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REVISED EUROPEAN SOCIAL CHARTER

2nd National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF MALTA

(Articles 3, 11, 12, 13, 14 and 23
for the period 01/01/2005 – 31/12/2007)

Report registered by the Secretariat on 10 November 2008

CYCLE 2009

SECOND REPORT ON THE

REVISED EUROPEAN SOCIAL CHARTER

submitted by the

Government of Malta

(for the period January 2005 to December 2007)

2008

Index

Report made by the Government of Malta in accordance with Article 21 of the European Social Charter, on the measures taken to give effect to the following accepted provisions of the European Social Charter, the instrument of ratification of which was deposited on the 4th October, 1989:-

Articles 3, 11, 12, 13, 14, and 23 for the period 1 January 2005 to 31 December 2007.

No observations have been received from the organisations of workers and employers regarding the practical application of the provisions of the Charter, of the application of legislation, or other measures for implementing the Charter.

I. INTRODUCTION

This Report by Malta is drafted within the context of the form for submission as adopted by the Committee of Ministers on the 26th March 2008.

The following information is to supplement previous information submitted by Malta with respect to the same provision under the European Social Charter and should be taken as additional information. Where a new provision of the Revised Charter has not been reported upon in previous Reports from Malta, full details of the situation of the respective Article in Malta will be provided.

II. PROVISIONS OF THE EUROPEAN SOCIAL CHARTER (revised)

Article 3 – The right to safe and healthy working conditions

With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;
2. to issue safety and health regulations;
3. to provide for the enforcement of such regulations by measures of supervision;
4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.

Appendix to Article 3§4

It is understood that for the purposes of this provision the functions, organisation and conditions of operation of these services shall be determined by national laws or regulations, collective agreements or other means appropriate to national conditions.

Article 3§1

1) Please describe the national policy on occupational health and safety and the consultation with employers' and workers' organisations in formulating this policy. Please specify the nature of, reasons for and extent of any reforms.

As has been described in previous reports, the OHSA – Occupational, Health and Safety Authority is the competent authority for regulating health and safety conditions in Malta. The OHSA, established in terms of the OHS Authority Act 2000, is responsible for ensuring that the physical, psychological and social well being of all workers in all work places are promoted, and to ensure that they are safeguarded by whoever is so obliged to do, by ensuring that the levels of occupational health and safety protection established by this Act and by regulations made under this Act are maintained.

Its primary focus is the promotion and safeguard of high levels of OHS for all workers at all workplaces within the parameters of the general national policy established by the national policy.

The national policy is based on the promotion of high levels of OHS with the involvement of social partners, the education and raising of awareness on benefits of OHS, the promotion of training on OHS, the production and dissemination of information, the encouragement of self regulation and taking punitive action against high risk sectors of the economy according to the OHSA's enforcement policy.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the national policy in consultation with employers' and workers' organisations.

During the period under review the OHSA focused its actions in the following areas:

1. **Awareness building, information, education and training initiatives** – including initiatives with school children, media initiatives, initiatives with Small Businesses, participation in the EU Healthy Workplace Initiative, participation in the European OHS Week, the publication of printed and electronic guidance and through the organization of the annual OHS Good Practice Awards;
2. **Ensuring compliance with existing OHS legislation** – mainly by focusing on those sectors which pose the highest risks Occupational Health and Safety Management

Systems, which aim towards self-regulation and which, if they function as they should, do not rely on the interventions by the OHSA other than to provide advice and guidance;

3. **Legislative reform** especially to transpose all recently published EU OHS Directives and also to reflects emerging trends, risks and technological innovation and;
4. **Capacity building** through recruitment of new staff, training development of ICT needs and acquisition of monitoring equipment**.**

Article 3§2

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The OHS Authority is made up of a 9-member tripartite Board, headed by a Chairperson while the Executive Branch, is headed by a Chief Executive Officer. The OHSA's Board is made up of members appointed by the Government, members representing the interest of workers and members representing those of the employers.

New OHS legislation is drafted by the Executive Branch of the OHSA, discussed at Board level and issued for consultation with the stakeholders and the general public, giving ample time for feedback and any comments to reach the OHSA. In addition the consultation process is publicized in the local media through various press releases and also on the OHSA's website http://www.ohsa.org.mt/. Following this consultation process, the final draft is drawn up, signed by the Minister and promulgated into law.

In addition, the OHSA also hosts a network of interested parties which includes the constituted bodies, technical persons, individuals and also representatives of the civil society.

One may also mention, an informal network whereby persons may register themselves with the OHSA's website and are thus regularly updated on all matters concerning the local OHS scenario, not limited to the issue of new regulations. Since Malta's accession to the European Union, the OHS Authority has continued the exercise of harmonization of all new occupational health and safety legislation with EU OHS Directives, while at the same time reviewing existing legislation to ensure that there are no regulatory gaps, and to identify any conflicting or burdensome legislation, with the scope of simplifying it.

The OHS Authority Act applies to all work places, to all sectors of activity, both public and private, and to all work activities. With regards to those activities carried out by members of the armed forces, the police force or of the civil protection services, the health and safety of workers must be ensured as far as reasonably possible in the light of the overall scope of those services. This is in line with the contents of Council Directive 89 / 391 / EEC. Contrary to the provisions of the Framework Directive, the Act is also applicable in Malta to workers carrying out domestic duties.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework in consultation with employers' and workers' organisations.

During the reference period, new legislation was drafted and published, as well as some amendment to already existing Legal Notices (please see full list in Annex I).

Article 3§3

1) Please describe the enforcement of safety and health regulations. Please specify the nature of, reasons for and extent of any reforms.

The Authority considers enforcement as one of its key core functions – the purpose of enforcement is to ensure that duty holders effectively control risks at their place of work. This

can be achieved if duty holders take action commensurate with the degree of risk. When no such action is taken, it is the duty of the enforcing authority to take legal action or any other action permitted by law.

The term 'enforcement' has a wide interpretation, but is often taken to include all interactions between the enforcing authority and the duty holders, which may include employers, employees, the self-employed, appointed competent persons, workers' health and safety representatives and others. The term should not be taken to mean exclusively punitive action, as for example through prosecution, but can also mean the provision of advice or information, or the issue of a warning or an order by an OHS Officer.

It remains the Authority's current policy to focus on those work activities that give rise to the greatest risk – this effectively means that the Authority cannot satisfy all demands made for enforcement action to be taken. The Authority has also stepped up its actions related to the last step within the hierarchy of available enforcement actions, namely the commencement of judicial proceedings.

Prosecutions by the Authority are conducted mainly before the Court of Criminal Judicature. The OHSA has also assisted the Executive Police in criminal proceedings instituted against all those concerned before the Court of Criminal Inquiry and has testified in a number of civil suits, instituted by third parties before the Civil Courts.

At the same time, it is also realized that the Officers of the Authority, limited in number as they are, cannot be everywhere all the time, so the Authority periodically carries out inspection campaigns focusing on specific issues.

Through the provisions of the OHS Authority a number of OHS Officers were appointed by the OHSA. These OHS Officers are deemed to be Public Officers under the Criminal Code and thus are protected by law while on duty. OHS Officers have a number of powers at law, including:

1. To enter freely and without previous notice in any work place at any time of day or night;
2. To inspect any document the keeping of which is prescribed by any OHS regulation and
3. To issue orders to any person to preserve OHS and
4. To carry out inspections to verify that OHS levels are being maintained.

2) Please provide pertinent figures, statistics (for example Eurostat data) or any other relevant information on the number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardised accident rates per 100,000 workers; on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections; and on the number of breaches to health and safety regulations and the nature and type of sanctions imposed.

1. **Occupational *Accidents*** – Statistical data for the number of occupational accidents claims for the reference period are being included in Annex II.
2. **Occupational *Fatalities* –** a full list of occupational fatalities for the reference period is being enclosed as per Annex III.
3. **Occupational *Diseases*** -The incidence of cases of ill-health remains somewhat blurred. It is a known fact that a considerable amount of cases of ill health remain unreported for various reasons, including a lack of awareness of legal obligations, and more importantly, the lack of appreciation of the association between work and the resulting ill health together with the vague legal framework on work related diseases
4. ***Activities of the labour inspectorate*** for the reference period may be found at Annex IV.

Article 3§4

1) Please describe the occupational health services. Please specify the nature of, reasons for and extent of any reforms.

The Occupational Health Unit within the Health Division carries out medical examinations to ascertain fitness for work. However the provision of occupational health services is the ultimate responsibility of an employer and the OHSA maintains a supervisory and consultative role.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The Occupational Health (Medical) Unit (OHU) exercises an occupational medical function broadly and fully, (physical and mental health-promoting advice is a powerful element of the clinical and non-clinical sessions). The Unit's function is purely medical and excludes direct concern in the working environment.

The OHU serves a four-fold function:

1. screening for specific occupations; (Periodical Medical Examinations: (Category 1)
2. certification of fitness prior to employment/appointment/transfers/apprenticeships etc., (Pre-placement Medical Examinations Category II
3. certification regarding specific cases (e.g. `fitness to drive`, disability status vis-à-vis the Social Security Act of l987 as amended); (Category III)
4. sundry requests for reports (including `Ergonomic` review cases and Colour Vision Testing as well as assessment and advice regarding Registered Disabled Person Candidates (Category IV)

3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Statistical data for the operations of the OHU, are provided in Annex V.

Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alias*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Further to information previously submitted by Malta: -

Article 11§1

1) Please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Organization of Health Care in Malta

The Maltese health care system is based on the principles of equity and solidarity with universal coverage. The public health care system provides a comprehensive basket of health services to all persons residing in Malta who are covered by the Maltese social security legislation. In addition, the health care system also provides all necessary care for special groups such as irregular immigrants or foreign workers who have valid work permits[1]. No user charges or co-payments apply. A few services including elective dental services, optical services and coverage of formulary medicines are means-tested[2].

Access to medicines required on an out-patient basis is completely free of charge to persons covered by free treatment schemes[3]. Expenditure on medicines that are provided through the public sector has continued to rise relentlessly and now accounts for around 22% of recurrent Government health expenditure, despite the fact that around two thirds of procured medicines are now generics. The private sector acts as a complementary mechanism for health care coverage[4]. Public health services are considered to be highly cost-effective and provide considerable value for money. It is estimated that around 7.0% of GDP is spent on health care in the public sector. Total health expenditure (that is, also including expenditure in the private sector) amounts to 8.6% of GDP. (Table 17, Annex VI).

One of the main strengths in this sector is the availability of competent and caring qualified human resources and demand for such human resources is currently sharply increasing.

The health care system has always offered a relatively large degree of patient choice. Several private hospitals and clinics supplement the services provided in the public health care sector[5]. Patients can move without restrictions between the public and private sectors. Patients can also choose their private general practitioner and their specialist in both private and public sectors but are not normally able to choose their general practitioner in the public sector.

The state health service and private general practitioners comprise primary health care in Malta. However, the two systems of primary care practice function independently of one

[1] EU citizens are also entitled to free emergency care through the European Health Insurance Card (EHIC). Irregular immigrants are only entitled for formulary medicines only.

[2] With the specific exceptions mentioned above, notably in relation to medicines, 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 and is complemented by private financing through out-of-pocket payment and private insurance. The public health care system is funded through general taxation and the system is deemed to be equitable and progressive.

[3] These schemes are regulated as schedules under the Social Security Act. Access to the Schedule II (Pink Card) Scheme is means tested. In the case of patients suffering from Diabetes Mellitus the Pink Card is issued without means testing. The Schedule V (Yellow Card) Scheme is used to cover persons who suffer from listed chronic diseases and is also issued without means testing.

[4] It is estimated that around 25% of the population have some kind of basic private health insurance.

[5] The bed capacity in the private sector accounts for 12.5% of the total number of acute care hospital beds.

another. The government delivers primary health care though eight health centres that offer a full range of preventive, curative and rehabilitative services, which are free at the point of use. It is estimated that around 70% of all GP consultations are carried out in the private sector[6]. Secondary and tertiary care is mainly provided by specialised public hospitals of varying size and function[7]. The main acute general services are provided by one main teaching hospital incorporating all specialised, ambulatory, inpatient care and intensive care services. Malta has become almost self-sufficient in terms of providing most tertiary care. Patients are sent overseas for highly specialised care required for rare diseases[8].

Health sector NGOs are mainly self-help and advocacy groups for specific diseases or sectors of the population. Some provide health or support services whilst others serve to raise funds for investment in specific areas.

Universal coverage is also in place for long-term care[9]. Access is linked to need and to capacity within the currently available infrastructure. Services are provided by the state, church and private/voluntary organisations. The mixed market of service providers fosters competition on price and quality[10]. The institutional sector that provides care for the elderly covers a span of needs ranging from custodial to highly dependant care. Homes for the elderly are dispersed across the country thereby often providing residential care closer to home. The infrastructure for residential long-term care is overall of high quality across both public and private/voluntary sectors. Most of the facilities are modern or are undergoing modernisation programmes.

