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Malta

Health system review

Natasha Azzopardi Muscat • Neville Calleja
Antoinette Calleja • Jonathan Cylus

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Jonathan Cylus (Editor), Sarah Thomson and Ewout van Ginneken were responsible for this HiT

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Natasha Azzopardi Muscat, *Ministry for Health, Malta*

Neville Calleja, *Ministry for Health, Malta*

Antoinette Calleja, *Ministry for Health, Malta*

Jonathan Cylus, *European Observatory on Health Systems and Policies*

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Health System Review 2014

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Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health-care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including

the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiTs and HiT summaries are available on the Observatory's web site http://www.healthobservatory.eu.

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The Observatory team working on HiTs is led by Josep Figueras, Director, Elias Mossialos, Martin McKee, Reinhard Busse, Richard Saltman, Sarah Thomson and Suszy Lessof. The Country Monitoring Programme of

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List of abbreviations

A&E	Accident and emergency
BMI	Body mass index
BST	Basic specialist trainees
DHIR	Department of Health Information and Research
DPA	Directorate for Pharmaceutical Affairs
EHES	European Health Examination Survey
EHIC	European Health Insurance Card
EPP	European People's Party
ESA	European System of Accounts
ESP	European Standard Population
ESPAD	European School Survey Project on Alcohol and other Drugs
EU	European Union
EU-GMP	EU Good Manufacturing Practice
EUROCARE	European Cancer Registry
FMCU	Financial Monitoring and Control Unit
FSWS	Foundation for Social Welfare Services
GDP	Gross domestic product
GFL	Government Formulary List
GFLAC	Government Formulary List Advisory Committee
GP	General practitioner
HTA	Health Technology Assessment
IT	Information technology
KNPD	National Commission for Persons with Disability
MMDNA	Malta Memorial District Nursing Association
NATO	North Atlantic Treaty Organization
NGO	Non-governmental organization
NHA	National Health Accounts
NHS	National Health Service
NHSS	National Health Systems Strategy
NOIS	National Obstetrics Information System

NPISH	Non-profit institutions serving households
NSO	National Statistics Office
OECD	Organisation for Economic Co-operation and Development
OHSA	Occupational Health and Safety Authority
POYC	Pharmacy of Your Choice
SVPR	St Vincent De Paul Residence
PES	Party of European Socialists
PPP	Purchasing power parity
PPS	Purchasing Power Standard
VAT	Value added tax
VHI	Voluntary health insurance

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Abstract

This analysis of the Maltese health system reviews the developments in its organization and governance, health financing, health-care provision, health reforms and health system performance. The health system in Malta consists of a public sector, which is free at the point of service and provides a comprehensive basket of health services for all its citizens, and a private sector, which accounts for a third of total health expenditure and provides the majority of primary care. Maltese citizens enjoy one of the highest life expectancies in Europe. Nevertheless, non-communicable diseases pose a major concern with obesity being increasingly prevalent among both adults and children.

The health system faces important challenges including a steadily ageing population, which impacts the sustainability of public finances. Other supply constraints stem from financial and infrastructural limitations. Nonetheless, there exists a strong political commitment to ensure the provision of a health-care system that is accessible, of high quality, safe and also sustainable. This calls for strategic investments to underpin a revision of existing processes whilst shifting the focus of care away from hospital into the community.

Executive summary

Introduction

The Republic of Malta consists of three main islands, Malta, Gozo and Comino, forming an archipelago in the Mediterranean Sea that has the highest population density in Europe combined with the lowest total population of any European Union (EU) Member State. Life expectancy has steadily increased over the past 20 years and compares well with the EU average. In 2011, life expectancy at birth was 78.4 years for men (compared with 77.4 years for the EU as a whole) and 82.6 years for women (compared with 83.2 for the EU).

Standardized mortality rates for circulatory diseases have decreased over time from 426 per 100 000 in 1990 to 232 per 100 000 in 2011, but are still higher than those of the EU-15 (161 per 100 000). While mortality rates for cancers are also showing a downward trend and compare well with the EU-15, this trend is less pronounced than that of circulatory diseases. Survival rates for common types of cancer such as breast cancer are improving but frequently remain below the average found in the EUROCARE (EUROpean CAncer REgistry-based study on survival and CARE of cancer patients) study.

Non-communicable diseases are a major issue. One preventable contributing factor is obesity, which is increasingly prevalent among both adults and children. Strategic policy documents with a strong focus on health promotion and primary prevention, including the Non-Communicable Disease Strategy 2010, the National Cancer Plan 2011, the Sexual Health Strategy 2011, the Healthy Weight for Life Strategy 2012, the Tuberculosis Prevention Strategy 2012 and a strategy that seeks to address the needs of people with dementia together with their families and carers as part of a holistic approach have been compiled. These strategy documents are generally target-based, with impact assessments in progress.

Organization and governance

The Ministry for Health (MFH) is responsible for the provision of health services, health services regulation and standards, and the provision of occupational health and safety. The Ministry for the Family and Social Solidarity (MFSS) is responsible for social policy and policy relating to the child, the family and persons with disability, elderly and community care, social housing, social security, pensions and solidarity services. The Ministry for Finance (MFF) is generally responsible for Malta's economic policy, preparing the government budget as it collects and allocates taxes and revenue. Other actors include other government ministries, the Foundation of Medical Services, government commissions, agencies, boards and committees, professional regulatory bodies and professional groups, private and voluntary sectors, the church and the general public.

The publicly funded health-care system is the key provider of health services. The private sector complements the provision of health services, in particular in the area of primary health care. In addition some services (especially for long-term and chronic care) are also provided by the private sector, the church and other voluntary organizations.

Financing

Total health expenditure as a percentage of gross domestic product (GDP) was 8.7% in 2012. This is below the EU average of 9.6% (WHO 2013: HFA). Of this, a third is private spending (2.9% of GDP, compared to 2.3% in the EU); public spending was only 5.6% of GDP, below the EU average of 7.3%. In recent years the increase in private spending has outpaced public health expenditure growth.

The publicly financed health system provides a comprehensive basket of health services to all persons residing in Malta who are covered by Maltese social security legislation. However, entitlement to a few services (including elective dental care, optical services and some formulary medicines) are means-tested. The means-test falls under the non-contributory scheme of the Social Security Act (Chapter 318 of the Laws of Malta). Accordingly, persons who fall within the low-income bracket as determined by the means test are entitled to free medicines from a restricted list of essential medicines and to certain medical devices (subject to certain conditions and the payment of a refundable deposit). Further, persons who suffer from chronic illnesses included in a specific schedule incorporated in the Social Security Act are entitled to free medicines strictly related to the chronic illness in question. This benefit is independent of financial means.

The public system is funded by general tax revenues. All forms of taxation feed into the Consolidated Fund from which all public budgets are drawn on an annual basis; the health sector competes with other public sectors for funding. The main private sources of health financing are out of pocket payments (for means-tested publicly provided services or privately provided services) and voluntary health insurance (VHI). Out-of-pocket payment accounts for nearly all private health-care expenditures and comprise a comparatively high percentage of total spending in comparison to other European countries. Some external financing has contributed to infrastructure investment, including the EU structural funds, a loan from the Council of Europe for construction of Mater Dei hospital.

Physical and human resources

There are five public hospitals in Malta, of which two are acute and three are specialized; there are two private hospitals. Malta has a bed occupancy rate in acute hospitals (81.5% in 2010), which is above the EU average (75.9% in 2011). The number of beds in acute hospitals is below the EU average, and has decreased by around 28% over the past decade. Average length of stay in acute hospitals is slightly below the EU average but has been rising.

The number of functioning diagnostic imaging technologies such as CT scanners and PET scans is among the highest per capita when compared to other countries in the Mediterranean region; however, Malta has comparatively few MRI units. Particular attention is being given to the use of information technology due to the creation of the Health-Care Information System and the introduction of new electronic medical record systems alongside the opening of Mater Dei Hospital in 2007. Currently there are a number of eHealth portal facilities to access health-related services. The latest progress in this area is the introduction of the myHealth service in 2012, which enables patients and doctors to access electronic health records through an e-ID card, which the government is in the process of deploying.

The numbers of specialist physicians, dentists and nurses per capita are below the EU average except for paediatricians, pharmacists, and midwives. Following EU accession, Malta experienced a severe net outflow of newly graduated doctors, mainly to the United Kingdom where Maltese doctors often carry out their specialization training. This has been effectively managed through a mutual recognition agreement with the United Kingdom General

Medical Council (as most medical school graduates undergo specialist training in the United Kingdom) and through the setup of formal specialization training programmes in Malta.

Provision of services

Public health is principally overseen by the Public Health Regulation Division within the MFH, supported by specialist bodies. Following the EU Council recommendation on cancer screening, a national cancer screening programme was commissioned in late 2008, and began administering breast cancer screening in October 2009 and colorectal screening in 2012; there are also plans for a cervical screening programme.

All publicly financed health services are free of charge at the point of use and primary care is readily accessible. However, the private sector accounts for about two-thirds of the workload in primary care; many people choose to pay out-of-pocket for primary care services in the private sector because it offers greater convenience and better continuity of care.

Secondary and tertiary care are provided through public and private general hospitals, with general practitioners acting as gatekeepers for onward referral to public services. The main acute general hospital (Mater Dei) provides the bulk of day and emergency care. In the public sector, medicines on the Government Formulary List are given free of charge to entitled patients. In the private sector, patients must pay the full cost of pharmaceuticals.

When it comes to the provision of highly specialized care for the treatment of rare diseases or specialized interventions, patients are often sent overseas because it would neither be cost effective nor feasible to conduct such treatment locally.

Rehabilitation services are offered by the public rehabilitation hospital free of charge to patients referred following inpatient admission at public hospitals, or who are referred from the community by a General Practitioner. All patients undergo a multi-disciplinary assessment.

Long-term care for older people is provided by the State, the church and the private sector, and also through partnerships between the State and the private sector. The largest residential home for older people is public. Increased demand for institutional care has put added pressure on the public system to adapt to population need. Community based services are being promoted to keep older people in their homes for as long as possible.

Dental care is provided by public and private providers. However, only acute emergency dental care is offered free of charge in hospital outpatient and health centres; most dental care is paid for out-of-pocket by patients. Few VHI schemes cover dental expenses.

Principal health reforms

The main events of the past decade that are most influential in shaping health reform are Malta's accession to the EU in 2004 and the construction of the new Mater Dei Hospital in 2007. The former was instrumental in driving policy on new legislation in the field of health, particularly public health and health protection, while the latter was significant in shaping the flow of capital resources.

Major health reforms that have taken place in recent years include use of health technology assessment to define the public benefits package, introduction of the Pharmacy of Your Choice scheme to provide more equitable access to medicines, and development of a remuneration system for medical consultants (specialists) that is partially performance-based. There have also been efforts to develop more community-based services for long-term and mental health care. A new Mental Health Act, which will promote the rights of mental health patients and support community treatment schemes, was approved and came into effect in 2013. A landmark Health Act was also approved by the Maltese Parliament in 2013, repealing the old Department of Health Constitution Ordinance and creating a modern framework separating policy from regulation and operations. This Act also enshrined patient rights into a legal instrument for the first time.

The focus on prevention and community services has led to progress in areas such as the development of cancer screening programmes. Since 2009, a number of national plans and strategies have been launched to address major public health issues, mainly cancer, obesity, sexual health and non-communicable diseases. An overarching National Health Systems Strategy is also being drafted to provide the overall direction.

Assessment of the health system

The Maltese health system provides a comprehensive basket of health services available universally for all its citizens, although in practice most primary care is provided privately. According to EU-SILC data, self-reported unmet need

due to financial constraints in 2010 was low in comparison to other European countries at 0.8% (the EU average was 2.3%), reflecting Malta's major focus on providing equal access to health services for all, particularly for disadvantaged groups. Indeed, socio-economic inequalities are more evident among health determinants, such as obesity and health literacy, rather than for health-care access. Maltese citizens enjoy one of the highest life expectancies in Europe. Strategies recently put in place all aim to reduce premature deaths, address risk factors, decrease morbidity, promote healthy lifestyles and improve quality of life.

A major challenge for the health system is ensuring sustainability, as Malta faces increasing demands from its citizens, an ageing population and the rising costs of medicines and technology. Despite the relatively low levels of public expenditure on health by EU standards, Malta's overall deficit-to-GDP ratio was 3.3% in 2012 (above the 3%-of-GDP EU Treaty threshold), and the relative share of government expenditure on health is in decline. As part of addressing the sustainability of public finances, there is focus on maximizing efficiency in the health system together with investment in primary and community-based health care. Systematic monitoring of health system performance has also become imperative, with a project underway in collaboration with WHO to put in place a health system performance assessment framework that will allow the regular and timely monitoring of a selected number of performance indicators. Waiting times are a long-standing challenge, with typical waiting times for some procedures being between 24 and 36 months. The adoption of a comprehensive healthy active ageing strategy that seeks to prolong the elderly's stay within their own home settings comprise crucial components that tap directly into the notion of sustainability.

Conclusions

Malta faces important entrenched challenges that above all affect the sustainability of public finances. These include a steadily ageing population, which is stretching the supply of a variety of services, including surgery and free medication. Other supply constraints exist, stemming from financial and infrastructural limitations. Nonetheless, there exists a strong political commitment to ensure the provision of a health-care system that is accessible, of high quality, safe and last but not least, sustainable. This is likely to require investment in the health system to revisit existing processes and to shift the focus of care away from hospital and into the community.

1. Introduction

The Republic of Malta consists of three main islands, Malta, Gozo and Comino, forming an archipelago in the Mediterranean Sea, and has the highest population density in Europe. Life expectancy has steadily increased over the past 20 years and compares well to the European Union (EU) average. In 2011, life expectancy at birth was 78.4 years for men and 82.6 years for women. Standardized mortality rates for circulatory diseases have decreased over time from 426 per 100 000 in 1990 to 232 per 100 000 in 2011, but are still higher than those of the EU15 (161 per 100 000).

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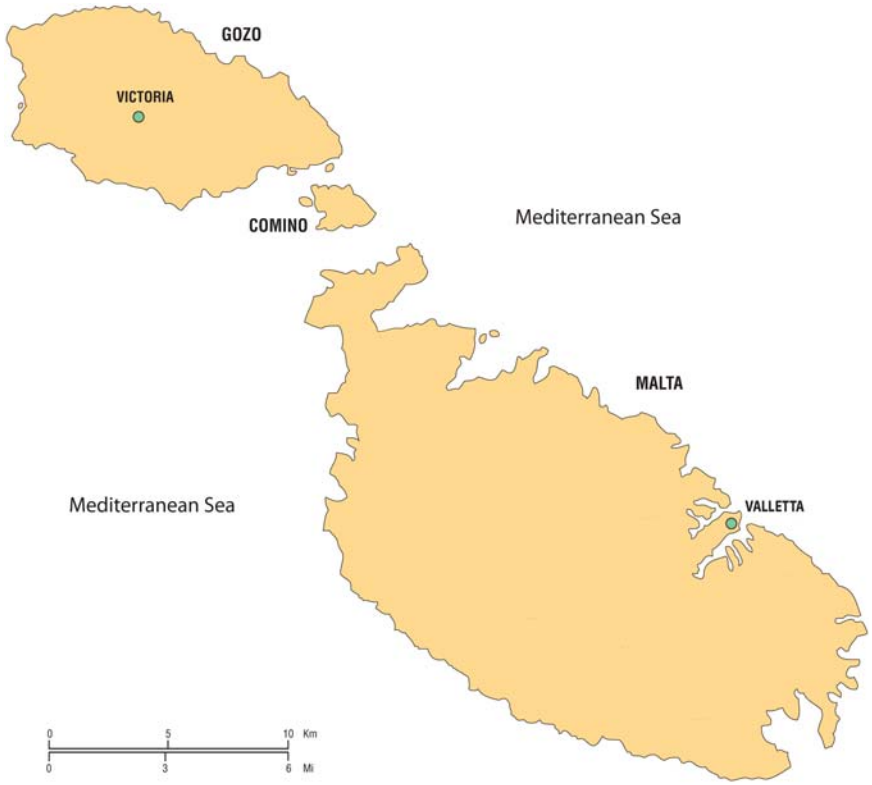
1.1 Geography and sociodemography

The Republic of Malta (i.e. the Maltese Islands, unless otherwise stated) consists of three main islands, Malta, Gozo and Comino, forming an archipelago in the Mediterranean Sea with Sicily 93 km to the north, Libya 288 km to the south, Gibraltar 1826 km to the west and Alexandria 1510 km to the east (Fig. 1.1). The climate is warm year-round. The total land area is 316 km² and the population was 416 110 in 2011 (NSO, 2012a). At 1300 persons per km² (Table 1.1), the population density is the highest in Europe.

Fig. 1.1
Map of Malta



Source: Author's own compilation.

Population growth has slowed from 1.0% per year in 1990 to 0.5% per year in 2010 (World Bank, 2013). While the crude death rate has been relatively stable over the past 20 years (7.9 per 1000 persons in 2011) there has been a decline in the fertility rate from 2 births per woman in 1991 to 1.4 in 2010. The crude birth rate was 10.3 per 1000 in 2011 (NSO, 2012a).

Table 1.1
Trends in population/demographic indicators, selected years

	1980	1990	1995	2000	2005	2010
Total population	325 721	361 908	378 404	391 415	405 006	417 617
Population, female (% of total)	51.4	50.8	50.6	50.5	50.4	50.3
Population aged 0–14 (% of total)	24.2	23.5	21.8	20.1	17.4	15.4
Population aged 65 and above (% of total)	8.3	10.4	11.0	12.2	13.4	15.2
Population aged 80 and above (% of total)	0.9	2.0	2.2	2.4	3.0	3.4
Population growth (average annual growth rate)	1.0	1.0	0.7	0.5	0.6	0.5
Population density (people per sq km)	993.8	1 106.6	1 158.8	1 205.7	1 261.0	1 300.0
Fertility rate, total (births per woman)	2.0	2.0	1.8	1.7	1.4	1.4
Birth rate, crude (per 1000 people)	17.6	15.2	12.4	11.3	9.6	9.7
Death rate, crude (per 1000 people)	10.4	7.7	7.3	7.7	7.8	7.2
Age dependency ratio (population 0–14 & 65+; population 15–64 years)	48.2	51.2	50.3	47.2	44.1	44.5
Percentage of urban population	89.8	90.4	91.0	92.4	93.7	94.7
Proportion of single-person households	N/A	N/A	14.8	N/A	18.9	18.8
School enrolment tertiary (% gross)	2.8	10.5	21.6	20.6	30.7	35.3

Sources: NSO (2011a); World Bank (2013); WHO (2013).

The Maltese population is ageing. According to the latest preliminary census report conducted during 2011, the average age has increased from 38.5 in 2005 to 40.5 in 2011. This is mainly attributed to a rise in the number of persons aged 55 and over accompanied by a concurrent decrease in the number of persons under 25 years (NSO, 2011c). Persons aged 65 and over represent 16.3% of the total population compared to 13.7% in 2005. In contrast persons aged 14 and under comprise 14.8% of the population compared to 17.2% in 2005 (NSO, 2011c). The old age dependency ratio, which measures the number of older people as a share of those of working age, stood at 17.2% in 1995, 19.9% in 2005 and 23.7% in 2011 (NSO, 2011c). Despite the notable increase in the older population, Malta's population is still relatively young when compared to an average old age dependency ratio of 25.9% across the EU. However, projections depict a totally different scenario with the ratio increasing, and exceeding the EU average, to 31.8% (EU average 31.4%), 36.3% (EU average 34.6%) and 39.2% (EU average 38.3%) for years 2020, 2025 and 2030, respectively (European Commission – Directorate General for Economic and Financial Affairs, 2012).

As of 2005 (NSO, 2007), 93.9% of residents were born in Malta; most others were born in the United Kingdom, Australia or Canada. In 2010 there was an estimated net immigration of 2247 persons, mainly from other EU Member States as well as returning Maltese nationals. While there are few reliable data,

from 2005 to 2009, authorities reported an average of 1911 irregular immigrants per year by boat, though only 47 were reported in 2010 (NSO, 2011a). Most are from Africa, with a small proportion from Asia.

Both English and Maltese are official languages. The official religion is Roman Catholicism, which is taught in schools. Schooling is compulsory for children aged 5–16 years. Approximately 23.6% of children attend Church schools and 7% attend private schools. There have been significant improvements in post-compulsory school participation rates from around 40% in 2000 to over 70% (Eurostat, 2013). Most marriages occur within the Church, however around 33% (in 2010) were civil marriages (NSO, 2011a). Legislation introducing divorce came into effect in October 2011 following the results of a national referendum.

1.2 Economic context

Malta's economy, though small, is highly diversified and exposed to international market forces. Economic development relies heavily on the generation of local investment resources and foreign direct investment. The economy is dependent on manufacturing, tourism and key service sectors including financial, business, information technology (IT) and remote gaming. In 2012, real gross domestic product (GDP) grew by 0.8%, compared with a 0.6% contraction in the euro area and according to the Ministry for Finance forecast real GDP growth is accelerating – to 1.4% in 2013 and 1.6% in 2014. Unemployment is projected to remain low and stable, decreasing from 6.5% in 2012 to 6.3% in 2013 and 6.3% in 2014 (Ministry for Finance, 2013).

In 2012, the deficit-to-GDP ratio stood at 3.3% exceeding the 2.2% target for that year and above the 3% of GDP maximum stipulated by the Excessive Deficit Procedure of the EU Stability and Growth Pact. The higher than planned deficit-to-GDP ratio was due to overly optimistic revenue budget estimates. In 2013 the deficit as a percentage of GDP is forecast to decline by 0.6 percentage points to 2.7% as revenue is expected to increase thus offsetting the projected increase in expenditure (Ministry for Finance, 2013).

In 2010 there were 179 712 in the labour force (Table 1.2) with unemployment in 2012 at 6.5% (World Bank, 2013). Skills gaps continue to pose an obstacle to the efficient utilization of human capital. While there was an increase in employment in all segments of the labour market, including among older workers and women, the female employment rate remains the lowest in the

EU (46.9% in 2012) (European Commission, 2013). Although measures have been introduced to encourage female participation in the labour market, the government is highly committed to introducing further incentives in this respect.

Table 1.2

Macroeconomic indicators, selected years

	1995	2000	2005	2010	2012
GDP (ESA 95) (euro millions)	3 054.0	4 121.0	4 938.0	6 377.0	6 830.0
GDP, PPP (current international US$ millions)	5 692.0	7 262.0	8 488.0	11 096.0	12 138.0
GDP per capita (current US$)	9 717.5	10 377.0	14 809.9	19 624.9	20 847.6
GDP per capita, PPP (current international US$)	15 364.6	19 041.6	21 018.6	26 672.2	29 013.5
GDP growth (annual %)	6.3	6.8	3.7	2.7	1.0
Total general government expenditure (% GDP)	N/A	N/A	43.6	41.6	43.4
General government deficit/surplus (% of GDP)	N/A	N/A	-2.9	-3.6	-3.3
Tax burden (% of GDP)	30.0	28.9	34.0	33.0	33.7[a]
General government gross debt (% of GDP)	34.2	53.9	68.0	67.4	72.1
Value added in industry (% of GDP)	50.0	50.8	37.8	32.7	N/A
Value added in agriculture (% of GDP)	2.9	2.4	2.6	1.9	N/A
Value added in services, etc. (% of GDP)	47.1	46.9	59.5	65.4	N/A
Labour force (total)	143 108	151 726	164 411	179 712	N/A
Unemployment, total (% of labour force)	N/A	6.3	7.3	6.9	6.5
At risk of poverty or social exclusion (% of total population)[b]	N/A	N/A	20.2	20.3	22.2
Gini coefficient of equivalized disposable income			26.9 (b)	28.4	27.2
Real interest rate	1.8	3.0	2.9	1.6	2.3

Notes: ESA: European System of Accounts; PPP: purchasing power parity. [a] 2011 figure latest available; [b] Individuals in one of the following three conditions: at risk of poverty, severely materially deprived, or living in households with very low work intensity.

