

Health Systems in Transition

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Malta

Health system review

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Health Systems in Transition

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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 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 HSPM is an international network that works with the Observatory on Country Monitoring. It is made up of national counterparts that are highly regarded at national and international level and have particular strengths in the area of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field and their track record of successful collaboration with the Observatory to develop and update the HiT.

The Department of Health Services Management within the Faculty of Health Sciences at the University of Malta is the leading provider of post-graduate courses and programmes in Health Services Management in Malta. It also carries out health systems and health policy research and is involved in several European research collaborations and networks. It has been a member of the HSPM network since 2014.

The Directorate for Health Information and Research within the Ministry for Health leads the collection, analysis and delivery of health-related information in Malta. It provides high quality epidemiological information and indicators on the health of the population and health services. The Directorate for Health Information and Research is responsible for the management of national health data sets and for carrying out the Health Interview Surveys.

This edition was written by Natasha Azzopardi-Muscat (Department of Health Services Management, Faculty of Health Science, University of Malta; Directorate for Health Information and Research, Ministry for Health, Malta),

Stefan Buttigieg (Directorate for Health Information and Research, Ministry for Health, Malta), Neville Calleja (Directorate for Health Information and Research, Ministry for Health, Malta) and Sherry Merkur (European Observatory on Health Systems and Policies). It was edited by Sherry Merkur of the Observatory's team at the London School of Economics and Political Science. The basis for this edition was the previous HiT on Malta, which was published in 2014, written by Natasha Azzopardi-Muscat, Neville Calleja and Antoinette Calleja, and edited by Jonathan Cylus.

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The European Observatory on Health Systems and Policies is a partnership, hosted by the WHO Regional Office for Europe, which includes the Governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, the United Kingdom, and the Veneto Region of Italy; the European Commission; the World Bank; UNCAM (French National Union of Health Insurance Funds); the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The European Observatory has a secretariat in Brussels and hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.

The Observatory team working on HiTs is led by Josep Figueras, Director, Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors), Ewout van Ginneken, Ellen Nolte and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Gabriele Pastorino. The production and copy-editing process of this HiT was coordinated by Jonathan North, with the support of Caroline White, Sarah Cook (copy-editing) and Pat Hinsley (typesetting).

List of abbreviations

A&E	accident and emergency
ALOS	average length of stay
ALP	Alternative Learning Programme
BST	Basic Specialist Trainee
CI	confidence interval
COPD	chronic obstructive pulmonary disease
DHIR	Directorate for Health Information and Research
DPA	Directorate for Pharmaceutical Affairs
DRG	diagnosis-related groups
EHIC	European Health Insurance Card
EU	European Union
EU-GMP	Good Manufacturing Practice
GDP	Gross Domestic Product
GFL	Government Formulary List
GFLAC	Government Formulary List Advisory Committee
GP	general practitioner
HCSD	Health-Care Standards Directorate
HSPA	Health Systems Performance Assessment
HTA	health technology assessment
ICT	information and communications technology
KNPD	National Commission for Persons with Disability
MDH	Mater Dei Hospital
MFSA	Malta Financial Services Authority
MRI	magnetic resonance imaging
NGO	Non-governmental Organization
NHSS	National Health System Strategy
NPISH	non-profit institutions serving households
OECD	Organisation for Economic Co-operation and Development
POYC	Pharmacy of Your Choice scheme

SAMOC	Sir Anthony Mamo Oncology Centre
SPC	summary of product characteristics
STH	St. Thomas Hospital
VHI	voluntary health insurance
WHO	World Health Organization

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Abstract

Maltese life expectancy is high, and Maltese people spend on average close to 90% of their lifespan in good health, longer than in any other EU country. Malta has recently increased the proportion of GDP spent on health to above the EU average, though the private part of that remains higher than in many EU countries. The total number of doctors and GPs per capita is at the EU average, but the number of specialists remains relatively low; education and training are being further strengthened in order to retain more specialist skills in Malta.

The health care system offers universal coverage to a comprehensive set of services that are free at the point of use for people entitled to statutory provision. The historical pattern of integrated financing and provision is shifting towards a more pluralist approach; people already often choose to visit private primary care providers, and in 2016 a new public-private partnership contract for three existing hospitals was agreed.

Important priorities for the coming years include further strengthening of the primary and mental health sectors, as well as strengthening the health information system in order to support improved monitoring and evaluation. The priorities of Malta during its Presidency of the Council of the EU in 2017 include childhood obesity, and Structured Cooperation to enhance access to highly specialized and innovative services, medicines and technologies.

Overall, the Maltese health system has made remarkable progress, with improvements in avoidable mortality and low levels of unmet need. The main outstanding challenges include: adapting the health system to an increasingly diverse population; increasing capacity to cope with a growing population; redistributing resources and activity from hospitals to primary care; ensuring access to expensive new medicines whilst still making efficiency improvements; and addressing medium-term financial sustainability challenges from demographic ageing.

Executive summary

The Maltese Islands are located in the centre of the Mediterranean. Malta has the highest population density in Europe, with the population having grown by over 7% in the last decade, though it remains the smallest EU Member State by population. Malta was relatively mildly affected by the financial and economic crisis in 2009, with a smaller GDP fall in 2009 and a stronger recovery than most other EU countries, and has a thriving economy based primarily on tourism and financial services. Immigration has become significant, which is changing the traditional culture. Malta is changing from a mono-ethnic population around fifteen years ago to a more diverse, multi-ethnic society. There has also been a shift from a devout Roman Catholic culture to a more socially liberal culture.

Life expectancy in Malta is higher than the EU average. In 2014 life expectancy for men was 79.8 years (compared to 78.1 for the EU), whilst that for women was 84.3 years (compared to 83.3 years for the EU). Moreover, Maltese people spend on average close to 90% of their lifespan in good health, longer than in any other EU country. Increases in longevity are largely due to declining death rates from all causes; Malta has the lowest rates of preventable mortality in the EU. Obesity is the principal public health problem, with 25% of the adult population and 27% of children (aged 11–15 years) being obese: the highest rate in the EU. Diabetes and HIV also have a relatively high prevalence compared to other European countries.

The Ministry for Health has been responsible for both regulation and provision of health services in what has hitherto been mostly an integrated public system of health services organization and delivery, though a substantial shift towards greater private sector involvement is under way. The private sector already carries out a significant amount of activity in the ambulatory and primary care sectors. Its role in the hospital sector is set to increase, with responsibility for management of three hospitals being granted to a private

sector provider in the form of a 30-year concession. The government will continue to remain responsible for the funding of the care provided, and those publicly funded health care services will remain free of charge at the point of use to all those entitled. This is an innovative development for the Maltese health system, although similar arrangements have been in place for several years in the long-term care system. As a result, the Ministry for Health's role will shift from being a direct provider of services to ensuring standards of care through its regulatory function.

Total health expenditure as a percentage of GDP was 9.75% in 2014, which is slightly higher than the EU average of 9.45%. Public spending was only 69.2% of total health expenditure (compared to 76.2% for the EU as a whole), but government spending on health care is increasing strongly, with an 11.4% increase in the current health budget for 2017, and this follows a 12.5% increase for 2016. Out-of-pocket payments made up 94% of the roughly 30% of health care expenditure that is privately funded. EU funding has also played a significant role in the health sector in recent years, providing €29m of infrastructure investment in health care (3.4% of the total EU structural funds allocated to Malta for the period 2007–2013).

The Maltese health system provides a comprehensive basket of health benefits, though a few services, such as elective dental care, optical services and some medicines, are means-tested. Primary and ambulatory care is readily available through the public and private sectors. Many people choose to access primary care services in the private sector because they offer better continuity of care. Secondary and tertiary care is currently provided mainly through public hospitals. The main acute general hospital (Mater Dei) caters for the bulk of emergency care. The private sector accounts for about two-thirds of the workload in primary care and is remunerated on a fee-for-service basis, and will be taking on an increasing role in hospital provision through the new public-private partnership described above, which is also expected to attract international patients. Malta had an acute bed occupancy rate of 83.2% (in 2012), which is above the EU average of 76.6%. Though the number of physicians per head reached the EU average in 2013, the numbers of specialist physicians, dentists, nurses and paediatricians per capita remain below the EU average. Education and training of health care professionals is being strengthened through the introduction of further specialization programmes and new facilities intended to retain more of these skills within Malta. 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 role of

e-health is increasingly important, and investment is planned so as to make more use of e-health services in the Maltese health system, in particular from the European Regional Development Fund.

Several strategies to tackle non-communicable diseases were adopted in recent years, e.g. for breastfeeding, nutrition, diabetes and alcohol, though more remains to be done. A new cancer hospital was built and opened in 2015 (using EU funding) which enabled new services to be introduced, and breast, colorectal and cervical cancer screening programmes have been introduced since 2010.

Reforms in the procurement, stock control and management systems have addressed a frequent problem of interruptions in supply for medicines. A system of health technology assessment has been in place for the approval of new medicines and health services since 2010. However, access to expensive innovative medicines remains a budgetary challenge. This is now being addressed through the introduction of disease management strategies combined with innovative procurement strategies including managed entry agreements and pay-for-performance models.

In response to resource supply constraints, the Government has been commissioning some care from the private sector, notably to address lengthy waiting lists for certain elective interventions. Coupled with increased activity in the public hospital sector, progress has been made in tackling waiting lists for surgical interventions and imaging investigations. Waiting times for diagnostic services and surgical operations as well as for accident and emergency services have been reduced and a Patient Charter has been published underlining the Government's commitment to keep waiting times reasonable (though the maximum waiting time proposed is still 18 months). Attention has now focused on addressing waiting times for certain specialties in public hospital outpatient appointments. Decentralization of services from the hospital setting to the primary care setting continues and a discharge liaison service has been introduced to improve integration of care across settings. Collaborations are being sought with private primary care providers for the provision of follow-up of specific chronic conditions.

The National Health System Strategy adopted in 2014 has the main objectives of: responding to increasing demand and challenges posed by demographic changes and epidemiological trends; increasing equitable access, availability and timeliness; improving quality of care; and ensuring sustainability. In 2015 Malta conducted its first national Health Systems Performance Assessment, with support from the WHO. According to this assessment, responsiveness of

the health system is good, whilst the dimensions of financing, quality, access and health status are fairly good. More, however, remains to be achieved in terms of ensuring sufficient resources, enhancing efficiency and tackling the determinants of health. There is low unmet need, and generally good access to services; however, as data availability improves, there are indications that equity of health outcomes is an important issue that merits further attention, and better capturing and monitoring of private sector performance activity is required. In the longer term, sustainable financing of the health system with a redistribution of resources from hospital to primary care remains an outstanding challenge.

Strong political and public health leadership over the years has allowed Malta to implement a number of important public health measures. This trend is continuing with the ban on tobacco smoking in vehicles (with children present) and the publication of the first national strategy to address alcohol-related harm. Although three out of four Maltese report being in good health, some health behaviours are of concern compared to other EU countries, in addition to the obesity challenge. Rates of binge drinking among young people have declined but remain an important health and social issue. Smoking prevalence has decreased significantly over the past decade. Poor health behaviours tend to be most common among lower socioeconomic groups. Frailty associated with ageing remains a major challenge facing the population as a whole, as does the old age dependency ratio, which rose from 19.3% (2005) to 27.6% (2015). Projections depict a rapidly ageing population, with the ratio estimated to reach 32.7% in 2020, exceeding the EU average of 31.8. This ratio is expected to climb steadily and reach 40.5% by 2030, when the EU average is projected to be 39.0%.

Health system capacity is being stretched due to a combination of factors which include population expansion due to immigration amongst workers and pensioners, a buoyant tourism industry, demographic ageing and altered risk-taking behaviours. Capacity expansion is planned through the construction of a new mother and child complex, which will release much-needed space in the Mater Dei Hospital. Further strengthening of the primary health and mental health sectors is considered to be an important priority for the next years. The development of a new primary health facility in the Southern Harbour area and the construction of a new mental health facility will make an important contribution. It will also be important to integrate the private and NGO sectors, which play an important role in primary and mental health service provision respectively. Strengthening of the health information system is important to enable monitoring and evaluation of the objectives set out in the National Health System Strategy. A renewed e-health strategy, with developments such

as e-prescription, will greatly facilitate the implementation of health system monitoring in situations where the public health system makes the transition from traditional integrated command and control models to an approach where pluralism in health service provision becomes more prevalent.

The priorities of Malta during its Presidency of the Council of the EU in 2017 include childhood obesity, and Structured Cooperation to enhance access to highly specialized and innovative services, medicines and technologies.

Overall, the Maltese health system has registered remarkable progress and this is evidenced by the improvements in preventable and amenable mortality, as well as the generally low levels of unmet need. The main outstanding challenges for the coming period include: adapting the health system to an increasingly diverse population; increasing health system capacity to cope with a growing population; implementing a redistribution of resources and activity from hospital to primary care; ensuring access to innovative expensive medicines whilst concurrently tackling the need to continue identifying efficiency improvements; and addressing the issue of medium-term financial sustainability associated with steep demographic ageing.

1. Introduction

Chapter summary

- The Maltese Islands have a total land area of 316 km² and are located in the centre of the Mediterranean Sea 93 km south of Sicily.
- Malta has the highest population density in Europe and has experienced significant population growth in recent years.
- A thriving economy is based primarily on tourism and financial services.
- Immigration has become an important phenomenon which is changing the traditional cultural context and presents new opportunities and challenges.
- Life expectancy is continuing to increase and reached 82.1 years in 2014 (79.8 years for men and 84.3 years for women).
- The population is ageing rapidly and the old age dependency ratio rose from 19.3% (2005) to 27.6% (2015).
- Obesity is a major public health problem with 25% of the adult population and 27% of children (aged 11–15 years) being obese.

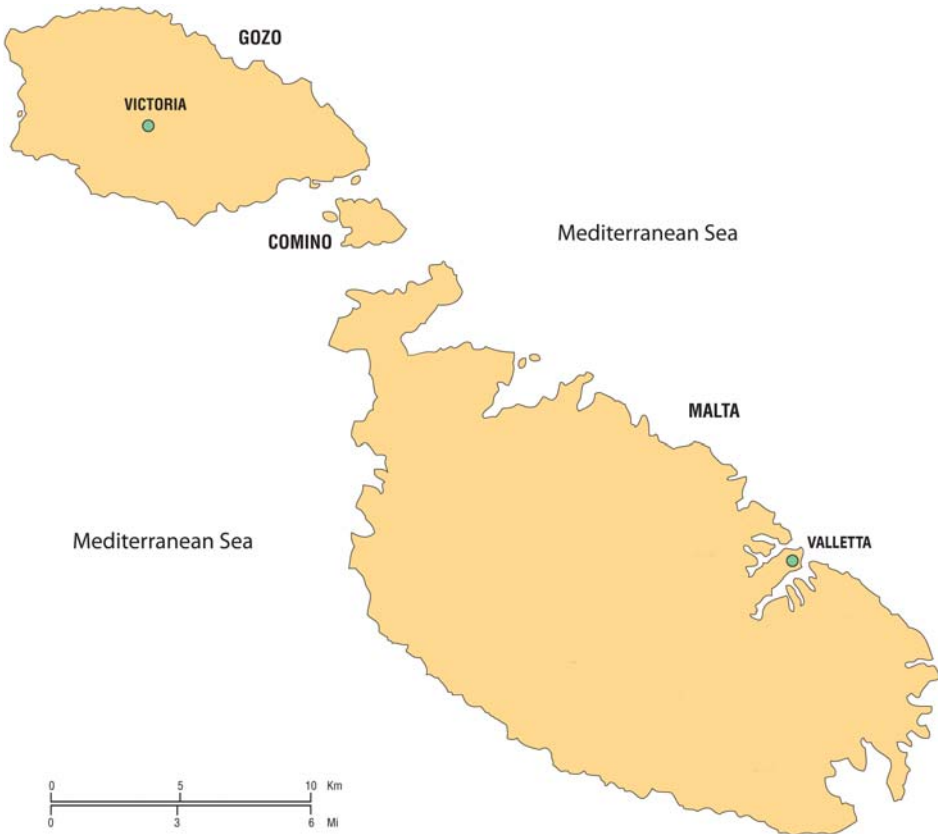
1.1 Geography and sociodemography

Malta comprises an archipelago of five islands; the island of Malta is the largest, followed by Gozo, Comino, Cominotto and Filfla. The latter two are uninhabited islets. The Maltese Islands are situated in the central Mediterranean Sea, 93 km south of Sicily and 290 km north of Libya, with Gibraltar 1826 km to the west and Alexandria 1510 km to the east. The climate is a Mediterranean one, characterized by hot, dry summers and cool winters, with an annual average rainfall of nearly 476 mm. Temperatures are stable, the annual mean being 19°C and monthly averages ranging from 15°C to about 31°C in the summer months

(National Statistics Office Malta, 2014) (Fig. 1.1). The total land area is 316 km² and the population was 431 333 in 2015 (World Bank, 2016). At 1348 persons per km² (Table 1.1), the population density is the highest in Europe.

Fig. 1.1

Map of Malta



Source: Authors' compilation

Population growth has been stable at 0.9% per year since 2013 (World Bank, 2016). Women make up 50.2% of the population. The population is ageing rapidly. The proportion of the population consisting of persons aged 0–14 years has continued to decline and stands at 14.4%, whilst the proportion of persons aged 65 and over has increased from 16.3% in 2011 to 19.2% in 2015 (World Bank, 2016). While the crude death rate has been relatively stable over the past 20 years (7.7 per 1000 persons in 2014), there has been a decline in the fertility rate from 2.0 births per woman in 1991 to 1.38 in 2014. The crude birth rate stood at 9.8 per 1000 in 2014 (World Bank, 2016).

Table 1.1

Trends in population/demographic indicators, 1995–2014, selected years

	1995	2000	2005	2010	2014
Total population	378 404	391 415	405 006	417 617	427 421
Population aged 0–14 (% of total)	21.8	20.1	17.4	15.4	14.4
Population aged 65 and above (% of total)	11.0	12.2	13.4	15.2	18.2
Population density (people per km ²)	1 158.8	1 205.7	1 261.0	1 300.0	1 335.7
Population growth (annual growth rate)	0.7	0.5	0.6	0.5	
Fertility rate, total (births per woman)	1.8	1.7	1.4	1.4	1.4
Distribution of population (percentage urban)	91.0	92.4	93.7	94.7	

Source: WHO Regional Office for Europe, 2016.

The old age dependency ratio, which stood at 19.3% in 2005, rose to 27.6% in 2015 (Eurostat, 2016a). Projections depict a rapidly ageing population with the ratio estimated to reach 32.7% in 2020, thereby exceeding the EU average. This ratio is expected to climb steadily and reach 40.5% (EU average 39.0%) by 2030 (Eurostat, 2016a).

In 2014 almost 94% of the resident population was constituted of Maltese citizens. Malta is currently experiencing net immigration. During 2014 an estimated 8946 persons immigrated to Malta. Less than a quarter of these immigrants were Maltese returned migrants, whilst half were EU nationals. The remainder were third-country nationals. Nearly two-thirds of immigrants were males, with the largest proportion of immigrants being males aged between 20 and 29 years. On the other hand, an estimated 5907 persons left Malta during the period under review. Nearly a quarter of these emigrants were estimated to be Maltese citizens, while half were EU nationals. During the year under review five boats carrying irregular migrants reached Maltese shores. These five boats carried 565 migrants – a decrease of 71.9% in persons on board when compared to the previous year (National Statistics Office Malta, 2016).

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, with all other children attending state-run schools. There have been significant improvements in post-compulsory school participation rates, with the proportion of early leavers from education and training having gone down from 23.8% in 2010 to 19.8% in 2015. The target is to reduce this to 10% (Eurostat, 2016a).

A total of 2871 marriages were registered in Malta during 2014 – an increase of 11.4% when compared to the previous year. Most marriages still occur within the Church; however, the proportion of civil marriages has risen from 33% in 2010 to 48% of total registered marriages in 2014 (National Statistics Office Malta, 2016). Legislation introducing divorce came into effect in October 2011 following the results of a national referendum. In 2014 the Civil Unions Act (Ministry for Justice, Culture and Local Government, 2016a) introduced the possibility for civil partnerships to be registered between two persons of the same sex.

1.2 Economic context

The Maltese economy progressed from one harnessed to the needs of the British colonial administration up to the mid-1960s, to a market-driven economy with an emphasis on higher value added economic activities in services, notably financial services and tourism. Challenges to the Islands' economy are the relatively small domestic market and the disadvantages brought about by insularity. Major assets are a pleasant and attractive climate, and a qualified and skilled labour force (National Statistics Office Malta, 2014). 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.

The Maltese economy weathered the financial and economic crisis successfully and has experienced marked growth rates over the past years. Real GDP growth was 3.5% in 2014 and 4.3% in 2015. The gross public debt stood at 65.9% of GDP in 2015. In the final quarter of 2016 Malta does not appear to face significant risks of fiscal stress. The European Commission projects medium sustainability risks which are entirely related to the strong projected impact of age-related public spending (notably pensions, health care and long-term care) (European Commission, 2015a).

Unemployment stood at 4.9% in the second quarter of 2016, one of the lowest rates in the European Union (Ministry for Finance, 2016). Employment has increased from 60% of the total population in 2010 to 68% in 2015. Unemployment reached a record low in 2015 at 5.4%. The employment rate of older workers (aged 55–64 years) has gone up from 33% in 2010 to 40% in

2015. The gender employment gap remains the highest in the EU at 28% (2015), but has exhibited a steady downward trend from 45% in 2005 and 37% in 2010 (Eurostat, 2016a).

The introduction of free child care centres was one of the measures introduced in 2014 to further incentivize women to remain in the labour market.

Table 1.2

Macroeconomic indicators, 1995–2015, selected years

	1995	2000	2005	2010	2015
GDP per capita	9 717.5	10 377.0	14 809.9	19 624.9	20 400
GDP per capita, PPP (current international US\$)	15 364.6	19 041.6	21 018.6	26 672.2	29 268.0 ¹
GDP growth rate (annual %)	6.3	6.8	3.7	2.7	6.4
Public expenditure (% of GDP)			43.6	41.6	43.3
Cash surplus/deficit (% of GDP)			-2.9	-3.6	-1.5
Public debt (% of GDP)	34.2	53.9	68.0	67.4	63.9
Unemployment, total (% of labour force)		6.3	7.3	6.9	5.4
Poverty rate*			14.3	15.5	15.9 ²
Income inequality (Gini coefficient)			27.0	28.6	27.7 ²

Source: Eurostat, 2016a.

Notes: ¹ 2013; ² 2014; *The 'at-risk-of-poverty rate' is the share of people with an equivalized disposable income (after social transfer) below the at-risk-of-poverty threshold, which is set at 60% of the national median equivalized disposable income after social transfers.

The share of the population at risk of poverty and social exclusion is lower than the average in the EU. The at-risk-of-poverty rate (the number of persons earning below 60% of the median national equivalized income) was 15.9% in 2014. 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 people aged 65 and over. Almost a quarter of children (24.1%) under the age of 18 and 16.9% of older people (aged 65 and over) were found to be at risk of poverty in 2014 (Eurostat, 2016a). Whilst the rate in the over 65 year olds shows a decreasing trend, the rate in children is increasing.

1.3 Political context

In 1964 Malta obtained independence from Britain, and 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 party, *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. In 2016 in Malta there are 68 local councils (54 in Malta and 14 in Gozo). Until 2015 elections were held every three years. The next elections are due in 2019 and will henceforth coincide with the European Parliament Elections. 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. 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. However, local councils are becoming increasingly involved in the provision of community health care (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 socialist party and the European People's Party (EPP) for the nationalist party; *Alternattiva Demokratika* has joined the European Greens.

Malta acceded to the EU in May 2004 and is holding the Presidency of the Council of the European Union for the first time between January and June 2017. Malta is also a member of international organizations including the United Nations, the World Trade Organization, the Commonwealth and NATO's Partnership for Peace.

1.4 Health status

Malta has experienced a steep rise in life expectancy since the 1990s (England, Vogt & Azzopardi-Muscat, 2016) and average life expectancy at birth in 2014 was 82.1 years, 79.8 years for men and 84.3 years for women (Table 1.3). The probability of dying in the younger age groups (15–60 years) has been decreasing steadily with a wide gap between males and females, partly attributable to ischaemic heart disease and external causes of death, such as traffic accidents and suicides. The total crude death rate in 2014 stood at 7.7, whilst the infant mortality rate was 5.0 per 1000 live births.

Table 1.3

Mortality and health indicators, 1995–2014, selected years

	1995	2000	2005	2010	2014	EU (2013)
Life expectancy at birth, total	77.3	78.2	79.4	81.5	82.3	80.6
Life expectancy at birth, male	75.0	76.0	77.2	79.3	80.0	77.7
Life expectancy at birth, female	79.6	80.3	81.4	83.6	84.4	83.4
<i>Mortality, SDR per 100 000 population</i>						
Circulatory diseases	318.6	326.1	272.0	189.3	174.7	202.5
Diabetes	22.3	18.9	22.0	17.18	22.9	
Malignant neoplasms	198.2	171.0	145.4	151.7	141.0	163.9
Communicable diseases	6.5	5.6	3.4	0.9	4.2	8.8
External causes of death (injury and poisoning)	25.84	25.57	25.86	24.9	20.0	34.4
All causes	748.6	707.56	627.88	514.14	487.2	575.5
Infant mortality rate	8.9	6.0	6.0	5.5	5.0	3.8

Sources: National Statistics Office Malta, 2016; WHO Regional Office for Europe, 2016.

Circulatory diseases accounted for 37.6% of deaths in 2014 and are the leading cause of death. Neoplasms accounted for 28.5% of all deaths, while 9.5% of deaths were due to respiratory conditions, mainly chronic obstructive airways diseases and chest infections. Diabetes as underlying cause of death accounted for 4.8% of all deaths. As the population survives to older age, deaths due to dementia become more important. Dementia accounted for 4.4% of all deaths in 2014 (Directorate for Health Information and Research, 2015).

While the overall number of deaths has been increasing over time, standardized mortality rates reveal a downward trend that compares well with the EU average.

Mortality from circulatory diseases has decreased markedly over the past 20 years and is now below the EU average, although it remains higher than in the EU-15. This decrease may be attributed to the decline in smoking prevalence, as well as the investment in local cardiac services that took place in the mid-1990s (Azzopardi-Muscat, 1997). The relatively high and still increasing prevalence of obesity and diabetes remains an important risk factor for circulatory disease. Standardized mortality rates for diabetes remain mostly unchanged. The standardized mortality rate for neoplasms has declined and this is also reflected in an overall increase in five- and ten-year survival rates.

Lung cancer accounted for 18% of total deaths in 2013, followed by colorectal (13%), breast (10%) and pancreas (8%) (Directorate for Health Information and Research, 2013). Cancer incidence is expected to continue rising by 1.5–2% per year. On the other hand, cancer survival in Malta is continuously

improving. The age-standardized ten-year survival rate from all cancers for patients diagnosed and managed in Malta (2008–2012) is now approaching 50%. Remarkable improvements in survival have been demonstrated for malignant melanoma, breast, testicular, thyroid and prostate cancers. However, outcomes have remained unchanged for some cancers, such as those of the lung, pancreas, stomach and brain, and specific types of acute leukaemias in adults (see also Section 7.2).

