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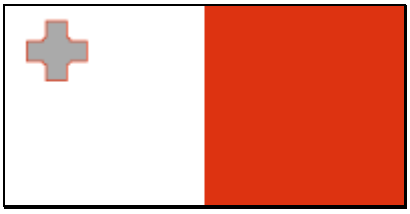
Study on the Social Protection Systems in the 13 Applicant Countries

Malta
Country Study



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Social Protection in Malta

1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

The Republic of Malta is a small, open economy with strong trade ties to the EU and accepted for EU accession in 2004. Malta has a population of around 383,000 and a labour force of just over 156,000. Its Gross Domestic Product currently stands at just over one half of the EU average on a per capita purchasing power parity basis, making Malta an Objective One country for the purposes of EU development Funds. In view of the absence of natural resources and the smallness of the domestic markets, Malta's imports, exports and gross capital flows each amount to over 100% of its GDP, of which over one half are undertaken with the EU.

Following a period of rapid real GDP growth during the first half of the 1990s - when it averaged 6% per annum - partly stimulated by fiscal expansion, the Maltese economy currently faces the twin problems of an excessively large fiscal deficit and a slowdown in economic growth, which at an average of 4% per annum over the past five years remains significant but insufficient for a country in Malta's state of development. If persisting, these factors could jeopardise the process of economic convergence to the EU.

The fiscal deficit reached a peak of 12% of GDP in 1995 and has been reined in to around 5% by 2001, mainly due to higher taxation. The Government plans to bring the fiscal deficit to 3% of GDP by 2004, but the economy can hardly withstand further increases in taxes, also because of the slowdown in economic growth rates. It is thus envisaged that the further reduction in the deficit is to be achieved mainly through efficiency gains within the public sector, concerning *inter alia* the collection of tax dues and the administration of social expenditure.

A long run reform of the social security system is also being contemplated, with a National Commission in which are represented the various social partners being set up for the purposes of studying the current situation and proposing reforms. The system of social protection in Malta is considered to be well-developed and offers a wide range of services. Its cost, estimated at around one-eighth of GDP and one-third of Government recurrent expenditure is thus being questioned in relation to the genuine needs of the population and the effectiveness with which these are being met. The extent to which the pervasiveness of social protection may be acting as a disincentive to economic growth, through for example, generous unemployment benefits, is another important issue in this respect. The

process of welfare reform is at present held up, mainly due to a lack of consensus of the parties involved.

The macroeconomic restructuring necessary to improve the long term sustainability of the economy and assist in the EU membership process is to be accompanied by a microeconomic reform intended to improve the country's competitiveness. This will involve privatisation, industrial restructuring and the removal of protectionist mechanisms for domestic producers who will thus be to a greater extent exposed to international competition. This process could thus place stronger demands on the social protection system in Malta through temporary increases in unemployment and the need for labour retraining and ancillary measures.

These economic developments are taking place within a context of an ageing population where birth and death rates have declined significantly, with the attendant potential pressures on pension expenditure within a Pay-as-you-go (PAYG) system. Another important phenomenon is the low but increasing female participation rate in the Maltese labour force, which is placing new demands on the social protection system related to gender and family issues.

In a nutshell therefore, there appear to be conflicting pressures on the social protection system in Malta. On the one hand, macroeconomic considerations call for economies in social expenditure aimed at curbing the fiscal deficit and removing disincentives for economic growth. From a microeconomic perspective, however, it is likely that economic restructuring would step up the demands for social expenditure. Additionally, demographic and social developments are likely to call for a re-orientation of the focus of the Maltese social protection system. This report evaluates these issues in terms of the factors that have contributed to the development of the social security system in Malta as it stands today.

1.1 Main influencing factors for social protection

The system of social protection in Malta has evolved in reposes to political, economic, demographic and social realities, and its expected future evolution will be strongly conditioned by the important changes that can be envisaged in these determinants in the light of economic reforms and prospective EU membership.

1.1.1 Economic and Financial Indicators

In the year 2001, Malta's GDP stood at 4 billion Euros at current market prices and exchange rates, implying a per capita annual income level of 10,500 Euros at current exchange rates. This places Malta as a middle-high income country by World Bank standards. Malta also generally ranks around the 30th position in the Human Development Index compiled by the United Nations (2002). At purchasing power parity standards, per capita GDP has

grown by an average of 6.2% per annum between 1996 and 2000, to reach 53% of the EU average. Due to the openness of the Maltese economy and the consequent significant investment by foreigners in Malta and by Maltese abroad, there could be significant differences between Gross Domestic and Gross National Product in any specific year. Although this difference was minimal in 2001, it had amounted to 5% of GDP in 2000. These differences however tend to cancel themselves out over time. It is also known that there exists a significant component of underground economic activity in Malta not captured by official statistics. Studies conducted in the late 1980s estimate the underground economy at 25% of official GDP (Micallef 1988, Briguglio 1989), but this ratio is likely to have declined to some extent following the introduction of VAT in 1995 (Cassar 2001).

According to Eurostat estimates, Malta had a per capita GDP of 53% of the EU average in 2000, placing the country third among the group of accession countries behind Slovenia and Cyprus. At the rates of growth in the year 2000, Malta is estimated to converge to the EU average per capita GDP of present members in a period of between 30 to 40 years.

Trends in GDP growth and in other relevant economic indicators in Malta between 1995 and 2001 are highlighted in Table 1.1. GDP growth tended to slow down during the period, as the economy underwent a period of fiscal tightening and lost some of its competitiveness compared to the first half of the 1990s. The volatility in the growth rates, peaking at 6.2% in 1995 and falling to -1% in 2001 are a result of the economy's openness and consequent vulnerability to shocks in the international economy. In 2001 for instance, the major manufacturing exporter on the Island, a subsidiary of a multinational electronics manufacturer, was significantly adversely hit by international economic developments, which was however fully absorbed by the profits of the multinational, leaving domestic employment and incomes almost unscathed. The economy is over time also tending to become increasingly driven by consumption, with the consumption ratio to GDP standing at 82% in 2001[1]. This is not only indicative of an increasingly consumption-oriented society, but has also important implications for economic development, as this phenomenon tends to crowd out saving and productive investment.

The sustainability of the economy is threatened by a persistent external deficit, which erodes the country's external reserves and could in the long run lead to crises similar to those experienced in South East Asia or South America. The external deficit is symptomatic of the fiscal deficit, excessive consumption and insufficient export competitiveness. It is however to be noted that the country's external reserves are at present very strong, standing at over 6 months of imports and virtually backing all of the domestic

[1] The peak in the consumption ratio in 1996 is attributed to statistical factors associated with the introduction of VAT in 1995, which led underground economic activity to be captured for the first time in official statistics.

currency so that the threat of a crises is only a long run consideration. This notwithstanding, the Authorities are very much conscious of the need to eliminate the external deficit (Bonello 2001).

Expenditure on wages in Malta hovers around one half of GDP, which is low compared to that in developed countries where it is usually found in the region of 60% to 70%. This reflects protectionist measures towards local industry, which help boost profit margins, together with relatively low wages in Malta in view of a relatively low productivity of labour, due mainly to the public sector of the economy. Malta is also characterized by relatively narrow wage differentials, such that whereas unskilled labour is relatively overpaid by EU standards, skilled workers receive a comparatively low salary. Convergence to EU economic activity levels will thus imply the need to meet increasing wages with higher productivity in order to sustain economic competitiveness, preparing society and the economy to absorb widening wage differentials, and potentially experiencing emigration of skilled labour attracted by better conditions in mainland EU countries.

Inflation is relatively low in Malta, and strongly dependent on price developments in the countries from which Malta imports its consumption goods, mainly to be found in the EU. Thus, inflation typically varies within the 2% to 4% range. Price levels in Malta are also typically close to the average in the EU, such that no significant inflationary pressures are expected to take place within the context of convergence to EU economic activity levels. Average wage increases have typically kept up with and even exceeded inflation. In Malta, there exists a wage indexing mechanism to inflation whereby wages are annually topped up with a nominal amount calculated by applying the rate of inflation of the previous twelve months to a reference average social wage. This mechanism further contributes to narrow wage differentials by more than compensating low wage levels for inflation, while only partially protecting higher wages from inflation.

From the perspective of the composition of economic activity in Malta, primary activities form a very low proportion. Manufacturing, services and the public sector contribute relatively large shares of activity, amounting to between one quarter and third of GDP each, as is typical in an advanced developing economy.

Expenditure on social programmes catered for by the Ministry of Social Security absorbs a relatively large share of economic activity and the Government budget in Malta. They include, apart from administration expenses, government's contribution to the social security system, expenditure on benefits, as well as expenditure on family welfare, care of the elderly services, housing and industrial relations. Health expenditure is not catered for by the Ministry of Social Security but by the Ministry of Health. Tables 1.2a, 1.2b detail the principal categories of social expenditure, including health, in Malta relative to GDP and to the total government expenditure. The data is limited to the expenditures undertaken

by Government as no data is available for private sector social expenditure activities, which are mostly of a voluntary nature. Estimates for private sector expenditure on health is however available and reported separately.

Social security expenditure in Malta absorbed around one-sixth of GDP in 2001, down by around half a percentage point from the 1995 level. This drop resulted almost exclusively from the introduction of means testing of children's allowances, as other expenditure components continued to grow moderately in line with demographic pressures and inflation adjustments. Public health care expenditure is also significant and perceptibly higher than private expenditure. The Government of Malta offers universally free complete hospital and clinic services to the Maltese population, and the quality of service is regularly highly commended by the World Health Organisation (2002). The long run affordability of such a system in future is however being put in question, notably by the Minister of Finance in his Budget Speech for 2002. The demand for private health care in Malta is thus relatively low, and typically exercised by persons who are unwilling to queue up for public health care or who believe that private health care is superior. Details on the nature of the benefits shown in Tables 1.2a, 1.2b are given in chapter 2 of this report.

From the perspective of shares of government expenditure, social security outlays represent a larger burden, amounting to 40% of the total. This proportion increased between 1995 and 2001, in spite of the drop in the share of social expenditure within GDP. This represents the government's efforts to reduce its total expenditure during the period, which however has hardly affected social expenditure, save for children's allowances mentioned above.

Other interesting developments emerging from the above data include the fact that the fastest growing categories of expenditure are those related to the elderly, a result of the ageing population. There is also a significant increase in public expenditure on health, due to the construction of a new hospital. There are doubts regarding the overall future financial viability of this project. The drop in family welfare expenditure reported between 1995 and 2001 is due to significant start-up costs being incurred in the former year.

Table 1.3 details the proportion of beneficiaries out of the total population for major categories of social benefit. It is noted that just under one-sixth of the population is dependent on social security for its main source of income. To the extent that the payment of a benefit covers the household rather than the individual, it may be argued that this estimate is understated.

1.1.2 Demographic Indicators

The Maltese population stood at 382,500 at the end of the year 2000, and is presently growing at the rate of 0.6% per annum. The present pattern of the

Maltese population is conditioned by a post-war baby boom, pronounced emigration during the 1950s and 1960s, and a significant decline in birth and death rates especially since the 1970s.

Table 1.4 presents the principal features of the Maltese population in 1990 and 2000[2]. The principal characteristics that emerge are a slowing rate of population growth from 0.8% per annum in 1990 to 0.6% per annum in 2001. This mainly reflected a drop in the crude birth rate to 11.2 per thousand population. According to the National Statistics Office, the fertility rate has been below replacement and tending to decline of the past five years, averaging at 1.81. The death rate is also declining, such that the average life expectancy at birth increased to 74.3 years for males and 80.2 years for females. The distribution of the population is clearly shifting towards the elderly category, with the proportion of population aged over 59 increasing from 14.7% to 17% within a period of 10 years.

Migration remains a marginal phenomenon in Malta, conditioned mainly by a trickle of returning emigrants from the massive emigration drive in the 1950s and 1960s. Immigration tended to outstrip emigration by around 0.1% of the population. Over 75% of immigrants were from Australia, Canada, the US and the UK, Malta's traditional targets for emigration. Indeed, most of the immigrants are pensioners. Emigration from the Islands is nowadays almost negligible.

1.1.3 Social Indicators

The social and economic dimensions of the social protection system are strongly conditioned by developments in the labour market and the distribution of income in Malta.

The principal source of internationally comparable data for labour market developments in Malta is the labour force survey being undertaken at a quarterly frequency by the National Statistics Office since the year 2000. Historical perspectives are thus difficult to derive, and comparisons between the results of the surveys undertaken so far would be significantly conditioned by sampling errors. This analysis is thus limited to a snapshot of the results of the most recent survey, covering December 2001. On the other hand, the distribution of income in Malta can be discerned from the results of the five-yearly household budgetary survey undertaken by the National Statistics Office.

Table 1.5 summarises the principal characteristics of the labour market in Malta in 2001. The overall participation rate is just under one half of the population aged above 15. There are however considerable gender differences in this respect, with the male participation rate being over double

[2] Consideration of a ten- rather than a five-year span in the data better explains trends in demography.

the female rate. This reflects social norms involving increased female participation in housework, a trend that is however changing rapidly as women are investing more heavily in education. Indeed, the year 2001 was the first time when the number of female graduates at the University of Malta, the only University on the Island, exceeded the number of males.

There also remain marked differences in wage levels earned by males and females, with the latter earning around 75% the wage levels of the former. Although in Malta there has existed the concept of same wage for same work for around 30 years, females tend to be generally far less prevalent in the higher-earning occupations, again because of the need for females to perform housework. This is very much apparent in the age distribution of females in employment, with a pronounced majority being under 35 years of age. Legislation is to be shortly presented to Parliament intended to ensure greater equality of opportunity between males and females, also through the provision of adequate facilities and mechanisms aimed at facilitating female participation in market work.

The unemployment rate in Malta stood at 6.5% at the end of 2001, with the female rate being higher than the male. Thus, there exists no serious unemployment problem in Malta, as the rate compares very favourably with the average of the EU and other accession countries. Historical data for claimant unemployment rates[3] indicates low levels of unemployment throughout the 1990s, ranging between 4% and 5%, in view of the strong growth of the economy together with labour legislation safeguarding workers against unfair dismissals. Unemployment in Malta is a phenomenon that concerns mainly persons under 25 years of age, mainly school leavers awaiting their first employment or switching jobs. There remains a hard core, though not numerous, of unskilled youth who encounter difficulties in finding a job because of insufficient training. The Employment and Training Corporation in Malta organizes specific training courses to deal with these problems and service areas of the economy where there actually exists an excessive demand for labour, such as technological and electronic skills in manufacturing industry. Another area of concern in unemployment is the category aged more than 44, which amount to around 15% of the unemployed. These are usually less trainable and employable than persons in other age groups and would thus be likely to form a structural component of the unemployed. There is a further danger that unemployment in this category would increase with the restructuring of the economy. The Employment and Training Corporation is organizing programmes specifically aimed to this category, whose results are still to be assessed.

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[3] Prior to the introduction of the Labour Force Survey, unemployment data in Malta covered only persons eligible for unemployment benefit. This thus excluded persons, mainly females, who were seeking work but were not the only breadwinners in the family.

From a geographical perspective, Malta may be divided into five districts namely, South Harbour, North Harbour, South East, West, North and Gozo and Comino. Unemployment in all of these regions is comparable to or lower than the national average, except for that in the South Harbour area, where it exceeds 9% [4].

The services sector is the primary employer in Malta. This not only indicates the development of the economy towards more service activities, but also a social perception that primary and manufacturing employment is somehow less desirable, possibly also because technical education in Malta was of an inferior quality. This is creating a persistent shortage of technical skills in manufacturing, and a possible glut in certain services including some areas of education. The Malta College for Arts Science of Technology has been set up in 2001 to promote the development of technical skills that could lead to fruitful and fulfilling employment opportunities.

A post-colonial mentality persists in Malta where a category of the population seeks jobs that are generally free of risk and not excessively demanding in terms of effort. The strong component of public sector employment, averaging one-third of the employed, and relatively low number of self-employed are evidence of this. These considerations may be leading to a society that is excessively dependent on government for its living, and may thus perceive restructuring and international competition as excessively traumatic. Indeed, the anti-EU membership lobby in Malta is playing on these very fears to illustrate its ideas.

The labour market in Malta is heavily unionised in the manufacturing and public sectors, but not as strongly in the services sector. Industrial unrest is relatively infrequent, also because of the existence of the Malta Council for Economic and Social Development which provides a form of debate wherein are represented all social partners.

The best available and most recent data source for other social indicators such as income distribution and household size in Malta is the Household Budgetary Survey undertaken by the National Statistics Office. The survey began in March 2000 and finished in March 2001. The survey provides socio-economic information and to determine those products and services which the Maltese population consumes most. This forms the basis of the Retail Price Index (RPI), which is the tool by which the inflation rate is calculated. For this survey 7,000 households have been randomly selected from the Electoral Register.

The average household size in the Maltese Islands was estimated to be 3.14 people per household. Only 4.2 per cent of all private households consisted of 6 members or more, while 12.7% of households consisted of a single member. The South Harbour district has the highest proportion of

[4] The source of this information is the Household Budgetary Survey.

single member households, partly reflecting social problems in the area, as well as an older population. Table 1.6 shows the distribution of household size by district.

Table 1.7 shows the cumulative distribution of household net income during the previous 12 months before the interview. Average household income is found at Lm 5,240 annually, with the South Harbour and Gozo and Comino districts having an average household income that is between 8% and 11% less than the national average. On a national level, 10.3% of households earned less than Lm 2,000 excluding tax and social security contributions, with higher proportions hailing from the South Harbour and the Gozo and Comino districts.

Table 1.8 shows the distribution of net income per capita of people living within the household. Average per capita income in Malta is found at Lm 1,625 per annum. Considering Lm 10 per week, equivalent to 3.2 US dollars per day, as the minimum income necessary for a person to live in Malta, then it appears that about 5% of the population is living below an estimate subsistence poverty threshold[5]. This is admittedly somewhat of an over-estimate, as other poverty indicators, such as the World Bank's 1 US dollar per day, would result in no absolute poverty in Malta.

In identifying possible groups that are more susceptible to poverty, households in the South Harbour area appear to be more vulnerable. There are also indications of gender differences. Sociological studies observe a feminisation of poverty, affecting lone parent women, in particular (Abela 1998a, 1998b). More recent studies report how "a few women … keep on living in difficult circumstances and for some reason or other, are trapped into a situation of poverty and feel socially excluded" (Abela 2002). A National Statistics Office (1999) publication, however, reports that illiteracy is lower for women than for men. It also shows that out of the 3.5% of the population that lived in sub-standard housing in 1995, 53% were women. The slightly higher incidence of women is mainly due to widows, who may thus be looked at as a vulnerable group in this category.

1.2 How does the described background affect social protection?

1.2.1 Forecasts and Projections

For the next 2 to 3 years, the Maltese economy is expected to grow at a stronger rate than in 2001, when its growth, but not its rate of unemployment, was substantially hit by the international recession. The resilience of the unemployment rate reflects the fact that employers were

[5] A poverty line has to date not yet been specifically defined for Malta. The poverty basis used for social policy in Malta is the social wage, which amounts to around Lm 60 per week for a representative 4-person household. It is however presumed that this is somewhat higher than what may be perceived as a poverty line.

reluctant to lay off people because the recession was expected to be short-lived. Thus, economic activity in the export-related sector should recover in line with international demand, while domestic demand is expected to expand in response to major capital investment projects to be undertaken, mainly in the tourism and real estate sectors. In addition, prospective and eventual membership in the EU, which subject to a national referendum, is expected to take place some time between 2004 and 2005, should act as a catalyst to foreign direct investment and attract structural funds, which should further contribute to improve economic growth in the forthcoming years.

The generally positive economic outlook should generally expand the demand for labour and restrain any increases in the rate of unemployment. Pressures towards higher unemployment in Malta emanate from the need of economic restructuring and privatisation, together with the imperative to reduce the fiscal deficit. It should however be noted that privatisation programmes in Malta generally contain specific guarantees safeguarding existing jobs. Moreover, the Maltese Government appears to be very reluctant to shed jobs in order to reduce its deficit, preferring to increase taxation or cutting other forms of expenditure instead. Finally, business restructuring undertaken to date, including the removal of part of the protective levies for industry, has not resulted in job losses, as the restructuring process was generally successful. Still, the levies in the more vulnerable agro-alimentary sector are to be removed in 2003, where potentially, there could be job losses of up to around 1% of the labour force. The government has however already announced a programme of assistance to the sector in order to facilitate its restructuring. Taking everything together, therefore, it is not expected that there should be any notable increases in the already relatively low rate of unemployment in Malta over the next few years.

In terms of demographic factors, the next few years are expected to build upon present trends, with the population continuing to age. Migration is expected to remain negligible, as Malta has negotiated a seven-year transition period whereby workers from other countries are precluded from working in Malta, although the Maltese can work in other EU countries. More than a migratory movement, this is expected to generate a general increase in wage levels in Malta, which are at present relatively low. The business sector will thus face the challenge of absorbing these higher wage costs either through lower profit margins of through increases in productivity.

1.2.2 Influences of economic, demographic and social developments on the social protection system

It thus appears that in Malta there exists no significant phenomenon of poverty at present and with unemployment being relatively low and the net

of social security is extensive and captures virtually all of the population. If anything, it is being claimed that the generous system may be imposing an excessive burden on economic growth. The pressures that can be expected over the short to medium term in this respect can be listed as:

a. a continued effort to restructure the economy, which may imply job losses in certain areas where protection is to be removed - these concern mainly agriculture and certain domestically-oriented manufacturers, which are however to receive specific assistance for their restructuring;

b. a further drive to reduce the fiscal deficit, which will call for rationalization and increased efficiency in expenditure, including social expenditure;

c. an increased participation by females in the labour force – the issue of gender equality needs to be reinforced in this respect to allow females to pursue long run careers and to protect the status of housewives who do not directly contribute to social security;

d. population trends are over the medium term expected to be unchanged from those observed in recent years, with the population total expected to continue rising at a slow rate until stability is achieved some time after 2010 but with the proportion of elderly population continuing to rise at least until 2020, when it is expected to amount to 25% of the total;

e. economic growth is expected to continue relatively strongly, especially as the international economy recovers and the domestic economy converges more rapidly to EU levels;

f. the strong economic activity may attract an influx of foreign workers, mainly from outside the EU as Malta has obtained a seven-year transition period during which workers from the EU may not obtain jobs in Malta.

It is nevertheless expected that a section of the population may be insufficiently prepared for the rapid changes in the economic environment expected to take place. This section is typically less educated, and would depend on Government for an easy job and on government benefits and services to supplement its income and consumption. It would also have a higher propensity to participate in underground economic activities. Membership of the EU as well as today's stronger need for economic competitiveness due to globalisation would imply the need for radical changes to these modes of life that tend to absorb resources without sufficiently contributing in return. It may be thus expected that the social security system would have to increasingly cater for this section of society, preferably in a way which helps it adjust to the new realities rather than by promoting a culture of continued dependence. It is thus expected that some of the focus of the social security system would shift away from the provision of direct universal benefits, which up to now constituted the

essence of the system, to the provision of specifically targeted services, especially to families, women, the elderly and the unemployed.

1.3 Annex to chapter one

Table 1.1: Selected Main Economic Indication Percent

Year	GDP per capita (PPS)	Total GDP in Billion Euro	GDP growth In %	Consumption ratio	External deficit ratio	Share of wages in GDP	Inflation	Wage growth
1995	n.a.	2.5	6.2	81.7	-13.7	49.6	4.0	4.6
1996	9,900	2.6	4.0	84.4	-12.3	49.9	2.8	6.1
1997	10,600	3.0	4.9	81.2	-7.0	49.8	3.1	7.0
1998	11,100	3.1	3.4	79.2	-2.3	50.2	2.3	5.1
1999	11,700	3.5	4.1	79.5	-4.1	50.5	2.1	4.6
2000	12,600	3.9	5.2	80.5	-9.3	50.3	2.4	2.8
2001	n.a.	4.0	-1.0	82.0	-2.9	50.7	3.0	6.0

Sources: National Statistics Office, Central Bank of Malta

Table 1.2a: Social Security Expenditure as % of GDP

In %	1995	1996	1997	1998	1999	2000	2001
Administration	0.3	0.3	0.3	0.4	0.4	0.4	0.5
Govt Contribution to Social Security*	4.0	4.0	4.0	3.9	3.9	3.9	3.9
Social Security Benefits:	11.8	11.7	11.6	11.5	11.4	11.3	11.2
Contributory	9.7	9.6	9.5	9.4	9.3	9.2	9.1
Retirement pensions	4.7	4.8	4.8	4.8	4.9	4.9	4.9
Children's allowances	1.6	1.4	1.3	1.2	1.0	0.9	0.8
Bonus to beneficiaries	0.7	0.7	0.6	0.6	0.6	0.6	0.6
Other	2.7	2.7	2.7	2.7	2.7	2.7	2.7
Non-contributory	2.1	2.1	2.1	2.1	2.1	2.1	2.1
Retirement pensions	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Disability	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Poverty assistance	0.8	0.8	0.9	0.9	0.9	0.9	0.9
Medical assistance	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Bonus to beneficiaries	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Supplements to poverty	0.2	0.2	0.2	0.2	0.1	0.1	0.1
Family and Social Welfare	0.2	0.1	0.1	0.1	0.1	0.0	0.0
Care of the Elderly	0.6	0.6	0.6	0.7	0.7	0.7	0.8
Housing	0.3	0.3	0.2	0.2	0.2	0.2	0.2
Industrial Relations	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**17.1**	**17.0**	**16.9**	**16.9**	**16.8**	**16.7**	**16.6**
Health care	**6.4**	**6.6**	**6.9**	**7.1**	**7.4**	**7.6**	**7.9**
Public	4.3	4.5	4.7	4.9	5.1	5.3	5.5
Private	2.1	2.1	2.2	2.2	2.3	2.3	2.4

Sources: National Statistics Office, Central Bank of Malta

Table 1.2b: Social Security Expenditure as % of Government expenditure

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Administration	0.7	0.7	0.8	0.9	1.0	1.0	1.1
Govt Contribution to Social Security*	8.9	9.0	9.1	9.2	9.3	9.4	9.6
Social Security Benefits:	26.5	26.6	26.7	26.8	26.9	27.0	27.1
Contributory	21.7	21.8	21.8	21.9	21.9	22.0	22.1
Retirement pensions	10.6	10.9	11.1	11.3	11.5	11.8	12.0
Children's allowances	3.6	3.3	3.0	2.7	2.4	2.2	2.0
Bonus to beneficiaries	1.5	1.5	1.5	1.5	1.4	1.4	1.4
Other	6.0	6.1	6.2	6.3	6.4	6.5	6.6
Non-contributory	4.8	4.8	4.9	4.9	5.0	5.0	5.0
Retirement pensions	0.9	0.9	0.9	1.0	1.0	1.0	1.1
Disability	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Poverty assistance	1.9	1.9	2.0	2.0	2.1	2.1	2.1
Medical assistance	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Bonus to beneficiaries	0.5	0.4	0.4	0.4	0.4	0.4	0.4
Supplements to poverty	0.5	0.4	0.4	0.4	0.3	0.3	0.3
Family and Social Welfare	0.4	0.3	0.2	0.2	0.1	0.1	0.1
Care of the Elderly	1.3	1.4	1.5	1.5	1.6	1.7	1.8
Housing	0.6	0.6	0.6	0.5	0.5	0.5	0.5
Industrial Relations	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total	**38.5**	**38.8**	**39.1**	**39.4**	**39.7**	**40.0**	**40.3**
Health care	**14.4**	**15.1**	**15.8**	**16.6**	**17.4**	**18.3**	**19.2**
Public	9.7	10.2	10.8	11.4	12.0	12.7	13.4
Private	4.7	4.9	5.1	5.2	5.4	5.6	5.8

Sources: Ministry for Social Policy, Ministry of Finance

*The Government contribution to social security includes a statutory contribution equal to one half of contributions collected from employers and employees.

Table 1.3: Beneficiaries of Social Benefits as % of population (average 1995-2000)

	%
Retirement Pensions	7.3
Invalidity Pensions	1.8
Widowhood Pensions	2.5
Injury Benefits	2.8
Poverty assistance	2.0
Total	**16.4**

Source: Ministry for Social Policy

Table 1.4: Principal Demographic Developments

	1990	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Total Population[(1)]:	361,908	378,404	381,405	384,176	386,397	388,759	391,415
Maltese	355,910	371,173	373,958	376,513	378,518	380,201	382,525
Foreign	5,998	7,231	7,447	7,663	7,879	8,558	8,890
Gender distribution (%):							
Males	49.4	49.4	49.4	49.4	49.5	49.5	49.6
Females	50.6	50.6	50.6	50.6	50.5	50.5	50.4
Age structure (%):							
0-14	23.3	21.5	21.4	21.3	20.8	20.4	20.0
15-29	21.6	21.3	21.4	21.4	21.7	21.9	22.0
30-44	24.3	22.7	22.0	21.5	21.0	20.8	20.5
45-59	16.1	18.8	19.3	19.5	19.8	20.1	20.5
60 and over	14.7	15.7	15.9	16.3	16.7	16.8	17.0
65 and over	10.5	11.2	11.6	11.7	12.1	12.1	12.4
Dependency Ratio							
% of total population	38.00	37.20	37.30	37.60	37.50	37.20	37.00
% of economically active pop.	61.30	59.20	59.50	60.30	60.00	59.20	58.70
Annual population growth (%)	1.0	0.8	0.8	0.7	0.5	0.4	0.6
Immigration	858	621	399	453	349	339	450
Emigration	160	107	94	73	121	67	50
Net Immigration	698	514	305	380	228	272	400
Net Fertility:							
per 1000 population	15.2	12.4	13.3	12.9	11.9	11.4	11.2
per 1000 females aged 15-44	67.1	61.0	64.8	63.0	58.1	55.5	53.7
Net reproduction rate	2.1	2.0	1.9	1.8	1.8	1.8	1.8

Death rate per 1000 pop:	7.7	6.7	6.6	6.5	6.4	6.2	5.9
Males	7.9	6.9	6.8	6.7	6.6	6.4	6.1
Females	7.5	6.6	6.5	6.4	6.2	6.0	5.7
Life expectancy:							
at birth – Males	73.7	73.9	74.0	74.1	74.1	74.2	74.3
– Females	78.1	79.5	79.7	79.1	80.0	80.1	80.2
at age 65 – Males	14.1	14.3	14.5	14.7	14.8	14.9	15.0
– Females	16.7	17.5	17.7	17.9	18.9	18.2	18.4

(1) all data excludes foreign population unless otherwise specified

(2) calculated as persons aged 0-14 and 60+ out of Maltese population

Source: National Statistics Office. It is to be noted that historical data reported by Eurostat in European Social Statistics – Demography (2001), does not conform to data produced by the National Statistics Office. For instance, Eurostat data implies an average population growth rate of almost 1% between 1995 and 2001, which is double that reported by the National Statistics Office. In view of these significant divergences and the need to accurately represent developments in Malta in the report, the National Statistics Office is here retained as the source for demographic data.