Eurostat defines people at *risk of poverty* as: "those living in a household with an equivalized disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equivalized disposable income (after social transfers). The equivalized income is calculated by dividing the total household income by its size determined after applying the following weights: 1.0 to the first adult, 0.5 to each other household members aged 14 or over and 0.3 to each household member aged less than 14 years old."

Eurostat defines the *severely materially deprived* as having: "living conditions constrained by a lack of resources and experience at least 4 out of the 9 following deprivation items: cannot afford 1) to pay rent/mortgage or utility bills on time, 2) to keep home adequately warm, 3) to face unexpected expenses, 4) to eat meat, fish or a protein equivalent every second day, 5) a one week holiday away from home, 6) a car, 7) a washing machine, 8) a colour TV, or 9) a telephone (including mobile phone)."
Eurostat defines people *living in households with very low work intensity* as: "those aged 0–59 who live in households where on average the adults (aged 18–59) worked less than 20% of their total work potential during the past year. Students are excluded."

The share of the population at risk of poverty and social exclusion is lower than the average in the euro area and compares favourably with that of the new Member States. The at-risk-of-poverty rate (the number of persons earning below 60% of the median national equivalized income) was 15.4% in 2011 (NSO, 2013). Nevertheless, the number of people at risk has grown considerably in recent years, with the most vulnerable groups being those below the age of 18 and the elderly people aged 65 and over. Just over one-fifth of children (21.1%) under the age of 18 and 18.1% of elderly people were found to be at risk of poverty in 2011 (NSO, 2013).

1.3 Political context

In 1964 Malta obtained independence from Britain; the island became a republic in 1974. A liberal parliamentary democracy, Malta holds regular elections based on universal suffrage. The President is the head of state, while executive powers rest with the Prime Minister and the cabinet. A unicameral Parliament made up of 65 representatives is elected every five years. This chamber serves as the national legislative body and also appoints the President.

The head of government is the Prime Minister, who is the leader of the party with an electoral majority. The main political parties are the socialist party, Partit Laburista, and the nationalist Partit Nazzjonalista, along with the much smaller Green party, Alternattiva Demokratika. In 1993 a system of local government consisting of local town councils was set up. Currently in Malta there are 68 local councils with elections held every three years. Over the past decade an increasing number of functions have been delegated to local government, or councils, in keeping with the government's policy of decentralization. Their functions are related to local activities, including traffic management and waste collection. To date the local councils have not been delegated responsibilities for health care although some local councils house the primary health-care centres or small local clinics. Local councils will be more involved in the provision of community health care in the future (see section 2.3).

In March 2013, the socialist party (Partit Laburista) was elected. The nationalist party (Partit Nazzjonalista) had previously been in government since 1987, save for a 22-month stint when the Partit Laburista was in power, between 1996 and 1998. Maltese political parties have aligned themselves with European parties – the Party of European Socialists (PES) in the case of the Partit Laburista and the European People's Party (EPP) for the nationalist party; Alternattiva Demokratika has joined the European Greens.

Accession to the EU in May 2004 has largely dominated the political agenda in recent years. Malta is also a member of international organizations including the United Nations, the World Trade Organization, and NATO's Partnership for Peace.

1.4 Health status

Life expectancy at birth in 2011 was 81.0, 78.8 years for men and 83.1 years for women (Table 1.3; see WHO, 2013). The probability of dying in the younger age groups (15–60) has been decreasing steadily with a wide gap between males and females (World Bank, 2013), partly attributable to ischaemic heart disease and external causes of death such as traffic accidents and suicides. The total crude death rate in 2011 stood at 7.86, 8.04 for men and 7.68 for women (WHO, 2013).

Table 1.3
Mortality and health indicators, selected years

	1980	1990	1995	2000	2005	2010	2011
Life expectancy at birth, in years (total)	70.4	76.2	77.3	78.2	79.4	81.5	81.0
Life expectancy at birth, in years (male)	67.9	73.8	75.0	76.0	77.2	79.3	78.8
Life expectancy at birth, in years (female)	72.9	78.4	79.6	80.3	81.4	83.6	83.1
Crude death rate per 1 000 population (total)	10.4	7.7	7.3	7.7	7.8	7.2	7.9
Crude death rate per 1 000 population (male)	11.1	8.0	7.5	7.9	7.9	7.2	8.0
Crude death rate per 1 000 population (female)	9.7	7.4	7.2	7.5	7.6	7.3	7.7

Source: WHO (2013).

Diseases of the circulatory system are the leading causes of death, accounting for 45% of all deaths in 2011 (Table 1.4) (DHIR, 2013a). Despite a generally downward trend, ischaemic heart disease mortality rates are higher than the EU15 average. Diabetes mellitus accounts for 3.4% of all deaths, also higher than the EU15 average. Neoplasms are the second major cause of deaths, accounting for 27% of all deaths, while the rest of deaths are largely attributed to other causes (18%), diseases of the respiratory system (7%), and external causes of morbidity and mortality (3%) (DHIR, 2013a).

Neoplasms are the next most common cause of death and accounted for 27% of all deaths in 2011 (DHIR, 2013a). While the overall number of deaths has been increasing over time, standardized mortality rates reveal a downward trend that compares well with the EU15 and is more favourable than for the EU12. The average age at death due to neoplasms is 70 years, approximately 9 years younger than for circulatory diseases.

Table 1.4

Standardized[a] mortality rates per 100 000, main causes of death, selected years

	1980	1990	1995	2000	2005	2010
Communicable diseases						
All infectious and parasitic diseases (A00–B99)	9.0	8.0	6.5	5.6	3.4	0.9
Tuberculosis (A15–A19) (absolute number)	0.0	0.6	0.8	0.7	0.1	0.2
Sexually transmitted infections (A50–A64)	N/A	N/A	N/A	0.0	0.0	0.0
HIV/AIDS (B20–B24)	0.0	0.5	0.2	0.6	0.3	0.3
Noncommunicable diseases						
Circulatory diseases (I00–I99)	N/A	426.7	318.6	326.1	272.0	189.3
Malignant neoplasms (C00–C97)	202.2	166.7	198.2	171.0	145.4	151.7
Colon cancer (C18)	N/A	N/A	19.2	17.7	14.4	13.4
Cancer of larynx, trachea, bronchus and lung (C32–C34)	38.8	32.4	35.7	29.9	26.7	29.8
Breast cancer (C50)	54.6	37.7	47.8	45.6	28.1	25.8
Cervical cancer (C53)	0.7	2.3	3.7	2.3	1.0	0.7
Diabetes (E10–E14)	89.5	31.4	22.3	18.9	22.1	17.2
Mental and behavioural disorders (F00–F99)	1.7	5.4	3.6	4.3	12.9	19.3
Ischaemic heart diseases (I20–I25)	413.1	230.8	177.2	171.8	149.7	106.4
Cerebrovascular diseases (I60–I69)	151.5	99.9	79.7	73.7	63.2	42.5
Chronic respiratory diseases (J00–J99)	68.7	66.7	63.0	68.4	60.6	47.1
Digestive diseases (K00–K93)	46.0	33.0	27.2	22.5	24.3	16.0
External causes						
Transport accidents (V01–V99)	8.4	2.5	6.4	4.1	4.5	3.6
Suicide (X60–X84)	0.0	2.5	4.6	5.8	4.2	7.4
Ill-defined and unknown causes of mortality (R96–R99)	N/A	N/A	0.3	0.8	0.5	3.6

Source: WHO (2013), Eurostat (2013).
Note: [a] Standardization is based on European Standard Population (ESP).

Lung cancer, followed by colorectal cancer, prostate, stomach and pancreatic cancer are the leading causes of death from neoplasms in males (DHIR, 2013a). Breast cancer followed by colorectal cancer, ovarian, pancreatic and lung cancer were among the leading causes of death in females (DHIR, 2013a). For most cancers there have been improvements in survival rates; however, survival rates are generally lower than in countries in the EUROCARE study (Berrino et al., 2007).

The increase over the last decade in the standardized death rate for mental and behavioural disorders is mainly due to deaths attributed to dementia, which have increased to some extent because of changes in coding practices. The number of individuals with dementia was estimated to be around 4388 in 2010, equivalent to approximately 1% of the general population, and expected to increase to 5585 persons in 2020 (Abela et al., 2007). Recently, Malta launched a strategy to address the needs of persons with dementia, their families and carers as part of a holistic approach to dementia care.

Low mortality rates from infectious diseases can be attributed to widespread availability of antibiotics. The free syringe distribution programme for intravenous drug abusers, which started in Malta in the late 1980s, has resulted in low rates of HIV infection. A free childhood immunization programme for all children has also resulted in lower morbidity and mortality from vaccine-preventable infectious diseases.

Despite health gains, many risk factors associated with noncommunicable diseases in Malta are on the rise. According to body mass index (BMI) data, the percentage of the male population that is obese has increased from 22.1% in 1984 to 29.6% in 2010 (Table 1.5). Data comparing Malta to other EU Member States in 2008 found that the proportion of males who are obese in Malta is the highest in the EU, while the proportion of females who are obese is third highest (Eurostat, 2013). The proportion of children who are obese or overweight is also one of the highest when compared to children in 41 other countries (Currie et al., 2008). According to the pilot European Health Examination Survey (EHES), 10.1% of the population between 20 and 79 years had diabetes in 2010 (DHIR, 2012). Data comparing Malta with other EU Member States ranks Malta as having the fourth highest self-reported diabetes mellitus prevalence during 2008 (Eurostat, 2013).

Table 1.5

Health indicators over the period 1984–2010

		MONICA 1984		HIS 2002		HIS 2008		Pilot EHES 2010	
	Age group	Male	Female	Male	Female	Male	Female	Male	Female
BMI: 18.5–24.99/normal	25–64	32.4	33.3	29.4	48.0	25.4	48.1	23.1	45.2
BMI: 25.00–29.99/overweight	25–64	45.5	31.4	42.2	30.6	46.9	31.0	47.2	26.9
BMI: ≥30.00/obese	25–64	22.1	35.3	28.5	21.4	27.7	21.0	29.6	28.0
Elevated blood glucose	18 years and over					9.6	7.8	9.0	10.7
Normal blood pressure	25–64	51.5	52.9					66.9	68.7
Stage 1 hypertension	25–64	32.7	30.9	17.5	16.1	21.6	19.7	30.8	16.3
Stage 2 hypertension	25–64	15.8	16.3					2.3	15.1
Total serum cholesterol ≤5	25–64	22.9	21.0					31.3	44.0
Borderline high: 5–6.18	25–64	30.1	29.9					39.1	41.4
High >6.18	25–64	47.0	49.1					29.7	14.7

Source: DHIR (2010, 2012).
Notes: MONICA: Monitoring Trends and Determinants in Cardiovascular Disease; HIS: Health Interview Survey.

Even though males still smoke more than females, the gap is shrinking. Deaths commonly associated with smoking, such as lung cancer and chronic obstructive pulmonary disease, are still more common among males. According to the latest European School Survey Project on Alcohol and other Drugs (ESPAD) carried out in 2011, 22% of Maltese students aged between 15 and 16 years participating in the study had smoked during the 30 days before the survey (Hibell et al., 2012). The study also found that 68% of those surveyed had consumed alcohol during the previous 30 days compared to the ESPAD average (57%). Unhealthy eating has also been found to be increasingly prevalent (Malta Standards Authority, 2010).

The infant mortality rate was 6.3 per 1000 live births in 2011, higher than the EU27 average of 5.76 and much higher than the EU17 average of 3.55 per 1000 live births (Table 1.6) (WHO, 2013). Caution needs to be exercised when interpreting such figures in view of the fact that termination of pregnancy is illegal in Malta. However, this fact alone may not fully explain such high mortality rates. There remains much scope for the conduct of an in-depth analysis to explore the reasons for such relatively high rates. The crude birth rate in 2011 was 10.3 per 1000 mid-year population (4283 live births) (NSO, 2012a); there were 4239 live births in 2012 (DHIR, 2013b). The caesarean section rate is rather high, 335 per 1000 live births, when compared to the EU27 figure of 268 (WHO, 2013). Indeed, there has been an overall increasing

Table 1.6

Maternal, child and adolescent health indicators, selected years

	1980	1990	1995	2000	2005	2010
% of all live births to mothers under 20 years of age	3.11 (1984)	2.7	3.1	5.6	5.9	6.4
Termination of pregnancy (abortion) rate	0.0	0.0	0.0	0.0	0.0	0.0
Perinatal mortality rate (per 1 000 births)	17.9 (1985)	10.9	9.9	7.3	5.4	7.9
Neonatal mortality rate (neonatal deaths per 1 000 live births)	12.0	6.7	7.4	5.3	4.4	4.5
Postneonatal mortality rate (postneonatal deaths per 1 000 live births)	3.6	2.8	1.5	0.7	1.6	1.0
Infant mortality rate (infant deaths per 1 000 live births)	15.5	9.5	8.9	6.0	6.0	5.5
Probability of dying before age 5 years per 1 000 live births	18.1	11.0	10.2	6.8	6.7	6.5
Maternal mortality rate (maternal death per 100 000 live births)	53.6	0.0	21.7	0.0	0.0	24.9
Syphilis incidence rate per 100 000 population				0.0	5.0	5.8
Gonococcal infection incidence rate per 100 000 population				0.8	5.7	11.3

Source: WHO (2013).

trend in caesarean section rates over the past 14 years (DHIR, 2013b). In 2012, 56.3% (2352) of deliveries were reported as having a spontaneous onset of labour, 28.1% (1174) were induced by drugs or artificial rupture of membranes and 15.5% (649) were carried out as elective caesarean sections. According to the National Obstetrics Information System (NOIS) the highest number of deliveries by maternal age group during 2012 was in the 30–34 year group and the average maternal age was 30 years. The percentage of births to teenage mothers has increased since the 1990s. In 2012, 5% of deliveries were for teenage mothers within the 15–19 age group.

The National Immunization Service is responsible for the administration of all vaccines given to the public; the scheduled vaccines for infants and children up to 16 years are free of charge. While vaccination coverage for children is quite good (Table 1.7), a degree of under-reporting exists because some children are vaccinated in the private sector.

Table 1.7
Vaccine uptake in Malta (%), 2008–2011

Vaccine	2008	2009	2010	2011
BCG	86.4	82.0	91.0	83.7
DTP1	88.0	91.0	97.0	100.0
DTP3	71.5	73.0	76.0	95.7
DTP4	64.0	63.0	78.0	76.7
Polio 1	88.0	91.0	97.0	100.0
Polio 3	71.5	73.0	76.0	95.7
Hep B 1	60.8	88.0	76.0	94.2
Hep B 3	86.0	86.0	75.0	81.5
Hib 3	71.5	73.0	76.0	95.7
MCV 1	78.0	82.0	73.0	83.6
MCV 2	83.0	85.0	97.2	85.1

Source: WHO (2013).

Chronic conditions associated with obesity, unhealthy lifestyles and ageing (such as dementia) are major challenges facing the population as a whole. A number of health policy documents, which have a strong focus on health promotion, primary prevention and intersectoral collaboration have been launched in recent years. These include the Noncommunicable Disease Strategy 2010, the National Cancer Plan 2011, the Sexual Health Strategy 2011, the Healthy Weight for Life Strategy 2012 and the Tuberculosis Prevention Strategy 2012. An important aspect of the National Cancer Plan is the gradual and successive implementation of screening programmes, initiated in 2009

with breast screening, colorectal screening in 2012, and with cervical screening planned for 2014. Vaccination of young girls against cervical cancer started in 2012. There is some evidence that targeted policies have been successful: for example, there has been improvement in the number of people with high serum cholesterol (Table 1.5), which may be due to specific legislation and policies introduced around 20 years ago regarding entitlement to free cholesterol medication.

2. Organization and governance

The Ministry for Health is responsible for the provision of health services, health services regulation and standards, and the provision of occupational health and safety. The Ministry for the Family and Social Solidarity is responsible for social policy and policy relating to the child, the family and people with a disability, elderly people and community care, social housing, social security, pensions and solidarity services. While both ministries are responsible for the financing and provision of services within their respective portfolios the Ministry for Finance is generally responsible for Malta's economic policy, preparing the government budget as it collects and allocates taxes and revenue. Other actors include other government ministries, the Foundation of Medical Services, government commissions, agencies, boards and committees, professional regulatory bodies and professional groups, private and voluntary sectors, the Church and the general public.

The public health-care system is the key provider of health services. The private sector complements the provision of health services, in particular in the area of primary health care. In addition some services, especially for long-term and chronic care, are also provided by the private sector, the Church and other voluntary organizations.

2.1 Overview of the health system

Health services are provided mainly by the state and the private sector, though there is some involvement by the Catholic Church and voluntary organizations to provide long-term and chronic care services. The public health-care system provides a comprehensive basket of services to all persons residing in Malta who are covered by the Maltese social security legislation and also provides for all necessary care to groups such as irregular immigrants and foreign workers

who have valid work permits. There are no user charges or co-payments for health services. The private sector acts as a complementary mechanism for health-care coverage and service delivery.

The state health service and private general practitioners (GPs) provide primary health-care services, although independently from one another as the latter account for two-thirds of the workload. Secondary and tertiary care is mainly provided by specialized public hospitals of varying sizes. The main acute general services are provided by one teaching hospital incorporating all specialized, ambulatory, inpatient care and intensive-care services. When it comes to the provision of highly specialized care for the treatment of rare diseases or specialized interventions patients are sent overseas because it would neither be cost effective nor feasible to conduct such treatment locally.

2.2 Historical background

The first social care service provided financial support, food, and free medicine to sick low-income women in large towns during the rule of the Order of St John. This service was continued under British rule by the 'physicians of the poor', who were attached to the civil hospitals. In 1832 the first government dispensary was founded and additional dispensaries, typically attached to the police station, were subsequently established. The 'physicians of the poor', whose duties included clinical, administrative and sanitary responsibilities, were incorporated into the Executive Police. In 1879 the 'police physicians' became known as district medical officers, accountable to the Department of Charitable Institutions. Until the late 1970s, district medical officers were responsible for treating low-income patients who qualified for a Medical Aids Grant. District medical officers had full-time posts as well as the right to practise privately, which compensated for their otherwise low salaries.

Hospital services became available around the middle of the fourteenth century. Hospitals started to develop rapidly during the rule of the Order of the Knights of St John as institutions for the poor; their numbers grew rapidly, with many military hospitals also being built. Eventually, as bequests ran out, hospitals became dependent on state subsidies while still designated as charitable institutions. In 1815, at the start of British rule, all hospitals were brought under a single authority responsible for the management of all charitable institutions. By 1936 the medical branches of the Charitable Institutions Department

were amalgamated with the Public Health Department. As hospitals came to be perceived less as an institution only for the poor, the demand for hospital services increased. Hospital services became free of charge in 1980.

In the domain of public health, in the last half of the nineteenth century a sanitary reform movement emerged and a Sanitary Office was established in 1875, though it was closed after a few years as a result of insufficient funds. The role of the sanitary officers was taken over by the police physicians and eventually the district medical officers. The 'sanitary laws' enacted at the turn of the century laid the basis for the organization of the Department of Health, the roles of medical professions, and laws relating to public health and communicable diseases.

In 1937 the Medical and Health Department (Constitution) Ordinance and the Medical and Kindred Professions Ordinance were created. For the first time, health and medical services came under the control of the Director (Health) who was responsible for public health, management of hospitals and the district medical service. In the early 1950s, having been influenced by the creation of the British National Health Service (NHS) in 1948, the Labour government of Malta made several attempts to introduce its own free NHS. In 1955 the government tried to introduce a pilot scheme in Gozo with a full-time salaried state district medical service; however it was opposed by the Doctors' Union. A doctors' dispute began in 1977. This was due to legal amendments introduced by the government in connection with the licensing of doctors. A requirement was introduced for newly qualified doctors to serve in hospitals for two years immediately after graduation in order to obtain a licence. This was intended to stop junior doctors departing to pursue studies abroad before another group of doctors was ready to take up hospital posts. As a consequence of the dispute, many doctors emigrated creating a professional vacuum, temporarily bridged by employing foreign doctors. The government opened several polyclinics in order to provide a free emergency primary care service during this period. Today's primary health-care system developed from these polyclinic services.

2.3 Organization

Since 2013, the main actor in the health system is the Ministry for Health, responsible for the provision of health services, health services regulation and standards, and the provision of occupational health and safety. The Ministry for the Family and Social Solidarity also provides some health services within its portfolio, which includes social policy and policy relating to the child, the

family and people with a disability, elderly people and community care, social housing, social security, pensions and solidarity services. Ultimately, the Ministry for Finance is generally responsible for Malta's economic policy and consequently allocates budgets for all ministries. The private system is market driven and comprised of autonomous, independent providers. In 1995, following an amendment to the laws regulating provision of private health care, private hospitals were opened and private clinics were able to register as hospitals provided they satisfied the regulations.

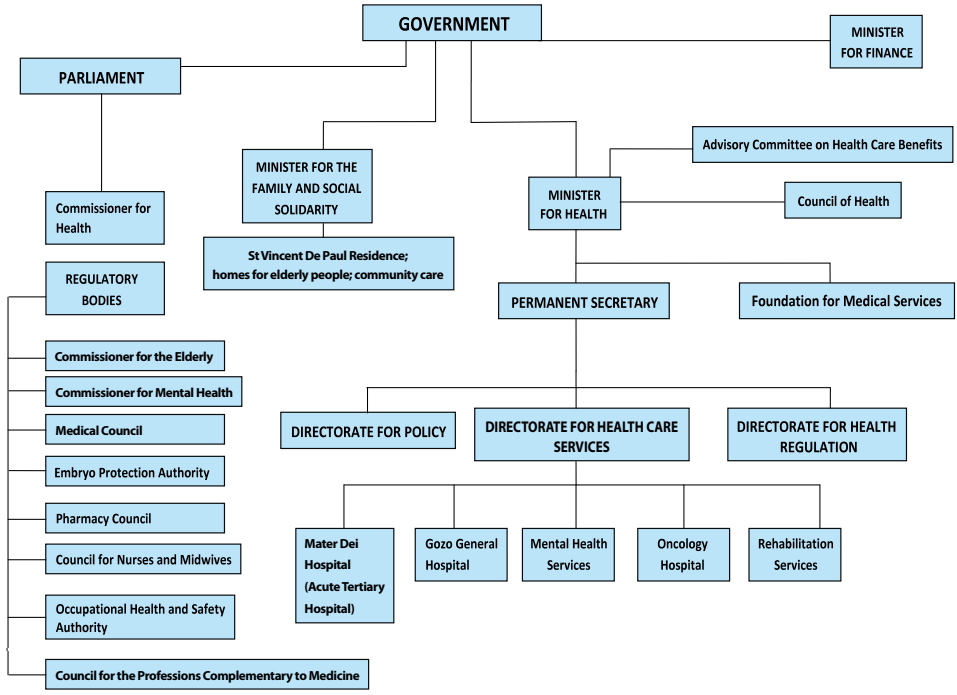
Fig. 2.1 depicts the new institutional framework underpinning the organization of the public health-care system. The 2013 Health Act replaces the Department of Health (Constitution) Ordinance, which was enacted in 1937 and assigned powers to specific government positions. It creates a basic framework for the public component of the health system. In essence it seeks to regulate the entitlement and quality of health-care services and providers, and to consolidate and reform the government structures and entities responsible for health. To this end, the Act establishes three directorates: the Directorate for Policy in Health, the Directorate for Health-Care Services and the Directorate for Health Regulation. In addition the Act also aims to empower patient rights and safety, and provides for the enactment of a Charter for Patient Rights and Responsibilities. Many details concerning the roles and responsibilities of the bodies established by the Health Act will be determined by subsidiary legislation.

