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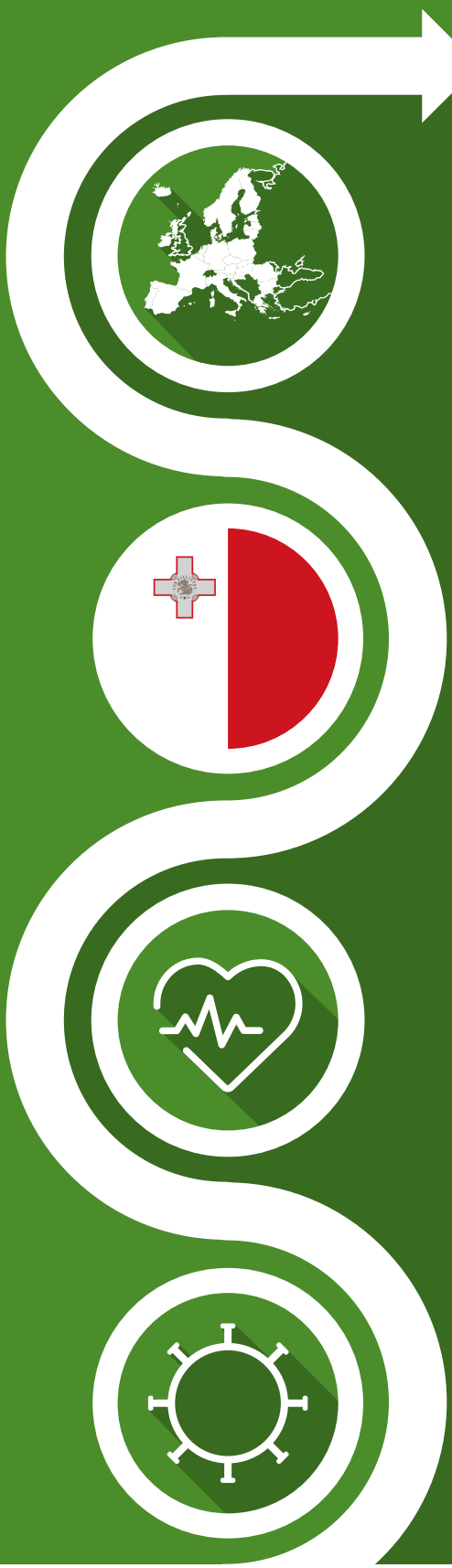


State of Health in the EU

Malta

Country Health Profile 2021

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The 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 the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated 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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

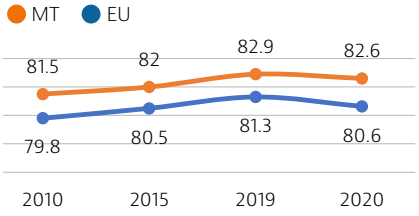
Demographic and socioeconomic context in Malta, 2020

Demographic factors	Malta	EU
Population size (mid-year estimates)	514 564	447 319 916
Share of population over age 65 (%)	18.5	20.6
Fertility rate[1] (2019)	1.1	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	28 746	29 801
Relative poverty rate[3] (%, 2019)	17.1	16.5
Unemployment rate (%)	4.3	7.1

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 60 % of median equivalised disposable income. Source: Eurostat database.

1 Highlights

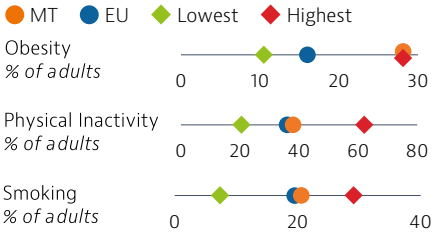
Life expectancy in Malta is the second highest among EU countries, but it declined in 2020 as a result of deaths during the COVID-19 pandemic. People spend more time living in good health compared to other EU countries, but rates of obesity are high and pose a major public health challenge. Malta's National Health Service provides good access to care, but the COVID-19 pandemic has highlighted structural weaknesses in the health sector, including low hospital capacity, insufficient investment in prevention and gaps in the workforce. Commitments to enhance the use of digital health, ongoing reforms to primary care and investment in physical infrastructure and the health workforce will help to build a more resilient health care system.



Life expectancy at birth, years

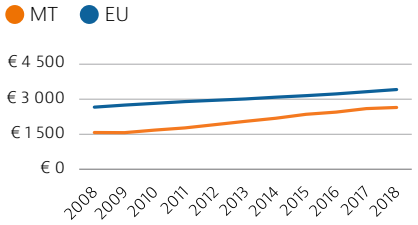
Health Status

Life expectancy in Malta in 2020 was two years higher than the EU average. While it fell by 0.3 years due to the COVID-19 pandemic, this was below the average decline of 0.7 years seen across the EU. Deaths from cardiovascular disease and cancer have declined substantially in recent decades, but deaths from diabetes remain high. Self-reported good health among the population is high, but sizeable income-based inequalities in health status persist.



Risk factors

Rates of obesity in Malta are the highest in the EU, with more than a quarter of adults classified as obese. Poor diets and physical inactivity contribute to high levels of obesity in the country. Smoking rates among adults are similar to the EU average.



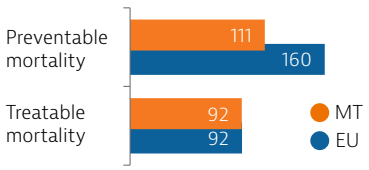
Per capita spending (EUR PPP)

Health system

Malta has seen one of the largest increases in total health spending in the EU between 2008 and 2018, although expenditure per capita and as a share of GDP remained below the EU average in 2018. The share of funding from public sources also remained relatively low, and private out-of-pocket payments were among the highest in the EU. Public spending on health nevertheless increased substantially during the COVID-19 crisis.

Effectiveness

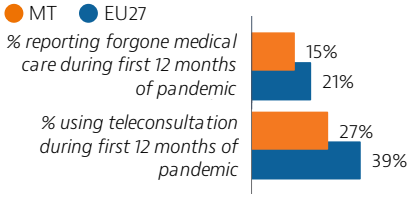
Mortality from preventable causes in Malta is among the lowest in the EU. Deaths from treatable causes have declined in recent years, and are now equal to the EU average. More deaths from cardiovascular diseases, cancers and diabetes could be avoided through more timely and effective diagnosis and treatment.



Age-standardised mortality rate per 100 000 population, 2018

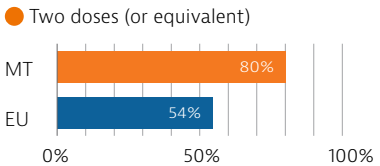
Accessibility

Malta's health system provides good access to care, and levels of unmet needs for care were the lowest in the EU in 2019. One in six people reported having forgone care during the COVID-19 pandemic – a share lower than the EU average. Use of e-prescriptions, remote consultations and remote monitoring of COVID-19 patients helped maintain access to care during the pandemic.



Resilience

Widespread testing and comprehensive public health measures formed central components of Malta's COVID-19 response. The country's vaccination programme was also implemented rapidly, and by the end of August 2021, 80 % of the population had received two doses (or equivalent) – the highest proportion in the EU at that time.



Share of total population vaccinated against COVID-19 up to the end of August 2021

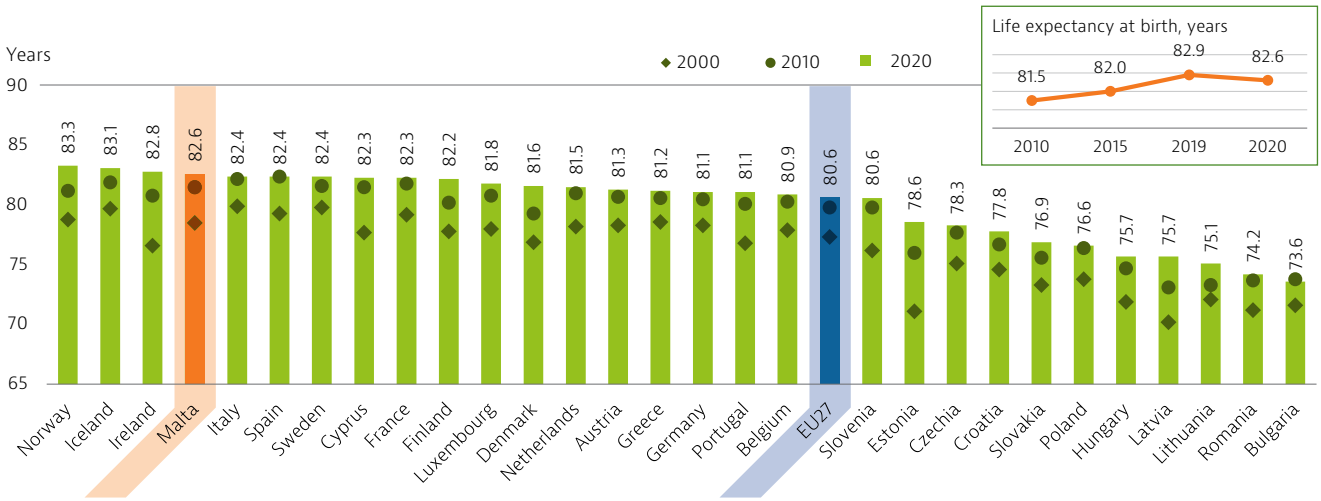
2 Health in Malta

COVID-19 led to a reduction in life expectancy in 2020, but this was smaller than the EU average

Life expectancy at birth in Malta was 82.6 years in 2020 – the second highest in the EU and 2.0 years higher than the EU average (Figure 1). Since 2000, life expectancy in Malta has risen by 4.1 years, which is higher than the average increase of 3.3 years in the EU. Most gains in life expectancy occurred between 2000 and 2010, with an overall increase of 3.0 years. Life expectancy gains slowed in the following decade, with an increase of 1.1 years, although this was above the EU average of 0.8 years.

Following the outbreak of the COVID-19 pandemic, life expectancy temporarily declined by 0.3 years between 2019 and 2020. This was nevertheless below the average decline of 0.7 years seen across the EU as a whole. Men in Malta were more affected than women: life expectancy fell by 0.4 years between 2019 and 2020 for men but remained unchanged for women. Overall, the gap in life expectancy between men and women is lower than the EU average, with women living on average 3.8 years longer than men, compared to the EU average of 5.6 years.

Figure 1. Life expectancy in Malta is among the highest in the EU



Note: The EU average is weighted. Data for Ireland refer to 2019
Source: Eurostat Database.

Cardiovascular diseases and cancer are the main causes of death in Malta

Life expectancy gains in Malta since 2000 have been driven by a decline in premature deaths from leading causes – notably, cardiovascular diseases and cancers. From 2000 to 2018, age-standardised mortality rates per 100 000 population from cardiovascular diseases fell by more than 50 %, and for all cancers by 14 %. Cardiovascular diseases nevertheless remained the leading cause of death in 2018, accounting for 34 % of all deaths, followed by cancer (28 %).

Looking at individual causes of disease, ischaemic heart disease was the leading cause of mortality in 2018, accounting for 17 % of all deaths, followed by stroke (Figure 2). Lung cancer remained the most frequent cause of death by cancer. Deaths attributable to diabetes (50.8 per 100 000 population) were the third highest in the EU, which is partly linked to Malta's high prevalence of obesity (see Section 3).

