

State of Health in the EU

Malta

Country Health Profile 2019

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 Information.

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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 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: <http://www.oecd.org/health/Country-Health-Profiles-2019-Malta.xls>

Demographic and socioeconomic context in Malta, 2017

Demographic factors

	Malta	EU
Population size (mid-year estimates)	468 000	511 876 000
Share of population over age 65 (%)	18.8	19.4
Fertility rate ¹	1.3	1.6

Socioeconomic factors

GDP per capita (EUR PPP ²)	29 300	30 000
Relative poverty rate ³ (%)	16.7	16.9
Unemployment rate (%)	4.0	7.6

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.

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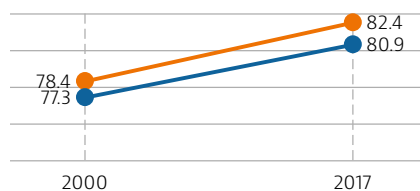
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1 Highlights

Malta's population enjoys generally good health and one of the longest life expectancies in the EU. Nevertheless, high obesity rates among adults and adolescents pose a serious threat to public health. The National Health Service provides universal coverage for a comprehensive benefit package, while the private sector plays a key role in the delivery of primary care. Strengthening primary care to improve efficiency and better serve those living with chronic conditions is an important policy goal.

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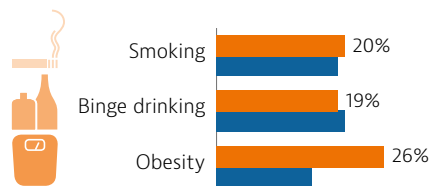


Life expectancy at birth, years

Health status

Life expectancy at birth has increased substantially since 2000, reaching 82.4 years in 2017, which is among the highest in the EU. These gains have been driven by declining mortality from some treatable cancers and cardiovascular diseases. Maltese people spend the majority of their lives in good health, with 67 % of life after age 65 spent without chronic diseases and disabilities, a far higher share than the EU average. However, the prevalence of diabetes is growing and socioeconomic inequalities in life expectancy and self-reported health status persist.

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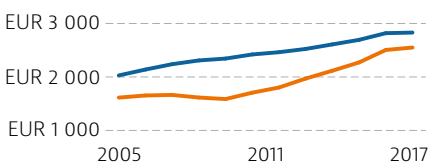


% of adults

Risk factors

Malta has the highest obesity rates in the EU, presenting a major public health challenge. More than a quarter of adults in 2017 and one third of 15-year-olds in 2013–14 were overweight or obese. Heavy alcohol consumption is also an increasing concern among adolescents. Overall, smoking rates among adults have remained stable since 2008 and remain slightly above the EU average. Many behavioural risk factors are more common among individuals with low education, contributing to health inequalities.

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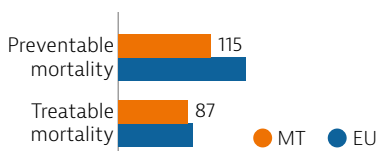
Per capita spending (EUR PPP)

Health system

Malta recorded one of the largest increases in per capita health expenditure in the EU over the last decade. Health spending per person in 2017 was EUR 2 732, more than 60 % higher than in 2007, although it remains below the EU average. This equates to 9.3 % of GDP, also below the EU average of 9.8 %. Although the health system provides practically universal coverage, out-of-pocket spending in 2017 was the joint fourth highest in the EU (34.6 % compared to an average of 15.8 %), due to high private spending on outpatient services, primary care and pharmaceuticals.

Effectiveness

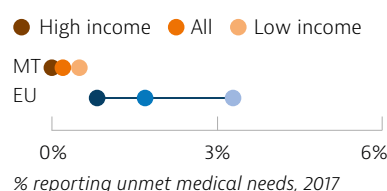
Effective public health policies have contributed to low preventable mortality rates, but scope remains to reduce mortality from treatable causes by improving timely access to quality acute care.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

Unmet needs for medical care are low, with little variation between income groups. Long waiting lists for inpatient care have been successfully reduced, but remain an important issue for specialist outpatient services.



% reporting unmet medical needs, 2017

Resilience

Despite the favourable economic outlook in Malta, projected spending increases due to population ageing pose some fiscal sustainability risks in the long term. Reorienting service delivery away from hospitals towards primary care to improve efficiency and reduce public spending remains a key priority.



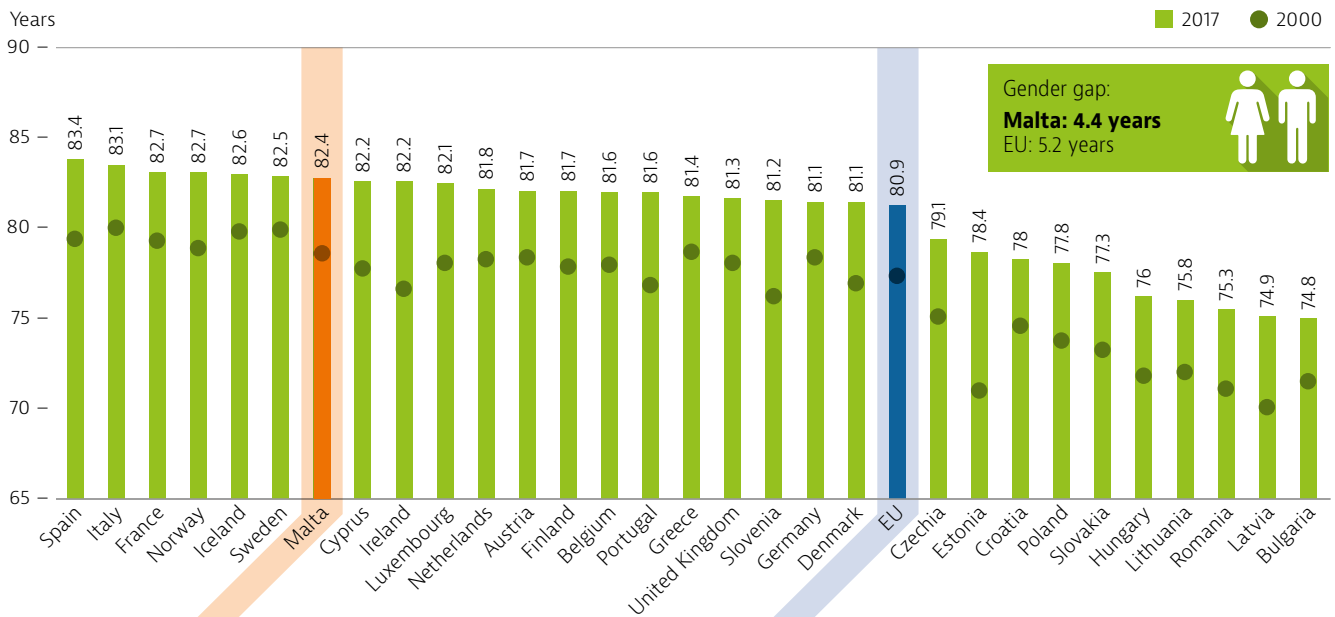
2 Health in Malta

Life expectancy is among the highest in the EU

Life expectancy at birth in Malta was 82.4 years in 2017, among the highest in the EU and 1.5 years higher than the EU average (Figure 1)¹. Life expectancy at birth has increased by more than four years since 2000, higher than the average increase across the EU.

Women can expect to live almost four and a half years longer than men (84.6 compared to 80.2 years), though this gender gap in life expectancy is smaller than the EU average (5.2 years). Maltese people spend the majority of their lives in good health, and in 2017 had the highest healthy life expectancy at birth for women in the EU (73.6 years) and the second highest for men (71.9 years) after Sweden.

Figure 1. Life expectancy at birth in Malta is one and a half years higher than the EU average



Source: Eurostat Database.

Mortality rates are declining for cardiovascular diseases, but have slightly increased for diabetes and some cancers

Gains in life expectancy have been driven by a marked reduction in the mortality rate from cardiovascular diseases, which fell by almost 50 % between 2000 and 2016 (Figure 2). Cardiovascular diseases nevertheless remain the leading cause of death for both men and women, accounting for two in every five deaths in 2016. Cancers were the second leading cause of mortality, responsible for almost 27 % of all deaths.

Considering individual disease-specific causes of mortality, one out of every five deaths in Malta in 2016 was attributable to ischaemic heart disease, with stroke accounting for 8.3 % of all deaths, making it the second leading individual cause of mortality in the country. The mortality rate from diabetes has remained relatively stable since 2000, with a slight increase seen in recent years.² However, rates

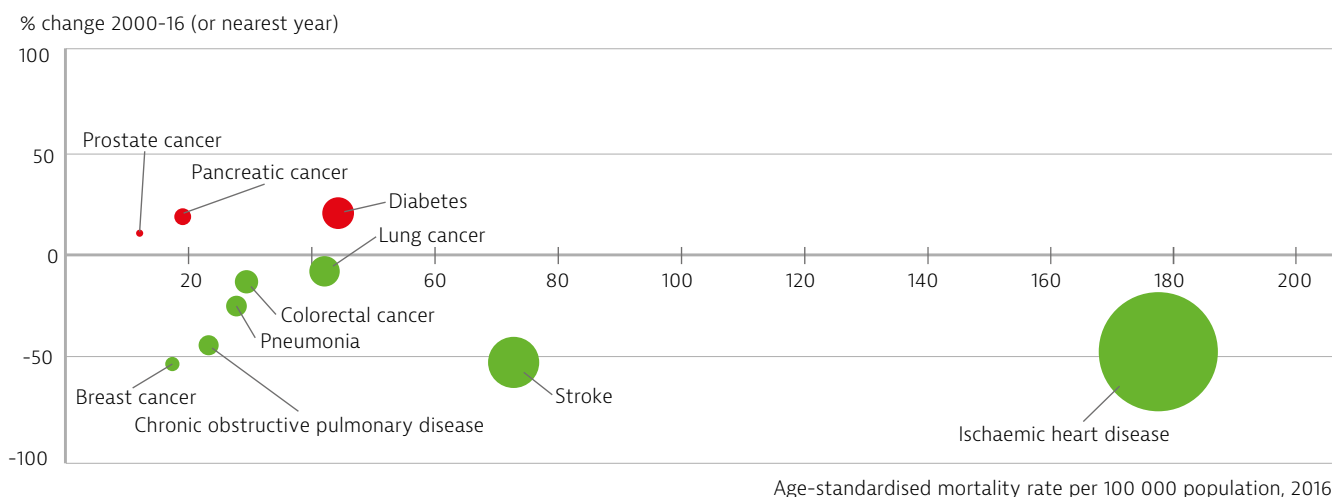
of diabetes are the third highest in the EU, which is likely linked to the high prevalence of obesity in Malta (Section 3).

