ESPN Thematic Report on Challenges in long-term care

Malta

2018

Mario Vassallo
February 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

EUROPEAN COMMISSION

European Social Policy Network (ESPN)

ESPN Thematic Report on Challenges in long-term care

Malta

2018

Mario Vassallo

Directorate-General for Employment, Social Affairs and Inclusion

2018

The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

Contents

Summary

Malta has a long tradition in the provision of long-term care for the elderly. Services traditionally provided by the Church and by the state have been in existence for centuries. But old people's institutional homes used to be considered a necessary evil where persons who were either too poor to remain in the community, or who had no extended family members to look after them, had no other option but to go. The ideal for every Maltese was to continue to live at home in the community which they knew.

This ethos persists to this very day. But as the traditionally strong family ties started to loosen, and economic development (with the ensuing extensive increase in out-of-home female activity rates), made it more difficult to find females who were available to look after the elderly as they had previously done, by the mid-1980s the issues related to long-term care started to be given more attention. Both institutional long-term care and home services started to be addressed concurrently.

A number of services that are focused on assisting persons to continue to live in the community have been developed. This report describes them in detail. Some have been more successful than others; and some, such as Home Help, eventually developed in areas they were not originally intended for – Home Help eventually developed into a purely maid service, but CommCare now provides a more integrated long-term service. Uptake of the carer's pension was low until this year when it was widened to capture persons ranked 0-4 on the Barthel index. Technology has been harnessed through the telecare system, a telephone-based monitoring system. With the decline in the availability of family members to look after their elderly relatives, many siblings in the middle- and higher-income groups have joined forces to recruit outsiders to provide full-time care. Recently a substantial increase in the subsidy for this service has led to a substantial increase in the number of foreign carers, primarily Filipinos, filling this gap. Initiatives at the local level have multiplied but they are unevenly distributed, and at times depend on political patronage for them to be available at all.

In respect of institutional care, three broad streams exist. Both the Church and the state continue to run homes. Parallel to this is a booming private sector, which has recognised that servicing this sector could be quite lucrative. The state also 'contracts' beds from both the Church and the private sector to meet some of the demand. Services in long-term care have been significantly improved, both at local and national level, but serious problems exist. Access is theoretically open to all, but political patronage and connections are known to exist all across the service. More importantly, those who do not manage to be admitted to a government home find it extremely hard to afford either Church or private services: the cost of these eats very considerably into pensions, the highest of which are lower than the minimum wage (except for Members of Parliament, who receive a pension equivalent to two-thirds of their salary). In instances described in this report, the costs exceed national pension rights. Even those elderly people in state-run homes face financial difficulties, since they have to contribute between 60% and 80% of their pension entitlements, plus 60% of any other income they have, towards their upkeep. Even terminally ill patients who cannot be moved to long-term care institutions or into the community are made to pay hefty bills for consultations whilst they are still at Mater Dei, the main hospital where services are supposed to be completely free.

The quality of care in institutions is not uniform. A 2015 national audit study reported huge deficiencies, and minimum standards of care have since been established. Whether these are being implemented in real life is difficult to establish.

According to a 2017 Central Bank report, long-term care costs in Malta are expected to increase by 1.2 percentage points between 2013 and 2060, out of a total increase in ageing costs of 6.5 percentage points (this latter is 4.7 percentage points higher than the EU average). The same report notes that Malta's current spending on social security as a

proportion of GDP is well below the EU average and is expected to remain so till at least 2040.[1]

In summary it can be stated that Malta's traditional system of care for elderly people is facing considerable challenges in modern times, resulting from changes in the economy and in social life generally. Concern has been exhibited and actions taken. But for the average Maltese, long-term care is still quite problematic and stressful, most especially if there are no close relatives who are prepared to shoulder the responsibility of care.

1 Description of the main features of the country's long-term care system

1.1 Long-term care

People in long-term care in Malta can be placed into three broad groups:

a) persons who continue to live in their homes, supported by services,
b) persons who live in privately run institutions for the elderly, and
c) persons who live in state-run institutions.

Each of these will be discussed in turn.

1.1.1 People who continue to live at home, supported by services

Traditionally, Maltese people have always preferred to spend the last years of their life at home, and a move to a residential home was always a last resort. Elderly people generally used to be looked after by next-of-kin, in an age when the extended family was much more widespread than it is now. With social change and expanded education, the availability of persons able and willing to take on care duties is fast declining. Despite this, many Maltese elderly people continue to be looked after, without any direct financial support, by family members. The exact extent to which this is so is, however, impossible to gauge as no documentation or ad hoc research exists.

