16/12/2020 RAP/RCha/MLT/14(2020)

# EUROPEAN SOCIAL CHARTER

14th National Report on the implementation of the European Social Charter

submitted by

## THE GOVERNMENT OF MALTA

Articles 3, 11, 12, 13, 14, 23 and 30

Report registered by the Secretariat on

16 December 2020

## CYCLE 2021


# REPORT ON THE EUROPEAN SOCIAL CHARTER (REVISED)

***submitted by the***

## Government of Malta

## for Thematic Group – Health, Social Security & Social Protection
## (1 January 2016 – 31 December 2019)
## 2020

# 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, 23 and 30 for the period 1 January 2016 to 31 December 2019.

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)

### Thematic Group – Health, Social Security and Social Protection

**Article 3 - Right to safe and healthy working conditions**

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;**

*a) Please provide information about policy formulation processes and practical arrangements made to identify new or emerging situations, that represent a challenge to the right to safe and healthy working conditions; also provide information on the results of such processes and of intended future developments*.

**MT reply**

Working environments are constantly changing - such change brings new opportunities as well as new risks for employers, self-employed persons and workers themselves. OHSA strongly believes in the importance of anticipating, monitoring and addressing new and emerging risks through the development of effective preventive frameworks as well, as the implementation of specific and appropriate actions. This is done without focusing away from the persistence of traditional OHS risks.

The current national strategy for health and safety at work[1] identifies "new and emerging risks" as one of the top five key priorities for 2014-2020. This approach was also reflected in the previous national OHS strategy[2]. The strategy also sets out a non-exhaustive list of specific initiatives that OHSA intends to take, thus confirming its commitment to achieve healthier and safer workplaces especially with regards to new and emerging risks.

[1] **Strategic Plan for Occupational Health and Safety 2014-2020**

[2] **Occupational Health and Safety: Consolidating achievements and engaging further commitment, Strategic Plan 2007-2012**

New and emerging risks require the adoption of an action plan incorporating amongst others, educational and enforcement initiatives. In this regard, OHSA has implemented, and is still implementing several measures to address new and emerging risks. Some of the measures taken by OHSA to address the effect of new and emerging risks consist of the following:

1. Regular review and update of policies and legislation - Such action not only ensures that policies and regulations remain valid, but it also ensures the inclusion of new and emerging risks;

2. The provision of continuous training for OHSA Officers to reflect changing circumstances which may result in new and emerging risks;

3. The implementation of various actions to address new risks such as COVID-19;

4. The provision of information and awareness-raising courses to employers, self-employed workers and workers covering traditional persistent OHS risks as well as new and emerging ones;

5. The implementation of specific actions targeting different risk groups;

6. The issuance of guidance documents addressing various OHS topics;

7. Monitoring and keeping up to date with research and findings pertaining to new and emerging risks;

8. The promotion of early warning systems to detect new and emerging risks and the formulation of an action plan to improve the quality of service provided by occupational health service providers;

9. The strengthening of OHSA's existing networks and the establishment of new ones to bring together various professionals in the field with the aim of improving exchange of information and the promotion of good practice especially with regard to new and emerging risks;

10. The provision of information and training to medical practitioners covering amongst others, legal responsibilities, the association between ill-health and work conditions and, identification and reporting of occupational diseases; and

11. Detailed analysis of workplace statistics to identify new risks and factors which may necessitate a different or high level of protection and, or a change in educational and enforcement initiatives.

OHSA is also working with various stakeholders to identify funding options to be able to carry out and, or to commission research with regard to new and emerging risks and is in the process of strengthening its legislative framework with regard to the obligation of medical practitioners to notify relevant authorities when work-related diseases are identified.

As mentioned earlier, OHSA implemented various measures to address the risks posed by COVID-19. Despite the fact that the COVID-19 pandemic constitutes a public health issue and thus falls specifically under the remit of the Maltese Public Health Directorate, OHSA still took an active role in such matter. In this regard, OHSA issued various guidance documents concerning the management of COVID-19 and participated in various webinars concerning COVID-19. It also participated in various radio and TV programs and addressed several of queries made by employers, self-employed persons and workers. OHSA also developed an internal action plan detailing the measures to be taken to address risks posed by COVID-19.

As clearly expected, the COVID-19 pandemic generated various discussions and data gathering amongst EU Member States. In this regard, OHSA took an active role whereby it fully participated in such initiatives. It also disseminated its guidance documents and action plan to serve as a guidance for EU labour inspectorates.

Another initiative which is also indirectly related to COVID-19, concerns the promotion of influenza vaccine – an important initiative taken on an EU level by the European Commission. Again, whilst such matter falls under the remit of the Health Directorate, OHSA didn't shy away from such initiative and took an active role by promoting the influenza vaccine during its inspections and through its media channels.

**2. to issue safety and health regulations;**

*a) Please provide detailed information on the regulatory responses adopted to improve occupational safety and health in connection with known and also evolving or new situations (including as regards stress and harassment at work; work-related substance use and employer responsibility; strictly limiting and regulating electronic monitoring of workers; mandatory digital disconnection from the work environment during rest periods – also referred to as "digital detox"; health and safety in the digital and platform economy; etc.) and about regulatory responses to newly recognised forms of professional injury or illness (such as work-related self-harm or suicide; burn-out; alcohol or other substance use disorders; post-traumatic stress disorders (PTSD); injury and disability in the sports entertainment industry, including in cases when such injury and disability can take years or even decades to become apparent, for example in cases of difficult to detect damage to the brain; etc.)*.

**MT reply**

Malta's national OHS regulatory framework is constantly updated to reflect the amendments made through specific OHS EU Directives. Such exercise not only fulfils Malta's obligation to properly apply, implement and enforce EU law, but it also ensures that workers are afforded a high level of OHS protection. Hence, EU OHS Directives are transposed into national legislation within the stipulated deadlines.

