

HIGHLIGHTS ON HEALTH IN MALTA



Country Highlights give an overview of the health and health-related situation in a given country and compare, where possible, its position in relation with other countries in the WHO European Region. The Highlights have been developed in collaboration with Member States for operational purposes and do not constitute a formal statistical publication. They are based on information provided by Member States and other sources as listed.

CONTENTS

OVERVIEW.....	1
THE COUNTRY AND ITS PEOPLE	2
HEALTH STATUS	6
LIFESTYLES	17
ENVIRONMENT AND HEALTH	21
HEALTH CARE SYSTEM.....	23
REFERENCES.....	26



TECHNICAL NOTES

Highlights on Health provide an overview of the health of a country's population and the main factors related to it. When possible, comparisons are made with other countries in the WHO European Region as one means of assessing the comparative strengths and weaknesses, what has been achieved so far and what could be improved in the future, similarly to the approach and rationale used for setting the 21 targets in HEALTH21, the health for all policy framework for the WHO European Region (*WHO Regional Office for Europe, 1999*). The country groups used for comparison are called reference countries and are chosen based on: similar health and socioeconomic trends or development and/or geopolitical groups such as the European Union (EU), the newly independent states, the central Asian republics or the candidate countries for EU accession.

For Malta, the reference countries are the 15 EU countries as well as Iceland, Israel, Norway and Switzerland.

To make comparisons between countries as valid as possible, data for each indicator have been taken from one common international source (such as WHO, the Organisation for Economic Co-operation and Development, the International Labour Office or EUROSTAT), whenever possible. Nevertheless, other factors such as recording and classification practices and cultural differences can influence the comparability of the data. Unless otherwise mentioned, the source of all data is the health for all statistical database of the WHO Regional Office for Europe. Information on national policies has been obtained from health for all evaluation reports from national authorities and by personal communication with them and from *Health in Europe 1997 (WHO Regional Office for Europe, 1998)*.

A special case of comparison is when each country is given a rank order. Although useful as a summary measure, ranking can be misleading and should be interpreted with caution, especially if used alone, as the rank is sensitive to small differences in the value of an indicator. Also, when used to assess trends, ranking can overshadow quite important absolute changes in the level of an individual country. Mostly bar charts (to indicate a country's position versus the reference countries according to the latest data) or line charts (usually to show time trends from 1970 onwards) have been used. Line charts present the trends for all the reference countries and for the EU or another geopolitical group, as appropriate. Only the country in focus and the appropriate group average are highlighted in bold and identified in the legend. This enables the country's trends to be followed in relation to those of all the reference countries, and performance in relation to observable clusters and/or the main trend or average can be recognized more easily. To smooth out fluctuations in annual rates caused by small numbers, 3-year moving averages have been used, as appropriate. For example, this is the case for maternal mortality for all reference countries.

Malta has a comparatively small population and the yearly statistics on births, mortality and morbidity may therefore undergo substantial random variation. Three-year moving averages are therefore used for these statistics wherever possible and appropriate. The 3-year moving averages used in the text and in the figures are indicated. The year mentioned is the middle of the 3 years: the second latest year for which data were available when this document was prepared.

Comparisons should preferably refer to the same point in time. However, the countries' latest available data are not all for the same year. This should be kept in mind, as the country's position may change when more recent data become available.

OVERVIEW

Most health status indicators in Malta are favourable. On the whole, the country has made good progress. Mortality in Malta has progressed from relatively high to levels closer to the European Union (EU) average. However, health has improved more for men than for women, who seem to be relatively more disadvantaged than in other western European countries. Cancer appears to be of growing importance as a health problem. Some chronic diseases such as diabetes, asthma and glaucoma cause specific concern and are targeted for more active intervention. However, there is very little information on

common risk factors related to lifestyles, such as smoking or low levels of physical activity, where problems may be hidden. The same applies to environmental risk factors.

The health care system is relatively equitable and comprehensive. The health care reforms are well focused on sustainability and quality based on an integrated and holistic approach. However, the reform implementation is slow, partly because of administrative, political and cultural obstacles. The political objective of EU accession is an opportunity to streamline and accelerate the process of reforms.

THE COUNTRY AND ITS PEOPLE

Malta is a republic with a single-chamber parliament. It was under the British crown from 1814 to 1964, when it gained independence. From 1964 to 1979 Malta retained close ties with the United Kingdom, which had a military presence. In 1974 a republican constitution was adopted, and the President of Malta replaced the Queen of England as the head of state. The President assents to bills and opens and dissolves Parliament. Except for rare constitutional matters, the President must act on the advice of the Prime Minister or in accordance with it. The executive power lies with the Prime Minister and the Cabinet, similar to the United Kingdom. Legislative power lies with the Parliament and judicial power with the courts. The appointment of ministers is a prerogative of the Prime Minister, but appointees have to be members of the Parliament (*Government of Malta, 1997*).

Elections are normally held every 5 years. However, in 1998, a parliamentary election was held after a period of only 21 months.

Malta is divided into 68 local council districts. Elections for local councils are held every 3 years. The national government is responsible for providing health care services.

Malta is a member of the British Commonwealth, the Council of Europe and the United Nations.

Malta applied for EU membership in 1990 (*Turner, 1998*). The application was put on hold during the period 1996–1998 in which the Labour Party held office but was re-activated by the Nationalist Government elected in September 1998.

The national language is Maltese. This is a unique language with Semitic roots mixed with Romance elements and is a good example of the cultural heritage of the country. Both English and Maltese are official languages. The official religion is Roman Catholicism, which is taught in all schools.

Demography

Malta's population of 377 516 in 1998 makes it one of the smallest countries in Europe. The population density is high, 1195 people per km² in 1998, which renders most of Malta urban area. In 1998, 90% of the population was living in urban areas.

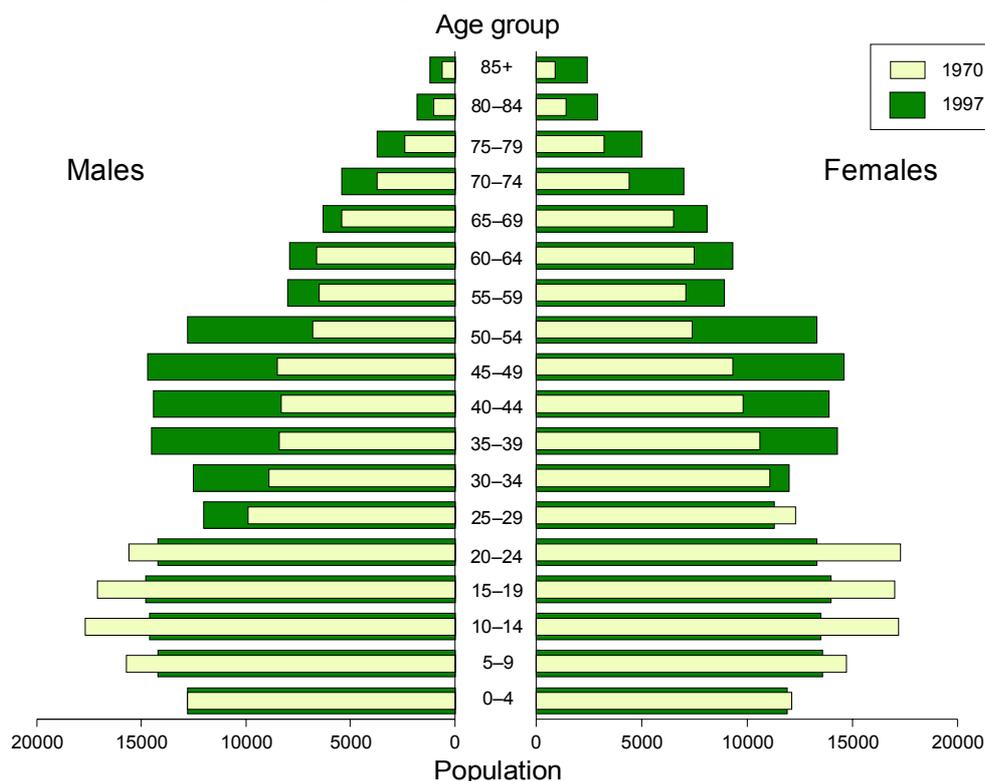
The age pyramid (Fig. 1) presents the age structure of the population in 1970 and 1997. The proportion of the population aged 0–14 years decreased to 21% in 1998. Compared with other countries, the number of people aged 25–34 is relatively small in Malta. This is partly due to a significant decrease in the birth rate first in the 1960s and partly due to emigration (*Central Office of Statistics, 1997*).

Table 1. Basic data on Malta and the EU (1998 or latest available)

	Malta	EU	Minimum among EU countries	Maximum among EU countries
Capital	Valletta			
Population (in millions)	0.378	374 162	0.426	82.028
• 0–14 years (%)	21	17	15	24
• 15–64 years (%)	67	66	64	68
• ≥ 65 years (%)	12	16	11	18
Area in km ²	316	3 243 654	2 600	552 000
Density per km ²	1 195	115	15	379
Urban population (%)	90	80	37	97
Births per 1000 population	11.9	10.7	9.1	14.7
Deaths per 1000 population	8.1	10.0	8.7	11.6
Natural growth rate per 1000 population	3.8	0.7	–0.9	5.7
GDP per person in US \$ (PPP)	13 180	20 327	13 912	33 119

GDP: gross domestic product; PPP: purchasing power parity

Fig. 1. Age pyramid, 1970 and 1997



The older age groups comprised a larger proportion of the population in 1997 than in 1970. The share of population aged 65 years or older increased to about 12%. The large proportion of the population born in the mid-1940s during Malta's "baby boom" will reach the retirement age of 60 years starting in 2005. At this time the dependency ratio will change significantly, and this is expected to increase welfare problems.

The natural population growth rate (Fig. 2) in Malta is higher than the EU average and than the rate in most reference countries. In 1998, the natural population growth was 3.8 per 1000 in Malta versus 0.7 in the EU on average. The natural population growth rate has been declining, mainly because the crude birth rate is falling, whereas there has been little change in the crude death rate. There has also been a concomitant decrease in the total fertility rate to 1.8 in 1998.

Household composition and family structure

According to the 1995 census, the average household size was 3.25 in 1995, higher than

in most EU countries (*United Nations Economic Commission for Europe, 1999*).

In 1998, 367 of 4125 total births were outside marriage (8.9%).

The number of marriages in 1998 was 2376 (6.3 per 1000 population) (*Central Office of Statistics, 1998*). The constitution of Malta does not recognize divorce, and only legal separation is therefore possible under the laws of Malta (*Central Office of Statistics, 1998*). This may have negative health effects on people who wish to divorce.

The relatively large households and the high population growth could have important implications in improving social cohesion and family health care.