In recognition of the need to provide external support, the first Parliamentary Secretariat for the Elderly (which was created in the second part of the 1980s) created a number of tailor-made initiatives to assist the elderly and their next-of-kin to cope – in response to the fact that it had become more common for females (these being the main carers) to go out to work and therefore be unavailable to care for the elderly in the same way as before.

The most popular of these started as the Home Help system, through which an elderly person or an elderly couple used to have a carer assigned to them, at a small charge, for a number of hours agreed between the carer and the elderly person. When introduced, this person's responsibility was primarily to ensure that the general needs of the person under her (home-helpers are practically all females) were catered for. The service has now developed into CommCare, and Home Help is now restricted to 'maid' services. CommCare is primarily provided through personal care workers, and the system is managed by a team of nurses supported by a multi-disciplinary team, who are jointly responsible for developing a care plan for each elderly person. Most CommCare services are outsourced to the private sector. Domiciliary nursing and care are the backbone of CommCare, which acts as gatekeeper for domiciliary care nursing services provided by the service provider; it has a regulatory function as authorised by the Active Ageing and Community Care Directorate. The CommCare team co-ordinates community services

[1] Grech A. G. & Zerafa S. 2017. 'Challenges and opportunities of sustainable economic growth: the case of Malta'. Malta. Central Bank of Malta. Accessible at: https://www.centralbankmalta.org/file.aspx?f=61596.

around the client's needs in a person-centred holistic manner with a case management approach, by involving all the team and referring to other professionals and entities as required. Training is given to ensure that the services are adequate and professionally provided. During 2017, there were 9,584 clients receiving nursing/caring services through CommCare, with as many as 801,250 nursing/caring interventions during the same year. In December 2017 the Home Help service was provided to 3,668 beneficiaries, spread all over Malta and Gozo.[2]

The CommCare service is supplemented by a *special telephone service* (known as Telecare Plus), under which special equipment is worn by the elderly person and the telephone system can be used to alert a central office in case of an emergency. With the introduction of new technology the service can cope with many more calls than when first introduced without increase in human resource input. It has also been improved by incorporating help in taking medicines regularly. As an additional (paid) option it can also be used to transmit an alarm when smoke is detected. Current usage runs into thousands but exact figures are not in the public domain.

Over the years, some local councils have also introduced initiatives to keep the elderly active and well looked after in the community. These councils run a programme of coffee mornings, special educational sessions, outings and keep-fit classes to which the elderly are particularly invited.

On top of this there is also the c*arer's pension*, which is available in limited cases for persons who cannot take up active employment because they need to look after an ailing member of their family. The uptake of this scheme was very limited up until last year: but between February 2017 and January 2018 the number of beneficiaries increased from a mere 81 persons to 498. This increase was a direct result of widening access to the scheme: whilst in 2017 access was only open to those ranked as 0 on the Barthel index:[3] now all those ranked 0-4 are eligible.[4]

One very important development that allows more elderly people to stay in the community is the scheme to financially assist families to employ a carer to look after an elderly family member who is on the waiting list for being admitted to long-term residential care. Through this scheme, known as the *Carer at Home* scheme, the government supports those older persons who employ a carer of their choice so as to assist them in their daily needs. The service of Carer at Home is being offered both in Malta and Gozo. Applicants need to be over 60 years of age and the carer (who cannot be a family member) needs to have a recognised qualification. The beneficiary receives a maximum of EUR 5,200 per year from when the service is approved. The benefit is paid each month directly into a bank account indicated by the service user. This initiative keeps the elderly person in the community; provides financial support to family members who have to maintain an elderly family member; and saves money for the state, since the scheme is cheaper than residential care. The system is run inconspicuously on an individual basis, and it is generally staffed by women who come from the Philippines to undertake this work. Over time these carers have organised themselves in informal networks; as the demand for their services has increased, so has the size of the Filipino community in Malta.[5]

Other services geared towards elderly people in the community managed through CommCare include the following.

[2] Personal communication from Private Secretary, Ministry for Family, Children's Rights and Social Solidarity, dated 17 January 2018.
[3] The Barthel index is the internationally recognised standardised scale that measures disability or dependence in activities of daily living in patients, particularly in patients who have suffered a stroke.
[4] Personal communication from the Director, Active Ageing and Community Care Directorate.
[5] For example, one woman has built a network of 60 carers since she first came to Malta as a carer herself six years ago, even before state support was available.

