# EUROFAMCARE

## National Background Report for Malta 2004

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17th May 2004
Valletta, Malta

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**Summary of Main Findings**

- Representative organisations of family carers and older people

In Malta, family carers are not officially registered. Moreover, no national research on family carers has ever been conducted in the Maltese Islands aimed at investigating the socio-economic conditions of these carers and at analysing their changing role and status with particular reference to the needs and problems arising from the wide changes which Maltese society and the family in Malta are passing through. Similarly also, Maltese family carers do not have any representative organisations as such.

On their part, the elderly can benefit from a number of self-help groups and organisations. There are a number of pensioners' associations. To ensure a dynamic and well-coordinated national response to the needs of the elderly in 1987, the government appointed a Parliamentary Secretary directly responsible for the care of the elderly. This ministerial post has been included within the executive organ of the government since then. In order to increase the opportunities for the continued involvement and participation of the elderly in all facets of life, a National Council for the elderly was set up in 1992. This Council is also responsible for protecting the rights of the elderly, ensuring their social and economic security and plan a national response to the challenges of population aging (Troisi J. 1988). In 1983, a University of the Third Age (U3A) was instituted within the Institute of Gerontology, University of Malta. By and large, the U3A has helped many members to rediscover an aim in life and have shaken off that feeling of uselessness which might have helped them to join in the first place (Troisi J. 2003). All these initiatives have contributed, each in its own way, to ameliorate the socio-economic conditions of their members.

- Service providers

Although Malta has a good and extensive formal care provision, the majority of care is still provided by family members in the formal sector. The central role played by the family as the principle provider of care for elderly members is still maintained and the exchange of obligations are still the basis of family relations.

It is, however, necessary to examine the social and cultural changes which have been shaking society at large and the family in particular. Among the emerging trends of family changes one notes the reduction in family size (Calleja S. 1997) and their dispersion as a result of which the number of potential carers for dependent old family members is being drastically reduced. Moreover, the changing role of women and their ever increasing participation in the labour force outside the home, further diminishes their availability as caregivers. It can no longer be assumed that female relatives will be available for full-time care. Furthermore, because of increased longevity, younger relatives, mainly daughters who used to be expected to take care of the elderly relative especially those who are frail are more likely to be already old themselves. Consequently, the needs of the frail elderly can no longer be met by the family alone without the support of specialised programmes and services sponsored by the State (Micallef T. 1994, 2000, Troisi J. 1995, 1991, 1984).

A number of research studies carried out in Malta (Abela N. 1988, D'Amato R. 1995, Micallef T. 1994, 2000, Mifsud J. 1999, Navarro M. 1995, Scicluna M. 1998, Vella M. 1993) show that while informal carers think that the family should bear the major responsibility to care, they also feel the need for support from the State and the voluntary sector. Many of them would feel guilty in institutionalising an elderly dependent family member.

Voluntary assistance towards the elderly is not a new feature of Malta's social environment. In the past such voluntary work was mainly provided by the Church. Voluntary groups still play a

leading role in providing various services to the elderly. One cannot but not mention the Good Neighbourhood Scheme run by Caritas, a leading Church organisation in the social field. It is intended to provide regular assistance to lonely persons by groups of volunteers. As expected the largest number of beneficiaries are elderly persons. The Malta Memorial District Nurses Association and the Malta Hospice Movement are two other voluntary non-profit organisations who are providing valuable work, though not exclusively, to Malta's elderly population (Malta Memorial District Nursing Association. 2004, 2003, Malta Hospice Movement. 2004).

Malta also prides itself with a number of self-help groups which help the elderly to form new identities in their old age. Through the programmes and services offered to their members, these groups are helping in no small way in giving a new meaning of life to the elderly and in ensuring their remaining part of Malta's mainstream society. Foremost among these self help groups is the University of the Third Age founded in 1993 (Troisi J. 2003).

Recently also a number of profitable organisations within the private sector have started providing care for the elderly especially in the areas of residential care.

- Policy makers

The system of social protection in Malta offers a wide range of services covering from birth to death. It is estimated that one eight of the country's GDP is spent on social protection. This amounts to one third of the Government's recurrent expenditure. (Cordina G, Grech A. 1999).

Care of the elderly in the community has, especially during the past two decades, become the policy of the Maltese government (Mifsud J. 1999, Troisi J. 1994b). Community care services, by providing care and support where the family and the individual are unable to manage alone, help to maintain the elderly in the community and, at the same time, enable families to cope, thus preventing or at least delaying the need of institutionalisation. A wide range of services have been created in this regard. It is important to note that such services complement rather than substitute for or replace care from family, friends or neighbours (Government of Malta. Ministry of Social Policy. 2004a6, Troisi J. 1994b).

However important the supporting role of the State, it is equally important to recognise the fact that family members, especially women, are the main players in caring for their elderly members (Cutajar M. 1997, Miceli P. 1994, Troisi J, Formosa M. 2002). Given the rapid changes which Maltese society is undergoing, carers are becoming more vulnerable than before and are being subjected to a lot of strain. It is high time to place the role and function of informal carers as well as their needs and problems, on current policy directions. Care giving tasks should not be assumed to be a natural part of family life to be done with little or no support. Investing in family carers is indeed the key to the future (Council of Europe 1993).

In times of need, older persons turn first to their own families for help, then to friends and neighbours and finally to the bureaucratic agencies. This is due to the fact that they expect families to be the main source of help.

**Introduction – An Overview on Family Care**

- Demographic trends related to family care-giving (supply and demand)

The Maltese population of the Maltese Islands as at the end of 2002 was estimated at 386,938 persons consisting of 191,975 males and 194,963 females. These did not include work and resident permit holders and foreigners residing in Malta which, for the same period, amounted to 10,358 persons, 4,861 males and 5,497 females bringing the total population of the Maltese Islands to 397,296 as on 31st December 2002. (National Statistics Office (NS0). 2003b)

In Malta, the old segment of the population, namely those aged 60 years and over, has been steadily increasing during the past fifty years, and now represents 17.0 per cent of the Maltese population or 65,628 persons. (NSO. 2003b).

According to the 1985 national census, the mean age of the Maltese population was 33.79 years while for the 1995 census, it was 35.73 (Central Office of Statistics (COS).1997b, 1986). This clearly shows the ageing process of the population. In the period between the two censuses, the 0-14 registered a decline of 9.25 per cent. Compared to this, the 15-59 age group and the 60+ age group recorded a growth of 16.6 and 35 per cent respectively. These figures clearly indicate that the 60+ population is growing at a faster rate than the rest of the population. Population projections show that this trend of population aging will not only continue for a number of years to come but it will experience an acceleration. In fact it is projected that by 2025, 27 per cent of Malta's population, or 104 thousand persons, will be above the age of 60. This percentage is projected to increase to 31.3 (NSO 2003b).

**Table 1 : Maltese population as at 31st December 1967, 1985, 1995, 2002**

| | Males | Females | Total | % Increase |
|---|---|---|---|---|
| **1967** | 150,598 | 163,681 | 314,216 | |
| **1985** | 167,875 | 173,032 | 340,907 | 8.49 |
| **1995** | 191,025 | 194,062 | 385,087 | 12.96 |
| **2002** | 191,975 | 194,963 | 386,938 | 0.48 |

Source: COS. 1986, COS. 1997a, NSO. 2003b.

**Table 2 : Maltese population by gender and age group as on 31st December, 1985, 1995 and 2002 and as projected for the years 2025, 2035, 2050**

| | 1-14 | Males | Females | 15-59 | Males | Females |
|---|---|---|---|---|---|---|
| **1985** | 82.5 | 42.4 | 40.1 | 210.0 | 104.0 | 106.0 |
| **1995** | 74.9 | 38.4 | 36.5 | 244.9 | 124.4 | 120.5 |
| **2002** | 73.2 | 37.6 | 35.6 | 248.1 | 126.1 | 122.0 |
| | | | **Projected** | | | |
| **2025** | 61.9 | 32.8 | 29.1 | 223.0 | 114.7 | 108.3 |
| **2035** | 52.7 | 28.0 | 24.7 | 215.5 | 111.4 | 104.1 |
| **2050** | 46.5 | 24.8 | 21.7 | 182.6 | 95.3 | 87.3 |

| | 60-74 | Males | Females | 75+ | Males | Females |
|---|---|---|---|---|---|---|
| **1985** | 35.5 | 16.3 | 19.2 | 12.9 | 5.1 | 7.8 |
| **1995** | 45.6 | 20.4 | 25.2 | 19.8 | 7.8 | 12.0 |
| **2002** | 45.3 | 20.4 | 24.9 | 20.3 | 7.9 | 12.4 |
| | | | **Projected** | | | |
| **2025** | 68.8 | 31.5 | 37.3 | 35.3 | 13.4 | 21.9 |
| **2035** | 62.0 | 28.7 | 33.3 | 39.7 | 15.0 | 24.7 |
| **2050** | 69.8 | 32.3 | 37.5 | 34.9 | 13.4 | 21.5 |

Source: COS. 1986, COS. 1997a, NSO. 2003b

It is necessary to examine the social and cultural changes which have been affecting the family. Among the emerging trends of family changes, one notes the reduction in family size. As is the case with a number of other countries, fertility rates in Malta have been declining for quite some time. For 2002, Malta's total fertility rate was 1.46 (COS. 1997c). The figure of 3,805 newborns to Maltese parents for the year 2002 was the lowest recorded over the past thirty years. Similarly, the Crude Birth Rate continued to drop to 9.86 in 2002 (See Table 3). The decrease in the number of children within a family is resulting in the fact that the care for dependent elderly family members can no longer be shared by several brothers or sisters as before ( Troisi J. 1998b, Cutajar C. 1991).

Moreover, the changing role of women and their ever increasing participation in the labour force outside the home, further diminishes their availability as caregivers. It can no longer be assumed that female relatives will be available for full time care (Drew E. Mahon E. 1998). One needs to be aware of the fact that the average age at which Maltese females contracted marriage in 2002 was in the age bracket 25-29, (48 percent or 482 females were married in this age group) In 2002**,** this age coincided with the average age of mothers at first birth, 40.2 percent or 1,528 females (NSO. 2003b).

**Table 3: Live births in the Maltese Islands by gender ( 1993-2002)**

| Year | Number | | | | | | | Crude birth rate* | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Maltese Islands | | | Malta | | Gozo | | | | |
| | Total | Males | Females | Males | Females | Males | Females | Maltese islands | Malta | Gozo |
| **1993** | 5,147 | 2,679 | 2,468 | 2,447 | 2,270 | 232 | 198 | 14.11 | 13.97 | 15.89 |
| **1994** | 4,826 | 2,479 | 2,347 | 2,274 | 2,165 | 205 | 182 | 13.12 | 13.04 | 14.12 |
| **1995** | 4,613 | 2,403 | 2,210 | 2,220 | 2,034 | 183 | 176 | 12.44 | 12.40 | 12.98 |
| **1996** | 4,944 | 2,555 | 2,389 | 2,340 | 2,171 | 215 | 218 | 13.25 | 13.08 | 15.36 |
| **1997** | 4,835 | 2,547 | 2,288 | 2,328 | 2,097 | 219 | 191 | 12.89 | 12.77 | 14.26 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **1998** | 4,488 | 2,308 | 2,180 | 2,131 | 1,994 | 177 | 186 | 11.89 | 11.84 | 12.50 |
| **1999** | 4,308 | 2,183 | 2,125 | 2,015 | 1,961 | 168 | 164 | 11.36 | 11.36 | 11.34 |
| **2000** | 4,255 | 2,126 | 2,129 | 1,967 | 1,937 | 159 | 192 | 11.16 | 11.10 | 11.89 |
| **2001** | 3,859 | 1,992 | 1,867 | 1,838 | 1,730 | 154 | 137 | 10.05 | 10.08 | 9.75 |
| **2002** | 3,805 | 1,997 | 1,808 | 1,840 | 1,677 | 157 | 131 | 9.86 | 9.88 | 9.55 |

Source: NSO 2003b

*Number of live births per 1000 persons in mid-year population

- The family network and reciprocity

In Malta, the central role played by the family as the principle provider of care is still maintained and the exchange of obligations are still the basis of family relations. The family plays an important role in providing financial, practical, emotional and social support. Elderly people value contacts by family. An elderly person still needs to feel security, recognition, respect and love (Micallef T. 1994, 2000, Troisi J. 1995, 1991, 1984).

Although many of the Maltese elderly live alone, they are deeply embedded in family support networks of interdependence, of giving and receiving. Very often, the elderly are a boon to their working children. This is manifested in various ways including financial assistance, baby sitting, etc. Moreover, older persons are often a source of conflict resolutions with the families of their children.

A great need has been created to encourage the maintenance of inter-generational family solidarity. On the one hand, the family should be supported, protected and strengthened so as to enable and encourage it to continue responding to the needs of its elderly members. On the other hand, the continued involvement of the elderly within their family should be more than encouraged.

- The public (State and local) care service provision.

Guided by the awareness that the family environment is the one best suited to the life style of older persons, while at the same time recognising the fact that, as in other countries, the family's traditional caring role is being subjected to various economic, social and psychological strains, the Maltese government has given rise to various policies and programmes to supplement family support to the growing elderly population so as to enable the elderly to remain within their family environment for as long as possible (Vella CG. 1990). To strengthen its commitment to the elderly and to the family, the Maltese government, in May 1987 appointed a parliamentary secretary exclusively for the care of the elderly. In so doing, the various issues of the elderly and also those associated with population aging started being dealt with holistically. The fact that it was placed under the Ministry of social policy was a clear manifestation that the government was fully aware of the fact that aging is not a sickness and that the elderly are primarily not to be seen as a health issue. Moreover, the concept of caring for the elderly was revolutionised.

In line with the stand taken by a number of European governments, the policy of the Maltese government is one of social inclusion of the elderly in all spheres (European Commission. 2001, Troisi J. 1992). Zammit Clapp Hospital rehabilitates elderly persons enabling them to return to live independently in the community. Residential homes in various parts of the country cater for those who do not wish to stay at home. These also serve as respite care centres to alleviate the

care given by family members. The range of services available for the elderly covers more than 30 services aimed at improving the quality of life of the elderly while maintaining them in their own homes, community and environment. These include Day Centres, Domiciliary Nursing, Handyman Service, Home Care Help, Incontinence Service, Meals on Wheels, Telecare, etc. (Abela N. 1988, Cachia JM. 1985, Troisi J. 1994b, 1990, 1989).

- The care "market" (or privately paid care, including and distinguishing between both the "regular" and the irregular or illegal care market), problems in supply and demand.

In recent years, a number of profitable organisations within the private sector have started offering long-term and short-term residential care to the elderly population of the Maltese Islands. Respite care services are also offered to those who ask for them. There are at present ten such homes. Rates are higher than those in State owned or Church run residential homes. These depend on the kind of 'hotel' accommodation and levels of nursing services which are required. On average these vary between 18 to 46 Euros a day. Opening a residential home for older persons requires the permission from a number of government departments and ministries. Moreover, the running of such homes requires following the guidelines as laid down by the Ministry of Health. Consequently these homes are constantly visited by a Board to ensure that these guidelines are adhered to.

In 1996, the government embarked on a partnership scheme with some of these private organisations which were offering residential care services for the elderly. Thus the administration of two of the seven State-owned residential homes is in the hands of a private organisation. Similarly government is in agreement of hiring a number of rooms and services from other private organisations.

During recent years, a small number of private agencies started providing home and nursing care. The rates charged are not fixed because they depend on the number of hours the clients use the service. However, some of the charges tend to be on the high side and not easily affordable by every family.