Training of the human resources working within residential long-term institutions ranges from basic care skills to specialised professional training. The quality of human resources in the sector is one of its major strengths.

Financing of state long-term care services is through general taxation and co-payments[11].

Government policy in the long-term care sector is focusing on keeping persons in their own home and attached to their surrounding community milieu whenever possible. The movement of older persons away from the home and community environment that they are accustomed to, may result in trauma. Thus, the on-going development of community-based services is a main priority area for Government in this field. The development of community day centres for the elderly as well as adult learning centres for the persons with disability exemplify

[6] Data according to the Health Interview Survey (2002).

[7] Although decentralisation of management is underway, there is still considerable input from central administration on the day-to-day running of state institutions. Health care personnel employed by government as salaried civil servants provide state health care services. The competence and commitment of the health care workforce is deemed to be one of the strengths of the health care system.

[8] Patients are referred overseas for treatment overseas for cases such as, bone-marrow transplants, liver transplants, complex major spinal surgery, paediatric cardiac surgery, maxillo-facial surgery, and specialist paediatric cases. To date there have been no strong clinical or economic arguments to develop these services in Malta since the investment cost is too high, the patients are too few and full time professional staff employed to perform this type of service will quickly become de-skilled. This system may be viewed as an extension of local health service provision in the public sector - a tertiary care backup service with centres of excellence abroad. A transparent authorisation process is in place to ensure equity and to balance need with financial and other resources when considering sending patients abroad for treatment. To date this process has passed the test of time and is considered as a prime example of good practice in determining and balancing access rights with individual patient needs.

[9] For the purpose of this report long-term care services are being defined as institutional and community services provided across a range of settings spanning from primary care to rehabilitation for diverse client groups including the elderly, persons with disabilities, mental health problems, substance abuse problems and chronic debilitating illnesses.

[10] The long-term care sector has yielded positive experiences in the area of managing the public/ private mix of service provision. These services have proven to be very effective and economical while also addressing quality issues. Whilst the Department for the Elderly runs several residential homes for older persons, two of these are operated by a private contractor through a long- term service level agreement. Another scheme that has been adopted is the 'purchase' of beds from the private sector. Again this has proven to be an economically-viable model since government did not have to invest in further infrastructure to gain additional beds.

[11] The system of co-payments that is in place ensures that pension contributions are linked to means. Funds collected through co-payments are re-directed into the long-term care sector. The private long-term care sector is financed through out-of-pocket payments and through payment provided by the state for services procured. A large contribution is also made by unpaid informal carers, mostly women. The mixed public and private financing is considered to be a strength to build on for the future sustainability of long-term care financing. In addition, the concept of co-payments and contributions in the public long-term care sector is now well established with broad political consensus.

Government's efforts to this effect. The experience with home services[12] has shown that these are also very popular and in great demand. The private sector also provides home care or support against payment.

In the mental health sector persons requiring institutional long-term care have full access to all the required facilities. Community services for mental health have developed in the past decade and include homes that focus on rehabilitation as well as support services from an inter-disciplinary team. The National Commission for Mental Health has been recently renewed and its first main priority is the drawing up of a modern Mental Health Act.

Collaborative initiatives between the private and public sectors in long-term care are yielding positive results. However, the private sector is only affordable to a select segment of the population. Furthermore, the highest dependency categories of patients are almost exclusively cared for by the Government services.

Taking into account these strengths, past accomplishments and the current socio-economic context in Malta**,** Government has set the following three over-arching policy priorities to guide its work in the area of health and long-term care;

1. Enhancing equity in access to care
2. Promoting quality and excellence
3. Improving governance to safeguard sustainability

Reforms Undertaken

In 2007, the restructuring of the general administration of the health and long-term care sectors into four divisions was carried out. It been important in laying the foundations for the new roles being developed to meet the challenges the health and long-term care sectors are facing. The four Divisions are:

1. Public Health Regulation,
2. Health Care Services,
3. Strategy and Sustainability, and
4. Resources and Support.

The Health Care Act has been drafted in order to give the new structure the required legal backing. However this legislation has not been discussed in Parliament and is presently under examination by the Attorney General.

The draft Health Care Act will introduce better systems of Governance for health and long-term care as well as outlining and consolidating the rights and responsibilities of patients, service providers and the sector's regulator.

This Bill provides for the separation of roles and functions between the funder, regulator and providers of health services, as exemplified by the organisational reform described above. The legislation is also intended to address the concern that to date the public health care services have not been subject to the same legislation regulating the private sector and will create the framework that will ensure uniform standards are applied throughout the health system.

Moreover, the Bill will also provide the legal framework for decentralisation of management. Devolution and decentralisation of management processes that place responsibility on service providers for effective and appropriate utilisation of resources have been introduced in some

[12] These include '*home help*', '*handy man*', '*meals on wheels*' and, '*tele-care*' schemes. For example, the latter is an innovative approach to retaining elderly in the homes. This is a telecommunications system that links the elderly in their homes with a central 24 hour station, whereby personnel receive automatic distress calls from elderly persons who are on their own and organise an appropriate response, using either state emergency services or relatives, friends and/or neighbours. This project was successfully launched in collaboration with a private telecommunications company whereby all infrastructure, equipment and maintenance are borne by the private sector while the Department provides the staff and premises. Recently a further 1000 users have been added to the system that now covers 9000 persons.

smaller hospitals[13]. These pilot systems have positively affected patient care and utilisation of resources. The Government intends to replicate these processes and systems in the main hospital.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

The following are a number of measures taken by government to implement the policy objectives and legal framework described in the previous sections.

Enhancing equity in access to care

- Patients' rights and responsibilities

The preliminary drafts of the Health Care Act and the Mental Health Act, which will ensure *inter alia* better recognition and respect for patients' rights and responsibilities, have been finalised and are under examination by the Attorney General. Patient advocacy will be further enhanced by the Malta Health Network, an umbrella organisation that brings together numerous health-related NGOs, which was officially established in November 2007.

Increasing civic responsibility among service users to ensure the sensible use of services remains a challenge. In this respect, a nation-wide media campaign and a booklet on hospital and primary care services were distributed from every public healthcare facility in the wake of the opening of the new acute hospital, Mater Dei (MDH) in 2007.

- Affordability of (and accessibility to) new medicines

A mechanism has been set up whereby the Consumer and Competition Division will monitor prices of medicines in the private market and investigate any cases of overpricing that may be referred through an ad hoc committee set up for the purpose. To promote wider use of generic medicines, an information leaflet to be distributed among the general public is being prepared. A similar initiative to encourage medical doctors to prescribe generic medicines over brand drugs is also planned.

Financial resources are a challenge in this area. Increased investment is needed to render access to new medicines and technology more rapid and timely.

- Community-based responses to health care needs

A pilot project on diabetes care in the community has been replicated in another two localities in partnership with their respective local councils. Government's drive to network with the voluntary sector has been boosted by the passing into law of the Voluntary Organisations Act. The allocation of space to NGOs, notably VOLSERV[14], at MDH was another sign of a closer relationship being forged with the voluntary sector.

Following a broad process of consultation with internal and external stakeholders, a strategic plan for the consolidation of primary health and community care has been finalised. The overarching aims of this plan include the fostering of a more interdisciplinary approach among health professionals, better networking with the educational and social sectors, the regionalisation of service planning and delivery and the creation of a process of continuous needs assessment at community level.

- Equitable access to long-term care

[13] For example, Zammit Clapp Hospital (an acute rehabilitation geriatric hospital) has successfully implemented its mission of incorporating an interdisciplinary team approach within a high quality atmosphere, which is also conducive to learning and continual development. This has been achieved by focusing upon the real needs of patients and their carers through a process of on-going consultation that also involves the whole professional team. The Hospital's autonomous management structure has enabled it to be more responsive to the many different and changing demands of an ageing population.

[14] VOLSERV is a project aimed at developing and organising voluntary services to support patients and relatives in the main general hospital as well as in the community.

Bed capacity in long-term geriatric care is being increased by 120 beds through the ongoing refurbishment of a new wing at St. Vincent de Paule Residence (SVPR). A further 130 beds have been added as a result of the completion and opening of a new community nursing home for the elderly (*Madonna tal-Mellieha*) in the north of Malta. This home, which is capable of providing for varying needs and dependency levels, will also ease demand for entry to SVPR. Plans to endow other residential homes with this capability spectrum are still being developed. The development of community services will also help to delay the need for institutionalisation.

Criteria for admission into state institutional facilities for long-term care have been established, and made public.

Promoting quality and excellence

- Opening of Mater Dei Hospital and planning of new rehabilitation facilities

The opening of MDH has improved the quality of the care environment and that of the medical equipment and information systems technology. A similar improvement was registered in long-term geriatric care through the continued refurbishment of SVPR.

Plans for the development of new cancer treatment facilities and for the procurement of new machines are underway. A strategy for cancer prevention, treatment and palliation is being finalised. A 'Non-Communicable Diseases Strategy' is also being developed. Plans for the implementation of population-based organised breast cancer screening programme for women aged 50-59 years have reached an advanced stage. A campaign to assist in the uptake of the national breast screening programme has been planned.

Plans for the construction of a new 280-bed facility for rehabilitative and intermediate care are underway. In the interim, this service is being expanded in part of the now vacated St. Luke's Hospital. Plans are underway to convert more wards within Mount Carmel Hospital (a mental health hospital) into an intermediate care facility.

- Developing new information technology systems to improve health care delivery

New IT systems within MDH have been installed. These include a Picture Archival System and a Radiography Information System, a Laboratory Information System, and an Intensive Clinical Manager (ICM) System. The need for similar systems in, and connectivity with, the primary care setting is being evaluated and addressed. These and other initiatives will be supported by an *e*health strategy which is being drafted.

- User involvement

The Health Interview Survey being conducted during 2008 will assess service users' views on the nature and quality of health services provided. Research and development capabilities are being enhanced through Malta's participation in the European Community Health Indicators (ECHI) project, which is leading to the harmonisation of health information indicators, as well as through enrolment in a number of clinical trials with very good timelines.

- Setting and enforcing quality standards

Efforts to develop and apply systematic patient care protocols are ongoing. With regard to the need to upgrade legislation regulating institutional and community long-term care, a new directorate for Health care standards within the newly formed Regulatory Division has been established. It has the regulatory capacity for licensing and monitoring of long-term care services and facilities and will strengthen the enforcement of approved quality standards across the public and private sector.

Safeguarding sustainability

- Prevention and health promotion

Several health promotion and disease prevention initiatives have been successfully undertaken. In the area of immunisation there was a substantial increase in population coverage of the influenza vaccination in the first two years of the outgoing policy cycle over the first two years of the previous policy cycle (30% in 2006, 26.9% in 2007 vs. 12.23% in 2003, 13.7% in 2004). There has also been a further rollout of immunisation against Hepatitis B. An Intersectoral Committee to Counteract Obesity (ICCO) by addressing its key determinants across all sectors has been set up. Legislation regulating underage drinking has been enacted, and a national information campaign was launched. Various programmes aimed at promoting lifestyle-changing activities among older people have also been run.

Health promotion and disease prevention among school children has been enhanced as a result of the reorientation of the role of the School Health Service to such functions as screening for development problems, learning difficulties, obesity issues and the promotion of healthy lifestyles.

Health promotion activities are also being offered to dementia patients, notably through a Dementia Clinic and an Activity Centre that were launched in Zammit Clapp Hospital (ZCH) and SVPR, respectively. Both are providing day care services.

Government is set to shift focus from institutional to community care by implementing the aforementioned strategic plan for the consolidation of primary and community care.

- Human resource development

The importance of the human workforce to the sustainability of the health and long-term care system has been recognised through a number of training initiatives.[15] These include an extensive training and development programme focused on leadership at different levels of management for public health care employees, induction programmes for newly recruited health professional, a specialists training scheme for medical staff and a pilot mentoring programme for newly recruited clerks.

The new collective agreements that have been signed with major groups of health professionals will also help address the challenges the with regard to human resources in the health and long-term care sectors. A positive development is the Continuous Professional Development (CPD) component that is an integral part of all agreements.

- Sustainable financial management and control systems

A central unit of financial management, monitoring and control has been set up within the public health sector. The unit needs to engage additional expertise to enable it to fulfil its mandate. To ensure better management of human and financial resources in the long-term care sector, a human resources management system (payroll system) was implemented at SVPR. Tax incentives to encourage take-up of private residential care by elderly people in need of such care were introduced.

Efforts are ongoing to implement financial management systems in MDH and in other service-providing health care entities to bring information on expenditure in line with EuroStat parameters. The setting up of the System of Health Accounts to ensure better monitoring of the performance of health systems is still under development.