Deaths from communicable diseases are low. Tuberculosis is an important condition in sub-Saharan migrants and the Chest Unit organizes screening and outreach programmes to monitor and manage this condition. In the years immediately following EU accession, when irregular immigration increased, an increase in HIV incidence was noted associated with sub-Saharan migrants. More recently, however, the increase in HIV incidence that has been documented is due to outbreaks of the disease amongst the men who have sex with men (MSM) community.

Whilst daily tobacco smoking prevalence has decreased (from 23.4% in 2002 to 20.1% in 2014), obesity remains an important public health issue both in adults and in children, with 25.3% of the adult population (Eurostat, 2016a) and 27.0% of 11–15 year olds (HBSC, 2016) being obese. Alcohol consumption is considered an important public health issue. Whilst binge drinking in adults appears to have increased between 2008 and 2014 (results from European Health Interview Survey), data from ESPAD shows how since 1999 the trend has been a downward decline in most patterns of alcohol use among young people aged 15 and 16. Alcohol use in the last 12 months (20+ times) declined from 51% in 1999 to 19% in 2015, while alcohol use in the last 30 days declined from 30% to 11%. Heavy episodic drinking in the last month (drinking more than five drinks in a row) declined from 57% in 2007 to 47% in 2015. Drunkenness in the last 30 days also declined from 19% in 2007 to 15% in 2016. Those reporting being drunk at 13 years or younger declined from 14% in 1999 to 8% in 2015 (Ministry for the Family and Social Solidarity, 2016).

In 2012 the Mental Health Act was adopted (Ministry for Justice, Culture and Local Councils, 2016b). This came into force in 2013. Since 2012 there has also been a Commissioner for Mental Health, whose role is to promote and protect the rights and interests of persons with mental disorders and their carers. The European Health Interview Survey conducted in 2014 showed that 4.6% of persons reported the presence of depressive symptoms. In the 2015 Annual Report, the Commissioner for Mental Health stated that patients are still far from being empowered about their rights, with fewer than 25% claiming

Table 1.4

Morbidity and factors affecting health status, 2002–2014, selected years

		2002	2008	2014	EU average (2014)
Morbidity past 12 months	Diabetes	5.7	6.7	8.3	
	Asthma	4.0	5.5	5.8	
BMI	Overweight + Obese	57.6	58.6	59.7	51.1
	Obese	23.1	22.3	25.3	16.1
Smoking	Daily smokers	23.4	20.3	20.1	19.5
Alcohol	Binge drinking at least once a month	–	11.2	19.0	22.0
Nutrition	Fruit consumption at least once a day	63.9	73.8	57.5	53.7
	Vegetable consumption at least once a day	28.9	50.5	39.9	48.6
	At least five portions of fruit and/or vegetables daily	–	–	16.8	14.4
Physical activity	Walking/cycling at least 30 minutes a day for transport	–	–	22.6	
	Sports/recreation/fitness activities at least once a week	–	–	51.5	
Mental health	Presence of major depressive symptoms	–	–	1.5	
	Presence of other depressive symptoms	–	–	4.6	

Sources: Directorate for Health Information and Research, Malta, 2016 (data analysis performed on the National Health Interview Survey, 2002; European Health Interview Survey Malta, 2008; and European Health Interview Survey Malta, 2014).

that their rights had been explained to them, although two out of three respondents felt that they had participated in their care as much as they wished (Commissioner for Mental Health, 2016).

Whilst the birth rate declined in the first few years of this millennium, since 2007 an upward trend in deliveries has been observed. This is due to an increase in deliveries in non-Maltese nationals, which made up 17% of all deliveries in 2014. Maternal age at delivery has shown significant changes in recent years with the average age at delivery increasing from 28 years in 2000 to 30 years in 2014. The percentage of births to teenage mothers increased between the 1990s and 2010 but has started to decline in recent years. There were four maternal deaths registered in the past 15 years (2000–2014), giving a maternal mortality ratio of 6.5 per 100 000 live births over this period. The caesarean section rate remains rather high at 32.5%. This is notably higher in non-Maltese persons, who have also been found to be more likely to present at antenatal clinics for booking later than fourteen weeks gestation (Directorate for Health Information and Research, 2014).

The infant mortality rate was 5.0 per 1000 live births in 2014, higher than the EU average of 3.8 (2013). An in-depth analysis has been conducted and shows that this figure is partly attributable to a higher rate of congenital anomalies which are carried to term delivery (Gatt et al., 2015). Furthermore, for example, the total prevalence rate of neural tube defects (i.e. including all cases: live births, stillbirths and terminations of pregnancy) reported for European countries (2008–2012) is similar to that reported by Malta. However, the live birth rate reported by Malta in the same period is the highest reported in Europe. Termination of pregnancy in Malta is illegal (Directorate for Health Information and Research, 2016b).

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, a degree of under-reporting remains because some children are vaccinated in the private sector.

Chronic conditions associated with obesity, unhealthy lifestyles and frailty associated with ageing remain major challenges facing the population as a whole. A number of health policy documents, which have a strong focus on health promotion, primary disease prevention and intersectoral collaboration, have been launched since 2014. These include the Food and Action Nutrition Plan 2015 and the first National Diabetes Strategy 2015. Implementation of earlier strategies, including the Non-communicable 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, is ongoing. Work is also under way towards the publication of the second national cancer plan (Ministry for Health, 2016e).

Box 1.1 **Health inequalities**

Self-perceived health and behavioural risk factors tend to be more common among persons with a lower level of educational attainment. For example, a quarter of people with education below completing secondary school in Malta were daily smokers, compared to 18% among those with a degree. Likewise, over 32% of those in the lowest income quintile are obese, compared to 19% in the highest income quintile. In terms of physical activity, persons with a lower level of educational attainment are far more likely to report low levels of physical activity than persons with higher levels of education. The self-reported prevalence of hypertension in persons having completed secondary school or lower levels of education was 29% compared to 25% in those with a degree. Even more striking is the gap in self-reported prevalence of diabetes, with 12% of persons having completed secondary school or lower levels of education reporting having diabetes compared to less than 6% of those with a degree (Eurostat, 2016a).

Source: Gauci, 2016.

2. Organization and governance

Chapter summary

- 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 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.
- The Ministry for Health is divided into three departments and three regulatory bodies. The three departments are the Department of Health Policy, the Department of Health Services and the Department of Health Regulation. The three main regulatory bodies are the Council of Health, the Health Policy and Strategy Board and the Advisory Committee on Health-Care Benefits.
- Private-public partnerships are being introduced within a number of hospitals and primary health care services.
- The Directorate for Health-Care Standards within the Department of Health Regulation plays a crucial role in the regulation of health care services provision alongside other entities such as the Medicines Authority and the National Commission on Higher Education.
- The recently published Charter for Patient Rights and Responsibilities is paving the way forward by empowering patients to be fully informed and receive health care within a reasonable time.

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 children, the family and people with a disability, older 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, in line with the latest Fiscal Responsibility Act enacted in 2014. 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. Public sector funding is from general taxation and public expenditure comprised almost 69% of total health expenditure in 2014, while out-of-pocket payments and voluntary health insurance make up most of the remaining spending (see Chapter 3).

2.1 Organization

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 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 are estimated to account for around two-thirds of consultations. 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 and 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 be neither cost-effective nor feasible to conduct such treatment locally.

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 children, the family and people with a disability, older 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.

The 2013 Health Act replaced the Department of Health (Constitution) Ordinance, which was enacted in 1937 and assigned powers to specific government positions. The Act 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.

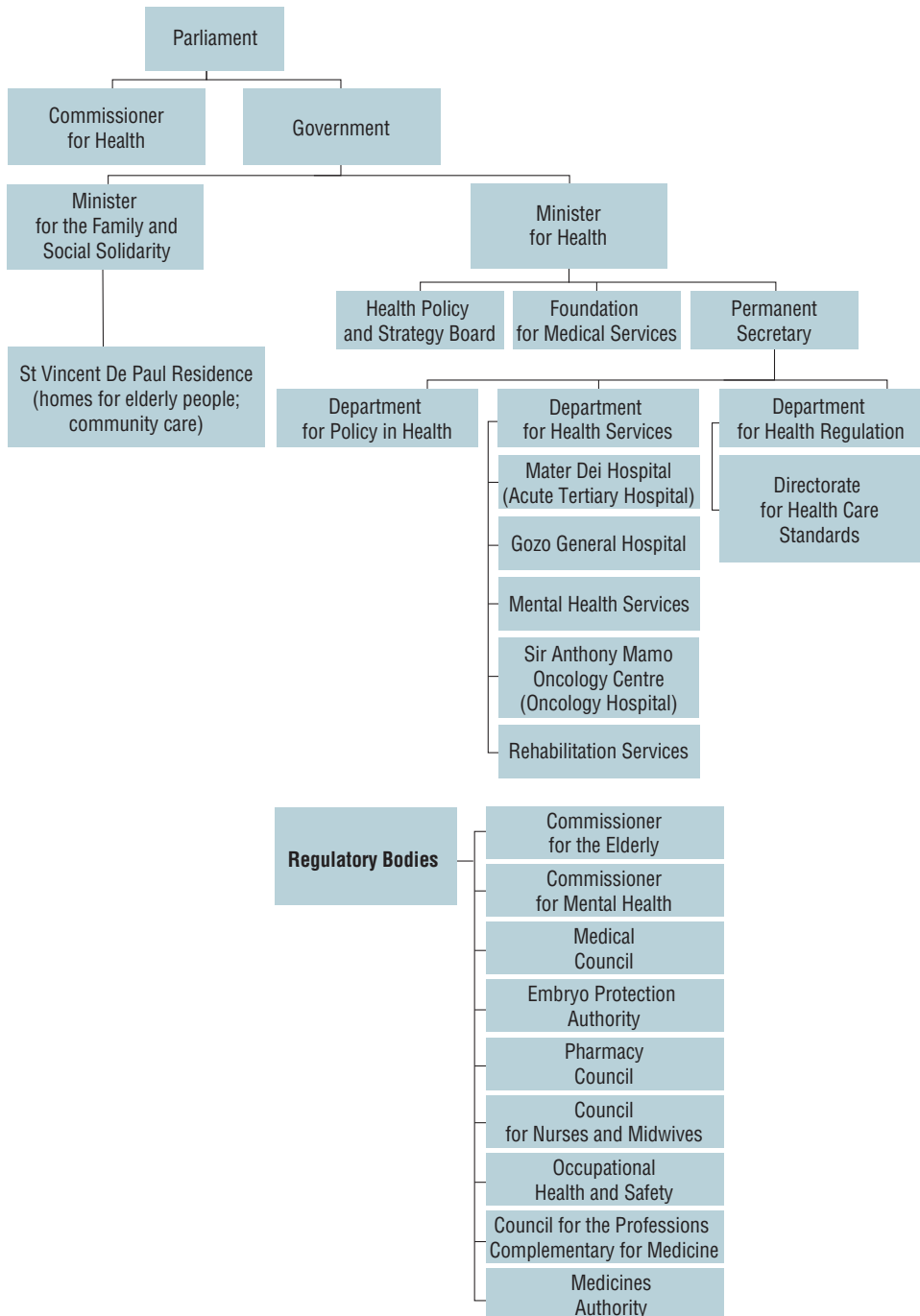
Within the Ministry for Health, the Permanent Secretary is the administrative head. S/he is a public officer accountable to the Prime Minister. S/he has the responsibility to support the general policies and priorities of the Government and to operate within the context of management practices and procedures 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 of Health 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 Superintendence 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 Superintendence will also advise the Minister of Health 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 Committee on Healthcare Benefits. The Health Policy and Strategy Board brings together all the directorates, the Minister of Health, 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 the Government and other stakeholders to advise the Ministry for Health on matters related to public health. The Advisory Committee on Healthcare Benefits recommends the benefits package to be provided by the public health care system and maintains a publicly accessible list of such benefits.

Fig. 2.1
Overview of the health system



Source: Adapted from Ministry for Health (2016h).

Box 2.1**Historical background**

In 2014 the Ministry for Health was incorporated with the Ministry for Energy as a result of a cabinet reshuffle, bringing about the appointment of a new Parliamentary Secretary for Health; this resulted in a number of developments which focused on the administrative and managerial aspect of health care. In the early months of 2016 the Ministry for Health was separated from the Energy Portfolio and was reinstated as its own Ministry. This reshuffle has not affected the structure of the Department of Health and the portfolio of duties since 2014 has remained the same.

This change has not affected the relationship between health and social care since care for older people has been under the Ministry for the Family and Social Solidarity.

The above reflects changes that have taken place since January 2014. For earlier references to the historical development of the services, readers are referred to earlier HIT reports (Azzopardi-Muscat et al., 2014; European Observatory, 1999).

In addition to the above, in the interests of patient rights the Government established three commissioner functions: the Commissioner for Health, the Commissioner for Mental Health and the 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 various 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: the 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 Catholic Church still plays an important role in the provision of nursing homes for older people, homes for people with a disability, homes for people with a mental disorder and homes for children. However, it is increasingly facing great difficulties in continuing to provide these services as the care providers are dwindling in number. This is because most nuns are now in older age and are not being replaced by sufficient younger ones, as well as the limited resources available.

A number of associations exist for the health 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-mentioned associations are also registered trade unions and represent their members to various bodies both at 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 Haddiema Maghqudin – Voice of the Workers.

2.2 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 2013 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.

However, this situation is set to change quite markedly. In 2016 a new development took place through the public-private partnership agreements between an international profit-making health care organization, Vitals Global Healthcare, and the Government of Malta. This agreement effectively transfers

responsibility for the management of Gozo General Hospital, St Luke's Hospital and Karin Grech Hospital to the private sector organization for a period of 30 years. Further details on this reform are provided in Chapter 6.

In primary health care there has been some delegation of primary health care services to local councils, with a number of peripheral clinics operating from local councils.

2.3 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 activities and serves as a platform for the numerous NGOs that are active both as policy advocates and as service providers in this field. Another significant example of intersectorality is seen in the Alternative Learning Programme (ALP) taking place at the ALP Vocational Creative Centre in Paola, where students are taught a different curriculum that focuses on the integration of students into the educational system and prepares them for employability after secondary school.

2.4 Regulation and planning

Public health strategies, including the national health systems strategy, are evidence-informed with planning being related to projected population needs based on the available epidemiological information. Nonetheless, services planning is also limited by the available financing as well as by the available human resources. For example, when the number of nurses was identified as insufficient, this was addressed through recruitment from other countries. In this sense, inputs can act as an important determinant of health system planning. In terms of health workforce, a number of educational programmes are limited by a numerus clausus (fixed numbers of students) but this is more closely

related to educational capacity. Although health planning is a central function of the Ministry for Health, capital projects are usually executed through the Foundation for Medical Services. There are no health plans at regional or local levels.

Box 2.2

Evaluating priority-setting and planning

The Department for Health Policy headed by the Chief Medical Officer is tasked with policy development and has developed a number of policies over the period 2014–16. Once policies are drafted, they are released for consultation by the Ministry for Health through the Consultations Portal available on the Government Network of sites (Government of Malta, 2016). Since 2014 various strategies have been released which have undergone this process, such as the Food and Nutrition Plan, the new bill on organ donation, the Diabetes Strategy and the National Health Systems Strategy.

Priorities are set out in the political parties' electoral programmes which were released before the 2013 general elections. The focus on key proposals, which include elements such as free and prompt health care for all, cutting down on waiting times and waiting lists, and acting relentlessly in the fight against cancer and diabetes, accurately reflects the focus of the Ministry for Health. As a member of the European Union (EU), Malta (and hence the Ministry for Health) is also guided by the EU and World Health Organization (WHO) priorities accompanied by close monitoring of epidemiological trends. At times, priorities are also driven by the media, and public pressure can play a part.

The policy development process has improved substantially over the past decade. A structured system of consultation is now in place and extensive reference is made to WHO and the EU in the drawing-up of strategies. Budgetary impact assessment has also become a mandatory component of policy and strategy development.

2.4.1 Regulation and governance of third-party payers

The Malta Financial Services Authority (MFSA) is the single regulator for financial services activities in Malta. It regulates and supervises credit and financial institutions, investment, trust and insurance businesses.

The voluntary health insurance (VHI) market is regulated by the MFSA in the same way as other insurance businesses. Although there is no VHI-specific regulation, in 2007 the MFSA issued an Insurance Rule that provided information for policyholders on the information that an insurer must provide to potential policyholders before agreeing a contract, the information policyholders must receive during the term of their contract, and the manner in which this information is to be provided. Over the years,

the Consumer Complaints Manager of the MFSA has received a number of complaints against private health insurers, usually related to increases in premiums and the unaffordability of VHI for older age groups (MFSA, 2012). Price increases are more common in the VHI market than in other types of insurance, mainly due to medical inflation and increased use of private care, but they have slowed down in the past couple of years, possibly due to increasing competition.

2.4.2 Regulation and governance of provision

The Government plays a crucial role in the regulation of health care providers at a national level through the Department for Health Regulation, specifically the Superintendence of Public Health. The role of the Superintendence is to give direction to the directorates falling within the Superintendence of Public Health to ensure that the regulatory functions emanating from the law are properly discharged. The Superintendent of Public Health assists and advises the Ministry for Health on the formulation of regulations and standards, and ensures that regulations and standards which are promulgated by the Government are implemented by both state and private service providers. Within the Superintendence, there is the Directorate for Health-Care Standards, which has a number of objectives related to the regulation and governance of health care provision, such as formulating and recommending national standards for hospital services, homes for older people and community care. In addition, the Directorate for Health-Care Standards also works to inspect and license hospital services, clinics, community and primary care services and homes for older people, amongst a significant number of objectives. The following table outlines the regulation and governance of provision in the Maltese health care system.

Table 2.1
Overview of the regulation of providers

	Legislation	Planning	Licensing/ accreditation	Pricing/ tariff setting	Quality assurance	Purchasing/financing
Public health services	Health Act 2013	Ministry for Health	Directorate for Health-Care Standards	Not applicable	Superintendence of Public Health	MFH
Ambulatory care (primary and secondary care)	Health Act 2013	Ministry for Health	Directorate for Health-Care Standards	Not applicable	Superintendence of Public Health	Households, MFH and VHI
Inpatient care	Health Act 2013	Ministry for Health	Directorate for Health-Care Standards	Not applicable	Superintendence of Public Health	MFH, VHI and Households
Dental care	Health Act 2013	Ministry for Health	Directorate for Health-Care Standards	Not applicable	Superintendence of Public Health	Households, VHI and MFH
Pharmaceuticals	Medicines Act 2003	Ministry for Social Dialogue, Consumer Affairs and Civil Liberties and Ministry for Health	Medicines Authority	Not applicable	Medicines Authority	Households, MFH
Long-term care	Proposal for Minimum Standards for Care Homes for Older People (Legislative Proposal 2016)	Ministry for Family and Social Solidarity	Directorate for Health-Care Standards	Not applicable	Directorate for Health-Care Standards	MFSS, Pensioner (Co-payment)
University education of personnel	Education Act 1988	Ministry for Education and Ministry for Health	National Commission for Higher Education	Set by providers	National Commission for Higher Education	MFE and Households

Source: Authors' compilation.

Notes: MFE = Ministry for Education; MFH = Ministry for Health; MFSS = Ministry for Family and Social Solidarity; VHI = voluntary health insurance.

2.4.3 Regulation of services and goods

Basic Benefit Package

The Advisory Committee on Healthcare Benefits is the main decision-making body that determines which goods and services are to be included or excluded from the statutory benefits package. In making decisions, the Committee examines the potential benefit to patients from the international evidence, health technology assessments (HTAs) and consultations with relevant stakeholders, as well as considerations for capacity within the public health system, social and epidemiological factors, and affordability and sustainability. In the case of vitally urgent and necessary treatment, the Chief Medical Officer may authorize the provision of specific health care benefits by duly reporting to the Minister for Health and the Advisory Committee at the first available opportunity.

Health technology assessment

Applications for market authorization of new medicines are received from 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. Researchers within the DPA perform 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 a new medicine to the Government Formulary List (GFL), as well as the relevant maximum reference price. The GFLAC submits recommendations to the Advisory Committee on Healthcare Benefits, which makes the final decision. 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; these have been included in the scope of evidence-based review and assessment in the Health Act 2013 which has been implemented in its entirety. The Ministry also collaborates with the European Network for Health Technology Assessment and the National Institute for Health and Care Excellence.

2.4.4 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 Superintendence 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 safety. The list of all authorized medicinal products and the approved package leaflet and the summary of product characteristics (SPC) 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 SPC 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 undertake product substitution at the pharmacy level as long as the product dispensed has the same active ingredient, dose and dosage form as that prescribed.

Regulation and governance of pharmacies

Pharmacy licence regulations specify the criteria for opening new pharmacies, as well as the standards to be maintained. The number of pharmacies that may be licensed within the boundaries of any town or village should not be less than two, and such pharmacies should be situated no less than 300 metres distant from each other. In every town or village the number of pharmacies should not exceed a pharmacy to population ratio of 1:2500. 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 purchase medicines from unauthorized Internet pharmacies, these cannot be regulated. In addition to the information on specific products available through published pack leaflets and SPCs, 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. Clawback systems do not exist.

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 EU legislation and is continuously updated to reflect changes in EU legislation.

2.5 Patient empowerment

The Health Act 2013 provides for the nomination of individuals representing patient associations to sit on the Council of Health. In addition, the Health Act also foresees the enactment of a Charter for Patient Rights and Responsibilities. In line with this requirement, a new Charter of Patient Rights and Responsibilities was published in November 2016.

2.5.1 Patient information

Patients have the right to receive all the 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 the intervention, the predicted duration and frequency, any potential contraindications relevant to 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.

Cultural mediators are often used to provide information and to translate into minority languages.

There is no recording and publication of medical errors.

In 2015 the “Care and Cure” nationwide campaign was launched by Mater Dei Hospital to raise awareness on patient care in an effort to provide a better experience for all hospital users (Mater Dei Hospital, 2015). It includes useful information for patients and visitors. However, in general patients do not have access to information on quality or cost of services. In the public health care system services are provided free of charge at the point of use.

Table 2.2

Patient information

Type of information	Is it easily available? (Y/N)	Comments
Information about statutory benefits	Y	
Information on hospital clinical outcomes	N	
Information on hospital waiting times	N	Information is made publicly available from time to time
Comparative information about the quality of other providers (e.g. GPs)	N	
Patient access to own medical record	Y	
Interactive web or 24/7 telephone information	N	
Information on patient satisfaction collected (systematically or occasionally)	Y	Only for Mater Dei Hospital
Information on medical errors	N	

Source: Authors' compilation.

2.5.2 Patient choice

Patient choice is virtually unlimited in the private sector with patients being able to choose between several private health insurances, GPs, specialists and allied health providers. There are also several licensed clinics and small hospitals in the private sector. 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.

In the public health care system there is no choice of insurer as the system is funded through general taxation. GP services are provided through health centres and patients do not have a specific relationship with a single GP. There is the possibility for some choice regarding specialist services since a particular preference may be indicated by the doctor making the referral. Choice in public hospital services is naturally restricted by the limited availability of hospitals on the islands. Some patients may opt to seek services at the Gozo General Hospital to be investigated in a shorter timeframe; this option is offered to patients by their consultants on a case-by-case basis.

Table 2.3
Patient choice

Type of choice	Is it available? (Y/N)	Do people exercise choice? Are there any constraints (e.g. choice in the region but not country-wide)? Other comments?
Choices around coverage		
Choice of being covered or not	N	There is no opt-out; automatic coverage
Choice of public or private coverage	Y	
Choice of purchasing organization	Y	Only for Voluntary Health Insurance
Choice of provider		
Choice of primary care practitioner	Y	Only in the private sector
Direct access to specialists	Y	Only in the private sector
Choice of hospital	Y	Only in the private sector
Choice to have treatment abroad	Y	In line with Cross-Border Directive
Choice of treatment		
Participation in treatment decisions	Y	
Right to informed consent	Y	
Right to request a second opinion	Y	In the public sector there is a right to request change of main care provider
Right to information about alternative treatment options	Y	

Source: Authors' compilation.

2.5.3 Patient rights

The new Charter for Patient Rights and Responsibilities, which was published in November 2016, is the main instrument regulating patient rights. The Charter was issued as a direct requirement from the Health Act 2013.

The Mental Health Act, which established the Office of the Commissioner for Mental Health, has made a significant improvement to promote and protect the rights and interests of persons with mental disorders and their carers. Particular provisions and safeguards have been implemented for patients who are admitted to a mental health institution (Ministry for Health, 2016a).

Table 2.4
Patient rights

	Y/N	Comments
Protection of patient rights		
Does a formal definition of patient rights exist at national level?	Y	Health Act
Are patient rights included in specific legislation or in more than one law?	Y	Included in more than one law (Health Act, Data Protection)
Does the legislation conform with WHO's patient rights framework?	Y	
Patient complaints avenues		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Y	Customer Care within Mater Dei Hospital/Customer Care Office within the Ministry for Health
Is a health-specific Ombudsman responsible for investigating and resolving patient complaints about health services?	Y	Commissioner for Health
Other complaint avenues?	Y	Phone, mail (electronic or conventional)
Liability/compensation		
Is liability insurance required for physicians and/or other medical professionals?	Y	Since 2013
Can legal redress be sought through the courts in the case of medical error?	Y	
Is there a basis for no-fault compensation?	N	
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Y	Tort system exists
Can class action suits be taken against health care providers, pharmaceutical companies, etc?	Y	

Source: Authors' compilation.

2.5.4 Patients and cross-border health care

Eurobarometer surveys have repeatedly shown that the Maltese population has the highest propensity to seek cross-border health care. Malta has a strong tradition of organizing cross-border health care services to make up for the limitations posed by the small population size rendering it impossible to provide the full scale of highly specialized health services locally. Patients who require highly specialized care for the treatment of rare diseases or specialized interventions may therefore be sent overseas in view of the fact that it would be neither cost-effective nor feasible to conduct such treatment locally. Cross-border referral for highly specialized services is organized by the National Highly Specialized Overseas Referrals Programme (Palm et al., 2013). This programme was established initially around 60 years ago. There are bilateral agreements in place with the United Kingdom and with a number of regions in

Italy (Azzopardi-Muscat et al., 2006; Saliba et al., 2014). The Treatment Abroad Committee evaluates all referrals made under this programme (Ministry for Health, 2016c). The following are the criteria for referral:

- the service cannot be provided locally;
- the case is discussed with other local consultants in other specialties and thus it is ascertained that patient has received all possible treatment locally;
- the service being requested forms part of Malta's health care package; and
- the service being requested is clinically proven and is not in its trial phase.

Since 2013, in line with the requirements of the directive on patients' rights in cross-border health care, the Ministry for Health has a national contact point on cross-border health care which provides patients with further information and practical assistance should they request it. Patients are encouraged to seek the services of the national contact point prior to obtaining cross-border health care services in order to verify the following points (Ministry for Health, 2016b):

- whether the health care service/treatment being sought forms part of the basket of services offered by the Maltese public health care system;
- whether formal permission/prior authorization is needed from the Department of Health;
- which health care services are refundable and what the funding will cover;
- what documentation must be provided before leaving Malta and on return to be able to claim reimbursement;
- planning for continuity of care, which will include any necessary aftercare on return to Malta;
- the standards and guidelines on quality and safety laid down by the Member State in which treatment is sought; and
- whether other options for treatment abroad apply.

