evident within the reporting period through the provision of fiscal initiatives. The development of community services has also been crucial to help delay the need for institutionalisation. Further development in these areas will be required to meet future challenges. As at the present state of knowledge of the authors of this report, quality assessments within the home have not been as yet addressed in Malta. It is furthermore not clear whether such assessments are planned for the immediate future.

Lastly, a detailed study of the financial sustainability of long-term care in Malta with the changing dynamics of demand and conditions of care is warranted, since this area may be not receiving sufficient policy attention at the moment.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The reform of the Maltese pensions system has been the subject of extensive public debate over a number of years. The main aim is to render the system adequate and sustainable. Act XIX of 2006 incorporates amendments under the Maltese Social Security Act. Some of the provisions introduced entered into force as from 2007 whilst others entered into force at a later stage[1].

Key reform measures included a gradual increase in the statutory retirement age, a progressive increase in contribution period to qualify for a full pension, a gradual change in method for calculation of the pension to achieve more equivalence as well as a gradual rise of the maximum pensionable income, on the basis of a formula comprising price inflation (with a 30 per cent weight) and growth in average wages (with a 70 per cent weight). The reforms also established a minimum pension guarantee of 60 per cent of the median income, introduced contributions credits for child and elderly carers and included provisions encouraging work beyond the new statutory retirement age. The Act does not provide for the specific rules to govern Second and Third Pillar Pensions.

The 2006 reform provides for a five-yearly review of the performance of the system. The first of these, entitled "Strategic Review on the Adequacy, Sustainability & Social Solidarity of the Pensions System", presented in December 2010, includes a number of recommendations for further reform. A Post Consultation Final Report including details of the stakeholder consultations as well as proposed next steps was presented in March 2012[2]. To date, these recommendations have not yet been legislated.

2.1.2 System characteristics

The contributory public pension system in Malta is classified as an unfunded, defined-benefit scheme. The system operates exclusively on a first pillar Pay-As-You-Go (PAYG) basis. It is a mandatory, earnings-related, scheme, which provides old-age pensions, survivor's benefits and invalidity pensions. The population which is not covered through the scheme may be covered by a non-contributory, means-tested system.

Occupational pension schemes and personal pension provisions are not widespread in Malta, although occupational schemes did exist before 1979. Occupational service pensions continue to apply for civil servants employed before that year and for specific occupational categories including Police and Armed Forces Officers, but these are a relatively minor element within the overall system. At present there are no voluntary or mandatory third pillar private pension schemes. There are a number of voluntary long term savings products on the market which however are not specifically pension products.

Currently, the statutory retirement age is 61 years of age for both males and females which will be incrementally increased to 62 years of age as from 2014, reaching 65 years of age by the year 2027[3]. Employees have the opportunity to ask an employer, who has the right of final decision, to continue in employment beyond the statotury retirement age.

1 https://secure3.gov.mt/socialpolicy/admin/contentlibrary/Uploads/MediaFile/frpensions.pdf
2 https://secure3.gov.mt/socialpolicy/admin/contentlibrary/Uploads/MediaFile/pwg_consultations_report_final_dsg.pdf
3 MISSOC comparative tables, Table VI, January 2013

Pension contributions are payable by all persons between age 16 and 65[4]. Employed persons pay a contribution of 10 percent of the basic weekly wage, which is matched by an equivalent payment from the employer. A maximum contribution per week applies which stood at € 37.85 in 2012. This is supplemented by the State contributions equivalent to 50 per cent of the total amount paid by both employee and employer. Persons over 65 who decide to continue working are not liable to pay contributions[5]. In the case of self-employed persons, the worker pays a contribution based on total net income, equivalent to 15%, subject to minimum and maximum amounts. Contributions may be credited without payment under certain circumstances, such as during sickness, unemployment, widowhood and invalidity. The 2006 reform introduced credits for parents with career breaks for a period up to two years for every child, together with provisions encouraging work beyond the new statutory retirement age (to curb early exit from the labour market).

The benefit formula is calculated as two-thirds of the average income of the best three consecutive years during the last ten years prior to retirement, after a contribution period of 30 years. For self-employed people, the income averaging period is extended to the last ten years. The required contribution period to be entitled to the full two-thirds pension will be gradually increased in a staggered manner to 35 years for those retiring in 2014, reaching 40 years for those retiring in 2027. Gradual changes have also been made to the calculation base to take effect as from 2014. The Pensionable Income will be calculated on the basis of the best three consecutive years in the last 11 years of their working lives while for self-employed persons it will be calculated on the average of 10 consecutive years in the last 11 years prior to retirement. The Pensionable Income will continue to be calculated in the same manner but will increase gradually to the last 13 years of their working lives. By 2027, the calculation base will be the yearly average income during the best ten years within the last 40 years, and there will no longer be a distinction between employed and self employed persons.

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

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

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

2.1.3 Details on recent reforms

No reforms were implemented following those described above. The 2013 NRP for Malta mentions that the new administration elected in March 2013 is currently in the process of evaluating developments in the area of pensions prior to considering further steps in the reform[6]. The 2014 Pre-Budget document states that the Pensions Strategy Group is assessing the Pensions Working Group (PWG)[7] report, after which a strategy will follow to address both the adequacy and sustainability dimensions[8].

The Strategic Review presented by the PWG in 2010 concluded that the parametric changes to the First Pension introduced in 2007 were deemed to have fulfilled by halting a degeneration of the replacement rate. However, the parametric reforms fall short of securing over time an average pension replacement rate that will secure the quality of life enjoyed by a pensioner as compared to that enjoyed during his or her employment.

As reported in the 2012 Annual Report, further recommendations for reform were presented by the PWG, namely:

- An further increase in credits for child rearing biasing towards families with more children and allowances given to persons to fill gaps in contributions due to lifelong learning;
- The introduction of a retirement longevity-index;
- The appointment of a working group to assess the possibility of transforming the first pillar Two-Third Pension into a Notional Defined Contribution so as to award higher replacement rates for persons who remain active in the labour market;
- The possible introduction of a mandatory second pillar;
- The introduction of a voluntary third pillar with a EET fiscal incentive framework; and
- The consideration of a housing equity release scheme, to allow retirees to leverage their home ownership investment into income during retirement. (It must however be highlighted that in the light of recent experiences[9], the extent of opinion in favour of this approach is weakening considerably.)
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Following a consultation process, a Final Report was presented in March 2012[10] with feedback and critique relating to:

- The macro economic assumptions used for the modeling
- Importance of achieving a full active participation rate in the labour market as a solution to demographic challenges
- Issues relating to a mandatory Second Pension particularly to its timing and its impact on the economy including on the cost of labour and household disposable income;
- Issues relating to the linking of the retirement age to a longevity index
- Issues relating to at-risk-of-poverty of pensioners
- Introduction of a Third Pension

6 Malta NRP 2013, p.55.

7 The PWG was commissioned by the then Minister for Justice, Dialogue and the Family

8 Pre-Budget Document, p.52.

9 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.

10 https://secure3.gov.mt/socialpolicy/admin/contentlibrary/Uploads/MediaFile/pwg_consultations_report_final_dsg.pdf

- Issues relating to claims with regards to anomalies in the pension system affecting current pensioners

The 2014 Pre-Budget document states that the Maltese Government believes that "raising the retirement age is one of the instruments which could lead to sustainability, but it is not the only one."[11] It also highlights that developments are underway with respect to a voluntary third pension pillar, where a technical advisory group has been evaluating the feasibility of introducing fiscal incentives to support voluntary retirement saving provision, including the viability of introducing the third pension pillar as from Budget 2014. The group's remit is to come up with a set of eligibility criteria that financial products would have to meet in order for fiscal incentives to be granted. The group is also evaluating different types of fiscal incentives which would be offered to savers, and possibly their employers, if they help support voluntary retirement saving provision.