2) Please supply any relevant statistics or other information on the main health indicators and on health services and professions (for example WHO and/or Eurostat data).

Statistical data provided as per Annex VI.

[15] These initiative earned the then Ministry of Health the award for Human Resources Development from the Malta Foundation for Human Resources Development.

Article 12 – The right to social security

With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1. to establish or maintain a system of social security;
2. to maintain the social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;
3. to endeavour to raise progressively the system of social security to a higher level;
4. to take steps, by the conclusion of appropriate bilateral and multilateral agreements or by other means, and subject to the conditions laid down in such agreements, in order to ensure:
   a. equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;
   b. the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties.

Appendix to Article 12§4
The words "and subject to the conditions laid down in such agreements" in the introduction to this paragraph are taken to imply *inter alia* that with regard to benefits which are available independently of any insurance contribution, a Party may require the completion of a prescribed period of residence before granting such benefits to nationals of other Parties.

Article 12§1

Further to previous reports: -

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

General Legal Framework

The Maltese social security scheme is governed by the Social Security Act (Cap. 318 of the Laws of Malta. This Act is available through the following link: http://docs.justice.gov.mt/lom/Legislation/English/Leg/vol_7/chapt318.pdf#

The Social Security benefits may be classified as follows: -

Contributory Benefits: There are two categories of contributory benefits short-term and long-term.

- **Short Term Benefits** cover: Marriage, Unemployment, Sickness, Injury at Work and Maternity.
- **Long Term Benefits** cover: Disablement, Invalidity, Old Age, Widowhood and Death (covers only Orphan's and Parent's of Deceased)

Non-Contributory Benefits: These are intended to cover persons who will not qualify for contributory benefits or as an addition to contributory benefits when these do not reach a minimum amount of income. These benefits cover disability, old age, carer's pension, social assistance, medical assistance, and family benefits. All these benefits are means tested.

There are two specific non-contributory benefits, which are not means tested namely tuberculosis assistance and leprosy assistance.

Benefits in kind: The benefits in kind provided for by the Act cover amongst others, free medical aid and health care. In the case of Health care, the Health Division is responsible to provide health care services and the necessary monitoring and control mechanism.

A synopsis of the Social Security Act is available through the following link: http://www.msp.gov.mt/documents/dss/synopsis_dss.pdf . This document provides practical and detailed information of the Maltese social security scheme. It also provides information regarding the Social Security Division and its administration.

2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.*

The following are the details of the legislative measures taken during the reference period, in line with the provisions of Article 12 § 1.

During the reference period 2005-2007 the Maltese Social Security Act experienced numerous amendments. These changes varied from routine amendments such as increases in the rates of the Social Security Benefits to major ones such as the reform of the pensions system.

Legal Notice 100 of 2006 (http://www.doi.gov.mt/en/legalnotices/2006/04/LN100E.pdf) provided for the increases in the rates of Social Security benefits and contributions, as previously announced in the Budget Speech for 2005. These increases were proportionately tied to the Lm1.75 cost of living increase rise in wages as awarded by Government.

There was no increase in the capital resources means test of persons applying for Non-Contributory Benefits. Thus the capital limit for the entitlement of Age Pension, Social Assistance and Sickness Assistance remained Lm 6,000 in the case of a single or a widowed person, and Lm 10,000 in the case of married persons. The Capital limit in the case of applications for Medical Aids Grant also remained the same, at Lm4,000 in the case of a single or a widowed person and Lm7,000 in the case of married persons.

Another provision by way of this legal notice pertained to the increase of the maximum pensionable income of Lm6,750 considered for Social Security purposes which was increased for the first time since 1981. Indeed during 2005 this income was increased by the cost of living adjustment to Lm6,841 per annum.

An Additional Bonus of Lm1.34 per week continued to be payable to all pensioners and those households in receipt of Social Assistance.

Legal Notice 101 of 2006 (http://www.doi.gov.mt/en/legalnotices/2006/04/LN101E.pdf) provided for the increases in the rates of Social Security benefits and contributions as had previously been announced in the Budget Speech for 2006 were proportionately tied to the Lm2.25 (inclusive of 50c extra paid in advance of 2007 to make good for the extra expense for energy) cost of living increase rise in wages as awarded by Government.

There was no increase in the capital resources means test of persons applying for Non-Contributory Benefits. Thus the capital limit for the entitlement of Age Pension, Social Assistance and Sickness Assistance remained Lm 6,000 in the case of a single or a widowed person, and Lm 10,000 in the case of married persons. The Capital limit in the case of applications for Medical Aids Grant also remained the same, at Lm4000 in the case of a single or a widowed person and Lm7000 in the case of married persons.

The Additional Bonus of Lm1.34 per week continued to be payable to all pensioners and those households in receipt of Social Assistance.

During the year 2006, two bills aimed at amending the Social Security Act (Cap 318) were presented in Parliament, namely: -

1. Proposals for changes to the invalidity scheme and the legal recognition and granting of certain powers to the Director (Benefit Fraud and Investigation)
2. The bill to implement the Pensions Reform

Both bills were enacted namely Act VI of 2006 (http://www.doi.gov.mt/EN/parliamentacts/2006/Act%20VI.pdf) and Act XIX of 2006 (http://www.doi.gov.mt/EN/parliamentacts/2006/ActXIX.pdf) respectively.

Legal notice 318 of 2007(http://www.doi.gov.mt/EN/legalnotices/2007/10/LN%20318.pdf) provided for the increases in the rates of Social Security benefits and contributions as had previously been announced in the Budget Speech for 2007 were proportionately tied to the Lm1.75 cost of living increase rise in wages as awarded by Government.

There was no increase in the capital resources means test of persons applying for Non-Contributory Benefits. Thus the capital limit for the entitlement of Age Pension, Social Assistance and Sickness Assistance remained Lm 6,000 in the case of a single or a widowed person and Lm 10,000 in the case of married persons. The Capital limit in the case of applications for Medical Aids Grant also remained the same, at Lm4000 in the case of a single or a widowed person and Lm7000 in the case of married persons.

Act XXXII of 2007 published on the 31st December 2007 (http://www.doi.gov.mt/EN/parliamentacts/2007/ACT%2032%20Budget%20Measures.pdf) carried the majority of the amendments to the Social Security Act as a result of the new measures introduced during 2007 as announced by Government.

Legal notice 170 of 2007(http://www.doi.gov.mt/EN/legalnotices/2007/06/LN%20170.pdf) was published to put into effect the implementation of the Invalidity Pension reform and Impairment Tables. Legal notice 62 of 2007reported the smoothing of certain thresholds as a result of the Euro changeover effective from the 1st January 2008.(http://www.doi.gov.mt/EN/legalnotices/2007/03/LN%2062.pdf).

The Administrative Scheme regulating the new Energy Benefit was launched by the Minister on the 19th April 2007 and was published in the Government Gazette of 20th April 2007. (http://www.doi.gov.mt/EN/gazetteonline/2007/04/gazts/GG%2020.4.pdf)

As a result of the 2007 Budget speech a number of initiatives in social security were announced by Government. In fact during the year 2007, the Social Security Division introduced the following measures:

- Disability Pension

Another measure introduced during 2007 was with respect to persons receiving a non-contributory disability pension. As a result of this new measure in the calculation of the income of the disabled person for the purposes of establishing a right to such pension, for the first five (5) years of marriage, no consideration would be made of the income and/or capital of the disabled person's spouse.

- Social Assistance Carers

The Social Assistance to carers' of elderly relatives which was previously payable only to female applicants was extended to male relatives.

- Supplementary Allowance

During year 2007 the percentage rates in the establishment of the Supplementary allowance were increased as follows:

Married – from 1.75% to 2% (max of Lm 3.08p/wk)

Single – from 1.25% to 1.5% (max of Lm 1.73p/wk)

- Work friendly measures

Further to the foregoing, in its endeavour to generate employment, in 2007 Malta introduced three changes in the Social Security Act, namely:

a. Change in the computation system of social security contributions on part-time employment

Up till 31st December 2006, part-time employees working more than eight hours per week, regardless of the amount earned, were obliged to pay a minimum contribution of Lm 5.79 per week which was equivalent to 10% of the then national minimum wage. In view of this, several people who wished to work were dissuaded from doing so. Therefore, with effect from 1st January 2007, social security contributions due by employees working eight hours a week or more was adjusted to 10% of what they earn from such work, with this pro-rata rate of contribution giving contributor a pro-rata entitlement to contributory benefits. This measure helps to alleviate the burden on workers and to strengthen the part-time work sector, a labour market sector that is predominantly resorted to by women as their principal form of employment.

b. Changes to the contributory widows'/widowers' pension

Up till 31st December 2006, a widow/widower who did not have children below the age of 16 years or unemployed children below the age of 18 years would lose pension entitlement if earnings derived from work exceeded the national minimum wage. These provisions compelled widows/widowers to reduce their working hours or to stay away from employment so as not to forfeit their pension.

As from 1st January 2007, a widow or widower with children under the age of 21 years (up from 16/18 years) who are not in gainful employment shall continue to be entitled to a widow/widower's pension at the fixed rate of this pension notwithstanding the fact that they earn more than the minimum wage.

Similarly a widow/widower who remarries shall retain fixed rate pension entitlement in the first five years of re-marriage.

c. Insurability – Host families

From January 2007, persons acting as host families to students, could, if their sole income was from the hosting of such students, opt whether such income is to be considered for the purposes of insurability under the terms of the Social Security Act.

3) Please provide pertinent figures, statistics or any other relevant information if appropriate.

For a detailed statistical analysis of the implementation of the Maltese Social Security Scheme, please refer to the Social Security Division's annual reports. These reports are available through the following links:

- Year 2005: http://www.msp.gov.mt/documents/dss/dss_2005.pdf
- Year 2006: http://www.msp.gov.mt/documents/dss/dss_2006.pdf
- Year 2007: http://www.msp.gov.mt/documents/dss/dss_2007.pdf

Article 12§ 3

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

1.1 Social Security Reforms - Legislation

As mentioned earlier, the period under review (2005-2007) was a very dynamic one for the Social Security System in Malta. Three (3) major legislative reforms were enacted, namely the reform of the contributory pensions system, the reform of the invalidity pensions system and the introduction of the so-called Energy Benefit in lieu of the Electricity Rebate.

1.1.1 Scope of the Pensions Reform

The current Pay As You Go pensions system is directly tied to a nation's demographic structure. The Pay As You Go pensions system is premised on the principle that today's workers will pay for today's pensioners, particularly so in Malta's case given that the Two-Thirds pension introduced in 1979 is yet to mature, and that tomorrow's worker's will pay for the pensions of today's workers. The mathematics of the Pay As You Go pensions system, as has been noted with increasing concern overseas, unravels when the main variable in the equation, that is the labour stock, is clearly seen that it will not perform as predicted.

Various reports commissioned by different legislatures, namely, the Camilleri Report (December 1997), the Watson Wyatt Report (August 1998), the National Commission for Welfare Reform Galdes (June 2001) and the Schembri (October 2003) Reports, and the World Bank Report (March 2004) (http://www.mfss.gov.mt/pensions/documents/maltesepensionsystem.doc) were all consistent in their conclusions. The pensions system in Malta, unless reformed, would have been challenged to provide adequate pension benefits for future generations in a sustainable manner. The current pensions system is not sustainable. Benefits would not be adequate. And the principle of 'self-help' must be inculcated to induce people to save to secure a decent standard of living upon retirement.

A review of the demographic structure of the Maltese Islands showed that by 2050 the population will fall; the 60 years of age and above cohort will increase exponentially in relation to other age groups, and life expectancy of the same cohort will also increase. On the other hand live births have been decreasing steadily since the post war period.

The challenge was also compounded by the fact that a perception exists in Malta that the provision of a pension is solely the State's responsibility. This perception has induced individual behaviour to take comfort with the fact that the payment of one's individual social security contribution will suffice to render an adequate pension in the future. To a large extent the concept of 'self-help' through saving for retirement has not taken root in Malta.

Furthermore, the financial sustainability of the pensions system would have been impaired, affecting both recent pensioners and future generations as the demographic replacement ration will not allow for the sufficient collection of contributions to meet the benefits promised to individuals under the current pensions system.

A decision was imperative. Refraining from reforming the pensions would have meant a postponement of the decisions that needed to be taken. The longer the postponement the more restricted the policy options would have been, the harder the impact of the decisions, and most certainly, a less adequate benefit secured.

1.1.2 Scope of the Invalidity Pensions Reform

In line with the Division's mission to achieve the best practices, the medical review aspect of different benefits was examined and proposals for amendments to the Social Security Act (Chapter 318 of the Laws of Malta) were drafted. These proposals aimed at improving the system and making it more transparent to the public. These amendments were presented, discussed and approved by Cabinet in November 2005.

