Peer Review on "Financing Long-term Care"

Estonia, 22-23 September 2020

Peer Country Comments Paper - Malta

Sustaining long-term care services - Adapting to challenging contexts

DG Employment, Social Affairs and Inclusion

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Table of Contents

1 Introduction

This paper has been prepared for the Peer Review on "Financing Long-term care". It provides a comparative assessment of the policy example of the Host Country and the situation in Malta. For information on the host country policy example, please refer to the Host Country Discussion Paper.

2 Situation in the peer country

Malta has one of the fastest-ageing population in the EU. The country has one of the best life expectancy rates in Europe and healthy life years at birth: females and males born in 2015 are expected to live until age 79 and 83.2 respectively, out of which 73.4 and 71.9 years without any activity limitations (disability) (European Commission, 2016). The percentage of the population indicating a self-perceived severe limitation in daily activities is amongst the lowest in Europe and considerably lower than the EU-average (Eurostat, 2019).

Evidently, such positive demographic trends do not come by coincidence. The Government of Malta offers a range of health and social care services. In addition, free medicines to chronically ill and vulnerable persons are offered free of charge. Moreover, in an attempt to address the social determinants of health, the Government of Malta increased efforts to reduce the risk of poverty for those aged 65 and over (Eurostat, 2014a), by means of revised pensions and additional benefits to vulnerable elderly. In fact, a decline in difficulties for older households 'in making ends meet' (n=3.4% in 2019) has been registered (Eurostat, 2020).

Undoubtedly, all this puts more pressure on national health and social care resources, including long-term care services, both institutional and community-based services. The Government of Malta is increasing its expenditure and efforts to address these challenges. According to the European Commission (2016), in 2013 the public expenditure on Long Term Care reached 1.1% of GDP. 0.8% of GDP was spent on in-kind benefits (EU: 1.3%), while 0.3% of GDP were provided as cash-benefits (EU: 0.3%). The country is experiencing an accelerated health and social care expenditure, including long-term care services. In fact, according to European Commission (2012), after Luxemburg, Romania and Slovakia, Malta is to set to experience the fourth highest increase in public LTC expenditure by 2060.

Type of LTC	**Malta % GDP**	**EU 27% GDP**
At home	0.09	0.53
Institution	0.56	0.8
Cash benefits	0	0.52
Total	0.65	1.84

European Commission (2012)

This means that planning is of utmost importance since current statistics show that population ageing is to peak within the next two decades or so. Such trends are compounding the dependency ratio thus putting stress on the national social security systems, including the local pension 'pay-as-you-go' system. This is a system where employed people pay contributions to finance the national pension system.

Malta's health and social care systems are mostly based on a Beveridge model, as these are funded through national security contributions and general taxation, but also by means of out-of-pocket expenditure. The latter is more popular within healthcare services rather than long-term care, though there are elderly who opt to seek private long-term care as well (both residential and community-based care). The Constitution of Malta and main legislations governing social policy services and benefits, such as the Social Security Act and the Health Act uphold values of equity, solidarity, universality and social justice. This means that most of the services are universal and free, whilst other entitlements to long-term care services are subject to eligibility

criteria mainly age, social and medical needs or means/income, thus securing access and accessibility.

The Ministry for the Family, Children's Rights and Social Solidarity, through the Departments of Elderly Care and Social Security, and St. Vincent de Paul Long-term Care Facility are responsible for elderly welfare in general, mainly community services, pensions, cash-benefits and institutional care respectively. The Department of Health is responsible for primary, secondary, tertiary and rehabilitative care. However, one can find many actors in the field, such as NGOs, church-based organisations, family members and caregivers. These types of arrangements or adaptations changed the service environment to a welfare mix, where different providers work together for the benefit of their elderly and their family members.