Table 1.5: Main Labour Market Indicators (2001)

	Males	**Females**	**Total**
Employed	103,607	41,980	145,587
Unemployed	6,626	3,538	10,164
Inactive	44,783	115,261	160,044
Total	155,016	160,779	315,795
Participation rate (%)	71.1	28.3	49.3
Unemployment rate (%)	6.0	7.8	6.5
Age distribution of employed (%)			
15-24 years	15.8	32.5	20.6
25-34 years	23.5	26.3	24.3
35-44 years	24.4	17.4	22.4
45-54 years	25.9	17.9	23.6
55-64 years	9.7	5.6	8.5
65+ years	0.7	0.3	0.6
Age distribution of unemployed (%)			
15-24 years	48.4	63.9	53.7
25-34 years	14.8	18.5	16.1
35-44 years	19.6	7.5	15.4
45-54 years	13.7	8.3	11.9
55-64 years	3.5	1.8	2.9
Average annual salary (Lm)*	5,081	4,047	4,762
Distribution of employees by activity (%):			

Primary	2.2	0.3	1.6
Manufacturing	36.7	22.7	32.4
Private Services	36.1	50.5	40.5
Health, education and community work	15.1	17.9	16.0
Public Administration	9.9	8.6	9.5
Private sector	66.1	68.2	66.7
Civil servants	33.9	31.8	33.3
Distribution by employment status (%):			
Employee	82.9	91.3	85.4
Self-employed	16.9	7.8	14.3
Family worker	0.2	0.9	0.4

Source: National Statistics Office *Lm 1 = 2.5 euros = 2.25 UD dollars

Table 1.6: Distribution of Household Size by district

Number of Persons	**South Harbour**	**North Harbour**	**South East**	**West**	**North**	**Gozo and Comino**	**Total**
	%	%	%	%	%	%	%
1	15.5	13.4	9.2	9.9	12.4	12.5	12.7
2-3	45.6	47.8	47.7	39.9	41.3	42.0	45.0
4-5	35.2	34.9	37.6	46.3	42.0	40.2	38.1
Over 6	3.6	3.8	5.6	3.9	4.2	5.3	4.2

Source: National Statistics Office

Table 1.7: Cumulative distribution of income by district

Income ceiling	**South Harbour**	**North Harbour**	**South East**	**West**	**North**	**Gozo and Comino**	**Total**
	Cum %	Cum %	Cum %	Cum %	Cum %	Cum %	Cum %
Lm 2000	14.9	9.3	9.5	6.7	7.3	14.3	10.3
Lm 4000	43.8	40.8	37.0	39.2	36.9	46.6	40.6
Lm 6000	70.7	66.3	64.5	69.7	66.3	74.8	68.1
Lm 8000	84.6	80.8	81.0	81.2	78.8	88.2	82.4
Lm 10000	94.3	87.3	90.5	91.7	87.2	93.6	90.6
Lm 12000	99.0	93.8	97.0	95.2	94.5	97.1	96.0
Over Lm 12000	100.0	100	100	100	100	100	100
Average (Lm)	4,854	5,434	5,410	5,326	5,580	4,708	5,240

Source: National Statistics Office

Table 1.8: Distribution of income in Malta

Income ceiling (Lm)	**Cumulative % of persons**
Lm 500	5.0
Lm 1000	23.0
Lm 2000	77.1
Lm 3000	93.8
Lm 4000	96.9
Over Lm 4000	100.0
Average (Lm)	1,625

Source: National Statistics Office

2. OVERVIEW OF THE SOCIAL PROTECTION SYSTEM

The Ministry for Social Policy administers the Social Security System in Malta. There are no other statutory insurances or systems of social protection in the country, save for voluntary NGOs that cater for specific needs, on which however there is a dearth of data. The private sector provides insurance schemes and pension plans that are, however, on a voluntary basis. Thus, the system is highly centralized with the Ministry of Social Policy supervising the system and actually implementing it. The Ministry is at present focusing on administering expenditure and services, as the collection of contributions has for the past three years become a responsibility of the Ministry of Finance. The provision of the public health services in Malta falls under the Ministry of Health.

2.1 Organisational Structure

2.1.1 Overview of the System

The Departments falling under the Ministry include:

a. Social Security. This is a major department involved in the assessment of eligibility for and payment of social benefits.

b. Family Welfare. The Department of Family Welfare offers services in social work that aim at favouring a better mutual adaptation of individuals, families, groups and the social environment in which they live, and developing the self-respect and self responsibility of the individuals utilising the capacity of persons, interpersonal relations and the resources provided by the community. The Department has the responsibility for operational matters, including the planning, development, and management of social welfare services. It ensures that the service delivery reflects local needs and policies and objectives as outlined by the Ministry for Social Policy.

c. Women in Society. This Department promotes and encourages the effective implementation of the principle of equality between women and men in every sphere of Maltese life by promoting co-responsibility of women and men in public life as well as within the family, ensuring that in the enactment of all legislation and in the implementation of Government policies, the role of women receives the fullest consideration, helping to increase the participation of women at all levels of decision-making and working for the creation of the necessary circumstances to enable women to assume positions of leadership and responsibility at all levels in Malta's development process and at all levels of management.

d. Elderly and Community Services. The objective of this Department is to promote the dignity of older adults by providing a range of services designed to address the actual needs of the individual.

e. Social Housing. The main role of the Department of Social Housing is to provide alternative accommodation for the people who do not have a suitable accommodation.

f. Housing Construction and Maintenance. The Department is responsible for construction of new housing units on behalf of the Housing Authority and conducting repairs in Government tenements.

g. NGO liaison. This Department coordinates the activities of NGOs in the provision of various social services.

h. Industrial and Employment Relations. This Department aims at protecting the interests of workers in employment contracts while actively promoting a healthy employment relationship in a spirit of social partnership, and to contribute towards stable industrial relations.

The main relevant legislation for social security, covering the provision of benefits, is the Social Security Act of 1987. The Act provides for two basic schemes. One Scheme is known as the Contributory Scheme, and the other as the Non-Contributory Scheme. In the Contributory Scheme, the basic requirement for entitlement is that specific contribution conditions are satisfied. In the Non-Contributory Scheme, the basic requirement is that the conditions of the means test are satisfied.

Non-contributory benefits are mainly aimed at providing social and medical assistance (the latter, both in cash and in kind) to heads of household who are unemployed and either in search of employment or unable to perform any work because of some specific disease, provided their family's financial resources fall below a certain level. Those who suffer from certain chronic diseases are allowed a medical aid grant free of charge as well, irrespective of their family's financial resources. Whoever qualifies for social assistance is also paid a rent allowance if the head of household is paying rent for his place of residence. Non-contributory benefits are paid on a flat rate basis, adjusted annually for inflation.

The Contributory Scheme may be said to cater for the other side of the coin. This scheme is universal since it practically covers all strata of our society. The contributory scheme in Malta is a system where an employee, self-occupied or self-employed person pays a weekly contribution as laid down by the Social Security Act. The Maltese system is thus a ‘pay as you go’ system. This is due to the fact that one contributes during the period that of gainful activity in order to provide for a later contingency such as sickness, unemployment or retirement occurs. A number of contributory benefits are available for a limited time period. Upon the expiry of this, persons can resort to non-contributory benefits.

All employed, self-employed, self-occupied as well as unemployed persons may be insured. This is precisely the reason why the scheme provides for the payment of different classes and categories of contributions, explained further on. Moreover, under certain conditions, the scheme acknowledges the non-payment (crediting) of contributions during a period of a specific contingency, and provides for the crediting in lieu of the payment of contributions.

2.1.2 Centralisation/De-centralisation of the System

The Ministry for Social Policy plays through its Departments, a focal role in the social protection system in Malta. An organisational chart is presented. It delivers its services through its offices spread around the country and through its website, which is part of the e-Government initiative in Malta. In view of the small size of the country, which is barely 300 square kilometers in area, there is limited role for regional government and all services are thus centralized within the National Ministry.

Operating under the umbrella of the Ministry are however various quasi-governmental organizations providing specialized services, namely:

a. **Foundation for Social Welfare Services.** The Foundation provides support services targeted at families with social problems, including domestic violence and substance abuse.

b. **National Employment Authority.** The Authority oversees the stability of employment relations in Malta and studies policies to improve the workings of the labour market.

c. **Employment and Training Corporation.** The Corporation is responsible for reducing unemployment in Malta by controlling information frictions and improving skills through the specific training courses.

d. **Housing Authority.** The Authority operates Government's schemes to provide housing at subsidized conditions to the population at large in order to widen home ownership in Malta.

e. **Co-operatives Board.** The Board monitors the setting up and operation of worker's co-operatives in Malta and assists in their running.

f. **Occupational Health and Safety Authority.** The Authority is charged with implementing relevant legislation and assist in its monitoring and enforcement.

g. **National Commission for Persons with Disabilities.** The Commission studies the impact of legislation on persons with disabilities and works to favour their continued integration into society.

In Malta there are also a number of voluntary NGOs, of which the most important ones have connections with the Roman Catholic Church. They are funded partially from the Government but they also rely on private donations. They provide services related to drug abuse, sheltering victims of domestic violence, helping in the rehabilitation of prisoners, providing residences for elderly people, and helping persons with disabilities. It may be claimed that there exists to some extent a duplication of effort with Government agencies, especially in the field of controlling substance abuse. Resources could perhaps be better deployed in this respect to reach of wider segment of population in a more effective manner. In this respect, Malta probably also needs specific legislation to regulate charities to render their funding and use of resources more transparent to Government and the donating general public.

2.1.3 Supervision

The supervision of the Social Security System in Malta is undertaken by the Ministry of Social Policy itself. The Ministry has not only the power to implement the provisions of the relevant law but also to supervise the way in which it is being implemented. This may admittedly generates problems of conflict of interest. The general public may challenge the Ministry's decisions in front of specific umpires, the Civil Courts as well as the Constitutional Court.

In terms of supervision of the system, the Ministry has very recently started to undertake initiatives towards conducting research into the workings of the social security system in Malta and its effects. There have however been no published results to date.

2.2 The Financing of Social Protection

2.2.1 Financing sources

Contributions by the social partners constitute the single source of social security financing in Malta. There are two classes of contributions: the Class One contribution payable in respect of Employed Persons and the Class Two contribution paid by self-employed Persons. Government also effects a statutory State contribution to the system.

Generally speaking, contributions are payable by all persons between the age of 16 years and the age of their retirement which could be anywhere between the age of 61 years (60 in the case of women) and the age of 65 years. This depends entirely on the date on which the person chooses to give up employment or self-occupation in terms of the Social Security Act and claim a pension in respect of retirement. Persons exempt from contributing are those in receipt of full-time education or training, non-gainfully occupied married women whose husband is still alive, persons in receipt of a pension

in respect of widowhood, invalidity or retirement or persons in receipt of a Parent's Pension, persons in receipt of non-contributory Social Assistance or a non-contributory pension. Non-gainfully occupied persons whose total means do not exceed Lm430 per annum in the case of single persons and Lm630 per annum in the case of married men, as well as 'gainfully occupied' self-employed persons whose earnings do not exceed Lm390 per annum may apply for a certificate of exemption from the payment of contributions. Other persons are credited with contributions, albeit not paying them, including a widow as long as she is not gainfully occupied, and a person who during any calendar week is entitled to sickness benefit, or injury benefit, or a benefit in respect of unemployment or a pension in respect of invalidity.

2.2.2 Financing principles

Malta operates pay-as-you-go funding of its social security system whereby contributions by employers, employees and the self-employed, topped up by a statutory amount by Government equal to one half of collected contributions[6], are set-off against social security expenditure including health[7]. The resulting deficit is known as the welfare gap. The welfare gap is estimated to have hovered at between 4% to 6% of GDP during the past five years, thus accounting for over one half of the overall fiscal deficit. Politicians and policymakers alike have often voiced concerns regarding the fact that the cost of the social security system in Malta is becoming unsustainable[8]. There are no social security funds in Malta, the last of these having been run down in 1979.

There thus exists a degree of lack of clarity in the precise patterns of financing of social security expenditure in Malta. The financing of social security is through contributions from employers, employees and the self employed, to which the State adds a contribution equal to 50% of all others. Expenditure set against this in the derivation of the welfare gap includes health (which is non-contributory, every citizen having the right to public health care irrespective of whether that citizen is contributing or not), but not some other forms of non-contributory expenditure. From a certain viewpoint, thus, one could consider contributions to form part of general government revenue, and all expenditure to be a charge against general government revenue. It is to be further pointed out that the formula for effecting the State contribution is not one where it is intended to make up for some presumed shortfalls in private sector contributions, as the two move together. On the other hand, it is a well-known fact that policy-makers

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6 This statutory amount paid by Government is over and above the contributions paid by Government as an employer.

7 The tradition of government accounting excludes certain types of social security expenditure form the computation of the welfare gap. Since there is no valid reason behind this practice, it is not taken into account in the comments which follow.

8 See for example, Budget Speech for 1999 delivered by the Minister of Finance (p.41).

often refer to contribution revenue as constituting some form of budget constraint to the undertaking of welfare programmes. This lack of clarity in financing sources was debated at some length in the National Commission for Welfare Reform and is expected to be addressed in future.

2.2.3 Financial administration

Contribution rates are presently 10% of the gross wage paid by each the employer and the employee, and 15% of pre-tax income in the case of self-employed persons. Each of these contributions is subject to a ceiling which currently stands at around Lm650 per annum and which increases in line with inflation. The payment of benefits is similarly capped to a reference wage of Lm6500 per annum, increasing in line with inflation. As indicative points, the average wage in Malta is around Lm4,500 per annum, with the minimum wage being Lm2,600. It is calculated that around 15% of employees earn a wage in excess of the maximum reference wage for contributions, thereby paying an effective contribution percentage that is lower than the statutory percentage. In fact, many regard the social security contribution to be a regressive form of tax. It is however to be noted that the benefits received under contributory schemes are related to contributions paid and since there is typically a strong element of government subsidy in the contributory system, then the lower income categories would benefit proportionately more strongly. The contribution base in Malta is therefore the economy's wage bill plus income earned by self-employed persons. Table 2.1 shows the growth of these variables and their proportion within GDP. Table 2.2 shows the development of contribution revenues.

The growth in the economy's wage bill has been slowing down since 1995, mainly due to the effects of the deceleration of economic growth on employment and wage increases. This dampened the growth of contribution revenues, as Table 2.2 shows. Growth in income from self-employment has been more erratic, responding with greater variability to economic developments as well as to Government's efforts to curb underground economic activity. In total, the base for contribution revenue has been growing at a slower rate, and, with the exception of the last two years, has shrunk as a percentage of GDP.

The growth in contribution revenue slowed down between 1995 and 1999, which was also reflected in its share of GDP. This trend was halted in 2000, when contribution rates from employees were raised from one-twelfth to one-tenth. Furthermore, for the purposes of capitalising on economies of scale, the responsibility for collecting contributions has recently been transferred from the Social Security Department to the Department of Inland Revenue.

2.3 Overview of Allowances

The schemes of benefits in Malta, together with eligibility rules, are as follows.

2.3.1 Health Care

Maltese citizens enjoy free health care from Government hospitals and clinics across the country. The service is offered on a universal basis and there are no contribution requirements. Medicines are also offered at zero cost to the user.

2.3.2 Sickness

A sickness benefit is offered under contributory schemes for a usual maximum period of 156 days which may be extended to 312 days. The weekly payment of this benefit is retroactive and paid as follows:-

- Lm3.89c per day per person.
- A married person whose spouse is not employed on a full-time basis, or a single parent, is paid Lm6.02c per day.

Persons are paid according to the number of working days in a week that could be either a five (5) or six (6) day week. No payments are effected for a public holiday

Beneficiaries who remain inmates at state-owned hospitals for more than 6 months or who become inmates at state-owned institutions for the elderly lose the right to a non-contributory pension but receive an allowance instead of it. Sickness Assistance is payable to persons suffering from a chronic disease or condition that requires a special diet. Tuberculosis Assistance is payable to the head of a household or any member of the household suffering from or having, within the last 5 years, suffered from Tuberculosis. This assistance is not subject to a means test and amounts to Lm7 per week for the first patient in the household, and Lm3.2 per week for each additional patient. Leprosy Assistance is payable to the head of a household or any member of the household who is receiving treatment for leprosy. It is not means tested and weekly benefit rates are: when a head of household is a leper (employed or not) – Lm10.75; any other member who is a leper, over 16 years old and unemployed - Lm10.75; any other leper under 16 years of age - Lm4.60; every other member of a household of a leper who is unemployed - Lm4.60.

Free medical aid is payable to a person who on account of disablement, sickness, or disease (and who is not hospitalised), is in need of medical, surgical or pharmaceutical aid. Medical aid is means-tested except for those cases where the person is suffering from tuberculosis, leprosy, poliomyelitis

or diabetes mellitus or other chronic diseases outlined in the Social Security Act. The weekly benefit rates are: First patient Lm6.70; each additional patient within the household Lm4.50.

2.3.3 Maternity

A maternity benefit is payable to local residing pregnant citizens of Malta in respect of the last 8 weeks of pregnancy and the first 5 weeks after childbirth. The maternity benefit is only payable, if the female is not entitled to maternity leave from her employer, if employed. It is not means tested and amounts to a lump sum payment of Lm227.5. Employed persons are entitled to a maternity leave consisting of 3 months on full pay which may be extended by a further one year of unpaid leave.

A milk grant is payable to the head of a household receiving Social Assistance when he or any member of the household has the care or custody of a child under 40 weeks of age either be weaned or is losing weight in spite of being breast fed or is a member of a household receiving Tuberculosis Assistance. The benefit amounts to Lm4.6 per week.

2.3.4 Invalidity, Long-term care, Disability

An invalidity pension is payable to persons deemed permanently incapable of suitable full-time or regular part-time employment. This is a long term contributory benefit, whose level would vary depending upon the degree of invalidity and the level of contributions paid. The average benefit paid in 1999 was Lm29 per week

A carer's pension is payable to single or widowed citizens of Malta who are taking care on a full-time basis of a bed-ridden or wheel-chair bound near relative. The benefit is non-contributory and long-term at the weekly rate of Lm30.44 plus an additional bonus of Lm1.34 weekly and a six monthly bonus of Lm58.

A non-contributory disability pension is payable to citizens of Malta over 16 years of age. Various types of handicaps are listed under the Social Security Act. The benefit rates are Lm37.46 per week when both of a married couple qualify, Lm22.88 per week when only one of a married couple qualifies and Lm28.32 per week in other cases (single, widowed, etc.).

In addition to the above a weekly bonus of Lm 1.34 is payable. In the case of a married couple, when both qualify they are paid Lm 0.67 each. A six monthly bonus of Lm 58.00 is also payable.

A pension for the visually impaired is payable to a citizen of Malta over 14 years of age whose visual activity has been certified by an

ophthalmologist to be so low as to render such persons unable to perform any work for which eyesight is essential. This is also extended to other disabilities. The rate payable is 55% of the national minimum wage, the latter current standing at close to Lm50 per week. This is a means tested benefit, as it is only payable to persons whose income falls below the minimum wage.

A disabled child allowance is payable to locally residing citizens of Malta who have the effective custody of a child suffering from cerebral palsy or severe mental subnormality or who is severely handicapped or to those who have a child under 14 years of age who is blind. If the two parents are gainfully occupied, only the highest income will be considered as long as this does not exceed Lm13,270 per annum. The maximum allowance is Lm5 weekly, but may be reduced according to means.

2.3.5 Old-age

The retirement pension is payable to persons on reaching pension age (61 in the case of men and 60 for women). The most prevalent pension is the two-thirds pension, which is an earnings-related contributory pension payable to persons who have retired after January 1979. This scheme basically provides for a pension equivalent to two-thirds of the insured person's pensionable income. There are applicable maximum and minimum rates. The two-thirds proportion may be reduced if the number of weekly contributions is less than 150 over the working life.

In the case of persons over the age of 60 with insufficient contributions, the age pension is payable. The applicable rates are: a married couple where both qualify - Lm38.70 or Lm19.35 each per week; where only one of a married couple qualifies on the basis of age - Lm21.88 per week; other persons (single, widowed etc.) - Lm29.44 per week. These rates are increased by a weekly Additional Bonus of Lm1.34 per week or Lm0.67 each when both qualify. A Six Monthly Bonus of Lm58.00 is also payable.

2.3.6 Survivors

The following benefits are paid on a contributory basis to survivors. They are thus not means-tested and the level of benefit would depend upon the level of past contributions. Indicative weekly rates for the levels of benefits paid in 1999 are provided where available.

Widows' Pension	Payable to widows, irrespective of age, who are not gainfully occupied or who are carrying out gainful activities but have the care and custody of children under 16 years of age. Rates may vary according to conditions outlined in the Social Security Act. The average benefit paid in 1999 was Lm39 per week.

Survivors' Pension	Earnings-related pension payable to a widow whose husband was entitled to a Two-Thirds' pension or whose husband would have been entitled to a pension had he reached retiring age at the time of his death. The average benefit paid in 1999 was Lm39 per week.
Widowers' Pension	Payable to Widowers' on the same conditions as that applicable to a female widow for a Widows pension as explained above. Rates equivalent to those of Widows' Pension. The average benefit paid in 1999 was Lm39 per week.
Orphans' Allowance	Weekly allowance paid to a guardian of a child or children who are under 16 years of age. The average benefit paid in 1999 was Lm22 per week.
Orphans' Supplementary	Weekly pension paid to a guardian of a child or children whose age lies between 16 and 21 years and who are unemployed or employed but earning less than the Maltese National Minimum Wage.
Parents' Pension	Payable to a parent of an employed person, who died as a result of industrial disease or accident at work and whom, prior to death of son or daughter, depended solely on their financial resources for livelihood.

2.3.7 Employment injuries and occupational diseases

An injury benefit is offered for a period of up to 12 months to workers injured on the place of work and unable to continue working as a result. This is a contributory benefit and hence related to the amounts of contributions effected. The average benefit paid in 1999 amounted to Lm2.5 per week. This benefit would be over and above other benefits receivable due to the inability to continue working.

A disablement pension under contributory schemes is payable on a long term basis if an injury or disease was caused or contracted whilst at work which is considered to cause a loss of physical or mental faculty calculated between 20% & 89%. The rates are distinguished according to the degree of Disability. Where the degree of disablement is assessed at 90% and over, the person concerned is automatically awarded an Invalidity Pension at the full rate.

2.3.8 Family Benefits

Emergency assistance is payable to a woman who is or has been rendered destitute by the head of household to the extent that she becomes an inmate of any institute for the care and welfare of such persons. It is a non-contributory benefit, determined on a case by case basis by the Department of Welfare

Children's allowance is payable to locally residing female citizens of Malta who have the care of children under 16 years of age, and where the household income does not exceed a stipulated amount (presently Lm10,270). The amount of the benefit is subject to a means test and to the number of children in the family. On the same basis, a special allowance is payable to locally residing female citizens of Malta who have the care of a child who is 16 years of age or over and who is either still at school or registering for employment. . The average level of benefit is 1999 was Lm9 per week.

2.3.9 Unemployment

The unemployment benefit is available for 156 days on the basis of a contributory test. This is payable for a short period of time to persons that do not normally qualify for social assistance. The special unemployment benefit is payable for the same period of time at a higher rate to persons who normally qualify for social assistance, as explained in 2.3.10 below. The rate payable to persons under pension age for unemployment is Lm2.38c per day, while that payable to persons under pension age for special unemployment is Lm4.00c per day. If an unemployed spouse is maintained or in the case of a single parent, the rate payable for unemployment is Lm 3.66c per day, while that for special unemployment is Lm6.14c. The payment is based on each day of unemployment, excluding Sundays.

2.3.10 Minimum resources/ Social Assistance

Social assistance is available through non-contributory schemes and is means tested . It is payable to heads of households, including single persons, who are either unemployed or seeking employment and the period of time for which unemployment benefit is payable has elapsed, and where the relative financial means falls below that established by the Social Security Act, currently Lm7,000. It is payable also to single or widowed women who lack financial resources and who are caring for an elderly or physically/mentally handicapped relative on a full-time basis. A social assistance allowance is further payable to inmates of Government recognised Centres for the rehabilitation of drug addicts and inmates of state-owned institutions for the elderly who are below the age of 60. The rate of assistance is Lm28.80 per week for the first person in the household and this amount is increased by Lm3.50 per week for each additional member in the household. A Weekly Additional Bonus of Lm1.34 and a Six monthly Bonus of Lm58 is payable to beneficiaries of Social Assistance. This is the most effective instrument for preventing poverty in Malta

A supplementary allowance is over and above payable to households where the total income of the members falls below the limits outlined by the Social Security Act from time to time. At present the income limit for this type of Allowance stands at Lm3770 for a married person and Lm3270 in

the case of a single person. The maximum amount of this allowance is Lm2.3 per week, which may be reduced according to means.

2.4 Summary: Main principles and mechanisms of the social protection system

Social security in Malta thus rests on two pillars. The first is universal, based on contributions effected from the state of employment. This affords short and long term benefits, mainly for the purposes of injury, sickness, unemployment and pension. Other cases of social assistance, mainly connected to poverty, disability and family issues are catered by non-contributory schemes that are in essence means tested. The Non-Contributory Scheme which originally was meant to cater for those below the ”poverty line” has over a period of years evolved into a comprehensive scheme with a number of provisions that are intertwined in such a way that one type of benefit supplements another. This has made possible the allocation of more than one benefit at the same time thus providing simultaneous coverage in those cases where more than one contingency is present. Moreover, through the process of targeting, this scheme has succeeded in the provision of additional assistance to certain specific group such as persons with a disability, single parents, as well as the family unit. There are thus both employment-centred as well as citizen-centred elements in social protection in Malta. Likewise, there are elements of assurance and of insurance. The contributory system also implies a degree of social solidarity underlying the system. This has effectively led to a situation where poverty is minimal in Malta and where most cases of social need are adequately covered.

It is however pertinent to point out that a certain gender discrimination remains in the system. The beneficiaries of contributory benefits, most notably retirement pensions, are mainly males who had contributed during their working lives. Women who did not perform market work, and hence did not contribute in their name, would be excluded. This may put housewives at a disadvantage, if families are broken, especially later in life. The wife can claim part of the social security benefits accruing to the husband only by instituting court proceedings, which may be costly and lengthy. Another gender discrimination is present in the fact that the higher non-contributory benefits payable in the case of married persons are available only to men.

2.5 Annex to chapter two

Table 2.1: The contribution base

	Growth (%)			**% of GDP**		
	Wage bill	Self-employed	Total	Wage bill	Self-employed	Total
	%	%	%	%	%	%
1995	12.7	3.2	11.7	52.3	5.9	58.3

1996	8.1	-0.9	7.2	53.1	5.5	58.7
1997	3.6	7.3	4.0	51.9	5.6	57.5
1998	5.4	16.4	6.5	51.0	6.1	57.1
1999	6.1	4.6	6.0	51.5	6.0	57.5
2000,	4.3	3.1	3.2	51.6	6.1	57.7

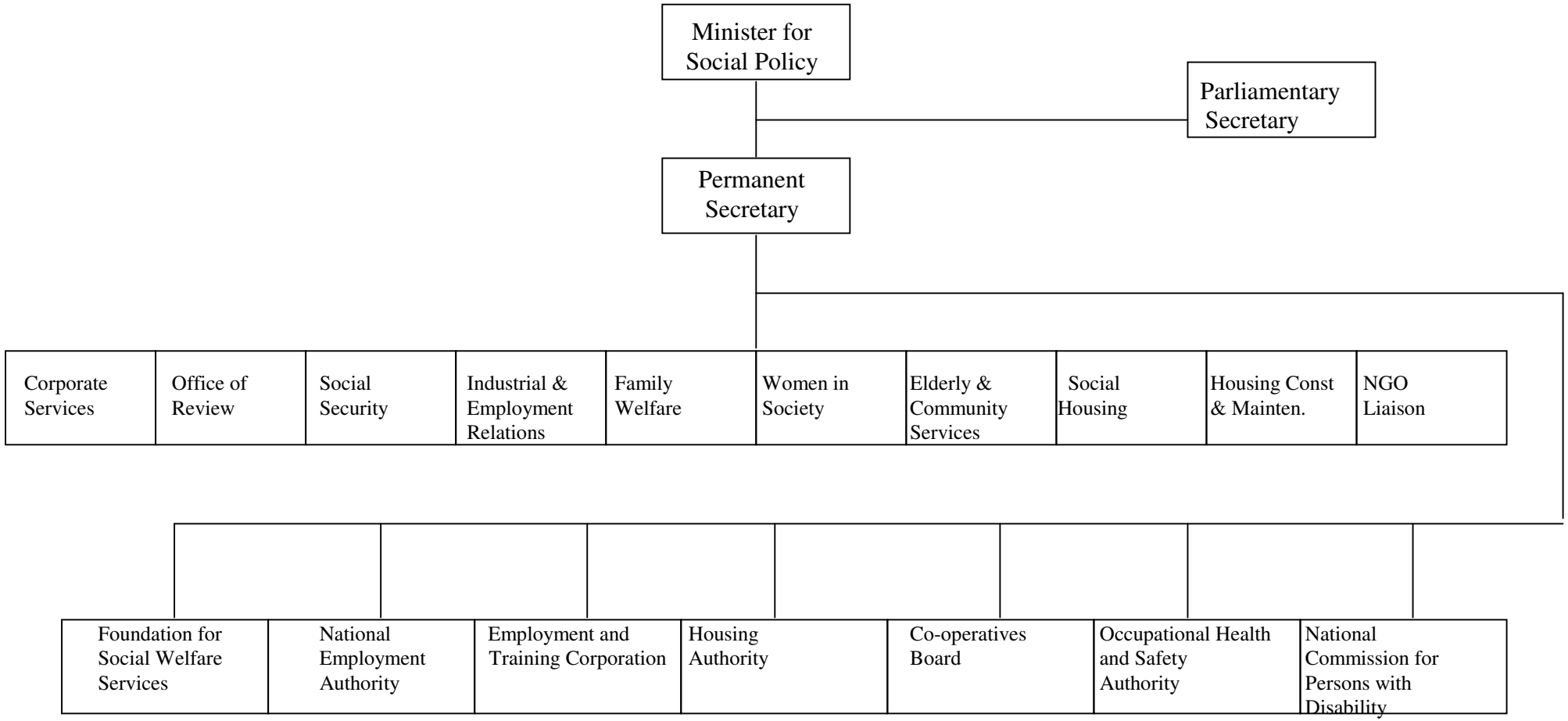
Source: National Statistics Office

Table 2.2: Contribution Revenue

Year	**Growth (%)**	**% of GDP**		
	Total	Employment and Self-Employment	Government	Total
	%	%	%	%
1995	14.0	8.6	4.3	12.9
1996	6.1	8.6	4.3	12.9
1997	7.9	8.7	4.4	13.1
1998	2.0	8.3	4.1	12.4
1999	2.3	8.1	4.0	12.1
2000	5.9	8.2	4.1	12.3

Source: Ministry for Social Policy

Figure 2.1 Organisational Chart for the Ministry of Social Policy



3. PENSIONS

3.1 Evaluation of current structures

The social security system (SSS) in Malta is a comprehensive one, covering a number of areas including retirement pensions. It operates on a Pay-As-You-Go (PAYG) basis administered by Government, whereby current contributions from employees, employers, and the State go towards the financing of current benefits. Benefits are broadly classified into contributory, whose award depends upon a minimum number of contributions being effected, and non-contributory, which are awarded upon the fulfilment of specific socio-economic criteria. A detailed description of these benefits is presented in Chapter 2.