It was decided that the reform to the medical panel system would be introduced gradually and the first benefit identified for specific changes was that of the Invalidity Pension awarded to persons who due to illness are unable to carry out full-time or regular part-time employment.

During 2006 steps to revise the whole invalidity claim procedures were taken. Amendments to the Social Security Act have been passed through Parliament during the year.

1.1.3 Scope of the Introduction of the Energy Benefit

Prior to the introduction of this benefit, the Division paid the so-called Electricity Rebate. This benefit entitled the beneficiaries for the compensation of the rental of the water and electricity meters as well as for the reduction of a very small percentage of the water and electricity bill..

The Energy Benefit was intended to mitigate the impact that the surge in the oil prices had on the water and electricity bills. This global phenomenon had an impact in the global scene and affected all the international markets, and Malta was no exception. In order to compensate for the financial burden generated by this phenomenon on a national level, the Government seeked to find the most adequate solution to assist both the persons in need as well as the society as a whole.

The surge in the international oil prices, resulted in the introduction of a surcharge in the water and electricity bills. The Energy Benefit is a compensation of the surcharge incurred by low-income earners.

1.2 Social Security Reforms – Administration

The review period 2005-2007 saw also a restructuring in the administration of the Department of Social Security as a whole.

A new unit responsible for international matters in the Social Security field was set-up. The International Relations Unit (IRU) became operative in May 2004.

On a larger scale, in 2006, the administration of the Social Security scheme evolved from a Department to a Division and it is now known as the Social Security Division.

1.2.1 The establishment of the International Relations Unit - Scope

Malta's accession to the EU inevitably brought about the need of an ad-hoc structure to deal with EU and International Relations. The Division already had expertise in the field of coordination of Social Security schemes, albeit on a bilateral level. This was gained from years of coordinating four bilateral agreements with Australia, Canada, United Kingdom and The Netherlands. As from 1st May 2004, the Social Security Division, through the International Relations Unit is also responsible for the implementation of the EU social security regulations which are much more comprehensive in the social security issues they cover than the mentioned bilateral agreements

1.2.2 Reform in the administration of the Social Security - Scope

From an analysis of the environment in which the Department of Social Security was operating it transpired that in order for the department to succeed in its strategic objectives, there was an urgent need to revise the structure of the organization and more specifically, the top management posts.

It was more than evident that there was a dire need to separate policy and strategic development management from the administration of social security provisions. Such an approach would have ensured a professional management approach to social security that resulted in laying greater emphasis on output and emphasizing the role of the customer, leading, in the long-run, to improved quality and lower costs.

It was concluded that these goals could only have been achieved by a restructuring of the Department of Social Security and more specifically the top management posts of the Department.

2) *Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.*

2.1 The International Relations Unit

The main responsibility of the International Relations Unit is the coordination of Council Regulations (EC) Nos. 1408/71 and 574/72 concerning the application of social security schemes to employed persons, self-employed persons and members of their families moving within the European Community. These regulations also apply to the European Economic Area (EEA) countries, namely Norway, Iceland and Liechtenstein, and also to Switzerland.

This unit is also responsible for all international payments under the above-mentioned Regulations and the bilateral agreements Malta has with Australia and Canada. Apart from placing the necessary infrastructure within the Department to coordinate the above-mentioned EU regulations and bilateral agreements efficiently and effectively, since its inception the IRU completed a number of important tasks, namely:

- Conducted a Twinning Project with the United Kingdom after obtaining €218,000 from the European Union under the Transition Facility for 2004 to strengthen the Department's administrative capacity and to enhance the Department's Information System, in dealing with the EU social security regulations.
- provided advice and support to the staff of the Department, employers, migrant workers and the public in general on the handling of social security claims and issues dealing with the coordination of the above-mentioned regulations;
- organised various seminars, including the TRESS Seminar, which was attended by both local and foreign experts in the field of social security;
- published an informative booklet, in collaboration with the Malta-EU Information Centre and the European Parliament representation in Malta, about the social security rights of EU citizens.

For a detailed overview of the operations of the IRU, please refer to the Division's annual reports (2005-2007).

2.2 The Pension Reform Act – Malta 2006

The Bill to implement the Pensions Reform entitled the "Social Security (Amendment) (No. 2) Act, 2006" was debated in Parliament during 2006. The Bill was adopted and became law on the 7th December 2006 by virtue of Act XIX of 2006.

Legal Notice 336 of 2006 brought into force the majority of the articles of the Act with effect from the 1st January 2007.

The Act includes significant changes to the current national social security pension system, to be introduced in a gradual manner which enables a smooth transition without causing social and economic disruptions.

The following are the salient elements of the Pensions Reform: -

1. Pension Age

Currently, pension age in Malta is sixty (60) years for women and sixty one (61) years for men who have retired from gainful activity. (Note: - Gainful activity for persons over pension age is deemed to be activity through which earnings of more than the National Minimum Wage are derived. Currently (2007) the National Minimum Wage is Lm59.63 per week.

The new provisions see a gradual increase in pension age as follows: -

- In the case of a person born on or before the 31st December 1951, the pension age will remain as is currently, that is for men pension age shall be sixty one (61) years of age whilst for women pension age shall be sixty (60) years of age; (Note: Women in such an age bracket have now been given the option to retire at sixty one (61) years of age and the employer will not be able to terminate her employment if such a women opts to work until sixty one (61) years of age);
- In the case of a person born during the calendar years 1952 to 1955, pension age shall be sixty two (62) years of age;

- In the case of a person born during the calendar years 1956 to 1958, pension age shall be sixty three (63) years of age;
- In the case of a person born during the calendar years 1959 to 1961, pension age shall be sixty four (64) years of age;
- In the case of a person born on or after the 1st of January 1962 pension age shall be sixty five (65) years of age.

2. Disqualification from a Pension in respect of Retirement

Persons born on or before the 31st December 1961 will continue to benefit from the provisions of current legislation. This essentially means that such persons, on reaching pension age, will not forfeit their right to such pension until sixty five (65) years of age if they work, as long as their earnings from such a gainful activity does not exceed the yearly average of the National Minimum Wage.

After attaining sixty five (65) years of age, any earnings from their gainful activity will not affect their entitlement to a social security pension.

Persons born on or after the 1st January 1962 will retire at age sixty five (65) and employment after such age will not affect their entitlement to their social security pension on retirement.

There is a specific restriction on employment whilst receiving a social security pension for persons who decide to avail themselves of a new opt-out clause. For further details refer to the information in the following paragraph 3.

3. Opt out for earlier Retirement

The Pensions Reform provides an early retirement opt-out clause. This opt-out clause provides that a person who has attained the age of sixty one (61) years, but has not yet attained the applicable pension age, may retire after attaining sixty one (61) years of age on the condition that such person has accumulated since his/her 18th birthday, a total of: -

- 2,080 paid or credited contributions if born on or after the 1st January 1962; or
- 1,820 paid or credited contributions in the case of a person born during calendar years 1952 to 1961.

Important: Any person retiring under this opt-out clause will not be able to carry out any gainful activity following such retirement. Obviously after attaining sixty five (65) years of age, gainful activity will not affect such pensioner's entitlement.

4. Calculation of contribution average – in the case of a two-thirds pension

The full rate of the two-thirds pension will be equal to two-thirds (2/3rds) of the pensionable income of a person who, following his or her eighteenth (18th) birthday has paid or been credited with a yearly average of 50 social security contributions over a period of: -

- Thirty (30) years in the case of a person born on or before the 31st December 1951;
- Thirty five (35) years for a person born during the calendar years 1952 to 1961;
- Forty (40) years in the case of a person born on or after the 1st January 1962.

In the case of persons born on or before the 31st December 1961, the contribution average calculation as indicated above will continue to be carried out under the current regime. This means that for each person two periods of contribution averages will be considered:-

1. The last ten (10) complete calendar years prior to a person's retirement, and
2. Any other twenty (20) or twenty five (25) contribution years, as applicable in the case, starting from the first day of the contribution years in which a person reaches the age of eighteen (18) and ending on the last day of the complete calendar years prior to the beginning of the last ten (10) calendar years prior to retirement.

The average of the two average periods as indicated above, will determine the pension ratio.

With respect to persons born on or after the 1st January 1962, the contribution average assessment will be carried out on one period which will be made up of any forty (40) years from the first day of the contribution years in which the person reaches the age of eighteen (18) years of age and ending on the last complete contribution years prior to retirement.

5. Calculation of the applicable Pensionable Income

Under the current pension system, a person's pensionable income is determined according to his employment status: -

- In the case of a person deemed to be an employed person, the pensionable income is assessed as the average of the best three consecutive calendar years out of the last ten (10) years' basic wages;
- In the case of a person deemed to be a self employed or self occupied person, the pensionable income is assessed as the average of the last ten calendar years' net income/net earnings of the self-employed/self-occupied respectively.

According to the Reform, in the case of persons born on or before the 31st December 1951, there will be no changes to the current system to calculate a pensionable income.

However, in the case of a person born during the calendar years 1952 to 1955 the calculation of the pensionable income will be as follows: -

- In the case of a person deemed to be an employed person, the pensionable income is assessed as the average of the best three (3) consecutive calendar years out of the last eleven (11) calendar years' basic wages;
- In the case of a person deemed to be a self employed or self occupied person, the pensionable income is assessed as the average of the best ten (10) calendar years' net income/net earnings of the self-employed/self-occupied respectively during the last eleven (11) calendar years prior to retirement.

In the case of a person born during the calendar years 1956 to 1958 the calculation of the pensionable income will become: -

- In the case of a person deemed to be an employed person, the pensionable income is assessed as the average of the best three (3) consecutive calendar years out of the last twelve (12) calendar years' basic wages;
- In the case of a person deemed to be a self employed or self occupied person, the pensionable income is assessed as the average of the best ten (10) calendar years' net income/net earnings of the self-employed/self-occupied respectively during the last twelve (12) calendar years prior to retirement.

In the case of a person born during the calendar years 1959 to 1961 the calculation of the pensionable income will become: -

- In the case of a person deemed to be an employed person, the pensionable income is assessed as the average of the best three (3) consecutive calendar years out of the last thirteen (13) calendar years' basic wages;
- In the case of a person deemed to be a self employed or self occupied person, the pensionable income is assessed as the average of the best ten (10) calendar years' net income/net earnings of the self-employed/self-occupied respectively during the last thirteen (13) calendar years prior to retirement.

In the case of a person born on or after the 1st January 1962, there will no longer be any distinction between employed, self-employed or self-occupied with respect to the calculation of a pensionable income.

For persons born on or after the 1st January 1962, the pensionable income shall be the yearly average of the basic wage/salary/net income/net earnings as the case may be, during the

best ten (10) calendar years within the last forty (40) calendar years prior to a person's retirement.

6. The Maximum Pensionable Income

The Pensions Reform has also envisaged changes to the Maximum Pensionable Income on which a social security pension is issued. In fact, the Maximum Pensionable Income to be considered in the case of a person: -

a. born on or after the 31st December 1961 shall be -

⇒ Lm7,049 (2007) increased by the Cost of living awarded generally by Government up to 2011

⇒ Between 2011 up to 2014, the Maximum PI will be increased in three (3) tranches up to Lm9,000

⇒ After 2014, the Maximum Pensionable Income will be indexed to a mechanism that is constituted of 70% wages and 30% inflation.

b. Born during calendar years 1952 and 1961 shall be –

⇒ Lm7,049 (2007) increased by Cost of living increases awarded generally by Government up to a maximum of Lm9,000

c. Born on or before the 31st December 1951 shall be –

⇒ Lm7,049 (2007) increased by Cost of living increase awarded generally by Government up to a maximum of Lm7,500

7. The Guaranteed National Minimum Pension

Effective from the 1st January 2011, changes are envisaged to the National Minimum Pension, which currently stands at 4/5ths of the National Minimum Wage for a married couple and 2/3rds of the National Minimum Wage for any other person. A person born on or after the 1st January 1962 shall in no case receive a social security pension (inclusive of any service pension where applicable) that is less than the rate of the Guaranteed National Minimum Pension (GNMP). The future Guaranteed National Minimum Pension (NMP) will be pegged against a minimum of 60% of the median national equivalised income. This upholds adequacy by maintaining the ratio with national equivalised overall earnings, thus providing a better safety net against poverty. Future indexation of pensions will be carried out through a mechanism that is constituted of 70% wages and 30% inflation. This mechanism should provide a flat increase to all pensioners annually rather than the minimum cost of living adjustment based on the cost of living increase awarded in the National Minimum Wage.

8. Crediting of Contribution for Parents for Child Rearing

Effective from the 1st of January 2007, credits of social security contributions will be awarded to parents. The maximum number of credits that may be awarded in such a case is two (2) years for each and every child or in the case of a child suffering from a serious disability the period of two (2) years is extended to four (4) years. The applicable period of credits may be shared between both parents but shall in no case exceed a total between both parents of two (2) or four (4) years as is applicable in the case.

