European Observatory on Health Care Systems

Health Care Systems in Transition

Malta



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine

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By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
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Keywords

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Contents

Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Norway and Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines and specific questions, definitions and examples to assist in the process of

developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) health data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally review by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at http://www.observatory.dk.

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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

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The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The series editors are Anna Dixon, Judith Healy, Elizabeth Kerr and Suszy Lessof.

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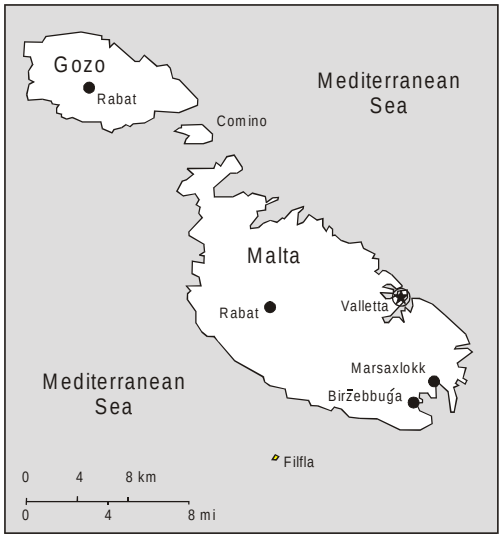
Introduction and historical background

Introductory overview

The Maltese archipelago is made up of three main islands: Malta, Gozo and Comino. It is located in the centre of the Mediterranean Sea with Sicily 93 km to the north, Africa 288 km to the south, Gibraltar 1826 km to the west and Alexandria 1510 km to the east. The total land area is 315 km². The total population of Malta is 376 513 (1997), giving a population density of 1189 persons per km² which is one of the highest country population densities in the world.

Fig. 1. Map of Malta[1]



[1] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

Malta has several natural harbours. The climate is warm with a mean air temperature of 19.2°C. Gozo is topographically rather different being hilly and greener than Malta. Malta is heavily dependent on imports due to the lack of any natural resources.

Malta scores high on the Human Development Index with a life expectancy of 74.9 years for males and 79.8 years for females. The infant mortality rate is 6.4/1000 live births. The birth rate has been steadily declining and is currently one of the lowest in the Mediterranean countries. The crude birth rate is 13.2/1000 and the crude death rate is 7.4/1000. The male to female ratio is 0.98 and the dependency ratio is 0.5. (All data is for 1997).

Coronary heart disease and stroke are the major cause of mortality and morbidity. Cancers account for 25% of deaths. Accidents are an important cause of death in those under 65 years. Diabetes is a significant national health problem with a prevalence of 10.3% in adults over the age of 35 years old.

The national language is Maltese. The language has Semitic roots mixed with Roman and Latin and is a good example of the cultural heritage of the country. Both English and Maltese are the official languages. The official religion is Roman Catholicism which is taught in all schools. Schooling is compulsory for all children aged five to sixteen years and is provided free of charge by the state. 33% of children attend church or private schools. A voluntary contribution is paid for church schools and the full fee is paid in private schools.

Five percent of the enumerated population in the 1995 census were born outside Malta. Most of these were born in the United Kingdom, Australia, Canada and the United States of America and represent returned migrants.

Historically, Malta's strategic geographic position made it an attractive base for naval powers. Malta has been occupied by Phoenicians, Carthaginians, Romans, Arabs, Normans, Knights of the Order of St. John, the French and the British throughout the ages. Its chequered history has bestowed a rich and colourful culture.

Self-government was first granted in 1921. However it was not before several constitutional upheavals that in 1964 Malta obtained its independence from Britain and became a sovereign state. In 1974 the island became a republic with its first President.

A unicameral Parliament made up of 65 representatives is elected every five years. This chamber serves as the national legislative body and also appoints the President. The head of government is the Prime Minister who is the leader of the party with an electoral majority. The executive and the judiciary are the other branches of the state. The main political parties are the Nationalist Party and the Malta Labour Party.

Malta is currently facing an economic imbalance in its public finances and external payments. The trade deficit in 1998 was –12% and the public debt stood at 55% of the GDP. Efforts are being made to re-structure the economy which is still dominated by a large public sector. Unemployment currently stands at 5%.

The main income generating activities are the service and manufacturing industries. The service industry has traditionally relied upon tourism, however financial services and Freeport (cargo deposit and storage) services are now increasing in importance. The manufacturing industry is dominated by electronics, food and beverages, furniture and ship building/repair. The latter has however become difficult to sustain. The electronics industry accounts for the bulk of export income.

Malta applied for European Union membership in 1990. The membership application was frozen by the Labour government in 1996 but was re-activated by the Nationalist government, elected in September 1998.

Historical background

Hospitals

Hospital services in Malta have existed since the middle of the fourteenth century. They started to develop rapidly during the rule of the Order of the Knights of St. John. The first Medical School was established in 1676 at the *Sacra Infermeria*. However medical and hospital services developed in a disjointed fashion, with an administrative structure being devised for each institution as it was established. Each institution was administered independently with no central authority to coordinate their activities. During this period philanthropists founded a number of institutions for the poor who had to resort to hospitals when they became ill. The growth in their number was not a result of planned policy and consequently they developed in an uncoordinated fashion. Eventually, as bequests ran out, these hospitals became dependent on state subsidies but they were still designated as charitable institutions.

In 1815, at the start of British rule, all hospitals were brought under a single authority, responsible for the management of all charitable institutions including orphanages. Although one of the Chief Government Medical Officer's roles was to act as Inspector of Hospitals, it was not until 1936 that the medical branches of the Charitable Institutions Department were amalgamated with the Public Health Department with a doctor at the helm. This is how the hospitals came under the umbrella of state medical services managed by the Department of Health.

As hospitals came to be perceived less as an institution for the needy poor and more as a place offering care for all sick persons, the demand for hospital services increased. Earlier this century, when Malta was a military and naval base for the British, a number of hospitals existed to serve the forces. Since then hospital services have slowly been rationalized onto fewer sites and this trend is set to continue.

Hospital admission and treatment became free of charge in 1980. This practice was introduced by the Department of Health as an administrative measure. The intention was that in due course this measure would be given legal standing through the formal enactment of a National Health Service. However, this has never happened.

All persons covered by the National Insurance Act of 1956 are eligible for free health care. The National Insurance Scheme is funded by government, employers and employees and provides welfare benefits, sickness benefits and pensions. All contributors and their dependants are covered, in addition a social assistance scheme exists to cover those not in employment.

Although spending on health care appears as part of the welfare system, in reality the National Insurance Contributions do not fund the health care system. Health care is in effect funded through general taxation.

Primary/domiciliary services

The first domiciliary service to be established was the service for poor and needy sick women, which operated in the main towns during the rule of the Order of St. John. This system commenced in the sixteenth century. Financial relief, food and free medicines were prescribed and provided.

This service was continued under British rule by the 'Physicians of the Poor' who were attached to the civil hospitals. In 1832 the first government dispensary was established. Further dispensaries, which were usually attached to the police station, were soon established. The 'Physicians of the Poor', whose duties included clinical, administrative and sanitary responsibilities, were incorporated into the Executive Police. In 1879 the 'Police Physicians' became known as District Medical Officers accountable to the Department of Charitable Institutions.

The District Medical Officer Service survived until the late 1970s. District Medical Officers were responsible for treating patients in their district who qualified for a Medical Aids Grant, based upon income thresholds. They had full-time posts with the right to unlimited private practice and their low salary was compensated by their private practice.

In the early 1950s, having been influenced by the creation of the British National Health Service (NHS) in 1948, the Labour government of Malta made several attempts to introduce a free NHS. In 1955 the government wanted to introduce a pilot scheme in Gozo with a full-time salaried state district medical service. The doctors' union was against this and a dispute ensued with the result that the District Medical Service remained unchanged.

In 1977 the ten-year doctors' dispute commenced (described in more detail under medico-political issues below). The government opened several polyclinics in order to provide an emergency primary care service during this period. This was provided free of charge. Today's primary health care system developed from the polyclinic service. Although the health centres are well equipped and also provide some specialty clinics, they are still largely oriented towards treatment of illness rather than the promotion of health.

The development of district nursing and midwifery services can be traced back to the time of the rule of the Order of St. John when doctors visiting sick women were accompanied by women who distributed food and alms. Through the centuries a health visitor service was established. However this was rather fragmented and did not achieve recognition until the Second World War.

Following the war, the Malta Memorial District Nursing Association was formed and this organization continues to provide nursing/midwifery domiciliary services contracted out on behalf of the statutory health service.

Public Health/ Health Service Organization

In the last half of the 19th century a sanitary reform movement emerged and a Sanitary Office was established in 1875. This measure was met with much resistance from the public and suspicion from the authorities. It was closed down after a few years as a result of insufficient public funds. The role of the Sanitary Officers was taken over by the Police Physicians, and eventually the District Medical Officers.

The 'Sanitary Laws' were enacted at the turn of the century. These laws were very similar to British Laws and laid the basis for the organization of the Department of Health, the roles of the professions and laws relating to public health and communicable diseases.

In 1937 the Medical and Health Department (Constitution) Ordinance and the Medical and Kindred Professions Ordinance were enacted. For the first time, health and medical services came under the control of the Director (Health) who was responsible for public health, management of hospitals and the District Medical Service.

In 1957, a review by the British Medical Services Commission was carried out. The Commission concluded that the Medical Service had become over-centralized and lacked a system for professional discipline. They recommended the setting up of professional regulatory bodies and Hospital Management Committees.

Medico/political issues

Relations between government and medical unions have been turbulent over the last few decades. The core issues that have always been the cause of strife are:

- the low salaries pegged to the rest of the civil service
- the issue of private practice
- the shortage of junior doctors.

The 1977 doctors' dispute lasted for ten years and had profound consequences for the health service and medical school. The dispute started when the government amended the legislation regarding licensing of doctors. A requirement was introduced for newly-qualified doctors to serve in hospitals for two years immediately after graduation in order to obtain a license. This was intended to stop junior doctors departing to pursue studies abroad before another group of doctors was ready to take up hospital posts. In addition the power of conferring licenses upon foreign medical graduates was shifted from the President of Malta to the Minister of Health. A partial strike ensued which rapidly led to dissenting doctors being barred from practising in the statutory service. A professional and social boycott was declared on members who did not join the strike.

The health service was mostly run by foreign doctors soon after the strike. These were recruited from central and eastern European countries, north Africa and Asia, but as the years passed more Maltese doctors joined the service.

A few months after the start of the strike, the law regulating licensing of private clinics was amended. Punitive legislation made it obligatory for all medical practitioners to obtain the Minister's authorization before they could practise in any private hospital. This authorization was dependent on the practitioner undertaking to work in the public health service in accordance with instructions given by the Minister. Most hospital specialists had to leave the island in search of work elsewhere because they did not wish to work in public hospitals during the dispute. The licensing regulations for private hospitals changed in 1980 so that hospitals were required to allocate 50% of their beds for government use. This led to the closure of the private hospitals.

A number of private clinics opened in subsequent years. Private clinics as opposed to private hospitals were not supposed to keep patients overnight but were only meant to perform diagnostic and minor treatment procedures. The law regulating private clinics and hospitals was again amended in 1995. This paved the way for private hospitals to open once again and for private clinics to legitimize their position.

One positive result of the strike was that doctors who left Malta were able to specialize in various fields whilst overseas. The doctors who returned after 1987 brought back with them this specialist experience. This resulted in a broader range of service provision and the introduction of specialties that were previously unavailable in Malta.

However, overall, nobody emerged a winner from this dispute. Doctors, medical students and the general public all suffered in some way. Relations were restored following a change of government in 1987 when doctors who had been barred were re-instated and Medical Council legislation was amended so that power for regulation of the medical profession was restored to the President of Malta. However the scars remain deep resulting in a situation where successive governments are very cautious when dealing with doctors.

Organizational structure and management

Organizational structure of the health care system

The Maltese health care system operates by means of an integrated health service that is organized at the national level. The statutory system is publicly financed and is free at the point of use. Private health care also has a significant role in Malta.

The Parliament is responsible for enacting health care legislation and for approving the health care budget. Otherwise most decisions regarding health care are taken at the level of the Ministry of Health.

Government Ministries

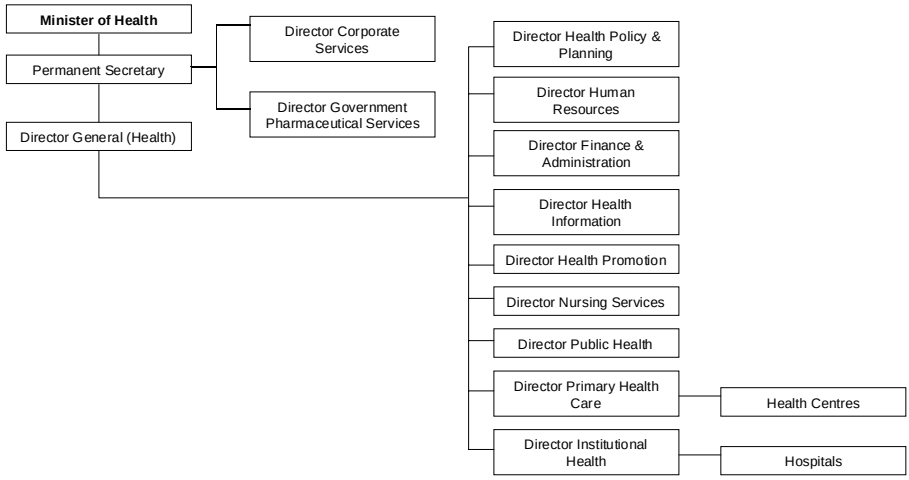
Ministry of Health

The Ministry of Health is responsible for the financing and provision of health care for all the population. It has several regulatory functions and nominates members on Government Commissions and Agencies related to health. The administrative structure of the Ministry of Health is shown in Fig. 2.

The Permanent Secretary is the administrative head within the Ministry. He is a public officer and is accountable to the Prime Minister. He has the responsibility to support the general policies and priorities of the Government and to operate within the context of management practices and procedures established for the government as a whole. He also has the duty to provide support and advice to the Minister, to provide leadership, to manage financial and human resources effectively and efficiently, to contribute to the collective management of Government and to ascertain coordination of policies between all Departments falling within the responsibilities of the Ministry.

The Director General (Health) (DG (Health)), is the head of the Health Division and is also the Superintendent of Public Health. The DG (Health)

Fig. 2. Organizational chart of Ministry of Health structure



must ensure that health services in Malta provide the highest affordable standard of care. The DG (Health) is legally responsible for all public health matters including communicable disease and environmental health. He has the responsibility of providing advice to the Minister on matters relating to health and health care. However in matters pertaining to allocation of financial resources, the DG (Health) advises the Minister through the Permanent Secretary. The DG (Health) is supported by the various Departments which perform an integrating role across the National Health Service.

The Director of Primary Health Care is responsible for primary care services and the management of health centres while the Director of Institutional Health is responsible for management of state hospitals.

The Health Division was created in 1993 to replace the Department of Health. It is presently the only division within the Ministry of Health. The major change was an internal re-structuring and the creation of the individual departments. This change was intended to reduce centralized bureaucracy and establish a system capable of meeting the expanding requirements of a modern health service. The Health Services Administration Act was drafted in 1995 in order to give the new structure the required legal backing. However this legislation has not been discussed in Parliament to this day and although the Division is structured in accordance with the proposed legislation, the Division continues to operate within the parameters of the existing legal framework.

A number of other Ministries have a health-related function.

Ministry for Social Policy
This Ministry is responsible for social welfare, social security, care for the elderly and occupational health and safety. It is also responsible for the government agency "Sedqa" (described below under Government Agencies).

Ministry of Finance
This Ministry determines the size of the health care budget for the public sector health care services.

Ministry of Education
Training of health professionals is undertaken by the University of Malta within the Faculty of Medicine and Surgery, Faculty of Dentistry and the Institute of Health Care.

Ministry for Home Affairs
The Civil Protection department forms part of this Ministry. This Department is responsible for health protection matters mainly those aspects that fall under disaster planning and require the services of the police, fire department etc. However in major disasters with significant public health consequences, the DG (Health) has overall responsibility.

Ministry for Economic Services
The Malta Standardisation Authority, which has replaced the Food Standards Board, forms part of this Ministry. It is responsible for regulating and monitoring standards relating to food, drinking water and labelling regulations.

Council of Health
The Council of Health is a forum with multisectoral representation. Its role is to act as the supreme advisory body to the Minister of Health on matters of health policy, particularly legislation. Some members are appointed by virtue of legislation whilst others are appointed by the Minister. It brings together representatives from the Health Division and representatives from industry. The Draft Health Services Administration Act, yet to be discussed in Parliament, is proposing that representatives from local councils and consumer affairs should also be included on the Council of Health. When this Act is approved, consumers will have an official role in the decision making process for the first time ever.

Mental Health Review Tribunal
The Mental Health Review Tribunal exists to review cases of compulsory psychiatric detention to ensure that the human rights of the mentally ill are safeguarded.

Foundation for Medical Services

The Foundation for Medical Services is an autonomous public body which was established in 1992. Its original strategic objectives were to support and promote medical and related studies through research, publications and teaching, to provide health care and other facilities and to collaborate with other similar entities on an international level. The research and studies aspect still needs to be developed and the main existing functions of the Foundation are service-related. It acts as the contractual client on behalf of the Ministry of Health for a new hospital currently being developed on a green-field site. It is responsible for the hospital commissioning process which includes all aspects of tendering, contracts, purchasing of equipment and management of the project. It also manages a rehabilitation hospital (Zammit Clapp Hospital).

Government Commissions

National Commission for Persons with Disability

This commission is a government-funded organization which coordinates activity and serves as a platform for the numerous NGOs which are active both as policy advocators and as service providers in this field.

National Commission for Mental Health

The National Commission for Mental Health has been involved in drawing up the new legislation for Mental Health. It has been given the task of spearheading reforms in this sector.

Commission for the Promotion of Occupational Health and Safety

This is a joint commission between the Department of Labour and the Health Division. The DG (Health) is the Vice President of this Commission which actually falls under the Ministry of Social Policy. The Commission is currently working on the development of sets of specific regulations for the various sectors in order to consolidate the basic health and safety legislation which was adopted in 1994. The Commission is also responsible for enforcing legislation and plans to set up a tribunal for the investigation of breaches of occupational health and safety legislation.

Government Agencies

Sedqa

Sedqa (Maltese name) is a government agency that has recently been transferred from the Ministry of Health to the Ministry for Social Policy. It acts as a

policy advocator, advisory body and service provider against substance abuse. It also educates about substance abuse.

