

State of Health in the EU Malta

Country Health Profile 2017

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

Contents

1 • HIGHLIGHTS	1
2 • HEALTH IN MALTA	2
3 • RISK FACTORS	6
4 • THE HEALTH SYSTEM	7
5 • PERFORMANCE OF THE HEALTH SYSTEM	9
5.1 Effectiveness	9
5.2 Accessibility	11
5.3 Resilience	12
6 • KEY FINDINGS	16

Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
<http://dx.doi.org/10.1787/888933593703>

Demographic and socioeconomic context in Malta, 2015

	Malta	EU
Demographic factors	Population size (thousands)	509 394
	Share of population over age 65 (%)	18.9
	Fertility rate ¹	1.6
Socioeconomic factors	GDP per capita (EUR PPP ²)	28 900
	Relative poverty rate ³ (%)	10.8
	Unemployment rate (%)	9.4

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

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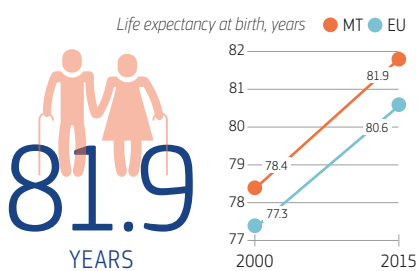
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1 Highlights

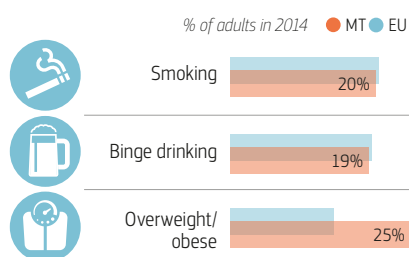
Life expectancy in Malta is high and the population spend on average 90% of their lifespan in good health, longer than in any other EU country. The health system provides universal coverage and access to a comprehensive set of services, but private out-of-pocket payments remain high. New public-private partnerships aimed at increasing capital investment and quality of care are changing the role of the Ministry of Health from a pure provider to that of provider and contractor of services.

Health status



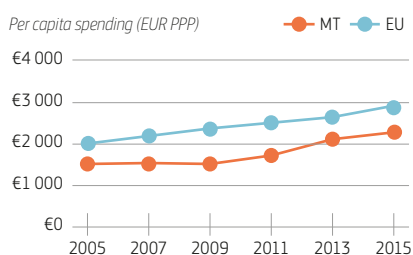
Life expectancy at birth was 81.9 years in 2015, up from 78.4 years in 2000 and above the EU average of 80.6 years. Life expectancy gains are mainly the result of a reduction of premature deaths from cardiovascular diseases, though these remain the leading cause of death for both men and women.

Risk factors



In 2014, 20% of adults in Malta smoked tobacco every day, which is slightly below the EU average. Heavy alcohol use also remains below the EU average, but consumption per adult has increased since 2000, reaching 8.5 litres in 2014. Obesity prevalence is the highest in the EU and represents a significant public health challenge, with a quarter of the adult population and 30% of 15-year-olds overweight or obese.

Health system

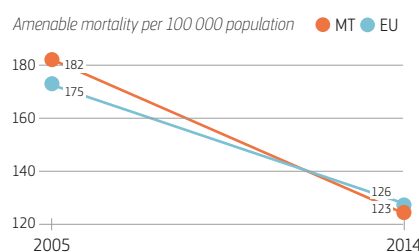


Health spending has increased steadily since 2005. In 2015, Malta spent EUR 2 255 per capita on health care, compared to the EU average of EUR 2 797. This equals 8.4% of GDP, below the EU average of 9.9%. Malta is among the top six EU countries with the highest private spending on health, amounting to 31% of total health expenditure in 2015, the majority of which is paid out of pocket.

Health system performance

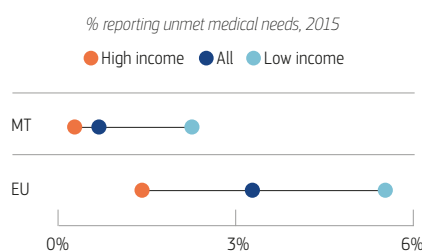
Effectiveness

Amenable mortality in Malta remains close to the EU average, but has fallen rapidly over the past 15 years due to lower mortality from cardiovascular diseases and some treatable cancers



Access

Access to health care in Malta is good, with low numbers reporting unmet needs for medical care and little variation between income groups.



Resilience

Malta faces some fiscal challenges from an ageing population, increased chronic care needs and controls linked to Fiscal Responsibility legislation for Eurozone countries. A 2015 Health System Performance Assessment identified future improvement avenues to respond to these pressures.



2 Health in Malta

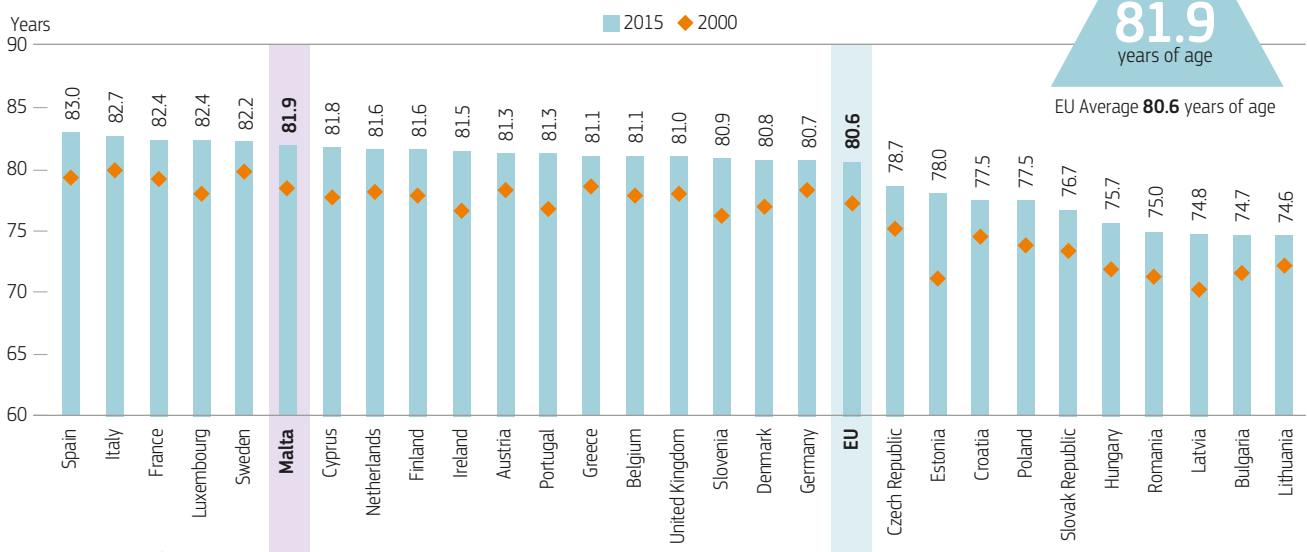
The Maltese population enjoys high life expectancy

Life expectancy at birth in Malta has increased markedly over the past decade, surpassing the average increase across all EU countries. It reached 81.9 years in 2015, the sixth highest among EU countries (Figure 1), with women living on average 4.3 years longer

than men. Life expectancy at the age of 65 has also increased by one fifth since 2000 to 20.3 years, higher than the EU average (19.7 years). However, there is at least a three-year gap in life expectancy between people with lower and higher education qualifications.¹

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).

Figure 1. Life expectancy in Malta has increased substantially over the last 15 years



Source: Eurostat Database.