The basic conditions for entitlement are that the parent: -

1. has the legal care and custody of a child who is less than 6 years of age (or 10 years of age in the case of a child suffering from a serious disability); and
2. has since returned to gainful activities for a minimum number of years equivalent to the period credited.

The above is also applicable to adoptive parents.

9. Pension System Review and the Introduction of the 2nd and 3rd Pillar Pensions

A legal provision has been introduced whereby the Minister from time to time responsible for the Social Security Division will, within intervals not exceeding five years, submit a report to Parliament, in which a review of the Pensions System will be carried out. This report is also to include recommendations for achieving further adequacy, sustainability and social solidarity.

The first of such reports is to be submitted by not later than the end of 2010, and shall be discussed by the Social Affairs Committee of Parliament.

In the meantime, the Pensions Reform also provides the legal vires for the Minister responsible for social security, in concurrence with the Minister responsible for finance to make regulations that would see the introduction of the mandatory 2nd pension scheme.

(The following table includes the main elements of the Pensions Reform)

SOCIAL SECURITY PENSION – REFORM ELEMENTS TO THE FIRST PILLAR PENSION:

Year of Birth	Age of Person as on 01.01.2007	Pension Age	Accumulation Period	Calculation Period	Maximum Pensionable Income
Persons born during or after calendar year **1962**	Such persons will be 44 years of age or under	65 years	40 years	Best 10 calendar years out of the full 40 calendar years prior to retirement	(a) Lm 7049 (2007) increased by COLA up to 2011, and then (b) between 2011 and 2014, increased by 3 equal tranches up to Lm9000, and then c) After 2014 will be indexed to a mechanism that is constituted of 70% wages and 30% inflation.
Persons born during calendar years **1959 to 1961**	Such persons will be between 47 and 45 years of age	64 years	35 years	Best consecutive 3 calendar years out of the last 13 calendar years prior to retirement	Lm7049 (2007) increased by COLA up to a maximum of Lm9000
Persons born during calendar years **1956 to 1958**	Such person will be between 50 and 48 years of age	63 years	35 years	Best consecutive 3 calendar years out of the last 12 calendar years prior to retirement	Lm7049 (2007) increased by COLA up to a maximum of Lm9000
Persons born during calendar years **1952 to 1955**	Such persons will be between 54 and 51 years of age	62 years	35 years	Best consecutive 3 calendar years out of the last 11 calendar years prior to retirement	Lm7049 (2007) increased by COLA up to a maximum of Lm9000
A person born on or before the **31st December 1951**	Such person will be 55 years of age or older	61 years	30 years	Best consecutive 3 calendar years out of the last 10 calendar years prior to retirement	Lm7049 (2007) increased by COLA up to a maximum of Lm7500
A woman born on or before the **31st December 1951**	Such woman will be 55 years of age or older	60 years of age (but will retain an entitlement to opt for retirement at age 61 years of age and in such an event, the employer will be obliged to retain such person up to age 61 years of age)	30 years	Best consecutive 3 calendar years out of the last 10 calendar years prior to retirement	Lm7049 (2007) increased by COLA up to a maximum of Lm7500

2.3 The Invalidity Pensions Reform

These measures seek to introduce a new medical review process for this benefit and amongst the measures involved one finds:

(i) Change in the application format – to include more medical data and further responsibility on the part of the claimant to prove his case.

As part of the new procedure, no invalidity pension will be issued for life and each case will be subject to regular reviews. All cases will be reviewed every three to four years – where updated medical evidence will be requested from the beneficiary.

(ii) Change in the medical panel system – In the new system, the Department of Social Security will recruit at least two medical practitioners through an Expression of Interest (which is currently in the adjudication process) to act as a Medical Review Team. The Team's main function will be to advise the Director (Social Security) on the medical aspects of Invalidity claims.

(iii) Establish specific medical criteria for the award of benefits – this has been achieved by establishing "Impairment Tables" that provide the basic guidelines under which that Medical Review Team would decide on *work-related impairment* for Invalidity pension.

The Tables consist of a number of system-based tables that contain specific sets of criteria classified into levels of impairment relating to that body system. These allow ratings to be assigned in proportion to the severity of the impact of medical impairments on functional work capacity.

(iv) Establish an independent systems audit – Establish a medical audit for benefit claims awarded and rejected on medical grounds, in order to establish whether such benefits have been awarded correctly.

Also other changes to the system have been made such as a minimum period of sickness before the payment of an invalidity pension. The proposed waiting period is three months from the first social security medical certificate submitted by the applicant. During this waiting period the applicant will in the majority of cases still be entitled to normal sickness benefits. Such waiting period should not be applicable in sudden severe or terminally-ill cases

2.4 The Introduction of the Energy Benefit

This benefit replaced the actual Electricity Rebate system. Refund through a payment voucher system given on the surcharge and water and electricity meters according to the typical consumption of water and electricity of family was established. The new system requires periodical estimates according to the number of members (being the dependant members considered for entitlement to a social assistance) in the household and the typical consumption of such household according to standard rates established by the National Statistics Office.

Persons in receipt of Unemployment and Social Assistance (including single parents), an Age Pension or persons in receipt of Special Unemployment Benefit automatically benefited without the need to apply. Other persons, such as persons in receipt of a Child or Supplementary Allowance or a Disability Pension and whose household income is less than Lm3,268 per annum also qualified and were required to apply for such a benefit. Approximately 29,000 persons qualified for such benefit.

The Energy Benefit was also payable on humanitarian grounds to families where:

(a) A member of the household has a medical condition which justifies excessive use of water and electricity; and

(b) The members of the household are permanently resident in Malta; and

(c) the household income, calculated in accordance with Part VII of the Second Schedule of the Social Security Act (Cap. 318) would entitle the head of the household or his/her spouse, as the case may be, to a Disabled Child Allowance

The Division engaged in an intensive publicity campaign to promote this new benefit. The following link refers to the information package published by the Division:

http://www.msp.gov.mt/documents/msp/energy_benefit_leaflet.pdf

2.5 Reform in the administration of the Social Security

The new organizational structure of the Social Security Division is available through the following link: http://www.msp.gov.mt/documents/dss/DG_Organogram.pdf

3) Please provide pertinent figures, statistics or any other relevant information on the improvement of the social security system as well as on any measures taken to restrict the system.

3.1 Pension Reform

The pension reform will be effective from year 2011 and therefore no statistical data can be provided at this stage.

3.2 Invalidity Pension – Statistics

The table below shows the number of Invalidity pensions paid during year 2007 and the comparison with the number of cases paid in 2006. It transpires that there was a decrease of 474 cases thus corroborating the effectiveness of the new system.

Type of Benefit	**Number of Claims**		
	2006	**2007**	**+ or -**
Invalidity Pension	1,821	1,619	-202
Increased Invalidity Pension	336	312	-24
National Minimum Invalidity Pension	7,307	7,059	-248
TOTAL	**9,464**	**8,990**	**-474**

Furthermore, the number of claims for Invalidity Pensions dropped from 1,203 in 2005 to 895 in 2006, a 25.6% decrease in one calendar year.

3.3 Energy Benefit - Statistics

The table below shows the number of beneficiaries of the Energy Benefit up to the 31st December 2007, as well as the total government expenditure for the same year.

As on 31.12.2007				
No. of Persons in receipt of Social Assistance				**28,926**
No. of New Applications Received	**No. of Accepted Claims**	**No. of Rejected Claims**	**No. of Pending Claims**	
166	79	73	14	**79**
Total Beneficiaries				**29,005**
Total Expenditure				**Lm911,259.94**

Article 12§4(a)

Further to previous reports: -

1) Please describe the general legal framework, in particular the complete list of bilateral and multilateral agreements or any other means such as unilateral, legislation proposed or adopted, or administrative measures and indicate how they allow for the various social benefits the implementation of the principles provided in sub-paragraphs a) and b).

Malta did not sign any agreement with other Revised European Social Charter Member States. Malta considers the European Social Charter Order, which was enshrined in the Maltese Social Security Act (Cap. 318 of the Laws of Malta) through Legal Notice 204/1999 (Annex VII.3), as an adequate multilateral legislative measure which guarantees equality of treatment to nationals of the European Social Charter, ordinarily residing in Malta. In fact when cases of this sort arise, the Maltese social security authorities investigate the individual circumstances, through meetings with the persons involved, through an analysis of the case scenario and eventually decision are taken in conformity with the provisions of the Revised European Social Charter. These facts are corroborated by the absence of legal actions in this regard against Malta and the Maltese social security authorities.

Furthermore, Malta is satisfied that the Social Security Act (Cap. 318 of the Laws of Malta) is a valid instrument for safeguarding equality of treatment in that the scope of this legislation was extended to refugees and stateless persons. An example of this is the right guaranteed by the Maltese Social Security Act (Cap. 318 of the Laws of Malta) in relation to the retention of accrued rights when a person decides to move outside of Malta. In fact, any social security pension, be it a Retirement, Invalidity or a Survivor's pension, are exportable worldwide. This ensures that the citizens of all the contracting parties are treated on the same footing as Maltese pensioners as regards exportability of benefits.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Malta's efforts are currently concentrated at revising the Legal Notice 204/1999 in order to extend its scope to cover the nationals of the countries signatories to the Revised European Social Charter.

3) Please provide pertinent figures or any other relevant information, Please, indicate also the length of residence requirements when applicable.

Malta will provide statistical data on the number of beneficiaries paid in other states of the Council of Europe in due course.

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. To ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. To apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

Appendix to Article 13§4
Governments not Parties to the European Convention on Social and Medical Assistance may ratify the Charter in respect of this paragraph provided that they grant to nationals of other Parties a treatment which is in conformity with the provisions of the said convention.

Further to previous reports by Malta on Article 13, the following is being submitted.

Article 13§1

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Malta has a well-established non-contributory scheme which has been in force since 1948 when the Old Age Pension Act was brought into being. Since then, this scheme has been enforced and ameliorated to guarantee a decent living to persons in need.

For a more detailed overview of the provisions of the Maltese non-contributory scheme you may visit the following links:

The Social Security Act (Cap. 318 of the Laws of Malta) - http://docs.justice.gov.mt/lom/Legislation/English/Leg/vol_7/chapt318.pdf

Synopsis of the Social Security Act –

http://www.msp.gov.mt/documents/dss/synopsis_dss.pdf

The official website of the Ministry for Social Policy -

http://www.msp.gov.mt/services/sif/service_index.asp?cluster=socprot

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

As reported previously, the Maltese benefits are increased annually to reflect the cost of living increases awarded in the National Minimum Wage. Amongst the initiatives taken was the introduction of the energy benefit. Point 2.4 in Article 12§ 3 refers.

In line with Directive 86.378 EEC-96.97, ratified by Malta, gender discrimination in the field of social assistance for persons caring for an elderly person was eliminated, in that such benefit was extended to single men or widowers.

With effect from January 2008, the eligibility criteria for the Children's Allowance were amended in order for every family with children to benefit from such an allowance, for each and every child. The high-income earners, who were previously disqualified from receiving Children's Allowance, are now entitled to receive such benefit, albeit at a fixed rate.

Furthermore, the discrimination between the percentage of the benefit due to the first and the percentage due to the second child was also eliminated. Malta will report further on this amendment, in the 2008 reference period report.

3) Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

The following scenarios compare the amount of social assistance payable under the Maltese scheme with the level of income of an employed person earning not more than the Maltese national minimum wage. The ratio between the two amounts is quantified in percentage. These calculations include also the benefits payable under the Maltese scheme, in addition to the social assistance.

Scenario 1: Single Person Household (under retirement age)

	Weekly Income of a Person in Receipt of Social Assistance		**Weekly Income of a Person employed earning the National Minimum Wage**		**% Ratio**
Year 2005	Basic Rate[16] :	Lm32.63	Basic Wage:	Lm55.63	**70.25%**
	Bonuses:	Lm 3.57	Bonuses:	Lm 4.23	
			Subtotal:	Lm59.86	
			Less N.I. contribution (10%)	Lm 5.56	
	Supplementary Allowance	Lm 1.44			
	Electricity Rebate	Lm 0.51			
	Total:	**Lm38.15**	**Total:**	**Lm54.30**	

	Weekly Income of a Person in Receipt of Social Assistance		**Weekly Income of a Person employed earning the National Minimum Wage**		**% Ratio**
Year 2006	Basic Rate :	Lm34.30	Basic Wage:	Lm57.88	**70.69%**
	Bonuses:	Lm 3.57	Bonuses:	Lm 4.23	
			Subtotal:	Lm62.11	
			Less N.I. contribution (10%)	Lm 5.78	
	Supplementary Allowance	Lm 1.44			
	Electricity Rebate	Lm 0.51			
	Total:	**Lm39.82**	**Total:**	**Lm56.33**	

	Weekly Income of a Person in Receipt of Social Assistance		**Weekly Income of a Person employed earning the National Minimum Wage**		**% Ratio**
Year 2007	Basic Rate :	Lm35.47	Basic Wage:	Lm59.63	**73.36%**
	Bonuses:	Lm 3.57	Bonuses:	Lm 4.23	
			Subtotal:	Lm63.86	
			Less N.I. contribution (10%)	Lm 5.96	
	Supplementary Allowance	Lm 1.44			
	Energy Benefit	Lm 2.00			
	Total:	**Lm42.48**	**Total:**	**Lm57.90**	

[16] The basic rate refers to the applicable weekly rate of a single-person household

The following table compares the annual income of a single person in receipt of social assistance, with the at risk of poverty threshold (applicable rate), defined as 50% of the median equivalised income, published by Eurostat.