3.1.1 Public-Private Mix

The system thus principally rests on the universal, public PAYG scheme which provides a number of benefits to elderly persons including retirement and old-age pensions, widowhood pensions, disability pensions and a number of illness-related benefits as described in Section 2 of this report. Retirement pensions are awarded under contributory and non-contributory schemes, but the principal one is the so-called ”two-thirds” contributory scheme. The non-contributory scheme caters for old-age pensions by providing a less generous benefit to persons with insufficient contributions during their working lives or who were dependent on social assistance.

The entitlement to a two-thirds contributory pension is attained upon reaching age 61 for men and age 60 for women and having made at least thirty years effective contributions. The initial benefits are calculated at two-thirds of the average income during the best three years out of the last ten prior to retirement in the case of employed persons. In the case of self-employed, the income averaging period is extended to five years. This system gives rise to abuse in that declared income and contributions are maintained low for most of the working life but are subsequently increased significantly during the final working years so as to attain the maximum possible retirement benefit. The two-thirds pension is indexed annually in line with developments in wages in the category in which a pensioner used to be occupied.

In the case of persons who did not effect sufficient contribution or were receiving social assistance prior to attaining retirement age, a non-contributory means tested flat rate pension is payable upon attaining pensionable age, revisable annually according to changes in the cost of living. In Malta, there exists also a so-called top-up pension, payable to persons receiving a pension outside the social security system. The rates of benefit vary according to the rate of pension received, but typically it allows

a total income that is slightly higher than that under a two-thirds retirement pension.

There exists no second pillar pensions system in Malta, by which workers would contribute towards a retirement fund. In the same manner, there exist no occupational pension schemes, as such funds were wound up in 1979 with a lump sum being then paid to contributors. The only exception to this relates to Civil servants employed before 1979, who are eligible to a service pension equal to two-thirds of their final salary. Other pension entitlements under the social security system would be reduced, but the total pension income would still be somewhat higher compared to a normal social security benefit. It is estimated that there are around 6,600 civil servants who are expected to fall under this scheme. Third pillar pensions are in their initial stages of development, albeit growing. Yet, they are unlikely to constitute an important source of retirement income within the next two decades. There is as yet no favourable tax treatment with respect to investments in pension funds.

In this respect, it is observed that the capital markets in Malta are still in their early development stages, albeit growing quite rapidly. The Stock Exchange, which became functional in 1992, has listing for government stocks, a handful of corporate equity instruments, and a number of investment funds based on local and foreign instruments. The eventual establishment of pension funds in Malta is not viewed to rely extensively on domestic investments, due to the smallness of the local economy and the lack of adequate diversification that would ensue. Indeed, the private funded pension plans currently available in Malta are primarily based on foreign investments.

Delia and Delia (1994) have summarised the results of the few surveys carried out to date on the lifestyles of the elderly in Malta. The elderly are a heterogeneous group; variability depends on age, gender, socio-economic grouping, health, intellectual abilities and enterprise skills. Following Neugarten (1982) elderly are categorised into the young-old, who are healthy vigorous persons and want age to become irrelevant as they pursue a wide variety of lifestyles, and the old-old, who have suffered major physical and/or mental deterioration and are dependent on others. In Malta, there are a number of facilities catering for the needs of the elderly. Public sector facilities include pension income provision, hospitalisation of the general, rehabilitative and geriatric type; outpatient services in hospitals and health clinics; community and residential care and educational programmes. Voluntary services focus more on direct support to the elderly in their homes and their participation in society. Church institutions and the private sector provide further residential facilities.

It is in general found that the majority of the elderly are dependent on state support for their income. For the provision of other services however, it appears that the family continues to play a major role. Delia and Delia

conducted fieldwork, which has shown that the elderly in Malta are generally healthy and mobile, and increasingly participating in social decision-making. Around 60% of the elderly own the house in which they live.

There is at present no data regarding the distribution and sources of income of the elderly in Malta. The National Statistics Office is known to be working on this issue based on data garnered from the Household Budgetary Survey.

3.1.2 Benefits

The principal retirement pension system in Malta is the ”two-thirds” system. This is a contributory scheme, subject to a minimum of thirty years contributions with the benefit being reduced pro-rata if the number of contributions is lower. Employed persons are entitled to a benefit equivalent to two-thirds of the average income of the best three years within the last ten years of contributions. Self-employed persons have a five-year income averaging period. However, the maximum pension benefit receivable is Lm 4,400 per annum, which would imply a replacement rate lower than two-thirds for persons with an average income in excess of Lm6,600 per annum. The ceiling is adjusted annually for inflation. Up to now, retiring persons with such income levels have been relatively few, but this issue is expected to become more significant in the near future particularly in view of the latest collective agreement for civil servants which provided for a substantial increase in salary levels following a number of years where these remained relatively stable.

Benefits are wage indexed and revisable annually, but remain subject to the same nominal maximum described above. The average retirement benefit paid per contributor in 1999 stood at Lm38 per week, plus a six monthly bonus of Lm58.

Table 3.1 below details the distribution of benefits of the two-thirds contributory pension system in 2000. The number of male beneficiaries exceeds by far the number of females, reflecting the fact that female participation in the labour force in Malta is a relatively recent phenomenon. It is also noted that around 40% of pensioners earn an annual benefit in excess of Lm 2,600, the minimum wage in the economy. Furthermore, around 6% of beneficiaries are earning the maximum possible benefit, and are therefore receiving a pension that is only inflation-indexed rather than wage-indexed. It is also noted that the beneficiaries earning more than the minimum wage are 30% in the case of men but only 15% in the case of women. This reflects the fact that men traditionally held higher paid jobs.

Table 3.1: Distribution of Two-thirds Benefits

Annual Benefit Lm	Males	Females	Total	Distribution of Males		Distribution of Females		Total Distribution	
				%	Cum %	%	Cum %	%	Cum %
0-1600	672	371	1043	5.3	5.3	14.5	14.5	6.9	6.9
1600-1849	752	1072	1824	6.0	11.3	41.8	56.2	12.1	18.9
1850-2099	2165	354	2519	17.2	28.6	13.8	70.0	16.6	35.6
2100-2349	1865	179	2044	14.8	43.4	7.0	77.0	13.5	49.1
2350-2599	1718	103	1821	13.7	57.1	4.0	81.0	12.0	61.1
2600-2849	1834	125	1959	14.6	71.6	4.9	85.9	12.9	74.1
2850-3099	1093	98	1191	8.7	80.3	3.8	89.7	7.9	81.9
3100-3349	659	84	743	5.2	85.6	3.3	93.0	4.9	86.8
3350-3599	447	92	539	3.6	89.1	3.6	96.6	3.6	90.4
3600-3849	244	31	275	1.9	91.1	1.2	97.8	1.8	92.2
3850-4099	221	13	234	1.8	92.8	0.5	98.3	1.5	93.8
4100-4349	900	44	944	7.2	100.0	1.7	100.0	6.2	100.0
Total	12570	2566	15136	100		100		100	

Source: Ministry for Social Policy. Cum = Cumulative

The non-contributory old-age pension is payable to persons with insufficient contributions, subject to a means test. In 2000, there were just under 8,000 beneficiaries of this pension. The applicable rates are: a married couple where both qualify - Lm38.70 or Lm19.35 each per week; where only one of a married couple qualifies on the basis of age - Lm21.88 per week; other persons (single, widowed etc.) - Lm29.44 per week. These rates are increased by a weekly Additional Bonus of Lm1.34 per week or Lm0.67 each when both qualify. A Six Monthly Bonus of Lm58.00 is also payable. The non-contributory old-age pension is adjusted for inflation on an annual basis.

There is also a universal minimum pension in Malta, set at two-thirds of the minimum wage and revisable annually by the rate of inflation. The minimum pension is currently at around 40% of the maximum pension benefit. No pension benefit is allowed to fall below the national minimum pension. The data in Table 3.1 shows that there are over 1,000 beneficiaries whose pension level falls below the minimum. This is due to the fact that the pension, which these beneficiaries would be receiving from the Social Security System, would be a top-up over a pension being received from other sources. The aggregate pension income from all sources typically received by these beneficiaries would exceed the two-thirds of employment income ratio.

The retirement age in Malta is presently 60 for females and 61 for males. Persons are allowed to work up to the age of 65 without any reduction in pension income provided that their earnings from employment are less than Lm3,000. The Minister for Social Policy has the right to waiver this condition for specific persons whose services may continue to be required in the public service.

As discussed in Section 1 of this report, the social security system in Malta is effectively removing poverty from the country. Pensions are a major tool in this respect.

3.1.3 Financing of the System

The general comments regarding the financing of the social security system made in section 2.2 of this report apply to the financing of the pension system as well. Pensions and other forms of old-age income are financed out of contributions paid by employers, employees and the state in a PAYG manner. Taking into account the cost of health, the contributions to social expenditure deficit has fluctuated between 4% to 6% of GDP in recent years. It is, however, to be noted that contribution revenue more than covers the cost of retirement pensions. This is why pensioners associations claim that pensions are not the reason of the deficit. This is obviously a fallacious argument, but it perhaps reflects the lack of accounting clarity in the financing of social security expenditure in Malta as discussed in section 2.2 of this report.

3.1.4 Incentives

A 1999 study of the Maltese pension system[9] found significant economic disincentive effects in the awarding of pension benefits and in the PAYG method of financing them. These relate mainly to disincentives to work effort and to the declaration of income, as PAYG contributions by workers and employers are being perceived as a tax with little linkages to the benefits actually received. It is only the contributions effected in the final few years used for income averaging that determine the pension benefits received, as discussed in section 3.1.2 of this report. This not only discourages work effort and encourages contribution shirking, but also provides a venue for abuse of the system. The study further argues that the pension system is contributing to encourage consumption at the expense of saving, as it is catering for two of the most important motives for saving, namely the coverage of risk and the provision of resources for future consumption. These adverse incentives are occurring at a time when population ageing will present other important challenges to economic development, primarily to the financing of the fiscal deficit and the shortage of labour. The study argues that a transition to a funded pension scheme should contribute to

[9] Cordina et al (1999)

remove distortions from labour market activity, stimulate saving and investment, and contribute to the development of domestic capital markets. It may here be further stated that parametric changes to the present system would also contribute to remove these distortions. For instance, the income-averaging period for the computation of benefits could be increased to improve the link between contributions paid during the working life and the benefit received.

3.1.5 Coverage of the System

The pension system in Malta is universal, covering every household through contributory or non-contributory scheme. No specific groups are excluded and there are no opt-out options. The only relevant variable in this respect is the extent of participation, as the effective nominal ceilings on contributions and benefits imply that higher income households would participate to a lesser extent relative to their means than lower income households would.

A gender issue that arises in this respect concerns the non-contributory old-age pensions. As explained above, these are paid at two benefit levels, a higher one, which pertains to a married person with a dependant spouse, and a lower one for a single person. Only men, however, may receive the higher benefit. Married women receiving the non-contributory pension and who have a dependant husband would still only receive the lower benefit applicable to a single person.

3.1.6 Public Acceptance of the System

The population is generally in favour of the pension schemes as they are at present generous. It is estimated that the PAYG system is equivalent to an investment with a 9% annual rate of return for the individual contributor, assuming wage growth at 5% p.a., inflation at 2.5% per annum, a contribution period of 30 years and benefits to be received for 15 years.

The system is properly and efficiently administrated, with payments being made in a timely manner and without error in a regular manner. It was one of the first systems to be computerised within the Government of Malta.

The public understands the operation of the pension system reasonably well, although some of the general mechanics of the computation of initial benefits and of indexing are complicated and generally not precisely understood. Furthermore, it is being noticed that people are only nowadays becoming more conscious of the effect of the ceiling on benefits, as the upward drift in incomes is rendering it more often effective. Indeed, this is an issue which private sector providers of third pillar pension plans highlight during the course of the marketing of their products.

The population is also becoming resentful of the fact that such a ceiling does not apply to Members of Parliament and upper members of the judiciary. Public debate is also sometimes stirred by the fact that under the present two-thirds formula, persons retiring earlier may earn a higher pension benefit, depending on the timing of the implementation of wage increases in collective agreements.

3.2 Evaluation of Future Challenges

Akin to systems in other countries, the pension system in Malta is increasingly coming under scrutiny regarding its cost and long term sustainability. This is to be seen within the context of concerns regarding the fiscal position and pre-occupation with the amount of resources that would be available to serve an ever-growing number of pension system dependants over future years.

3.2.1 Main Challenges

In particular, two prominent and equally important issues that are debated are:

The impact of demographic shifts on the patterns of contribution revenue and social security expenditure, and hence, on the affordability of the system.

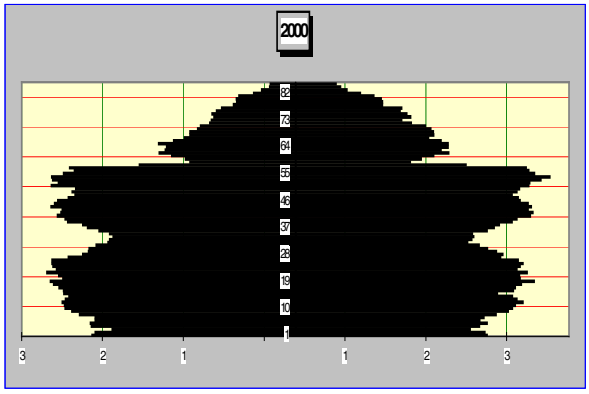
Demographic shifts are a major challenge to pension systems around the world. The principal considerations in deriving demographic projections are the present distribution of the population by gender and age, and the present and expected developments in fertility and in the probability of dying by age. The rate of fertility by age is assumed to remain unchanged throughout the forecast period from the relatively low levels that were observed in 1998. The probability of dying by age, on the other hand, was assumed to continue declining throughout the forecast period, until it settles at around 75% of the present rates by 2065. This ratio is somewhat arbitrary, and indeed calls for close scrutiny in future in assessing the extent to which the projections presented here will mirror actual developments. To the extent that the decline in the probability of dying is underestimated, the baseline scenario would overestimate the affordability of the pension system. Migration patterns are ignored for the purposes of this study Table 3.2 summarises the principal demographic developments that arise out of these assumptions. These demographic assumptions represent typical of studies of this type and also in line with demographic projections produced by the Maltese National Statistics Office.

Table 3.2: Demographic Trends

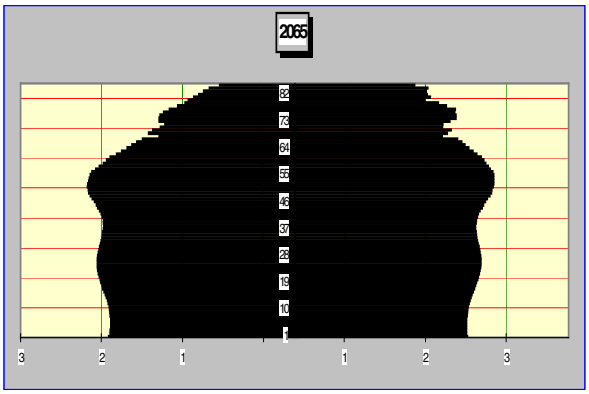
Year	Total Population (000s)	Population Growth Rate	Share of Population above Retirement . Age	Persons of working age per person of retirement age	Life Expectanc y at Birth: Male	Life Expectanc y at Birth: Female	Life Expectanc y at Retirement : Male	Life Expectanc y at Retirement : Female
1998	378.5		16.1%	3.9	72.3	78.2	78.0	81.3
1999	380.1	.4%	16.3%	3.9	72.3	78.3	78.0	81.3
2000	381.6	.4%	16.5%	3.8	72.4	78.3	78.0	81.3
2005	389.2	.4%	17.5%	3.6	72.6	78.5	78.2	81.5
2010	395.6	.3%	20.0%	3.1	72.8	78.7	78.3	81.6
2015	400.4	.2%	21.6%	2.7	73.0	78.9	78.5	81.8
2020	403.1	.1%	23.2%	2.5	73.2	79.1	78.7	81.9
2025	403.5	(.0%)	24.0%	2.4	73.5	79.2	78.8	82.1
2035	400.2	(.1%)	23.9%	2.4	73.9	79.6	79.2	82.4
2045	394.8	(.1%)	25.4%	2.2	74.4	80.1	79.5	82.8
2065	382.3	(.2%)	26.1%	2.2	75.5	81.0	79.3	83.5

Among the more interesting demographic statistics, it can be noted that the share of the population above retirement age is to rise from the present 16% to 26% by 2065. This implies that whereas around 4 persons of working age currently support each person of retirement age[10], by 2065 this ratio will drop to 2.2. This is in part explained by an increase in the average life expectancy. Life expectancy at birth is expected to rise from the current 72.3 years to 75.5 years for males, and from 78.2 years to 81 years for females. For persons that actually attain retirement age, life expectancy would be expected to be higher, as Table 3.2 shows.

Figure 3.1: Population Pyramids, 2000, 2065.



[10] The working age is statutorily defined in Malta as 16-60 for women and 16-61 for men.



Based on the above assumptions, developments in the demographic structure of the population can also be discerned from the population pyramids shown in figure 3.1. As the population ages, the age structure of the population is projected to become less of a conical shape and more of a cylindrical shape.

Developments in the labour market are essential to derive projections regarding contributors to the SSS. Among the more important assumptions, there are those relating to the participation rate, the unemployment rate and the typical progression of income throughout the working life of a person. The participation rate of males is assumed to remain unchanged from the relatively high levels that already prevail at present. In the case of females, however, the participation rate of persons aged 25 and over is assumed to rise gradually until it grows by a factor of 50% by 2065, in line with the expected continued increase in the participation of females in the labour market. The participation rate of females aged under 25 is not expected to rise further from the already high levels at present. The unemployment rate is, somewhat simplistically, assumed to remain unchanged from present levels. The income progression pattern by age was discerned from the latest Census data, and assumed to remain unchanged throughout the forecast period.

The extent to which the current system will be able to afford a decent living standard to beneficiaries in future, given a nominal ceiling that applies especially to the two-thirds pension scheme.

This nominal capping system has three important implications for the workings of the SSS, namely:

- due to the nominal capping of contributions, the effective rate of contributions collected out of the average wage will fall over time in spite of the fact that the statutory rate will remain unchanged, as wages will reach and exceed the relevant nominal cap;

- due to the nominal capping of contributory benefits, the effective proportion of entry benefits received out of the average wage will also fall over time;
- as benefits reach the cap level, the effective method of indexing benefits will change from one which is predominantly wage-based to one which is mainly based on the cost of living adjustment (COLA)[11] awarded by Government – this, because benefits that reach the cap are indexed in this way.

3.2.2 Financial Sustainability

This section of the report evaluates the current structure of the pension system in Malta studies its likely future financial development through a simulation of the present system by means of the World Bank's Pension Reform Options Simulation Toolkit (PROST).

Among earlier studies on the future behaviour of the pension system in Malta, the principal ones are those compiled by Camilleri (1997) and the study presented with the Interim Report of the National Commission on Welfare Reform (2000). The two reports reach broadly similar conclusions in terms of identifying the potential for a significant funding problem.

For the purposes of this analysis, retirement benefits are sub-divided by functional categories namely retirement, widowhood, disability/injury and other, mainly of a non-contributory nature. Retirement, widowhood and disability/injury benefits are explicitly modelled in this exercise. Benefit expenditure is further sub-divided into the degree of financing to which the Department of Social Security would be committed, namely provision of full benefit, supplement to benefit received from another source (mainly service pensions), which would under no circumstance fall below the minimum benefit. In turn, contribution revenue was divided into that obtained from the employed, employers, self-employed and the State contribution, to reflect differences in contribution rates and other factors.

In all cases, full account was taken of the impact of nominal ceilings on revenue and expenditure. Broadly speaking, this was undertaken in the following manner. For any specific benefit, the position of the number of beneficiaries split by age and benefit level was assessed as at the year 2000. As time was allowed to progress in the simulation, the beneficiary could die or if the beneficiary survives, could remain in the same benefit bracket, or move to a higher benefit bracket (depending on the extent of annual revision

[11] In Malta, wages are annually adjusted by a nominal amount equal to the inflation rate of the past twelve months multiplied by a notional social wage, equivalent to the minimum wage plus a number of social security benefits and currently equal to around Lm 65 weekly. Thus a uniform cost of living increase is awarded universally and is equivalent to Lm 65 weekly multiplied by the rate of inflation. The notional social wage would in the following year be increased accordingly

of the benefit) until the cap level of benefit is reached, when further increases would be limited to two-thirds of the COLA. The development of contributions was modelled in a similar manner, with contributors ageing, dying, or achieving retirement or some other benefit status. As contributors age, they would be modelled to either remain in the same or going to a higher contribution bracket until the cap is perhaps reached, in which case, only the COLA would be considered for the purposes of the increase in contribution revenue.

The main macroeconomic assumptions inherent in the PROST simulations are summarised in Table 3.3 below. Real GDP growth is in the model used to determine the increase in output, which will in part accrue to wages and hence be reflected in contribution revenue. It is in the model set at 3.5% in the year 2000 and is conservatively assumed to slow down gradually during the forecast period as the economy develops further and eventually converges to the slower rates of growth of developed countries.

Table 3.3: Macroeconomic Trends

	1998 %	**1999 %**	**2000 %**	**2065 %**
Real GDP Growth	3.1	3.0	3.5	2.5
Labour Productivity Growth	1.5	1.5	1.5	1.5
Inflation Rate	2.4	2.0	2.2	2.5
MINIMUM WAGE AS % OF AVERAGE WAGE	52.6	51.6	50.8	40.0

Retail price inflation is in the model used to convert real data to nominal data, as the statistics of the SSS are initially in nominal values. Inflation, which stood at 2.2% in 2000, is assumed to converge to 2.5% over the forecast period. The minimum wage development is necessary in the model to determine such variables as minimum contribution and benefit levels. In relation to the average wage, it is assumed to drop gradually over the forecast period, to reflect increasing wage differentials that are typical of a developing economy and converging with its main trading partners.

The effective rate of contributions out of wages, the effective replacement rate of entry benefits out of wages, and the effective benefit-indexing pattern were established on the basis of an exercise simulating the evolution of beneficiaries/contributors and benefit/contribution levels over time, as described above. The results are given in Table 3.4a.

The effective collection rate of contributions currently stands at just under 78%. This in part reflects the non-collection of contributions due because of administrative difficulties. More importantly, however, there is the fact that a number of workers in Malta are already earning a salary above the maximum considered for the purposes levying contributions. This phenomenon is set to increase over time, until the effective collective rate is

projected to fall to just over 30% by 2065. The basic entry benefit replacement rate currently stands at 58.5%, falling short of the statutory 66%, mainly because of retirees who had been earning a salary above the cap level. The basic entry benefit replacement rate is set to fall to around 20% by 2065, if the current system of capping remains in place. This effectively means that the SSS will be providing the average retiree with only one-fifth of the pre-retirement salary. Contributory benefits are at present predominantly wage-indexed. Inflation (i.e. COLA) indexation of benefits that are already at the cap level is comparatively scarce. This situation is bound to change over time as a greater number of beneficiaries achieve the capped benefit level, beyond which the benefit would be only revised on the basis of the COLA. It is to be noted that since the COLA is awarded on the basis of the social wage, it is assumed that it accounts for around 80% of the decline in purchasing power of the **average** wage.

Table 3.4a: Social Security System Effective Rates

	2000 %	**2010** %	**2015** %	**2020** %	**2025** %	**2035** %	**2045** %	**2065** %
EFFECTIVE COLLECTION RATE FROM EMPLOYEES AND EMPLOYERS	77.8	75.8	73.8	68.0	61.2	46.8	36.9	30.4
BASIC ENTRY BENEFIT REPLACEMENT RATES	58.5	46.7	43.6	40.1	36.6	32.2	23.7	19.7
Benefit Indexation:								
To inflation	2.7	16.4	26.9	39.3	50.4	70.4	77.3	79.8
To wages	96.6	79.5	66.3	50.8	37.0	12.1	3.4	0.2

The results are categorised into three aspects, namely the number of contributors and beneficiaries by main benefit type, the impact on public finances and the implications for individual retirement financing.

Following the functional distribution of benefits described above, the development of the number of beneficiaries over time is analysed in terms of invalidity, widows and the retirement pension beneficiaries which receive a full benefit from the SSS, and those that receive a top-up over a benefit from some other source, such as a service pension. Data for the projected development in beneficiaries together with contributors is shown in Table 3.4b.

The number of recipients of invalidity and widows benefits is projected to remain relatively stable. Although increased life expectancy should contribute to some reduction in the amount of widows and invalidity beneficiaries, this reduction is entirely reflected in the top-up category that is in those who are already receiving a service pension, mainly from the military services or the local civil service.

Table 3.4b: Contributors and Beneficiaries

	Persons (000s)					% age of population				
Year	Beneficiaries				Contrib.	Beneficiaries				Contrib.
	Inval-idity	Wid-Ows	2/3 retire	Top-up		Inval-idity	Wid-ows	2/3 retire	Top-up	
2000	5.7	5.4	15.8	11.3	149.2	1.5	1.4	4.1	3.0	39.1
2005	6.6	5.5	18.4	10.4	158.0	1.7	1.4	4.7	2.7	40.6
2010	6.7	5.6	26.7	9.0	159.7	1.7	1.4	6.8	2.3	40.4
2015	6.6	5.8	34.0	7.5	158.5	1.7	1.4	8.5	1.9	39.6
2020	6.2	5.7	41.7	6.1	157.0	1.5	1.4	10.3	1.5	38.9
2025	6.0	5.1	47.7	4.4	157.1	1.5	1.3	11.8	1.1	38.9
2035	6.7	5.4	56.7	2.5	163.5	1.7	1.3	14.2	0.6	40.9
2045	6.4	5.8	65.7	1.4	160.8	1.6	1.5	16.6	0.4	40.7
2065	6.1	5.8	73.7	0.6	160.3	1.6	1.5	19.3	0.2	41.9

Table 3.4c: System Dependency Ratio

Year	Beneficiaries				Contrib-utary	System dependency ratio
	Invalidity	Widows	2/3 retire	Top-up		
2000	5.7	5.4	15.8	11.3	149.2	25.6%
2005	6.6	5.5	18.4	10.4	158.0	25.9%
2010	6.7	5.6	26.7	9.0	159.7	30.1%
2015	6.6	5.8	34.0	7.5	158.5	34.0%
2020	6.2	5.7	41.7	6.1	157.0	38.0%
2025	6.0	5.1	47.7	4.4	157.1	40.2%
2035	6.7	5.4	56.7	2.5	163.5	43.6%
2045	6.4	5.8	65.7	1.4	160.8	49.3%
2065	6.1	5.8	73.7	0.6	160.3	53.8%

Beneficiaries under the two-thirds pension scheme are expected to rise significantly over the forecast period, from just under 16 thousand to almost 74 thousand. This reflects population ageing, an increased female participation rate in the labour force, which would eventually result in an increased amount of pension beneficiaries and a shift away from top-up retirement pension beneficiaries towards full two-thirds pension scheme beneficiaries, as service pensioners in the population are gradually replaced by other pensioners.

Owing to the assumed increase in female participation in the labour market, the number of contributors within the population is projected to rise by some 3-percentage points. Due to the stronger increase in the population of beneficiaries, however, the number of contributors per beneficiary is projected to decline from the current 3.9 to just under 1.9 by 2065. This is reflected in a rise in the system dependency ratio shown in Table 3.4c.