With regards to matters concerning harassment, electronic monitoring of workers, mandatory digital disconnection from the work environment during rest periods, these form part of the conditions of employment and thus are addressed and regulated by the Department of Industrial and Employment Relations (DIER).

With regards to work-related stress, such topic has always been high on OHSA's agenda. Work-related stress has been consistently identified within EU as one of the major workplace concerns including Malta. In this regard, OHSA has implemented various activities to address such critical hazard – activities involving amongst others, the organisation of seminars, the provision of awareness-raising courses, TV and radio programs, internal training for OHSA inspectors and, the coordination of EU-OSHA's Healthy Workplaces Manage Stress 2014-2015 campaign. OHSA also developed a Maltese framework agreement on work-related stress. This agreement outlines the various steps that must be taken for the early recognition and prevention of work-related stress. It also lays out a model policy establishing an effective and consistent approach to the prevention of work-related stress. The agreement was endorsed by the social partners forming part of OHSA's board and was welcomed by many employers.

OHSA has also established a collaborative relationship with various organisations involved in the prevention and management of work-related stress. Such important relationship has resulted in the organisation of various activities addressing work-related stress such as but not limited to, seminars, TV and radio programs, awareness-raising courses and, the provision of support in matters concerning the various preventive and protective measures that can be adopted by employers to address work-related stress.

Stress at work is also considered one of the various factors that may lead to substance abuse. While on a national level no regulatory provisions were adopted with regards to the use of drugs and, or alcohol in the workplace, OHSA has still promoted the importance of having specific workplace programs to address such sensitive issue. This has been mostly done through media initiatives and participation in various seminars organised by third parties. OHSA has also been involved in various discussions with local insurance companies and agencies concerning the need to introduce legal provisions in OHS legislation addressing the use of drugs and, or alcohol in the workplace.

The lengthy discussions led to the formulation and posting of a KSS question to acquire information from Member States on (i) whether national OHS legislation regulated the use of drugs and/or alcohol at the workplace and, (ii) whether national OHS legislation regulated drug and/or alcohol testing at the workplace. Whilst the lack of introducing legal provisions in the national OHS legislation concerning the use of substances in the workplace was the result of a tripartite level decision, OHSA is still confident that such decision may be re-evaluated and does not rule out a change in the national OHS legislation. In that case, OHSA will support such decision.

**3. to provide for the enforcement of such regulations by measures of supervision;**

*a) Please provide statistical data on prevalence of work-related death, injury and disability including as regards suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders, as well as on epidemiological studies conducted to assess the long(er)-term health impact of new high-risk jobs (e.g. cycle delivery services, including those employed or whose work is managed through digital platform; performers in the sports entertainment industry, including in particular contact sports; jobs involving particular forms of interaction with clients and expected to use potentially harmful substances such as alcohol or other psychoactive products; new forms of high-yield highstress trading; military and law enforcement; etc.) and also as regards the victims of harassment at work and poor management.*

**MT reply**

Note: This reply is strictly limited to statistics concerning work-related accidents which include injuries, fatalities and ill-health. OHSA does not collect statistics on suicide or other forms of self-harm, PTSD, burn-out and alcohol or other substance use disorders. The same applies with regard to the conduct of epidemiological studies concerning the long(er)-term health impact of new high-risk jobs and studies and, or information concerning victims of harassment at work and poor management. Issues pertaining to harassment at work and poor management fall under conditions of employment. Hence such matters fall under the remit of the Department of Industrial and Employment Relations.

With regard to work-related statistics, these are obtained from various Government entities including OHSA itself, the National Statistics Office (NSO), and the Department for Social Security (DSS). Data on non-fatal accidents is collected by the Department of Social Security, while data concerning fatal accidents is collected by OHSA. The data pertaining to non-fatal accidents include all cases for which an injury benefit claim form has been submitted to the DSS, irrespective of the number of days lost. It must be noted that revisions to previous year's data are carried out annualy by NSO upon publication of the first semester of the following year. This is done due to the fact that figures may contain double entries and may also include claims which are not related to any work activity. In this regard, the revised number of claims for injury benefits for 2019 will be included in OHSA's 2020 annual report.