Government Boards and Committees

These have specific functions as their names imply. Their main role is to act as advisors to the DG (Health) and the Minister on specific issues. Some of the Boards also have a decision-making function related to their area of concern. The membership of these Boards and Committees is partly determined by statute and partly by appointment by the Minister. Statutory members usually occupy clinical or administrative posts in government departments. The main statutory ones are:

- General Services Board
- Clean Air Board
- Bioethics Consultative Committee
- Hospital Management Committee – St. Luke's Hospital.

Other non-statutory committees include:

- National Advisory Committee on AIDS prevention and control
- Treatment Abroad Advisory Committee
- Smoking and Health Board
- Drugs and Therapeutics Committee
- Medical Equipment Committee
- National Steering Committee on Diabetes Prevention and Care
- Blood Products Advisory Committee
- Health Information Steering Committee.

Professional regulators

The professional regulators are responsible for granting of licences, maintaining and updating professional registers. They also act as self-regulators by monitoring professional and ethical standards and carrying out disciplinary proceedings.

- **Medical Council** – regulates physicians, dentists and veterinary surgeons;
- **Nursing and Midwifery Board** – This is the only board to hold specialist registers. These are for mental and paediatric nursing;
- **Board for the Professions Supplementary to Medicine** – regulates clinical psychologists, dental hygienists, dental laboratory technicians, health

inspectors, medical laboratory analysts, medical laboratory technologists, occupational therapists, operating department assistants, optometrists, orthoptists, perfusionists, physiotherapists, chiropodists, radiographers and speech therapists. The Board is currently debating whether to include complementary medicine practitioners;

- **Pharmacy Board –** This is responsible for regulating pharmacists.

Voluntary sector

A number of NGOs exist to promote health-related activities. They range from those having a broad scope of activity to patient self-help groups for specific illnesses. They act as policy advocators, self-help groups and service providers. There is no umbrella organization to bring these groups together and they are not formally represented on decision-making bodies.

General public

There are presently no mechanisms whereby consumers are represented on decision-making bodies in health care. The draft Health Services Administration Act proposes that local councillors should be represented on the Council of Health. No consumer organizations exist specifically for health care.

Church

The Roman Catholic Church played an active role in health care provision until the late 1970s. Nuns worked in state hospitals as well as church hospitals. These hospitals, which used to provide maternity care and acute medical and surgical care, were closed down during the "medical crisis" in the late 1970s. The church still plays an important role in the provision of nursing homes for the elderly, homes for the disabled, homes for the mentally handicapped and homes for children. It is facing difficulties to continue to provide these services as the care providers are dwindling in numbers. This is due to the fact that most nuns are now rather elderly and are not being sufficiently replaced by younger ones.

Private sector

The private sector is involved in both the financing and the provision of health care. Primary care practitioners and specialists have always rendered their services to the private sector. A law passed in 1980 effectively led to the closure of all private hospitals. As a consequence a number of private clinics

mushroomed. In 1995, following an amendment to the laws regulating provision of private health care, private hospitals were opened and private clinics were able to register as hospitals provided they satisfied the regulations. Private medical care accounts for 12% of acute hospital beds as well as 18% of beds in homes for the elderly. The private sector is taking on an increasingly important role in financing health care, as private medical insurance is becoming more widespread.

Professional groups

A number of associations exist for the various professional groups. These include the Medical Association of Malta, Dental Association, Chamber of Pharmacists, Nursing Association of Malta and Midwifery Association. The Malta College of Family Doctors and a number of specialist associations are also active mostly in the field of providing continuing education.

Whilst some of the above associations carry out union-like activities, notably the Medical Association of Malta and the Chamber of Pharmacists, other health service employees have specific organizations that function as unions, notably: the Malta Union of Midwives and Nurses and the public sector sections of the two largest national unions; the General Workers Union and the Union Haddiema Maghqudin.

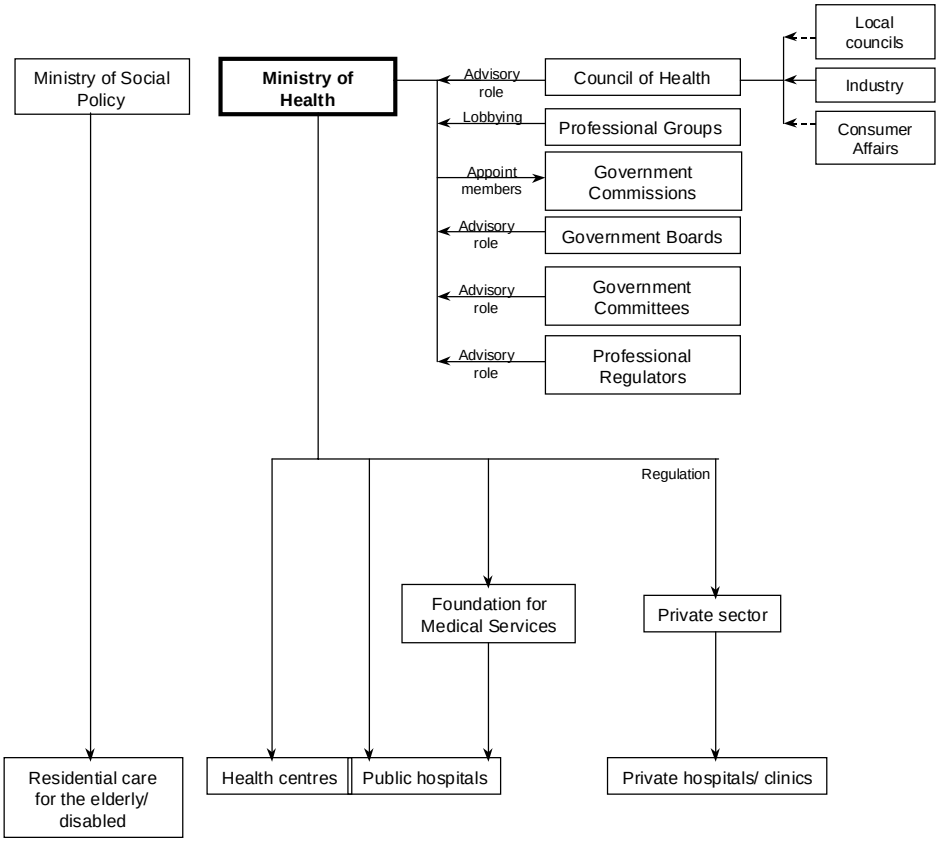
Future challenges

The above organizations are all organized at a national level. No regional or district tiers of health care exist in the Maltese health care system.

The number of players in the field of health care has increased during the past few years. This has occurred as a result of government decentralization, through the creation of Commissions and Committees as well as greater involvement by the voluntary and private sectors. In addition it is recognized that several determinants of health lie outside the sphere of responsibility of the Ministry of Health and intersectoral collaboration is strongly encouraged.

The re-structuring process within the Department of Health, now called the Health Division, has led to the creation of a number of Departments which perform an integrating function across the National Health Service. However the problems of excessive centralization and bureaucracy as well as inefficient management have not been overcome. In addition the reform process has not yet filtered down to the lower levels of control within hospitals and health centres. As a result, most decisions involving day-to-day running of facilities still have to be taken centrally far away from the people and services being affected.

Fig 3. Actors in the health care sector



In order for decentralization to occur, management structures must be strengthened at the level of service provision. This is a prerequisite for the completion of the process of decentralization which will lead to the Health Division relinquishing much of its power to the periphery and taking on the role of regulator and resource allocator rather than that of direct service provider. A balance between public and private care provision appears to have been established and it is unlikely that the private sector will experience further extensive growth at the present moment.

Within the clinical professions, the power of the medical profession has slowly been eroded and paramedical professions appear to be increasing their

share of control. To-date, specialists wield a far larger amount of power than general practitioners.

It remains to be seen whether clinical professions will lose some of their power to management after the management reforms in the public sector take place. Whilst the Medical Association is weaker than it was earlier this century, the unions that represent nurses, midwives and other health care personnel continue to gain strength.

An increasingly vocal public and body of NGOs is likely to exert more pressure on health care in the future.

Planning, regulation and management

The Maltese health care system is highly centralized and regulated. The government acts both as third party payer and also as service provider for statutory health care. Thus the integrated model of health care presently applies in Malta.

Planning

Health and health services policy

The functions of the Health Division as stipulated in new draft legislation include needs assessment, planning, resource allocation and ensuring that services are equitable, cost-effective and achieve value for money. The Division is also responsible for health promotion, disease prevention and public health. It has the duty to enforce health legislation and carry out evaluation and audit. This new legislation has incorporated the functions of "new" Public Health. From being primarily concerned with communicable diseases and environmental health, the Health Division now has responsibility for health promotion and preventive health as well as advocacy on all health related matters, planning based on needs assessment, resource allocation and management of health services rather than administration. Current legislation still refers to functions associated with the traditional role of public health. The present government is supportive of the draft Health Services Administration Act and it is hoped that the Draft Bill will be sent to Parliament for enactment in 1999.

National Health Policy

The Department of Health Policy and Planning is responsible for advising the Health Division on all major health policy issues. The current national plan for health was drawn up in 1994 and is called "Health Vision 2000".

Priority setting process

A priority setting process took place in the early 1990s when the "Health Vision 2000" was being formulated. The priority areas were identified by using a combination of techniques. These included analysis of scientific evidence, feedback from stakeholders and modified Delphi analysis. The areas which emerged as top priorities were: coronary heart disease and stroke, lung cancer, breast cancer, diabetes, mental health and road traffic accidents. Subsequently, asthma was added to this list. The risk factors selected as target areas were: smoking, obesity, high blood pressure, serum cholesterol and inadequate physical activity. The capacity to benefit from an existing intervention was a necessary prerequisite for inclusion. The third strand of the Health Plan dealt with objectives for health sector reform. Decentralization of the health care system, in particular the autonomous management of hospitals, is one of the main thrusts of the reform process.

Implementing change

The Department of Health Policy and Planning advises the Health Division on the introduction of health policies and conducts operational research to formulate more efficient ways of working. A strategic action plan for health sector reform has been drawn up. The Ministry has overall responsibility for implementing government policy through the relevant departments. This requires interdepartmental and wider intersectoral collaboration. The health care system in Malta has not undergone major or radical change within the last ten years. The planned reform of the health service has commenced but is proceeding slowly.

Capital planning

Decisions regarding capital expenditure planning are taken centrally by the Ministry of Health. The Ministry of Finance allocates funds for capital expenditure when determining the health care budget. Due to Malta's size there is no regional or district level organisation which is responsible for capital planning.

The construction of a new general hospital, which will take over all acute care from present hospitals, is currently the focus of capital planning. The new hospital was originally planned as a 450-bed hospital for specialty treatment and research. It was intended that this would expand gradually to assume all acute care functions and facilities. Following a change in government in 1996, these plans were altered such that the new hospital was to become the sole acute general hospital on the island containing circa 800–1000 beds at the start of its operation. In 1998 the government changed once again. The new government decided to retain plans for the hospital to be an acute general hospital from the start.

Several concerns have been raised about the fact that the extended "New Hospital" appears to have been planned in isolation from the rest of the health care system. The Health Division has strongly advocated that a holistic approach be adopted and plans for reforms in primary care, community services, rehabilitation, mental health care and geriatric care must be taken into consideration. Such a holistic approach is currently being developed.

Human resources planning

Different mechanisms of planning numbers of health professionals existed until recently. The number of doctors was tightly regulated by means of a *numerus clausus* (fixed number of new University entrants). This restriction has now been removed. Pharmacists, nurses and other allied health professions were not subject to this form of regulation. However the employment of all health professionals in the public sector as recommended by the Ministry of Health, must be authorized by the Public Service Commission and requires approval from the Management and Personnel Office of the Office of the Prime Minister. State providers do not have the authority to "hire or fire". Human resource plans are drawn up from time to time to help forecast future requirements of health professionals.

Operational reforms in the public hospitals initiated in 1996 have started to address the issues of appropriate levels of human resources by carrying out audit of workload in the hospitals. Results achieved thus far have shown that certain lower grades are overstaffed whilst some professional grades and middle management are understaffed and in certain instances inappropriately deployed. This is the first exercise of its kind to attempt to quantify the required numbers of human resources based on actual workload.

Regulation

Pharmaceutical system

The Government Pharmaceutical Service (GPS) is responsible for procurement and regulation of standards for government pharmaceuticals.

The Medicines Regulatory Affairs Unit (MRAU) of the GPS deals with three aspects of regulation:

- **Product certification** – this is based on the WHO certification scheme of pharmaceutical products and is applied to medicines used in the state health care system only. No local registration system exists as yet. The WHO certification scheme has now been extended to cover all imported products.

- **Enforcement** – this includes inspection of community retail pharmacies to ensure they conform to legal requirements as well as controlling unlicensed activities.
- **Pharmaco-vigilance** – monitoring of products.

The Ministry of Health regulates the number of community retail pharmacies.

Technology

The Ministry of Health regulates purchasing of high technology equipment for state hospitals through the Medical Equipment Committee. With regard to the purchasing of high technology equipment by the private sector, regulations exist to ensure that the equipment is safe and of good quality. However there are no restrictions on supply of health care technology.

Private health providers

Regulations for the licensing of Private Medical Clinics were updated in 1995. The regulations governing the granting of such licences refer to facilities and staffing. Physical location, construction, state of repair, food, laundry and safety of facilities are assessed as part of the structure. There are rules for resident medical coverage and numbers and qualifications of nursing staff required. Specific regulations exist for surgical procedures that may be performed in private clinics and hospitals; exceptions require approval by the Minister.

Whilst medical clinics/hospitals and medical diagnostic laboratories are regulated by legislation, private elderly care homes, radiology clinics, laboratories and dental clinics do not have specific legislation. A number of guidelines for the licensing of these facilities have been drawn up by the Health Division. These refer almost entirely to the premises themselves; hygiene, privacy, access, heating/cooling and safety precautions. There are no written regulations governing quality of care.

The private sector for health care has grown considerably in the past few years. There are 14 licensed medical clinics and 19 licensed nursing homes. Whilst medical clinics pay an annual registration fee, nursing homes are not subjected to pay annual registration fees. The issuing of licences is still subject mainly to structural and buildings issues. A regulatory framework for issues relating to standards of care is lacking. None of the private clinics is accredited as a teaching institution.

Health personnel

Registration and licensure of health professionals is carried out by various bodies for the different health professions. The Medical Council is a self-

regulatory body that governs the registration and licensure of doctors, dentists and veterinary surgeons. Other professional regulators holding registers include the Nursing and Midwifery Board, the Pharmacy Board and the Board for Professions Supplementary to Medicine. These professional regulators are responsible for monitoring and enforcing professional and ethical standards.

Doctors, dentists, midwives, pharmacists and pharmacy technicians are issued with a licence to practise whilst all other health professionals are issued with a certificate of registration. Nobody can exercise a regulated profession without a licence or certificate of registration issued locally by the respective regulatory boards.

Hospital management

The Head Office of the Department of Health was responsible for hospital management in the past. The Department of Institutional Health is currently deeply involved in the day-to-day running of hospitals. Reforms envisage that the Department should begin to function as a body responsible for coordination and implementation of quality standards and other health service policies. This would be a role similar to that of "purchasers" in other countries. Each hospital is to have its own autonomous Management Committee. This model was first introduced in a small specialist geriatric rehabilitation hospital set up in the early 1990s. In this hospital, most of the day-to-day decisions are taken by the care providers themselves. They have also been allowed flexibility in arranging hours of work and shifts. The budget for this hospital is managed at the Hospital Board level. The Board has several members appointed by the Ministry of Health and is accountable to this Ministry. It is hoped that similar models of autonomous management will be applied to the other hospitals in due course.

Within the larger hospitals, it is envisaged that a move towards budgetary autonomy at the level of service units will be introduced with each clinical and support department holding a budget. In order for this to occur an input-output model has been developed. Trained personnel will be required to manage this system. The aim of this financial and management reform is to eliminate several tiers of bureaucracy, have decisions taken at the level of service provision and render people accountable throughout the whole organization.

Decisions on resource allocation are taken at DG (Health) level within the Health Division based upon advice from the various Boards and Committees, for example, the Drugs and Therapeutics Committee and Medical Equipment Committee.

Although health care priorities have been identified on paper, in practice there has not been any redistribution of resources within the health care budget programmes to reflect these priorities.

To date, there are no mechanisms for citizens' participation in the management of the system. However consultation with the relevant NGOs usually takes place at the planning phases of new policies.

Decentralization of the health care system

Malta's size makes it unnecessary to have any regional or district level health authorities. However the principle of subsidiarity underpinning the process of decentralization is one of the major issues in the planned/ongoing health service reforms. The centralized system is too bureaucratic and hinders efficient working of the Health Division.

The re-structuring of the Department of Health to a Health Division with several departments has decentralized certain tasks from Head Office to other departments but until legislation for the re-structuring is enacted, certain procedures require involvement of the DG (Health).

The process of establishing autonomous management committees in all the hospitals is intended to bring about devolution rather than simply deconcentration. However this may be difficult to achieve in practice because of restrictions imposed by the legal framework and financial regulations within the civil service.

The government has delegated the process of commissioning the New Hospital Project to the Foundation for Medical Services. However some indirect control is maintained as the Ministry of Health provides the budget for the Foundation.

Several other agencies and commissions have been set up to take over functions that were previously under the control of health and social policy government departments. However the government usually retains control over the appointment of key posts such as chief executives and members of the Governing Boards of such agencies.

Privatization is also being carried out in the Maltese health care system. The Community Nursing Service is provided by a private organization, the Malta Memorial District Nursing Association. Privatization has been partially carried out for support services such as cleaning services and maintenance of equipment. Management and daily running of one of the state residential homes has also been contracted out to the private sector. The results of privatization

have been mixed. Privatization of the cleaning service may have brought about cost-savings; however the quality of the service is perceived to have deteriorated by Nursing Officers in charge of wards. On the other hand contracting out the management of one of the state residential homes is perceived to have increased efficiency. No formal evaluations of privatization have been carried out. It is envisaged that privatization of services will continue with specific plans for catering services currently being drawn up. Experience so far has shown that the infrastructure for monitoring and supervision of services which are contracted out is weak and must be strengthened for privatization to have the desired effect.

The process of decentralization is proceeding at a slow pace. This is partially due to highly centralized financial and administrative regulations and a centrally controlled recruitment process, but may also be explained by resistance to erosion of the central power base. In addition the appropriate structures for decentralization are still being created.

The thrust for decentralization is clearly set out in the document, *Strategy for Health Care Reform*. In primary care this may take the form of partial privatization with a move towards having independent general practitioners contracted to provide services for the Health Division. This would entail changing the model of GP remuneration from a salaried basis to a mixture of flat rates, capitation and target payments. In hospital care, autonomous management, partial privatization and contracting out of services form part of the strategy to increase efficiency in the public health sector.