Population	**2020**	**2025**	**2030**
Age 65+ as % of total population	21.2	23.3	24.4
Age 80+ as % of total population	4.9	5.8	7.8
Age 80+ as % of work age population	7.7	9.4	12.9
Old-age dependency ratio	33	38	41

European Commission 2014

Despite COVID 19, the Maltese economy has held up well during the past years and economic growth continued at a strong pace. According to European Commission Country Report 2019, Malta's GDP growth in 2018 is estimated at 6.2%, based on strong domestic demand and, in particular, both private and public consumption. The effects of the pandemic are expected to lower it by -2.8% in comparison to the average EU contraction of -7.5%, thus being the lowest amongst the EU-28. Malta's success is most likely related to a steady economic diversification and growth, a sound banking sector and high employment rates, the latter are among the lowest in Europe. These are key factors that contribute to the financing of health and social care services through national insurance and general taxation, amid efforts to improve the financial sustainability of national healthcare system and pension reform measures. One has to keep in mind that Malta's welfare expenditures have never reached the averages of other EU welfare states. Although expenditures have risen over the past years, they are still below the rate when compared to the other EU27 countries (Malta Enterprise, 2020)). The bulk of Malta's public expenditures on long-term care goes toward institutional and community-based services (Malta Enterprise, 2020).

3 Assessment of the policy measure

3.1 Long-term Care - Institutional Care

Despite the fact that most of the elderly live independently in the community, a number of highly frail elderly are unable to be supported in the community thus opt, possibly as a last resort, for institutional care. The 2007 Special Eurobarometer on Health and Long-term care reveals particular attitudes toward elderly care in Malta. For the highly dependent elderly, institutional care in Malta is a much more preferred option, when compared to other EU27 counterparts. For the Maltese, institutional care seems to be a better care-option for these frail elderlies. One might say that the island has a long history and deep roots in institutional care, provided by both government and faith-based organisations, mainly Roman Catholic. This also might reflect opinions of older persons to help retain the independence of the nuclear family, but also could be linked to the favourable accessibility characteristics of a small island (when we say small – we really mean it) and facilities, mainly short distances to reach facilities and wide-ranging opening hours.

3.2 Access and Entitlement

Access to national institutional care is granted to persons over 60 years. There are two types of long-term care facilities on the island. The most popular are licensed nursing homes, aimed to take care of frail elderly who are highly dependent. Others who are semi-dependent are admitted to residential homes, which are slowly being converted to nursing homes due to an increase in demand for high dependent care. The majority of elderly people in Malta opt to live assisted in the community rather than in institutions. An inter-disciplinary team visits and evaluate the needs of these elderly thus maintaining gatekeeping in an attempt to use long-term care beds solely according to high dependent needs and within a framework governed by social justice and equity.

St. Vincent de Paul (SVP) is Malta's largest long-term care facility. The 80-million-euro government-owned organisation aims to be a centre of excellence in client-focused care through innovation practices and specialised geriatric care for highly dependent persons with complex needs (Active Ageing, 2020a). The facility offers specialised services and professionals that are available to help around 1500 patrons. According to the National Social Security Act, elderly in public long-term care (nursing) institutions (such as SVP) contribute 80% of their pension and 60% of their remaining net income, provided that these retain less than EUR 1,398 per year, including pension or other income. Others who are in residential care homes, contribute less (n=60%). This means that these services are highly subsidized by the Government of Malta. In 2018, the Government of Malta had over 2,600 elderly in public long-term care facilities.

3.3 Strategies - institutional care

The strategies of the Government of Malta for institutional care can be considered fivefold: increase in financial commitment to meet the needs of highly dependent elderly; increased outsourcing, a move towards a social model of care, specialisation and gatekeeping, and uphold of standards of care.

3.3.1 Financial commitment

The focus on residential care has been steadily increasing on a yearly basis. In fact, during the past decade, the recurrent expenditure on residential care increased almost fourfold. For the 2020 recurrent expenditure on residential care, the Government of Malta increased the expenditure by another EUR 25 million. This means that more beds shall be available for highly dependent elderly requiring institutional long-term care. For instance, at St Vincent de Paul Long-term Care Facility a new 500 beds extension and further beds-increasing refurbishments have just been completed and currently highly dependent elderly are being admitted from the community or transferred from acute or rehabilitation hospitals. This means that lists of elderly waiting to be transferred in nursing homes are being adequately addressed. This is of particular importance, especially for elderly who maybe living precariously in their own homes or occupying acute care beds, thus making space for patients in need of tertiary or rehabilitative care, thus helped to be supported in a more appropriate less-medicalised environment. Such demand in service provision is making it harder to find qualified professionals in the fields, thus authorities and private contractors are employing qualified foreign professionals, following a process governed by local employment agency and other national commissions to check that working conditions and academic accreditations are in line with local laws and regulations.