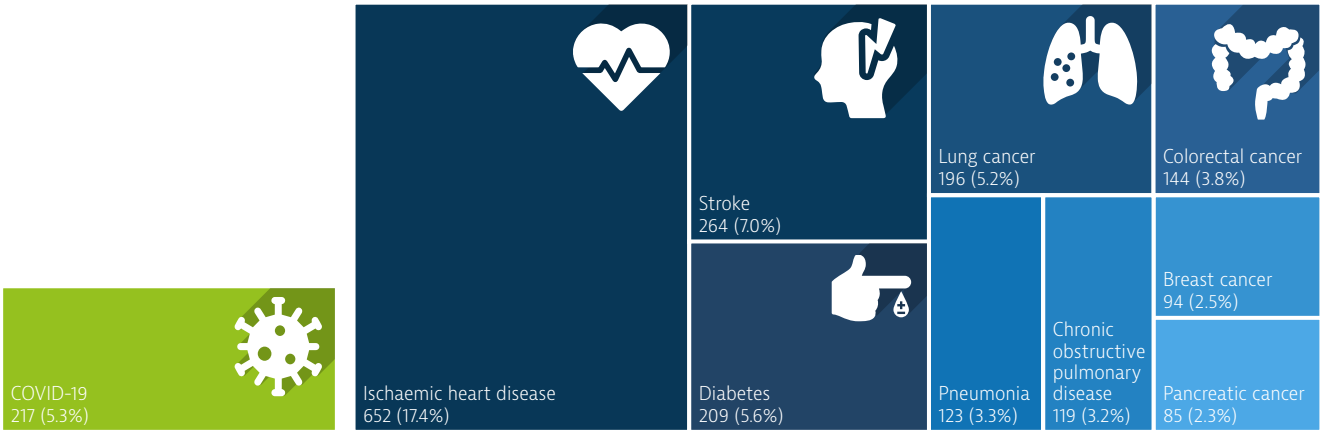
Deaths attributed to COVID-19 in 2020 were lower than the EU average, but may be underestimated

In 2020, COVID-19 accounted for 217 deaths in Malta (an estimated 5.3 % of all deaths). An additional 223 deaths were registered by the end of August 2021. Most deaths were among older people. The cumulative mortality rate from COVID-19 to the end of August 2021 was about 46 % lower in Malta than the average across EU countries, at approximately 855 per million population compared with an EU average of about 1 590.

However, the broader indicator of excess mortality – defined as deaths from all causes above what would

normally be expected based on previous years – suggests that the direct and indirect death toll related to COVID-19 in Malta could be higher. The number of excess deaths from March to December 2020 (about 500) was more than twice that of COVID-19 deaths, although the extent to which these deaths were caused by COVID-19 is unclear.

Figure 2. Ischaemic heart disease and stroke are the leading individual causes of mortality



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat Database (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

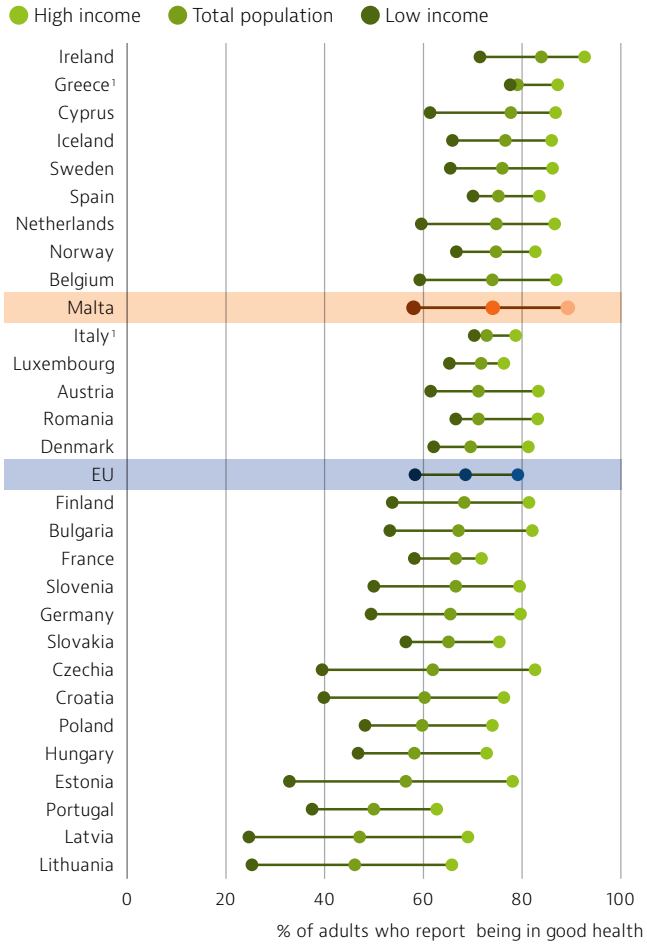
The majority of the population report being in good health, but socioeconomic disparities persist

In 2019, almost three quarters (74 %) of the Maltese population reported being in good health – a proportion higher than the EU average of 69 %. More men (76 %) reported being in good health than women (72 %). In addition, 89 % of the Maltese population in the highest income quintile reported being in good health, compared with 58 % of those in the lowest: these income-based disparities were much larger in Malta than the EU average (Figure 3).

Prostate and breast cancers are the most frequently diagnosed cancers in Malta

According to estimates from the Joint Research Centre based on incidence trends from previous years, around 2 400 new cancer cases and 1 000 deaths from cancer were expected in Malta in 2020[1]. More men are expected to be diagnosed with and die from cancer than women, with an age-standardised incidence rate of 619 per 100 000 men and 464 per 100 000 women. These rates are lower than the EU averages. The main cancer sites among men are prostate (26 %), lung (16 %) and colorectal (13 %), while among women breast cancer is the leading cancer (36 %), followed by colorectal (11 %) and uterus (7 %) (Figure 4).
To improve prevention, access to care and care coordination, Malta has launched a second National Cancer Plan for 2017-21 (see Section 5.1).

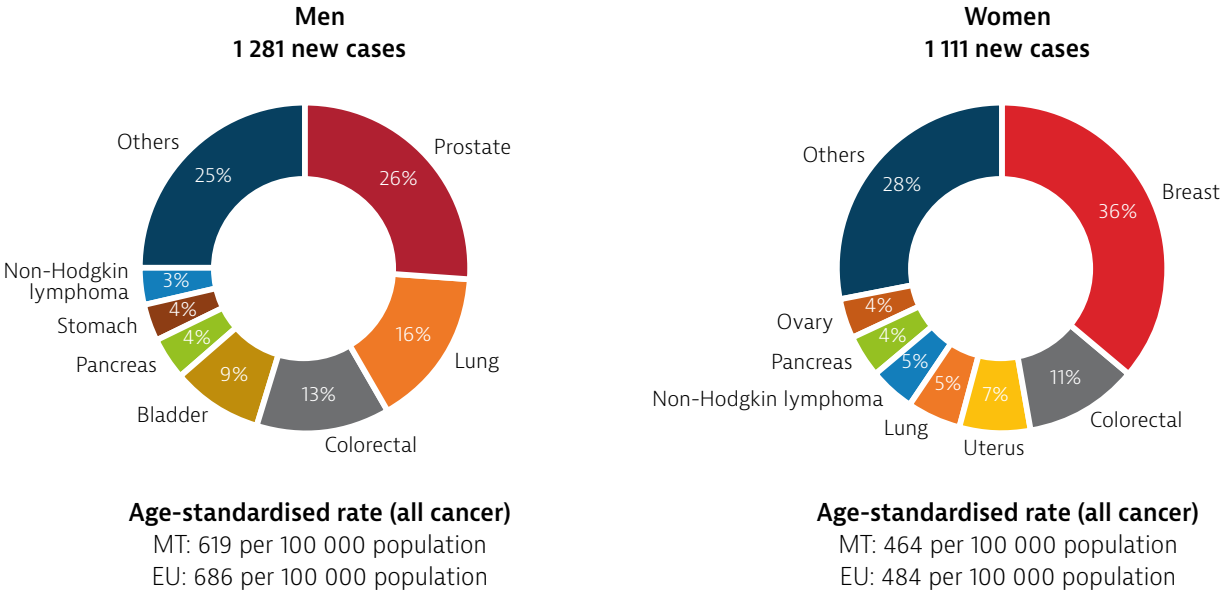
Figure 3. Disparities in self-reported good health by income in Malta are among the largest in the EU



Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2019).

1. It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.

Figure 4. An estimated 2 400 people in Malta were diagnosed with cancer in 2020



Note: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

Numbers of refugees and asylum seekers have increased and many have physical or psychological issues

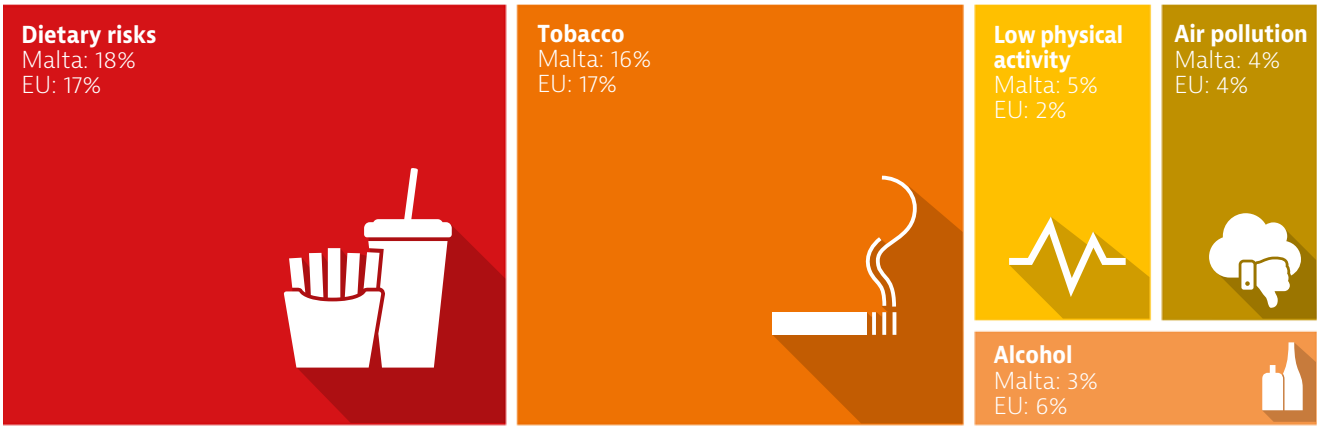
In recent years, Malta has served as an EU entry point for migrants and refugees fleeing conflicts. In 2020, about 2 300 people were rescued at sea and disembarked in Malta (UNHCR, 2021). Common health problems among migrants and refugees are gastrointestinal and respiratory disorders, diabetes, hypertension, pregnancy-related complications, and physical and psychological trauma. Malta's health system in general provides good population coverage, including for refugees and asylum seekers, but there are gaps for some other migrant groups (see Section 5.2).

3 Risk factors

Behavioural and environmental risk factors are major drivers of mortality

Over one third of all deaths in Malta in 2019 could be attributed to behavioural risk factors – a proportion similar to the EU average (Figure 5). Some 18 % of all deaths were attributed to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), and 16 % of deaths related to tobacco smoking (including direct and second-hand smoking). These proportions are similar to the EU average. About 5 % of all deaths were related to low physical activity, which is a much greater share than the EU average (2 %), while about 3 % of all deaths can be attributed to alcohol consumption, which is much lower than the EU average (6 %). Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 4 % of all deaths in 2019.

Figure 5. Dietary risks and tobacco are major contributors to mortality in Malta



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020); Global Health Data Exchange (estimates refer to 2019).

Rates of overweight and obesity among adults and adolescents are the highest in the EU

Rates of overweight and obesity in Malta have increased over the past decade and are the highest in the EU for both adults and adolescents (Figure 6). More than one in four adults were obese in 2019. Men (28 %) were more likely to be obese than women (23 %). Over one in three 15-year-olds were overweight or obese in 2018 – almost double the EU average.