Health care benefits and rationing

A highly comprehensive package of health care benefits is offered by the state health care system. At a primary care level the package includes GP consultations, home visits, minor treatment, community nursing and preventive programmes including immunization and screening. Within the hospital setting, diagnostic and therapeutic interventions are carried out both at specialist outpatient clinics and inpatient hospital wards. Emergency care is offered from the one main hospital casualty department. Complex procedures and interventions are also offered free-of-charge at the point of use to all Maltese citizens. It can be seen that few items are not covered as health care benefits in the Maltese health care system.[2] In addition treatment abroad, in the United Kingdom is also provided by the government for cases requiring highly specialized care which is not available in Malta.

Explicit rationing by denial exists for only a few interventions. These include techniques of assisted conception such as in-vitro fertilization and cosmetic surgery that is not medically indicated.

Alternative forms of medicine and therapy are mostly not available in the National Health Service. Acupuncture services have been provided for several years but herbal medicine and aromatherapy, for example, are not provided. This issue was raised in 1997 in the context of alternative therapy in the treatment of cancers and was widely debated at a national level.

A number of government health care services including optician services, dental care and pharmaceuticals, are only made available to specific categories within the population. These services are available free-of-charge to the general public if they are "Pink Card" holders. The "Pink Card" is issued as the Medical Aids Grant under the Social Security Act. This is based on an assessment of total household income which must fall below a certain threshold. All members of the particular household are entitled to the above services free-of-charge on

[2] Abortion is illegal in Malta and thus not covered by the Maltese Health Service.

the basis of this card. In addition the following population groups are entitled to these services free-of-charge:

- Members of religious orders
- Inmates of charitable institutions
- Certain grades of employees in the Health Division
- Certain grades of employees in the police and armed forces
- Prisoners
- Persons injured on government duty (for a condition resulting from the injury).

Medical aids

Sight tests are offered free-of-charge to all persons in the primary health care setting. However visual aids and glasses are only offered to Pink Card holders. Contact lenses are only authorized in special cases. Hearing aids are also only made available to Pink Card holders.

Dental services

All health care beneficiaries are covered for full dental examination, investigations, preventive treatment, emergency treatment and surgery requiring general anaesthesia.

Comprehensive dental services are offered to Pink Card holders, special population groups described above and persons suffering from coagulation disorders, valvular heart disease, physical or mental disability, and head and neck cancer.

School children are offered preventive care, restorative dentistry and orthodontic care.

Pharmaceuticals

All pharmaceuticals within the approved formulary, are provided free-of-charge to Pink Card holders and persons belonging to special population groups described above. Drugs for specific chronic conditions are issued to Yellow Card holders. These conditions are listed in the Fifth Schedule of the Social Security Act which was updated in 1998.

- Malignant Diseases
- Cardiovascular Diseases
  - ischaemic heart disease
  - congestive cardiac failure
  - persistent hypertension with a diastolic reading above 110 if left untreated

- Respiratory Diseases
  - chronic respiratory failure
  - respiratory asthma
- Collagen Disease
  - 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 steathorrhea
  - Crohn's disease and ulcerative colitis
- Disease of the liver
  - hepatic cirrhosis associated with ascites or neurological symptoms
  - Wilson's disease
- Diseases of the Central Nervous System
  - epilepsy
  - incapacitating Parkinson's disease
  - myasthenia gravis
  - multiple sclerosis
  - motor neurone disease
- Schizophrenia
- Haemophilia
- Paget's disease
- Glaucoma
- Extensive psoriasis
- Huntington's chorea
- Auto-immune enteropathy

Diabetics are entitled to free diabetic treatment under a separate schedule.

All persons who have illnesses that do not fall under the above schemes are required to pay the full cost of pharmaceuticals other than inpatient drugs and a three-day supply of drugs following hospital discharge which are provided free-of-charge.

Implicit rationing

Rationing occurs implicitly for certain services by means of a waiting list. Waiting lists are not a major problem in most services but are rather lengthy for certain surgical specialties, namely: orthopaedics, cardiac surgery, ophthalmic surgery and minor elective surgery. Implicit rationing also exists for services such as dialysis.

Rationing was raised as an important issue in 1997–1998 with regard to certain expensive treatments such as multiple retroviral therapy and cholesterol lowering agents. Explicit criteria for entitlement to free treatment have been drawn up to clarify the situation. Certain expensive and non-formulary drugs require a complex process of authorization. These are usually only approved if compliance to a protocol for their use is demonstrated.

An overhaul of the pharmaceutical system is long overdue. There is general belief that people entitled to a Pink Card abuse the system. Doctors feel powerless to challenge patients demanding a monthly supply of paracetamol, cotton wool, etc., as their right. On the other hand, pensioners whose assessed household income does not entitle them to a Pink Card and who do not have a specific illness as registered under the Fifth Schedule are not entitled to any subsidy on the full price of pharmaceuticals.

Cost-sharing options are not likely to be politically acceptable at present. There are no specific plans for reform in the pharmaceutical financing and expenditure sector. Cost-containment policies in the pharmaceutical sector and a specific proposal for reform are urgently required.

Health care finance and expenditure

Health care financing in Malta is split between the statutory (60%) and private (40%) systems. The state system covers all Maltese citizens irrespective of income or ability to pay. The voluntary system provides supplementary financing and does not replace any mandatory statutory contributions. State health care is financed through general taxation. State financing is complemented by private financing through out-of-pocket payment and private insurance.

Compulsory systems

The state health care system is financed by general taxes collected at a national level. Taxation is progressive, based on income and rates of income tax in Malta are amongst the lowest in Europe. Although there are proposals to introduce tax rebates for people who take out private health insurance, opting out of the system will not be permitted as this could lead to fragmentation of health care financing.

The Ministry of Health is responsible for providing health care coverage to beneficiaries. Entitlement is based on citizenship and is free at the point of use. Exemptions or reduced rates are available for United Kingdom and Australian citizens falling within the parameters of bilateral agreements between Malta and these countries. All other foreigners pay full charges except for refugees whose fees have traditionally been waived by the Minister of Health. There are no special population groups that have their own parallel health care system.

This system of population coverage has been in place for 20 years and there is a wide consensus that it is a fair and equitable funding system. Although it is felt that insufficient funds are being directed to health care as a result of decisions taken beyond the Ministry of Health, the funds which are allocated could be better utilized.

Although there is a system of employer/employee national insurance payments, these are not earmarked taxes for health care but go towards the financing of welfare in general. Although health care appears under the general heading of "welfare" in the government budgetary estimates, it is actually financed through general taxation. National Insurance is used to finance pensions, unemployment benefits, disability benefits, etc. It is paid by government, employees and employers. Rates are payroll-related and are fixed. Self-employed persons pay a higher rate. "Sin" taxes, e.g. on tobacco or alcohol are not earmarked for health care.

At present there are no co-payments for any part of the state health care system. In January 1998, the government introduced a prescription charge of 50 Malta cents per prescription on free medicines. This was not of significant importance as a revenue generating mechanism since the charge was a small one. It was hoped that the co-payment would curb practices such as "hoarding" of medicines as well as dissuading people from accumulating medicines they did not require. This co-payment was scrapped in September 1998 when a new government was elected as it was considered to be regressive and of little revenue importance. Some policy-makers and most health professionals believe that co-payments would cut down on unnecessary use of the health care system and tend to be in favour of their introduction. Experience with demand-side cost-containment measures in other countries has generally proved less successful than supply-side measures as they tend to be politically unpopular and generate insufficient revenue.

Persons requiring medical aids such as walking frames or wheelchairs pay a deposit which is refunded when the article is returned.

There is therefore no use made of co-payments in the statutory health care system. It would be politically difficult to introduce co-payments for health care as people have an ingrained mentality that government services should be provided free of charge.

Voluntary systems

Although universal coverage for government health services exists, there is significant private sector activity in Malta. People tend to use the private sector for what they perceive to be more personal attention, to be guaranteed that they will be seen by the consultant, to fix appointments at convenient times and to attempt to bypass waiting lists for surgery in the public sector.

Until fairly recently, direct out-of-pocket payment used to be the method of payment for all private health care services ranging from consultations to interventions. It is still the predominant method of payment for private general

practitioners and features extensively in specialist consultations. Out-of-pocket payment thus accounts for a significant part of the total payment for private health care. This makes the contribution of private expenditure for health care extremely difficult to quantify as there is no effective fiscal audit trail.

The opening of private hospitals in recent years and the increasing provision of specialist and secondary/tertiary private health care has increased the demand for voluntary private health insurance. Most private health insurance is offered by international companies; however, the first health insurance scheme organized by a Maltese insurance company was launched in 1998. Insurers compete for customers and there are no regulations covering this activity. An increasing number of employers provide a package of private health insurance for employees and their families; however, this is often insufficient to provide comprehensive health care coverage.

It is not known precisely how many people take out private voluntary insurance, but the trend is increasing and is expected to continue to gain in popularity. The practice is encouraged and tax rebates have been proposed for those taking out private insurance. This could entice more people to insure themselves privately. There are no incentives for people to take out private health insurance at present. Private health insurance is mainly taken out for the eventuality of elective surgery, hospital care and medical treatment overseas. The different insurance packages offer varying levels of coverage that may include primary care, hospital care and nursing at home. People requiring long-term care such as the elderly, diabetic and chronically ill usually find it more difficult to take out private insurance because higher premiums are required. There also exists a perception that "complex" interventions are only possible, or are safer, in state hospitals. Private insurance companies offer a cash rebate per diem for insured persons who opt to make use of the state hospitals. The above factors combined mean the state bears the brunt of the financial burden of health care. It is important to ensure that equity in the Maltese health care system is preserved.

Unofficial payments

Unofficial payments are not really an issue in the Maltese health system. People often pay to go and see their hospital doctors privately as they believe that this may ensure them better care when they are in hospital, such as being operated on by a consultant instead of by a junior. However with the opening of private hospitals this is no longer as widely practised as patients can now opt for a completely private service if they want to assure themselves of personal attention by the consultant himself. Gifts are still given by patients to their doctors but there is a perception that this practice is no longer as widespread as it was

once. Patients may "tip" health care staff or bring cakes and chocolates on the wards to show their gratitude.

External funding

The Council of Europe is providing a loan of up to Lm 50 million towards the building of the New Hospital (see Section on Planning Regulation and Management: Capital Planning) from its Social Development Fund. Since Malta has a relatively high GDP and human development index in comparison to the central and eastern European countries, where the focus has shifted, it has become more difficult for Malta to attract external sources of grants and soft loans.

The socioeconomic indicators used by international organizations for distribution of funds do not encompass the nature of small island states with the attendant problems of geographical insularity. Thus external funding does not contribute in any significant manner to funding of the Maltese health care system.

Problems and challenges

Although the system of health care financing is commendable for its equity and comprehensive coverage, there is a chronic insufficiency of funds in the face of increasing health care demands.

Pressure for change to the present system of health care financing is coming from various areas, most notably the private sector (insurers and providers) as well as the health professionals who are poorly paid and see an alternative system of financing as the means to improving their level of remuneration.

Pressure also arises as newer and more expensive drugs become available, draining the pharmaceutical budget. High technology services such as cardiac surgery and transplantation and a rapidly ageing population all add to exert upward pressures on health care expenditure. Besides, the large amount of capital investment that has been channelled into the construction of the New Hospital, this will also require substantial recurrent expenditure when it becomes fully functional.

The Health Division believes that reform of health care financing should occur with additional sources of funding to supplement general taxation. However the only Government proposal on this matter is the introduction of tax rebates for those who take out private health insurance. Any reforms in health care financing should not occur in isolation but should be part of a national debate on the reform of the welfare sector in general.

Health care expenditure

The development of total health care expenditure in Malta is shown in Table 1. The figures for 1980, 1985 and 1990 include expenditure on care for the elderly and health care for Gozo and therefore are not strictly comparable with the data 1991 onwards. This change in the system of budgeting accounts for the drop in % GDP health expenditure between 1990 and 1991. Since 1991 absolute total health expenditure has increased from year to year, yet the share of the GDP spent on health care has remained relatively stable having reached a maximum of 6.9% in 1994. The rise in % share of GDP between 1992 and 1993 was due to increased government expenditure as capital funds for the building of the New Hospital.

Table 1. Trends in health care expenditure in Malta Liri (Lm), 1980–1997

Total expenditure on health care	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Value in current prices (Lm '000)	26 330	33 588	48 361	48 708	54 532	64 286	69 565	72 262	76 459	91 072
Value in constant prices (Lm '000)	17 647	20 161	25 354	24 708	26 713	30 617	32 571	32 125	33 203	–
Share of GDP (%)	6.7	7.1	6.6	6.0	6.2	6.8	6.9	6.4	6.4	–
Public as share of total expenditure on health care (%)	59.4	62.7	57.4	55.5	59.3	62.4	62.3	62.3	60.2	60.1

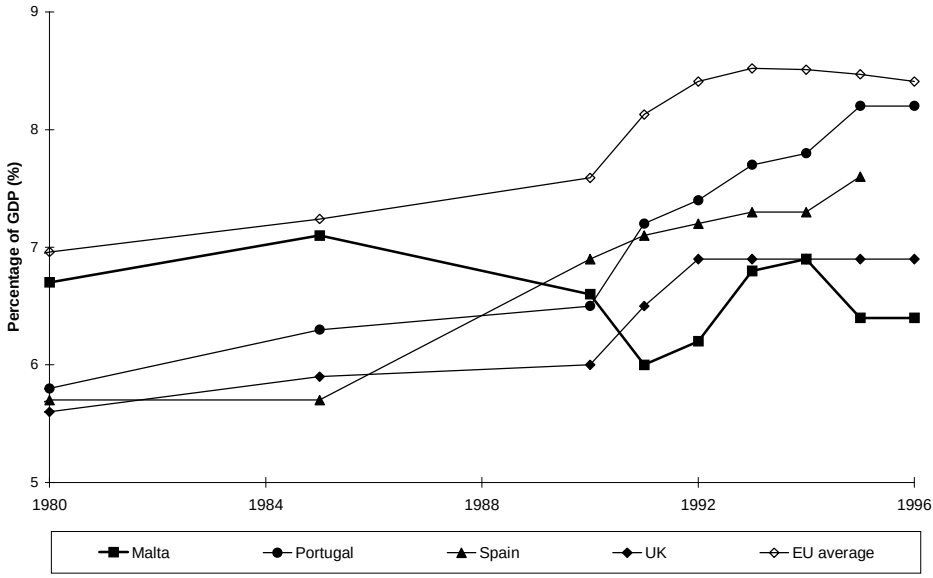
Source: Central Office of Statistics Malta & Budgetary Estimates.

Notes: Constant prices refer to 1973.
Figures for 1997 are estimates and are not based on actual expenditure.

The current level of GDP spending on health at 6.4% is lower than the western European average of 8.2% (see Figs. 4 and 5). Malta's share of GDP spent on health care is similar to that spent by the Denmark and the United Kingdom. Both these countries do not have a tradition of extensive private sector involvement and public health care is funded from a general taxation base. Malta has not had extensive private sector involvement at secondary and tertiary care levels until the last couple of years. It is too early to analyse the effect that this has had on health care spending. The impact of private sector involvement on health care expenditure will be studied in the coming years.

Public expenditure as a share of total health expenditure is one of the lowest in Europe (see Fig. 6). At 60%, it is comparable to the share of public expenditure in Portugal. Public expenditure as a share of total health expenditure peaked in 1993 and has decreased since then. An increase in private health expenditure occurred in 1995 when private hospitals were opened as a result of a change in

Fig. 4. Trends in health care expenditure as a share of GDP (%) in Malta and selected western European countries, 1980–1996



Source: WHO Regional Office for Europe health for all database; Central Office of Statistics Malta & Budgetary Estimates.

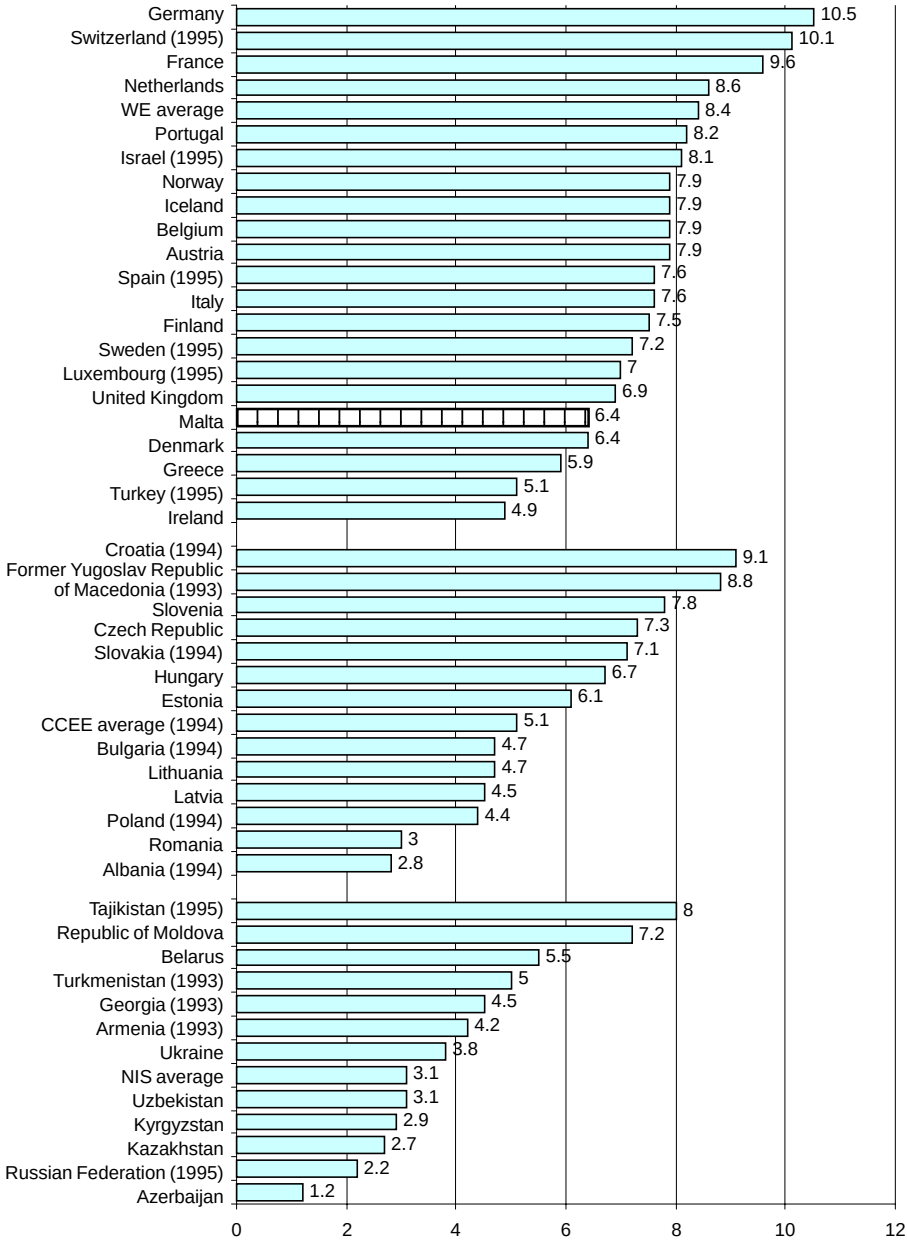
legislation. It is possible that the share of public expenditure may actually be lower than the percentages shown in Table 1 due to under reporting of private activity which leads to lower estimates of private health care expenditure.