The projection of the current SSS in terms of its effects on public finances represents the interplay of the developments in the number of beneficiaries and contributors described above and the pension system rules that determine the amount of per capita benefit and its evolution. The principal results on public finances are shown in Table 3.5, which details revenue from contributions (including the State contribution), expenditure on retirement pensions, expenditure on other contributory benefits such as widows pensions, and expenditure on all non-contributory benefits as derived by the exercise described above. The financial balance on the SSS is shown with State contributions included with revenue, and with state contributions excluded, which shows the true cost of the SSS to the Exchequer.

In 2000, the deficit on the SSS stood at around Lm12 million, if the State contribution is included with revenue, or Lm65 million if the State contribution is excluded so as to capture the underlying charge of the SSS against other fiscal revenue sources. Respectively these amounted to 0.8% and 4.3% of the income generated by the country during that year.

The projections shown in Table 3.5 indicate that these deficits are expected to rise significantly over time, with the deficit on the SSS excluding State contribution from revenue is projected to amount to Lm573 million by 2065. But in comparison to the output that is expected to be generated by the economy, these deficits are not expected to worsen to any appreciable extent from the 2000 level. For instance, the deficit on the SSS with the State contribution included in revenue is expected to peak at around 2.3% of GDP in 2035, and stabilise at 1.1% of GDP by 2065.

Table 3.5: Financial Simulation

Year	**Contributions** ***Lm millions***	**Expenditure** ***Lm millions***			**Balance** ***Lm millions***		**Balance** **% of GDP***	
		2/3 retirement	Other contributory	Non-contributory	with State contrib	without State contrib.	with State contrib..	Without State contrib
2000	161.4	40.2	79.6	53.2	-11.6	-65.4	-0.8%	-4.3%
2005	211.2	53.4	96.1	55.7	6.1	-64.3	0.3%	-3.4%
2010	254.0	88.5	108.5	60.3	-3.3	-87.9	-0.1%	-3.7%
2015	288.7	129.2	119.9	59.5	-19.9	-116.1	-0.7%	-4.0%
2020	316.0	181.0	131.0	59.4	-55.5	-160.8	-1.5%	-4.4%
2025	341.2	232.5	139.4	59.8	-90.5	-204.2	-2.0%	-4.5%
2035	399.3	339.0	160.9	59.7	-160.3	-293.4	-2.3%	-4.2%
2045	452.9	445.9	180.0	60.4	-233.4	-384.4	-2.1%	-3.5%
2065	815.7	791.3	264.0	61.3	-301.0	-572.8	-1.1%	-2.2%

It thus appears that the charge of the present SSS on the Exchequer is not expected to increase significantly in future compared to the size of the economy. This is primarily because the impact of demographic

developments is viewed to be contrasted by the persistence of the nominal ceilings on benefit and contribution rates that are progressively expected to shrink the size of the SSS in relation to the economy. This, however, does not automatically eliminate concerns about the cost of the SSS.

In this projection, the statutory contribution rate in retained unchanged but is effectively diminished as wages exceed the nominal contribution ceiling, as explained in Table 3.4a. At the same time, the system of capping on benefits not only restrains growth in overall fiscal expenditure but also carries important implications for the development of the benefits received by individual beneficiaries. Table 3.6 shows that due to the caps on benefits, the average per capita retirement benefit is projected to grow at a progressively slow rate, until the purchasing power of the average would start to decline after 2020. This indicates another element of potential un-sustainability of the system, namely the fact that individual benefits would decline initially relative to the average wage earned in the economy, but eventually also in terms of their own purchasing power, implying an overall lower standard of living for beneficiaries. This would obviously bring pressures to increase benefits, which, all else being equal would adversely affect, the negative balance between contributions and benefits.

Table 3.6 Development in Per Capita Retirement Benefit

Year	**Average Annual Growth in per capita retirement benefit**			
	Nominal	Real	Nominal	Real
	Lm	Lm	%	%
2000	2543	2543	3.1	0.7
2005	2901	2502	2.7	0.2
2010	3315	2527	2.7	0.2
2015	3800	2560	2.8	0.3
2020	4342	2585	2.7	0.2
2025	4874	2565	2.3	-0.2
2035	5980	2458	2.1	-0.4
2045	6786	2179	1.3	-1.2
2065	10737	2104	2.3	-0.2

The main conclusions arising out of the baseline simulation are that the cost of the actual SSS is expected to increase somewhat in the coming years in relation to the size of the economy at the same time that it will yield lower relative and absolute living standards for beneficiaries.

3.2.3 Pension Policy and EU accession

EU accession should present no major needs for reform of the Maltese pension system. No major problems are envisaged for the implementation of

Regulation 1408/71/EEC by Malta. The only issue that can be identified at this stage is the rectification of the gender discrimination issue raised in section 3.1.5 of this report. It is also expected that the retirement age be put at the same level for men and women. Malta concluded its accession negotiations with the EU on Social Policy in November 2001, with no derogations or transitional periods as regards the pension system.

Malta has a number of bilateral reciprocal pension agreements which mutually recognise pension rights acquired in the countries that are party to these agreements. These are with countries to which Maltese used to emigrate during the 1950s and 1960s, namely Australia, Canada and the United Kingdom. An agreement has recently been concluded with the Netherlands, and discussions are under way for similar agreements with Greece and Slovenia.

3.3 Evaluation of recent and planned reforms

3.3.1 Recent reforms and their objectives

Maltese Governments have long been aware of the possibility of a future financing problem with respect to the pensions system in Malta. This within the realisation that the population will age significantly up to 2020 and that pensions are a politically sensitive issue, and likely to become even more so as persons of retirement age occupy a larger share of the electorate. Efforts to analyse these problems within the Malta Council for Economic Development[12] have been afoot since the early 1990s, as indicated in the review of earlier studies in section 3.2.2. In June 1999, the Government appointed a National Commission for Welfare Reform so as to analyse the problems and achieve consensus from the social partners involved on the best solutions to be implemented.

In the meantime, the Government has been implementing a number of ad hoc measures with respect to the welfare system. In the mid-1990s, there has been a significant upward revision of benefits not related to the two-thirds system that contributed to increase expenditures. Over the 1990s, employers' and employees' contribution rates have been gradually raised from one-twelfth to one-tenth each. This helped to increase contribution revenue so as to meet the rise in expenditure. In the Budget Speech for 2002, the Minister of Finance has indicated that he would envisage a social security system where there are clear delineations in the application of contributions to health and as opposed to social security benefits.

[12] This is a forum where social partners meet to discuss economic and social matters of national interest.

3.3.2 Political directions of future reforms

The terms of reference of the National Commission for Welfare Reform are to:

- gain an actuarial understanding of current and prospective pensions financing;
- gain an understanding on the welfare gap as it results from existing legislation;
- gain an increased understanding of the strengths and weaknesses of various pensions options as revealed by experience abroad;
- recommend proposals for the reform of pension funding provision as well as possible incentives and related measures;
- identify the demographic, social and -economic attributes of the context within which proposals for welfare reform are formulated;
- assess the likely impact of these proposals upon social groups, industry and the economy;
- estimate the administrative costs and skills required to implement proposed reforms.

A respected business leader who had served as Governor of the Central Bank of Malta chaired the Commission. It was composed of members from Government, trade unions, employers' associations, pensioners' associations and youth associations. The Commission met a number of times and produced an Interim Report. The production of the final report, which was expected in 2001, was halted by political difficulties in achieving consensus amongst the members. It is known that this report was to propose a number of parametric reforms to the current PAYG system together with the introduction of a possibly mandatory funded second pillar for pensions. The Chairman resigned and has recently been replaced by a person with experience in the fields of accounting and finance consultancy.

3.3.3 Conclusions

The provision of income to the elderly is a central element of the social security system in Malta. This operates on a pay-as-you-go system, whereby contributions by employees, employers and the State finance pensions in respect of retirement, widowhood, injury and sickness. Benefits are received on a contributory and on a non-contributory basis. The main pension benefit is contributory, offering a two-thirds replacement rate and is wage-indexed, subject to a nominal ceiling. Non-contributory benefits are generally inflation indexed. There is also a minimum pension that is inflation indexed.

The system is run by Government and has universal coverage, although some minor gender discrimination issues remain that should be rectified in

the near future, especially with EU membership. The social security system in Malta runs a deficit when the expenditure on health is considered. Due to accounting methods used, it is difficult to attribute the deficit to specific items of expenditure, but the Minister of Finance has already indicated a need for this to be rectified. Third pillar pension systems have only recently started to be provided by the private sector, and are not expected to start noticeably contributing to old-age income before another two decades. With the exception for a specific category of civil servants, there exist no second pillar pension systems in Malta, these having been wound up in 1979.

It may be stated that there is generally no severe poverty problem in Malta, and this carries on to the elderly. It is found that the elderly are substantially dependent on the social security system for their income, but are otherwise self-reliant or reliant on their family. Mainly, this is because there exists a network of support services for the elderly, based on Church and voluntary services, with the private sector recently also taking some initiatives. On the whole, the elderly in Malta are a relatively mobile and healthy community, taking an increasing role in social participation.

The pension system in Malta is found to introduce negative economic incentives, as the pay-as-you-go system tends to dissociate benefits received from contributions paid, with the result that formal labour market participation as well as saving is discouraged. The general public however shows a strong degree of acceptance of the system, also because it is relatively generous and well administered. The public is however becoming increasingly concerned with the effects of the nominal ceiling on pension payments.

Two prominent and equally important challenges are being faced in the future development of the pensions system in Malta. One is the impact of demographic shifts on the patterns of contribution revenue and social security expenditure, and hence, on the affordability of the system. The other is the extent to which the current system will be able to afford a decent living standard to beneficiaries in future, given a nominal ceiling that applies especially to the two-thirds pension scheme. It is indeed found that the cost of the actual system is expected to increase somewhat in the coming years in relation to the size of the economy and that the present system will imply lower relative and absolute living standards for beneficiaries.

A National Commission for Welfare Reform has been set up in 1999 to examine the extent of these problems and suggest solutions. Lack of consensus among the social partners is holding up the publication of the final report, which is known to suggest a number of parametric reforms to the present system together with the introduction of a funded pillar. The Commission is expected to start functioning again in the coming weeks.

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of current profiles of poverty and social exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

Government officers contend that poverty is a harsh reality faced by persons with low or no economic means. Although official documents do not generally make any direct reference to the concept of poverty, Government policies reflect the reality of poverty as an acute situation faced by a proportion of the Maltese population (Galea-Seychell 2001).

People in Malta generally explain poverty as an outcome of laziness and lack of will power and less because of social injustice, misfortune or socio-economic development. Over the years, however, there has been an increase in those who find fault with social injustice and a decrease in blaming the poor for their condition.

Accordingly, the European Values Study (1999/2000) reveals how the Maltese are more likely to hold that people are in need because they are lazy and lack will power (70%) than because of social injustice (55%), misfortune (29%) or as inevitable part of progress (35%). Over the past decade, however, there has been a slight shift from blaming the poor towards a higher negative appraisal of social injustice. In fact, at the beginning of the twenty first century, the majority of people in Malta (55%) similar their average counterparts in member states (53%) and applicant countries (59%) of the European Union find fault with injustices in society. [Table 4.1]

Table 4.1. Perceptions of poverty

			European Union**	
	Malta	**Malta**	**Members**	**Candidates**
	1991	**1999**	**2000**	**2000**
	%	**%**	**%**	**%**
Why people are in need*:				
Laziness, lack of willpower	76	70	38	44
Unlucky	31	29	39	44
Injustice in our society	42	55	53	59
Inevitable part of progress	22	35	44	41

Source: Malta Values Study, 1991, 2000 (N =1002); European Values Study 2000 (N = 39303).

Notes: * first and second options, ** mean for EU member and candidate countries.

The first Caritas Poverty Watch (1994) reports how perceptions of poverty in Malta are related in descending order of importance to disability, family stress, old age, single parenthood, marital problems and cohabitation,

depression, solitude, gambling, inadequate housing, alcohol and drug abuse, long illness, illiteracy economic stress, immigration, violence, problems of work, prostitution and transexuality. The two reports that followed developed these issues in view of the mission of the Church (Caritas 1996, 1998). In these studies, a link is established between material poverty and social exclusion.

Sociological studies show how economic poverty adversely hits women head of households, the elderly, cohabiting and separated people, the long-term unemployed and those dependent on welfare benefits. Lack of financial means is often accompanied by stress, sickness, substance abuse, and mental health problems. Poverty is not unrelated to unequal access to work and the environment. Minorities who do not conform to the predominant culture also risk social exclusion (Abela 1998b).

The Malta Human Development Report observes that the advance of citizenship in Maltese society moves beyond the satisfaction of material needs and is concerned with non-material qualities. The latter include good health, a clean environment, gender equality, non-discrimination, mutual help, trust and care for others in society. The Human Development Index for Malta compares well with those of neighbouring Portugal, Cyprus, Greece, Italy and Spain (UNDP 1996: 58-59, 106).

In Malta, people generally believe that the country has lower poverty rates than in neighbouring southern European countries and that no one or only very few people live below subsistence level. Accordingly, people in Malta think that the greatest challenges in the contemporary world include reducing social inequalities between rich and poor countries and combating poverty in developing countries (Abela 1996: 47, 81). The Maltese government shares the international commitment to fight global poverty and to meet the set objectives as enshrined in the Millennium declaration.

4.1.2 National definitions of poverty and social exclusion

In Malta, there are no official definitions of poverty or a poverty line, but there are references to an administrative poverty threshold and the minimum wage.

For Social Security purposes, the administrative threshold of poverty is directly linked to the minimum wage as established every year in the Budget speech of the Minister of Finance. The latter is raised in accordance to the government's cost of living increases. In fact, the minimum wage is updated depending on the state of the economy and indicators of its deficiency.

The official measurement of poverty is an offshoot of the Retail Price Index. The first attempt to calculate the impact of the cost of living on the average workman's household goes back to 1936. Beginning in 1971, Household Budgetary Surveys were periodically administered to establish the cost of living, thereby to determine the national minimum weekly wage. (COS 1997).

The final report from the 1995 Census of the Population and Housing (1998 (4): 668-671) gives a breakdown of income groups by household size and gender of economically active reference persons but there is no reference to an established poverty line.

Nevertheless, policy-oriented academic sociological research using data from the 1995 Census (Abela 1998a) estimates an approximate poverty line, calculated as 50 percent of mean disposable income, to be Lm 2000 per annum.

A Social Welfare Survey (Abela 1996) measured poverty and social exclusion in terms of social relations with one's family, neighbours and friends, labour force participation, home ownership, the possession of utilities in the home, the sufficiency of family income, cuts in spending, reliance on social security, and experience of hardship in the family. A follow-up study examined women's welfare in society (Abela 2002a).

Since the beginning of 2000 the National Statistics Office [NSO] is undertaking a periodical Labour Force Survey [LFS] and a Household Budgetary Survey [HBS] for the Maltese islands. The definitions and criteria of the LFS and HBS are in conformity with international methodologies of the International Labour Organization [ILO] and Eurostat, respectively. Results from the LFS have been published for May and December 2000 and for March and June 2001.

Preliminary findings from the LFS the HBS indicate that in the year 2000, the median income of a person in the labour force stood at Lm 4,300 per annum (10,922 Euros). Although the proportion of people with 50 percent of the median household income has still to be established, results show that between 11% (LFS) to 10.3% (HBS) earn below Lm 2000 (5080 Euros). The final report from the HBS is still in the making (COS, 82/2000).

A joint 'Minimum Income Level Project' of the National Statistics Office and the Ministry for Social Policy is to establish a poverty line on the basis of the Household Budgetary Survey and the Retail Price Index. The prospected poverty line is to reflect the basic requirements of a person to live adequately in Malta and is not simply a matter of equivalent household income.

Current policy documents of the government of Malta make explicit reference to the concept of "social exclusion" and its counterpart "social inclusion". In fact, state social policy assumes a preferential option for the most vulnerable members of society. State social policy seeks to develop an inclusive society by taking a subsidiary responsibility alongside families and non-governmental organisations, thereby ensuring equal opportunities for all with specific emphasis on the most vulnerable.

The strategic objectives of the Ministry of Social Policy (2002) include the transformation of society into one that fights social exclusion, reforms in social protection systems, combating the abuse of welfare benefits,

developing welfare support services, the implementation of family-friendly measures to facilitate an increase of women's participation in the labour market, research for grounded policy, improving standards and information about social services.

Target groups include:

I. family members in difficult circumstances,

II. people in high-risk substance abuse environments, gambling and adolescents experiencing developmental problems,

III. older persons,

IV. persons with disabilities,

V. women in society,

VI. homeless people.

These objectives are being addressed by:

VII. A plethora of new services for the support of family members in difficult situations.

VIII. Services to young people in high-risk substance abuse environments

IX. Community-based home-help and residential care services for older people.

X. Equal Opportunities Act: ensure access of persons with disabilities to public places, a Support Community Living Project, schemes for increased access to labour market.

XI. Gender Equality Act: flexible and family-friendly legislation, child day-centre services, training schemes for women returners to workforce, policies against sexual harassment, protection of working mothers and/or pregnant women.

XII. Attune housing schemes and grants to needs of clients, single parents and small family units, in particular.

XIII. Social Security: Review of operations and service delivery to ensure timely and entitled benefits. Use of Information technology. Network of Area services for customer care.

XIV. Employment Relations Act and amendments to Industrial Relations Act. Employment and Training Corporation: New schemes for disadvantaged groups and to fight welfare dependence. Literacy, instruction and continuous education main objectives.

XV. Occupational Heath and Safety: gradual implementation and enforcement of regulations. Educational programmes and prevention campaigns.

XVI. Collaboration with Non-Governmental Organisations: Government subsidies and monitoring of activities.

4.1.3 18 EU Indicators of Social Exclusion

Researchers find it extremely difficult to obtain timely and adequately relevant official indicators on poverty and social exclusion on Maltese society. In part, this is because the collection of reliable data on poverty and social exclusion as required by Eurostat and other international bodies, has been initiated very recently. Accordingly, the National Statistics Office is in the process of compiling the 18 EU Indicators on Poverty and Social Exclusion from the Household Budgetary Survey (2000) and other international surveys. There is a general reluctance, however, to release provisional statistics on allegedly similar sensitive issues to avoid political controversies.[13] Alternative indicators are accessible from Eurostat and NSO news releases. (Table 4.1b).

Additional information may be obtained from social surveys that are carried out by independent researchers in collaboration with Governmental and Non-governmental Organizations. These include national representative studies of the European Values Study (1983-2000), Social Welfare (1995) and the Women's Welfare Study (2000).

The EU indicators have the advantage of producing standard measurements of poverty and social exclusion achieved in the course of international collaboration and the application of social scientific research methodology. Similar data sets make possible the comparative analyses of previously identified topics in participant European countries over time. The study of poverty and social exclusion in a small island state like Malta, however, requires the consideration of other equally important variables, including political and cultural values.

The Women's Welfare Study (2000) estimates that about 15 percent of all households in the Maltese islands fall below an estimate poverty line of Lm2000 per annum. Similarly, Eurostat's poverty indicators compiled from Malta's Household Budgetary Survey (HBS 2000) report an overall 15 percent at the risk of poverty in Malta. Similar poverty rates are reported for the overall mean in EU member states and accession candidate countries. Most at risk, similar to the average in EU member and candidate countries but to a higher extent in Malta, are unemployed men (57%) single parent households (55%), under 30 years olds single person households (34%), unemployed women (32%), large households consisting of two adults and three or more dependent children (29%), older women (21%), under 15 year old men (22%), over 65 year old men (19%) and under 15 year-old women (19%). (Tables 4.2; 4.3a, 4.3b, 4.3c, 4.3d).

Table 4.2. Net family income groups in Malta

[13] Following persistent requests, the Malta National Statistics Office has compiled most of the EU indictors on poverty and social exclusion. The Director of the NSO, however, was unable to release the data prior to the official publication of the 2000 Household Budgetary Survey. The first "Structural, Poverty and Social Indicators" were presented to the public in a seminar on December 16, 2002.

	Frequency	Percent	Valid %	Sum %
Less than Lm2000*	59	11.8	15.0	15.0
Lm2001 – Lm7500	252	50.4	64.0	79.0
Lm7500+	83	16.5	21.0	100.0
Total	394	78.7	100.0	
Missing: no answer	106	21.3		
Total	500	100.0		

Source: Women's Welfare Study 2000
Note: * estimate poverty line = net family income below Lm 2000.

Table 4.3a. Poverty Indicators for Malta and EU member and candidate countries

			MT	EU-15	ACC
			2000	1999	1999
S80/S20 quintile share ratio			4.5	4.6	4.4
Gini coefficient			30.38	29.0	28.7
Risk-of-poverty threshold	*1 person hh*	*NAT*	2036	:	:
(illustrative values)		*EUR*	4927	:	1475.1
		PPS	6351	7263.0	3069.2
	2 adults 2 dep. children	*NAT*	4276	:	:
		EUR	10347	:	3097.6
		PPS	13337	15252.3	6445.3
Dispersion around	*40% of median*		3	5.0	4.3
the risk-of-poverty	*50% of median*		8	9.0	8.6
threshold	*60% of median*		15	15.0	14.9
	70% of median		23	23.0	22.4

Source: Eurostat, December 2002.

Table 4.3b. Risk-of-poverty rate by age and gender in Malta and EU member and candidate countries

		MT		EU-15		ACC
		2000		1999		1999
Age years old	***Gender***	%		%		%
0-15	All	21		19.0		20.1
	M	22		19.0		20.3
	F	19		19.0		20.0
16-24	All	10		21.0		17.0
	M	10		20.0		17.1
	F	10		21.0		16.9
25-49	All	14		13.0		14.8
	M	13		12.0		15.2
	F	14		14.0		14.4
50-64	All	12		12.0		9.7
	M	10		12.0		10.2
	F	14		13.0		9.4
65+	All	20		17.0		8.8
	M	19		15.0		5.8
	F	21		19.0		10.5
Total	All	**15**		**15.0**		**14.9**

	M	**15**		**15.0**		**15.1**
	F	**15**		**16.0**		**14.6**

Source: Eurostat, December 2002.

Table 4.3c. Risk-of-poverty rate by most frequent activity by gender in Malta and EU member and candidate countries

		MT		**EU-15**		**ACC**
		2000		**1999**		**1999**
Economic activity	***Gender***	**%**		**%**		**%**
Employed	All	6		6.0		6.6
	M	8		6.0		7.8
	F	2		6.0		5.4
Self-employed	All	1		14.0		21.6
	M	1		14.0		21.3
	F	-		13.0		21.9
Unemployed	All	50		39.0		38.0
	M	57		45.0		41.1
	F	32		33.0		35.0
Retired	All	18		15.0		9.8
	M	18		14.0		8.4
	F	18		16.0		10.7
Inactive/other	All	18		24.0		19.7
	M	10		24.0		19.2
	F	19		24.0		19.9

Source: Eurostat, December 2002.

Table 4.4. Risk-of-poverty rate by household type and tenure status in Malta and EU member and candidate countries

		MT %, 2000		EU-15 % 1999		ACC % 1999
Household type:	***Gender***					
1 person hh	***All***	25		22.0		14.3
1 person hh	***M***	17		32.0		18.9
1 person hh	***F***	28		15.0		13.0
1 person hh <30yrs		34		24.0		8.7
1 person hh 30-64		23		19.0		16.5
1 person hh 65+		25		24.0		12.7
2 adults no children	*(at least one 65+)*	25		13.0		8.8
2 adults no children	*(both < 65)*	11		9.0		7.5
Other hh no children		5		9.0		9.1
Single parent	*(at least 1 child)*	55		38.0		23.9
2 adults 1 dep. child		13		11.0		9.8
2 adults 2 dep. children		16		13.0		12.7
2 adults 3+ dep. children		29		25.0		28.8
Other hh with dep. children		8		18.0		17.6
Tenure status:						
Owner-occupier		11		12.0		15.1
Tenant		29		24.0		15.5
Total		**15**		**15.0**		**14.9**

Source: Eurostat, December 2002.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets

Official policy documents do not generally identify a link between poverty and economic activity or inactivity. Nevertheless, the analyses of data from HSB (COS 2000), LFS (NSO 11/2002), the Employment Training Corporation [ETC] (NSO 16/2002), and of social surveys posit a relationship between poverty and social exclusion and unemployment, economic inactivity and poor quality employment.

Most households whose reference person is unemployed report a net income of less than Lm 2000 per year. The greatest proportion of households whose reference person is inactive report a net income between Lm 2000 and Lm 3999. By contrast, most households whose reference person is employed report a net income between Lm 4000 and Lm 5999. [COS 82/2000]

Low income is associated with single member households, and those with an inactive or unemployed reference person. As elaborated in Section 4.2.7 of this report, low-income households are more to be found in the South Harbour district, Gozo and Comino. On the other hand, high-income

households are more found in the Western and Northern districts (Tables 4.4a, 4.4b)

Table 4.4a: Distribution of income by economic activity of reference person

	employed	**Inactive**	**unemployed**	**Total**
Net Income	%	%	%	%
Below Lm 2000	1.4	21.8	53.8	10.3
Lm 2000-Lm 3999	20.9	47.5	35.4	30.4
Lm 4000-Lm 5999	34.1	16.4	6.2	27.1
Lm 6000—Lm 7999	18.7	6.4	3.8	14
Lm 8000-Lm 9999	11.4	3.5		8.3
Lm 10000-Lm 11999	7.4	2.3	0.8	5.5
Lm 12000-Lm13999	2.7	0.9		2
Lm 14000-Lm15999	1.4	0.7		1.1
over Lm 16000	2	0.7		1.5
Total	100	100	100	100

Source: Household Budgetary Survey 2000, COS 82/2000.

Table 4.4b: Distribution of income by district

	South Harbour	**North Harbour**	**South East**	**West**	**North**	**Gozo and Comino**	**Total**
Net Income	%	%	%	%	%	%	%
Below Lm 2000	14.7	9.3	9.9	6.7	7	14.2	10.3
Lm 2000-Lm 3999	28.0	31.9	27.8	32.3	29.9	32.2	30.3
Lm 4000-Lm 5999	26.5	25	27.6	30	29.6	28.5	27.2
Lm 6000--Lm 7999	13.8	14.7	16.2	11.6	12.7	13.4	14
Lm 8000-Lm 9999	9.1	6.9	9.7	10.1	8.3	5.4	8.2
Lm 10000-Lm 11999	4.0	6.6	6.1	3.4	7.8	3.3	5.4
Lm 12000-Lm13999	2.0	2.3	1.2	2.2	1.6	2.1	2
Lm 14000-Lm15999	0.6	1.5	1	1.7	1	0.4	1.1
Over Lm 16000	1.3	1.8	0.5	2	2.1	0.4	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Household Budgetary Survey 2000, COS 82/2000.

Results from the LFS show that income level is related to the occupation of the reference person. Thus, men employed in the fishing industry (Lm 1636), private households (Lm 3300), agriculture, hunting and forestry (Lm 3744), and women employed in private households (Lm 1815), hotels and restaurants (Lm 2828), wholesale, trade or repairs shops (Lm 3121) and manufacturing (Lm 3638) belong to the lowest income groups.

The Government combats unemployment through the activities of the Employment and Training Corporation (ETC). One of the objectives of the ETC is to fight social exclusion of disadvantaged groups. Since its foundation in 1990 the ETC has identified a number of target groups and

developed services to meet their needs. Table 4.5 gives a description of services and evidence of success. The ETC has since commissioned a number of research projects to evaluate the effectiveness of the programmes. Results from these studies are still in the making. Earlier studies reveal no unemployment and very low inactivity rates of university graduates (Baldachino *et al.* 1997: 55-57).

Table 4.5: Employment and Training Corporation, schemes and performance

ETC SCHEMES	DESCRIPTION	OUTPUT 2000-2001
Youth:		763 job placements
Job Start Initiative 16-24 yrs	Job plans, training	359 participants
Job Experience Scheme	Training with organization. 13 wks max	73 participants
Basic Employment Passport Scheme	Training in vocational skills to unqualified school leavers	192 males and 100 females trained by 3rd yr univ. students
Youth Outreach Programme	Training meetings 2x/wk for 6 wks in Cottonera and Zejtun	31 attended, 13 found job
Unemployed 40+ yrs old		199 job placements
Employment Training Placement Scheme [ETPS]	50% subsidy of min wage for 12 months max to employers recruiting persons requiring training	32 participants
Community Work Scheme [CWS]	Projects of 52 wks max. for long term unemployed wages shared by ETC & NGO	24 projects, 54 participants
Traineeships	3-12 months training & job experience, 25% wage subsidy	9 participants
Business Promotion Act	Additional incentives to existing grants	
Women:		*998 job placements,* *1444 attended ETC courses*
Empowerment Skills Course	60 hrs intensive course to women (40+ yrs) returnees	6 courses, 84 participants
Child Care Task force and Childcare courses	Stock taking and recommendations; courses for carers	2 courses, 49 participants
Action Plan for Gender Equality	Measures to encourage women workers	
Persons with disability		
Bridging the Gap	Lm 30 weekly allowance max. 1 yr, employer pays no wages	Beneficiaries: 18 disabled, 12 ex-substance abusers, 4 ex-prisoners, 3 w social problems
Implement law on employment of people with disabilities	Target orgs. employing 50 or more. 2% workforce persons with disabilities to be enforced	
Supported employment Scheme	Multidisciplinary team to identify type and extent of help; subsidies for job coach and employer	Awaiting govt. approval
Supported Employment for other clients:		

Ex-substance abusers	Collaboration with other agencies	37 trained, 15 job placements
Correctional facilities clients	Advise and training to outgoing inmates	7 trained, 4 job placements
The registered long-term unemployed	Eligibility to ETPS and CWS	384 trained, 12 trainees, 138 job placements
The illiterate unemployed	Applied literacy & numeracy training skills in Zejtun; partnership with Paolo Freire Institute & University of Malta; 1 facilataror/5 clients	98 participants to be extended to other towns

Source: ETC Annual Report 2000-2001.