The number of healthy life years is the highest in the EU

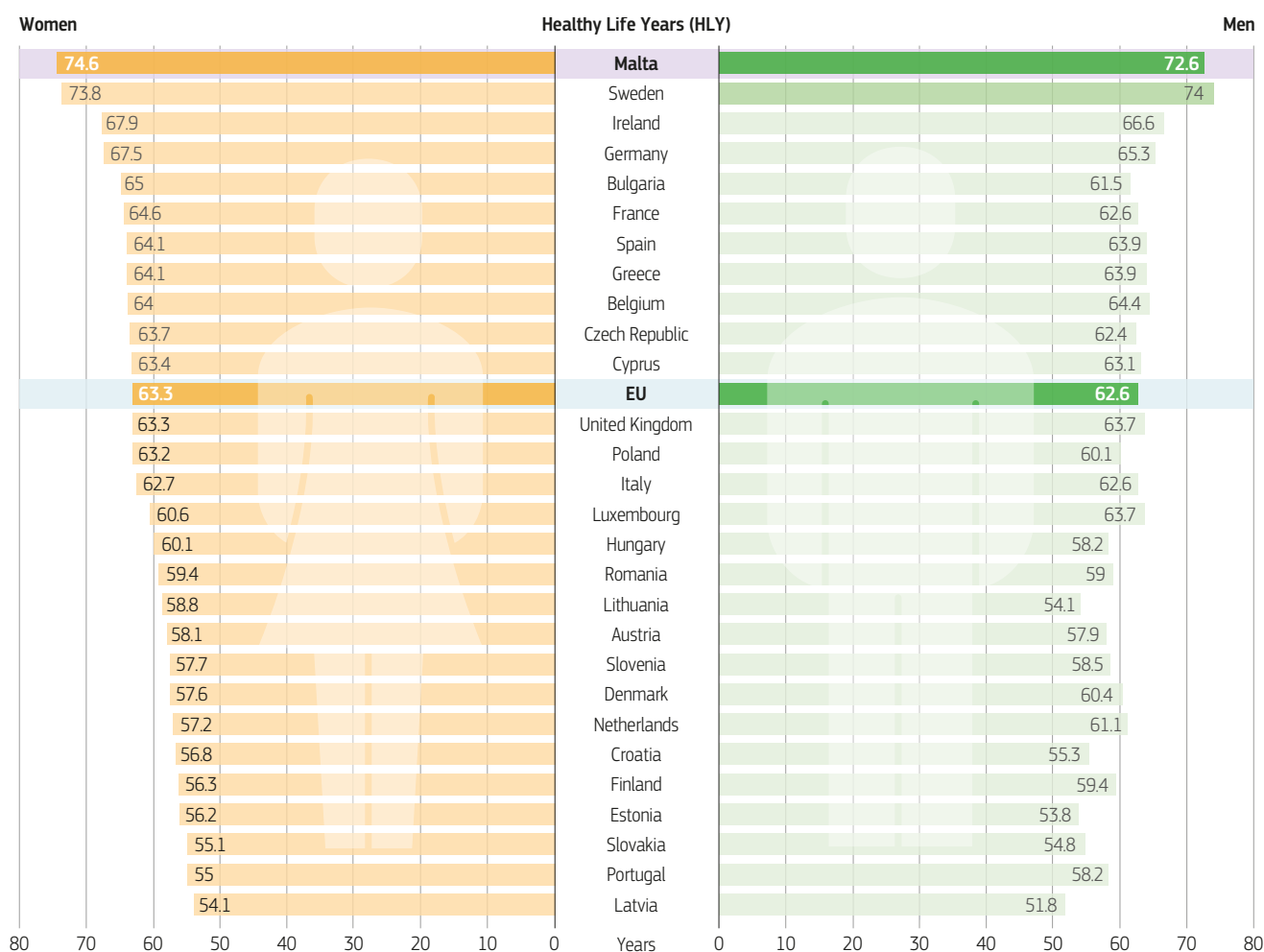
Not only do Maltese men and women live longer, they also enjoy close to 90% of their lifespan in good health. In 2015, the number of healthy life years at birth was 72.6 years for men and 74.6 years for women,² the highest rate in the EU for women, and the second highest rate for men (Figure 2). Similarly, Maltese men and women aged 65 and over can expect to live 13.4 years and 14.0 years respectively of their remaining life free of disability, the second highest among EU countries. Despite these good results, the increase of risk factors such as obesity and alcohol consumption in recent years (see Section 3) may well have a negative impact on healthy life expectancy in the future.

The leading cause of death in Malta is cardiovascular diseases, with a quarter of deaths occurring prematurely

Increases in life expectancy are mainly the result of a decrease in deaths from cardiovascular diseases, although they remain the leading cause of death for men and women (Figure 3). Death rates from ischaemic heart disease in Malta remain above the EU average but have shown a relatively consistent downward trend. More than a quarter of all deaths from ischaemic heart disease were premature, occurring in people aged under 75. These are potentially preventable through appropriate action within the health care system and wider policies affecting population health (see Section 5.1).

2. 'Healthy life years' measures the number of years that people can expect to live free of disability at different ages.

Figure 2. Maltese people enjoy the longest lifespan spent in good health among all EU countries



Source: Eurostat Database.

Mortality from treatable cancers and respiratory diseases have declined substantially

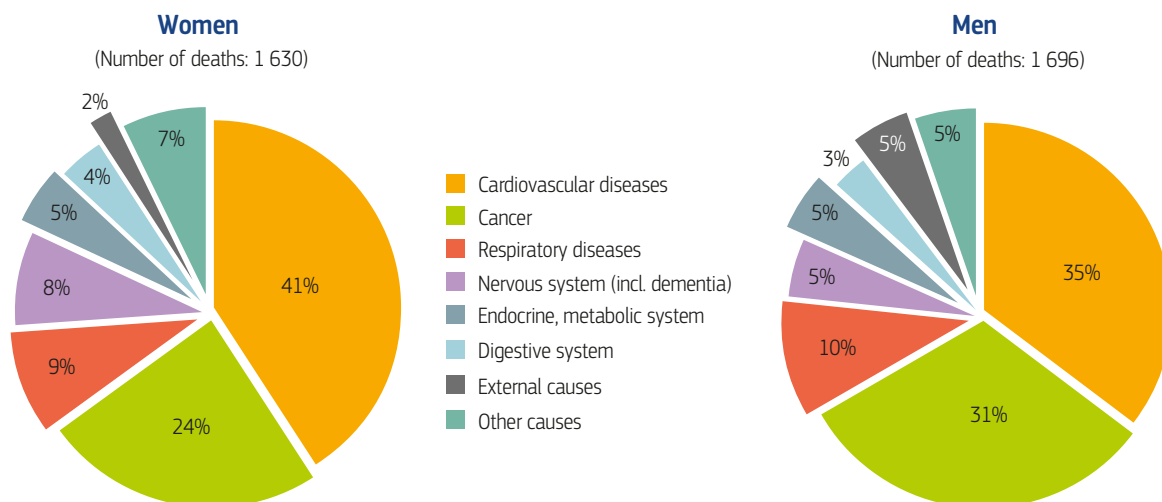
Overall, cancers account for 27% of all deaths in Malta. There has been a substantial reduction in breast cancer mortality since the early 2000s (Figure 4), bringing death rates down from the highest in the EU to closer to the EU average. Further remarkable improvements in survival have been demonstrated for malignant melanoma, testicular, thyroid and prostate cancers. However, outcomes have remained unchanged for some cancers, such as those of the pancreas, stomach and brain, and specific types of acute leukaemias in adults. Deaths from lung cancer have also remained fairly stable and are among the lowest in the EU. Of other major causes of death, mortality from respiratory diseases also reduced steeply in the 2000s, converging to the EU average. These trends partially reflect improvements in available treatments and public health policies related to smoking (see Section 5.1).

The burden of infectious diseases is low, but incidence of HIV and TB are rising

Infectious diseases have not been seen as a pressing health concern in Malta and reported cases of major infectious diseases including HIV and TB remain low. However, since 2006 rates of newly reported HIV diagnoses have more than doubled, and in 2015 Malta recorded the third highest rate of newly reported HIV cases in the EU/EEA (ECDC, 2016). This increase is largely attributable to outbreaks among the men who have sex with men (MSM) community. Migrants represent a further at risk group with foreign-born cases accounting for more than half of newly reported HIV cases in 2015.

Similar upward trends were observed for tuberculosis (TB) notifications between 2010–2014, although new notifications declined in 2015 to 7.5 cases per 100,000 population, below the EU/EEA average of 11.9. Approximately three-quarters of reported TB cases in 2015 were in individuals born outside of Malta, far higher than the EU/EEA average of 30% of reported cases originating from outside the region (ECDC, 2017).

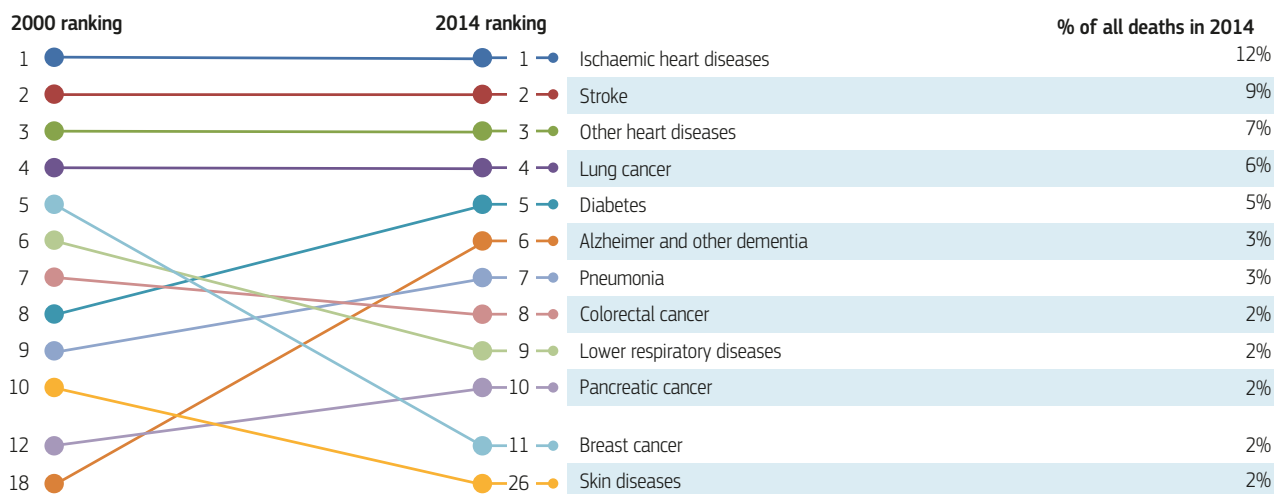
Figure 3. Two thirds of all deaths are due to cardiovascular diseases and cancer



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 4. The top four causes of death remain stable, but deaths from diabetes and dementias are rising substantially



Source: Eurostat Database.