The web site on Cross-Border Health Care also provides a 'frequently asked questions' section seeking to cover common patient queries.

An evaluation of the early impact of the directive showed that a much-feared patient exodus had not materialized. This is likely to be due to several factors, including the national highly specialized overseas referrals programme which already caters for over 400 patients annually (Azzopardi-Muscat et al., 2015).

Malta has built a steady dental tourism industry. Some patients are also reported to seek cosmetic surgery services. However, no official statistics are available. During the conflict in Libya, Malta was a destination for Libyan patients seeking treatment for injury as well as medical services. The Government has declared its strategy to embark on a medical tourism programme as part of the public-private partnership arrangements referred to earlier in this chapter (Grima, 2015). The development of medical tourism is viewed as an important component in the overall strategy to maintain a public health service that is available to all free of charge at the point of use.

Around one in ten patients admitted or seen within hospitals and health centres is non-Maltese (personal communication from the CEO of Mater Dei Hospital, based on data obtained from the Clinical Performance Unit at MDH). These people are usually tourists or residents rather than people specifically seeking health services in Malta.

3. Financing

Chapter summary

- Total health expenditure as a percentage of GDP was 9.75% in 2014, which is above the EU average of 9.45%. Private spending accounted for 3% of GDP (compared to 2.2% in the EU), while public spending was only 6.74% of GDP (compared to 7.24% in the EU).
- Private spending consists mostly of out-of-pocket expenditure with private health insurance contributing a minor component.
- In 2016 €466 million was budgeted for health, a 12.5% increase over the previous year.
- Government expenditure on health has increased and now accounts for over 15% of general government expenditure.
- The Advisory Committee on Health Benefits (ACHB) has been set up as a result of the implementation of the Health Act 2013. The mandate of this committee is to advise on allocation of resources, together with the Government Formulary List Advisory Committee (GFLAC). This committee determines the contents of the comprehensive benefits package.
- A few services such as elective dental care, optical services and some formulary medicines are means-tested.
- EU funding has played an important role in the health sector in recent years with 3.4% of the total allocated funds earmarked for direct health care investments in the period 2007–2013.
- The Annual Government Budget allocation, which is funded by national taxes and other sources of general revenue, provides fixed budgets to the Ministry for Health and the Ministry for the Family and Social Solidarity. The Ministry for Health finances primary care, acute hospitals, mental health, ambulatory specialities, medicines and equipment, whilst social care is funded by the Ministry for Social Solidarity.

- Hospitals are funded through global budgets.
- Financial sustainability is an issue for the medium term.

3.1 Health expenditure

Total health expenditure as a percentage of GDP was 9.75% in 2014 (above the EU average of 9.45%). 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 in Msida. The increase in 2011 is explained by the capital investment in the construction of the new Sir Anthony Mamo Oncology Centre in Msida, adjacent to Mater Dei Hospital. Inpatient care makes up the largest share of public health expenditure (Table 3.2) on a consistent basis.

Table 3.1

Trends in health expenditure in Malta, 1995–2014, selected years

Expenditure	1995	2000	2005	2010	2014
Total health expenditure per capita in Int USD (Purchasing Power Parity) – current US dollars	898	1 338	1 994	2 373	3 072
Total health expenditure as % of GDP	5.7	6.8	8.8	8.3	9.8
General government expenditure on health as % of total expenditure on health	68	69	68	63	69
General government expenditure on health per capita in Int USD (Purchasing Power Parity)	412	477	956	1 103	1 709
Private expenditure on health as % of total expenditure on health	32.5	30.6	32.1	37.1	30.8
General government expenditure on health as % of general government expenditure	9.8	11.8	14.2	12.7	15.6
Government health spending as % of GDP	3.8	4.7	6.0	5.2	6.7
OOP payments as % of total expenditure on health	28.5	28.4	28.8	32.9	28.9
OOP payments as % of private expenditure on health	88	93	90	89	94
Private insurance as % of private expenditure on health	4.2	2.7	5.3	5.9	5.7

Source: Global Health Expenditure Database, 2016.

Table 3.2

Percentage of public health expenditure by service programme, 2011

	Inpatient care	Outpatient care	Long-term care	Pharmaceuticals	Public health	Administration	Ancillary Services to Health Care	Total (€ millions)
General government	39.7	12.7	13.2	19.0	1.8	4.5	9.1	441

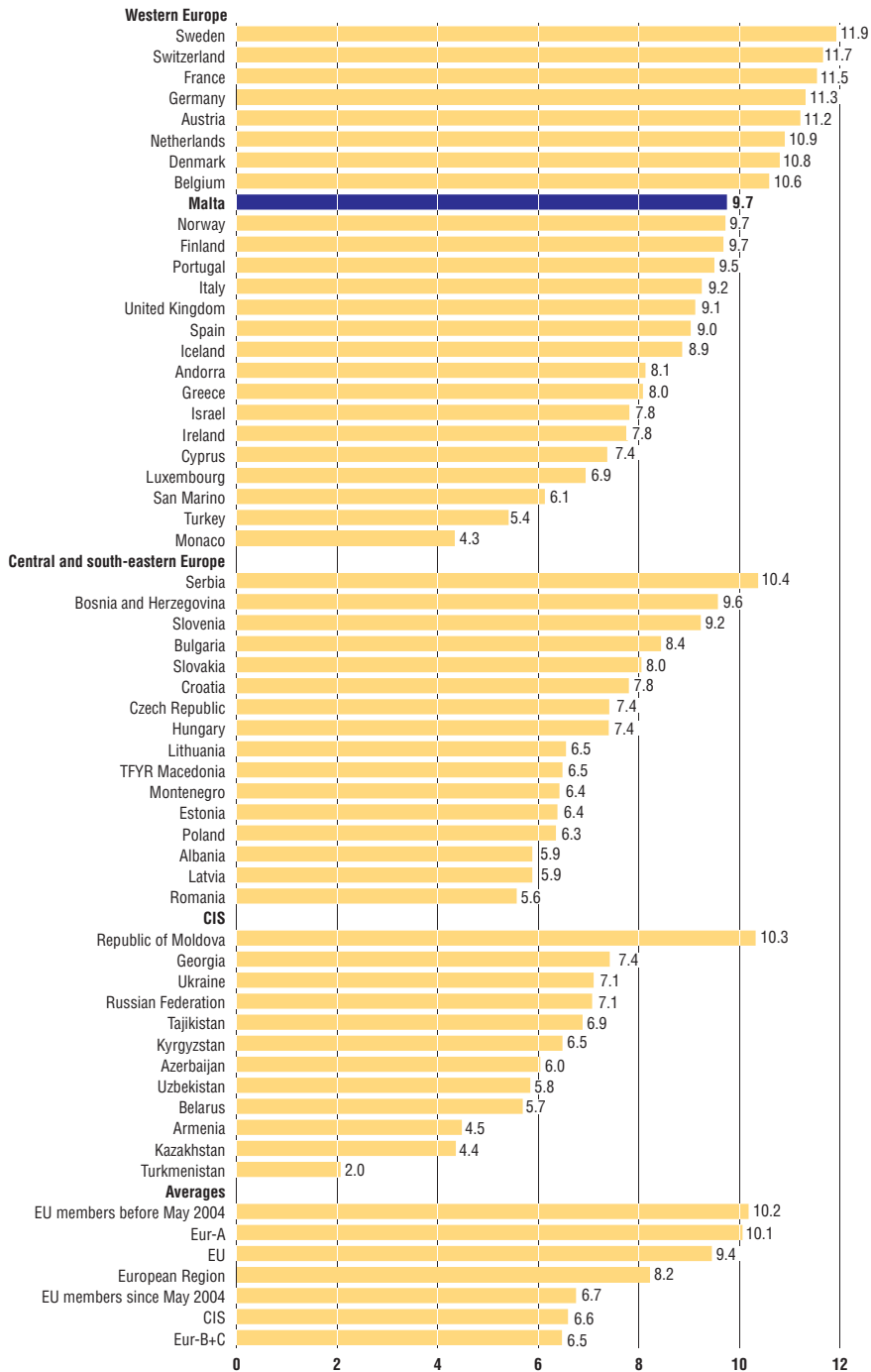
Source: Internal data from the Directorate for Health Information and Research.

Note: Data in Malta are only available for general government expenditure and not as a percentage of total health expenditure. Data are also not broken down by service programme for private health care, which totalled €10 million.

Whilst health expenditure as a share of GDP in Malta has traditionally been relatively low, the situation is changing since Malta continued to experience steady expenditure growth even during the financial crisis when several European countries experienced declines in health expenditure. Therefore, health expenditure in Malta has caught up to and surpassed the EU average (Figs. 3.1 and 3.2). Notwithstanding, per capita spending remains among the lowest in Western Europe (Fig. 3.3).

Fig. 3.1

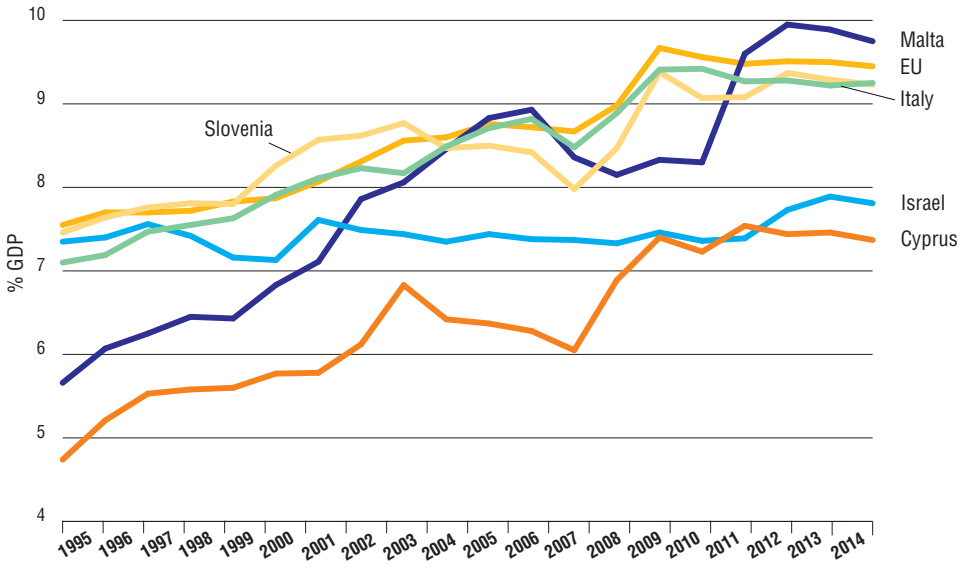
Total health expenditure as a share (%) of GDP in the WHO European Region, 2015



Source: WHO Regional Office for Europe, 2016.

Fig. 3.2

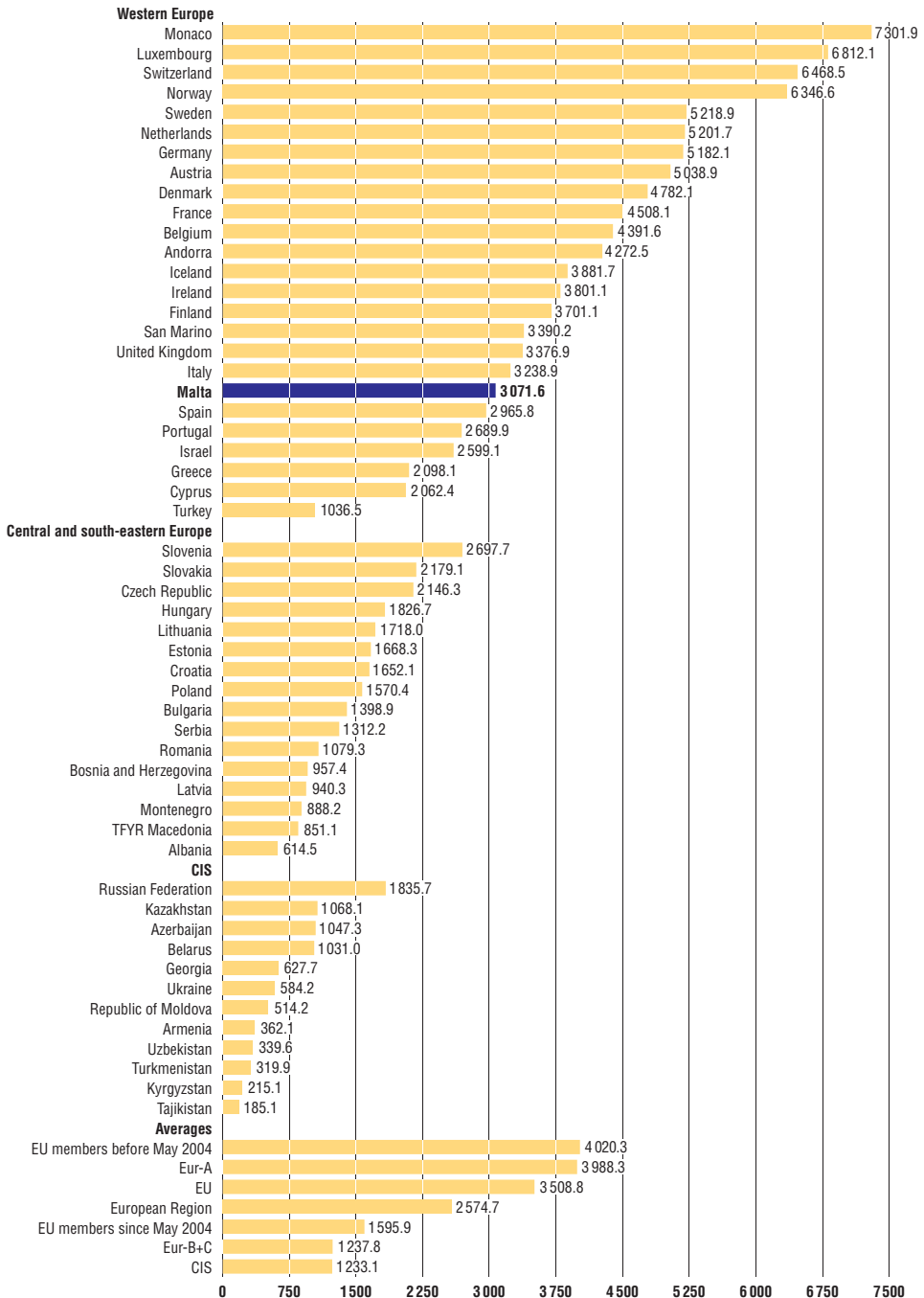
Trends in total health expenditure as a share (%) of GDP in Malta and selected countries, 1990–2015



Source: WHO Regional Office for Europe, 2016.

Fig. 3.3

Total health expenditure in US\$ PPP per capita in the WHO European Region, 2015



Source: WHO Regional Office for Europe, 2016.

3.2 Sources of revenue and financial flows

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.

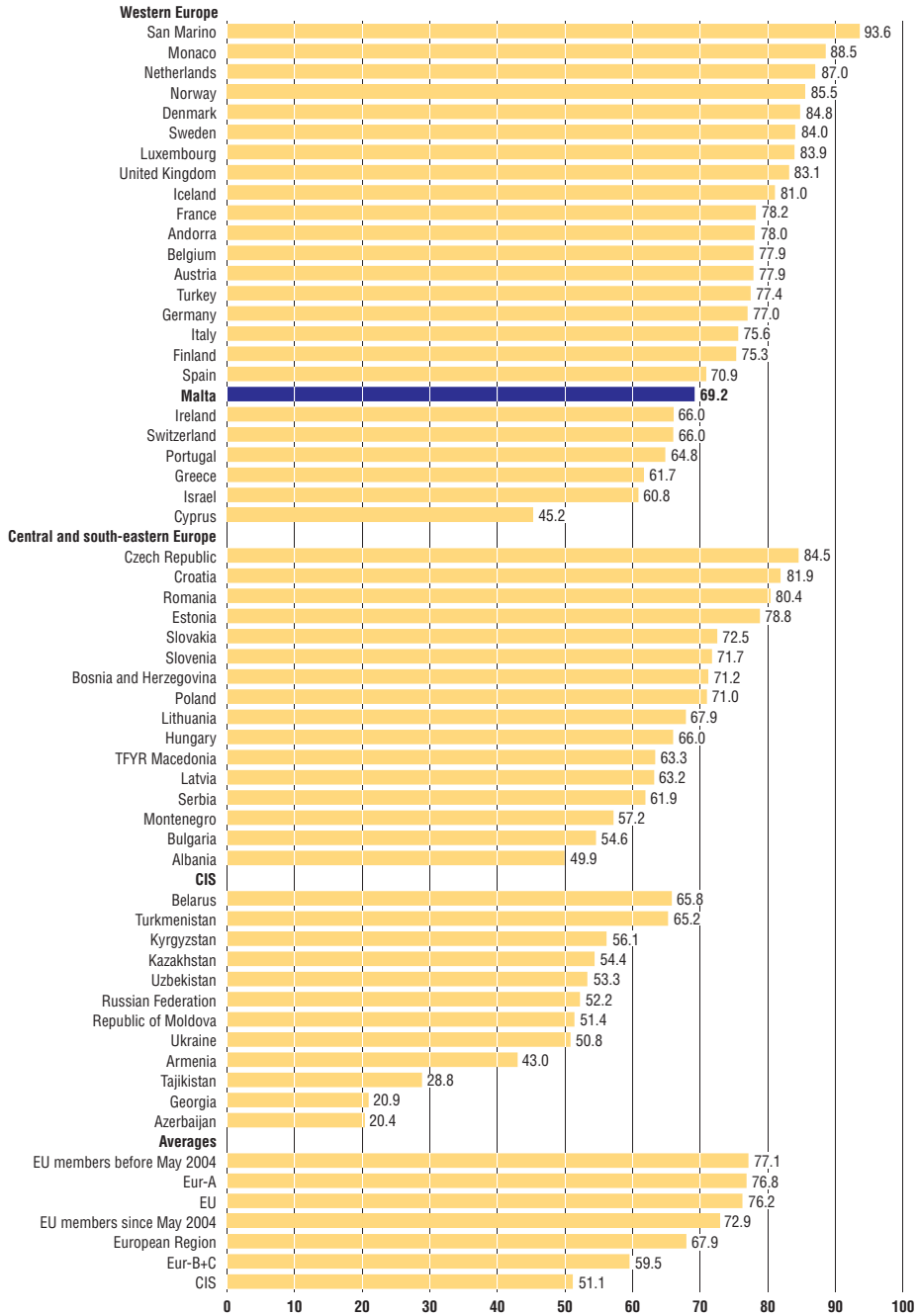
While private spending comprised 3% of GDP (compared to 2.2% in the EU), public spending was only 6.74% of GDP, below the EU average of 7.24%. In recent years the increase in private spending has outpaced public health expenditure growth. Public expenditure comprised almost 69% of total health expenditure in 2014, with out-of-pocket payments and VHI making up most of the remaining spending (Fig. 3.4). Public expenditure as a percentage of total health expenditure was the seventh lowest in Western Europe in 2012, implying high private expenditure (Fig. 3.4).

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, 2016). Private providers receive public funds only in instances where a particular service has been outsourced to the private sector, usually in areas where there is a long waiting list in the public sector. Recent initiatives have taken place in the area of orthopaedic surgery.

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 medicines, HIV/AIDS care, infertility care and normal pregnancy services, as well as mobility aids and organ transplant. Within the private sector, only secondary care data are collected by the Ministry for Health.

Fig. 3.4

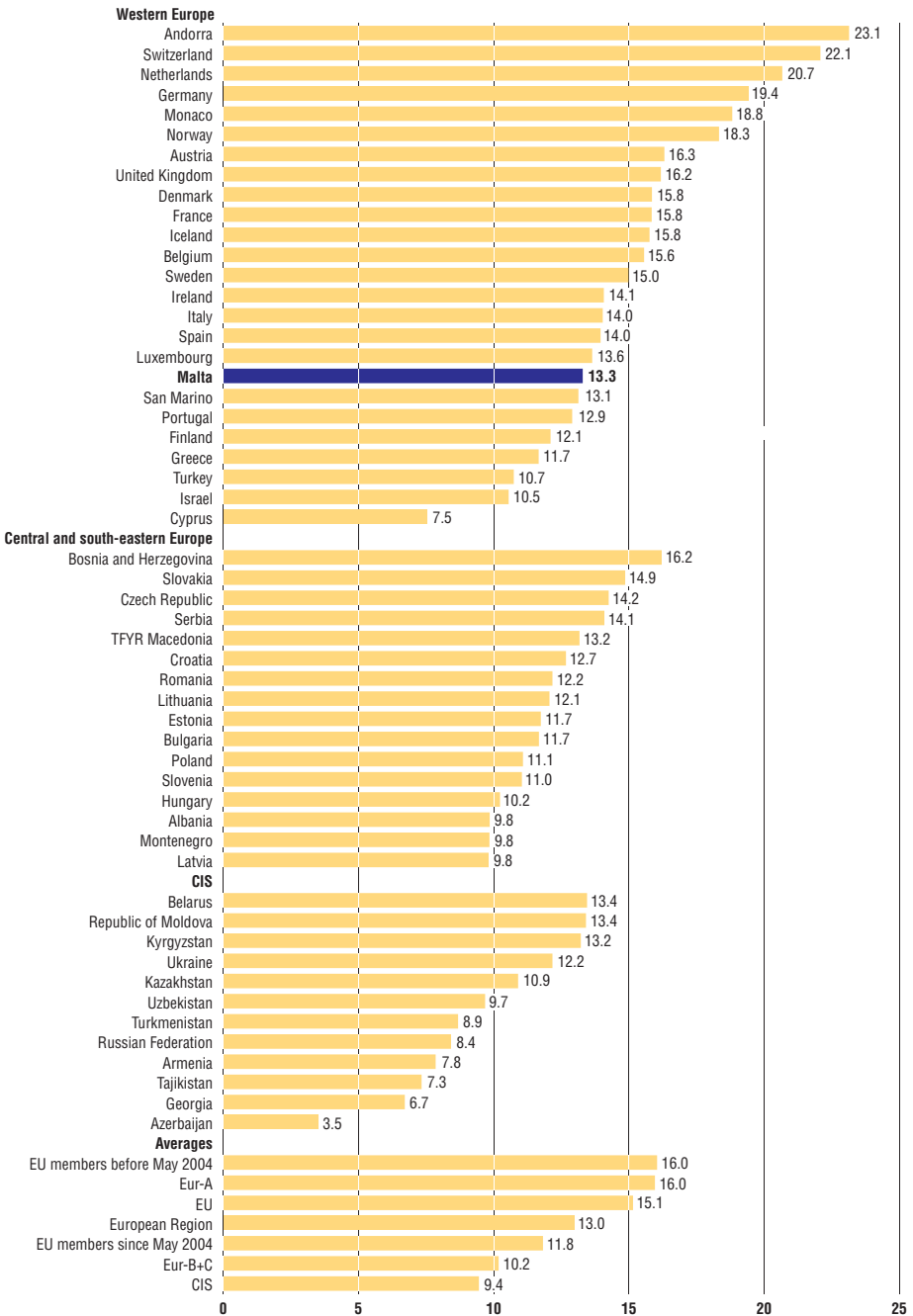
Public sector health expenditure as a share (%) of total health expenditure in the WHO European Region, 2015



Source: WHO Regional Office for Europe, 2016.

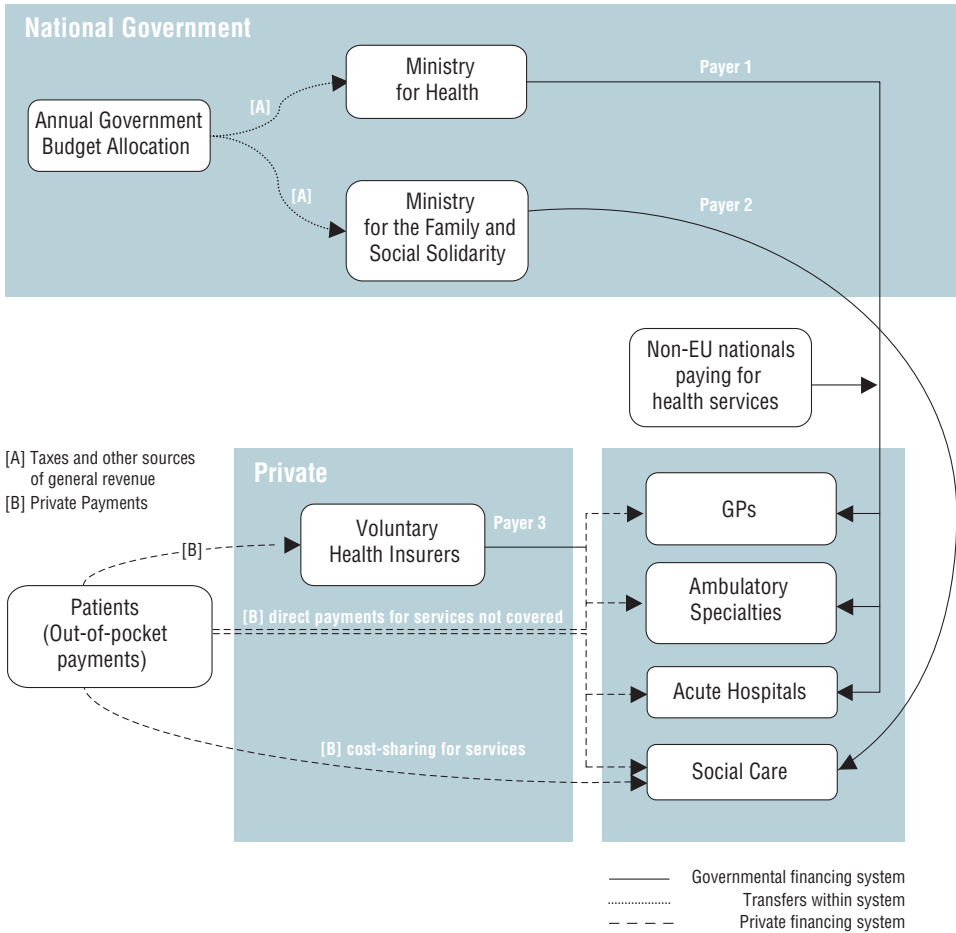
Fig. 3.5

General government health expenditure as a share (%) of general government expenditure in the WHO European Region, 2015



Source: WHO Regional Office for Europe, 2016.

Fig. 3.6
Financial flows feeding into the national health system



Source: Authors' compilation.
Note: Public and private providers are distinct and financed separately.

Box 3.1**Assessing allocative efficiency**

The health system must compete with a number of other public sectors, such as social security and education. Historical expenditure has traditionally acted as a basis on which to set up the Annual Government Budget allocation. A comprehensive spending review across all ministries is carried out. Traditionally hospitals have been given priority at the expense of primary care and other community services.

There are no risk-adjusted resource allocation formulas within the Ministry since there is no system of regional or local health budgets.

The Advisory Committee on Health Benefits (ACHB) has been set up as a result of the implementation of the Health Act 2013. The mandate of this committee is to advise on the allocation of resources, together with the Government Formulary List Advisory Committee (GFLAC). This committee will continue to work and build upon the existing work of the GFLAC, whose main role is prioritizing new medicines. Malta relies very heavily on empirical evidence obtained from other health care settings but throughout the last five years, Health Technology Assessment (HTA) has come to play an increasingly important role in deciding whether to introduce new medicine and technologies. This has been facilitated with the formal setting up of HTA in accordance with the directive on the application of patients' rights in cross-border health care.