- Other informal unpaid care (volunteers, neighbours, friends, church etc.)

The various efforts of the government to improve the care services being given to the ever growing number of Maltese elderly and, at the same time, to help them remain in the community for as long as possible, are being significantly complemented by the sterling services provided by a number of voluntary organisations, foremost among which is the Catholic Church (Abela N. 1988, Bonello R. 1995, Troisi J. 1994b). The Catholic Church in Malta was the pioneer in providing most of the care and assistance to the needy including the elderly. Since a long time back, the elderly were very well looked after in the Church-run residential homes. There at present 18 such homes for the elderly providing around 600 beds.

The main source of voluntary action for the benefit of the elderly is through Caritas Malta which provides a powerful force of volunteers. Among the most important services offered by Caritas aimed at helping the elderly t continue living in their own homes and environment one finds the following schemes: Good Neighbour Scheme; Social Clubs; Self-Health Care; Awareness Programmes in Schools (Troisi J. 1990, 1989).

Besides Caritas there are various voluntary organisations like the Catholic Action Movement, Legion of Mary, Social Action Movement, the St.Vincent de Paule Society, which help the elderly in a number of ways be it in their own homes, in hospitals, in residential homes for the elderly, and in the community itself. These organisations usually derive their inspiration from the Church's teachings. The fact that most of the voluntary endeavour in under Church auspices

helps to a large extent to avoid the difficulties experienced in other countries, where the very plethora and variety of organisations often makes it difficult to secure effective coordination.

Mention must also be made of a number of Self-Help groups including various Pensioners' Associations, all of which contribute through a number of programmes and activities to ameliorate the socio-economic conditions of their elderly members (Troisi J. 1990).

- Estimated needs for care in >65 year olds based on disability levels (local or national data)

The needs of an elderly person can be categorised into at least three categories, namely 1) financial needs; 2) physical needs; 3) social-emotional needs. Living on a 'fixed income' describes the situation of many elderly persons. In a comparative study about the adequacy of the income of the Maltese elderly carried out in 1990 based on the findings of an earlier study carried out 8 years earlier (Delia EP. 1982) it was established that only 21 percent of those interviewed considered their income to be sufficient for their needs as compared to the 77 percent of the respondents in the 1982 survey. This could be due to the fact that notwithstanding the marked change which has been taking place over the past years in the life styles and expectations of the 'young old' as compared to those of the 'old old', this has not been matched by the enhanced economic benefits and assistance offered by the State or by voluntary organisations. Some also consider the recent pension increases as not sufficient to the rise in prices. (Camilleri R. 1993)

As people advance in age they find themselves generally slowing down, some of their facilities declining and at the same time, developing certain disabilities. Although aging does not constitute a disease, certain ailments, especially chronic ones, are more prevalent among the elderly. These gradually limit the elderly's ability to autonomy and to undertake the normal activities of daily living. Consequently many of these physical problems require frequent medications, or specialised treatment. Mobility might also be heavily affected (Lungaro Mifsud S. 1995).

Enjoying social contacts and feeling a part of a family network is very important to an elderly person. Visiting relatives and friends are highly valued. The emotional attachments of family and friends cannot be easily duplicated by formal carers. Consequently, a decrease in mobility might often result in greater difficulties in visiting other people. Hence the onslaught of feelings of loneliness and isolation. As people age they tend to become more emotional. Feelings tend to control their actions more easily. Thus, it is imperative that elderly persons more than ever have their emotional needs met. An elderly person needs to feel secure, respected and loved. This is quite natural when one becomes aware of the fact that aging is a time of losses, including, health, home possessions, friends, neighbours and sometimes even relatives.

- A short overview on the current state of the socio-political discussion in each country related to the financial situation of long-term care insurance and health insurance and its consequences to family care. This will also include reference to the national socio-economic and demographic context.

The Maltese government offers long-term care to all citizens. This is largely administered through the seven government community homes as well as through St. Vincent de Paul Residence (SVPR). At SVPR, a resident pays 80 per cent of his total income provided that he/she is not left with less than Lm 600 (Euros 1380). In the other homes the resident pays 60 percent of his total income as long as the same condition is observed. SVPR houses more than 1,000 elderly persons. The long-term care and health insurance system has traditionally been highly centralised with nearly all decisions being taken at the level of the Ministry of Health. Since the early 1990s, a planned process of decentralisation has gradually been taking place. This was in

keeping with general Maltese Government policy in an attempt to reduce bureaucracy and is in line with a wider decentralisation process that has taken place in the Maltese public sector over the past decade. The decentralisation process has enabled a number of management decisions to be taken within the hospitals and health centres. However, the management system is still somewhat bureaucratic due to complex civil service procedures notably involving financial regulations and human resource management. Although these are intended to ensure transparency and accountability, they are slow and laborious thus rendering the health care system incapable of responding rapidly to evolving situations and new demands.(Xerri RG. 1995).

In 1992, a household budgetary survey (COS. 1992) estimated that around two thirds of primary health care is provided by the private sector. Continuity of care is a strength of these practices as patients usually tend to consult the same doctor. However, there is no system for patient registration and patients are free to move around from one general practitioner to another. Unfortunately, this sector has never been subject to regulation and records may be poorly kept. Investment in IT systems for patient management has been totally up to the individual doctors and, as a result, is not widespread. Fees charged are modest and affordable. Most doctors offering these services are paid out-of-pocket by patients directly. Private health insurance only tends to provide limited coverage for primary health care. Within the private sector, the relationships between the financing authorities and the providers is different. Several private health insurance schemes exist in Malta. These tend to be private-for-profit insurance companies. Some are affiliated with international insurance schemes whilst others are local companies. Private health care insurance is subject to regulation by the Malta Financial Services Centre (Azzopardi Muscat N, Dixon A. 1999).

These issues have had two repercussions on the state of family care for older persons in Malta. First, in actual fact, formal services complement, rather than replace, the efforts of family members. Nonetheless, many family members believe that the use of formal services signifies their own inadequacies as caregivers. For many caregivers, the use of formal services is an admission of their own inability to live up to family expectations. Therefore, one may say that there exists an uneasy partnership between caregivers and formal service providers. One reason could be that it is not often made explicit to family caregivers that formal service providers rely on them to serve as advocates and liaisons for their elderly relatives, and that in order to be successful, formal services require the involvement and participation of family caregivers. Secondly, there exists a challenge relating to the recruitment of family caregivers into a formal care delivery. To the extent that family caregivers interface with the formal system early in the care giving process, the process is facilitated for everyone. However, this is rarely the case to the extent that late integration does not permit the development and coordination of a comprehensive plan of service delivery, one that best meets caregivers' and acre recipients' current and anticipated needs.

- Country specific issues

Since the 1960s, present and acceding countries of the European Union experienced unprecedented levels of population ageing (Camilleri R. 2000). This event, closely connected with the decline of fertility, is strengthened today by progress obtained in life expectancy at high ages. Malta is no exception and has evolved out of the traditional pyramidal shape to an even-shaped block distribution made up of equal numbers at each age cohort except at the top (Troisi J. 1998b). In 1998, life expectancy at birth reached 74.4 and 80.1 years for men and women respectively, figures that correspond well to other EU countries (NSO. 2003b, European Commission 2003, Camilleri R. 2000). Indeed, during 2002, the Maltese population included 67,574 persons who were aged 60 years and over (17.0 percent of the total population and an increase of 33 percent over the 1985 figure), with persons in the 60-74 and 75+ age brackets totalling

46,704 and 20,870 respectively (COS. 1986; NSO. 2003b). During the same year, whilst the total elderly-child ratio consisted of 68 elderly persons per 100 children, the total dependency ratio stood at 46.09. Similar to international statistics, as Malta's population ages, the proportion of women to men tends to increase. In 1998, the national sex ratio stood at 90.5, among the 'young-old' and the 'old-old' sectors it reached 80.8 and 64.6 respectively. With respect to marital status, in 1995, there were 6,835 females aged 75 years and over who were widowed. This amounted to 71 per cent of all females in this age bracket. Invariably, this explains the higher proportion of female one-person households amongst the 70+ age group.

Studies on elderly persons are sparse in the Maltese Islands. This could be partly due to the fact that gerontology in Malta is considered as part of the study of social problems, with most dissertations relating to ageing focusing on medical and social security issues. Indeed, most published information on elderly persons in Malta is found in publications by the National Statistics Office. Building on such sources, one can construct a 'representative' profile of Maltese elderly persons from a number of related issues ranging from health, education, to housing conditions, participation in the labour force, and finally, to average levels of income and expenditure.

Health. Although elderly persons, in general, enjoy good health and live independent lives, there exists a high proportion of disabled persons amongst those aged 75 and over who tend to frequent outpatient clinics and hospitals, residential homes, and are users of community services (National Commission Persons with Disability 2003, 2000). The most common diseases afflicting Maltese elderly persons are arthritis, high blood pressure, diabetes, and heart disease. However, health patterns are not solely dependent on age but are also gender-related (Williamson J. 1982). Males (albeit holding a lower life expectancy) are generally more healthy than females. The latter record a higher incidence of morbidity (Government of Malta.Ministry of Health. 2004b, 2004c, Dipartiment tas-Sahha. 1989, Government of Malta, Department of Health. 1986).

Social and medical care. Due to the mentality emanating from an extensive Catholic influence, the family constituted in the past the only pillar for elderly care. Yet, the decreasing size of the Maltese family and increasing number of females in paid employment reduced drastically the number of available family carers (Troisi J. 1994). Moreover, Malta receives a yearly average of 400 migrant returnees which functions to increase the demand for support when frailty sets in Gauci M. 2001). The 1990s saw the government setting up a diverse range of State-supported services which function to enable elderly persons to remain living in the community (Gatt Depares J. 1994, Piscopo T. 1994).

Education. The 1995 census indicates that the educational status of elderly persons is of a lower standard than the national average (COS. 1997b). Almost 18 percent have no schooling experience, 23.4 percent left school before completing their primary education, and 32 percent and 20 percent left school at their completion of primary education and secondary education respectively. It is, therefore, not surprising that 81.4% of the 60 plus cohort have no qualifications. Elderly persons comprised 42.8% of the total illiterate population. Females manifested a higher level of illiteracy. The data also points strongly to the fact that, as a direct result of post-war educational policies, each incoming generation boasts better educational records.

Social activity. Studies hold that the favourite leisure opportunities for elderly persons remain those associated with traditional pastimes, where bocci (a game similar to French boules) and bingo, and church feasts and band clubs, are important avenues for males and females respectively. Yet, this seems too stereotypical in the light of more recent research which highlights the various activities undertaken by today's elderly persons. Indeed, a substantial number of local community councillors are over the age of 60, the University of the Third Age in Malta is a thriv-

ing hub, and elderly cohorts have become major consumers of travel packages. Moreover, more elderly persons are passing their leisure time outside the home.

Housing conditions. More elderly persons own their home than in the past : 63.2 per cent in 2000, compared to 59 per cent in 1990, with the majority living in owned terraced houses and better home-safety environments (NSO, 2003a). However, some houses are not suitable for age-related functional problems. Hence, as they get frailer they may not have the resources or energy to get the necessary aids and adaptation to the property to cope with their growing disability.

Employment. In 2003, 2,930 persons aged 60 and over were in paid employment (NSO, 2003b) However, this is a greatly under-represented figure. Moreover, Malta contains many family run businesses, and many elderly men and women continue helping out without receiving a formal wage packet. The latest trend is for elderly women to take care of grandchildren and nephews/nieces whilst their mothers take up full-time employment. While some recipients of such informal child care compensate their mothers or aunts in kind, many provide the latter with a weekly remuneration.

Income. Malta has a comprehensive retirement pension package and it is rather rare for current elderly persons to be in receipt of a private pension (Government of Malta. Ministry of Social Policy. 2004k, l, m, n, p, q, r, s). The most prevalent pension is the two-thirds pension, which is an earnings-related contributory pension payable to persons who have retired after January 1979 (Grech L. 2000). Statutory pensionable age is 60 for females and 61 for males. However, the 2000 Household Budgetary Survey [HBS] found that many elderly persons supplement this income with a range of subsidies, interests, insurances, rents, sales of items, and various other earnings. The HBS states that the 60+ cohort have an average annual income of LM3,830(Euros 8,800) second only to the 50-59 age group. However, when one breaks down this average income it becomes evident that the median is a much lower figure. From other research it arises that two groups of elderly persons are in receipt of high income levels – that is, migrants who hold pensions from high-income countries and elderly persons in paid employment (NSO 2003a, Schembri K. 2001, Kelleher D. 2000).

# 1 Profile of family carers of older people

Although a number of studies have been carried out on various characteristics of elderly persons in Malta and on the wide gamut of services which the formal and the informal sectors offer to ameliorate the quality of life of elderly persons, to-date no national research has been conducted specifically on the characteristics of the informal carers of elderly persons in the Maltese Islands. Moreover, there does not exist any country-wide register of these family carers.

The information for this report is based on a number of sources including the National Statistics Office; the Department of Social Security especially its schemes of Carer's Pension and the Social Assistance for Females caring for sick and older persons; a number of research-based theses carried out by students of the Institute of Gerontology, University of Malta in fulfilment of the postgraduate degree in Gerontology and Geriatrics, (Agius Cutajar D. 1994, Bonello R. 1995, Briffa R. 1994, Busuttil MR. 1998, Grixti J. 1999, Laferla A. 1997, Micallef T. 1994, 2000, Navarro M. 1995, Scicluna M. 1998,), theses carried out by students in the Faculty of Arts, University of Malta, (Abela N. 1988, Cutajar C. 1991, D'Amato R. 1995, Mifsud J. 1999, Vella M. 1993 ).

Furthermore, a research was carried out for the purpose of this report by the European Centre of Gerontology, University of Malta. (Troisi J, Formosa M, Navarro M. 2004). This research is

based on 100 personally administered interviews of informal carers. The persons interviewed were chosen from two groups of family carers. The first was the list of persons who are benefiting from the two government schemes namely: i) the Carer's Pension and ii) the Social Assistance for Females taking care of a sick or elderly relative. The second was drawn from a list of persons given by the parish priest in charge.

Maltese society has always been characterised by its strong family structure. (Troisi J. 1999) Despite recurrent misgivings about the commitment of the family to care for its elderly members, it is generally accepted that most help continues to come from the family. (Troisi J. 1991). In fact, less than 5 per cent of the country's elderly population live in government and private run homes. (This does not take into account the elderly persons living in mental asylums). The rest are living in their own homes or that of their adult children, relatives or friends.

One, however, cannot deny the fact that in recent years, as in other countries, various social and cultural changes such as industrialisation and modernisation, have subjected the traditional care provided by Maltese families to their elderly members to a considerable strain .

## 1.1 Number of carers

The fall in the average Maltese family size, which has occurred during the last five decades, has had the effect of reducing the number of available supporters for the elderly. The number of multi-generational families has drastically decreased. The gradual emergence of the two-child family and its eventual acceptance as the 'standard' size of the Maltese family has been evident during the past years. As a result of the growth in industry and tourism, as well as the rapid advances in the tertiary education of women (Troisi J. 2000, 1998a), young and middle-aged women are increasingly engaged in paid employment. Families are furthermore separated as younger daughters, on getting married, move into newer housing areas. (COS 1997a, Troisi J. 1990)

We do not have any statistical data allowing for a valid assessment of family care of older persons in Malta. The Department of Social Security keeps a very basic statistical register of the persons who are eligible to receive the Carer's pension, (Government of Malta, Ministry of Social Policy. 2004o) and another for those benefiting from the scheme called the Social Assistance for Females taking care of a sick or elderly relative. (Government of Malta, Ministry of Social Policy. 2004t). But as such there is no formal register of family carers in Malta. Detailed data concerning the situation of family carers including their number, age, gender, source of income and education is not available. Although a number of researches have been carried out directly or indirectly on this subject these have not been representative enough to the extent that one could reach certain generalisations applicable to the whole Maltese population or to the Maltese families.