In the last 15 years, the mortality rate from breast cancer has fallen markedly, declining from the highest in the EU in 2000 to below the EU average in 2016. The mortality rate from lung cancer, the most common individual cause of cancer deaths in 2016, has remained stable and is among the lowest in the EU. However, a rising trend has been observed in lung cancer mortality in women. Deaths from prostate cancer are among the lowest in the EU and, despite a slight increase from 2015 to 2016, the overall trend in mortality from prostate cancer continues to decline. Similar progress has not been observed for pancreatic cancer, with death rates in men continuing to rise. A second National Cancer Plan has been launched that builds on the first plan and aims to further improve prevention and treatment of cancer in Malta (Section 5.1).

1: Contrary to the Health at a Glance approach, 3-year averages for life expectancy, healthy life expectancy and mortality rates are not used in Country Health Profiles for Cyprus, Luxembourg, Malta and Iceland.

2: Changes to the coding practice for diabetes account for much of the observed increase in recent years.

Figure 2. Cardiovascular diseases remain the main causes of deaths in Malta



Note: The size of the bubbles is proportional to the mortality rates in 2016. Source: Eurostat Database.

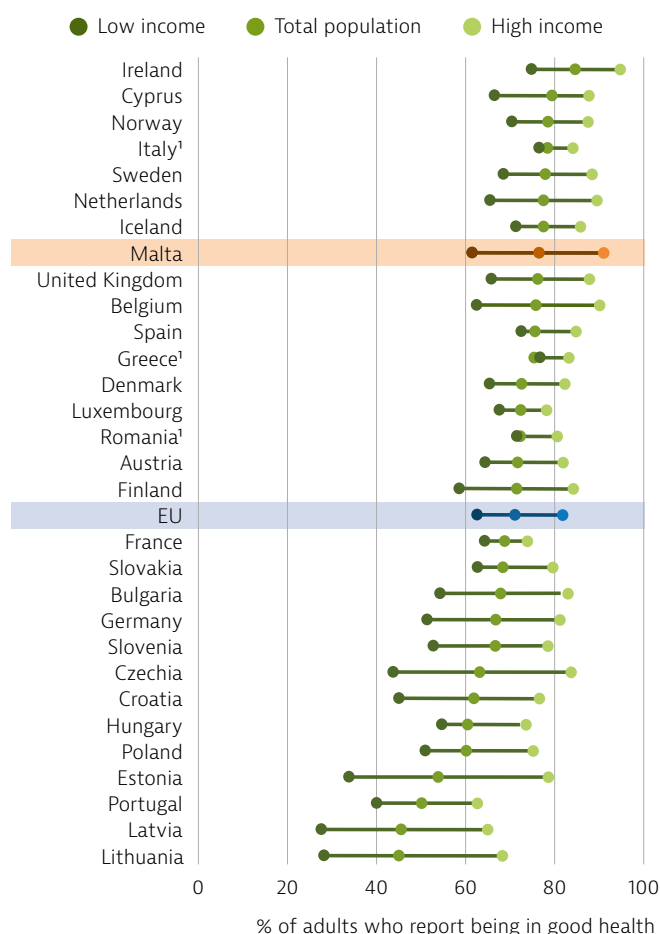
HIV remains an important public health challenge

In 2017, Malta reported the third highest notification rate of new HIV cases in the EU. Although the rate of newly reported cases of 10.4 per 100 000 population was lower than in 2016 (14.5 per 100 000 population) (ECDC/WHO, 2018), HIV remains an important public health issue. Rates of newly diagnosed cases overall have increased by more than 50 % since 2008, in contrast to a general downward trend observed across the EU (ECDC/WHO, 2018). Efforts to improve diagnosis rates, which remain below the EU average, are being supported by increased provision of rapid-testing HIV kits. In addition, a new HIV strategy is being outlined and new HIV treatment lines are being procured. However, meeting the costs of new medicines for the increasing number of people living with HIV remains a major challenge.

There are substantial disparities between income groups in terms of self-reported good health

Three quarters of the Maltese population reported being in good health in 2017 (Figure 3). However, disparities among income groups are substantial, with nine in ten people in the highest income quintile reporting good health compared to only six in ten in the lowest income quintile. More men than women report being in good health (77.2 % compared to 73.5 %), but this gap is smaller than the EU average (5 percentage points).

Figure 3. Three quarters of the population in Malta report being in good health, but with sizeable inequalities by income group



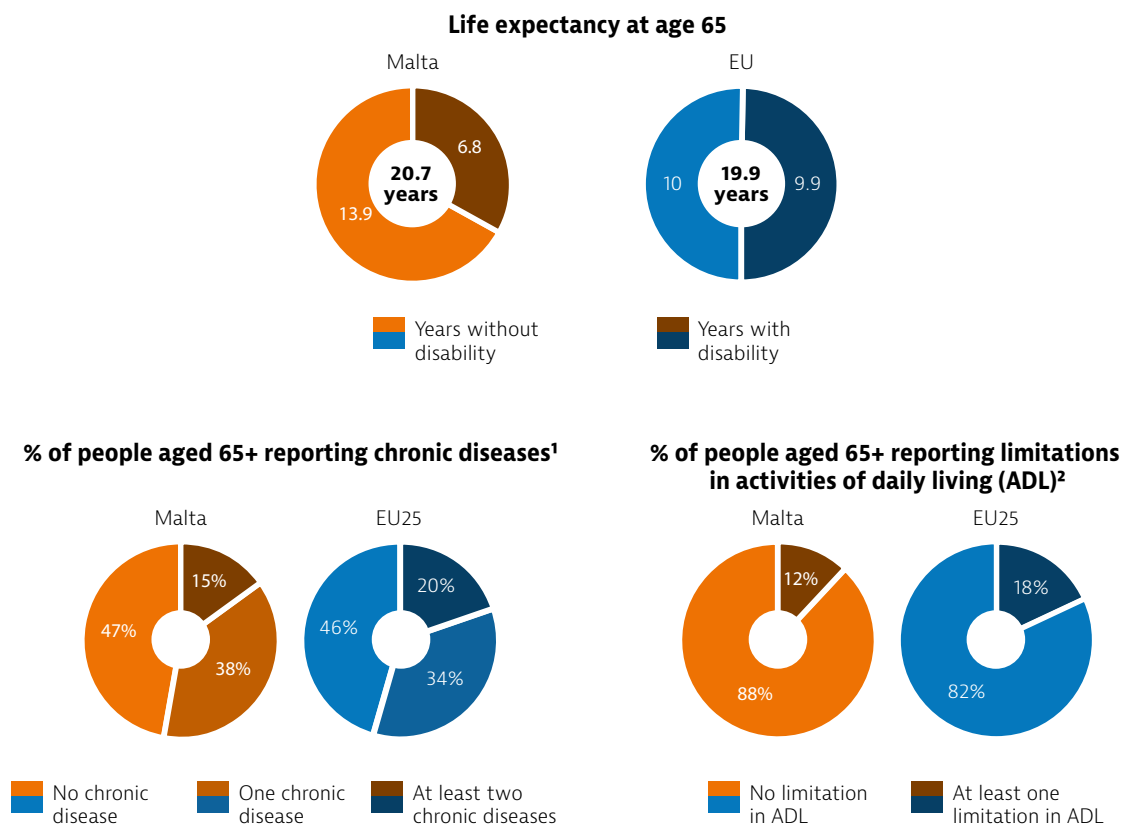
Note: 1. The shares for the total population and the low-income population are roughly the same. Source: Eurostat Database, based on EU-SILC (data refer to 2017).

The Maltese population live over half of life after age 65 free of health problems and disabilities

Life expectancy at age 65 in Malta is the fourth highest in the EU. In 2016, Maltese people aged 65 could expect to live an additional 20.7 years, four years more than in 2000. Two thirds of this time is spent free of chronic diseases and disabilities, which is far higher than the EU average (Figure 4). The gender gap in life expectancy at age 65 is over three years in favour of women (19.0 years for men

compared to 22.2 years for women). Yet, there is no gender gap in the number of healthy life years³ at age 65 because women on average live a greater proportion of their lives after this time with some health issues or disability. Just over half of people aged 65 and over report having at least one chronic disease, a proportion that is similar to other EU countries. However, only about one in eight people in this age group report severe disabilities in the form of limitations in basic activities of daily living, such as dressing and showering, lower than the average rate across the EU.

Figure 4. In Malta, the majority of years beyond age 65 are spent free from disability



Note: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson disease, Alzheimer's disease, rheumatoid arthritis and osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet. Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

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

3 Risk factors

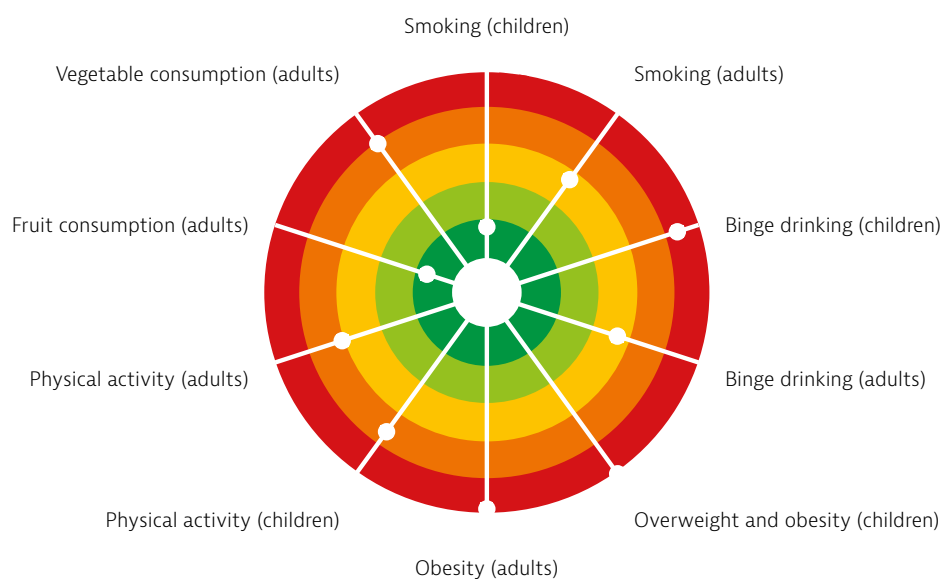
Two in five deaths can be attributed to behavioural risk factors

Almost two in five deaths in Malta can be attributed to behavioural risk factors, close to the EU average of 39 % (IHME, 2018). Dietary risks, including low vegetable and fruit intake, and high sugar and salt intake, were linked to one in five deaths in 2017, with tobacco consumption (including direct and second-hand smoking) and low physical activity responsible for an estimated 17 % and 4 % of all deaths respectively (IHME, 2018).