Within the Ministry for Health, the Permanent Secretary is the administrative head. S/he is a public officer accountable to the Prime Minister. S/he has the responsibility to support general policies and priorities of the government and to operate within the context of management practices and procedures established for the government as a whole.

The Act clearly defines the roles of the three directorates. The Chief Medical Officer, as the person responsible for the Directorate for Policy in Health, will act as chief adviser to the Minister on all matters related to government health policy. The Director-General for Health-Care Services will ensure the effective and efficient operation and delivery of health-care services. The Superintendent of Public Health, who leads the Directorate for Health Regulation, will safeguard public health, licensing, monitoring and inspecting provision of health-care services with respect to quality and safety; the Superintendent will also advise the Minister on matters related to public health.

In addition to the three directorates described in the Health Act, there are three bodies that play an important regulatory and advisory role. These include the Health Policy and Strategy Board, the Council of Health and the Advisory

Fig. 2.1
Overview of the health system



Committee on Health-Care Benefits. The Health Policy and Strategy Board brings together all the directorates, the Minister, the Permanent Secretary and the financial controller of the Ministry for Health to ensure a concerted approach towards policy development and implementation. The Council of Health brings together government and other stakeholders to advise the Ministry for Health on matters related to public health. The Advisory Committee on Health-Care Benefits recommends the benefits package to be provided by the public health-care system and maintains a publicly accessible list of such benefits.

In addition to the above, in the interest of patient rights the government established three commissioner functions: Commissioner for Health, Commissioner for Mental Health and Commissioner for the Elderly. These officials act as ombudsmen in dealing with grievances and concerns from the public in their respective areas. In particular, the newly established Mental Health Act assigns rights and responsibilities to the Commissioner for Mental Health, primarily to safeguard the well-being of patients and the public.

There are also a number of other bodies, which arise out of other legislative instruments. These include regulatory professional councils, government boards and committees with specific functions. Their main role is to act as advisers to the health authorities and the Minister on very specific issues. Some of the Boards also have a decision-making function related to their area of concern. Boards and committees include, but are not limited to: Advisory Committee for Immunization Policy, Committee on Smoking and Health, Food Safety Commission and Government Formulary List Advisory Committee and Appeals Board.

A number of voluntary organizations (non-governmental organizations, NGOs) exist to promote health-related activities. They range from those having a broad scope of activity to patient self-help groups for specific illnesses. They act as policy advocates, self-help groups and service providers. There is no umbrella organization to bring these groups together, although the Malta Health Network is increasingly assuming this role, and they are not formally represented on decision-making bodies.

The Church still plays an important role in the provision of nursing homes for elderly people, homes for people with a disability, homes for people with a mental handicap and homes for children. However, it is increasingly facing great difficulties in continuing to provide these services as the care providers are dwindling in numbers. This is because most nuns are now rather elderly and are not being replaced by sufficient younger ones, as well as limited resources available.

A number of associations exist for the various professional groups. These include the Malta Union of Midwives and Nurses, the Medical Association of Malta, the Dental Association, the Chamber of Pharmacists, the Nursing Association of Malta, the Malta Association of Physiotherapists and the Midwifery Association. The Malta College of Family Doctors and a number of specialist associations are also active, mostly in the field of providing continuing education.

Some of the above associations are also registered trade unions and represent their members to various bodies both at the local and international level, including government. Other health service employees are represented by sections of the two largest national unions; the General Workers Union and the Union Ħaddiema Magħqudin.

2.4 Decentralization and centralization

Governance, regulation, provision and financing in the public system are generally centralized. For example, all decisions regarding resource allocation and procurement are typically made centrally at the Ministry level. While day-to-day operations are managed at the facility level, facilities still have limited autonomy. The new Health Act provides direction for the Directorate for Health-Care Services to work towards an established framework of controlled decentralization and autonomy. Under the new legislation, there is emphasis on the active involvement of local government in the provision of community health care.

2.5 Planning

The new 2013 Health Act seeks to delineate between policy-making, management and regulation. The management of health-care services is occasionally seen to be in conflict with the policy-making function. This is one of the reasons for their separation under the new framework. Regulation 16 of the Health Act provides for the establishment of a Health Policy and Strategy Board. This Board is to be led by the Minister for Health and seeks to discuss and evaluate the policy, strategy developments and direction in the health sector, and to monitor and follow the implementation of the health policy and strategy adopted by the government.

2.6 Intersectorality

Apart from the Ministry for Health and the Ministry for the Family and Social Solidarity, there are other important actors in the public sector that have an impact on, promote and safeguard health. These include the Office of the Prime Minister, the Ministry for European Affairs and Implementation of the Electoral Manifesto, the Ministry for Education and Employment, and the Ministry for Finance. In addition, various government commissions, agencies, boards and committees play a role in the health sector. For example, the National Commission for Persons with Disability (KNPD) is a government-funded organization which coordinates activity and serves as a platform for the numerous NGOs that are active both as policy advocates and as service providers in this field.

2.7 Health information management

2.7.1 Information systems

The Directorate for Health Information and Research (DHIR) within the Ministry for Health is in charge of collecting, reporting and analysing national health statistics. Most health statistics are generated through a combination of surveillance registries and surveys. Registry data is complemented by population surveys to establish community-level data on morbidity, lifestyle and health status. Data is also pooled from a variety of sources external to the DHIR. Analysis and dissemination is carried out for a range of audiences, including the Ministry for Health, international organizations, the research community and the general public.

2.7.2 Health technology assessment

Applications for market authorization of new medicines are received from the importers or manufacturers (marketing authorization holders) or clinical consultants working within the public sector. Market authorization applicants provide detailed dossiers, though head-to-head trial data is often lacking. Applications are processed by the Directorate for Pharmaceutical Affairs (DPA) within the Ministry for Health. The researchers within the DPA perform health technology assessments (HTAs) which are then presented to the Government Formulary List Advisory Committee (GFLAC). The GFLAC is responsible for coming up with a recommendation as to whether to add new medicines to the Government Formulary List (GFL), as well as the relevant maximum reference price. The GFLAC submits recommendations to the Superintendent of Public Health who makes the final decision. The applicants are informed accordingly by the DPA. When a new medicine is approved for the GFL the DPA liaises with the Central Procurement Supplies Unit to purchase the medicine. HTA has also been used to assess medical technology and services, though only informally; these have been included in the scope of evidence-based review and assessment in the 2013 Health Act which as yet has to be fully implemented.

2.8 Regulation

2.8.1 Registration and planning of human resources

Registration of health-care professionals is regulated by the Health-Care Professions Act. The registration of all such professionals is under the responsibility of the Superintendent of Public Health. Professional regulators are responsible for granting of licences, and maintaining and updating professional registers for each health profession. They also monitor professional and ethical standards and carry out disciplinary proceedings. With regard to nursing and paramedical professions, due to concerns over the supply of workers there has been engagement between the health authorities and Faculty of Health Sciences. As a result the capacity of this Faculty's nursing course has been increased and a drive for the recruitment of foreign nurses organized.

Every year, the Ministry for Health presents a consolidated business plan and a human resource plan based on the needs of all health facilities and departments. All capacity building is thereafter negotiated with the Ministry for Finance, as it is responsible for coordinating all public sector requests. Long-term human resource planning typically involves health authorities and education authorities collaborating with the University of Malta to decide which courses should be offered and at what frequency. Recently the government has embarked on the local provision of specialized training. In addition, there is the local foundation programme, which prepares newly graduated doctors for full registration with the Medical Council.

2.8.2 Regulation and governance of pharmacies

Legislation specifies criteria for opening new pharmacies, as well as the standards to be maintained. Current legislation does not allow for Internet pharmacies. Pharmacies can only purchase medicines from authorized wholesale dealers. The supply chain is regulated to minimize the risk of counterfeit medicines entering the supply chain. However when patients do purchase medicines from unauthorized Internet pharmacies, these cannot be regulated. In addition to the information on specific products available through published pack leaflets and summaries of product characteristics, the Medicines Authority – which is tasked with protecting and enhancing public health through the regulation of medicinal products and pharmaceutical activities – makes available additional medicines information to empower patients and to support rational medicines use.

2.8.3 Regulation and governance of pharmaceuticals

Medicinal products are regulated through a national legal framework presented in the Medicines Act, Chapter 458 of the Laws of Malta and its subsidiary legislation. Based on this Act, the Superintendent of Public Health is the Licensing Authority for all regulatory functions. The Licensing Authority delegates some functions related to licensing and surveillance of medicinal products and clinical trials to the Medicines Authority.

All products are authorized in line with procedures as specified in European legislation. Post-authorization, all medicinal products on the local market are monitored for their quality and for their safety. The list of all authorized medicinal products and the approved package leaflet and the summary of product characteristics are published on the web site of the Medicines Authority. All products placed on the market must be manufactured in EU Good Manufacturing Practice (EU-GMP) certified and authorized facilities; products imported directly from outside the EU must first be tested and batch released. EU-GMP certificates issued by the Medicines Authority are recognized by partner countries through a European Mutual Recognition Agreement. Standards of EU Good Distribution Practice are applied for wholesale distribution. Medicinal products can only be brought into Malta from the EU through EU authorized wholesale dealers. Each authorized wholesale dealer must retain a registered pharmacist, who is responsible for all technical aspects of the operations carried out by the wholesale dealer.

Advertising of prescription medicines is not allowed, consistent with EU law. Only information approved in the summary of product characteristics is allowed in advertisements of non-prescription items. Sale of pharmaceutical items is only permitted within pharmacies. Legislation stipulates that, unless a prescriber specifically requests the dispensing of an originator drug, pharmacists can do product substitution at the pharmacy level as long as the product dispensed has the same active ingredient, dose and same dosage form as that prescribed.

2.8.4 Regulation of medical devices and aids

Medical devices are regulated by the Malta Competition and Consumer Affairs Authority, which forms part of the Ministry for Social Dialogue, Consumer Affairs and Civil Liberties. The legislation on medical devices is fully in line with the EU legislation.

2.8.5 Regulation of capital investment

On the basis of advice from the Health Policy and Strategy Board, the Minister for Health approves recommendations for capital investments commensurate with published health strategies. Such capital proposals also require clearance from the Ministry for Finance. Following EU accession, Malta has also been able to access European funds, including the European Regional Development Fund. Capital projects are managed by the Foundation for Medical Services – from project planning to execution – and handed back to the Ministry once complete and operational. All public procurement follows EU public procurement regulations.

2.9 Patient empowerment

There are currently no mechanisms whereby consumers are represented on decision-making bodies in health care. However, this is set to change with the enactment of the new Health Act as it provides for the nomination of individuals representing patient associations to sit on the Council of Health. In addition, the new Health Act also sees to the enactment of a Charter for Patient Rights and Responsibilities.

2.9.1 Patient information

Patients have the right to receive all information necessary in order for them to gain insight into their state of health, so as to be able to make informed decisions. Patients must give consent before any procedures; therefore they must have access to appropriate information, such as the aim of the intervention (whether diagnostic or therapeutic), the nature of the intervention (such as whether it has any predictable side-effects, risks or will cause pain or other symptoms), the degree of urgency to perform intervention, the predicted duration and frequency, any potential contraindications relevant for the patient, the need for follow-up, possible alternatives, and possible consequences if consent is refused or withdrawn. Health-care professionals are trained to acquire consent using the appropriate procedures and specifically prepared consent forms.

2.9.2 Patient choice

Most patients use private providers for primary care and choose their own family doctor. Patients can self-refer to any private specialist of their choice. However, access to a specialist in the public sector can only be arranged following a doctor's referral (either by a public or private provider). A preference for a particular specialist can be specified in the referral.

2.9.3 Patient rights

While patients are afforded a number of patient rights by various legislative instruments, to date there is no single comprehensive piece of legislation that covers all aspects in one law. However, with the passing of the new Health Act patients will enjoy a Charter for Patient Rights and Responsibilities.

2.9.4 Complaints procedures

A complaint can be made in person, by phone, mail (electronic or conventional) or by a client survey. In 2012, the position of Commissioner for Health (see section 2.3) was created to act as Ombudsman and handle health-related complaints (see section 6.1). A customer care office located centrally within the Ministry for Health was established in 2013 to manage patient complaints. In addition, commissioner positions for mental health and for elderly people carry out similar functions. There is also a Customer Care Department within Mater Dei Hospital.

2.9.5 Public participation

Citizens are invited and may participate actively in public debates on draft national health policies. Members of the general public can also participate indirectly through their representatives in Parliament and the local councils, and through their involvement in voluntary organizations. However, generally the participation of patients, patients' representatives and patients' groups in the planning and management of the health system and the health-care services has been relatively low. Nonetheless, the situation is anticipated to change with the active involvement of local councils in the delivery of community care and other efforts to increase public participation as stipulated in the new Health Act.

2.9.6 Patients and cross-border health care

Patients who require highly specialized care for the treatment of rare diseases or specialized interventions may be sent overseas in view of the fact that it would be neither cost-effective nor feasible to conduct such treatment locally.

3. Financing

Total health expenditure as a percentage of GDP was 8.7% in 2012. This is below the EU average of 9.6% (WHO, 2013). While private spending comprised 2.9% of GDP (compared to 2.3% in the EU), public spending was only 5.6% of GDP, below the EU average of 7.3%; in recent years the increase in private spending has outpaced public health expenditure growth.

The publicly financed health system provides a comprehensive basket of health services to all people residing in Malta who are covered by Maltese social security legislation. However, entitlement to a few services (including elective dental care, optical services and some formulary medicines) are means tested. The means test falls under the non-contributory scheme of the Social Security Act (Chapter 318 of the Laws of Malta). Accordingly, those who fall within the low-income bracket as determined by the means test are entitled to free medicines from a restricted list of essential medicines and to certain medical devices (subject to certain conditions and the payment of a refundable deposit). Further, those who suffer from chronic illnesses included in a specific schedule incorporated in the Social Security Act are entitled to free medicines strictly related to the chronic illness in question. This benefit is independent of financial means.

The public system is funded by general tax revenues. All forms of taxation feed into the Consolidated Fund from which all public budgets are drawn on an annual basis; the health sector competes with other public sectors for funding. The main private sources of health financing are out-of-pocket payments (for means-tested publicly provided services or privately provided services) and voluntary health insurance (VHI). Out-of-pocket payment accounts for most private health-care expenditures and comprises a comparatively high percentage of total spending in comparison to other European countries.

3.1 Health expenditure

Total health expenditure as a percentage of GDP was 8.7% in 2012. This is below the EU average of 9.6% (WHO, 2013). Health expenditure has shown a steady increase over the years and the rate of increase has outstripped increases in GDP (Table 3.1). The slightly more rapid increase in health expenditure in the mid-2000s coincides with the construction of the new Mater Dei Hospital. Inpatient care makes up the largest share of public health expenditure (Table 3.2).

Table 3.1

Trends in health expenditure, 1995–2010

Expenditure	1995	2000	2005	2010
Total expenditure on health/capita at PPP (NCU per US$)	877	1 248	1 967	2 261
Total health expenditure as % of GDP	5.8	6.7	9.3	8.6
Public expenditure on health as % of total expenditure on health	67.5	72.5	68.6	65.5
Private expenditure on health as % of total expenditure on health	32.5	27.5	31.3	34.5
Government health spending as % of total government spending	9.9	12.1	14.4	13.2
Out-of-pocket payments as % of private expenditure on health	95.8	96.9	93.6	93.5
VHI as % of total expenditure on health	1.4	0.9	1.7	2.1
VHI as % of private expenditure on health	4.2	3.1	5.5	6.0

Source: NHA (2013).
Note: NCU: national currency unit.

Table 3.2

Percentage of public health expenditure by service programme, 2010 and 2011

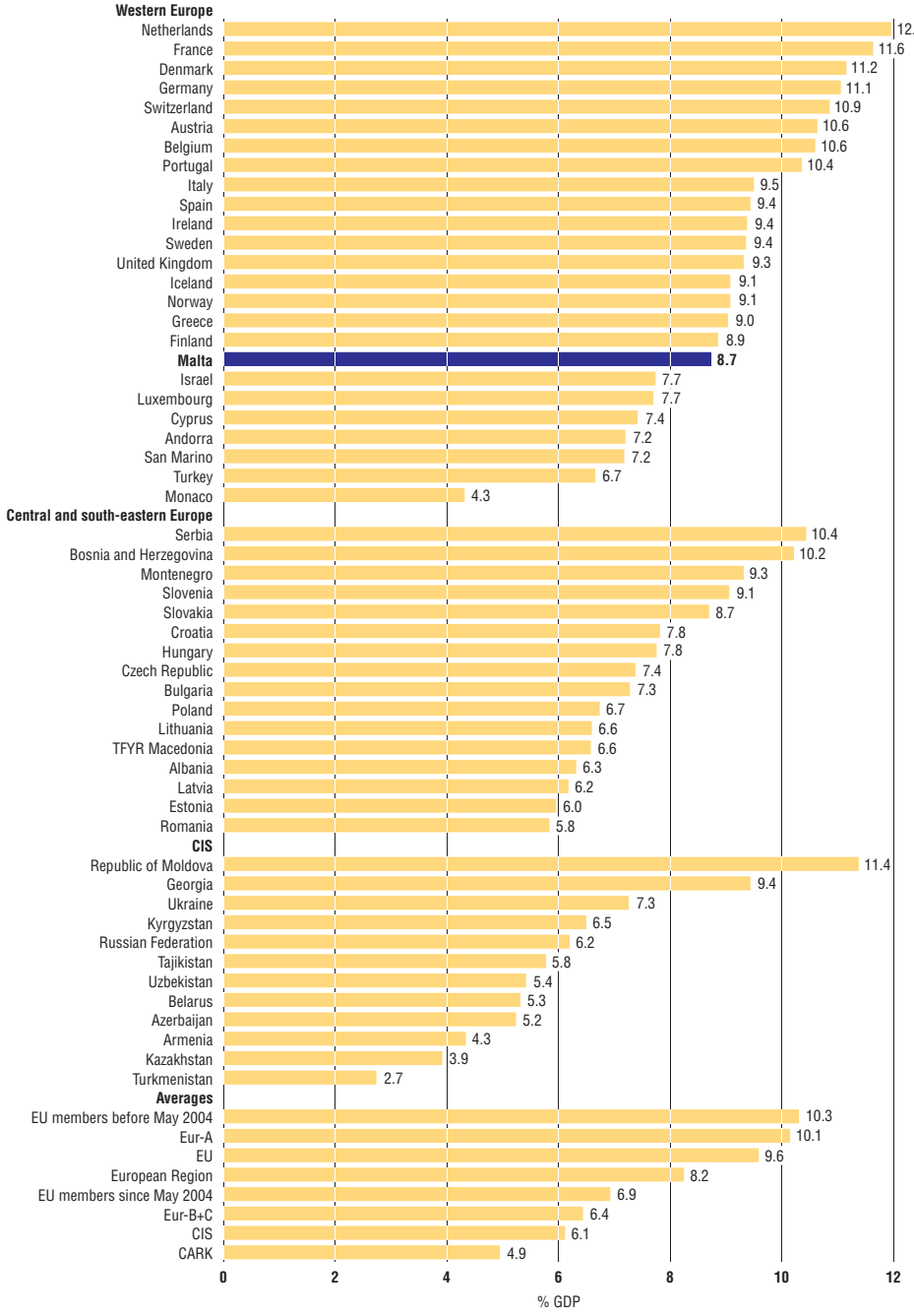
	2010	2011
Health administration and insurance	6.9	6.2
Education and training	0.4	0.5
Health research and development	0.0	0.0
Public health and prevention	1.0	0.2
Medical services:		
– Inpatient care	36.9	31.8
– Outpatient/ambulatory physician services	11.0	10.1
– Outpatient/ambulatory dental services	0.7	0.7
– Ancillary services	4.4	9.2
– Home or domiciliary health services	15.0	N/A
– Mental health	6.8	4.6

Source: NHA (2013).

Compared to other countries in Western Europe, health expenditure as a share of GDP is fairly low (Fig. 3.1). However, it is higher than the average for other countries that joined the EU since May 2004 (6.9%). Despite being

Fig. 3.1

Health expenditure as a share (%) of GDP in the WHO European Region, latest available year

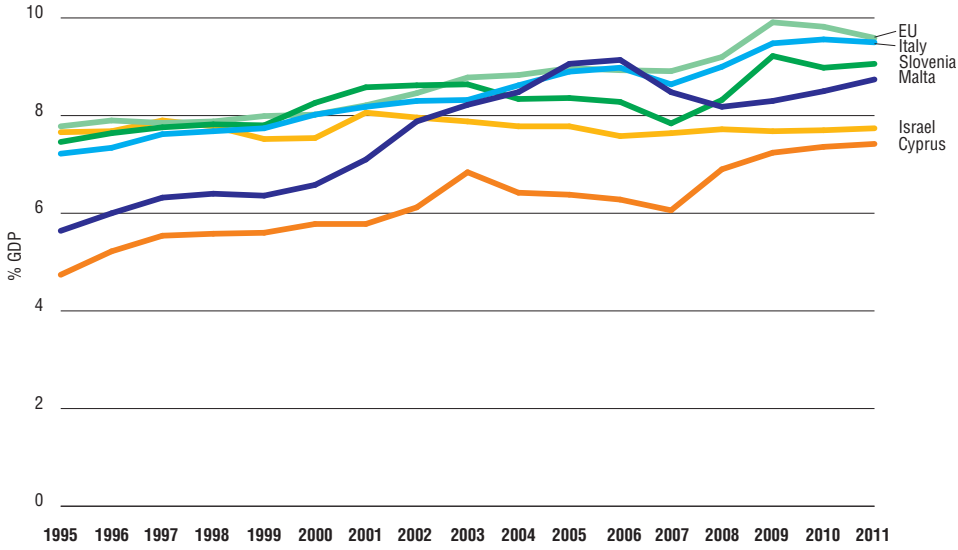


Source: WHO (2013).

at a higher level than the EU average in 2005 and 2006, during construction of Mater Dei Hospital, spending as a share of GDP was below the EU average (Fig. 3.2). Per capita spending is also among the lowest in Western Europe (Fig. 3.3).