With reference to the second part of the second Country Specific Recommendation (CSR) for Malta, the 2013 NRP reinforces the importance of fostering longer working lives through the development of an Active Ageing policy and the implementation of measures to increase the participation of older workers in the labour force whilst discouraging the use of early retirement schemes. The NRP is tasking the Pensions Strategic Unit to focus this issue as well as the promotion of adult participation in lifelong learning, which will also serve to enhance participation of older people in the labour market.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

The PAYG system provides a generous benefit to contribution ratio, offering a theoretical 66% replacement rate out of a 20% contribution rate. Higher income levels are excluded from this system by means of ceilings, expressed in absolute terms, on contribution and pension levels. These offer better replacement rates to lower income earners while containing the financial cost of the system. In the past two decades, however, the ceilings have restrained the living standards of pensioners, thereby creating pension adequacy concerns.

The at 'risk of poverty or exclusion'[12] indicator for pensioners aged between 65-75 years of age reveals that this category in Malta was worse off in 2011 when compared to their European counterparts, most notably amongst males. (MT, males: 23%, females: 22%; EU-27, males: 16%, females: 21%). Material deprivation indicators compare favourably with the rest of the EU. The typically lower female participation rate in the labour market corresponding to this age cohort results in one earnings related pension that has to be shared between both married persons[13]. Due to the higher life expectancy amongst females relative to that of males, the at risk of poverty rate diminishes substantially for women within the 75+ age cohort, since widows typically continue to receive five-sixths of their husband's pension. This makes widows financially better off compared to married retired couples on a per capita

[11] Interview with Finance Minister accessed at: http://www.timesofmalta.com/articles/view/20130811/local/maintaining-growth-and-further-pensions-reform.481665#.UlUtcRUjvDd

[12] Eurostat

[13] It must be mentioned that these effects may be less accentuated in the future since the female participation rate of the younger generation of workers is increasing. Therefore, females accumulate their own pension rights, making them less dependant on their spouse.

basis. Therefore, counter to the tendency in the EU, Maltese females aged 65+ are in a better financial position than males, and markedly more so in the 75+ category[14].

Furthermore, the median relative income of older people[15] in Malta fares worse than that of the EU-27, reflecting a lower overall income situation of older people relative to the active population, possibly reflecting adequacy issues of the PAYG system and the lack of financial savings during one's lifetime, within the context of non-existing second pillar and third pillar elements. (MT: Males - 81, Females – 82; EU-27: Males - 92, Females – 86, 2010).

Future pension adequacy was one of the main concerns motivating the 2006 reform which braked the accelerated degeneration of the average pension replacement rate. However, the PWG mentions that further recommendations presented in the 2010 report that have not yet been implemented to better secure pension adequacy. In addition, one must mention that it is still too early to detect changes brought about by the 2006 reform within the current adequacy indicators since the relative measures are in the main still to be implemented in a gradual manner. However, poverty trends may be accentuated by the increase in contribution years required to qualify for a full pension, and mitigated by the increase in the maximum pensionable income.

In this light, a number of additional challenges need to be addressed such as the extension of longer working lives through the development of active ageing policies. In particular, the planning for different retirement methods across different careers is not well-developed. Support structures for transition from full labour market participation to a managed reduction in work commitment are as yet to be devised. Furthermore, the introduction of complementary second and third pillar private pensions, with appropriate incentives and adequate safeguards, are needed to improve pension adequacy in old age.

2.2.2 Sustainability

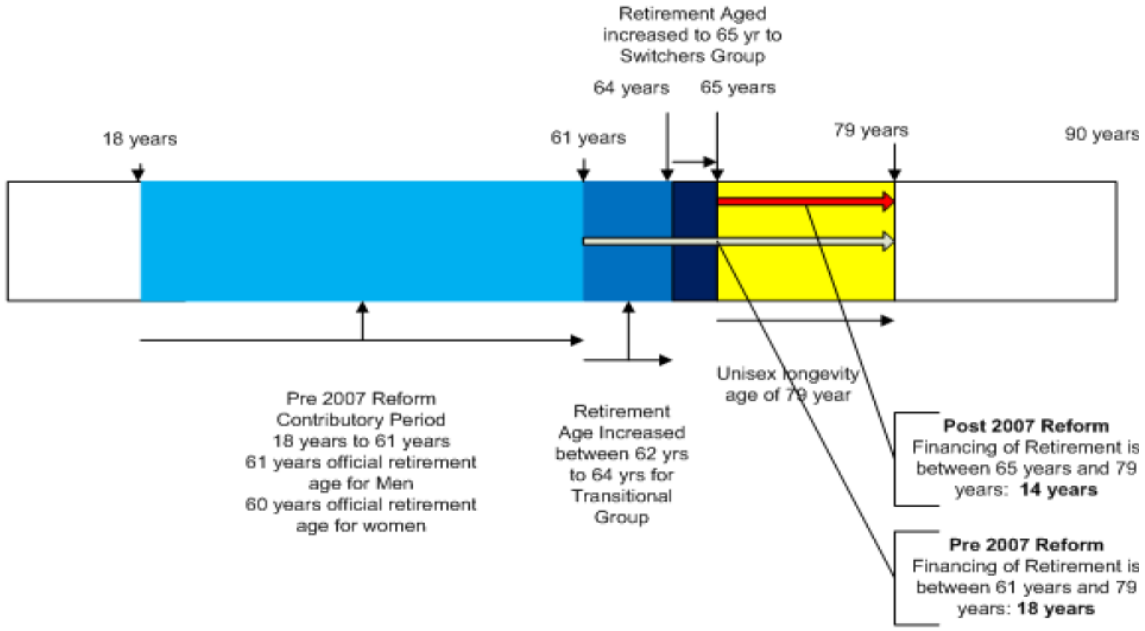
Population ageing as well as the low employment rates of older workers due to early exit from the labour market are contributing to pension system sustainability concerns in Malta. The increase in the statutory retirement age to 65 years means that the period of retirement that is to be financed with regards an individual person from the day he or she retires to the day he or she passes away is reduced from 18 years to 14 years[16] as illustrated in Figure 1 below.

[14] This may no longer be the case if the life expectancy for males increases with advancements in the medical field. This is however counter-acted by increased labour market participation and accruing of pension rights by females.

[15] Eurostat

[16] As at 1st January 2007

Figure 1 - Impact of 2007 Increase in Retirement Age on Pension Financing Period



Source: PWG Final Report, March 2012

The age structure of the Maltese population will continue to change dramatically in the coming decades due to increases in the life expectancy that far exceed increases in fertility rates.

According to the Ageing Report 2012[17], the working age population (aged 15-64) as a % of total population for Malta, is estimated to decline by around 14 p.p over the whole projection period (2010-2060). On the other hand, the elderly population aged 65 and over as % of the total population will double to 31% by 2060 [18]. The population shares of the elderly (aged 80 years and above) and very elderly (aged 85 years and above) will increase by 7.9 p.p. and 4.6 p.p. respectively over the same period. As a result, the demographic old-age dependency ratio (people aged 65 or above relative to those aged 20-64) is projected to increase from 24% to 61%. This entails that Malta would move from having four working-age people for every person aged over 65 years to under two working-age persons.