Table 4.6: Employment and unemployment by gender (2001-2002)

Labour Status	**Sex**				**Total**	
	Males		Females			
	No	%	No	%	No	%
March 2002						
Employed	99,948	92.2	43,937	92.5	143,885	92.3
Unemployed	8,415	7.8	3,568	7.5	11,983	7.7
Total	108,363	100.0	47,505	100.0	155,868	100.0
March 2001						
Employed	102,598	93.9	42,584	93.9	145,182	93.9
Unemployed	6,648	6.1	2,784	6.1	9,432	6.1
Total	109,246	100.0	45,368	100.0	154,614	100.0

Source: Labour Force Survey, March 2001, 2002.

Table 4.7: Duration of job search of unemployed persons by gender (2001-2002)

Duration	**Sex**				**Total**	
	Males		Females			
	No	%	No	%	No	%
March 2002						
Less than 5 months	2,640	31.4	1,865	52.3	4,505	37.6
6 – 17 months	2,451	29.1	1,074	30.1	3,525	29.4
18 + months	3,324	39.5	629	17.6	3,953	33.0
Total	8,415	100.0	3,568	100.0	11,983	100.0
March 2001						
Less than 5 months	1,199	18.0	706	25.3	1,905	20.2
6 – 17 months	2,013	30.3	1,327	47.7	3,340	35.4
18 + months	3,436	51.7	751	27.0	4,187	44.4
Total	6,648	100.0	2,784	100.0	9,432	100.0

Source: Labour Force Survey, March 2001, 2002.

Comparative results from two Labour Force Surveys give evidence on how unemployment, however much on the increase (from 6.1% in 2001 to 7.7% in 2002), seems to be shifting from long-term to short-term duration. Table 4.6 shows how in the interval of one year, the number of unemployed men and women has increased from 6648 to 8415 and from 2784 to 3568, respectively. The number of people reporting to be unemployed for 18 months or longer, however, has dropped from 4187 in 2001 to 3953 in 2002. At the same time, as evident in Table 4.7, the duration of job searching for most of the unemployed has become less than five months duration (from 1905 in 2001 to 4505 in 2002). It seems that for most people, unemployment is a transitory condition. If this trend continues, such that the current short-term unemployed - who in the main are women and men under 24 years old, including 15 year-old school-age young people (in the LFS) - find adequate jobs in the near future, then ETC programmes are proved to be effective.

4.2.2 Guaranteeing Adequate Incomes/Resources

The Welfare State is generally expected to guarantee basic needs for all. For this purpose the Social Security Act provides for retirement pensions, children's allowances, unemployment benefits, invalidity pensions, injury and sickness benefits, widow's and survivors' pensions, orphans' allowance, disability pension and gratuity, marriage grant, and maternity benefits. In addition, non-material needs are met by a multiplicity of social services that are provided by governmental and non-governmental organizations.

The Social Welfare Study (Abela 1996) found that the majority of households (61%) have at least one member of their family receiving one or more social benefit, including children's allowance (55%), old people's pension (53%), widow's pension (13%), disability pension (3%), disability benefits (8%), unemployment benefits (6%), home help (3%) or social assistance for separated people (1%). In a follow-up study (Abela 2002), questions addressed exclusively to individual women respondents, uncovered that the most common benefits by women recipients are children's allowances, old people's pensions, widow's pensions, and university stipends. Much fewer women respondents receive unemployment benefits, disability benefits, and social assistance for the separated or single parents. As can be expected, women are the large majority of claimants for such benefits.

In this day and age it is often assumed that nobody lacks basic needs such as food and shelter. Accordingly, results from the Women's Welfare Study show how with the exception of the very few, almost everybody has fruit and vegetables every day, meat, fish or vegetables every other day, new clothes, a waterproof and heavy coat, a bathroom, heating facilities, carpets in the living room and bedroom, a refrigerator and money to repair broken appliances or to buy gifts for the family. The greatest majority also have a colour television set, hot water, money to buy medical prescriptions, and a telephone line. Most of the latter utilities have become necessities and only the very few do not want to have them.

The Women's Welfare Study, however, shows how the majority of respondents, do not want to have what by Maltese standards are generally considered as luxuries. Accordingly, Table 4.8 reports that the majority of respondents do not want to have a dishwasher (68.5%), a satellite TV (63%), access to the Internet (62.2%), a tumble dryer (58.8%), a mobile phone (55.9%), a microwave oven (50%) or a PC computer (50%). Many others do not want to have a newspaper everyday (45.5%), home insurance (44.9%) or a CD player (38.8%).

Fewer women respondents, however, do not want to have two meals a day (28.6%), to change worn out furniture (22.4%), a videocassette recorder (16.9%), a dictionary (14.8%), a car (14%), or an automatic washing machine (12.6%). Indeed, very few women respondents do not want to have a dry home with no humidity (6.7%), pocket money every week for own use (8.3%), money to repair broken appliance (7.6%) and home maintenance (3%), or to save a small amount of money every week for a rainy day (5.4%). In contemporary society similar possessions have become needs for decent living and those who cannot afford them are relatively poor. Thus, quite a few women respondents would like to enjoy the comfort of a satellite TV (30.4%), a mobile phone (24.4%), home insurance (24.4%), a tumble dryer (20.2%), a dishwasher (20.3%), a personal computer (15.9%), access to the Internet (17.7%) and a CD player (11.2%) but cannot afford them.

Table 4.8: Utilities, needs and wants

		do not	**cannot**	
	have	**want**	**afford**	**n/a**
	%	**%**	**%**	**%**
Two pairs of shoes	99.6	0.2	0.2	
Bed and blankets for all household	99.6	0	0.2	0.2
Refrigerator	99.0	1.0	0	
Colour TV	98.5	0.8	0.6	
Hot water	98.1	0.9	1.0	
Buy doctor's prescription	97.8	1.3	0.8	
Telephone	97.5	1.7	0.8	
Fresh fruit and vegetables everyday	97.4	1.6	1.0	
New clothes	97.2	1.8	1.0	
Bathroom	97.2	0.7	2.1	
Dress for special occasions	95.4	3.4	0.8	0.4
meat/fish/ vegetables every other day	95.2	3.8	1.0	
Gifts to family once a year	92.8	3.5	3.7	
Heater	91.8	4.7	3.5	
Carpets in living and bedroom	91.6	6.1	2.3	
Deep freezer/fridge freezer	87.4	9.3	3.1	0.2
Repair broken appliances	87.4	7.6	3.4	1.6
Suit for an interview	86.3	7.7	1.2	4.9
Waterproof and heavy coat	84.4	13.5	2.1	

Dictionary	83.4	14.8	1.2	0.6
Dry home: no humidity	82.9	6.7	5.8	4.6
Automatic washing machine	81.7	12.6	5.7	
Money for house maintenance	81.7	3.0	12.7	2.7
Pocket money every week for own use	76.9	8.3	14.4	0.4
Video cassette recorder	76.1	16.9	6.6	0.4
Car	75.5	14.0	9.8	0.7
Save Lm15 weekly for rainy day	69.9	5.4	24.3	0.4
Two meals a day	69.5	28.6	1.9	
Change worn out furniture	55.5	22.4	20.0	2.1
CD player	50.0	38.8	11.2	
Newspaper everyday	48.8	45.5	5.5	0.2
Microwave oven	35.3	50.0	14.6	
PC computer at home	34.1	50.0	15.9	
Home insurance	28.7	44.9	24.4	2.0
Tumble dryer	21.0	58.8	20.2	
Mobile phone	19.5	55.9	24.4	0.2
Access to internet	16.0	62.2	17.7	4.1
Dishwasher	11.4	68.5	20.1	
Satellite TV	6.6	63.0	30.4	

Source: Women's Welfare Study, 2000.

If Maltese society seems to have little or no subsistence poverty, social surveys give evidence of relative poverty. Results from the Women's Welfare Study uncover the persistence of economic and social deprivation. Table 4.8 shows that a considerable number of respondents cannot afford to save a small amount of money every week for a rainy day (24.3%), pocket money (14.4%), or home maintenance (12.7%). A few others would like to have but cannot afford a car (9.8%), a videocassette recorder (6.6%), a dry home (5.8%), an automatic washing machine (5.7%), a daily newspaper (5.5%), money to repair broken appliances (3.4%), carpets in the living and bedroom (2.3%), a bathroom (2.1%), waterproof coat (2.1%) and two meals a day (1.9%). About one percent or less cannot afford to have a colour TV, hot water, a telephone line, fresh fruit and vegetables everyday, meat or fish every other day, new clothes or a dress for special occasions (Abela 2002: 83).

Table 4.9 shows how quite a few live on their savings (6.4%) or borrow money to live (1.7%). Similar proportions face quite (4.7%) or many (2%) problems to make ends meet until the end of the month (see Table 4.10). In fact, quiet a few confess that at some time during the preceding year, they reduced spending on food (12%), borrowed money for living expenses (4.3%) or did not pay a bill or instalment (4.1%). Quite a few were unable to buy something necessary for the family (7%). Many others did without something necessary for themselves (34.5%) and reduced spending on small things (46.6%) (see Table 4.11). These results give evidence of the

persistence of economic deprivation. Notwithstanding the great achievements of the welfare state, and widespread social benefits to people in need, there are still a number of people living in relative poverty.

Table 4.9: Family financial situation

	%
Borrow money to live	1.7
Live on savings	6.4
Spend all earnings	34.7
Save something	45.5
Save quite a lot	11.8
Total	100.0

Source: Women's Welfare Study, 2000.

Table 4.10: Family budget up to end of month

	%
Many problems	2.0
quite some problems	4.7
Some problems	30.6
Certain ease	53.4
great ease	9.4
Total	100.0

Source: Women's Welfare Study, 2000.

Table 4.11. Economic measures last year

	%
Reduced spending on small things	46.6
Did without something necessary for self	34.5
Reduced spending on food	12.0
Resumed/kept working to help family	9.8
Did not buy necessary things for family	7.0
Borrowed money for living expenses	4.3
Did not pay bill or instalment	4.1
Changed house, too expensive	0.2
Other measures	9.1
No economic measures	42.8

Source: Women's Welfare Study, 2000.

Table 4.11b: Recipients of Welfare Benefits by net family income and socio-economic status

	net family income			**Socio-economic status**			
	Under Lm 2000	Lm2001–	over	AB	C1	C2	DE

		Lm 7000	Lm 7001				
Receive social benefits:	Row%	Row%	Row%	Row%	Row%	Row%	Row%
Old people's pension	35	58	7	10	18	42	29
Widow's pension	42	44	14	12	17	32	39
Home help	50	33	17	13	25	37	25
Parental care benefits	100	0	0	0	0	100	0
Disability benefits	62	38	0	12	11	23	54
Work accident benefits	26	26	48	29	12	15	43
Unemployment benefits	57	43	0	5	15	25	55
Disability pension	51	49	0	0	0	51	49
Maternity benefits	0	100	0	0	51	0	49
Single parents benefits	100	0	0	100	0	0	0
Children's allowance	9	80	11	11	24	40	26
Child disability benefits	38	62	0	0	34	66	0
Social assistance for separated	50	50	0	0	23	10	67
University maintenance grants	15	54	31	44	15	20	21
Row %	15	64	21	16	23	35	27

Source: Women's Welfare Study, 2000. Notes: Socio-economic class: AB = upper social class, professional, managerial workers; C1 = lower middle class; C2 = working class, skilled workers; DE = semi-skilled/unskilled workers, unemployed, dependent on state welfare.

The gap between the percentage of women respondents reporting having had to do without buying necessary things for the family (7%) and those who had to do without something necessary for themselves (34.5%) posits a problem of intra-household distribution of income and resources. It gives evidence on how poverty and inequality adversely affects women more than other members of the family.

Table 4.11b shows how recipients of means-tested social benefits are in the main respondents from the lower social classes whose net family income falls below an estimate poverty line. Thus, the greatest proportion of benefits for the care of parents (100%), home help (50%) disability benefits (62%), unemployment benefits (57%), disability pensions (51%), benefits for single parents (100%) and social assistance for separated people (50%) goes to respondents with a net family income below Lm 2000. As can be expected, however, the majority of respondents from families with a net average household income are recipients of work-related benefits such as retirement pensions (58%), maternity benefits (100%), children's allowance (80%) child disability benefits (62%), social assistance for the separated (50%) and university stipends (54%).

Table 4.11c. Risk-of-poverty rate before and after social transfers in Malta and EU member and candidate countries

	MT		**EU-15**		**ACC**

	2000		1999		1999
Risk-of-poverty rate:	*%*		*%*		*%*
Before all transfers	30		40.0		44.2
including pensions	21		24.0		26.9
including all transfers	15		15.0		14.9

Source: Eurostat, December 2002.

Table 4.11c indicates the extent of the effectiveness of social welfare. The proportion of people at risk of poverty in Malta is reduced from a high of 30 percent before social transfers to 20 percent after pensions and to 15 percent after all social transfers.

4.2.3 Combating Education Disadvantage

In Malta, education is compulsory for those aged between 5 and 16. It is provided free of charge at all levels. In addition, there is a system of maintenance grants paid to all students at the post-secondary and tertiary levels. The majority of schools are state owned and cater for about 70 percent of the student population, while the rest are run by private organisations. Over the past decade there was a tendency for Private Schools (27% in 1992 against 30% in 2000) to increase their share of the student population at the expense of State Schools.

Although national illiteracy rates have dropped from 33.4% in 1948 to 12.02% in 1985 and 11.24 in 1995, illiteracy and inadequate labour skills remain a major concern. On a national level, males (12.56%) have a higher illiteracy rate than females (9.96%). Significantly, and despite the expansion of compulsory education, the 15-19 year olds (4.9%) report higher illiteracy rates than their 20-29 year old (3.2%) counterparts (COS 1998 [4]: iv-v).

Tables 4.12a and 4.12b show how from 1991 to 1999 the total number of students in educational institutions has increased by almost 8 percent. In particular, the number of students in state post-secondary and tertiary education has more than doubled, but there has been a decline in general vocational education and an increase in the rates of truancy and illiteracy for children from State Schools.

Between 1990 and 1999, the student population in State Primary Schools declined by almost four thousand, whereas Private Primary Schools increased their intake by almost two thousand.

The decline in the number of students in Special Education, however, marks government's new strategy of "inclusive education" whereby children with special needs are provided with a facilitator to enable them to attend schools in their hometown or village. Thus, the number of students in Special Education dropped from 404 in 1990 to 297 in 1999.

A National Literacy Survey of virtually all 6-7 year olds in Malta reports that children with special needs or who receive complementary education have difficulties with literacy (Mifsud, Milton and Hutchison, 2000). These

children risk dropping out of school without qualifications and skills and to live dangerously on the margins of society (Bartolo 2002).

Table 4.12a: Students in Full-time Educational Institutions Classified by Level 1990-1999

	1990/91	**1994/95**	**1998/99**
State Institutions			
Pre-School level	7060	6799	6678
First level (a)	26142	23391	22382
Second level: General	15591	19123	18608
Second level: Vocational	5438	3293	2152
Post Secondary: General	2469	3172	1651
Post Secondary: Vocational	1712	1362	2352
Post Secondary: Junior College	(b)	(b)	2033
Third level: Day Courses	2831	5166	6064
Third level: Evening Courses	292	639	895
Special Education	404	424	297
Private Institutions			
Pre-School level	4253	4320	3898
First level	10757	11660	12404
Second level: General	7190	7877	13389
Post Secondary: General	399	700	732
Total in Full-time education	84538	87926	91502

Source: National Office of Statistics. (a) data from 1991/92 onwards excludes opportunity centres; these were combined with Secondary schools. (b) Data included with Post Secondary General.

Table 4.12e shows how over the past few years, candidates from primary level Private Schools (28% in 1985; 70.5% in 2000) increasingly obtained higher success rates in Junior Lyceum entrance examinations than their State School counterparts (34.8% in 1985, 48.9% in 2000).

Over the past decade there was an increased demand for academic education in preparation for admission to university, and a professional career. To accommodate this popular demand, the Government opened new (secondary level 'grammar') Junior Lyceums and closed down secondary vocational schools. Over a period of nine years the number of students in secondary vocational education dropped from 5438 in 1990 to 2152 in 1999. During the same period, students attending Junior Lyceums or area secondary schools of the State increased by three thousand. At the same time, however, the student population in Private Secondary Schools (the counterparts of State Junior Lyceums) almost doubled from about 7000 in 1990 to over 13000 in 1999. In addition, within the same period, official statistics report a fifty percent increase in students attending evening private tuition. It is a known fact that a considerable number of parents pay exorbitant fees to send their children to private lessons, in preparation for

public examinations. Private lessons do not just supplement State and Private schooling but most significantly they ensure high success rates.

Table 4.12b: Part-time Students in State and Private Educational Institutions 1990-1998

	1990/91	**1994/95**	**1997/98**
State Institutions:			
School of Arts	351	449	573
School of Music	1731	1401	1407
Arts and Design Centre	33	(a)	(a)
Academy of Dramatic Arts	70	122	343
Evening Classes Centres	2761	3950	2748
Adult Education			723
Private institutions: Evening Classes Centres	2275	2592	3381
Total in Part Time/Evening Education	7221	8514	9175

Source: National Office of Statistics. (b) Data included with Post Secondary Vocational.

Table 4.12f uncovers how students in State Secondary Schools have higher rates of unauthorised absenteeism than their Private School counterparts. Thus, in 2000, boys and girls from State Secondary Schools had an average of 11 and 8 unauthorised absent days, respectively, in contrast to less than one unauthorised absent day for their counterparts from private schools.

Qualitative studies show how parents often speak of State Schools in negative terms, and find Church and Private Schools more attractive for the education of their children. The reasons for choosing Private Schools include their being perceived as offering a superior and integral education, social advantage, personal and moral development and access to better resources (Cilia and Borg 1997: 246).

The drive towards private education is seen to socialise select students into a particular form of life, constructing a distinction in the organisation of social relations within and outside schools. This entails a political positioning of students with different abilities within society (Mifsud 1997: 349). The popular demand for private education at the pre-school, primary and secondary levels is not unrelated to a greater concentration of children with social problems and high illiteracy rates in State Schools. The private-public schools divide reproduces a system of social inclusion for elites, coupled with the social exclusion, however much unintended, and the ensuing social disadvantages of the less resourceful students in State Schools.

Table 4.12c: Students in State and Private Educational Institutions by gender, 1998/99.

	State	**Private**	

	Male	Female	Male	Female	All
Pre-First level	3515	3163	1976	1922	10576
First level	11720	10662	6107	6297	34786
Special Education	215	82			297
Second level:					
Junior Lyceums	7933	9762	4945	3639	26279
Area Secondary schools	511	402			913
Vocational Trade Schools	2058	94			2152
Post-Secondary General	1551	2133	413	319	4416
Post-Secondary Vocational	1372	980			2352
Tertiary	3396	3563			6959
Total	32271	30841	13441	12177	88730

Table 4.12d: Students in Educational Institutions by type of school and gender in percentages, 1998/1999

	State	Private		Male	Female
	Row %	Row %		Row %	Row %
Pre-First level	63	37		52	48
First level	64	36		51	49
Special Education	100	0		72	28
Second level:					
Junior Lyceums	67	33		49	51
Area Secondary schools	100	0		56	44
Vocational Trade Schools	100	0		96	4
Post-Secondary General	83	17		44	56
Post-Secondary Vocational	100	0		58	42
Tertiary	100	0		49	51
Total	71	29		52	48

No official data is available on the relation between socio-economic variables and education. Social surveys, however, show how poor educational levels are not unrelated to poverty and social exclusion. Accordingly, the Values Study (1999) and the Women's Welfare Study (2000) give evidence on how respondents with only a primary level of education or lower report the lowest average household incomes. In fact, those in possession of an inadequate level of education fall far below the national income average. They are more likely to feel lonely or excluded from society than their higher educated counterparts. By contrast, respondents with a higher level of education report the highest mean household income and are the least likely to feel socially excluded. Generally, women respondents report lower net household incomes and greater social exclusion than their men counterparts.

Table 4.12e: Success rates of candidates sitting for State Junior Lyceum Entrance Examinations by type of School, select years

	State			Private		
	Total			Total		
Year	Candidates	Successful	%	Candidates	Successful	%
1985	2508	872	34.8	314	88	28.0
1990	3427	1542	45.0	556	309	55.6
1995	3604	1765	49.0	811	539	66.5
2000	3805	1860	48.9	809	570	70.5

Source: Children National Office of Statistics, 2002: 29.

Table 4.12f: Absenteeism in State and Private Schools, 2000.

	State Schools		Private Schools		
	Male	**female**	**male**	**Female**	**All**
Authorised absent days/student					
Primary	5.8	5.5	5.1	5.1	5.5
Secondary	6.7	5.2	4.5	5.1	5.5
Trade/Vocational	9.7	9.9			9.7
Unauthorised absent days/student					
Primary	2.8	2.6	0.3	0.5	1.9
Secondary	10.6	8.3	0.7	0.8	6.6
Trade/Vocational	1.6	31.6			3.0

Source: National Office of Statistics, 2002, authors' elaboration.

Tables 4.13 and 4.14 give evidence on how people with inadequate or a primary level of terminal education report the lowest annual income levels and the lowest levels of social inclusion. In particular, women (Lm 2500) and men (Lm 2750) with inadequate education fall much below the national annual average income score (Lm 4911). Similarly, women (2.21) and men (2.58) with inadequate education, relative to the national average (2.96) report the lowest levels of social inclusion.

Education levels in the workforce remain relatively low (JAE 2001: 11). Statistics from the ETC [JAE Table 19] show how the majority of the unemployed are in possession of low academic qualifications. Illiterate persons are over-represented among the unemployed of whom they constitute 19%.

The Government is committed to reduce illiteracy rates and improve vocational education. The Ministry of Education (2002) strives to ensure that education is appropriately related to the social, cultural and economic aspects of a learning society. One of its objectives is the promotion of social inclusion.

*Table 4.13: Mean household yearly income and highest level of education by gender**

	Male	**female**	**All**

	Lm '000	Lm '000	Lm '000
Highest level education			
Inadequate education	2.750	2.500	2.591
Primary completed	3.480	3.680	3.596
Technical secondary	5.234	3.933	4.919
Secondary general	5.000	4.949	4.974
Sixth form	6.700	6.600	6.662
First degree	7.000	6.111	6.714
Post-graduate	7.538	6.667	7.182
Total	5.149	4.649	4.911

Source: Malta Values Study 2000, N =1002. * measured on a 10-point scale, where 1 = Lm 1000 or less; 10 = Lm 10000 or more. F = 29.89 p <.000.

*Table 4.14: Social inclusion and highest level of education by gender**

	Male	**Female**	**All**
	4-pt scale	4-pt scale	4-pt scale
Highest level education			
Inadequate education	2.58	2.21	2.33
Primary completed	2.98	2.74	2.83
Technical secondary	3.23	3.25	3.23
Secondary general	3.11	2.89	2.99
Sixth form	3.33	3.12	3.24
First degree	3.02	2.73	2.91
Post-graduate	3.06	3.00	3.03
Total	3.10	2.83	2.96

Source: Mal

a Source: Malta Values Study 2000, N =1002

* measured on a 4-point scale, where 1 = often; 4 = never feel lonely. F = 6.25 p <.000

At the Primary and Secondary level of education the Ministry has set up a Foundation For Educational Services (FES) and an Institute for Child and Learning Support (ICPLS).

The FES provides a range of primary and secondary prevention and intervention measures aimed at reducing school failure, illiteracy and absenteeism. Current initiatives include *Hilti* [Skills] Clubs, *Id f'id* [Hands-in-hands], *Hilti Tezor* [Treasure Skills], *Klabb Tfal Kittieba* [Children Authors' Club], Parent Empowerment for Family Literacy Project [PEFAL] and Training, as follows:

Hilti after-school clubs provide primary school students with a range of opportunities for self-development, creative expression and literacy. Beginning as a pilot experiment in Gzira Primary School, Hilti clubs are now operational in six other state primary schools.

Id f'id is a partnership programme with parents who wish to work to provide and acquire the necessary skills that would enable them to support their children's studies and learning more effectively. Common concerns are determined through intensified dialogue with parents at community level. *Id f'id* experiments were successfully undertaken at the Gzira Primary School and are now extended to 5 other schools.

The Hilti Tezor project aims to cultivate among children the reading of books in Maltese and to publish children's books in Maltese for the 5-9 year olds. Resources include the skills of emerging child writers, publishing books written by university students who pass the scrutiny of an adjudicating board, and commissioned culture- and gender-sensitive books.

Klabb Tfal Kittieba is a club for under-12 year old children identified by teachers and parents as budding writers of children books in Maltese.

Parent Empowerment for Family Literacy Project focuses on experiments in three local schools in partnership with organisations from seven other European countries. An agreement was signed with the European Commission in December 2001.

Training courses are organised for local animators, activity teachers and volunteers who are responsible for the skills projects in different schools.

Over the past fifteen years, Malta has seen a rapid expansion of adult education but there is still a shortage of Vocational Education Training (European Commission 2001: 11). To remedy the situation, the Maltese Government has set up the Malta College of Arts, Science, and Technology (MCAST), six institutes of which started functioning in October 2001. In addition, the Department of Further Studies and Education is reviewing its services to ensure equitable provision and active participation in the knowledge-based society and economy. No data is available as evidence of the success of the above programmes.

4.2.4 Family Solidarity and Protection of Children

The Maltese retain a very strong attachment to the family as a source of solidarity, care and support. Marriage remains a valid institution and divorce is not allowed. The norm of the two-parent family, however, co-exists with a diversity of family situations and lifestyles. Table 4.15 shows how over the past few years the number of publicly registered marital separations has almost doubled. At the same time, as evident from Table 4.16, almost eleven percent of all children are now born outside of marriage.

Table 4.15: Marital Separations in Malta

Year	Number
1995	245
1996	293
1997	351

1998	331
1999	335
2000	425

Source: Public Registry (reproduced from *White Paper*

on The Family Division – Civil Court 2001: Annex A)

Table 4.16: Births outside of marriage

Year	Births	Of which outside Marriage	% Outside Marriage
1960	8565	63	0.74
1980	5602	59	1.05
2000	4255	464	10.9

Source: National Statistics Office

Maltese family law makes provisions for the financial maintenance of separated spouses and children, the modalities of which, however, are established in each individual case by the law courts. Single parents are also eligible for [means-tested] social assistance to be granted at the discretion of the Department of Social Welfare. To better address the increasing number of marital and family problems, the government is setting up a Family Division within the Civil Court (Ministry for Justice 2001).

Data from social surveys shows how family breakdown and lone parenthood breeds poverty and social exclusion. Accordingly, Table 4.17 shows how women of a separated marital status report the lowest average yearly income and perceive themselves to be poorer than their married or single counterparts. In fact, as evident in Tables 4.18-4.22, women of a separated marital status are more likely to spend all their earnings, borrow money for day-to-day living, and to economise on spending. They experience greater social exclusion and are very worried about their present and future financial situation.

Table 4.17: Annual income and wealth

	income	Wealth
	Lm '000	10-pt scale
Current legal marital status		
Married	5.211	5.69
Widow	3.398	5.39
Separated	3.412	4.89
Single	5.707	5.76
Total	5.070	5.65
children ever had		
None	5.635	5.75
One	4.775	5.75

Two	5.035	5.72
Three+	4.790	5.50
Total	5.070	5.65

Source: Women's Welfare Study 2000. N = 500; mean on ten-point scale

Table 4.18: Family financial situation

	Current legal marital status				**Children ever had**				**Total**
	married	Widow	separated	single	none	One	two	three+	
	%	%	%	%	%	%	%	%	%
Borrow money to live	1	2	21	1	1	2	3	1	2
Live on savings	6	4		8	9	6	6	5	7
Spend all earnings	38	37	50	25	20	38	35	45	35
Save something	46	49	29	46	50	45	45	42	45
Save quite a lot	10	8		20	20	9	11	7	12
Total	100	100	100	100	100	100	100	100	100

Source: Women's Welfare Study 2000. (N = 500).

Table 4.19: Financial situation immediate future

	current legal marital status				**children ever had**				**Total**
	married	Widow	Separated	single	none	one	two	three+	
	%	%	%	%	%	%	%	%	%
Very worried	17	15	27	12	14	10	17	17	15
Quite worried	44	42	40	43	42	40	47	44	44
Indifferent, do not think about it	35	33	33	38	37	44	34	34	36
n/a	4	10		6	7	6	2	5	5
Total	100	100	100	100	100	100	100	100	100

Source: Women's Welfare Study 2000. (N = 500).

Table 4.20. Family budget up to end of month

	current legal marital status				**children ever had**				**Total**
	married	Widow	sepa-rated	single	None	one	two	three+	
	%	%	%	%	%	%	%	%	%
Many problems	1		27	3	1	2	2	2	2
Quite some roblems	5	14	7	1	2	2	3	8	5
Some problems	33	24	47	25	26	30	36	30	31
Certain ease	52	56	13	59	57	55	49	54	53
Great ease	9	6	7	12	14	11	10	5	9
Total	100	100	100	100	100	100	100	100	100

Source: Women's Welfare Study 2000. (N = 500).

Table 4.21: Economic measures last year

	current legal marital status				children ever had				Total
	married	Widow	sepa-rated	single	none	one	two	three+	
	%	%	%	%	%	%	%	%	%
Reduced spending on food	10	11	42	14	12	10	11	13	12
Changed house, too expensive				1	1				0
Did not pay bill or payment	3	5	27	4	3	8	5	3	4
Resumed/kept working to help family	8		46	12	11	15	9	9	10
Reduced spending on small things	50	30	75	42	41	53	49	48	47
Did not buy necessary things for family	7	5	29	5	6	4	8	7	7
Did without something necessary for self	36	29	68	29	25	36	38	39	34
Borrowed money for living expenses	3	5	35	4	4	8	4	4	4
Other measures	9	4	34	8	7	10	9	10	9
no economic measures	40	59	20	48	52	41	41	37	43

Source: Women's Welfare Study 2000. (N = 500).

Data analyses give evidence of how women single parents [having children outside of wedlock] and lone parents [who raise children on their own] and to a lesser extent large families [women with three or more children] experience poverty and social exclusion. Accordingly, single parents and lone parents, and mothers of large families report lower average yearly household income and perceive themselves to be poorer than their counterparts.