Obesity is a major public health threat

Obesity rates in Malta have risen over the past decade and are now the highest in the EU for both adults and children (Figure 5). One in four adults in 2017 and almost one in three 15-year-olds in 2013–14 were obese. These high rates are driven by a number of factors, such as sedentary lifestyles, larger portion sizes, access to ready-made foods and the traditional Mediterranean diet increasingly being replaced by intake of unhealthy foods. In 2017, only half of adults reported eating vegetables daily, while two in five did not undertake the recommended level of 150 minutes of moderate physical activity per week. Physical activity among 15-year-olds is also below the EU average (9 % for girls and 16 % for boys), but daily vegetable consumption is relatively high (32 % for girls and 38 % for boys). A series of intersectoral actions have taken place in recent years to address the obesogenic environment (Section 5.1).

Figure 5. Obesity and excessive alcohol consumption among children are major public health issues 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.

Source: OECD calculations based on ESPAD survey 2015 and HBSC survey 2013–14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

Smoking rates among adolescents have declined substantially

One in five adults in Malta reported smoking daily in 2014, a higher proportion than the EU average. Smoking rates are higher for men (23 %) than women (17 %). Smoking rates among adults overall have remained stable since 2008, in contrast to a general downward trend in most EU countries. More positively, smoking rates among 15- to 16-year-olds in the last 10 years have fallen substantially and were the fifth lowest in the EU in 2015. Smoking rates have declined faster among boys than girls, with reported cigarette use during the past 30 days in 2015 higher for girls (17.6 %) compared to boys (11.6 %).

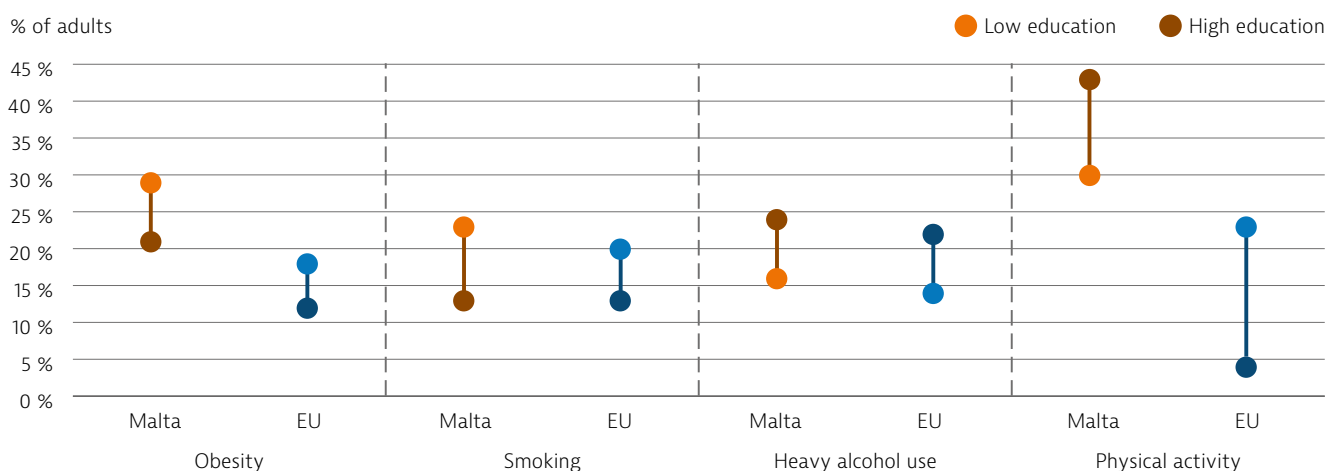
Excessive alcohol consumption among teenagers is a public health concern

Almost one in five adults in Malta reported heavy alcohol consumption at least once a month in 2014, which is similar to the EU average. Heavy drinking was more than twice as high for men than women, with one in four men compared to one in eight women reporting binge drinking⁴ at least once a month. Heavy alcohol consumption among 15-to 16-year-olds has declined since 2007, but remains a public health concern. Half of 15-to 16-year-old girls and 45 % of boys reported at least one episode of binge drinking during the past month in 2015, above the EU average.

Socioeconomic inequalities have a negative impact on health behaviours

Sizeable disparities in health behaviours according to educational attainment are observable in Malta (Figure 6)⁵. In 2014, individuals who had not completed their secondary education were 1.8 times more likely to report smoking than those with a tertiary education, compared to 1.5 times more likely across the EU as a whole. Similarly, in 2014 almost 1 in 3 people without a secondary education in Malta were obese (28.9 %), compared to 1 in 5 (20.7 %) among those with a higher education. Adults with a tertiary education were also 1.5 times more likely to undertake at least 150 minutes of health enhancing physical activity per week in Malta compared to individuals that had not completed secondary education, although this gap is smaller than the EU average (1.8 times higher among better education individuals). The unequal distribution of these health behaviours according to education contributes to important inequalities in health outcomes and life expectancy. It should, however, be noted that heavy alcohol use was almost 1.6 times higher in adults with a tertiary education compared to those with low education in both Malta and the EU, suggesting better educated individuals may, to some extent, be more likely to engage in risky behaviours related to alcohol consumption. A cross-sectoral response to address health inequalities and their causes in Malta has been launched (see Section 5.3).

Figure 6. Inequalities in obesity and smoking rates according to educational attainment are higher in Malta than the EU average



Source: Eurostat Database (data refer to 2014 or nearest years).

4: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for children.

5: Lower education levels refer to people with less than primary or lower secondary education (ISCED levels 0-2) while higher education levels refer to people with tertiary education (ISCED levels 5-8). Inequalities in 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.

4 The health system

The National Health Service provides practically universal coverage

Malta's health system is a tax-financed National Health Service (NHS) that provides virtually universal coverage to all residents. Health governance, regulation and financing are centralised under the Ministry for Health. The Ministry is also the main provider of public health care services, with the private sector complementing provision, particularly for primary care and outpatient services. Until recently, a purchaser-provider split only existed when a specific service was outsourced to the private sector, mainly to overcome long waiting lists in the public sector. However, a major reform implemented in 2017 saw the government contract a private, for-profit company to develop and manage three hospitals in Malta and Gozo (see Box 1).

Health spending per capita has increased substantially in the last decade

Malta has seen one of the largest increases in total health expenditure per capita in the EU over the past decade. From 2007 to 2017, per person spending increased by more than 60 %, to reach EUR 2 732, yet this remains below the EU average of EUR 2 884 (Figure 7). A significant increase in the public share of health spending from 2008 onwards saw total health expenditure reach 9.3 % of GDP in 2017, only marginally below the EU average of 9.8 %. When measured as a share of GDP, health spending in Malta

declined from 2015 to 2017 as a result of Malta's robust economic performance, which has seen rising health spending absorbed by strong and sustained GDP growth.

The share of public spending in total health spending was 63.6 % in 2017, below the EU average of 79.3 %. This share is relatively low for a predominantly tax-financed European health system and reflects high private expenditure in the form of out-of-pocket (OOP) payments (Section 5.2). Public spending as a percentage of current health expenditure nevertheless increased in 2016 as a consequence of a 12.5% increase in the health budget.

Financial support from the European Structural and Investment Funds (ESIF) has played an important role in the health sector in recent years, with EUR 29 million allocated for health care infrastructure investment for 2007-13, accounting for 1.2 % of Malta's health expenditure during the period. Malta was allocated a further EUR 19 million under the current ESIF programme (2014-20) to support primary care strengthening, upskilling of health workers, developing eHealth and digital technology, promoting healthy and active ageing and reducing health inequalities (European Commission, 2016).

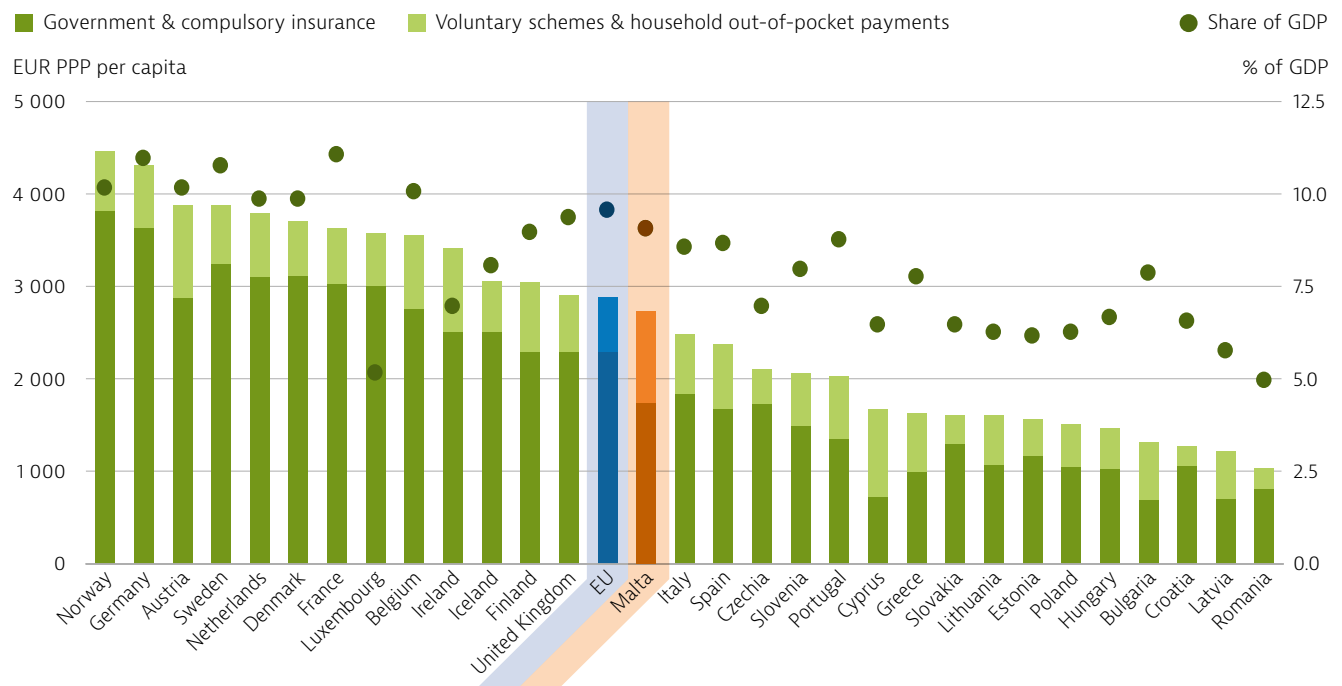
Box 1. A public-private partnership aims to enhance hospital capacity