Gains in life expectancy (LE) and healthy life years (HLY) at age 65 have been achieved over the years due to improvements in living standards and the improvement in health systems, with gains in LE exceeding gains in HLY, especially for women[19]. Projections reveal that further increases in LE will be achieved in the future, whereby in 2060 Maltese men at age 65 are expected to live for 22.2 years up from 17 years in 2010, while women are expected to live for an additional 25.4 years at age 65, from 20.2 years in 2010[20].

[17] Data obtained from the 2012 Ageing Report, Malta Country Fiche, page 429
[18] DG Empl calculations
[19] Over the period 2005-2011 there was an increase in life expectancy of around 0.8 years for both men and women, whilst healthy life expectancy remained constant for women and increased by 1.3 years for men. If this trend continues in the coming decades, women will spend a greater part of their retirement in poor health.
[20] Commission Services, 2012 Ageing Report

According to projections presented in the 2012 Ageing Report[21], Malta is one of seven Member States where the strictly-age-related increase in public spending will be very significant. A projected increase of just over 8 p.p. of GDP is estimated to occur over the projection period up to 2060, with the main contributor being public spending on pensions. Therefore, coping with the future prospects is deemed as a challenge for Malta, requiring urgent policy action.

Extending working lives not only reduces the length of the retirement period that needs to be financed but also increases the supply of labour, raises the potential levels of gross domestic product (GDP) and income. In addition, extending working lives is likely to lead to an improvement in the position of the public finances, in particular, through boosting tax revenues. Studies carried out by the PWG 2010 Strategic Review show that a one-year increase in the retirement age would result in a 1 p.p. beneficial impact of the pension system balance on the GDP. [22].

The employment rate for persons aged 60-64 years in Malta has risen from 10.8% in 2000 to 15.1% in 2011. In 2009, the average exit age from the labour market stood at 60.3 years, is projected to reach 62.4 years in 2020 and 63.3 years by 2050[23]. The reform in the social security legislation to allow for retired persons to continue working without forfeiting their pensions[24] has played an important role in this regard. In fact in 2012, 17.17% of the total retirement pension population (after reaching the statutory retirement age) were still in employment.

Statistical data for Malta reveals that since the introduction of the invalidity reform proposals in 2007, a significant amount of savings has been made on pension expenditure and beneficiaries, by serving as a deterrent to labour market exit. Between 2008and 2011, the number of beneficiaries was in this way reduced by 3,161 persons. This resulted in an annual recurrent saving to Government of approximately € 10.3 million. Furthermore, during 2012, Government introduced a psycho-social assessment which is carried out by a multi-disciplinary panel to ascertain the working capacity of persons making claims for social benefits as a result of work incapacity.

The participation rate of older workers (55-64 years) is expected to increase from a low 32.6% in 2010 to 59.3% in 2060. The participation rate of older workers stood at 14.3% amongst females and 51% amongst males in 2010, projected to increase to 44% and 72% for females and males respectively.

In order to render the pension system sustainable and reverse a projected deficit of 5.8% of GDP in 2060, the PWG 2010 recommended in the Strategic Review that the Government should give consideration to a retirement longevity-index that would act as one of the inbuilt triggers to secure sustainability of the system over time.

[21] Table 2, page 38
[22] Executive Summary and Recommendations of the Final Report: Strategic Review – Outcome of the Consultation Process and Proposed Next Steps
[23] The 2012 Ageing report
[24] This has been applicable from 1st January 2008

2.2.3 Private pensions

Private pension products to enhance retirement incomes are lacking in Malta. A survey carried out by the NSO on behalf of the PWG 2010 revealed that 70% of the respondents expect that their sole source of income during retirement will be the First Piullar Pension, with only 10% stating that their First Pension income will be complemented by a private pension[25].

The enhancement of retirement incomes through the introduction of a Mandatory Second Pension is mentioned in the PWG 2010 recommendation and is directed towards persons who are aged 45 years and younger at the time when it is introduced. As reported in the Final Report of the PWG in 2012 and the NRP for 2012, the introduction of mandatory occupational schemes is being hampered by concerns regarding the cost-competitiveness of the labour market in Malta as well as the impact on the disposable income of households.

It is the belief of the author of this report that third pillar voluntary pension schemes are desirable for Maltese residents to divert savings away from housing wealth towards financial wealth. Data published recently by the ECB on household wealth shows that average wealth levels in housing and non-pension financial assets in Malta are relatively high, partly because of the lack of development of funded, including occupational pension schemes[26]. There is therefore a need to divert household resources into pension savings. This would however require the enactment of income tax incentives for Maltese contributors into such schemes.

It should be observed that the Retirement Pensions Act (Cap 514) of 2011, which has been approved by the House of Representatives but has still to come into force, allows for the licensing of retirement schemes in Malta. However, this is mainly intended to promote the development of the international financial services sector in Malta in the area of pension funds serving foreign customers.

2.2.4 Summary

A major strength of the social protection system in Malta is that employment of the elderly is increasingly being promoted. A best practice example highlighted earlier in this document is the amendment in the social security legilsation that allows elderly persons to remain in employment after retirement age without losing their pension benefits. The only pitfall of this amendment is that NI contributions must still be paid up to 65 years of age, without resulting in any increase in future pension benefits, thus reducing the incentives for longer working lives over the coming decade until the statutory retirment age reaches 65. Another best practice example is the measure that was introduced in the Budget for 2012 aimed at encouraging older people to remain active in the labour market was the entitlement to those pensioners working part time with Government to a reduction rate of 15% in income tax. This reduced rate was already applicable to those working part-time in the private sector.

It is the authors' belief that the Commission's CSR for Malta to statutorily link the retirement age with life expectancy should be acted upon to address longer term sustainability and adequacy concerns. This however should be done with proper safeguards in place to minimize socioeconomic inequalities between different occupational categories, including the consideration of healthy life expectancy issues. This is because the link between retirment and life expectancy may serve to increase existing disparities between workers in different occupations. In contrast to highly educated professionals, persons from lower socio economic

[25] The Public Perception of the Pensions System, Supplementary Paper 2, 2010 Pensions Working Group, 2010
[26] http://www.ecb.int/home/html/researcher_hfcn.en.html

backgrounds tend to have lower levels of education, enter the labour market at a relatively younger age and have lower healthy life expectancy.

Within the context of the EU 2020 employment target and the Country Secific Reccomendation (CSR)[27] for Malta, reforms to promote active ageing particularly through the retention of workers within the labour market beyond the statutory retirement age are required both for sustainability and adequacy concerns. A holistic approach to extending working lives must be supported by policies that focus on the promotion of lifelong learning, healthy and active ageing. Lifelong learning must target older workers specifically and cater for their needs whilst work places must be made more flexible to cater for the needs of older workers through a managed reduction in work commitment. These reform initiatives involve efficient social policy spending as well as active inclusion and are therefore in line with the Social Investment Package.

Another key reform also mentioned in the CSR is the increased access to supplementary pension schemes to improve the adequacy of pensions, as outlined within Section 3.2.3 of this document. The implementation of a voluntary private pension system with appropriate fiscal incentives will allow individuals to save for retirement and increase holdings of financial wealth through investment in pension products.

[27] http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/

2.3 Reform debates

The inclusion of a CSR on pensions within the context of a re-opening excessive deficit procedure, is bringing pensions reform, including the extension of working lives and the inclusion of funded pillar pensions at the forefront of policy attention, as well as public and political debate at national level.