**Fatal and Non-Fatal Accidents**

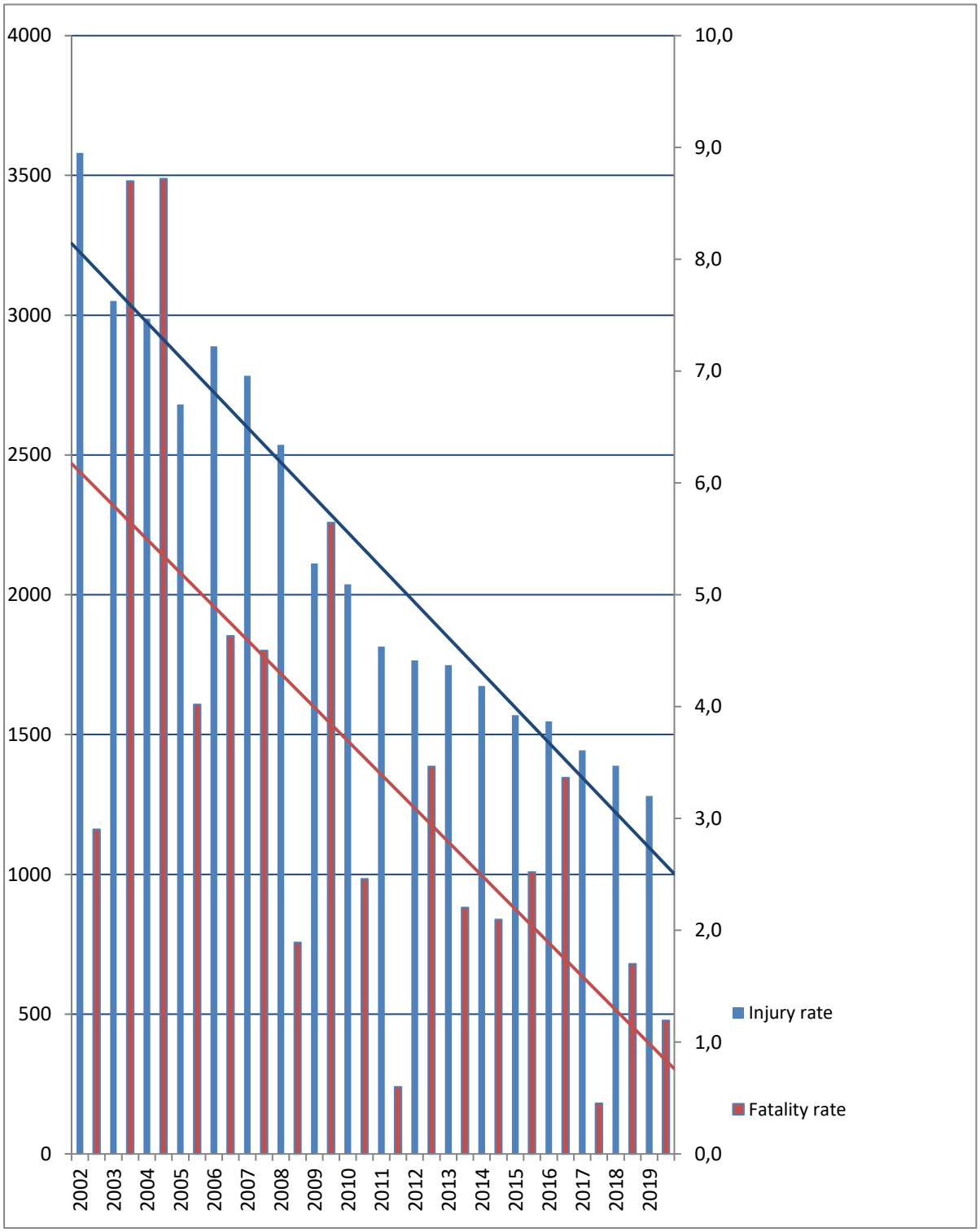
In 2019, Malta registered three fatal accidents which resulted from falls from height in the construction sector. In this regard, the rate for 2019 was of 1.2 per 100,000 employees. Hence, the number of injuries was of 3,220 per 251,398 employees. With regard to non-fatal accidents, the rate of injuries in 2019 was of 3220 per 100,000 employees. As mentioned above, these figures refer to all injuries at work which resulted in a period of injury leave (one day and over).

**Figure 1 – Rate of fatalities and injuries**

| | Employed persons | Injuries[3] | Injury rate | Fatalities[4] | Fatality rate |
|---|---|---|---|---|---|
| **2002** | 137,863[1] | 4,936 | 3,580 | 4 | 2.9 |
| **2003** | 137,939[1] | 4,208 | 3,051 | 12 | 8.7 |
| **2004** | 137.614[1] | 4,111 | 2,987 | 12 | 8.7 |
| **2005** | 149,307[2] | 4,002 | 2,680 | 6 | 4.0 |
| **2006** | 151,145[2] | 4,366 | 2,889 | 7 | 4.6 |
| **2007** | 155,486[2] | 4,328 | 2,784 | 7 | 4.5 |
| **2008** | 158,635[2] | 4,023 | 2,536 | 3 | 1.9 |
| **2009** | 159,404[2] | 3,366 | 2,112 | 9 | 5.6 |
| **2010** | 162,631[2] | 3,314 | 2,038 | 4 | 2.5 |
| **2011** | 166,628[2] | 3,024 | 1,815 | 1 | 0.6 |
| **2012** | 173,161[2] | 3,057 | 1,765 | 6 | 3.5 |
| **2013** | 181,614[2] | 3,176 | 1,749 | 4 | 2.2 |
| **2014** | 190,871[2] | 3,195 | 1,674 | 4 | 2.1 |
| **2015** | 198,322[2] | 3,112 | 1,569 | 5 | 2.5 |
| **2016** | 208,132[2] | 3,220 | 1,547 | 7 | 3.4 |
| **2017** | 220,489[2] | 3,182 | 1,443 | 1 | 0.5 |
| **2018** | 234,138[2] | 3,252 | 1,389 | 4 | 1.7 |
| **2019** | 251,398[2] | 3,220 | 1,281 | 3 | 1.2 |