Migrant population and ethnic profile

Immigrants and ethnic minorities can have specific patterns of disease and health needs because of cultural, socioeconomic and behavioural factors and exposure to a different environment in their country of origin. Obtaining access to health care that can meet such specific needs and is culturally and

linguistically acceptable can also be difficult. Moreover, many immigrants have a higher risk of living in relative poverty and being marginalized in their countries of residence, which can result in reduced health status compared with non-immigrants. Illegal immigrants, in particular, can find it difficult to obtain health care, and following up any care given can be problematic.

Malta has no significant ethnic minorities, and emigration is generally considered to be a more important issue than immigration. Immigrants, mostly from Libya, comprise less than 1% of the population.

In 1997, 300 people were granted refugee asylum in Malta (*United Nations Economic Commission for Europe, 1999*).

Education

The relevance of educational attainment to health has been well documented. The literacy rate among the population aged 15 years or older has often been used as an indicator, but this is not very useful in Europe. In addition, all the reference countries have universal primary education with almost all children participating. Therefore, the gross enrolment ratio¹ for primary education is also not a very sensitive indicator for detecting differences in educational levels.

There are, however, data on the enrolment ratios in secondary education (such as middle school, high school and vocational and technical schools) and tertiary education (universities and other higher professional schools). In 1997, the gross enrolment ratio in Malta was 85% for secondary and 31% for tertiary education (*UNESCO, 1999*). The latter was the lowest among the reference countries despite increases.

Based on 1995 census data, an estimated 50% of men and 44% of women have completed at least the secondary level of education. Including people who have some secondary

education, the proportions are 65% of men and 57% of women.

Schooling is compulsory for all children aged 5 to 16 years and is provided free of charge by the state. Thirty-three per cent of children attend non-public schools. A voluntary contribution is paid for church schools, and the full tuition is paid in private schools.

Economy and labour

Malta has a small economy with few natural resources. The economy depends heavily on trade and tourism. Although Malta has experienced rapid economic growth recently and the gross domestic product (GDP) per person increased by 20% in real terms from 1993 to 1998, it still has the status of a developing economy (*European Commission, 1999*).

The GDP per person in Malta was US \$13 180 (PPP) in 1997 (Fig. 3). It has increased substantially in recent years but remains low compared with the EU average.

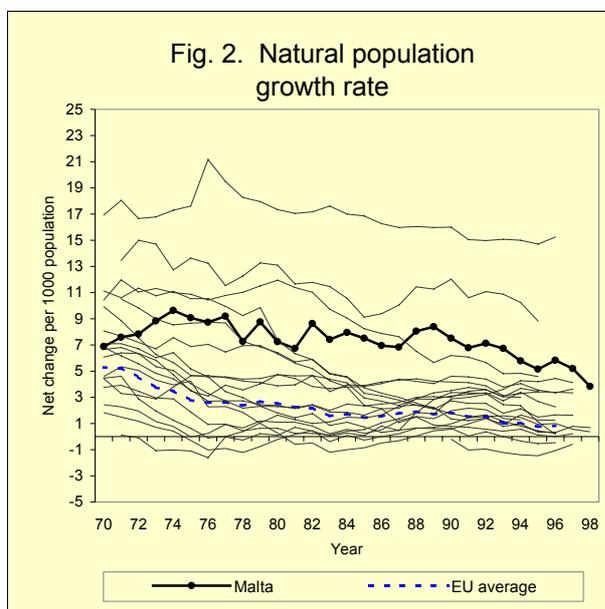
The share of agriculture and fisheries in the GDP is only 3%. The industrial sector accounts for less than one third of GDP. Of this, manufacturing and shipbuilding and repair represent the largest sub-sectors. The electrical machinery sector continues to be a driving force in terms of exports, investment and employment. Its share of the total manufacturing value added increased from 15.2% in 1993 to 27.9% in 1997. The service sector has grown further in importance over the last decade and today accounts for almost two thirds of the GDP. The tourism sector is by far the most important sub-sector, with its contribution to employment and extensive links to other sectors of the economy. More than 1 million tourists visit Malta each year; four fifths are from the EU, and half of these are tourists from the United Kingdom (*European Commission, 1999*).

Most of Malta's foreign trade is with the EU. More than half of Malta's exports go to the EU, and about two thirds of Malta's imports come from the EU countries. In recent years the current account of the balance of payments has gone into a considerable deficit, partly because exports have declined (*European Commission, 1999*).

¹ A gross enrolment ratio for a given level of education is derived by dividing the total enrolment for this level of education regardless of age by the population of the age group that, according to national regulations, should be enrolled at this level (*UNESCO, 1999*).

The population in employment increased from about 132 000 people in 1993 to about 138 000 in 1999. The share of public sector employment is still relatively high: 34% in 1999. The percentage of the population participating in the labour force is 37%, which is rather low compared with most other European countries.

In 1999, the total labour force in Malta was about 146 000 people; 29% of these were women. This is low in international comparison, and one reason may be unfavourable incentives for married women to remain in the labour market. However, the recent introduction of such measures as reduced hours for working mothers has started to change this situation.



Data for Malta are 3-year moving averages



HEALTH STATUS

Life expectancy and health-related quality of life

In 1998, the overall life expectancy was 77.5 years. The latest 3-year moving average (1997) was also 77.5 years (Fig. 4). This ranks 14th of the 20 reference countries. The 3-year moving averages were 80.0 years for women and 74.9 years for men. For men, life expectancy has exceeded the EU average since the late 1980s (Fig. 5); for women, life expectancy has become very close to the EU average (Fig. 6), increasing more rapidly than that of the EU in the past two decades.

The life expectancy at age 65 for men was 14.6 years in 1997 (3-year moving average) (Fig. 7). After a significant drop in the 1970s, this has increased substantially in recent years and has nearly caught up with the EU average of 15.6 years.

For women, the figure was 18.3 years (Fig. 8) and followed a trend similar to men.

The loss in life expectancy from premature mortality is decreasing in Malta as in the EU as a whole (Fig. 9, 10). For both genders the loss in life expectancy from premature mortality (men 4.8 years, women 3.3 years, 3-year moving average in 1997) was less than the respective EU averages. The progress among men in Malta has been impressive.

In summary, mortality in Malta has changed from relatively high to more average levels compared with the reference countries. For men this change was more substantial than for women.

Main causes of death

Comparing the death rates from main causes between countries can indicate how far the observed mortality might be reduced. As almost all the causes underlying the deaths attributed to cardiovascular diseases, cancer and accidents are influenced by collective and individual habits and behaviour, a wide variety of health promotion and prevention measures can bring about changes to reduce health risks and thus disease and premature deaths. In general, Malta's age- and sex-specific death rates by cause are close to the EU averages. The main causes of premature death (under the age of 65 years) are cardiovascular diseases, cancer and external causes of death and injury.

Cardiovascular diseases

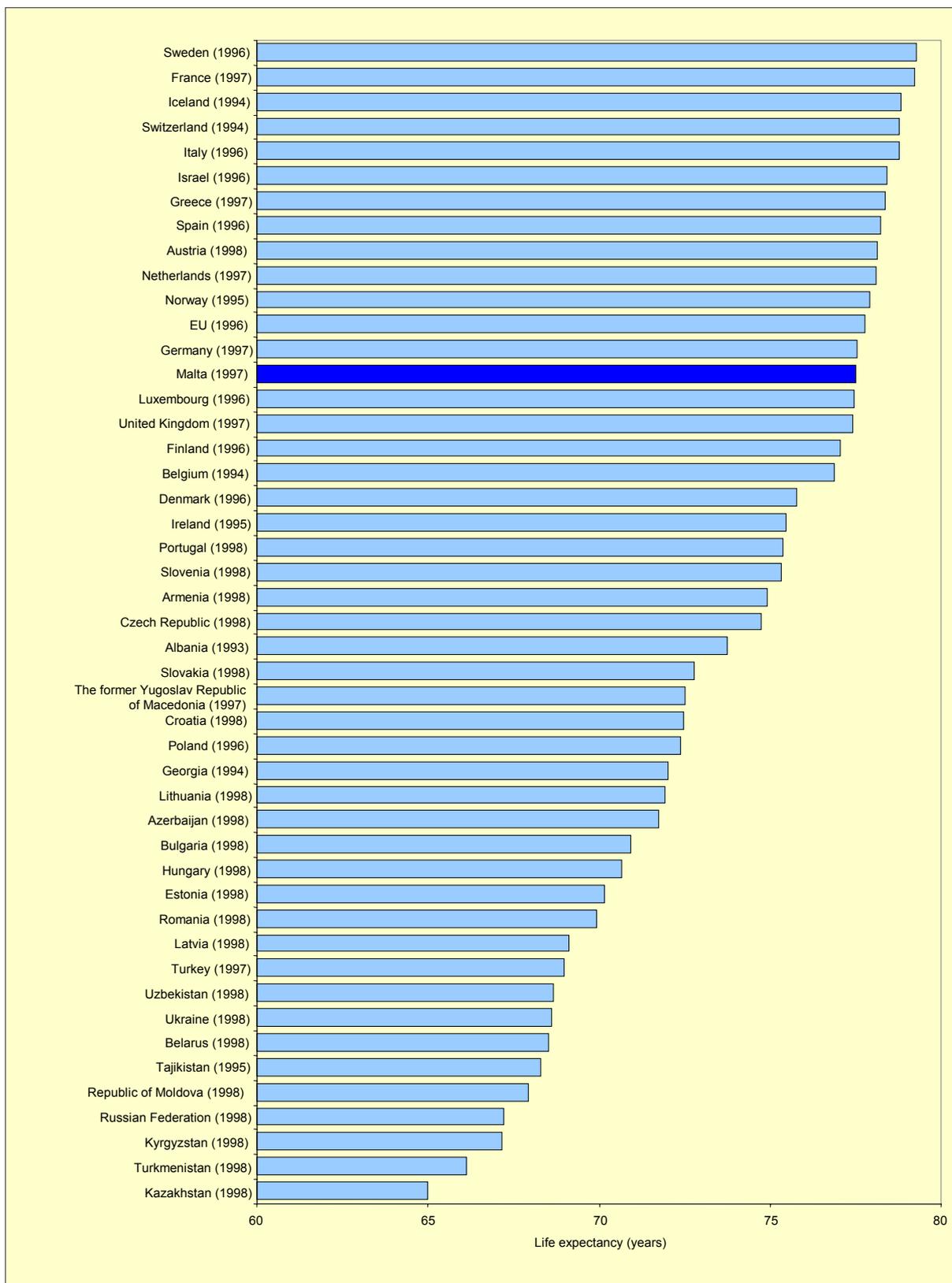
The most frequent cause of death is cardiovascular diseases (CVD). The SDR from CVD declined from 612 per 100 000 population in 1971 to 331 in 1996 (all ages, both genders) despite a major increase in the 1970s and became relatively close to the EU average of 280 (1996).

In the age group 65 years and older, CVD is the most common cause of death. Although mortality from CVD in this age group has declined significantly overall since 1970, it showed the same increase as the general population in the 1970s.