Chronic diseases account for a large share of disability adjusted life years

The leading determinants of disability adjusted life years³ (DALYs) in Malta in 2015, taking into account both the mortality and morbidity burden, were ischaemic heart diseases, musculoskeletal disorders (including lower back and neck pain) and diabetes (IHME, 2016). The disability and mortality burden from Alzheimer's disease and other dementias has increased sharply since 2000, with associated DALYs up by nearly 50%. This increase reflects population ageing, better diagnosis and lack of effective treatments, as well as more precise coding. The disability and mortality burden from diabetes has also risen substantially since 2000, reflecting rising obesity rates

(see Section 3) and a change towards using automated coding in recent years that has a higher tendency to choose diabetes as the underlying cause of death than previous manual coding.

Self-reported data from the 2014 European Health Interview Survey (EHIS) indicate that more than one in five people in Malta lives with hypertension, one in twelve lives with diabetes, and one in seventeen lives with asthma. Wide inequalities exist in the prevalence of these chronic conditions by education level, with nearly one in three people with the lowest level of education living with hypertension, compared with fewer than one tenth among people with the highest level of education.⁴

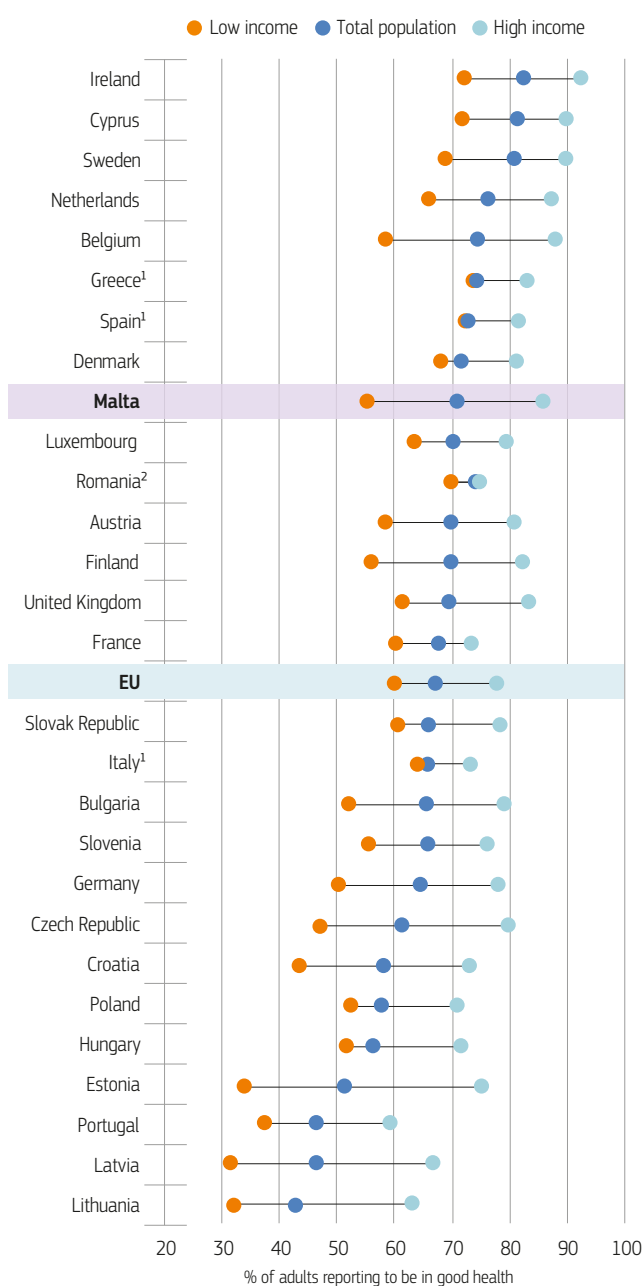
3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

The majority of the population report being in good health, but there are large disparities by income

More than 70% of people in Malta report being in good health, which is nearly on a par with the EU average (67%). However, there are large disparities across income groups, with 86% of people in the highest income group reporting to be in good health, compared to only 55% of people in the lowest income group in 2015, the first time this rate has fallen below the EU28 average since 2010 (Figure 5).

Figure 5. There are large disparities in self-reported health by income group



1. The shares for the total population and the low-income population are roughly the same.

2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

Malta's obesity rate is a major public health concern

Behavioural risk factors contribute to a quarter of the total burden of disease, with diet and smoking estimated to be jointly responsible for some 20% of all ill-health in 2015 (IHME, 2016). Figure 6 illustrates that Malta has the highest obesity rates in the EU for adults as well as children. In 2014, one in four adults reported being obese (compared to the EU average of 16%), a steady increase from 23% in 2008. Rising obesity rates are partly attributable to a change in dietary patterns, with traditional Mediterranean diets being replaced by consumption of foods high in sugar, salt and saturated fats.

The overweight and obesity rate among 15-year-old children has grown by 36% since 2001, and is now almost one in three (30%), more than one and half times the EU average. There are substantial differences in obesity rates between girls (26%) and boys (34%). The high rates in children foreshadow continuing high rates in the future as they enter adulthood. The government has acknowledged the seriousness of the issue, launching a number of health promotion initiatives in recent years (see Section 5.1).

Smoking rates continue to decline, but overall alcohol consumption is increasing

Overall smoking rates have decreased steadily since 2000, with one in five people aged over 15 currently being daily smokers. The daily smoking rate is still higher among men (26%) than women (16%) but while the rate in men has declined, for women it has remained stable.

Alcohol consumption in litres per capita has increased from 5.6 in 2000 to 8.5 in 2014, although this level has remained stable since 2006 and remains below the EU average of 10. However, rates of repeated drunkenness and binge drinking⁵, particularly among younger people, are a concern. More than 26% of 15-year-old boys and 28% of 15-year-old girls reported having been drunk at least twice during their lives (in 2013–14). More generally, 19% of adults reported having had six or more alcoholic drinks on a single occasion at least once a month during the past 12 months, slightly below the EU average of 20%. This rate of binge drinking was two times greater among men than women (26% vs. 13%).

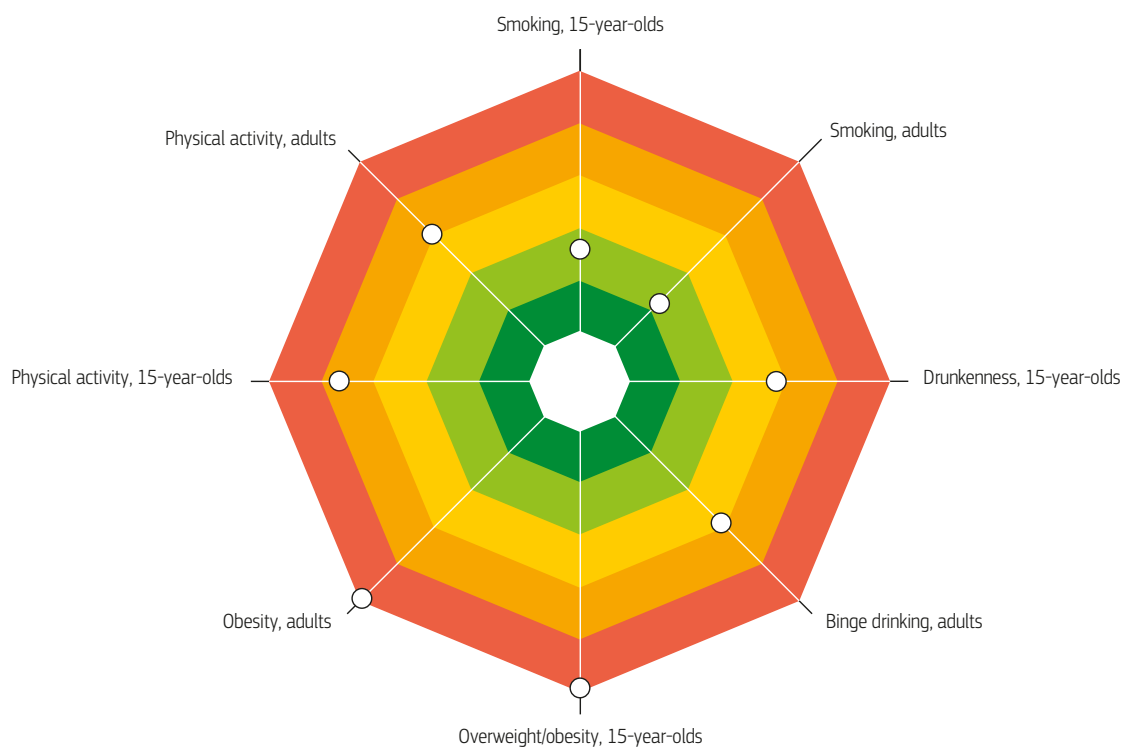
5. Binge drinking behaviour is defined as consuming six or more alcoholic beverages in a single occasion, at least once a month over the past year.