3.3.2 Outsourcing of services

Over the years, such a model of care provision resulted to be generally successful and till inception it has accelerated to meet an increase in demand. The Government of Malta established different public-private partnerships (PPP) with various private service providers, reserving over 1 000 beds for elderly in need of institutional care, mostly residential care. The most successful PPP models include direct procurement of

service or management agreements with private service providers to administer government-owned homes. The Government of Malta, based on demographic changes and population projections, calculates that more than 300 new residential beds a year are needed to meet the needs of an elderly population, especially for the frailest and most vulnerable.

3.3.3 A move towards a social model

Whilst along the years institutional care has been predominantly based on the medical model, lately a very interesting conceptual, but also political, decision has been taken to transfer the Department for the Elderly and Community Care, from its position within the Health Ministry to the Ministry for the Family and Social Solidarity. This move resulted in a service-provision shift, incorporating not just the medical and nursing services but services that are more open and comprehensive, through the help of specialised professionals that aim towards comprehensive care and active ageing activities. In fact, even within institutional facilities, active ageing centres have been developed to offer services of a more social nature. Such a concept is also enshrined in Malta's National Strategic Policy for Active Ageing (2014-2020) (National Commission for Active Ageing, 2014). More on the aim and objectives of this strategy in section 3.4. All this helped to pronounce social care and support services, as for many years these lived under the penumbra of healthcare services, sometimes with more efforts, including financial, channelled towards acute care rather than social care and support.

3.3.4 Specialisation and gatekeeping

Demographic changes increased the incidence of elderly suffering from dementia. The Government of Malta took such a reality seriously and authorities are organising specialised training for health and social care professionals, but also informal carers, working with older adults in need of dementia care. Whilst all training is accredited with the University of Malta and mostly provided at St Vincent de Paul Long-Term Care Facility, other training includes care of frail elderly for carers, informal carers, nurses and allied-health care professionals. Other degrees in the fields of elderly care and geriatric care are available at the University of Malta. This is also in line with the National Dementia Strategy. The aim of this strategy is to ameliorate the quality of life of persons with dementia and their informal carers and relatives by means of awareness, timely diagnosis and evidence-based dementia management and care, workforce development, and research (Scerri, 2015). Nevertheless, dementia-specialised wards are also available for elderly who cannot live in the community and are in need of specialised care within a controlled and safe environment.

The use of finite resources is of utmost importance. Institutional care has to be channelled to the frailest and most highly dependent elderly. To guarantee this, efforts persists to uphold a system of gatekeeping by means of comprehensive and objective assessments. The aim is to postpone institutionalisation as much as possible, whilst ensuring that the necessary support is given to the elderly living in their own homes.

3.3.5 Maintaining standards

Following the inception of the Social Care Standards Authority in 2018, the Government of Malta published a White Paper on National Minimum Standards for care homes for older people (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2015). This has been enacted through Parliament of Malta and now it is being implemented by the Social Care Standards Authority. This means that all public and private homes are now governed by means of a set of regulations, ranging from nursing care to upkeep places and safeguarding of users' rights. The most challenging part of all this is to find adequate qualified resources to keep pace with the steady increase in demand of long-term care services.