3.3 Overview of the statutory financing system

3.3.1 Coverage

Breadth: who is covered?

Entitlement to public health services is practically universal. All those who are covered by the Social Security Act, either through payment of contributions or through a mechanism of exemption from payment, are covered. Foreigners covered under the Social Security Act 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 exempt from the need to show a valid EHIC when they seek emergency medical care at a public hospital or government health care centre. 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 Maltese public health care institutions on an inpatient and/or outpatient basis, as well as specialist services such as General Surgery and Cardiology.

Breadth of coverage is currently an important issue being addressed in the Maltese health system. The legal notice 201/2004, regulating payment of fees by foreign patients, is outdated and in mid-2016 is in the process of being replaced. Two developments have drawn heightened attention to this issue. Firstly the number of immigrants in Malta has increased rapidly over the past decade, making the issue of health care entitlement for foreigners a salient one. These include persons of varying categories and means, including workers, pensioners and their dependents, mariners registered with the Malta fleet, as well as refugees and asylum seekers. The relevant EU regulation on Coordination of Social Security is applied to determine entitlement. Furthermore the Refugees Act transposes EU legislation setting out the health care rights of persons who are refugees or who hold the status of temporary humanitarian protection. Although there is no specific legislation pertaining to undocumented migrants, those in need of care are usually covered through a system of administrative waivers on humanitarian grounds.

The immigration phenomenon through the central Mediterranean route witnessed in recent years has posed a new challenge to the Maltese health system. Overall, the health system provides good coverage to all categories of immigrants, but this stretches the limited human resources available. The health system through its migrant health unit has sought to adapt the health system to meet the new and specific needs of persons coming from different cultures. Yet recent research is indicating that health providers are experiencing strain and need to be supported to ensure that the health system continues to respond effectively to the additional burden imposed through immigration (MIPEX, 2015).

Secondly, the transposition of the patients' rights and cross-border health care directive emphasizes a clear definition of insured person. Although the coordination of the Social Security Act and the Health Act both make reference to the principle of health care coverage, further clarity is deemed helpful in the light of the above-mentioned developments. The Ministry for Health is evaluating how it can enhance clarity of the definition of an insured person under the Maltese health system in order to balance the dual objectives of ensuring access to health care for all with safeguarding the financial sustainability of a health system in a country with a large proportion of users who are not Maltese nationals.

Membership of an insurance scheme is not compulsory. All enrolees with private health insurance choose this option on a voluntary basis. For some persons, a form of private cover is offered by private sector employers.

Scope: what is covered?

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) 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). 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 provided to people by virtue of having the condition, independent of financial means.

The 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. In addition, the GFL defines which medications are available from the public sector, including which patient groups are entitled to which medications and who can prescribe them.

In mid-2016 the Healthcare Benefits Package is undergoing review and being updated, therefore it is not available in the public domain. The GFL, which details the availability of medicines, is publicly available, although there is no negative list. Private VHI providers grant a cash benefit to those who use public services.

Depth: how much of benefit cost is covered?

User charges do not apply throughout the public health care system. Out-of-pocket payments are mainly found in ambulatory private health services.

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 in 1977–87 (for a detailed explanation see European Observatory, 1999), public health services were rendered free of charge by means of an administrative

decision. In 1996 the Labour Government introduced a nominal prescription fee of 50 cents (equivalent to around €1.2). In 1998 this charge was removed by the Nationalist Government immediately upon being elected. Since then, the issue of user charges or co-payments for the public health system has been anathema for both major political parties. Both parties repeatedly state their commitment to preserving the current system in which public health services are provided free of charge at the point of use.

Box 3.2

Assessing coverage

Overall, the Maltese health system provides practically universal coverage to a broad scope of health services and medical goods. The depth of coverage is 100% since no user charges apply in the system. However, upon closer scrutiny, the relatively high proportion of out-of-pocket payments may raise concerns. Out-of-pocket payments are typically used in the ambulatory setting. There are two main reasons that explain this phenomenon. The first reason is a cultural one and applies mostly to the use of private primary care. Persons with a certain level of education and income have traditionally been accustomed to seeking primary and ambulatory services in the private sector. These services remain relatively affordable for a considerable segment of the population. The second reason that persons may seek recourse to the private sector is to bypass waiting lists for specialist ambulatory care and elective diagnostic and therapeutic interventions. Here issues of equity do arise since persons who lack the means to seek private ambulatory care services may be left to languish on waiting lists. This issue has become a top government priority, with several initiatives being pursued to cut waiting lists. Finally, the scope of coverage is somewhat at risk due to increasing difficulty in keeping up with the funding requirements for innovative medicines. This is an aspect that could eventually lead to erosion of coverage in certain areas, such as oncology.

3.3.2 Collection

General government budget

In 2016, €466 million was budgeted for health, compared to €414 million in 2015; this amounts to a considerable increase of 12.5%. 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; however, the health sector still receives a budget like all other ministries from the Government's General Consolidated Fund, so in practice there is no earmarking.

Taxes, contributions or premiums pooled by a separate agency

Malta does not have a pooling agency. Contribution rates are determined by Parliament and tax rates vary according to the worker's income. All persons who are active in the labour force pay National Insurance (Social Security

Contribution). All those who are economically active and earn more than the minimum threshold pay Income Tax. The Department of Inland Revenue is tasked with collecting these two contributions, as well as all other sources of government revenue. National Insurance is shared between the employer and the employee in a 1:1 ratio, each contributing 10%. Self-employed persons pay a higher rate. The current lower and upper thresholds for Income Tax are dependent on the worker's chargeable income and their current status, whether they are single, married or a parent. National Insurance is only paid by those who are active in the labour market. It creates the set of entitlements to social benefits and access to the health system. Retirees and the unemployed do not pay National Insurance. The system is a legacy system that provides revenue to the Government. All revenue pours directly into the general government revenue.

Box 3.3

Assessing progressivity and equity of health financing

Income Tax in Malta is progressive and it is very much dependant on chargeable income and whether the worker is single, married or a parent. The tax rates are increased proportionally with the chargeable income, with rates starting from 15% and going up to 35%. The lower threshold is dependent on marital status and whether the worker is a parent or not, whereas the higher threshold is fixed at €60,000. In contrast, VAT and National Insurance (Social Security Contribution) are regressive. In the 2015 Health Systems Performance Assessment the need for progressivity of health financing was outlined, especially owing to the fact that out-of-pocket payments are still high (Ministry for Energy and Health, 2015).

3.3.3 Pooling and allocation of funds

Allocation from collection agencies to pooling agencies

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.

Allocating resources to purchasers

The Ministry for Health is a third-party purchaser for the public health system. It is fully funded by the Ministry for Finance through the General Consolidated Fund. The budgeting process is standardized across the country. Public

providers receive fixed budgets. These budgets are calculated according to historical precedent and political negotiation. Risk-adjusted capitation is not used to allocate resources.

3.3.4 Purchasing and purchaser-provider relations

The Maltese health system is an integrated health system and to date a clear purchaser-provider split has not existed. All health workers in the public sector are salaried civil servants and public facilities are cost centres under the Ministry for Health. This implies that they are funded through annual budget allocations as 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 has occasionally entered into agreements with private providers to procure services in order to bridge gaps in provision or address waiting lists. These agreements follow public procurement regulations. Other private care is purchased out-of-pocket by patients on a fee-for-service basis. For patients with private VHI, care is usually purchased out-of-pocket but covered costs are reimbursed. In certain cases the private insurer has a contract with the private provider and will pay directly.

The health system model of organization and delivery is now entering a new phase as the Government has entered into a public-private partnership agreement with an international private provider, Vital Global Healthcare. Through this agreement, the Government has given the private provider a 30-year concession at St Luke's, Karin Grech and Gozo General Hospitals. A redacted version of the contracts has been made publicly available. Analysis of the available information indicates that payments will take the form of agreed budgets for volumes of activity. The public information provided thus far indicates that the private providers not only will rely on the Government to purchase beds and services for revenue, but are expected to create an important parallel revenue stream through medical and health tourism. Further information on this major reform is provided in Chapter 6.

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, but the majority of out-of-pocket spending is for general practice and

ambulatory 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. The Maltese health system registers a relatively high percentage of out-of-pocket payments when compared to other EU health systems.

Residents of homes for older people contribute 60% of their total income (this includes their 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 €1,400 per year at their disposal (Parliamentary Secretary for Rights of Persons with Disability and Active Ageing, 2016).

3.4.1 Cost-sharing (user charges)

There is no cost-sharing for public health services in Malta.

3.4.2 Direct payments

In Malta there are no user payments at the point of use for goods or services for health care. However, for the few services which are means-tested, such as elective dental care, optical services and some formulary medicines, these are largely paid for out-of-pocket, although some patients may be covered through private insurance for certain services and medicines.

3.4.3 Informal payments

Whilst there is no evidence of the existence of informal payments for utilization of public health care services, anecdotally it is suggested that patients may seek to consult doctors privately in the hope that this will give them more individual attention or preferential care within the public health service. No studies on this particularly sensitive topic are known to have been carried out.

3.5 Voluntary health insurance

Everyone is eligible to purchase VHI coverage, either individually or as part of a group. Most people take out VHI in order to access private providers. This is driven by preferences as well as providing a safety net to access rapid services in those areas where waiting times are still considered long. About 22% of the population has some form of private health insurance coverage (Directorate for Health Information and Research, 2010), and reported take-up

rates remained unchanged between 2002 and 2012. 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 person 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 (MFSA) is the local authority regulating insurers.

Insurance companies in Malta are mainly regulated by the Insurance Business Act, which provides for the authorization and supervision of insurance companies by the MFSA and the Insurance Intermediaries Act, which governs insurance agents, insurance brokers, insurance managers and tied insurance intermediaries. Further detailed information on VHI is provided in the report on VHI in the EU (Sagan & Thomson, 2016).

3.6 Other financing

3.6.1 Parallel Health Systems

Malta does not have any parallel health systems.

3.6.2 External Sources of Funds

Since accession to the EU, the public health sector has made use of a number of funding sources, such as the European Social Fund, the European Regional Development Fund and the Swiss Fund, for the purchase of medical equipment. For the period 2007–2013, the EU allocated €840 million to Malta in Structural Funds, with one of the main objectives being to utilize these funds to achieve a better quality of life. In all, €29 million or 3.4% of Total Structural Funds have been allocated to health care, the fifth highest share in Europe. This value only constitutes the direct investment in health infrastructure and excludes indirect health sector investments and non-health sector investments with a potential for added health gain (Parliamentary Secretariat for the EU Presidency 2017 and EU Funds, 2016). European Funds have benefited a number of areas throughout the health care sector and regions within the Maltese Islands, including the new Sir Anthony Mamo Hospital Oncology Centre, a new ePortfolio for Postgraduate Medical Training, Capacity Building for Medical Physics Services in Malta, Specialized Research on Occupational Health and Safety

(OHS) and Development of OHS Accreditation System and training Healthcare Professionals for Integrating Acute and Community Care. The island of Gozo also benefited from EU funding through a project that involved upgrading operating theatres and setting up a radiology unit at Gozo General Hospital.

The Ministry for Health has also benefited from some networking and capacity building 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.

3.6.3 Other sources of 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 most important NPISH is 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. A significant change took place in 2015 when the Malta Memorial District Nursing Association (MMDNA), which previously was a significant NPISH, had its contract with the Government terminated. Before 2015, MMDNA provided numerous nursing services to the community, but since then it has been replaced by a private entity, Caremark, which now has a contract to provide services on behalf of the Government.

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

The Malta Community Chest Fund Foundation (Malta Community Chest Fund Foundation, 2016) is another important funding source. It is a charitable foundation, regulated by the civil code and chaired by the President of Malta. It organizes a number of fund-raising events to help organizations and individuals in need and has taken an increasingly visible and important role in providing funding for new medicines used to treat cancer which are not included on the GFL.

3.7 Payment mechanisms

3.7.1 Paying for health services

Hospitals and primary health centres are funded through line budgets which feature in the General Government Budgetary Estimates. Each hospital has its own budget and there is a single budget for primary care. These global budgets have been determined through historical incrementalism, largely driven by estimates of human resources expenditure and contractual obligations.

The new public-private partnership also appears to be based on the subvention of a global budget to the private provider. In the future it is envisaged that diagnosis-related groups (DRGs) could be introduced. This is partly a result of the requirements of the patients' rights and cross-border health care directive to have a publicly available list of tariffs upon which to determine the eligible reimbursement rate in cross-border care situations. However, it may well be that these will play an increasingly more important role in categorizing hospitalization costs, particularly if the Government will earnestly take up the role of active purchaser and commissioner of hospital services through the newly established public-private partnerships.

3.7.2 Paying health workers

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 since 2014.

New collective agreements were signed between the Government and Trade Unions representing the government health workers in various categories late in 2012 and early in 2013. These continued to build on the notion of performance-related payment for additional sessions of work performed. But all health care workers remain salaried in the public health system. Table 3.3 provides an overview of payment mechanisms used for providers in the health system.

Table 3.3

Provider payment mechanisms

Payers	Ministry for Health	Other ministries	Private/voluntary health insurers
Providers			
Public GPs	S	N/A	N/A
Private GPs	N/A	N/A	FFS
Ambulatory specialists	S	N/A	N/A
Private ambulatory specialists	FFS	N/A	FFS
Other ambulatory provision	S	N/A	N/A
Private other ambulatory specialists	N/A	N/A	FFS
Public acute hospitals	B	N/A	FFS
Private acute hospitals	N/A	N/A	FFS
Other hospitals	B	N/A	FFS
Hospital outpatient	B	N/A	FFS
Hospital OP (private)	FFS	N/A	FFS
Dentists	S	N/A	N/A
Dentists (private)	N/A	N/A	FFS
Pharmacies	C	N/A	N/A
Public health services	B	N/A	N/A
Social care	PD/B	PD/B	PD

Source: Authors' compilation.

Notes: FFS = Fee-for-service; PD = Per diem; S = Salary; C = Capitation; B = Bundled payment; N/A = Not applicable.

4. Physical and human resources

Chapter summary

- A noticeable increase in human and physical resources has taken place in the Maltese health system since 2010. This was in response to identified bottlenecks in the health system due to limited supply exercising constraints on expansion of services to meet burgeoning demand.
- There are four licensed public hospitals, of which two are acute and two are specialized; there are six licensed private hospitals, four licensed day care clinics, and nine licensed mental health facilities. Malta has an acute bed occupancy rate of 83.2% (in 2012) which is above the EU average (76.6% in 2012).
- A public-private partnership contract has been implemented in 2016 and is expected to play an important role within the Maltese health system in the future in regard to modernization of physical infrastructure.
- The numbers of specialist physicians, dentists, nurses and paediatricians per capita are below the EU average; however, there are higher numbers of pharmacists and midwives.
- Education and training of health care professionals is being strengthened through the introduction of further specialization programmes and new facilities, and numbers of doctors and nurses have risen since 2010.
- The role of eHealth is increasingly important and is expected to take a more central role within the planned investment in the coming years.

4.1 Physical resources

4.1.1 Capital stock and investments

Current capital stock

There are four licensed public hospitals, of which two are acute hospitals and two are specialized hospitals in oncology and rehabilitation respectively. There are six licensed private hospitals, four licensed private day care clinics, and nine licensed mental health facilities (Table 4.1). All hospitals are located in Malta with the exception of one hospital located on the island of Gozo. The majority of patient services were moved from St Luke's Hospital to Mater Dei Hospital (MDH) in November 2007; MDH 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 construction and commissioning of MDH and the Sir Anthony Mamo Oncology Centre (SAMOC) located adjacent to it. The Foundation has recently overseen the construction of the SAMOC – a project part-financed by the EU through European Regional Development Funds, among other development projects. This led to the migration of oncology services from the old Sir Paul Boffa Hospital to MDH and SAMOC hospitals, thus further centralizing health care operations.

The Foundation for Medical Services typically appoints the head of public hospitals' management teams and there has been a trend to appoint non-clinical people to the position of Chief Executive. Recently, there have also been efforts to involve clinicians in the management of clinical services. In contrast, private hospitals are managed by individual, for-profit companies.

MDH and SAMOC are modern hospitals that have been built within the last ten years, whereas the other hospitals were built during the 20th century. Hospitals in the private sector have been built during the past 20 years.

Regulation of capital investment

To date, once a new hospital application fulfils the necessary requirements and standards, there is no capping on the number or geographical distribution of facilities, unlike that for pharmacies. Public primary health care has struggled because of chronic underinvestment during the period that MDH was being developed. Since 2010 several refurbishment initiatives have taken place in health centres, for example the Rabat and Mosta Health Centres. A plan has been developed for a new Paola primary health care facility.

Investment funding

Investment is generally financed by national public funds generated through taxation. However, EU membership has created opportunities for investment funding using European Regional Development Funds.

Since 2013 the Government has embarked on an initiative to use private capital investment to modernize the existing capital stock through strategic collaboration with a private partner. This is a new model for the Maltese health care system. The selected private company will invest capital and in return acquire ownership of St Luke's Hospital, Karin Grech Rehabilitation Hospital and Gozo General Hospital for a period of 30 years. In addition, there has been a continuation of public-private partnerships within the long-term care sector, where several variations of public-private associations exist, ranging from models whereby hotel and infrastructural services are provided by the private sector, while social and health care provision is funded by public sources through procurement of the full long-term care service at an established per diem rate.

There is no money borrowed through public allocation earmarked for the health care sector.

4.1.2 Infrastructure

The total number of beds per capita has increased in recent years both in acute care hospitals and in long-term care facilities. The switch of designation of St Vincent De Paule Residence, the main geriatric facility, from 'nursing home' status to a speciality hospital and then back to a nursing home accounted for earlier substantial shifts in long-term capacity statistics. The building of the new SAMOC has also increased the number of beds available as a result of Boffa Hospital being restructured and refurbished to accommodate patients for long-term care.

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 MDH 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 was due to a change in the series definition.

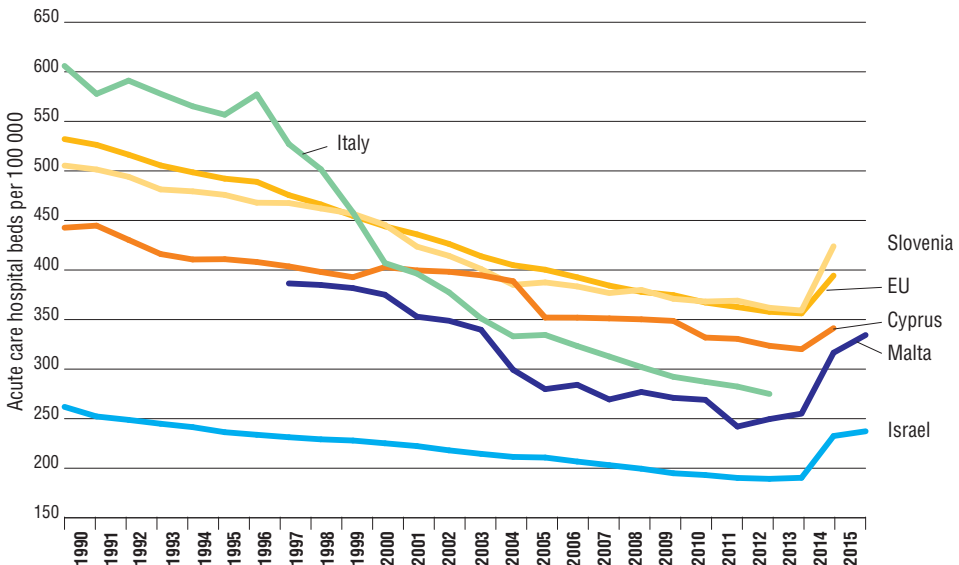
Box 4.1**Assessing the geographic distribution of health resources**

This is not applicable for Malta due to its geographical limitations, although it is significant to state that Gozo has its own general hospital based in Victoria, the capital city of Gozo.

Malta has a higher bed occupancy rate in acute hospitals (81.8% in 2014) compared to the EU average (76.9% in 2014) (WHO Regional Office for Europe, 2016). One explanation for this higher occupancy rate is that the number of beds in acute hospitals is also below the EU average (Fig. 4.1). In fact, the number of acute care beds in Malta has increased from 279.8 acute care beds per 100 000 population in 2005 to 334.4 acute care beds per 100 000 in 2015, an increase of 20%. Average length of stay (ALOS) in acute hospitals has increased in recent years. This goes against the general trend of shorter lengths of stay across the EU. Nonetheless, although ALOS in Malta increased, it is still lower than the EU average.

Fig. 4.1

Acute care hospital beds per 100 000 population in Malta and selected countries, 1990–2015



Source: WHO Regional Office for Europe, 2016.

4.1.3 Medical equipment

Regulation of medical devices and aids

The Malta Competition and Consumer Affairs Authority (MCCAA) is the competent authority responsible for regulating medical devices and implementing the relevant EU Directives in this sector. Health Technology Assessment is, however, the remit of the Advisory Committee for Health Benefits within the Ministry for Health. Both public and private sectors have the same level of medical technology available at their disposal. There is no capping on investment in complex technology. Medical equipment is mostly hospital-based, but there is an increasing availability of medical imaging devices such as X-ray machines at specific primary health care centres on a 24-hour basis and in private clinics.

Equipment infrastructure

In terms of CT exams per 1000 inhabitants, Malta is comparable to the Netherlands and Croatia. The number of MRI scans per 1000 inhabitants is higher than in Cyprus and lower than in Greece. When compared to the OECD average, Malta has a low number of both MRI and CT exams per 1000 population. Due to the fact that there are two PET scanners (one in the public and the other in the private sector), Malta emerges as having a high ratio of PET scanners per capita when compared to other countries (Eurostat, 2016b).

Table 4.1

MRI and CT exams per 1000 population in 2013

Item	Malta	OECD average
MRI exams	28.26	52 (OECD 28)
CT exams	71.11	120 (OECD 27)

Sources: Eurostat, 2016; OECD, 2015.

4.1.4 Information technology and eHealth

In 2014, 73% of the Maltese population had used the Internet within the last three months, while 53% reported accessing the Internet for health information (Eurostat, 2016b).

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.

In 2006 an eHealth Portal was 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 which allows patients and the doctors they choose to gain direct access to their electronic patient record through the Internet, providing the first IT link between the private family doctor community and the public sector.

Uptake of the myHealth system increased considerably in 2016 following the introduction of a paper-based consent form and improvements in the user experience of the sign-up process, which practically facilitated uptake by patients and physicians alike. This resulted in a 681% increase in July 2016 (13,090) compared to September 2015 (1,674) in the total number of patients who subscribed to the myHealth system and have been accepted by their respective doctors.

The development of health information systems at hospital level took a significant leap forward with the opening of MDH 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. Since 2007 a number of additional systems have been introduced to cater for the increased demands within the health care systems, such as the Centralized Theatre Management System, Cardiovascular Information System (CVIS) and Online Surgical Register. In 2013 the old Patient Administration System was migrated to a new system known as the Clinical Patient Administration System (CPAS), which also acts as an electronic appointment booking system and is used nationwide through the health care system as a patient master index. In 2016 a Clinical Decision Support System, known as UpToDate, was implemented at MDH and SAMOC.

On a national level, in 2015 a Digital Health Portal was launched (<http://digitalhealth.gov.mt>) which intends to consolidate all online resources related to eHealth, such as the recently launched electronic Patient Referral Form, fast-track colorectal clinic referral form (authorized to trained GPs) and a number of paper-based forms which are used on a regular basis.

The nationwide deployment of the e-ID card that stores electronic identification data is well under way in mid-2016. 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 have 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. At this point, electronic patient records are only partially implemented at MDH and SAMOC, as the majority of clinical documentation is paper-based, with a number of units having their own electronic patient records, such as the Cardiovascular Information System within the Cardiology Department.

In 2015 the process commenced to apply for European Regional Development Funding through the 2014–2020 programme. If this project comes to fruition, it will enable the implementation of the next phase of the health information systems, which will include electronic patient records in the primary health care sector, electronic prescriptions, entitlement approval system, health data exchange, fully digitized patient registries and improved national electronic health records. An updated eHealth strategy is currently being developed and eHealth Week 2017 will take place in Malta during its Presidency of the Council of the EU.

4.2 Human resources

4.2.1 Planning and registration of human resources

The majority of future health care workers are trained at the University of Malta Faculty of Health Sciences and Faculty of Medicine and Surgery. There are fixed numbers of students for Dentistry and most allied health degree courses. The degree courses for Doctor of Medicine and Surgery, Pharmacy and Nursing do not operate a fixed number clause to limit the number of places available. There are plans to open a medical school in Gozo in partnership with Bart's and the London School of Medicine and Dentistry and a second nursing school. The Malta College for Science, Arts and Technology (MCAST) plays an important role in training care workers and clinical aides to the professions.

Since Malta's EU membership, there have been several initiatives to introduce specialized post-graduate training programmes for doctors. This trend is now also being taken up in the allied health professions and nursing.

There are a number of regulatory councils responsible for the registration of qualified practitioners. These include the Medical Council (doctors, dentists), the Pharmacy Council, the Council for Nurses and Midwives, and the Council for Professions Complementary to Medicine. These are all regulated under the Health Care Professions Act. In addition, with regards to doctors, there is also a Specialist Accreditation Committee which certifies doctors who have completed their specialist training within the different respective fields. As an EU Member State, Malta is now obliged to implement Continuous Professional Development as per Directive 2013/55/EU but as yet there are no revalidation mechanisms in place.

4.2.2 Trends in the health workforce

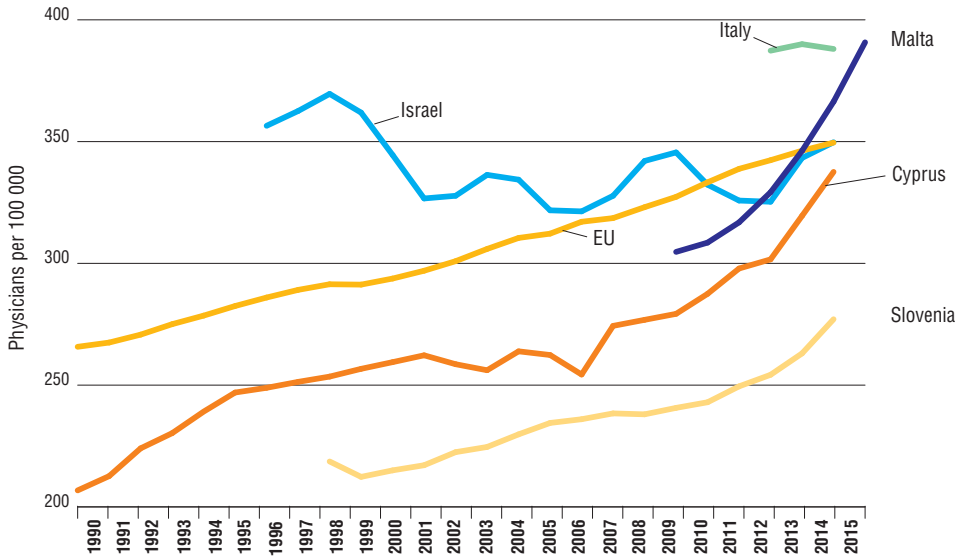
The health sector is one of the largest employers. In 2015, 30.3% of total Ministry for Health recurrent expenditure was allocated for salaries. Government health-sector employees are civil servants. In addition to health professionals, various categories of support staff, ranging from auxiliary workers to clerical workers to engineers, make up the health care workforce. Safeguarding the status of workers in the public health system is one of the key issues that has been discussed in the proposed public-private partnership model between the Government and the unions representing health care workers.