Poor nutrition is the main factor contributing to overweight and obesity. In 2019, only 30 % of adults and 25 % of 15-year-olds reported eating vegetables daily. While daily fruit consumption was higher than in many EU countries, only 57 % of adults and 34 % of 15-year-olds reported eating fruit daily.

Low physical activity levels also contribute to high rates of overweight and obesity. Physical activity among 15-year-olds has declined by 25 % since 2014 and was the fourth lowest among EU countries in 2018. Proportions who report being physically active are especially low among girls (5 % compared with 15 % for boys). More than one third of Maltese adults did not undertake the WHO-recommended level of 150 minutes of moderate physical activity per week in 2014 – a proportion higher than the EU average.

Tackling high rates of overweight and obesity in Malta has been recognised as a government priority over the past decade, and a number of inter-sectoral actions have been implemented to address the obesogenic environment (see Section 5.1).

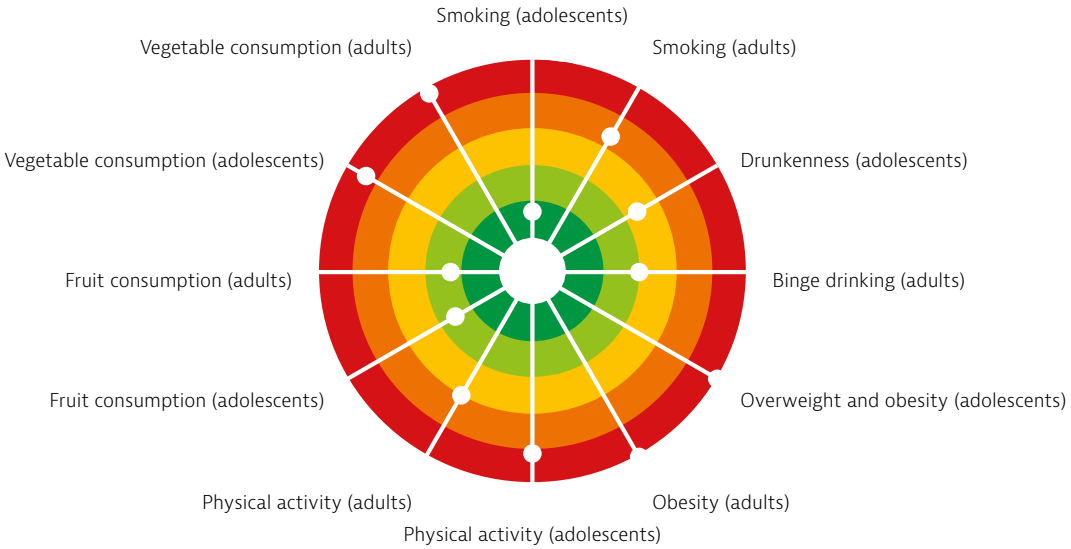
Smoking rates and use of e-cigarettes among adolescents are among the lowest in the EU

Smoking rates among adults in Malta are similar to the EU average, with one in five reporting that they smoked daily in 2019. Smoking rates are higher for men (24 %) than women (17 %). The share of 15-year-olds reporting that they smoked cigarettes in the past month has steadily declined and was among the lowest in the EU in 2018. Reported rates of smoking were higher for boys (14 %) than girls (8 %). The reported use of e-cigarettes by 15-year-olds in the past month in 2019 was the third lowest in the EU after Portugal and Sweden. The European Commission (2021a) has set an ambitious goal of ensuring that less than 5 % of the population uses tobacco by 2040 as part of the Europe's Beating Cancer Plan (see Section 5.1).

In 2019, 16 % of adults in Malta reported binge drinking[2] at least once a month – a proportion slightly lower than the EU average (19 %). Men were twice as likely to report binge drinking as women. Excessive alcohol consumption among adolescents is close to the EU average, with 15 % of 15-year-old girls and 26 % of boys in 2018 reporting that they had been drunk more than once in their life. In recognition of this public health challenge, a new alcohol strategy has been published, containing specific actions to tackle underage drinking (see Section 5.1).

2. *Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

Figure 6. Obesity is a major public health issue in Malta



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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and EHIS 2014 and 2019, and national source for adults indicators.

4 The health system

Malta has a predominantly tax-financed National Health Service

Malta's National Health Service (NHS) is predominantly financed through general taxation, and provides almost universal coverage to all residents. The Ministry for Health is responsible for governance, regulation and financing of the health system, and is the main provider of public health services. The Ministry also played a central role in leading Malta's COVID-19 pandemic response (Box 1).

The private sector complements provision of care, particularly for primary care and outpatient services. Historically, a purchaser–provider spilt for health care provision only existed when certain services were outsourced to the private sector, often to help tackle long public sector waiting lists. In 2016, the Maltese government entered into a public–private partnership to transfer responsibility for the development and management of three public hospitals to a private contractor – Vitals Healthcare Group – who failed to deliver on obligations after entering insolvency. The partnership was transferred in 2018 to Steward Health Care, the largest private hospital operator in the United States. These public–private partnerships have raised some concerns over value for money and are currently being reviewed by Malta's National Audit Office.

Health spending in Malta has increased substantially over the last decade

Malta has seen the largest real-terms growth rate in total health spending in the EU in the past decade, and the third highest growth in per capita health spending, behind only Bulgaria and Romania. Health spending per capita (EUR 2 646) and measured as a share of GDP (8.8 %) in 2018 nevertheless remained below the EU averages (Figure 7). Malta's strong economic performance prior to the COVID-19 pandemic has seen rising health spending absorbed by high GDP growth, so that total health spending as a proportion of GDP has declined slightly over the past five years.

The share of public funding for health care in Malta (63.5 %) is low compared to other predominantly tax-funded health systems, and is below the EU average of 79.7 %. The low share of public funding is driven by the high proportion of health spending paid out of pocket (see Section 5.2).

Malta saw a substantial increase in public funding for health during the COVID-19 pandemic, with an additional EUR 130 million initially committed to the health sector during 2020. The majority of this funding was allocated to procuring PPE, critical care beds and other medical equipment, and to increasing the numbers of health workers working directly on COVID-19.

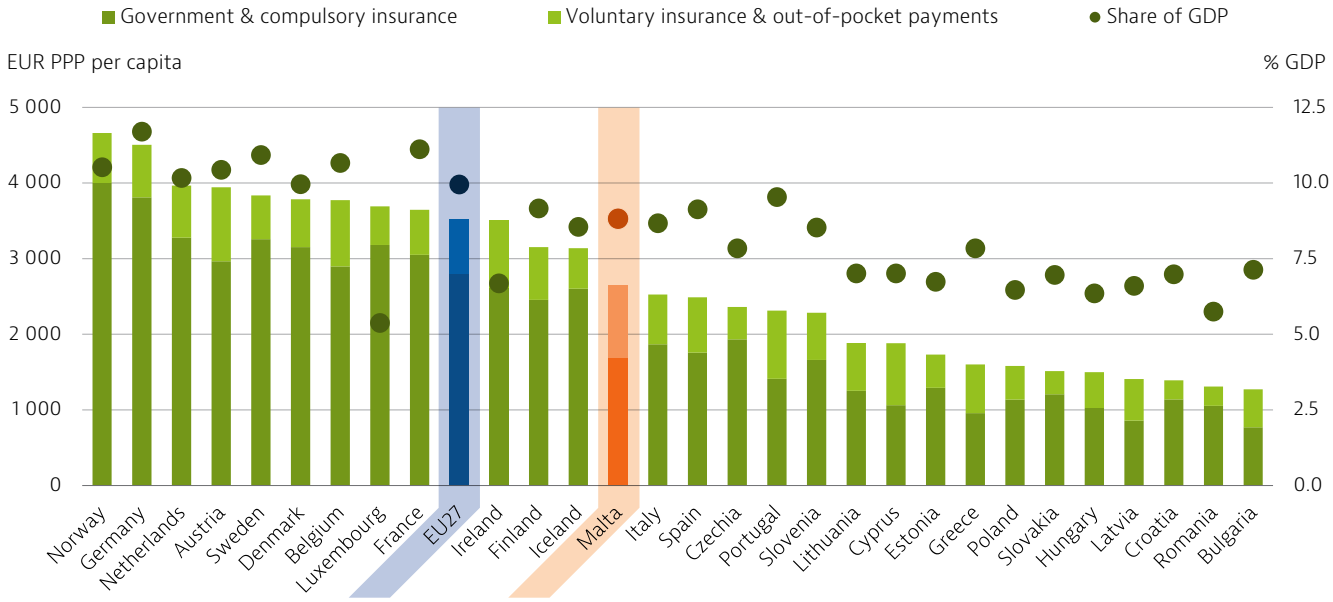
Box 1. Policy direction for Malta's COVID-19 response was provided by the Ministry for Health

Malta's COVID-19 response was led by the Superintendent of Public Health, acting under the aegis of the Ministry for Health. Following the declaration of a state of emergency on 7 March 2020, the Superintendent used her resulting authority to pass certain legislation and directives within the framework of the Public Health Act, such as on physical distancing measures and lockdowns. The Superintendent of Public Health is responsible for making recommendations on potential public health actions to a Cabinet Interministerial Committee chaired by the Deputy Prime Minister and Minister for Health, and for directing the COVID-19 Response Team, which was formed to respond to the public health needs of the pandemic. A Senior Advisory Group based within the Ministry for Health was also created to advise the Superintendent on the latest international and local evidence-based developments and guidance.

Malta has a highly centralised health system, and allocations of responsibilities between central and local governments were not changed during the pandemic. Procurement of personal protective equipment (PPE), medical equipment, vaccines and all other items related to the pandemic response remained the responsibility of the Ministry for Health to ensure adequate planning for critical resources and accountability of utilisation.

Source: COVID-19 Health Systems Response Monitor.

Figure 7. The public share of health expenditure in Malta is among the lowest in the EU



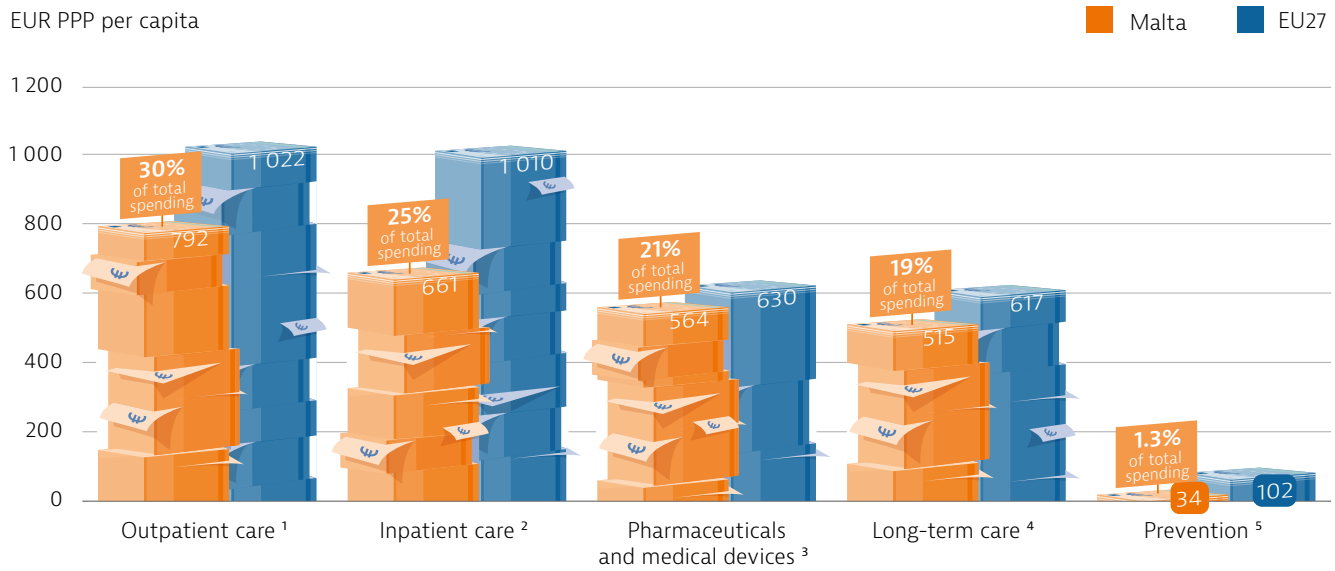
Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

Spending on prevention prior to the COVID-19 pandemic was relatively low

Per capita health expenditure in Malta was lower than the EU average across all health care functions in 2018 (Figure 8). Almost a third of total health spending in 2018 was allocated to outpatient services, with a quarter spent on inpatient services. However, when health spending is measured as a share of total health spending, Malta spends relatively more on outpatient care, long-term care (LTC), pharmaceuticals and medical devices than most other EU countries.