Inequalities in risk behaviours persist according to socioeconomic status

Similar to many other countries, behavioural risk factors tend to be more common among populations with low socioeconomic status. For example, in Malta a quarter of people with a low education

level are daily smokers compared to 18% of those with a tertiary degree. Likewise, a third of those in the lowest income quintile are obese compared to only one fifth in the highest. These differences are long-standing and point to wider socioeconomic conditions and determinants of health, such as living and working conditions, air pollution and the quality of the physical environment.

Figure 6. Malta has the highest obesity rates for adults and children in the EU



Note: The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas. Comparable data on a comprehensive measure of physical activity among adults are not available for Malta.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).



4 The health system

Malta has a highly centralised National Health Service

Malta has a tax-financed National Health Service (NHS) characterised by predominantly public providers in the hospital sector and a pluralism of providers in the primary care and ambulatory (or outpatient) care specialist sectors. Governance, regulation, provision and financing have until recently been fully centralised within the Ministry of Health, which owns and runs public facilities. Past reform efforts have concentrated on defining the regulatory and operational functions of the health system, improving management and enhancing delivery of services. In a new policy direction, Malta has entered into a 30-year public-private partnership agreement (from 2017) for capital investment and management responsibility for three hospitals with an international profit-making health care organisation (see Section 5.3).

The public share of health expenditure has increased in recent years

Health expenditure per capita in Malta has increased by more than one third since 2005, reaching EUR 2 255 (adjusted for differences in purchasing power) in 2015, which remains below the EU average (Figure 7). This equalled 8.4% of GDP, compared to the EU average of 9.9%. In terms of sources of funding, the public share of total

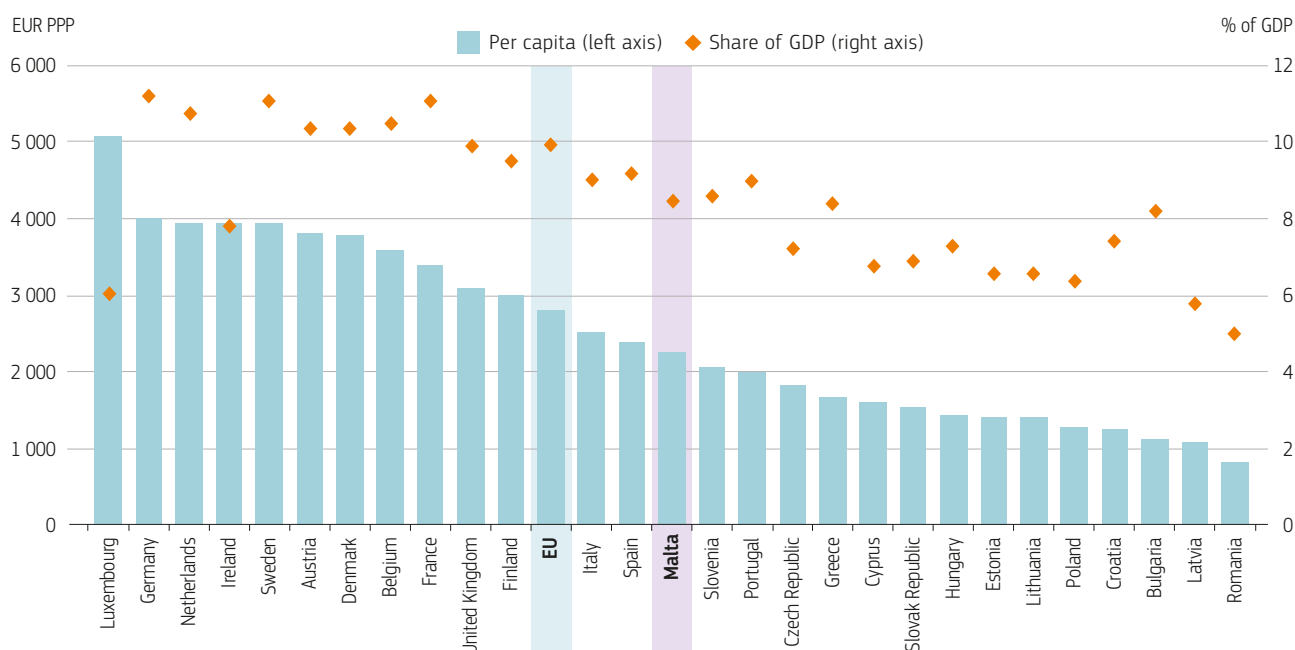
health expenditure (69%) is significantly below the EU average (79%) (see Figure 11 in Section 5.2), but has grown steadily from a historic low in 2010, benefiting in part from EU funding sources (Box 1). Malta is among the top third of countries with the highest private spending on health, nearly all of which is out of pocket.

Out-of-pocket spending is high due to significant private sector involvement in providing services

The health system provides practically universal coverage for all residents to a comprehensive basket of publicly provided health services. Unlike many other European countries, there are no user charges or copayments for health services in Malta. However, direct out-of-pocket payments are substantial and made primarily for pharmaceuticals and private general practitioners (GPs) and specialists, who are paid on a fee-for-service basis.

The NHS is the key provider of health services, with the private sector acting as a complementary mechanism for health care coverage and service delivery, particularly in primary care where the network of NHS public health centres operates alongside private GPs. Notably, private GPs account for two thirds of all primary care contacts, although the reasons for this are historical and cultural rather than a lack of GPs within the NHS. A large segment

Figure 7. Malta spends below the EU average on health care



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

BOX 1. EU FUNDING PLAYS AN IMPORTANT ROLE IN THE HEALTH SECTOR

Financial support from the European Structural and Investment Funds (ESIF) has played a significant role in Malta's health sector in recent years. From 2007 to 2013, Structural Funds totalling EUR 29 million were allocated for health care infrastructure investment, accounting for 1.2% of total health expenditure during the programme period (European Commission, 2016). Malta has been allocated a further EUR 27.5 million under the 2014–2020 ESIF programme, with EUR 19 million earmarked for investment in health care to relieve pressure on the main hospital, to support healthy lifestyles and to support integration of vulnerable people into health care. The remaining funds have been allocated to consolidate and develop e-government services, to train health care professionals and to support measures to reduce health inequalities.

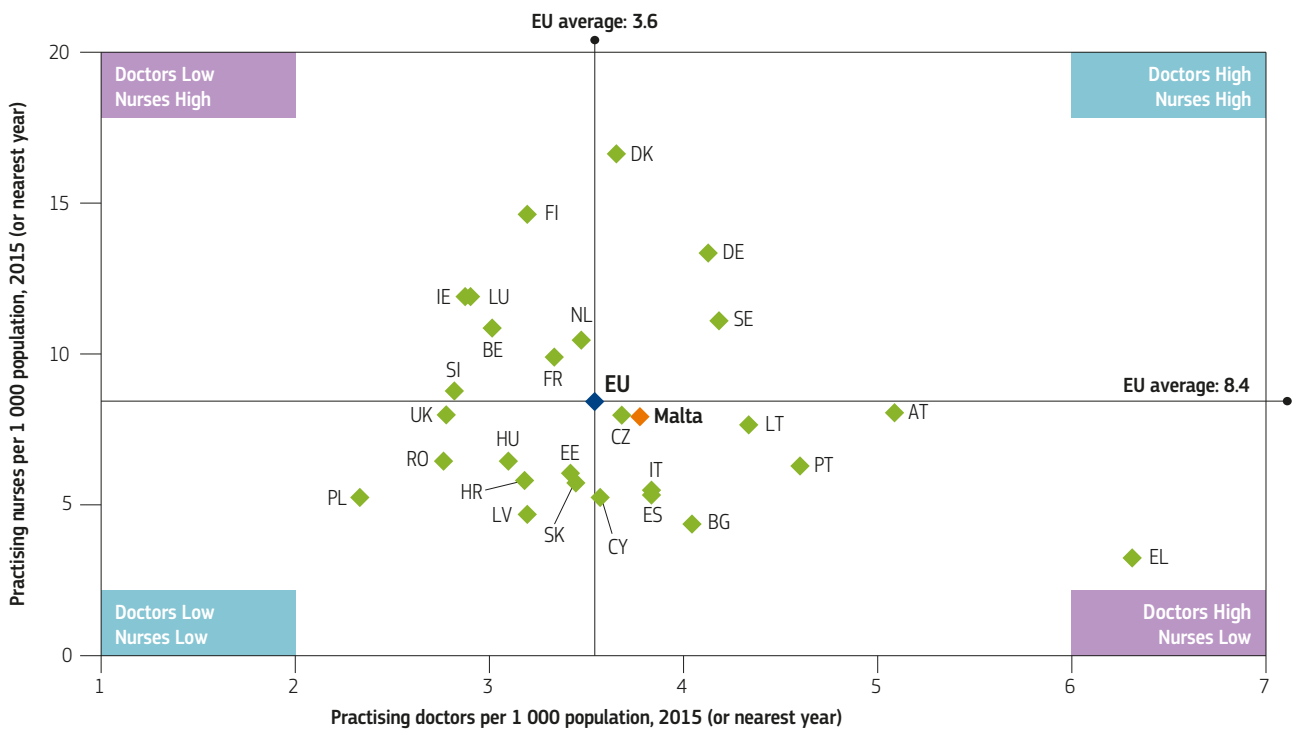
operate on a walk-in basis and have different GPs on duty, which many patients find hinders good doctor-patient relationships and undermines continuity of care. In ambulatory care, people may choose to seek consultations directly from private specialists. This is a combination of cultural preferences as well as a mechanism to avoid waiting lists for certain outpatient specialities in the public sector (see Section 5.2).