The Maltese government entered into a public-private partnership in 2016 to transfer responsibility for the refurbishment, development and management of three public hospitals to a private contractor (Section 5.3). The initiative brings a purchaser-provider split into the hospital sector with the Ministry of Health now acting as a commissioner of services. The original idea was to encourage medical tourism as part of the project, as well as the construction of a new medical school. The development of the medical school has been completed, but capital investment projects in the three hospitals have been delayed.

The deal has undergone much public scrutiny over transparency of ownership, with the original

contractor entering insolvency after receiving EUR 150 million without delivering on obligations. The contract is now being investigated by the National Audit Office. In 2018, the partnership was transferred to Steward Health Care, the largest private hospital operator in the United States, and a revised timeline for delivery of the projects is under negotiation. The Ministry for Health is in the process of developing capacity building in service commissioning through a project funded by European Structural Funds. This function is critical to guaranteeing careful monitoring in order to ensure that government investment in this partnership improves quality of care while maintaining equitable access and safeguarding health system sustainability.

Figure 7. Health spending per capita and as a share of GDP are now close to the EU average



Source: OECD Health Statistics 2018 (data refer to 2017).

Total health expenditure on outpatient care exceeds spending on hospital services

Outpatient services were the largest function of total health spending in 2017 with a 29 % share of total health expenditure, followed by inpatient services with a 26 % share. On a per capita basis, spending on both inpatient and outpatient care is below the EU average (Figure 8). Spending on prevention is more than two times lower than the EU average and accounts for just 1.3 % of total health spending compared to an EU average of 3.2 %. Low spending on prevention may suggest some allocative inefficiency in the health system and strengthening health promotion and prevention remains a health sector priority. Per person spending on pharmaceuticals and medical devices is, however, above the EU average. A relatively large proportion of this spending is private due to persistent challenges in funding innovative medicines that are much needed in the public sector through public sources. A number of recent initiatives aim to enhance availability of cheaper, therapeutically equivalent medicines (Section 5.3). Long-term care spending per capita is also relatively high and is expected to rise further in coming decades as the absolute number of older people in Malta increases.

Entitled individuals can access a comprehensive benefit package

Entitlement to public health services in Malta is practically universal. All residents covered by social

security legislation or a humanitarian exemption are entitled to access a comprehensive basket of publicly provided health services. The majority of these services are provided free at the point of use, with cost-sharing virtually non-existent in the public system. The provision of some services, such as elective dental care, optical services and certain formulary medicines, is nonetheless subject to a means test. All medicines prescribed during inpatient care in public hospitals and three days post-discharge are available free of charge to entitled individuals and for outpatient treatment for certain chronic conditions, but other medicines and medical devices must be paid for out of pocket (Section 5.2).

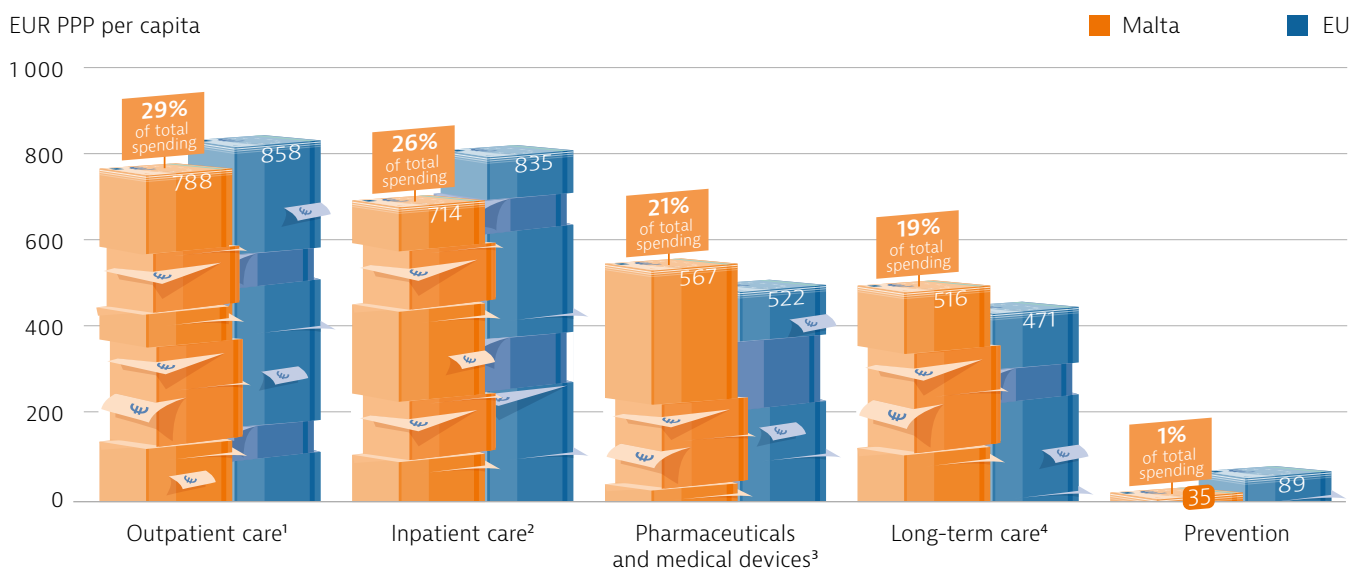
The private sector plays a substantial role in providing primary care and outpatient services

Inpatient care is provided mainly by public hospitals, with primary and outpatient care delivered by both public and private providers. Long-term care for older people is delivered by the public and private sectors as well as by religious organisations. The private sector plays a key role in the delivery of primary care despite the existence of a state-run primary care system, with private general practitioners (GPs) accounting for 70 % of primary care visits. This is often due to cultural preferences, with people preferring not to attend public clinics that operate on a walk-in basis and instead opting for private practices where they are able to choose their physician. Private and public GPs act as partial gatekeepers to public outpatient

services. However, many individuals opt to pay out of pocket to see private specialists without a referral as a way to avoid long waiting lists (Section 5.2). This creates a de facto “two-tier” system, with private-sector GPs and specialists working in both public and private sectors being able to refer patients back to public-sector services.

Major refurbishments and restructuring in the hospital sector have been undertaken in recent years to improve their physical condition and expand capacity (Section 5.3), with major funding received from European Regional Development Funds. The number of acute and long-term care beds in Malta has fluctuated in recent years due to restructuring, but overall the number of hospital beds has increased since 2010 to reach 4.4 per 1 000 population in 2018, which remains below the EU average of 5.0 per 1 000 population.

Figure 8. Per capita spending on pharmaceuticals and medical devices is high



Note: Administration costs are not included. 1. Includes home care; 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component.
Source: OECD Health Statistics 2019; Eurostat Database (data refer to 2017).

Reforms to education, training and employment conditions have increased the number of doctors and nurses

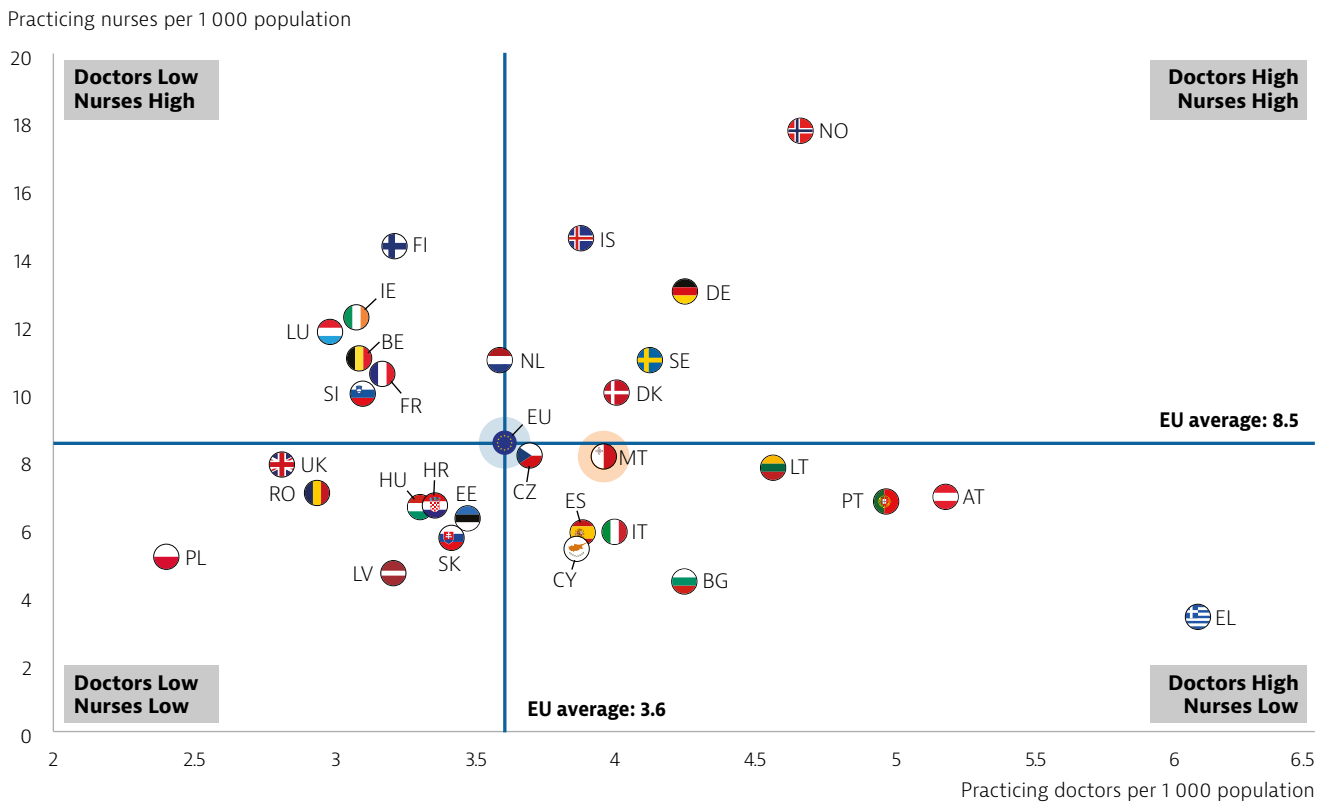
The number of physicians has risen steadily since 2000, to reach 4.0 per 1 000 population in 2018, above the EU average of 3.6 (Figure 9). A number of reforms in the past 15 years have contributed to addressing previous physician shortages, including establishing a Foundation Course in 2009 for newly graduated doctors in collaboration with the United Kingdom, investing in specialisation programmes for physicians and actively recruiting from abroad. Shortages in the physician workforce nevertheless persist for certain specialities. Improved remuneration for GPs and establishing family medicine as a specialty have improved capacity in the GP workforce and the number of GPs per capita is now close to the EU average. However, the share of GPs within