Making using of Alan Walker's methodology (the number of females in the total population aged between 45-70 as compared to the total population of Maltese aged 70 and above), (Walker A. 2001) one could come to the conclusion that there were 2.36 females (67,782) per every Maltese citizen aged 70 and above (28,762) (COS 1997a).

## 1.2 Age of carers

The effects of age on the quality of care giving are nearly impossible to disentangle from the effects of other caregiver and care recipient characteristics. Some studies found that age and kinship ties are confounded with spouse caregivers, who are significantly older than other groups of caregivers. It is also suggested that caregiver age is confounded with other factors

such as ethnicity and class. From the study conducted by the European Centre of Gerontology, University of Malta (Troisi J, Formosa M, Navarro M. 2004) it resulted that the majority of care-givers who are in receipt of a carer's pension in Malta are in the 40 to 59 age bracket. This means that a substantial number of caregivers may be employed or looking for work, and, at the same time, taking care of smaller children.

**Table 4 : Respondents by Age**

| Age group | No. |
|---|---|
| **18-29** | 19 |
| **30-39** | 9 |
| **40-49** | 29 |
| **50-59** | 27 |
| **60-69** | 15 |
| **70-74** | 1 |
| **Total** | **100** |

Source : Troisi J, Formosa M, Navarro M. 2004.

It is interesting to note that out of the 259 family carers who as of the 31st December 2003 were benefiting from the Government's Carer's Pension (Ministry of Social Policy. 2004o), 60.6 per cent, or 157 carers, belonged to the 45-69 age bracket. The majority of male carers, 56 percent, or 59 persons belonged to the 20-44 age bracket, while the other 47, or 44 per cent, were 45 years of age or above. In the case of female family carers, the majority or 72 percent of the family carers (110 persons), were above the age of 45. Only 28 per cent of the female carers (43 persons) were below the age of 45.

As on 31st December 2003, there were 456 family carers, who were benefiting from the government scheme called Social Assistance for Females taking care of a sick or elderly relative. 63.8 per cent of these, or 291 carers, were above the age of 45 as compared to the 165 carers or 36.2 per cent who were aged between 20-44. The majority or 106 persons, 23.2 percent were aged between 55-59 ( Government of Malta. Ministry of Social Policy. 2004t).

**Table 5: Number of female family carers benefiting from the Scheme Social Assistance for Females taking care of a sick or elderly relative as on 31.12.2003**

| Age group | Number |
|---|---|
| 20-29 | 85 |
| 30-34 | 22 |
| 35-39 | 21 |
| 40-44 | 37 |
| 45-49 | 70 |

| | |
|---|---|
| 50-54 | 93 |
| 55-59 | 106 |
| 60-64 | 19 |
| 65-69 | 3 |

Source: Government of Malta. Department of Social Security. 2003

## 1.3 Gender of carers

Traditionally women, especially wives and daughters had the responsibility of caring for elderly members within the family. The traditional Maltese female was very much family oriented and tied to her domestic roles. Women were often trapped within a web of traditional values which assigned a very high value to childbearing and hardly anything to other roles and functions (Cutajar M. 1997, Miceli P. 1994, Troisi J. 2002**).** One may add that it has been part of Malta's social pattern that where a daughter remained unmarried, or was married but bore no children, she was expected to look after her elderly parents especially when they become frail (Busuttil S. 1971, D'Amato R. 1995, Micallef T. 2000)

Research has shown that even in the last decades, as women have entered the workforce in unparalleled numbers, the commitment to caring for elderly family members is still being carried out by females. Research also shows that although fewer in number, there are men who are also involved in providing care to their elderly family members. (Micallef T. 2000). There seems to be a common understanding that sons become caregivers only in the absence of available female caregivers. However, sons are just as likely as daughters to provide both financial and emotional support to their parents and share their homes with them. In another research (D'Amato R. 1995) it was found out that men in their traditional roles may foot the bill for the care of the elderly parents but many others are likely to help their parents in other ways also. As sex roles become more flexible, more sons will become involved in caring for their elderly parents when the need arises.

It is interesting to note that out of the 259 family carers who, as of the 31st December 2003 were benefiting from the Government's Carer's Pension (Government of Malta. Ministry of Social Policy. 2004o), 59 per cent or 153 persons were females as compared to 106 males or 41 per cent. A similar situation emerged in the study carried out by the European Centre of Gerontology (Troisi J, Formosa M, Navarro M. 2004) where 74 per cent of the interviewed family carers were females.

## 1.4 Income of carers

In the year 2001, Malta's GDP stood at 4 billion Euros, implying a per capita annual income level of 10,500 euros at current exchange rates. (Abela A., Cordina G, Muscat Azzopardi N. 2003).

There is no information on the income of carers. In the research carried out by the European Centre of Gerontology (Troisi J, Formosa M, Navarro M) 42 per cent of those interviewed reported that they only received the Carer's Pension or the Social Assistance for Female Carers scheme. 15 per cent said that they depended on their contributory national pension, while 22 per cent reported that they were gainfully employed. 21 per cent did not state their income.

However, from the past census one notes that a total of 92,046 households or 78.6 percent of all Maltese households, reported having an annual gross income that does not exceed Lm6,999

(Euros 16,100). A good proportion of these, namely 38,157 households, or 32.6 percent of all Maltese households, had an annual gross income of up to Lm2,999 (Euros 6,900). Another 22,360 households, or over 19 percent of all Maltese households, reported having an annual gross income in excess of Lm7,000 (Euros 16,100). One may therefore deduce that majority of carers have a household income in the Lm5000 – 6999 bracket (Euros 11,500 – 16,100).

**Table 6 : Distribution of Maltese households by income group (Malta Liri)* as on 25th November 1995**

| Income Group | Total | Malta | Gozo and Comino |
|---|---|---|---|
| **>2,999** | 38,157 | 34,249 | 3,908 |
| **3,000 – 4,999** | 34,429 | 31,901 | 2,528 |
| **5,000 – 6,999** | 19460 | 18,145 | 1,315 |
| **7,000 – 8,999** | 11,102 | 10,498 | 604 |
| **9,000 – 10,999** | 5,935 | 5,690 | 255 |
| **11,000 – 12,999** | 2,681 | 2,573 | 108 |
| **13,000 – 14,999** | 1,235 | 1,183 | 52 |
| **< 15,000** | 1,407 | 1,359 | 48 |
| **Non-respondents** | 2,771 | 2,646 | 125 |
| **Total** | **11,7177** | **10,8234** | **8,943** |

Source : COS. 1999b.

* 1 Malta Lira is equivalent to Euros 2.3

## 1.5 Hours of caring and caring tasks, caring for more than one person

The elderly population is characterised by a high degree of heterogeneity in terms of its dependency on and its respective needs for various services. It is precisely in this regard that it is important to distinguish and analyse the 'young-old' population (those aged between 60-74) and the 'old-old' population (those aged 75 and over). While the 'young old' are expected to be in a position to participate actively in their society, (Macelli N. 1988) the 'old old' are at higher risks to long-term illnesses, disabilities and frailty. With advancing age, pathological conditions tend to increase. Many of these problems are usually chronic and require attention for an indefinite period of time. Moreover, an increase in health problems often decreases the mobility of the elderly person. Consequently, their level of dependency is expected to increase. This will inevitable result in a heightened demand for care and extended supportive services. According to the 1995 national census, the 'old old' represented 30 percent of the Maltese elderly population. (COS. 1986) This figure is projected to increase to 34 per cent by the year 2025 (NSO 2003b). It is also worth noting that while in 1995, the 75+ constituted 5.14 per cent of the total Maltese population, they are projected to constitute 9.07 and 10.45 per cent in 2025, and 2050 respectively.

Consequently, one needs to distinguish between caring for a totally dependent elderly person such as a bedridden or wheelchair bound relative, where continuous and personal tending is required, and caring for independent or semi dependent elderly relatives. Difficulties often arise when elderly family members are in need of constant care and nursing help. 99 per cent of the interviewed family carers replied that they only had one elderly relative in their care (Troisi J, Formosa M, Navarro M. 2004).

a) **Frequency of providing help:**

As expected the frequency with which care for on older family member is provided depends on a wide variety of factors including, among others, relation of the carer to the cared; the gender, marital status, family obligations, working demands of the carer; the age of the carer; the proximity of dwelling (is the carer living in the same house as the cared); the level of dependency of the cared-for person, etc. For some, caring is a 24 hour a day, 7 days a week job. Others have to combine their working lives with informal care responsibilities. Elderly persons who require help to perform the personal activities of daily living need longer hours daily.

65.6 per cent of the interviewed family carers replied that they spend practically the whole day in the care of their elderly relatives, some even being waken up during the night. This was mainly the case with those relatives who were very frail, bed-ridden and with those suffering from dementia. As expected the majority of these carers were benefiting from the Carer's Pension or from the Social Assistance for Females taking care of a sick or elderly relative scheme. 13.8 per cent replied that they spend 8 hours daily in caring for their elderly relatives while the remaining 10.6 per cent remarked that they provide less than 40 hours of care a week.

b) **Types of help**:

As pointed out earlier, the type of help depends very much on the level of dependence and lack of autonomy of the cared elderly family member. The same holds good depending on whether the carer and the cared are living in the same dwelling. Sometimes, especially in the case of caring for persons who are not bedridden or wheelchair bound, caring involves primarily surveillance, for instance to ensure that the relative does not need anything. In the case of fully dependent and frail elderly family members, however, regular and full-time care is needed and mainly consists of nursing care.

Family members are particularly adept at providing care for an elderly relative that does not require a high degree of specialisation. Here, the most common needs are preparing meals, helping with the laundry, shopping, walking outdoors and bathing.

According to the research carried out by the European Centre of Gerontology, University of Malta (Troisi J, Formosa M, Navarro M. 2004), 53.2 per cent of the interviewed family carers said that they only provided household duties including cooking, cleaning, etc. 26.6 per cent claimed that, besides the normal household duties, they also gave certain basic nursing care including bathing, feeding, and administering of insulin injections. 5.3 per cent gave only nursing care while the care given by 4.3. per cent consisted in the keeping company to their elderly relative. Compared to all this, 10.6 per cent of the interviewed carers claimed that they carried out all kinds of jobs on behalf of their dependent elderly relatives.

## 1.6 Level of education and/or Profession/Employment of family carer.

According to the 1995 national census, 9.63 per cent of the population aged 16 years and over had received no schooling. (COS 1998b). The majority of these were elderly women. The reason for this is the fact that since such a high value used to be attached to the reproductive function, formal education tended to be seen as irrelevant for girls who were destined for marriage

and motherhood at a relatively early age (Troisi J. 1998a, 1996). Moreover, greater expectations led parents with limited resources to invest more in their sons than in their daughters. This explains why parents in low income families were apparently less willing to invest in the education of their female than of their male offspring. The great social division of gender thus also had a major and sustained impact on the distribution of educational opportunities. The 1995 national census analysis indicates that 17.5 percent of those above the age of 60, had no schooling experience. 18.3 percent of these were females while 16,2 percent were males. 23.4 per cent left school during their primary school years. Another 32 and 20 per cent left school at their completion of primary education and secondary education respectively (COS. 1998b) As can be seen in Table ,7 except in the attainment of secondary education, females exceeded males both numerically and proportionally.

Table 8 illustrates how, in 1995, illiterate older persons comprised 42.8 percent of the total illiterate population in Malta. More than half of these, 23.2 percent, were persons aged 70 and older.

**Table 7: Distribution of Maltese population aged 16 years and over by educational attainment as on 25th November 1995**

| Level of Education | Males | % | Females | % |
|---|---|---|---|---|
| **Total** | **141,269** | **100.00** | **148,280** | **100.00** |
| **No Schooling** | 6,206 | 4.39 | 7,772 | 5.24 |
| **Primary level not completed** | 11,974 | 8.48 | 14,869 | 10.03 |
| **Primary Level Completed** | 29,221 | 20.69 | 38,874 | 26.22 |
| **Secondary level not completed** | 17,013 | 12.04 | 17,334 | 11.69 |
| **Secondary Level Completed** | 40,385 | 28.59 | 44,052 | 29.71 |
| **Vocational Level not Completed** | 4,548 | 3.22 | 2,376 | 1.60 |
| **Vocational Level Completed** | 12,030 | 8.52 | 7,664 | 5.30 |
| **Tertiary Level not completed** | 5,343 | 3.78 | 4,752 | 3.21 |
| **Tertiary Level Completed** | 8,380 | 5.93 | 6,129 | 4.13 |
| **Post-Graduate Level not completed** | 1,262 | 0.89 | 851 | 0.57 |
| **Post-Graduate Level Completed** | 3,086 | 2.18 | 1,321 | 0.89 |
| **Non Respondent** | 1,821 | 1.29 | 2,086 | 1.41 |

Source: COS. 1998b.

**Table 8: Percentage distribution of illiterate persons in the Maltese Islands by broad age groups as on 25th November 1995**

| | 1948 | | 1985 | | 1995 | |
|---|---|---|---|---|---|---|
| **Age Group** | **Illiterate** | **%** | **Illiterate** | **%** | **Illiterate** | **%** |
| **All Ages** | 72,088 | 33.4 | 34,274 | 12.0 | 36,444 | 11.24 |
| **10-14** | 3,466 | 10.9 | | | | |
| **15-19** | 6,605 | 23.5 | 534 | 1.1 | 1,775 | 4.9 |
| **20-24** | 6,261 | 24.4 | 838 | 3.1 | 1,135 | 3.1 |
| **25-29** | 6,017 | 26.2 | 1,632 | 5.7 | 1,217 | 3.3 |
| **30-34** | 5,261 | 29.2 | 2,050 | 7.5 | 2,053 | 5.6 |
| **35-39** | 6,580 | 35.5 | 5,594 | 8.7 | 2,807 | 7.7 |
| **40-44** | 7,683 | 41.2 | 1,954 | 9.1 | 2,903 | 8.0 |
| **45-49** | 6,043 | 40.6 | 2,154 | 11.5 | 3,610 | 9.9 |
| **50-54** | 6,631 | 46.3 | 3,324 | 18.7 | 2,647 | 7.3 |
| **55-59** | 5,636 | 49.8 | 3,616 | 22.6 | 2,687 | 7.4 |
| **60-64** | 5,931 | 57.1 | 3,853 | 25.3 | 3,643 | 10.0 |
| **65-69** | 4,131 | 58.5 | 3,146 | 28.4 | 3,519 | 9.6 |
| **70+** | 6,635 | 69.0 | 8,579 | 38.4 | 8,448 | 23.2 |

Source: COS. 1998b

Fully aware that human resources are by far the principal resource of the Maltese Islands, Government has made the development and efficient deployment of human resources as a primary concern of the Maltese educational system. With the introduction of obligatory school attendance between the ages of 5 and 16, the number of persons finishing school at secondary level of education increased and is bound to continue increasing. The State provides entirely free education in all institutions up to the tertiary level. As a result the proportion of those obtaining a tertiary level of education is increasing very rapidly.