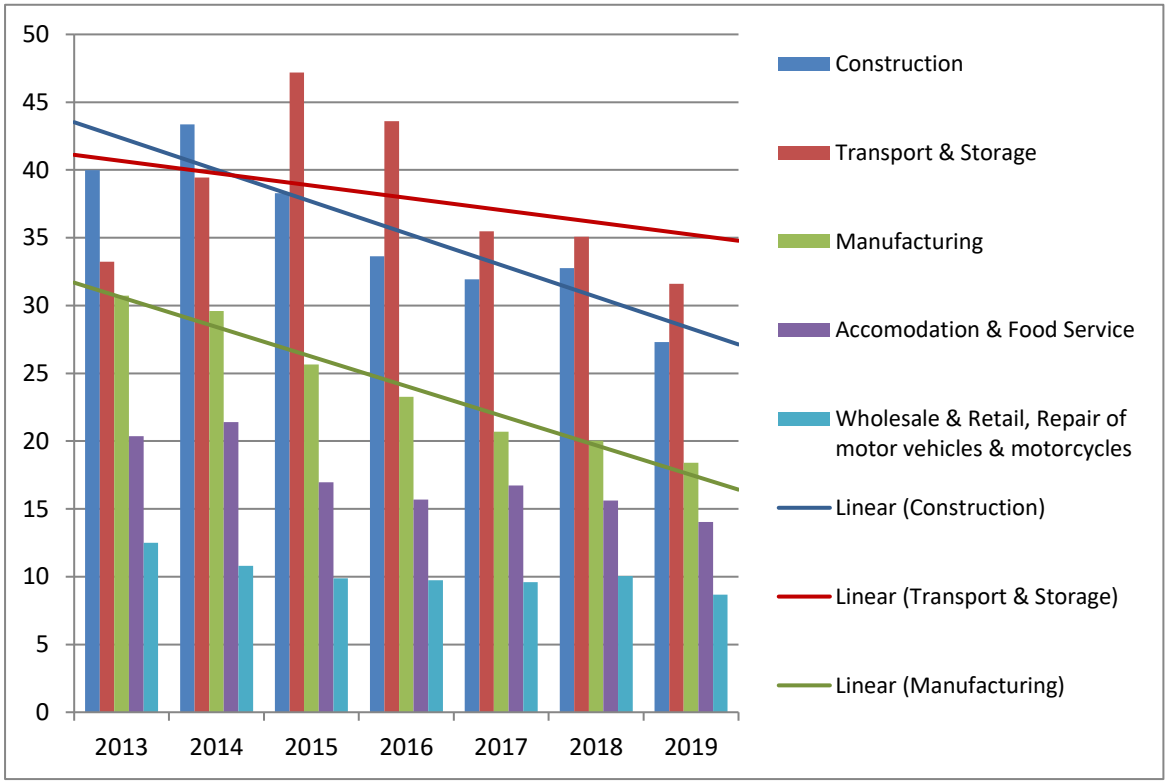
[1] Gainfully occupied (yearly average), ETC data [2]Labour Force Survey [3]Source: DSS / NSO, [4]Source: OHSA.

**Figure 2 - Injury and fatality rates: 2002 – 2019**



With regard to sectoral rates, for the past five years, the transport and storage sector (which incorporates land, air and water transport, warehousing and support activities for transportation and postal and courier activities) has been associated with the highest rate of claims (number of injuries per 1000 workers) for injury benefits in terms of the Social Security Act. While the construction sector and manufacturing sector have also been associated with a high rate of claims, the rates obtained for such sectors reporting indicate downward trends.

**Figure 3 – Sectoral rates**




*b) Please provide updated information on the organisation of the labour inspectorate, and on the trends in resources allocated to labour inspection services, including human resources. Information should also be provided on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections as well as on the number of breaches to health and safety regulations and the nature and type of sanctions.*

**Organisation of labour inspectorate**

OHS Officers are appointed in terms of Art. 15 of the Occupational Health and Safety Authority Act, Chapter 424 of the Laws of Malta. OHS Officers are deemed to be "public officers" and thus no person may threaten, insult, molest or disturb them in the performance of their duties, or knowingly give them false information or break or tamper with any seal made or with any monitoring equipment installed, put up or left by an officer.

The Act also lays down the powers of Officers such as but not limited to, (i) enter freely and without previous notice in any workplace at any time of day or night, (ii) to question alone or in the presence of witnesses the complainant, worker or employer on any matter falling under OHS legislation, (iv) to inspect any relevant documents which may throw light with regard to OHS at any workplace and, (v) to order that nothing be disturbed at any workplace for the purpose of any examination, investigation or inspection.

All OHS officers fall under the direction of the Head of Technical Operations who ultimately reports to the Chief Executive Officer. OHSA's techincal division is made up of a number of sections as follows:

1. Machinery, Equipment, Plant and Installation (MEPI) and Control of Major Accident Hazards (COMAH);
2. General;
3. Construction and Quarrying;
4. Accident Investigation;
5. Biological and Chemical Agents.

**Workplace inspections**

Throughout 2019, OHSA carried out 3,511 workplace inspections targeting various sectors such as but not limited to, construction, manufacturing, agriculture and, transport and storage. OHSA also organised several campaigns which focused on specific activities and sectors associated with a particular risks. While the main aim of such campaigns is to ensure complaince with OHS regulations, these also serve as an important channel to disseminate information on the preventive and protective measures that can be implemented by employers within the sectors targeted.

In 2019, OHSA targeted warehouses and agricultural establishments, specifically nurseries and garden centres. As mentioned above, OHSA inspects various sectors especially ones associated with high risk such as, the construction sector. This sector also generates the largest number of complaints from members of the public. All complaints logged with OHSA, whether construction-related or not, are immediately investigated by its Officers.

Inspections are carried out in line with OHSA's own enforcement policy and procedures which stress that Officers must act in a firm, proportionate, consistent and fair manner, and to be accountable for all decisions taken. The action to be taken by Officers during workplace inspections will vary from one workplace to another. In this regard, the action must commensurate with the risks involved and the seriousness of the breach of OHS legislation. Officers are also expected to be consistent in their approach and actions especially with regard to the provision of advice, the issue of orders, the imposition of an administrative fine and, prosecutions.

Workplace inspections may result in the issue of administrative fines in terms of the Occupational Health and Safety (Payment of Penalties) Regulations. When an offence against the Act or subsidiary regulations is committed, OHSA may impose a pecuniary fine instead of instituting criminal proceedings. Such decision depends on various factors and it is up to OHSA to decide whether the situation warrant the imposition of an administrative fine or the institution of criminal proceedings. For example, in the case of repeated offenders, OHSA does not issue an administrative fine but proceeds to the institution of criminal proceedings. Since the decision to issue an administrative fine or to institue criminal proceedings depend on various factors, OHSA has established an internal Standard Operating Procedure document entitled "Administrative Fines: The introduction of pecuniary penalties within a broader enforcement framework". These procedures are intended to assist Officers in their daily decisions.