the physician workforce is currently 20.7 %, which remains below the EU average (22.5 %), and retention of GPs remains a challenge.

The Maltese Nursing Conversion Programme⁶ and the introduction of specialist nurse training have strengthened the skills, competencies and size of the nursing workforce. The number of practising nurses has increased by more than one third in the last decade, to reach 7.9 per 1 000 population in 2018, slightly below the EU average of 8.5. Despite this, Malta continues to experience a shortage of nursing staff in hospitals and long-term care and the nursing workforce in these settings is increasingly reliant on migrant workers, posing challenges for recruitment and retention (Section 5.3).

6: This allowed first-level nurses to register as second-level nurses and brought qualifications in line with EU directives.

Figure 9. Physician numbers have risen but nurses are still in short supply



Note: 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 Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.
 Source: Eurostat Database (data refer to 2017 or nearest year).



5 Performance of the health system

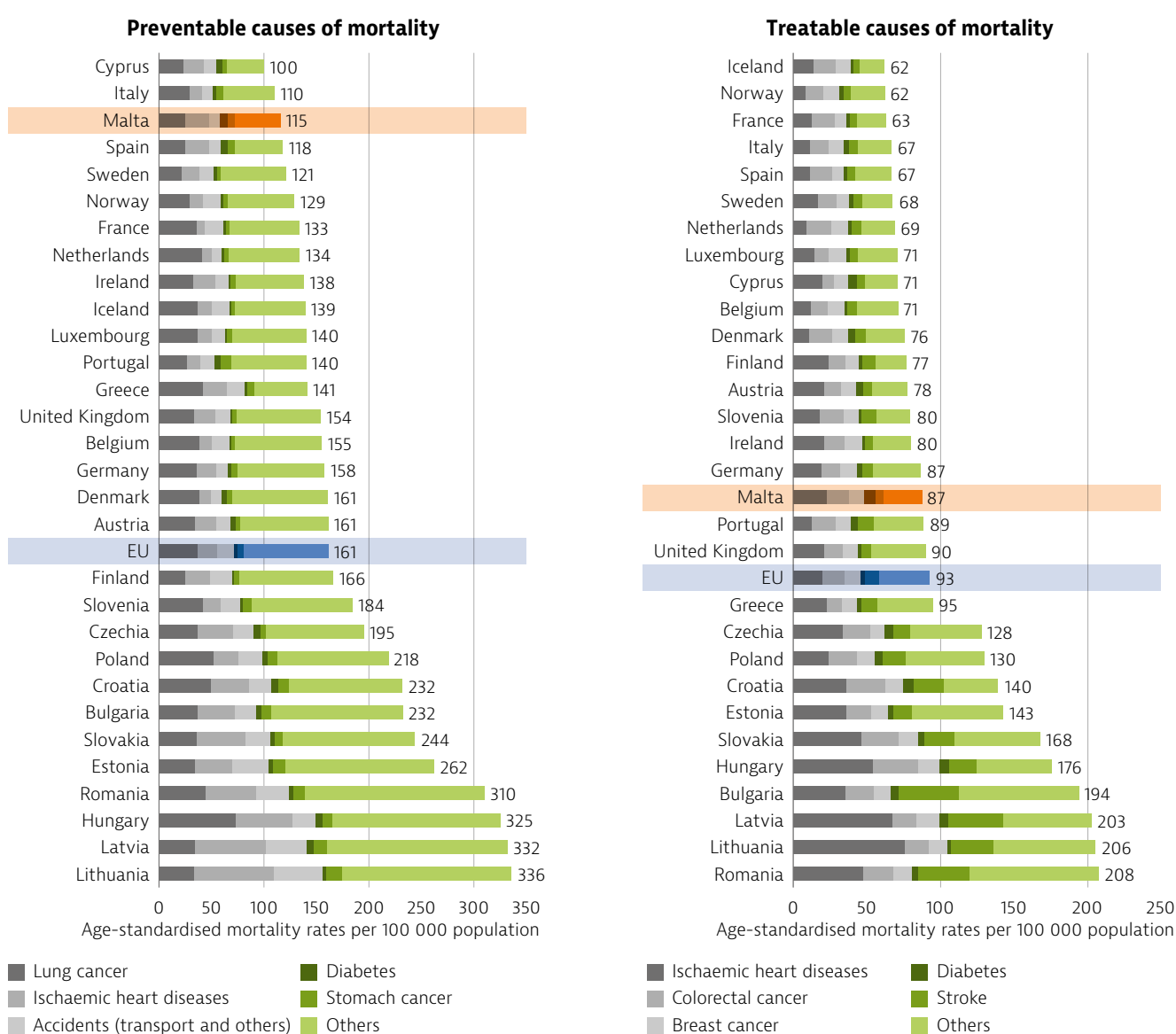
5.1. Effectiveness

Preventable mortality in Malta is among the lowest in the EU

Malta had the third lowest rate of deaths from preventable causes in the EU in 2016 (Figure 10). This reflects, in part, strong public health policies that have targeted tobacco and alcohol consumption, as well as the effectiveness of national immunisation

programmes. Deaths from alcohol-related conditions, lung cancer and accidents (road and others) are now among the lowest in the EU. Lung cancer remains the primary cause of preventable deaths, closely followed by ischaemic heart disease.

Figure 10. Deaths from preventable causes are low and mortality from treatable causes is better than the EU average



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. 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 2016).

Deaths from ischaemic heart disease, which is considered to be preventable both through public health policies and effective medical care, and diabetes remain above the EU average. This is partly attributable to Malta's high prevalence of obesity. The Maltese government has recognised the severity of this issue and has developed several strategies to reduce the prevalence of obesity in adults and children. Current actions include the Healthy Weight for Life Strategy 2012-20, the Food and Nutrition Action Plan 2015-20, and the Non-Communicable Diseases Act 2016. Regulations in the school environment on food provision have also recently been strengthened, with legislation enacted to regulate food available in schools and to restrict advertising or sponsorship of unhealthy foods.

Tobacco and alcohol control policies are continually being strengthened

Regulations on tobacco advertising and legislation introducing a smoking ban in 2004 have successfully contributed to a fall in smoking rates among adults and young people. Many existing laws on cigarettes, such as a total ban on advertising and mandatory health warning on labels, also apply to electronic cigarettes, which are regulated as tobacco products. New legislation introduced in 2017 prohibits smoking in private cars carrying children under the age of 18 to help limit their exposure to harmful second-hand smoke. Furthermore, a new tobacco strategy is currently being developed.

The first National Alcohol Policy for Malta was introduced in 2018, covering a five-year period up to 2023. It recommends specific actions targeting the sale, purchase, consumption and supply of alcoholic products to those aged under 17 to curb underage drinking. Prevention of drunk-driving will be strengthened by introducing stricter penalties for drunk-driving offences and lowering blood alcohol concentration level limits. Efforts are under way to translate these policy recommendations into new laws and actions.

Improvements in health system performance have contributed to a reduction in mortality from treatable causes

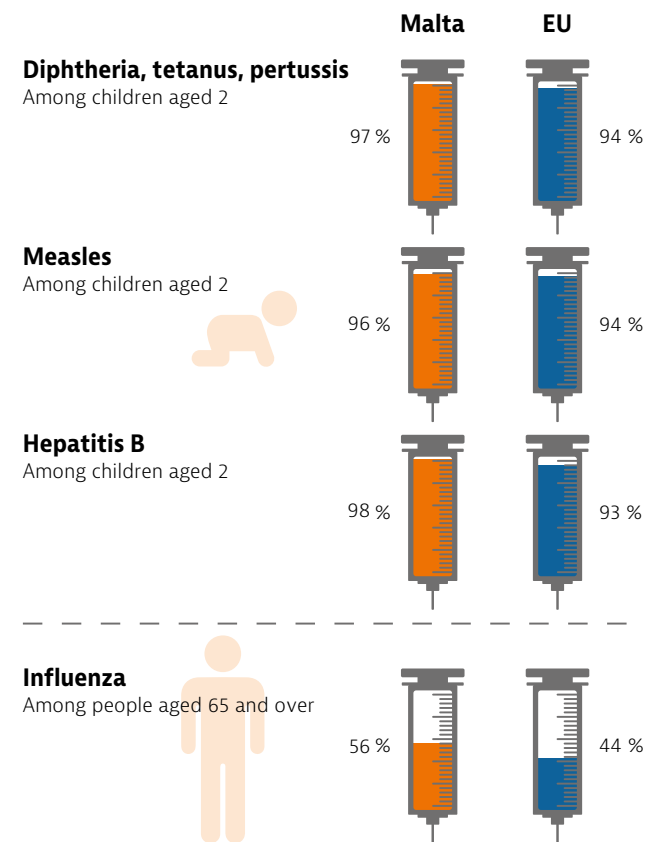
Deaths that can be mainly avoided through timely and effective health care interventions have fallen by a fifth in Malta since 2011, and their rate is now below the EU average. The overall decline reflects improvements in health system performance, with increased access to, and availability of, key services and innovative medicines and medical technologies. In terms of individual causes, mortality from colorectal cancer in females was higher than the EU average for 2016, whereas the mortality rate from

breast cancers was equal to the EU average. On the other hand, mortality from stroke and pneumonia were lower (see Figure 10).