Physicians

The number of physicians per 100 000 population (inclusive of specialist trainees) has been rising steadily in recent years and in 2013 reached the EU average (Fig. 4.2). This is the result of a combination of factors. The number of medical students has more than doubled annually over the past ten years. The development of the UK Malta Foundation Programme has been instrumental in retaining medical graduates in Malta. Also, the setting-up of formal specialization training programmes held primarily in Malta with fixed periods of training overseas have contributed to counteract the medical brain drain which was experienced immediately upon accession to the EU.

In 2015 there were 391 physicians per 100 000 population, 65% of whom were working in hospitals. The number of physicians in Malta has now exceeded the EU average. The number of GPs has been increasing steadily and has now reached 83 per 100 000 population, again surpassing the EU average. Malta has a very small number of full-time academic physicians but a large proportion of medical specialists are also engaged in teaching and research activities.

Fig. 4.2
 Number of physicians per 100 000 population in Malta and selected countries, 1990–2015



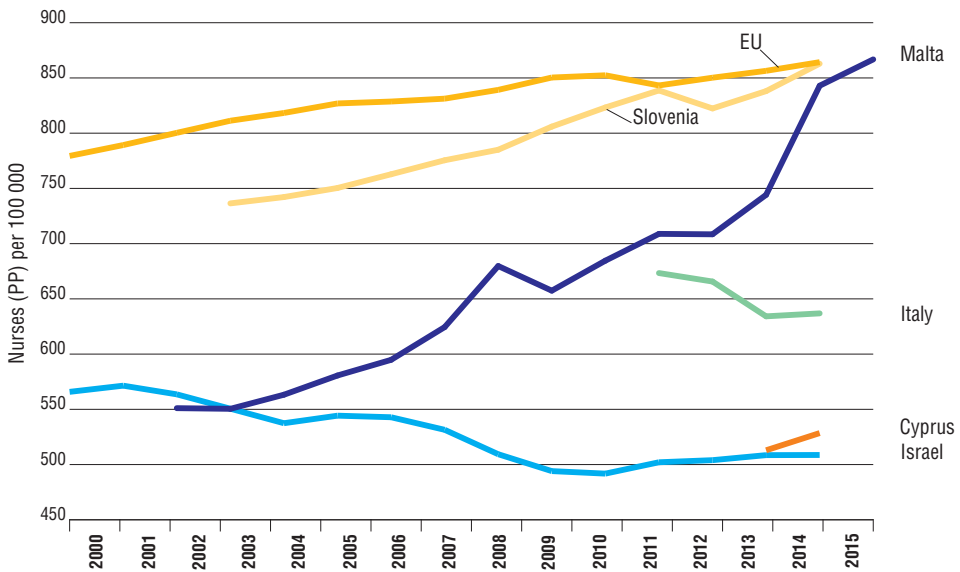
Source: WHO Regional Office for Europe, 2016.

Nurses and midwives

From 2009 onwards, data refer to nurses employed in state and private institutions. The number of nurses has increased steadily in recent years from 709 per 100 000 population in 2012 to 867 per 100 000 in 2015 (Fig. 4.3). Malta has a relatively high number of midwives, with 47 per 100 000 population in 2015.

Fig. 4.3

Number of nurses per 100 000 population in Malta and selected countries, 2000–2015



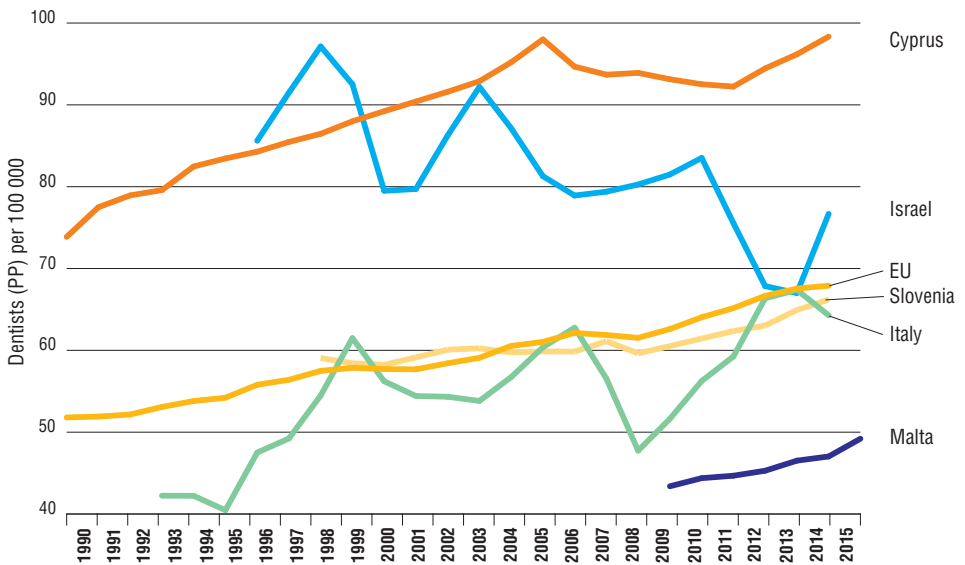
Source: WHO Regional Office for Europe, 2016.

Dentists

In 2015 Malta still had a low number of dentists per population at 49 per 100 000 (Fig. 4.4). This is well below the EU average and could be explained by the fixed number clause capping the number of dental students accepted by the University of Malta at eight per year (Kravitz et al., 2015).

Fig. 4.4

Number of dentists per 100 000 population in Malta and selected countries, 1990–2015



Source: WHO Regional Office for Europe, 2016.

Pharmacists

In 2009 the Pharmacy Council changed its methodology to count the number of practising pharmacists rather than all persons registered as pharmacists. The change in methodology led to significant fluctuations in this figure, making cross-country comparison difficult (Fig. 4.5). The number of pharmacists in 2015 stood at 133 per 100 000 population, up from 115.34 in 2014. This is the highest amongst the comparator countries and well above the EU average.

Fig. 4.5

Number of pharmacists per 100 000 population in Malta and selected countries, 2014

Country	2014
Malta	115.34
Italy	106.53
EU	85.05
Israel	70.6
Slovenia	60.34
Cyprus	22.04

Source: WHO Regional Office for Europe, 2016.

Note: Table has been used since the data for Malta is not reliable prior to 2014.

Public health professionals

In Malta the specialty of public health medicine is listed as one of the specializations on the medical specialist register. Medical doctors undergo four years of training in public health after successfully completing a two-year period of Foundation Training to obtain their full medical registration (Ministry for Health, 2016d). The University of Malta offers an MSc in Public Health which is also open to non-medical graduates. There are 42 public health physicians and 10 medical specialist trainees in Public Health Medicine (Ministry for Health, 2016d). Medical specialists in public health are assisted by various other professionals, including environmental health officers, nurses, nutritionists, allied health professionals and statisticians since public health practice is considered to be interdisciplinary in nature.

Professionals allied to medicine

There is a wide variety of other types of health care professional. The most common are medical laboratory scientists, physiotherapists and radiographers.

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 that providers work together

for the benefit of patients and their carers. Through European Funding and as a result of the new SAMOC, there was a concerted effort to improve capacity building within the area of medical physics, with a number of Maltese students going abroad to undertake undergraduate degrees in this field. Furthermore, the undergraduate degree for radiography introduced increased elements of radiotherapy within their curriculum to adapt for the increased demand.

The Government relies on foreign consultants for some types of service, including both orthotics and prosthetics. Likewise, the Government has an agreement with the Chinese Government whereby an acupuncturist is available daily at MDH, 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.

Managerial staff

The positions of Director General and Director within the Ministry for Health are filled through calls for headship positions issued by the Office of the Prime Minister. Within hospitals, non-clinical managers are usually appointed through the Foundation for Medical Services, whilst Clinical Chairs, Nursing Managers and Managers in the allied health professions are selected via competitive selection processes managed through the Public Service Commission¹ and in line with criteria set out in the respective collective agreements.

Social workers and care workers

Social workers have their own accreditation system and are given a warrant once they complete the required amount of work experience. The Social Work Profession Board is regulated by the Social Work Profession Act and the board members are appointed by the Minister for the Family and Social Solidarity. The board processes applications for the Social Work Warrant. The majority of care workers are employed by the private sector and a number of courses are offered by different institutions to provide for their educational and training needs.

¹ The Public Service Commission is an independent statutory body established under the terms of Article 109 of the Constitution of Malta. The Constitution assigns to the Commission responsibility for staffing and discipline in the Public Service.

Box 4.2**Evaluating the geographic distribution of health workers**

The majority of health care workers are found in Malta. Gozo General Hospital has a number of full-time health care professionals and in addition there are a number of consultant specialist physicians who commute on a regular basis to Gozo and provide services in both MDH and Gozo General Hospital. The small size of the country precludes meaningful analysis on geographic distribution of health workers.

4.2.3 Professional mobility of health workers

Following EU accession, Malta experienced a severe net outflow of newly graduated doctors, mainly to the United Kingdom, where Maltese doctors traditionally carry out their specialization training.

Other paramedical professions have been experiencing this brain drain to a much lesser extent. The outflow of doctors was addressed in the recent past through the 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 a postgraduate training facility, and through renegotiation of the health care professional collective agreement which has improved the remuneration package.

In the nursing profession 9% of the workforce is foreign, with 28 unique nationalities. During 2014 there were a number of recruitment drives and official bilateral agreements to obtain nurses from different countries, such as Spain and Cyprus.

4.2.4 Training of health personnel

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 (Caruana, 2015). This is an important issue in view of the setting-up of overseas medical and nursing schools. 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.

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 has been completed.

To date there is no specialist accreditation structure for the nursing profession. There have been concerted efforts to empower nurses to further their training in different areas, e.g. diabetes, infection control, tissue viability, pain management and radiotherapy.

The official body for setting education standards within Malta is the National Commission for Further and Higher Education (NCFHE).

4.2.5 Physicians' career paths

Graduating medical doctors are expected to join a two-year 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 automatically provided with 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 the successful completion of a three-year formal specialist training programme with an exit exam 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 needs 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. Promotion of staff is organized at national level and at this point in time physicians are not moving around as much as other health care professions.

4.2.6 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 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. Amongst allied health care professions, promotions are also organized at the national level.

For all public sector health care workers, promotions are governed through criteria established in the respective collective agreements and implemented by the Public Service Commission.

5. Provision of services

Chapter summary

- All publicly financed health services are free of charge at the point of use for persons entitled to statutory provision.
- Primary and ambulatory care is readily available through the public and private sectors.
- Secondary and tertiary care is provided mainly through public hospitals. The main acute general hospital (Mater Dei) caters for the bulk of emergency care.
- 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.
- 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.
- Publicly provided dental care is free at the point of use for certain population groups, including children, while in the private sector payment is usually out of pocket.

5.1 Public health

The main entity responsible for public health is the Public Health Regulation Department within the Ministry for Health. This Department was established under the Health Act. Its powers are also derived through other Acts such as the Public Health Act. Specific public health functions are administered by the following organizations.

The Infectious Disease Prevention and Control Unit is responsible for 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 played a crucial role in the launch of the Healthy Weight for Life Strategy in 2012, the Food and Nutrition Action Plan in 2014, and the Mediterranean Diet campaign in 2016. It was also responsible for the release of a number of strategies addressing major risk factors over the past decade, for example, the Non-Communicable Disease Strategy launched in 2010.

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 for international travellers, as well as vaccinations against tuberculosis and hepatitis B. Influenza vaccination is offered to older 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 Directorate for Health Information and Research (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 Health Screening Services Malta administers the National Cancer Screening Register for the Maltese Islands for breast, colorectal and cervical cancer screening. These plans were implemented following the launch of the first National Cancer Plan in 2011. Another screening programme offered through primary health centres targets glaucoma.

The Sedqa agency has offered health promotion, disease 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.

Box 5.1

Assessing the effectiveness of public health interventions

Smoking rates have been declining. Consumption of alcohol by under-age adolescents has decreased and there is evidence of a decline in the rate of teenage pregnancy. In these areas a concerted and sustained public health effort has taken place over the past ten to fifteen years. On the contrary, there is no evidence that public health campaigns have affected the rising overweight and obesity phenomenon. However, there appears to be a slight increase in physical activity measured through health interview surveys. Malta does well in terms of preventable mortality, but it is not possible to associate this directly with any specific public health intervention. In assessing the effectiveness of public health interventions at a generic level, the success factors would appear to relate to a strong public health workforce, political leadership and broad consensus on public health action coupled with a desire to tackle the growing burden of non-communicable disease.

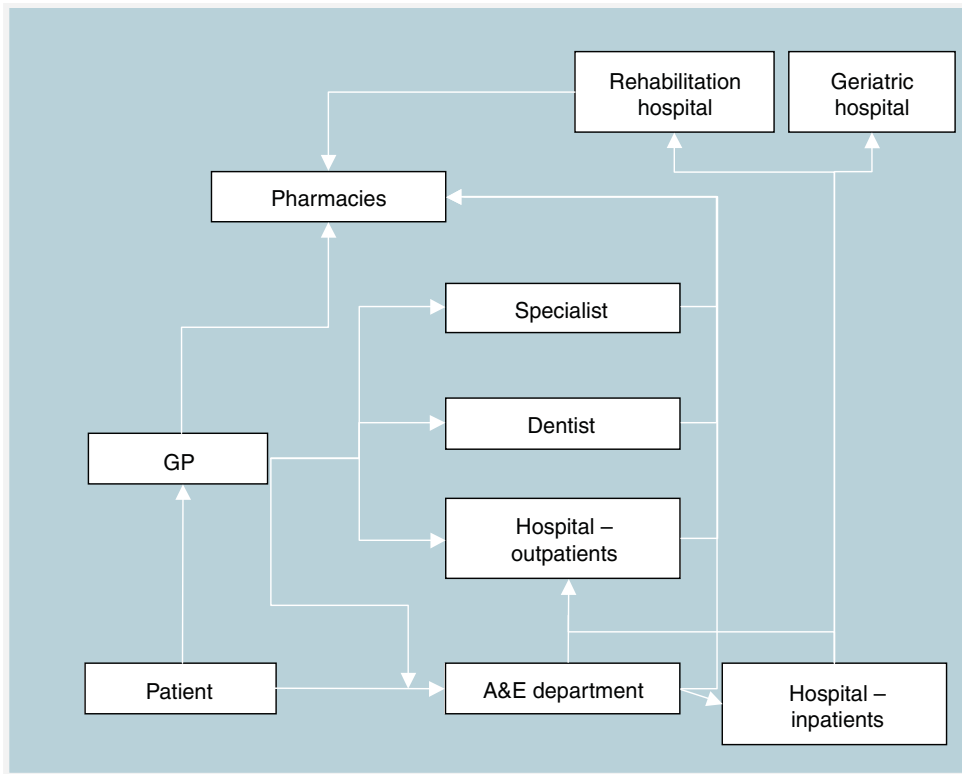
5.2 Patient pathways

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

Patients access health services through different pathways in the public and private sectors. General practitioners (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 Hospital (MDH), or from 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.

Fig. 5.1a

Patient pathways to access the public health care system



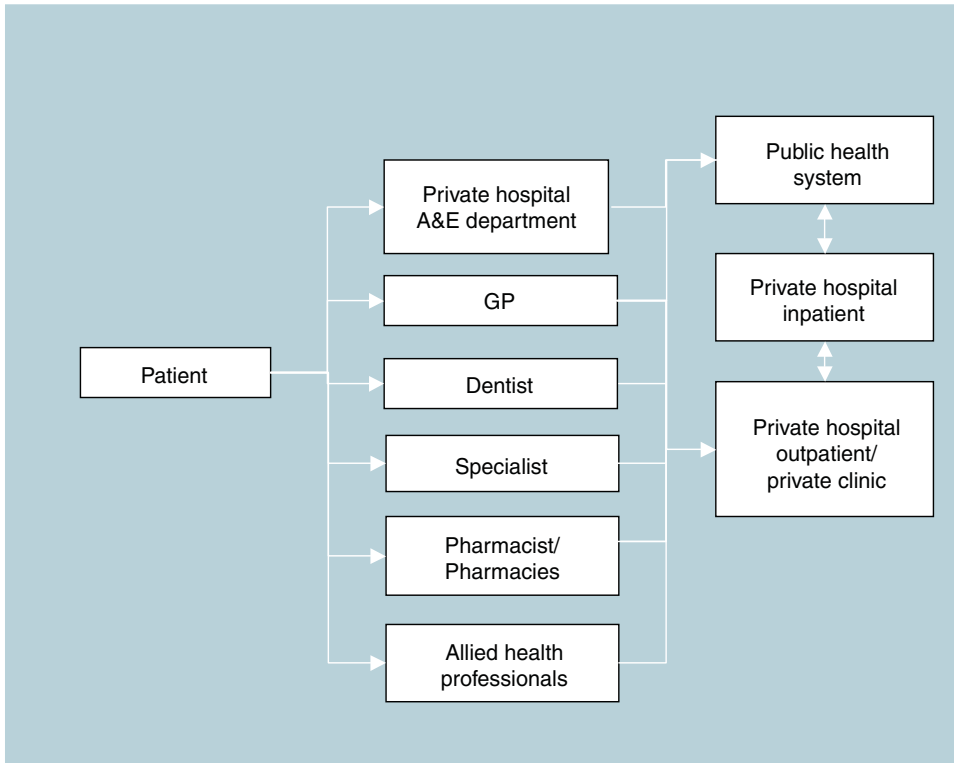
Source: Authors' compilation.

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.

Fig. 5.1b

Patient pathways to access the private health care system



Source: Authors' compilation.

Box 5.2**Integration of care**

Better integration of care between primary care and hospital services is considered vital to avoid unnecessary hospital admissions and to facilitate discharge both from acute settings and from hospital outpatient departments. Integration between the health and social care systems has been high on the agenda since 2013, when care for older people once again became the responsibility of the Ministry for the Family and Social Solidarity.

Some examples of initiatives that have been taken to strengthen integration and coordination of care include:

- The Mental Health Act, which introduced several new obligations for clinicians and service providers in terms of the setting-up and reviewing of multi-disciplinary care plans (Ministry for Justice, Culture and Local Government, 2016b).
- Within the health centres in the public primary health care system, a number of specialized clinics have been developed that serve to interface directly with hospital services whilst providing care in the extramural setting, e.g. for cardiac, diabetes, dementia, chronic disease management, anticoagulant, gynaecology, medical consultant, etc. (Ministry for Health, 2016f). One of the best developed programmes is the diabetes shared care programme whereby GPs have undertaken training and conduct diabetes clinics in line with a shared care protocol developed with the Diabetes Department at the MDH.
- The establishment of a directorate for cancer care pathways promoting continuity of care between the ambulatory and inpatient sectors for patients with cancer.
- The development of a discharge liaison nursing and midwifery service which was funded through the European Social Fund (ESF) to facilitate and coordinate aftercare following hospital discharge.
- The Shared Care Diabetes Programme, an initiative between the Primary Health Care Department and the Department of Endocrinology and Diabetes at MDH, has been taking place for several years and all data are collected in a computerized system serving also as a basis for the establishment of a register of diabetic patients enrolled in this system.

5.3 Primary/ambulatory care

The private sector accounts for around 70% of primary health care contacts (Directorate of Health Information and Research, 2010). This information is collected through self-reported data (in the section on health service utilization) in the Health Interview Survey. The state primary health care system includes general practice, community care, immunizations, child guidance clinics, child development and assessment unit, national screening unit, occupational health units 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, as well as well-baby and gynaecological clinics. Laboratory tests are sent to and performed in the MDH. 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, and all services are free of charge. Most clinics are by appointment except for GP clinics, which are walk-in. GP services are provided solely by salaried 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.

Box 5.3

Assessing the strength of primary care

Over the past 30 years the primary care sector has been the object of many attempted reforms. The main reason for the proposed reforms has been the need to establish some form of patient registration for the purposes of continuity of care in both the public and the private sector. However, such reforms have always met stiff opposition, mostly from the medical profession, and reforms that have been successful in primary care have been incremental in scope and have revolved around expanding service provision, investment in infrastructure and equipment, and increasing access to public health services by privately practising GPs.

The Healthcare Budget has traditionally been skewed towards acute care in the public sector, particularly during the intensive investment in the construction of the MDH in the 1990s and the start of the millennium.

In primary care in the public sector continuity and comprehensiveness of care are currently limited, with GPs having a limited range of medicines which they can prescribe *de novo*. Throughout the health centres there is a good level of coordination, but there are still silos between private GPs and the public system. Efforts to remedy this situation have been stepped up since 2012 with GPs working in the private sector being able to request imaging and laboratory investigations from the public sector. Furthermore, the development of the myHealth Electronic Health Record and Patient Health Record System provides private GPs with salient information in relation to the patient's health care episodes within the public system, together with laboratory results, radiology reports and information on upcoming hospital appointments.

As yet, health centres are not being sufficiently used as the first port of call in an emergency as patients would rather go to the A&E Department at MDH. In a recent international comparative study on the strength of primary care in Europe, Malta ranked highly in the areas of primary care workforce development and coordination of primary care, whereas it scored lower in primary care governance, economic conditions, continuity and comprehensiveness of primary care, and access to primary care (Kringos et al., 2013).

In the public sector, patients are seen by the GP on duty within the health centres. 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 they are encouraged to visit their GP first whenever possible. GPs are encouraged to be directly involved in health promotion activities, such as smoking cessation and lifestyle clinics. They have an important contribution to make to public health through initiatives such as sentinel surveillance of influenza infections.

In June 2016, the National Audit Office released a comprehensive report on GP function, which is perceived as the core primary health care function. The recommendations of this audit encourage assessing the feasibility of broadening and extending GP function through exploiting the complementarity of services provided by doctors in the public and private sectors. In addition, it also encourages a shift in budgetary allocations within the health sector in favour of primary health care, a push towards an increased health promotion and disease prevention role, and strategic, management and operational collaboration (National Audit Office, 2016).

The last major planned reform to primary care, which was launched in 2009, foresaw the implementation of a patient registration system; however, it stalled after resistance was encountered in favour of small concrete steps to improve facilities and services in the public health centres, as well as promotion of integration between the public and private health centres.

This approach has been intensified with the development of several services, including an operating theatre at the Mosta Health Centre. New areas of collaboration with primary care physicians in the private sector are being sought. Examples include the follow-up of stable post-breast cancer patients by their family doctor, rather than in oncology outpatient units, with the potential for re-referral where needed. A similar approach is being undertaken for patients with stable mental disturbance. Future plans include the development of a new health centre in the south of Malta, specifically in Paola (see Chapter 6).

5.4 Specialized ambulatory/inpatient care

5.4.1 Specialized ambulatory/inpatient care

Specialized ambulatory care services are provided both in hospitals and in health centres in the public health sector. In the private sector, services are provided in a range of settings – from clinics operating adjacent to or embedded within local community pharmacies, through to fully fledged licensed private clinics and private hospitals.

Outpatient services at public general hospitals are available for practically all specialties. Patients are referred by their private GP, by a health centre GP within the public primary care sector, or by another specialist from the private or public health sectors. Patients may choose their own specialist. Waiting times vary depending on the nature of the specialty. Some specialties operate a triage filtering system to ensure that urgent cases are seen without delay, whilst inappropriate referrals may be redirected accordingly.

Access to specialists in the private sector does not require GP referral; this generally allows for the quick setting of appointments and access to care. Patients can choose any private specialist they wish.

Where highly 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. As part of such arrangements, a series of visiting consultant clinics are held within the outpatient departments in order to ensure appropriate patient selection for procedures as well as to jointly review and follow up patients who have received care across borders.

Specialized ambulatory and inpatient care is available both in Malta and Gozo at MDH and Gozo General Hospital respectively. There are currently no national programmes to improve the quality of such services, but the Clinical Performance Unit within MDH works in collaboration with the Ministry for Health and MDH Management to produce relevant reports outlining activity and performance. The National Health Systems Strategy played a crucial role in highlighting these reports and taking more relevant data-driven decisions within hospital management structures.

5.4.2 Inpatient Care

Secondary and tertiary care is mainly provided through public hospitals, with private hospitals playing a complementary role. The main acute general hospital, MDH, which was commissioned in 2007 (which has 972 beds; it previously had 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 (which has 143 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, MDH. In cases of emergencies necessitating specialist care and urgent transfer to MDH, helicopter services are provided. In 2014 there were major refurbishment works with the majority of funding provided through EU funds.

There are also three private hospitals, St James Capua Hospital (79 beds) and St James Hospital, Żabbar (6 beds), and St Thomas Hospital (33 beds). STH opened its doors in September 2016. There are also 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 (501 beds), which provides both acute and chronic psychiatric care.

Oncology and Haematology services are offered at the Sir Anthony Mamo Oncology Centre (SAMOC) (86 beds and located adjacent to MDH), which was opened in 2014 and was constructed and equipped using EU Structural Funds. Previously, these services were mostly offered at an older, small hospital (Sir Paul Boffa Hospital). Dermatology services are currently still offered at Sir Paul Boffa Hospital (48 beds), which has also been converted into a long-term care nursing facility.

There have been a number of initiatives to replace inpatient care with less expensive outpatient or home care. In particular, the use of day-care facilities for surgery has continued to increase. Decentralization of services has not only been promoted for its cost-effectiveness, but also to improve patient experience. For example, several patients residing in Gozo who require chemotherapy are now able to receive their therapy at Gozo General Hospital, which allows them to avoid a lengthy commute and ferry crossing. Integration between primary and secondary care is improving and the Shared Care Diabetes Programme is an excellent example of the implementation of quality improvements. Through this programme, GPs who have undergone a specific training programme

manage the diabetes clinics organized in the health centres. They are supported through outreach visits by diabetes specialists who carry out clinics in the community and are able to review challenging cases.

Box 5.4

Assessing the appropriateness of care

In order to alleviate the long waiting lists resulting from a mismatch between supply and demand, fuelled by demographic change (migration and ageing), certain services have been contracted out by way of public-private partnerships, as has been the case for general surgery, ENT, orthopaedic and vascular surgery procedures. Similar projects were also rolled out for MRI services, arthroscopy services and weekend cover for triage level 3 emergencies.

There are no data available that demonstrate over-provision of services in comparison with other countries, but it is necessary to highlight that data on private sector activity (other than some inpatient activity) are not routinely collected.

In 2013 the Patient Safety and Quality Improvement Team (PaSQIT), a multidisciplinary group consisting of health care professionals from various backgrounds, was set up with the main intention of providing recommendations to improve patient safety and quality of care within MDH, and implementing them. The EU Commission's reports on the implementation of the Council Recommendation on Patient Safety, however, show that more remains to be achieved. However, success has been registered in decreasing hospital-acquired infections (European Commission, 2014) .