In response to the Commission's recommendation to statutorily link the retirement age with life expectancy, the NRP for 2013 drafted and presented under the new administration, led by a party within the Group of European Socialists, states that that there is "no urgency in further accelerating the progressive increase in the retirement age beyond 65 years of age contemplated in the 2006 Pension Reform". In response to this CSR, the 2013 NRP states that "the pension reform initiated in 2006 is projected to contribute to an average increase of 4.8 years in average exit age over the period 2006-2030". It is also stated that "this compares with expected gains in life expectancy of 60 year olds amounting to 3.3 years and 3.1 years for males and females, respectively". Furthermore, the NRP mentions that "though the increases in expenditure relative to ageing are not insubstantial, these increases are concentrated over the outer years of the projections i.e. the years 2040-2060 and hence are subject to a higher degree of uncertainty relative to projections applicable for the period 2040-2060. These results are also consistent with the outlook for life expectancy up to 2030, as described above".

As reported in the 2012 Annual report, there are various positions held by different stakeholders regarding the PWG reform proposals. In particular, the Green Party, Forum of Maltese Unions, General Workers Union, Union Haddiema Maghqudin and the Civil Society Forum are against the automatic linking of the retirement age to longevity beyond 65 years of age. The statement by the General Workers Union in this regard is that 'Retirement aged should be a 'personal choice' provided that a certain amount of contributions have been paid'. The Green party believes that all workers should be eligible for a State pension at the age of 65 years without losing their right to continue to form part of the workforce. A voluntary retirement age system should be implemented to ensure tht everyone is left free to work as long as desired but nobody should work beyond 65 years of age. The party also believes that an Independent Commission should establish whether a different retirement age for pension eligibility is established for physically or mentally demanding jobs. Furthermore, it is believed that Government should establish scheme to encourage the re-skill and re-train persons in demanding jobs so that these remain actively engaged.

On the subject of voluntary third pensions, the majority of stakeholders believe that such schemes should be implemented as a complement to the first pillar, managed and guaranteed by Government. On the other hand, there are a number of stakeholders which have a number of reservations regarding the implementation of mandatory second pillar pensions due to their impact on low-income earners. In particular, the Malta Employers Association believes that Third pillar pensions are a better instrument than Second pillar Pensions to shift dependence away from the PAYG First Pension. The Malta Insurance Association argues in favour of the introduction without any further delay of voluntary third pillar pensions, suitably incentivized with fiscal instruments, followed by the establishment of mandatory second pillar pensions.

An article entitled *Time to act on pensions* (Bianchi, 2013) highlights that "the timing of the PWG recommendation in 2011 to implement funded pensions (shortly before the last general election and in the midst of a global financial crisis) made it very difficult for the previous Administration to implement but we are now over the first hurdle and, thankfully, in a better state financially than most other jurisdictions." Furthermore, the article highlights that if incentives are adequate and properly targeted to mitigate the tax burden for third pillar savers

it is almost a sure guess that young families will be drawn to the opportunity to save for their retirement. Any fiscal initiatives, when introduced, will be supplemental to the incentives already bearing some fruits including reduced tax rates on bank interest income and other fixed income investments when tax is withheld at source; a favourable tax system for investment-linked life insurance policies that are often promoted as retirement planning tools, and others.

A study entitled Social Class Dynamics in Malta Amongst Older Persons (Formosa, Marvin 2009) seeks to construct, theoretically and empirically, a map of class structuring and action amongst older persons. The study suggests that life expectancy is lower among persons with the lowest educational attainment and contends that in view of this, it is imperative for the government to enact a 'social justice' agenda that mitigates against the disadvantages and lack of opportunities faced by older persons from working-class backgrounds, whilst continuing to support other persons in middle- and upper-class sectors to reach their aspirations. Building on the same theme, the paper entitled Formalising the link between Retirement Age and Life Expectancy: Implications for Equity (Borg A. & Cordina G. 2013), explores whether the link between statutory retirement age and life expectancy is optimal from the perspective of equity among socioeconomic groups and between genders. This hypothesis is examined on the basis of data considering both life expectancy as well as healthy life expectancy. The study of this hypothesis has policy implications both within the context of automatic links between life expectancy and retirement age and the need to promote social investment to lengthen working lives within the context of later and more flexible retirement.

An academic paper entitled Population trends and ageing policy in Malta (Formosa, Marvin 2013)[28] delves into Malta's social policy on active ageing which is related to labor issues, participation in society, and healthy, independent and secure living in later life. It notes how to-date many older people already participate in and contribute to society in a variety of ways such as providing support to their families by caring for spouses or grandchildren, and working as volunteers or paid employees. The study also mentions that although several inroads have been made in welfare ageing policies, further initiatives are warranted for older persons to lead active, successful, and productive lifestyles.

[28] http://www.academia.edu/3659090/Population_trends_and_ageing_policy_in_Malta

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

Key reform measures include initiatives to improve accessibility and reduce waiting times for surgical procedures and scanning through PPP arrangements, an increase in the nationwide spread of the Pharmacy of your Choice scheme as well as the provision of free medicines and new health care services, previously available under the Maltese public health system only in the UK. The recent launch of eHealth and electronic hospital records is empowering patients by introducing access to their medical data. Furthermore, the development of the new oncology centre is a crucial element of the National Cancer Plan launched in 2011.

3.1.2 System characteristics

The public health care system in Malta is funded through taxation and national insurance and operates through public hospitals and health care centres. There is no obligatory health insurance payment for Maltese citizens.

The system covers all residents and offers primary, secondary and tertiary health care services that are free of charge at the point of use in accordance to the National Insurance Act of 1956. Provisions include free medical services at Health Centres and free hospitalisation. As reported in MISSOC Table II, due to the geographic size of the country, there are only a limited number of hospitals available with one general hospital in Malta and another one on the sister island of Gozo.

No user charges or co-payments apply. There are a few services that are provided subject to means testing. These include dental treatment, optical services and certain formulary medicines. All pharmaceuticals are provided free of charge during hospitalisation, otherwise on a means tested basis. Drugs for specific chronic conditions are issued to persons suffering from conditions contained within an official list whilst diabetics are entitled to free diabetic treatment under a separate schedule. All persons who have illnesses that do not fall under the above schemes are required to pay the full cost of pharmaceuticals other than inpatient drugs and a three-day supply of drugs following hospital discharge.

Other benefits provided include free immunisation and vaccination services, free ante-natal and post-natal care and treatment as well as care of the elderly that is free of charge in government institutions for persons who are not in receipt of a pension.

Patients are sent overseas for highly specialised care required for rare diseases. The private sector acts as a complementary mechanism for health care coverage, funded by out of pocket payments and private health insurance. Most foreign residents need private medical insurance. An exception is made for British passport holders as Malta has a reciprocal arrangement regarding the provision of health care with Britain.

3.1.3 Details on recent reforms

Contrary to other countries, the onset of the recent crisis did not alter policy approaches with respect to health. Budgetary allocations remained stable in absolute terms during the past 2

years, whilst an increase is expected to be registered for 2013. The approved estimate[29] for recurrent expenditure within the Ministry of Health, Elderly and Community care stood at €302,147,000 in 2011 whilst that for 2013 increased to €354,065,000[30].

There has been a significant amount of investment in public-private partnerships, in order to further alleviate these waiting times in relation to surgical operations as well as emergency services. As reported in the Annual report for 2012, recent reforms also include an improvement in the overall benefit package through the launch of the National Cancer Plan 2012-2015 which includes a comprehensive screening programme, particularly in the field of breast and coloractel cancer[31]. A new oncology centre partially funded under ERDF is currently being built and developed adjacent to the general hospital in Malta.