It must be noted that a highly comprehensive public health care system is provided despite the low share of public expenditure. The provision of such a system is possible because health care is labour intensive and the wages of health care employees in the public sector are low. If health care personnel working within the public sector were paid at rates equivalent to their western European counterparts, the proportion of public expenditure would increase.

The budgeting system at present does not allow for breakdown of government expenditure into inpatient and outpatient activity. It was only possible to calculate percentage expenditure of total expenditure on pharmaceuticals, capital investment and salaries for the public sector (see Table 2).

Expenditure on pharmaceuticals forms a substantial part of the public health care budget. Since government accounting was based on a cash flow system rather than an accruals system until recently, the figures for pharmaceutical expenditure reflect payments made during the period rather than actual expenditure incurred. The sharp increase in % expenditure on pharmaceuticals between 1996 and 1997 is mostly due to a large amount of arrears which

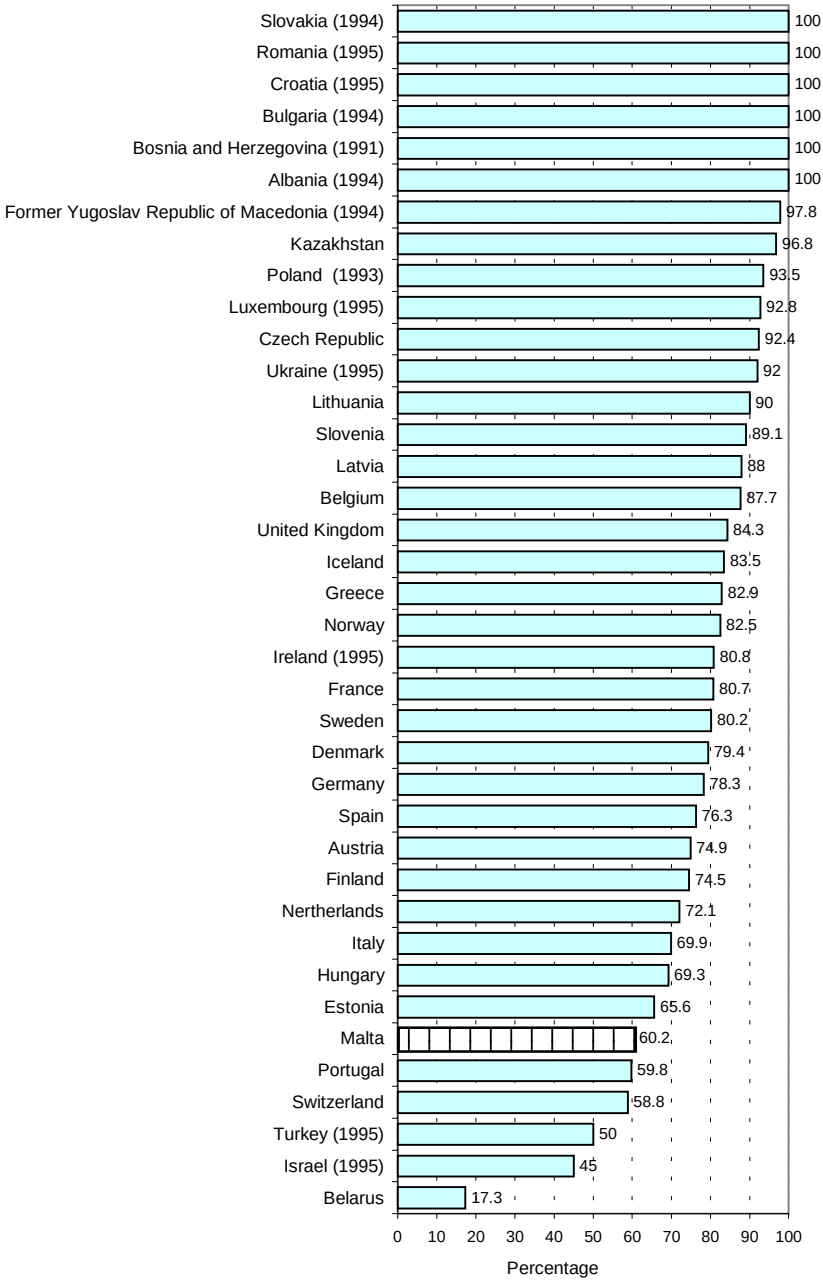
Fig. 5. Total expenditure on health as a percentage of GDP in the WHO European Region, 1996 or latest available year



Source: OECD health data, 1996; World Bank; WHO Regional Office for Europe health for all database; Central Office of Statistics Malta & Budgetary Estimates.

Notes: Data for Malta may not be directly comparable.

Fig. 6. Public expenditure as a percentage of total expenditure on health in WHO's European Region, 1996 or latest available year



Source: OECD health data file, 1998; World Bank; WHO Regional Office for Europe health for all database. Central Office of Statistics Malta & Budgetary Estimates

Note: Data for Malta may not be directly comparable.

Malta

Table 2. Health care expenditure by categories as % of total government expenditure on health care, 1980–1997

Total expenditure	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Pharmaceuticals	10	9	16	19	17	14	13	15	15	22
Public investment	7	4	3	4	2	7	9	7	13	12
Salaries	62	70	65	60	68	66	66	65	61	55
Other recurrent expenditure	21	17	16	17	13	13	12	13	11	11

Source: Budgetary Estimates & Government Pharmaceutical Services.

government had to pay to suppliers. However it is becoming more difficult to be able to provide all the new and expensive pharmaceutical therapies which become available and priority setting in this field is urgently required. As yet there are no concrete plans to tackle this problem. Implicit ad hoc rationing on the basis of recommendations from the Drugs and Therapeutics Committee is used to prioritize patients and treatments.

Public investment decreased in the early 1980s when an annexe to the main hospital was completed. A sharp rise in investment occurred between 1992 and 1993 when the New Hospital Project was initiated. A further increase in investment took place in 1995 when actual works on the hospital started and this level of investment will have to be maintained for a while. It was initially planned that the hospital should have been completed by 1998. The target date for completion has been shifted to 2003 as works have fallen behind schedule.

The percentage expenditure on salaries has decreased and is relatively low compared to other western European countries. This has not come about as a result of redundancies but reflects the low salaries paid to health care personnel which have not grown at the same rate as expenditure in other areas including technology. Recruitment at the lower grades has stopped and a natural wastage policy is being pursued. Salaries paid to health care personnel vary depending on rank and are pegged to civil service salary scales.

It can be seen that the structure of health care expenditure has changed with pharmaceuticals and capital investment making up a larger proportion of total health care expenditure at the expense of salaries and other recurrent expenditure.

The issue of sustainability of health care financing has been discussed earlier. The problem of increasing demand and insufficient health care expenditure should be tackled together with welfare sector reform. So far the public health care system has survived because of the relatively low wages paid to health care personnel. The current situation with regards to the large public sector deficit means that year on year increases in public health care expenditure may be difficult to sustain.

Health care delivery system

Primary health care

Primary health care is provided by the state health service and by private general practitioners. These two systems of general practice function independently of one another. It has recently been estimated that the private sector accounts for about two thirds of the workload in primary health care. General practitioners (GPs) in public service are allowed to carry out private practice.

State primary health care

The state primary health care system covers general practice, community care, immunization and the school health service.

General practice

Primary care by general practitioners
Primary health care is offered free of charge at the point of use from government health centres for all the population. General practitioners are available in health centres 24 hours a day seven days a week. They may be visited for emergencies without any prior appointment on a first-come-first-served basis. They also carry out domiciliary visits, which after 20.00 hours are restricted to urgent cases only.

Within this system, patients are not registered with their own general practitioner and are seen by the doctor who happens to be on duty at that particular time. This leads to a lack of continuity of care and is not conducive to the development of a sound doctor-patient relationship which is one of the fundamental aspects of primary care. This leads to dissatisfaction for both patients and doctors. The system treats patients when something goes wrong and offers very little opportunity for health promotion and disease prevention interventions.

Such prevention interventions are nevertheless organized in health centres by other health care personnel. Examples include smoking cessation and weight reduction clinics.

Formal medical record keeping was started in 1997. Records are kept manually although it is planned that a single computerized medical record for all patients will be developed in the future. Besides improving continuity of patient care, medical records also provide an invaluable epidemiological tool.

One of the consequences of the absence of a patient registration system in primary care is that hospital specialists find it more difficult to discharge patients from their outpatient clinics. Patients thus tend to be followed up at hospital outpatient clinics instead of in the primary care setting. There is no system of liaison GPs, who know the patient well and can be relied upon for appropriate follow-up.

General practitioners working in primary health centres are directly employed by the government and paid on a salaried basis. They do not undergo any specific training in primary health care and usually take up post after completion of a two-year house-officer rotation. Turnover is quite high and there is a problem both with recruitment and with retention as health centres are not viewed as rewarding or prestigious places in which to work. Doctors work a complex shift system and do not feel they are well remunerated. They state that most of their workload is made up of writing prescriptions, repeat prescriptions, verifying sick leave and treating minor illness. Nearly all general practitioners working in health centres also carry out their own private work. Amongst junior doctors, a health centre placement is often viewed as a stepping stone and an aid to building up private practice. According to a small survey carried out by the Director of Primary Health Care, health centre doctors appear to be ready to relinquish their private practice and work solely within the public system if the system is changed to provide them both with job satisfaction and adequate remuneration.

Specialists at health centres

Hospital-based specialists visit health centres to conduct out-reach clinics. A variety of clinics are organized on a regular basis. These include medical clinics, diabetes, antenatal and postnatal care, gynaecology clinics, well-baby clinics, ophthalmic, community paediatrics and psychiatry. Two medical consultants have been appointed to work in health centres on a permanent basis. The aim is to reduce new case referrals to hospital when these can be dealt with and investigated in the primary setting as well as to offer supervision and training to other health centre doctors. There is no evidence that referrals to hospital outpatients have decreased as a result of the appointment of these consultants. However it

must be noted that referrals from the health centres only make up a small proportion of referrals to outpatient departments.

Health centre general practitioners are supposed to act as gatekeepers for secondary care. Unfortunately, patients often demand referral to hospital outpatient clinics as they believe they will receive better care from there. Patients may indicate if they have a preference to see a particular specialist.

Screening

The health centres offer a glaucoma screening service. This is open to all adults aged over 45 years and those aged over 35 years with a history of diabetes or a family history of glaucoma .

Cervical screening is available for all women who request it or are referred by their GPs. This is run from health centres. There is no standard protocol or organized recall system. The onus lies with the women themselves to request the service.

Facilities

Health centres

There are presently eight health centres, seven in Malta and one on the island of Gozo. The health centres developed from what were originally known as "polyclinics". These replaced the primary health care service provided by District Medical Officers (DMOs). DMO services were only provided free of charge to families with a Medical Aid Grant (Pink Card). In 1977 the DMO Service ceased to function during the doctors' strike. A number of polyclinics providing free emergency GP services were established. Thus the present day health centres originated from what was an emergency primary care organizational set up. This is reflected in the way health centres are organized with a disease-centred focus rather than a health promotion and disease prevention focus.

The health centres have evolved and now offer a number of services. General practitioners, nurses and dentists are based in health centres. Besides emergency primary care and minor treatments, a number of specialist clinics take place in health centres as described above. Paramedics also provide services in health centres. These include chiropody, speech therapy and physiotherapy and psychology. Acupuncture clinics are also provided in one health centre. The number of general practitioners and nurses at health centres varies from one place to another and also varies depending on the time of day to reflect workload patterns.

Health centre doctors can request basic investigations. The larger health centres are equipped with basic X-ray facilities and ECG machines. X-ray services are available on a daily basis in most health centres. Doctors have direct access to most pathology tests. All health centres have a health centre pharmacy attached to them where pharmacists dispense free medicines. An ongoing programme of health centre refurbishment is currently taking place.

Local clinics

There are 47 local clinics in Malta and Gozo located in most of the older towns and villages. These are usually staffed by a nurse who administers the system for distribution of pharmaceuticals which would have been dispensed from a health centre pharmacy. This is particularly useful for patients on repeat prescriptions who may obtain their monthly supply of drugs within their village without having to go to health centres. A doctor visits these local clinics on fixed days and times of the week for a short while to write out prescriptions and provide very basic care such as blood pressure monitoring. There are no pharmacists present in these local clinics. These local clinics are not found in any of the newer suburbs. Whether their existence is still required is a matter of debate and any future reform of the government pharmaceutical system and primary health care system will address the role of these local clinics.

Community care

Domiciliary nursing

The Malta Memorial District Nursing Association (MMDNA) provides domiciliary nursing. This organization is contracted by the government to provide domiciliary nursing and midwifery services. These services are available on a daily basis although they are restricted to emergency calls after 20.00 hours. They are free-of-charge at the point of use and all persons are entitled to use them.

School medical services

The school health service is part of the child community service and falls under the Department of Primary Care. Doctors and nurses are assigned to primary state and church schools to staff these services which mainly carry out immunization and child health surveillance. In 1997 child health records were established. These have enabled standardization of the process for carrying out medical examinations of children and in the long term will provide an important source of epidemiological information.

The school dental service provides free treatment including emergency treatment, orthodontic treatment and preservation for children up to 16 years of

age. There is also a school programme where dental hygienists and dental surgeons screen all school children on a yearly basis.

Immunization

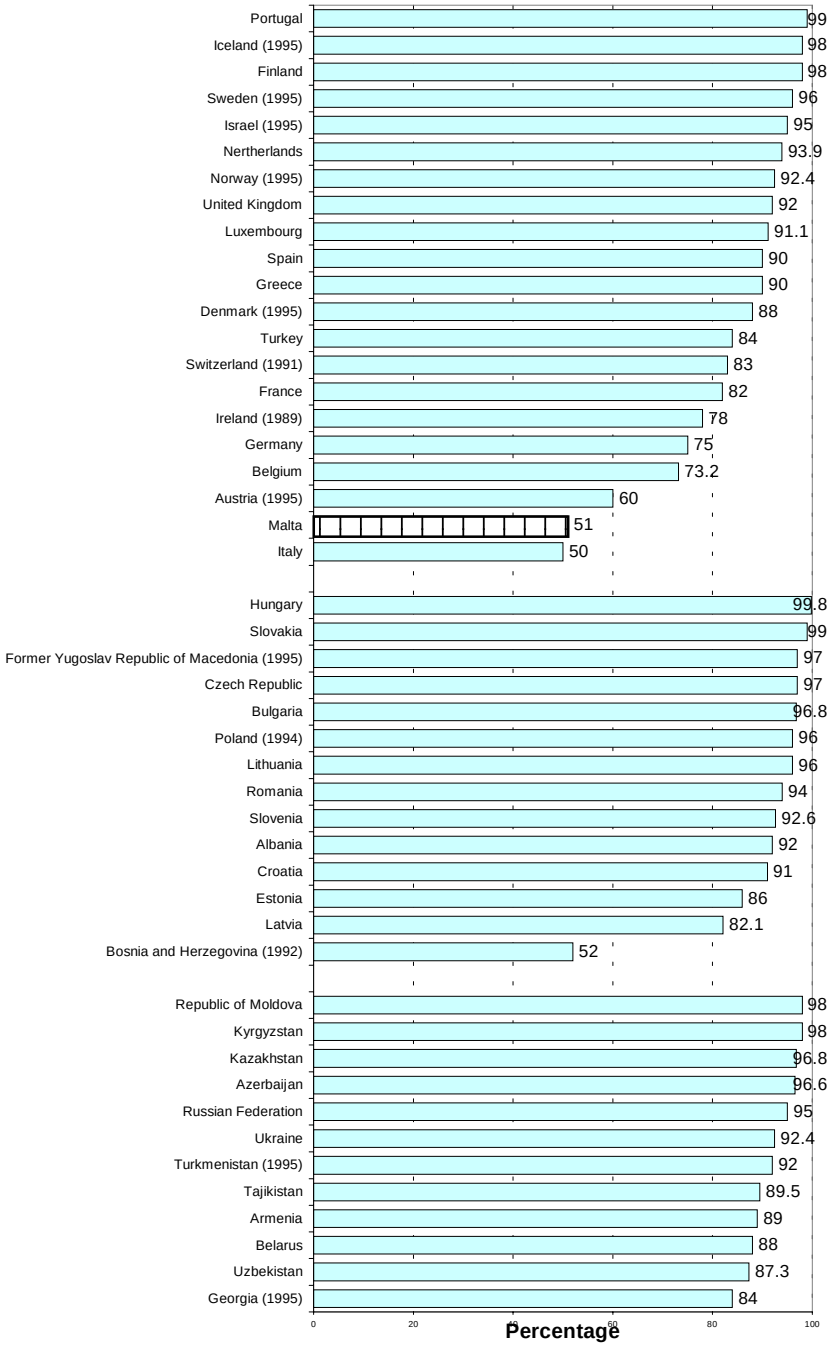
Immunization services are provided by the Department of Primary Health Care. A free childhood immunization schedule is given to all children. The scheduled vaccinations are as follows, with coverage rates for 1997 shown in brackets: Diphtheria, Tetanus, and Polio (90%), Pertussis (85%), Mumps, Measles and Rubella (50%) and Haemphilus influenzae B (80%). Vaccination of school children on a national basis with Hepatitis B vaccine was introduced in 1997. BCG vaccination is also offered to schoolchildren at 12–13 years of age. A strategy is being formulated to try and improve the level of immunization for MMR, which is one of the lowest rates in Europe (see Fig. 7). The levels of MMR vaccination are thought to be low as a result of under-reporting and late vaccination. Influenza vaccination is offered to the elderly, persons with chronic illness and health care staff. Hepatitis B immunization is given to persons in at-risk occupations.