The relatively high share of spending on pharmaceuticals reflects longstanding challenges in ensuring access to innovative medicines in a sustainable way through public financing sources (see Section 5.2). Spending on prevention accounted for 1.3 % of total health spending in 2018, which is less than half the EU average of 2.9 %. Strengthening health promotion and prevention is a priority (see Section 5.3).

Figure 8. Malta spends less per capita on all functions of health care than the EU average



Note: The costs of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019, except for Malta 2018).

Cost-sharing plays a limited role in the Maltese health system

All residents in Malta covered by the Social Security Act or a humanitarian exemption are entitled to receive a comprehensive set of publicly provided health services. Unlike in many EU countries, there are no user fees for public health services: most are provided free at the point of use. Eligibility for elective dental care, optical services and certain formulary medicines are nevertheless subject to a means test. All pharmaceuticals prescribed for outpatient treatment for most chronic conditions, or during inpatient care in public hospitals and for three days following discharge, are available free of charge to entitled individuals, but other specific medicines and medical devices must be paid for out of pocket. However, residents on a low income as determined by a means test are entitled to receive certain medications free of charge (see Section 5.2).

In the interests of public health, all COVID-19-related testing, screening and care was available free of charge to all individuals, irrespective of residence or nationality.

Many patients opt to purchase private primary care and outpatient services

The NHS is the key provider of health services in Malta, but there is significant private sector involvement in the provision of primary care and outpatient services. Private general practitioners (GPs) account for approximately 70 % of primary care visits, with many patients opting to attend private practices – where they can choose their physician and set appointments – rather than public clinics which, in the main, operate on a walk-in basis.

Private and public GPs act as partial gatekeepers to public outpatient hospital services. However, many people choose to seek outpatient care directly from private specialists without a referral, often to circumvent long waiting lists for certain specialities in the public sector, essentially creating a de facto two-tier health system. Strengthening primary care and provision of outpatient services has been high on the government reform agenda in recent years (see Section 5.2).

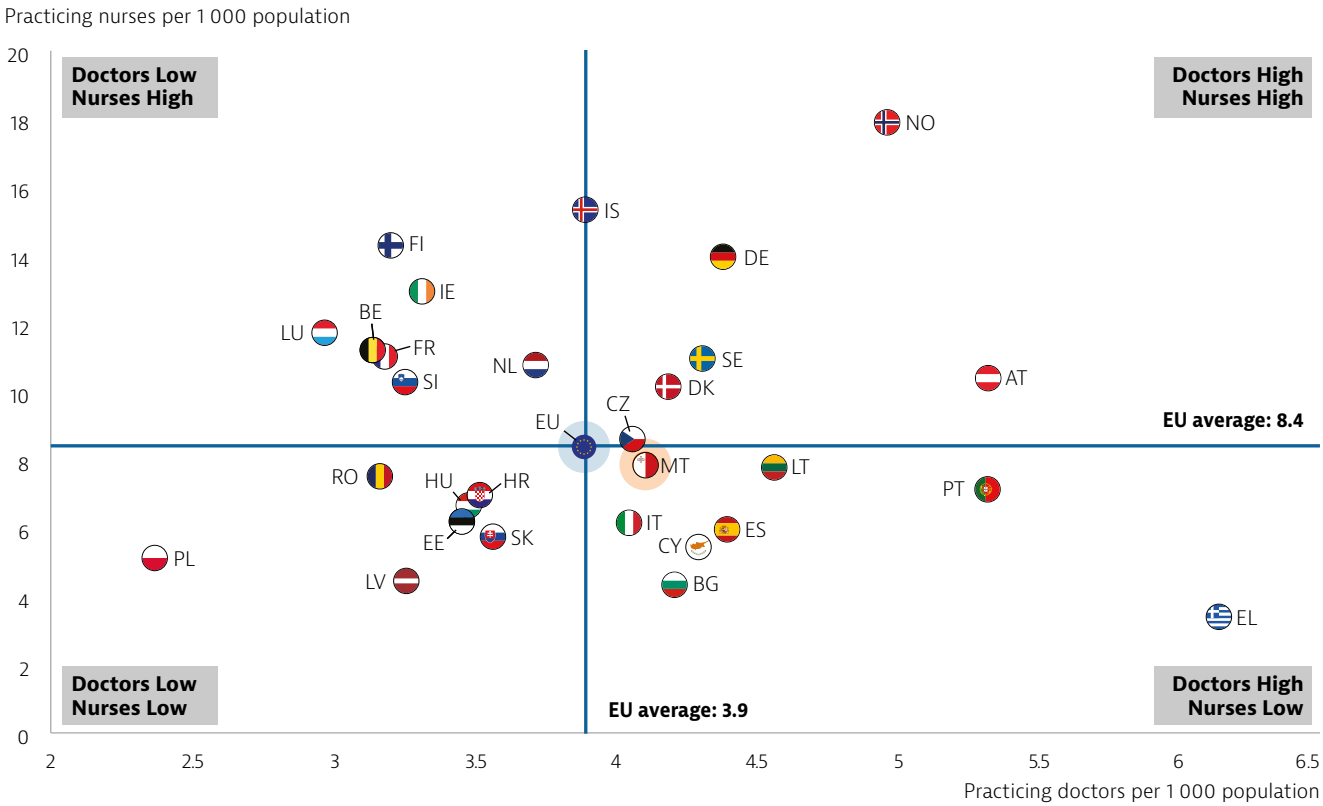
Malta has implemented a number of reforms to address shortages of doctors and nurses

Malta has implemented a series of reforms to improve education, training and employment conditions since 2000 to help address persistent shortages of health professionals. These reforms have contributed to the numbers of doctors and nurses rising steadily over the past decade. Malta now has a higher number of doctors per capita (4.1 per 1 000 population) than the EU average (3.9), and a number of nurses (7.9 per 1 000 population) just below the EU average (8.4) (Figure 9).

Moreover, the number of medical graduates more than trebled from 2008 to 2018, and the number of nursing graduates almost doubled. However, recruitment and retention of GPs has proved challenging; the share of GPs within the physician

workforce has declined since 2009, and at 20.5 % in 2019 remained below the EU average of 26.5 %. Malta also has a shortage of nursing staff in hospitals and LTC, and is increasingly reliant on recruiting foreign-trained nurses in these settings – notably from India, Pakistan and the Philippines. Shortages of nursing personnel in Malta have been exacerbated by the sizeable increase in outward migration of these foreign-trained nurses over the past two years, in particular to the United Kingdom and other countries that offer more competitive working conditions.

Figure 9. A relatively high number of doctors in Malta masks shortages in certain specialities



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

Malta entered the COVID-19 pandemic with limited hospital capacity

Major refurbishments and restructuring in the hospital sector have been undertaken in recent years to expand capacity and improve their physical condition (see Section 5.3). This has seen the number of acute and LTC beds in Malta fluctuate. In 2019, the number of hospital beds was 4.2 per 1 000 population – 13 % lower than in 2009, and below the EU average of 5.3 per 1 000 population. Occupancy rates of acute care beds before the crisis frequently ran at over 80 %, which is among the highest rates in the EU. Rapid action was also taken during the COVID-19 pandemic to expand hospital capacity, with 600 extra beds put in place for COVID-19 patients and intensive care beds increasing five-fold in March and April 2020.

5 Performance of the health system

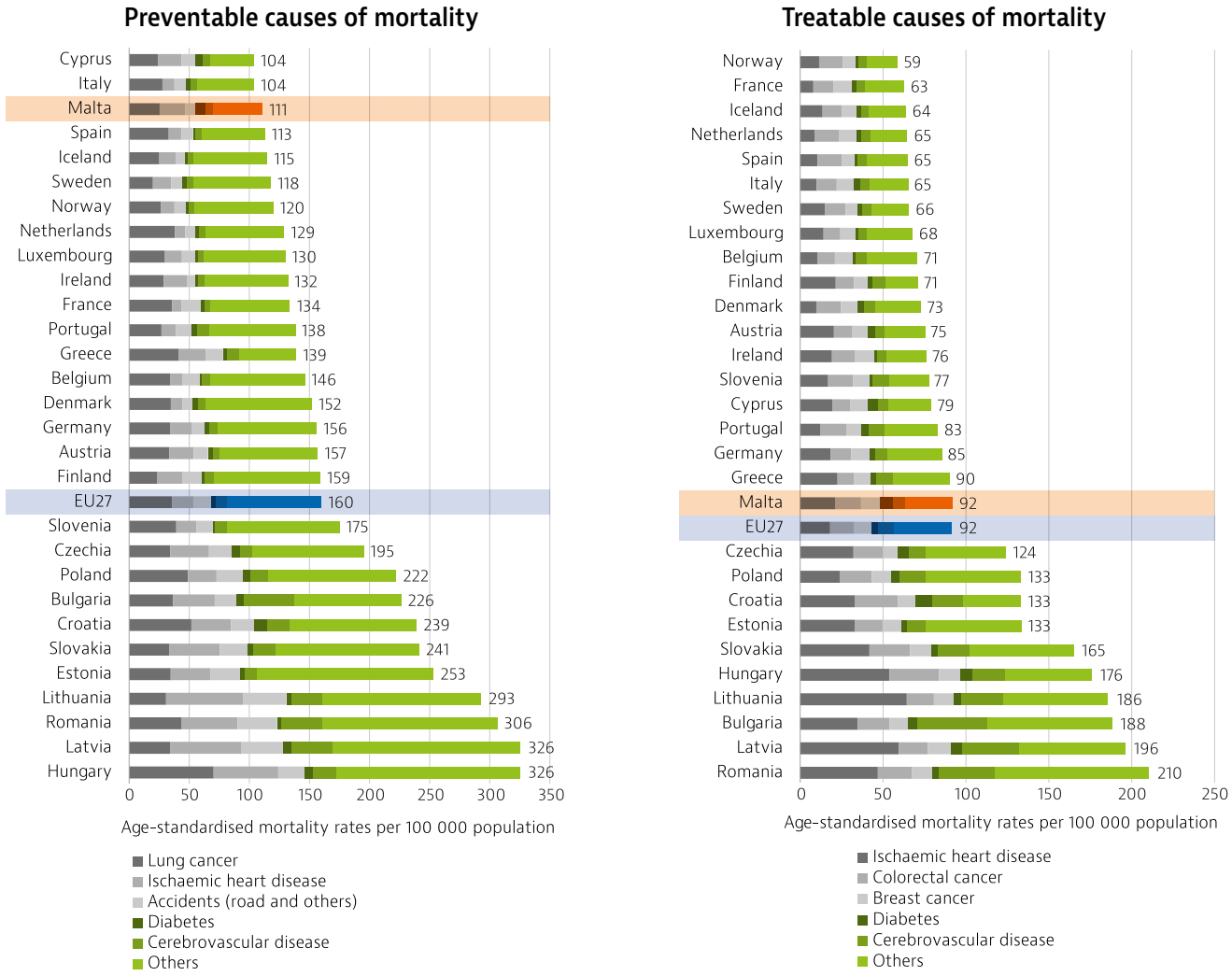
5.1 Effectiveness

Malta has low levels of preventable mortality

Deaths from preventable causes in Malta are among the lowest in the EU (Figure 10). Lung cancer is the leading cause of preventable mortality, but death rates from this cause are much lower than in most other EU countries. Mortality rates from accidents, chronic lower respiratory diseases and alcohol-related diseases are similarly far lower than the EU average. However, the mortality rate from diabetes is the third highest in the EU, and the death rate from ischaemic heart disease is also relatively high.