Compulsory immunisations contribute to high childhood vaccination rates

Childhood immunisations are available free of charge in Malta, with vaccination against diphtheria, tetanus and pertussis (DTP) also mandated by law. This contributes to Malta having high immunisation coverage for DTP, measles and hepatitis B, with vaccination rates above the EU average and the WHO recommended target of 95 % (Figure 11). Vaccination coverage for influenza among people 65 years and over is high compared to elsewhere in the EU, reflecting extensive use of health promotion and educational campaigns to promote awareness, as well as wide availability of the vaccine, which is free of charge (Rechel, Richardson & McKee, 2018). However, immunisation rates remain below the WHO recommended target of 75 %. The national immunisation programme has recently been expanded to include the pneumococcal and meningococcal vaccines, with procurement currently in progress.

Figure 11. Malta records relatively high vaccination coverage for childhood immunisations and influenza



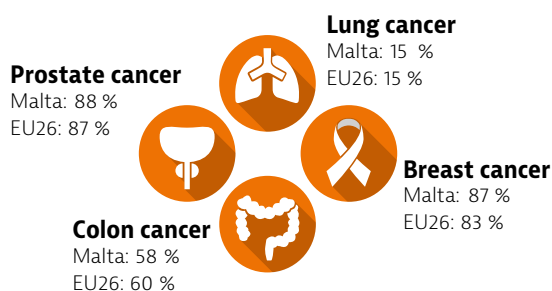
Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

Cancer survival rates have improved considerably but screening rates are low

Five-year survival rates for a number of cancers improved substantially in Malta between 2000–04 and 2010–14 and are now above the EU average for breast and prostate cancers (Figure 12). Five-year survival for colorectal cancer has remained stable over the same period and is slightly below the EU average (58 % compared to 60 %).

Malta has offered national screening programmes for breast and colorectal cancer for a number of years, with a national cervical cancer screening programme for women aged between 25 and 35 years launched in 2016. Attendance rates for breast cancer screening have shown notable improvements since 2010 and are now the same as the EU average (60 %). Uptake for cervical cancer screening through the NHS National Cancer Screening programme remains low at 32 %, less than half the EU average⁷. A second National Cancer Plan (2017–27) has been adopted, which aims to strengthen primary prevention. It also commits to improving integration of care and reducing inequalities in access to cancer screening, cancer care and survival outcomes.

Figure 12. Five-year cancer survival rates are above the EU average for breast and prostate cancers



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

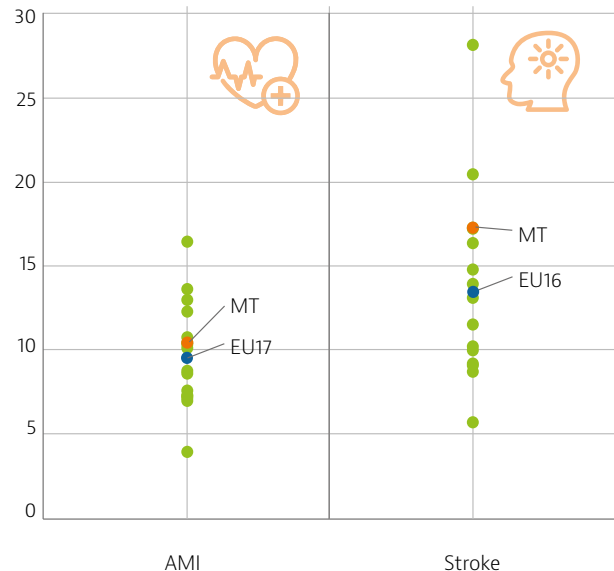
More people survive following admission for heart attack and stroke, but relatively high mortality rates persist

Deaths following admission for acute myocardial infarction and stroke are relatively high in Malta (Figure 13). These indicators capture important elements of quality in acute care such as processes of care, timely transfer of patients and delivery of effective care in dedicated stroke or cardiac units. Mortality rates are also dependent on prompt presentation to emergency departments, requiring

knowledge of symptoms among the population. The introduction of thrombectomy to remove blood clots at Mater Dei Hospital in 2015 and a public awareness campaign both aim to improve survival following stroke.

Figure 13. Mortality following stroke and acute myocardial infarction is relatively high

30-day mortality rate per 100 hospitalisations



Note: Figures are based on patient data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI and ischaemic stroke.
Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

A strategy and action plan has been developed to combat the threat of antimicrobial resistance

In 2016, almost 50 % of the population in Malta reported having taken antibiotics in the past year, which was the highest proportion in the EU/EEA (ECDC, 2017). Incorrect and excessive use of antibiotics, including last-resort antibiotics in hospitals and broad-spectrum antibiotics in the community, contributes to Malta having high levels of antimicrobial resistance (AMR) (ECDC, 2017). In response, the government held a consultation on an AMR Strategy and Action Plan (2018-25) in 2018. The strategy sets out objectives and broad areas where integrated and simultaneous action is required and will contribute to strengthening antimicrobial stewardship and surveillance practices, raising awareness of AMR and appropriate antibiotic use (Ministry for Health, 2018).

⁷: Data from the European Health Interview Survey 2014-2015 suggests that the majority of cervical cancer screening is undertaken in the private sector instead of through the National Cervical cancer screening programme provided by the NHS and uptake rates may be closer to 75 % of women.

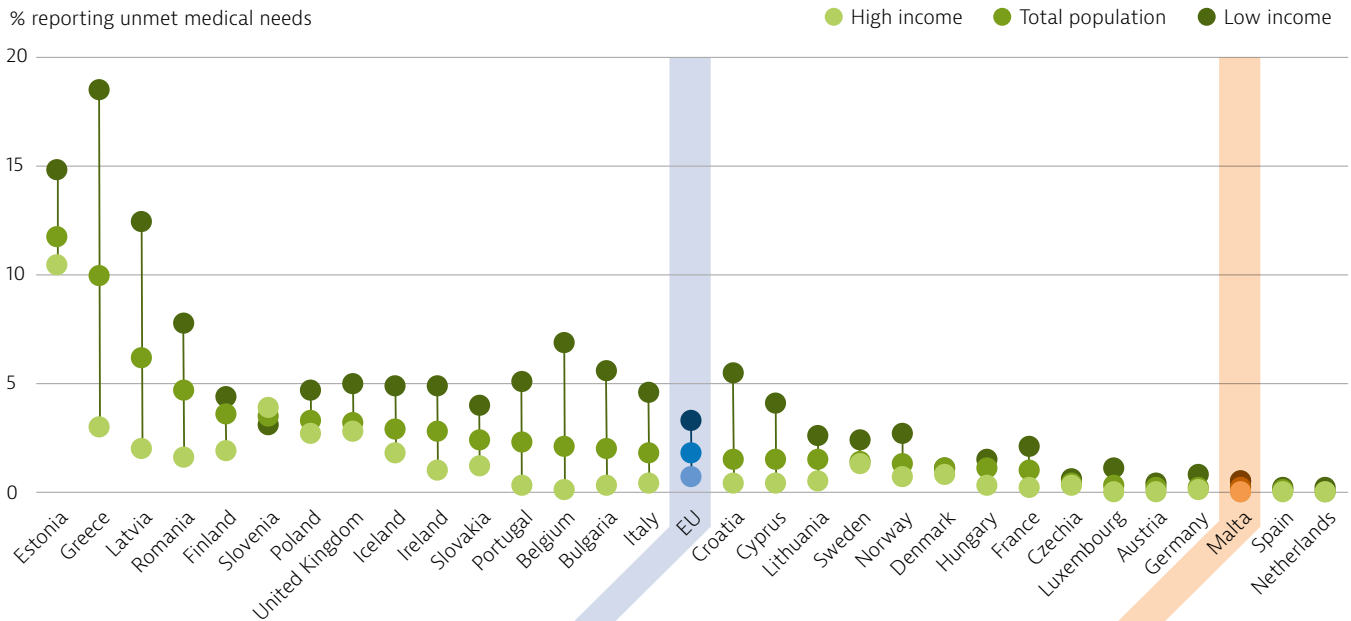
5.2. Accessibility

Unmet needs for health care are low with little difference between income groups

All residents of Malta covered by social security legislation as well as refugees and asylum seekers covered by humanitarian exemptions are entitled

to access the NHS. The proportion of people who reported unmet needs for medical care due to cost, distance or waiting times was close to zero in 2017, based on EU-SILC data, with little difference between high-income and low-income groups (Figure 14)⁸.

Figure 14. Levels of self-reported unmet needs are among the lowest in the EU



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 2017).

The Maltese health system in general provides good population coverage, including for migrants, and recent reforms have expanded entitlements to provide health care services to minority groups (Box 2). Nonetheless, some who enter Malta legally but are not entitled to work in the formal sector⁹ are also not entitled to receive free public health care. Problems in accessing health care are a rising concern for this group, particularly those with long-term conditions, such as mental health issues or HIV, where initial treatment and antiretroviral therapy may be provided, but subsequently discontinued if payment is not received (Vassallo & Borg, 2018).

Box 2. Recent reforms have expanded access to care for LGBTQ individuals

In 2018, amendments to the Embryo Protection Act of 2012 expanded entitlement to in-vitro fertilisation (IVF) services to any individual irrespective of gender or sexual orientation, enabling same-sex couples and single women to access IVF services. In the same year, the government launched a document on Transgender Healthcare Services, one of the first of its kind in Europe, which committed to expanding medical benefits by including gender identity and sex characteristics as conditions eligible for free treatment, allowing transgender individuals to access hormone therapy and gender-affirmation care free of charge (Ministry for Health, 2019). This change was implemented as part of a wider strategy to improve transgender services through the delivery of multidisciplinary care in Gender Wellbeing Clinics.