With regard to data concerning administrative fines and judicial proceedings, in 2019 OHSA issued 354 administrative fines and initiatied 97 judicial proceedings. OHSA also issued 341 intimation letters.

*c) Please indicate whether Inspectors are entitled to inspect all workplaces, including residential premises, in all economic sectors. If certain workplaces are excluded, please indicate what arrangements are in place to ensure the supervision of health and safety regulations in such premises.*

On a national level, OHS is regulated by the Occupational Health and Safety Authority Act, Chapter 424 of the Laws of Malta and through a number of subsidiary regulations made under the said Act.

The Act applies to all work places and to all sectors of work activity, both public and private, and to all work activities, but does not apply in the case of those activities carried out by members of a disciplined force inevitably conflicting with the Act, including activities relating to civil emergencies, public order, national security or operations by the military. However, in such cases, the health and safety of the workes concerned must be ensured for the purposes of the scope of the Act. The Act also stipulates that the phrase "operations by the military" must exclude any action antecedent to the operation. OHSA has also established a collaborative relationship with the Civil Protection Department, the Armed Forces of Malta, and the Malta Police Force to ensure the implementation of OHS regulations and the achievement of healthier and safer workplaces especially in situations excluded by the Act.

The Act also regulates the powers of OHS Officers which include amongst others, the power to enter freely and without previous notice in any work place at any time of day or night. However, in the case of workplaces used as a dwelling house, the Act states that OHS Officers must not enter a workplace which is at the time used as a dwelling house without the consent of the occupier, or unless that officer is accompanied by a police officer not below the rank of Inspector.

**General objective of the policy**

The European Strategy 2007-2012 was implemented in Malta through the publication of the Strategic Plan: 2007 – 2012 (*Occupational Health and Safety: Consolidating achievements and engaging further commitment*) by OHSA. This strategic plan outlines OHSA's vision for OHS in Malta as well as the national policy to be followed by all parties though the period 2007 – 2012. This plan, which is solidly based on fostering a prevention culture with the involvement of all stakeholders, follows closely the pillars established in the EU strategy, but has been modified to reflect national priorities. The Maltese strategic plan focuses on:

- Legislation & Enforcement;
- Capacity building;
- Seeking partnerships to change the prevailing culture and attitudes towards OHS;
- Taking appropriate action against existing and emerging risks and
- Evaluating effectiveness of actions taken.

(Reference link: http://ohsa.org.mt/Portals/0/docs/strategic_plan7_12.pdf ).

**Reduction of legislative burdens / legislative amendments**

During the reference period OHSA managed to convince the Department of Industrial and Employment Relations (DIER) to amend a number of Legal Notices administered by DIER which erroneously made reference to legal requirements not present in OHS legislation. As a result, these clauses in DIER regulations placed various bureaucratic burdens on *bona fide* employers. Following lengthy discussions, DIER amended the following regulations, bringing them in line with OHS legislation and removing unnecessary burdens on employers:

(a) Organisation of Working Time Regulations,
(b) Young Persons (Employment) Regulations,
(c) Protection of Maternity Regulations

These amendments were published in 2012.

OHSA also finalised amendments (which were published in 2012) to simplify the frequency of fire drills organised in places of work as per LN 44 / 2002.

OHSA also simplified the workplace First Aid regulations, is so far as a simplifying the process of recognition of a "first aid trainer" under these regulations.

With respect to the amendments to the principal OHS Act, whilst the legal amendments have been prepared by OHSA and discussed at OHSA Board level, political direction to proceed with their publication was not given. As a result these amendments were not published and have been put on hold.

**Organisation of occupational risk prevention**

During workplace visits, the findings of the visits are always discussed with the employer during the inspection, and relevant enforcement action / observations made (normally in the form of a written confirmation of any verbal orders issued during the visit) are sent to that employer for the necessary action.

The 2012 research report commissioned by OHSA being quoted sought to identify the prevailing levels of OHS in Malta. Therefore, this research highlighted the relevant field observations, both negative findings as well as the positive ones. However, while it is true that a number of workers are not being provided with a number of OHS measures, the same research also reported a number of workers and companies reporting that adequate measures were being taken in line with local legislation and practices.

In addition, even the various inspection campaigns organised by OHSA (as reported in OHSA's activity reports) make reference to the findings by Officers i.e. shortcomings observed, as well as areas where compliance by employers was noted.

**Improvement of occupational safety and health**

During the reference period OHSA continued to deliver training / lecturing including:

- Various faculties of the University of Malta (e.g. Degree Plus course for freshers, Architecture, Medicine, Engineering etc). In these cases, the curriculum is agreed beforehand with OHSA and members of OHSA deliver the lecturing to students.
- In addition, various members of OHSA also participate in the delivery of lectures in the University's undergraduate Diploma course on OHS, as well as act as student supervisors and examiners;
- Lecturing to Government Departments (e.g. though Government's training centre)
- Participation in awareness initiatives organised by Social Partners (through seminars, workshops or conferences organised by social partners and in which OHSA is invited to deliver keynote speeches).

For clarification purposes, the *Turu Micallef Institute* is not a research centre, but an awareness raising centre within the set up of the General Workers Union (GWU). This institute is mostly involved in

raising awareness among GWU members. In such cases, OHSA deals with the parent organisation (GWU) and not with the individual Institute.

**Consultation with employers' and workers' organisations**

By policy OHSA is requesting Safety Representatives to be appointed where 10 or more workers are employed. Where fewer workers are employees, employers may choose not to appoint such representatives but may opt for direct communication and participation with the workers. Where a WHSR has been appointed, an employer is duty bound to ensure their consultation on all matters of OHS. Also, during visits by OHSA, OHSA's OHS Officers request the presence of such Representatives, and where no Reps have been appointed, enforcement action is taken ordering employers to rectify this matter.