Year	Annual Income of (Single) Person in Receipt of Social Assistance	At risk of poverty threshold (50% of median equivalised income) published by Eurostat (Single person)
2005	Lm1957.28	Lm1693
2006	Lm2044.12	Lm1819
2007	Lm2208.96	Not yet Published

Scenario 2: Two adults (under retirement age) with two children household

	Weekly Income of a Two adults with Two Children Household in Receipt of Social Assistance		Weekly Income of a Married Person with two children employed earning the National Minimum Wage		% Ratio
Year 2005	Basic Rate[17] :	Lm43.13	Basic Wage:	Lm55.63	**90.84%**
	Bonuses:	Lm 3.57	Bonuses:	Lm 4.23	
			Subtotal:	Lm59.86	
			Less N.I. contribution (10%)	Lm5.56	
	Children's Allowance	Lm12.98	Children's Allowance	Lm12.98	
	Electricity Rebate	Lm 1.44			
	Total:	**Lm61.12**	**Total:**	**Lm67.28**	

	Weekly Income of a Two adults with Two Children Household in Receipt of Social Assistance		Weekly Income of a Married Person with two children employed earning the National Minimum Wage		% Ratio
Year 2006	Basic Rate :	Lm44.80	Basic Wage:	Lm57.88	**90.59%**
	Bonuses:	Lm 3.57	Bonuses:	Lm 4.23	
			Subtotal:	Lm62.11	
			Less N.I. contribution (10%)	Lm5.78	
	Children's Allowance	Lm12.98	Children's Allowance	Lm12.98	
	Electricity Rebate	Lm 1.44			
	Total:	**Lm62.79**	**Total:**	**Lm69.31**	

	Weekly Income of a Two adults with Two Children Household in Receipt of Social Assistance		Weekly Income of a Married Person with two children employed earning the National Minimum Wage		% Ratio
Year 2007	Basic Rate :	Lm45.97	Basic Wage:	Lm59.63	**91.12%**
	Bonuses:	Lm 3.57	Bonuses:	Lm 4.23	
			Subtotal:	Lm63.86	
			Less N.I. contribution (10%)	Lm5.96	
	Children's Allowance	Lm12.98	Children's Allowance	Lm12.98	
	Energy Benefit	Lm 2.07			
	Total:	**Lm64.59**	**Total:**	**Lm70.88**	

[17] The basic rate refers to the applicable weekly rate of a two adults two children household

During the reference period 2005-2007, supplementary allowance was paid to persons whose gross income did not exceed Lm4, 200 for Married persons and Lm3, 270 for Single persons. However, households in receipt of Children's Allowance are not eligible to receive the Supplementary allowance simultaneously.

A person in receipt of social assistance and is seeking employment (through registration with the local employment authorities) is also credited with the contribution payments for the unemployment period. These credits amounted to Lm5.56 in 2005, Lm5.78 in 2006 and Lm5.96 in 2007.

The benefits mentioned above, are supplemented by free medical aid ranging from medicines to hospital treatment. Furthermore, if a person in the household suffers from a chronic disease these are entitled to medical assistance (in cash). The sickness assistance rate for 2005 was Lm7.55, for 2006 was Lm8, and for 2007 was Lm8.35. For any other member of the household who suffers from a chronic disease, a separate rate is awarded amounting to Lm6.15 in 2005, Lm5.80 in 2006 and Lm5.35 in 2007.

Other benefits awarded to such households are the waiving off of exam fees, an increased stipend when the children attend post-secondary school and higher maintenance grants when attending university.

Year	Annual Income of Two adults with two children in Receipt of Social Assistance	At risk of poverty threshold (50% of median equivalised income) published by Eurostat
2005	Lm3178.24	Lm3556
2006	Lm3265.08	Lm3819
2007	Lm3358.68	Not yet Published

Scenario 3: Elderly Couple in Receipt of Non-Contributory Age Pension

	Elderly Couple in Receipt of Non-Contributory Age Pension	
Year 2005	Basic Rate[18] :	Lm26.82
	Bonuses:	Lm 3.57
	Telephone Rebate	Lm 0.47
	Electricity Rebate	Lm 1.44
	Supplementary Allowance	Lm 1.44
	Total:	**Lm33.74**

	Elderly Couple in Receipt of Non-Contributory Age Pension	
Year 2006	Basic Rate :	Lm28.49
	Bonuses:	Lm 3.57
	Telephone Rebate	Lm 0.47
	Electricity Rebate	Lm 1.44
	Supplementary Allowance	Lm 1.44
	Total:	**Lm34.44**

	Elderly Couple in Receipt of Non-Contributory Age Pension	
Year 2007	Basic Rate[19] :	Lm29.65
	Bonuses:	Lm 3.57
	Telephone Rebate	Lm 0.47
	Electricity Rebate	Lm 1.44
	Supplementary Allowance	Lm 1.44
	Total:	**Lm36.57**

As stated in the previous scenarios, the above benefits are supplemented by free medical aid.

[18] The basic rate refers to the applicable weekly rate of a two adults two children household
[19] The basic rate refers to the applicable weekly rate of a two adults household

Elderly persons are entitled for a range of benefits, both in cash and in kind. These are described in more detail in the submission to Article 23.

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. To ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. To apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

Appendix to Article 13§4

Governments not Parties to the European Convention on Social and Medical Assistance may ratify the Charter in respect of this paragraph provided that they grant to nationals of other Parties a treatment which is in conformity with the provisions of the said convention.

Further to previous information submitted by Malta: -

Article 13§2

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Under Maltese legislation, any person in receipt of social assistance (general term encompassing all types of assistances and/or benefits payable to a person in need) is not discriminated. This is evident from the lack of court cases in this regard. From a research carried out in the Ministry of Justice website (www.mjha.gov.mt), although various cases of discrimination were filed, no cases based on a plea of discrimination against a person in receipt of social assistance could be traced. Indeed, the legal machinery is evidently in operation and this includes methods of redress. Maltese law does not discriminate in any way among citizens because of their social standing.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

In view of the dearth of occurrences under Article 13 §2 of the Act, no measures were taken in this regard. However, Malta has set up the National Commission for the Promotion of Equality (NCPE). Although not directly related to the provisions of Article 13§2. the NCPE is an autonomous body which primary task is to monitor the implementation of the Act to Promote Equality for Men and Women (Cap 456 of the Laws of Malta) that came into force in December 2003, LN 85 of 2007 Equal Treatment of Persons Order, LN 181 of 2008 Access to Goods and Services and their Supply (Equal Treatment) Regulations, and to promote equality in spheres where it may be lacking. The Commission, therefore, works to ensure that Maltese society is a society free from any form of discrimination based on sex, family responsibilities in all sectors and at all levels with respect of training and employment, and the provision of services and benefits. The Commission also works to ensure that there is no racial and/or ethnic origin discrimination in the provision of goods and services.

Further information on the NCPE is available through the following link:

www.equality.gov.mt

Article 13§3

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Further to Malta's previous submissions to article 13, the Committee was informed of the vast and established network of social security offices in the Maltese islands. In fact, in Malta's 92 square mile territory, there are 24 social security offices; almost one office per locality. Furthermore, the Ministry for Social Policy operates a call centre which handles any query regarding social policy. SPIC (Social Policy Information Centre) – www.spic.gov.mt is an information centre offering greater access to citizens for the provision of information related to Social Security services. It is an additional channel through which the public may obtain information, in parallel to the services already being provided by the Social Security Division, and its district offices. In so doing, the system provides assistance to the persons in need, directly in their locality and thus ensuring the preventive, supportive and treatment role of the system, as prescribed by Article 13 § 3.

In terms of social welfare services, the Foundation for Social Welfare Services (FSWS) offers a vast range of services, programmes and assistances, all free of charge. The following submission to Article 14 elucidates better the operations of the FSWS.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Please refer to the submissions to Article 14.

3) Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Please refer to the submissions to Article 14.

Article 13§4

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

In order to implement the provisions under Article 13§4, Malta adopted the following legal instruments which are attached to this report (Annex VII):

1. Legal Notice 16/1987 – Extension of social security rights to the other members of the European Convention on Social and Medical Assistance
2. Legal Notice 204/1999 – Application of the Social Security Act to the signatory countries of the European Social Charter
3. Legal Notice 291/2001 – Ratification of the UN Convention relating to the Status of Refugees
4. Ratification of the European Convention on Social and Medical Assistance
5. L.N. 320 of 2005, which transposes Council Directive 2003/9/EC is available through the following link: http://www.doi.gov.mt/EN/legalnotices/2005/09/LN320E.pdf

Social and medical assistance is provided to refugees, persons benefiting from subsidiary protection, and asylum seekers – but also to irregular immigrants – under these frameworks (some of which are being revised in order to cater for new circumstances).

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

In February 2007, the Organization for the Integration and Welfare of Asylum Seekers (OIWAS) was set up. Since its onset, OIWAS engaged in the following tasks:

- Intensive process of staff recruitment

- Building an institutional identity; procedures, networking
- Coordinating the open centre network, standardizing procedures, service agreements, identification of new centres
- Data collection and Trends
- Customer Care
- Setting up of professional teams to cater for vulnerable groups of immigrants
- Project in closed centres
- Intensive networking with UNHCR, IOM, and NGO's
- Contribution to the policy-making functions of the Ministry for Social Policy
- Membership to ENARO, and other institutional contacts such as close cooperation with COA
- Training of Staff
- Strengthening the administrative base for complex operations
- Strengthening of identity and presence: primarily assisting government to elaborate policy
- Focus of best practices in the field of integration
- Regular and in-depth evaluation of operations
- Addressing long-term residence in Malta – integration and welfare implications

Further information on the operations of OIWAS are provided in Annex VIII (Irregular Immigrants, Refugees and Integration – Policy Document)

Article 14 – The right to benefit from social welfare services

With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:

1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;
2. To encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

Further to information previously submitted by Malta: -

Article 14§1

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Foundation for Social Welfare Standards (FSWS), within the Ministry of Social Policy, is the responsible authority in the field of prevention, support and treatment services, both on community and residential settings within the fields of substance abuse; children, families and adults in need; and disability. The remit of the FSWS encompasses the following legislation:

1. Dangerous Drugs Ordinance 1939 (Chapter 101 : Laws of Malta) last revised by Act III of 2002 and LN 278 of 2003 and 1 of 2004;
2. Medical and Kindred Professions Ordinance– Drugs (Control) Regulations 1976 (Chapter 31: Laws of Malta) Last revised by Act No. II of 1998;
3. Prevention of Money Laundering Act 1994 (Chapter 373 : Laws of Malta) Amendments of Second Schedule Regulations 1999, last amended by Act VI of 2005;
4. United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 : (Malta became party of the Convention in 1996);
5. Probation Act (Chapter 446 – Laws of Malta);
6. Criminal Code (Chapter 9 – Laws of Malta);
7. European Convention on Illicit Trafficking 1995.

The above Acts can be found on the official website of the Ministry of justice and Home Affairs at http://www2.justice.gov.mt/lom/home.asp

The operations of the FSWS are carried out by two major agencies: SAPPORT and APPOGG. The former is committed to enhance the quality of life of persons with a disability through innovative personalised support, expertise, and advocacy whilst the latter aims at the enhancement of the lives of people in need, through the provision and availability of professional care and support.