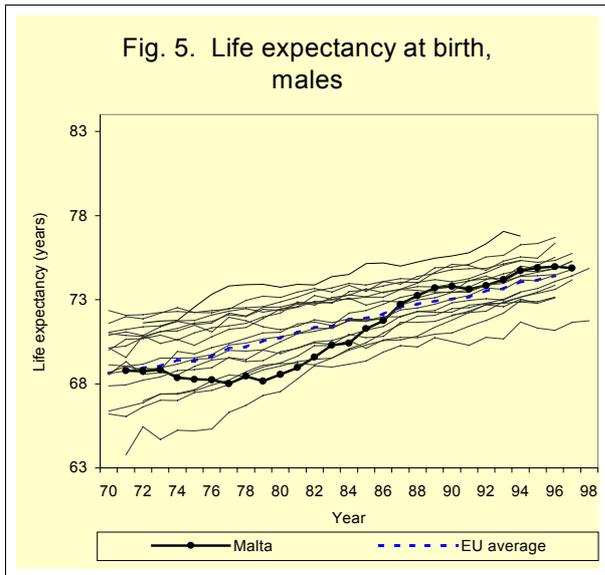
Table 2. Selected health indicators in Malta and the EU (1998 or latest available)

	Malta	EU	Minimum among EU countries	Maximum among EU countries
Life expectancy (years)	77.5	77.8	75.4	79.3
Men	74.7	74.4	71.7	76.7
Women	80.1	81.0	78.6	82.8
SDR for cardiovascular diseases per 100 000 population	331	280	176	385
SDR for cancer per 100 000 population	180	191	160	226
SDR for external causes per 100 000 population	26	42	28	73
New cases of tuberculosis per 100 000 population	4.2	13.7	5.3	51.4
New cases of AIDS per 100 000 population	0.9	3.5	0.3	10.6
SDR: standardized death rate; AIDS: acquired immunodeficiency syndrome				

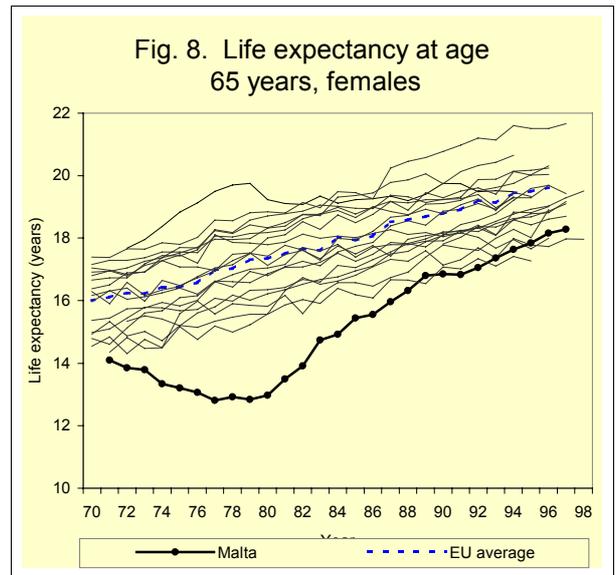
Fig. 4. Life expectancy at birth in years, latest available data



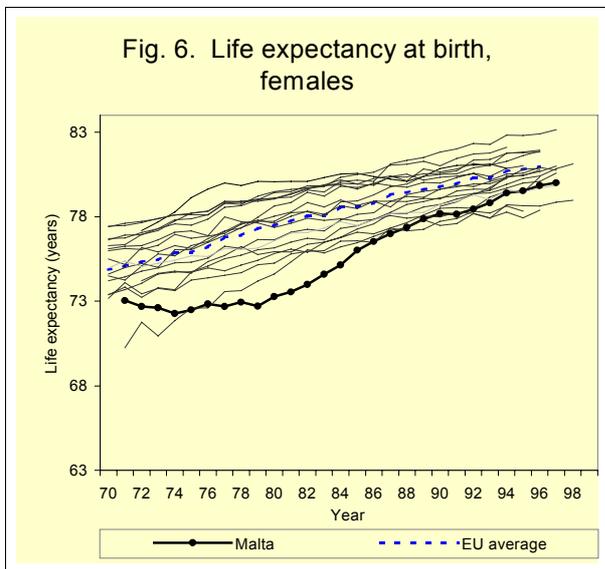
Data for Malta are 3-year moving averages



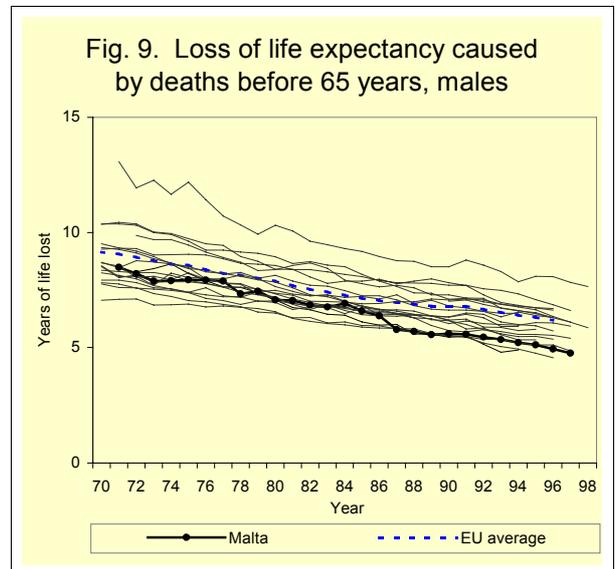
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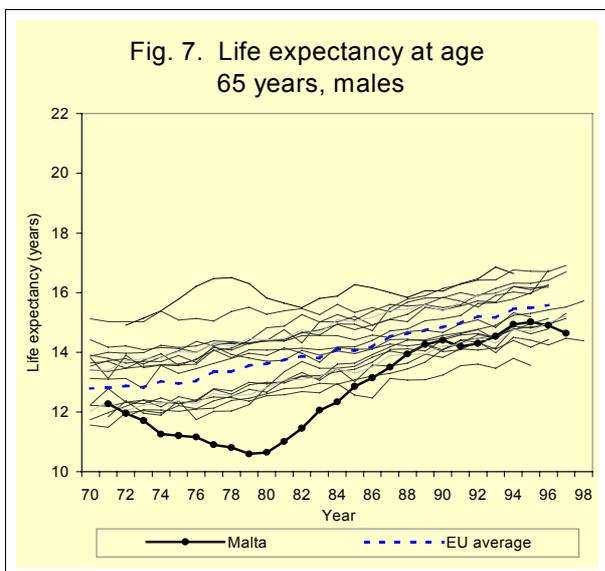
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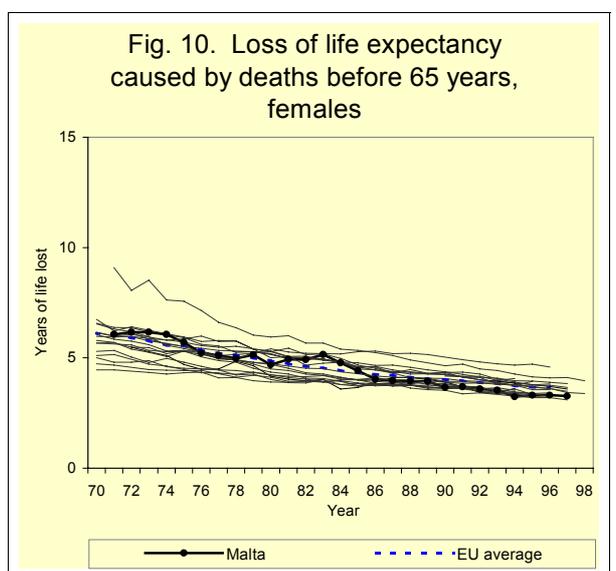
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Data for Malta are 3-year moving averages



Data for Malta are 3-year moving averages

In the age group 0–64 years, the CVD mortality of men was above the EU average in the 1970s and the 1980s (Fig. 11), but these rates are now about the same. The CVD mortality of women 0–64 years was also higher than the level in the EU but has converged to the EU average (Fig. 12).

The mortality from ischaemic heart disease is higher than the EU average, both in the age group 0–64 years (Fig. 13, 14) and among those 65 years or older.

The mortality from cerebrovascular disease is lower in Malta than in the EU for the age group 0–64 years (Fig. 15, 16). Among people 65 years or older, mortality for men is at the EU average, but slightly above it for women.

Overall, the situation in cardiovascular diseases has improved significantly in the last two decades or so after a transient deterioration. A case study of this experience would be a useful reference for policy-makers in other countries.

Cancer

The mortality from cancer among males is lower than the EU average. The rate for females has fluctuated greatly, but the long-term average seems to be close to the EU average. In the age group 0–64 years, the situation is similar (Fig. 17, 18).

The mortality from cancer among people 65 years or older resembles the pattern for those younger than 65 years and has converged with the EU average from previously lower levels.

The mortality from lung cancer among men in the age group 0–64 years (Fig. 19) is lower than the EU average.

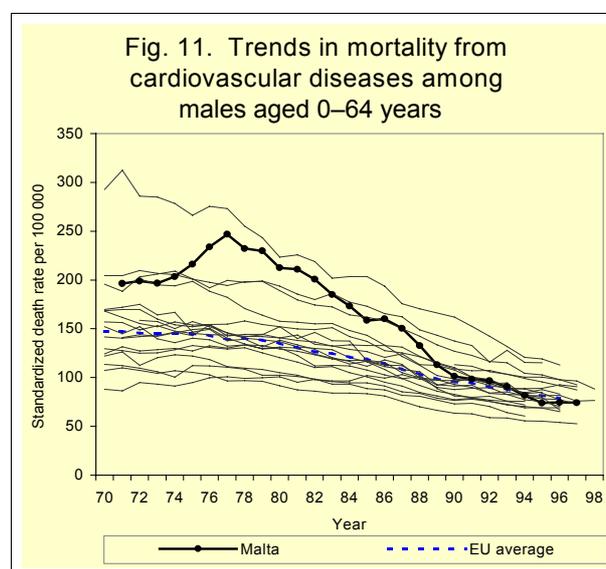
The mortality from lung cancer among women has not been increasing as in the EU (Fig. 20) and remains among the lowest.