The ESENER findings being quoted also make reference to other options which local workers reportedly preferred when seeking OHS information (such as information through OHSA, their employers, their Union etc). The ESENER was simply reporting what the workers replied when asked from where they obtained OHS related information.

**Article 11 - Right to protection of health**

**Paragraph 1 - Removal of the causes of ill-health**

***Right to the highest possible standard of health***

**MT reply**

Replies for this article will be provided in addendum when submissions are received from the respective Ministry.

**Article 12 – Right to Social Security**

**1. to establish or maintain a system of social security;**

**MT reply**

## *Risks covered, financing of benefits and personal coverage*

Malta's social security system is a mandatory one and all active population is insured and therefore covered for each of the branches available under Malta's system. It is also pertinent to state that by active population it is understood those persons who are gainfully occupied which under the Maltese

system are the employed and the self-occupied, whose earnings are derived from the gainful occupation.

### *Adequacy of the benefits*

Malta's sickness benefit (SB) and unemployment benefits (UB) are not earnings related; fixed rates are paid according to marital status. However the SB or UB rates of claimants who satisfy the means test applicable for non-contributory assistances are increased up to €108.26pw (2019 rates) plus an additional €8.15pw for every other eligible member in the same household. Furthermore, when on SB or UB, a person is also eligible for supplementary allowance (SPA) and energy benefit (EB) as per following examples;

1. UB and SB – Single parent + one child who satisfies means test gets €108.26 + €8.15 + €4.57 (SPA) + €5.27 (EB) = €126.25
2. UB and SB – Married + one child who satisfies means test gets €108.26 + €8.15 + €8.15 + €12.54 (SPA) + €6.71 (EB) = €143.81
3. UB and SB – Single person who satisfies means test gets €108.26 + €4.57 (SPA) + €3.83 (EB) = €116.66

Given that 40% of the median equivilised income[3] for 2019 is €118.12 pw (€6142/52) all three examples above satisfy the 40% of the MEI with the exception of example 3 which falls short by €1.46.

With regards to Invalidity pensions it is to be noted that the applicable rates for 2019 are as follows;

| **Contribution average** | **Invalidity Pension*** | | **National Minimum Invalidity Pension** | |
|---|---|---|---|---|
| | Married | Single | Married | Single |
| >50 | €103.38 | €90.23 | €147.72 | €127.92 |
| 40 – 49 | €99.03 | €87.34 | €138.96 | €122.82 |
| 30 – 39 | €91.13 | €82.05 | €122.95 | €113.60 |
| 20 – 29 | 83.23 | €76.79 | €110.26 | €104.33 |

* Payable where claimant is also in receipt of a service pension

In view of the above table it is pertinent to note that persons eligible for Invalidity Pension (IP) rates are also in receipt of a service pension and therefore their income from pensions exceeds the 40% of the NEI.

Persons eligible for National Minimum Invalidity Pension (NMIP) rates who do not have any other income are automatically eligible for SPA and EB, and if in receipt of the lowest single rate - €104.33 –

[3] https://nso.gov.mt/en/News_Releases/Documents/2020/08/News2020_135.pdf

also eligible to an increase through the non-contributory scheme. Thus further to the SPA and EB he/she also receives an additional €3.93 through social assistance.

Furthermore, all persons in receipt of an IP or a NMIP also receive a special bonus of €3.12pw, a six monthly bonus of €135.10 and a cost of living bonus with a minimum of €1.16 and a maximum of €12.80pw.

The above shows that persons on NMIP and SPA and EB, all satisfy the 40% of NEI minimum requirement with the exception of a single person receiveing the minimum NMIP; here it falls short by €1.46 as well.

It is aslo pertinent to note that medical care and hospitalisation is available for free to all the population.

**3. to endeavour to raise progressively the system of social security to a higher level;**

*c) Please provide information on any impact of the COVID-19 crisis on social security coverage and on any specific measures taken to compensate or alleviate possible negative impact.*

**MT reply**

The COVID19 crisis had no negative impact on social security coverage in Malta and all benefits continued to be issued at the rates due. Notwithstanding the non negative impact of the COVID19 crisis, three new benefits were implemented to specifically target;

i. COPB to parents who due to the closure of schools in March had to stay at home to care for their children and could not perform remote work due to the nature of their employment,
ii. COMB to vulnerable persons who due to their medical condition could not attend to their employment in view of the instructions issued to such persons to stay at home by the Ministry for Health,
iii. CODB to persons in employment who suffer from a disability who in view of the instructions issued by the Ministry for Health had to stay at home.

Furthermore, all persons who due to COVID19 became unemployed had their unemployment benefit rates increased to the same rates applicable for the other three above mentioned benefits.

**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;

**MT reply**

## *Right to retain accrued benefits and Right to equal treatment*

Malta's social security system is mandatory with everyone who is gainfully occupied insured. Through this, all gainfully occupied persons, including third country nationals have coverage to all benefits under the contributory scheme provided the minimum contribution conditions are satisfied.

Therefore although bilaterals are only available to persons coming from Australia, Canada and New Zealand, and the Legal Notice on equal treatment has not been published, equal treatment is applied to all persons who through their residency, employment and payment of social security contributions are covered for benefits under the contributory scheme and also the non contributory scheme.

To this effect it should be noted that data for 2019 available to the Department of Social Security shows that a total of 7,303 foreigners not residing in Malta are receiving a pension from Malta under the contributory scheme as follows;

i) 454 residing in EU member states
ii) 6,849 residing in the rest of the world

Furthermore, another 11,452 foreigners who reside in Malta are also receiving benefits/pensions from Malta as follows;

i) 5,600 from EU member states
ii) 5,852 from the rest of the world

It is also pertinent to note that from the 5.852 non-EU beneficiaries, a total of 1,830 are recipients of family benefits, a further 1,732 are recipients of a non-contributory benefit and another 105 are recipients of a contributory pension.