Mortality rates from treatable causes – those that should not have occurred in the presence of timely and effective health care – have fallen by 15 % in Malta since 2011, and are now the same as the EU average (Figure 10). Ischaemic heart disease is the leading cause of treatable mortality in Malta, and deaths rates remain above the EU average. Mortality rates for cerebrovascular disease are, however, lower than the EU average. Looking at specific cancers, mortality rates for breast cancer are higher than the EU average, but for colorectal cancer are the same as the EU average. The overall decline in treatable mortality reflects improvements in health system performance, with increased availability of key services, innovative medicines and medical technologies.

Figure 10. Mortality from preventable causes in Malta is fourth lowest in the EU



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

Tackling obesity is a public health priority

Relatively high mortality rates from diabetes and ischaemic heart disease are partly attributable to the high prevalence of overweight and obesity among Malta's population (see Section 3). Recent legislation to regulate food available in schools and to restrict advertising and sponsorship of unhealthy foods has been enacted to help tackle this public health priority. In the 2021 government budget, funding was committed to support educational campaigns to address eating disorders and obesity among minors. Funding of EUR 11 million was also committed to help promote a new culture of physical activity by refurbishing and developing sport venues and facilities.

Malta is continually strengthening public health policies to address smoking and alcohol intake

Malta has implemented comprehensive policy actions to tackle smoking since 2000, which have successfully contributed to reducing smoking rates among adults and young people (see Section 3). These include regulations on tobacco advertising, a smoking ban implemented in 2004 and legislation in 2017 prohibiting smoking in private cars carrying children under the age of 18. A new tobacco strategy is being developed. Many laws on cigarettes – such as a total ban on advertising and mandatory health warning on labels – also apply to e-cigarettes, which are regulated as tobacco products.

The first National Alcohol Policy for Malta was introduced in 2018, covering a five-year period to 2023. The policy outlines actions targeting the sale, purchase, intake and supply of alcoholic products to those aged under 17 to reduce underage drinking, and recommends stricter penalties for drink-driving offences.

Influenza vaccination coverage among older people is relatively high

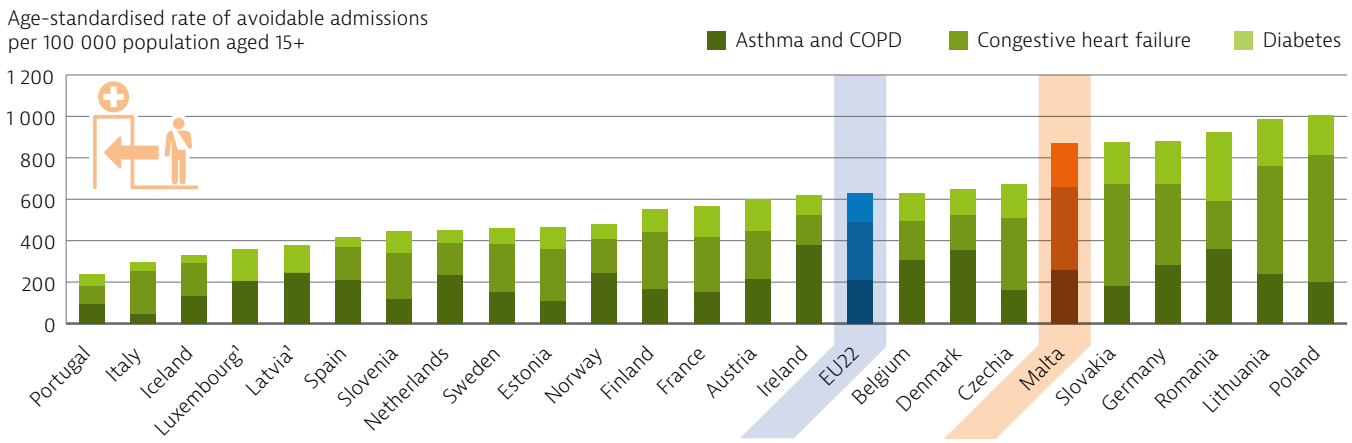
Seasonal influenza vaccines are available free of charge in Malta, and health promotion and educational campaigns are undertaken each year to promote uptake. These campaigns and widespread availability of the vaccine contribute to Malta having a relatively high rate of immunisation against influenza among older age groups. In 2019, more than half of the population aged 65 and over received an influenza vaccine, which is significantly above the EU average of 42 %, but lower than the WHO target of 75 %. In 2020, the Ministry for Health ordered 200 000 doses of the influenza vaccine – double the number ordered in 2019 – as part of efforts to inoculate as many at-risk people as possible during the COVID-19 pandemic.

Strengthening primary care is a priority to help improve the management of chronic conditions

Hospital admission rates in Malta for asthma and chronic obstructive pulmonary disease (COPD), chronic heart failure and diabetes are higher than in many other EU countries with available data (Figure 11). While an above-average prevalence of these diseases in Malta partly explains these high admission rates, many hospital admissions could be avoided through stronger primary and outpatient care interventions and more effective care coordination between ambulatory and inpatient care settings.

Strengthening primary and community care to improve health system performance and efficiency has been a government priority in Malta over the past two decades. As part of these reform efforts, EUR 39 million (of which EUR 33 million comes from EU funds) is being invested to develop a primary care hub in southern Malta, which is scheduled to open in 2022 and will serve approximately one third of the population. A similar hub is planned in the north of the country.

Figure 11. Rates of avoidable hospital admissions in Malta are relatively high



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg
Source: OECD Health Statistics 2021 (data refer to 2017 for Malta and 2019 for most other countries).

Survival rates for many cancers have improved

Malta recorded a substantial increase in five-year survival rates for lung, breast and prostate cancers between 2000-04 and 2010-14, reflecting earlier diagnosis and more effective treatment. The survival rate for lung cancer is now the same as the EU average, while survival rates for breast and prostate cancers are higher (Figure 12). The five-year survival rate for colon cancer has been stable over the past decade and remains slightly below the EU average. The survival rate for cervical cancer is also slightly below the EU average.

Figure 12. Malta has higher five-year survival rates for breast and prostate cancers than the EU average

Prostate cancer
Malta: 88 %
EU23: 87 %

Breast cancer
Malta: 87 %
EU23: 82 %

Cervical cancer
Malta: 57 %
EU23: 63 %

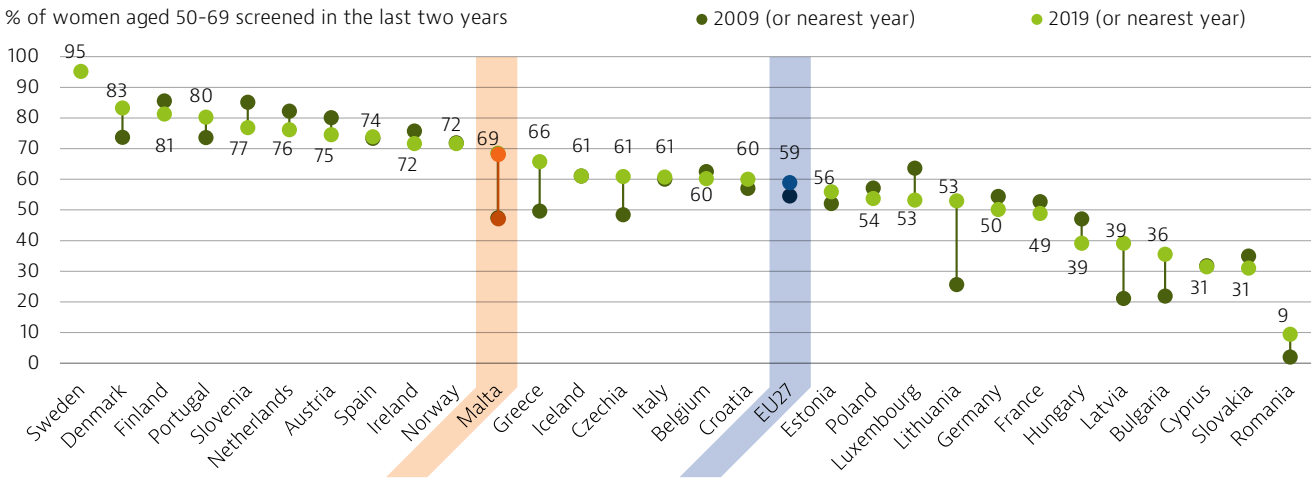
Colon cancer
Malta: 58 %
EU23: 60 %

Lung cancer
Malta: 15 %
EU23: 15 %

Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

National screening programmes for breast and colorectal cancers in Malta have been available for several years. Attendance rates for breast cancer screening have increased by more than 20 percentage points since 2010, but more than 30 % of women in the target group did not attend routine mammography appointments in 2019 (Figure 13). In 2016, a national cervical cancer screening programme for women aged 25-35 was launched. Programme data for 2018 indicate that only 22 % of eligible people had attended cervical cancer screening in the prior two years, but national survey data indicate that uptake may be as high as 62 %, suggesting that people are opting to undertake screening in the private sector. Malta has adopted a second National Cancer Plan for 2017-21, which aims to improve prevention and treatment (Box 2).

Figure 13. Nearly 70% of women in Malta participate in recommended mammography screening



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys.
Sources: OECD Health Statistics 2021 and Eurostat Database.

Box 2. Malta has adopted a second National Cancer Plan for 2017-21

Malta's second National Cancer Plan (2017-21) aims to strengthen primary prevention, enhance care integration and reduce socioeconomic inequalities in access to cancer screening, cancer care and survival outcomes (Ministry for Health, 2017). Preventive activities focus on promoting healthier lifestyles, reducing environmental risk factors and enhancing attendance at cancer screening programmes. The plan also outlines efforts to:

- provide training and support to GPs and other health care professionals to increase early diagnoses
- implement fast-track referral tools
- increase integration between primary and secondary care

Malta's Cancer Plan aligns with Europe's Beating Cancer Plan, launched in February 2021 (European Commission, 2021a), which sets out a new EU approach to tackle the entire disease pathway.