8: A separate survey, the European Health Interview Survey (EHIS), which targets people who have health or dental care needs as opposed to all individuals, shows greater levels of unmet needs for medical care and dental care. In the EHIS, about 5 % of the population reported some unmet medical needs for financial reasons in 2014, with 5 % of the population reporting unmet needs for dental care. The rate of unmet needs for both medical and dental care was higher among low-income groups.

9: For example, those who received humanitarian protection in another EU Member State.

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

Malta's NHS offers a comprehensive benefit package, with public health care services and emergency dental care available free of charge at the point of use. Elective dental services and prostheses, spectacles and hearing aids are provided free of charge to children under the age of 16, police and armed forces personnel and those on low incomes.

While medicines prescribed during hospital stays and three days following discharge are available free of charge, all other pharmaceuticals must be paid for out of pocket by people not eligible for free medication. Free medication is provided for a large number of chronic conditions as defined by law and for a number of items on the Government Formulary List that are available free of charge for those whose income falls below a basic threshold, as established through a means test. Over 140 000 individuals were covered for at least one of their chronic conditions in 2019, corresponding to approximately one third of the population.

In 2018, the list of medicines included in the Government Formulary List was expanded. All patients with hepatitis C are now eligible to receive direct-acting antiviral therapy treatment for free, while medical cannabis was legalised for the treatment of chronic pain, chemotherapy side effects and multiple sclerosis. People with rare diseases face particular challenges in accessing medicines. In 2018, a special committee was established to assess requests for exceptional medicinal treatment. However, implementation has stalled due to difficulties in determining whether new medicines should be fast-tracked through the exceptional route or added to the benefit package in a routine manner. Other evidenced-based strategies have been launched to promote better access to medicines (see Box 3).

Box 3. Ensuring access to innovative medicines remains a major challenge

As a small country, Malta faces considerable challenges in ensuring availability of new medicines. Greater use of Managed Entry Agreements, clinical pathways and protocols for the evaluation of new medicines have helped facilitate access in recent years. Malta is also a founding member of the Valletta Declaration, an alliance of southern EU Member States, which aims to facilitate joint negotiations of prices with pharmaceutical companies. Decisions on whether to add new medicines to the Government Formulary List are supported by a Health Technology Assessment (HTA) system established in 2010, which applies maximum reference pricing and external reference pricing and assesses whether procedures deliver value for money.

Malta is also a member of EUnetHTA, which supports collaboration between European HTA organisations. Nevertheless, major challenges remain in obtaining funds for new medicines to enter the formulary.

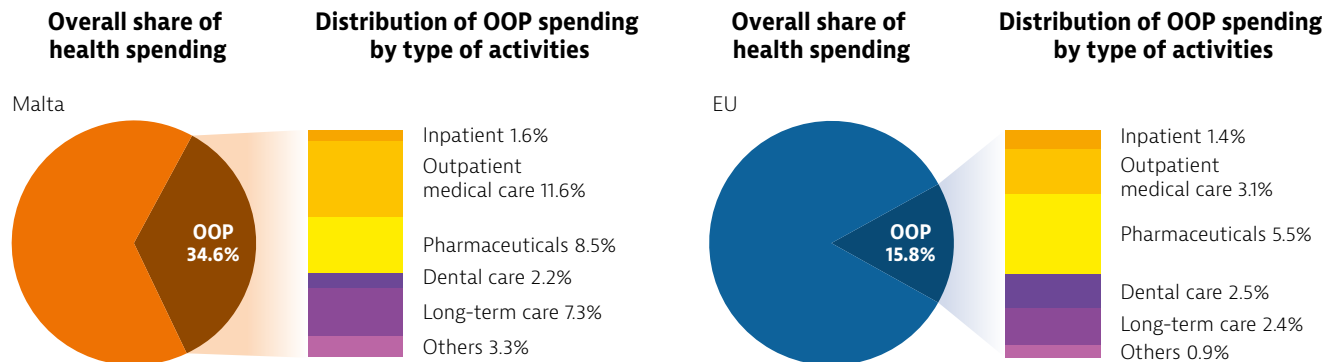
Stronger European collaborations, greater use of generics and biosimilars, and the new committee for rare illnesses have been highlighted by the Malta Medical Agency as key strategies to improve access to new medicines. Better information, introduction of incentives for biosimilar prescription and substitution at pharmacy level are policy options that could foster uptake. Indeed, as with generics, acceptance and trust of biosimilar medicines by patients and health professionals remains of key importance.

Malta has among the highest out-of-pocket expenditure in the EU

In 2017, OOP spending as a share of total health expenditure (34.6 %) was the fourth highest in the EU and more than twice the EU average (Figure 15). High OOP spending is driven by spending on private primary and outpatient specialist services due to individuals opting for private care (Section 4).

Pharmaceuticals accounted for the second largest share of OOP spending due to a large proportion of the population being required to pay for medicines prescribed in outpatient and primary care settings. OOP spending on health as a share of final household consumption in 2016 was 5.2 %, the second highest share in the EU.

Figure 15. High out-of-pocket expenditure is driven by spending on outpatient care and pharmaceuticals



Source: OECD Health Statistics 2019 (data refer to 2017).

Waiting times have been reduced for inpatient care but still remain an issue for outpatient services

Malta has successfully reduced waiting list times for some inpatient services in recent years by introducing routine Sunday activity and outsourcing certain elective surgeries and diagnostic procedures to the private sector. In 2016, only 0.1 % of respondents reported unmet needs for medical care due to waiting times, one of the lowest proportions in the EU. However, this figure masks variation between procedures; while waiting lists have been virtually eliminated for some procedures such as echocardiograms and cataract surgery, they remain longer for others such as orthopaedics.

Waiting times for outpatient specialist services remain high for some services, with an average wait of 37 weeks for a first outpatient appointment across all clinical specialities at the Mater Dei Hospital in 2016. The highest waiting times are for neurology, urology, vascular services, genetics and gastroenterology (NAO, 2017). Long waiting lists for outpatient and some inpatient services raise equity concerns over access to care, with those who can afford to do so paying to access private GPs and specialist outpatient care to bypass waiting lists in ambulatory settings and to gain expedited access to public hospitals through fast-tracked referrals (Vassallo & Borg, 2018).



5.3. Resilience¹⁰

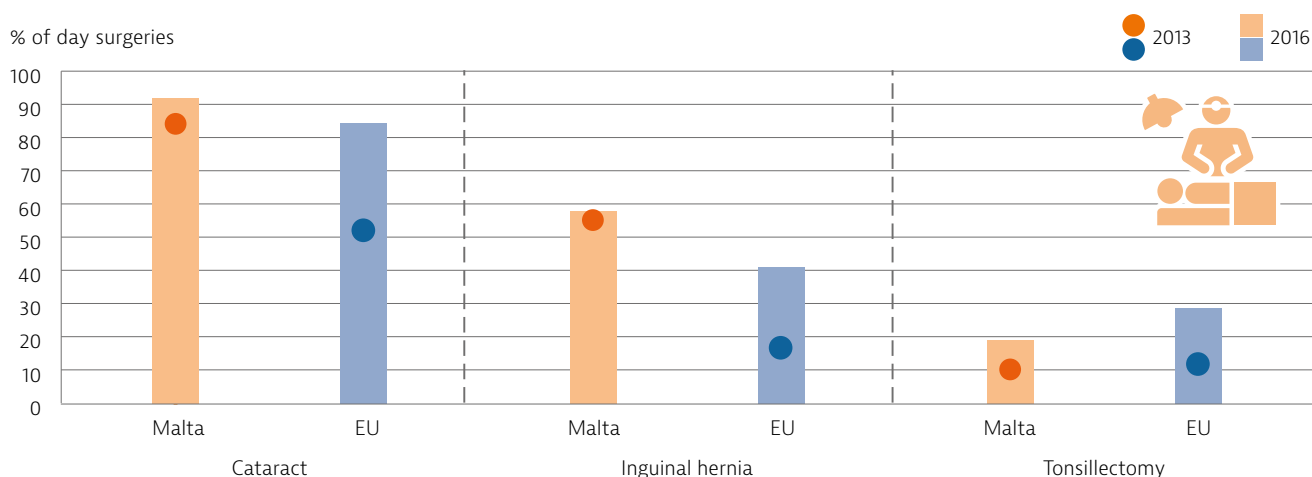
Despite a strong economic outlook, age-related health spending increases pose long-term fiscal sustainability challenges

In the coming decades, health expenditure is expected to increase markedly to meet rising demand from a growing and ageing population with ever more complex care needs. Public health care spending is projected to rise by 2.7 percentage points of GDP between 2016 and 2070, the largest estimated increase in the EU (European Commission, 2018). Although Malta has a favourable medium- and long-term economic outlook, the future predicted growth in health spending may pose a medium fiscal sustainability risk in the long term (European Commission, 2019; Council of the European Union). Improving the cost-effectiveness and efficiency of the health system remain important goals to moderate future health spending growth.

There is potential for more efficiency gains in the hospital sector

Efforts have been made to promote more appropriate use of hospital resources, as evidenced by the increasing share of surgical procedures performed as day surgery (Figure 16). Further efficiency gains are nevertheless possible; while the proportion of cataract surgery and inguinal hernia repair performed in ambulatory settings is above the EU average, the share for other surgeries such as tonsillectomies remains low. Greater use of activity-related payment for specialist outpatient care may help increase the proportion of day surgeries by incentivising hospitals to undertake work in cheaper outpatient settings (European Commission, 2019).