Table 4.22: Social exclusion because of money problems

	current legal marital status				children ever had				Total
	Married	Widow	sepa-rated	single	None	one	two	three+	
	%	%	%	%	%	%	%	%	%
Feel excluded because of money problems:									
Never	72	75	33	71	72	73	71	70	71
Sometimes	24	15	53	24	25	25	25	23	24
Often	3	10	13	4	3	2	3	7	4
Total	100	100	100	100	100	100	100	100	100

Source: Women's Welfare Study 2000. (N = 500).

Over the past few years, state social policy, partly in collaboration with non-governmental organisations, has intensified and further developed its services to address family-related problems. In addition to the financial help provided by social security and social assistance, there has been an expansion of social services, social work, counselling and marital mediation, in particular. The recently established *Appogg* (literally meaning "Support" an offshoot of the former Social Welfare Development Programme) and *Sedqa* (literally meaning "well-being"; both agencies founded in the mid-nineties) provide services to several client groups including victims of child abuse, domestic violence, marriage breakdown and substance abuse.

The most common benefit under the Social Security Act is children's allowance. Originally a universal benefit, the children's allowance has become means tested. In 1998 there was a total of 40225 girls and 42955 boys receiving a children's allowance.

The second most common benefit under the social security system is retirement or widow/ers' pension. Significantly more men (29827) are beneficiaries of social security for retirement than their women counterparts (7449). Similarly more men (4472) than women (1353) receive an invalidity or a disability social security pension. Conversely, more women (12945) are beneficiaries of a widows' social security pension than men (26).

Older women (3472), however, are more likely to be beneficiaries of an old age social assistance pension than men (830). Significantly more men receive a unemployment or a sickness social assistance than their women counterparts. Quite a few other older people, married men, widowed and single women, in particular, receive supplementary allowances. Certain older women and men also receive sickness assistance.

Beneficiaries of social assistance are in the main women (3129 compared to 964 men in 1999), under sixty years old, legally or *de facto* separated and single women. (Central Office of Statistics, 1999: 107-118).

Although there is little official data on the provision of personalized social services to children and other family members at risk, social surveys manifest the extent of assistance received by persons experiencing family-related problems, including family breakdown. Table 4.23 shows how most separated people receive social assistance and children's allowance, and a few others receive unemployment benefits or a university stipend to help them improve their qualifications for work. Conversely, women with large families receive children's allowances, an old people's or a widow's pension, disability pensions or a social assistance for lone parents or the separated.

Table 4.23: Receive social benefits

	Current legal marital status				**Children ever had**				**Total**
	Married	widow	sepa-	single	none	One	two	three+	

			rated						
	%	%	%	%	%	%	%	%	%
Old people's pension	16	43	5	17	15	10	12	29	18
Widow's pension		76			4	7	4	13	7
Single parents benefits		2						1	0
Disability benefits	1	5		3	2		1	3	2
Work accident benefits	2			2	2		2	1	1
Unemployment benefits	4		7	5	4	4	4	4	4
Children's allowance	45	4	42	6	2	52	50	35	32
Child disability benefits	2						1	2	1
Disability pension		2		1	1			1	0
Social assistance for separated			50	2		6	3	1	2
Home help	1	9			1	2	2	2	2
University maintenance grant	6		7	13	11	5	8	4	7
Maternity benefits	1				1		1		0

Source: Women's Welfare Study 2000. (N = 500).

Table 4.24 shows how quite a few separated people and to lesser extent women from large families have at some point in life received personalised assistance from a social welfare institution.

Table 4.24: Appointment with social worker in agency over past year

	Current legal marital status				**children ever had**				**Total**
	married	widow	separated	single	none	one	Two	three+	
	%	%	%	%	%	%	%	%	%
Yes	6	8	27	7	7	6	5	9	7
No	94	92	73	93	93	94	95	91	93
Total	100	100	100	100	100	100	100	100	100

Source: Women's Welfare Study 2000. (N = 500).

Table 4.25 shows how separated women and to a lesser extent women from large families would like to receive more financial help.

Table 4.25: Other help needed

	Current legal marital status				**children ever had**				**Total**
	Married	widow	sepa-rated	single	none	one	two	three+	
	%	%	%	%	%	%	%	%	%
None, happy with what I have	40	63		25	25	41	45	42	38
More financial help	23	31	71	14	10	25	24	31	23
Help from professionals	2	2		3	2	8	2	1	2
Help from volunteers	1	2			1	2		1	1

Hospitality in special centre		2						1	0
Help to working women	0						1		0
Don't know	34		29	58	61	24	28	25	36
Total	100	100	100	100	100	100	100	100	100

Source: Women's Welfare Study 2000. (N = 500).

4.2.5 Accommodation

Between 1988 and 2001, there were a total of 357 registered cases of homelessness with the Department of Social Welfare. Most are 18-26 year olds who are unable to live with their parents, and quite a few have teenage pregnancy problems. A YMCA survey carried out in September 2001 found that of the 250 persons living in homeless shelters, 64 were children. (Planning Authority 2002).

Table 4.26: Social Housing Beneficiaries (1990 - 2000)

	Year	**Beneficiaries**
Sale	1990-2000	1679
Rent	1990-2000	524
Rental Subsidies	1987-2000	583

Source: Housing Authority.

Although there is no evidence of widespread homelessness, it is not uncommon for certain people to live in substandard or inadequate conditions. Data from the 1995 Census of the Population and Housing uncover a total of 6792 families constituting 5.7 percent of all households living in substandard conditions. Over three thousand households are without a bathroom, another two thousand and seventy do not have a kitchen, and about one thousand have neither a bathroom nor a kitchen. An additional 939 have inadequate housing and 104 families live in one multi-purpose room. Female-headed households, lone parents and older women in particular, are the worst hit (Abela 1998c: 108-9).

Table 4.27: Social Housing Applications (1996 – 1999)

Year	**Applications**	**Percent of applicants allocated housing**
1996	4,772	5.7
1997	5,091	4.7
1998	3,163	10.1
1999	3,330	4.7

Source: Miljanic Brinkworth 2000

Table 4.28. Social Housing Applicants By Income Group (1999)

Number of applicants	Income over Lm 4,000	Income less than Lm 4,001	Elderly under Lm 4,001	Single Parents under Lm 4,001
3,309	494	2,815	572	722

Source: Miljanic Brinkworth 2000

Table 4.29: Housing Authority Schemes

Year	Scheme	Scheme Title	Applicants	Beneficiaries
1996	Home purchase assistant grant and home purchase interest subsidy on loan for the purchase by tenants of privately owned residences	M	31	20
1996	Subsidy on adaptation work in owner occupied dwellings	N	625	436
1996	Subsidy on adaptation works in leased private dwellings	L	454	308
1998	Financial aid for adaptation work in residences occupied by persons with disability	1	135	121
1999	Purchase and improvement of private dwelling houses	X	9	0
1999	Subsidy on adaptation works in leased private dwellings	5	199	175
1999	Subsidy on interest on house loans	Y	291	119
1999	Subsidy on adaptation work in private owner occupied dwellings and subsidy on loans	Z	227	175
1999	Purchase of government owned dwelling houses	6	222	0
1999	Financial aid for adaptation work in residences occupied by persons with disability	7	155	23
1999	Rent subsidy on leased privately owned property	R	354	176
1999	Refund of vat on first dwelling house	S	408	230
1999	Subsidy on adaptation works in vacant privately owned residences which are leased to Maltese citizens	T	6	3
1999	Subsidy on adaptation works in government owned residences	W	218	68
2001	Lift installation in government owned blocks	V		
2001	Ground Redemption of plots of land under the HOS Scheme 1977 – 1987	K	32	28
2001	Ground Redemption of plots of land under the HOS Scheme prior to 1979	P	4	-
2001	Ground Redemption of plots of land under the HOS Scheme 1977 – 1993	Q	43	43
TO-TAL			3,214	1,501

Source: Housing Authority

The highest number of substandard dwellings is found in the densely populated Inner and Outer Harbour regions. In particular, the localities of Valletta, Paola, Hamrun and Cospicua have an average of 773 substandard dwellings within the Inner Harbour region closely followed by B'Kara and Qormi with an average of 716 substandard dwellings within the Outer Harbour region. A smaller number of similar dwellings are found in localities within the other regions.

The Department of Social Housing has as its main function to ensure a fair distribution of the housing stock. Social housing, as distinct from affordable housing refers to the provision of housing and housing assistance to households that are in particularly severe need, usually on a rental basis. Currently there is an estimate of 7,800 units owned by Government and leased as social housing. This figure represents five percent of the Islands' total dwelling stock. A further 2,053 dwellings are currently rented out at affordable rents by the Joint Office in the administration of ex-Church property (Planning Authority 2002).

The number of housing units provided by the Government has declined from an average 1,219 units provided each year between 1980 and 1987, to 607 between 1988 and 1994 and to 240 per year between 1995 and 2000. Between 1990 and 2000, 524 households were allocated rental units while almost 600 applicants living in private rented accommodation benefited from rental subsidies. This is in conformity with governmental policy to develop and update the rental market in conjunction with limiting the provision of social housing to the most needy.

The Social Housing Department receives applications from the public for alternative housing. On average, there are some 925 new applicants every year. The waiting list has an average of 3500 applicants, of which four to ten percent are satisfied annually. The year-end figure is on the decline.

Within the group of persons requiring housing assistance are the socially excluded and people with special needs, many of whom live in residential institutions. These include children in boarding schools, victims of domestic violence, ex-prisoners, disabled persons, older people, and victims of drug abuse. The advantages of offering care in the community, rather than in large institutions, are increasingly being acknowledged. This leads to an increased demand for small-scale sheltered housing.

The new strategy of the Housing Authority provides housing support through a wide range of schemes. Most assistance is in the form of home loan interest rate subsidies and the popular Schemes 5 (previously L) and Z (previously N), which provide close to full grants for improvements to owner occupied and leased private dwellings (see Tables 4.26-4.29). No evaluation studies on the effectiveness of housing policy in countering exclusion poverty are available.

4.2.6 Ethnicity

Malta is a very homogeneous society with no apparent divisions along ethnic lines. The most recent Census of the Population and Housing (1997 (1): li) reports a total of 7213 non-Maltese citizens living in Malta consisting of 556 Australians, 410 Italians, 297 Americans, 285 Libyans, 259 Canadians and 128 stateless persons. The vast majority of the Maltese population (97.8%) obtained their citizenship by birth, a few others by registration (1.2%) or naturalisation (0.6%). Non-Maltese citizens, who in the main are either the spouses of Maltese nationals or children of returned migrants, constitute only 1.94% of the total population. Although there has since been a continuous incursion of illegal immigrants mainly from North Africa and other developing countries, the population in Malta remains very much homogeneous. Illegal immigrants travel by boat sometimes in difficult circumstances and at the risk of their lives on their way to neighbouring European countries. At the end of December 2002, not less than 1000 illegal immigrants were being held in overcrowded detention centres on the island.

This situation, however, coupled, as it is with limited economic resources and lack of job opportunities for local nationals in a small city-island state, is not unrelated to an observed prejudice against people of a different race, religious conviction or cultural origin.

Table 4.30 shows how people in Malta have become increasingly unwilling to accept in their neighbourhoods Muslims, Jews, Hindus, minority religious sects or cults, people of a different race, immigrants and foreign workers. In this way, ethnic minorities living in Malta risk poverty and social exclusion. No data is available on the social and economic conditions of these minority groups.

Table 4.30: Social intolerance

	---------- M a l t a ----------				Europe*
	1984 %	1991 %	1995 %	1999 %	2000 %
Do not want to have as neighbours:					
Muslims	Na	15	28	28	20
Jews	Na	9	20	21	12
Hindus	Na	9	21	Na	Na
Minority religious sects/cults	42	19	33	Na	Na
People of different race	9	11	21	19	13
Immigrants/foreign workers	Na	10	15	16	16
N	*467*	*393*	*400*	*1000*	*39303*

Source: Maltese Values Studies (1984-1999). *The European Values Study: A Third Wave 2001*. *Europe = average for 32 European countries. N = number of respondents, randomly selected. Na = Not asked.

4.2.7 Regeneration of Areas

Results from the HBS show how low-income households are more to be found in the Inner Harbour region, and the sister islands of Gozo and Comino. Conversely, high-income households are more found in the Western and Northern districts.

Very recently, the Government has initiated a long-term programme for the Rehabilitation of Valletta and the regeneration of the Cottonera area, within the Inner Harbour region, and set up a ministry exclusively responsible for the development of Gozo and Comino.

The Three Cities within the Cottonera Area are characterised by economic and social decline. The Cottonera saw a first mass exodus of the population during the Second World War. Economic decline became even more evident after the closure of the British military base in 1979, the waning shipbuilding accompanied by a diminishing residential population (from 17889 in 1967 to 12426 in 1995) and lack of facilities for the development of tourism. Social decline is evident in the high residential density of poor people living in depressed neighbourhoods, lack of open spaces, substandard and poor housing, low educational levels, economic deprivation, poor accessibility to other parts of the country, presence of dockyards, and social prejudice.

The Government approved the Cottenera Waterfront Project for the regeneration of the area by a wide range of mixed uses including yachting facilities, cultural and tourist facilities, catering establishments, social and community buildings and a landscaped public promenade. This is to be achieved through the rehabilitation and restoration of historical buildings, the reversal of population decline, improved access and public

transportation system to the Three Cities, open spaces and recreational facilities, employment and small-scale retail outlets for the local community. (Planning Authority 1997). This is accompanied by joint social initiatives including community development and training in working skills for the local people. A new sports centre is also under construction in the Cotonnera area.

Foremost amongst the objectives of the Ministry of Gozo is to improve the economic infrastructure so as to offset the island's geographical and structural disadvantage. The Ministry provides support for productive investment, the growth of sustainable employment, the protection of the island's natural environment and cultural heritage. Initiatives include improvements to inter-island sea and helicopter service, road networks, adequate supply of water and electricity, improved education and skills for the employability of Gozitans.

During 2001 the Ministry of Gozo carried out infrastructural works in most primary and secondary schools, opened five special laboratories at the Centre for Advanced Studies, modernised facilities at the Gozo General Hospital, upgraded road and the sewage system, introduced a second new ferry boat for inter-island travel, and saw an 60 percent increase of hotel tourism, amongst other. This resulted in more work opportunities for Gozo residents.

4.2.8 Other factors influencing poverty and social exclusion

Foremost amongst other major factors influencing poverty and social exclusion are activity limitations of older and disabled people. In the 1995 Census 16,576 persons or 4.4 percent of the total population report having activity limitations. In the main, they have only a primary or an inadequate level of education and are economically inactive or unemployed. Out of total of 2165 persons with activity limitations in the labour market, 245 are unemployed (Abela 1998c: 89-90).

More recently, the Women's Welfare Study (Abela 2002) reports how fourteen percent of all women respondents suffer from either a long sickness or a disability, half of whom also experience activity limitations. Seriously sick and disabled people also report significantly lower average annual family income than their able-bodied counterparts. [Tables 4.31-4.35]

Table 4.31: Long illness or disability

	Frequency	**%**
Yes	70	14.0
No	430	86.0
Total	500	100.0

Source: Women's Welfare Study 2000. (N = 500).

Table 4.32: Sickness/disability limits activity

	Frequency	%	Valid %	Sum %
Yes	39	7.8	55.9	55.9
No	31	6.2	44.1	100.0
Total	70	14.0	100.0	
N/a	430	86.0		
Total	500	100.0		

Source: Women's Welfare Study 2000. (N = 500).

Table 4.33. Net income and poverty of persons suffering from long illness or disability

	net income	poor-rich
	Lm '000	10 pt scale
Long illness or disability	3.853	5.17
No long illness or disability	5.258	5.73
Total	5.070	5.65

Source: Women's Welfare Study 2000. (N = 500).

Table 4.34. Unable to use service because disability/sickness last year

	Frequency	%
Book hotel or guest house	3	8.4
Insurance	2	5.6
Use bank services	7	18.8
Use public telephone	5	12.4
Use other service	7	17.9
No difficulty to use services	28	71.7

Source: Women's Welfare Study 2000. (N = 500).

The Women's Welfare Study gives evidence on how limited mobility and time-poverty constitute major factors for social exclusion. In fact, the most common reasons why women feel cut off from others are lack of own transport, irregular bus services and having to look after their family and children. Certain women feel isolated because they have problems with accessibility or a disability. Others feel cut off because of the demands of their job, or because they have no friends or family. A few others find fault with sexism and racism (Table 4.36).

Table 4.35: Difficulties of people with disabilities

	Frequency	%
Have difficulty to:		
Find reading facilities	10	14.8
Reach destination	24	34.2
Access small doorways, no ramps, etc.	12	16.8
Move around: no lift, narrow corridors	12	16.4
Communicate	10	14.7
Lack facilities:		
Parking, adequate trolleys, WC, etc.	7	10.7
Refused entry	1	1.6
Refused service	4	6.2
Asked to leave	0	0.0
Other difficulty	9	12.7
no difficulties	33	47.3

Source: Women's Welfare Study 2000. (N = 500).

Table 4.36: Reasons for feeling excluded/isolated

	Frequency	%
Work demands	18	3.7
Child care	60	12.0
Care for family members	64	12.8
No own transport	75	15.1
No regular bus service	64	12.8
No friends	19	3.9
No family	12	2.3
Access problems	19	3.9
Sexism	14	2.8
Racism	2	0.4
Disability	2	0.4
Other reason	29	5.9
None of the above	277	55.5

Source: Women's Welfare Study 2000. (N = 500).

Table 4.37 shows how people experience poverty and social exclusion when they undergo financial problems, unemployment or incur debts and loans. Poor people are also prone to stress, mental heath problems, depressions or long serious illness, accidents and physical disabilities. Poverty and social exclusion are also related to greater incidence of trouble in the family, including problems with one's parents and relatives, single and lone parenthood, problems with one's children and neighbours, disruption of intimate relationships, conflicts over property, accidents at

home, wife abuse and adultery. People who experience substance abuse, or who have been physically or sexually abused are also more likely to live in poverty and to feel excluded from society.

Table 4.37: Experience of difficulties by poverty and social exclusion

	Poverty self-assessment*			**Social exclusion**		**Total**
	Poor	Average	Rich	Yes*	Not at all	
	%	%	%	%	%	%
Experienced:						
Financial problems	59.8	30.2	16.1	40.5	21.7	30.2
Loss of job by a family member	22.2	11.4	5.6	12.5	10.2	11.2
Debt, loan	11.2	9.2	8.8	11.2	7.8	9.3
Tired, stressed	78.3	67.7	62.2	75.5	61.1	67.6
Mental heath problems, depression	31.3	10.3	7.7	20.3	5.3	12
Serious long illness	25.8	18.7	18.1	28.8	11.6	19.3
Other sickness, serious accident	9	5.4	6.4	8.0	4.4	6
Physical disability	8	5.9	4.6	9.6	2.7	5.8
Family trouble	39.6	16.9	19.3	26.6	14.4	19.9
Parents/relatives problems	16.8	9.9	5.6	12.7	7.2	9.7
Upbringing children alone	20.6	7.5	7.1	14.0	4.7	8.8
Problems with children	17.4	7.1	7	12.0	5.0	8.2
Problems with neighbours	13.2	7.1	8.3	12.4	4.5	8
Separation from an intimate relation	9.2	6.5	6.4	10.1	4.0	6.8
Conflict over property	5.9	4.2	3.3	4.6	3.8	4.2
Children out of wedlock	5.6	3.4		4.6	1.4	2.9
Accident at home	6	2.5	1	4.2	1.2	2.5
Battered by husband	5.6	2.6		3.4	1.5	2.3
Husband unfaithful	5.6	2	1.4	4.3	0.7	2.3
Alcohol problems	7.6	1.9	1.4	2.9	2.0	2.4
Drug problems	3.6	1.5		2.6	0.4	1.4
Physical abuse	3.9	0.9		2.3	0	1
Sexual abuse, rape	1.9	1		0.9	0.8	0.8

Source: Women's Welfare Study, 2000. poverty self-assessment on a 10-point scale: 1-3 = poor, 4-7 = average, 8-10 = rich. Social exclusion (yes) = felt excluded at least for one reason.

To counter the disadvantages of disabled people the National Commission Persons with Disabilities is consolidating its administrative capacity to enforce the Equal Opportunities Act with regards to accessibility and equality, in particular. The Supported Division within the Foundation for Social Welfare is also undertaking a pilot project to enable persons with

severe disabilities live in a community setting with the assistance of professional support workers. In addition, the Employment and Training Corporation is putting into practice training and employment schemes for persons with disabilities and employers.

The Government is also committed to implement a Gender Equality Act. The new law makes provisions for flexible and family friendly employment conditions, child day-care services, training schemes and empowerment programmes for women job-returnees, policies and standards against sexual harassment at the workplace, and regulations protecting working mothers or pregnant women. The Ministry for Social Policy (2002) is committed to enhance and develop shelter and respite services to women experiencing difficulties or abuse, as well as treatment programmes for perpetrators.

4.2.9 Administration, Access and Delivery of Services

The social protection system in Malta differentiates between Social Security and Social Services. The first provides cash-benefits to people in need and the second looks after non-material needs. The Department of Social Security is run from a Central Office within the Ministry for Social Policy, but has a number of district offices spread all over Malta and Gozo. On the other hand, social welfare services are coordinated by the Department of Family and Social Welfare and provided through the various units or agencies of Government-run *Appogg* and *Sedqa* and Non-Governmental Organisations.

The Department of Social Security is undertaking a review exercise of its operations and service delivery to ensure that social benefits are given rightly and timely to all those who are entitled to them. Its proactive use of information technology disseminates information about benefits whilst cutting back on assessment and processing time for the payment of benefits.

In fact, Table 4.11b above reveals how quite a few women respondents from the upper-income groups (11% from the managerial and upper professions with annual income above Lm 7001) are still receiving means-tested children's allowance. They also avail themselves of home help (17%), university maintenance grants (31%) and other benefits. The lower income groups, however, those below the estimate poverty line (Lm 2000 or lower), in particular, are the main beneficiaries of a disability benefit (62%) or pension (51%), a widow's (42%) or old people's pension (35%), home help (50%), parental care benefits (100%), unemployment (57%) and work accident benefits (26%), child disability benefits (38%), social assistance for single parents (100%) or separated people (50%). Much fewer, however receive, a university maintenance grant (15%).

The Department is also undergoing a business engineering exercise leading to an administrative reorganisation. This is to enhance service delivery within the network of Area Offices on the islands, with respect to refurbishment of buildings; customer service standards, training and

mentoring of customer care officers, in conjunction with private institutions. Similar measures will ensure that services are customer-friendly and accessible to all clients in their own towns and villages, including persons with disabilities, who in the main have difficulties to access public places with small doorways, lacking ramps (16.8%) or other facilities (10.7%), making it impossible for them to move around in offices with narrow corridors and no lifts (16.4%). In fact, in the present state of affairs, quite a few have experienced problems to communicate (14.7%) and a few others were refused a service (6.2%) if not also entry into a public place (1.6%). Able-bodied women also report having experienced social exclusion because they do not have their own transport (15.1%) or because of irregular bus services (12.8%). (Refer to Tables 4.35, 4.36 above). Accordingly, the premises of welfare services need to become more accessible to all those who because of disability, lack of transport or family commitments are unable to use the already updated and well-established but over-centralised welfare agencies.

The Ministry for Social Welfare also sponsors and subsides Non-governmental Organisations that operate in the field of social welfare support services. The NGO Project Selection Committee monitors their activities for financial probity and service quality, providing support to those activities that lie within the mission of the Ministry.

4.3 Evaluation of future challenges

4.3.1 Main challenge

Foremost amongst the major challenges for a greater social inclusion in Maltese society are the need for a concerted effort to ascertain the sustainability of the welfare system, addressing the causes of current social problems and achieving a political consensus on Malta's relationships with the European Union. There is also a need for greater social tolerance of an increasing diversity of individualized lifestyles and family structures of minority groups.

Accordingly, social policy would need to address the new problems emerging in a changed social context where changing family structures and community networks, and individualised living arrangements require a multi-faceted approach including support from legal, psychological, financial, religious, educational and social services.

In the present circumstances, single parents, widows, separated and unemployed women with or without dependent children, and persons with disabilities experience new forms of poverty and social exclusion. Moreover, in an increasingly consumerist and alienating culture, young people in possession of little or no educational qualifications and poor working skills are most vulnerable to substance abuse and organised crime. To meet these challenges, the currently expanding targeted social services need to be supplemented by long-term structural changes of the educational,

legal and social systems that would guarantee the full participation of disadvantaged groups in society. The immediate support that is being provided by a sufficiently well functioning network of social services now requires a concerted strategic effort to address the causes of current social problems.

At a time when people are opposed to paying higher taxes, such that the State cannot continue to increase its expenditure on social welfare, studies of existing welfare organisations (Abela 2002a) recommend:

I. a strategic reorganization in the management and provision of social welfare

II. policies to encourage the development of more partnership ventures between voluntary organizations and the State

III. social policies to empower women to return to and/or continue working, including:

   A. more job opportunities for women

   B. training and re-training programmes in work skills for women, the unemployed, and underemplyed

   C. a widespread social education for a just sharing of housework by women, men and children in the household

   D. assistance for the development of various childcare services by voluntary organizations, women's cooperatives, or joint private/public ventures at Local Council levels, communities, neighbourhoods and places of work

IV. an increase in cash benefits to women and men in difficult circumstances

In addition, it is recommended for existing welfare agencies to:

I. make better use of voluntary workers and an increase of part-time workers in organizations of social welfare

II. improve collaboration between welfare agencies offering similar services

III. introduce fees for select welfare services to those who can afford them

IV. introduce greater participation in decision-making, including relations between welfare workers, coordinators and their clients

V. develop and maintain a detailed database of all clients

VI. ensure that premises and office hours are accessible to clients

VII. improve the supervision of welfare workers by experienced professionals

VIII. ensure the regular evaluation of exisitng welfare agencies by an independent authority

IX. ascertain a greater transparency, accountability and economy in spending of organisations of state welfare

Finally, diffusing the current political polarisation on Malta's accession to the European Union would allow for greater collaboration between the major political parties and their social partners, in their determination to ensure the provision, regulation and timely delivery of adequate services to the disadvantaged in society.

4.3.2 Links to other social protection policies

As explained in chapter 2, the Government is projecting a general reform of the social protection system to ascertain sustainable pensions and social welfare. A Welfare Reform Commission has been appointed to review the present welfare system in view of the challenges facing future generations as a result of demographic realities and to make recommendations for the reorganization of welfare. As a first step, in the Budget Speech for 2002, the Minister of Finance announced the Government's decision to apportion pensions from health insurance and other social benefits. Government is committed to upkeep the existing safety net for the most vulnerable, but also to reorganise social welfare and curb abuse of the system.

4.3.3 Political directions of future reform

There is a general agreement that Malta should have the best relationship with the European Union. But whereas the present Government's Nationalist Party is committed, after completion of negotiations, to abide by the outcome of a referendum on Malta's accession into the European Union, the Malta Labour Party, if returned to government at a general election, would re-negotiate a special partnership with the European Union on the model of a "Switzerland in the Mediterranean". The Malta Labour Party (2001) holds that full membership in the European Union generates greater prosperity to the already well off, but puts undue burdens on the weakest of society. It claims that in the EU, workers will have to pay higher prices for basic commodities, leading to increase in the cost of living, demands for higher wages, rise in unemployment and uncompetitive tourism. Whilst negotiating a partnership with the EU, a future Labour Government would be committed to promote new economic initiatives with European and non-European countries, redistribute wealth, and ascertain that workers, small self-employed, pensioners and the most needy will not fall behind.

The Malta Labour Party has not accepted the Government's invitation to participate in the Welfare Reform Commission and the General Workers' Union has also criticised the likely recommendations on pensions of an unpublished preliminary report of the Welfare Reform Commission.

The political direction for the immediate future, however, is best discerned from the options of the people. Accordingly, comparative research on the political values of the Maltese and other member and applicant countries of the European Union show how only the very few support extreme left or extreme right political ideologies. Instead, the majority favour middle ground positions standing between left and right political orientations. In Malta, just as in post-communist applicant countries and Universal welfare states of the European Union the majority favour middle-ground positions or 'third way' politics.

As in most member and applicant countries of the European Union there is a general consensus for the state to guarantee the basic needs for all in terms of food, housing, clothes, education and health; and to recognize people on their own merits. A smaller majority also find important for the state to eliminate big inequalities in income between citizens. Similar political middle-ground positions are accompanied by a greater preference for the principle of freedom over and above equality, and a support of the free market where the state has only a limited control. They are also supportive of joint welfare responsibilities to be shared by the individual, intermediate social groups and the state. Relative to other member countries of the European Union, however, the majority of people in Malta retain a predominant traditional and materialist value orientation, which in turn has an impact on their options for future reforms in politics, social policies and accession into the European Union (Abela 2002b).

4.3.4 Social exclusion, poverty and EU accession

As can be expected, in contrast to the economically better off, poor people and those who because of their insecure family financial situation risk poverty and social exclusion are apprehensive about Malta's accession into the European Union. In particular, the weakest members of society constituting the lower social classes think that Malta's accession into the European Union will result in a weaker economy, rising taxes, foreign workers taking the jobs of local nationals, and the country being unable to compete with much larger countries of the European Union. Similar positions, however, are also highly politicised (Tables 4.37, 4.38).

In response to these concerns, in its pre-accession negotiations with the European Union, the Government of Malta has requested and achieved special concessions on the movement of people and goods, ensuring the protection of the most vulnerable from foreign competition, the self-employed, the unemployed, fishermen and farmers, in particular. The island of Gozo is also being considered as a separate region.