A focus on capacity building has resulted in rising numbers of doctors and nurses

Following its EU accession in 2004, Malta experienced a severe net outflow of newly graduated doctors, mainly to the UK where Maltese doctors often carry out their specialisation training. This has been effectively managed through a mutual recognition agreement setting up a UK Foundation School in Malta and through formal specialisation training programmes in Malta. Consequently, the number of doctors has risen steadily over the decade, reaching 3.7 practising doctors per 1 000 population, slightly above the EU average (Figure 8). Capacity building has also been strengthened within the nursing workforce. Although the number of practising nurses (8.0 per 1 000 population) is still slightly below the EU average, numbers have increased by a third since 2009.

of the population is accustomed to accessing primary services directly in the private sector where patients can freely choose their own private GP and set appointments. In contrast, public clinics

Figure 8. Policies to increase the stock of physicians and nurses now put Malta close to the EU average



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

5 Performance of the health system

5.1 EFFECTIVENESS

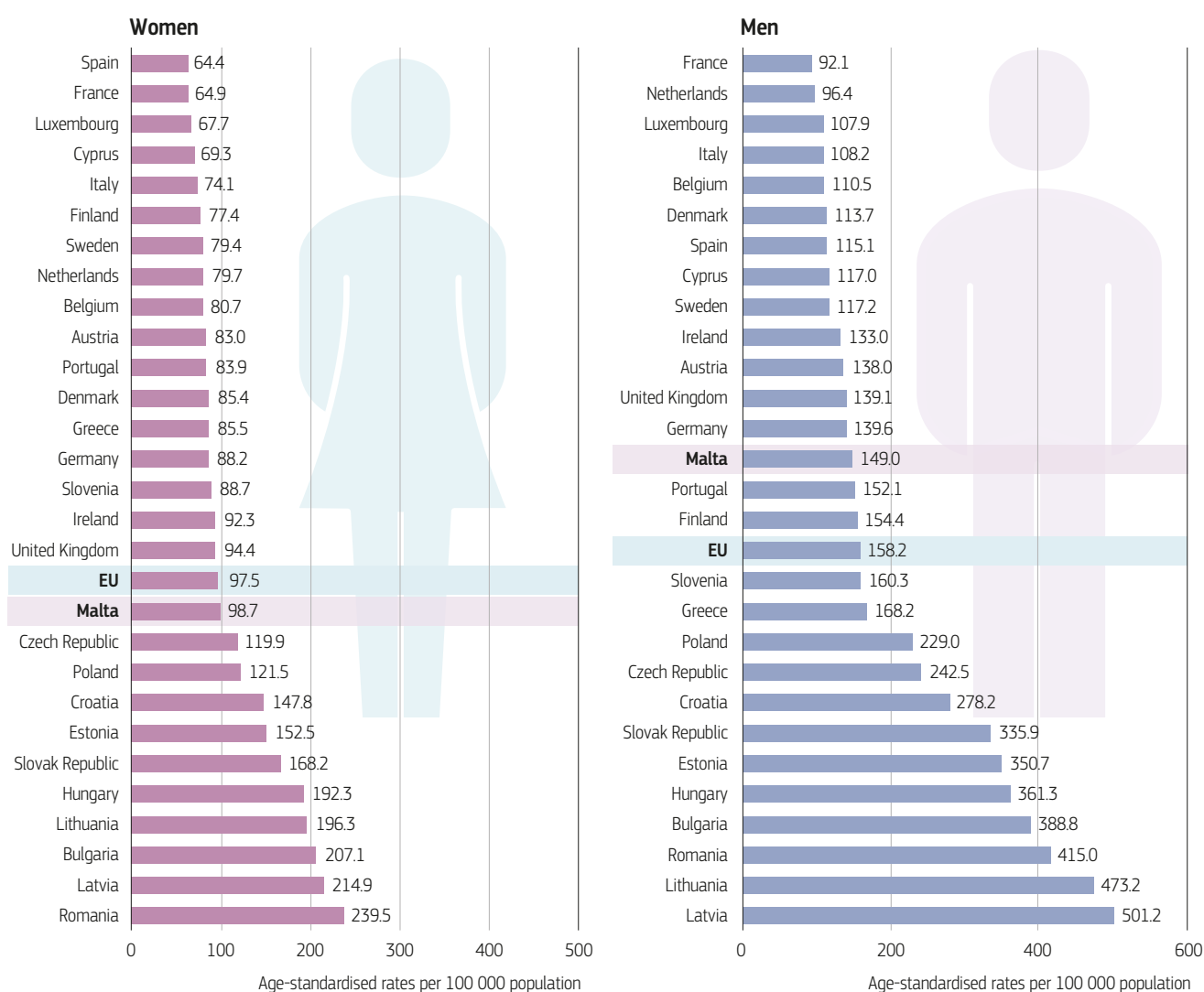
Amenable mortality has halved since 2001

Mortality amenable to health care in Malta is now close to the EU average, although it lags behind neighbouring countries, particularly for women⁶ (Figure 9). Looking at trends over time reveals impressive falls in amenable mortality over the past 15 years. This reflects the overall progress in providing better availability of, and access to, an increasing range of different services, medicines and medical technologies. Examples of success include the remarkable improvements in survival for some treatable cancers, such as breast and testicular cancer. Breast cancer mortality has fallen

significantly since the late 1990s, and five-year survival rates have improved to reach 87% (2010–14).

Lower mortality and better survival from treatable cancers result from combined efforts to introduce population-based screening programmes that allow for timely detection and effective treatment. A national breast cancer screening programme was introduced in 2009 following recommendations by the EU Council (IARC, 2017). Programme data show that the number of women taking up screening has risen rapidly, reaching 61% in 2015. The swift uptake of the programme has been encouraged by continuing awareness campaigns. However, progress for other treatable cancers, such

Figure 9. Big falls in amenable mortality rates mean that Malta is close to the EU average



Source: Eurostat Database (data refer to 2014).

6. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

as cervical and colorectal cancer, has lagged behind the EU overall. The 2011–2015 National Cancer Plan introduced national organised screening programmes for cervical and colorectal cancer in order to begin addressing this issue more systematically, while a new national cancer plan was released for consultation in early 2017. Malta also offers Human Papilloma Virus tests as primary screening for cervical cancer identification.

Malta has low rates of important causes of preventable mortality

Preventable mortality provides an important indicator of the effectiveness of inter-sectoral public health policies. Malta is among the countries with the lowest levels of important causes of preventable deaths in the EU, including lung cancer, transport injuries and, as an indicator for alcohol policies, liver disease. However, there is little room for complacency as lack of progress in further reducing mortality from chronic liver disease among Maltese men has led to an increase in the gender gap for preventable mortality from this cause in recent years.

The urgency of this problem has been recognised by successive governments. Alcohol is one of the four lifestyle-related factors tackled by the 2010 Non-communicable Disease Strategy. Legislative measures to cut binge drinking through restrictions that reduce access to lower priced alcohol and its consumption in specified areas were introduced in 2011. More recently, the first national alcohol policy was issued for consultation in 2016.

Action has been taken to tackle smoking rates and obesity

Legislation has played a key role in combating smoking. Malta was one of the first countries to introduce a smoking ban in 2004 and has continually updated regulations on tobacco advertising and promotion. These efforts effectively contributed to a steady fall in smoking prevalence among adults, particularly among men.