Figure 16. Day surgery in hospitals has increased



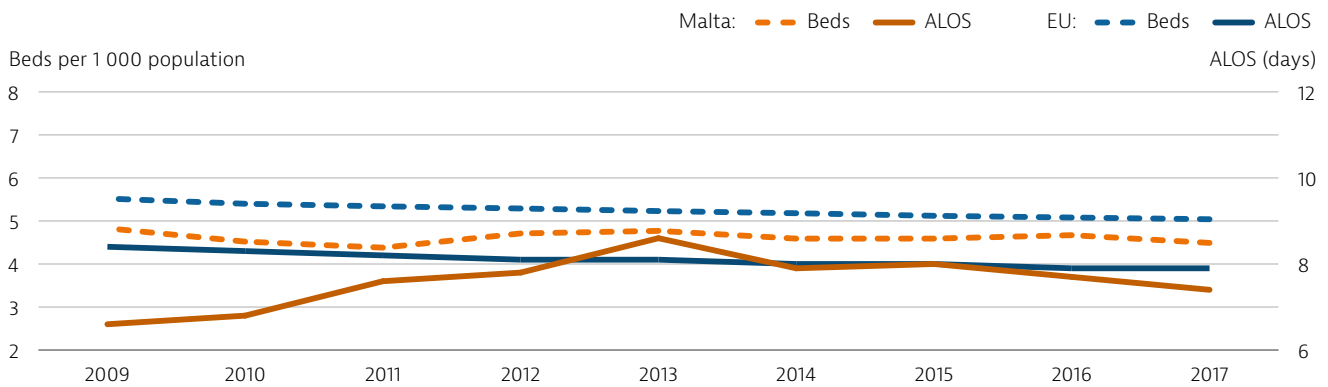
Source: OECD Health Statistics 2018; Eurostat Database (data refer to 2013 and 2016 or nearest year).

Increased capital investment aims to modernise hospitals and improve acute care capacity

The current capacity and physical condition of hospitals in Malta is insufficient to appropriately meet rising demand for health care. While the average length of stay (ALOS) in acute hospitals in Malta has remained stable in recent years and is below the EU average (Figure 17), bed occupancy rates are among the highest in the EU/EEA and some evidence suggests that pressures on long-term care capacity are preventing the movement of debilitated patients from acute beds to more appropriate settings.

In part to address these issues, the government signed a 30-year public-private partnership in 2016 for the refurbishment and development of three hospitals and the establishment of a new medical school (see Box 1 in Section 4). The partnership will see Gozo General, St Luke's and Karen Grech hospitals refurbished to increase bed capacity for geriatric care and rehabilitation. Outside of the new partnership, the government has committed to building a new block for outpatient services at Mater Dei Hospital, which will help reduce long waiting times for certain specialities. The government is also investing in new equipment at the hospital, including the introduction of artificial intelligence robots to assist in surgeries.

¹⁰ Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

Figure 17. Average length of stay in Malta is below the EU average

Source: Eurostat Database (data refer to 2017 or nearest year).

Strengthening primary care is a priority

Strengthening primary and community care is a government priority in Malta to help improve health system performance and efficiency. Stronger primary care will support the delivery of comprehensive and continuous care for chronic diseases, and will contribute to reducing inappropriate use of emergency departments and high rates of avoidable hospitalisations in Malta for conditions including asthma, diabetes and congestive heart failure that can be effectively managed in more cost-effective ambulatory settings.

To strengthen primary care, multidisciplinary and integrated primary and secondary care teams have been introduced to support the delivery of services for the management and treatment of chronic conditions in primary care. The myHealth electronic portal has also been implemented to facilitate enhanced access to patient records for GPs. Moreover, EUR 39 million (EUR 33 million from EU funds), is being invested in opening a primary health care hub in southern Malta, which will serve approximately one third of the population. Actions to shift long-term care away from institutional and hospital settings are being taken by incentivising home- or community-based care by, for example, financially compensating informal carers.

Malta has published its first Mental Health Strategy to support reform of mental health care

While the burden of mental health has increased over recent decades, investment in improving mental health facilities and services has lagged behind. In response, the first Mental Health Strategy (2020–30) has been developed, which proposes a multisectoral approach to promote mental health throughout the course of life and a strengthening of integrated care with service delivery reoriented towards community settings (Ministry for Health, 2019). Investments in developing physical and human resource capacity for

mental health services are also being made, which will see the refurbishment of the existing Mount Carmel Hospital and the building of a new acute psychiatric hospital.

Integrated care is being strengthened to improve diabetes prevention and treatment

Diabetes is a major health issue in Malta (Section 2) and steps have been taken to improve prevention and treatment (Box 4). The first National Diabetes Strategy (2016–20) has also been developed. It emphasises the need for improved prevention and early diagnosis, an expansion of treatment options and further development of integrated care for diabetes (Ministry for Health, 2019). As part of the strategy, newer diabetes therapies became publicly available in 2016.

Although the health workforce has grown, staff shortages and an ageing GP workforce pose challenges

Although Malta has taken a number of steps to strengthen the health workforce (Section 4), many challenges in recruitment and retention remain. Nursing shortages in the acute and mental health care settings have led to a reliance on migrant workers, leading to an unpredictable supply of health professionals. In addition, an ageing private GP workforce, combined with younger doctors reluctant to work in private solo practices, is changing the model of care needed for primary and outpatient care. Efforts to respond to these challenges and develop a workforce with the right numbers and skill mix are under way and a new health workforce document is under development.

Malta is investing in digital health services to improve quality of care

Malta is taking steps towards developing a comprehensive digital health infrastructure. The myHealth electronic patient portal aims to empower patients and improve continuity and timeliness of care by allowing patients and authorised doctors to access medical records online using the national e-ID card. It also allows GPs to make referrals for services previously only made by specialist doctors. More than EUR 9 million from both national and EU funds have been allocated to further strengthen digital health infrastructure, including the development of electronic health records in primary care, electronic hospital records and a system for population-based health registries among others. Enhanced use of mHealth applications is planned, such as the provisions of free continuous glucose monitors to diabetic children.

Malta is enhancing efforts to tackle the social determinants of health from a cross-policy perspective

Malta has established a Social Determinants of Health Unit within the Ministry of Health to help coordinate a whole-of-government response to tackle health inequalities. The unit has partnered with other key ministries and civil society representatives to establish a national platform to address the social determinants of health, which is funded by EUR 2.5 million from the European Social Fund. In 2019, the unit will undertake qualitative research with policymakers and educators and oversee a cross-sectional national survey to document and review social determinants in Malta and their impact on health inequalities. Current policy responses to reduce health inequalities will also be assessed.

Strategic actions are contributing to improved governance and health system effectiveness

Malta adopted a National Health System Strategy (2014-2020) in 2014, which outlined a number of strategic directions to improve health system performance. A health system performance assessment framework was developed in 2015 with support from WHO to monitor implementation of the first strategy. This framework now serves as a mechanism through which improvements in health system performance are measured and assessed, with monitoring undertaken approximately every three years. Malta is currently preparing a collection of documents, which will together form the new national health strategy for the coming decade.

Box 4. A multidisciplinary shared-care diabetes programme aims to improve quality of care

In 2014, Malta implemented a multidisciplinary shared-care diabetes programme between primary care health centres and the Endocrinology and Diabetes Department in Mater Dei Hospital. Diabetes shared care is mainly managed in primary care unless there are complications warranting referral to the hospital clinic. The multidisciplinary care teams consist of doctors, nurses, podiatrists and ophthalmologists with a special interest in diabetes. Coordination with the hospital is facilitated through a computerised system that serves as a register of all diabetic patients in Malta and enables real-time consultation of cases with specialist doctors. Within the first three years of implementation, the programme was operationalised in all health centres and more than 3 000 patients (approximately 7 % of the diabetic population) had been transferred to receive care in the community. Government data indicates the programme has increased patient satisfaction, reduced diabetes-related complications, improved care continuity and enhanced access to primary and specialist care (Government of Malta, 2019).

6 Key findings

- Maltese people enjoy generally good health and one of the longest life expectancies in the EU. Improved health system performance over the last two decades has helped to reduce mortality rates from treatable causes, particularly cardiovascular diseases and some cancers, while public health policies have contributed to low levels of preventable mortality. Further reductions in mortality from cardiovascular diseases have been targeted by increasing timely access to quality acute care. The rising disease burden from diabetes and mental health issues has led to them being recognised as priorities for the health sector.
- Obesity is a major public health challenge, with adult and childhood obesity rates the highest in the EU. Binge drinking among adolescents also remains a concern. Recent initiatives addressing food provision in schools and alcohol sales to minors aim to tackle these risk factors. Socioeconomic inequalities in health status and related risk factors persist and tackling health inequalities and their causes is a new cross-sectoral political focus.
- Malta spent 9.3 % of GDP on health care in 2017, which is slightly below the EU average (9.8 %). Reorienting services away from hospital settings towards primary and outpatient care to improve efficiency and enhance care for chronic conditions is a priority. Primary care is being strengthened through upskilling the workforce, building new facilities and upgrading existing ones, and expanding the range of services. A reorientation of services to more cost-effective settings will help accommodate future projected increases in spending due to an ageing population.
- Reported unmet needs for medical care in Malta are generally low, but some evidence points to a higher impact on lower income groups. A comprehensive benefit package is available free of charge; however, out-of-pocket spending is among the highest in the EU, due to private expenditure on primary and outpatient care. This is partly due to attempts to bypass long waiting lists for specialist services and a large proportion of the population being required to pay out of pocket for some pharmaceuticals prescribed in these settings. While efforts to reduce waiting lists for inpatient care have been largely successful, waiting lists for outpatient services are growing.
- Reforms to education, training and working conditions for health professionals have successfully increased the number of physicians and nurses working in Malta. An increasing reliance on migrant nurses in acute and long-term care, and an ageing private general practitioner workforce may pose future workforce challenges.
- As a small country, Malta faces difficulties in ensuring availability of new medicines. This is now a critical issue, with the government's list of approved medicines struggling to keep up with innovation. The increased use of Managed Entry Agreements, biosimilars and clinical pathways, and protocols for the evaluation of new medicines has contributed to improved access in recent years. Stronger cross-border collaboration and policy options facilitating the use of generics and biosimilars, as well as new models encouraging joint procurement and price transparency, are key strategies to further enhance access to medicines.
- New public capital investment has been made to upgrade medical equipment in hospitals and to build additional hospital units to improve capacity for outpatient services, mental health care and mother and child care. A new public-private partnership aims to secure further capital investment to modernise hospitals and improve capacity, but careful monitoring is needed to ensure it improves quality of care, while maintaining equitable access and safeguarding health system sustainability.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovak	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	United Kingdom	UK

State of Health in the EU

Country Health Profile 2019

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.

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