The 'Pharmacy of your Choice' scheme has continued to enhance access to medicines within the community through improved convenience and proximity for the patient and longer opening hours. The recent launch of the myHealth system was made possible primarily by the developments in eHealth and electronic hospital records. The system is empowering patients by introducing access to their hospital case summaries, their Pharmacy of Your Choice entitlement data and enabling one or more doctors to have electronic access to their medical records.

As from 2007 to 2013, a number of projects within the health care sector have been financed through Cohesion Policy. Apart from the development of the Oncology Centre mentioned above, Cohesion Policy has partially funded the Upgrading of an Operating Theatre and the setting up of a Radiology Unit at the Gozo General Hospital. This increased accessibility to health services in Gozo, thereby reducing regional disparities and increasing the quality of life of the people living on the island.

Complementary projects include the ESF funded ePortfolio for Postgraduate medical training project (ESF 1.211) will improve and facilitate postgraduate training through the setting up an on-line educational tool for use by postgraduate medical training which will enhance the learning experience of the trainees and trainers. Through the Online e-learning Management System for Post-Graduate Medical Training Activities project (ESF 1.19), specialists in the medical sector will have access to online educational e-resource which will improve access and increase the effectiveness of post-graduate medical training. This project enables participants to follow part of the modules related to the post graduate medical training online.

3.2 Assessment of strengths and weaknesses

The public health system in Malta is facing issues related to the demographic and epidemiological transitions associated with an ageing population, advances in medical technologies and pharmaceuticals as well as rising public expectations.

Public hospital care has in the past few years been upgraded in terms of hotel services,resulting in demand for care shifting from the private to the public sector, particularly in obstetrics. This has led to the closure of some private hospitals. On the other hand, the setting up of public-private partnerships may enhance the private health sector and the extent and quality of services provided.

[29] Ministry of Finance, the Economy and Investment, Financial Estimates 2012
[30] Ministry of Finance, Financial Estimates 2013
[31] In 2010, uptake of breast cancer screening through the National Breast Screening programme was 61.8% of the eligible population which is on par with most of the high performing countries.

Individuals living on low-incomes report a higher perceived unmet need for medical examination or treatment in Malta, as compared to those on higher income levels. Possible reasons include affordability issues for private sector medical examiniations as well as the lack of information on services available. In comparison to the rest of the EU however, for each income quintile, Malta records lower perceived rates of unmet needs, possibly due to free medical health care and geographical proximity to service providers.

It must also be highlighted that extensive bilateral discussions have taken place with the pharmaceutical industry to decrease the pricing of a wide range of medications to enhance accessibility.

Weak areas within the health system and the health status of the Maltese population are being addressed through a number of efforts. To date however, health care reform implementation in Malta has been slow due to administrative, political and cultural obstacles, as well as inertia from certain stakeholders. For example, progress is required in customer care. Differences in patient satisfaction between the public and the private system in primary healthcare are significant (Agius A)[32] in this regard. Efforts to reform public primary health care must furthermore be pursued, whereby the basis must be to improve doctor-patient relationships and continuity of care. In turn, this will reduce the need and demand for expensive institutional health and long-term care while managing the individual's care from an early stage.

There is also the need for a stronger focus on healthy lifestyle choices within disease prevention, focusing on social determinants, early diagnosis and control of disease progression. Of the total deaths that occurred in Malta in 2010, 18.8% involved people aged between 20 and 64 years of age[33]. The significantly-high incidence of deaths and illnesses in the Maltese population as a result of chronic diseases underlines the importance of preventive health care, vis-à-vis the cost of human capital development and its productive return. Research suggests that for every 1% improvement in health outcomes from preventive programmes, there would be a reduction in public expenditure by £190 million, a reduction in family/societal spending of £700m and a lowering of employer costs by £110m, not to mention the reduction in premature death and disability (National Social Marketing Centre, 2010). There are also weaknesses in management and efficiency that can be overcome through research and innovation and further developments of financial and activity-based information.

3.2.1 Quality and performance indicators

The World Health Organization (WHO) ranking of 191 member states around the world ranks Malta in the 5th place in its World Health Report 2000. This measurement approach is based on rankings related to disability-adjusted life expectancy, speed of service, protection of privacy, and quality of amenities and fair financial contribution. It is to be noted that this ranking system has been the subject of significant controversy and was in effect not published in the 2010 report.

Table 1 presents indicators for Health Outcomes for Malta in 2011. Life expectancy for the Maltese population at birth is higher than the EU average (EU – from 73 yrs in 1970 to 80 yrs in 2011, WHO). There are fewer acute hospital beds[34] and physicians in Malta in relation to

[32] https://ehealth.gov.mt/download.aspx?id=1343
[33] http://www.nso.gov.mt/statdoc/document_file.aspx?id=3173
[34] Acute hospital beds is being used rather than hospital beds for the purposes of cross country comparisons due to differences in the definition

WHO) This reflects the small size of the territory and the high population density of the country, which leads to more intensive use of the beds available.

Table 1 - Health Outcomes (Malta, 2011)

Indicator	**Value**
Life expectancy at birth	81 years from 70 years in 1970
Physicians per 100000	324
Dentists per 100000	45
Pharmacists per 100000	81
Nurses per 100000	710
Acute care hospital beds per 100000	250

Source: WHO database 2013

3.2.2 Sustainability

There are concerns about the long-term sustainability of the public health care system. Whilst public health expenditure in Malta was at 5.4% of GDP in 2010 (EU 7.1%), projections show that expenditure may grow to 8.6% of GDP (EU 8.5%) in 2060, sosley on account of population ageing. Consideration of other factors outlined in the Ageing 2012 report may result in an even stronger increase.

Public expenditure on pharmaceuticals in Malta stood at 1% of GDP in 2010, marginally lower than that of the EU. This corresponds to a total of 65 million euro, 162.5 euro per capita. Entitlement to free pharmaceuticals excludes certain types of medicines which are offered in other EU countries including for conditions such as mental health and cancer. These medicinals started to be offered as from 2012. It is furthermore known that controls on eligibility to such medicines are somewhat lax, both in term of original entitlement as well as in the monitoring of distribution.

The challenge of health care sustainability must also be tackled through improvements in governance and work practices. The workforce is an important pillar to the sustainability of the public health care system in Malta. To improve retention of qualified staff, particularly doctors, local post-graduate specialist programmes have started to be offered in Malta through the Malta Foundation School[35].

Shortages in the nursing field remain[36]. The Malta Union of Midwives and Nurses has recently claimed[37] that the lack of nurses and in nursing management is affecting the service provided within the psychiatric hospital. Government has recently recruited an additional 140

[35] http://fpdoctors.info/

[36] http://www.timesofmalta.com/articles/view/20130904/local/clinic-appointments-cancelled-due-to-shortage-of-nurses.484832#.Ul-wGxUjvDc

[37] http://www.timesofmalta.com/articles/view/20130613/local/Mount-Carmel-wards-being-run-without-nursing-officers.473612#.UmUvZxUjvDc

nurses who graduated recently[38]. In the past, Government has reverted to recruiting suitably qualified nurses from overseas as an interim measure[39] whilst initiatives to encourage young people to join the nursing profession have been under way.

3.2.3 Summary

One of the major strengths of the sytem is the recent amount of investment in public-private partnerships with the private health sector, increasing access to services due to long waiting times in the public health system. The recent national initiative to introduce electronic patient records contributes to the EU 2020 Digital Agenda flagship.

Health care reform implementation in Malta has been slow due to administrative, political and cultural obstacles, as well as inertia from certain stakeholders. Efforts to reform public primary health care must be further pursued, whereby the basis must be to improve doctor-patient relationships and continuity of care.