- *Community geriatrician services*: community geriatricians carry out domiciliary medical visits upon referral.
- *Respite*: the service is available for families who take care of elderly relatives at home, by providing a maximum of three weeks of care services. Families may make use of this service three times a year.
- *Dementia activity centres*: this is a form of respite service which helps the caregiver reduce stress, while at the same time providing therapy that helps people with dementia to stay active. These centres allegedly provide a safe, secure and dementia-friendly environment and are run by staff who are knowledgeable in dementia care. But the service is often criticised by the next-of-kin of users for not really delivering what it promises.[6]
- *Meals on wheels*: a meal a day is provided to older persons and others who are still living in their own home but who are unable to prepare a decent meal.
- *Night shelters*: these are available in a limited number of localities for older adults who live alone and who, for various reasons, may feel insecure.
- *Continence service*: this alleviates the problems to which a person may, as a result of incontinence, be subjected. Free or subsidised nappies are offered through this scheme, depending on eligibility.
- *Telephone rent rebate*: this service is a discounted bimonthly rental charge on a direct telephone line installed at a person's residence .
- *Handyman service*: this is intended to help older adults and persons with special needs to continue living as independently as possible in their own home. The service offers a range of repair jobs that vary from electrical repairs to plumbing, carpentry and transportation of items from one room to another.
- *Active ageing centres*: these centres[7] offer opportunities for older adults to remain physically, mentally and socially active. The centres enable older adults to meet people of the same age and enjoy themselves during the activities organised. Each centre offers a varied programme of activities, which include talks, outings, a variety of games, and lifelong-learning programmes. Apart from promoting socialisation and entertainment, these centres are hubs where the individual can learn in an informal way and share their skills with others. A special programme is provided for Gozitans through the Be-Active Gozo service.
- *Social work* service: this is designed to provide psychological support, guidance and assistance. It deals with social casework; provides advocacy for clients; facilitates self-help management and develops action plans; performs crisis intervention work; provides assessments for the Home Help service; and liaises with the geriatric and general rehabilitation hospitals. It provides reports on older persons with acute situations who are in residential homes. The Social Work Unit also investigates social cases and deals with them accordingly. It also liaises with the health department, police, local councils, parish priests and other community organisations.

[6] A personal communication by the next-of-kin of the user of this service states that: 'When my elderly aunt was placed in a dementia unit at the *** home centre, they [demented persons] were just plonked on a chair and made to stare at each other all day with no activities at all'.

[7] There are 21 such centres spread all over Malta. In addition, the Active Ageing and Community Care Directorate has also set up six other centres with a totally new concept: these centres are being run in collaboration with local councils and other entities, and focus mainly on lifelong learning. There are two of these centres in Malta and two on Gozo. See: https://activeageing.gov.mt/en/Pages/Elderly%20Services%20Catalogue/Active-Ageing-Centres.aspx. Accessed on 27 January 2018.

Services are free to all persons who qualify through a means test for the 'pink form',[8] but charges to other beneficiaries are minimal.

1.1.2 Persons who live in privately run institutions for the elderly

Private residential homes for the elderly were first set up by the Church centuries ago, and they are still going strong. These used to be considered a natural extension of the Church's activity, and were run by nuns. In many instances these institutions were financed through donations and/or bequests. Those homes which still survive charge for the service and increasingly employ professional carers, since the number of nuns available to run the service has declined dramatically.

In parallel to these Church-run homes, private residential homes have flourished rapidly over the past few years. These are run on a commercial basis and have become quite a lucrative business. Their numbers have spiked in recent years. These homes are now regulated by national minimum standards of care.[9]

In some cases these operate on a public-private partnership basis, where the state pays for a certain number of beds, since public institutions are full. This raises issues of equity and transparency since there is no statutory set of parameters governing who is sent where, and the overall impression is that political patronage often exists as to who is placed in the best accommodation. It is thus often claimed that patronage and clientelism are what determines who gets these superior services in private institutions at the taxpayers' cost.

Table A1 in the Annex gives a breakdown of the beds available in the private sector, covering both Church and private homes. This Table also provides details of the number of beds 'bought' by government from these private institutions.

1.1.3 Persons who live in state-run institutions

In Malta there is one central state-run institution for permanent elderly residents (known as the St Vincent de Paul Home, or *Ħas-Serħ*), supplemented by eight regional residences. In addition, there is a state-run central mental institution that provides treatment and care for mentally impaired persons who need psychiatric treatment. Another central institution (Karin Grech), hitherto run by the state but now theoretically privatised, provides rehabilitation services and long-term care for patients with ailments with a long-term prognosis.