The overall incidence of lung cancer was 36 per 100 000 in 1995. The SDR was 33. These figures roughly indicate the poor chances of surviving lung cancer. Resources aimed at combating cancer have increased considerably, notably with the establishment of a cancer hospital. Nevertheless, resources are not sufficient for setting up a comprehensive screening programme for cancer. The mortality

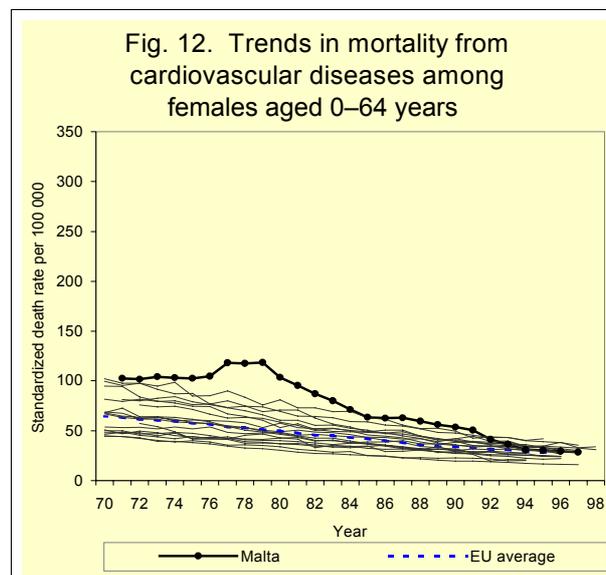
from breast cancer is very high: 40.6 per 100 000 women in 1998, which is the second highest in Europe after Iceland (51.5 in 1995). The pattern is closer to the Nordic and western European countries than to the Mediterranean countries.

External causes of death and injuries

External causes of death and injuries covers all deaths caused by accidents, injuries, poisoning and other environmental circumstances or events such as violent acts (homicide) and suicide. The trend for mortality from these causes, and in particular from road traffic accidents, has been declining in western Europe since 1970.

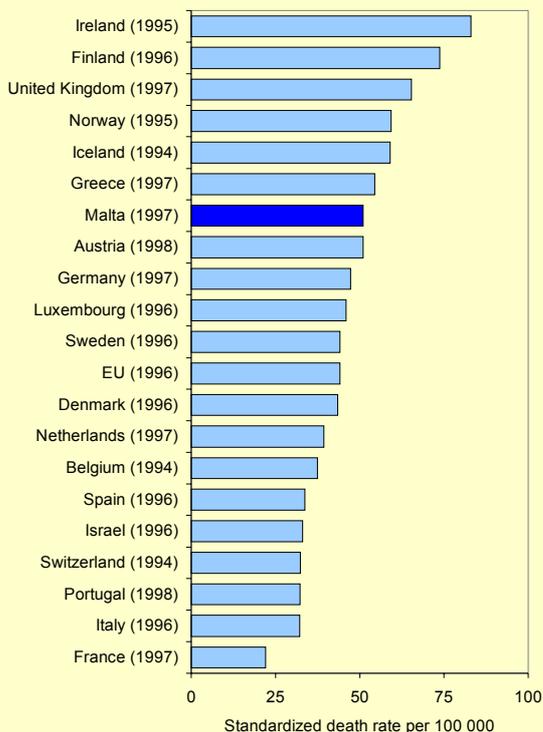


Data for Malta are 3-year moving averages



Data for Malta are 3-year moving averages

Fig. 13. Mortality from ischaemic heart disease among males aged 0–64 years, latest available data



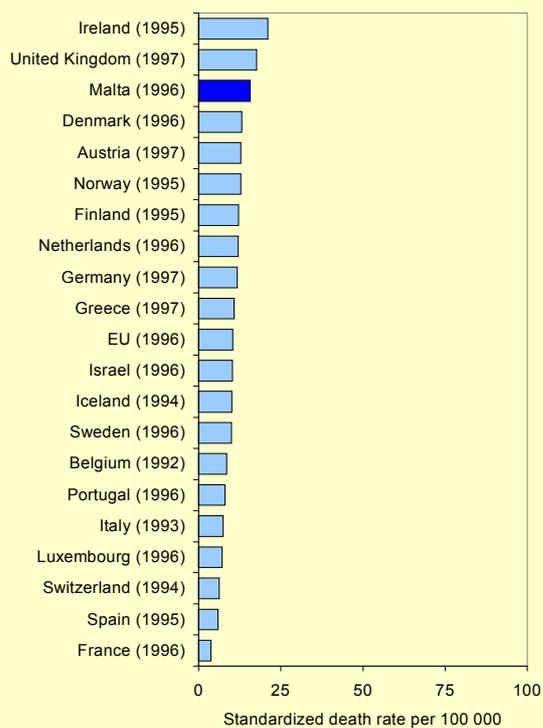
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Fig. 15. Mortality from cerebrovascular diseases among males aged 0–64 years, latest available data



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Fig. 14. Mortality from ischaemic heart disease, females aged 0–64, latest available data

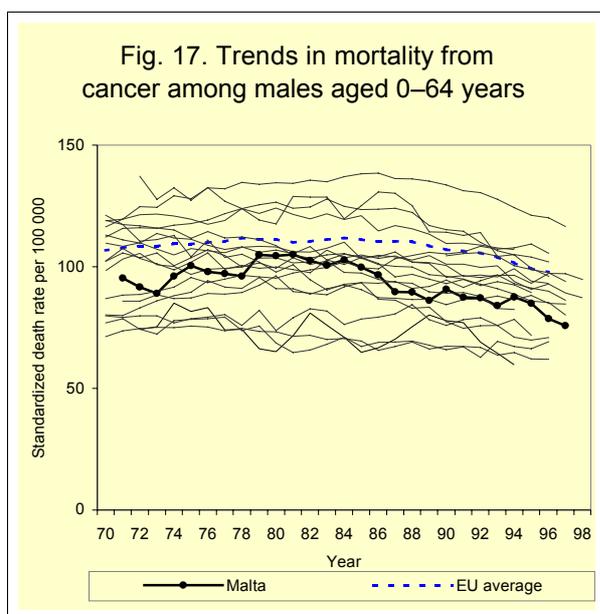


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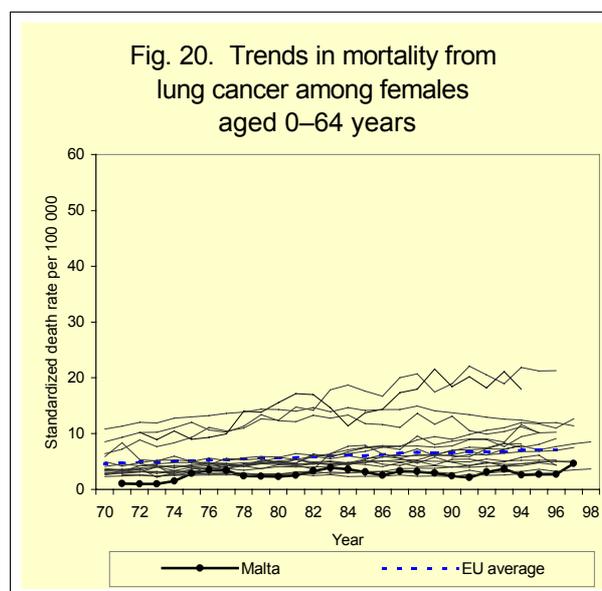
Fig. 16. Mortality from cerebrovascular diseases among females aged 0–64 years, latest available data



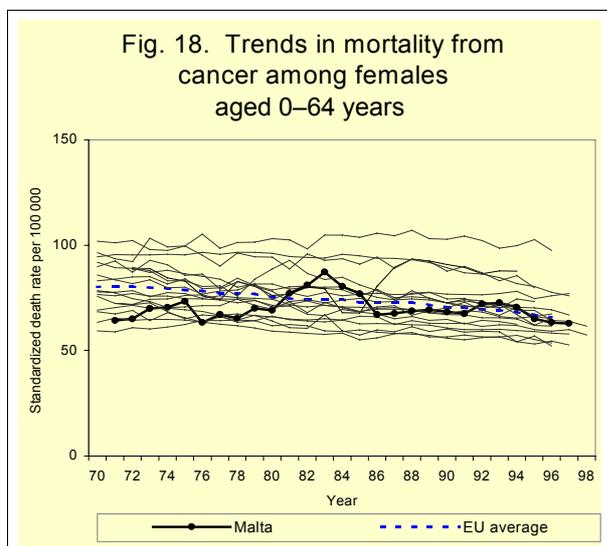
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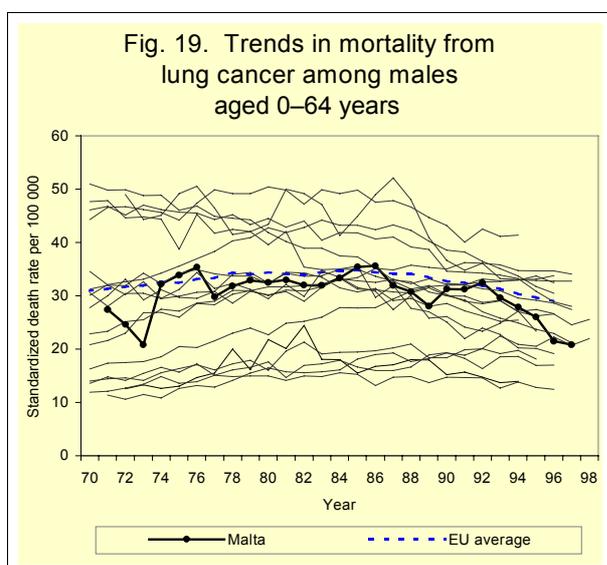
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Data for Malta are 3-year moving averages

Mortality from external causes in Malta was 26 per 100 000 in 1998, below the EU average of 42 in 1996. The rate in Malta has been relatively stable, whereas the EU average has declined.

For both men and women aged 0–64 years, the SDR from external causes is below the level for the EU (Fig. 21, 22). In the age group 65 years or older, the mortality from external causes has not shown a clear trend but appears to be slightly under the EU average.

The mortality from external causes can be divided into four groups: motor vehicle accidents, suicide, homicide and other external causes. The mortality from motor vehicle traffic accidents (Fig. 23, 24) is considerably lower than the EU average. However, among males, neither the overall trend in mortality from external causes nor the trend in mortality from external causes seems to follow the downward trends of the respective EU averages.

Mental health

Although mental and psychosocial wellbeing is an important aspect of health-related quality of life, too little information is usually available to allow these important dimensions of the population's health to be described reliably. Suicide can be used as an indicator of the overall level of mental health problems.

Up to the late 1980s, mortality from suicide was reported to be near zero because the stigma associated with suicide in a religious country prevented the proper transmission of information about the problem (Fig. 25, 26). New information systems and practices and the compilation of data from different sources led to the actual situation being revealed. The Department of Health Information has found no evidence of a rising trend in the actual number of suicides.

According to estimates for some reference countries, the prevalence of mental problems is about 15–20% in the general population and 10–12% for diagnosable mental disorders. Assuming this is also applicable to Malta, this means that about 75 000 people in Malta have a mild mental problem or more severe mental disorder. It is uncertain whether the incidence of such disorders has increased in the last one or two decades.

The mental health policy in Malta is in a phase of establishment and change. Mental health policy was previously conducted with a custodial approach, whereas it is now aimed to orient the policy towards personal development.