3.4 Long-term Care – Community Care

Community services in Malta are wide ranging and akin to institutional care, commitment increased to support elderly people live in their own homes as much as possible. A National Strategic Policy for Active Ageing (2014-2020), has been incepted. It evolves on three main pillars that aim towards helping elderly to stay in the community and postpone institutionalisation through active participation in the labour market; social participation by means of volunteering, intergenerational solidarity, civic engagement and grandparenthood. Also, there has been a push towards independent living with the help of health prevention and promotion within the community sector. The latter is of particular importance, as despite the positive demographic trends in life expectancy and years without disabilities, elderly in Malta are the most obese in Europe (Eurostat, 2012). The policy also aims to link acute care, rehabilitation, and wellbeing that are sustained through formal and informal care in the community.

The 2007 Special Eurobarometer on Health and Long-term Care revealed that Maltese are more inclined towards community social support than their European neighbours. They want to help and visit their loved ones in their own homes as much as possible. This is very much in line with Mediterranean-family-type culture, amid the dwindling role of women as elderly caregivers due to a steady increase of female employment supported by government incentives, such as free child-care centres that encouraged many women return to work.

Following assessment, by either a medical doctor or a multi-disciplinary team (depends on the service), a myriad of social care services is available in the community. These include community geriatrician and allied-healthcare professional services, respite services, dementia activity centres and intervention teams, meals-on-wheels; night shelters for elderly living on their own; continence service; telephone rent rebate; telecare, handyman service; active ageing centres; social work services and free transport to elderly in certain areas (Active Ageing, 2020b).

3.5 Strategies – community-based services

The Government of Malta strategies for community-based services can be classified as three: financial commitment to sustain services, outsourcing of services to meet demand and help to informal carers.

3.5.1 Financial commitment

In the 2020 Government of Malta recurrent expenditure, one could note a steady increase in the financial commitment towards community services. Community services are offered either free or against a negligible minimum contribution. The Government of Malta's commitment is to keep this model of service provision. For instance, the meals-on-wheels service costs EUR 2.20 for each daily meal. This consist of door-to-door delivery of three main course meals to elderly. Another example is the supply of expensive diapers through the continence service. The supply is either free or heavily subsidised at a price of EUR 0.23 per adult diaper.

3.5.2 Outsourcing of services

Currently there are various community services that are being provided by private companies, such as the meals-on-wheels and community nursing. Even the upgrading of telecare was carried out with the help of private service providers. The telecare service provides an alarm gadget to eligible elderly, triggering an alert if the person is in need of serious help, like a fall or feeling sick.

3.5.3 Help to informal carers

With the aim to keep the elderly in their own homes and support informal carers as much as possible, the Government of Malta introduced another service in 2016, called Carer at Home Scheme (Active Ageing, 2020c). The aim is to offer over EUR 5 000 per

year to the elderly who employ a carer of their choice. The scheme is quite popular and attracted a number of national and foreign carers and service providers, to help Maltese families supporting elderly in their own homes. Moreover, other allowances have been revised to encourage more persons, even if these are in employment, to take care of a relative, with low dependency, on a full-time basis living within the same household (Inclusion, Equality and Social Welfare, 2020). Informal carers are also supported by means of respite care for their loved-ones and accredited free training to help them cope with care in the community. The latter courses are offered at St. Vincent de Paul Long-Term Care Facility, but also various NGOs or faith-based organisations, such as Caritas.

4 Assessment of success factors and transferability

What is most striking at present is the prosperity that is helping Malta to keep on offering health and social care services. This needs firm prioritisation skills to uphold a 'wealth-sharing' ideology. Malta's incremental approach to health and social services has always been in line with GDP growth. Meanwhile, long-term care services are expected to be available free of charge or heavily subsidised, striving for a balance between accountability, solidarity and standards of care, amid challenges of finding adequate resources, mainly qualified human resources and change in demographic trends.

In the context of long-term care and policy transferability, the need for and significance of *context-sensitive local solutions* is not to be undervalued. Without lessening the benefits of a push towards transferability of policies, the latter require a description that is not universalising or simple but one that is multidimensional and complex. Conceptually, this means that policy transfers should not be lock-stock and barrel but take form of adaptations. Whether coming from different locations or constituting a remodelling of current service design, policies and services have to be congruent with the new context.