Collaboration between the state and the private sector can take two distinct forms. In the first case the state contracts out the management of an existing property, while in the second case the private sector develops extensions to an existing state property and then manages it for a period of time (normally 25 years). As has already been described above (see Table A1), through the second scheme government buys a number of beds from the private sector to house elderly people who otherwise would not be able to afford such institutions.

As at February 2017 there were 1,400 persons waiting for a place at an old-people's home. By December 2017, the number had increased to 1,847. This relatively large waiting list exists despite the fact that, in December 2017, the state was buying as many as 1,068 beds from the private sector.[10]

Residents in state-run homes for the elderly contribute 80% of their pension and 60% of their remaining net income, provided that residents are not left with less than EUR 1,398

[8] A person qualified for the pink form, which entitles them to free medicines if they satisfy the conditions of a means test. For details see: https://socialsecurity.gov.mt/en/Documents/Benefits-and-Assistance/Pink%20Form.pdf. Accessed on 22 January 2018.
[9] See: https://activeageing.gov.mt/en/Documents/NMS_ENG.pdf. Accessed on 22 January 2018.
[10] Private communication, Director, Active Ageing and Community Care Directorate, February 2017.

per year (pension and other income) at their disposal. Table A2 in the Annex gives details of the population in government-run homes for the elderly.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Challenges in long-term care

2.1.1 Access and adequacy challenge

In Malta a wide range of services to cater for long-term care do exist. But equally the challenges are tough. In December 2017 there are 1,847 persons waiting for a place at an old-people's home. This relatively large waiting list persists despite the fact that, in January 2018, the state was buying as many as 1,068 beds from the private sector.[11] The situation is made even harsher since it has to be recognised that the decision to move to long-term care is very often an urgent decision based on a sudden decline in health, cognition or function. This often blurs the extent to which the elderly themselves are free to exercise their right of choice, and in this regard appropriate support services need to be developed to ensure that the rights of the elderly at this critical juncture in their lives are respected and their dignity is not trampled on.

As such there are three very distinct challenges related to access and adequacy in Malta in the field of long-term care:

a) state provision is not meeting demand, as is clearly evident from the waiting lists;

b) private provision is also not meeting demand both in terms of places and especially cost;

c) despite community-based services, and the recent introduction of a substantial subsidy on the carer service described above, the balance payable after the subsidy is too high for persons on minimum pensions.

There are no empirical studies documenting this situation. But a rare initiative taken in 2015 by the National Audit Office (NAO)[12] to examine long-term care structures and services in Malta noted that, even in those cases where the state is buying services from private homes, standards fell below acceptable adequacy levels.

Among other things, the NAO report noted that, despite the millions in taxpayers' cash paid to finance beds for long-term and high-dependency patients in private homes, minimum nursing and caring times had fallen well short of contractual obligations. This was attributed to chronic understaffing and a lack of rigorous enforcement, sometimes allowing contractual obligations to be ignored altogether. Table A3 in the Annex, sourced from this study, gives details of the daily variance between contractual agreements and the actual caring services provided in the homes audited by the NAO.[13]

The shortfall in caring and nursing time meant that even some high-dependence patients were not receiving the care they needed, despite clear contractual obligations. As has

[11] Private communication, Director, Active Ageing and Community Care Directorate, February 2017.
[12] NAO. April 2015. Performance Audit: Provision of residential long-term care (LTC) for the elderly through contractual arrangements with the private sector. Available at: http://nao.gov.mt//loadfile/f833d410-39c8-4996-95db-a8c98b2c248d. Accessed on 21 January 2018.
[13] The NAO study reports that the Mellieha home was found to have given over 80 hours less caring time during three inspections in 2013 and 2014; the Zejtun home fell short by 178-202 hours; the Roseville home fell short by some 40 hours; and Casa Leone fell short by 35 hours on average. The reported noted that, moreover, the negative variance in the provision of caring services in specific homes was generally at the same level during three points in time over a period of approximately nine months.

already been indicated above, minimum standards have since been established, but it is difficult to establish the extent to which they are actually being implemented, as no concrete data have been generated since the 2015 NAO study. The Parliamentary Secretariat for Persons with Disability and Active Ageing is committed to the promotion of equality for older people and disabled persons, to safeguard their right to active inclusion and participation and to live independently in their communities. In addition to establishing policies, it is also directly responsible for auditing the level of services provided.

2.1.2 Quality challenge

Obviously the state of affairs described by the NAO in 2015 might not be the current one; neither are there studies stating that the quality of the service is the same in different institutions. Significant efforts have been made by the government to improve the quality of care provided in state-run institutions. Extensive investment has been made to upgrade facilities, and to train staff. However, there is little to prove that quality is ensured at all times. Concurrently, at the higher end of the spectrum, privately run homes offer hotel-like facilities to their clients. However, the average Maltese is unlikely to be able to afford that level of care, and therefore the question whether the average Maltese is able to have access to adequate long-term care stands.