Box 5.5

Patient evaluations of the care they receive

There are no official research publications in relation to patient-reported outcome measures, user experience or public satisfaction in the Maltese health system. Social networking sites, such as Facebook, provide a public forum where patients may share their experience within the Maltese health system and despite the fact that such measures are not objective measures, they can often gauge public feedback. In relation to this, in late 2015 MDH launched the 'Care and Cure' campaign with the aim of providing relevant information to the general public and improving the user experience through a user-friendly, responsive website, posters hung at strategic places within hospital premises, a social network hashtag '#thankyouMDH', and extending patient visiting hours.

MDH also has electronic patient satisfaction surveys (at the bedside), which every in-patient can complete. The outcomes of these surveys are made available to hospital management and for internal use.

5.4.3 Day care

The definition of day care adopted in the Maltese health system is that used by EUROSTAT; namely, a day-care discharge is the release of a patient who was formally admitted in a hospital for receiving planned medical and paramedical activities and was discharged on the same day.

MDH, which provides the bulk of 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 Rehabilitation Hospital) for the provision of interdisciplinary assessment and care and at SAMOC for maintenance treatment.

Following the migration of Haematology Services from MDH to SAMOC, MDH has increased capacity at its Medical Investigations and Treatment Unit, which provides a significant amount of medical services on a day care basis, such as specific endocrine investigations and treatment related to gastroenterology disorders. At SAMOC, 27 of the 113 beds cater for day care.

Data on day care indicate that the absolute number and proportion of day-case interventions have shown an increasing trend over the past decade.

5.5 Emergency care

Emergency care in the Maltese health system is defined as any care that is unplanned. This can be care given within an A&E setting, both at health centres and in hospitals. Health centres also operate clinics that deal with urgent primary care consultations (e.g. fever, cold) through walk-in clinics where no prior appointment is required.

Emergency hospital admissions include unplanned admissions, the bulk of which arise from the A&E Department but can also result from an urgent admission following an outpatient consultation.

Emergency care is provided in the A&E Department at MDH and in health centres. Although various initiatives have been undertaken to encourage the use of health centres for emergency services, the bulk of emergency care services are delivered at MDH. The decision as to whether to opt for emergency care at

MDH or a health centre is at 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 MDH and at the health centres. There are two primary health centres, in Paola and Mosta, which offer emergency services for minor emergencies on a 24-hour basis. Patients in Gozo can access emergency care at the A&E Department within the Gozo General Hospital. There are also licensed A&E facilities in the private sector.

The A&E Department at MDH 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%) as urgent and 51 (17%) as not urgent, while the remaining 91 (31%) were not seen in the Department but referred to other departments (Vella, 2013). 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 prolonged waiting times where 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 the lack of senior medical doctors to discharge or admit patients as 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 outpatient department in the hope of seeing a specialist more quickly (Messina, 2013).

In response to this report, but also as part of the Government's overall strategic priorities for the health sector, a series of reforms and targets were implemented in the MDH A&E Department. The number of beds available in A&E was increased and a Paediatric Emergency Unit (catering for paediatric medical and surgical cases) was introduced. In addition, a patient tracking system known as 'Ctrack' was introduced in early 2015 and became fully operational by mid-March 2015. This allows the daily monitoring of patient waiting times at A&E. Box 5.6 describes the patient pathway in an emergency care episode.

Box 5.6**Patient pathway in an emergency care episode**

Most patients arrive at the A&E Department driven in a private car by a relative. Upon arrival, they are registered at reception and seen in the triage room by a triage nurse. Their onward pathway is determined by their triage assessment outcome.

In the community, in case of a severe emergency requiring external assistance, 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 an ambulance arrives.

The ambulance service is provided by the Department for Health. An ambulance will be sent to the address provided. In the case of a life-threatening situation, ambulances are accompanied by a nurse, and, if need be, a doctor. In the case of emergencies at sea, a helicopter may be dispatched. During large public events, public ambulance services are often complemented by organizations such as the Red Cross or the St John's Ambulance Services staffed by trained volunteers.

Emergency care is initiated in the ambulance. First, the patient is stabilized and then, depending on how urgent the situation is, treatment may be started on site or within the ambulance during transfer. Thrombolysis is not given in ambulances. Primary percutaneous coronary intervention (angioplasty) is performed on site within the hospital.

Ambulances take patients to MDH or the Gozo General Hospital A&E Department (depending on location), where the patient is triaged by a specialist 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 with their family doctor.

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. In August 2016 the number of licensed pharmacies, including hospital pharmacies, was 226. Production of pharmaceutical products is mainly of generic medicines and medicinal gases. In August 2016 there were 18 licensed manufacturers of pharmaceutical products. These are dispersed throughout the Maltese Islands and licences are issued on the basis of geo-demographic criteria laid down in regulations under the Medicines Act.

In the private system, patients have to pay the full price for pharmaceuticals. In the public sector, the medicines listed on the Government Formulary List – around 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 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); and
- (2) those suffering 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.

Legal Notice 302 of 2015 brought about legislative changes to the Social Security Act to increase the number of chronic illnesses that entitle patients to free medicines from 79 to 85. The Pharmacy of Your Choice scheme (POYC), introduced in 2009 in several localities in Malta, resulted in free medicines being available to patients at a registered pharmacy of their own choice where they can collect their medicines. The introduction of the POYC Unit's IT Systems within the Health Centres' Pharmacies of Paola and Floriana and the Gozo General Hospital Outpatients Pharmacy facilitated electronic dispensing of free Government's stock to eligible patients. The POYC Unit has also created a National Outpatients Repository, a data hub holding real-time pharmaceutical data for all the patients and pharmacies registered with the Unit, amounting to over 140 000 outpatients and delivered through 219 community pharmacies. Medicines cannot be dispensed through any outlets other than licensed pharmacies.

Although pharmacists are not compelled to substitute pharmaceuticals from branded to generic products, they are encouraged to do so and the take-up of generic products has been reported to be on the increase by the Medicines Authority (Medicines Authority, 2016). The Medicines Authority has an ongoing information campaign, *Mediċini: Għażla Aħjar Għalik* (Medicines: Better Choices for You), where patients are informed about the choice of medicines available and the importance of discussing these choices with health care professionals.

In 2016 the prescriptions for medicines provided to patients on the chronic illness scheme (Schedule V of the Social Security Act) were computerized, launched and are undergoing deployment across all the public health centres and district clinics.

Box 5.7

Evaluating efficiency in pharmaceutical care

In 2014 a Medicines Intelligence and Access Unit was established within the Medicines Authority with the main aims of taking a proactive and targeted approach to introducing and facilitating the adoption of best practices and enhancing medicines intelligence and access. Furthermore, the Medicines Authority is continuously updating the lists of generic medicines with those that have been recently authorized and also compares the prices of these medicines with the originators and other generics so that the consumer can use such information to decide on the best treatment option. Within the public health system, protocols regulating the cost-effective prescription of medicines are established; however, the legality of these protocols has been questioned by the Ombudsman. Despite this, the Department for Health has maintained their use with the justification that these are an evidence-based and cost-effective use of public resources.

5.7 Rehabilitation/intermediate care

Public rehabilitation services are offered at Karin Grech Rehabilitation Hospital. Free services are offered to patients who are referred from other public hospitals or from the community by their GP. The hospital comprises 269 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.

The majority of referrals to this hospital come from MDH. In 2016 the process of privatization of the management of Karin Grech Rehabilitation Hospital started as part of a public-private partnership agreement. Through this agreement, the hospital will be leased for a period of 30 years to a private health care organization, with the aim of moving towards increased rehabilitation services and the reconstruction and equipping of a fully functional rehabilitation hospital.

5.8 Long-term care

Long-term care for older people 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 older people, it also offers a number of services to support older people within the community, such as home care help, telecare, meals on wheels, handyman services, and incontinence services. The Department also manages 18 day-care centres within the community. Older residents living 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 €400 per year at their disposal (The Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2016).

The largest care home for older people is a public institution, St Vincent De Paul, which has 1149 beds. This is the only geriatric facility which has 24/7 medical care on site. It 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 have otherwise provided care to family members (Abela, 2012). The public sector has attempted to find solutions to this challenge by involving the private sector and setting up contracts with private care 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.

Since 2014 the ‘Parliamentary Secretariat for Care of the Elderly’ has started a process to implement 39 Minimum Care Standards for Older People’s Homes. It was envisaged that in the second half of 2016 a bill would be passed to enforce such standards and set up a national authority tasked with maintaining these standards. Home care is still in its infancy. The short distance to A&E is believed to dissuade people from staying in their own homes when unwell so there is no natural demand for home care. This is a gap in the health system which needs to be addressed and is particularly evident in relation to the relatively high admission rates for congestive heart failure and COPD when compared with other EU countries.

5.9 Services for informal carers

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 (SOS Malta, 2016). This revealed important gaps, for example in access to urgent respite care, as well as support for carers looking after patients with dementia.

5.10 Palliative care

The provision of palliative care services in the public sector is mainly for adult patients requiring palliative care, and a multidisciplinary team approach is used. The palliative care services, which were previously at Sir Paul Boffa Hospital, were migrated to a new 16-bed Palliative Care Ward which was set up in 2015 at the SAMOC. 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 living with 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. It receives around 25% of its funding

through a service agreement with Government. In 2016 it announced plans to develop its inpatient palliative care facility, which will be funded by the Church (Micallef, 2016).

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

The Office of the Commissioner for Mental Health strives to continually keep issues concerning this vulnerable cohort at the top of the national agenda. Services for people suffering from mental health problems have vastly improved in recent years and there have been a number of important developments in both 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 major policy driver in mental health was 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 patient-focused 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 health problems. 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. The approval, monitoring and review of compulsory care is through the Commissioner for Mental Health.

Mental health care services are mostly delivered through the 595-bed Mount Care Hospital comprising 501 beds for acute and chronic conditions and 94 for long-term care. Furthermore, a 15-bed Psychiatric Unit is available at MDH.

Migrant mental health is emerging as an important issue within the mental health services, with 10.8% of acute admissions for psychiatric care being refugees or asylum seekers (Office of the Commissioner for Mental Health,

2015). Furthermore, psychiatrists working in Malta are specialized in a number of sub-specialties, with the most recent addition being a new consultant psychiatrist specializing in child and adolescent 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 non-communicable 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 public and private dental services. Only acute emergency dental care is offered free of charge in hospital outpatient departments 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, MDH and Gozo General Hospital. Patients are free to choose in which setting they would like to receive dental care. If a patient visits a private dental practitioner, then the patient pays for their treatment. A Mobile Dental Unit was set up in 2015 by the University of Malta in collaboration with the Dental Public Health Unit with the main intention of visiting different localities in Malta and Gozo and providing free dental check-ups and personalized advice to the population. The Mobile Dental Unit is also used for data collection for the National Oral Health Survey.

In 2015, the Dental Clinic at St Vincent de Paul Residence was refurbished as part of an agreement signed between the University of Malta and the Ministry for Health, as part of the initiative to further increase the provision of services. In addition, the Dental Public Health Unit is striving to update standards for dental clinics to ensure that they provide a minimal standard with regards to quality of care and ensure the provision of safe dental health practice.

6. Principal health reforms

Chapter summary

- Legislation and health strategies to tackle non-communicable diseases, including obesity and diabetes, were adopted. Waiting times for diagnostic services and surgical operations as well as for A&E services have been reduced and a proposal for a Patient Charter has been published.
- A public-private partnership agreement for capital investment and management of the hospital in Gozo, and a cluster of hospital facilities on the footprint of the old St Luke's Hospital, including rehabilitation and geriatric care, was signed in 2016. Also, a new cancer hospital was built and opened in 2015 using EU funding and enabling new services to be introduced; cancer screening programmes were expanded.
- Reforms in the procurement, stock control and management systems addressed stock-outs for medicines. However, access to expensive innovative medicines remains a challenge and is being addressed through the introduction of clinical pathways and innovative procurement strategies, including managed entry agreements and pay-for-performance models.
- Decentralization of services from the hospital setting to the primary care setting was continued and a discharge liaison service was introduced to improve integration of care across settings. Collaborations are being sought with private primary care providers for the provision of follow-up of specific chronic conditions.
- Powerful unions and industry interests still often oppose or delay the introduction of reforms, as demonstrated through the example of opposition to the public-private partnership 30-year concession.

6.1 Analysis of recent reforms

This chapter discusses the key reforms and initiatives implemented since 2014. Reforms that were implemented between 2004 and 2013 are described in the HiT report 2014 (Azzopardi-Muscat et al., 2014). This chapter highlights the policy reforms pursued by the Government since its election in 2013. Whilst in some instances results have already been achieved and health system impact reported, other initiatives are still in the process of being implemented. Box 6.1 lists the major reforms and policy initiatives in chronological order.

Box 6.1

Major reforms and policy initiatives since 2014

Standing Committee for Health – 2014

National Health Systems Strategy – 2014

Food and Nutrition Action Plan – 2014

Discharge Liaison Services – 2014

Opening of SAMOC Oncology Hospital – 2014

National Breastfeeding policy and action plan – 2015

Diabetes: A national public health priority – 2015

Care and Cure Campaign – 2015

First Health System Performance Assessment – 2015

Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act – 2016

Human organs, tissues and cell donation Act – 2016

Charter of Patients' Rights – 2016

Launch of cervical cancer screening programme – 2016

Privatization of hospitals through a public private partnership agreement – 2016

Ban on tobacco smoking in vehicles in the presence of children – 2017

Reforms in the medicines sector (ongoing)

Further strengthening of primary care services (ongoing)

Increasing hospital bed capacity (ongoing)

Reduction of waiting lists (ongoing)

Parliament and Legislation

Standing Committee for Health

The House of Representatives established a Standing Committee for Health in March 2014. Previously, health matters were dealt with by the Social Affairs Committee. The original objective of the Standing Committee for Health was

to facilitate consultations and discussions to encourage political consensus in health care decision-making. Between March 2014 and September 2016 the Committee met 26 times and has been highly active. Many topics have been discussed, including primary care, infection control, and mental health in adolescents. It has contributed to the formulation of important legislative acts such as the organ donation act and has presented an opportunity for civil society to engage actively with Parliament in the discussion of controversial topics, such as lowering the age of sexual consent and the availability of the morning-after pill. It has not, however, tackled the topic of health care funding sustainability specifically (Parlament ta' Malta, 2014).

Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act

This enabling act caters for the setting-up of an advisory council composed of representatives from sectors outside health to ensure a health-in-all-policies approach. The act was initially proposed as a Bill to combat obesity and was eventually widened to tackle non-communicable diseases. It is considered to be an innovative legislative tool which provides a legal basis to issue subsidiary legislation for the prevention and care of non-communicable disease (Ministry for Justice, Culture and Local Government, 2016c).

Human organs, tissues and cell donation Act

This act provides for the setting-up of an organ and tissue donation register. It expressly allows a person to either opt-in or opt-out as a donor and to specify which organs they wish or do not wish to donate. It also provides for the regulation of procedure around live donations and updates the criminal code on organ trafficking (Ministry for Justice, Culture and Local Government, 2016c).

Health Strategies

A National Health Systems Strategy for Malta: Securing our Health Systems for Future Generations

The National Health Systems Strategy for 2014–2020 was adopted in September 2014. The drafting of the strategy commenced in 2012 and was supported by WHO EURO. The strategy informs the priorities to be developed in the health sector in the coming years in order to address the challenges facing the Maltese health system. The vision underlying the strategy is that of a “whole of society” approach to health improvement and building sustainable health systems grounded on healthy communities in line with the WHO European Health Policy – *Health 2020*. Strengthening prevention and primary care, making better use of technologies, harnessing existing resources and further developing

health system governance are the key thrusts upon which a sustainable health system, which respects the fundamental principle of equitable access for all, is based (Health.gov.mt 2016a).

Food and Nutrition Policy Action Plan for Malta (2015–2020)

Malta was the first country in the WHO EURO region to publish a National Food and Nutrition Policy Action Plan in line with WHO recommendations (in December 2014). The Action Plan aims to tackle public health challenges facing Malta in the area of nutrition and food security. The document presents a whole of government and whole of society approach. This Policy and Action Plan complements the Healthy Weight for Life Strategy (2012), the National Cancer Plan (2011) and the Non-communicable Disease Control Strategy for Malta (2011), all of which focus on improving dietary habits in order to maximize health and well-being. In line with *Health 2020*, the Action Plan adopts a life-course approach since the impact of nutrition on health accumulates over time. One of the first deliverables from this Action Plan has been the implementation of the first National Food Consumption Survey (Health.gov.mt 2016a).

Diabetes: A National Public Health Priority

A cross-party parliamentary working group was established in April 2014 to focus on diabetes (the first such group to be set up to tackle a specific disease). It was instrumental in instigating the development of the first diabetes strategy for Malta. Diabetes is common in Malta with an estimated prevalence between 6.4% (self-reported) and 10% (actual measurement). The first national diabetes strategy was published in December 2015 following an extensive period of stakeholder consultation. The overall aim of this strategy is to emphasize prevention and early diagnosis, expand treatment options, and further develop integrated care and management of diabetes so as to prevent or postpone complications. One of the main thrusts of the strategy is to make newer diabetes medicines available on the Government formulary (Health.gov.mt, 2016a) and implementation of this measure commenced in 2016.

National Breastfeeding policy and action plan

This policy seeks to increase both the initiation of breastfeeding rates at hospital discharge and its exclusive continuation for the first six months. It aims to achieve this through the adoption of legislation and policies regulating the marketing of breast milk substitutes; encouraging a breastfeeding policy in hospitals; providing training for health professionals; and developing strategies for the promotion and support of breastfeeding in the community (Health.gov.mt, 2016a).

National Alcohol Policy

A draft national alcohol policy was published for consultation in October 2016. The National Alcohol Policy identifies general measures addressed to the entire population as well as measures targeting young people. It aims to ensure intersectoral consolidation of initiatives and coordination to prevent alcohol use among those aged under seventeen and reduce the harmful use of alcohol among adults. A special focus is on measures to address drink driving. The policy attempts to reduce and prevent the potential harm and negative consequences of alcohol on the individual, the family and society (Ministry for the Family and Social Solidarity, 2016).

Ban on Tobacco Smoking in Vehicles where children are present

From January 2017 it will be illegal to smoke tobacco in vehicles where children are present. Malta will be the sixth European country to introduce this legislation, maintaining a proactive approach to combat the harmful effects associated with tobacco smoking through passive exposure.

Health Services

Charter of Patients' Rights

A Patient Charter was issued by the Parliamentary Secretary for Health for consultation between April and June 2016 (Social dialogue.gov.mt, 2016a). The Patient Charter is the first of its kind in Malta and is an important step in promoting patients' rights. The Charter was published in November 2016 (Ministry for Health, 2016g). The obligation to issue a Patient Charter was set out in the Health Act of 2013 and is linked to the transposition obligation within EU Directive 2011/24 on patients' rights and cross-border health care. The document is set out in eight parts: Health Protection, Access, Information, Participation and Informed Consent, Privacy and Confidentiality, Dignity and Respect, Safe health care, and Comments and Complaints.

The Charter proposes a particularly important undertaking, namely that, "if a predetermined maximum acceptable waiting time is not respected", a patient would have the right to seek "healthcare through a local private healthcare provider or in another European country for state or private treatment, in accordance with the Maltese Cross-Border Healthcare Regulations, under the Health Act". The maximum waiting period proposed is 18 months and this has attracted some criticism. In its transposition of Directive 2011/24, the Maltese Government did not include the right to seek services in the domestic private sector. The Opposition Party had tabled a motion calling for the legislation to be amended such that patients on waiting lists would be able to seek care at a

local domestic provider, but this was not approved. The Charter now proposes that this would be possible under specific circumstances as described above. The Charter's full implementation is expected during 2017.

Further strengthening of primary care services

Efforts to strengthen the infrastructure and provide new equipment in primary care centres have continued. The major health centres are now equipped with digital X-ray facilities allowing real-time transmission of images to the general hospital and a specialist opinion, for example in orthopaedics, to be sought, avoiding the need for patients to visit the hospital A&E Department. A series of services have been introduced including: new chronic disease management clinics, plastering facilities in all health centres, and healthy lifestyle clinics. Several hospital clinics have introduced outreach services (including cardiology, gynaecology, sports and medicine, anticoagulation clinic, etc.). General practitioners, including private family doctors who are linked in to myHealth have been provided with wider access for direct referral to many services which previously could only be requested by hospital specialists.

Cancer Screening Services Expanded

In May 2016 the first national cervical cancer screening programme was launched. Women aged 25–35 years are being invited for a smear test (Times of Malta, 2016). The colorectal cancer screening programme, offered through the faecal occult blood test, was launched for persons aged 60–64 in 2012. In 2015 the second cycle commenced and the programme was extended to persons aged up to 66 years (Times of Malta, 2015). The breast cancer screening programme has been gradually expanded and now includes women aged 50–65 years. The main challenge experienced is the need to increase invitation acceptance rates which are currently at 60% for breast cancer and 50% for colorectal cancer (Health.gov.mt, 2016b).

E-Health

The National Health Systems Strategy adopted in 2014 highlights the importance of further developing the use of ICT in the Maltese health system. The myHealth system, which is a system that allows patients to access their electronic record through a nominated doctor of their choice, has been improved since its rollout in 2012 and its coverage multiplied through an outreach working around the restrictions of the e-id system. An investment plan for E-health infrastructure, which envisages the creation of electronic patient records in primary health care, E-prescription services on a national basis, patient registries, and the necessary enablers for E-prescriptions (including the Government Formulary for medicine,

the entitlements approval system, and health data exchange backbone), has been drawn up. This will lead to the development of national electronic health records which ‘pull’ data from all electronic patient data.

Care and Cure

In 2015 the acute general hospital, Mater Dei Hospital (MDH), launched a campaign called Care and Cure. This campaign was intended to render the hospitalization experience a more positive one, as well as to disseminate information for patients and visitors. Visiting hours were increased and information about aspects of care such as infection prevention was made available (Mater Dei Hospital, 2015). In addition, a Patient Safety Committee (PASQIT) was established to investigate incidents and promote patient safety. Since its inception the committee has conducted over 150 cases of root cause analysis.

Increasing bed capacity

Limited bed capacity has been one of the major supply constraints impeding better health system performance. Bed capacity in MDH has been increased by 68 beds through the creation of two additional wards and the number of substandard beds has declined. Nevertheless, this was deemed insufficient and plans are being developed to build a new maternity wing on the MDH site, thereby increasing capacity by around 300 beds. The target set is that substandard beds (e.g. trolleys, holding bays) will cease to exist (Mater Dei Hospital, Personal Communication, 2016).

Addressing waiting lists

A series of measures have been introduced to reduce waiting lists for certain diagnostic and surgical procedures. This has been acknowledged in the Commission’s assessment report on the National Reform Programme (European Commission, 2016b). Such measures have improved access in key areas. For example, waiting time for MRI investigations has decreased from around 18 months to around four months. This has been possible due to a second MRI machine in the public sector and the extension of appointments to twilight hours (use of equipment on a 24/7 basis), as well as outsourcing procedures to the private sector. Such schemes have been designed to incentivize health professionals to deliver more within the public health care system to avoid the creation of perverse incentives. For echocardiograms, a 30-month average waiting time has gone down to two months. The average waiting time for an ultrasound is around five months and that for a CT scan around six

months. Waiting time for cataract surgery has been reduced from three years to six months. Waiting times for hip and knee replacements are also being reduced gradually.

These results have been achieved through a combination of increasing the number of procedures performed in the public hospitals, through, for example, the introduction of routine Sunday lists, as well as outsourcing procedures to the private sector. In addition, a waiting list management system ensures that patients who are no longer deemed to require the intervention or who need to lose weight prior to being eligible for the intervention do not feature on the waiting lists (Mater Dei Hospital, Personal Communication, 2016).

Accident and Emergency Department

A series of reforms were implemented; and the layout of the A&E Department was completely redesigned, providing more cubicles for patients to be seen. In addition, the service of a reception nurse was introduced. This ensures that patients who would be better served by being seen directly in a Specialty Department (depending on the type of complaint they have) would be immediately diverted to the particular department. A patient tracking system was developed and a new minor care clinic was established.

Improvements in bed management mean that patients who need to be admitted to hospital no longer have to wait for a long time in A&E until a bed is found.

In December 2015 a purposely designed separate emergency department for children was inaugurated. In 2016, 75% of discharged patients had a total length of stay in A&E of less than four hours, whilst 80% of admitted patients had a total length of stay in A&E of less than six hours (Mater Dei Hospital, Personal Communication, 2016).

Discharge Liaison Service

The service was established in 2014, having started with a project funded through the European Social Fund aimed at linking hospital services with community services following patient discharge. Nurses received training in Northern Ireland. The discharge planning process starts upon admission for patients who are deemed to require post-discharge support. This project contributed both to a decrease in the length of stay and to a decrease in hospital readmission rates (Directorate for Nursing Services, Personal Communication, 2016).

Opening of Oncology Hospital (Sir Anthony Mamo Oncology Centre project)

Towards the end of 2014 this new oncology hospital, based on the same grounds as the acute hospital MDH, received its first patients. The centre, named after the first President of the Republic of Malta, was funded through the European Regional Development Fund (ERDF 2007–2013) and replaced the former hospital where cancer patients previously received treatment. Paediatric oncology and haematology services, previously housed within MDH, were incorporated into the SAMOC, thereby releasing much-needed beds for acute care services. Investment in new radiotherapy equipment enables the delivery of precision radiotherapy in stronger doses, thereby reducing the number of sessions required, as well as the duration of each session. Tumours previously treated abroad can now be treated locally. The project was also the catalyst for the establishment of university training programmes leading to qualifications in therapeutic radiography and medical physics (Times of Malta, 2014; Health.gov.mt, 2016c).

Public-private partnership hospital project

The Government has entered into a 30-year contract with Vitals Global Healthcare, a private contractor for the refurbishment, development and management of three hospitals in Malta and Gozo. The private contractor will be responsible for capital investment. The new Gozo hospital and the development of Karin Grech and St Luke's are expected to be completed within 24 months from the start of construction, but the latter date cannot be established as the necessary building permits are still pending. The Government is anticipating paying the sum of €55 million annually into the partnership, which is the sum currently paid for the running of these hospitals (Allied Newspapers Ltd, 2016). All Government workers in the three hospitals will remain Government employees, but the management of the hospitals and staff was handed over to the private contractor in June 2016. Agreements between the Government and unions on the future of their employees has been achieved with the Malta Union of Nurses and Midwives and the General Workers Union, but remains outstanding with the Medical Association of Malta and the UHM Voice of the Workers. Redacted versions of the privatization contracts were made public in October 2016. The Medical Association of Malta and the UHM Voice of the Workers have called for an investigation by the Public Accounts Committee. The extent to which this initiative will alter the landscape of the Maltese health system will depend on the way it is going to be implemented. Concerns have been raised about threats to equity of the health system, long considered one of the strong hallmarks of the Maltese health system. Yet from public statements,

the Government has sought to provide reassurance that no changes in terms of access and coverage will occur. This is a particularly important point for the Gozo hospital, where the only hospital on the island has been handed over through this 30-year concession. On a positive note, it is hoped that standards of care will improve through the pursuit of projects such as international hospital accreditation. However, on a more cautious note, critics fear that the hospitals will eventually need a larger Government subvention and therefore it is not possible to establish at this stage whether this reform will contribute to enhanced health system sustainability or will in itself trigger higher levels of expenditure. The impact of this reform will require close monitoring over the next three to five years.