SAPPORT is committed with the implementation and enforcement of the following legislation:

1. Equal Opportunities 2000 Act (Cap 413 : Laws of Malta)

docs.justice.gov.mt/lom/legislation/english/leg/vol_13/chapt413.pdf

2. Disability Pensions Act;
3. Inclusive Education Act;

http://www.education.gov.mt/ministry/doc/pdf/acts/edu_laws/amendment_to_2003/Act_XIIIE.pdf

4. Professional Secrecy Act; (Cap 377 : Laws of Malta)
5. Social Work Profession Act; (Cap 488 : Laws of Malta)
6. Data Protection Act. (Cap 440 : Laws of Malta)

For further information you may visit the official website http://www.sapport.gov.mt/

APPOGG is committed with the implementation and enforcement of the following legislation:

1. Children and Young Persons (Care Orders) Act Cap 285 of 1980 as amended by Act XIII of 2002;

http://www.education.gov.mt/ministry/doc/pdf/children_and_young_persons_care%20Orders_act.pdf

2. Refugee Act (Cap 420 : Laws of Malta)
3. Civil Code - Minority and Tutorship Act (Cap 16 : Laws of Malta)
4. Civil Code Cap 16 – Paternity Act Section 67 →
5. Civil Code Cap 16 – Paternal Act Section 131
6. Criminal Code (Cap 9 : Laws of Malta) Section 203
7. Civil Code – Separations Act Cap 16 Sections 35 →
8. Commissioner of Children Act (Cap 462 : Laws of Malta)
9. Domestic Violence Act

docs.justice.gov.mt/LegalPub/Legal_Publications%5C**Act**s%5CEnglish%5C2005%5C**ACT**%20

10. Fostering Act

http://www.doi.gov.mt/EN/parliamentacts/2007/ACT%20XVII%20english.pdf

For further information you may visit the official website http://www.appogg.gov.mt

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

During the reference period (2005-2007) the FSWS, was engaged in the following programmes:

- re-structuring of Court Services, which service encompasses Court Expert Reports (whereby Court Experts prepare Court Custody Reports as part of the Court Separation Proceedings),
- re-structuring of Supervised Access Visits (offering supervisors who are present during access visits between children and their non-custodial parent, as order by the Court or through recommendations of the Advisory Board for children under a Care Order)
- setting up of the Court Monitoring Service (which offers a social work service to monitor family situations, as ordered by the Court, following a Court decree concerning care and custody and children's access rights with their non-custodial parent), as well as the setting up of payment procedures for the service.
- The Weekend Monitoring Service (whereby a social work service is offered to monitor children over the weekends when they are on home access visits), which was set up as a pilot initiative and extended following an evaluation showing the effectiveness of the service
- Setting up of the High Support Service (which offers individualized care support to children in Residential Care who are under a care order and who present challenging behaviour), also form part of the Court Services.
- The development of a new Youth Outreach Service set up to replace the previous residential setup for Adolescent Boys – Formula One.
- ESF Project – 20, which is a programme focusing on the training of professional workers on empowering service users towards employment;
- Equal Project for Refugees, which targets a number of irregular immigrants with refugee or humanitarian status, providing them with employment skills and thereafter assisting them into going into gainful employment;

- European Refugee Funding for the Refurbishment of Hal-Far Open Centre and the employment of professional workers to provide assistance to irregular immigrants;
- European Commission application for the setting up of a Hotline to Combat Child Internet Pornography.
- APPOGG was also a partner in the ESF, Equal Action Project 'HeadStart', which is rightly hailed as one of the major achievements which has brought new hope and aspirations to about thirteen adults leaving foster care or institutionalised care.

3) Please provide pertinent figures, statistics or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

The statistical data for the above-mentioned programmes are presented in annex IX (Appogg Biennial Report) and annex X.

Article 14§2

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

During the reference period (2005-2007) the Non-Governmental Organizations sector was at the centre of various debates and public consultations with a view to ameliorate this sector and to incorporate it in an appropriate legal framework. With this in mind, the government in 2005 launched a white paper – Strengthening the Voluntary Sector http://www.msp.gov.mt/documents/ngo/strengthening_voluntary_sector.pdf. This white paper was followed by numerous consultations with the civil society. In December 2007, the Voluntary Organizations Act was passed by parliament. http://www.doi.gov.mt/EN/parliamentacts/2007/ACT%20XXII%20English.pdf

Amongst other provisions, this Act established the role of the Commissioner for Voluntary Organizations.

Furthermore, the Department for Social Welfare Standards (DSWS) was set up with the intent to improve quality and standards in social welfare services to protect and enhance the dignity, safety and welfare of all service users. The DSWS monitors the standards of the social welfare services offered in terms of adequacy and availability.

The following is the link to the DSWS official website:

http://www.msp.gov.mt/services/subpages/content.asp?id=17

Annual reports for the DSWS may be downloaded through the following link:

http://www.msp.gov.mt/services/subpages/content.asp?id=1136

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The Non Governmental Organisation Project Selection Committee (NGOPSC) advises the Ministry for Social Policy on the purchase of outputs from the 'Support to Voluntary Organisation Fund' in order to purchase services from NGO Programmes that are related to the implementation of Current Social Inclusion Policy and Strategy.

The Committee's terms of reference include receiving and assessing NGO services for Government's consideration of Social Inclusion Programmes and recommending to the Ministry which programmes should be included according to Government Social Inclusion Priorities. It also ensures that the projects give a value for money output and verifies through financial and service audits that agreed outputs and services have been adhered to.

NGOPSC purchases services from "Not for Profit" NGOs working in the Social Inclusion field. These are mainly in the fields of:

- Substance Abuse (rehabilitation programmes and prevention programmes to the community at large);
- Disability (including employment training to intellectually disabled people);
- Mental Health (training and supervision in employment; housing);
- Domestic Violence;
- Homelessness (ex prisoners and others);
- Residential Care (children and young girls);
- Day Care for Children of Problematic Families;
- Community Social Work Services (in partnership with Government Entities);
- Family (counselling);
- Service Providers to other NGOs (including resources and training for staff);
- Elderly (providing companionship to the elderly house bound);
- Helping new projects in the field of social inclusion (funding the inception of a Guide Dog training service);
- Small Support Groups (administrative costs).

Such services are purchased if Government Entities are not providing this or because NGOs can offer such a service more efficiently and/or are more cost efficient.

NGOPSC does not provide state aid. It purchases outputs from NGOs that if provided by Government would be less cost effective.

The NGOPSC and the service provider sign an annual contract whereby the service being purchased is defined. The contract states the responsibilities of both the NGOPSC and the service provider. In an appendix to the contract, the outputs are costed and defined. A methodology of how these outputs are measured is also outlined. Agreements are for a minimum of one year and a maximum of three years.

For Profit Non Governmental Organisations provide services in the fields of:

- Substance Abuse
- Elderly
- Health
- Day Care for Children
- Employment (mental/intellectual health).
- Such services are not being scrutinized by NGOPSC, therefore no further information can be provided.

3) Please provide pertinent figures, statistics or any other relevant information to demonstrate the participation of the voluntary sector to the provision of social services, as well as the effective access of individuals to these services.

The Maltese Government's total budget allocation, appropriated by NGOPSC for all projects, for the period 2005-2007 is available through the following link:

http://finance.gov.mt/image.aspx?site=MFIN&type=estimate&ref=416

From these figures it transpires that the total government expenditure in the sector during the reference period 2005-2007 increased considerably, thus witnessing the government's commitment to the success of the voluntary sector.

Article 23 – The right of elderly persons to social protection

With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

- To enable elderly persons to remain full members of society for as long as possible, by means of:
  - A. adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
  - B. provision of information about services and facilities available for elderly persons and their opportunities to make use of them;
- to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:
  - A. provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
  - B. the health care and the services necessitated by their state;
- To guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

Appendix to Article 23, paragraph 1
For the purpose of the application of this paragraph, the term "for as long as possible" refers to the elderly person's physical, psychological and intellectual capacities.

1) Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The regulation of Old People's Homes falls under the Medicine and Kindred Professionals Ordinance, Chapter 31 of the Laws of Malta.

The above mentioned legal framework necessitates that Homes for Older Persons need to be registered and licensed on a yearly basis by the Ministry of Health.

Although this legal framework that has been serving its purposes for a good number of years, and offers a basic safety net to ensure an acceptable level of protection to the elderly service users, the need has been felt to update it.

The major draw back of the above mentioned legal tool is that it operates on the 'all or none' rule. A Home, deemed by the Inspectorate team not to have acceptable standards of care, leaves the Minister of Health with only one option – namely not to issue a license and thus the Home would be liable to police prosecution if the licensee of the home does not cease to operate.

A newly set up Department namely the Directorate for Health Care Services Standards in collaboration with the Department for Nursing Services Standards have already drawn up a set of National Care Standards to be applicable across all Homes for Older Persons so as to have a national benchmark to measure the standards of care deliverance.

Presently these standards of care are being discussed amongst a wide spectrum of stakeholders including the service users and service providers alike using the model of participatory regulation. It is planned that these standards would be subsequently enshrined in an updated legal framework complete with a set of penalties and fines to replace the above mentioned regulation of Old People's Homes. Equipped with such a flexible legal tool the Directorate for Health Care Services Standards would be in a better position to fulfil its mission statement: regulating for improvement. Thus inspections are carried out to ensure improvements in the quality of service being delivered as opposed to closure of the service provision.

Moreover this same regulation of Old People's Homes refer to the latter entities as 'hostels' with the model of care at the time being set at the level of sheltered accommodation. With the passage of time and the consequent growing dependency levels of the residents these hostels have evolved as nursing care homes. The new National Care Standards will be addressing this issue by ensuring staffing ratios with the appropriate certified competencies and skills to satisfy the needs of the residents according to the latter's dependency levels.

Another legislation which relates impact on the right of elderly persons to Social Protection is the:

- The Social Security Act (Cap 318 of the Laws of Malta):
- State Financed Residential Services Rates Regulations, 2004 as per L.N. 259 of 2004

The above legal framework regulates contributions to Government by residents in state financed residential care.

2) Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

- Action Plan:

The policy priorities within Malta's National Reports on Strategies for Social Protection and Social Inclusion cut across diverse population groups, situations and needs, in a way as to promote a comprehensive social protection (based on social inclusion, pensions, health and long-term) strategy for both the general population as well as to a number of identified vulnerable groups. In view of the specific needs of elderly persons, Malta's NSR reports have identified older persons, as being a vulnerable population which may require particular social protection attention.

Through its primary focuses of promoting the access, quality and the affordability and sustainability of health and long-term care services, the 'National Strategy Report on Healthcare and Long-Term Care for the period 2008-2010 provides for a number of measures aimed at promoting the welfare of elderly persons and which as a result contribute towards safeguarding 'The right of elderly persons to social protection'. Such reforms include:

- Measures to promote Access:

Although Malta's main goal is for older people to remain active and independent in the community for as long as possible, the state of health of some individuals, especially amongst the very elderly, may deteriorate to a point where 24-hour long-term institutional care becomes necessary. A great deal of long-term care in Malta was previously provided by the families of the dependent persons, however changing lifestyles have and will continue to pose challenges for the sustained provision of such type of informal care. As a result, the provision of new forms of long-term care services need to further addressed.

In this respect, the demographic increase in the age-group of the 'very old' is a major challenge to access to institutional long-term care. Besides homes for those who do not have the possibility to be cared by families or for whom their requirements are such that they become too hard to handle by relatives, there is the need for more formal community-based care services. This is perceived to be of vital importance since one of the major problems that the new acute hospital (MDH) is facing is the congestion of beds caused primarily by elderly patients who cannot be discharged back to the community for various reasons. To counteract such difficulty, a new community nursing home for the elderly (*Madonna tal-Mellieha*) in the north of Malta has been opened.

For this reason, an increase in capacity in institutional care for elderly people is being proposed through the following mechanisms:

i) increase in beds through expansion and refurbishment at St. Vincent de Paule Residence (SVPR),

ii) conversion and expansion of long-term care and intermediate facilities at Mount Carmel Hospital (a mental health hospital) and

iii) building on the recent success of the new facility in Mellieha to plan further nursing homes in the community. In this regard, plans for the construction of a new 280-bed facility for rehabilitative and intermediate

care are underway. In the interim, this service is being expanded in part of the now vacated St. Luke's Hospital.

More information regarding the availability of long-term care services with consistently applied and transparent admission criteria will be made more available and will be better enforced. In this regard, criteria for admission into state institutional facilities for long-term care have been established, and made public. Further development is also proposed to take place as regards to the present dementia services.

Malta needs to strengthen existing measures and introduce new ones for delaying institutionalisation and encouraging formal and informal care in the community. As part of the reform and development of community services, focus will be on supporting dependent persons to stay in their own homes for as long as possible. Community-based care structures will target both dependent and independent long-term sufferers. Day care centres are available at local councils, however re-structuring is needed to increase and improve their availability and accessibility to more patients needing long-term care. Night shelters will be introduced on the same guiding principle as day care centres, so as to enhance the safety of elderly citizens residing in their homes. In this regard, discussions are ongoing with the Church Curia with a view to opening a night shelter pilot project for senior citizens in the south of Malta. Furthermore, community centres co-located with nursing homes will be set up as a hub from which to deliver community health support services.

The ongoing rollout of the 'Pharmacy of your Choice' scheme has enhanced access to medicines within the community through improved convenience and proximity for the patient, longer opening hours and a closer relationship with dispensing pharmacists. This scheme will continue to be rolled out across all of Malta and will also be extended to Gozo. Government will continue to invest in the necessary information systems to support the smooth and efficient functioning of the scheme and ensure the necessary financial and management control systems.