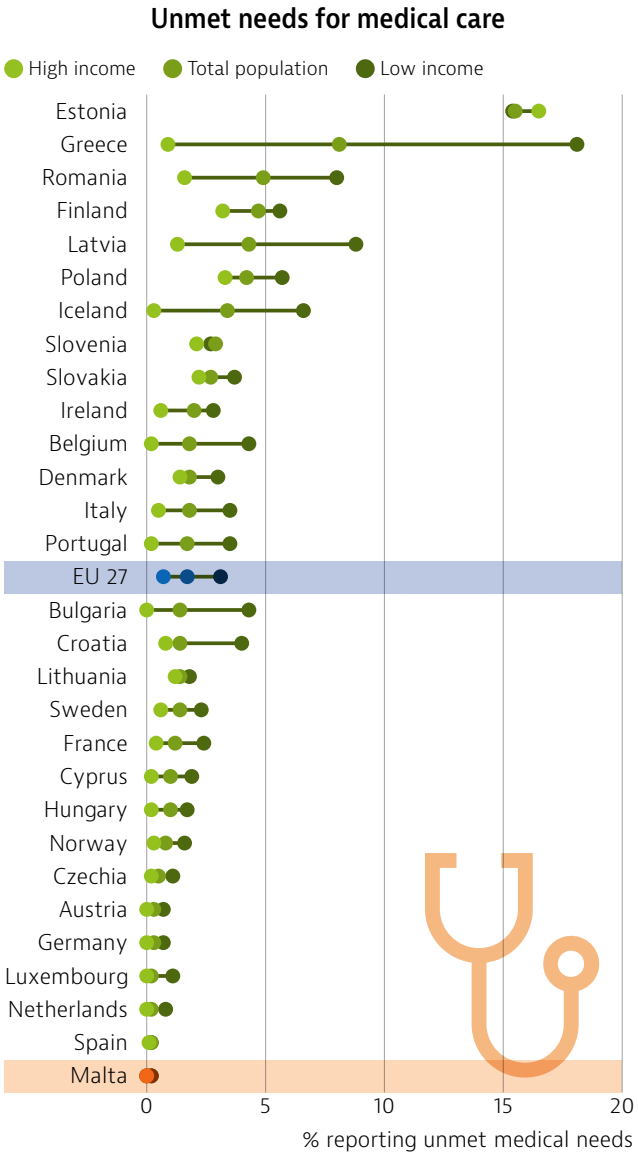
5.2 Accessibility

Malta had the lowest unmet needs for health care in the EU in 2019

The Maltese health system provides good population coverage, including for most immigrants. All residents of Malta covered by social security legislation, and refugees and asylum seekers covered by humanitarian exemptions, are entitled to access the NHS. Good population coverage contributed to Malta having the lowest reported unmet needs for medical care due to cost, distance or waiting times in the EU in 2019 (Figure 14), with little difference between high-income and low-income groups. Nevertheless, concerns are rising over access to health care for some people who enter Malta legally but are not entitled to work in the formal sector[3], and therefore cannot receive free public health care – in particular those with mental health issues or HIV (Vassallo & Borg, 2018). However, it should be noted that, in some instances, treatment will still be funded by the government on humanitarian grounds.

During the pandemic, COVID-19-related services were available free of charge to all individuals. According to Eurofound (2020) survey results, 15 % of the population reported unmet medical care needs during the pandemic, which is one of the lowest shares in the EU[4].

Figure 14. Maltese people reported almost no unmet needs for medical care prior to the COVID-19 pandemic



Note: 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 2019, except Iceland 2018).

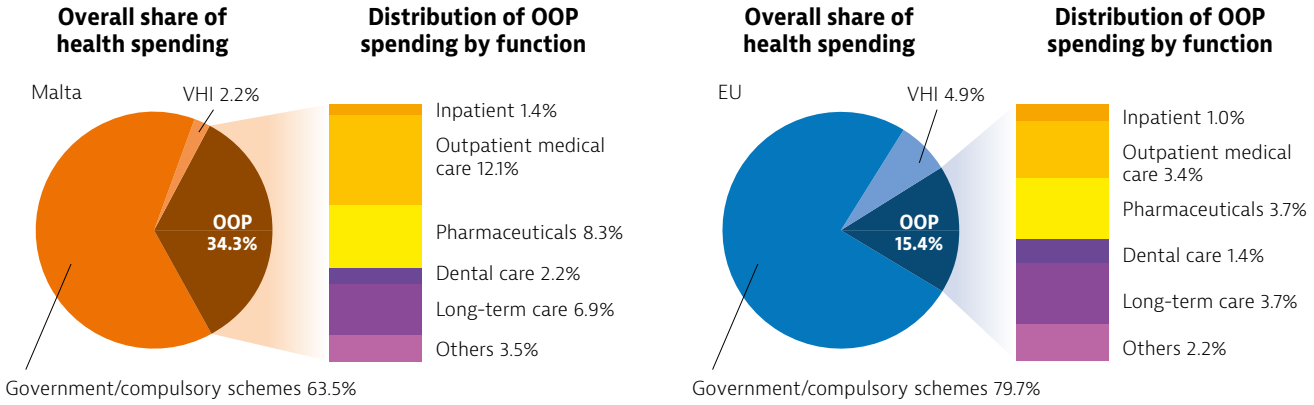
Expenditure on outpatient care and pharmaceuticals drives Malta's high out-of-pocket spending rates

Out-of-pocket (OOP) spending as a share of total health spending in Malta in 2018 was 34.3 % – the fourth highest proportion in the EU and more than twice the EU average (Figure 15). Spending on outpatient care accounted for the largest share of OOP spending. This is driven by a substantial proportion of the population opting to purchase private primary and outpatient specialist care

3. *For example, those who received humanitarian protection in another EU Member State.*
4. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies*

services, either for longstanding sociocultural reasons – Maltese people with a certain level of income and education have traditionally sought care from private practitioners – or to circumvent long waiting lists for some specialities. OOP spending on pharmaceuticals and LTC was also high. In 2018, OOP spending on health as a share of final household consumption was 5.5 %, which is about 80 % higher than the EU average of 3.1 %.

Figure 15. Outpatient medical care accounts for the largest share of out-of-pocket spending



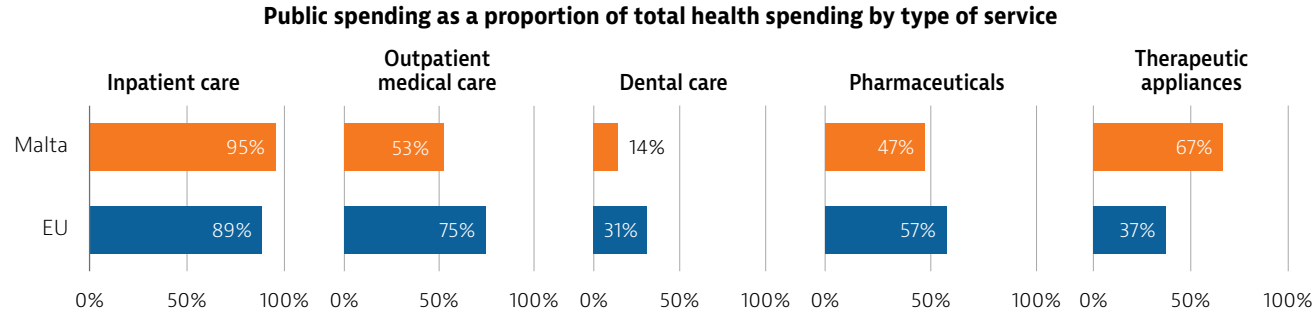
Note: The EU average is weighted. VHI = voluntary health insurance, which also includes other voluntary prepayment schemes.
Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019 for the EU and 2018 for Malta).

Low-income groups and people with certain chronic conditions can access essential medicines free of charge

Malta's NHS covers a broad benefits package, with public health care services and emergency dental care available free of charge to entitled individuals. Children under the age of 16, police and armed forces personnel and those on low incomes are also entitled to free elective dental services, prostheses, glasses and hearing aids. The rest of the population must pay out of pocket for elective dental care, which explains Malta's low share of public spending on dental care.

Medicines prescribed during hospital stays and the three days following discharge are available free of charge. Under the Pharmacy of Your Choice Scheme, people with certain chronic conditions are entitled to free medication related to that condition, while people with low incomes – as established by a means test – are entitled to receive certain medicines on the government formulary list free of charge. The Scheme covered approximately one third of Maltese residents in 2019. However, the majority of the population must pay for other prescribed pharmaceuticals out of pocket, contributing to a high share of pharmaceuticals being paid for from private sources (Figure 16).

Figure 16. The majority of inpatient care is publicly funded



Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

As a small country, Malta faces considerable challenges in ensuring availability of new medicines

Ensuring access to innovative medicines is a major challenge in Malta, and has been a policy priority in recent years. These challenges stem from various issues, including a lack of transparency over pricing and reimbursement and a small market, which limits Malta's ability to negotiate prices with pharmaceutical companies. To enhance access, Malta has made greater use of managed entry agreements, clinical pathways and protocols for evaluation of new medicines. A health technology assessment system, which applies maximum and external reference pricing and assesses whether procedures deliver value for money, was established in 2010 to guide decisions on whether to add new medicines to the government formulary list. Malta is also a founder member of the Valletta Declaration, an alliance of 10 EU Member States that aims to facilitate joint negotiations of prices and procurement of drugs with pharmaceutical companies.

Key strategies highlighted by the Malta Medicines Authority to further improve access to new medicines include stronger European collaborations and greater use of generics and biosimilars. Access to innovative and affordable medicines in Malta will be supported by the European Commission's new pharmaceutical strategy for Europe, launched in November 2020. This sets out enhanced co-operation between national authorities on pricing, payment and procurement policies, with a view to improving the affordability and cost–effectiveness of medicines (European Commission, 2020).

The COVID-19 pandemic led to a rapid rise in use of digital health tools to promote access

Use of remote consultations in primary care during the COVID-19 pandemic increased substantially to ensure continuity of care where face-to-face contact was no longer possible. Most public and private GPs shifted towards using telemedicine services with support from Malta's Medical Council, while public primary care health centres were reorganised to carry out remote medical triage for possible COVID-19 cases. A special telemedicine hub for primary care was established, staffed by approximately 30 doctors and 11 nurses, which patients can call 24 hours a day, seven days a week. Up to the end of July 2020, 15 000 people had made use of the service. Other remote services have been established, including TeleHealth Physio, which facilitates remote consultations with physiotherapists. Digital tools were also used to support remote monitoring of COVID-19 patients, with doctors assessing patients on a daily basis to help identify those at risk of deterioration.

E-prescriptions and electronic submissions for sickness certifications were also enabled through emergency directives. The transition to e-prescriptions seen during the pandemic is likely to remain permanent. To ensure quality of services, professional guidelines on safe use of remote consultations and e-prescribing were developed by Malta's Medical Council.

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[5]. As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Malta in 2020, albeit less so than many other EU countries. By the end of August 2021, Malta had recorded 440 deaths caused by COVID-19 (see Section 2). Measures taken to contain the pandemic also had an impact on the economy: Malta's GDP in 2020 is estimated to have declined by 7.0 %, compared to an EU average fall of 6.2 %.