Fig. 3.2

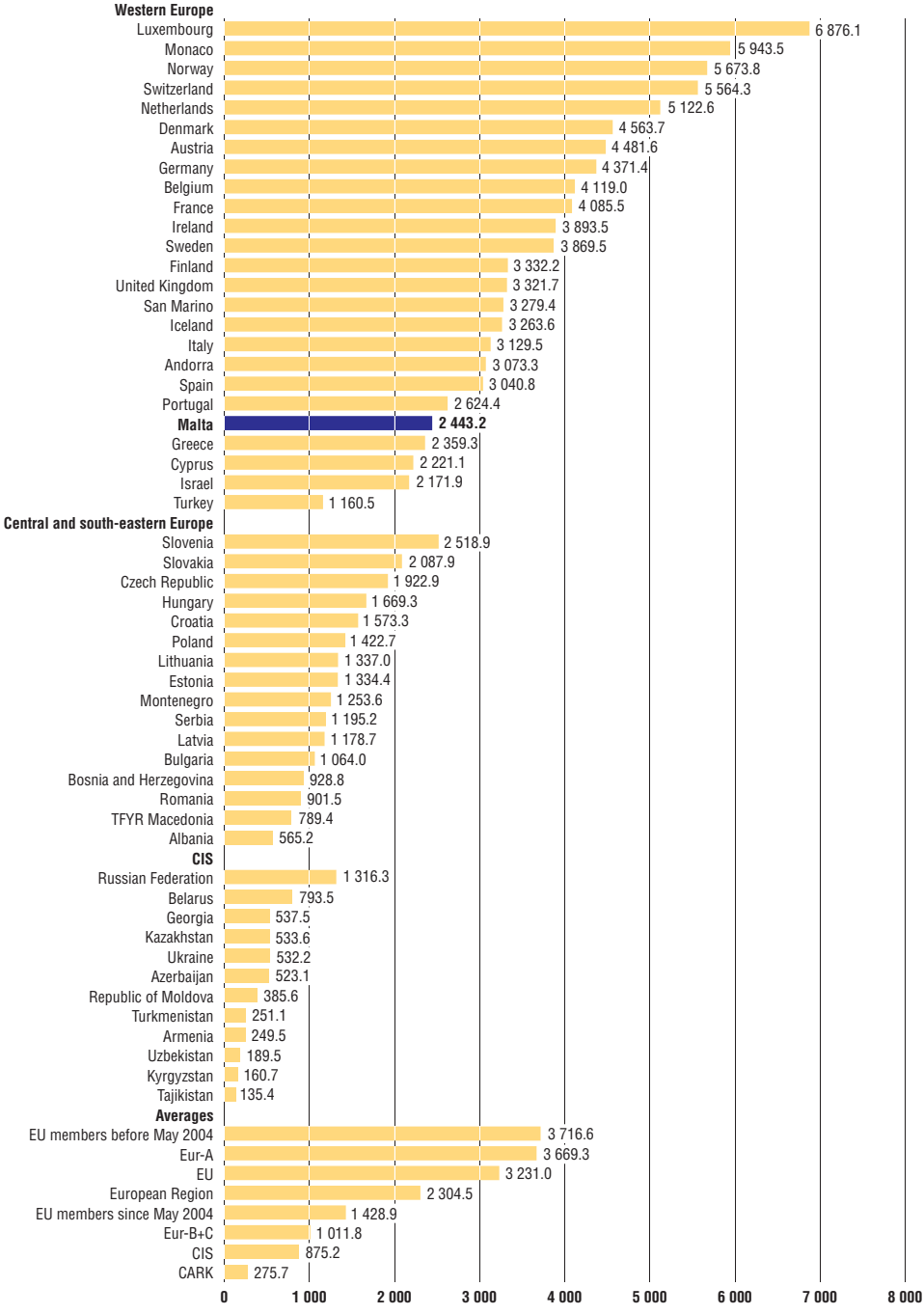
Trends in health expenditure as a share (%) of GDP in Malta and selected countries, 1995 to latest available year



Source: WHO (2013).

Fig. 3.3

Health expenditure in PPP per capita in the WHO European Region, latest available year



Source: WHO (2013).

3.2 Sources of revenue and financial flows

Public expenditure comprised almost 66% of total health expenditure in 2010, with out-of-pocket payments and VHI making up most of the remaining spending (Table 3.3). Public expenditure as a percentage of total health expenditure was the third lowest in Western Europe in 2012, implying high private expenditure (Fig. 3.4). Until recently there has been a separate ministry for Gozo, which was administratively responsible for Gozo Hospital. Health services in Gozo now form part of the remit of the Ministry for Health since March 2013.

Table 3.3

Sources of expenditure as a percentage of the total expenditure on health, 2011

Sources of expenditure on health	% of total expenditure on health
General government expenditure	64.0
Out-of-pocket payments	34.0
VHI	2.0

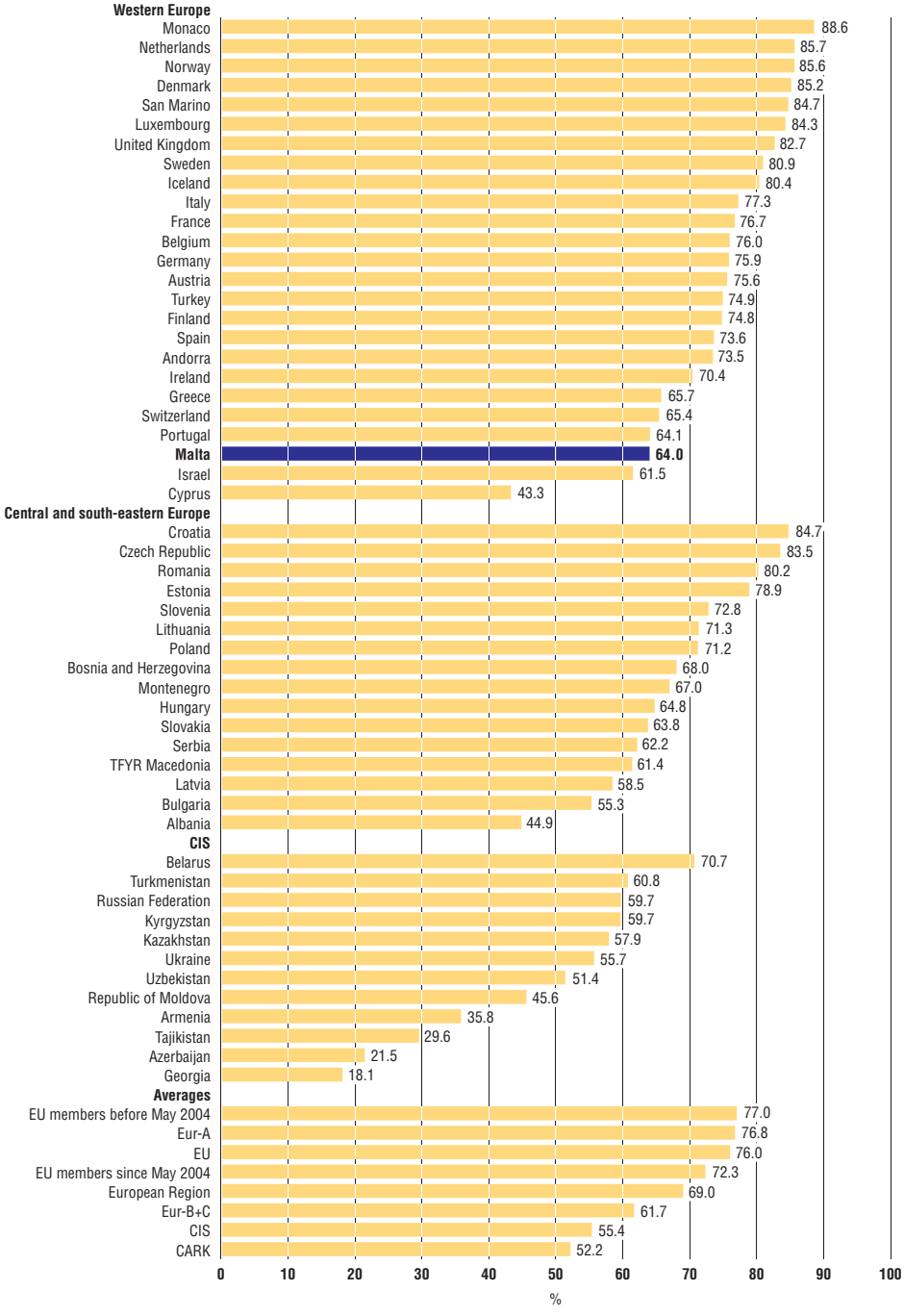
Source: NHA (2013).

Public sector funding is from general taxation (Fig. 3.5). Rates of contribution for income taxation are set by Parliament. Income taxation is progressive, rising according to income up to a maximum of 35%. The health sector competes with other ministries for funds from the government's Consolidated Fund.

People tend to use the private sector to receive more personal attention, to have better continuity of care by seeing the same provider, to set appointments at convenient times and to avoid waiting lists for surgery in the public sector. There are two major types of private health-care financing which account for about one-third of total expenditure on health. Out-of-pocket payments remain the main source of funds for purchasing medicines and paying private GPs, and are also still widely used for private ambulatory specialist consultations. Out-of-pocket payments thus account for a significant part of the total payment for private health care (over 90% since 2005 according to WHO, 2013). Private providers receive public funds only in instances where a particular service has long waiting lists in the public sector.

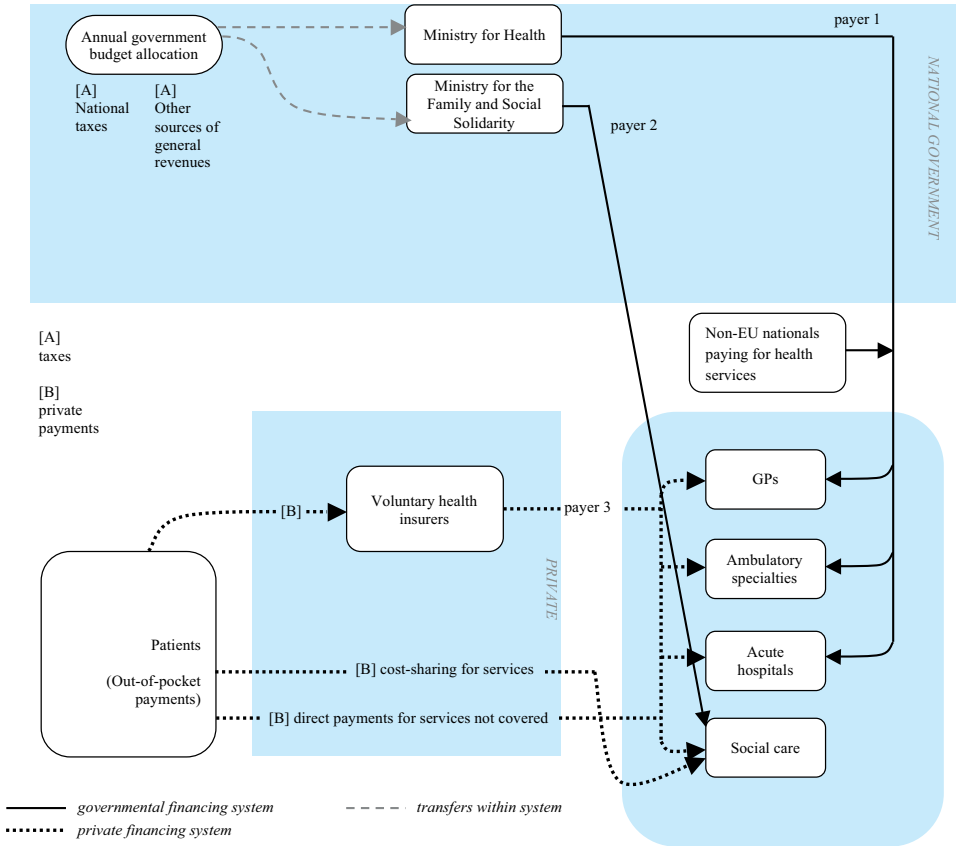
Fig. 3.4

Health expenditure from public sources as a percentage of total health expenditure in the WHO European Region, latest available year



Source: WHO (2013).

Fig. 3.5
Financial flows feeding into the national health system



Note: Public and private providers are distinct and financed separately.

In addition, supplementary voluntary private insurance is fairly prevalent. In the majority of cases, however, the coverage is not comprehensive and offers few benefits compared to the public system. Services not covered by private insurance include care for chronic and pre-existing conditions, palliative care, routine screening tests, drug abuse counselling, treatment of self-inflicted injuries, outpatient drugs, HIV/AIDS care, infertility care, normal pregnancy services, as well as mobility aids and organ transplant. Within the private sector, only secondary care data is collected by the Ministry for Health.

3.3 Overview of the statutory financing system

3.3.1 Coverage

The publicly financed health system provides a comprehensive basket of health services to all those residing in Malta who are covered by Maltese social security legislation. Entitlement to a few services (including elective dental care, optical services and some formulary medicines) is means tested. The means test falls under the non-contributory scheme of the Social Security Act (Chapter 318 of the Laws of Malta). Accordingly, those who fall within the low-income bracket, as determined by the means test, are entitled to free medicines from a restricted list of essential medicines and to certain medical devices (subject to certain conditions and the payment of a refundable deposit). Further, persons who suffer from chronic illnesses included in a specific schedule incorporated in the Social Security Act are entitled to free medicines strictly related to the chronic illness in question. This benefit is independent of financial means.

Prior to 1982, those making use of the public health-care system had to make co-payments according to set tariffs. During the doctors' dispute (see section 2.2), public health services were rendered free of charge by means of an administrative decision. Both major political parties have committed themselves to preserving the current system.

The current national benefit package is determined based on availability, evidence-based practice and affordability. A rapid HTA is first carried out to evaluate any procedure or service that is proposed for inclusion. At this time, a committee is set up to provide recommendations to health authorities regarding health-care benefits, being mindful of financial constraints and legislation. A publicly accessible list of benefits is available on the Ministry for Health web site. In addition, the GFL defines which medications are available from the public sector, including which patient group is entitled to which medications (see section 5.6) and who can prescribe different drugs.

As well as citizens, other groups have rights regarding health-care access. Legal resident foreigners are entitled to the same care as nationals. Temporary visitors from EU Member States have direct access to public health care upon presentation of a European Health Insurance Card (EHIC) together with an identification document. If the relevant forms are not presented, all bills must be paid in full prior to leaving the health-care facility. Furthermore, the government is not responsible in any way for any treatment or care given to EU citizens in private hospitals, health centres or otherwise by practitioners

in their private capacity. There is one bilateral agreement in place, relating to citizens of the United Kingdom who are exempted from the production of a valid EHIC when they call at a public hospital or government health-care centre to be given emergency medical care. Those registered with the Entitlement Unit of the Ministry for Health under this scheme are issued with an entitlement card referred to as the RHA Entitlement Card, and can obtain free health-care services in local public health-care institutions on an inpatient and outpatient basis, as well as other specialist services provided.

Services for asylum-seekers are regulated by the Refugees Act of 1 October 2001; these people are entitled to receive state medical care. However, there is no specific legislation with respect to health care for undocumented migrants. Yet at the beginning of 2005, the government published its *Irregular Immigrants, Refugees and Integration* policy document (National Legislative Bodies, 2005), which describes a number of principles and, with respect to health care, states that, "People in detention shall be entitled to free state medical care and services." This means that health care for undocumented migrants must be understood in the context of the Maltese authorities' policy of systematically detaining all irregular immigrants (including asylum-seekers). Although immigrants have free access to health care, relative lack of access to health services is common due to lack of education, fear, and language or cultural barriers. All other third-country nationals have to pay for all health-care services. There is an almoner who collects payments from these patients.

3.3.2 Collection

In 2012, €415.9 million was budgeted for health – €7.6 million more than in 2011. The budget is financed by the General Consolidated Fund. Revenues in the General Consolidated Fund come from a variety of sources, mainly taxes and some other areas across government. Since 2003, value added tax (VAT) has been raised from 15% to 18%. This increase has been theoretically earmarked for health; currently, however, the health sector still receives a budget like all other ministries from the government Consolidated Fund, so in practice there is no earmarking.

3.3.3 Pooling of funds

Taxes and other government revenues go directly into the General Consolidated Fund. Annual budgetary allocations come out of this source of funds, and are determined by the Ministry for Finance following consultations and

approved by Parliament. Malta also benefits from a number of European funding instruments that support research, capital projects and human resource development; these funds are kept separate and are project-specific.

3.3.4 Purchasing and purchaser–provider relations

Health workers in the public sector are salaried civil servants; public facilities are cost centres under the Ministry for Health. This implies that they are funded through annual budget allocations described earlier. The public health sector is increasingly investing in management, particularly through the setting up of key performance indicators and devolution of accountability and financial management to lower levels of management.

The government also occasionally enters into public–private partnerships to bridge gaps. These partnerships follow public procurement regulations. Other private care is purchased out of pocket by patients on a fee-for-service basis. For patients with private health insurance, care must be purchased out of pocket but covered costs are reimbursed.

3.4 Out-of-pocket payments

Out-of-pocket payments mainly consist of direct payments, which can be for private general practice care, specialist care, medicines and elective surgery; the majority of out-of-pocket spending is for general practice and specialist care. Two entitlement schemes that exempt individuals from out-of-pocket payments for medicines are in place – one is means tested and the other is disease specific. Recently there was an increase in the number of formulary medicines, which was followed by a decrease in the total amount of direct payments.

When it comes to long-term care, those in receipt of benefits in kind (community or semi-residential or residential care) are expected to contribute to the costs of goods or services rendered via co-payment. In the case of home care help such contributions are as follows:

- €2.33 per week if single and without meals;
- €3.49 per week if single and with meals;
- €3.49 per week if couple and without meals;
- €5.24 per week if couple and with meals;
- meals on wheels: €2.21 per meal;

- handyman service: rates vary according to job, and the clients should provide materials;
- incontinence: normal and extra absorbent pads from €0.19 to €0.29 according to size.

Users of semi-residential care pay a nominal fee that ranges from €2.33 to €5.82 per month. Residents of homes for elderly people contribute 60% of their total income (this includes the pension from the Social Services Department, bonuses, foreign pensions, bank interests, rents, etc.). Residents at St Vincent De Paul contribute 80% of their income, provided that they are not left with less than €1400 per year at their disposal (Employment, Social Affairs and Inclusion, 2012).

3.5 Voluntary health insurance

Everyone is eligible to purchase VHI coverage, either individually or as part of a group. About 22% of the population has some form of private health insurance coverage (DHIR, 2010), and reported take-up rates remained unchanged between 2002 and 2008. All VHI is provided by profit-making insurance companies. Premiums are risk-rated based on an individual's risk for those purchasing individual coverage, and community-rated if the client is part of a group. The range of benefits covered depends on the type of VHI purchased; benefits are subject to ceilings, however. Health insurance premiums may be paid annually, semi-annually, quarterly or monthly. Insurers pay providers either via claims forms or by direct settlement of bills for inpatient and day care. The benefits are provided in cash. The Malta Financial Services Authority is the local authority regulating insurers.

3.6 Other financing

Other sources of funding include non-profit institutions serving households (NPISH), which comprise all resident non-profit institutions that provide care to households free of charge or at reduced prices. The two most important NPISH are the Malta Memorial District Nursing Association (MMDNA) and Hospice Malta. Hospice Malta cares for around 600 patients and their families each year. Most of these patients have cancer while some have motor neurone diseases. The MMDNA provides numerous nursing services to the community.

There are also a number of NGOs that, through voluntary and charitable financing, help those in need. These include the Down Syndrome Association, Dar tal-Providenza, Hospice Malta and the Richmond Foundation. The Church still plays an important role in the financing and provision of nursing homes for elderly people, homes for the disabled, homes for people with a mental handicap and homes for children. However, it is increasingly facing great difficulties in continuing to provide services because there are fewer nuns to provide care.

During the construction of the acute Mater Dei Hospital, Malta benefited from a loan from the Council of Europe for construction costs and a grant from the Fifth Italian Protocol for the procurement of furniture. Furthermore, since accession to the EU, the public health sector has made use of a number of funding sources such as training funds from the European Social Fund, and the European Regional Development Fund for the construction of the new oncology centre within Mater Dei Hospital, and the Swiss Fund for the purchase of medical equipment. In addition, the bilateral Italy–Malta protocol is ongoing. The Ministry for Health has also benefited from some research funds, mainly through the Directorate-General for Health and Consumers Public Health Programme. Another minor source of external funding is the Biennial Collaborative Agreement with the WHO that funds capacity building. Overall, external funding does not contribute much to recurrent health expenditure.

3.7 Payment mechanisms

In the public sector health-care workers are paid salaries according to a scale system from 1 – the highest – to 20 – the lowest. Since 2007, remuneration for senior medical staff has been session based, including an element of performance-based remuneration. In the private sector salaries are negotiated between employers and employees or providers are paid a fee for service, either directly by the patient or indirectly via VHI. The only time that private providers receive public funds is when certain procedures – typically surgical procedures with a waiting list in the public sector – are outsourced to the private sector; this has only become a notable payment mechanism recently, however.

4. Physical and human resources

There are five public hospitals, of which two are acute and three are specialized; there are two private hospitals. Malta has a bed occupancy rate in acute hospitals (81.5% in 2010) which is above the EU average (75.9% in 2011). The number of beds in acute hospitals is also below the EU average, and has decreased by around 28% over the past decade. Average length of stay in acute hospitals is slightly below the EU average but has been rising.

The number of functioning diagnostic imaging technologies such as CT scanners and PET scans is among the highest per capita when compared to other countries in the region; however, Malta has comparatively few MRI units. Particular attention is being given to the use of IT due to the creation of the Health-Care Information System and the opening of Mater Dei Hospital in 2007. Currently there are a number of eHealth portal facilities to access health-related services. The latest progress in this area is the introduction of the myHealth service in 2012, which enables patients and doctors to access electronic health records through an e-ID card, which the government is in the process of deploying.

The number of specialist physicians, dentists and nurses per capita is below the EU average except for paediatricians, pharmacists and midwives. An increased number of health workers have opted to work and train abroad as a result of EU accession. This has been effectively managed through a mutual recognition agreement with the United Kingdom General Medical Council (as most Medical School graduates undergo specialist training in the United Kingdom) and through the setting up of formal specialization training programmes in Malta.

4.1 Physical resources

4.1.1 Capital stock and investments

There are five public hospitals, of which two are acute hospitals and three are specialized hospitals; there are two private hospitals (Table 4.1). The majority of patient services were moved from St Luke's Hospital to Mater Dei Hospital in November 2007; Mater Dei Hospital is an acute general teaching hospital offering a full range of services.

Founded in 1990, the Foundation for Medical Services is a public entity managing capital projects. It was responsible for the new Mater Dei Hospital. The Foundation is currently overseeing the construction of the Mater Dei Hospital Oncology Centre – a project part-financed by the EU through European Regional Development Funds, among other development projects. This will lead to the eventual migration of oncology services from Sir Paul Boffa Hospital to Mater Dei Hospital. Extensive work has already been done and it is expected to be functional by 2014. The centre will have 74 inpatient beds, including 16 for palliative care and 10 for children and adolescents.