AIDS and HIV infection

The acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which can be transmitted in three ways: sexual transmission; transfusing infected blood or blood products or using non-sterile injection equipment; or from mother to child. There may be a delay of about 10 years or more between initial infection with the human immunodeficiency virus (HIV) and developing the clinical illness of AIDS in untreated individuals.

Malta's incidence rate was 0.9 cases of clinically diagnosed AIDS per 100 000 population in 1997. The rate was lower than the EU average (Fig. 27). AIDS incidence rates in the reference countries have declining trends since about 1995, which shows the effect of preventive measures aiming to change people's behaviour, but the small numbers for Malta do not allow trends to be assessed. The information on AIDS suggests that, after the first wave of the conditions in the 1980s, when

haemophilia patients received contaminated blood products, the only relevant mode of transmission has been sexual relations with infected partners. No case of local transmission of HIV infection through intravenous drug use has been recorded.

Other infectious diseases

Several vaccine-preventable diseases of childhood have been eradicated through comprehensive immunization programmes. The recommended schedule includes immunization for diphtheria, polio, tetanus (these three are statutory), pertussis, *Haemophilus influenzae* type b meningitis, measles, mumps, rubella, tuberculosis (by BCG) and hepatitis B.

The incidence of measles in 1998 was 0.8 per 100 000 population (EU 48.6), mumps 2.1 per 100 000 population (EU 36.9) and pertussis 1.1 per 100 000 population (EU 6.5). The rubella incidence was very high in 1995, with 112.2 cases per 100 000 population and two cases of congenital rubella in 1996. In 1998, the rubella incidence was down to 2.1 cases per 100 000 population. Normally there is no congenital rubella.

No cases of polio have been notified in Malta since 1964. Active surveillance of acute flaccid paralysis is carried out as part of the global strategy for the eradication of polio. Wild poliovirus has not been detected.

There have been no cases of diphtheria since 1969 and no cases of cholera since 1911.

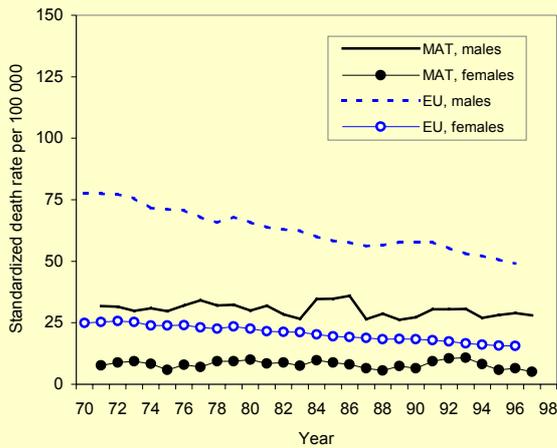
Some cases of brucellosis (also known as undulant fever, Mediterranean fever or Malta fever) still occur in Malta. The incidence has been low since an outbreak of 140 cases in 1995 (37.3 per 100 000 population).

There are no official statistics on the incidence of syphilitic and gonococcal infection in Malta, but laboratory evidence indicates that the rates of infection are low.

There are few new cases of tuberculosis per year (4.2 per 100 000 in 1998 versus 13.3 in the EU) (Fig. 28).

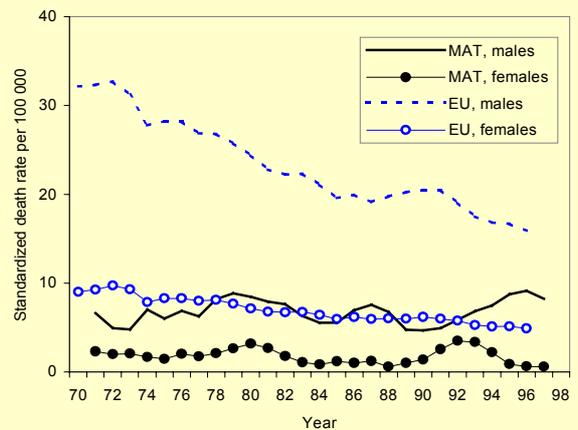
There are some cases of malaria, 30 over the 9 years from 1990 to 1998, the cases being imported via residents returning from malaria-endemic countries (*Department of Health Information, 1998*).

Fig. 21. Trends in mortality from external causes, age 0–64 years



Data for Malta are 3-year moving averages

Fig. 23. Trends in mortality from motor vehicle traffic accidents, age 0–64 years



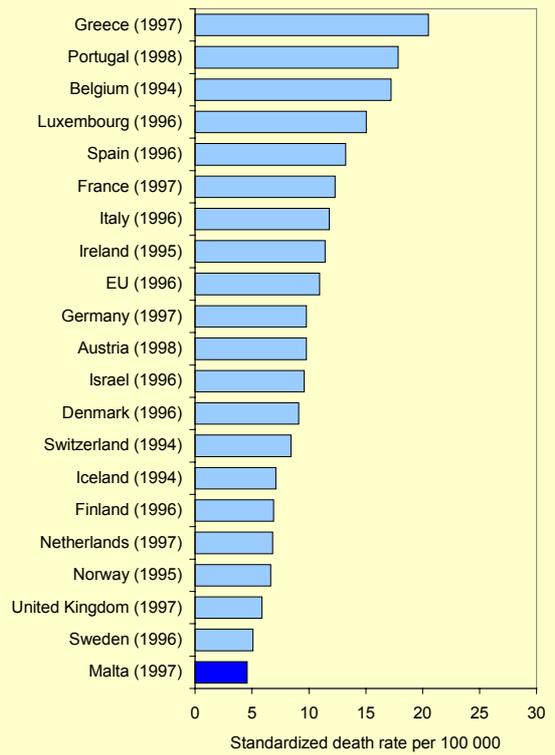
Data for Malta are 3-year moving averages

Fig. 22. Mortality from external causes at all ages, latest available data



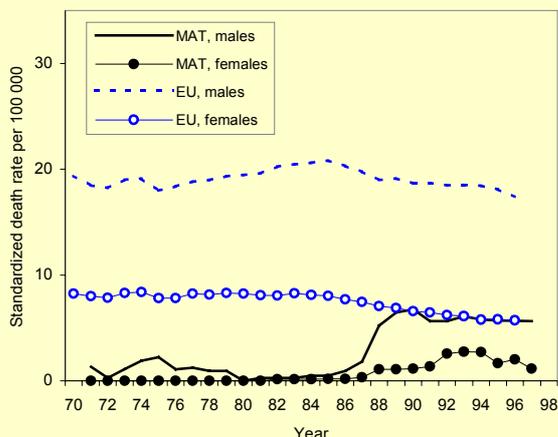
Data for Malta are 3-year moving averages

Fig. 24. Mortality from motor vehicle traffic accidents at all ages, latest available data



Data for Malta are 3-year moving averages

Fig. 25. Trends in mortality from suicide and self-inflicted injury, all ages



Data for Malta are 3-year moving averages

Fig. 27. Incidence of AIDS per 100 000 population

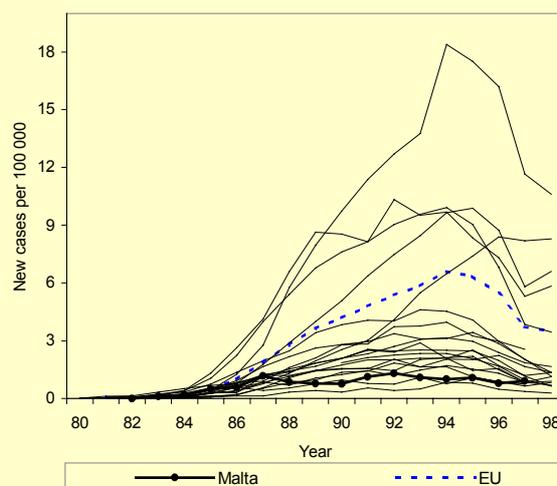
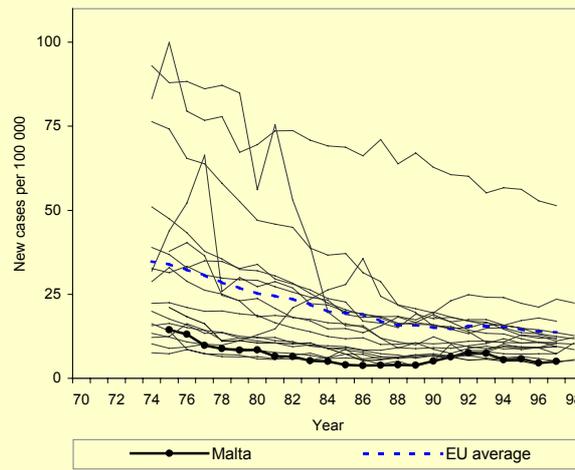


Fig. 26. Mortality from suicide and self-inflicted injury at all ages, latest available data



Data for Malta are 3-year moving averages

Fig. 28. Incidence of tuberculosis per 100 000 population



Data for Malta are 3-year moving averages

Immunization rates are generally high in Malta. In 1996, 96% of children were immunized against tuberculosis, 92% against diphtheria, 92% against tetanus, 84% against pertussis and 92% against poliomyelitis. Only

51%, however, were immunized against measles, a substantial decrease since 1990–1993, when 90% of children were immunized against measles. The decrease is caused by a change in the method of reporting in 1992, and since then the immunization rate is measured at age 2 years and not age 12 years, as previously. As attempts are made to immunize before the age of 2 years, the rate is likely to increase in the future.

In addition, vaccination against *Haemophilus influenzae* type b meningitis was introduced in 1996. Immunization against most communicable diseases is free of charge in Malta.

Malta's hepatitis incidence rate is well below that of the EU. In 1998, there were only 3.7 cases per 100 000 inhabitants. The EU average in 1998 was 23.8.

Disability

The prevalence of long-term illness and disability is an important indicator of a population's health status and health-related quality of life.

The National Commission for Persons with Disabilities (Kummissjoni Nazzjonali Persuni d'Dizabilita', www.knpd.org) is active in organizing conferences and developing policy recommendations in the field of disability. They also offer special services, including the running of a resource centre. In September 1996, 4754 people were registered users of the services.

Health of children and adolescents

The first year of life is a critical phase as regards mortality; in most countries, only after the age of 55 years do death rates return to the same level. The infant mortality rate in Malta in 1997 was 8.5 per 1000 live births (Fig. 29), which is slightly above the EU average of 5.5. Although it is falling, infant mortality has decreased less than in most reference countries in recent years. One reason is the relatively high neonatal mortality rate in Malta, although it fell to 3.8 per 1000 live births in 1998, only slightly above the EU average of 3.5 (1996). One factor in the high neonatal mortality rate in Malta is the fact that abortion is not legal in Malta.

In this connection, Malta's Congenital Anomalies Registry has proved that the lack of abortion is responsible for a higher rate of births of children with congenital anomalies (which in turn leads to higher neonatal mortality rates). Further, unlike some other countries, Malta's Central Office of Statistics includes all births described as "live", even when birth weight is below 500 g. This has led to the apparently higher infant mortality rate.