Within the context of the EU 2020 strategy and the upcoming programming period, there is evidence that Government's health policy is directed towards responding to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on the course of life, children, elders and vulnerable groups. However, the authors believe that this approach should be more extensive to cater not only for employment related goals and increased competitiveness but also towards inactive groups and the reduction of poverty.

3.3 Reform debates

The EU 2020 strategy has not directly impacted on health reform debates at local level. Political debate and action has rather strongly focused on the continued provision of health care services in the public system free of charge to the user. The challenge of long waiting times in the public health system and availability of free pharmaceuticals remain topics of debate.

For the first time, there has been mention of health care reform within the 2013 CSRs for Malta specifically to "pursue health-care reforms to increase the cost-effectiveness of the sector, in particular by strengthening public primary care provision". It also puts forward the "Improvement of efficiency and reduction in the length of public procurement procedures".

National debate regarding this CSR has been somewhat limited. There are indications that health care costs will be studied by Government and realistic costings of all procedures will be provided[40]. There are also indications that it is Government's "challenge and goal" to improve primary healthcare, which would also result in decreasing the burden on the state hospital[41].

The Draft Partnership Agreement describing Malta's efforts towards the EU 2020 objectives refers to "health and obesity matters that have direct and indirect economic costs which impose significant monetary and productivity costs to the economy". It also explicitly states that "measures identified in the 2012 Healthy Weight for Life National Strategy for Malta and

[38] http://www.timesofmalta.com/articles/view/20131009/local/141-new-nurses-are-starting-work.489559#.Ul-xSBUjvDc

[39] http://www.timesofmalta.com/articles/view/20100602/local/overseas-nurses-recruitment-drive-launched-as-shortage-bites.310078#.Ul-wyxUjvDc

[40] http://www.timesofmalta.com/articles/view/20130703/local/Health-costs-to-be-studied.476395#.UmFDAxUjvDc

[41] http://www.timesofmalta.com/articles/view/20130912/local/government-seeking-to-improve-primary-healthcare.485883#.UmFC3RUjvDc

the Noncommunicable Disease Strategy for Malta, as well as the 2011 Sexual Health Strategy that contribute towards a healthier workforce (both current and future ones) shall be supported through ESI funds". Focus shall also be directed towards addressing the needs of those suffering from mental health illness and children and youth with challenging behaviours, with the aim to provide them with specific services directed towards their particular needs in order to reintegrate in society with a view to play an active role.

To complement the efforts undertaken so far and the ones envisaged under the 2014-2020 programming period, focused activity will be carried out to establish a well-trained health care service workforce that is multi-skilled and which is appropriately multi-tasked to carry out community and primary health care that supports both the preventable and curative approach that Government envisages to adopt.

It is the opinion of the authors that interventions within the field of health and long term care should support not only competitiveness-related initiatives directed at improving the quanitity and quality of employment. Support for vulnerable groups that are unable to form part of the workforce due to inherent disadvantages such as very old persons, persons with severe mental health problems and persons with chronic substance abuse problems should also be dealt with, even though interventions contribute to poverty alleviation targets rather than competitiveness-related ones.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The demand for formal long-term care has increased as a result of the increasing elderly population as well as the dwindling role of the extended family as a primary support network, partly a reflection of increased labour market participation by women. In the light of such challenges, initiatives that have been undertaken to improve availability of long term institutional care, through PPP arrangements, an increase in private institutional care provision as well as the promotion of independent living within the community for the elderly and persons with disability. The development of community services has also been crucial to help delay the need for institutionalisation. Further development in these areas is required to meet future challenges.

4.1.2 System characteristics

According to MISSOC Table XII, there is one central institution for permanent elderly residents in Malta, supplemented by eight regional residences – all State-run. There are also private residential homes. In addition, there is a State-run central mental institution that provides treatment and care for mentally impaired persons who need psychiatric treatment. Another central and State-run institution/hospital provides long-term care for cancer patients and other malignant diseases[42].

Further research indicates that there are sixteen private residential homes and sixteen Church homes for the elderly. The former have flourished rapidly over the past few years[43]. In addition, there are two rehabilitation centres, one State-run and one private, that provide rehabilitation to the elderly and younger adult patients. One non-profit organisation provides therapeutic services to persons with disabilities in two facilities in Malta and Gozo. There are twenty day centres that cater for older persons and persons with disabilities[44]. Activites are organised within these centres with the aim of motivating the elderly and persons with disabilities to participate so as to remain as independent and socially integrated as possible whilst providing respite for their relatives and carers[45].

Over the last few years, long-term care has benefitted from an expansion of community-based services and residential care places. In an effort to reduce bed blocking and obtain cost savings, long-term care beds within Malta's single state run general hospital have been almost

[42] In view of the smallness of the country and distance between centres, different sources may quote slightly different values for the number of centres by aggregating or differentiating between specific facilities. Differences between sources also reflect divergences between the definition of long term care as is the case of treatment of cancer and rehabilitation services.

[43] Detailed information can be obtained from the Health Care Standards Department, Ministry of Health, at: https://ehealth.gov.mt/HealthPortal/public_health/healthcare_serv_standards/homes_for_older_persons.aspx

[44] https://ehealth.gov.mt/HealthPortal/elderly/day_centres_services.aspx

[45] If LTC is defined to include treatment and rehabilitation from substance addication and abuse, facilities would then include one State-run facility that provides a safe detoxification process from alcohol and drugs and two State-run rehabilitation facilities. The Church offers rehabilitation for persons suffering from drug abuse within two residential facilities. Community services are provided within three facilities, two that are State-run and one that is run by the church.

completely transferred to elderly homes[46]. The number of psychiatric care beds in hospitals amounts to approximately 579 beds or 144.7 per 100,000 inhabitants.

In 2012, the number of licensed beds in institutions amounted to 4,545 beds, 57% in the Government sector with the remaining located in church and private homes.

4.1.3 Details on recent reforms in the past 2-3 years

Over the last three years, an increasing number of long term care beds have been purchased in partnership arrangements with private homes for the elderly to cater for the increase in demand for institutional care.

As reported in the 2012 Annual Report, long-term care policy focused to provide support to enable dependent persons to remain in society and lead, as far as possible, an independent life. Measures included an increase in community day care centres and night shelters, the inauguration of an Independent Living Centre for persons with disabilities as well as a yearly payment of €300 made to elderly people aged 80 years or over and who still live independently at their own home or with their relatives. This initiative will cost EUR 3.5 million, and will benefit nearly 12,000 elderly persons (3% of the total population)[47].

Dementia services and refurbishment of wards within the major state residence for these patients have improved in recent years, whilst further investment is expected to continue in the coming years, to be outlined in the forthcoming National Dementia Strategy.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Eligibility for long term care in elderly State-run institutions that cater for permanent residents is granted to persons over 60 years and/or those with a disability that leaves them unable to cope with living within their own home. In order to cater for the increasing demand for long term care, the public system is being improved through PPP arrangements and the purchase of beds within the private sector.

Need and the type of disease are pre-requisites for persons using psychiatric institutions and the other institutions/hospitals in the public sector. For all cases, eligibility is determined by a medical evaluation. Access to church-provided services is conditioned by the limited number of places available.

Regional disparities within health and long-term care services in Malta are in general mitigated by the smallness of the island and geographical proximity to service providers. The population on the island region of Gozo, which amounts to one-twlefth of the total, may be at relative disadvatange to that on the main Island in terms of access to services.