The most noticeable change which has occurred in the educational field in so far as opportunities for women are concerned is, without doubt, in the tertiary sector. During the past 4 decades, there has been a constant increase in absolute numbers and in the relative weight of female students reading for a degree at the University of Malta. 42 years ago, the university student ratio was 8.75 females to every 100 males. Since 1993 the situation has been reversed and there are more females than males reading for a degree. One is justified in saying that while the level of education of elderly female family carers is rather low, the majority of the young female family carers have a secondary level of education.

The increased investment in the educational system was instrumental in bringing about a change in women's traditional roles. In fact, the recent research conducted by the European Centre of Gerontology on 100 family carers of older persons, 17 percent of the carers had a primary level of education, 73.4 per cent had a secondary level, whilst 9.6 per cent of the respondents had a tertiary education. (Troisi J, Formosa M, Navarro M. 2004).

## 1.7 Generation of carer, Relationship of carer to OP

Sociological studies in Malta still find that the average Maltese citizen family is of the opinion that the family should be the major institution offering support to older persons (Tabone C. 1987). Although there is no doubt that the family underwent fast and radical changes throughout the second half of the past century, familiar bonds have not disintegrated in a complete fashion (Troisi J. 1999, 1995, 1991). In fact, various studies on family carers in Malta report that most elderly persons who need care reside with family members rather than friends or neighbours. The most dominant forms of relationship between care-giver and care recipient are that of wife-husband, daughter-mother, daughter-father, sister-sister, and son-mother respectively.

In the case of most of the married elderly people, it is the partner who is the main carer. Since women have a higher life expectancy than men, 80.5 years as compared to 75.9 years, (NS0. 2003b), and given the fact that men marry younger women, very often it is the wife who provides the highest care of her frail and dependent older husband. Wives feel morally obliged to live up to their marital vows especially in as far as care is concerned. Elderly married women often become part-time nurses for their older husbands especially when the later are homebound or become bedridden. In such cases, children might provide additional assistance.

The predominance of female-male pattern in giving and receiving care is not surprising considering the following three features. First, notwithstanding the rapid socio-economic transformations, the Maltese family has still retained a strong familiar tie. This is largely the result of strong roots that the Roman Catholic Church has in Maltese towns and villages. Secondly, Maltese females (similar to other international statistics) are over represented in the 60 plus age cohorts, especially in the 'old-old cohort' (see Table 9 ). In 1995, the sex ratio of the total Maltese population stood at 97.4[1] (COS, 1996).

[1] However, the observed higher sex-ratio in the early stage of life decreases with the advance in age. In fact, as Table 3 clearly shows, the over-representation of women is much more pronounced among the older population. It is projected that by the year 2025 there will be a sharp decrease in the sex-ratio among the "young old" or those in the 70-74 age bracket becoming sharper still among those aged 75 and above or the " old old" amounting to a sex-ratio of 72.6 and 61.7 respectively (Troisi 1998).

**Table 9 : Sex-ratio of total population in the Maltese Islands as on 25 November 1995**

| AREA | AGE GROUP | | | |
|---|---|---|---|---|
| | **Under 14** | **15-60** | **61-69** | **70+** |
| **Maltese Islands** | 105.57 | 100.69 | 81.19 | 72.02 |
| **Malta** | 105.30 | 100.95 | 81.70 | 71.72 |
| **Gozo & Comino** | 108.74 | 97.74 | 75.75 | 74.54 |

Source : COS. 1997b

Finally, in Maltese society it is still socially expected that single and married daughters (especially those without children) take on the responsibility of caring for elderly family relatives.

Studies also indicate clearly that the following three dominant features are under a lot of stress and strain (Tabone C. 1987). One reason is the decreasing family size which, in turn, has resulted in a reduction in the number of available family carers (Troisi J. 1994). Another strain is that Maltese society is experiencing a growth in job and career opportunities for middle-aged women (ibid.). Moreover, increasing materialist values have engendered a consumption-dominated lifestyle which causes young and middle aged married women to be increasingly attracted towards seeking work outside the home. Another strain is that families are now less matrilocal than before in the sense that many children are living in other towns/villages than those of their parents (Council of Europe. 1994). Although in Malta these distances are rarely more than a few kilometres, these tend to have a great effect on the traditional and accustomed level of support. Furthermore, longevity has resulted in multi-generational families, with some now boasting of three and sometimes even four living generations. This has given rise to what is now termed as the sandwich generation of middle aged women - that is having to take care both of theory children and parents. When this is combined with the smaller number of siblings available for providing care, the strain on the dominant forms of elderly care in Malta is becoming heavier.

From the research carried out by the European Centre of Gerontology, University of Malta, it transpired that 74.5 per cent of the interviewed family carers were the children of the cared-for elderly person.

## 1.8 Residence patterns (household structure, proximity to older person needing care, kinds of housing etc.)

The dramatic fall in family size during the past forty years is a salient feature of Maltese society. Table 10 illustrates the gradual transition of the average Maltese household from a large group of 4-6 persons in 1948 to a smaller unit consisting of 2-3 persons in 1995.

**Table 10: Percentage distribution of multi-person households in the Maltese Islands by size according to censuses1948-1995.**

| Census Year | Number of persons per household | | | |
|---|---|---|---|---|
| | **2-3** | **4-6** | **7-9** | **10+** |
| **1948** | 38.3 | 42.4 | 16.0 | 3.3 |
| **1957** | 42.1 | 38.8 | 14.9 | 4.2 |
| **1967** | 42.8 | 41.2 | 12.6 | 3.4 |
| **1985** | 49.6 | 47.8 | 2.5 | 0.1 |
| **1995** | 50.8 | 47.6 | 1.5 | 0.0 |

Source: COS. 1998a, Camilleri R. 1993

Whereas, in 1948, the households consisting of more than 10 persons and those consisting of 7-9 persons represented 19.3 per cent of the multi-person households, 47 years later, namely in 1995, there was no household consisting of 10 persons or more while the number of households with 7-9 persons decreased to only 2.5 per cent. The dramatic fall in family size was also clear in the smaller households. Thus, while in 1948 the 4-6 person households accounted for 42.4 per cent of all households, in 1995 they represented 47.6 per cent. The biggest change however was reported in the 2-3 persons' households. In 1948, 38.3 percent of the Maltese households belonged to this category. In 1995, the figure increased to 50.8 per cent.

As expected, these changes have resulted in a reduction of available family carers. Middle aged children feel an increased strain owing to their having fewer siblings on whom to rely in their caring roles. Kin networks offer fewer options and resources when the younger generations are smaller in size. A growing number of elderly persons would prefer to live in their own house and often find it difficult to live with their children. Among the reasons given for this fact is what is termed as "the generation gap". Given the rapid social change, characteristic of modern society, as a result of which the younger generations are harbouring different values, ways of life, habits, fashions, patterns of behaviour and personal relations, elderly persons feel that their 'conservative' way of life is being threatened. They feel that they are not understood and cannot understand the younger generations. The young often consider the elderly generation as too demanding while the latter see the younger generation as too frivolous. Moreover, living with one's family might give rise to misunderstandings which in turn might result in rejection and irritation by both generations. (Abela N. 1988). There are also cases in which elderly persons, especially men, prefer to live alone rather than become a burden on their married children. This is the more so in the case of married daughters.

A study of 120 Maltese elderly persons aged 70 and over found that informal care is greater than formal sources. This is due to the fact that family members are still the main carers for the elderly even when they do not live in the same house.(Vella M. 1993).

Research carried out shows that many of the carers of dependent elderly persons either reside in the same household or else reside close by where the two households are in walking distance with each other. This is because although Malta is a small country it is well-known that informal care needs constant attention and intermittent support to the extent that even a 20 minute car distance becomes too long for carers to commute twice or three times a day. Moreover, various studies also point out that, although elderly persons tend to have higher than average families, they all tend to have a primary care giver who is a female and lives close by.

Another interesting issue is that the latest Census (COS, 1998d) shows that the largest concentration of elderly persons in the Maltese islands (8,388 males and 11,432 females) are to be found in the inner harbour region. They constitute almost 33 percent of the country's elderly population. This region also contains the largest number of older females, 11,432 persons or 31 percent of the country's elderly females. The northern region has the smallest number of elderly persons, 2,539 males and 3018 females, constituting 9.3 percent of the country's elderly population. This region also contains the smallest concentration of elderly females. This means that the largest concentration of care is to be found in the inner and outer harbour regions.

78.7 per cent of the respondents in the research carried out by the European Centre of Gerontology, University of Malta (Troisi J, Formosa M, Navarro M. 2004) lived in the same dwelling as their dependent elderly relative. 18.1 per cent lived between 1-2 kilometres away. The remaining 3.2. per cent had their house about 10 kilometres away.

**Table 11 : Distribution of Maltese population by region, gender, and age group. 25 November 1995**

| AGE | SEX | REGION | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Inner Harbour | Outer Harbour | South Eastern | Western | Northern | Gozo & Comino | Total |
| 0-14 | **M** | 7,869 | 12,962 | 6,067 | 6,155 | 5,552 | 3,348 | 41,953 |
| | **F** | 7,324 | 12,391 | 5,834 | 5768 | 5,342 | 3,079 | 39,738 |
| 15- 60 | **M** | 26,531 | 36,150 | 16,035 | 16,345 | 14,293 | 8,379 | 117,733 |
| | **F** | 26,503 | 35,752 | 15,985 | 16,169 | 13,196 | 8,596 | 116,921 |
| 60-69 | **M** | 4,382 | 3,702 | 1,678 | 1,650 | 1,375 | 1,109 | 13,898 |
| | **F** | 5,671 | 4,194 | 2,053 | 2,174 | 1,561 | 1,464 | 17,117 |
| 70+ | **M** | 3,956 | 2,924 | 1,294 | 1,470 | 1,164 | 1,323 | 12,131 |
| | **F** | 5,761 | 4,185 | 1,610 | 2,056 | 1,457 | 1,775 | 16,844 |
| All | **M** | 42, 738 | 55,740 | 25,074 | 25,620 | 22,384 | 14,159 | 185,715 |
| | **F** | 45,259 | 56,522 | 25,482 | 16,167 | 22,276 | 14,914 | 19,620 |
| **Total** | | **87,997** | **12,262** | **50,556** | **51,787** | **44,660** | **29,073** | **376,335** |

Source : COS. 1997b.

Statistics published in the Household Budgetary Survey (NSO, 2003) provide information on the type of dwellings of elderly persons in Malta. As can be seen in Table 11, whilst 18.7 and 12.8 per cent of all individuals who live in terraced houses are in the 60-69 and 70 plus age group respectively, 25.4 and 12.6 per cent of individuals living in maisonettes or ground floor dwelling are in the 60-69 and 75 plus age brackets respectively. At the same time, 16.5 and 8.2 per cent of all individuals who live in apartments/flats are in the 60-69 and 75 plus age brackets. Compared to this, 14.9 and 10.1 per cent of individuals living in either fully- or semi-detached housing are in the 60-69 and 70 plus age group. One also notes that 5.9 percent of those who live in

other types of housing other than terraced houses, maisonettes or ground floor, apartments/flats, and fully- or semi-detached housing are in the 60-69 age bracket.

**Table 12: Percentage of households by type of main dwelling and age group (2000)**

| Age | Terraced House | Maisonette/ ground floor | Apartment/ Flat | Fully-/semi-detached | Other |
|---|---|---|---|---|---|
| **60-69** | 18.7 | 25.4 | 16.5 | 14.9 | 5.9 |
| **70+** | 12.8 | 12.6 | 8.2 | 10.1 | - |

Source: NSO 2003a

Household Budgetary Survey (NSO, 2003) Statistics also provide information on the extent that elderly persons in Malta own their own households. Thus in Table 13 it is very clear that 21.6 and 12.6 per cent of all individuals who own their own dwelling are in the 60-69 and 70 plus age brackets. In comparison, 16.8 and 20.8 per cent of individuals living in rented furnished housing are in the 60-69 and 70 plus age brackets respectively. At the same time, whilst 27.5 and 16.4 percent of all individuals who live in rented furnished housing are in the 60-69 and 75 plus age brackets respectively, 23.3 and 17.7 per cent of individuals living in free-of-charge housing are in the 60-69 and 75 plus age brackets respectively. One also notes that 2.6 percent of those who own their house but with an outstanding loan are in the 60-69 age bracket.

**Table 13 : Percentage of household ownership of main dwelling and age group (2000)**

| Age | Owned | Owned, with outstanding loan | Rented furnished | Rented un-furnished | Used free-of-charge |
|---|---|---|---|---|---|
| **60-69** | 21.6 | 2.6 | 16.8 | 27.5 | 23.3 |
| **70+** | 12.6 | - | 20.8 | 16.4 | 17.7 |

Source: NSO. 2003a

## 1.9 Working and caring

During the past thirty years, there has been a growing tendency on the part of a greater number of women to take up employment in the formal sector and to hold on to their job even after marriage, combining their family commitments with their outside work. (Troisi J. 1996, Tabone C. 1987). Today's Maltese men and women enjoy equal access opportunities to employment with the result that no discrimination exists at law in this respect. However, it is to be admitted that, women are still insufficiently represented in the labour market in Malta. In fact, the local female labour rate participation is perhaps the lowest in Europe. Less than 31 per cent of the Maltese females aged 16-64 were gainfully employed according to national statistics for December 2002 (NSO. 2003c COS. 2000b). Moreover, when one looks at the age cohort among the 22 year-olds, almost six out of every nine Maltese women are gainfully employed in full-time jobs. There is a sharp drop in ratio when one takes into account other age groups.

The demands of combining paid employment and caring can create stress. Informal carers face considerable difficulties when trying to combine caring and employment (Micallef T. 2001). This is the case especially for middle aged and elderly workers. As married women finish with their child caring responsibilities, they are faced with the additional responsibility of having to provide care to a dependent elderly family member. While employment might ideally make a welcome contribution to household income, the double strain of work and caring, may prove to be too great and sometimes unbearable.

Researchers have shown that, especially among the elderly carers, the sense of the constant responsibility and awareness of the guilt they would feel should anything happen to the cared elderly relative in their absence, are very predominant (D'Amato R. 1995. Micallef T. 2000). However, with the improvement in the communication systems in general and the introduction of the Telecare Service specifically, younger caregivers are becoming more open to look for paid employment. In fact a number of carers who went out to work seem to experience less conflict in respect to caring.

## 1.10 General employment rates by age (part time/full time/ self-employed) for general population (special focus on women aged 45+) but if rates available for carers then they should be stated.

According to the Labour Force Survey (NSO. 2003c) in the month of December 2002, the total economically active population stood at 148,403. This was composed of 102,120 males and 46,283 females.

As illustrated in Table 14, the economically active population is still male dominated. They accounted for 68.8 per cent of the Maltese labour force while the females accounted for 31.2 per cent (COS. 2000b). Similarly, 67.2 per cent of the males aged 15-64 were employed. Compared to this only 30.2 per cent of the females in the same age group were in paid employment. The male-female proportion is reversed when one takes into consideration the non-economically active population. According to the 1995 national census, in the week preceding the Census, there were only 27.2 of all males aged over 16 who were not economically active. Compared to this, non-economically active females aged 16+ amounted to 74.0 per cent. The relatively low female participation rate may be attributed to a number of social and cultural factors. One may mention the traditional size of the average Maltese family, the lack of job opportunities in the past, etc. The dominating factor, however was the fact that the traditional Maltese woman was very much tied to her traditional roles, namely those of motherhood and domestic carer (Troisi J, Formosa M. 2002).