Table 4.1
Hospitals in Malta

Hospital	Description	Year founded	Location	Beds
Mater Dei Hospital	Main public hospital	2007	Msida	827 (2011)
Sir Paul Boffa Hospital	Public oncology and dermatology	1918	Floriana	48 (2011)
Gozo General Hospital	Public acute general hospital	1975	Victoria, Gozo	158 (2011)
Mount Carmel Hospital	Specialized psychiatric public hospital	1861	H'Attard	527 (2011)
Karin Grech Rehabilitation Hospital	Public rehabilitation hospital	1981 (re-inaugurated 2008)	Pietà	212 (2012)
St James Capua Hospital	Private hospital	1996	Sliema	79 (2012)
St James Hospital, Żabbar	Private hospital	1984	Żabbar	6 (2012)

Source: Personal communication, Ms Joanna Chetcuti, Director of the Department of Health-Care Standards (5 June 2012).

Investment is generally financed by national public funds generated through taxation. However, the EU has opened opportunities for investment funding using European Regional Development Funds and other related sources (see section 3.6). Public–private partnerships have been set up, mainly in

the long-term care sector, whereby lodging and infrastructural services are provided by the private sector, while social and health-care provision is funded by public sources.

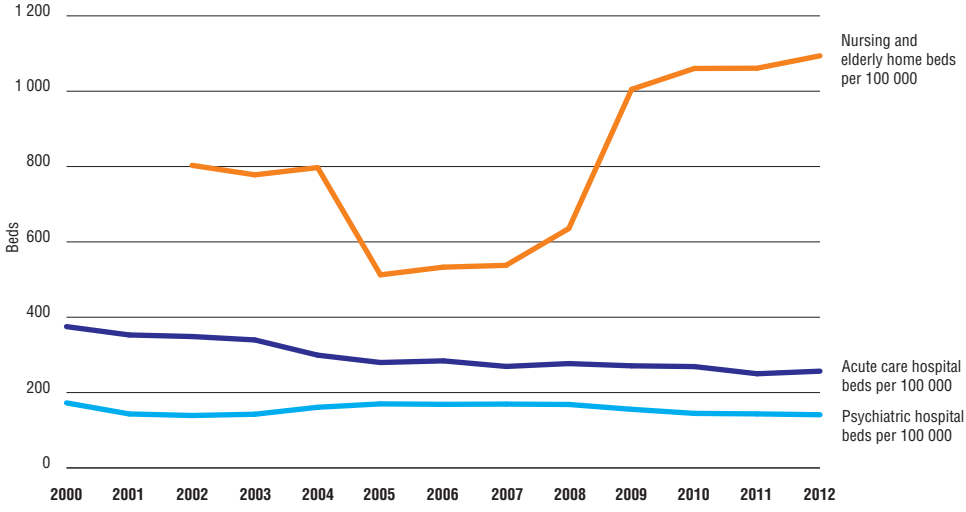
4.1.2 Infrastructure

The total number of beds per capita has increased in recent years, as a result of large increases in beds in nursing homes and homes for elderly people (Fig. 4.1). The switch of St Vincent De Paul, the main geriatric hospital, from 'nursing home' status to a speciality hospital and then back to nursing home has resulted in a substantial shift in long-term capacity statistics.

Changes in the mix of beds are partially due to restructuring, such as shifting the main state general hospital's (St Luke's Hospital) capacity to the new Mater Dei Hospital in 2007; a number of beds were retained as long-term or rehabilitation beds in Karin Grech Rehabilitation Hospital within the grounds of the old main general hospital. A decrease in the number of acute beds in 2005 is due to a change in the series definition.

Fig. 4.1

Mix of beds in acute hospitals, psychiatric hospitals and long-term care institutions per 100 000 population, 2000–2010

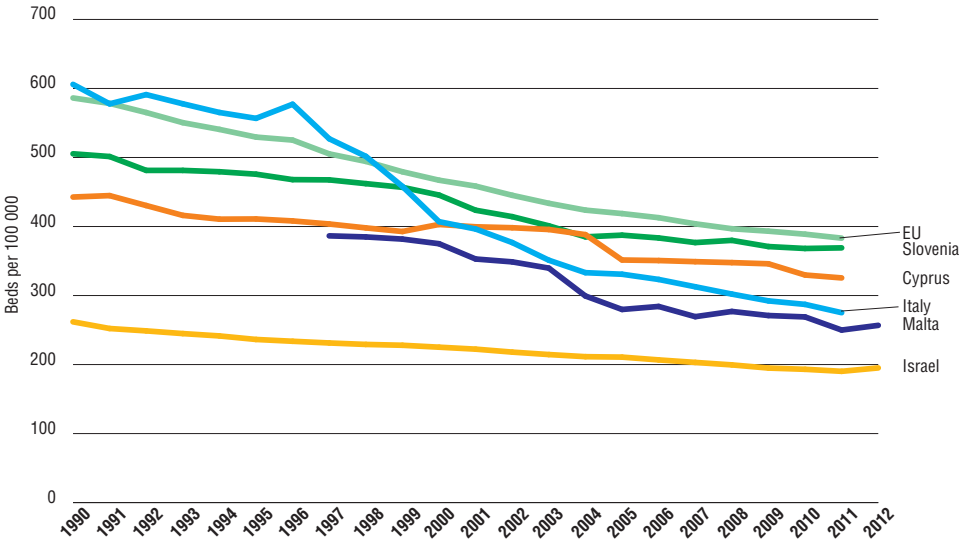


Source: WHO (2013).

Although there was a significant downward shift in bed occupancy as a result of the opening of Mater Dei Hospital, Malta has a higher bed occupancy rate in acute hospitals (81.5% in 2010) compared to the EU average (75.9% in 2011). One explanation for the higher-than-EU-average occupancy rate is that the number of beds in acute hospitals is also below the EU average, and has decreased by around 28% over the past decade (Fig. 4.2). Average length of stay in acute hospitals has however increased in recent years to be on a par with the EU average (Fig. 4.3). The apparent paradox of longer lengths of stay with no accompanying rise in bed occupancy rates can likely be attributed to the new policy in Mater Dei Hospital of not allowing extra beds to be set up inside wards. This means that patients awaiting admission are often cared for in a holding bay for extended periods of time in the Emergency Department until a bed becomes available. At the same time, patients admitted to acute care hospitals who are medically discharged but unable to live independently remain in the hospital because long-term care capacity is now in increasingly short supply. Therefore the movement of debilitated patients from acute care beds to rehabilitation or long-term care services is hindered, which leads to longer average length stay in acute care hospitals.

Fig. 4.2

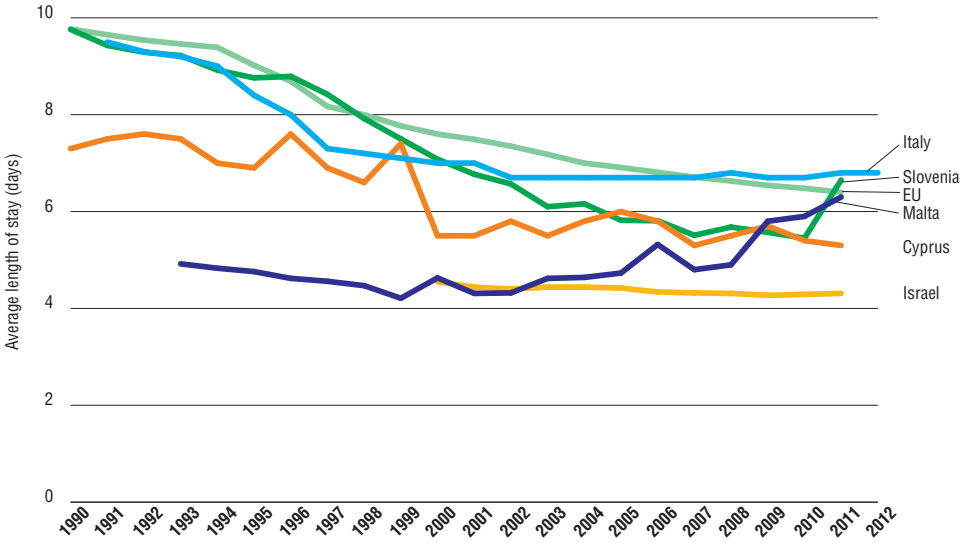
Acute care hospital beds per 100 000 population in Malta and selected countries, 2000–2010



Source: WHO (2013).

Fig. 4.3

Average length of stay in acute care hospitals in Malta and selected countries, 2000–2010



Source: WHO (2013).

4.1.3 Medical equipment

In terms of CT scanner availability, Malta is comparable to Italy and only slightly below Greece and Cyprus (Table 4.2). The number of MRI units per capita is lower than in other comparator Mediterranean countries, but is in line with the United Kingdom. The number of PET scanners available in Malta seems to be one of the highest compared to other countries (Eurostat, 2013).

Table 4.2

Items of functioning diagnostic imaging technologies (MRI units, CT scanners, PET) in Malta and selected countries per 1 000 population for the year 2009/2010

Country	Medical equipment		
	MRI	CT scanners	PET
Greece	0.023	0.034	0
Italy	0.021	0.031	0.002
Cyprus	0.019	0.034	0
Malta	0.007	0.031	0.002
Slovenia	0.004	0.013	0.001
United Kingdom	0.006	0.008	N/A

Source: Eurostat (2013).

4.1.4 Information technology

In 2011 81.3% of the Maltese population aged 16–74 had access to the Internet at home. Around 57.5% of the population reported accessing the Internet for health information, an increase of 3% since 2010 (NSO, 2012b).

Since the early 1990s there has been steady growth in the use of IT throughout the health system, and this is most evident in public secondary care. In particular, the implementation of the Health-Care Information System in 1997 and the first phase of the Integrated Health Information System in 2007 led to noticeable penetration of IT infrastructure and applications throughout public hospitals and health centres.

Public hospitals and health centres have been operating an integrated appointment booking system since 1998. This has recently been integrated into the myHealth portal. Uptake of the myHealth system is on the rise, but is seriously hindered by the current government e-ID secure electronic identification system that is still quite cumbersome and not yet fully in operation.

In 2006 an eHealth Portal was first launched. This facilitates access to specific health-related e-services, such as online referral to hospital, health information and information about government health services. In 2012, the myHealth system was launched. This allows patients and the doctors they choose to gain direct access to their electronic patient record data through the Internet, providing the first IT link between the private family doctor community and the public sector.

The development of electronic medical records at hospital level took a significant leap forward with the opening of Mater Dei Hospital in 2007. Systems introduced include a radiology information system, a picture archiving and communication system, an integrated laboratory information system, and an order communication system. The data from these systems is now integrated into a common electronic medical record that is used at all government hospitals and primary health-care centres. The development of IT systems within the public sector is guided by the internal eHealth strategy for 2008 to 2013.

The government is planning the nationwide deployment of an e-ID card that will store electronic identification data. This will allow secure identification and authentication of patients and health professionals, and hence facilitate authorization of online access to personal health data.

IT literacy and IT system use among private health-care providers has also increased at a steady rate, but the use of electronic patient records by private family doctors has generally lagged behind and still depends largely on personal initiative.

4.2 Human resources

4.2.1 Health workforce trends

The health sector is one of the largest employers. In 2010, 47% of total Ministry for Health recurrent expenditure went towards salaries. Government health sector employees are part of the civil service. In addition to health professionals, various categories of support staff, ranging from auxiliary workers to clerical workers to engineers make up the health-care workforce.

Four competent authorities, under the Superintendent of Public Health, are responsible for registration and licensing of all the health-care professions. The majority of health-care professionals are employed by the public sector. Human resource planning takes place centrally within the Ministry for Health.

Pharmacists and dentists mostly work independently in the private sector, as do a large proportion of primary care doctors. Pharmacists are usually employed in community retail pharmacies as company representatives or in industry, and are usually salaried. A large number of doctors and some paramedical professionals who are employed as salaried professionals in the public system also work independently in the private sector on a fee-for-service basis. In some situations, the salary received from the public sector may be a small part of their total earnings. Nurses are mostly employed as salaried professionals in both the public and private sectors. Most nurses attempt to boost their income by working additional hours.

Malta has a lower concentration of many types of health workers than the EU average, with the noted exception of paediatricians and midwives (Table 4.3).

Table 4.3
Health workers in Malta (2005, 2010) and selected countries per 1 000 population for the year 2009/2010

	Malta		Israel	Italy	Greece	Andorra	Slovenia	Spain	EU
	2005	2010							
Physicians medical group	N/A	0.59	0.89	1.21	1.77	0.93	0.73	N/A	0.89
Physicians surgical group	N/A	0.53	0.57	0.83	0.97	0.44	0.48	N/A	0.66
Obstetrics and gynaecology	N/A	0.11	0.19	0.21	0.24	0.17	0.16	N/A	0.16
Paediatric	N/A	0.14	0.32	0.13	0.29	0.26	0.24	0.14	0.13
GPs	N/A	0.71	0.69	0.77	0.28	0.49	0.50	0.74	0.87
Hospital-based physicians	N/A	1.70	N/A	N/A	2.42	N/A	1.38	N/A	N/A
Nurses	5.50	6.46	4.76	6.3	3.31	3.55	8.02	4.87	8.23
Midwives	0.31	0.37	0.21	0.28	0.23	0.14	0.04	0.16	0.32
Dentists	N/A	0.44	0.84	0.52	1.31	0.61	0.61	0.58	0.66
Pharmacists	N/A	0.72	0.64	0.88	N/A	0.93	0.52	0.80	0.77

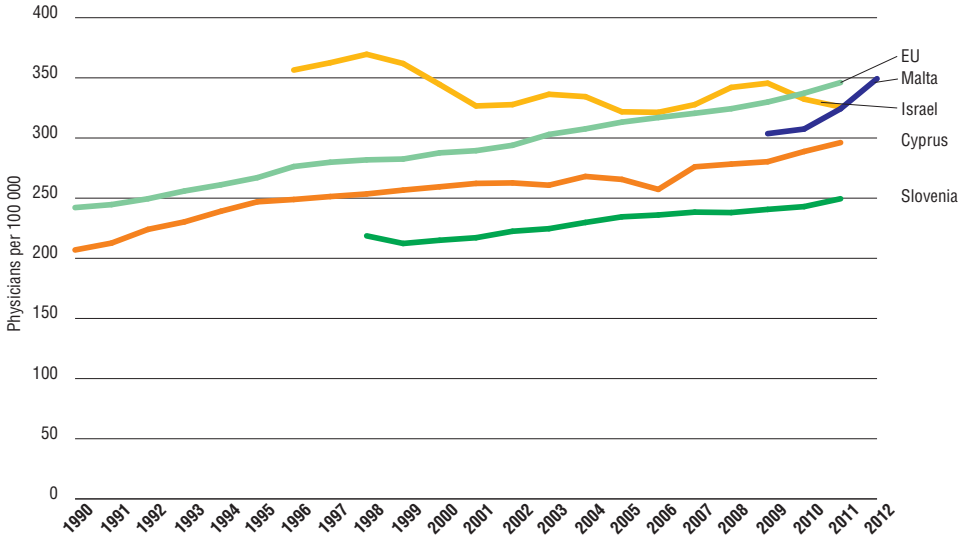
Source: Eurostat (2013).

Physicians

The number of physicians per population (inclusive of specialist trainees) in 2010 was below the EU average but has since risen to be on a par with the rest of the EU (Fig. 4.4). As noted, this has been effectively managed through a mutual recognition agreement with the United Kingdom General Medical Council (as most Medical School graduates undergo specialist training in the United Kingdom) and through the setting up of formal specialization training programmes held in Malta. The number of hospital-based doctors was 1.7 doctors per 1000 population, which amounts to around 55% of total physicians (Table 4.3). The number of physicians per population in medical groups and those specializing in obstetrics and gynaecology were both the lowest out of the selected countries. The number of physicians engaged in general practice is probably greater than the figure reported because specialists are allowed to provide general practice services.

Fig. 4.4

Physicians per 100 000 population in Malta and selected countries, 1990 to latest available year



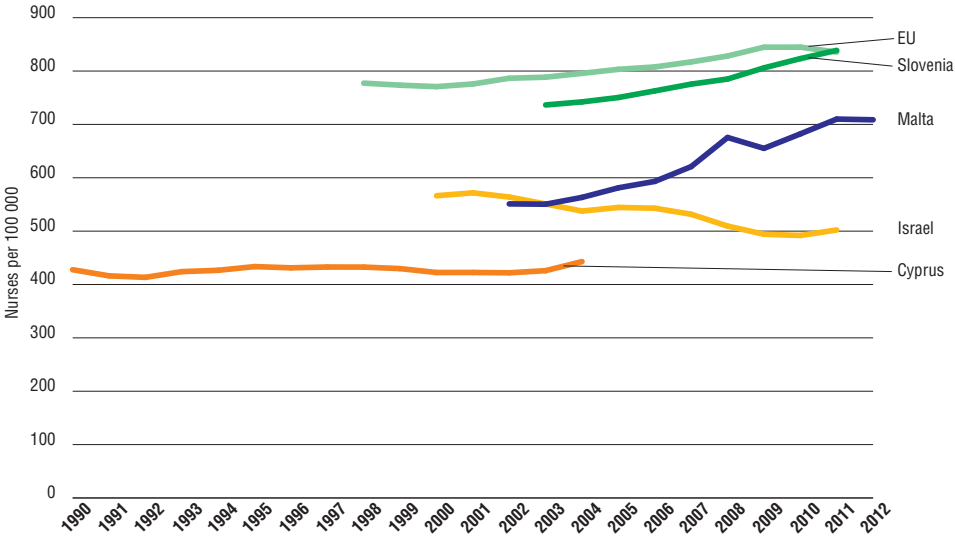
Source: WHO (2013).

Nurses and midwives

From 2009 onwards, data refers to nurses employed in state and private institutions. The number of nurses per population in Malta is below the EU average, although the number of nurses is increasing following collaboration between the University of Malta and the government on capacity building (Fig. 4.5). Malta had the highest number of midwives per 1000 in 2010 compared to selected countries as well as to the EU average (Table 4.3). The reported increase in the quantity of midwives, however, is due to improvements in private sector reporting.

Fig. 4.5

Nurses per 100 000 population in Malta and selected countries, 1990 to latest available year

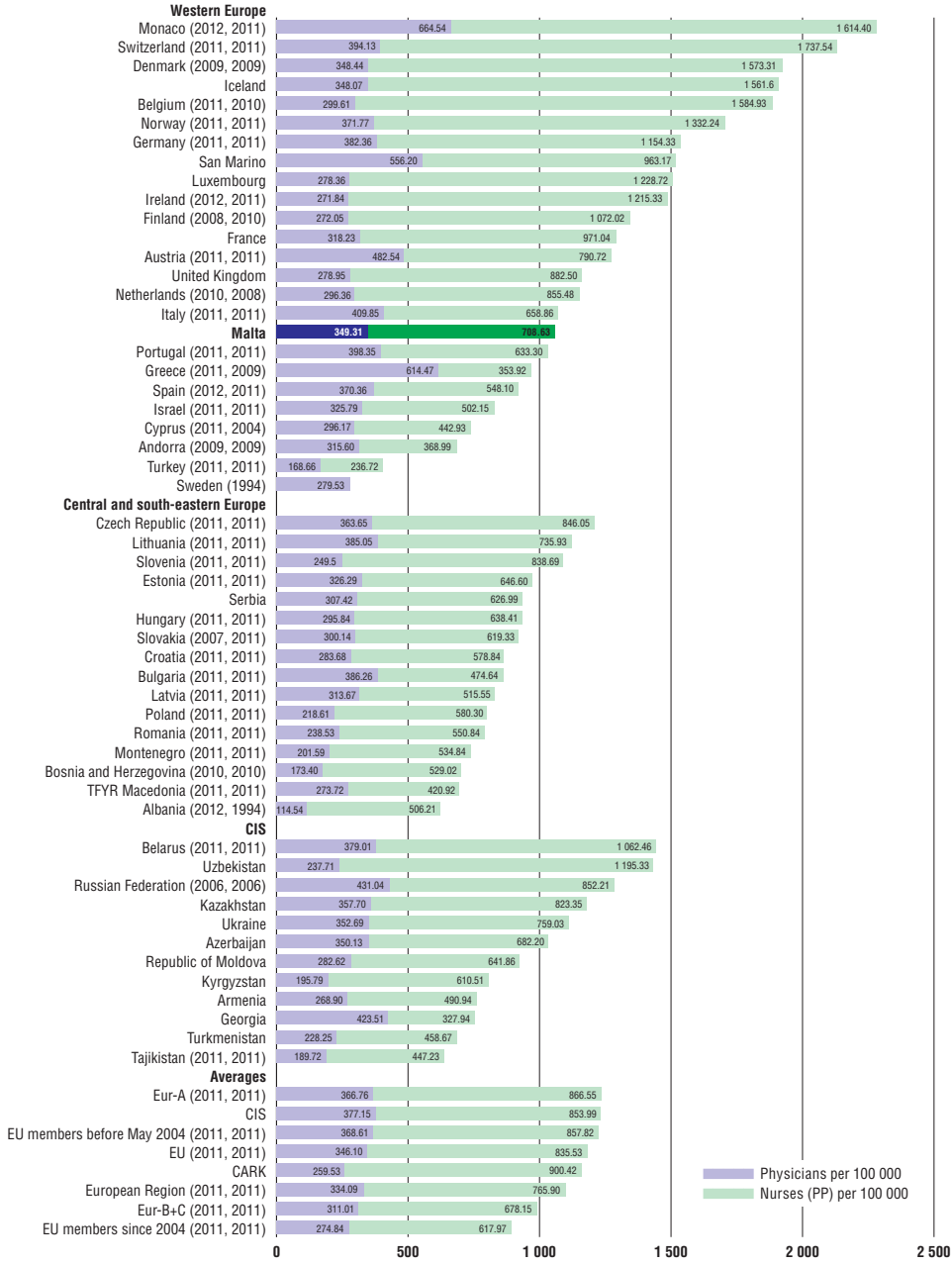


Source: WHO (2013).

Malta is near the EU average for the total number of physicians but relatively low for nurses, despite recent increases in nursing supply (Fig. 4.6). There remains significant cross-country variation, however (Table 4.3).