**Article 13 - Right to social and medical assistance**

**Paragraph 1 - Adequate assistance for every person in need**

**MT reply**

Replies for this article will be provided in addendum when submissions are received from the respective Ministry.

**Article 14 - Right to benefit from social services**

**Paragraph 1 - Promotion or provision of social services**

**MT reply**

Replies for this article will be provided in addendum when submissions are received from the respective Ministry.

**Article 23 - Right of the elderly to social protection**

## Legislative framework

**MT reply**

The Commissioner for Older Persons Act (Chapter 553 of 2016) was ratified by Parliament in January 2016 and the provisions of the said Act came into force on 15th October 2016 (by virtue of L.N. 339 of 2016).

Among the various functions of the Commissioner as outlined in the Act are the protection and the advocacy of the human rights and interests of older persons, such as:

- promoting and advocating the human rights and interests of older persons,
- promoting opportunities for older persons;
- eliminating discrimination against older persons;
- promoting the protection of older persons from the various forms of abuse and exploitation;
- to keep under review any legislation relating and affecting the interests of older persons.

The Current Commissioner for Older Persons, Dr Mary Vella (hereinafter referred to as "the Commissioner") took up office in April 2019. The Commissioner is currently setting up the office and is also in the process of reviewing operations with a view to further identify the necessary skills and HR capacity.

The Act also provides the Commissioner with the facility to carry out an Older Persons Impact Statement relating to decisions or policy proposals affecting older persons. This document aims to set out the probable impact on older persons of such decision or policy proposal. Despite the limited resources available, the Office of the Commissioner has recently embarked on providing input in decisions where the Commissioner believes it can impact the lives of older persons.

The Commissioner's role (in this regard) will be promoting the welfare of older persons and to monitor the conditions under which older persons progress. It shall be encouraging the provision of public

information designed to promote an understanding of the rights of older persons. Wherever possible, it shall conduct or encourage research into matters relevant to services for older persons (and advocate better practices in this regard).

The Commissioner for Older Persons in Malta also take into consideration the National Strategic Policy for Active Ageing, which compels us to envisage a society where each and every older citizen is empowered to reach his or her unfulfilled potential and where older persons have the possibility of taking responsibility for their own quality of life and wellbeing. The emphasis throughout the Policy demonstrates a commitment in renewing public policies on ageing so as to focus on the needs and wishes of the older population.

The Government believes that older persons are to have greater control over the identification of the type of support they require and more choice about and influence over the services offered. Whilst elderly persons are put at the centre of the assessment process, they are also provided with greater freedom in choosing the care they want. Older persons are empowered through improved access to comprehensive information, a choice from a range of options and the right to redress any perceived injustices and discrimination.

These measures serve as a vehicle for capacity and confidence building, skills development and training and opportunities for direct and collective action.As Commissioner for Older Persons we encourage longer working lives, whilst maintaining workability, promote social inclusion and non-discrimination of older persons, promote a healthy lifestyle and regular screening from a young age to safeguard health, independence and autonomy in later life.

**With regards to the query about safeguarding the right of older persons in engaging in autonomous pronouncements, or assisted decision making in respect of the elderly, it should be noted that the following bills have been drafted;**

***i)*** ***Personal Autonomy Bill*** – The legislation adopted would replace the 'black-or-white' system of interdiction, incapacitation or guardianship – a substituted decision-making regime which is currently the existing framework regulating legal capacity under Maltese law – with a much more flexible system, in line with international standards such as those mandated by the UN CRPD. It will amend existing legislation and be based on the core concept of juridical equality as the supreme norm, while implementing legal safeguards in the form of supported decision-making and co-decision-making, factoring in elements such as a person's mental capacity. An accessible public consultation will be launched, ensuring that methodologies will be in place to best establish the will and preferences of persons such as persons with intellectual disabilities and persons with dementia.

***ii)*** ***Protection of Adults in Situations of Vulnerability Bill*** – Once adopted, the Act will have the effect of ratifying the 2000 Hague Convention on the International Protection of Adults by Malta, while creating a legal basis and framework for

enforcement of the Convention's main principles. It will create a dedicated office to investigate and proceed with mainly complaints of elder abuse. However, disabled adults in situations of temporary/ permanent disability would also fall within its purview. At the same time, this legislation would enable Malta to also meet its legal obligations in overlapping fields, such as those addressed by the amendments put forward by the Personal Autonomy Bill. The public consultation in this area will be carried out on the same lines as for the Personal Autonomy Bill, and for the same reasons.

Both pieces of legislation are linked, due to the international obligations Malta already has and that it will assume, ensuring that both sets of obligations would sit in harmony. Thus, concurrent adoption is envisaged following the processes described.

## Institutional care

The Commissioner has signed a Memorandum of Understanding with the Social Care Standards Authority (SCSA), committing to collaborate between the two entities to ensure that the elderly enjoy the highest standards. Through this MoU, the parties agreed to co-operate in the field of social welfare services, particularly through the exchange of information acquired in the course of carrying out duties entrusted by law with the aim of protecting and promoting the rights and best interests of older persons. This MoU was signed so that residents in homes for the elderly are guaranteed a level of service that they deserve, ensuring that the elderly are treated with dignity and privacy particularly during communication, physical examination and activities of daily living, thus guaranteeing the provision of the best care and treatment possible.

The Social Care Standards Authority was established through Chapter 582 of the Laws of Malta, as an independent body to regulate social welfare services in Malta in May 2018. Furthermore, through Legal Notice 446 of 2018, the Authority was also assigned the performance of such roles for services offered to older persons.