Likewise, the cost of privately employing a Filipina under standard minimum statutory work conditions, plus a trip home every two years, is definitely higher than the maximum national insurance pension.[14] With the carer subsidy described earlier these costs have been mitigated, but they still remain far beyond the reach of many. This effectively means that a high-quality service (as having a home carer is universally perceived in Malta) is no more than an unaffordable dream except for those who either have additional capital, or have a large enough family able to support it.

2.1.3 Employment challenge

In Malta, the vast majority of carers who opt to look after their elderly dependent relatives requiring long-term care do not receive compensation, and they have to find a way to finance themselves. This stems from the fact that it is generally assumed that women who give up their work to take on care duties would be supported by their husband/partners. The only exceptions to this would be single or widowed citizens who might be eligible for a carer's pension or for carer's social assistance. In both cases the carer has to satisfy both a stringent capital and income means test. As has been explained above this is now available if the elderly person is ranked up to 4 on the Barthel index. Naturally the support services listed above and provided by CommCare are also available to them if these are considered necessary.

It is important to note that in Malta public sector employees are in an advantageous position in view of the set of family-friendly measures that are open to them (such as time off, reduced working hours, teleworking and extended leave), but which are denied to workers in the private sector. Although these measures are not specifically intended to assist carers with dependants requiring long-term care, they are de facto available to be used in such circumstances. The exact level of take-up specifically related to long-term care is not available, since the government unit that collects the data centrally does not differentiate uptake according to the reason for it.

[14] Filipino carers are employed under private work contracts, but it is known that their conditions are more or less standard. They enjoy a fixed wage, mostly at or above the minimum wage, plus additional benefits such as a fully paid trip home every two years. They pay social security contributions like all other employees. Qualitative research shows that clients and their next-of-kin are generally very satisfied with the service if they can afford it.

The decreasing availability of intra-family care has already been referred to above as the necessary corollary of constantly increasing female participation rates. This, together with the dwindling size of families and the increased mobility of young couples (who no longer necessarily live near their parental home, as used to be the case for many centuries), is creating lots of pressure on 'who' is to provide long-term care for elderly parents. In a rapidly expanding economy with practically full employment, the number of females available to do caring work for family members is practically non-existent in contemporary Malta. Eurostat data unfortunately group together two reasons why females either do not seek employment or why they seek only part-time employment (looking after children and looking after incapacitated adults). In the first case figures are considerably in decline (from 41.2% in 2007 to only 26.7% in respect of females in 2016). In respect of those seeking only part-time employment, figures fluctuate around 19.8%. But in reality it is widely known that in Malta it is responsibility for children that primarily makes adults stay at home or seek part-time employment, rather than the need to care for incapacitated adults.[15]

Those doing undeclared work in long-term care have few opportunities to improve their skills, or to have their skills and experience formally recognised, in order to assist them in becoming long-term care professionals. In 2017, a specialised course, including theory and practice in the care of the elderly, was offered through the University of Malta by St Vincent de Paul. The University of Malta accredited this course as a unit within its programme in the liberal arts and sciences (PLAS). It is unknown how many attended and if this will be repeated. Paid courses are also offered by Caremalta, which has a training academy.[16]

The employment opportunities for caring are effectively opening up opportunities for non-Maltese people, since young Maltese females seek more lucrative jobs and follow more attractive career routes. As such most of the new posts being created in this sector are being filled in by non-Maltese people, and in the case of home-based carers, as has already been discussed above, by Filipinos.

2.1.4 Financial sustainability challenge

With Malta's ageing population, the sustainability of long-term care is certainly a major concern for economic planners. Malta has around a quarter of its population (24.5%) aged over 65. SILC data clearly show that this segment of the population is becoming relatively poorer and their number is on the increase. A number of social measures have been announced in successive budgets, but so far the results have not been positive enough. The cost of long-term care adds a further burden to this problem, especially since institutional care is heavily labour-intensive. This is in addition to the cost of maintaining the high-quality medical structures needed to keep an ageing population healthy.

The measures undertaken by the Maltese government to entice more elderly people to remain in the community, rather than to seek institutional care, were meant to alleviate the overall costs. As has already been pointed out, this matches the culture, and therefore no opposition exists. Institutional care still carries a social stigma (except for the high-end homes which only the very rich can afford), which the average Maltese would do their utmost to avoid for as long as possible.