Gozo hospital project

The Gozo hospital will be modernized, expanded and upgraded as part of the public-private partnership agreement. This will not only improve access for Gozitans and expand the health care capacity available for residents in Malta but is also expected to create niche medical tourism. The first new service launched by the privately owned hospital is a helicopter air ambulance service for the transfer of seriously ill patients needing emergency treatment in Malta. This replaces the need to rely on the helicopter service provided by the Armed Forces of Malta and reduces transit time whilst improving facilities available during air transfer (The Malta Independent, 2016a). Its increased capacity should also enable the Barts and the London School of Medicine and Dentistry to establish an overseas medical school at Gozo General Hospital. This is expected to host the first students in September 2017 and will build to a capacity of 300 medical students by 2022.

Rehabilitation Hospital

Through the same agreement, the private sector will be investing in the development of a rehabilitation hospital on the grounds of the former St Luke's Hospital, which was left mostly unutilized following the migration of services to MDH. This facility is intended to introduce services that are presently not available in Malta. While it is primarily geared towards medical tourism, 80 beds will be exclusively designated for use by domestic patients through the public health services. The hospital will have 350 beds and is expected to be completed in mid-2018 (The Malta Independent, 2016b).

Capacity for elderly care

The Karin Grech Hospital, which is currently used both for geriatric rehabilitation and nursing care, will be taken over through the public-private partnership and used as a 250-bed geriatric hospital with 125 beds available for the public sector and 125 beds for the private sector

Reforms in the Medicines Sector

The procurement of medicines and medical supplies was identified as a key outstanding challenge in the 2014 HiT report (Azzopardi-Muscat et al., 2014). Stock-outs for common medicines in the public health system were a frequent occurrence due to bureaucratic processes and procedures, lack of forecasting and inadequate budgetary provision. In 2015 the European Commission noted that “*an improvement in procurement and distribution processes for medicines and medical devices led to substantial savings. Furthermore, a pay per use system on high costs devices has reduced the holding of stock*” (European Commission, 2015b). The problem with out-of-stock medicines has therefore been successfully tackled. The Pharmacy of Your Choice Scheme has continued to be strengthened with the next phase being a pilot project to deliver medicines directly to the private residences of elderly people in line with the Government’s electoral programme. E-prescription services are also being introduced.

Access to innovative medicines remains a considerable challenge. The Government Formulary List Advisory Committee has introduced the concept of clinical pathways and protocols for the evaluation of new medicines. This means that evaluation of new medicines now takes place around the concept of diseases management moving away from the introduction of single medicines. Some inroads have been made with the use of bio-similars, and this also leads to savings in the medicines budget. Savings can then be used to procure expensive new medicines. The Government is embarking on the use of Managed Entry Agreements. Furthermore, in recent years the Malta Community Chest Fund (a philanthropic Foundation presided over by the President of Malta) has extended its role in the financing of new medicines, particularly those for cancer that are not yet included on the Government Formulary. Cancer medicines now account for the largest expenditure of this Fund (Malta Community Chest Fund Foundation, 2016). In spite of these measures, funding innovative medicines remains an important challenge to the reconciliation of the dual objectives of health system access and sustainability.

6.2 Future developments

Most of the current and recent debates in the health sector have been related to ethical/moral issues, such as debates on revisions to the Embryo Protection Act in order to allow more possibility for embryo freezing, access to the morning-after pill, and euthanasia.

Health policy has been an area in which political consensus has prevailed in recent years with most legislative initiatives receiving support from both the governing party and the opposition. There is consensus on the desire to retain public health services free of charge at the point of use and preserve the current model of health care funding. There is a reluctance to debate health system sustainability notwithstanding that Malta received a Country Specific Recommendation urging the Government to tackle health system sustainability in 2013 and 2014. The public health system continues to be under pressure to deliver more with less. To this, one might add the recent drive by the Office of the Prime Minister to introduce key performance indicators for all ministries in Malta. The Ministry for Health is using a number of selected dimensions from the Health System Performance Assessment framework for this purpose.

Health care expenditure is projected to increase significantly in the long term, reflecting demographic trends. According to the European Commission, the efforts by the authorities to contain the long-term expenditure growth in the pension and health care systems so far do not appear sufficient to address this risk (2016). The steep increase in projected age-related expenditure is related in particular to pension expenditure (3.2 percentage points of GDP) but health care and long-term care expenditure also contribute to this projected increase (2.1 and 1.2 percentage points, respectively) (European Commission, 2016a).

Financing of the public health system has increased in recent years, albeit still remaining lower than the EU average. The Ministry for Health has to ensure tight budgetary control on the one hand with the Fiscal Responsibility legislation that has been introduced for Eurozone countries and on the other hand has to cope with demands made by newly established institutions to protect the patient, such as the Health Commissioner (within the Office of the Ombudsman) and the Mental Health Commissioner. Furthermore, the implementation of the patients' rights charter pledging to give access to the private sector for those patients who wait for a period longer than 18 months has also exerted pressure to increase activity and reduce waiting lists.

The major development is the privatization of three state hospitals. Some concerns have been raised in the public domain about the need to safeguard equity between private overseas fee-paying patients and domestic patients covered by the public health system. Efforts to strengthen the regulatory infrastructure and build capacity for service monitoring are expected to intensify in order for the Ministry to be adequately equipped to ensure quality and value for money in a future scenario where the integrated care model for funding of public hospitals, through direct budgetary control, is being replaced by a contractual relationship with a private for-profit provider.

Initiatives to curtail waste, promote evidence-based health care, foster efficiency in service organization and supply chain management, and monitor health systems performance have started and are expected to be further developed in the future. Areas of the health system which are considered to be underperforming compared with other European countries, e.g. mortality from cerebrovascular disease, are being identified with a view to closing this performance gap.

Investment is planned in a primary health care facility in the Southern Harbour region, a maternity hospital and a new mental health hospital. These are intended to redress the imbalance in resource allocation between the acute hospital sector and the remainder of the health system. The introduction of a single number and a call centre for all patient appointments is being planned. Likewise, EU funds have been sought for important E-health projects intended to develop a nationwide electronic health record, facilitate E-prescriptions and ease integration of services. The Church in Malta has announced its intention to support the development of an inpatient Palliative Care Facility in conjunction with the Malta Hospice Movement.

A strong focus on tackling non-communicable diseases is expected to remain high on the health agenda with the Second National Cancer Plan, and a Health Enhancing Physical Activity Strategy expected to be adopted in the coming months.

In the first half of 2017, Malta assumes its Presidency of the Council of the European Union for the first time. The health sector has chosen as its main themes childhood obesity and structured cooperation between health systems as a means of enhancing access to innovative medicines, technologies and highly specialized services. A conference on HIV/AIDS will also be organized.

7. Assessment of the health system

Chapter summary

- In the 2015 Health Systems Performance Assessment, Malta scored ‘good’ on responsiveness of the health system, ‘fair’ on dimensions of financing, quality, access and health status, and ‘poor’ on dimensions of resources, efficiency and determinants of health. An outstanding challenge remains in capturing and monitoring private sector performance activity.
- The Directorate for Health Information and Research is responsible for the management of national health datasets and for the implementation of the European Health Interview Surveys. Operational level data are held at the level of the individual hospital/institution.
- The 2014 Maltese National Health System Strategy has the main objectives of: responding to increasing demand and challenges posed by demographic changes and epidemiological trends; increasing equitable access, availability and timeliness; improving quality of care; and ensuring sustainability. Important public health strategies have been published, e.g. for breastfeeding, nutrition, diabetes and alcohol.
- The Maltese health system has made an important contribution towards the reduction of mortality, where rates have fallen in all age groups. The Maltese population enjoys the highest healthy life expectancy in the EU and amenable mortality has declined sharply in both men and women.
- There is low unmet need, and access to services is generally good; however, as data availability improves, there are indications that equity of health outcomes is an important issue that merits further attention.
- A system of HTA has been in place for the approval of new medicines and health services since 2010; moreover, the Maltese health system generally maximizes the use of capacity and resources available.
- Medium-term sustainable financing of the health system with a redistribution of resources from hospital to primary care remains an outstanding challenge.

7.1 Monitoring health system performance

In 2015 Malta published its first ever Report on the Performance of the Maltese Health System. Work on this report commenced in 2012 and was supported by the Division for Health Systems and Public Health of the World Health Organization, Regional Office for Europe (Grech et al., 2015). Malta's first Health Systems Performance Assessment (HSPA) was developed subsequent to the creation of Malta's National Health System Strategy (NHSS) as a means to monitor the implementation of this strategy. The development of the HSPA took place over three stages. During the first stage the HSPA working group developed an appropriate model or framework for Malta's HSPA. The second stage consisted of the extraction, identification and population of the model with key system performance indicators. The final stage comprised the measurement of the performance indicators and presentation of the results. In all, 350 performance indicators were extracted from 17 national sectoral health strategies. An iterative deductive process was used to reduce the number to the final set of 57 performance indicators. These indicators were incorporated into the HSPA framework as follows:

- Drivers: Stewardship, Resources and Financing
- Intermediate goals: Efficiency, Access, Responsiveness and Quality
- Goals: Health status, Determinants of Health

For each of the identified indicators a score was applied. The score that was given depended on longitudinal trend analysis and a comparative analysis. The overall score was derived from a combination of whether the trend for the particular indicator was positive, negative or stable, as well as whether the particular score was better, worse or in line with some international average, usually the EU average.

On the basis of this analysis, an overall score for each of the dimensions was produced. Using this scoring system, the overall responsiveness of the health system emerged as being 'good'. The dimensions of financing, quality, access and health status emerged as 'fair'. The health system scored poorly on the dimensions of resources, efficiency and determinants of health. The stewardship domain could not be assessed because of a lack of data for the selected indicators. Overall this report set a relatively high benchmark since an indicator had to be improving and above the EU average for a highly positive score to be attained, and at least improving or above the EU average for a positive score.

Since this assessment was only conducted once, it presents a snapshot of the situation mostly based on 2012 data. The real value of such an HSPA lies in the repeated assessment over a period of time since this will allow for reflection on the domains that are improving. The use of HSPA dimensions as key performance indicators for the Ministry for Health, as described before, should facilitate this.

The HSPA exercise also served to highlight the domains for which data availability remains a problem and the areas where capacity for information generation and monitoring needs to be improved. It is expected that the implementation of a new e-health system will enable more information to become available for health system performance monitoring purposes.

One of the outstanding challenges remains that of capturing and monitoring private sector performance activity. Data capture has improved in recent years, for example for surgical operations. However, the development of a strong framework to capture private providers has become more important in view of the changes to the architecture of the Maltese health system with the rollout of public-private partnership agreements for the running of public hospitals. Training and capacity building initiatives, which are aimed at strengthening quality and performance monitoring within the public health information and regulatory system, are under way. These projects are being conducted with overseas partner agencies in the field of health system quality and performance monitoring. Responsibility for performance monitoring insofar as ensuring that the conditions of licence are adhered to lies with the Directorate for Health-Care Standards. The licence conditions, however, are mostly focused on structural elements and have not traditionally focused on output or outcome measures. Payment is not linked to performance since public hospitals are paid through a global budget and private hospitals are normally paid on a fee-for-service basis through out-of-pocket payment or reimbursement through private insurance.

Information Systems

The Directorate for Health Information and Research is responsible for the management of national health datasets on mortality, cancer, congenital anomalies, organ transplants, obstetrics, hospital information systems, accidents and injuries, and dementia, as well as for a number of other databases on health service activity. It is the clearing house for the submission of health information and statistics to WHO, EUROSTAT and OECD. It plays an important role in collecting and collating information which can be compared to other countries in Europe. This forms a good basis for analysis of health systems performance at a macro level.

Operational level data, for example data on waiting times and patient satisfaction, are normally organized and kept at the level of the individual hospital/institution. It is not usually available in the public domain on an ongoing basis, but is most often disclosed in the form of Parliamentary Questions. Waiting time features in the access dimension of the HSPA, which is also being used as a key performance indicator, so one hopes to achieve better visibility of this indicator. Data on quality and outcomes are not widely available as yet.

The Directorate is also responsible for the implementation of the European Health Interview Surveys with the latest survey having been carried out in 2014.

Some of the registers are well established and are regularly used in international comparative studies, e.g. the National Cancer Registry has participated in the EURO CARE studies and the National Obstetrics System has been involved in comparative studies, such as PERISTAT. Other registers, e.g. dementia, have been developed more recently.

Notwithstanding, in the Malta country report published with the *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability*, prepared by DG ECFIN and the Economic Policy Committee, a call has been made for enhancing the HSPA function, in particular with regard to monitoring of quality of care (European Commission, 2016a). Furthermore, in the same report the European Commission also recommended that data collection on expenditure, resources and care utilization, as well as evaluations of quality of care, should be improved. However, it should be acknowledged that small countries face specific challenges in their capacity to support extensive high quality health information systems (Azzopardi-Muscat et al., 2016). These challenges are being addressed through the recently established WHO Small Countries Health Information Network.

A Eurobarometer survey published in 2014 found that 94% of the Maltese population (surveyed) reported health care quality in Malta as being 'good', an increase of 13% from the Eurobarometer survey conducted in 2009. Almost half of the respondents (45%) state that health care in Malta is at least as good as that in other EU Member States (Eurobarometer, 2014).

Licensed public and private health services providers have a duty to provide data in line with the regulations on public health statistics published by EUROSTAT. Furthermore, the Health Act 2013 empowers the Chief Medical Officer to request and collect data. Despite this, the lack of specific local legislation detailing the type, nature and periodicity of data submission

obligations is considered as a lacuna that needs to be addressed. This issue has heightened salience in view of the recently concluded public-private partnership agreements.

Stated objectives of the health system

The Health Act 2013 formulated the public health system objectives. The latest National Health System Strategy (NHSS) launched in 2014 lists four main objectives as follows (Parliamentary Secretariat for Health, 2014):

1. Respond to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on the whole course of life, children, the elderly 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 delivered by competent health workers supported by robust information systems.
4. Ensure the sustainability of the Maltese Health Systems.

A senior implementation committee for the NHSS has been established. Monitoring reports published by the European Commission as part of the European Semester process acknowledge that some progress has been made in addressing issues such as out-of-stock medicines and waiting times for certain elective procedures. However, the efforts to shift resources away from hospitals to primary health services need to be intensified. Furthermore, the measures being taken to address the medium-term financial sustainability of the health system are being questioned in terms of whether they will prove sufficient to address the funding gap that is expected to emerge in the coming years. Proposals for the use of EU funds to invest in a primary health care hub in the south of Malta and for investment in e-health systems are expected to contribute towards the achievement of the stated objectives. More remains to be done in terms of ensuring speedy access to specialized outpatient services as well as access to innovative medicines. In terms of quality, whilst progress has been registered in certain areas, for example five-year cancer survival, the 30-day mortality from acute myocardial infarction and stroke is an area where improvement is still necessary.

In terms of enhancing patients' rights, the publication of a Patient Charter is an important first step in the right direction. Its full implementation is expected during 2017, by which time patients whose rights are not observed will be able to see redress according to the provisions described in the Charter.

Since 2014, work on the publication of important public health strategies has continued at a steady pace. The publication of the national breastfeeding policy, the Food and Nutrition Action Plan and the National Diabetes Strategy are all important examples in this regard. Some actions have already started being implemented, e.g. modernization of the diabetes formulary. The recent publication of a draft plan to address the public health and social implications of alcohol consumption is an important landmark. The implementation of the proposed measures will be an effective tool to start addressing the issues of binge drinking, accidents, violence and alcohol consumption in young persons. A strategy to address the increasing incidence of HIV is also expected to be published.

In early 2016, legislation promoting intersectoral action to tackle non-communicable disease was adopted. This legislation provides for the establishment of an intersectoral committee. This committee has been established although specific legislation promoting intersector measures to tackle non-communicable disease has not yet been published.

Valuable intersectoral action has, however, already been taking place between the Ministries responsible for health and education respectively in the targeting of childhood obesity. Whilst it is still too early to gauge the effectiveness of these initiatives from an outcomes perspective, certain measures to dissuade children from consuming unhealthy food, such as strict guidelines for food products allowed in school tuck shops, are expected to yield positive results in the coming months and years. There is also increasing recognition of the role taxation can play in decreasing consumption of harmful products. The Ministry of Finance has adopted taxation measures for tobacco and alcohol over the past years. More remains to be done in terms of intersectoral collaboration between the transport, environment and health sectors in improving walkability and providing access to activities, such as running and cycling, taking place in a safer environment. There is also a need for more intersectoral action between the Ministries responsible for health and social welfare, and data increasingly show that poor health determinants cluster in lower socio-economic groups. Nevertheless, overall successive governments in Malta have demonstrated a high level of political commitment to health improvement.

7.2 Health system impact on population health

The Maltese health system has made an important contribution towards the reduction of mortality. Mortality rates have fallen in all age groups, including children. The Maltese have experienced a significant increase in life expectancy and now enjoy the highest healthy life expectancy in the EU. Between 2000 and 2014 amenable mortality declined sharply in both men and women at a rate of 3.8% per annum. This mortality reduction has come about primarily as a result of a reduction in cardiovascular mortality. This trend, which started in the second half of the 1980s, continued in the 1990s and gathered momentum after Malta's accession to the European Union. Whilst there is no doubt that quality of life generally has improved indirectly as a result of the marked socio-economic development that has taken place particularly over the past decade, there is evidence that amenable mortality has also been significantly reduced. Amenable mortality in 2013 was the same as that of Greece, slightly higher than Cyprus and Italy but well below the EU average (Fig. 7.1). In terms of preventable mortality, Malta fares very well and has a low level on a par with that of Cyprus and well below the EU average (Fig. 7.1).

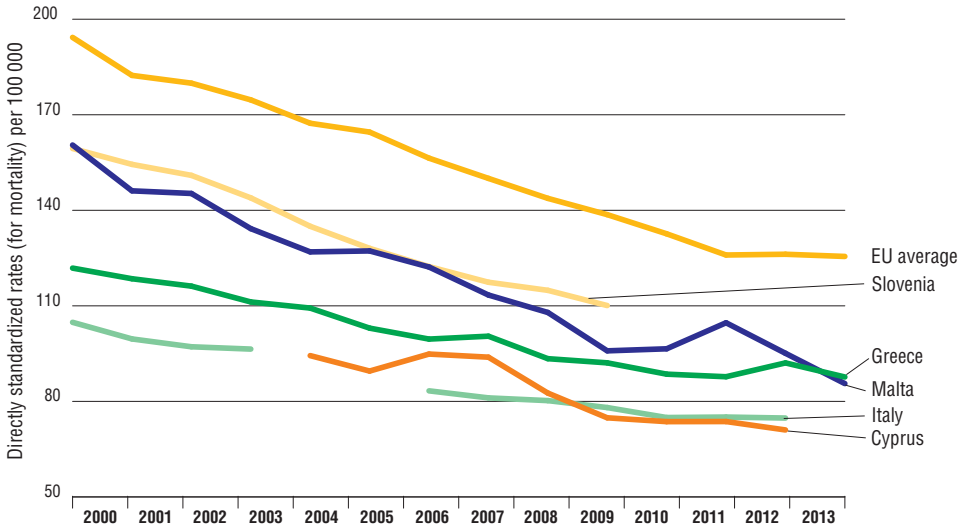
The hefty investment in local services that would seem to have contributed to this mortality decline can be described in two phases. In the 1990s a series of measures were implemented to develop a fully independent cardiac medical and surgical service on the island, reducing the need for patients to travel overseas for cardiac care. This was accompanied by an increase in the availability of anti-hypertensive medicines and statins free of charge for all the population meeting set clinical criteria. This investment in primary and secondary prevention, as well as tertiary services such as coronary angioplasty and CABG, altogether led to a decrease in cardiovascular mortality, notwithstanding the relatively high prevalence of obesity and diabetes.

In the first decade of this century the emphasis on investment shifted to the prevention and treatment of cancer. Malta was the second country after Ireland to ban tobacco smoking in public places. Daily smoking prevalence has come down from 23% in 2002 to 20% in 2014. Organized cancer screening services for breast cancer, colorectal cancer and more recently cervical cancer have been introduced since 2010. The building and equipping of a modern oncology centre using EU funding, together with training and recruitment of human resources that are critical to the delivery of quality cancer care, are all important measures which together have begun to make a difference in the five- and ten-year survival rates for certain cancers. Around one in two people receiving a cancer diagnosis in Malta can now expect to live ten years or more

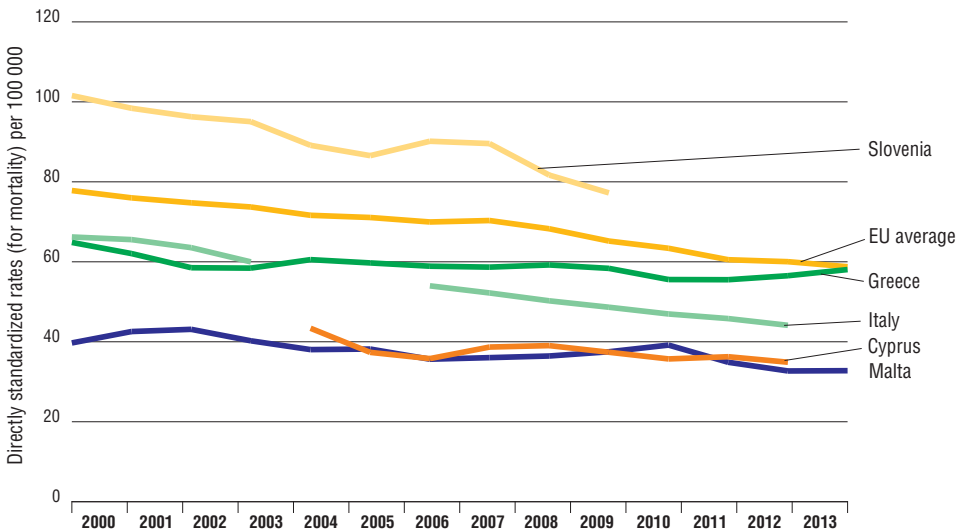
Fig. 7.1

Amenable and preventable mortality in Malta and selected countries, 2000–2013

Amenable mortality



Preventable mortality



Source: Observatory calculations using WHO details, mortality files 2016, based on Nolte & McKee (2004) list of amenable and preventable mortality.

after their diagnosis. This progress has been driven by improvements in overall knowledge of how to control and treat cancer, combined with the commitment of the national health systems to deliver cancer control and care services that are persistently being expanded and upgraded.

Remarkable improvements in survival have been demonstrated for some types of cancer, notably malignant melanoma, breast, testicular, thyroid and prostate cancers. However, there are also clusters of cancer patients for whom outcomes in terms of survival, morbidity and quality of life have remained unchanged and are particularly poor. For example, to date survival has remained intractably low for patients diagnosed with certain cancers, such as those of the lung, pancreas and stomach, and specific types of acute leukaemias in adults, as well as most brain tumours (Table 7.1).

Table 7.1

Five-year standardized relative survival for adult cancer patients

Site	EUROCARE-4 [1995–1999]		EUROCARE-5 [2000–2007]		
	European Mean	Malta	European Mean (CI)	Malta (CI)	Best performer (CI)
Stomach	24.1	17.2	25.1 (24.8–25.4)	18.7* (14.2–23.6)	Iceland – 34.5 (27.8–41.3)
Colon	54.3	50.9	57.0 (56.8–57.3)	58.1 (53.4–62.4)	Germany – 62.2 (61.7–62.8)
Rectum	53.6	53.6	55.8 (55.5–56.1)	52.8* (46.5–58.7)	Iceland – 73.2 (65.2–79.6)
Lung	12.2	8.5	13.0 (12.9–13.1)	10.3* (7.9–13.0)	Austria – 16.7 (16.1–17.2)
Skin Melanoma	83.1	84.5	83.2 (82.9–83.6)	87.7 (78.7–93.1)	UK (N. Ireland) – 90.7 (88.1–92.8)
Breast (women only)	81.6	78.1	81.8 (81.6–82.0)	80.8* (77.0–84.0)	Iceland – 87.2 (83.1–90.4)
Ovary	41.9	38.4	37.6 (37.1–38.0)	39.3 (32.2–46.2)	Sweden – 44.1 (42.5–45.6)
Prostate	77.7	69.9	83.4 (83.1–83.6)	84.9 (79.0–89.2)	Austria – 90.4 (89.7–91.0)
Kidney	59.9	61.6	60.6 (60.2–61.0)	48.4* (39.3–56.9)	Austria – 71.4 (70.1–72.6)
Non-Hodgkin's Lymphoma	55.0	62.7	59.4 (59.0–59.7)	47.8* (41.8–53.6)	Iceland – 74.1 (67.2–79.8)

Sources: Comparable rates taken from the EUROCARE-4 (European average) and EUROCARE-5 (European average and best performer) studies, with results compared to EUROCARE), Directorate for Health Information and Research, 2016.

Notes: Data are % relative survival for adult patients with cancer; European mean data are population-weighted means of the country specific relative survival estimates; (*) and bold – survival rates for Maltese patients that are lower than the European average.

In terms of preventable mortality, the Maltese health system scores very highly. Maltese men have the second lowest rate of preventable mortality after Swedish men, whilst Maltese women experience the lowest levels of preventable

mortality in the EU. Whilst the possible positive influence of a cohort experience effect (brought about by a generation of non-smoking, non-drinking, monogamous women and, to a lesser extent, men) cannot be excluded, a score adopted by McKee and Mackenbach (2013) on the implementation of successful public health policies placed Malta in a fairly positive position, particularly in comparison with other EU Member States that acceded to the EU since 2004. Therefore, it is reasonable to assume that the positive outcomes for preventable mortality can be ascribed to the successful implementation of vigorously pursued appropriate public health policies.

The early and explicit formulation of a modern national health policy under the guidance of the WHO Office for the European Region, with specific targets in 1995 known as “Health Vision 2000” (Ministry for Social Development, 1995), is a good example of the early innovator approach that placed Malta on the right track. This document had specifically highlighted the importance of intersectoral action. Whilst the intersectoral committee at permanent secretary level for health did not materialize, several specific initiatives were spearheaded by the health sector driving a working group composed of representatives from different Ministries. This was the case for the development of the Healthy Weight for Life Strategy, which commenced in 2006. The generally high level of political consensus that has prevailed since the late 1990s on issues relating to public health policy is probably another important determinant that has permitted successive governments to move forward relatively smoothly with the implementation of favourable public health policies.

This is reflected in the relatively low rates of preventable mortality achieved. This success is, however, threatened by the high rates of overweight and obesity, particularly worrisome in children, the rising prevalence of diabetes, together with increasing numbers of diagnosis of Type 2 diabetes in younger persons, as well as the rising incidence of TB and HIV.

In 2011 a sexual health policy and strategy were published for the first time. This gave increased visibility to sex education campaigns. Although one cannot directly attribute a link, since 2011 the rate of teenage pregnancies in Malta has started to decline.

Equity of outcomes

Until 2003 Malta was a fairly homogenous society with very little division along ethnic lines. Geographically the island is very small, with a high population density. Over the years Malta has also had a favourable Gini coefficient with none of the wide income inequalities traditionally registered in larger countries. Furthermore, strong family and community social networks often compensate

for the tendency for unmet need to become visible. However, since Malta's accession to the EU the island has undergone a very rapid socio-economic and demographic transition. Malta is now firmly established as a multi-ethnic society. Over the past five years, since the 2009 recession, the at-risk of poverty rate (AROPE) has been rising and poverty is now an issue that has risen to the fore of the domestic agenda.