In its capacity as regulator, the Authority has created a new model of Social Regulatory Standards based upon quality and performance indicators in order to qualitatively measure the quality of the services being provided. It is to be noted that the Social Regulatory Standards for Residential Services for Older Persons were launched for Public Consultation and are in their final stages for publication. The mentioned Social Regulatory Standards being drafted by the Social Care Standards Authority are based on the principles of person-centred care, dignity, physical and mental wellbeing, privacy, equality, self-fulfilment, autonomy and empowerment following a thorough process of consultation with all stakeholders involved. In this respect, such standards are based upon the resident's rights, the personal care plan, the residents' personal health and medical care, protection and safeguarding principles, the physical environment within the residential home, service provision and service quality management.

In this respect, such standards also form part of the measurement upon which such services are licensed as well as form the basis of the recommendations issued by the Authority following inspection and/or enforcement visits.

In 2021, the Social Care Standards Authority is also envisaging to launch its Social Regulatory Standards for Active Ageing Centres as well as for services dealing with Dementia. It is also worth mentioning that in this regard, the Authority shall also be enforcing its established Regulations for Residential Homes for Older Persons enforcing the use of administrative penalties in cases of non-conformity to the established criteria. In this respect, it is also to be noted that such services are also licensed by the same Authority as well as continuously monitored or investigated in cases of feedback from service users and their relatives through the Inspectorate and Enforcement functions. Through such capacities in 2020, the Authority conducted over 2,000 inspections both in a physical as well as virtual manner in order to provide the necessary support especially due to Covid-19.

With regards to the information submitted in Malta's last report vis-à-vis the **multidisciplinary assessment process**, it should be clarified clarify that in our explanation there was no reference to refusal nor age-based criteria. In fact, residents in our long-term facilities also include younger age groups in their early twenties. The criteria for prioritisation are based on the medical needs of the applicants that must to be addressed. The entity is not a residential home but for practical purposes it is a first level stepdown from an acute general hospital. Therefore, resources are allocated to clients with high dependency, complex medical conditions and advanced dementia with behavioural challenges.

Furthermore, the cap on the number of refusals refers to the number of refusals for admission in a care home an applicant or his/her relative/s can make. Thus, upon three (3) refusals, the application is put on hold and will be made active again once a new medical report is presented.

## Services and facilities

The Active Ageing and Community Care (AACC) has introduced an Audit, Quality Assurance and Compliance Unit that will be monitoring and assessing our services on a regular basis through scheduled/surprise visits and through the conduction of survey reports on our services. Such reports assess the customer care satisfaction of our clients, which will assist in the continuous improvement of our services.

The AACC has also devised a Standard Operating Procedure (SOP) indicating the complaint procedures and remedies. The SOP specifies that clients can forward their complaints by phone, email, one to one meetings with our officers, or forward any suggestions through our suggestion boxes. A standardised template form has been developed, titled "Customer Care Complaint and Suggestion Handling Form". Once our officers log in the complaint, the complaint form is then forwarded to the respective Manager of each section. The assigned personnel make the necessary arrangements by contacting the claimant by email or phone. An expected time frame was established for the responsible employee, where the client must be contacted and given a reply within 15 working days, which includes;

- A time frame for the completion of the entire form (7 days) to be increased to 10 working days in complicated cases,
- The forwarding of the form to top management (3 days),
- The client is then contacted by the Head of Section/Service once the top management is in agreement with the decision taken (within 2 working days),

Clients who do not agree with the decision taken can contact the top management. Throughout the whole process, staff are expected to rigorously follow the steps indicated in the "Customer Care Complaints and Suggestion Handling Form". The whole process focuses on client satisfaction and in giving an opportunity to clients to express any concerns or difficulties that they may be encountering. Thus, AACC aims to address these queries in the best possible manner.

**Housing**

The Housing Authority is in the process of delivering two residential complexes in Valletta which are specifically designed for the needs of elderly residents who may still live independently but would benefit from living in a residence with other elderly residents and share communal spaces with them. Other projects are being carried out in conjunction with NGO's to assist elderly residents who are in need of more assistance.

The Housing Authority is also designing a major residential project earmarked for intergenerational living. This project will aim to encourage elderly persons to continue living with their relatives, whilst also enjoying the support of a home for the elderly situated in an adjacent property. Furthermore, the Housing Authority is in the process of installing 109 lifts in blocks allocated for social housing which will be of great benefit to elderly residents who live in them. This latter project is being carried out through ERDF funds.

With regards to the Committee's query on '***whether elderly persons were treated on an equal footing as regards access to social housing'***, it should be noted that elderly residents who require social housing are given preferential treatment. Any units which become available for social housing and are not hindered with mobility issues are earmarked almost exclusively for elderly and disabled persons. When no such units are available, elderly residents are allocated other units which may be rendered suitable for their needs and are then given a grant to carry out the necessary works.

With regards to '***whether there were any compensation mechanisms for the elderly to meet the costs of private rental housing',*** a compensation mechanism is available for all residents irrespectively whether they are elderly or not. The mechanism is means tested and therefore elderly residents are more likely to be eligible to benefit since their income is usually lower.

With regards to '***whether the needs of elderly persons are taken into account in national or local housing policies',*** all new units are equipped with a lift and are wheelchair accessible which also ensures they are suitable for elderly residents with reduced mobility. In fact, the Housing Authority undertakes that any new apartments that are built in the near future will have small sized apartments accessible by lifts.

With regards to '***what extent dwellings occupied by elderly persons complied with standards concerning safety***', a mechanism is in place to provide financial assistance to render properties safe and another mechanism is in place to ensure that additional safety features may be added if required for persons with reduced mobility (including elderly).

With regards to '***adequate living conditions***', a mechanism is in place to provide financial assistance to render dwellings adequate for the occupants' needs and basic amenities and, prompt action is taken to assist the occupants whenever a case without such amenities is identified.

Finally, with regards to '***whether supply met demand***', it should be noted that there are just 201 elderly (60+) persons on the waiting list to obtain social housing. This amount represents 0.16% of this age group.