Cash and in-kind benefits are partly means tested and others are needs-based. There is the general perception that Access to public long-term care institutions is favourable towards those with low means relative to needs. Residents of Government elderly homes contribute 80% of their pension and 60% of their remaining net income up to a maximum of €16 daily, provided that residents are not left with less than € 1,398 per year (pension and other income) at their disposal[48]. It is the opinion of the authors that the latter potentially creates a risk of a

[46] http://www.maltatoday.com.mt/en/newsdetails/news/national/1-020-beds-provided-for-elderly-needing-long-term-care-20130306,http://www.timesofmalta.com/mobile/view/20130722/local/call-issued-for-provision-of-spaces-for-elderly-in-need-of-long-term-residential-care.479076

[47] Budget Speech 2012, page 88.

[48] https://www.oconnorandassociates.ie/docs/malta/Social_Security_Rights_(ENG).pdf

perverse incentive for assets to be transfered from elderly parents to children, leaving the elderly in a more vulnerable position. Some private homes offer contracts involving claims on the estate of a person receiving care in exchange for reduced daily rates for the provision of services.

Co-ordination between formal care in institutions and care at home (formal and informal care) may be improved through the development of fully medically supported or independent sheltered housing dwellings as well as the development of quality assessments within informal settings. Studies show that elderly people do not feel comfortable or safe living within their own home, thereby causing elderly people to move directly from one's own home to a nursing home.

4.2.2 Quality and performance indicators

Inspections of Government homes and long-term care facilities for the elderly are coordinated by the Health Care Standards Directorate. Emphasis is currently on finalising a draft of National Standards for Homes for Older Persons. These standards are to be launched for public consultation at the end of 2013. As reported in the 2012 Annual Report, 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. As at the present state of knowledge of the authors of this report, quality assessments within the home have been as yet addressed in Malta. It is furthermore not clear whether such assessments are planned for the immediate future.

4.2.3 Sustainability

Population ageing will exacerbate concerns regarding the financial sustainability of long term care in Malta, and the deployment of adequate human resources in sufficient numbers.

With respect to people with disability, in 2010, 43% of them (aged 15+) were receiving institutional care, followed by 34% receiving informal/no care and 22.6% receiving home care. Demand for institutional care will exhibit an increase of 11.3p.p. reaching 55% whilst informal/no care will exhibit the largest decline of 18p.p. to 16.2% by 2060[49]. The latter is projected to decline due to labour market trends and the evolution of family arrangements.

Recruitment of medical personnel within the long-term care workforce in Malta is expected to increase in line with demand requirements. As reported within the Health care section of this report, a number of initiatives are in place in this regard, which may need to be further developed in future.

Informal care plays an important role in Maltese society, due to the strong traditional role of the family, which has however waned over the past decade or so. Most care givers are female aged between 40-59 years. The percentage of female caregivers with labour force participation problems as a consequence of caregiving tasks relative to the number of working caregivers for Malta stood at 76, which is high in comparison to the EU 27 average of 50. (Mot E., Faber R., Geerts J., and Willeme P, 2012).

Support measures offered to informal carers in Malta include a combination of cash benefits and care leave. Cash benefits include the Carer's Allowance[50] and the Carer's Pension[51]. Care

[49] Long-term care expenditure projections, Note to the attention to the Ageing Working Group attached to the Economic Policy Committee, Brussels, 09/12/2011, ECFIN/C2(2011)

[50] A single or widow male / female, whether registered or not as an unemployed person, and who is taking care of a sick or elderly relative all by herself and on a fulltime basis, may become eligible to Social Assistance

leave is granted through Responsibility Leave which involves unpaid leave for public employees (up to a maximum of 8 years during the whole working life) to take care of dependent elderly parents, sons and daughters, or spouses if no other live-in carer is available. In 2011, there were 162 beneficiares receiving the Carer's Pension and 372 persons receiving the Social Assistance. But there is no formal register of family carers in Malta. Detailed data concerning the situation of family carers including their number, age, gender, source of income and education is not available. Although a number of research studies have been carried out which focus directly or indirectly on this subject, these have not been representative enough to the extent that one could reach certain generalisations applicable to the whole Maltese population or to the Maltese families (Troisi J. & Formosa M. (2004)).

Respite and support for informal carers is provided through benefits in-kind via community services (listed beforehand) and the CommCare Unit[52]. The latter consists of nurses, physiotherapists, occupational therapists, social workers and carers who provide services to clients that are house-bound[53]. A number of one-off training initiatives have been organized by the private sector within a number of localities to improve the abilities and skills of informal carers. Sessions have been delivered on dementia and manual handling and lifting. Attendance has been strong and feedback obtained has been encouraging[54].

In order to focus on its key HR functions in long-term care, Government is relying on contracting out work for non-health care professional grades. Following allegations that some workers employed by a private company were not paid their minimum dues, a new union for Professional Carers has been set up to safeguard the interests and rights of those employed in public and private hospitals, public clinics and homes for the elderly. Upon official registration last year, the union registered 200 members. A positive development is that all the new collective agreements will also help address the challenges with regard to human resources in the long-term care sector, including the component of Continuous Professional Development.

A Diploma level in Health and Social Care is the minimum qualification required to commence work at an operational level in the elderly care sector. General concerns about staff shortages are not widespread but there are significant lacunae with respect to specific areas of care, most notably dementia.

To date, apart from the work that is underway on the National Dementia Strategy, prevention programmes in place target the population at large and deal with the prevention and control of non-communicable diseases. This is an important facet of future sustainability of care provision. However, preventive strategies that target the elderly in a specific manner are

Carers.
In order to be eligible, there must not be another unemployed person in the same household and or if the other unemployed person is not medically fit to take care of the sick or elderly relative.

51 A person who is either single or a widow and who all by her/himself and on full-time basis, takes care of a sick relative who is bedridden or confined to a wheel-chair in the same household, is entitled to receive Carer's Pension. Relatives referred to in this section can be the parents, grand-parents, brothers, sisters, uncles, aunts, brothers or sisters in-laws and father/mother in laws. Eligibility is subject to the Capital Resource Test and Means Test. Capital Resources must not exceed €14,000.

52 During the year 2012, the CommCare Unit received 8,446 requests for domiciliary nursing care, of which 3,173 were new referrals and 5,273 were follow-up cases (accessed at: http://www.independent.com.mt/mobile/2013-01-26/news/more-than-8000-elderly-persons-use-commcare-services-756744192/)

53 https://ehealth.gov.mt/HealthPortal/elderly/commcare_unit.aspx

54 http://www.caremalta.com/CareMalta/TrainingandEducationCentre/OutreachProgramme/tabid/767/Default.aspx

somewhat lacking, including the promotion of "healthy-living prevention" with a focus on exercise. In relation to support for independent living, the national policy for Active Ageing to be presented at the end of this year aims to bridge community and residential-nursing living by ensuring that the latter settings include opportunities for residents to live "positive, successful and productive lives".

4.2.4 Summary

The system includes the provision of community based services as well as a number of recent initiatives undertaken to encourage independent living such as the new annual grant to elderly persons over 80 living in their own home, the removal of VAT on private nursing and home help as well as tax reductions for respite care and community support services paid by disabled persons. These are being complemented by sheltered housing arrangements so as to eliminate the general tendency for elderly people to move directly from one's own home to a nursing home due to the very limited intermediate living options for elderly persons in Malta.

A major weakness of the system is that to date preventive strategies that target the elderly are somewhat lacking. It is the opinion of the authors that such key measures must form part of the national policy for Ageing to be presented at the end of the year.