The post-neonatal mortality in Malta is below the EU average: in 1998 it was 1.6 per 100 000 live births versus the EU average of 1.9 (1996).

In the years 1993 to 1995, the annual average was 33 congenital anomalies per 1000 live births (*Department of Health Information, 2000a*). This is relatively high by international comparison. However, few countries have data on this, and no regional averages exist.

Children's oral health is an important contributing factor to long-term benefits for general health. The latest estimate of DMFT (decayed, missing or filled teeth) at age 12 was 1.6 in 1991. The level of this measure has been relatively constant since 1985, when it was first recorded. The DMFT level is among the best in international comparison.

Adolescents make efforts to take on adult roles. This transition involves experimentation and imitation, which can make young people vulnerable to damage to their health. Acute health problems can result from accidents, experiments with drugs, unsafe sex or unwanted pregnancies. In the longer run, adopting an unhealthy lifestyle pattern can lead to chronic degenerative diseases. This is also a transition phase in the life cycle when social insecurity compounded by, for example, unemployment, can lead to mental health problems. Unfortunately, at present there are only very limited data on adolescent health in Malta.

One of the few routinely available indicators of adolescents' sexual health and behaviour is the rate of teenage childbirth, which can reflect social factors as well as access to and use of contraception. The births to mothers under 20 years of age have declined in almost all the reference countries in recent decades; Malta has a low and stable percentage (Fig. 30). The frequency of all teenage pregnancies, as indicated by the sum of births and legal induced abortions, is presented for 11 reference countries and Malta in Fig. 31. Malta has relatively few teenage pregnancies.

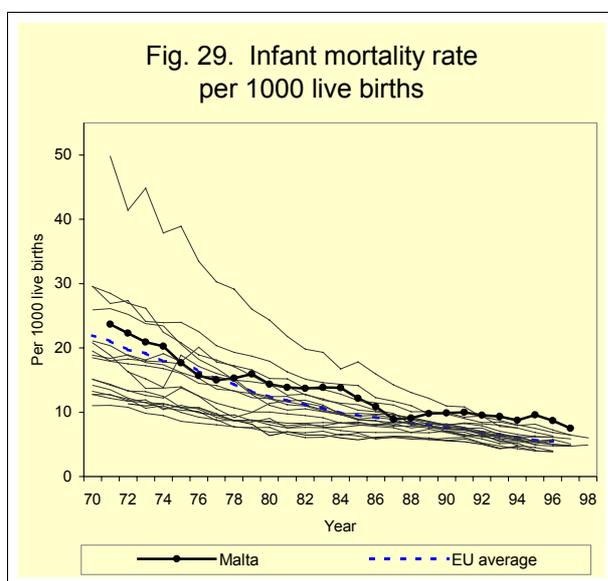
Women's health

Women as a group live longer than men and have lower mortality rates for most causes of death. However, women have higher rates of morbidity and utilization of health care services (especially related to childbirth), and they can be more affected by social welfare

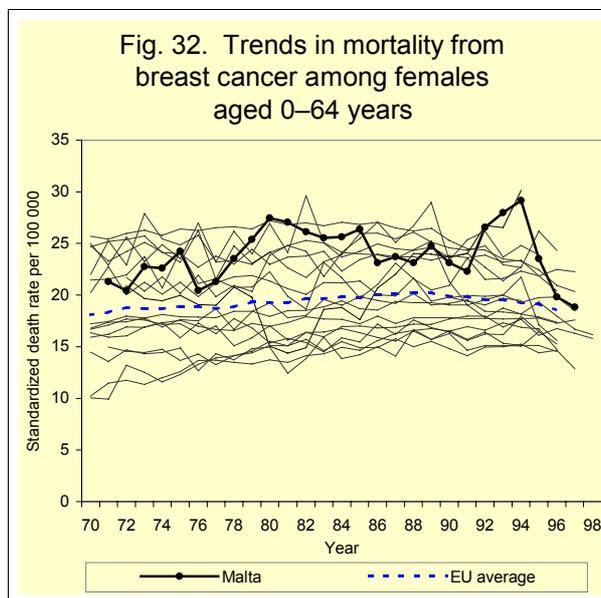
policies than men are. As described earlier, the life expectancy at birth for females in Malta was 80.1 years in 1998, about the same as the EU average. The gender gap in life expectancy at birth was 4.6 years in 1998. At age 65, the gender gap was 3.4 years in 1998, smaller than in most countries.

The maternal death rate in Malta is difficult to evaluate, as there are very few cases per year and no cases at all in some years.

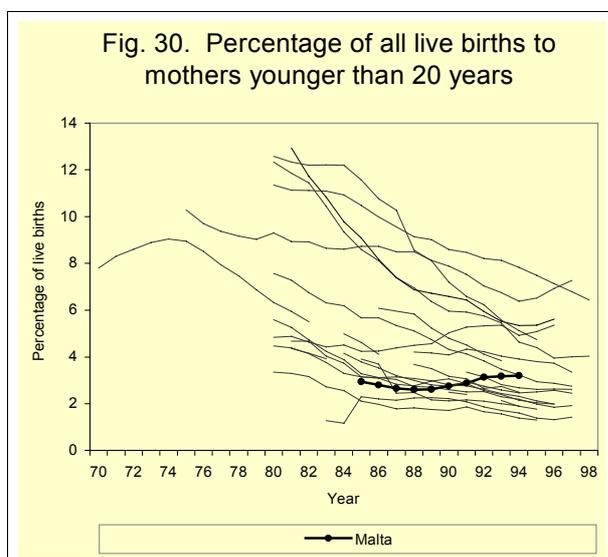
As mentioned, the mortality from breast cancer among women is above the EU level (Fig. 32). Mortality from cancer of the cervix is low; this is believed to reflect the limited numbers of sexual partners among Maltese women.



Data for Malta are 3-year moving averages



Data for Malta are 3-year moving averages



Data for Malta are 3-year moving averages

LIFESTYLES

Among the factors (including genetics and the physical and social environments) influencing health, behaviour substantially affects the health and wellbeing of each individual and the population. Lifestyle patterns such as nutritional habits, physical activity and smoking or heavy alcohol consumption together with the prevalence of such risk factors as elevated blood pressure, high serum cholesterol or overweight influence premature mortality, especially from cardiovascular diseases and cancers. These diseases are the main causes of death in Europe. Unhealthy behaviour also contributes to a wide range of other chronic illnesses and thus affects the quality of life in general.

Lifestyle, however, is also influenced by behavioural patterns common to a person's social group, and by more general socioeconomic conditions. Evidence is growing that, at least in most western European countries, improvements in lifestyles have largely been confined to the more socially and economically privileged population groups, who are better placed to adopt health-promoting changes in behaviour (*WHO Regional Office for Europe, 1993, 1999*).

Tobacco consumption

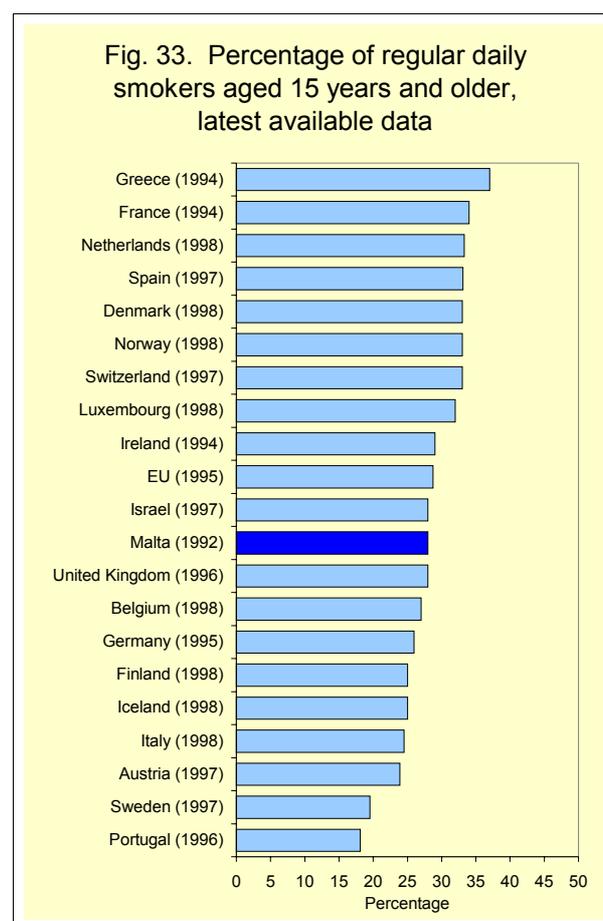
In Malta, the number of cigarettes sold per person per year increased from 1038 in 1980 to 3702 in 1990 and declined slightly to 3627 in 1999. The average number sold in the EU was 1602 in 1999.

The rise in cigarette sales has often been attributed to the concomitant rise in tourist arrival figures; however, it is difficult to gauge the size of the effect, as the tourist mix has changed significantly over the years. The number of tourist arrivals in 1999 was 1.2 million, which is more than three times the size of the resident population; therefore, the relevant effect certainly cannot be discounted.

In Malta, a 1992 primary care study found a smoking prevalence among people aged 15 years and older of 28% (40% male; 18% female) versus 29% in the EU in 1995

(Fig. 33). This indicates a decrease in smoking prevalence among males and an increase among females since 1985, when the prevalence rates were 49% among men and 10% among women (*WHO Regional Office for Europe, 1995a*).

Malta's policy on tobacco control builds on three pillars: control of marketing of tobacco products, protection of nonsmokers and health education. Control measures include a ban on direct advertising, health warnings on cigarette packets and age restrictions on purchase of cigarettes. Protection of nonsmokers includes prohibition of smoking in public areas, such as passenger airplanes, cinemas and schools. Health education comprises smoking cessation courses (*WHO Regional Office for Europe, 1995a*).



Alcohol consumption

The consumption of alcoholic beverages in the EU has slowly, but steadily, declined since 1980 following an increase in the 1970s. The information on alcohol consumption in Malta is based on surveys. In 1992, a survey of 1000 people showed that 39% of the population aged 15 years and older drink alcohol (43% of 15- to 19-year-olds; 54% of 20- to 24-year-olds). Alcohol consumption was higher among men than among women (wine: 22% among men, 10% among women; beer: 32% among men, 3% among women; spirits: 15% among men and 6% among women). The survey showed that the higher the level of education, the lower the consumption of wine and the higher the consumption of beer and spirits (*WHO Regional Office for Europe, 1995b*).

Home-produced wine is rather popular in Malta.

The mortality from liver cirrhosis is low in Malta; in 1998 the SDR was 6.1 per 100 000 population, compared with 14.4 in the EU on average (1996).

Alcohol policies in Malta comprise mass media campaigns, development of specialized treatment and the addressing of particular problems such as drinking and driving. Further, the policy development is directed towards a joint approach for alcohol, drugs and tobacco. There is an age limit of 16 years for purchasing alcohol. There are restrictions on the distribution and production of alcohol (*WHO Regional Office for Europe, 1995b*).