At present, Malta's booming economy appears to be able to continue to provide the current level of long-term care, and to introduce gradual improvements as well. This was not always the case, and during the difficult times of the recent financial crisis, there were instances when spending had to be curtailed. A 2016 study, covering that period of the financial crisis, noted that: 'It has long been normal for government departments to

[15] See Eurostat lfsa-igar and lfsa-epgar.
[16] See: http://www.caremalta.com/academy. Accessed on 26 January 2018.

be told, halfway through the financial year, to curtail their spending to less than was originally budgeted. These procedures are difficult for an outside observer to know about, still more to quantify them. However, the cuts due to EU excessive deficit procedures had to be publicly announced, as a way to publicly allay the European Commission's reservations, thus, affording visibility to the citizen that would not have been achievable with internally ordered savings from the original budget.'[17] In general the reductions were not drastic, but improvements have been relatively slow. Planners and politicians are very aware of the dangers that an economic downturn could create, and constantly remind their followers that service improvements have got to be kept within limits to avoid possible drastic measures in times of economic downturns.

2.1.5 Assessment

In summary it can be stated that since the mid-1980s Malta has become increasingly aware of the need to cater for more adequate and more accessible long-term care. The emphasis has been on expanding home-based services whilst at the same time improving the services provided in institutional settings, both through physical upgrading of facilities and more importantly by training personnel in the caring professions to be able to provide good-quality services.

Today, the general ethos among the Maltese is that long-term institutional care should be avoided as much as possible, and that people should seek to stay active in the community. In recent years, long-term care services have multiplied and have been considerably improved. However, there are many pending challenges which need to be addressed, the most pressing of which are as follows.

a) *Ensuring equitable and transparent accessibility.* It is particularly important that supply is increased to match the demand, and to establish clear criteria as to how individuals are selected to occupy beds that the government buys from the private sector.

b) *Ensuring pensions are adequate to allow people a real choice between the various options available.* Currently pensions are too low to allow persons without savings or third-party support to have a real choice about which of the three available streams of long-term care to opt for.

It is not clear how (a) above will be tackled in the short term. It has not been the subject of public debate despite the urgency of the problem.
Concrete action to address (b) has been undertaken through measures taken over the past few years to: improve pensions; increase the amount of tax-free income for pensioners; and provide new investment opportunities with premium returns aimed at pensioners. A number of other measures have been taken, aimed at the elderly in general. But the possibility that an elderly person can effectively be able to choose how and where to spend their time in long-term care is still a remote one for many Maltese.

One particular situation related to access to long-term care is particularly disturbing in Malta. If a patient is terminally ill and is being give care at Mater Dei, Malta's main hospital where services are completely free, but for some reason they cannot be moved to a state-run long-term care home or into the community, they are charged very hefty bills as if they were a private patient. This is a great anomaly in the system which hits individuals and their families when they are at their weakest situation and calls for very urgent redress.[18]

[17] Pace, C., Vella, S. & Dziegielewski, S. F. 'Long-Term Care of Older Adults in Malta: Influencing Factors and their Social Impacts amid the International Financial Crisis'. Journal of Social Service Research Volume 42, 2016 - Issue 2, pp. 263-279.
[18] Patients flagged for long-term care are consulted by a multi-disciplinary team. Once a person is admitted to Mater Dei for acute treatment and the acute cycle is completed, patients are discharged back into the

2.2 Policy recommendations

Some policy recommendations that could contribute to an improvement in the overall provision of long-term care in Malta are listed below. Action should be taken to:

a) launch an intensive programme of community-based homes where persons requiring institutional care can be served within their own town or village;

b) improve the Telecare Plus service through a video-monitoring system that allows elderly people living at home to interact with a care control centre in case of need;

c) launch a training programme for neighbours who would be interested in assisting the elderly in their neighbourhood;

d) relaunch the Home Help service in its original form, namely personalised care and not simply a maid service as it has developed into over the years;

e) improve the co-ordination of services, integrating service providers into regional teams to improve efficiency and costs;

f) encourage more volunteering, and involve volunteers already organised in groups, such as the Church-run *Diakonia*, in official programmes of care at local level;

g) improve Malta's still very low pensions so that all persons can aspire to a more adequate retirement and those requiring long-term care can have real access to choice;

h) give incentives to family members who provide documented care to elderly relatives, through either fiscal incentives or time off from work (especially to