In its negotiations on Social Policy and Employment (Chapter 13) with the EU, Malta has agreed to align its legislation with the *acquis communautaire*. In particular Malta is committed to implement:

I. Amendments to the Conditions of Employment (Regulation) Act and the Industrial Relations Act, to allow for, and encourage, the use of collective bargaining

II. A Gender Equality Act to prohibit any form of direct or indirect discrimination based on sex

III. The Protection of Maternity at Work Places Regulations

IV. Amendments to the Social Security Act (Cap. 318)

V. Amendments to the Criminal Code (Cap. 9) rendering acts of racial discrimination a criminal offence

VI. A National Human Resources Development Policy, including equal treatment of men and women as regards access to employment, vocational training, promotion and working conditions

VII. A Council for Economic and Social Development Act for social dialogue

VIII. Minimum Health and Safety Requirements for Work with Display Screen Equipment Regulations

Malta has also expressed its willingness to participate in:

I. activities of the European Monitoring Centre on racism and xenophobia.

II. programmes to combat drug dependence, AIDS or other communicable diseases

III. Standing Committee on Employment and in the Sectoral Dialogue Committee promoting dialogue between the social partners at European level.

In the final stage of negotiations in Copenhagen, the European Commission agreed for Malta to receive a net financial package of Lm81 million spread over the first three years after accession in May 2004. This would enable the country to develop further its infrastructure, extend higher vocational education and training in work skills, promote new economic initiatives, pursue its prospected reform of the welfare system and compensate those who are adversely hit because of EU membership. The impact of Malta's EU accession, however, can be better assessed after the outcome of the referendum and general elections, which are expected to take place sometime between the first half of 2003 and the beginning of 2004.

Table 4.37: Malta in the European Union by poverty and prospects for family financial situation

	Poverty-wealth scale*			Family financial situation, in the near future			Total
	Poor	Average	Rich	Gets Better	No Change	Gets worse	
	%	%	%	%	%	%	%
Malta in the European Union:							
Economy does better	37	49	70	65	52	15	48
Foreign workers take jobs of locals	44	35	20	26	33	69	35
Malta too small to compete	56	51	37	42	46	84	50
Better study opportunities for youth in Europe	60	75	84	83	76	51	72
Higher taxes	55	52	32	42	45	72	48
More work opportunities in Malta & Europe	53	62	82	78	63	37	61
Taking all things into consideration, agree:	44	53	79	70	56	17	52
Malta to negotiate with EU							
Malta to join the EU	42	51	70	65	54	18	50

Source: Malta Values Study, 1999. Notes: Poverty-wealth scale, net annual family income: poor = Lm 2000 or lower, i.e. below estimate poverty line; average = Lm 3000 - Lm 8000; rich = Lm 9000 or higher.

4.3.5 Conclusions

In Malta, the development of social policy has much to gain from comparative social research that make good use of standard European indicators on poverty and social exclusion. In an increasingly European and global society, social policies are most effective when they are developed in response to findings from the analysis of reliable and comparative data and the rigorous and independent evaluation of existing social programmes. In fact, social policies are often the result of a learning process in the course of exchanges on the factual experiences of other European countries. For this purpose, the State is to ensure the independent collection and timely dissemination of standard indicators and data sets from national surveys. Established researchers should also have easy access to current information and to data archives of national statistical offices.

Table 4.38: Malta in the European Union by socio-economic class and voting political party

	Socio-economic class				Political Party				Total
	AB	C1	C2	DE	PN	MLP	AD	N/A	
	%	%	%	%	%	%	%	%	%
Malta in the European Union:									
Economy does better	74	66	39	35	87	5	64	32	48
Foreign workers take jobs of locals	18	30	41	40	9	72	27	37	35
Malta too small to compete	28	38	59	61	15	90	73	63	50
Better study opportunities for youth in Europe	90	82	70	59	94	46	73	66	72
Higher taxes	29	45	53	52	20	83	73	52	48
More work opportunities in Malta & Europe	82	73	57	48	91	26	91	50	61
Taking all things into consideration, agree:									
Malta to negotiate with EU	78	70	42	39	92	9	36	37	52
Malta to join the EU	76	67	40	37	90	7	55	32	50

Source: Malta Values Study, 1999. Notes: Socio-economic class: AB = upper social class, professional, managerial workers; C1 = lower middle class; C2 = working class, skilled workers; DE = semi-skilled/unskilled workers, unemployed, dependent on state welfare. Political Party: PN = Nationalist Party (in government), MLP = Malta Labour Party (in opposition), AD = Alternattiva Demokratika, N/A = No answer/don't know/refused to answer.

The current shift in social policy having as its objective to transform the post-War Welfare State into a Welfare Society would require a radical change in politics and popular culture. The major prospected reforms in welfare shall only take place when politicians and the new generations give greater importance to the values of sustainable development and leave behind excessive traditionalist and materialist concerns. In accordance with research findings, social inclusion has to be worked out primarily at the level of the individual, family and community networks with the subsidiary, but inalienable assistance of the State and Non-governmental organizations.

5. HEALTH CARE

5.1 Evaluation of current structures

5.1.1 Organisation of the health care system

The Maltese health care system consists of a public health care system that covers all the population supplemented by a private health care system that operates independently.

The public health care system is publicly financed and is free at the point of use. It is currently in the process of being transformed from an integrated health care system to a contractual health care system. This reform was publicly announced in July 2001 and will be implemented gradually starting with public hospitals.

In the current set up in Malta, the Ministry of Health acts both as a regulator and as a service provider for primary and secondary / tertiary care. The public health care system falls under the portfolio of the Minister of Health. The annual budget for public health care is determined through consultation between the Minister of Health and the Minister of Finance. It is then endorsed by Parliament. The Minister also takes direction from Cabinet on any major proposals for change. Otherwise the day-to-day decisions for implementing government policy in health are taken at the level of the Minister of Health.

The Permanent Secretary heads the Ministry of Health. The Director General (Health) heads the Health Division and carries out the statutory functions of the Superintendent of Public Health. He is also the chief medical officer. He is supported by a number of Directors who collectively have the overall role of ensuring that the high level of affordable health care is provided and that the health status of the population is safeguarded and improved. (Fig 5.1.1)

The Departments of Public Health, Health Promotion and Health Information are primarily responsible for carrying out activities related to public health. Malta has had a long tradition of public health medicine practice based upon the British system. The main responsibilities of the Department of Public Health include health protection, disease surveillance, environmental health, food safety and the provision of public health laboratory services. The Department of Health Promotion carries out educational campaigns and provides services related to lifestyle interventions for better health. This Department also carries out intersectoral activities to promote the health perspective in society. The Department of Health Information collects, collates and analyses data and information pertaining to health status and health service activity.

The health care system has traditionally been highly centralised with nearly all decisions being taken at the level of the Ministry of Health. Since

the early 1990s a planned process of decentralisation has gradually been taking place. This was in keeping with general Maltese Government policy in an attempt to reduce bureaucracy and is in line with a wider decentralisation process that has taken place in the Maltese public sector over the past decade. The decentralisation process has enabled a number of management decisions to be taken within the hospitals and health centres. However, the management system is still somewhat bureaucratic due to complex civil service procedures notably involving financial regulations and human resource management. Although these are intended to ensure transparency and accountability, they are slow and laborious thus rendering the health care system incapable of responding rapidly to evolving situations and new demands. Government has created a number of parastatal organisations in an attempt to generate a degree of flexibility and responsiveness in decision-making. The Foundation for Medical Services, responsible for the construction and commissioning of the Mater Dei Hospital still under construction, has also been given the mandate to eventually oversee the running of Malta's public hospitals through a system of autonomous agencies.

Privatisation has not featured strongly as a mechanism for decentralisation within the public health care sector. Efforts to privatise certain services such as cleaning have yielded mixed results and were not pursued further. The government has recently given renewed impetus to the formation of public-private partnerships and it is expected that the commissioning of the new Mater Dei Hospital will bring about an innovative element of partial decentralisation via privatisation of support services such as catering amongst others.

A more successful venture has been to decentralise activity through the creation of workers' cooperatives. This was carried out for the laundry services and provided a positive result with a rapid transformation of the system of laundry provision for public hospitals, into an effective, efficient and dependable service. Other services may adopt similar strategies.

Malta's size does not make it necessary or feasible to support regional or district level health authorities. However, the island of Gozo has a fairly independent status and is responsible for managing the health services offered on the island through the Ministry for Gozo.

In the present scenario the government fulfils the role of financing authority and service provider. The government does not carry out a purchaser function. The Ministry of Health presents its rolling annual business plan to the Ministry of Finance. The latter provides a yearly allocation to the Ministry of Health. This allocation is approved by Parliament as part of the national budget plan. The budget for the Ministry of Health is divided into a number of cost centres. Each public hospital has its own cost centre. There are also cost centres for primary care and for medicines and medical materials. The introduction of financial management systems within the public hospitals has led to a greater degree of autonomy in managing hospital finances.

Within the private sector, the relationships between the financing authorities and providers are different. Several private health insurance schemes exist in Malta. These tend to be private-for-profit insurance companies. Some are affiliated with international insurance schemes whilst others are local companies. Private health care insurance is subject to regulation by the Malta Financial Services Centre. The Ministry of Health does not regulate and has no relationship with private health insurance. Private health insurance reimburse patients or providers retrospectively for the services incurred / provided and often, but not always, in accordance with pre-determined rates. Individuals are free to choose amongst the private health insurers. Insurers are not obliged to accept all prospective applicants requesting cover. Choice of private insurer is restricted when the employer as part of the employment package provides cover.

The private health care system co-exists alongside the public health service with the only link being the providers who often work in both systems. Although the latter provide comprehensive health care coverage for all, a thriving private market exists from primary through to tertiary care.

In 1992 a household budgetary survey (COS 1992) estimated that around two thirds of primary health care is provided by the private sector. In the vast majority of cases, solo general practitioners provide this care. These doctors often referred to as ”family doctors” work from within their own clinics or from pharmacy offices. Self-dispensing is not permitted under Maltese legislation. Registered pharmacists may only carry out dispensing and a person may not be registered concurrently as a doctor and as a pharmacist. Continuity of care is a strength of these practices as patients usually tend to consult the same doctor. However, there is no system for patient registration and patients are free to move around from one doctor to another. Unfortunately, this sector has never been subject to regulation and records may be poorly kept. Investment in IT systems for patient management has been totally up to the individual doctors and, as a result, is not widespread. Fees charged are modest and affordable. Most doctors offering these services are paid out-of-pocket by patients directly. Private health insurance only tends to provide limited coverage for primary health care.

The public health service provides primary care services through a number (8) of health centres situated in towns across the country. These health centres were originally designed to provide an emergency general practitioner service during the protracted medical dispute in the late 1970s and 1980s. Eventually, these health centres flourished and began to provide a range of services including dental clinic, immunisation, well-baby clinic, speech therapy, podiatry and other specialist services. However some severe structural and systematic problems were never tackled. This led to a situation where a system for patient registration and continuity of patient care remains inexistent. Doctors are expected to provide emergency care, elective primary care and home visits. General practitioners working in these health centres are quite demotivated and for many these posts have been a

stepping stone prior to setting up private practice. As a result, health centres are chronically short of doctors and this has adversely affected service quality and development (Azzopardi Muscat and Dixon 1999).

The interface between primary and secondary care remains under-developed. Whilst specialists provide outreach clinics in the health centres, the communication and dialogue between general practitioners and specialists remains poor. Informal yet effective communication systems prevail in the private sector where established referral and discharge patterns exist. However, in the public sector, patients are not discharged to a named primary care practitioner who is responsible for patient follow-up, but merely discharged into the community where it is expected that they will be followed up as required. This is one of the major reasons for the existence of a revolving door system with repeated referrals to the hospital outpatient services or unnecessary attendance at the Accident and Emergency Department.

Secondary / Tertiary health care within the public health care sector is provided in a number of public hospitals that together cater for the different health care needs. The main hospital is St. Luke's Hospital. This is an 890-bedded acute general hospital catering for all major specialities. This hospital will be decommissioned when *Mater Dei Hospital,* where all acute care will be rationalised onto one site, will be commissioned. Mount Carmel Hospital is a 450-bedded psychiatric hospital with declining bed numbers as new strategies are adopted to promote mental health care in the community setting. A small 60-bedded hospital caters for dermatology and oncology. It is envisaged that these functions will be transferred to Mater Dei Hospital during a subsequent phase of construction. Zammit Clapp Hospital is a 60-bedded geriatric rehabilitation hospital that has been managed autonomously since its inception in 1991. The island of Gozo has its own general hospital with 260 beds catering for acute adult and paediatric general medical and surgical conditions, maternity, psychiatry and geriatric care. (Table 5.1)

Patients requiring elective hospital care must be referred to a specialist to be reviewed at an outpatient clinic. Patients are given the option to consult the specialist of their choice. Patients may be referred by any doctor be it a general practitioner or a specialist operating in the public or private sector. Self-referrals for emergency care are accepted, however patients are encouraged to consult a GP in the first instance wherever possible.

Secondary care is also provided by three small private hospitals that are fully equipped to cater for major and complex admissions. (Table 5.1) Several private clinics are also in operation. These clinics offer a range of services including day surgery but are not licensed for in-patient activities.

There are no formal links between the public and private health care providers, neither at primary nor at secondary/tertiary level. However it should be borne in mind that a number of medical doctors and paramedical professionals working within the public health care system also work as private practitioners. It is this unique feature that enables patients to move

between the two parallel and independent systems with a relatively high degree of flexibility and continuity of care despite the absence of formal procedures/systems for communication. The Ministry of Health is the licensing authority for private clinics and hospitals. Standards are prescribed by legislation and regular (yearly) monitoring takes place through a system of programmed inspections.

There is no structured system for ensuring quality assurance across the health care system. Departments and units often carry out quality assurance activities in the course of their daily work e.g. pathology laboratories. Quality assurance or clinical governance is mandatory neither for public or private hospitals nor for primary care practitioners. It is planned that the proposed split between regulator and provider roles will allow the Ministry of Health to ensure that quality assurance systems are introduced by all providers be they public or private.

5.1.2 Benefits

A highly comprehensive health care package is provided by the public health care system. Entitlement to health care benefits is determined by nationality for Maltese citizens and by means of social security contributions for non-Maltese nationals. Foreigners with refugee status are also entitled to health care benefits. Emergency care is also provided to illegal immigrants.

Health care benefits are provided free of charge at the point of use. Benefits include goods and services. The health care benefits provided range from primary care through to tertiary care. Medicines are also provided free of charge to in-patients and for outpatients through two separate schemes for which there is no co-payment. For medicines that are not covered by one of the two schemes, patients must buy the medicines from pharmacies and pay the full cost.

Primary health care benefits for all beneficiaries irrespective of income include:

- unrestricted access to a general practitioner by means of walk in clinics
- home visits by doctors, nurses and midwives
- services provided by paramedical professionals e.g. speech therapy, podiatry, physiotherapy, occupational therapy
- emergency dental treatment
- emergency minor medical and surgical treatment
- immunisation
- preventive programmes e.g. smoking cessation, weight reduction
- preventive and screening programmes for school children offered through the school medical and dental services

Most secondary and tertiary care benefits are provided to all health care beneficiaries irrespective of income or social status. Broadly the package of care includes:

- Outpatient specialist services for all major specialities and several sub-specialities
- Diagnostic and therapeutic interventions including CT scan and MRI technology, laboratory testing, endoscopic procedures, laparoscopic procedures and traditional surgical procedures
- Emergency medical care
- Psychiatric care
- Rehabilitation – physiotherapy, occupational therapy etc
- Geriatric hospital care
- (Azzopardi Muscat and Dixon 1999)

The spectrum of specialist services provided has expanded and is now very comprehensive. It includes complex services such as cardiac services, neurosurgery, organ transplantation (including heart and kidney), and dialysis. (Table 5.2a)

The Maltese Government also provides overseas treatment for conditions necessitating highly specialised care that cannot be provided locally such as bone marrow transplantation.

A number of specific medical goods and services including optical services and goods, elective dental care and medicines are only provided to certain categories of persons within the population. Medicines must be included within the Government formulary in order to be provided free of charge to Pink Card holders. These benefits are provided free of charge only to persons eligible for a Medical Aids Grant. A ”Pink Card” is issued to these persons by the Department of Social Security under the Social Security Act on a means tested basis. Eligibility can change over time and is dependent on assessment of household income that must fall below a fixed threshold. A ”Pink Card” is also issued to the following groups of persons

- Members of religious orders
- Inmates of charitable institutions
- Certain grades of employees in the Health Division
- Certain employees in the police force
- Armed forces
- Prisoners
- Persons injured on duty
- Refuse collection employees
- Persons suffering from Tuberculosis, Leprosy and Diabetes

For the remainder of the population, the services that are provided to ”Pink Card” holders must be obtained in the private sector and paid for in full. The only exception is for medicines required for a number of chronic conditions listed in the Fifth Schedule to the Social Security Act. Persons suffering from these conditions are provided with government-approved medicines that are specific to that particular chronic illness free of charge. (Table 5.2b)

Explicit exclusions from the package of care are very few and tend to be related to cosmetic interventions, experimental interventions, alternative therapies and certain types of assisted fertility interventions. Abortion is illegal in Malta.

The main criticism that may be proposed is the fact that innovative medicines are often relatively restricted. This is primarily due to the budgetary constraints and the spiralling drug cost. Another issue that has often been a source of national debate is the lack of organised screening services such as cervical screening, breast screening etc.

In conclusion, it may be stated that the statutory system provides a wide range of health care benefits and an all-inclusive package of care. It must be noted that there is no legislation that determines the quantitative or qualitative aspects of health care provision or that these should be provided free of charge at the point of use. This has generally been determined through administrative decisions.

5.1.3 Financing of the health care system

When a National Insurance Scheme was introduced in the 1950s, it was intended that health care would be covered by this scheme. However it rapidly became evident that the scheme was not capable of covering the escalating social and health care costs. In practical terms the statutory health care system began to be financed out of the consolidated fund through general taxation. There is no form of earmarked tax for health care. The level of income tax and National Insurance that each individual pays determines contributions. However, there is no form of relationship between amount contributed and entitlement to health care benefits.

In November 2001, the Minister of Finance in his budget speech announced that henceforth, health care would be funded directly out of the National Insurance Fund and would cease to be funded by general taxation. This reform has not yet been implemented. In practice it is unlikely to make a big difference since presently, Government directly manages both the National Insurance Fund and the Consolidated Fund.

Contributions towards the statutory health care system are therefore fundamentally linked to ”ability to pay” and are not in any manner risk related.

Contributions by the social partners constitute the single source of social security financing in Malta. There are two classes of contributions: the Class One contribution payable in respect of Employed Persons and the Class Two contribution paid by self-employed Persons. Government also effects a statutory State contribution to the system.

Generally speaking, contributions are payable by all persons between the age of 16 years and the age of their retirement which could be anywhere between the age of 61 years (60 in the case of women) and the age of 65 years. This depends entirely on the date on which the person chooses to give up employment or self-occupation in terms of the Social Security Act and claim a pension in respect of retirement. Persons exempt from contributing are those in receipt of full-time education or training, non-gainfully occupied married women whose husband is still alive, persons in receipt of a pension in respect of widowhood, invalidity or retirement or persons in receipt of a Parent's Pension, persons in receipt of non-contributory Social Assistance or a non-contributory pension. Non-gainfully occupied persons whose total means do not exceed Lm430 per annum in the case of single persons and Lm630 per annum in the case of married men, as well as 'gainfully occupied' self-employed persons whose earnings do not exceed Lm390 per annum may apply for a certificate of exemption from the payment of contributions. Other persons are credited with contributions, albeit not paying them, including a widow as long as she is not gainfully occupied, and a person who during any calendar week is entitled to sickness benefit, or injury benefit, or a benefit in respect of unemployment or a pension in respect of invalidity.

Malta operates pay-as-you-go funding of its social security system whereby contributions by employers, employees and the self-employed, topped up by a statutory amount by Government equal to one half of collected contributions[14], are set-off against social security expenditure including health[15]. The resulting deficit is known as the welfare gap. The welfare gap is estimated to have hovered at between 4% to 6% of GDP during the past five years, thus accounting for over one half of the overall fiscal deficit.

As such there is no deficit for Social Health Insurance calculated on its own since there are no specific Health Insurance Funds. This may change in the future when the flow of funding becomes more clearly demarcated between health care and other social care.

The National Insurance system can be considered as a more regressive taxation regime that the General Income Tax system since the former is based on a flat rate whilst the latter rises progressively.

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[14] This statutory amount paid by Government is over and above the contributions paid by Government as an employer.

[15] The tradition of government accounting excludes certain types of social security expenditure from the computation of the welfare gap. Since there is no valid reason behind this practice, it is not taken into account in the comments that follow.

There is no form of co-payment or user charge within the public health care system.

In the private sector, health care financing is a mixture of private health insurance and out of pocket payment. Around 25% of the population have some type of private health insurance.[16] However the vast majority of these insured persons have rather ”basic” cover that is not comparable to the cover provided by the statutory health care system. Financing of primary care and medicines tends to take place almost entirely through out of pocket payment whilst private health insurance cover is increasingly financing specialist ambulatory care and hospital care. There is no evidence of the existence of unofficial (informal) payments for utilisation of the public health care services. However it is believed that patients may seek to consult doctors privately in the hope that this will give them more individual attention or preferential care within the public health service. No studies on this particularly sensitive topic have been performed.

Health Expenditure

Health care expenditure in Malta has been rising steadily in recent years (Azzopardi Muscat and Dixon 1999). It is estimated that total health care expenditure as a proportion of GDP is now higher than 8% (Department of Heath Information 2000). These estimates include Government spending on health care and private consumer expenditure.

Government also funds long-term care and health care in Gozo. These are not included in the Ministry of Health expenditure. Government presently has a high capital expenditure on health care due to the construction and commissioning of a new 850-bedded hospital. The main increases in Government expenditure over the past decade are mostly due to increased expenditure on pharmaceuticals and emerging new technologies.

Information on private health expenditure is hard to obtain and is usually estimated from a variety of sources including but not limited to household budgetary surveys. The main categories of private health expenditure are medical goods (notably pharmaceuticals not covered by the public health care benefit schemes) and health care professional fees. Private health expenditure accounts for around one third of all health related expenditure (Table 5.3).

Services that are provided predominantly in the private sector e.g. dental and optical care are almost entirely financed through out-of-pocket payments. Private primary health care services are also financed mostly by out-of-pocket payment. Increasingly, specialist ambulatory care, hospital and clinic interventions are becoming financed through private health insurance and the proportion paying out-of-pocket for expensive procedures appears to be declining (Mallia 2002). Unfortunately there is no expenditure data broken down by sector for private health care expenditure.

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[16] Information obtained from the Malta Insurance Association in October 2001.

Government health care expenditure can be broken down according to identifiable cost centres in the budgetary estimates (Ministry of Finance 2002). Government expenditure on all personal emoluments falling under the Ministry of Health accounts for 63% of the recurrent health expenditure by the Ministry of Health. Around 20-25% of recurrent government health expenditure is directed towards procurement of medicines and medical materials. Almost half of recurrent health expenditure is directed to St Luke's Hospital and Sir Paul Boffa Hospital, which provide almost all the acute care services. Just under 10% of recurrent government expenditure on health is directed to mental health care whilst only 7% goes towards primary health care. Long-term care institutions are financed through another Ministry.

5.1.4 Incentives

Health care policy in Malta to date has not formally evaluated and addressed incentives, favourable or perverse, that exist within the system. Incentives shall be described from the points of view of the patient, provider and funder for both the public and private sectors.

Public sector

Patients utilising the public health care service face a zero charge at the point of use. There are no deductibles or co-payments. This is believed to generate a high degree of consumer moral hazard. This phenomenon is thought to be particularly troublesome for the Accident and Emergency services, for ambulatory services as well as for the primary care services provided in health centres. Doctors working within the public health service are salaried. There is therefore no incentive to increase activity since this is not related to any rewards. General practitioners have no incentive to retain patients since there is no system of patient registration. Specialists do not have any incentives to provide better services or higher levels of activity. In addition, doctors who are active in the private sector (accounts for an overwhelming majority) theoretically face the perverse incentive of losing out on their private work should waiting lists decrease or service quality improve. The funder (Government) allocates a fixed budget to the different elements of the health care system and therefore does not explicitly promote increased activity.

In the private health care sector, patients who are in possession of a private health insurance also have an incentive for consumer moral hazard. This problem is further compounded by the possibility of supplier moral hazard. Doctors working within the private sector are paid on a fee for service basis. This model of paying doctors rewards increased levels of activity. Although the existence of supplier induced demand has not been demonstrated locally, anecdotal evidence would suggest that this phenomenon might be occurring to some extent in certain therapeutic areas. Private health insurers are becoming more organised in order to be capable of recognising consumer and supplier moral hazard.

The commissioning of new services and the appointment of more consultants tends to be followed by an increase in activity. This trend is particularly noticeable when services that used to be carried out only in centres overseas started to be provided locally (Azzopardi Muscat 1997).

The numbers of available health care human resources to work within the public health care service has always been a limiting factor to the number of new services that could be commissioned as well as to the range and extent of the service provision. For example, in the year 2000, a decision was taken to curtail opening times of certain health centres due to insufficient numbers of general practitioners working in the public health service. Furthermore, some services take longer than predicted to commission because of a shortage of nursing staff. Therefore the numbers and types of health care professionals constitute an important determinant of health care provision.

The largest element of recurrent cost in the health care budget is staff salaries. Increasing the number of health care professionals employed would have a direct effect on health care expenditure. However, the relationship between staff and costs is not that simple. Staff shortages are often compensated by overtime work. This is paid at higher rates than the normal salary, so it is possible that staff shortages may indirectly contribute to increased health care expenditure because of overtime wages.

Although there is no data about the relationship between the structure and size of the health care workforce and health care expenditure, certain conclusions may be drawn. Health care professionals carry the greatest responsibility for committing expenditure on health. It is postulated that in this manner, size and skill mix of the health professional workforce do affect health care provision and expenditure indirectly. Doctors, by virtue of their authority to prescribe and take decisions pertaining to patient care are the main locus of decisions that directly impinge upon utilisation of medicines, in-patient beds, surgical supplies and services of other health care professionals.

Four professional regulatory bodies are responsible for registering health care professionals. The number of health care professionals registered in 2001 is shown in Table 5.4. These figures include persons who are retired and also those working overseas so that the actual number of active professionals in Malta is lower than the registered numbers. For nurses, the registers are not updated regularly and therefore the actual numbers working within the health care service are provided. These do not include a few private practitioners and persons working for other Ministries e.g. Gozo.

5.1.5 Coverage of the system and access to care

The statutory health care system covers all groups of persons. No part of the population is excluded from the statutory system. To date there is no system of opting out permitted. Persons who choose to purchase a private health insurance do so on a voluntary basis and are not exempt from paying their

contributions towards the statutory health care system. In November 2001, the Minister of Finance when announcing the proposed reform described in Section 5.1.3, alluded to the possibility of a limited form of opting out that could gradually be extended for those groups of persons covered by private insurance (Ministry of Finance 2002).

Waiting lists for the provision of medical services do exist for certain specialities. To date there is no centralised booking system and the management information available is somewhat limited. Waiting times are not published officially. Official information on the number of persons waiting for a particular intervention is often released through Parliamentary Questions. Areas that usually tend to give rise to problems due to prolonged waiting time include cardiac investigations (invasive and non-invasive), hip and knee replacement operations and cataract surgery. The limiting factors are a mixture of skilled human resources, theatre time, equipment and/or beds.

The statutory health care system does offer a relatively high degree of choice and flexibility for elective secondary and tertiary care where there is no natural monopoly. However, this choice is not available in the public primary health care service. The nature of the walk-in clinic means that the doctor who is on-duty at that particular moment sees patients as they come in. However, when being referred onward to secondary or tertiary care, patients may indicate their preference for a named specialist and are referred accordingly. This has the effect of creating unequal access times and popular specialists would generate longer waiting times. For emergency admissions, new patients are admitted under the care of the consultant on duty.

The regional distribution of health care facilities is very good with 8 health centres and a small health clinic in nearly every town or village. The island of Gozo also has its own district hospital that is equipped with a coronary care unit, obstetric care and renal dialysis.

Statutorily, the health care system provides equal access for both men and women. From the available data it would not appear that the health service poses any restrictions that render the system less accessible for either men or women.

Furthermore, it has become increasingly common for patients to take on the roles of partners in the decision making process. This is more evident in specialities treating chronic illness.

Evasion of contributions to health care funding falls under the more general possibility of evasion of payment of National Insurance or evasion of payments into the General Government Revenue. This is possibly more likely to happen with self-employed rather than with employed persons. Pensioners are not required to make direct contributions. However, they contribute indirectly if they pay tax on their income.

5.1.6 Public Acceptance of the system

There are no formal systems in existence that regularly survey the public's views on health care provision in Malta. Several parts of the health care system, including two primary health care centres, operate a Quality Service Charter system. As part of this system, customers are invited to fill in feedback forms and make suggestions. However, this feedback is highly service specific. Customers attending hospitals are also sometimes surveyed. A number of unpublished dissertations have reviewed elements of patient satisfaction within specific service areas throughout the public health service.

In October 2000, a national newspaper carried out a public opinion survey on the public health sector (The Malta Independent on Sunday 2000). This survey attempted to explore people's attitudes; satisfaction and trust around the public health service. It demonstrated that two thirds of the population were satisfied with the public health service. The remaining third stated that they were generally unhappy with the service. People aged over 65 and single persons were most satisfied whilst those aged 36-50 and those with children at home were least satisfied with the service.

The main reason given for preferring the public health service to private health care was the fact that the former is free whilst the latter is expensive. The main reasons given for dissatisfaction with the public service were long waiting times, length of time to receive results and lack of a personalised service.

Earlier in the report it was stated that private health care play a significant role in the Maltese health care system. This is also borne out by the fact that the private consumer expenditure on health-related activities is almost equal to government expenditure on health (Department of Heath Information 2000). This phenomenon could lead one to assume the view that a number of Maltese persons are voting with their feet and choosing to opt out of a system they find does not meet their needs adequately. However, in actual fact opting out is not permitted so that people who choose to utilise the private sector are paying twice for health care, namely through their taxes and then again by subscribing to private insurance or by paying out of pocket.