Illicit drug use

Cannabis is the most used illicit drug in Malta. According to a 1991 survey, 4.7% of young people (aged 12–17 years) had ever tried cannabis, and 1.9% had tried it within the previous year. The most common hard drug used was heroin (*WHO Regional Office for Europe, 1997*).

In 1994, 100 people attended a detoxification centre for the first time. By 1993, a cumulative 731 people had attended a detoxification centre. Most drug users in Malta are reportedly multi-drug users, predominantly male. The male-female ratio among the drug users

attending a detoxification centre in 1994 was 9 to 1. This ratio is high in international comparison. More than two thirds of the people undergoing detoxification in 1994 were in the age group 20–34 years (*WHO Regional Office for Europe, 1997*). The cumulative number of deaths related to drug use for the period 1991–1998 was 51 (*Department of Health Information, 1998*).

There are policies to reduce the harm caused by illicit drug use in Malta, including drop-in centres and free syringe distribution 24 hours a day in eight health centres. People seeking treatment are tested for HIV and hepatitis (*WHO Regional Office for Europe, 1997*).

Nutrition

Nutritional habits are rooted in cultural traditions and food production. Nevertheless, in recent decades changes have occurred with increasing globalization, as global food markets have opened up, transport has become more rapid and more efficient techniques for conserving food have been developed. These factors together with increased mobility and increases in purchasing power are some of the reasons why the historically different nutrition patterns in Europe appear to converge.

The historical differences in Europe between the northern and southern dietary patterns are confirmed by national food balance sheets (data relating to the amount of food available within each country) collected since the 1960s by the Food and Agriculture Organization of the United Nations. Typical for northern Europe is a high availability of saturated fat accompanied by a low availability of fruit and vegetables. In contrast, in southern Europe, the diet typically consists of large quantities of fruit and vegetables and small quantities of saturated fat (Fig. 34). The available data suggest that the pattern in Malta is similar to that of southern Europe, except for the high consumption of sugar. It should be noted that Malta has the highest prevalence of diabetes in the European Region (5.2% of the population in 1992; the second highest prevalence recorded was 4.8% in Portugal, and the lowest was 0.2% of the population in Iceland), which is considered a significant national health

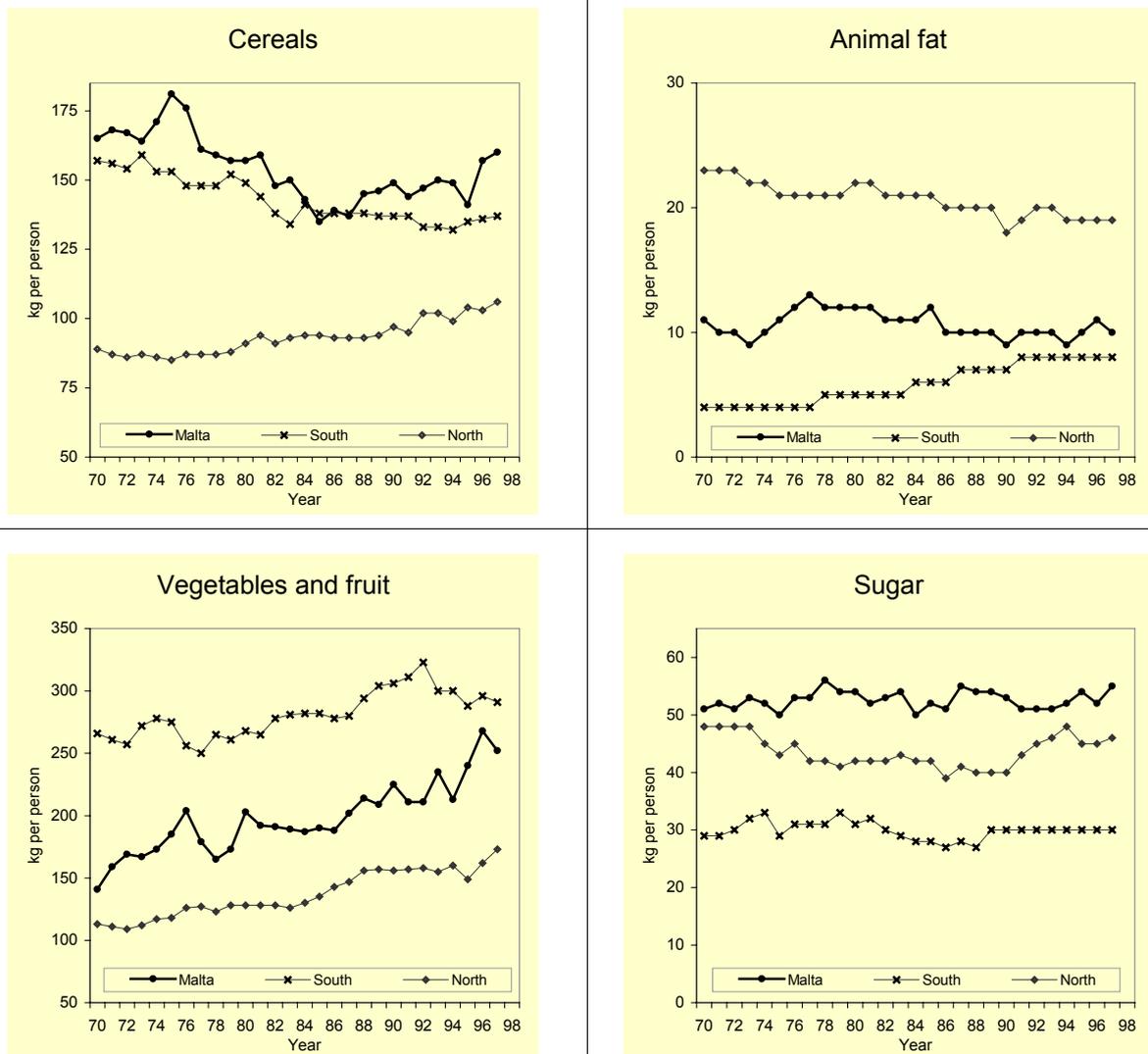
problem (Fig. 35). The average number of calories consumed per person per day is close to the EU average. In 1997, the average person consumed 3398 calories per day, versus 3413 in the EU.

Consistent with the Mediterranean nutrition pattern, the diet is low in fat. In 1997, the percentage of energy from fat was 28% versus the EU average of 39% (Fig. 36).

Overweight

A 1991 survey in children found that 13% of boys and 12% of girls at the age of 5 years were obese. At the age of 10 years, 24% of girls and 19% of boys were obese (*Department of Health Information, 1998*).

Fig. 34. Food consumption patterns, 1970–1997

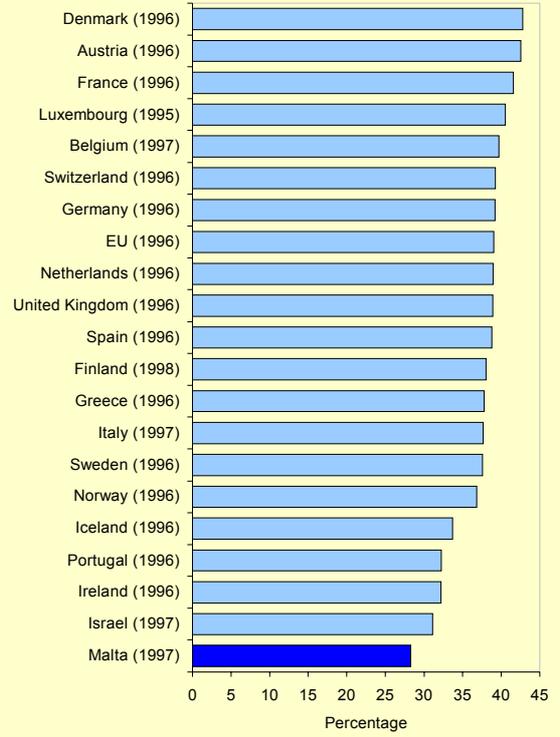


South: population-weighted average for Greece, Italy, Portugal and Spain.
 North: population-weighted average for Denmark, Finland, Iceland, Norway and Sweden.
 The increase in international trade accelerated in 1994, when food was incorporated into international free trade agreements (the GATT Uruguay Round). This process has affected the national food statistics, which became less reliable, making international comparisons more difficult since 1994.
 Since there are no estimates from population surveys, the figures for Malta must be considered even more carefully because the numbers of tourists visiting Malta (1.2 million in 1999) is very large in relation to the permanent resident population of 0.378 million.

Fig. 35. Percentage of population with diabetes, latest available data



Fig. 36. Percentage of energy available from fat, latest available data



ENVIRONMENT AND HEALTH

Environmental conditions affect humans through short-term and long-term exposure to noxious factors. In the long term the main objective is to promote sustainable development compatible with good health. Short-term environmental protection means avoiding or at least reducing potentially harmful situations, bearing in mind that people are not exposed equally to adverse environmental conditions and not all people and social groups are equally vulnerable to them. Thus, children, pregnant women, elderly people and ill people are more likely to be affected by polluted air or contaminated food. Also, specific population groups tend to experience more adverse environmental conditions. Low income, for instance, is often associated with exposure to environmental hazards at work (noxious substances and risk of accidents) and poor housing conditions (such as crowding, air pollution and noise). These situations may affect health and wellbeing either directly or indirectly by causing discomfort and stress, giving rise to unhealthy coping behaviour such as the use of intoxicating drugs or heavy drinking.

Air quality

In 1995, carbon dioxide emissions were 7.1 tonnes per person, while most EU countries had emissions around 10 tonnes per person (*United Nations Economic Commission for Europe, 1999*).

Policy on air quality is focused on developing the capacity to monitor air quality. In 1999, the Pollution Control Coordinating Unit of the Environment Protection Department within the Ministry of the Environment initiated a national air quality monitoring programme. This covers parameters such as sulfur dioxide, carbon monoxide, nitrogen oxides and particulate matter.

Water and sanitation

In the EU, more than 97% of the population has access to a supply of drinking-water at home. Virtually the entire population of Malta

is reported to have access to hygienic sewage disposal and safe drinking-water.

Waste

Almost all countries generate increasing quantities of waste. In Malta, the total amount of solid waste accepted at public waste management sites in 1996 was 1.6 million tonnes, of which 8% was municipal waste, 11% industrial waste and the remaining 81% construction and demolition waste (*Department of Health Policy and Planning, 1997*).

Food poisoning

In 1997, there were 16 outbreaks of *Salmonella* food poisoning, affecting 181 people (48 per 100 000 population). In addition, sporadic cases of *Salmonella* food poisoning affected 91 people (24 per 100 000 population). There were three outbreaks and several sporadic cases of *Campylobacter* food poisoning, affecting a total of 34 people (9 per 100 000 population). Cases of *Escherichia coli* and unspecified food poisoning also occurred (*Department of Health Information, 1998, 2000b*).