Malta has invested significant efforts to address the growing prevalence of overweight and obesity among children and adults, with recent initiatives including the 2012 Healthy Weight for Life Strategy, the 2014 Food and Nutrition Action Plan and the 2016 Mediterranean Diet campaign. However, the impact of these initiatives has yet to be demonstrated and tackling obesity more effectively remains a key concern of the government.

BOX 2. A NATIONAL AMR ACTION PLAN IS UNDER DEVELOPMENT

Antimicrobial Resistance (AMR) is a major public health threat in Malta. Surveillance data show that in 2015 5.4% of *Klebsiella pneumoniae* bloodstream infections were resistant to carbapenems, a major last-line class of antibiotics to treat bacterial infections, which is higher than the EU/EEA median (0.5%) and the fifth highest total in the EU/EEA (ECDC, 2017). Malta also reported the third highest proportion of *Salmonella* Typhimurium isolates resistant to ciprofloxacin in the EU/EEA (EFSA, 2017). The development of a National Action Plan on AMR was initiated by the Ministry of Health in 2016.

Improving the quality of acute care remains critical to further reduce the avoidable disease burden

Much of the decrease in amenable mortality has been driven by a rapid fall in deaths from ischaemic heart disease, rates of which are now similar to the EU average, although they remain high compared to neighbouring countries. Falling smoking prevalence and the introduction of local cardiac services from the mid-1990s explain part of the steady decline in heart disease. Yet Malta records relatively high levels of deaths within 30 days of admission to hospital for acute myocardial infarction, at 9.5 per 100 admissions among those aged 45 years and older, compared with 7.4 in the EU and 5.5 in Italy (2013). Similarly, higher-than-EU-average case-fatality rates were recorded for people hospitalised for stroke. Taken together, this may point to potentially systemic challenges in providing high quality treatment in the acute sector, although further investigation of the data is needed to better understand the causes for Malta's lower performance on these indicators.

Better integration remains a priority

Initiatives to enhance care coordination and integration have focused on mental health, dementia and cancer as well as post-acute care arrangements. A well-established example is the shared care diabetes programme, which involves GPs with specialist training managing diabetes clinics in health centres, with support from (hospital-based) diabetes specialists who organise clinics in the community. However, multiple efforts are needed to effectively address the avoidable diabetes burden in Malta. The 2016 National Strategy for Diabetes exemplifies coordinated action along the patient journey to achieve this aim. It emphasises prevention and early diagnosis, expanded treatment options and the further development of integrated care and management of diabetes to prevent or delay complications.

5.2 ACCESSIBILITY

Universal coverage in Malta contributes to low levels of unmet needs for health care

The NHS can be accessed by all residents covered by Maltese social security legislation. All necessary care is also available to other groups living in Malta, such as foreign workers with valid work permits and irregular migrants. Malta has seen rapid increases in the numbers of irregular migrants, refugees and asylum seekers over the past decade. While there is no specific legislation with respect to access to health care for irregular migrants, they have free access to health care through a system of administrative waivers on humanitarian grounds. As in other countries, this vulnerable group may face barriers to using health services due to lack of information, fear, and language or cultural barriers. Third country nationals who are not covered under social security legislation have to pay for all health care services.

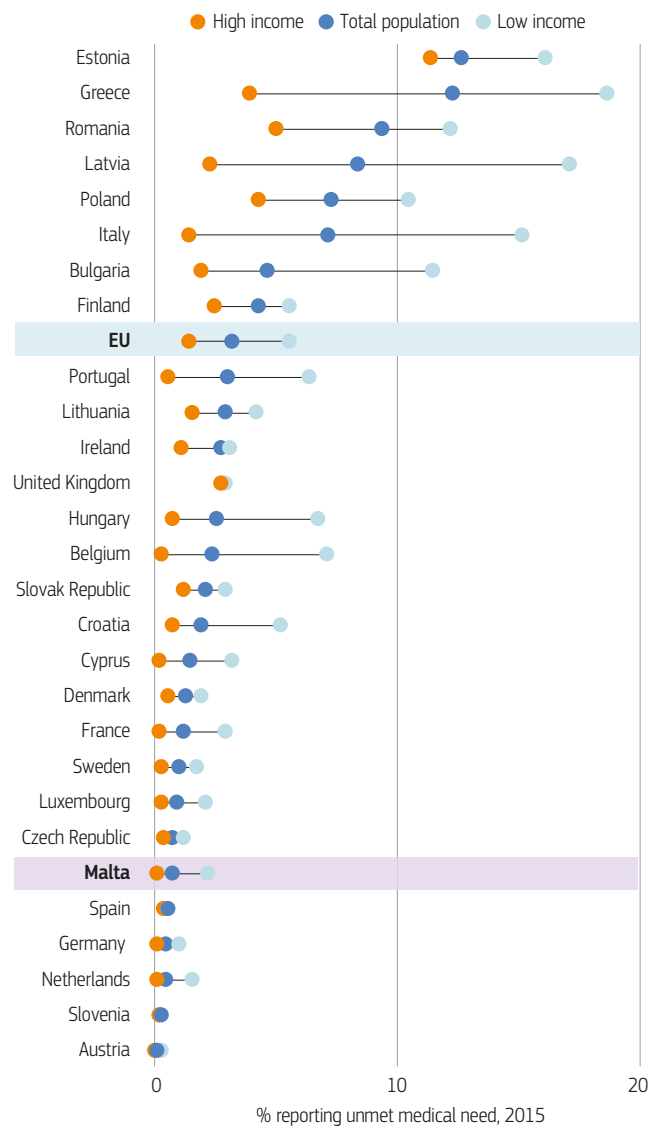
Population coverage in the public system is high, so in 2015 only 0.8% of the population reported feeling unable to obtain medical care when needed because it was too expensive, too far to travel, or waiting lists were too long. This amounts to the sixth lowest share in the EU (Figure 10). In addition, there is little variability in the reporting of unmet needs between the lowest income quintile (2.2%) and the highest (0.1%), suggesting fairly equitable access to services across income groups. Unmet needs for dental examination are also very low, ranking fourth lowest among EU countries in 2015, despite some dental services not being covered for all residents under the public health care system.

Essential medicines are free of charge for low income households

The publicly funded health system offers a comprehensive benefits package. Entitlement to a few services, including elective dental care, optical services and some formulary medicines, is means-tested. Therefore, people who fall within the defined low income bracket are entitled to free medicines from a list of essential medicines and to certain medical devices. Moreover, those who suffer from chronic illnesses are also entitled to their disease-specific medicines free of charge, without means-testing. Since 2008 these can be collected from any pharmacy, including those in the private sector, resulting in improved access. In all other cases, patients must purchase pharmaceuticals out of pocket, except during hospitalisation and for the first three days following discharge (MISSOC, 2016).

Access to innovative medicines, however, remains a challenge. The government has adopted various savings measures in the medicines budget in order to spend more on expensive new

Figure 10. The low level of self-reported unmet needs also shows small variations across income groups



Note: The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

medicines, including the introduction of Managed Entry Agreements and the concept of clinical pathways and protocols for the evaluation of new medicines. Furthermore, the President's Malta Community Chest Fund (a philanthropic foundation) has extended its role in financing drugs that are not yet included in the benefits package. In addition, the second national cancer plan published in 2017 outlines a government pledge to include more cancer medications on the Government's Formulary List in the coming years. Furthermore, the Government has pledged to increase access to medicines for rare diseases.

High out-of-pocket expenditure does not seem to pose a barrier to access

Although NHS services are free at the point of use, patients often choose to seek care in the private sector, particularly for primary and specialist care, resulting in high out-of-pocket expenditure. In 2015, such direct payments, as a share of total health expenditure, totalled 29%, significantly higher than the EU average of 15% (Figure 11). This share has remained stable since 2005. Out-of-pocket spending accounts for 5% of total household final consumption, which is the second highest in the EU. Low income households in Malta generally spend a larger proportion of their income on health than their higher income counterparts. Despite this, the lowest income group reports very low rates of unmet needs for medical care due to cost (2.4% in 2015).

Waiting lists for inpatient care have been reduced substantially in recent years

Inability to access health services for geographical reasons is not a major issue in Malta due to the small size of the country. There are two public acute hospitals, one located on Malta and the other on the island of Gozo. There are also specialised hospitals for oncology, rehabilitation, mental health and older people, as well as a number of private inpatient and outpatient centres.

Although data show that only 0.1% of respondents reported unmet needs for medical examination due to waiting lists in 2015, waiting times have traditionally been a long-standing challenge in Malta. This is partially due to a weak gatekeeping system. GPs in public health clinics act as full gatekeepers, referring patients to public specialists and hospital care, whereas private sector GPs and specialists can provide referrals to other levels of care in both the

public and the private systems, thus reintroducing private patients back into the public system. There is also a problem in terms of equity of access, given that people who can afford to do so are able to bypass waiting lists for specialist ambulatory and elective diagnostic and therapeutic interventions by going directly to private sector physicians.