On the other hand, it could well be that a certain part of the population choose to utilise the private sector because of certain historical and cultural situations that have developed in the medical sector. During the late 1970s and early 1980s a 10-year medico-political dispute existed (German 199?). Several doctors left the island and for a number of years the public health service was highly dependant on imported doctors mainly from former Communist countries. Although private hospitals were closed down, private health care in the ambulatory setting flourished. This sector remained particularly strong even after local specialists returned to work in the public hospitals. New private hospitals were allowed to open in 1995. These events

undoubtedly influenced the level of acceptance of the public health system at that time and for several years later.

5.2 Evaluation of future challenges

5.2.1 Main challenges

The Maltese population enjoys a relatively high health status. Mortality indices are good and life expectancy in 1998 was 74.4 years for men and 80.1 years for women. The infant mortality rate in 1998 was 7.2/1000 live births but it should be noted that abortion is illegal in Malta. Diabetes has a high prevalence of around 10% and is one of the most important chronic diseases. The highest cause of mortality in both males and females is cardiovascular disease. Cancers are also a major source of mortality and morbidity with annual average of 1329 cases (701 in males and 628 in females) over the period 1993-1997. Whilst improving health status is always the main goal for any health care system, it has to be acknowledged that the current health status is already quite high and only marginal improvements can be expected in the near future.

The main challenges facing the health care system in the future revolve around the following issues:

a) Construction and commissioning of an 850-bedded hospital and rendering it operational within the wider health care system

Malta faces the issue of sustaining the new Mater Dei 850-bedded hospital. This will involve a system of phased transfer of staff and services from the current acute general St. Luke's Hospital to the new Mater Dei Hospital. Staff will have to become accustomed to different systems of management as well as a new environment and new building. Effective decommissioning of the existing hospital must also be dealt with. This requires a difficult exercise of consensus building with the unions on the best ways to make this possibly turbulent period of change as smooth as possible for staff and patients alike. It is hoped that this development will redress certain problems and inefficiencies that currently prevent the public health service from achieving better indices of patient satisfaction.

Another challenge is the adoption of seamless interfaces between primary care and secondary care and social care. Unless this issue is tackled urgently, the secondary and tertiary care facilities will be unable to cope and operate effectively.

b) Implementing the EU *Acquis* pertaining to health and health care

Adoption and implementation of the EU *Acquis* will have an immediate effect upon regulation of the pharmaceutical market. This involves setting up de novo a system of registration for all medicines on the Maltese market. It is likely that during the implementation of this new system, changes will occur on the medicines market in Malta. Ultimately, the Maltese public will

gain a system that evaluates medicines for quality, safety and efficacy. However, this process will be a steep learning curve both for the regulator as well as for the local industry.

c) Further developing IT systems in health care

Malta has to date developed an integrated system for patient administration within the public health service. New IT systems need to be adopted such as the electronic patient record and the health project. These systems will have far-reaching implications for work practices and health care delivery in the future. A key challenge is this area should be the attempt to electronically integrate with the private health care system. Presently, the public and private health care systems operate entirely in parallel with ensuing duplication of costs and effort and with little flexibility for the patient to move with continuity between the two systems.

d) Building solid and healthy relationships between stakeholders in health care

A new culture of partnership with patients, NGOs active in health care, the private health care market and unions needs to be established. Unfortunately, the health care sector has been hindered from developing more rapidly because of frequent management-union skirmishes. Patients are becoming more actively involved and are no longer happy to be passive recipients of care. Solid relationships also need to be forged with other entities that interface with the health care system.

e) Improving health status by addressing emerging diseases and environmental health issues

The Maltese population has become increasingly aware of environmental health issues. Public perception has lately focussed on air quality, bathing water quality and the management of waste disposal. Programmes to monitor bathing water and air quality are in place. However, it is anticipated that dealing with public concern over emerging diseases e.g. BSE and environmental health concerns will be a key issue for the public health section of the health care system over the coming years.

f) Combating lifestyle related illness and other illness through preventive care

Health promotion and preventive care strategies remain a key challenge for the health care system. Despite repeated calls to reorient the health care system towards primary care and prevention and a national health policy that acknowledges and embraces the importance of these activities, far more needs to be done in order to combat lifestyle related illness e.g. tobacco smoking, obesity. Organised screening programmes are currently not available within the national health care system. The introduction of a breast-screening programme became a highly politicised issue over the last

decade. The last multidisciplinary committee set up in 1999 to examine the issue recommended that given the local situation it was not feasible to introduce a National Breast Screening Programme at this point in time (National Advisory Committee 2000). It, however, gave specific recommendations for the improvement of current diagnostic and therapeutic services, the introduction of services for women at higher risk, and for addressing the female general population through education and information. It is possible that pressure for the introduction of screening programmes by the general public will create greater challenges that need to be addressed by the health care system.

g) Maintaining an innovative yet financially sustainable health care system

Health care is rapidly evolving. New technologies emerge and the process of globalisation has meant that as soon as new medicines or interventions are introduced they become immediately readily available. Both public and private health care services face inordinate pressures to introduce these new technologies. In addition the public health service faces the pressure of making available the newest medicines and modalities of investigation and treatment free of charge under the health care system. A balance has to be found between ensuring that the health care system can continue to keep up with innovation as it has always striven to do whilst keeping the system affordable.

5.2.2 Financial sustainability

Overall, the major challenge facing the Maltese health care system in the next few years is the issue of sustainability. Malta like other developed countries is facing the challenges of meeting the health care needs of an increasingly elderly population supported by a relatively smaller working population. Together with the needs of the elderly, one must take into account the exploding costs of high-tech medical interventions and new, highly effective but extremely expensive medicines. The Maltese population has become very health conscious and expectations are continually on the increase. The issue relating to sustainability was discussed at a National Consensus Conference, ”A National Agenda for Sustainable Health Care” organised by the Foundation for Medical Services and the Forum of Health Care Professionals in the year 2000.

The only changes that have taken place so far were the announcement of policy decisions relating to the shift of funding health care from the National Insurance Fund rather than from the Consolidated Fund. This decision has not directly addressed the issue of sustainable health care financing but rather has shifted towards an earmarked system of health care financing.

Whilst there are no future health care finance projections, rendering and keeping the Mater Dei Hospital operational will be an extensive cost development. Failure to effectively decommission the existing acute care hospital would also imply huge costs for the health care system. Other cost

developments relate to new medicines and the increasing needs of the elderly population.

5.2.3 Health care policy and EU accession

When EU legislation was screened against existing Maltese legislation in 1999, it resulted that the major changes affecting the health care system would be the significant reforms that had to take place in order to introduce a system of registration of medicines and remove import controls. In fact, this reform has already commenced and a system for provisional marketing authorisations for medicines is in the process of being set up. Malta has acquired a four-year transition period. When the *Acquis* on medicines for human use is fully implemented, it is expected that the quality of medicines on the market will improve. Malta is concurrently also developing a medicine pricing control policy since presently the system is one of profit control rather than price control.

EU accession will affect the health care system in several other ways. As a result of the adoption of the *Acquis* on mutual recognition of qualifications, local specialist accreditation systems will be set up and all specialists will have to be registered as such in order to practice their speciality. Local development of structured specialist training and continuing medical education is also expected to take place. This will enable health care professionals to carry out more of their specialist training locally, a feature that should facilitate specialisation, especially for women. It will remain to be seen whether Malta will experience a ”brain drain” of health care professionals. It should be noted, however, that health care professionals wishing to study and work overseas have had the opportunity to do so and in fact this has been happening for a number of years.

Malta will have to comply with the Working Time Directive. This may mean the need to adopt different working practices in certain areas. However, any changes would need to be discussed and agreed to with the Unions. The Directive is flexible enough to allow internal agreements to be made that may be mutually convenient for the employer and the employees as long as these do not harm the health and safety of the employees or of the patients.

The events taking place relating to the ECJ Court rulings on free movement of patients are being followed closely by Malta. In its position paper on Co-ordination of Social Security in health care, Malta states that it will set up the necessary mechanisms to implement the procedures in the social security regulations 1408/71 and 574/72. However, it is known that changes in the policy area are taking place at a rapid pace; e.g. with the proposal to introduce a health card instead of the E111 and E112 forms. Malta may be in a position to benefit from medical tourism due to the spare capacity available in private hospitals. This coupled with renowned medical expertise and, ability of the Maltese population to communicate in English and often several other European languages, apart from the favourable

climate, could mean a source of revenue for the country. The main problem would arise if a large number of people would seek treatment overseas without obtaining prior authorisation. The system currently operates in such a way that a Treatment Abroad Committee evaluates requests by the respective consultant, for patients to be sent overseas for treatment that is necessary and not available in Malta. Over recent years the development of more sophisticated services and technology in Malta has meant that Maltese people are referred abroad mostly for supra-specialist and quaternary care that is not cost-effective to set up in Malta due to the very small catchment population. Persons have not been referred overseas for treatment in order to alleviate the pressure on long waiting lists to date. Should this become strictly mandatory, sustainability of the health care system could be compromised. However the Smits/Peerbooms rulings do refer to the need to balance system sustainability against free movement for treatment without prior authorisation.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms and their objectives

In the early 1990s politicians and health care policy makers agreed that there was a need for major reform in the health care sector. Whilst it was acknowledged that the level of medical care provided had reached very high standards, it was felt that reforms were necessary in order to ensure that client-centred, evidence-based and financially sustainable health care policies would be pursued. The highly centralised and bureaucratic system was failing to respond adequately to the exigencies of managing a dynamic health care system in the present day and age.

In 1995 a National Health Policy document ”Health Vision 2000”, was launched (Xerri 1995). This came about after extensive discussions with a number of stakeholders. An entire section of the National Health Policy was dedicated to reforming the Health Sector. A programme of health reforms embarked upon in the early 1990s was featured in the National Health Policy document. The programme described was as follows:

1. Establishing a clear distinction between the roles of the Health Division, the hospital services and the community services
2. Decentralising the health care services by removing the day-to-day management of services from the Health Division allowing decisions to be taken at the operational level. Reconstituting the Health Division as the focal policy-making body responsible for planning, coordination, monitoring and evaluation, quality assurance, prioritisation in the allocation of resources as well as enhancing its role as the Superintendent of Public Health
3. Allowing as much freedom and autonomy as possible in the management of each public hospital and in the community services within an agreed framework

4. Reforming the hospital services by creating an integrated group of autonomously run hospitals to provide a comprehensive and complementary range of services
5. Restructuring the primary and community health care services
6. Strengthening the health promotion and preventive component of the primary health care service. Good health care facilities are important but alone, cannot be expected to significantly improve the overall health status
7. Meeting the needs of particular sections of the population including: the health care and social needs of the growing elderly population by enabling them to remain in the community for as long as possible; the care of the mentally ill by introducing an efficient management set up with responsibility for the entire mental health sector; transforming the custodial approach by providing rehabilitation and community services with an emphasis on mental health promotion, prevention, early intervention and community support
8. Formulating a new health financing strategy to ensure that financial resources are available to sustain and improve the health status of our population

Although launched in 1995, this document can still be considered to be the master plan upon which current health service reforms have been fashioned. The main focus of the reform was to be decentralisation in management of health service provision coupled with the development of a strong regulatory and public health function for the Health Division.

Although the document essentially outlined the need for a radical reform, this did not take place. Instead, a series of incremental and low-key reforms commenced. These were necessary in order to lay solid foundations for the major changes planned to take place. Although the objectives and strategy laid out in ”Health Vision 2000” were never subject to formal evaluation, a brief examination of the stated reform objectives is provided below.

The Health Division was restructured so that a number of departments with their own remits and functions were created. The intention was to devolve power from the Chief Government Medical Officer to individual Directors in order to reduce bureaucracy and devolve responsibility for decision-making. The following Directorates were created within the Health Division:

- Health Policy and Planning
- Public Health
- Health Promotion
- Health Information
- Primary Health Care
- Institutional Health Care

- Human Resources
- Finance and Administration
- Nursing Services

A series of reforms intended to bring about decentralisation, commenced in the smaller public hospitals. These reforms centred mainly on the design and implementation of financial management and stock control systems, as it was firmly believed that the appropriate systems for accountability would need to be set up before authority could be delegated to the individual hospitals.

Caring for elderly persons in the community required the setting up of community homes and services. This objective was achieved to a large extent.

In the case of the mentally ill, a programme of rehabilitation was instituted with the result that the inpatient population within the main psychiatric hospital has declined by around one-third over the past few years. However, the implementation of appropriate community services to ensure a sustainable approach has yet to take place. This will require close collaboration with other entities that provide social care services.

One area that has not been tackled satisfactorily is the strengthening of primary care. Whilst successive Governments have repeatedly declared their intention to build a strong primary care set up in their electoral programmes, this reform has failed to materialise. A fresh attempt to tackle this issue is required if sustainable health care is to be achieved. Any successful policy must take into account the large proportion of private sector activity in the field.

A number of health-promoting activities and services have been introduced, e.g. smoking cessation clinics, weight reducing clinics. However, a shift in emphasis and culture within the health care system from treatment to prevention has not really occurred and the distribution of the health care budget between cure and prevention testifies to this effect.

With regards to the formulation of a new health financing strategy, this has still not been decided. In 1997, a flat-rate co-payment for medicines provided free of charge by the public health service was introduced. This co-payment system only lasted for nine months and was immediately lifted after a change in Government in 1998 (Azzopardi Muscat and Dixon 1999). Since then, no co-payments have been introduced in any part of the system.

The only policy statement that describes changes to the present health care financing system, was the policy direction given in the November 2001 budget speech by the Minister of Finance (2002). The intention is to return health care financing to the National Insurance Fund, the place where it was originally meant to reside. In practical terms it is yet to be seen how this will affect health care financing overall. The policy direction also states that

persons in possession of private health insurance would probably have to pay for making use of the public health service. In time, some form of opting out would be considered.

One major criticism that may be directed towards the National Health Policy is the failure to give sufficient emphasis to the private health care sector. The reason for this could be that at the time the document was being drawn up, private sector activity was far less significant than it is today. Indeed, the first ”new” private hospitals were licensed after 1995 when new legislation governing the licensing of private clinics and hospitals was adopted. Private hospitals had been closed since 1980 due to a law passed during the medico-political dispute (German 1991).

The opening of private hospitals created a renewed interest in private health insurance. It is firmly believed that any health care policies planned in Malta now have to take the private sector into consideration if successful implementation is to occur. With private health expenditure accounting for one third of total health expenditure, the role of the private sector cannot be underestimated or worse ignored.

The reform programme laid out in the National Health Policy document ”Health Vision 2000” was revisited in October 1998 in two complementary documents ”The Vision Behind the Health Sector Reform” and ”The Strategy Behind the Health Sector Reform” (Xerri 1998a, 1998b). These documents reiterated the necessity to adopt a strategy that gives due consideration to:

- Generation of resources
- Allocative efficiency
- Organisational reform
- Effective resource management

The voluntary and private sectors were recognised as key partners in implementing the new health care strategy. These documents explicitly called for a change in the role of the Ministry of Health and the Health Division. They called for the Ministry of Health to strengthen its planning, monitoring and regulatory functions and to relinquish direct responsibility for day-to-day management of health services.

This strategy was adopted by the present Government and was formally launched in July 2001 (The Sunday Times 2001). The Ministry of Health will become responsible for purchasing hospital services and using contracting as an instrument to guarantee quality and value for money in the public health service. The Health Division will be transformed into a standard setter and regulator for both the public and private health sectors. Public hospitals will cease to be managed by the Health Division and will be given an autonomous management status under the auspices of the Foundation for Medical Services. (Fig 5.3.1) The latter organisation is currently responsible for the construction and commissioning of the Mater

Dei Hospital project. It has also been responsible for the management of a 60-bedded acute geriatric rehabilitation hospital that served as a pilot project for autonomous hospital management.

5.3.2 Political directions of future reforms

The public health sector in Malta is currently undergoing radical reform. The reform that had been projected to commence in 1993 and had been taking place incrementally until the year 2000 has suddenly gained in momentum and visibility (Azzopardi Muscat and Grech 2001). Most of the reforms that were carried out between 1993 and 2000 were ”back office” management reforms that had not really brought about a visible improvement for customers. The main areas of visible improvement were the reform of the laundry services and the development of new services and technologies that had previously not been available locally, e.g. cardiac surgery, MRI scanning. These reforms did not involve any major changes in the management structures and roles of the key players in the public health sector. This has suddenly changed and the major actors i.e. Ministry of Health, Health Division, Foundation for Medical Services and Hospitals are finding themselves having to develop new skills and reorient their roles.

Two main reform thrusts are occurring in the health sector at the present moment:

1. EU accession related reforms

2. Hospital management related reforms

EU accession related reforms

These reforms mainly affected the areas of medicines and health care professions with regards to the health care system. The reforms related to medicines have necessitated a multiple split in what used to be the Government Pharmaceutical Services Department. This has been divided into a:

- Medicines Regulatory Unit
- Medicines Policy and Audit Unit
- Procurement, Storage and Distribution of Medicines
- Hospital and Clinical Pharmacy – still to be set up

A Medicines Act is in the process of being drafted. This Act will outline the system for registration of medicines and will set up a Medicines Authority. This will also be responsible for ensuring Good Manufacturing Practice, Good Distribution Practice and Pharmacovigilance. It is envisaged that the introduction of these changes in a relatively short time frame could create difficulties for the local pharmacy manufacturing and wholesale importing and distribution industries. However, the Ministry is taking measures to ensure that the impact will be as small as possible whilst

fulfilling the necessary steps to adopt and implement the *Acquis*. The main impact could be a decrease in the number of products from third countries on the local market. However, it is not expected that this will create any consequences with respect to public health.

In the case of health care professions, a new Health Care Professions Act has been drafted in consultation with the various stakeholders. It will regulate issues pertaining to registration, specialisation and good conduct of health care professionals.

The accession process has provided an opportunity for legislation in the area of health care to be updated and brought in line with present needs. A number of changes that are not strictly related to EU accession have been proposed, e.g. greater representation of the respective professions and patient representation on the regulatory Councils for health care professionals.

In Malta, public opinion is divided on the EU membership issue. The Nationalist party in Government is strongly in favour of EU membership whilst the Labour opposition party is against membership but in favour of a special partnership agreement. Therefore, in principle, it cannot be said that the Opposition favours EU related reforms. However it is likely that consensus on necessary issues such as a pharmacovigilance system and the introduction of specialist registration will be attained.

Hospital management related reforms

Government's strategy for autonomous management of public hospitals under the auspices of the Foundation for Medical Services was announced in July 2001. The implementation of this strategy is expected to bring about a tremendous change in the health care system. A shift from a system of "command and control" to one of "remote control" via contracting will require a new culture and will require new skills.

Broadly speaking, there is political consensus that decentralisation of health services management is required within the public health service. However, the mechanism of implementation and the timing has been criticised by the Opposition. Criticism has focussed particularly around the role of the Foundation for Medical Services and whether it was necessary to have an additional tier between the Ministry of Health and the autonomous hospitals. Government has cited the need for a seamless service and economies of scale in the smaller hospitals as reasons for the Foundation for Medical Services to act as the contracting partner to the Ministry of Health.

These reforms are expected to bring about a level playing field for private and public health care providers. To date, the Ministry of Health has acted both as regulator and as service provider. In practice, the public sector has never been subject to regulation and monitoring of standards. This will not be possible in the future. The reforms are also intended to increase transparency and accountability by bringing about a balance of power

between the purchaser and the providers. Furthermore, it is expected that once free from the shackles of civil service bureaucracy, hospitals will be able to provide a more responsive client-centred service.

The unions have in principle declared themselves to be in favour of this reform. However, they are tying it to improved work conditions. Negotiations with the unions on the status and conditions for health care workers within the new system are as yet to commence formally. The successful outcome or otherwise of these negotiations will be the key issue in determining how rapidly and to what extent this reform can be successfully and fully implemented.

5.3.3 Conclusions

From this report it can be seen that the main thrust of health policy in recent years has been directed towards improving management systems and decentralising power. Although a number of incremental changes have occurred, the main areas requiring change still have to be tackled. Most of the changes have been introduced in the smaller hospitals. Much, still remains to be achieved in the main hospital. Some of the required reforms should take place prior to migration of services to Mater Dei Hospital and it is hoped that this will serve as a catalyst for change. However, time is running short and it is becoming increasingly unlikely that the desired reforms can be implemented within such a short period of time.

Primary health care and health promotion has not been made the corner stone of the health care system. Unless these areas are tackled, certain fundamental problems in the health care sector cannot be resolved.

Much emphasis to date has rested with improving efficiency and curbing waste in order to be able to contain costs reasonably in the face of rising demand. However, unless the system of health care financing can guarantee sufficient funds to cope with innovation and the needs of the elderly, the system will fail to provide sustainable yet innovative health care.

It must be ensured that the funds being spent in private health care as well as in public health care are going towards activities that will ultimately result in health gain. Duplication of activity between the public and private sectors should be avoided. The private sector has to be a partner with the public sector in pursuing sustainable and affordable health care.

The planned reforms are well geared to cope with future challenges if the above points are also addressed. The recent burst of activity has heightened the momentum for health care reform. These rapid activities can be attributed to the EU accession process and the Mater Dei Hospital project acting as catalysts for change. The real test will be bringing the important stakeholders on board and ensuring that all parties are working towards a common goal. This is not an easy task as Malta's history of change and relationships with key unions in the health care sector has amply demonstrated.

Finally, it has to be emphasised that reform in the health care sector has to be dynamic and continuous in order to ensure that the system keeps up with the rapid developments in health care and is in a position to adapt to ever-changing needs and demands.

5.4 Annex to chapter five

Table 5.1: Distribution of Hospital Beds

Name of Hospital	No of Beds	Type of Hospital
Public Sector		
St. Luke's Hospital (eventually to be mostly decommissioned around 2005 when services migrate to New Hospital and assume rehabilitation function)	879	Acute general, specialist services both emergency and elective
Gozo General Hospital	259	Acute general, Psychiatry, Geriatrics
Boffa Hospital (to be decommissioned around 2007 when services migrate to New Hospital)	60	Dermatology, Oncology
Mount Carmel Hospital	450	Psychiatry
Zammit Clapp Hospital	60	Geriatric Rehabilitation
Mater Dei Hospital (to be commissioned over the period 2003-2005 Phase 1, 2007 later Phases)	850	Acute general, Specialist services, emergency and elective
Private Sector		
St. Philip's Hospital	75	Acute General
Capua Palace Hospital	80	Acute General
St. James'	13	Acute General

Source: Department of Institutional Health – Ministry of Health

*Table 5.2a: List of Secondary/Tertiary Care Services**

List of patient services offered by St Luke's Hospital:

Department of Medicine

Anti-coagulant clinic
Asthma clinic
Cardiac Catheterisation Lab
Cardiac Laboratory
Cardiology clinic
Chest clinic
Clinical Nutrition Service
Coronary Care Unit
Diabetes clinic
ECG Department
EEG/EMG Department
Endocrinology clinic
Gastroenterology clinic
General Medical wards
Hepatology
Infectious Diseases Unit
Lipid clinic

Medical Endoscopy
Nephrology
Neurology outpatient clinic
Neurology ward
Pacemaker clinic
Pulmonary Function Laboratory
Renal clinic
Renal Unit – Renal Dialysis
Respiratory Medicine
Rheumatology clinic

Department of Surgery

Audiology Service
Breast Care Service
Burns and plastics unit
Burns outpatient clinic
Cardiac Intensive Care Unit
Cardiology clinic
Cardio-thoracic Unit
Day Surgery
ENT outpatient clinic
ENT ward
General Dependency ward
General Surgery outpatient clinics
General Surgery wards
Neurosurgical outpatients
Neurosurgical ward
Operating Theatres
Ophthalmic outpatient clinic
Ophthalmic ward
Paediatric Surgery
Paediatric Surgery outpatient clinic
Plastic and reconstructive surgery
Renal Transplant Service
Stoma Care Service
Surgical Endoscopy
Urology outpatient clinic
Urology ward
Vascular Surgery

Department of Orthopaedics

Day Surgery
Fresh Trauma clinic
Hand clinic
Operating Theatres
Orthopaedic outpatients
Orthopaedic wards

Department of Psychiatry

Child Guidance Clinic
Psychiatric outpatients
Psychiatric Unit

Department of Radiology

Angiosuite
CT
Diagnostic Imaging
Gamma Unit
Interventional Imaging
Mammography
MRI
Ultrasound
IVP

Department of Paediatrics

Child Development and Assessment Unit (CDAU)
Child Guidance Clinic
Day Surgery
Genetics clinic
Hospital Teachers unit
Neonatal clinic
Paediatric Cardiology Out-patients clinic
Paediatric Medicine ward
Paediatric Oncology Unit
Paediatric outpatient clinics – Medicine and Surgery
Paediatric Surgery ward
Special Care Baby Unit
Subspecialty clinics
Well-baby clinics (Health centres)

Department of Obstetrics and Gynaecology

Antenatal clinic
Antenatal ward
Bone Density Clinic
Day Surgery
Emergency Gynae services
Gynae outpatient clinics
Gynae wards
Labour ward
Nursery
Operating Theatres
Parentcaft
Postnatal outpatient clinics
Postnatal ward
Ultrasound Antenatal clinic
Urodynamics (Gynae)

Department of Pathology

Bacteriology
Blood donation Centre
Blood Transfusion Centre
Hospital Blood Bank
Clinical Chemistry
Cytology
Emergency Laboratory
Haematology
Histopathology
Immunology
Mortuary
Mycology
Pathology Department
Phlebotomy
Toxicology
Virology

Department of Dentistry

Dental clinic
Dental Hygienist
Dental laboratory
Emergency Service
Prosthetics
Restorative

Department of Anaesthesia

CPR team
High Dependency Unit
Intensive Therapy Unit
Outpatient Pain Clinic
Pain Management Service

Hospital Pharmacy Department

Chemotherapy
Clinical Pharmacy
Colostomy Section
Drugs and Therapeutics Committee
Narcotics and Psychotropic Section
Out-patient Pharmacy
Pharmacy Inpatient service
Pharmacy Outpatient service

Rehabilitation Services

Dieticians
Hospital Social Work Department
Occupational Therapy Department

Orthotic and Prosthetic Unit
Physiotherapy Department
Podology Department
Speech and Language Therapy Department

Patient Support Services

Billing
Customer Care Department
Hospital Chaplaincy
Hospital Transport
Loaning of Equipment
Main Reception
Personal belongings of patients
Schedules for drugs
Treatment abroad
Refreshment area

Accident and Emergency Department

Emergency Ambulance Service
Emergency ophthalmic and dental services
Helicopter Service
Hyperbaric Unit
Medical, surgical, paediatric divisions
Triage, resus, X-ray, etc.

Others

Detox Section
Medical Records
Sedqa
Thalassaemia Clinic
Central Sterile Services Department
Infection Control Unit

List of new or revamped services at the New Hospital:

Emergency Admissions Wards
Paediatric Intensive Care Unit
Elderly Assessment Unit
Integrated Day Care Unit
Medical Investigations and Treatment Unit
Hospital Library
Hospital Educational/Academic Facilities
Sleep Laboratory
Physiological Measurement Unit
Staff and public Restaurants
Main Entrance Concourse with retails outlets, restaurants etc
Hospital Broadcasting Studio
Occupational Health Department

*Source: Office of the CEO. Mater Dei Hospital.

Table 5.2b: Chronic Conditions listed in Schedule V of the Social Security Act (Entitlement to Free Medicines for the Condition)

Malignant Diseases:

Cardiovascular Diseases
- Ischaemic Heart Disease
- Congestive Heart Failure
- Persistent Hypertension (with diastolic reading above 110 if left untreated)

Respiratory Diseases
- Chronic respiratory failure
- Chronic asthma

Collagen Diseases
- Chronic rheumatoid arthritis
- Systemic lupus erythematosus
- Systemic sclerosis
- Dermatomyositis
- Polyarteritis nodosa

Endocrine
- Addison's disease
- Hypopituitarism (including Diabetes Insipidus)
- Enzyme deficiency disorders
- Endometriosis

Renal
- Nephrotic syndrome
- Chronic renal failure

Digestive system
- Chronic peptic ulcer
- Coeliac disease and idiopathic steatorrheoa
- Crohn's disease and ulcerative colitis

Disease of the liver
- Hepatic cirrhosis
- Wilson's disease

Diseases of the Central Nervous system
- Epilepsy
- Parkinson's disease
- Myasthenia Gravis
- Multiple sclerosis
- Motor neurone disease

Schizophrenia

Haemophilia

Paget's disease

Glaucoma

Psoriasis

Huntington's chorea

Auto-immune enteropathy

HIV positive
Congenital indifference to pain

Table 5.3: Health Care Expenditure in Malta, 1997-2000.

	1997*	**1998**	**1999**	**2000**
GDP at market prices (Lm '000)	1,288,000	1,362,324	1,456,099	1,560,583
Consumers' expenditure on goods/services (Lm '000)	31,000	35,446	39,322	43,378
General government final consumption expenditure on health (Lm '000)	68,000	70,527	71,204	79,138
Capital expenditure, Ministry of Health (Lm '000)	7,000	8,112	10,486	15,103
Total Health Expenditure (Lm '000)	106,000	114,085	121,012	137,619
Total Health Expenditure (% of GDP)	8.2	8.4	8.3	8.8
Public Health Expenditure: Ministry of Health Malta (Lm '000)	48,410	49,686	51,026	58,528
*Total Public Health Expenditure (Malta & Gozo)/ THE*100**	*70.8*	*68.9*	*67.5*	*68.5*
Capital expenditure as % of THE	6.6	7.1	8.7	11.0
Salaries as % of Total Public Health expenditure on health	62.5	63.6	63.3	59.2

Source: National Accounts; Estimates,. 2000. Department of Health Information, Malta as submitted to WHO-HFA-DB. *Estimates; THE = Total Health Expenditure.

Table 5.4: Health Care Professionals

Year		**Males**	**Females**	**Total**
1995	Doctors	852	176	1028
	Dentists	102	22	124
1997	Doctors	869	190	1059
	Dentists	111	25	136
1999	Doctors	905	199	1104
	Dentists	120	27	147
2001	Doctors	909	235	1144
	Dentists	122	36	158
	Pharmacists			750
	Nurses*			1327*

Source: Ministry of Health , *Includes only nurses working in the public health care sector

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