Private primary health care

The proportion of private primary health care has been estimated to be two thirds of the primary health care workload from a Household Budget Survey carried out in 1992. Private primary care is provided by general practitioners mostly working in single-handed practices. A few firms are being established which are specifically contracted by large employers to cover their employees, mostly for purposes of sick leave verification. The better-established GPs have their own offices and premises whilst other GPs work in offices based within community retail pharmacies which they attend according to specific time-tables.

The service offered by private GPs is generally perceived to be superior from the point of view of continuity of care. The GP gets to know the whole family and provides a more holistic type of care. These GPs tend to be well respected in their communities and are still considered as popular personalities in the town or village. This fact is borne out by the election results for those GPs who contest general and local elections. The private GPs charge relatively modest fees and also carry out home visits. It is difficult to monitor standards and quality of care as the service is very fragmented and no system of patient registration exists. There is no quality assurance mechanism and few practices keep detailed patient records. Patients also tend to shift from one GP to another.

Fig 7. Levels of immunization against measles in the WHO European Region, 1996 or latest available year



Source: WHO Regional Office for Europe health for all database.

Malta

Patient satisfaction

A customer satisfaction survey to assess public primary care was carried out in 1996 by the Department of Primary Health Care (see Table 3). This inquired about aspects related to staff behaviour, the service received and the facilities. The results obtained were very positive. It is well known however that not all of the population utilize the health centres and a large number of people prefer to use private primary care services.

Table 3. Level of satisfaction with public primary health care services, 1996 (%)

	Very good	Good	Bad	Very bad
Level of service	60.0	34.5	3.5	1.9
Appearance of premises	56.8	36.4	4.4	2.4
Cleanliness of premises	62.2	33.9	2.5	1.4
Appearance of staff	62.7	34.6	1.9	0.8
Staff behaviour	64.5	32.9	1.8	0.8

Source: Department of Primary Health Care.

Reforms

The stakeholders in the current primary health care service believe that the system could deliver better quality primary care. There is a general consensus on this issue between politicians and health professionals. The major problem is the separation and duplication between public and private care and the lack of continuity of care. There is also inappropriate use of both primary care and hospital services.

The new government has committed itself to reform primary care in its electoral manifesto. For this to occur, it is essential that primary health care is given the real importance it merits in terms of funds and resources.

Discussions with the relevant professional associations are presently taking place and concrete proposals to tackle the issue of primary care have emerged. This will be the second attempt to reform the primary health care system. A major change to the system was attempted in 1991. The government at that time wanted to introduce a scheme whereby patients would be registered with a GP of their own choice. GPs were to be remunerated on a capitation basis and allowances. The scheme was to be voluntary, not all GPs would be obliged to join. Due to a series of problems, the initiative never materialized, the project was abandoned and an opportunity to make a difference to the primary health care service was lost.

The present proposals for reforms in primary health care are being finalized. They seek to address the rift that exists between the public and private systems of health care provision and take Malta's historical, cultural, social and economic context into account. The principles underlying the reform will be similar to those proposed in 1991, but the details differ having learned from previous experience. The present system of primary care is inefficient and reforms in this sector are urgently required. These must occur in the wider context of health care reform with particular attention to community support services and an emphasis on health promotion and disease prevention.

Linkage between primary and secondary care

The Health Division has consistently emphasized that a holistic approach to health care reform is required. Although policy documents such as "Health Vision 2000" stress the importance of primary health becoming the cornerstone of the health care system, in practice this has not happened. Political party manifestos commit themselves to improving the state of primary health care, but the experience of the early 1990s, when a plan to ensure primary health care for all with a registered GP failed to become policy, has made successive governments more cautious. It is always very tempting for governments to embark on visible projects. The current emphasis on the 'New Hospital' project will make it difficult to retain primary health care reform at the top of the agenda.

The current situation in Malta is one where primary care services and community support services and facilities are inadequate. There is no continuity of care between the various provider settings.

Public sector

The links between primary and secondary care are weak as there is no patient registration system in primary care. Health centre GPs may refer patients to outpatient clinics and emergency services. Patients require a ticket of referral to attend hospital outpatient clinics but this is not necessary for emergencies. Unfortunately, there is no dialogue between private and public GPs or between GPs and hospital specialists in the public sector. Upon discharge from secondary care, patients are not referred to a specific GP and discharge letters are kept by the patient. Shared care does not formally operate.

Patients may also be referred to public secondary care facilities by GPs and specialists from the private sector.

Private sector

Within the private sector GPs refer patients to specialists when necessary. The major difference lies in the fact that specialists may refer patients back to their own GP and some interaction occurs between GPs and specialists.

There is no gate-keeping system in the private sector and patients may choose to consult specialists directly. In addition specialists may refer patients from their private clinics directly to outpatient departments.

The aim is to move towards systems that will allow the provision of seamless care both within the public and private sectors and between the public/private interface. This will require reform and strengthening of primary care and community services. It is only when these elements are well developed that costly hospital care may be utilized effectively and efficiently instead of serving as an expensive and inappropriate substitute for care that can be delivered in other settings. The development of a unified patient record is feasible and possible in Malta due to its geographical characteristics. The development of such a record is a major factor in ensuring the delivery of seamless care.

Secondary and tertiary care

The present health service in Malta can be considered as essentially hospital-based with a weak supporting primary care structure as explained in the previous section. Specialized ambulatory services, inpatient care and highly specialized care all take place side-by-side in the main general hospital and in some other hospitals including private clinics.

Specialized ambulatory care

Specialized ambulatory care is delivered in various settings. The most common within the state health care system is at outpatient clinics. These outpatient clinics form part of the hospital and are staffed by the same doctors who provide inpatient care. This ensures relatively good continuity of care at secondary and tertiary levels. Patients are referred to outpatient clinics by a general practitioner at health centres or private practice, and also by hospital specialists from their private clinics. The latter group is responsible for the largest number of referrals. Having seen the patients privately, hospital specialists may refer them to hospital for further investigation and treatment. Not all these patients pass through the official channels or have organized hospital appointments. Some are simply added to the outpatient list at the last minute following instruction from the

specialist. This is one of the examples where the distinction between public and private sectors within the health care service becomes blurred. The gatekeeper role of the general practitioner is bypassed in this situation.

The above services are directly provided as part of the integrated state health system and are thus available for all those who demand them. They tend to be over-utilized as people prefer to be seen by a hospital specialist than by a health centre GP. Patients often exert pressure on the GP to refer them to a hospital specialist. Such pressure also occurs in the private sector.

Specialist ambulatory services are also provided by the private sector. These have traditionally been provided directly by specialists working from pharmacy consulting rooms. The opening of private clinics and hospitals has led to specialists providing ambulatory services from these settings. These consultations are paid for by out-of-pocket payment or by private insurance cover on a fee-for-service basis. Most of the specialists offering private services are also employed full-time by the government. Their position is legal as they are allowed to do private work "as long as it does not interfere with public duties". However it is widely felt that the extensive private work that takes place does impinge on the delivery of publicly provided health services. A few specialists do not devote the amount of time they should to the public service and conflicts of interest often arise, with private patients receiving preferential treatment in hospital. Such problems could be overcome by appointing doctors to work full-time without private practice. However this is likely to be a rather contentious issue.

Hospital care

Hospital care forms the main focus of the state health care system at present. Besides the state hospitals, private hospitals also exist, run as private for-profit organisations. There are no longer any acute care hospitals owned by voluntary organizations such as the church. The distribution of hospital beds in the public and private sectors is shown in Table 4.

Public sector

Hospitals are run by a management committee or team. This is composed principally of clinical health professionals who work in that same hospital.

State hospital services are provided by health care personnel employed by government as salaried civil servants. Most hospital care is presently centred on St. Luke's Hospital. This is an 879-bed hospital providing basic hospital care as well as highly specialized care such as heart surgery and transplantation. Malta has become almost self-sufficient in terms of providing most tertiary

Table 4. Distribution of hospital beds

Name	No. of beds	Type of hospital
	Public sector	
St. Luke's Hospital	879	Acute general (A&E services)
Gozo General Hospital*	259	General, psychiatric, geriatric
Sir Paul Boffa Hospital	80	Skin, cancer, fever cases, convalescence
Mount Carmel Hospital	666	Psychiatric
Zammit Clapp Hospital	60	Geriatric rehabilitation
	Private sector	
St. Philip's Hospital	75	Acute general
Capua Palace Hospital	80	Acute general
St. James' Hospital	13	Acute general

Source: Department of Health Information
*Note: Approximately 150 beds in Gozo General Hospital are used for long-stay care.

care. Patients are still sent overseas, usually to the United Kingdom for care that tends to be organized at supra-regional levels in the United Kingdom. Maltese patients benefit from the bilateral agreement that exists with the United Kingdom whereby free treatment is offered to United Kingdom tourists in return for a number of Maltese patients treated by the United Kingdom National Health Services.

As St. Luke's Hospital became unable to cope with the increased demand for health care, especially with unmet demand for social care required by the elderly, it started to face problems with bed-blocking and overcrowding. In 1992, a decision was taken to build a 450-bed hospital for research and specialized elective care. The new hospital has now been re-designed to take over all the functions of acute care, both secondary and tertiary. In addition it will facilitate the provision of research and teaching services due to its proximity to the University Campus. The 'New Hospital' project has required considerable capital investment. Recurrent costs will also increase with implications for the health care budget. One of the main reasons for the projected increase in expenditure is the planned expansion of activity in fields where waiting lists are a problem. The 'New Hospital' will have a larger number of operating theatres and a dedicated day care unit to cater for modern trends in service delivery.

Dermatology, infectious diseases and oncology services are today provided at Sir Paul Boffa Hospital. These services will eventually be transferred to the 'New Hospital' to enable better integration with other acute care services.

There remain several issues that still have to be solved such as what to do with the vacated hospitals, and how to collaborate with other sectors to determine appropriate patterns of provision for elderly patients requiring long-term care.

Rehabilitation for the elderly is currently organized at Zammit Clapp hospital, which was opened on the site of a former church hospital. This hospital has a different management structure to that found in other state hospitals with more budgetary autonomy and different working patterns. It is unable to cope with the demand for rehabilitation/convalescent services and expansion of this service is planned, possibly by creating another unit.

The psychiatric hospital has over 600 beds most of which are long-stay beds. This hospital is being refurbished and new management styles are being introduced. It is expected that the reform in mental health care will lead to patients being cared for in community settings and the need for medium- and long-term psychiatric beds may diminish. Acute psychiatric services will eventually be transferred to the "New Hospital".

Gozo has its own 259-bed general hospital with 109 short-stay and 150 long-stay beds. This provides comprehensive basic hospital care and some specialized care. The population (30 000) is not large enough to support the development of specialized services. Because residents have to cross over to Malta to obtain certain types of treatment, it creates problems of geographical inequity. This is a typical problem which archipelagos encounter in health care provision.

Table 5. Acute care inpatient utilization and performance, 1993–1997

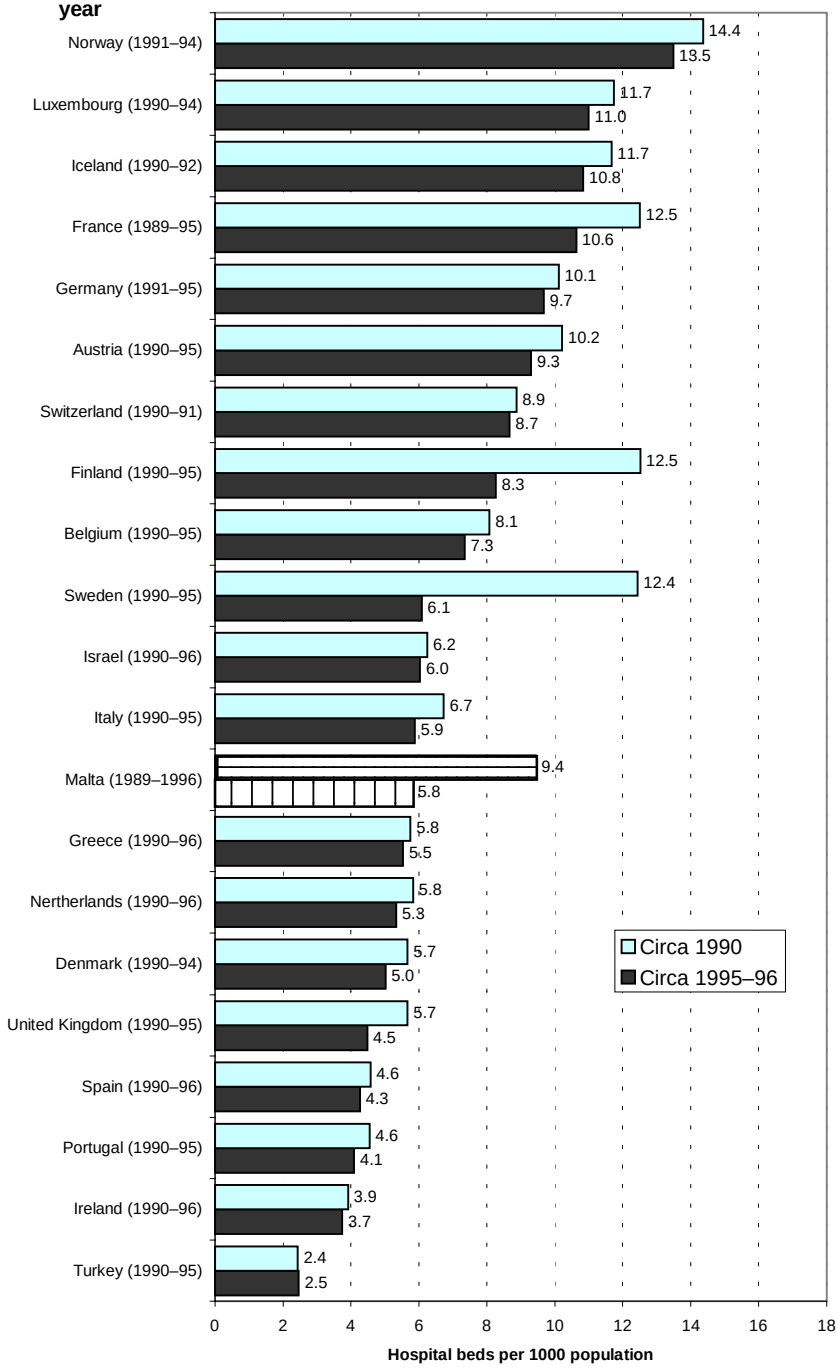
Inpatient	1993	1994	1995	1996	1997
Hospital beds per 1000 population	5.84	5.62	5.43	5.78	–
Admissions per 100 population	17.3	17.8	18.0	18.1	20.2 (16.0*)
Average length of stay in days	4.92	4.83	4.76	4.62	4.56
Occupancy rate (%)	n/a	72.6	72.0	71.9	72.2

Source: Department of Health Information
Note: Average length of stay and Occupancy rate has been calculated for St. Luke's Hospital only. The calculation takes into account even lengths of stay longer than 30 days. Admissions and discharges occurring on the same day are considered as having a LOS of zero days. Acute admissions to St Luke's Hospital and Gozo General Hospital constitute the bulk of all acute hospital admissions in the Maltese islands and have therefore been used as a proxy indicator for all hospitals. * The figure in brackets for admissions in 1997 is the only figure to reflect admissions excluding day-cases.

Private sector

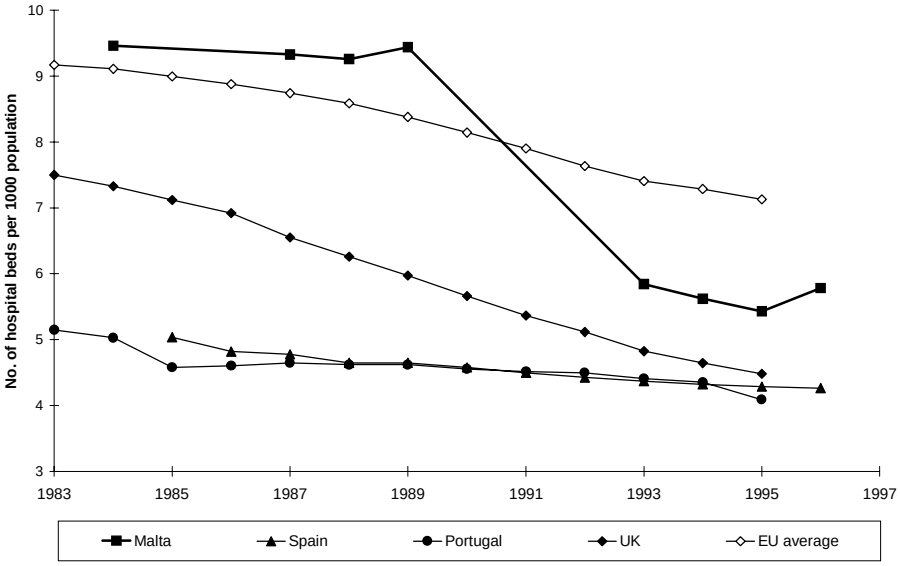
A range of services including both secondary and tertiary care is provided within the private sector. Inpatient care is carried out in small private clinics as well as in private hospitals. The number of private facilities has grown in recent years. Most of the private hospitals and clinics are very well equipped. Indeed an MRI scanner and other high technology equipment are available in the private sector but not yet in the state health care system. All private services are paid

Fig. 8. Hospital beds per 1000 population in western Europe, 1990 and latest available year



Source: WHO Regional Office for Europe health for all database

Fig. 9. Hospital beds per 1000 population in Malta and selected European countries, 1983–1996



Source: WHO Regional Office for Europe health for all database.

for on a fee-for-service basis. Private expenditure on health care is growing exponentially and at a faster rate than growth in public health care expenditure. However private providers of health care in hospitals are finding difficulty in sustaining their market share as they do not benefit from operational economies of scale. The state purchases MRI investigations from the private sector and this type of collaboration is favoured by the present government.

The number of hospital beds per 1000 population in Malta is 5.78. By comparison with European Union countries, this is lower than the European Union average. It is similar to figures for Italy and Greece but higher than those of Spain and Portugal (see Table 6). Although a new hospital is being built, the number of acute care beds is expected to remain more or less unchanged but an increase in beds will be required for convalescent and long-term care. The change in beds seen from 1989 to 1996 in Fig. 9 is artificial as geriatric hospital beds were included in the 1989 figure. This phenomenon is similar to that observed for Sweden.

The admission rates and length of stay appears to be amongst the lowest, however they are calculated on the basis of figures from the acute state general hospital. Private hospitals and chronic care hospitals are not included.