Waiting lists for hospital interventions have been successfully reduced by increasing the number of procedures performed in public hospitals through, for example, introducing routine Sunday lists and outsourcing some procedures, such as cataract treatment, MRI and arthroscopic services, to the private sector. More remains to be done to decrease waiting times for outpatient hospital appointments in other areas and the Government is committed to building a new outpatient block to provide increased capacity to cater for the demand. An ongoing exercise to improve internal efficiency in the management of outpatient services is also under way with a view to reducing waiting times.

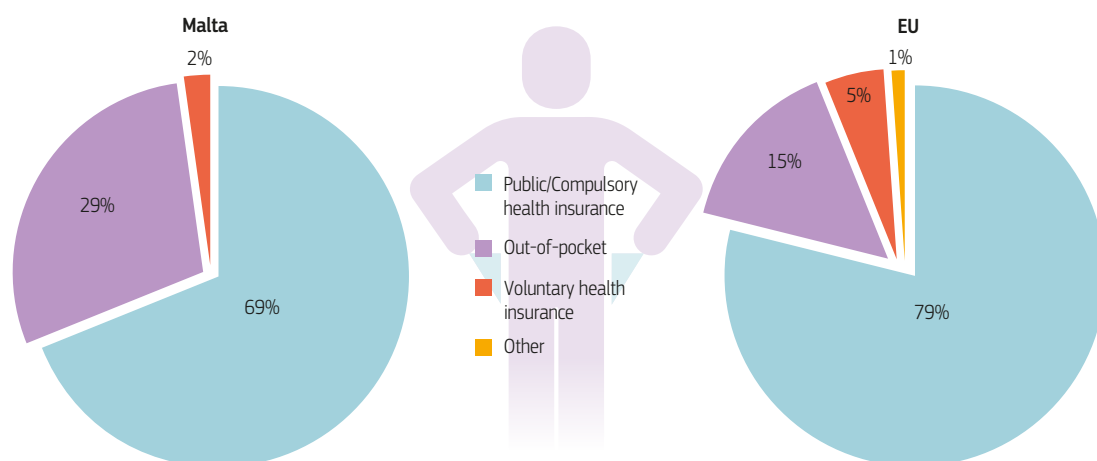
5.3 RESILIENCE⁷

Economic reforms have strengthened the fiscal sustainability of public expenditure on health

Malta faces important fiscal challenges, in part due to the expected costs of caring for its ageing population and associated increases in chronic conditions. Other factors stretching health system capacity include increased immigration from workers and pensioners, tourists using the health system and changing population risk behaviours.

7. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

Figure 11. Direct out-of-pocket payments are much higher in Malta than in most other EU countries



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

Projections from the EC 2015 Ageing Report (European Commission and Economic Policy Committee, 2015) suggest that Malta is poised for an increase of 2.1% in health care expenditure as a share of GDP over the period 2013–60, the second largest increase in the EU after Portugal. However, recent structural reforms and investments in energy infrastructure have resulted in higher growth and a more buoyant labour market than initially projected. The improved economic outlook for Malta has strengthened the sustainability of public expenditure and is creating the necessary fiscal space to accommodate projected increases in health expenditure driven by the ageing process. Nevertheless, health budgets are still facing tight control in line with Fiscal Responsibility legislation introduced for Eurozone countries. Although current demographic trends do not pose any serious threat to the health sector's fiscal sustainability, a strong commitment to securing adequate health budgets is required.

A new public-private partnership initiative aims to expand acute hospital capacity and geriatric care

Limited availability of capital investment resources is one reason the government entered into a 30-year public-private partnership with a private contractor in 2016 for the refurbishment, development and management of three public hospitals in Malta and the island of Gozo. Aside from transferring responsibility for capital investment, the contract anticipates an expansion of acute hospital capacity and geriatric care for Maltese residents as well as the creation of a niche medical tourism market, particularly for one of the hospitals earmarked for rehabilitation services. The move also entails a shift in stewardship arrangements: in contrast to its traditional 'command and control' role of direct management, the Ministry of Health is expected to exercise influence via its newly adopted role as the contractor of services.

The reform is the subject of an ongoing debate in Malta about the transparency of the ownership of these hospitals and equity in access and coverage. The contracts were heavily redacted when presented in the public domain and have been referred to the National Audit Office for scrutiny by the Ministry of Health. The reform will need to be monitored carefully, not least to ascertain whether it is contributing to the fiscal sustainability of the health system and meeting other goals such as maintaining equitable access and improved quality of care.

Malta is aiming to enhance its physical and eHealth infrastructure

Malta's National Health System Strategy highlights the importance of modernising health centres by providing the latest technological equipment. In this regard, the opening of the Mater Dei Hospital in 2007 and a new cancer hospital in late 2014 have enhanced capacity in clinical services.

The National Strategy also gives particular attention to the use of information technology and the creation of a Health Care Information System. In particular, the rollout of the myHealth service since 2012 enables patients and doctors to access electronic medical records through a nominated doctor of their choice and an e-ID card, thus strengthening continuity of care for patients. Moreover, investment plans have been drawn up for an integrated portfolio of eHealth systems that include the creation of electronic patient records in primary health care, e-prescription services and patient registries.

Health Technology Assessment informs decision-making on the allocation of resources

Decisions on resource allocation are supported by a Health Technology Assessment (HTA) system that has been in place since 2010 to help deliver care that represents value for money. HTA is used to inform decisions on whether to add new medicines to the Government Formulary List, to set the relevant maximum reference price and to assess whether procedures should be included in the public benefit package.

There is scope for increasing efficiency particularly through strengthening primary care

The cost-effectiveness of the health system can be intimated, albeit rather crudely, through relating amenable mortality rates to total per capita expenditure levels. On this measure, the result for Malta is relatively low (Figure 12), implying that health care resources are generally used cost-effectively, but with the proviso that health behaviours as well as health system factors influence the level of amenable mortality. Nevertheless, Malta has one of the highest rates in the EU of hospital expenditure as a proportion of total expenditure in the public sector, which impacts on the health system's efficiency.

Stronger primary care could contribute to improving the health system's performance and efficiency in a number of ways. Firstly, the weak gatekeeper system leads to inappropriate referrals and

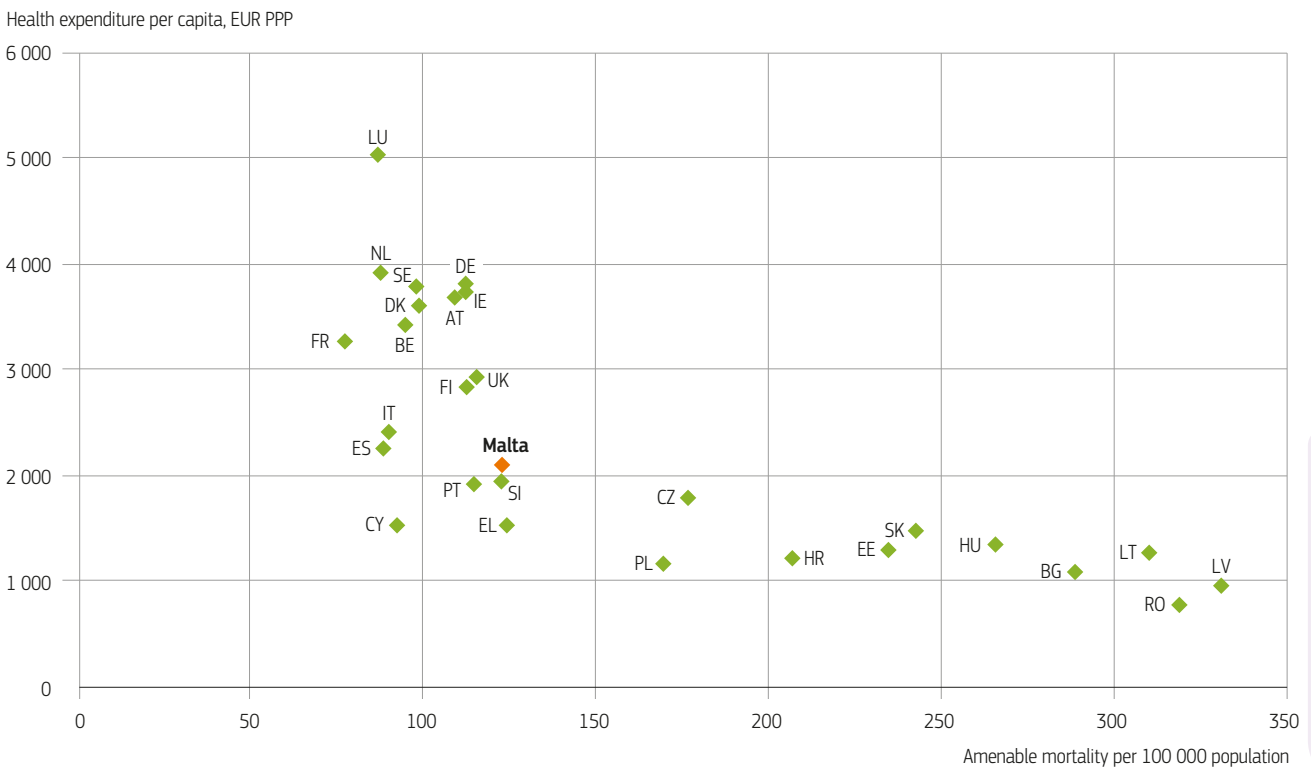
contributes to wasted resources in the form of hospital care that could take place in less costly settings. Strengthening public primary and community care would also result in fewer self-referrals to hospital emergency departments for minor ailments and conditions where treatment costs are much higher. Finally, managing chronic conditions better within primary care settings would contribute towards preventing deterioration and the need for hospital care.