A wide array of pilot projects have been initiated by different institutions at national level. In the field of community services for persons with mental health difficulties, Richmond Foundation[55], a local NGO works with persons suffering from mental health difficulties, undertakes promotion of mental health and prevention of mental illness amongst the public. Residential and day, community-based rehabilitiation facilities are provided, housing with support and opportunities for training, employment and support at the work-place. It also provides services which will prevent mental health problems in the work-place from developing, self-help in the field of mental health, positive public awareness of mental health issues, psycho-social support for children with challenging behaviour, within a residential setting together education and assistance in Information Technology that increases the employability and enhances personal development.

The Malta Dementia Society[56] is a non-governmental and a not-for-profit organisation for persons with dementia, their carers, families and friends. The society brings together healthcare professionals and interested persons to improve their knowledge about dementia and to increase public awareness of the condition. Courses are organised, together with lectures and conferences in the various areas relating to dementia. Through its work, the society helps establish good relations with the general public and other providers of services to persons with dementia and influences policy making.

Through the Sonia Tanti Independent Living Centre (ILC)[57] an ERDF funded project, the National Commission for Persons with Disability can provide persons with disability and their families with advice, information and training in aspects of independent living such as mobility and assistive technology. Following their training at the ILC, disabled persons may be referred to employment and training opportunities that may be suitable for them thereby integrating such persons within the world of world.

Care Malta, a private health care provider celebrates Falls Awareness Day[58] by organising a number of activities across its elderly homes to raise awareness about falls and older people. The activities include exercise classes and talks on eye care and environmental hazards. Families are encouraged to participate aware of such environmental hazards so as to reduce the risk of any disability of their loved ones.

[55] http://www.richmond.org.mt/home
[56] http://www.maltadementiasociety.org.mt/
[57] The Centre has been part-financed by the European Regional Development Fund
[58] Falls are a major cause of disability in persons over 75 years of age. 33% of persons aged 65+ and 50% of persons aged over 85 fall once a year (Care Malta)

4.3 Reform debates

The EU 2020 strategy has not directly impacted on long term health care reform debates at local level. However, the provision of long term health care services can be viewed as a major contributor to the EU 2020 strategy pillar aimed at poverty reduction. Access to State institutional long-term care favours those at the lower end of the income scale, but may not be sufficient for others who are close to risk of poverty.

Within the context of the EU 2020 employment targets, the expansion of long-term care work (paid or unpaid) opens up employment opportunities for and adds potential burdens on women, raising important concerns about gender equity within households and in the labour market. It is often debated that informal care-givers in Malta still face significant struggles: "they bear a financial burden , dedicate significant amounts of time, and report that they often don't know where to turn to for official assistance. In addition to granting financial assistance, Malta and other European countries should establish Points of Contact for caregivers. Knowledge is almost costless to provide, but can make a huge difference[59]". Furthermore, there are no formal measures in place to grant leave or flexible working arrangements.

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. Furthermore, the debate on dementia is focusing on increasing awareness amongst the public about this condition. A recent study showed that there will be almost 10,000 people aged over 60 suffering from dementia by 2030 (from 5,198 persons in 2010) or 2.3% of the total Maltese population. (Scerri A. & Scerri C., 2012). It is reported[60] that "the significant increase in the number of individuals with dementia in the coming years will invariably put greater demands on health care services that will lead to considerable socio-economic consequences. In order to face these present and future challenges, we need to make dementia a national public health priority. Furthermore, "Poor understanding creates barriers to timely diagnosis and to accessing ongoing medical and social care, leading to a large gap in treatment".

It is the opinion of the authors of the present report that a detailed study of the financial sustainability of long-term care in Malta with the changing dynamics of demand and conditions of care is warranted, since this area may be not receiving sufficient policy attention at the moment.

[59] http://www.maltatoday.com.mt/en/newsdetails/news/national/Casa-calls-for-changes-in-informal-medical-care-20130704

[60] http://www.timesofmalta.com/articles/view/20130511/opinion/Changing-face-of dementia.469213#.UmoyVhUjvDc

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Annex – Key publications

[Pensions]

BORG A. & CORDINA G., Formalising the link between Retirement Age and Life Expectancy: Implications for Equity, 2013 (Upcoming publication)

This study explores whether the link between statutory retirement age and life expectancy is optimal from the perspective of equity among socioeconomic groups and between genders. This hypothesis is examined on the basis of data considering both life expectancy as well as healthy life expectancy. The study of this hypothesis has policy implications both within the context of automatic links between life expectancy and retirement age and the need to promote social investment to lengthen working lives within the context of later and more flexible retirement.

FORMOSA M., Population trends and ageing policy in Malta, Malta, 2013 accessed in October 2013 at http://www.academia.edu/3659090/Population_trends_and_ageing_policy_in_Malta

This paper mentions that although several inroads have been made in welfare ageing policies, further initiatives are warranted for older persons to lead active, successful, and productive lifestyles. In particular, reference is made to the provision of policies and programs in education and training that support lifelong learning for women and men as they age.

FORMOSA M., Social Class Dynamics in Malta Amongst Older Persons, Malta, 2009 accessed in October 2013 at http://books.google.com.mt/books?id=2hKqZav_xoEC&pg=PA2&lpg=PA2&dq=Social+Class+Dynamics+in+Malta+Amongst+Older+Persons&source=bl&ots=TTBSLc9acH&sig=uM6jzQsXWyt44RaefCu6g1sHh80&hl=en&sa=X&ei=BhhlUtLSE8aY4gTkoYDYBw&ved=0CDsQ6AEwAg#v=onepage&q=Social%20Class%20Dynamics%20in%20Malta%20Amongst%20Older%20Persons&f=false

The study seeks to construct, theoretically and empirically, a map of class structuring and action amongst older persons. As the term ‘dynamics’ in the title indicates, the primary concern was not to fit older persons in a particular class schema. The ambition to construct a map of class positions was only pursued as a means to an end, to investigate if, and how, ‘new’ classes emerge following retirement, and the impact that later life has on subjects’ role in the class system.

[Health care]

AGIUS A., Patient Satisfaction in Primary Healthcare, Malta, accessed in April 2013 from https://ehealth.gov.mt/download.aspx?id=1343

This study identifies characterisitcs of family doctors most likely to lead to patient satisfaction. It also compares characteristics of family doctors in private and public sectors of primary healthcare together with patient satisfaction in both sectors.

[Long term care]

SCERRI A. & SCERRI C. (2012), Dementia in Malta: new prevalence estimates and projected trends, Malta Medical Journal, 2012: 3 21-24 – retrieved in September 2013 at: http://www.um.edu.mt/umms/mmj/showpdf.php?article=362

The data presented in this study show a significant increase in the current number of individuals with dementia among the Maltese population compared to previous estimates. This will invariably put greater demands on health care services resulting in considerable socio-economic consequences. In order to face these present and future challenges, dementia care and management should be considered as among the most important health priorities in the Maltese islands.

TROISI J. & FORMOSA M. (2004), Eurofamcare: National Background Programme for Malta, European Centre of Gerentology, University of Malta – retrieved on 9/9/2013 at http://books.google.com.mt/books?id=PmYbwlZ26e8C&pg=PA142&lpg=PA142&dq=Eurofamcare+Malta&source=bl&ots=kdJWwm66M5&sig=FSKx9rfyzmc7VbbqeWeSYgevZ7A&hl=en&sa=X&ei=uMMtUoa2CYWGswbb9oGoCw&ved=0CD4Q6AEwAw#v=onepage&q=Eurofamcare%20Malta&f=false

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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