As can be seen in Table 15**,** 95.6 per cent of the economically active males had a full time job while only 3,392 persons or 3.3 per cent had a part-time job. Compared to this, 37,427 females or 80.9 percent of the economically active females had a full-time job compared to 12.2 per cent who registered a part-time job and the rest 6.9 percent having a full-time job with reduced hours of work.

**Table 14: Distribution of total employed persons in the Maltese Islands by age group and gender as on September 2002**

| Age group | Males | % | Females | % | Total | % |
|---|---|---|---|---|---|---|
| **15-24** | 16,069 | 15.7 | 13,955 | 30.1 | 30,024 | 30.1 |
| **25-34** | 23,488 | 23.0 | 12,325 | 26.6 | 35,813 | 24.1 |
| **35-44** | 24,142 | 23.7 | 9,566 | 20.7 | 33,708 | 22.7 |
| **45-54** | 27,103 | 26.5 | 8,039 | 17.4 | 35,142 | 23.7 |
| **55-64** | 10,338 | 10.1 | 2,222 | 4.8 | 12,560 | 8.5 |
| **65+** | 980 | 1.0 | 176 | 0.4 | 1,156 | 0.8 |
| **Total** | **102,120** | **100.0** | **46,283** | **100.0** | **148,403** | **100.0** |

Source: NSO. 2003c

**Table 15: Type of employment in the Maltese Islands by gender as on September 2002**

| Age group | M ales | % | Females | % | Total | % |
|---|---|---|---|---|---|---|
| **Full-time job** | 97,606 | 95.6 | 37,427 | 80.9 | 135,033 | 91.0 |
| **Full-time with reduced hours job** | 1,122 | 1.1 | 3,214 | 6.9 | 4,336 | 2.9 |
| **Part-time job** | 3,392 | 3.3 | 5,642 | 12.2 | 9,034 | 6.1 |
| **Total** | **101,159** | **100.0** | **46,283** | **100.0** | **148,403** | **100.0** |

Source: NSO. 2003c

## 1.11 Positive and negative aspects of care-giving (Carers' health problems and estimated needs for their own care and support; Emotional aspects; Elderly abuse etc.)

Although care giving has positive as well as negative effects on care givers, the focus is more on the negative effects of care giving. The role of the family care giver for a frail elderly relative is demanding, complex and frequently associated with negative health effects on the caregiver. It is an undeniable fact that caring for a dependent elderly family member can be stressful. Care giver burden is the term used to describe the negative consequences for caring for en elderly person (Flynn. 1999). These consequences include depression, psychological distress, lowered life satisfaction, interpersonal conflict, social isolation and stress-related physical health complaints. These strains very often threaten the very ability of the care giver to provide care over a long period of time. (Mifsud J. 1999) The experience of stress can vary. People may feel differently about the same situation at different moments in their caring life (European Consensus Conference. 2001, OECD 1996).

Among the various factors causing or leading to care giver strain, one finds the level of dependency of the cared-for person, especially the level of his physical, cognitive and social im-

pairment. The quality of the relationship between care giver and care receiver is also a determining factor of the level of strain. Furthermore, the care giver's gender, marital status, types of care provided, non availability of necessary assistance with care giving, as well as the extent to which the demands of care giving disrupt the carer's social and personal life also bear an effect on the level of strain of the caregiver. (Micallef T. 2000, D'Amato R. 1995)

The work of carers is often accompanied by considerable stress which can be classified under four main categories, namely: physical, emotional, social and financial. The daily work of caring for a dependent elderly person is a difficulty that the carer must cope with. Carers undoubtedly do experience a level of physical exertion in their daily living. Lifting up and down stairs, in and out of bed, bath, wheelchair, special cooking, feeding a helpless person, coping with incontinence and extra washing are some of the physical tasks of the carer. Female family carers of elderly relatives suffer financial burdens because they themselves cannot go out to work because of their caring task. A full-time carer of a demented or a mentally derailed elderly relative, or the one caring for a constantly bickering relative, or the one who finds no co-operation from the very relative whom he is caring for, often suffer from great emotional stress which could result in illness. This becomes more aggravated if the caring relative is the only carer and does not receive any support from friends or kin (Grixti J. 1999).

Some carers complained that their social life suffered as a result of their having to provide full-time care. Care giving left little for engaging in social and/or leisure activities. Others remarked that caring affected their relationship with their friends because they could not go out with them. It was also reported that, many times, care giving caused a great deal of quarrels and conflicts between the cared-for and the carer, and in the case of married carers between the carer and his/her family. As a result, life became unbearable due to a sense of divided loyalty

Research has shown that carers were better able to cope when siblings were also actively involved in the elderly parents' care. Support is especially important when these carers are passing through difficult times and start to experience stress. (Troisi J, Formosa M, Navarro M. 2004).

Although the negative effects of informal care predominate, one must not forget that, for some informal carers, caring for an elderly relative might also have positive effects or benefits. The benefits primarily come from emotional satisfaction. Religion is a major factor in the lives of the Maltese. The Maltese regard the Church and its values as a very important part of their lives and derive great comfort from its spiritual and material support. According to the research carried out by the European Centre of Gerontology, University of Malta, (Troisi J, Formosa M, Navarro M. 2004), for quite a number of family carers, the major motivating factors of care giving are attachment and obligation. Some of the family carers felt that they were caring for their elderly relatives out of responsibility, obligation, a sense of repayment for what their parents had done for them when they were younger and themselves in need of their parents' care and support D'Amato R. 1995). The feeling of filial piety prevailed as a result of deep-rooted religious values. Looking after their dependent parents gave the carers a sense of satisfaction. Loving others through caring was seen by some as a tangible way of being loved. In fact, the majority of the interviewed family carers, amounting to 78.7 per cent, remarked that seeing their elderly relatives happy and safe gave them a lot of satisfaction. 19.1 per cent claimed that caring for their dependent elderly relative was considered to be their duty.

The importance of respite care was highlighted. It can give the carers a breathing space to help them continue with the emotional and physical demands of care giving.

## 1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand.

There are no official data available on the subject of care services by migrants and legally or illegally employed persons.

However, it is worth pointing out that the Maltese Islands rank among the world's most densely populated countries in the world. During the last seventy years, there have been marked fluctuations in the overall density of Malta's population. In the 1931 census, the enumerated population resulted in a density level of 765 persons per square kilometre. This went up to 969 persons in 1948 to 1,013 in 1957 and 1,049 in 1985 (Camilleri R. 1993). As on the 26th November 1995, the national census day the population density of the Maltese Islands was of 1,200 persons to the square kilometre. Malta, the larger island had a population density of 1,417 persons to the square kilometre while the smaller island of Gozo, has a population density of 422 persons (COS. 1997b). This increased further to 1,257 persons in 2002 (NSO. 2003b).

The high population density has been a key element in Malta's migration history. The Maltese Islands have had a long history of outbound migration. During the two decades following the Second World War, between 1945-1965, there was a heavy migration from Malta mainly to Australia, Canada, UK and USA. This was mostly due to unsatisfactory economic conditions on the Islands during that period. It is estimated that between 1931 and 1980 no less than 155,000 persons left Malta to settle abroad (COS. 1986).

Migration has decreased drastically in recent years and inward migration has by far exceeded outward migration. Since 1975, given the considerable improvement in the country's economic conditions, the number of returned migrants has seen a steady growth, gaining momentum in the eighties and nineties (Gauci M. 2001). Thus, during the year 2002, there were 382 returning migrants as compared to 96 persons who left the island (COS. 1998c). The majority of these returned migrants were elderly persons thus increasing the rate of population aging.

Migration patterns may change noticeably in the future particularly as a result of membership in the European Union.

Another aspect on migration statistics which needs to be taken into consideration concerns clandestine migration. Notwithstanding the stringent measures which the Maltese authorities have been taking to curb illegal migration, this has increased dramatically over the past decade. During 2002, Malta had to cope with around 1,600 boat people. (NSO. 2003b). There is a shortage of reliable studies and data about this issue.

## 1.13 Other relevant data or information

The elderly in Malta are, in general, well supported and social security and welfare services are highly developed and progressive. Over the past decades the government of Malta and voluntary organisations have, through various policies, programmes and schemes, contributed to the care and well-being of the elderly. More than 50 years ago, the Old Age Pensions Act was brought into effect on 1st August 1948 providing for the payment of pensions to persons over the age of 60 years. This was not based on contributions but on a financial means test. In 1956, the National Assistance Act was introduced providing for social and medical assistance to the unemployed heads of households. Free medical assistance was also offered to those who suffered from a chronic disease. This Act also provided for free institutional care for the elderly as well as free hospitalisation and treatment in all government-run hospitals and institutions.

At the same time, The National Insurance Act was introduced. It provided for a comprehensive scheme of social insurance financed through contributions paid by the employee, the employers and the State. This compulsory scheme covered various contingencies including sickness, employment injuries/diseases, unemployment, widowhood, orphanhood and old age. In 1971, an annual bonus to all social security pensioners and recipients of social assistance. Three years later, a non-contributory pension scheme for persons with disability was introduced (Government of Malta. Ministry of Social Policy. 2004m, n, p, q, r). In 1979, a new contributory scheme for the payment of a wage/income related retirement pension was introduced within the National Insurance Act. A national minimum pension was introduced whereby any person claiming a contributory pension was ensured not to fall below a certain rate of pension provided he/she had a full contribution record to his/her credit. In 1987, the three Acts, namely the Old Age Pensions Act of 1948, the National Assistance Act and the National Insurance Act of 1956 were consolidated into the Social Security Act. (Government of Malta.Department of Social Security. 2003).

The family in Malta also benefits from a number of social security measures, including children's' allowance, family allowance, maternity leave, cost of living allowance, etc.

The majority of the Maltese elderly own their place of residence. Non-owners live in property with controlled rents. By and large, housing is of good standard. Almost all houses have adequate space and sanitation. One does not find evidence in Malta of conditions of poverty relating to the elderly. Health services are highly developed with free hospitalisation and environmental services. Personal health services are widely available and free for all. There is also a free drugs distribution service for low income persons as determined by a means test and for those suffering from a number of scheduled chronic diseases.

During the past two decades, especially with the appointment of a Parliamentary Secretary for the elderly, the need was felt for a radical change of perspective breaking the policy of segregation and replacing it with a strategy of enabling the elderly to participate in society to the greatest extent possible. The Maltese government started planning a wide range of policies and programmes to respond to the unique needs and requirements of the elderly and aimed at socially integrating them within their society. These national policies for the elderly were formulated within the wider national, economic and social development. Maintaining the elderly in the community in which they live became the accepted perspective of present social policy.

# 2 Care policies for family carers and the older person needing care.

The increased prevalence of care giving towards elderly persons is a relatively recent phenomenon in Malta, stemming from major social and demographic changes occurring throughout the second half of the past century. These changes include an unprecedented number of elderly Maltese persons (especially the 'old-old' who are most in need of assistance), and smaller and more diverse type of families. Moreover, one notes novel and more efficient types of medical technology that prolongs life without restoring functioning, and finally, new roles for women in the upcoming post-industrial type of Maltese society. The outcome of such socio-economic transformations engendered the care of elderly persons as a 'social problem'. As the number of older persons in need of care increased, families find it more difficult and are less able to assume this responsibility when compared to the not so distant past. In turn, it is reasonably expected that there would be increasing pressures on the public sector due to escalating expenditures for long-term care. It is to such a scenario that the national policy of the Maltese government on elderly care is attempting to come to terms with.

## 2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people.

Qualitative studies on caring for elderly relatives indicate that the care received comes from a variety of sources. Informal care is always the most preferred and frequently used source of assistance by elderly adults, formal care services also provide a good deal of support, especially amongst those who live alone or who have no family or friends to provide a service. Given a choice, the majority of Maltese elderly persons prefer receiving care and support from their family members and friends for as long as possible. An overview of local research on care giving and caring in later life locates the three following patterns of expectations by elderly persons who are in need of care :

1. The primary care giver as the main person in charge. When it becomes clear that an older family member requires some form of structured assistance, families go through a period of reorganisation as they restructure their lives. Frequently, one individual, whether by choice or convenience, becomes the primary caregiver. The job of the primary caregiver, although rarely specified, is to be the direct provider of the elderly person's care. The stressful nature of providing care caused many primary caregivers to seek assistance form other families, friends or service providers. However, it is understood by everyone, including the government authorities, that the primary caregiver is the main person in charge of the care. On the other hand, secondary caregivers typically are defined as individuals who provide unpaid or intermittent assistance.

2. A large majority of care givers remain very active in their caring role. Until recently, the tasks and responsibilities of care giving were thought to end once a care recipient was placed in an institutional setting. However, local research indicates that caregivers continue to remain very active in the lives of impaired family members once institutionalisation becomes necessary. Care givers of nursing home residents, for example, often perform many of the tasks they did while caring for their elderly relatives at home including assistance with eating, personal care, and walking. In fact, a large majority of care givers remain very active for many years after the initial placement has occurred.

3. Providing in-home care results in stress. In all studies one finds empirical evidence that the providing in-home care over a long term affects a caregiver's mental and physical health in a negative way. Caregivers are more depressed than age-matched controls, exhibit defects in physical mobility and immunological functioning, and use prescription drugs for depression, anxiety and insomnia more than the average rate. Care givers also report financial strain as a result of providing care over the long term (Mifsud J. 1999).

### 2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

Care of the elderly is an extremely complex matter and the elements of care are highly interdependent. The health and happiness of the elderly should not only be seen as dependent on the purely clinical aspects of physical and mental health. Equally important are the social, emotional and psychological factors. In the past, a number of countries especially those purely based on the Welfare State ideology had been more preoccupied with meeting the "humanitarian" issues of ageing directing their programmes mainly if not exclusively towards "protecting" the elderly especially those who were frail and dependent. Such an approach resulted in institutionalising the elderly. Here the elderly were expected to pass the last part of their life in security if not in comfort under the supervision of trained nursing personnel.

Various studies have shown that such a strategy was uprooting the elderly from their environment, separating them from their families and from the customs to which they were so deeply attached. This is why in both International Plans of Action on Aging, it was repeatedly stressed that institutionalisation should indeed be the last resort. It is also because of the need to integrate the elderly in mainstream society that the need was felt for a radical change of perspective replacing the policy of segregating the elderly with a strategy of integration, enabling them to participate the society to the greatest extent possible. The participation of the elderly within society necessarily and basically implies their actual involvement within the family. Care of the elderly in the family and in the community is becoming the accepted of present day social policy in a number of countries.

With the appointment of a Parliamentary Secretary for the Elderly in 1987, the reforms and improvements in the field of aging have all been based on the assumption that the family is the foundation of care giving in Malta. Social Policy in Malta is so much family-centred that Giacinto Giarchi remarked that "There can be few European countries with such a family oriented welfare policy as Malta" (Giarchi GG. 1996). Indeed, care is anything but a private matter in Malta as the country boasts of a high level of intergenerational support and reciprocity. Close contact and mutual exchange among parents, their adult children, and other kin persisted throughout the 21st century and in these first years of the millennium.

The welfare of the Maltese family is a primary political commitment of the government (Government if Malta. Department of Information. 1989). The challenges of population aging were to be seen in a social policy with a family oriented approach. To this effect the Government of Malta in 1989 organised a European conference on *Integrating Social and Family Policy For the 90s* (Vella CG 1990). However, the government is aware of the strain which the traditional Maltese family is passing through. The fall in the average size of the Maltese family has reduced the number of available family carers (Troisi, J. 1994). To further improve the quality of life of the elderly while at the same time supporting the family to continue being the main supporter of their elderly members, the government has developed an extensive network of community health and social services.