---

community. If the person is kept at Mater Dei, or is directed to long-term care in state-run institutional care, charges start to apply under subsidiary Legislation 318.13 of January 2004, and are as follows.
Level 1 care: any resident receiving level 1 care, where a residential service with only minimal basic care is provided, shall contribute 60% of any pension, social assistance and bonus receivable, net of income tax, and 60% of any other income received during the calendar year. The resident cannot be left with less than EUR 1,397.62 per annum at their disposal. If they were resident at the state-financed institution before the legislation, the payment must also not exceed EUR 24.46 per day.
Level 2 care: any resident receiving level 2 care, where the residential service provided includes such level of care that goes beyond minimal basic care as certified by the interdisciplinary assessment team within the Elderly and Community Services Department, shall contribute 80% of any pension, social assistance and bonus receivable, net of income tax, and 60% of any other income received during the calendar year. The contribution made by the resident shall not exceed the cost of the service provided (EUR 31.45 per diem for residents who were at the facility prior to the legislation), and the resident must not be left with less than EUR 1,397.62 per annum at their disposal.
When the individual is a parent who is either: the sole bread winner; raising a minor or a child above 16 still undergoing education or training; or registered as unemployed, a calculation is used to determine the contribution, which takes into account:
- the value of any property (excluding the house of residence) which is, or could be, invested or put to profitable use, excluding furniture, jewelry and other personal effects:
- any income derived from cash at a bank, liquid assets, time deposits, bonds, stocks, shares and other securities;
- any pension, benefit, social assistance, bonus or allowance, whether such pension, benefit, assistance, bonus or allowance are paid under the Act or not;
- any other income or privilege which is or could be received or enjoyed by such resident, and which for this purpose shall include any income or privilege that residents had directly or indirectly deprived themselves of in order to have their contribution due in terms of these regulations assessed at a lower rate;
- the cost per diem of the service being provided.
Any other income is not to be considered, except where the resident is in receipt of insurance money intended to cover part or all of the treatment required by the resident.
The establishments to which the legislation applies are as follows: Saint Vincent de Paul Residence; the geriatric wards and St. Anne residence of the Gozo General Hospital; Mater Dei Hospital; Karin Grech Rehabilitation Hospital; Mount Carmel Hospital; Sir Paul Boffa Hospital; Gozo General Hospital; the hostels for the elderly at Cospicua, Floriana, Gzira, Mosta, Msida, Mtarfa, Zejtun, and Mellieħa; and any state-financed beds in non-state-owned homes for older persons or institutions as may be contracted by the government.
See http://justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=9774&l=1. Accessed on 25 January 2018.

those not working in the public sector, and who cannot currently benefit from advantageous family-friendly conditions of work);

i) introduce systems whereby the advantages currently available to public servants are also extended to workers in the private sector;

j) undertake constant research to be able to assess needs on the basis of facts and not mere impressions;

k) establish clear codes of conduct for gate-keepers that ensure an equitable allocation and distribution of resources that manifestly does not depend on political patronage;

l) ensure that the quality of care is monitored on a regular basis in both private and public sector institutions;

m) provide training and up-skilling opportunities to informal carers to improve their chances of returning to the formal labour market after stints away from paid work because of long-term care needs in their family; and

n) take measures to ensure that persons who are either terminally ill patients at Mater Dei or for some reason are unable to be moved to a state-owned residence or returned home would not receive bills for their remaining stay at Mater Dei as if they were private patients.

3 Analysis of the indicators available in the country for measuring long-term care

In Malta there does not exist a set of standardised indicators, either at national or local level, whereby access, adequacy or sustainability can be systematically and repeatedly measured. The initiative of the NAO in 2015 was a one-off initiative, which should be regularly repeated in order to eventually develop a set of instruments that could be systematically used for assessment purposes. The document published to promote minimum standards in institutional care is a very good initiative, but it now needs to be backed up by constant research and enforcement.

In this regard, an action-research programme involving practitioners from the various professions and administrators concerned, and possibly managed by the university, could be undertaken. This would develop the necessary research instruments, and at the same propose policy innovations that were tailor-made to the meet the needs of elderly Maltese people efficiently and effectively, as an alternative to methods imported from elsewhere that do not reflect the local culture.

Annex: Tables

Table A1: Beds in Church-run and private homes

Church-run homes				Private homes		
	PPP (beds paid for by government	Total capacity			PPP (beds paid for by government	Total capacity
Apap Institute		38		Age Concern Central	96	103
Casa Leone	60	99		Casa Antonia		162
Dar Hanin		40		Casa Arkati	127	229
Dar Madre		23		Casa Francesco	42	77
Dar Sagra Familja	41	87		Casa Paola	72	109
Dar San Pietru		17		Casa San Paolo	191	196
Dar Sant'Anna	28	38		Casa Serena	93	114
Dar Saura	38	65		Charian Residence		32
Dar tal-Kleru		51		Simblija HillTop		153
Pax et Bonum		92		Jasmine Residence		106
Porziuncola House		8		Marina Palace		93
St Catherine's		96		Roseville	95	157
St Dominic		26		Sa Maison		60
St Paul's		59		St Elizabeth		149
TOTAL	**167**	**739**		St Mark's		21
				Villa Messina	145	218
				Villa San Lawrenz	40	64
				TOTAL	**901**	**2,043**

Source: Private communication, Director, Active Ageing and Community Care Directorate, January 2018.