Table 6. Inpatient utilization and performance in the WHO European Region, 1996 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	9.3[b]	24.7[b]	10.9[b]	75.9[b]
Belgium	8.3[b]	19.6[b]	11.4[b]	81.4[b]
Denmark	5.0[c]	21.6[c]	7.5[b]	81.7[c]
Finland	8.7[b]	26.8	11.6	74.0[b]
France	10.6[b]	22.7[b]	11.2[b]	75.4[b]
Germany	9.7[b]	21.5[b]	14.2[b]	81.3[b]
Greece	5.8	13.5[d]	8.2[b]	–
Iceland	10.8[e]	28.0[c]	16.8[e]	–
Ireland	3.7	15.1	7.5	82.3
Israel	6.0	18.6	10.1	94.0
Italy	5.9[b]	16.6[b]	10.5[b]	75.7[b]
Luxembourg	11.0[c]	19.4[c]	15.3[b]	–
Malta*	5.8	16.0[a]	4.56[a]	72.2[a]
Netherlands	5.3	10.2	13.9	73.2
Norway	13.5[c]	15.0[b]	10.0[b]	79.4[b]
Portugal	4.1[b]	11.3[b]	9.8[b]	72.6[b]
Spain	4.3	10.7[c]	11.0[b]	73.9[c]
Sweden	6.1[b]	18.5[b]	7.8[b]	75.9[b]
Switzerland	8.7[f]	15.0[c]	–	78.4[d]
Turkey	2.5[b]	6.3[b]	6.4[b]	55.6[b]
United Kingdom	4.5[b]	15.9[b]	9.9[b]	–
CCEE				
Albania	3.2[b]	9.0[b]	8.2[b]	–
Bosnia and Herzegovina	4.5[f]	8.9[f]	13.3[f]	70.9[f]
Bulgaria	10.7	17.5	13.2	64.1
Croatia	6.2	14.8	13.3	89.6
Czech Republic	9.0	20.4	12.5	74.3
Estonia	7.6	17.9	12.7	71.9
Hungary	8.2	24.2	10.3	74.4
Latvia	10.3	20.9	14.2	–
Lithuania	10.6	20.8	14.0	–
Poland	6.3[b]	–	10.8[b]	–
Romania	7.6	21.5	10.0	–
Slovakia	7.5[b]	18.3[b]	11.7[b]	79.2[b]
Slovenia	5.7	15.5	10.5	77.6
Former Yugoslav Republic of Macedonia	5.4[b]	9.7[b]	15.0	59.9
NIS				
Armenia	7.1	7.5	14.5	40.4
Azerbaijan	9.5[a]	5.7[a]	17.5[a]	–
Belarus	11.6	24.9	15.2	88.7[c]
Georgia	4.7	4.6	10.6	26.8[c]
Kazakhstan	8.4[a]	15.1[a]	16.5[a]	80.8[a]
Kyrgyzstan	8.4	16.4	14.9	80.5
Republic of Moldova	12.1	18.9	18.1	80.8
Russian Federation	11.6	20.5	16.9	87.7
Tajikistan	7.2	10.7	15.0	59.9
Turkmenistan	11.5[c]	17.0[c]	15.1[c]	63.6[c]
Ukraine	10.8	20.2	16.8	81.9
Uzbekistan	7.9	16.2	13.9	–

Source: OECD health Data File, 1996, WHO Regional Office for Europe health for all database. Note: [a] 1997, [b] 1995, [c] 1994, [d] 1993, [e] 1992, [f] 1991; *Data for Malta was obtained from the Department of Health Information in Malta, this is based upon data for acute general hospital care.

Problems and reforms

Hospital care is one of the strongest features of the state health care system. Care is delivered by highly qualified specialists. The weaknesses arise primarily out of the way the system is managed. It is very bureaucratic and there is a dearth of incentives for health care personnel. Salaries are poor and are tied to civil service scales. Doctors and other paramedical staff attempt to augment their salaries by doing private practice, working extra duties and over time. This has its disadvantages as people feel tired and demotivated.

The main issues for hospital reforms are the continuation of a process to develop autonomous hospitals. With the introduction of clinical budgeting it is hoped to involve clinicians more in resource utilization and allocation as well as enhance accountability. The introduction of evidence-based practice and quality assurance protocols is necessary and will become easier as the stages of computerization proceed allowing better clinical audit and data capture.

Another major problem associated with hospital care is ward overcrowding. This problem reaches crisis levels in winter when patients are often placed on a bed in the ward corridor. It is exacerbated by the fact that there is only one acute general hospital on the island and patients may not be transferred elsewhere for care. It is expected that this problem will be overcome through hospital re-structuring and the introduction of appropriate bed management policies.

The issue of overcrowding is not merely one of space but also leads to staff being overworked and unable to cope effectively with the number of patients. This problem however must be solved in partnership with providers of social care, as patients must have alternative accommodation in order to be discharged from hospital when medical care is no longer necessary. At present "social cases" block expensive acute care beds and are the main reason for ward overcrowding.

Public health services

In Malta, unlike other southern European countries, there has been a long tradition of public health medicine, which has much in common with British public health medicine. Doctors wishing to specialize in public health were sent to the United Kingdom to further their studies. Non-medical personnel were also sent abroad to specialize in fields such as nutrition and health promotion.

Department of Public Health
This Department is made up of the following branches, which work in an integrated manner to promote a healthy living environment through prevention and control.

- Health protection branch coordinates: the District Public Health Service, the Port and Airport Health Services, the Pest Control Services, the Burials Services, Drugs and Toxic Substance Control and Public Health Legal proceedings;
- Disease surveillance branch carries out disease surveillance and outbreak control as well as giving advice on travel health;
- Environmental health branch monitors the quality of drinking and recreational water, coordinates control of air pollution, hazardous waste, radiation protection and hazardous consumer goods;
- Food safety branch monitors food processing and catering as well as promoting food safety;
- Public health laboratory services;
- Drugs branch deals with import and export authorizations for narcotics and psychotropics;
- Chest clinic runs a programme for prevention and control of TB;
- Occupational Health unit carries out medical screening of personnel in employment.

Department of Health Promotion

The Department of Health Promotion is a relatively new department. It is responsible for conducting campaigns to promote a healthy lifestyle. These include campaigns about smoking, safer sex and healthy eating. The department also acts as a policy advisory body on nutrition, tobacco control, accident prevention and women's health. This department is mostly staffed by non-medical health promotion specialists. It provides on-line information, helplines, HIV counselling, smoking cessation and weight reduction clinics.

Department of Health Information

The Department of Health Information strongly supports all public health services and clinical services. This department has medical staff trained in public health and medical informatics as well as non-medical support staff. It is responsible for data collection in order to maintain disease registers, monitor hospital activity and disseminate data about the population's health status and the health services in general. It is also responsible for information systems strategy, planning and management and for corporate data management.

Training

The first ever university postgraduate programme leading to a Masters degree in public health in Malta ran from 1995–1997. It allowed a number of doctors

working in the field of public health, who had not had the opportunity to study public health abroad, to ground themselves in public health theory. This initiative was very popular and attracted not only doctors from public health but also doctors from school medical services and primary health care as well. The course helped to raise the profile of public health and enabled people in the field to come together and exchange ideas. As the experience was such a positive one, the course will be repeated regularly.

Future challenges

The impetus to decentralize managerial authority is set to continue. This requires strengthening of management at the hospital level. Public health services will support the Health Division through policy guidance, regulation and monitoring of standards. Care must be taken to ensure that public health physicians do not become too distant from the sites of health care delivery as the Ministry sheds its role of direct service provider. The resources of the public health services are important tools in the provision of high quality clinical services.

Social care

Social care in this context will be taken to cover long-term institutional care, psychiatric care, day care and social welfare services for the elderly, chronically ill, mentally and physically handicapped. Social care is provided in various settings by multiple providers. The state firmly believes that society in general should be responsible for social care and encourages the involvement of agencies and nongovernmental organizations in care provision for this sector.

Long-term care of the elderly

Care for the elderly is provided in hospitals, nursing homes and in the community. Malta has a rapidly growing elderly population. Average life expectancy at birth is 74.9 years for males and 79.8 years for females. The dependency ratio is 0.5. The total number of long-term beds available represents 4% of the 60+cohort. The demand for long-term institutional care has increased both as a result of the increasing elderly population in absolute and relative terms, increasing longevity as well as the concomitant breakdown of the extended family as the primary support network. This can be partly attributed to the fact that women who traditionally provide most of the care have left their homes and gone out to work.

Public sector

Institutional care

Long-term residential care is provided in the St. Vincent de Paule Residence. This complex has units with different dependency levels ranging from 24-hour nursing and medical attention to quasi-independent bed-sits. It is staffed by nurses doctors and paramedics, a good proportion of whom are trained in geriatric care. In the past it did not have a good reputation owing to its history as a "poor home" as well as a predominant culture that elderly should be cared for by their families within their homes. However in recent years it has become more popular as the needs of the elderly who are living longer and becoming more dependent cannot always be met at home by informal care.

The state owns several community homes which have been built over the past few years, most of which were purpose designed. These were originally intended for elderly persons who were well and could live independently but policy is now changing and more dependent patients have started to be admitted. However these nursing homes only provide very basic care and elderly people who develop limitations to independent living have to be relocated to St. Vincent de Paule Residence. All these homes except one are directly managed by the state in an integrated system. In 1994, management and service provision for a newly built state residential home was contracted out to a private provider. Initial results of this experiment appear to be good and it is possible that such arrangements may be adopted in other homes eventually.

Long waiting lists exist to access both the hospital and the community nursing homes. These waiting lists reflect demand and not necessarily need for care. The figures in Table 7 are derived from pending applications. It is estimated that around 10% of applicants have filed a request for admission in more than one setting.

Table 7. Distribution of long-term stay beds for the elderly in Malta, June 1998

Residential Setting	Level of dependence	Number of beds	Number of applicants awaiting admission
St Vincent de Paule Residence			
– State hospital	low to medium to high	1050	646
State Community Homes	low	336	522
Church Homes	low to medium	657	n/a
Private Homes	low to medium	463	n/a
Total		2506	1168

Source: Department of Care for the Elderly.

Application forms requiring both a medical and a social assessment are duly filled. Applications are prioritized by means of an informal scoring system. Priority is based on need and not on the length of time spent on a waiting list.

The state retains 40% of the social security pension for elderly hospitalized at St. Vincent de Paule residence. In state community homes, residents pay 60% of their total income not exceeding Lm4 per day.

Day Centres

A number of day centres have opened to promote interaction and social integration of the elderly. These centres organize recreational and educational activities and contribute to the psychological and social wellbeing of the elderly.

Community services

The elderly, depending on their needs, are entitled to make use of the following services: Telecare (device connected to 24 telephone life lines), home help, handyman at home, meals on wheels and incontinence service. The introduction of these services in the late 1980s was a novelty and was highly acclaimed. Despite various commitments to upgrade the services, the current strategy for community services are not good enough to meet a wide range of levels of need for care.

Private and voluntary provision

Long-term care for the elderly has traditionally been extensively provided by church run nursing homes. Church homes currently account for 26% of beds for the elderly. They tend to take healthy old people and have only basic nursing care. These homes charge their own rates which are affordable to the general public. These homes are experiencing considerable human resource problems due to the dwindling number of nuns. The state does not at present support church homes financially or otherwise. If current demographic trends persist and no form of support is forthcoming, it is likely that these homes will have to cut down on the number of beds and services. If government does not choose to support church homes, it may have to compensate by increasing its own provision of beds.

The most recent form of long-term provision for the elderly has been the introduction of private-for-profit nursing homes. Standards vary immensely and the levels of nursing care also vary from custodial care to high-dependency nursing care. These nursing homes tend to be rather expensive and are not affordable for the average Maltese pensioner.

People with special needs

Mental health and social care

Reform of mental health services is under way. The objective is to introduce standards for mental health care and to de-institutionalize the mentally ill as far as possible. This reform requires a shift of resources and investment in community services. It can only take place gradually as it is important not to curtail institutional care before the appropriate community facilities and services are available. A pilot project for community mental health care in 1993–1995 unfortunately failed to achieve its objectives due to insufficient primary care support.

The state psychiatric services consist of outpatient clinics, an acute psychiatric unit within St. Luke's Hospital, institutional psychiatric care at Mount Carmel Hospital and care in a community home. Psychiatric care is provided by multidisciplinary teams.

Disabled persons

Social care for the disabled is mostly the prerogative of voluntary organizations. Institutional care for the mentally handicapped is provided by a church home whilst a recently established foundation provides education, training and rehabilitation for physically and mentally handicapped adults and children. These organisations rely entirely on voluntary contributions for their operation.

There is a vacuum in provision of long term care for the young disabled and chronically ill. Neither the state nor voluntary organisations provide residential care for this group of patients. Depending on the nature of the disability and expected duration of care patients are accommodated at St. Luke's Hospital, Sir Paul Boffa Hospital, St. Vincent de Paule Residence or Mount Carmel Hospital. Most palliative care services are offered by the voluntary sector. An outpatient facility for multi-disciplinary assessment and care was established a few years ago within St. Luke's Hospital. It is known as the Child Development Assessment Unit.

Future challenges

The need and demand for social care is expected to increase. The impact of the elderly population will be a higher prevalence of illness and disability in the population. The changing fabric of Maltese society with women going out to work means that fewer persons are being cared for at home by their relatives.

One way of addressing the need to enhance service provision is by providing training to create a pool of carers who can effectively manage a range of needs in various care settings. The Department is supporting various training programmes to achieve this aim.

It is felt that a clear policy direction with the accompanying political and financial backing is required within the area of social care. There is a pressing need for community services to be developed and strengthened. Health care cannot become more effective and efficient unless it is adequately supported by a network of community and social care services.

Human resources and training

The health sector is one of the largest employers in Malta. Government health sector employees are part of the civil service. Besides health professionals, various categories of support staff ranging from auxiliary workers to clerical workers to engineers make up the health care workforce. 55% of total government expenditure on health goes towards the salaries for human resources in health care. This figure is lower than that of other western European countries due to the relatively low wages paid to health care personnel as well as the considerably large capital investment making up a significant proportion of health care expenditure.

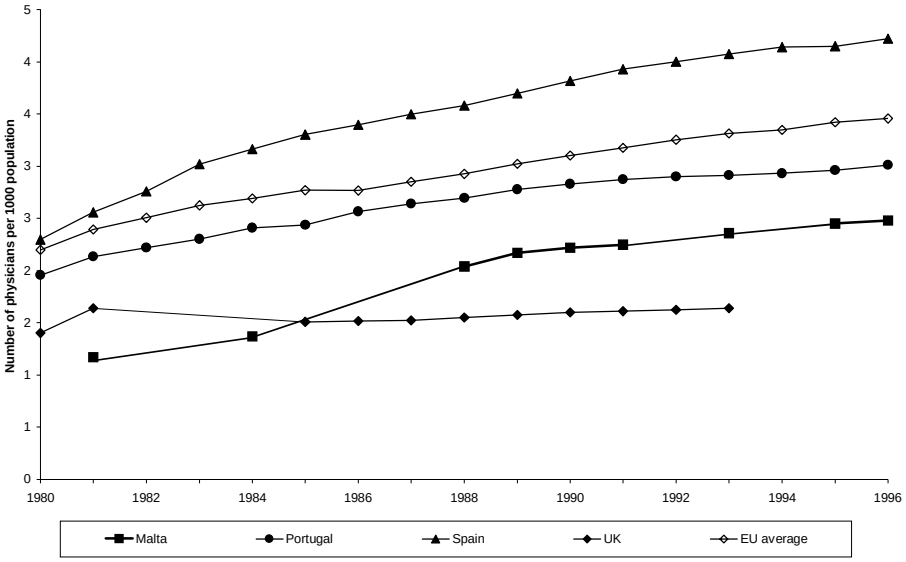
A number of problems and issues are common to all personnel within the health care sector. Health care staff consider themselves to be underpaid even though their salaries are similar to those of other civil service employees of a comparable grade. Health care workers attempt to boost their incomes by working extra hours or carrying out second jobs. Consequently staff may be tired and may not maximize their potential at work. With regard to doctors, the demands of their private practice may infringe upon their duties in the public sector.

The triad of life long contracts, inadequate accountability and salaried remuneration produces a system with few incentives for productivity or efficiency. Health professionals lack sufficient managerial and technological support and complain that they spend too much time carrying out tasks which do not require the skills of trained health care staff. The gradual computerisation of the health care system should relieve health care workers of some administrative work.

Human resource issues are dealt with centrally at the level of the Director of Human Resources within the Health Division. There is no adequate system for effective internal communication. This contributes to creating resistance when attempting management changes, as there is no system whereby employees

can obtain information to allay their fears and insecurity. The lack of devolution of power makes it difficult for unit managers to negotiate flexible working agreements with their own staff according to the specific circumstances that the job may require.

Fig. 10. Physicians per 1000 population in Malta and selected European countries, 1980–1996



Source: WHO Regional Office for Europe health for all database; Department of Health Information (Malta).

Physicians

The number of physicians has increased steadily in the last two decades and is expected to be 2.6 per 1000 population at the end of 1998. This still remains a relatively small rate when compared with most of the other western European countries but is larger than the United Kingdom, the country by which Malta has traditionally set its standards (see Fig. 9). This figure is expected to rise due to a change in policy which has resulted in less restriction on university entry to the medical doctor course.

A dispute with the medical profession in 1977 led to doctors having to seek work overseas and several hospital specialists left the island. Foreign specialists mostly from countries in central and eastern Europe were employed to staff the hospital. In 1987, following a change in government the doctors' dispute officially ended and specialists returned from overseas to work again in the Maltese health system. A number of foreign doctors remained in Malta in fields

such as surgery, radiology and anaesthesia. These are gradually declining in number as the island becomes more self-sufficient. A number of British consultants still visit Malta and hold clinics in supra-regional specialties.

There is a shortage of doctors in the junior and middle grades as most doctors spend a number of years overseas carrying out higher specialist training. The number of consultants is also below the average for western Europe. Some areas are more stretched than others; however, there are no incentives for doctors to enter primary care, psychiatry or geriatrics. The solution is not solely to increase the recruitment of medical students but to ensure that the appropriate skill mix is available and to encourage the extended role of nurses and paramedical professions. The Medical Association is lobbying for the development of a consultant-based service. This would entail a shift from the traditional hierarchical pyramid firms to specialist teams of consultants. It would enable a larger proportion of care to be delivered directly by consultants and reduce reliance on junior staff for service delivery.

Another issue that remains to be tackled is the number of hours being worked by doctors. A re-structuring of the working patterns will be necessary in order to conform to the EU directive of a 48-hour working week. The Working Time Directive currently applies to civil servants but under a proposal presently being debated by the European Commission, would extend to include doctors. In addition it is envisaged that services should be provided on a full-day basis rather than the current situation where only emergency services are provided after 14.30 hours. It is not clear how this change would be designed. One possibility under consideration is that doctors would be allowed to work on a sessional basis.