Fig. 4.6

Physicians and nurses per 100 000 population in the WHO European Region, 2012 or latest available year



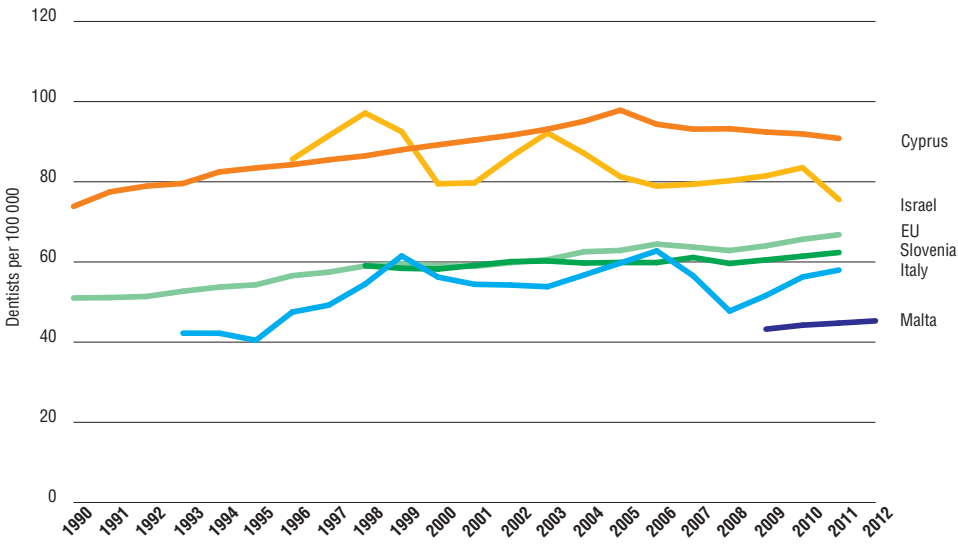
Source: WHO (2013).

Dentists

Malta has the lowest number of dentists per population out of all the selected comparator countries, although comparable cross-country data is only available for 2009, 2010 and 2011 (Fig. 4.7).

Fig. 4.7

Dentists per 100 000 population in Malta and selected countries, 1990 to latest available year

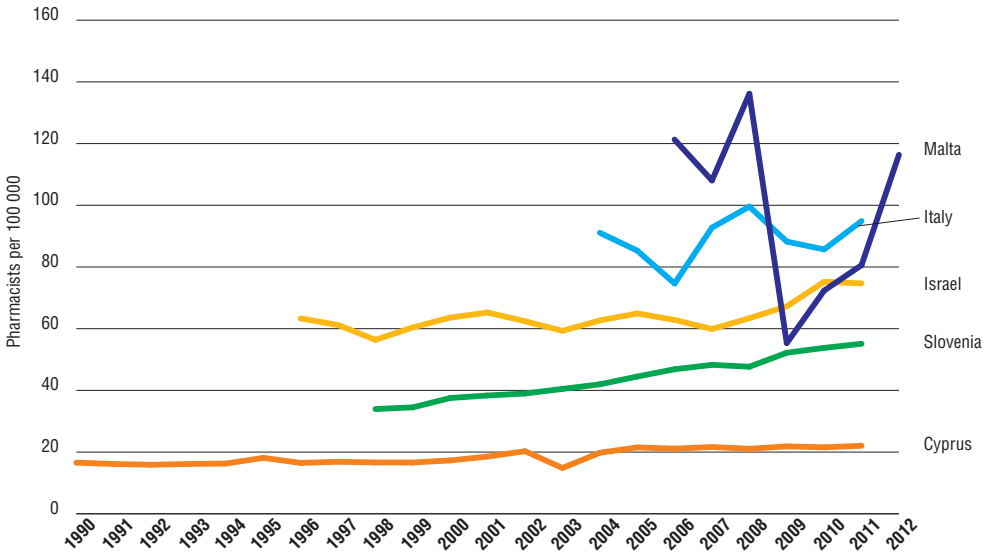


Source: WHO (2013).

Pharmacists

In 2009, the Pharmacy Council changed its methodology to count the number of practising pharmacists rather than all registered as pharmacists. The change in methodology led to significant fluctuations in this figure, making cross-country comparison difficult (Fig. 4.8).

Fig. 4.8
Pharmacists per 100 000 population in Malta and selected countries, 1990 to latest available year



Source: WHO (2013).

Other health professionals

There is a wide variety of other types of health-care professionals (Table 4.4). The most common are medical laboratory scientists, physiotherapists and radiographers. Additionally, in 2010 there were 39 public health professionals, of whom 12 were specialist trainees and 27 public health physicians comprising 3% of the physician population (Medical Council, 2011).

In September 2010, a directorate was set up within the Ministry for Health to coordinate allied health-care professions within the diverse network of public providers, to bridge any gaps and ensure providers work together for the benefit of patients and their carers.

The government relies on foreign consultants for some types of services, including both orthotics and prosthetics. Likewise, the government has an agreement with the Chinese government whereby an acupuncturist is available daily at Mater Dei Hospital, with one doctor in attendance, and once weekly in Gozo. Moreover, the Chinese government supports the purchase of equipment and medicines for these facilities. Traditional Chinese medicine is also available in the private sector.

Table 4.4
Allied health-care professionals, 2011

Profession	Count
Acupuncturists	16
Audiologists	1
Chiropractors	9
Clinical perfusionists	5
Dental hygienists	21
Dental surgery assistants	29
Dental technologists	49
Dieticians	3
Environmental health officers	169
Medical laboratory scientists	374
Medical physicists	3
Nutritionists	35
Occupational therapists	141
Ocularist	1
Optometrists	13
Orthoptists	2
Orthotics and prosthetics services	3
Paramedic aides	102
Physiological measurement services	1
ECG technicians	55
Physiotherapists	341
Podiatrists	60
Psychotherapists	74
Radiographers	237
Social workers (engaged in health services)	59
Speech and language pathologists	130

Source: Council for Professions Complementary to Medicine (2012).

4.2.2 Professional mobility of health workers

One of the greatest challenges is the recruitment, training and retention of highly skilled competent health-care professionals. Following EU accession, Malta experienced a severe net outflow of newly graduated doctors, mainly to the United Kingdom where, traditionally, Maltese doctors carry out their specialization training. Other paramedical professions have been experiencing this "brain drain" to a much lesser extent. The outflow of doctors has been addressed through mutual recognition of medical training in Malta between the United Kingdom General Medical Council and the Maltese Medical Council, the establishment of formal specialization programmes in Malta coordinated by the new postgraduate training facility, and through renegotiation of the health-care professional collective agreement which has improved the remuneration package.

4.2.3 Training of health workers

Training of health-care professionals within Malta takes place at the University of Malta. Doctors, pharmacists and dentists are trained at the Medical School within the Faculties of Medicine and Surgery, and the Faculty of Dentistry; the Medical School is over 400 years old. The number of dentists commencing training is still limited by means of a *numerus clausus* system, due to the small number of training places. Removal of the University of Malta's *numerus clausus* has helped to maintain an adequate supply of medical graduates. Since the intake of medical and pharmacy students has grown considerably in recent years, some concerns are being voiced about a possible reduction in the quality of clinical teaching. It is important to ensure that while a steady flow of graduates is maintained, the quality of teaching is not compromised. After basic training doctors are required to carry out two years of practical training, working under supervision before being registered as fully qualified practitioners.

Training for nurses and paramedical professions takes place within the Faculty of Health Sciences; since 1988 there has been a transition from training nurses and paramedical staff at the Department of Health to the University of Malta. The Faculty of Health Sciences now mainly offers degree courses although some diploma courses are still running, such as for nursing. Some Master's courses are offered and in-service training courses are also organized. All training conducted has been certified as being fully compliant with EU requirements.

Nurses who previously only had a certificate qualification have been given the opportunity to undergo further training and upgrade their qualification to that of a nursing diploma recognized within the EU. This leads to incentives for career progression in the nursing stream.

As part of the changes to conform to EU requirements, pharmacy practical training has also been introduced during the final year of studies for pharmacists. GP vocational training has also been introduced for all doctors who wish to work in this specialty.

Accession to the EU has made it easier for doctors to train and work abroad. The Ministry for Health has obtained bilateral accreditation of the local medical training programme with the United Kingdom General Medical Council. That, together with the creation of formal training programmes leading to specialist accreditation, has significantly restricted the outflow of Maltese graduates.

The 2004 Health-Care Professions Act set up a specialist accreditation body and specialist registers for doctors, in line with EU requirements. The process of accrediting specialists already practising as well as laying down requirements for entry into the specialist registers is under way.

4.2.4 Doctors' career paths

Graduating medical doctors are expected to join a foundation training programme, at the end of which they are encouraged to take up specialist training. Recruitment into a specialist training programme is subject to a competitive call for basic specialist trainees (BST), which is regulated by the general public service recruitment framework. The portfolio that doctors are required to keep during their foundation years (which includes feedback from supervising consultants) is considered as part of candidates' assessment. Most specialties have their own structured training programmes, lasting between four and five years in total, during which candidates are required to obtain relevant qualifications either locally or abroad. After obtaining such qualifications, BSTs are eligible to apply for higher specialist trainee posts. Upon completion of the respective training programme, candidates are awarded their specialist accreditation and can apply for resident specialist status. Upon completion of two years at resident specialist level, specialists may apply for consultant or designate consultant (shadowing a retiring consultant) posts. This system is slightly different for GP posts, but still requires engaging in a formal specialist training programme to follow a career path in family medicine.

Posts are always created by the Ministry for Health following approval by the Ministry for Finance as part of an annual capacity building exercise. Post descriptions are endorsed by the Public Service Commission to ensure that they are in line with public service regulations and then advertised publicly via the government's online recruitment portal and the *Government Gazette*. Clinical posts may be created by the Ministry for Health or by the Ministry of Gozo.

4.2.5 Other health workers' career paths

In 1996 the Directorate of Nursing Services was set up symbolizing the growing importance of the field. The Health-Care Professions Act has given nurses a greater sense of autonomy and self-regulation. Specialist nursing opportunities have been created lately to allow nurses to take up more specialist tasks within their clinical stream.

Other allied health-care professions and pharmacists work within the civil service or the private sector, similar to doctors and nurses.

5. Provision of services

All publicly financed health services are free of charge at the point of use and primary care is readily accessible. The private sector accounts for about two-thirds of the workload in primary care and is remunerated on a fee-for-service basis. Many people choose to access primary care services in the private sector because it offers better continuity of care.

Secondary and tertiary care are provided through public and private general hospitals. The main acute general hospital (Mater Dei) provides the bulk of day and emergency care and most of its services are provided free of charge. In the public sector, medicines on the GFL are provided free of charge to patients who are entitled to them. In the private sector, patients must pay the full cost of pharmaceuticals.

Rehabilitation services are offered by the public rehabilitation hospital free of charge to patients referred following inpatient admission at public hospitals, or who are referred from the community by a GP. All patients undergo a multidisciplinary assessment.

Long-term care for older people is provided by the state, the Church and the private sector, and also through partnerships between the state and the private sector. The largest residential home for older people is public. Increased demand for institutional care has put added pressure on the public system to adapt to population need. Community-based services are being promoted to keep older people in their homes for as long as possible.

Dental care is provided by public and private providers. Publicly provided dental care is free at the point of use while in the private sector payment is usually out of pocket. Few VHI schemes cover dental expenses.

5.1 Public health

The main body providing public health services is the Public Health Regulation Division within the Ministry for Health. However some public health functions are administered by other bodies.

The Infectious Disease Prevention and Control Unit is charged with the surveillance and management of infectious diseases. It also provides data on infectious diseases to the local and international scientific community, as well as advice to health workers and the general public.

The Health Promotion and Disease Prevention Directorate conducts campaigns to promote healthy lifestyles and to provide information and support services related to healthy living. This Directorate is also responsible for the coordination of the National Sexual Health Strategy launched in 2011. The Noncommunicable Disease Prevention and Control Unit within the Directorate monitors implementation of the Noncommunicable Disease Strategy (launched in 2010) and the National Obesity Plan (launched in 2011).

The National Immunization Service within the Primary Care Services division of the Ministry for Health offers free scheduled immunizations to children, vaccinations for employees at risk of particular diseases and international travellers, as well as vaccinations for tuberculosis and hepatitis B. Influenza vaccination is offered for elderly people, those with chronic illness and health-care staff.

The Environmental Health Directorate deals with environmental issues that affect health and well-being. The Directorate covers health inspectorate services (including food safety and hygiene), public health laboratories, port medical services and a policy coordinating unit. The national entity responsible for Occupational Health and Safety is the Occupational Health and Safety Authority (OHSA) established by the OHSA Act XXVII of 2000.

The DHIR supports all public health services and clinical services through data collection and epidemiological research initiatives. It is responsible for data collection to maintain disease registers, monitor hospital activity and disseminate data about population health and health services.

The National Cancer Screening Programme was commissioned in late 2008, and began administering breast cancer screening in October 2009. This campaign covers all women aged 50–60 on a three-year cycle. A colorectal screening programme was launched in 2012; there is also a recent human

papillomavirus immunization scheme for 12-year-old girls. There are plans for an organized cervical cancer screening service. These plans originated after the National Cancer Plan was launched in 2010. Another screening programme offered through primary health centres targets glaucoma.

The Sedqa agency has offered health promotion, prevention, treatment, and rehabilitation services to persons with drug, alcohol and/or compulsive gambling problems, and to their families since 1994 and is part of the Foundation for Social Welfare Services within the Ministry for the Family and Social Solidarity.

5.2 Patient pathways

Fig. 5.1a and Fig. 5.1b provide an overview of the patient pathways in accessing the health-care services offered by the private and public sector.

Fig. 5.1a
Patient pathways to access the public health-care system

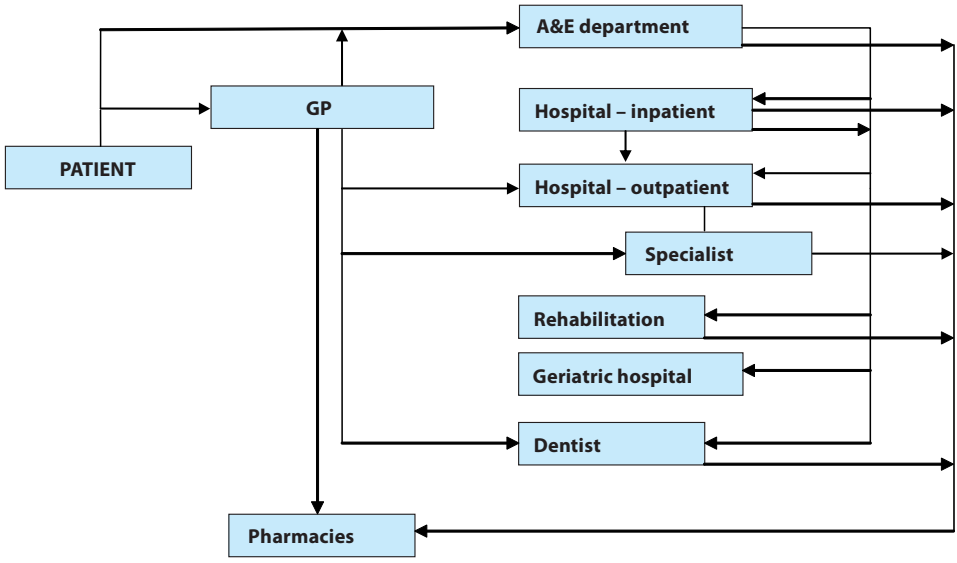
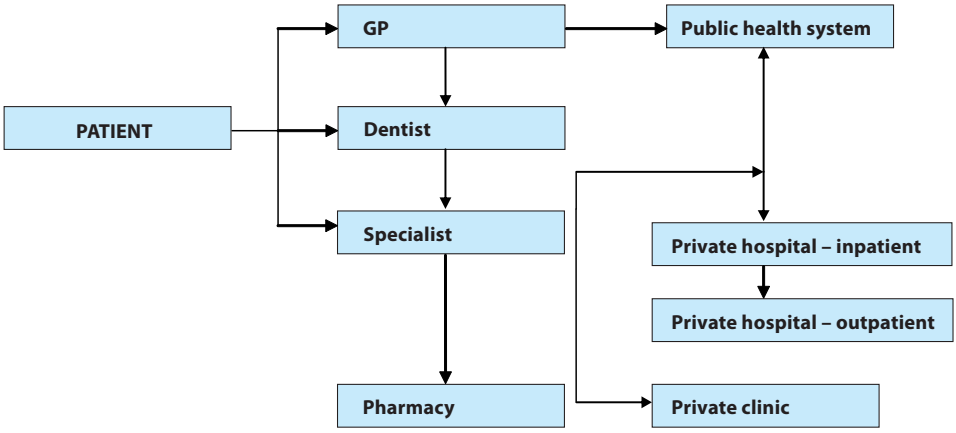


Fig. 5.1b
Patient pathways to access the private health-care system



Patients access health services differently in the public and private sectors. GPs in the public sector function as gatekeepers. They refer patients to specialists (both public and private), hospital outpatient facilities and accident and emergency (A&E) departments; GPs can also refer patients needing rehabilitative services to the rehabilitation hospital, the Karin Grech Rehabilitation Hospital. Admission to hospital inpatient services is via hospital A&E or outpatient departments. Patients requiring rehabilitation services after an inpatient stay can also be referred from the acute general hospital, Mater Dei, or Gozo General Hospital, to the rehabilitation hospital. Free dental services can be accessed directly by the patient and do not require a GP referral. Dentists in the public sector can refer patients to A&E or hospital outpatient departments if needed.

In the private sector, patients have direct access to GPs, specialists and dentists; private GPs make referrals to specialists when necessary. Private GPs, specialists and dentists can all refer patients to the public and private outpatient hospital services and the A&E departments.

Patients requiring emergency services have direct access to both public and private A&E departments. Only over-the-counter medications can be purchased directly from pharmacies; other medications require a prescription from a GP, specialist or dentist.

5.3 Primary/ambulatory care

The private sector accounts for around 70% of primary health-care contacts (DHIR, 2010). The state primary health-care system includes general practice, community care, immunization, child guidance clinic, child development and assessment unit, national screening unit, occupational health unit and the school health service. These are offered mainly through eight public health centres in Malta and one in Gozo. There are also local health clinics which are staffed by their respective district health centre. Other services available in the primary care setting include podiatry, speech therapy, physiotherapy, radiography, medical consultant clinics, ophthalmology and optometry, well baby and gynaecological clinics; referrals are needed for these services. Laboratory tests are sent to and performed in Mater Dei Hospital. Doctors from health centres provide home visits free of charge in urgent cases where patients lack transportation.

Aside from GP services, all public primary and ambulatory services require physician referral; all services are free of charge. Most clinics are by appointment except GP clinics, which are walk-in. GP services are provided solely by GPs. Patients are not registered with any particular doctor or group practice in the public sector, thereby hindering continuity of care. In the private sector, only a few GP group practices exist; most are solo practices.

In the public sector, patients are seen by the doctor on call. Patients are free to choose their GP or specialist in the private sector and can self-refer to the A&E Department of the state hospital, although patients are encouraged to visit their GP first whenever possible.

5.4 Specialized ambulatory/inpatient care

Secondary and tertiary care are provided through public and private general hospitals. The main acute general hospital, Mater Dei (827 beds), provides the bulk of day and emergency care free of charge. On the island of Gozo, public secondary care is provided at the Gozo General Hospital. The Gozo General Hospital comprises 158 beds. This hospital provides general medical and surgical services, as well as orthopaedic, obstetrics and gynaecology services, and has a renal unit. When it comes to other specialized care in view of the hospital's limitations, such care is provided in Malta's acute general hospital, Mater Dei Hospital. In cases of emergencies necessitating specialist care and urgent transfer to Mater Dei Hospital, helicopter services are also provided.

Recently there were major refurbishment works with the majority of funding provided through EU funds. There are also two private hospitals, St James Capua Hospital (79 beds) and St James Hospital, Żabbar (6 beds), and a number of private clinics which patients access without referral and pay for care out of pocket or through private insurance. There is one public psychiatric hospital, Mount Carmel Hospital (512 beds), which provides both acute and chronic psychiatric care.

Oncology and dermatology services are offered at Sir Paul Boffa Hospital (41 beds). However, with the opening of the new oncology hospital, which is envisaged to be functional by 2014, all oncology services will be transferred to this new hospital and dermatology services transferred to Mater Dei Hospital.

Outpatient services at public general hospitals are available for a number of specialties. Patients are referred for a new case appointment by their private GP or a health centre GP within the public primary care sector. Patients may choose their specialist; however waiting time for an appointment depends on the urgency of the case.

Access to specialists in the private sector does not require GP referral; this generally allows quick setting of appointments and access to care. Patients can choose any private specialist they wish. When very specialized services such as liver or bone marrow transplants are required, patients are transferred to other European countries, such as the United Kingdom. The provision of such services is usually arranged through reciprocal agreements.

In order to alleviate the long waiting lists certain services have been contracted out by way of public–private partnerships as has been the case for cataract extraction procedures. This has resulted in a marked decrease in waiting times from a maximum of 60 months to a maximum of 12 months by the end of 2012. Similar projects were also rolled out for MRI services, arthroscopy services and weekend cover for triage level 3 emergencies.

5.4.1 Day care

Mater Dei Hospital, which provides the bulk of the day-care services, has 149 designated day-care beds, which includes beds designated for dialysis. Day-care services are also provided at the Gozo General Hospital and within private hospitals, however no beds are specifically designated to day care but rather are designated according to demand.

Day care is also provided in the rehabilitation hospital (Karin Grech Hospital) for the provision of interdisciplinary assessment and care.

5.5 Emergency care

Emergency care is provided in the A&E Department at Mater Dei Hospital and in health centres. Although various initiatives have been taken to encourage more use of the health centres for emergency services the bulk of emergency care services are delivered at Mater Dei Hospital. The decision as to whether to opt for emergency care at Mater Dei Hospital or a health centre rests upon the discretion of the patient. The only exception is in minor emergencies when an ambulance is dispatched and the patient is usually directed to a health centre in order to receive the necessary care. No standard protocols exist delineating the provision of emergency care services at Mater Dei Hospital and at the health centres. Some primary health centres offer emergency services for minor emergencies on a 24-hour basis. Patients in Gozo can access emergency care at the A&E Department housed within the Gozo General Hospital.

The A&E Department at Mater Dei Hospital is made up of the Pre-hospital/Ambulance Service, the Emergency Department and a short-stay observation unit of 11 beds. A 2012 review found that almost 300 patients per day attended the A&E Department, of which 91 (31%) were categorized as very urgent, 64 (21%) urgent and 51 (17%) not urgent, while the remaining 91 (31%) were not seen in the Department but referred to other departments (Messina, 2013a). According to investigations conducted by the Health Commissioner in his capacity as Ombudsman, various shortfalls in the provision of care were identified, among which were overly prolonged waiting times wherein patients were being left for hours, or even days, on stretchers, devoid of privacy, dignity and general hygiene. The Health Commissioner identified the lack of space and lack of senior medical doctors to discharge or admit patients as among the main problems. The Health Commissioner also observed that patients were using the A&E Department in order to bypass the long waiting lists in the outpatients department in the hope of having their investigations done urgently (Messina, 2013a).

With a view to addressing the problems at the A&E Department and further to the government's strategic direction, which puts major emphasis on the reorganization and upgrading of primary health-care provision, the government plans to increase both the area available and health-care staff at the A&E Department.

Box 5.1 describes the pathway by which patients access emergency services.

Box 5.1 Patient pathway in an emergency care episode

The patient (or someone on behalf of the patient) calls 112. All calls to 112 regarding acute illness or injury are directed to health professionals able to guide the patient or bystanders until the ambulance arrives. An ambulance will be sent to the address. In the case of a life-threatening situation, ambulances are accompanied by nurses, and, if need be, a doctor. In the case of emergencies at sea, a helicopter may be dispatched.

Emergency care is initiated in the ambulance. The patient is stabilized and, depending on the urgency, treatment may be started at the address or within the ambulance during the transfer.