Health inequalities have traditionally not featured as a key concern for the Maltese health system (see next section on unmet need). As data availability improves, there are indications that equity of health outcomes is an important issue that merits further attention. There are differences in standardized mortality rates between the different regions, with the southern part of the island experiencing higher age standardized mortality rates than the north and the west. Differences are visible in the rate of external causes of death such as accidents. The western region has a lower rate of deaths from circulatory disease but experiences a higher rate of breast cancer, typically associated with affluence. A one-off exercise linking data on mortality with that on the highest level of educational attainment for mortality rates in 2006–2008 confirmed that age standardized mortality rates increase with lower levels of educational attainment, with the exception of cancer in women.

Data from the European Health Interview Survey also confirm that there is a clear age-adjusted social gradient for self-perceived health, as well as self-reported mental health. Individuals with a high level of educational attainment are more likely to participate in physical activity, less likely to smoke and less likely to be obese. As a result, persons with lower levels of educational attainment are more likely to report having high blood pressure or diabetes.

In terms of ethnicity, data from the national obstetrics information system show that foreigners, particularly those without permanent residence status, are more likely to undergo caesarean section and far less likely to attend for an antenatal visit prior to 14 weeks of gestation.

7.3 Access

Access to the health system is generally good. All persons covered by the Social Security Act are entitled to services from the public health system. This generally covers all workers and their dependents, pensioners and other persons in receipt of benefits who are unable to work. The Refugees Act lays down the

criteria for access for refugees and persons who have Temporary Humanitarian Protection status. In practice, however, asylum seekers are also provided with necessary health care services and the Ministry also operates a system through which hospital fees can be waived on humanitarian grounds.

A highly comprehensive package of health care benefits is offered free at the point of use. This effectively means that the system provides a good breadth and depth of coverage. The main issue with regards to coverage relates to provision of novel medicines, typically those used to treat cancer or other forms of rare diseases. In recent years the President's Malta Community Chest Fund charity foundation has had to step in to cover treatment which is not provided by the statutory health system, suggesting that the public health system is struggling to keep up with coverage of innovative medicines.

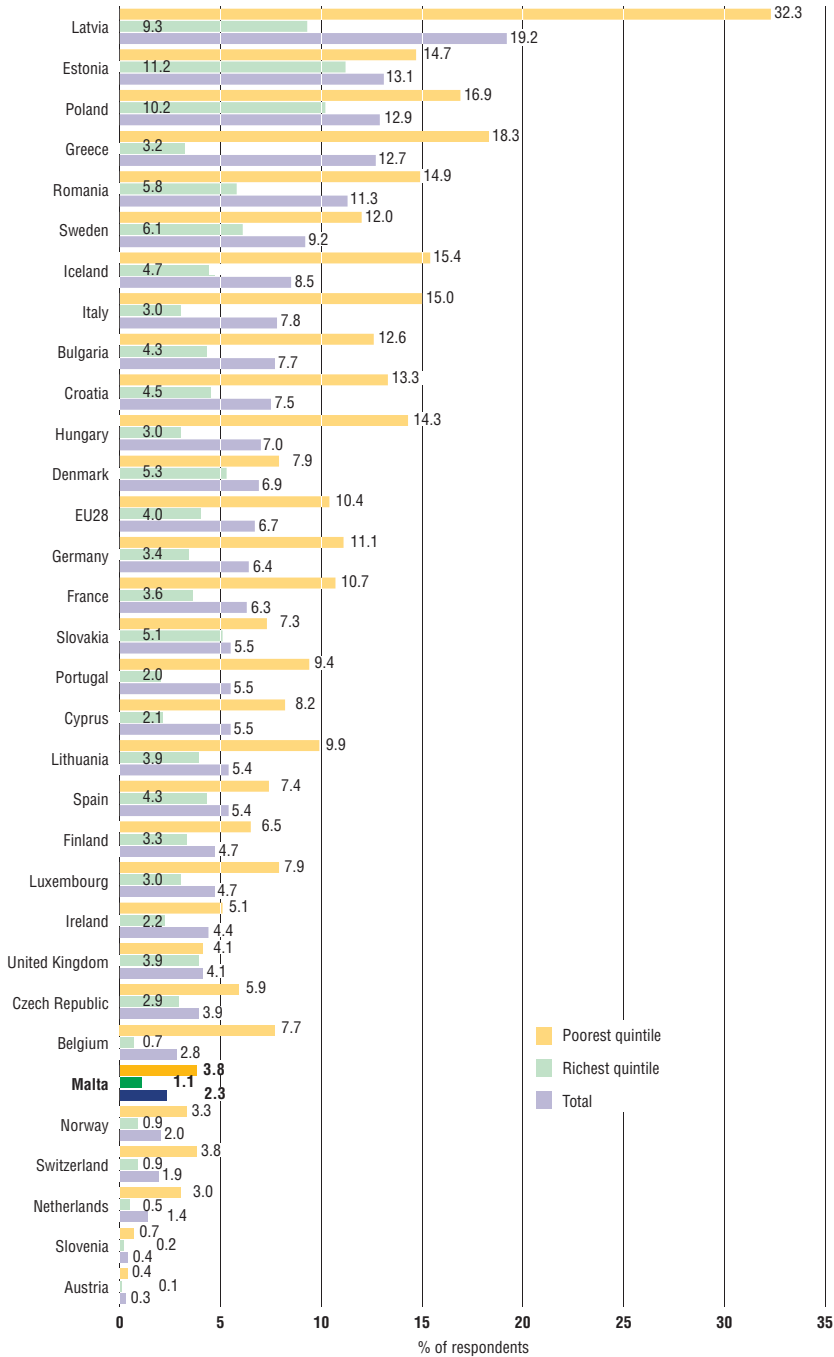
Waiting times for certain diagnostic interventions and elective surgery was highlighted as being a particular challenge in the earlier HiT report (Azzopardi-Muscat et al., 2014). Whilst some difficulties still exist, notably in waiting times for specialist outpatient clinics and orthopaedic interventions, it has been noted that waiting times in the health system have generally decreased over the past years.

Given the small size of the country, distribution of health workers and facilities is not considered to present a problem. The numbers of doctors and nurses per capita have increased significantly over the past five to ten years, and in terms of doctors Malta has now reached and surpassed the EU average.

Health inequalities have traditionally not featured as a key concern for the Maltese health system. This is probably the result of a combination of the factors described above, as well as the fact that no user charges or co-payments apply to the public health system and therefore there is a general perception that there are no barriers to access health services. This perception is borne out by the data generated from the Survey on Income and Living Conditions which repeatedly demonstrates a low level of unmet need and a relatively narrow gap in reported unmet need between the highest and lowest quintile population groups. In 2014 Malta had the fourth lowest level of unmet need for medical care in the EU after Austria, Slovenia and the Netherlands (Fig. 7.2). Unmet need fluctuated in Malta, peaking at the height of the financial crisis in 2010 at 6%, and then falling to 2.3% in 2014. In terms of unmet need, the absolute inequality gap in both Malta and the EU has increased since the onset of economic crisis. In Malta the unmet need for those with lower incomes grew at a faster pace during the recession, and fell at a slower pace afterwards.

Fig. 7.2

Unmet needs for a medical examination (for financial or other reasons), by income quintile, EU/EEA countries, 2014



Source: Eurostat, European Union Statistics on Income and Living Conditions (EU-SILC), 2016a.

Malta consistently scores well in terms of low levels of unmet need for medical and dental health, as evidenced by the data from the SILC survey. In 2014 only 1.1% of the population reported feeling unable to access needed medical care because it was either too expensive, too far to travel or due to waiting lists. There is only marginal variability in the reporting of unmet need for a medical examination between the lowest income quintile (3.8%) and the highest income quintile (1.1%), suggesting fairly equitable access to services according to income (Fig. 7.2). Unmet need for dental examination is also very low, ranking third lowest among EU countries in 2014 despite elective dental services not being covered for all persons under the public health care system.

Data from the 2008 European Health Interview Survey had indicated that utilization of GP services in government primary health care centres tended to be higher in the lower socio-economic groups.

Only 0.2% of respondents reported unmet needs for medical examination due to waiting lists in 2014. Health centres still operate walk-in clinics for emergencies and urgent GP consultations. Furthermore, around 70% of all referrals to the Accident and Emergency Department were classified as self-referrals (Grech et al., 2015). This is considered to be on the high side but also indicates the ease with which health services can be accessed.

7.4 Financial protection

Out-of-pocket health care expenditure as a share of total expenditure is relatively high in Malta and was 29% in 2014, compared to the EU average of 15%. This share has remained mostly stable over the years. Out-of-pocket spending accounts for 4.4% of total household final consumption according to data from the latest year available (2013), which is the third highest in the EU. Lower-income households in Malta generally spend a larger proportion of their income on health than their higher-income counterparts.

The high rate of out-of-pocket expenditure presents a stark contrast to the low level of unmet need for care. This is thought to be the result of a high volume of relatively low-cost transactions taking place in the primary care and ambulatory care sectors, as well as expenditure on medicines not covered by the public health care system. In the case of medicines, all persons with the exception of means-tested individuals need to pay fully for medicines unless they have a chronic disease listed in the Fifth Schedule of the Social Security Act, in which case medicines for that particular condition are provided free of

charge irrespective of means. Therefore this high out-of-pocket spending is not due to user charges, but rather is the result of waiting times or gaps in scope (medicines) as well as social preferences.

Whilst there have not been any health sector specific measures to strengthen financial protection, general government measures to protect low-income persons include the recent decision not to tax pensioners earning up to €3 000 annually.

Occasionally, single cases of financial hardship make the media headlines. These are almost always inevitably related to expenditure on innovative treatments for cancer. It should be noted that often there is insufficient evidence to approve these medicines on the public medicines formulary on the basis of decisions informed through HTA. However, there is no official information on the phenomenon of catastrophic or impoverishing health expenditure.

Box 7.1

Universal health coverage

The Maltese health system provides universal health coverage. The low level of unmet need indicates that those who are in need of health care are able to access the services. All public health care services are provided free at the point of use. A comprehensive system of coverage provides for all persons covered by the Social Security Systems, as well as refugees and migrants with Temporary Humanitarian Protection Status. The reduction in amenable mortality reflects the ongoing investment in services quality improvement. The Maltese health system provides support not only for care provided in Malta but also for highly specialized care provided overseas through the National Highly Specialized Referrals Programme. This programme also provides logistical support for patients and their relatives. All these initiatives, together with support from the Malta Community Chest Fund, a local charitable Foundation, ensure that as far as possible no one experiences financial hardship as a result of paying for services.

7.5 Health system efficiency

7.5.1 Allocative efficiency

Judging by the significant improvements registered in health outcomes between 1990 and 2015 (Global Burden of Disease Collaborators, 2015), amongst which is the steady decline in amenable mortality, indicates that the Maltese health system is providing an appropriate mix of services/interventions that maximize health improvements. The National Health Systems Strategy adopted in 2014 outlines the high level health system priorities until 2020. Since 2010 a system

of HTA has been in place for the approval of new medicines and health services. This was strengthened in 2013 when the Health Act established the Health Benefits Advisory Committee. All new services and medicines have to be approved by this body.

In formulating the list, the Committee is required to primarily base its consideration on the impact of such benefits on the patient and should take into consideration: international evidence, HTAs, consultation with relevant stakeholders, capacity within the public health system, and social and epidemiological considerations, as well as affordability and sustainability (Health Act 2013).

Although the situation has improved greatly with evidence from health information and HTAs feeding into the policy-making process, the report on the assessment of the Malta health system prepared by DG ECFIN calls for increased use of HTA in decision-making. (European Commission, 2016a).

The imbalance of resource allocation between hospitals and primary care services emerges as an area where the efficiency of the Maltese health system could benefit from improvement. Malta has one of the highest rates of hospital expenditure as a proportion of total expenditure in the public sector. It is to be borne in mind that three out of four primary care consultations occur in the private health sector (European Health Interview Survey, 2008). Nonetheless, further investment in infrastructure and human resources in the primary care sector appears to be an important point for health system improvement in Malta. The European Commission has called for the inclusion of more elements of activity-related payment in primary care and specialist outpatient care to induce a higher number of consultations as well as to continue to enhance primary care provision by increasing the numbers and spatial distribution of GPs and nurses.

7.5.2 Technical efficiency

The Maltese health system generally maximizes the use of the capacity and resources available. In terms of average length of stay (ALOS) for acute care hospitals, the Maltese health system has been a relatively good performer with an average stay of 5.2 days in 2014 compared to the EU average of 6.4 days. However, between 2007 and 2013 an increasing trend in ALOS developed. This trend appears to have started being reversed in 2014. Whilst the ALOS for normal deliveries (2.4 days) was lower than the EU average (3.6 days), data for acute myocardial infarction showed a higher than EU average (7.1 days) at 8.0 days for Malta (OECD, 2014), indicating that there may be variation between different specialities.

The proportion of day case surgery has increased over the past decade. However, with approximately one in three discharges being day cases, there remains scope for further efficiency to be achieved in this area and this indicator is regularly monitored as a key performance indicator in public hospitals. Recent trends show that the day surgery rate for specific procedures is increasing and that 87% of cases of cataract surgery in 2014 were day cases (OECD, 2014).

In terms of human resources, efforts have been made to improve the skill mix of human resources available in the health sector. The number of nurses has increased, as has the number of GPs. Furthermore, investment in the training and education of allied health professionals has also taken place and these professions have witnessed significant growth and development over the past two decades. Work practices laid down in collective agreements are often difficult to change. While some attempts have been made to develop the concept of job plans for medical consultants and resident specialists with outputs being subject to monitoring, there remains scope to introduce better efficiency incentives in the health workforce. The privatization contracts for three public hospitals make reference to potential changes in work practices to better harness health system efficiencies.

The use of carers to support nurses and of paramedic aides to support allied health professionals has increased over the past years, particularly in settings such as long-term care. Proposals to regulate the carer stream are being developed with a view to ensure that the necessary patient safeguards are in place as their role in health and long-term care systems has become more important both in the hospital and community (or household) settings.

In the area of medicines, technical efficiency is pursued through a number of measures. These include prescribing guidelines and protocols, use of generics and bio-similars, procurement through tendering processes and streamlining of the stock control and distribution system.

Improved financial control has also been adopted through the enforcement and monitoring of financial and procurement protocols. Nonetheless the European Commission has called for continued implementation of reforms to improve health system efficiency in order to ensure that the system is adequately prepared to deal with the forecast increasing health care expenditure over the coming decades.

7.6 Health care quality and safety

Malta records relatively high mortality rates within 30 days of admission to hospital for acute myocardial infarction (at 9.5 per 100 admissions), compared with 7.5 in the EU. Similarly, higher than EU average case-fatality rates were recorded for people hospitalized for stroke. Further attention to these areas is warranted to better understand the reasons for this relatively low performance.

Five-year survival for cancers has improved overall. However, performance for specific cancers varies, with survival for breast and colorectal cancer having improved, whilst survival for other cancers has remained the same and is far lower than the European mean, e.g. for kidney, stomach and lymphoma.

When considering hospital admission rates for various conditions, these are: asthma and COPD (233 per 100 000), congestive heart failure (34 per 100 000) and diabetes (135 per 100 000) in 2013. These rates compare favourably with the EU average for countries surveyed in the Health at a Glance Europe 2014 (OECD, 2014) with the exception of congestive heart failure, where the admission rate was relatively high.

Consumption of antibacterials for systemic use in the community remains on the high side in Malta, with a reported rate of 23.7 defined daily doses per 1000 inhabitants per day in 2014 (European Centre for Disease Control, 2016), and shows no signs of trend reversal.

Data on other patient safety indicators collated by OECD are missing for Malta. This is an area where efforts to enhance data collection are needed. Calls for efforts to assess and publish evaluations of the quality of care provided have been made by the European Commission.

7.7 Transparency and accountability

Malta ranked in 37th place in the Transparency International Corruption index in 2015 (Transparency International, 2015). In recent years the opportunity for public and stakeholder involvement in health decision-making has increased. All new health legislative and policy developments and public health strategy initiatives go through a period of public consultation through the Government's online portal where "In the spirit of open and transparent governance, the Ministry for Health encourages the general public, civil society organisations,

trade unions, business organisations, political parties, governmental institutions and all others that would like to contribute, to participate in the process of online public consultation” (Social Dialogue, 2016b).

Between November 2014 and November 2016 four such public consultations have taken place on diabetes, organ and tissue donation, IVF legislation and the patient charter. Although no public consultation was held on the hospital privatization initiative, the relevant unions representing health care workers were consulted.

Implementation of the National Health Systems Strategy (2014–2020) together with exercises such as the Health Systems Performance Assessment 2015 are examples of the positive way in which the Government is seeking to exercise a stewardship role for the development of the health system. Efforts to continue to strengthen governance through inter alia the development of strong and robust health information systems will also need to continue in view of the privatization of hospitals, which will see the Government moving from a ‘command and control’ style of direct management to a role where influence and control are exercised through contracting and commissioning, relying heavily on data and evidence.

The contracts regulating the hospital public-private partnership initiative were published in redacted versions in October 2016. Analysis of the available information indicates that payments will take the form of agreed budgets for volumes of activity. There is currently ongoing debate about transparency of ownership of the hospitals.

The performance assessment report published in 2015 rated the responsiveness dimension as ‘good’ (Grech et al., 2015). This was one of the dimensions with the highest rating achieved. Initiatives to improve user experience are ongoing. The Care and Cure campaign launched by MDH in 2015 is a positive example of such an initiative. Patient and lay representation on decision-making bodies, such as the Council of Health, the Treatment Abroad Advisory Committee and the Health Benefits Advisory Committee, are also indicative examples of patient involvement. In 2016 the Ministry for Health launched an initiative to better engage with health sector NGOs. A patient charter was published in November 2016.

8. Conclusions

The Maltese health care system offers universal coverage to a comprehensive set of services that are free at the point of use for people entitled to statutory provision. Nevertheless, people often choose to visit private primary care providers, who take up around two-thirds of this workload and obtain fee-for-service payment, because they offer greater convenience and continuity of care. Consultation and treatment from specialists directly is commonplace in the private ambulatory sector. Secondary and tertiary care is provided mainly through public hospitals. The main acute general hospital (Mater Dei) also caters for the bulk of emergency care. Out-of-pocket expenditure remains high and deserves closer scrutiny.

Malta has recorded an overall increase in total health expenditure as a percentage of GDP (9.75% in 2014), which is above the EU average (9.45%). Private spending is higher than in many EU countries and accounted for 3% of GDP (compared to 2.2% in the EU), with out-of-pocket payments making up 94% of this expenditure. Public spending was only 6.74% of GDP (compared to 7.24% in the EU), but government spending is increasing such that €20 million was budgeted for recurrent health expenditure in 2017, representing an 11.4% increase over 2016, which in turn had previously represented a 12.5% increase over 2015. These escalating costs are one of the most important issues that must be addressed over the next five years to ensure that the Maltese health system continues to expand to meet its obligations and responds to increasing demand in a manner that is sustainable over time.

In terms of supply of health care professionals, increases in the numbers of doctors and nurses have taken place over the past years such that for doctors and GPs the number per capita has now reached the EU average. On the other hand, the numbers of specialist physicians, dentists, nurses and paediatricians

per capita remain below the EU averages. Education and training of health care professionals are being strengthened through the introduction of further specialization programmes and new facilities.

In response to resource supply constraints, the Government has been commissioning some care from the private sector notably to address pre-existing lengthy waiting lists for certain elective interventions. Coupled with increased activity in the public hospital sector, waiting lists for surgical interventions and imaging investigations have been tackled successfully in a number of areas. Attention has now focused on addressing waiting times for certain specialties in public hospital outpatient appointments.

Health system capacity is being stretched due to a combination of factors, which include population expansion due to immigration amongst workers and pensioners, a buoyant tourism industry, demographic ageing and altered risk-taking behaviours. Capacity expansion is planned through the construction of a new mother and child complex which will release much-needed space in the Mater Dei Hospital.

A public-private partnership contract for three existing hospitals (Gozo General Hospital, a Geriatric Hospital at Karin Grech and a Rehabilitation Hospital to be developed on the old St Luke's Hospital facility) has been implemented in 2016. This represents a new development in terms of the purchaser role being assumed by the Government and is expected to play an important role within the Maltese health system in the coming years by attracting international patients. Its impact on equity and health expenditure needs close monitoring over the coming months and years.

Further strengthening of the primary health and mental health sectors is considered to be an important priority for the next years. The development of a new primary health facility in the Southern Harbour area and the construction of a new mental health facility will make an important contribution. Nonetheless, in these two sectors the importance of integrating the private and NGO sectors, which play an important role in primary and mental health service provision respectively, remains a vital objective.

Strengthening of the health information system is deemed important to provide greater emphasis on monitoring and evaluation in order to ensure that the objectives set out in the National Health System Strategy are achieved. A renewed e-health strategy, with developments such as e-prescription, will greatly facilitate the implementation of health system monitoring in situations

where the public health system makes the transition from integrated command and control traditional models to one where pluralism in health service provision becomes more prevalent.

The priorities of Malta during its Presidency of the Council of the EU include childhood obesity, and Structured Cooperation to enhance access to highly specialized and innovative services, medicines and technologies.

Life expectancy in Malta is higher than the EU average and Maltese people spend on average close to 90% of their lifespan in good health, longer than in any other EU country. Increases in longevity are largely due to declining death rates from all causes, with circulatory diseases remaining the leading causes of death in Malta (37.6% of deaths in 2014).

Malta has the lowest rates of preventable mortality in the EU. Strong political and public health leadership over the years have allowed Malta to implement a number of important public health measures. This trend is continuing with the ban on tobacco smoking in vehicles (with children present) and the publication of the first national strategy to address alcohol-related harm.

Although three out of four Maltese report being in good health, some health behaviours are of concern compared to other EU countries. Malta has the highest obesity rate in the EU, and this remains the major public health issue, both in adults and in children. Rates of binge drinking among young people have declined but remain an important health and social issue. Smoking prevalence has decreased significantly over the past decade. Poor health behaviours tend to be most common among lower socio-economic groups. Frailty associated with ageing remains a major challenge facing the population as a whole.

Overall, the Maltese health system has registered remarkable progress and this is evidenced by the improvements in preventable and amenable mortality, as well as the generally low levels of unmet need. The main outstanding challenges for the coming period include: adapting the health system to an increasingly diverse population; increasing health system capacity to cope with a growing population; implementing a redistribution of resources and activity from hospital to primary care; ensuring access to innovative expensive medicines whilst concurrently tackling the need to continue identifying efficiency improvements; and addressing the issue of medium-term financial sustainability associated with steep demographic ageing.

9. Appendices

9.1 References

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9.2 Useful web sites

Ministry for Health

<https://health.gov.mt/>

Ministry for Justice, Culture and Local Government

<http://www.justiceservices.gov.mt/>

myHealth

<https://myhealth.gov.mt/>

National Health Strategies

<http://health.gov.mt/en/Pages/National-Strategies/NHS.aspx>

Medicines Authority

<http://www.medicinesauthority.gov.mt/home?l=1>

Public Consultations Online

<http://www.konsultazzjoni.gov.mt/>

Malta Financial Services Authority

<https://www.mfsa.com.mt/>

Electoral Manifestos of Maltese Political Parties

<http://www.um.edu.mt/projects/maltaelections/maltesepolitics/politicalparties/manifestos>

Government of Malta – Inland Revenue

<https://ird.gov.mt/default.aspx>

European Pathway Association

<http://e-p-a.org/care-pathways/>

The Parliamentary Secretariat for Active Ageing

<http://activeageing.gov.mt/>

Malta Insurance Association

<http://maltainsurance.org/>

National Statistics Office – Malta

<https://nso.gov.mt/en/Pages/NSO-Home.aspx>

Voluntary health insurance in Europe: country experience

<http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/voluntary-health-insurance-in-europe-country-experience>

National Audit Office – Malta

<http://www.nao.gov.mt/>

European Network for Health Technology Assessment

<http://www.eunetha.eu/>

Patient Safety and Quality Improvement Team – Mater Dei Hospital

<https://pasqit.wordpress.com/>

Commissioner for Mental Health

<https://health.gov.mt/en/CommMentalHealth/Pages/Commissioner-For-Mental-Health.aspx>

Healthcare Delivery in Malta Report by PWC

https://www.pwc.com/mt/en/publications/healthcare/assets/healthcare_delivery_august_2012.pdf

Care and Cure – Mater Dei Hospital

<http://careandcure.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. This HiT has used a revised version of the template that is being piloted during 2016–2017 and will be available on the Observatory web site once it has been finalized. The previous (2010) version of the 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.

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 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 and health workers 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 information technology 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 and dental care.
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 of systems for monitoring health system performance, the impact of the health system on population health, access to health services, financial protection, health system efficiency, health care quality and safety, 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 and useful web sites.

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.
- 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.

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

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The Health Systems in Transition reviews

A series of the European Observatory on Health Systems and Policies

The Health Systems in Transition (HiT) country reviews provide an analytical description of each health system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the WHO European Region and beyond. The HiT reviews are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health services;
- to describe accurately the process, content and implementation of health reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- 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 countries of the WHO European Region.

How to obtain a HiT

All HiTs are available as PDF files at www.healthobservatory.eu, where you can also join our listserve for monthly updates of the activities of the European Observatory on Health Systems and Policies, including new HiTs, books in our co-published series with Open University Press, Policy briefs, Policy summaries and the *Eurohealth* journal.

If you would like to order a paper copy of a HiT, please write to:

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HiT country reviews published to date:

Albania (1999, 2002^{ag})
Andorra (2004)
Armenia (2001^g, 2006, 2013)
Australia (2002, 2006)
Austria (2001^e, 2006^e, 2013^e)
Azerbaijan (2004^g, 2010^g)
Belarus (2008^g, 2013)
Belgium (2000, 2007, 2010)
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Switzerland (2000, 2015)
Tajikistan (2000, 2010^g, 2016)
The former Yugoslav Republic of Macedonia (2000, 2006, 2016)
Turkey (2002^{gi}, 2011ⁱ)
Turkmenistan (2000)
Ukraine (2004^g, 2010^g, 2015)
United Kingdom of Great Britain and Northern Ireland (1999^g, 2015)
United Kingdom (England) (2011)
United Kingdom (Northern Ireland) (2012)
United Kingdom (Scotland) (2012)
United Kingdom (Wales) (2012)
United States of America (2013)
Uzbekistan (2001^g, 2007^g, 2014^g)
Veneto Region, Italy (2012)

Key

All HiTs are available in English.
When noted, they are also available in other languages:

^a Albanian

^b Bulgarian

^j Estonian

^c French

^d Georgian

^e German

^k Polish

^f Romanian

^g Russian

^h Spanish

ⁱ Turkish

* More recent versions are available from the Asia Pacific Observatory.



The European Observatory on Health Systems and Policies is a partnership, hosted by the WHO Regional Office for Europe, which includes the Governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, Switzerland, the United Kingdom and the Veneto Region of Italy; the European Commission; the World Bank; UNCAM (French National Union of Health Insurance Funds); the London School of Economics and Political Science; and the London School of Hygiene & Tropical Medicine. The European Observatory has a secretariat in Brussels and it has hubs in London (at LSE and LSH/TM) and at the Technical University of Berlin.

HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.