In addition, more older persons are immigrating to retire in Malta, creating an increase in demand for family support when frailty sets in. With the ease of migration now that Malta is part of the European Union, more younger Maltese emigrants are likely to be leaving Malta , leaving their elderly relatives behind and cutting back the number of potential family carers still more.

Maltese society is highly homogenous. Consequently the very limited number of ethnic minorities in Malta are hardly manifest. Moreover, they are considered to be integrated in mainstream Maltese society to such an extent that they do not support a different ideology from the rest of the population in the way their families take care/support their elderly members.

### 2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

According to the Malta Social Security Act (2004) the institutional definition of 'dependence' refers to an individual who "because of infirmity is bedridden or confined to a wheel-chair" (Government of Malta.Department of Social Security.2003). This definition is age-irrelevant. The carer of a dependent person and who is either single or a widow and who all by herself/himself and on full-time basis is entitled to receive Carer's Pension at the weekly rate of Lm30.44 (Euros 70) plus and an additional bonus of Lm1.34 (Euros 3) weekly and a six monthly bonus of Lm58 (Euros 133). At the same time, the dependant person qualifies to purchase

various products whilst being exempt from Value Added Tax. These include a number of : Bathroom / toilet equipment & accessories; buoyancy products; computers and accessories; dressing equipment; equipment for the visually impaired; hearing aids and accessories; household aids; incontinence products; kitchen, feeding & household equipment; leisure aids, lifts specially designed for disabled persons; lifters and accessories; transfer equipment; medicine aids; mobility aids and accessories; wheelchairs, chairs and accessories; orthopaedic beds and accessories; pressure relief equipment; transport facilities

### 2.1.3 Who is *legally* responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psychosocial support or similar)?

The Maltese Civil Code of Laws states the provision of care for elderly persons in need of help in daily living depends on the marital status of the persons needing care. Primarily, if the latter is married, then the first responsibility for providing care falls on his/her spouse. In fact, Article 3 of Chapter 16 of the Civil Code states that "both spouses are bound, each in proportion to his or her means and of his or her ability to work whether in the home or outside the home as the interest of the family requires to maintain each other an to contribute towards the need of the family" (Civil Code, 2004 : 110). As to what constitutes 'maintenance' Article 19, paragraph 1 states "maintenance shall include food, clothing, health and habitation" (Civil Code, 2004 : 113).

However, here one must note that Article 16 adds that "the duty of one spouse to maintain the other shall cease if the latter, having left the matrimonial home, without reasonable cause refuses to return thereto" (Civil Code, 2004 : 111). Hence, the husband or wife are only legally bound to take care of each other if they live in the same house. At the same time, any or both of the spouses have a right to be cared for by any descendants of the family (Government of Malta. Ministry of Justice. 2004c).

Article 8 within the same Chapter clearly states that "the children are bound to maintain their parents or other ascendants who are indigent". According to the Maltese Civil Code children are entitled to inherit their parents. This can be seen as a recompensation for the care which children gave to their parents when in need.

Moreover, the laws mean that no family member is legally entitled to care for unmarried or widowed older persons with no children. In such situations, it is the responsibility of the government to maintain and see that the needs of indigent elderly persons are met. This is performed through the various agencies and services provided by the government's welfare services.

### 2.1.4 Is there any relevant case law on the rights and obligations of family carers?

In connection with what was said in **2.1.3.** Article 13 (1) of the Maltese Civil Law states that “nevertheless it shall be lawful for the court, in urgent cases, to condemn any of the persons liable for maintenance, in whatever degree, to supply maintenance, reserving to such person the right to claim reimbursement from such persons as, according to the said order, were bound to supply such maintenance“.

Notwithstanding this, the number of case laws regarding the rights and obligations of family carers as to be found in the court registers during the past 10 years is indeed negligible.

### 2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits etc.)

Academically, the terms 'elderly persons/adults' and 'aged' have a distinctively qualitative meaning. Generally, the use of 'chronological age' as a method to differentiate elderly persons from the rest of the population is deemed as inadequate since such an approach neglect other significant social factors such as relations and biographies. Indeed, the terms 'elderly persons/adults' and 'aged' are used frequently to refer to people, whatever their chronological age, who are retired from paid employment However, such an approach may be confusing for social policy makers who use age to decide who qualifies or not for special services. The Government of Malta deems the passing of the 60th and 61st birthday - for women and men respectively - as the beginning of old age. This is the legal age of retirement. Aware of the rapidly growing absolute and relative weight of elderly persons in Malta, the government is expected to raise the legal age of retirement very shortly.

## 2.2 What national policies (general principles, orientation, action plans) currently exist for:

### 2.2.1 Family carers?

The government of Malta is aware that family carers play an enormous role in the lives of elderly dependent persons, the majority of whom live in the family home. In fact, the government asserts that there needs to be a wider recognition of the support that the in formal carers themselves need, whether financial, practical or emotional - as well as greater appreciation of their role as partners with professionals in seeking to enable people with learning disabilities to lead full lives.

### 2.2.2 Disabled and/or dependent older people in need of care/support?

The officially recognised disability policy in Malta is expressed in guidelines adopted by the Government, and in guidelines adopted by a national commission for persons with a disability (National Commission Persons with Disability 2003. 2000) The emphasis is on the social integration of these persons into mainstream society (Troisi J. 1992). In Malta, the rights of persons with disabilities are, protected by general legislation. The general legislation applies to all persons with different disabilities (WHO. 1980) with respect to: education, employment, political rights, and property rights (Kummissjoni Nazzjonali Persuni b'Dizabilita'. 1995, Government of Malta. 1969) .

The government has also enacted laws and regulations and set up a national authority so as to ensure accessibility of the build environment. The following measures have been promoted to facilitate accessibility in the build environment: levelling of pavements, marking parking areas (Government of Malta.Ministry of Social Policy. 2004a5) , improving accessibility in housing (Government of Malta. Ministry of Social Policy. 2004a10, 2004a11), financial support for the costs of adapting private buildings to the needs of persons with disabilities (Government of Malta. Ministry of Social Policy. 2004i, 2004j) and specially adapted motor vehicles. Special transport arrangements for persons with disabilities are provided for by a foundation for specialised transport at subsidised prices and available for the purposes of education and work.

### 2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

The Maltese government is highly aware of the need for the setting up of 'family-friendly' policies and practices in order to support employees who also have caring responsibilities for elderly persons (Vella CG. 1990). Indirectly, a number of community services dealt with in section **4** of this report especially, Day Care Centres and Telecare Service do help informal carers to maintain their caring role while also having paid employment. Notwithstanding this, however, there are no formal measures granting special rights as special leave, job sharing, etc to the gainfully employed family carers.

## 2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

With a geographical area of 316 square kilometres and a population of less than 400,000 inhabitants, Malta is the smallest country within the European Union. Consequently all policies are promulgated and passed by the national government. There are no different legal frameworks and no local or regional policies.

Notwithstanding this, however, on 30 June 1993, the Local Councils Act, 1993 (Act XV of 1993) was published modelled on the European Charter of Local Self-Government. Six years later, on 21st December 1999, this Act was considerable amended by Act No. XXI. In the Laws of Malta, the Local Councils Act is referred to as Chapter 363. (Government of Malta.Ministry of Justice. 2004a, 2004b). There are 68 Local Councils in the Maltese islands each of which has an administrative role. Many of these Councils have an elected member who is responsible for ensuring the smooth running of services for the elderly in the locality and for organising activities for them from time to time.

All aspects of social welfare are in the hands of the government and thus follow a nation-wide form of regulation.

## 2.4 Are there differences between local authority areas in policy and/or provision for family carers and/or older people?

As mentioned in section **2.3**, although the Maltese Islands are divided into 68 Local Councils, these do not have any policy-making powers. They are in fact local administrators of policies passed at the national level. Hence there are no differences between these Local Councils in policy for family carers. However, there exists the possibility of differences between local authority areas in the provision of activities for family carers and/or elderly persons. One must note that entry to community residential homes is given priority to an elderly person who lives in the respective community area. Similarly it is the government's policy to set up Day Care Centres in collaboration with the Local Councils. In fact, it is a particular Local Council which requests government to start discussions on opening a Day Centre in the locality. In the majority of cases, it is also the Local Council which makes available and furnishes the premises.

# 3 Services for family carers

Over the past decades, the government of Malta and Voluntary Organisations have, through various policies, programmes and schemes, contributed to the care and well-being of the country's elderly population. Although the majority of these programmes and services are geared m

mainly to improve the quality of life of the elderly, there are also a number of programmes and services which are directly and/or indirectly aimed at supporting the family carers of elderly persons.
Among the programmes aimed at directly supporting family carers one finds: 1) the Carer's pension; 2) Social Assistance for Females taking care of a sick or elderly relative; 3) the Social Work services and 4) Training. Since the first two schemes will be dealt with in section 5.7.1. only schemes 3 and 4 will be dealt with here.

Social Work Services: The aim of the social work unit is to provide psychological counselling, guidance and assistance. It deals with social casework, provides advocacy, facilitates self-help management and develops action plans. It also performs crisis intervention work, provides assessment for residential homes and assessments of Carer's Pension (De Lucca E. 1991). It liases with the geriatric, general and rehabilitation hospitals, the health department, police, local councils and other community organisations. (Government of Malta. Ministry of Social Policy. 2004h).

The social work service at St.Vincent De Paule Residence offers a wide variety of services to the elderly residents and their relatives. (Government of Malta. Ministry of Social Policy. 2004c) The service helps the elderly to adapt and to adjust in their new residence, identifies any social problems which the elderly and their relatives might have and motivates them to cope with these social problems. (Government of Malta. Ministry of Social Policy. 2004f)

The social work service at St.Luke's hospital helps patients and their families to cope with physical and emotional trauma caused by their being admitted to hospital. (Government of Malta.Ministry of Social Policy. 2004e). The social work service at Sir Paul Boffa hospital forms part of a multi-disciplinary team which provides supportive service to people with cancer or motor neutron disease and to help and support their families. (Government of Malta. Ministry of Social Policy. 2004a). Social Work services are also offered within the Social Housing Department (Government of Malta. Ministry of Social Policy. 2004d) and some of the Day Care Centres (Government of Malta. Ministry of Social Policy. 2004g).

Training: The Training Unit in the Skills Centre at the Employment Training Centre offers training programmes covering fundamental issues concerning carers, both formal and informal, of elderly persons. These training programmes, consisting of five sessions of three hours each, are provided at different levels. These are taken as step by step format (Mifsud J. 1999) The topics for the training programmes are: Knowing the elderly; Understanding the true role of the carer' Caring for the frail elderly; The dependant client; and Co-ordinating Care.

| Services for family carers | Availability | | | Statutory | Public, Non statutory | Voluntary | | Private |
|---|---|---|---|---|---|---|---|---|
| | Not | Partially | Totally | | | Public funding | No public funding | |
| Needs assessment (formal – standardised assessment of the caring situation) | | X | | X | | | | |
| Counselling and Advice (e.g. in filling in forms for help | | **X** | | X | X | X | X | |
| Self-help support groups | **X** | | | | | | | |
| "Granny-sitting" | X | | | | | | | |
| Practical training in caring, protecting their own physical and mental health, relaxation etc. | | X | | | | X | X | |
| Weekend breaks | X | | | | | | | |
| Respite care services | | X | | X | | | X | |
| Monetary transfers | X | | | | | | | |
| Management of crises | | X | | | | | | |
| Integrated planning of care for elderly and families (in hospital or at home) | | X | | X | | | | |
| Special services for family carers of different ethnic groups | X | | | | | | | |
| Other | X | | | | X | | | |

## 3.2 Briefly describe any examples of:

### 3.2.1 Good practices

As discussed earlier, the various efforts of the government to improve the care services given to the ever growing numbers of elderly persons aimed at helping them to remain in the community for as long as possible and also to support their family carers, are being significantly complemented by the sterling services provided by a number of voluntary organisations. The fact that most of the voluntary endeavour is under Church auspices helps to a large extent to avoid the difficulties experienced in other countries, where the very plethora and variety of organisations often makes it difficult to secure effective co-ordination (Williamson J. 1982)

#### 3.2.1.1. Caritas (Malta)

The main source of voluntary action in the field of aging is through Caritas Malta. It gives two kinds of support to carers of elderly persons, namely information and formation. Caritas informs the carers about the existence and availability of services for the elderly being provided by the State, the Church, other voluntary organisations and the private sector.

In its formative role, Caritas, has, since 1996, been organising training programmes for family carers who care for an elderly relative at home. Guided by the Christian outlook on care giving,

Caritas firmly believes that the place of the elderly is in the family and, therefore, family carers need support of specific programmes which will enable them to give real and effective support to their elderly relatives.

Each programme called "Care for Carers" is open to all carers. It consists of nine sessions aimed at supporting the carers by, among others, helping them to reduce stressful situations, improve communications, provide care in a more effective and efficient manner, etc. The themes covered include: communication skills; stress and strain management; time management; dealing with guilt feelings. Through group workshops, these programmes provide opportunities for carers to exchange experiences and discuss the management of problem behaviour and difficulties; allows relatives to express feelings of sorrow, guilt and anger; offers self-help; supplies information and advice. These training programmes have been an effective means in terms of the emotional support provided by carers.. (Mifsud J. 1999, Seychell A. 1998)

#### 3.2.1.2. Cana Movement

The Cana Movement (another Church organisation) also supports informal carers of elderly relatives through the running of monthly training programmes similarly called "Care for Carers". The topics dealt with include, solitude and loneliness; first aid; spirituality; technical aids and equipment; need of communication between the carer and the elderly person being cared for and also how this can be effected; personal hygiene; existing services for older persons and how to make use of them; caring for demented persons and for those who are mentally disabled.

#### 3.2.1.3. Malta Memorial District Nursing Association (M.M.D.N.A.)

As already pointed out, notwithstanding the difficulties and strain which the informal carers face in proving care for their elderly relatives and the changes which the family is undergoing, it is the family which offers the majority of care to its elderly members. It is only in cases when the family can no longer cope with the situation that institutionalisation is resorted to. One of the main difficulties which family carers often face is their inability to offer nursing care to their frail elderly relatives. It is precisely in this regard that the work carried out by the Malta Memorial District Nursing Association (MMDNA) is beneficial not only to the elderly but also to their family carers.

Under contract with the Health Division of the government of Malta, this non-governmental nursing association is responsible for co-ordinating all government domiciliary general nursing services throughout Malta. The range of services given can be classified under 4 main categories, namely: 1) general care which includes blanket baths, prevention and treatment of bed sores, enemas, wash-outs, dressing of wounds, stoma care, and toe nail cutting, 2) surgical dressings; 3) injections (other than intravenous); and 4) diabetic care. It does not include physiotherapy, chiropody and sitting in service with patients. However, the Association may help a person to contact a private nursing agency to provide a nurse for a patient, by day and night on payment. Requests for this 7 day week service come from private and government general practitioners as well as, in the case of patients discharged from hospital, from hospital doctors.

During 2003, the total number of visits carried out under the contract with government was 372,422. This means that an average of 1,020 visits were carried out daily. As expected, this service which is run by a staff complement of 60, the majority of whom are qualified nurses, is highly involved in the care of the elderly who form the majority of the patients visited. During 2003, the elderly took up 86.7 percent of all the services offered by MMDNA during that year.

#### 3.2.1.4. The Malta Hospice Movement

The Malta Hospice Movement is a private voluntary organisation inspired by Christian values which exists to provide and promote the highest possible standards of palliative care for persons with cancer or motor neurone disease and to help and support their families. The aim of the Movement, which was founded in 1989, is to enhance the patients' well-being and quality of life, to help them live as fully as possible until they die and to support their families during this difficult time.