Training

Doctors, dentists and pharmacists are trained at the Medical School. The Medical School is over 400 years old and has enjoyed a very good reputation. Graduates from the School have excelled overseas in various centres often taking up highly prestigious posts. The number of doctors and dentists commencing training was limited by means of a *numerus clausus* system, rendering these courses very competitive and highly prestigious. The rationale behind this policy was to maintain quality in training and to minimize supplier induced demand. Since the degrees for professional qualification in medicine and dentistry were the only ones to have a *numerus clausus*, this was regarded suspiciously by other professions as a ploy to retain control and monopoly within the market. In fact the *numerus clausus* for medicine has now been removed.

Undergraduate medical training lasts for five years. The medical curriculum is dominated by hospital medicine with little exposure to primary care or public health. Students get a good opportunity to have direct patient contact during

their training. Immediately upon qualification, doctors are required to undergo two years of post-qualification hospital-based work experience (houseman jobs) in order to obtain a warrant to practice.

There is no formal postgraduate training required to become a general practitioner. On obtaining their warrant, doctors may set up their own private general practice, be employed in health centres or apply for a Senior House Officer post in hospital. The latter posts are becoming saturated in certain specialties. In health centres doctors are awarded lifelong contracts but in hospital specialties they are now being awarded a fixed contract during which postgraduate qualifications must be obtained after which the contract will be extended for life. Although basic postgraduate training is carried out in Malta, doctors usually proceed overseas for higher specialty training.

In the past doctors who went abroad to train remained on unpaid leave for an indeterminate period of time. Most of these doctors settled overseas and did not return to work in Malta yet still retain the right to do so if they wish. Since 1995, doctors leaving to pursue higher specialist training have to resign their posts. This means that the government will not be obliged to employ them upon their return and this could lead to medical unemployment which is as yet unknown in Malta. If they leave to pursue further studies on a specialty in which there is a shortage, they may not be required to resign and in special cases may even be granted paid study leave.

Nurses

An increasing trend in the number of nurses is observed with the number of nurses currently standing at 11 per 1000 population (see Table 8). This gives an apparent nurse to doctor ratio of approximately 4:1 which is unusually high for a southern European country. This is partially due to the inaccuracies in the nursing register which gives rise to inflated figures. Although there is a wide-

Table 8. Health care personnel in Malta, 1981–1998

Per 1000 population	1981	1984	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Physicians	1.17	1.37	2.04	2.17	2.22	2.25	–	2.36	–	2.45	2.48	–	2.62
Dentists	0.15	0.16	0.23	0.27	0.27	0.27	–	0.30	–	0.30	0.33	–	0.36
Midwives	0.67	0.71	0.72	0.73	0.75	0.77	–	0.77	–	0.78	0.80	–	0.83
Nurses	3.7	–	10.30	10.76	10.95	10.91	–	10.99	–	11.06	–	–	11.54
Pharmacists	0.98	0.94	0.98	1.06	1.10	1.23	–	1.43	–	1.56	1.74	–	1.86

Source: Department of Health Information (Malta), WHO Regional Office for Europe health for all database.

Note: The figures for 1998 are provisional.
Some registers, notably nursing and midwifery, are not live registers and figures shown above are therefore inflated. Fresh estimates may be issued in the future.

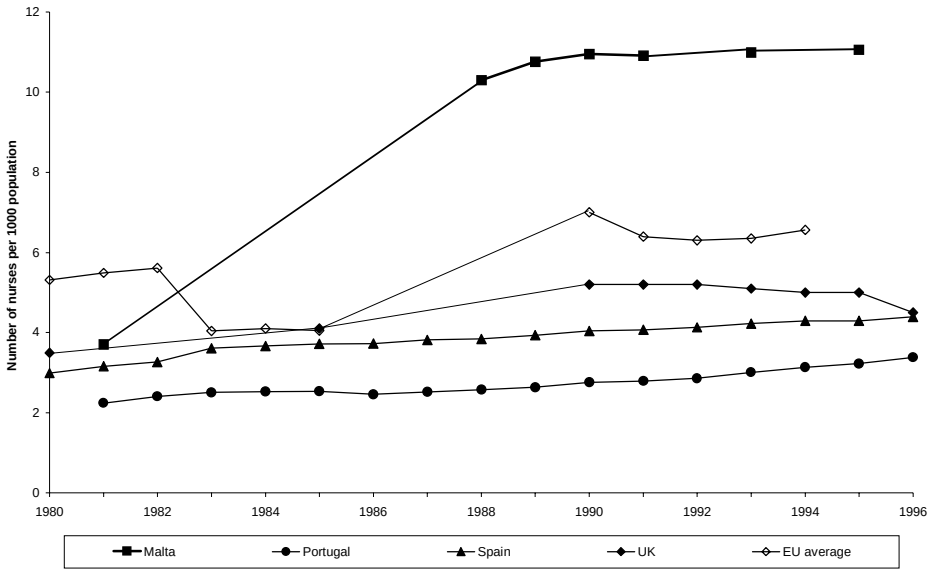
spread perception that a chronic nursing shortage exists, this is exacerbated because of overall inappropriate deployment of staff. However staff re-deployment will be a long and difficult process.

However there is also a number of inactive nurses, since a large proportion of nurses are women who tend to take long career breaks sometimes not returning to take up their profession.

The nursing profession has achieved greater recognition during the 1990s. In 1996 the Directorate of Nursing Services was set up symbolizing the growing importance of the nursing establishment. The post of Director Nursing Services was also created for the first time. There is a strong movement towards the attainment of official professional status for nurses and midwives. However the view that standards will have to be raised before professional status could be granted is held by many senior persons within the Health Division.

Conditions of work for nurses were greatly improved in 1993. The relatively attractive conditions attracted a large number of nursing students and the shortage of trained nurses has been somewhat alleviated. Nurses still have to contend with problems such as poor nurse to patient ratios when wards are overcrowded in winter.

Fig. 11. Nurses per 1000 population in Malta and selected European countries, 1980–1996



Source: WHO Regional Office for Europe health for all database; OECD Health data 1998; Department of Health Information (Malta). The number of nurses for Malta is inflated since the register is not a live register.

Nurses spend a lot of their time carrying out tasks which do not require their expertise. The introduction of health assistants, nursing aides and ward clerical assistants in 1995 was intended to relieve the nurses of some of these tasks. It is debatable to what extent this has been achieved. Nurses are also concerned that the introduction of nursing aides has lowered the perceived status of the nursing profession.

In 1994 the nursing grades were reformed and a new management structure was created. This reform did not bring about the expected improvements as management structures cannot be changed successfully unless they are part of an overall strategy, in which appropriately trained managers are given the necessary authority and support.

Paramedical staff

The Health Division employs clinical psychologists, dental hygienists, dental laboratory technicians, health inspectors, medical laboratory analysts, medical laboratory technologists, occupational therapists, operating department assistants, optometrists, orthoptists, perfusionists, physiotherapists, chiropodists, radiographers, speech therapists and social workers.

A number of issues are common to most of the above categories of personnel. For the first time in a number of years most departments have the full staff complement. Since paramedical grades are predominantly staffed by women, staffing levels were significantly affected by the introduction of a three-year parental leave career break which was introduced in 1996. It is hoped that the number of personnel availing themselves of parental leave at any point in time will stabilize thus enabling appropriate staffing projections to be carried out.

The paramedical grades generally do not have problems with recruitment of staff. So far the Health Division has employed all paramedical personnel completing the necessary education and training. It is highly likely that the Health Division will be unable to continue to employ all paramedical graduates. A policy decision will have to be taken as to whether to limit the numbers in training or to allow unemployment. Only a few graduates from these fields are absorbed into the private health care sector.

A number of paramedics left government service when the law regulating private clinics was amended and private hospitals were opened. However staff retention is generally good. This is due to the fact that most paramedical professionals work short days, approximately 7.30 hours to 14.30 hours. This leaves adequate time for family commitments or part-time jobs which provide extra income. It is not known how these professions would react to a re-structuring of the working day for hospitals to function on a full-day basis.

Training

In 1988 the nursing school was transformed into the Institute for Health Care a branch of the University of Malta. This effectively meant that responsibility for training of nurses and paramedical professions was transferred from the Department of Health to the University of Malta. This enabled degree courses to be established in nursing, physiotherapy, midwifery, radiography and speech therapy. Masters courses are also offered and in-service training courses are also organized.

With regard to training of nurses, various grades of nurses exist depending upon their training. A three-year training period is required to obtain a certificate of qualification as an "enrolled" nurse. These nurses have had very limited career progression opportunities. State registered nurses undergo a four-year training period leading to a diploma. In 1998 a conversion course commenced to give enrolled nurses the opportunity to become state registered nurses. Since 1989 a four-year university degree course in nursing has also been offered.

The Institute of Health Care has helped raise the profile of the paramedical professions, but also raised the expectations of new graduates who are often not satisfied with the status and conditions of work they find upon completing their studies.

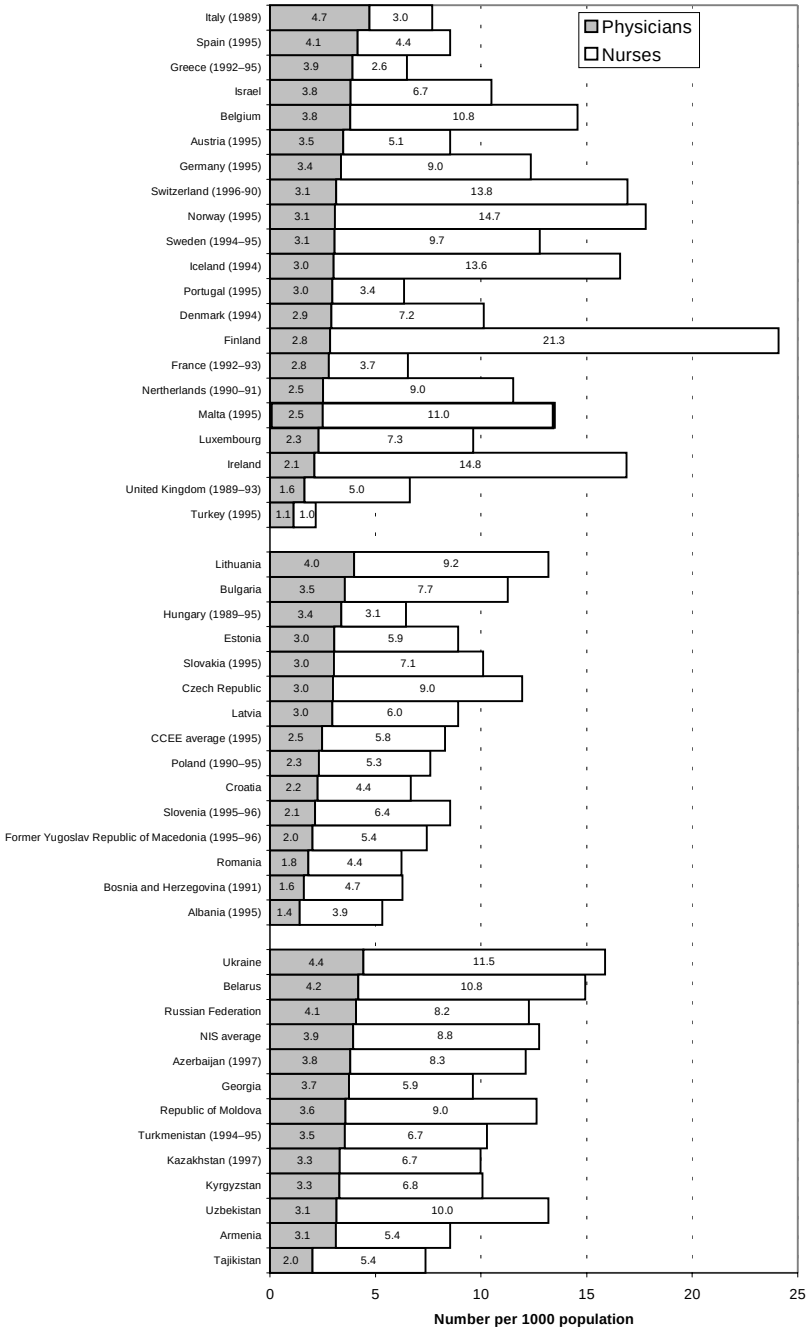
Future challenges

Attempts to streamline the large public sector have meant that recruitment of additional personnel must be well justified. New appointments require approval from the Management and Personnel section in the Office of the Prime Minister. This excessive bureaucracy means that it takes a very long time for the process of staff recruitment to be completed. An exercise to analyse staffing levels in all units and re-deploy people from over-staffed to under-staffed areas is being carried out as part of the health care reforms. The appropriate skill mix must be available to ensure the delivery of care. These initiatives may encounter resistance from the unions and professional associations.

More flexible working conditions should be introduced. The excessive hours worked by doctors will have to be revised to conform to European Directives. It has been proposed that more generous pay packets should be offered to specialists willing to work exclusively in the public sector but it is doubtful whether sufficient funds would be available to provide attractive enough contracts for them to give up private work.

The professional associations and unions are lobbying for health care employees not to remain civil servants in the hope that this would lead to better pay deals and conditions of work. No concrete proposals have yet been put forward and it is unlikely that such a change will happen in the near future.

Fig. 12. Number of physicians and nurses per 1000 population in the WHO European Region, 1996 or latest available year



Source: OECD health data 1998; WHO Regional Office for Europe health for all database.

Pharmaceuticals and health care technology assessment

The pharmaceutical sector in Malta involves several actors. Malta has only one pharmaceutical manufacturing company and relies almost entirely upon imports. Private Maltese pharmaceutical importers represent the international pharmaceutical companies. These importers act as purchasers and distributors both to the state and to private pharmacies or clinics.

The state pharmaceutical sector falls under the Government Pharmaceutical Services. This department carries out certification for government tenders and controls pharmaceutical supplies. The size of Malta's population generates only small orders for drugs. Since almost all supplies are imported it takes 8–20 weeks for pharmaceuticals to be supplied. It is often difficult to obtain stocks quickly and this has been a problem when drugs are urgently required. Expenditure on pharmaceuticals is steadily increasing (see Table 2) and now accounts for more than 20% of total government recurrent expenditure on health.

The Medical Regulatory Affairs Unit (MRAU) has three branches:

- **Registration** – There is no local registration system in Malta as yet. Approval for pharmaceutical products takes place on the basis of products being registered abroad usually supported by WHO certification scheme;
- **Pharmaco-vigilance** – monitoring of products on the market for side-effects, adverse reactions, etc.;
- **Enforcement** – Legislation relating to dealers, manufacturers, pharmacies and pharmaceutical activities is enforced by the MRAU. The government also regulates licensing of pharmacies and requires a qualified pharmacist to be in attendance at all times.

Price control

The present legislation governing pharmaceutical pricing was established in 1982. It allows a 15% profit margin after cost, insurance and freight to the importer/wholesaler. The pharmacist is allowed a further 20% profit. The price for each drug at the point of sale is calculated in this way. The system regulates profit margins but does not impose price controls in same manner as occurs in certain European countries.

Drugs list

The state health care system has an essential drugs list in a national formulary which is dynamic and encompasses a wide range of pharmaceutical products. This is drawn up by the Drugs and Therapeutics Committee, which is also

responsible for authorizing requests for non-formulary items. This essential drugs list is applicable to drugs prescribed to inpatients and Pink/Yellow Card holders, all of whom receive free treatment. Only drugs from this list are made available in health centre pharmacies and government local clinics. This restriction does not apply to private retail community pharmacies.

Dispensing

The government-purchased brands, which may be generics, are dispensed to those patients entitled to free drugs. This often leads patients to perceive that free drugs are of inferior quality because they lack the familiar packaging and branded names.

Medicines provided under the state health care system are dispensed from health centre pharmacies and local clinics. This system has been criticized for being both impersonal and inconvenient for the patient. A pilot project was carried out a few years ago to attempt to introduce a system whereby patients could collect their monthly drugs from a pharmacy of their choice. This would avoid long queues and allow continuity of care as a pharmacist-patient relationship is built up. A committee is currently drawing up proposals for the implementation of the scheme.

Cost-containment measures

Expenditure on pharmaceuticals has been steadily increasing and now accounts for around 20% of government recurrent expenditure on health care. There are currently no mechanisms to influence doctors' prescribing practices, to promote cost-effective treatments or to analyse prescribing patterns and give doctors feedback or prescription profiles. Information exists about drugs purchased by the state and where they are being used but no prescription monitoring occurs.

Legislation for over-the-counter treatment is rather outdated despite over-the-counter treatment being very common. Even drugs which require a prescription such as antibiotics may sometimes be obtained over-the-counter as laws are not always rigidly adhered to.

The principal cost-containment measure is the strict procedure for authorization of non-formulary drugs. There are no mechanisms to curtail public abuse of the free pharmaceutical systems. In 1997 a flat-rate co-payment system for pharmaceuticals was introduced. This was revoked in 1998 by the present government since it was considered to be ineffective and regressive.

Areas for reform

International experience has demonstrated that cost-containment measures have been more effective when applied to the supply side rather than the demand

side. Supply side measures such as the introduction of ward pharmacists has been proposed but has not been possible so far due to lack of human resources. Ward pharmacy is now being piloted on two wards and initial results are encouraging. It is believed that the ward pharmacist could help bring about cost-containment by monitoring prescribing practices and advising accordingly. This alone is not sufficient and appropriate information technology systems must be in place to track supplies and monitor prescription practices.

Incentives for cost-effective prescribing must be introduced in both the public and private sectors. These must be attractive enough to counteract those offered to doctors by importers such as sponsorship for attendance at conferences. They should not only work on doctors but also on pharmacists possibly by allowing pharmacists to substitute drug brands prescribed by doctors.

Private sector

The private pharmaceutical sector plays a significant role in the Maltese health care system as a large number of persons are not entitled to free government pharmaceuticals on the basis of income or disease. There are 203 private retail pharmacies, which is approximately one pharmacy per 2000 inhabitants. The Department of Health tightly regulates licensing of pharmacies. There has been strong resistance by the industry to proposals for an increase in liberalisation of this sector.

Health technology

There are no official bodies to regulate health care technology. For the state health care system, the Medical Equipment Committee approves the purchase of new technology. The procedure is rather bureaucratic and heavily centralized. Individual provider units are not allowed to purchase medical equipment without central approval. Health care technology in the private sector has to satisfy regulations pertaining to quality and method of operation. There is however no restriction on the amount of medical technology that can be purchased by the private sector. The Malta Standards Authority regulates the quality of imported goods.