Ambulances take patients to the public A&E department where the patient is triaged by a specialized nurse who assesses the urgency of the case.

Following assessment by an emergency physician, the patient will receive emergency care within the A&E department and, if further inpatient care is required, will be admitted to hospital. Patients requiring follow-up ambulatory care are provided with a follow-up appointment, or referred for follow-up by the family doctor.

Another possibility is that the patient arrives at the emergency department by him/herself.

Minor emergencies are also handled by GPs at the primary care health centres.

5.6 Pharmaceutical care

The Medicines Authority is the body that regulates, monitors and inspects medicinal products and pharmaceutical activities. Distribution of pharmaceutical products is conducted through private pharmacies in the community and hospital pharmacies. By the end of July 2012 the number of pharmacies, including hospital pharmacies, was 226. Expenditure per capita on pharmaceutical products in 2011 was €232, which is an increase from €200 in 2010. Production of pharmaceutical products is mainly of generic medicines and medicinal gases. As of July 2012 there were 18 manufacturers of pharmaceutical products.

In the private system patients have to pay the full price for pharmaceuticals. In the public sector the medicines listed on the GFL – 1300 different medicinal products – are provided free of charge to entitled patients.

All medicines used during inpatient treatment and for the first three days after discharge are free of charge for the patient. If an illness requires the use of medicines or medical devices at primary care level or at outpatient level, or following discharge from a day-care or inpatient facility (except for the first three days for medicines), a prescription from a licensed medical practitioner is required. Medicines and medical devices can be purchased in any of the retail

pharmacies in Malta and the costs are met in full by the patient, who pays for them directly. However, there are two exceptions to this rule and these apply to persons living in Malta who are covered by Maltese social security legislation:

(1) those who are in the low-income group, as determined by a means test, are entitled to free medicines from a restricted list of essential medicines and to certain medical devices (subject to certain conditions and the payment of a refundable deposit);
(2) those who suffer from chronic illnesses included in a specific schedule incorporated in the Social Security Act are entitled to free medicines strictly related to the chronic illness in question. This benefit is independent of financial means.

On 27 March 2012 legislative changes were made to the Social Security Act to increase the number of chronic illnesses that entitle patients to free medicines from 38 to 79. In 2009 the Pharmacy of Your Choice scheme (POYC) was introduced in several localities in Malta (see section 6.1). As a result those entitled to free medicines are now able to choose a registered pharmacy of their own choice where they can collect their medicines. The POYC scheme aims to increase accessibility to prescribed medicines and decrease the need for public pharmacies.

Despite such efforts to increase accessibility to prescribed medicines there has been a problem concerning out-of-stock medicines since around 2011. In this respect, in July 2013 the Commissioner for Health, in his capacity as Ombudsman, conducted on his own initiative an inquiry concerning this problem, which in effect is of a persistent nature and has negative repercussions for patients entitled to free medicines (Messina, 2013b). As a consequence patients are being left with no alternative other than to buy the medicines on an out-of-pocket basis or wait for the heavily overdue medicine consignment which is detrimental to their health. The report highlights various deficiencies in the whole procurement system and, among various recommendations, the Commissioner for Health advocates (1) that the manual stock-taking system be replaced with an electronic system; (2) that Mater Dei Hospital, which is the largest consumer of medicines, provide a ward pharmacy service or facilitate the top-up system in order to exert better control over stock levels; (3) that staff levels at the POYC unit be increased in order to make up for the 38% understaffing; and (4) due consideration be given to addressing the high cost of medicines for the POYC system. In response, the government took note

of the Health Commissioner's recommendations and determined that a final road map would be set to meet the challenges of ensuring the timely provision of medicines.

5.7 Rehabilitation and intermediate care

Public rehabilitation services are offered at Karin Grech Hospital. Free services are offered to patients who are referred from other public hospitals or from the community by their GP. The hospital comprises 212 inpatient beds for assessment, post-acute care and rehabilitation, a day hospital for interdisciplinary assessment and care, a medical outpatient department, a physiotherapy and occupational therapy outpatient department, and an orthotics and prosthetics unit. The services are provided by one consultant in physical rehabilitation and eight consultant geriatricians. All patients undergo comprehensive multidisciplinary assessment.

There has been a fairly steady increase in the number of admissions throughout the past years at Karen Grech Hospital – from 732 in 2008 to 1498 in 2011 (Treasury Department, 2012). Concurrently, such an increase has been accompanied by an increase in the mean length of stay – 14 days, 35 days, 38 days and 43 days for 2008, 2009, 2010 and 2011 respectively. The majority of referrals to this hospital come from Mater Dei Hospital.

5.8 Long-term care

Long-term care for the elderly is provided by the state, the Church and the private sector. The Elderly Care Department was set up in 1987 and, apart from managing the state homes for elderly people, offers a number of services to support elderly people within the community, such as home care help, telecare, meals on wheels, handyman service and incontinence service. The Department also manages 18 day-care centres within the community. Elderly residents residing in state homes contribute 60% of their total income (this includes the pension from the Social Services Department, bonuses, foreign pensions, bank interest, rents, etc.). Residents at St Vincent De Paul contribute 80% of their income, provided that they are not left with less than €1400 per year at their disposal (Employment, Social Affairs and Inclusion, 2012) (see section 3.6).

The largest care home for old people is a public institution, St Vincent De Paul, which has 1126 beds, 7 of which are respite beds. This complex has units with different dependency levels ranging from 24-hour nursing and medical attention to quasi-independent bedsits. It is staffed by nurses, doctors and paramedics, a good proportion of whom are trained in geriatric care. Admittance is open to persons aged 60 and over, and an Admissions Board prioritizes admission for those who most need care. The demand for long-term institutional care has increased as a result of the ageing population as well as the reduction in size of extended families, which otherwise serve as the primary support network. In addition, the proportion of working women has risen steeply over the past decade, particularly among those under 40, who would otherwise provide care to family members (Abela A, 2012). The public sector has attempted to find solutions to this problem by involving the private sector and setting up contracts with private homes for the provision of long-term care beds. Apart from such contractual arrangements, the provision of long-term care in private institutions operates independently from the public sector.

5.9 Services for informal carers

At present there are no specific services available for informal carers. In 2012, a local NGO, SOS Malta, conducted a survey to look into the needs of informal carers.

5.10 Palliative care

The provision of palliative care services in the public sector is mainly for adult cancer patients, wherein a multidisciplinary team approach is used. A 10-bed specialist palliative care ward was inaugurated at Sir Paul Boffa Hospital in 2011. These beds are designated for inpatient palliative care. In addition, an outpatient palliative care clinic is held once a week. Patients are usually referred to the outpatient clinic from the Oncology Department. Patients often receive other treatments within the hospital on the same day as their palliative care outpatient visits.

Hospice Malta is a voluntary organization that provides palliative care services to patients suffering from cancer, motor neurone disease and other terminal diseases. The organization is reliant on volunteers, as well as professional salaried staff such as nurses, social workers and doctors. Hospice

Malta offers a wide range of services such as hospital support, day care, home care, loan of equipment, physiotherapy, social work services, spiritual support and bereavement counselling.

Puttinu Cares Foundation is a children's cancer support group, which was officially set up in 2002. It is a non-profit-making NGO. Among its various aims it seeks to advocate on behalf of affected children and their families by representing their needs; to promote models of good care and practice and to support families with a national information service.

5.11 Mental health care

Services for people suffering from mental disorders have vastly improved in recent years and there have been a number of important developments in both the hospital and community-based care settings. The expansion of network community services is shifting the locus of service delivery into towns and villages. These services include home visits, telephone interventions, psychological sessions, support group sessions, depot injection administration, social work interventions and psychotherapy sessions. The introduction of the crisis intervention team, which operates in the A&E Department of Mater Dei Hospital, has moved acute psychiatry to the general hospital setting. This service addresses the needs of psychiatric patients in crisis situations.

The major policy driver in mental health in the coming years will be the new Mental Health Act, which came into force in 2013. The previous law had been in force since 1981 and reflected outdated views on mental illness and treatment. The new Mental Health Act has two main aims: to regulate the provision of mental health services, care and rehabilitation, and to promote and uphold the rights of those suffering from mental disorders. Provisions include a holistic and multidisciplinary team care approach, a care plan with timeframes and outcomes, and the identification and involvement of a responsible carer identified by the patient. Approval, monitoring and review of compulsory care will be through the Commissioner for Mental Health.

5.12 Dental care

The Dental Public Health Unit is responsible for promoting oral health. Oral health has been included in the strategy document on noncommunicable diseases, with targets set for 2020, although currently there is no direct monitoring of the quality of dental health services. All dental clinics are inspected on an annual basis prior to provision of their clinic licence.

Dental care is provided by both the public and private dental service. Only acute emergency dental care is offered free of charge in hospital outpatient and health centres. Most dental care is paid for by patients themselves out of pocket. Few VHI schemes cover dental expenses. Children up to 16 years of age are eligible for comprehensive dental treatment, including orthodontic care. Such comprehensive services are also offered to adults who qualify for certain free medical services. All other adults are covered for diagnostic care, investigation, preventive care, emergency treatment and surgery.

Public dental services are provided in the dental departments at the main hospitals in Malta and Gozo, that is, at Mater Dei Hospital and Gozo General Hospital. Recently the public dental clinics in the community have been closed. This has resulted in decreased accessibility and increased waiting times. However dental clinics are to be included in some of the public health centres that are being refurbished or developed de novo. Patients are free to choose in which setting they would like to receive dental care. If patients visit a private dental practitioner, the patient pays for treatment; in general, private health insurance reimburses very little dental treatment.

5.13 Complementary and alternative medicine

At present, in accordance with the Health-Care Professions Act (Chapter 464) (see section 4.2.3), the Council for the Professions Complementary to Medicine regulates the practice of acupuncture, chiropractic and osteopathy. Acupuncture is offered at Mater Dei Hospital free of charge. Other complementary and alternative medicine services can be accessed within the private sector on a fee-for-service basis.

5.14 Health services for specific populations

The Migrant Health Unit was set up within the Department of Primary Health Care in August 2008 in view of the large influx of irregular immigrants arriving in Malta. The Migrant Health Unit offers community-based health education to migrants on health issues while also helping migrants to access health-care services when required. On-site trained cultural mediators assist health professionals and clients to overcome language and cultural barriers. The Unit also serves to train health-care professionals and students on cultural diversity issues in health care.

6. Principal health reforms

The main events of the past decade that have been most influential in shaping health reform are Malta's accession to the EU in 2004 and the construction of the new Mater Dei Hospital in 2007. The former was instrumental in driving policy on new legislation in the field of health, particularly public health and health protection, while the latter was significant in shaping the flow of capital resources.

Major health reforms that have taken place in recent years include use of HTA to define the public benefits package, introduction of the POYC scheme to provide more equitable access to medicines, and development of a remuneration system for medical consultants (specialists) that is partially performance based. There have also been efforts to develop more community-based services for long-term and mental health care. A new Mental Health Act, which will promote the rights of mental health patients and support community treatment schemes, was approved and came into effect in 2013. A landmark Health Act has also been approved by the Maltese Parliament in 2013, repealing the old Department of Health Constitution Ordinance and creating a modern framework separating policy from regulation and operations, as described in Chapter 2. This Act also enshrined patient rights in a legal instrument for the first time.

The focus on prevention and community services has led to progress in areas such as the development of cancer screening programmes. Since 2009, a number of national plans and strategies have been launched to address major public health issues, mainly cancer, obesity, sexual health and noncommunicable diseases. An overarching National Health Systems Strategy (NHSS) is also being drafted to provide the overall direction. Notwithstanding, much remains to be done in this area, and this will be defined in the new NHSS.

6.1 Analysis of recent reforms

A reform process started within the Ministry for Health in 2006. A number of reforms and national strategies have been launched since then (Box 6.1). The following section describes each of these reforms in detail.

Box 6.1 Major reforms and strategies since 2007

2007 – Restructuring to separate regulatory and service provider functions
2007 – Collective agreements with health-care unions
2007 – Commissioning of a new acute tertiary referral centre
2007 – Implementation of new IT systems
2008 – Pharmacy of Your Choice scheme
2008 – Pharmaceutical policy reform
2008 – Commissioning institutional care for elderly people from private providers
2008 – Setting up of a foundation programme and postgraduate medical training centre
2009 – Launch of breast cancer screening programme
2009 – Primary care reform proposal
2010 – Noncommunicable Disease Strategy
2011 – National Cancer Plan
2011 – Sexual Health Strategy
2011 – Outsourcing of clinical services
2011 – Setting up of commissioners for health, for mental health and for elderly people
2012 – Embryo Protection Act
2013 – Move of social care from Ministry for Health to the Ministry for Family and Social Solidarity
2013 – Mental Health Act
2013 – Health Act

2007 – Restructuring to separate regulatory and service provider functions
With Malta's accession to the EU, important legislation to regulate aspects of health-care provision was implemented, notably in the areas of food safety, medicines, environmental health, public health and blood, tissues and cells. It was deemed pertinent to bring all these functions together under a single department – the Superintendent of Public Health – which would have as its remit public health regulation. Through this reform, a split between the responsibilities for setting standards and licensing of health-care providers and that for the provision of a public health-care service was implemented. Although this was an administrative reform, it also signified an important step

because the regulatory part of the Ministry for Health could apply the same standards to both government and private health-care providers in terms of standards of service provision.

2007/2008 – Collective agreements with health-care unions

Prior to the general election of March 2008, a number of important collective agreements were made with the trade unions representing health-care professionals. These agreements paved the way for recognition of clinical specialist roles among professionals other than doctors. The agreement for medical doctors for the first time devised a different remuneration package for doctors who opted out of part-time private practice. The next round of collective agreements, in 2012, further refined the session-based system and extended it to the second highest level of doctors. Unfortunately, too few doctors have chosen this option to date, thereby diluting the impact of this policy initiative. However the introduction of part remuneration for sessional activity is an important concept in moving towards structured performance reviews and payment for activity. Agreements with nurses were intended to address the chronic nursing shortage. Engagement of nurses has increased notably, but not enough to plug the deficit fuelled by the increase in demand for health care.

2007 – Commissioning of new acute tertiary referral centre

In November 2007, a new 850-bed tertiary referral centre was commissioned, with all acute health-care services migrating from the old hospital to the new Mater Dei Hospital. The new facility's infrastructure and equipment allowed for the development of a number of new services for which patients were previously referred abroad or managed conservatively. Activity levels in ambulatory care, patient admissions and surgical procedures have increased year on year since 2007. However the hospital is still not providing a full day of outpatient activity to reduce waiting lists for outpatients, as originally planned. Changes in health-care professional working practices have been difficult to implement. The acute hospital is also hindered by the health system not keeping up with the demand for alternative provision for frail elderly people unable to cope independently in the community, who often remain in the acute hospital for prolonged periods.

2007 – Implementation of new IT systems

The new hospital paved the way for new IT systems, particularly in the area of radiology and laboratory information systems, which have been implemented nationwide and have revolutionized patient services. Further expansion of these systems is planned, fully taking into account the role IT can play in continuity of care between primary and secondary care.

2008 – Pharmacy of Your Choice scheme

Until 2008, eligible patients could access free medicines through the public system only from regional health centres or local government dispensaries. In 2008 an agreement was signed with the private retail pharmacies and the professional organization representing pharmacists to implement the POYC scheme. Government-procured stock is supplied through all the pharmacies through a central logistics and distribution centre. Pharmacies are remunerated on a yearly capitation basis. Consequently, eligible patients can collect their medicines from any pharmacy of their choice, greatly facilitating access and swelling the number of beneficiaries. National coverage was achieved in 2013. It is hoped that pharmacists can be further engaged in reviewing the utilization of medicines.

2008 – Pharmaceutical policy reform

The necessity to implement the EU Transparency Directive triggered the setting up of a directorate specifically for pharmaceutical policy in 2008. Legislation was amended in 2009 to introduce the concept of a maximum reference price at the point of approval of a medicine for inclusion on the government positive list. Evaluations of requests for entry to the positive list are carried out by means of HTA (as discussed in section 2.7.2 *Health technology assessment*), relying heavily on other centres in Europe, mostly the National Institute for Clinical Excellence (NICE) in the United Kingdom for the technical evaluation and applying local epidemiology and costs to carry out the budgetary impact analysis. With newer medicines generally being more expensive than their older counterparts and in the current financial and economic climate, the acceptance rate for introduction on the government formulary seems set to decline. Innovative mechanisms to target new medicines for the most deserving patients are being piloted through, for example, clinical peer review committees for approving very expensive new medicines.

2008 – Commissioning institutional care for elderly people from private providers

The government has been investing in the construction and direct management of a number of residences and nursing homes for elderly people. In seeking the optimum model to develop and run these institutions, the government has established various contracts with the private sector. Most recently, the government began purchasing beds in private facilities and paying a flat rate per diem according to dependency level. While this has been a popular policy measure, it has indirectly decreased demand for private long-term care. Each person in institutional long-term care has to contribute 60% or 80% of their income, depending on the institution. This deduction helps to pay part of the

costs payable by the government. This commissioning role is still developing the skills and set-up required to monitor level of care, because of differences from the traditional public set-up. The increase in nursing home capacity over the past years has not been sufficient to keep up with the growing demand.

2008 – Setting up of a foundation programme and postgraduate medical training centre

EU accession accelerated migration of newly qualified doctors to around 80%. In response, the Ministry for Health set up a United Kingdom Foundation School in Malta. This project served to reverse the outward migration trend for new doctors (attracting foreign graduates too) as well as setting a benchmark for postgraduate medical training programmes. A new postgraduate medical training centre will enable medical doctors to enrol in several recognized and externally reviewed specialist training programmes following successful completion of the foundation programme.

2009 – Cancer screening services

The publication of the European Union Council recommendation on cancer screening programmes, led the Ministry for Health to set up a national breast cancer screening programme, despite a commissioned report that had not recommended this. Local scepticism centred around the resources that were required to be channelled into the programme. After a slow start in 2009, the programme has established itself and developed important quality assurance service benchmarks. Colorectal cancer screening was initiated in 2013, and the human papilloma virus (HPV) vaccine against cervical cancer was introduced into the national free immunization schedule.

2009 – Primary care reform proposal

In 2007 an extensive consultation process on strengthening primary health and community services established the need for some type of registration system with a GP. A working group developed a consultative document centred around setting up a patient registration system, based on the present context, in which 70% of primary care activity occurs in the private sector, in 2009. This was fiercely criticized by political and medical stakeholders. Different solutions for patient registration were proposed by different stakeholders. Civil society provided little support and government decided to initiate reform in primary care starting with measures with a broad consensus, such as IT systems access for private GPs, modernization of regional health centres, and further GP empowerment for lab investigations and prescriptions. Although a patient registration system – like previous attempts at primary health-care reform – is regarded as being effectively stalled, there is no doubt that sustainability of

the health system depends on a cultural shift from secondary to primary care. The main obstacle is the popular belief that quality of care in a hospital setting is superior. Yet unless an integrated primary care pathway with an increasing gatekeeping role is developed, the hospitals will not be able to cope and endless outpatient hospital appointments and a revolving door syndrome will result. Renewed efforts are being made to strengthen and reform primary care services.

2010 – Noncommunicable Disease Strategy

In 2010 the Noncommunicable Disease Strategy for Malta was launched in collaboration with the WHO, defining priorities for common ailments, particularly cardiovascular disease and diabetes, and guiding health promotion and disease prevention programmes for the coming years.

2011 – National Cancer Plan

Malta adopted its first ever National Cancer Plan early in 2011, bringing together prevention, screening, care and support. The National Cancer Institute in France provided expert input. The plan sets out timed targets and deliverables, and its implementation to date has been satisfactory particularly in the areas of health promotion, expansion of access to medicines and the construction of a new cancer facility, funded through EU Structural Funds.

2011– Sexual health policy and strategy

A long-awaited sexual health policy was published in 2010, facilitating discussion with stakeholders presenting very different perspectives. The concept of individual empowerment in one's relationships, and the accompanying rights and responsibilities were a main tenet. Maximal ownership by stakeholders and other policy sectors was thus achieved and a strategy document was published in 2011, which upholds the applicable public health principles. Implementation is under way.

2011 – Outsourcing of clinical services

To further decentralize service provision and facilitate patient access, the Ministry for Health began outsourcing surgical services to the private sector in 2011, in a bid to reduce waiting times for elective interventions by boosting activity. Following some initial problems with acceptance of such an innovative approach, cataract surgery services were commissioned from the private sector (see section 5.4). This project was also rolled out for MRI services, arthroscopy services and weekend cover for triage level 3 emergencies. These were considered as pilot projects, heralding an organized commissioning and outsourcing process through which private and public providers can equally provide public health-care services, challenging the traditional link between

public health-care services and government-operated health-care facilities. It also sets the agenda for the development of activity and target-based part-funding rather than full funding through a global cash budget independent of throughput.

2011 – Setting up of commissioners for health, for mental health and for elderly people

The government has created three new posts designed to empower patients. The Commissioner for Health was established as part of the legislation regulating the Office of the Ombudsman, to investigate complaints received from citizens dissatisfied with the health services. The Commissioner for Health may also investigate aspects of the health service through "own initiative" measures.

The Office of the Commissioner for Mental Health and that of Commissioner for Older People are separate. While the Commissioner for Mental Health already has a defined role laid out in the draft Mental Health Act legislation, the necessary legislation to protect older people still has to be drafted and this is the role currently being undertaken by the appointed Commissioner for Older People. These offices have been a first step towards addressing European criticism levelled at Malta regarding its patients' rights framework.

2012 – Embryo Protection Act

An Embryo Protection Act has set up an authority to oversee artificial reproductive technologies and eligibility for such treatment. This has paved the way for these procedures to be offered within the public health service in a regulated manner. In order to allow multiple IVF cycles to occur without the woman being exposed to the harrowing oocyte harvesting process, storage technologies need to be in place. The main technology that is expected to be used is oocyte vitrification to circumvent the ethical implications of embryo freezing.

2013 Mental Health Act

The Mental Health Act, enacted in 2013, revolutionized the status of the mental patient in Maltese law. It replaces older legislation, where the mentally ill individual barely had any rights and in which care was effectively limited to institutionalized care. The new Act grants the appropriate dignity to the mentally ill patient and paves the way to better care within the community. It also grants legal status to the position of the Commissioner for Mental Health, particularly for protecting the rights of the patients and carers.

2013 Health Act

The Health Act, enacted late in 2013, is another landmark legislative instrument which replaces the somewhat archaic Department of Health Constitution Ordinance of 1937. The Health Act establishes the basic functions in the

public health set-up, clearly delineating three separate roles: regulation, strategy and coordination of health-care services (see Chapter 2), together with a number of advisory entities that bring the three functions together. It also makes a declaration on patient rights and responsibilities. While the Health Act is not exhaustive in the delineation of the granular operation of the health ministry, nevertheless it provides an adequate framework for further implementing legislation.

6.2 Future developments

While much progress has been made in recent years, some reforms have been less successful. A major challenge for the health system is ensuring financial sustainability. Financial projections depict unsustainable public finances in the medium to long term, in view of projected increases in age-related expenditure.