During the past 15 years, the Movement has developed the following services which can be classified into 5 main categories: 1) Home Care which includes respite nursing, physiotherapy, hydrotherapy, occupational therapy, complementary therapies, psycho-social and spiritual support; 2) Day Therapy, which includes regular nursing assessment, assisted bathing, salon services, and divisional therapy; 3) Hospital Support; 4) Loan of Specialised Equipment; and 5) Bereavement Support.

The services are delivered by fully qualified professional staff and are complemented by dedicated and trained volunteers. These services are provided free of charge. Although cancer does not have any age, statistics issued by the Department of Health, show that the incidence of cancer is more prevalent among the elderly. During 2003, 328 patients were newly referred to Hospice. Of these, 74 per cent, or 242 patients, were over 60 years of age. Furthermore, a little over half of the other 26 per cent were in their late 50s. (Malta Hospice Movement. 2004)

# 4 Supporting family carers through health and social services for older people

In Malta, health and social services have developed side by side. In 1987, a Parliamentary Secretariat for the Care of the Elderly was set up within the Ministry for Social Policy with the aim of brining to the fore, implement policies and co-ordinate services directed towards the needs of the elderly in the country. Social services in Malta include, among others, counselling, day centres financial support for the elderly person and his family, handyman service, home adaptation and maintenance, home help, incontinence service, meals on wheels, residential services, social work, Telecare Service, and telephone rebate service. Closely linked are the primary health care services, domiciliary nursing, etc.

The provision of integrated health and social care of the elderly in the community enable the elderly especially the lonely and the disabled to maintain good health and to lead independent lives within the desirable environment of their own family and community.

## 4.1 Health and Social Care Services

In 2001, around one-sixth of Malta's GDP was absorbed by social security expenditure (Government of Malta.2003). Public health care is also significant. The Maltese benefit from free complete hospital and clinical services paid for by the Maltese government. The World Health Organisation highly commended the quality of the health services offered in Malta (WHO 2002). Consequently, the demand for private health care services is relatively low.

### 4.1.1 Health services

In Malta there is a comprehensive health service provided by government to all Maltese residents. This health service, which is entirely free at the point of delivery, is funded from general taxation. In Malta there is no obligatory "Health Insurance". All workers and employers pay national insurance contributions on a weekly basis, but this money goes to finance welfare services in general and not health services in particular. The government recurrent expenditure for health services, in 2003, amounted to Lm 28.6 million (Euros 66 million). This amounted to 26.44 per cent of the total recurrent expenditure (Government of Malta, Ministry of Finance. 2004).

All residents have access to preventive, investigative, curative and rehabilitative services in government health centres and hospitals (Xerri RG. 1998). Persons with a low income who wish to obtain free medicines from the government hospital must undergo a 'means test' . If they qualify for assistance they are given a pink card which entitles them to free pharmaceuticals. This card also entitles the holder to free dentures, spectacles, hearing and walking aids. Moreover, a person who suffers from one or more of a specified list of chronic diseases is also entitled to receive free treatment for his/her ailment, irrespective of financial means (Government of Malta. Ministry of health, the elderly and community care. 2004a).

The Minister of Health is over all responsible for the health services. The Permanent Secretary is the administrative head within the Ministry. The Director General manages the Health Division supported by a management team of Directors for the nine Departments, including Finance and Administration, Health Information, Health Policy and Planning, Health Promotion, Human Resources, Institutional Health, Primary Health Care, Public Health and Nursing.

The Department of Health Promotion which encompasses the Health Promotion Unit and the Nutrition Unit coordinates national health promotion activities. Several preventive programmes are run on a national scale including free immunisation covering a wide range of illnesses such as: diphtheria, HiB, measles, mumps, polio, pertussis, rubella, tetanus and tuberculosis. Health Centres provide extensive preventive services including, routine blood pressure and cholesterol check-ups, ophthalmologic check-ups smoking cessation clinics, screening for diabetes, and Well Baby clinics and Well Woman clinics.

The Department of Public Health consists of a number of branches including health protection, disease surveillance, environmental health, food safety and public health laboratory services. It aims to maintain a healthy physical and human environment through a combination of appropriate regulatory and preventive interventions.

There are 1,084 registered physicians living in Malta. 53 per cent of whom, or 578, are in government service. Of the 150 registered dentists, 47 are in government employment. There are 710 registered nurses, 624 enrolled nurses and 90 midwives in full-time employment with government. Other Para-medicals employed full-time by government include 102 pharmacists, 93 pharmacy technicians, 97 physiotherapists, 42 occupational therapists, 24 dental hygienists and technologists, 148 medical laboratory technologists and 58 radiographers. (Government of Malta, Ministry of health, the elderly and community care. 2004e.)

#### 4.1.1.1 Primary health care

- Community and homecare teams (e.g. doctor, nurse, health visitor, physiotherapist etc.)

The government delivers primary health care mainly through the eight health centres which are spread all over the Maltese Islands, 7 of which are to be found in Malta and 1 in Gozo. They offer a full range of preventive, curative and rehabilitative services. Besides the general practi-

tioner and nursing services, various specialised health services are provided including antenatal and postnatal clinics, immunisation, dental services, Well Baby clinics, diabetes clinics, ophthalmic clinics, psychiatric clinics, paediatric clinics, podology, physiotherapy, speech therapy and language pathology clinics. A general practitioner service is provided free of charge in each of these health centres Although these centres are open to all sections of the population, those aged 60 and over are among the highest users (Buttigieg T. 1995).

Four of these health centres offer a 24 hour service although the general practitioner service switches over to 'emergencies only' between 5.00 pm and 8.00 a.m. weekdays and from 1.00p.m. Saturday to 8.00 a.m. Monday. The other four open all day but close at 8.00p.m. from Monday to Friday and from 1.00p.m. Saturday to 8.00a.m. the following Monday with the general practitioner service stopping at 5.00p.m. During 2003 there were 60 general practitioners employed on a full-time schedule with another 10 available on reduced hours, an average of 9 general practitioners per health centre. (Government of Malta. Ministry of health, the elderly and community care. 2004d).

General practitioners hold clinics regularly at each of the 47 government district dispensaries spread throughout the Maltese Islands, 36 in Malta and 11 in Gozo. A nurse is also in attendance. The clinics are held between Monday and Friday in the morning. This service provides basic medical and nursing services as well as a postal system for the distribution of routine monthly medical prescriptions.

The School Dental Clinic provides a complete dental service to children under 16 years of age. The School Health Service is an integral part of the child community service designed to meet the health needs of school age children. It provides a monitoring and surveillance programme within mainstream public, church schools and special schools with an emphasis on early detection of disease and physical defects, health promotion and disease prevention. It includes medical review of children at school entry and at the ages of 8 and 12 as outlined in the school health surveillance programme.

- Other home care health services (dental care services at home, home chiropody service, home lab tests etc.)?

Requests for domiciliary visits may be made by phoning up the health centre corresponding to the patient's area of residence. Between 8.00 p.m. and 8.00 a.m. only urgent consultations are carried out.

The Government's health centre system works side by side with a thriving private sector. Many Maltese opt for the services of private general practitioners and specialists who work in the primary care setting. A number of Maltese families choose to make use of private general practitioners whom they adopt as their own family doctor and on whose services they can rely during the day and night for a very modest fee. It is estimated that there are around 400 general practitioners who work in the private sector as family doctors.

Community nursing services in Malta are made available through the Malta Memorial District Nursing Association (MMDNA) (Malta Memorial District Nursing Association. 2004. 2003). As explained in section **3.2.1.3**. this non-profit making organisation which employs qualified staff as well as other health carers, provides general nursing services including general care of patients, blanket baths, prevention and treatment of bed sores, toe nail cutting, injections (other than intravenous), enemas, wash-outs, dressing of wounds, catheterisation, nursing care and treatment of diabetics both to its members as well as to all the Maltese community on behalf of the Health Division.

The physiotherapy, speech therapy and occupational therapy departments of St.Vincent de Paule Residence for the Elderly offer free home services in these specialities for those in need. Furthermore, a number of health care professionals including, physiotherapists, speech therapists, occupational therapists, nurses, etc. privately offer their services at a remuneration to those patients who ask.

#### 4.1.1.2 Acute hospital and Tertiary care

- General provision for older people

The objective of the Government hospital services is to provide diagnostic treatment and other medical care services from hospitals on an in-patient and out-patient basis. The total bed capacity of the government hospitals is around 2,000. The hospital services are centred around St.Luke's hospital which provides a full range of services. The hospital has a well equipped admission and emergency department, physiotherapy and speech therapy, acute psychiatric in-patient and out-patient treatment, and departments of general medicine and surgery. Among the general specialities provided, there are E.N.T., intensive cardiac and coronary care, metabolic ward, intensive therapy, orthopaedic, ophthalmology, paediatrics, obstetrics and gynaecology, neurosurgery, urology, and renal unit. There is also a hyperbolic unit, an infectious disease control unit, and a national blood transfusion centre. The hospital also provides facilities at the out-patient department. There is a diabetic clinic which caters for the high percentage of diabetic patients in Malta, the majority of whom are over the age of 50. Extensive laboratory and radiology back-up are available within the hospital. St.Luke's also provides transplant surgery and open heart surgery. The average length of stay in a general medical ward at St.Luke's is 6 days, while in a general surgical ward it is 5 days. For Gozo there is a separate acute hospital with 259 beds and only those patients requiring very specialised treatment are referred to St.Luke's.

Psychiatric care is provided at Mount Carmel hospital which has 563 beds for short and long stay and at a smaller unit in Gozo. There is another hospital, Boffa Hospital, with 85 beds. It is a cancer and skin hospital which houses the radiotherapy and oncology department, the dermatology department and the genitourinary clinic. (Government of Malta. Ministry of Health, the elderly and community. 2004f)

Although St.Luke's hospital provides secondary and tertiary care to the whole population, it constitutes the main source of hospital care for elderly persons who are admitted into the general specialities suffering from acute or sub-acute illnesses. In fact the age composition of patients in the acute medical wards at St.Luke's shows a high percentage of elderly persons especially females.

There are also two private general hospitals in Malta with a capacity of 173 beds. Although neither the government nor the private sector have issued any statistics regarding the utilisation of private hospitals, there is no doubt that the number of elderly persons making use of private health services has been increasing steadily. Both hospitals firmly believe in having the latest technology available. Of interest to this study is that St. James Hospital has recently opened two new branches as out patients diagnostic and prevention centres. These branches are fully equipped with the latest technology and treat a number of specialities.

The government has embarked on the building of a new 850 bed teaching hospital next to the University of Malta. It is expected to start functioning in 2005 and will eventually succeed St.Luke's Hospital in the provision of acute secondary and tertiary services.

Hospital services and health facilities in the Maltese Islands enjoy a reputation of efficient caring service to the extent that they have been ranked very high by the World Health Organisation (WHO 2002).

**Table 16: Acute care analysis including number of hospital beds, physicians, admissions per 100 Maltese population as on 30th April 2004**

| | Hospital beds per 100 | Total number of hospital beds | Physicians per 100 | In-patient care admissions per 100 | Average length of stay, all hospitals | Average length of stay, acute hospitals |
|---|---|---|---|---|---|---|
| **2004** | 1.934 | 2,000 | 3.57 | 2.15 | 6.0 | 5.0 |

Source: The Medical Association of Malta, 2004. The Government of Malta, Ministry of Health, the elderly and community. 2004f.

- Are there special Geriatric facilities (Geriatricians, geriatric beds, assessment units, rehabilitation units etc)?

Following the establishment of a Parliamentary Secretary for the Care of the Elderly and the setting up of a Department for the Care of the Elderly in 1987, work started in converting a former private hospital run by a religious organisation of nuns for medical, surgical and maternity cases with a complement of 109 beds into a specialised geriatric hospital. The new 60 bed government hospital, known as Zammit Clapp Hospital (ZCH) was officially opened on the 26th September 1991. The aim of this hospital is to concentrate on those frail elderly patients requiring assessment, management and rehabilitation by an interdisciplinary team, so as to enable them to return to live in their own homes (Council of Europe). As clearly stated in the mission statement, "the staff of ZCH works with the patients and their carers in an interdisciplinary team approach within a high quality atmosphere, conducive to learning and to continual development which promotes rehabilitation for the older persons to regain maximal independence for reintegration into society" (Zammit Clapp Hospital. 2003)

As can be seen in Table 17, during 2002 there was a total of 936 admissions, 52 per cent of which (486) being direct transfers from St.Luke's Hospital. 65 per cent of those admitted, or 609 cases, were females, as compared to the 327 males or 35 per cent. The mean age of those admitted was 79. The mean bed occupancy was 98 per cent whilst the mean length of inpatient stay amounted to 22 days.

As regards to placement outcome on discharge, 66 per cent of those who had been admitted returned to live in their homes whilst 3.2 per cent were transferred to St.Vincent de Paule Residence for Elderly Persons. 16 per cent returned to, or were newly admitted into residential or nursing homes. The two most common main diagnosis for inpatients were strokes (16.7 per cent of admissions) and post fracture femur surgery (14.6 per cent of admissions).

**Table 17: Zammit Clapp Hospital patients' data between 1996 to 2002**

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|---|---|---|
| **Inpatients** | 1,072 | 981 | 917 | 1,030 | 1,010 | 1,002 | 936 |
| **Total admissions** | 80 | 79 | 79 | 80 | 80 | 79 | 79 |
| **Mean age (years)** | 20 | 18 | 21 | 20 | 21 | 21 | 22 |
| **% admissions from SLH** | 53 | 58 | 80 | 53 | 51 | 52 | 52 |
| **% discharged to own home** | 80 | 75 | 73 | 77 | 74 | 69 | 66 |
| **% monthly mean occupancy** | 95 | 92 | 95 | 98 | 98 | 98 | 98 |
| **Day Hospital Patients** | | | | | | | |
| **New Patients seen** | 676 | 713 | 685 | 711 | 755 | 825 | 762 |
| **Total attendances** | 4,953 | 5,814 | 7,120 | 7,188 | 6,880 | 6,749 | 6,382 |
| **Daily Mean attendances** | 21 | 23 | 28 | 26 | 28 | 23 | 25 |
| **Consultations** | | | | | | | |
| **Total patients assessed** | 868 | 863 | 1086 | 941 | 914 | 919 | 927 |
| **% Patients transferred** | 65 | 66 | 67 | 58 | 58 | 59 | 54 |

Source: Zammit Clapp Hospital. 2003

The mean Barthel Activities of Daily Living Index, which is taken as a reflection of functional dependence, increased from 7.1/20 on admission to 10.8/20 on discharge. This increase of 3.7 suggests that the functional abilities of the patients admitted were significantly improved as a result of the treatment received at ZCH. However, as can be seen in Table 18, the mean discharge ADL index is less than that recorded for the previous two years.

**Table 18: The mean Barthel ADL Index for the years 2000-2002**

| | 2002 | 2001 | 2000 |
|---|---|---|---|
| **Admission index** | 7.1 | 7.5 | 8.1 |
| **Discharge index** | 10.8 | 11.4 | 11.3 |
| **Increase index** | 3.7 | 3.9 | 3.2 |

Source: Zammit Clapp Hospital. 2003

During 2002, the hospital had a staff complement of 213 persons. This included 6 fully qualified geriatricians, 114 nurses, 11 occupational therapists, 8 therapists, 5 social workers. As expected, given the high quality of service being offered to the elderly at ZCH and the staff com-

plement employed, running the complex is a costly affair. It is estimated that the cost per bed per day at ZCH is between Lm 65-70 (Euros 150-160). Notwithstanding this, the service given is free of charge for all irrespective of the economic means of the patients.