Financial resource allocation

Third-party budget setting and resource allocation

The Health Division submits its request for funds to the Ministry of Finance after prioritizing its requirements. The Ministry of Finance carries out resource allocation between the different sectors at a national level and thus determines the overall health care budget. Government health care expenditure is therefore capped by means of a fixed budget determined by the Ministry of Finance. The Division's full request for funds has never been met. The national budget is discussed and approved by Parliament. The budget is earmarked to various expenditure headings and programmes. Each Department is allocated a budget as a cost centre.

Resource allocation between different programmes occurs through discussions held between the Ministry of Health, Director General (Health) and the Director of Finance and Administration after considering the requests for funds put forward in the business plans of the various Departments. This tends to be based on historical allocation and it is rather difficult to shift and relocate funds. Levels of income of health professionals are determined according to civil service salary scales and collective agreements with unions are made by the Office of the Prime Minister.

Geographical resource allocation is not applicable to Malta as there are no regional or district levels in the health care system. Total budgeted expenditure is divided into recurrent and capital expenditure. Decisions regarding capital investment are made on a national level by Government. There are no private sector controls on capital investment but the building or opening of clinics, pharmacies and hospitals requires a licence from the government.

There are several problems with the system:

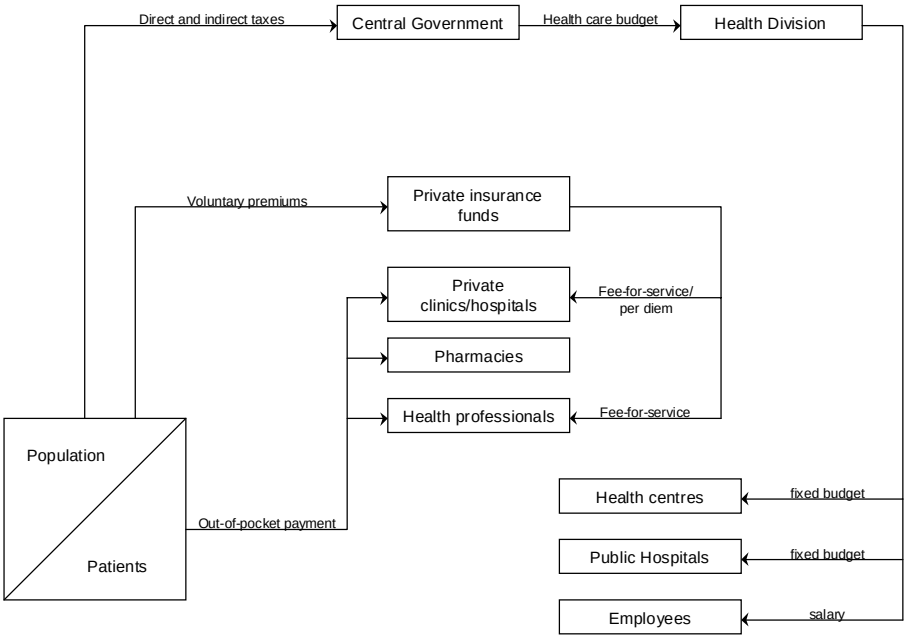
- lack of control over budgetary allocation
- lack of accountability for resource utilization at unit level

- rudimentary information on expenditure at unit level
- no incentives for cost-containment.

The reform of the financial system in state hospitals will improve accountability and provide detailed information on expenditure at ward level. So far there are no concrete proposals to overcome the remaining problems described.

The private health sector does not have a fixed or limited budget. The level of spending is determined by retrospective insurance reimbursement and patients' out-of-pocket payments. Reimbursement operates by means of a combined per diem and fee for service basis. This leads to a situation where there are no macro cost-containment measures. Health care expenditure in the private sector shows an increasing trend at present.

Fig. 13. Financing flow chart



Payment of hospitals

Public sector

The state health care system follows the integrated model with public hospitals being owned by the state. As from the 1999 budget, global budgets are being directly allocated to individual hospitals budgets calculated on a historical basis.

Until 1998 government had allocated funds directly to the Department of Institutional Health and funds were not earmarked for the various hospitals. Funds could be utilized in any hospital and there was no incentive for hospitals to contain costs and stay within a given budget.

The flow of funds has been difficult to track in the past but it is hoped that this reform will make the process more transparent. People working in the system usually have little idea of the costs incurred by their decisions and actions and the system is not very responsive. It does not encourage any cost-effective or cost-containing behaviour. On the other hand it does not promote productivity either, as budgets are not related to activity.

It is hoped that as hospitals are made more financially accountable and managerially autonomous, clinical level budgeting will be adopted. Hospital autonomy will not affect the way in which hospitals are funded as they will still have global budgets. However it will allow decisions requiring financial outlays to be taken closer to the source as well as allowing the development of the appropriate management structures and hospital systems. Incentives for cost-containment will have to be built into the system. It is not clear at this stage what types of financial incentives will be utilized.

Private sector

Private hospitals and clinics are paid either directly in the form of out-of-pocket payment or retrospectively through reimbursement from voluntary insurance schemes. They are paid on a combination of fee-for-service and per diem basis. Case payment exists only for special package deals such as maternity care. There are no pressures to be efficient or to contain costs but there may be incentives to increase activity. Prices are not regulated by the government. Patients usually pay for the services and are later reimbursed by their insurance.

Payment of physicians

Public sector

Doctors working within the public health care system are civil servants and are therefore salaried irrespective of whether they work in primary care or in hospitals. The salary is determined according to the civil service scale that corresponds to the doctor's grade. Civil service salaries are in turn determined by collective agreements following negotiations with national trade unions where the doctors' association is represented. The doctor's pay packet consists

of the salary and allowances. The allowances are for working duties after hours, Sundays and public holidays. Doctors are paid the standard rate for duties for the first extra ten hours a week and one-and-a-half times the rate for additional hours after that. For Sundays and public holidays they are paid two and two-and-a-half times the standard rate respectively.

Doctors' salaries are comparable with other salaried professionals within the civil service. However salaries are poor compared to possible earnings outside the public sector. This means that nearly all public sector doctors carry out some form of private practice. The income from their private work usually exceeds the state salary and for top earners may be several times greater than what they earn from the state. Doctors' basic salaries range from approximately Lm 360 per month for junior doctors to approximately Lm 600 per month for consultants. These salaries are much lower than those paid to for example engineers and accountants in the private sector.

A few years ago attempts were made to introduce a merit award scheme; however, this mostly favoured consultants and it was agreed with the Medical Association that the scheme would have to be reconfigured before repeating it. There are no target or bonus payments to reward activity within the system.

Physician payment is considered unsatisfactory as it leaves doctors feeling demotivated and does not encourage productivity or efficiency.

Private sector

In the private sector doctors' fees are supposed to be determined by the Minister of Health based upon recommendations from the Medical Council. However the fees have not been appropriately revised and updated, so the Medical Association has attempted to fulfil this function. They can only issue guidance and do not oblige practitioners to charge the recommended fees. Most patients pay out-of-pocket for ambulatory general practitioner and specialist care. Physicians are paid on a fee-for-service basis by voluntary insurance agencies. Last year, the Medical Association of Malta finalized an agreement with a major private insurance company about the appropriate level of fees to be charged. This was intended to avoid over-pricing but the agreement only issued guidelines and did not oblige doctors to follow the fee schedule issued.

Some large companies may pay doctors on a capitation basis to look after their employees.

Future challenges

Whilst the Medical Association views withdrawal from the civil service as the only hope to improve the level of salaries, the government has been considering the idea of introducing improved pay packages for specialists willing to work exclusively within the public sector. The problems with such a proposal are that the package offered must be sufficiently attractive to entice people to give up private work and it is uncertain whether the state can afford such levels of pay. It may also lead to similar demands from other health professionals. Some directors within the health service remain rather sceptical about the possibility that this would increase productivity and efficiency in the government service. Finally the medical profession considers the right to private practice as an important privilege and may resist the introduction of such pay packages.

Health care reforms

Aims and objectives

A number of factors instigated the health care reforms launched in 1993. The need for radical management reforms was a combined result of the highly centralized and bureaucratic system together with the conspicuous absence of:

- effective managerial structures
- cost-containment measures
- incentives for productivity and efficiency
- audit and accountability
- quality control.

In addition the deterioration of estate and infrastructure necessitated an extensive refurbishment and modernisation programme. The weak and fragmented primary care system and lack of community services and facilities also need to be specifically addressed in the reform process.

The main aim of the health care reform is to make the transition from a piecemeal planning approach based upon crisis management to planning with foresight in a holistic manner. In order to ensure that the holistic dimension is present, intersectoral collaboration is being pursued.

The policy orientation of the reforms as outlined in the documents, *The Vision Behind the Health Sector Reform* and *The Strategy Behind the Health Sector Reform* will be:

- an integrated approach
- client-centred
- outcome driven (evidence-based)
- financially sustainable.

Reforms and legislation

Legislation

The reforms that have taken place so far have not been accompanied by many legislative changes. This section describes both enacted and pending legislation.

Private medical clinics
In 1995 legislation governing the licensing of private medical clinics was enacted. This legislation paved the way for the opening of private hospitals. There had been no private hospitals in Malta since 1980 when a law prohibiting private hospitals was passed during the doctors' strike. This legislation hailed a change in policy regarding the involvement of the private sector in hospital care. The legislation deals with aspects such as facilities, human resources required and types of procedures that may be carried out. It does not refer specifically to private nursing homes.

Co-payments on pharmaceuticals
In 1997 administrative measures were taken to introduce a flat-rate co-payment for medicines provided free of charge by the State. This was mostly intended to curb abuse rather than to provide significant revenue. This measure only lasted for nine months as the co-payment system was abolished by a new government. These circumstances make it seem unlikely that similar co-payments within any part of the state health care system will be introduced in the foreseeable future.

Draft Health Services Administration Act
This draft act establishes the reformed administrative set up of the Health Division. Parliamentary time is still required in order for the legislation to be discussed and enacted. The Health Division is currently organized as stipulated in this Draft Act but it operates within the legal framework provided by the Constitution in addition to provisions of the old legislation.

Policy proposals

Family doctor scheme
In 1991 a scheme for the much-needed reform of primary health care was drawn up. It proposed that patients should be registered with a general practitioner in order to improve continuity of care. It also proposed changes to the method of remuneration for general practitioner from salaries to a mixture

of capitation and allowances. The scheme was intended to incorporate family doctors both from private practice and from the government service. Efforts are presently under way in order to re-submit a proposal for primary care reform based upon similar principles.

Health Vision 2000

This document encompasses the national Health for All Policy. It serves as the point of reference for all current health policy initiatives and reforms. It is composed of three sections:

- Diseases
- Risk factors
- Health sector reform.

The most important diseases and risk factors were identified using a priority setting approach. The individual areas are now being tackled separately in detail and recently policy documents on prevention and management of road traffic accidents and asthma have been drawn up in conjunction with the relevant sectors. The objectives for health sector reform are also highlighted in *Health Vision 2000*. This document was approved by Cabinet in 1994 and publicly launched in December 1995.

Mental health policy

This document outlines the strategy for reform in mental health care highlighting the importance of multi-disciplinary work and the shift towards community-based care. Despite being approved by Cabinet, the reforms in this area have proceeded at a very slow pace.

The Vision behind Health Sector Reform* and *The Strategy behind Health Sector Reform

These two documents were completed in 1998 and have not yet been published. They outline the objectives for health sector reform and the methods to be employed in carrying out the reform. They have not yet been approved by Cabinet; however, all reforms currently being implemented are designed according to the parameters laid out in these documents.

The main thrust of health sector reform is focused on the following:

- Decision-making is to be devolved to unit level both in hospitals and in health centres. This necessitates reform both in the management structures as well as in the systems of financial flows. The appropriate information technology is necessary to support such a change.
- Financial responsibility and accountability has to start at unit level.

- Resources have to be redirected towards health promotion and disease prevention in the primary care setting.
- The Health Division must cease to be a direct provider of services whilst strengthening its functions of policy-formulation, resource allocation and regulation of health service provision. It must also develop mechanisms to monitor and audit quality of service provision.
- The Director General of the Health Division must develop and strengthen the role of coordinator in order to ensure that all departments work harmoniously towards a common goal.
- All operational systems in the health service are to centre on financial control and accountability, performance assessment and outcome evaluation.

Future legislation
All future legislation will have to conform to European Union Directives as Malta is an applicant country for EU membership. An exercise to identify the gaps and discrepancies between EU and Maltese law in health and health-related matters has just been completed (PACMAN).

Reform implementation

Private sector
The reforms to give greater scope to the private sector have borne fruit. The re-introduction of private hospitals has also created a demand for voluntary private insurance. It is probable that tax rebates on private health insurance will shortly be introduced.

Partnerships with the private sector have been established for contracting out services such as community nursing, cleaning and MRI services. This initiative will be extended to other sectors.

Administrative sector
The changes proposed in the Draft Health Services Administration Act have mostly been introduced even though the new structures do not yet have the legal backing they require. Delays in approving legislation and policy proposals slow down the implementation of reforms. The Health Division still remains a very centralized and bureaucratic structure that lacks the capability to respond flexibly to changes in the internal and external environment.

Hospital sector
Reforms in this sector are well under way. Management and financial reforms have been implemented in a small specialized hospital, (Boffa Hospital) and

are almost complete in the psychiatric hospital (Mount Carmel Hospital). In 1999 reforms will commence in the main hospital (St. Luke's Hospital). The aim is to have new management systems and quality control in place prior to the transfer process to the New Hospital. This is an ambitious agenda, which will require a supportive environment and the necessary resources for reform implementation.

Primary care/community services

The failed attempt at reform in the early 1990s had subdued politicians', doctors' and the public's hopes for a reformed primary care system. However the process has been re-started and negotiations are currently taking place with unions and care providers to try to attain agreement on a policy proposal for reform in this field. This proposal is expected to be presented to Cabinet some time during 1999.

Drivers for reform

The driver for health sector reform as part of the reform of the entire civil service was initiated by central government. Reforms did not commence in response to health professional or public pressure. The reform process was taken up enthusiastically by the Ministry of Health and the Health Division who are now pushing for the introduction of efficient systems with further decentralization. The health professionals are also lobbying for autonomy from the civil service. The economic situation of the country with an escalating public deficit has also exerted pressure on the health care system to function more efficiently and achieve value for money.

Obstacles to reform implementation

Civil service regulations

The bureaucratic and outdated civil service regulations impede the introduction of many of the necessary reforms. This problem has also been recognized by the health professionals and they are lobbying for health care to be independent of the civil service. The strict hierarchical structure hampers the organization from being flexible and responsive to its surroundings.

The lack of control at unit level, over recruitment and job conditions makes it difficult to introduce change in a service that is well known for being highly labour intensive. The strict financial regulations stipulate low cash limits for procurement.

Requests have to be channelled from the Director of Finance and Administration, via the Permanent Secretary to the Ministry of Finance. This renders the process lengthy and highly bureaucratic.

Political framework

This incorporates both party politics as well as internal politics. On a macro-political level, there is wide consensus on a number of health-related issues in Malta. Internal politics is an important issue in health care as a number of professional and other groups strive to achieve power and recognition. The Health Division recognizes that support from politicians and health professionals is of paramount importance for the successful implementation of health reforms. For this reason it is seen as wise to adopt a gradual and cautious approach giving time for staff to become accustomed to new ideas and ways of working.

Cultural context

The most difficult barrier to overcome when implementing reforms in Malta is the cultural context. One has to understand that as part of the civil service, the health sector never operated a system of incentives and penalties. The relatively low pay and the nature of health care work have engendered a situation where working overtime or carrying out an additional job in the private sector is the norm for the vast majority of health care employees. Any proposed reforms must take this phenomenon into account if success is to be achieved.

Conclusions

The Maltese health care system is commendable for its equity and comprehensive coverage for all citizens. Over the years it has developed innovative services offered free of charge to all those who require them. In spite of the fact that Malta has a small population with highly limited resources the health care system offers a highly comprehensive service.

The major challenges facing health care in Malta are ensuring sustainability of the system, developing micro-efficiency and building mechanisms to measure quality and outcome. The reform process, based upon objectives drawn up in 1993, has commenced but is proceeding slowly. It is important that implementation of the necessary reforms continues in order to ensure that the health care system attains the identified health policy goals.

A policy framework, launched in 1995, identifies the key diseases and risk factors that must be targeted to achieve the desired health gains. Indicators of health status in Malta are generally favourable. The public health service is well established and the population approach towards health gain based on health promotion and disease prevention will be sustained paying particular attention to the target areas.

The goal of efficiency is currently a priority throughout the public sector in Malta. Health care expenditure, both public and private, has shown an upward trend. Whilst public expenditure is controlled by budgetary capping, private health care expenditure may continue to grow exponentially if present trends persist. Within state health care, the reforms of management structures and the establishment of systems for accountability are being carried out to improve micro-efficiency. This requires the support of information technology and personnel training. Techniques that are known to reduce lengths of stay are available and their use needs to be consolidated. However for hospitals to be able to function more efficiently, staff incentives linked to performance must be introduced.

Inappropriate utilization of acute hospital services needs to be tackled. For this to diminish a strong primary and community care service is required. Reform in this sector is urgently needed alongside the development of community services. Both are necessary to ensure that the needs of the growing elderly and frail population are met appropriately by the health care system.

The widespread availability of private health care services and the opening of private hospitals since 1995 has greatly enhanced consumer choice. In private health care, consumer choice is virtually unlimited both for primary and specialist care as there is no gatekeeper function. Choice in the public sector is somewhat restricted in terms of facilities due to Malta's size. It would not be cost-effective to have several hospitals and specialists who perform highly specialised procedures. Otherwise patients are offered a choice of specialist in most areas of hospital care. In primary care the public system does not guarantee consumer choice and this is one of the major issues that will be addressed in the reforms. The involvement of patient groups as partners in developing policy is gradually being established.

One of the major strengths of the health care system is the highly professional and dedicated health care workforce. However the very high standards of clinical care are often compromised by environmental constraints such as hospital overcrowding in winter. This problem can only be overcome by intersectoral collaboration with social care providers for the elderly, as well as by ensuring an adequate gate-keeping function exercised by a strong primary health care system. The professional regulatory boards serve to monitor ethical and professional standards. However the Ministry of Health needs to transform itself from direct provider of services to regulator. It must develop its role as auditor and must establish effective quality assurance mechanisms. It must also strengthen its role as regulator for the private sector especially in view of the recent increase in private health care delivery.

A holistic approach to health care reform is being pursued. Collaboration between primary care and hospital care services together with the support from the well developed public health services will be necessary to ensure that the health care system develops in a sustainable manner in the coming years.

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