Older people often require intensive care and support within the community or within institutions. Insufficient placements in long-term care and inadequate support for the dependency levels being encountered at community level results in a situation where beds are inappropriately taken up within the acute hospital. Generally speaking, when it comes to ageing, current policies are geared towards hospitalization and institutionalization. These are policies that send the wrong signals for they assume hospitalization and institutionalization at the first instance, that is, as soon as the first signs of sickness or disability appear.

The primary care reform has not achieved as much attention as intended. The provision of primary care services by the state is limited as the private sector accounts for two-thirds of the workload in this respect and functions independently from the public sector. The system of GPs acting as gatekeepers to further levels of care is very often bypassed. This points to a weakness in the system as a whole and possibly contributes to inefficient use of health-care resources and longer waiting times for hospital care. Further, the relatively limited number of nurses and GPs per capita also results in bottlenecks in the provision of primary care services and adds to longer waiting times for hospital care.

Indeed, long waiting times for outpatient appointments and elective interventions pose a major problem. This issue is complex and what is required is that inappropriate referrals should be tackled effectively, a strong primary care led service should be developed, there should be greater efficiency, and the number of hours Mater Dei Hospital is open should be extended.

Another supply constraint seems to lie within the availability of free drugs, as defined under Schedule V of the Social Security Act (see Chapter 2). A number of instances still occur each year when certain medications tend to be out of stock for a number of days. This is likely to be due to a combination of the ever-increasing number of beneficiaries and issues within the procurement and distribution process.

Another issue that demands attention is the infant mortality and amenable mortality rates. Infant mortality in Malta in year 2011 stood at 5.5 per 1000 live births compared to 4.1 per 1000 in the EU; amenable or avoidable mortality rates, that is those that could be reduced if there were timely and effective care, are high in a series of important causes of death (AMIEHS, 2011 cited in European Commission, 2013: 15). Strategies recently put in place all aim to reduce premature deaths, address risk factors, decrease morbidity, promote healthy lifestyles and improve quality of life.

The above issues featured as significant elements in the Labour Party's electoral manifesto in 2013 and today feature prominently in the programme of priority initiatives of the new Labour government.

7. Assessment of the health system

The Maltese health system provides a comprehensive basket of health services available universally for all its citizens. According to EU-SILC data (Eurostat, 2013), self-reported unmet need due to financial constraints in 2010 was low in comparison to other European countries, reflecting Malta's major focus on providing equal access to health services for all, particularly for disadvantaged groups. Indeed, socioeconomic inequalities are more evident among health determinants, such as obesity and health literacy, rather than health-care access.

Maltese citizens enjoy one of the highest life expectancies in Europe. The objectives set out in *Health vision 2000* (the original strategic document written by the Ministry for Health in 1995) have been at the heart of all health policies and reforms that have occurred since then. Strategies recently put in place all aim to reduce premature deaths, address risk factors, decrease morbidity, promote healthy lifestyles and improve quality of life.

A major challenge for the health system is ensuring sustainability, as Malta faces increasing demands from its citizens, an ageing population, and the rising costs of medicines and technology. To address the sustainability of public finances, there is a focus on maximizing efficiency together with investment in primary and community-based health care and social care. Systematic monitoring of health system performance has also become imperative. The adoption of a comprehensive healthy active ageing strategy that seeks to help older people to stay within their own home setting is a crucial component that taps directly into the notion of sustainability.

7.1 Stated objectives of the health system

The objectives of the Maltese health system are stated in the new Health Act. Accordingly the "Act intends to establish and ensure a health system based on the principles of equity, accessibility, quality and sustainability by regulating the entitlement to, and the quality of, health-care services in Malta, consolidating and reforming the Government structures and entities responsible for health and by providing for the rights of patients" (Government of Malta, 2013).

A new NHSS is currently under development; four primary objectives of the health system have emerged:

(1) respond to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on course of life, children, elderly people and vulnerable groups;

(2) increase equitable access, availability and timeliness of health and social services, medicines and health technologies;

(3) improve quality of care by ensuring consistency of care and having qualified health personnel supported by robust information systems;

(4) ensure the sustainability of the Maltese health system.

Likewise, a number of policy documents with a strong focus on health promotion and primary prevention have been launched in the last few years (see Chapter 6), reflecting high-priority policy objectives. There is a political commitment to intersectoral approaches and health in all policies.

7.2 Financial protection and equity in financing

7.2.1 Financial protection

The government is committed to preserving the solidarity-based model of universal access to care.

There are no user charges for public services. Out-of-pocket payments, however, are still the dominant financing mechanism for the private sector, accounting for around one-third of total health expenditure. Although it is estimated that around one-fifth of the population has private health insurance, most are basic plans that provide very limited hospital care. Despite the high

frequency of spending by households, most of this spending is for relatively inexpensive ambulatory care services, dental care and medication, mostly for acute, self-limiting illness.

7.2.2 Equity in financing

Health-care expenditure is regressive since lower-income households spend a larger proportion of their income on health. According to the Household Budgetary Survey for 2008, 6.4% of total expenditure by households is on health-related expenditure (NSO, 2008). Lower-income households spend a larger proportion of their income on health than their higher-income counterparts at 9% and 5%, respectively. The system as a whole could be seen as progressive, however, because higher earners pay more in taxes, which are used to finance the public system.

7.3 User experience and equity of access to health care

7.3.1 User experience

At Mater Dei Hospital, suggestion boxes have historically been used to allow patients to convey their comments and suggestions on a specific form and patient satisfaction surveys are increasingly being employed. An example of such a survey is the Mater Dei Hospital Patients' Experience Survey (Health-Care Standards Directorate, 2010). Notwithstanding the overall positive experience of service users (with 80% rating the care received to be excellent or very good), there are gaps in service provision that need to be addressed, such as better communication between health-care professionals and patients. In this Patients' Experience Survey, 97% of patients were satisfied with the general ambience of the new public hospital while 95% stated that they had full trust in the medical staff. Recently, this feedback process has been modernized through the introduction of an interactive online customer care survey available at patients' bedside on the personal entertainment system. Patients are strongly encouraged to fill it in and volunteer helpers also offer their assistance should the patient not be IT literate, in order to get as representative a picture as possible. A variety of dimensions are being continually assessed through this medium and fed back to both individual wards and to management.

All efforts are made to ensure confidentiality as personal data is processed, managed and stored in accordance with the Data Protection Act 2001. This extends to both medical records in digital format and those in paper format.

Access for purposes of research is regulated by the Chief Executive Officer, who may delegate his authority to the Director for Information Management and Technology. In specific situations, ethical approval may be sought before such access is granted.

Waiting times are a long-standing challenge in both health and long-term care, which may have an adverse impact on the health and quality of life of patients, apart from reducing their overall satisfaction with the health and long-term care systems. Transferring responsibility for certain services from the institutional, secondary and tertiary sectors to the primary and community sectors will be an important component of this solution as well as an increase in the provision of those services where longer waiting times exist. In both settings, waiting times and lists are being monitored. In the health-care setting, a large number of surgical procedures and outpatient clinics are being monitored. As at the end of June 2013, there were 1926 individuals who had been waiting for cataract surgery for more than six months. Admittedly this number was much higher prior to cataract surgery being commissioned from the private sector. While the median waiting time is now around 12 months, it was closer to 36 months prior to this subcontracting. A similar problem exists with a select number of orthopaedic procedures, with typical waiting times being between 24 and 36 months (Parliamentary Question, 2013). A two-pronged approach is being taken to address these waiting lists – cutting back on the existing list, and addressing capacity to meet demand based on the observed throughput of new cases.

7.3.2 Equity of access to health care

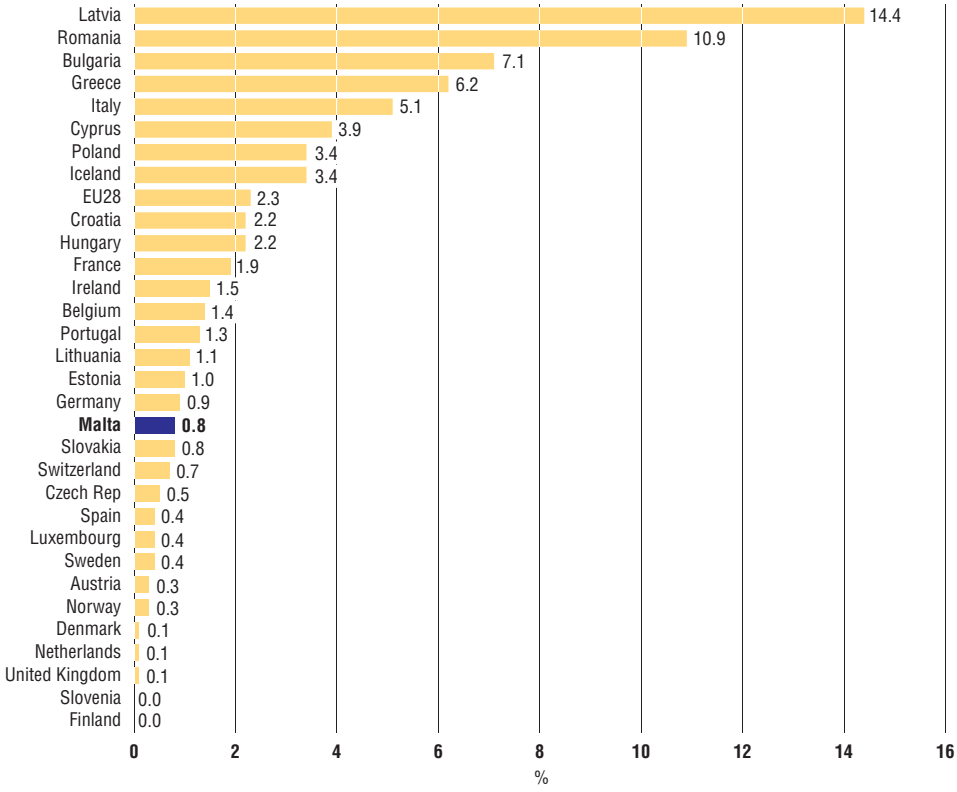
Inability to access health services for geographical reasons is not a major issue due to the small size of the country. Nevertheless, to ensure that residents of Gozo have better access to care closer to home, the government is investing EU Structural Funds to purchase new equipment for the operating theatres and a radiology department in Gozo General Hospital.

Evidence from EU-SILC suggests very low levels of unmet need due to financial barriers. As shown in Fig. 7.1, only 0.8% of the Maltese population reported not having had a medical examination in the previous year for financial reasons, as compared to an EU average of 2.3% (Eurostat, 2013).

Efforts are also being made to focus on improving access to services for migrants. All health-care needs of migrants are catered to; appreciably, this has presented new challenges to the health system. As an example of an initiative effectively meeting the needs of migrants, a bill to ban female genital

Fig. 7.1

Percentage of unmet need for medical examination due to financial reasons



Source: Eurostat (2013).

mutilation is currently being discussed in Parliament. There are dedicated clinics for migrants and a Migrant Health Unit, as well as cultural mediators to facilitate access and overcome language and cultural barriers.

7.4 Health outcomes, health service outcomes and quality of care

7.4.1 Population health

Maltese citizens enjoy one of the highest life expectancies in Europe (see section 1.3). Nonetheless, there remains scope for improvement, particularly through compressing morbidity in older age groups and reducing amenable mortality rates. There remains scope for improvements in further reducing

prevalence as well as deaths due to ischaemic heart disease. This requires an aggressive approach targeting risk factors, such as obesity, careful control of hypertension and diabetes, and more effective and timely interventions in the hospital setting. For cancer, Malta compares favourably with other EU countries; efforts are under way to strengthen cancer services by expanding the newly introduced screening for breast and colorectal cancers.

7.4.2 Health service outcomes and quality of care

While initiatives exist that capture some data on health service outcomes, there is no comprehensive system to capture health service outcomes and quality of care. Therefore, a project is under way in collaboration with the WHO to put in place a Health System Performance Assessment framework that will allow the regular and timely monitoring of a selected number of performance indicators.

Collected data include a number of Organisation for Economic Co-operation and Development (OECD) Health-Care Quality indicators, the Performance Assessment Tool for Quality Improvement in Hospitals (PATH) initiative measures and various others. Since 2009, Mater Dei Hospital has been collecting seven performance indicators for PATH. These were: caesarean section rate; patient-based stroke 30-day in-hospital mortality rate; patient-based acute myocardial infarction (AMI) 30-day in-hospital mortality rate; use of blood components; exclusive breastfeeding; prophylactic antibiotic use; and operating theatre performance. One particular area of concern locally has been the caesarean section rate. In 2010, Malta had reportedly the fourth highest section rate in Europe (EURO-PERISTAT, 2013), and, like most other countries, the rate has increased since 2004.

Malta participates in the European Health-Care Associated Infections Surveillance Network (HAI-Net) coordinated by the European Centre for Disease Prevention and Control (ECDC). In addition, Malta participates in the Antimicrobial Resistance Surveillance Network (EARSNet) which is a European wide network of national surveillance systems, providing European reference data on antimicrobial resistance for public health purposes. Methicillin-resistant *Staphylococcus aureus* (MRSA) is one main source of hospital infection in Malta. In 2006, the percentage of *Staphylococcus aureus* isolates resistant to methicillin was as high as 66.7%. Thanks to various campaigns and measures within hospital practices this has been driven down to 49% by 2011 (TESSy, 2013).

With regard to maternal care, Malta participates in the EURO-PERISTAT network, which aims to contribute to better health for mothers and babies (EURO-PERISTAT, 2013). In spite of the two indicators mentioned earlier – that is, caesarean section rate and infant mortality rate – Malta performs fairly well in a number of other areas. The percentage of women starting antenatal care within the second trimester is, by far, the highest in Europe. Maternal mortality in Malta is among the lowest with only two deaths between 2002 and 2011. The percentage of babies born with low birth weight is also on a par with the European average. On the other hand, breastfeeding rates at 48 hours after birth are among the lowest in Europe (WHO, 2013; EURO-PERISTAT, 2013).

As described earlier, a number of vaccinations are made available to Maltese citizens as per the National Immunization Schedule. Vaccination coverage in children is around 96% for most vaccines, with the exception of the MMR vaccine whose uptake is still low, even compared to the EU average (WHO, 2013). Influenza vaccination uptake among the elderly, while reported as the third highest in Europe, is still below public health recommendations (DHIR, 2010).

Malta is working towards a legal framework for patient safety through the preparation of subsidiary legislation to be published under the Health Act. To date, there is no system that collects data in a comprehensive manner.

7.4.3 Equity of outcomes

Socioeconomic inequalities, as evidenced by the Gini coefficient, are less pronounced in Malta (27%) then in the remainder of the EU (30%) (Eurostat, 2013).

Health inequalities by level of income or by region in Malta are typically largely explained by differences in level of education achieved. Even when adjusted for age differences among the educational groups, certain inequalities persist – such as the presence of chronic illness, activity limitation or lower self-perceived health. All of these show evidence of marked differences by educational level. At a more specific level, certain diseases also show such inequality by level of education, such as lung cancer and chronic lower respiratory disease (DHIR, 2012). A number of lifestyle practices also show differences by level of education – typically smoking, obesity and alcohol consumption (DHIR, 2010).

In addition, the typical gender inequalities observed in Western nations are observed in Malta – such as activity limitation and self-perceived health. These are typically more pronounced in the elderly cohort, especially given the longer life expectancy in women. A number of adverse lifestyle characteristics are more pronounced among men – such as obesity, smoking and alcohol consumption, while lack of physical activity is more pronounced among women. Interestingly, obesity awareness was found to be markedly lower among women, on the other hand (DHIR, 2012).

Nevertheless, no formal framework exists to monitor equity in health care. Further work in this area is required, particularly on inequalities experienced by migrants. Sporadic reports have been produced by a number of entities on the barriers to health care for migrants in Malta, and a number of these concerns have been partially addressed or mitigated, as discussed earlier. Very little in the way of official health statistics are available for the migrant population to date. Following the lull in migrant arrivals experienced during the latter years of the Gaddafi regime in Libya, this became less of a priority. However, in view of the recent resurgence of illegal migration flows from North Africa, measuring and addressing the inequities migrants are experiencing as compared to the native population becomes imperative.

7.5 Health system efficiency

7.5.1 Allocative efficiency

The health system must compete with other public sectors like education and social security for allocation of scarce funds. Budgeting is traditionally based on historical expenditure. In recent years HTA has been increasingly used for deciding whether to introduce new medicines and technologies. However, there is no explicit threshold for inclusion in the package of services offered through the public health system. The Health Act has set up a formal structure, known as the Advisory Committee on Health Benefits, whose mandate will be to advise on allocation of resources. This Committee will continue to build on the experience attained through the GFL Advisory Committee, which has been used to prioritize decisions regarding inclusion of new medicines. The formal setting up of HTA in accordance with the Directive on the application of patients' rights in cross-border health care will facilitate the application of HTA in Malta which, as a small country, needs to rely heavily on empirical evidence obtained from other settings.

Within the public sector, there has historically been an emphasis on allocation of resources for hospitals to the detriment of the primary care and other community services. Even within secondary care there are allocative inefficiencies. In terms of current capacity, the current allocation of beds across acute, rehabilitative and long-term care does not adequately address demand for services. This is partly due to changes in demographics, as well as changes in capacity (see section 4.1.2 *Infrastructure*).

7.5.2 Technical efficiency

Improvement of technical efficiency is a key priority for the Maltese health system. The setting up of the Financial Monitoring and Control Unit (FMCU), with satellite units across all public health service providers, was a step in the right direction. However efforts should be intensified to merge clinical performance and financial data in order to make appropriate decisions on achieving much-sought efficiency gains.

Inefficiencies are apparent due to the recent rise in average length of stay in acute hospitals, a relatively low day surgery rate and considerable clinical variations in practice resulting in different thresholds for diagnostics, interventions and follow-up outpatient visits. The lack of price incentives in the system makes it harder as this means that technical efficiency gains need to be made solely through supply-driven reforms.

Better integration between hospital and community services, empowerment of GPs and community discharge planning and liaison services are critical factors for improving technical efficiency.

Another source of inefficiency is the current mechanism in place to procure medicines and medical supplies. The systems are overly bureaucratic and do not guarantee timely supply at the right price. A thorough review and reform of the procurement processes is under way, with a view to avoiding problems over out-of-stock drugs, curbing waste and improving the value through lower pricing.

In terms of human resources, there has been an increasing trend to support health-care professionals with carers and paramedic aides, thereby expanding the range of skill mix available to the system. Pay for performance is generally not employed within the public health service, where human resources are salaried. However, senior medical specialists are subject to annual job planning built around flexible sessions which, if properly managed, could serve to create the correct incentives to improve system performance and output.

Technical efficiency will begin to be monitored annually through a Health System Performance Assessment, the framework of which is presently under development.

7.6 Transparency and accountability

Transparency and accountability are considered to be key values for the health system but they are as yet insufficiently dispersed through the system. During health policy development and implementation there are consultations with all stakeholders and public participation in such processes is strongly encouraged. Patient participation has been traditionally low, with a strong asymmetrical influence by associations of health professionals in the health NGO field. The situation is changing, however, with some patient groups becoming more involved and more vocal.

Since 2009, the public health service has made the register of health benefits publicly available for both services and medicines. Nonetheless, this is often challenging to navigate for the lay public. There is a thrust to continue to increase the information available in the public domain.

A measure that has been considered in order to improve transparency is the publication of the maximum reference price. This measure has been heavily contested by the pharmaceutical stakeholder bodies and has not been implemented to date.

The Ministry for Health is determined to increase the accountability of the Maltese health system by creating capacity for performance monitoring and the creation of a framework wherein monitoring and evaluation must address performance in terms of both health system measures such as availability, access, quality and efficiency, and population health measures like health status, responsiveness, user satisfaction and financial risk protection.

The Ministry for Health is committed to move towards the setting up of specialized business units within hospitals such that a culture of accountability for resource consumption is inculcated among clinical professionals whose activities ultimately determine expenditure in the health system.

8. Conclusions

While marked improvements in health status have been registered in certain areas, the threats posed by obesity could hinder further progress. The increase in life expectancy means that there is a significant number of frail elderly people whose needs need to be more effectively addressed by both the health and social care systems. This need, coupled with supply constraints, gives rise to gaps between demand and supply, especially in services required by elderly people. These gaps include specific surgical procedures, specific types of ambulatory specialist care, and even occasional shortages of free medication for chronic conditions.

In terms of financing, Malta has registered an overall increase in the total health expenditure as a percentage of GDP (8.7% in 2011), although this stands slightly below the EU average (9.6% in 2011; WHO, 2013). This increase is mainly attributed to increasing expenditure within the private sector by way of out-of-pocket payments (34%), which are relatively high when compared to other EU countries (16%). Indeed the relative share of government expenditure on health is in decline.

The structure and processes of the public primary care system need to be evaluated and redesigned to take a larger role within the overall health system. Good practices from the private sector may be used to inform the changes that need to be carried out.

In terms of the hospital sector, the most striking feature that emerges is the bottleneck in shifting patients out of acute care hospitals into rehabilitative and long-term care facilities. This leads to longer stays in hospitals and compromises safety. The number of acute hospital beds per capita in Malta is well below the EU average. To be on a par with the EU average, it is estimated that around 500 additional acute hospital beds would be needed.

In terms of supply of health-care professionals, Malta compares favourably with the EU average, with the exception of nurses, where the number is still below the European average, although progress has been registered recently.

Malta faces important entrenched challenges that, above all, affect the sustainability of public finances. Nonetheless, there exists a strong political commitment to ensure the provision of a health-care system that is accessible, of high quality, safe and – not least – sustainable. This is likely to require investment in the health system to revisit existing processes and to shift the focus of care away from hospital and into the community.

9. Appendices

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9.2 Useful web sites

myHealth: the Government of Malta's portal for online access to health records: www.myhealth.gov.mt

9.3 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.

4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.4 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

9.5 About the authors

Dr Natasha Azzopardi Muscat was Chief Medical Officer for Malta between 2011 and 2013. Prior to that she was responsible for strategy and sustainability, together with EU and international affairs within the Ministry for Health. She was a founding member and past President of the Malta Association of Public Health Medicine. She has also been Section President for Public Health Policy and Practice in the European Public Health Association since 2006. She is currently pursuing her doctoral studies with the University of Maastricht, Department of International Health. Her research interest focuses mainly on European public health policy and the interface between European institutions and Member States in public health and health system.

Dr Neville Calleja is a public health specialist and medical statistician. He has been responsible for health information and epidemiological research within the Ministry for Health since 2007 and, as such, is the focal point for national health indicators for Malta. His doctoral studies with the Open University in the United Kingdom focused on statistical methods to deal with differences between examination and self-reported health surveys and their implications for health policy.

Antoinette Calleja is a PhD candidate at the University of Hull in the United Kingdom. Her doctoral studies focus on EU public procurement and its impact on society with implications for policy-making. She qualified as a nurse in 1984 and in 1986 as a midwife and she actively practised the profession for 11 years. She pursued her studies, completing a Master's Degree in Health Services Management and a Master's Degree in Business Management, both with the University of Malta. She is the founder of the Malta Union of Midwives and Nurses and today is its Honorary President.

Jonathan Cylus is a research fellow at the European Observatory on Health Systems and Policies based at the London School of Economics and Political Science.

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