This means that one has to study policies and services in a way that is consistent with the context or with the current design and to highlight particular contextual differences. The table below shows a multi-level conceptualisation between the provider and user worlds in both Malta and Estonia. In fact, the provider world can be evaluated for its country's values, laws and policies at a macro-level, the organisation and its systems at a meso- level, and face-to-face service provision at a micro-level.

Common Service Aims & Rationale	**The provision of long-term care services**	
The different contexts	**Estonia**	**Malta**
The Provider Context	A priority to explore new financing models, mainly from the State to local governments.	Long-term care services are funded through general taxation and national insurance, offered either free or heavily subsidised following needs-assessments.
	Responsibility of Local governments, amid lack of formal services, placing care	Services funded central government through a welfare mix model – Government, PPP, faith-based organisations, informal carers.

	responsibilities on informal carers. GDP growth of more than 4%	 GDP growth of more than 6%
The User World in terms of own culture living setting needs	Rise in number of elderly people Preference to live life in the community In 2014, 15% of 65+ had difficulties in personal care activities High out-of-pocket payments	Rise in number of elderly people Preference to live in the community, however seeking residential/nursing care if highly frail In 2014, 14% of 65+ had difficulties in personal care activities Services are free, heavily subsidised or means-tested
The Service Solution in terms of design and inputs	Prioritise and increase provision of services Increase state funding through general taxation since no more room on national security and payroll taxes (depending on government prioritisations and economy) Use an incremental approach and enhance services in line with GDP growth. What New Adapted service solutions can be proposed - PPP models of care that may be more cost-effective - Prioritisation and Gatekeeping to channel long-term care services to the most in need. - Help informal carers	

Adapted from Adaptive Remodelling Template (Pace, 2012 & Carabott, 2018)

5 Questions

- What services are currently available in the community to support elderly in their own homes?
- Are there any services offered through public-private partnership schemes?
- The introduction of the needs-led service programme at a local level is highly praised. Who are the professionals that are going to be engaged and what kind of service design, such as case management etc?

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Annex 1 Summary table

The main points covered by the paper are summarised below.

Please summarise the main points covered by the paper. Give a maximum of five bullet points per heading.

Situation in the peer country
• Change in demographic trends • Health and social care systems that are mostly based on a Beveridge model, funded through national security contributions and general taxation, but also by means of out-of-pocket expenditure. Most services are free, heavily subsidised and means-tested according to age and needs. • Though funded through national expenditure, one finds a welfare-mix type of service environment: State services, PPP, private contractors, NGOs, faith-based organisations, informal carers and family members…
Assessment of the policy measure
• Financial commitment • Outsourcing/PPP • Specialisation and gatekeeping • Upholding standards of care • A move towards a social model • Help to informal carers
Assessment of success factors and transferability
• Incremental approach to health and social care services where increase in services reflects GDP growth … • PPP models of care that are more cost-effective • Prioritisation and gatekeeping to channel long-term care services to the most in need. • Help informal carers
Questions
• What services are currently available in the community to support elderly in their own homes? • Are there any services offered through public-private partnership schemes? • The introduction of the needs-led service programme at a local level is highly praised. Who are the professionals that are going to be engaged and what kind of service design, such as case management etc?

Annex 2 Example of relevant practice

Short summary of a relevant policy practice/example, key fields indicated below (max. 1 page)

Name of the practice:	Increase of long-term care beds at St. Vincent de Paul Long-Term Care Facility through a public-private partnership model of care provision.
Year of implementation:	2018 - 2020
Coordinating authority:	Government of Malta
Objectives:	• To increase bed capacity by another 500 beds to meet the needs of highly dependent elderly.
Main activities:	• Nursing/institutional care
Results so far:	• All units have been completed and elderly patrons are being admitted either from acute or rehabilitation care hospitals or their own homes.

Name of the practice:	Introduction of Carer at Home Scheme
Year of implementation:	2015 - 2020
Coordinating authority:	Government of Malta
Objectives:	• Supporting elderly and their families, in the employment of a formal carer of their choice to assist in the daily needs, by means of a yearly grant of 5,000Euros.
Main activities:	• Community care and support
Results so far:	• 400 families


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