Table A2: Elderly population in government homes

Government homes and hospitals		
	No of beds	Sub-total
Main elderly people's residence		
Saint Vincent de Paul Residence	1,500	1,500
Rehabilitation hospital		
Karin Grech	270	270
Regional homes		
Bormla Home	136	
Boffa Residence	52	
Floriana Home	46	
Mellieha Home	180	
Mosta Home	68	
Msida Home	64	
Mtarfa Home	123	
Residenza Sant'Anna	81	
Zammit Clapp Residential Home	131	
Zejtun Home	204	1,085
Mental health		
San Gorg Preca Ward Mount Carmel Hospital	34	
Santa Bernardetta Ward Mount Carmel Hospital	29	
Jean Antide Ward Mount Carmel Hospital	31	
Male geriatric ward	40	134
Total		**2614**

Source: Private communication, Director, Active Ageing and Community Care Directorate, January 2018.

Table A3: Daily variance between contractual agreements and actual caring service provided

	Inspection by DfE *(daily hours)*	**August 2013** *(daily hours)*	**Inspection by NAO and DfE** *(daily hours)*
	May to September 2013	**Average for month of August 2013**	**January to February 2014**
Mellieħa Home	*81*	*80*	*81*
Żejtun Home	*202*	*178*	*192*
Roseville Home	*35*	*40*	*44*
Casa Leone Home	*36*	*34*	*36*

Source: Table 9: NAO 2015 Study.

References

Care Malta. 2016. 'The future of long-term care of elderly discussed'. See: http://www.caremalta.com/future-long-term-care-elderly-discussed/. Accessed on 25 January 2018.

Dimech, J. et al. 'Pre-admission assessment of elderly applicants to long-term care'. Malta Medical Journal Volume 15 Issue 02 November 2003.

Grech A. G. & Zerafa S. 2017. 'Challenges and opportunities of sustainable economic growth: the case of Malta'. Malta. Central Bank of Malta. Accessible at https://www.centralbankmalta.org/file.aspx?f=61596.

Malta Government. 2018. Active Ageing Centres. https://activeageing.gov.mt/en/Pages/Elderly%20Services%20Catalogue/Active-Ageing-Centres.aspx.

Malta Government. 2018. Elderly and Community Care Services Information. https://activeageing.gov.mt/Elderly-and-Community%20Care-Services-Information/Pages/default.aspx.

Malta Government. Pink Form. https://socialsecurity.gov.mt/en/Documents/Benefits-and-Assistance/Pink%20Form.pdf.

Malta Government. Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing: National minimum standards for care homes for older people. https://activeageing.gov.mt/en/Documents/NMS_ENG.pdf.

Malta Government. Subsidiary Legislation 318.13 of January 2004. http://justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=9774&l=1.

National Audit Office. April 2015. Performance Audit: Provision of residential long-term care (LTC) for the elderly through contractual arrangements with the private sector. http://nao.gov.mt//loadfile/f833d410-39c8-4996-95db-a8c98b2c248d.

Pace, C., Vella, S. & Dziegielewski, S. F. 'Long-Term Care of Older Adults in Malta: Influencing Factors and their Social Impacts amid the International Financial Crisis'. Journal of Social Service Research Volume 42, 2016 - Issue 2, pp. 263-279.

The Malta Independent. 15 January 2015. 'Elderly persons who give up their property for private long-term care homes "is not abuse"'. http://www.independent.com.mt/articles/2015-01-15/local-news/Elderly-persons-who-give-up-their-property-for-private-long-term-care-homes-is-not-abuse-6736128754. Accessed 20 January 2018.

The Malta Independent. 22 July 2017. 'Long-term care patients who pay fees consulted by "multi-disciplinary team" – Mater Dei CEO'. http://www.independent.com.mt/articles/2017-07-22/local-news/Long-term-care-patients-who-pay-fees-consulted-by-multi-disciplinary-team-Mater-Dei-CEO-6736176672. Accessed 20 January 2018.

The Caremalta Academy. http://www.caremalta.com/academy.