Housing

Housing conditions affect people's health and wellbeing, but the health situation of homeless people is especially critical. They often suffer from health problems typically associated with poverty, including malnutrition, infectious diseases and psychosocial stress caused by solitude and insecurity, and they may also be more vulnerable to health problems than the rest of the population.

No cases of homeless people were reported in Malta for several years in the mid-1990s. Although some cases appear to have occurred more recently, homelessness is not perceived as a public health problem.

However, many of the houses built in earlier periods are not of good quality, and there are problems of dampness. The number of people

per habitable room is 0.62 (*Department of Health Policy and Planning, 1997*).

Increasing urbanization and road and air traffic has brought to the fore the issue of noise and its effects on health. Noise is a serious problem in Malta, with a range of health consequences including stress and permanent damage to hearing. In particular three fields are identified as problem areas: noise from road traffic, aggravated by the high density of motor vehicles (0.7 vehicles per person) and the high population density; construction and demolition noise, industrial noise and fireworks, the latter widely used in celebrating (*Department of Health Policy and Planning, 1997*).

Occupational health and safety

Health hazards at the workplace are still an important cause of ill health and death. Nevertheless, information about exposure in terms of the type, frequency and intensity of hazards and the number of workplaces or people affected is scarce.

In 1998, 4151 people were injured by work-related accidents per 100 000 gainfully employed people. The rate has decreased considerably since 1988, when it was at its

highest with 6945 injuries per 100 000 inhabitants. The downward trend is believed to mainly result from a significant economic shift from heavy industry to services.

However, the number of deaths from work-related accidents does not seem to be following a similar downward trend.

An Occupational Health and Safety Unit within the Ministry of Social Policy is responsible to the Director of Employment and Industrial Relations. There is also a multisectoral Commission for the Promotion of Health and Safety. There has been a first reading of an Occupational Health and Safety Bill in Parliament that caters for the setting up of an independent Occupational Health and Safety Authority that will be directly accountable to the Minister for Social Policy.

The Occupational Health and Safety Unit is in the process of aligning its statistics with those of EU countries as part of the European Statistics on Accidents at Work (ESAW) project.

The Occupational Health and Safety Unit is also in the process of implementing an EU recommendation on the list of notifiable occupational diseases.

HEALTH CARE SYSTEM

Institutional structures and resources

The state is responsible for the health care system. There is one main hospital, St Luke's Hospital, in Guardamangia, close to Valetta², and a number of smaller hospitals in charge of less specialized treatment. Eight health centres provide primary health care (*Department of Health Information, 1998*).

Distances in Malta are small, and the health service is developed such that a state primary health centre can be reached within 10 minutes by car and a state hospital can be reached within 30 minutes by car.

Public health care is financed through general taxation and is free of charge at the point of delivery. Pharmaceuticals are paid for by users, but people of low means and chronically ill people can obtain pharmaceuticals free of charge (*Department of Health Information, 1998*).

Primary health care

The public health care services offered are preventive, curative and rehabilitative. The personnel employed at the eight health centres are general practitioners and nurses. In addition, other clinics provide services in maternal and child health, diabetes, ophthalmology, psychiatry, podology and chiropody, physiotherapy and speech therapy. Community nursing and midwifery services are provided by these groups on a contractual basis (*Department of Health Information, 1998*).

In 1998, Malta had 261 physicians per 100 000 population (Fig. 37) versus the EU average of 348 (1997) and 36 dentists per 100 000 population versus the EU average of 68 (1997).

In 1998, Malta had 49 pharmacists per 100 000 population versus 80 in the EU on average (1997).

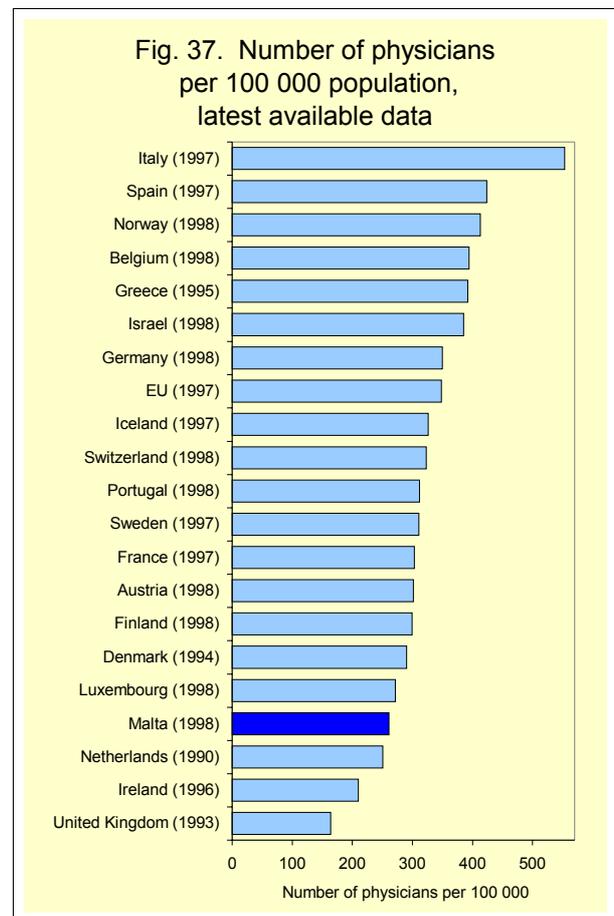
² Although the bulk of the population in Malta lives close to Valletta, in the Harbour Region, the name Valletta is used only for the old fortified city. The suburbs are known by their own names.

Hospital care

Secondary and tertiary care is provided by five public hospitals. St Luke's hospital has 850 beds and offers a wide range of secondary and tertiary services, including cardiac and renal transplantation. Another three hospitals qualify as specialized, one of them being a psychiatric hospital. There is a general hospital on Gozo (*Department of Health Information, 1998*).

In addition to the public hospitals, three private hospitals have a total bed capacity of 168 beds. (Statistically, there is a fourth private hospital, but this has only seven beds and is usually described as a clinic.)

The state owns, manages and funds the public hospitals. They deliver health care services free of charge at the point of delivery to all residents and at a charge to non-residents.



Private sector

There is a significant private health care sector in Malta, consisting of private general practitioners and specialists and three hospitals. Other clinics offer both private and public services. Even taking into account the fact that physicians could take up other occupations, it has been concluded that around 250 physicians are employed privately (*Department of Health Information, 1998*).

The private health care sector is functioning in partnership with the state health service.

Half the registered dentists are in public employment. Working conditions seem to be better in the private sector, causing the staff turnover rate to be quite high in the public sector (*Department of Health Information, 1998*).

Use of private health care is financed through private health insurance or out-of-pocket payments (*Department of Health Information, 1998*).

Health expenditure

International comparisons of health care expenditure are difficult because the definitions underlying health statistics as well as accounting practices vary from one country to another. The following data on health expenditure should therefore be used with caution, as the boundaries of what constitutes health care can vary substantially between countries.

The latest available estimate of the percentage of gross domestic product spent on health is 6.4% versus 6.8% for the United Kingdom and 8.6% for western Europe. The data for Malta are estimated and may not be directly comparable.

Public expenditure as a share of total health expenditure is an estimated 60% and one of the lowest in Europe. It is possible that the share of public expenditure may actually be lower because of underreporting of private activity, which leads to underestimates of private health care expenditure.

Malta has a highly comprehensive public health care system despite the low share of public expenditure, because health care is

labour-intensive and the wages of health care employees in the public sector are relatively low.

The budgeting system does not allow for breakdown of government expenditure into inpatient and outpatient activity (*European Observatory on Health Care Systems, 1999*).

Health care reforms

The state of health care reform can be summarized as follows (*European Observatory on Health Care Systems, 1999*).

The main aim of the health care reform is to make the transition from a piecemeal planning approach based on 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* (*Department of Health Policy and Planning, 1998a*) and *The strategy behind the health sector reform* (*Department of Health Policy and Planning, 1998b*) aims towards:

- an integrated approach;
- a client-centred policy;
- an outcome-driven (evidence-based) health sector; and
- financial sustainability.

The reform process has commenced but is proceeding slowly. The reforms implemented so far have not been accompanied by many legislative changes.

Greater scope has been given to the private sector. Partnerships with the private sector have been established for contracting out some services, such as community nursing.

Proposed changes in the administrative sector have mostly been introduced, but delays in approving legislation and policies are slowing down the reforms.

Reforms in the hospital sector are ambitious and well under way. However, implementing the reforms will require continuous political support, new management systems, quality control and adequate resources.

The Department of Health Information reports that health legislation and regulations are being thoroughly reviewed in preparation for possible accession to the European Union to bring Malta in line with the *acquis communautaire*. Moreover, reforms are taking place in several sectors, such as the pharmaceutical sector, in order to ensure a clear division between regulatory and service provision roles.

Health promotion and disease prevention

The 1995 health policy document *Health vision 2000 (Department of Health Policy and Planning, 1995)* pinpointed specific health service priorities and proposed targets for progress in key areas. Among the proposed key areas were a strategic plan on asthma and the prevention and management of road traffic injuries.

A disease-oriented approach is applied to combating chronic diseases, including screening programmes for thalassaemia and glaucoma and improved control of diabetes. In the field of communicable diseases, a surveillance branch monitors outbreaks and developments. Immunization schemes have been improved, with the introduction of Haemophilus influenzae type b and hepatitis B immunizations. Special project activities and educational materials are used to prevent the development of AIDS.

Other prevention and health promotion measures include: seat-belt legislation, regulations towards limiting smoking in public places, food labelling regulations, standards for food and water quality and restrictions on tobacco advertising. Other health promotion projects are “Quit and Win” (smoking), Healthy Cities and Healthy Prisons, a national breastfeeding policy and baby-friendly restaurants.

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GLOSSARY OF SELECTED TERMS

Incidence rate: the number of new cases of a disease occurring in a population per 100 000 people during a specified period (usually 1 year).

Infant mortality rate: the yearly number of deaths of children aged less than one year per 1000 live births.

Life expectancy at birth: an estimate of the average number of years a newborn child can expect to live provided that the prevailing age-specific patterns of mortality at the time of birth were to stay the same throughout the child's life.

Prevalence rate: the total number of people in a population who have a disease or any other attribute at a given time or during a specified period per 100 000 of that population.

Purchasing power parity (PPP): a standardized measure of the purchasing power of a country's currency, based on a comparison of the number of units of that currency required to purchase the same representative basket of goods and services in a reference country and its currency (usually US dollars). The EU uses the purchasing power standard to measure this.

Standardized death rate (SDR): a death rate (usually per 100 000 population) adjusted to the age structure of a standard European population.

Total fertility rate: the average number of children that would be born alive per woman during her lifetime if she were to bear children at each age in accordance with prevailing age-specific birth rates.

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