Malta introduced a number of public health measures to contain the spread of COVID-19

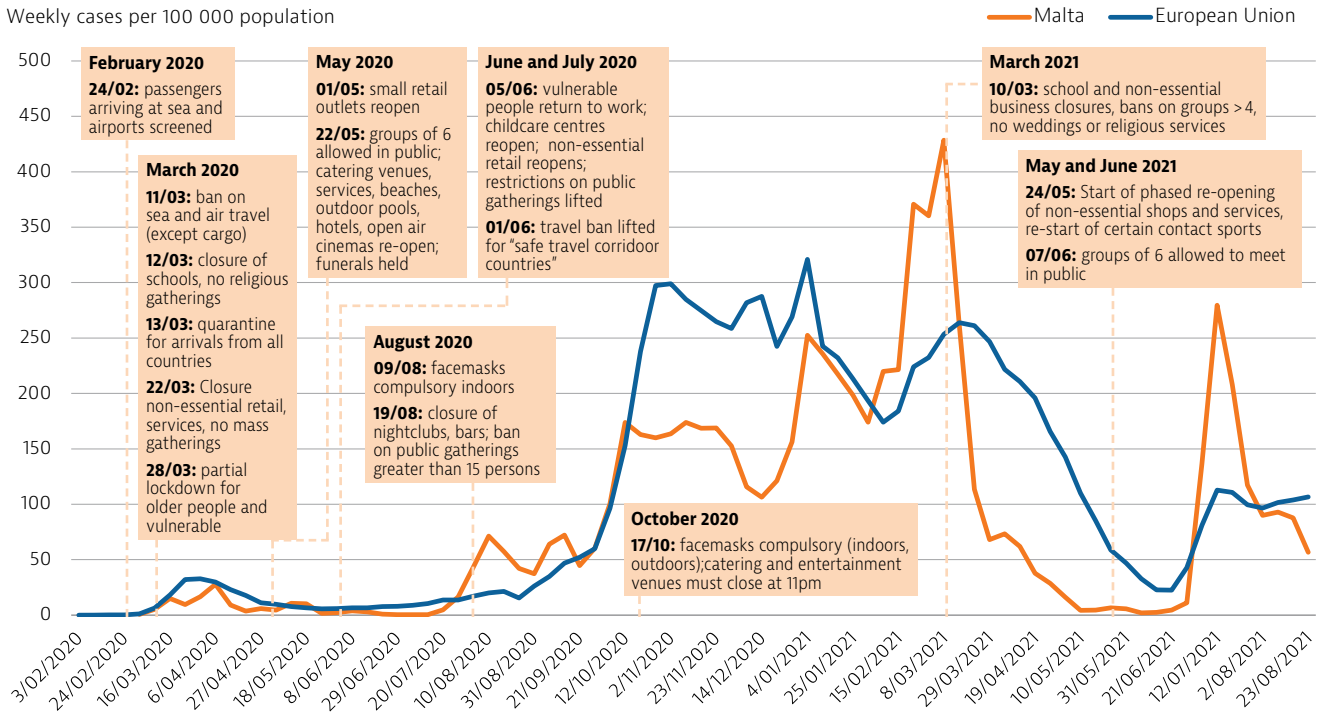
The first confirmed case of COVID-19 was recorded in Malta on 7 March 2020. A range of preventative public health measures were quickly introduced to contain transmission of the virus, including mandatory quarantine for travellers from all countries, closure of borders and shutting of schools and childcare facilities (Figure 17). Measures were further strengthened later in March, when non-essential retail and services were ordered to close and a ban on mass gatherings was imposed. Unlike many other EU countries, Malta did not resort to implementing a full lockdown or issuing stay-at-home orders for the entire population, but older people and those with chronic conditions that placed them at elevated risk of complications from COVID-19 were placed under partial lockdown. Anyone testing positive for COVID-19 was subject to mandatory isolation until being cleared by the public health authorities.

These measures initially proved effective, and contributed to Malta recording a relatively low rate of COVID-19 infections compared to the EU average during the first wave. From May to early August 2020, restrictions were gradually lifted. However, a rapid rise in cases in September saw some measures reintroduced, and it became compulsory to wear

5. *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

face masks in public spaces, including outdoors. A further spike in cases in February 2021, including variants of concern, saw restrictions tightened once more, with all non-essential businesses and services closed, schools and childcare facilities shut and mass gatherings banned. A phased reopening began from May 2021, but regulations concerning the use of face masks, limits on group gatherings and rules for using public spaces and services remained in place. A system of rules for travel during the summer season was also put in place as part of ongoing containment measures.

Figure 17. Strong containment measures helped to keep infections relatively low during the first wave



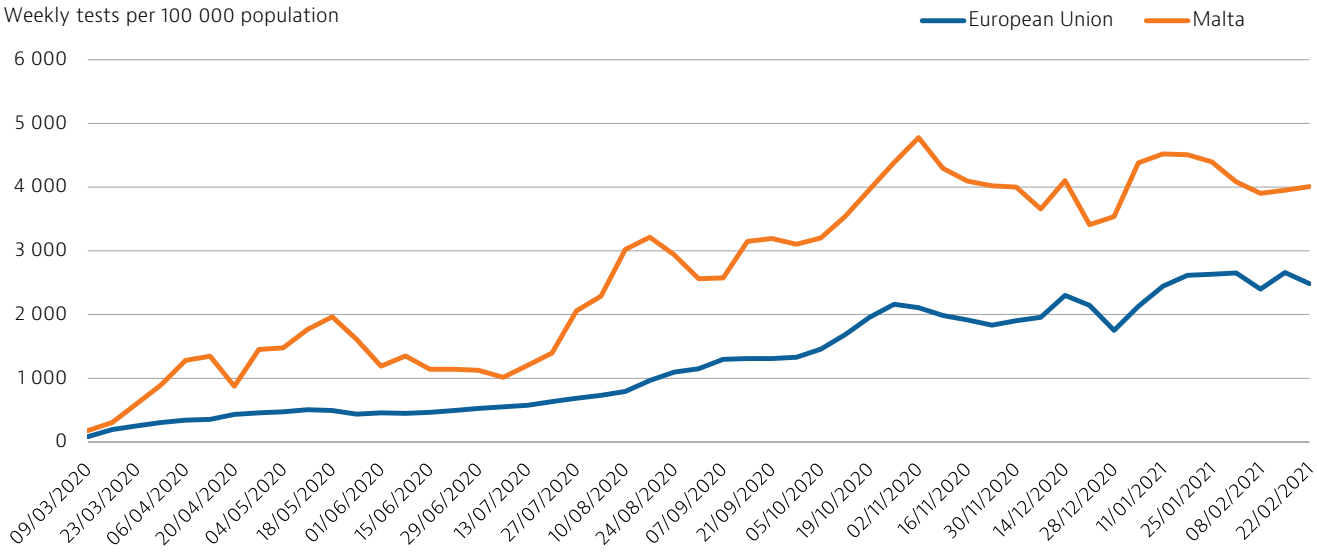
Note: The EU average is unweighted (the number of countries included in the average varies depending on the week).
Sources: ECDC for COVID-19 cases and authors for containment measures.

COVID-19 testing in Malta has been higher than in most other EU countries

Widespread testing linked to a comprehensive contact tracing programme was a cornerstone of Malta's COVID-19 strategy to support early detection and contain the spread of the virus. Throughout the first year of the pandemic, Malta was consistently one of the highest rated countries in the EU (and globally) in terms of the number of tests carried out per capita (Figure 18). By the end of February 2021, more than 4 000 tests per 100 000 population were being carried out in Malta per week – a rate 60 % higher than the EU average.

High testing rates were supported by the creation of seven drive-through testing centres on Malta and Gozo to facilitate access. Initially, only symptomatic travellers from abroad were tested, but this was expanded in March 2020 to anyone with symptoms, along with testing of asymptomatic health workers and random testing of workers in large companies. PCR testing was later made available for anyone who requested it, irrespective of symptoms. In February 2021, rapid antigen tests became available for symptomatic and asymptomatic close contacts of confirmed cases and for people from certain settings, including LTC facilities and detention centres. Testing for COVID-19 was undertaken in both public and private laboratories, with Mater Dei Hospital Laboratory serving as the reference laboratory. All providers of rapid antigen tests are required by law to register with the Malta Medicines Authority, and the Superintendent of Public Health is to be notified of all test results.

Figure 18. Levels of COVID-19 testing in Malta have been consistently high



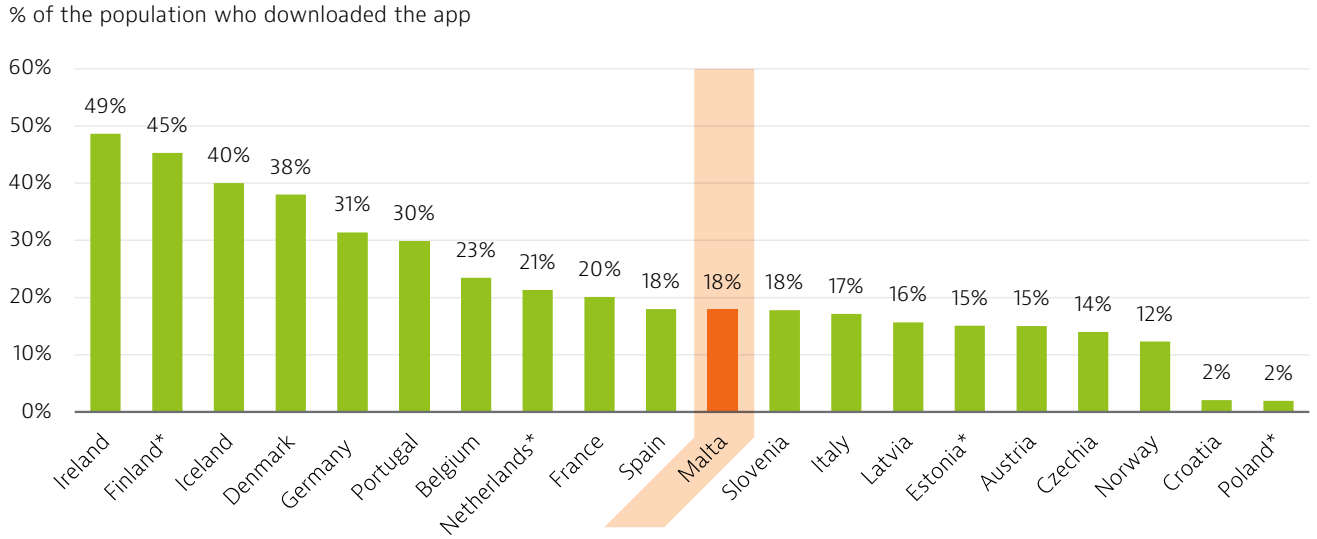
Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

A smartphone application was launched to support manual contact tracing

Contact tracing in Malta is conducted for all positive COVID-19 cases, with all contacts subject to a mandatory 14-day quarantine. While COVID-19 cases were generally contacted within 24 hours, and contacts traced within four days, a surge in cases in the first few months of 2021 stretched the system, leading to significant delays in case management. Due to a shortage of professional contact tracers, tourism workers who were unemployed as a result of the pandemic were recruited to support public health professionals with contact tracing efforts.

To complement manual contact tracing, Malta launched the "COVIDAlert Malta" application in September 2020. This uses Bluetooth technology to exchange random codes with users if they have been in close contact with another user who tests positive for COVID-19. The app does not store or share personal details, and connections between the app and server are encrypted to protect privacy (COVIDAlert Malta, 2021). The voluntary app had been downloaded by 18 % of the population by January 2021 (Figure 19). As in other countries, its effectiveness and contribution to helping contact tracing efforts is currently unknown. Malta's app is currently inter-operable with national apps in other EU countries, enabling use across borders (European Commission, 2021b).