- Measures to enhance Quality:

Care standards are considered to be very important. A phased programme of inspections of Government homes and long-term care facilities for the elderly, coordinated by the Department of Health Care Services Standards, has begun on the same lines as the inspections carried out in the private sector. Improving the quality of care in government residential homes is being considered as a first step in the conversion of these homes into nursing homes. This will include, as mentioned previously, increased emphasis on care standards, more medical care and increasing availability of paramedical services.

Government is presently drawing up a plan for long-term care needs over the coming five years. In the field of elderly long-term care, outreach home services manned by multidisciplinary teams composed of such professionals as nurses, psychologists, occupational therapists and physiotherapists are planned. The team would also include a number of carers specifically trained in activities of daily living and a number of domestics. Such teams will be able to visit elderly people in their homes and assess their needs so as to provide and mobilise any identified necessary services. The service will be aimed at allowing elderly persons to continue living in the community as much as possible thus delaying entry into a residential home, at providing support to any existing carer network and at facilitating discharge from acute/rehabilitative hospitals.

A regular setup for consultation with service users needs to be established. Work is underway to make these initiatives more ongoing, structured and inclusive. Furthermore, a policy will be developed that will address the need to increase awareness and understanding of what constitutes abuse, prevention of abuse and procedures to be followed in cases of suspected abuse. This will apply to both institutional/residential settings as well as for those elderly persons living in the community.

As already stated above, there will be further development of rehabilitation services. Long-term care facilities in both SVPR and Mount Carmel Hospital are being refurbished to improve and maintain them in line with modern needs and expectations. Furthermore, a plan to completely renovate a number of wards in both institutions has been in operation for a number of years and several wards have now been renovated and others will be refurbished in future. By the end of 2008 all remaining rehabilitation services at Zammit Clapp Hospital

will be transferred to Karin Grech Hospital, which is undergoing refurbishment to accommodate the additional patients and services. Malta is also planning to construct a new purpose-built rehabilitation facility to fulfil the functions required for effective rehabilitation services.

- Measures aimed at increasing Affordability and Sustainability:

Beds for respite services in the public sector are necessary to help alleviate the load on informal carers on a temporary basis. Across all the facilities for long-term care, a proportion of the bed capacity will be earmarked for respite care to provide relief and assistance to carers and families. The number of respite beds available in Malta will soon be increased through a number of beds that were identified at the new Mellieha home. The setting up of networks for informal carers and the provision of training for such carers will also provide support. Financial support to enable families to keep dependent relatives in their own homes will be strengthened. This can take the form of further subsidies on aids and care devices and also through the consideration of compensation.

The remit of the 'Home Help' service, a community service for helping elderly people to live in their own homes through the provision of domestic chores will be extended to also include personal care. Furthermore, supervision of 'home helpers' will be enhanced through the running of a training programme for those responsible for such supervision.

The involvement of the voluntary sector, represented by VOLSERV, in the care of elderly and dependent persons living in the community, is also being actively explored.

- Other General reforms:

Despite soaring costs and demand for health and long-term care, Government is committed to preserve the solidarity-based model of universal access to care. For the past five years, a degree of coordination between the systems of health care and long-term care for the elderly has been achieved through their joint administration by a single Ministry (i.e. Ministry of Health, Elderly and Community Care), whereas social care for non-elderly groups such as the disabled and drug users was managed by a different Ministry (Ministry for the Family and Social Solidarity). These two ministries have now merged (Ministry for Social Policy), an amalgamation that should favour the development of better coordination and synergy between all strands of care.

In addition to the general policy lines indicated above, in order to improve access, quality and the affordability and sustainability of health and long term care services, Malta plans to expand and modernise its provision of primary and community care in order to reduce the need and demand for expensive institutional health and long-term care while also bringing care closer to patients and their families. Another priority which has multiple and far-reaching benefits beyond health and care is the focus on a preventive approach to health and long-term care.

Considerable attention will be devoted to enhancing Malta's entitlement policy to make free provision of health services reflect better the real needs of patients. Waiting times are a long-standing problem in both health and long-term care which is having an adverse impact on the health and quality of life of patients as well as on their overall satisfaction with the health and long-term care systems. Government is determined to find a solution to the problem. Transferring responsibility for certain services from the institutional, secondary and tertiary sectors to the primary and community sectors will be as important a component of this solution as an increase in the provision of those services where excessive waiting times exist.

Furthermore, a series of measures aimed at promoting patients' rights and responsibilities are at the heart of Government's plans for the health sector. Increasing health-related knowledge among patients and the nature of chronic diseases have necessitated a shift from a paternalistic approach to an approach in which service providers and service users work in partnership to achieve the best possible outcomes.

The emphasis across all services thus shall be a preventive approach together with a focus on rehabilitation to ensure that people remain active and independent within their communities wherever possible. Through continuing to improve access, quality and the

affordability and sustainability of health and long term care services, these reforms and measures are apt to continue to improve present services for elderly persons.

- Provision of Services for Elderly Persons

Malta provides for various services aimed at promoting the right of elderly persons to social welfare and protection. Primary examples of such services include:

- Day Centre Service

The purpose of the Day Centre Service is to help prevent social isolation and the feeling of loneliness, and to reduce the social interaction difficulties which older persons tend to encounter. It also aims to motivate the elderly by encouraging them to participate in the planning of Day Centre activities. By enabling older persons and persons with disabilities to remain as independent and socially integrated as possible it also provides respite for their relatives and carers. The main activities that are organised in each sixteen Day Centres in Malta include the service of Physiotherapy sessions, Occupational Therapy, Podologist, Creative, Social, Physical and Educational activities. These activities are complemented by educational talks on topics of particular relevance to older people. Guest speakers are invited to deliver lectures about health issues, home safety, welfare services, etc. In addition, outdoor activities are also organized on a bi-monthly basis. Table 1 in Annex XI refers.

- Handyman Service

The objective of this service is to help older adults and persons with special needs to continue living as independently as possible in their own home. The Handyman Service offers a range of repair jobs that vary from electricity repairs to plumbing, carpentry and transport of items. The service is also available for Adult Training Centres, Homes (excluding St Vincent De Paule) and Day Centres. The Handyman Service is basically rendered free of charge to senior citizens holding the Pink Form and Special ID Card. Non-Pink Cardholders, on the other hand, are entitled to receive this service at a nominal fee. Table 2 in Annex XI refers.

- Home Care Help

The Home Care Help Service offers non nursing, personal help and light domestic work to older adults or persons with special needs. The aim of such service is to allow the recipients of such service to continue living in their community as independently as possible. It also aims to provide respite and support for informal carers. Ultimately, the Home Care Help Services helps to avert or delay the demand for long-stay residential care by providing the required support in the client's own home. The service is terminated if the client enters a residential home, dies or goes to live with a relative. Table 3 in Annex XI refers.

- Incontinence Service

The aim of the Incontinence Service is to alleviate the psychological problem(s) to which a person may, as a result of incontinence, be subjected. Moreover, through the supply of heavily subsidized diapers, this service helps to decrease the physical and financial strain exerted on those families who have members with incontinence problems. The Incontinence Service, thus, supports and encourages incontinent disabled persons and older adults to continue living in their community. Table 4 in Annex XI refers.

- Kartanzjan

Kartanzjan is a card, which is issued automatically to every person upon his or her sixtieth birthday. A second version of the Kartanzjan is issued once the holder reaches his/her seventy-fifth birthday. This Card entitles its holder to obtain certain rebates and concessions. These may include reduction on football ground tickets, reductions on bus fares, reductions on the Gozo ferries and other establishments and telephone rebates.

Persons who hold the second type of Kartanzjan, namely that issued upon the seventy-fifth birthday, are entitled to additional benefits, such as being given priority in queues at hospitals and health centres.

- Meals on Wheels

The scope of the Meals on Wheels is to support elderly persons and others who are still living in their own home but who are unable to prepare a decent meal. The Maltese Cross Corps (a non-governmental organization) in collaboration with the Department for the Elderly and Community Care provide these individuals with a cooked meal on a daily basis or as the need arises. In addition, clients are regularly checked upon to confirm their health status. Tables 5 and 6 in Annex XI refer.

- Residential Homes for the Elderly

This service provides residential care consisting of a physically and emotionally safe and secure environment to elderly persons and persons with disability, who can no longer cope with living in their own homes. The bedrooms in these residential homes are equipped with an ensuite bathroom and kitchenette. They also have a Nurse Call system in case of emergencies. Other facilities include air-conditioning, central heating, and telephones in each room for incoming and internal calls, card phone facilities, communal dining rooms, communal T.V./living rooms and chapel. Once an application is lodged, a social assessment is carried out in the applicant's own home by a social worker. The applicant is then referred for a medical assessment. Following these assessments, the Board examines the potential resident's conditions/circumstances and prioritises according to scores/ratings based on a list of criteria, such as, whether the patient runs a risk of being rendered homeless or of being abused, the medical and/or social condition, etc.

In this regard, for example, the St Vincent De Paul Residence (SVPR) aims to provide care while safeguarding and promoting the welfare of older adults. The aims and duties of this service are focused on medical and nursing care, physiotherapy and occupational therapy, dental and ophthalmic care, podology and speech therapy. Tables 7 and 8 in Annex XI refer

- Social Work Unit

The scope of the Social Work Unit is to provide psychological counselling, guidance, and assistance to older persons who are living alone and have a high level of dependency; including those who are of an advanced age; older persons who are suspected to be suffering from physical, psychological, social or financial abuse; and demented or disorientated older persons. This Unit deals with social casework, provides advocacy for clients, facilitates self-help management and develops action plans, performs crisis intervention work, provides assessments for residential homes, home care help service and assessments of Carer's Pension for the Department of Social Security, and liaises with the geriatric, general and rehabilitation hospitals, the Health Department, police, Local Councils and other community organizations. Table 9 in Annex XI refers.

- TeleCare Service

Telecare is a 24-hour emergency service, provided by the Department for the Elderly and Community Services in conjunction with GO plc. The Telecare Service enables the subscriber to call for assistance when required. It aims to provide peace of mind to older adults, disabled persons and those with special needs, thus encouraging them to continue living in their own home. Telecare is also a source of reassurance for the subscriber's carers and relatives. In case of an emergency, the client just presses a large button that is found on the Telecare set (a special telephone set) to make contact with the Telecare Centre from where the client is assisted. The Telecare client is also supplied with a pendant which is to be worn indoors and kept within reach during the night since this gives the subscriber access to the service even though the telephone set is not at hand. Table 10 in Annex XI refers.

- Telephone Rebate Service

The scope of this service is to benefit older persons by providing them with discounted telephone rentals. For those subscribers who satisfy all the eligibility criteria, the rent payable is charged at a discounted rate of €14.95 yearly instead of €71.70 and is also granted a relative rebate on the telephone bill. Table 11 in Annex XI refers.

- Zammit Clapp Hospital for the Care of the Elderly

The Hospital is an autonomous publicly funded hospital specializing in Geriatric Medicine under the responsibility of the Hospital Management Committee and the Foundation for Medical Services. Its main objective is to provide specialized hospital based services for those frail and ill elderly whose medical problems are complicated by functional and social factors and who want to continue living in the community. The assessment, rehabilitation and management of patients is carried out by an interdisciplinary team led by a consultant geriatrician. The core members of this interdisciplinary team include doctors, nurses, physiotherapists, occupational therapists, social workers, pharmacists and speech therapists all working together with the carers according to the wishes and needs of the clients. ZCH provides in-patient, out-patient and Day Hospital services; however it is a short stay hospital and does not provide for long stay facilities. Tables 12 to 15 in Annex XI refer.

- Administrative Arrangements

To ensure the adequate provision of such services, a number of administrative arrangements are presently in place. Amongst others, these include a number of boards and committees such as the:

  - Admission Board – ST. Vincent De Paule Residence/Residential Homes for the Elderly
  - Council of Health
  - General Services Board
  - Home-Care Help Service Board
  - Hospital Management Committee – SVPR
  - Meals on Wheels Committee
  - Medical Council
  - National council for the Elderly
  - Zammit Clapp Hospital Management Committee

3) Please provide pertinent figures, statistics or any other relevant information on measures taken to ensure that elderly persons have access to adequate benefits in cash or in kind; on the level of public expenditure for social protection and services for the elderly; on the accessibility of measures and the number of elderly people benefiting from them; on the number of places available in institutions for elderly persons; on the number of elderly living in such institutions, and on whether a shortage of places is reported.

Statistical data on the number of beneficiaries of the benefits mentioned in question 2, are listed in Annex XI.

The total government expenditure in the field of elderly care, for the reference period 2005-2007, is available through the following link:

http://finance.gov.mt/image.aspx?site=MFIN&type=estimate&ref=401