Several initiatives have already been adopted to strengthen primary care. For example, GPs and private family doctors linked in to the myHealth system are now able to make referrals for services that could previously only be requested by hospital specialists. Additionally, the range of services provided in primary care has been expanded to include, for example, chronic disease management clinics and healthy lifestyle clinics. Infrastructure investments have also been made to upgrade public primary care facilities and to build a Primary Care Regional Hub in the Southern Harbour area.

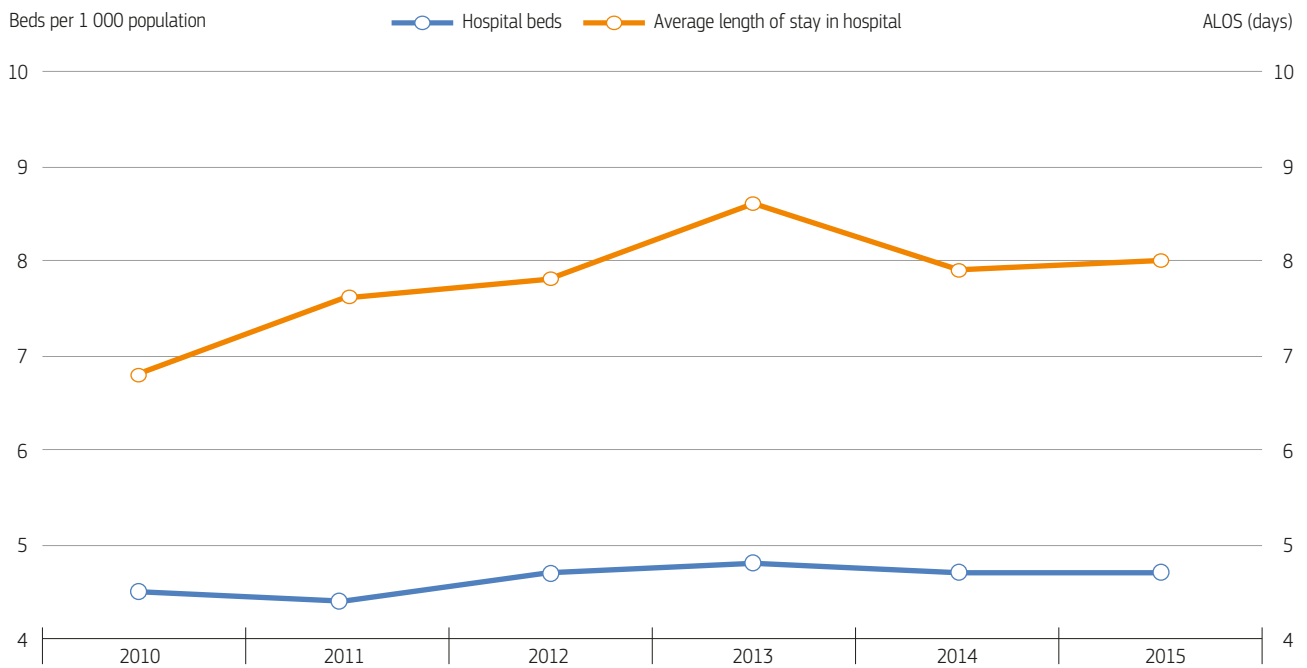
There is also potential for efficiency gains in the hospital sector

In terms of bed numbers, large fluctuations in the data reflect hospital restructuring, changes in hospital designations and definitions of beds over the years, making it difficult to ascertain accurate levels and trends. With this caveat in mind, the overall number of hospital beds has increased in recent years, reaching 4.7 per 1 000 population in 2014 (Figure 13), which is still below the EU average (5.2) but is contrary to the declining trend in many other EU countries. In acute care, the number of hospital beds decreased by around 14% over the period 2000–15. This has contributed to Malta's relatively high bed occupancy rate (81.7% in 2015) compared to the EU average (76.6%). Bed occupancy rates have been further exacerbated by a substantial increase in the average length of stay in acute hospitals over the past decade (Figure 13). This is caused by pressures on long-term care beds and capacity that prevents the movement of debilitated patients from acute beds to more appropriate settings.

Figure 12. Amenable mortality is relatively low given spending levels



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2014).

Figure 13. The number of beds and the average length of stay are increasing

Note: A break in time series occurred in 2011.

Source: Eurostat Database.

Strategic tools have been formulated to strengthen governance

The National Health Systems Strategy for 2014–2020 was adopted in September 2014, the first since 1995. It sets out key objectives to address the challenges facing the health system, namely: responding to the demands posed by demographic changes and epidemiological trends; increasing equitable access, availability and timeliness; improving quality of care; and ensuring fiscal sustainability.

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. The Strategy focuses on strengthening prevention and primary care, making better use of technologies, harnessing existing resources and further developing health system governance to ensure the development of a sustainable health system that respects the fundamental principle of equitable access for all.

In order to monitor the implementation of the Strategy, Malta developed its first Health Systems Performance Assessment (HSPA) in 2015, supported by the WHO (Grech et al., 2015). The overall responsiveness of the health system emerged as being ‘good’. The dimensions of financing, quality, access and health status emerged as ‘fair’, while the health system scored poorly on the dimensions of resources, efficiency and determinants of health, although it should be noted that the assessment set a high benchmark to achieve highly positive and positive scores. The stewardship domain could not be assessed because of a lack of data for the selected indicators, signalling where information systems capabilities need to be improved to support monitoring and evaluation efforts. This first HSPA now serves as a baseline to gauge any improvements in domains of evaluation over time.

6 Key findings

- The Maltese health system has registered good progress, as evidenced by high life expectancy, good health status and generally low levels of unmet needs. However, some risk factors are of concern compared to other EU countries and may well have a negative impact on healthy life expectancy in the future. In particular, obesity prevalence is the highest in the EU and represents a major public health challenge.
- Malta faces important fiscal challenges due to an increasingly diverse, growing and ageing population with commensurate rising chronic care needs. However, recent economic reforms and prudent fiscal management are currently creating the necessary fiscal space to accommodate projected increases in health expenditure. Nevertheless, improving health system capacity to cope with changing needs requires a strong commitment to securing adequate health budgets.
- Strengthening primary care would reap a number of benefits for the Maltese health system and its users, including efficiency gains from reducing pressure on hospital care and ensuring better management of care for patients with chronic conditions. Ongoing initiatives to strengthen primary care include an expansion of the range of services, infrastructure investments to improve facilities and the development of a new primary health centre.
- Malta has successfully tackled long waiting times for surgical interventions and diagnostics through a number of measures, including increasing capacity and commissioning some services from the private sector. Reducing waiting times for outpatient specialist appointments in public hospitals remains a priority, especially as direct access to private specialists in order to by-pass waiting lists for those who can afford it could create an equity issue.
- The implementation of the next stage of development in Malta's eHealth infrastructure, such as electronic medical records in primary care, e-prescriptions and patient registries, will not only contribute to longer term efficiency of health care spending but will also enhance quality and continuity of care for patients. A digital strategy is being prepared.
- Access to expensive innovative medicines remains an important budgetary challenge. In response, the government has adopted various savings measures in the medicines budget in order to spend more on expensive new medicines. These include the use of clinical pathways and protocols for the evaluation of new medicines and the introduction of managed entry agreements.
- Malta has embarked on new health system stewardship arrangements through public-private partnership agreements, to enhance hospital infrastructure investment and management of services. The Ministry of Health's commissioning of private sector services entails a relatively new role as the purchaser of care, as opposed to being a direct provider of health care services through government-operated facilities. A robust legislative and governance framework to underpin this change is needed as a matter of urgency. Careful monitoring and evaluation of these new arrangements will ensure that they meet their policy objectives and derive the expected value for money and quality of care for the health system.



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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

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