Figure 19. One in five people have downloaded Malta's contact tracing app



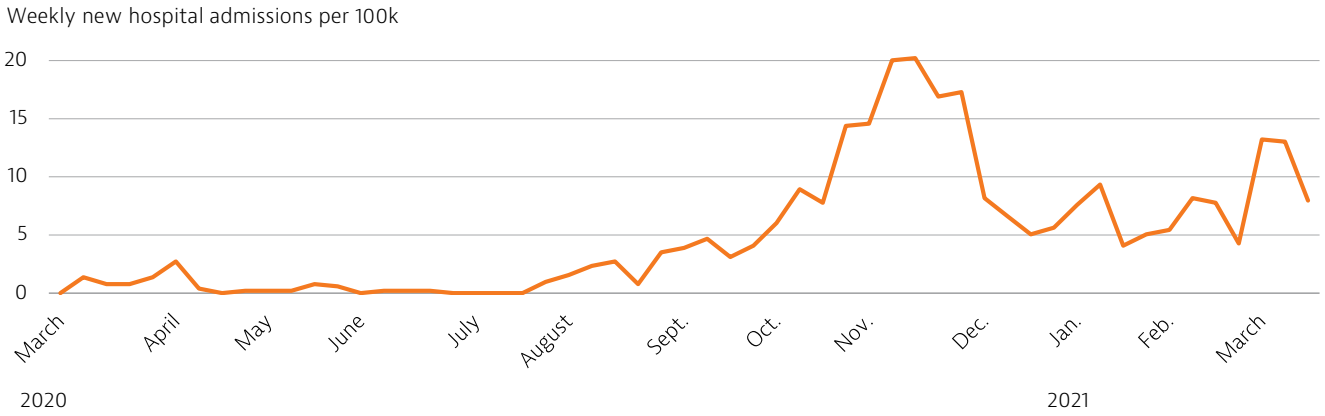
*Note: Data as of April 2021. * Data to Autumn 2020.*
Source: National data.

Malta took rapid action to scale up hospital bed capacity

Prior to the COVID-19 pandemic, Malta had lower numbers of curative care beds (319 per 100 000 population) and intensive care unit (ICU) beds (5.4 per 100 000 population) than the EU averages. In anticipation of a rise in demand for care, rapid action was taken to increase surge capacity in hospitals. The number of ICU beds was increased five-fold from 20 to over 100, with ICU beds from different wards also converted into ICU beds for COVID-19 patients. An additional 600 beds were created in non-clinical areas of Mater Dei Hospital, private medical facilities and some state-owned health facilities for COVID-19 patients. Elective surgeries and elective outpatient services were postponed from mid-March to mid-May 2020 to focus resources on COVID-19 patients and urgent care.

To manage supplies, Mater Dei Hospital created a COVID-19 Emergency Operation Centre to simulate predicted demand and supply, using real-time data on indicators such as current bed occupancy levels in different wards (Cuschieri et al., 2020). While hospitalisations remained low during the first wave, they rose rapidly from September 2020 (Figure 20), but never exceeded capacity. At the peak of the second wave in March 2021, additional COVID-19 ICU units were utilised, but following the re-introduction of restrictive public health measures, together with the vaccine rollout, hospitalisations decreased markedly.

Figure 20. Hospital admissions were low during the first wave, but rose rapidly from September 2020



Sources: National data sources as reported to TESSy database; ECDC (2021).

Multifaceted actions were taken to increase surge capacity of the health workforce

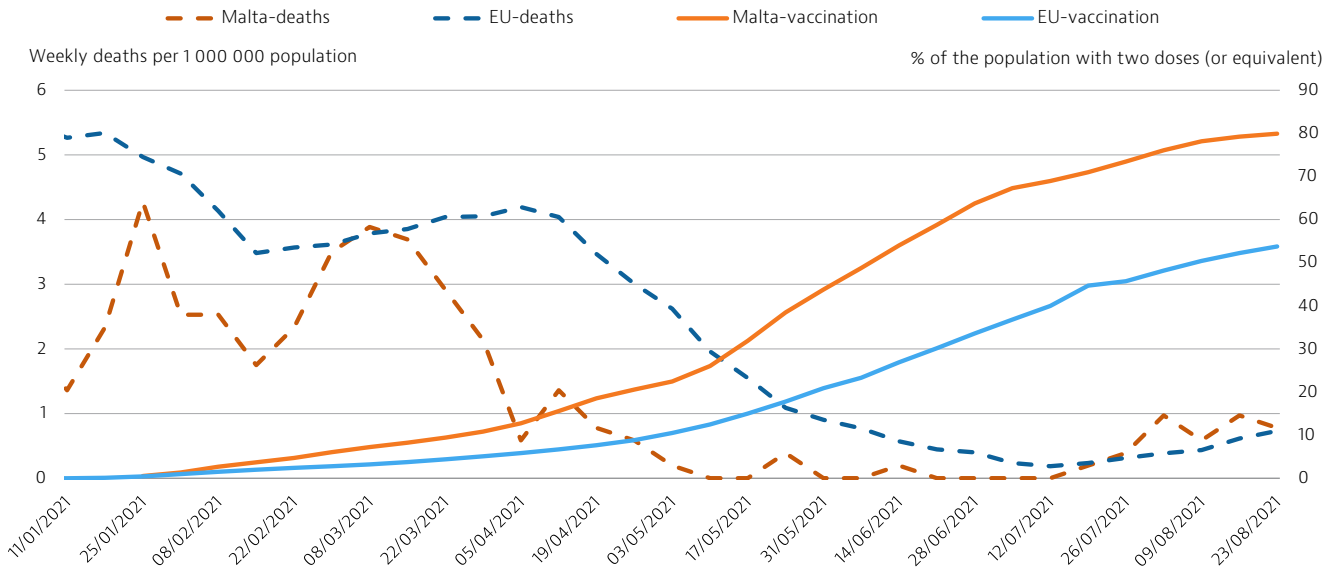
Malta implemented multifaceted strategies to maintain and enhance the capacity of the health workforce during the COVID-19 crisis. Many health professionals working in the public sector were redeployed from primary care settings to hospitals, and from usual hospital wards to COVID-19-designated wards. Final-year medical and nursing students were allowed to graduate early to assist health professionals; some private sector health professionals were offered temporary employment in the public sector; and volunteers were recruited to assist with tasks such as answering COVID-19 helplines. Public health specialists working in regulatory bodies, ministries and other agencies were also redeployed to assist with coordination, case management and contact tracing.

Malta's COVID-19 vaccine programme began in December 2020 and progressed quickly

The rollout of Malta's COVID-19 vaccination programme began on 21 December 2020, following authorisation of the Pfizer/BioNTEch vaccine by the European Medicines Agency. Everyone in Malta with a valid residency card is eligible to receive a COVID-19 vaccine free of charge. Malta's vaccine rollout progressed quickly, and by the end of August 2021, over 80 % of the population had received two doses (or equivalent), which was the highest share in the EU at that time (Figure 21).

Malta implemented a priority list guiding vaccine rollout, starting with health and LTC workers, people residing in LTC facilities and those aged 85 and over. Subsequent priority groups included other front-line workers (such as police and armed forces), people with chronic conditions that place them at increased risk of COVID-19 complications, staff at schools and childcare centres, and population groups based on descending age. Vaccines are administered by nurses and other health care workers, including volunteers and students.

Figure 21. Malta's COVID-19 vaccination rate was the highest in the EU by the end of August 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World In Data for vaccination rates.

New investment in the health sector aims to improve resilience and sustainability

As noted in Section 4, an additional EUR 130 million in public spending was committed to the health sector during 2020 to respond to COVID-19. In the 2021 budget, further funding for the health sector to combat COVID-19 was committed through the creation of a "pandemic reserve". This will primarily be used to hire additional health facilities to ensure that acute care can continue to be provided, and to have flexible resources in terms of PPE, respirators and beds; this will be necessary to upscale health services in the event of another pandemic shock or similar event. The introduction of clinical management systems and a telemedicine client support centre to facilitate communication between health care professionals and patients will also be supported.

The 2021 budget also commits funding to support longer-term health sector objectives. Prevention activities will be strengthened by training health care professionals, as well as through information and educational campaigns to encourage citizens to take action to improve their own well-being. Support for cancer patients will be enhanced through improved access to oncological drugs and treatment, development of a national strategy for palliative care and a facility for delivery of inpatient hospice care. Health sector infrastructure will continue to be strengthened through development of a new outpatient building at Mater Dei Hospital, together with modernisation of health centres and community clinics across Malta and Gozo.

Reforms to improve the resilience and sustainability of the health sector will be further supported by the EU's Recovery and Resilience Facility. Under this Facility, Malta has requested grants of EUR 50 million to establish a new Blood, Tissue and Cell Centre; invest in new technologies and digitalisation, including of the pathology function; improve radiotherapy delivery; and develop the new outpatient facility (Government of Malta, 2021). Additional grants have been requested to improve the energy efficiency of public hospitals, which will also contribute to fiscal sustainability.

Investing in digital health is a key strategy to improve efficiency, care coordination and access

The Maltese government has acknowledged the importance of developing digital health technologies to strengthen the resilience of the health sector. Plans are in place to support the digital management of medical and clinical patient information and to provide physicians with access to real-time patient data. Establishment of integrated electronic patient records across the primary health care system will see paper-based record-keeping being replaced by electronic notes that link up to other relevant health information technology systems within the Maltese health care system (Ministry for Health, 2020).
The project is supported by the European Regional Development Fund. Malta's ambitions in the area of digital health will be supported by the development of a new European Health Data Space (European Commission, 2021c), which aims to promote better exchange and access to different types of health data (such as electronic health records, genomics data and data from patient registries), to support health care delivery as well as health research and policy making.

6 Key findings

- Life expectancy in Malta is high, but income-based disparities in health status persist. Strong public health policies contribute to low levels of preventable mortality, and deaths from treatable causes have declined substantially in recent decades as a result of improved health system performance. Further reductions in cancer mortality are targeted through stronger and more equitable access to primary prevention and treatments and improved care integration.

- Obesity rates among adults and adolescents in Malta are the highest in the EU. Recent legislation regulating advertising and food provision in schools, along with inter-sectoral investment to promote a culture of physical activity, aims to help tackle this major public health challenge. Prevention overall will be strengthened through training of health professionals and encouraging citizens to improve their own health and well-being.

- Life expectancy in Malta fell by 0.3 years in 2020 as a result of the COVID-19 pandemic, which is below the average decline of 0.7 years recorded across the EU. Until early 2021, widespread testing linked to contact tracing alongside other public health measures contributed to Malta having a lower rate of infection than the EU average. A strong rise in cases in early 2021 put pressure on the health care system, but the rapid rollout of the vaccination programme saw over 80 % of the population vaccinated by August 2021– helping to reduce hospital admissions and deaths. Additional public funding was committed to the health sector during 2020 to support the COVID-19 response – in particular, to procure personal protective equipment and to scale up hospital and health workforce capacity.

- Malta's National Health Service provides good access to care to the population, and levels of unmet needs for care are the lowest in the EU. However, out-of-pocket spending is high, primarily due to private expenditure on primary and outpatient care and on pharmaceuticals prescribed in these settings. Private care is often purchased to bypass waiting lists for certain outpatient services in the public sector. Long waiting lists are a persistent challenge, and are likely to increase due to delayed treatments during the COVID-19 pandemic.

- Malta enhanced the use of digital technologies during COVID-19 to support communication, surveillance and monitoring, and provision of remote services. Use of e-prescriptions, clinical management systems and a telemedicine hub are likely to remain after the pandemic. Greater use of digital health technologies is acknowledged as a key strategy to support efficiency, access and the sustainability of the health sector.

- Strengthening primary and outpatient care has been a health system objective in Malta for the past two decades to shift service delivery away from more expensive hospital settings and improve care for chronic conditions. A new outpatient building at Mater Dei Hospital and two regional primary care hubs are being built, while health centres and community clinics across the country are being modernised. Reorienting service delivery towards more cost-effective settings will help improve health system sustainability.

- Ensuring availability of affordable medicines is a critical challenge facing Malta as a small country. Increased use of managed entry agreements and clinical protocols for the evaluation of new medicines have contributed to improved availability in recent years. Initiatives to promote stronger cross-border collaboration, joint procurement and price transparency will work to enhance access.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

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/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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