ZCH is divided into a number of departments including nursing, physiotherapy, speech pathology, occupational therapy, social work, pharmacy and activities. As already pointed out, the members of each department work as a multi-disciplinary team. Following discharge, patients and their carers are visited at home by the staff nurses. The aim of such visits is to ensure that patients are coping well in the community. The visits also serve to offer advice when required. It is important to note that community nurses have a specialised role in which they not only deal with the patient but also with the family members/carers. Their responsibilities include educating and giving advice on the delivery of nursing issues including bathing and dressing, prevention of pressure sores, handling and transferring of patients, etc. During 2002, there were 553 such home visits carried out by the community nursing team.

The physiotherapy services were provided to all admitted patients according to goals set on initial assessment and through continuous evaluation. This was done in collaboration with the inter-disciplinary team. During 2002, the Speech and Language Pathology Department catered for 241 patients, the majority of whom were stroke patients. During the same year, 5,495 treatment sessions were carried out by the staff of the OT department (Scerri C. 1997). In liaison with the Physiotherapy and the Speech and Language Pathology Department, the OT department organised a number of dementia classes for the patients.

ZCH has a well equipped modern laboratory and pharmacy. The complex serves as a centre for the distribution of medicine both to inpatients as well as to outpatients. The standard of ZCH Social Work Practice requires the social workers to screen clients in an effort to prioritise their caseload. In order to enhance the building of a reciprocal relationship, and to establish client expectations, wishes, needs and concerns, each patient and his family/carers receive an assessment by a social worker. This also serves for the development of an effective and timely plan of action.

During 2002, ZCH continued to provide respite care service when this was considered appropriate and possible. In fact, 4.3 per cent of all admissions (40 cases) were solely for respite purposes. The mean age of the 27 females and 13 males who were admitted for respite purpose was 82 years, ranging from 64 to 94 years. Their average stay was 14.3 days, ranging from 1 to 34 days. Although their stay was usually meant to be for 14 days, some stayed longer because they developed medical complications or because their carer remained unwell. In fact ,4 admissions were due to the fact that the carers were themselves unwell, 27 were to give carers a break and 9 were to enable the carers to go abroad.

The complex also serves a day hospital. Besides the normal outpatient care, it gives regular and full clinical attention to those elderly patients who are not hospital bound. The total number of attendances recorded during 2002 amounted to 6,382. Clinics at the day hospital included the Memory, Dementia, Psychiatric, Parkinson's Class and Nutrition. The physiotherapy service was attended by 30 patients a day. During 2002 there were 4,300 treatment sessions for 1,632 patients, 579 males and 1,053 females.652. Apart from all this ZCH therapists also carry out home visits. As a result of this service the patient is not only receiving a high quality care but he is also enabled to continue living as much as possible a normal type of life at his own home and environment.

ZCH also provides teaching services in the field of geriatrics, consisting of clinical placements, tutorials and site visits. Students from all health disciplines both Maltese are foreign, attend

regularly for tutorials and clinical placements. Staff professional development is considered as essential ensuring a high standard of care (Zammit Clapp Hospital. 2003).

The percentage rates of elderly persons in Gozo are higher when compared to those of Malta. In 1985, there were 5,079 persons or 20.3 per cent of Gozo's total population of 24,994 persons, who were above the age of 60 (COS. 1987. 1986). Ten years later, their number increased to 5,477. In March 2001, their number further increased to 6,475, as much as 22.4 per cent of the total population (NSO, 1998, 2002).

A new wing of the Gozo General Hospital was opened with 120 geriatric beds. There are two wards one for females and the other for males. As on 31st December 2003, there were 60 female residents and 39 males all above the age of 60. 88 percent of the residents ( 87 persons) were aged 75 and above. Among the 60-74 age group, there was an equal number of males and females. However, among the 'old old' 62 per cent were females. These are admitted because of a number of reasons including a high incidence of chronic diseases, a high level of frailty both of which make it very difficult for the individual to remain living in the community; lack of family carers and/or facilities within the home.

#### 4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

In the past, the Maltese government like many other governments of Western countries was more preoccupied with meeting the 'humanitarian' issues of the process of aging, directing their programmes towards 'protecting' the elderly. They contemplated a system of care of the elderly which was to a large extent restricted to medical care and physical comfort (Troisi J. 1994, Tonna V. 1992). Hardly any emphasis was put on how to 'socialise' the growing population of elderly citizens who were no longer economically active. Such a strategy resulted in emarginating the elderly from society. This further led to their institutionalisation where the elderly were expected to pass the last part of their lives in security, if not in comfort, under the supervision of trained nursing personnel. (Delia EP. 1982).

Prior to 1987, when the Department for the Elderly and Community Services was set up, St.Vincent de Paule Residence for the Elderly (SVPR) which is still the largest residential complex for the elderly in Malta was the only long-term health care facility in Malta. In past years, this government-owned long-term care and residential accommodation has been modernised so as to incorporate a more functional organisation with smaller numbers of elderly persons grouped together. Greater emphasis is being made on the quality of accommodation and at upgrading the care facilities and services.

Although it is a long-term care facility for the elderly, where the majority of the residents are in need of medical and nursing care, SVPR is not completely a geriatric hospital. With the passage of time, SVPR has served as a hospital, residential nursing home and sheltered accommodation for the elderly. Moreover, the complex contains a number of services for the care of the elderly. To some it offers sheltered housing, to others residential care and to the majority it offers health services. Apart from medical and nursing care, SVPR offers such services as physiotherapy, occupational therapy and speech therapy, as well as dental and ophthalmic care and podology. Except in the case of those who require specialised treatment, residents are now being medically cared for within the complex itself without having to be sent to St.Luke's Hospital as was formerly the practice.

This residence has experienced great improvements during these last years. These improvements are not only structural, such as the refurbishment and air-conditioning of the majority of the wards and the building of flat lets, but also in the strengthening of human resources such as the specialisation of the medical and nursing staff in geriatrics and the training of health care

professionals. More nursing and specialised staff has been employed. At present there is a staff complement of 920. This includes: one Medical Director, two Consultant Geriatricians, four Senior Registrars, four Registrars, three Medical Officers, five Physiotherapists, eight Occupational Therapists, three Speech and Language Therapists, four Podologists, 500 nurses, Care Workers and Health Assistants, one Dentist and the rest are employed in the administration and day to day running of the complex. It is estimated that there is one nurse for every 4.4. patients. The majority of the wards have given way to separate rooms accommodating 4 persons. Every bed has access for a telephone line, a radio and television, outlet, a nurse call. Each room also has its own toilet and bathing facilities.

As at the end of December 2003, there were 1,015 residents, 68 per cent of whom (688 persons) were females as compared to 327 males. As can be seen from Table 19, 92.5 per cent of the residents were 65 years of age or over. 795 residents, or 78.3 per cent, were 75 years of age and above. As expected, the female percentage of the residents increases with age. In fact, 70 per cent of the 'old old', or 552 residents, were females. The majority of residents at SVPR are either bed-ridden or semi-independent. Their number is constantly increasing.

**Table 19: Resident population at St.Vincent de Paule Residence (SVPR) by gender and age group as on 31st December 2003.**

| Age group | Males | Females | Total |
|---|---|---|---|
| **60-64** | 31 | 45 | 76 |
| **65-69** | 23 | 34 | 57 |
| **70-74** | 30 | 57 | 87 |
| **75-79** | 72 | 113 | 185 |
| **80-84** | 74 | 181 | 255 |
| **85-89** | 60 | 128 | 188 |
| **90-94** | 29 | 83 | 112 |
| **95-99** | 8 | 45 | 53 |
| **100+** | 0 | 2 | 2 |
| **Total** | **327** | **688** | **1,015** |

Source: Department for the Elderly and Community Services

In former times, there were no formal admission criteria. This explains the number of 76 residents aged between 60-64. The majority of these have been at SVPR for a very long number of years due to the fact that they had been suffering from a disability. As part of the extensive integrated programme for upgrading care at SVPR, an Admission and Assessment Unit with 10 beds was opened on the 6th May 1988. Here, applicants requesting admission are assessed by a multi-disciplinary team consisting of a geriatrician, one medical officer, a nurse, a physiotherapist and a social worker. These assessments are, in turn, vetted by an Admissions Board which decides the priority. A programme of care for those who will be admitted is set out prior to their being sent to the respective location within the complex. There are approximately 300 admissions each year of which 40 per cent are males and 60 per cent are females. There is

also a Hospital Management Committee which is responsible for the formulation of policies concerning the running of the complex.

In order to remove the ghetto mentality and the feeling of helplessness which had existed and , at the same time, in order to instil a certain amount of social involvement, various cultural and social activities are organised both within and especially outside the complex. Those who are fully mobile are encouraged to make frequent visits to their communities and relatives. Conversely, the latter are encouraged to visit their relatives in the complex.

Residents are required to pay 80 per cent of their total income provided that he/she is not then left with less than Lm 600 (Euros 1,400) per annum at his/her disposal. Payment is usually deducted at source from the residents' social security pension and is then passed to the Welfare Committee. The service at SVPR is highly subsidised by government. It is estimated that the actual daily cost per resident amounts to Lm 21 (Euros 48.30) (Department for the Elderly and Community Services).

SVPR provides the facility for couples, especially those who are mobile or semi-mobile, to share a flat let accommodation. It also provides respite care service to provide some temporary relief for carers. A person can be admitted for respite care more than once a year. Each time the period of stay will be approximately 3 weeks. During 2002, 81 persons, 65 females and 16 males benefited from the respite service. The staff of the Rehabilitation Department also offers community services going to homes of elderly persons for physiotherapy, speech therapy and occupational treatment (Muscat A. 2000, Zammit R. 2000).

It is pertinent to point out that in the past, the history of SVPR as the old Poor House where the destitute could find refuge, had left it with an unfortunate image and rather low reputation. As a result only those elderly who could not obtain admission to one of the other residential homes found their way there. As a result of the policies adopted recently and the extensive upgrading which has taken place, the stigma associated with admission to SVPR has been removed. In fact there is now a considerable waiting list of around 750 elderly persons who want to be admitted (Government of Malta. Ministry of Social Policy. 2004a2). During 2003, there were 303 admissions, 173 females and 130 males).

Long-term health care facilities are also to be found in the two geriatric wards attached to the Gozo General Hospital (see **4.1.1.2)**, in one of the government-run residential homes. Similarly, the 18 Church-run homes and a number of the private homes also offer long term health facilities.

#### 4.1.1.4 Are there hospice/palliative/terminal care facilities?

One of the main departments at the 58 bed Boffa government hospital is the radiotherapy and oncology department. During the year 2000, a total of 868 new patients were seen by this department. Of these, 596 or almost 69 per cent received radiotherapy at the time of presentation, 200 received chemotherapy as out patients and 170 received hormone therapy. The number of attendances for those who received chemotherapy treatment during the year 2000 was 3,541. Outpatient radiotherapy clinics are held at Boffa Hospital and at Gozo General Hospital thrice a month. Boffa hospital also runs these outpatient clinics daily but in a less formalised manner. A weekly palliative care clinic is held at Boffa Hospital. (Government of Malta. Ministry of Health, the elderly and community care. 2004g)

This work is significantly complemented by the service offered by the Malta Hospice Movement, a voluntary organisation which, as explained in section **3.2.1.4,** provides and promotes the highest possible standards of palliative care for persons with cancer or motor neurone disease while at the same time providing help and support to the patients' families. Given the fact that

cancer patients and their families are often faced with many complex issues which cannot be addressed by one professional alone, the palliative care given is characterised by the multi-disciplinary approach. In Malta, this includes the medical doctor specialised in palliative medicine, the care services manager, home care nurses, day therapy unit nurse, chaplain, volunteer services manager, physiotherapist, complementary therapist, social worker and occupational therapist. (See also section **7.2(2**))

#### 4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

Malta's public hospitals and residential institutions cater for all the needs of the elderly. This means that elderly persons with no available family carers are well taken care of. At the same time, if family members so not seem to care about their elderly relatives, the latter do not become subjected to neglect. However, in the majority of cases, one finds that family carers play and active role in many forms of in-patent care, a role that is expected from them according to Maltese norms and customs. Many perform many important decisions that directly affect their elderly relative. For instance, family carers tend to provide plain-language information to the care-recipient on his/her condition, prognosis, treatment, care needs and management (including behaviour management); give central information to care-recipients on various issues such as in-home and residential respite care options, counselling, peer support groups, financial entitlements, self-care and coping strategies); offer their relatives the opportunity to contact care associations and state-wide specific bodies that may help them achieve a speedier recovery or rehabilitation; discuss and, where appropriate, assess their relative's own physical and psychosocial health needs; and finally, engage other family members in understanding and sharing care responsibilities. Moreover, many perform more mundane caring tasks for the care-recipient such as washing their clothes, personal care, cooking meals, housekeeping, accompanying the patient to appointments, and taking specimens and collecting results.

### 4.1.2 Social services:

#### 4.1.2.1 Residential care (long-term, respite)

When, in 1987, the newly created Parliamentary Secretary for the Elderly started reviewing the situation at SVPR, it was found out that almost 40 per cent of the residents there could have been most suitably placed in the community or in sheltered accommodation suitably supported by community care services.(Dimech J. 1999, Laferla A. 1997). Furthermore, the flat let accommodation within the same complex, although a useful experiment in sheltered accommodation is not very community oriented given the fact that SVPR is situated far away from the community. One must also take into consideration the fact that important as it is, housing is not mere shelter, but especially for many elderly persons, it has a long-established psychological identity with 'place'. As such it should relate to a wide range of personal, family and social identities and relationships. Moreover, the adequacy of housing also depends on the availability of basic community infrastructure, public services and maintenance of social contacts (Gauci M. 1993).

Aware of these facts and also of the growing demands of the elderly living in the community, the Nationalist Party's electoral manifesto for the general elections of 1987, included the promise "to build homes for the elderly in each locality so that those who cannot live in their own homes will not have to live far away from where they used to live" (Nationalist Party. 1986). These homes were to serve as an ideal home to those elderly persons who although being fully mobile and can, therefore, lead a normal life, cannot for various reasons, live on their own, ei-

ther for a temporary period or permanently, even though they were to be provided with a number of community services (Scerri ML. 1995, Troisi J. 1994b). There are seven government-owned residential homes for the elderly in Malta (Government of Malta. Ministry of Social Policy. 2004a7). Each home is situated in the centre of the community so as to enable the residents to continue living, as far as possible, in the same environment in which they were brought up and used to live. All the homes have single and double rooms, each with its own bathroom, small kitchenette and also have ample living space. There are also communal facilities such as dining room, recreation room, prayer room. Apart from accommodation, residents are provided with all meals, laundry, limited individual assistance and social and recreational activities. A medical practitioner from one of the Primary Health Care Centres in the vicinity visits the residents regularly. The residents can also benefit from the community nursing care offered. A health assistant attached to MMDNA is also available on call whenever a resident is unable to bathe himself/herself.

So as to ensure that only those who are really in need avail themselves of this service, prior to their being admitted in one of these homes, each applicant, after having filled in the necessary application form which needs to be signed and accompanied by a medical certificate, is visited at home by a Social Worker who comprehensively assesses the application made. The application along with the assessment made by the Social Workers is then referred to the Assessment Rehabilitation Team (ARTeam) which decides about the eligibility and priority of the case. To enter one of these homes, an elderly person must be fully mobile and capable to live independently. With one exception, these homes do not have a nursing wing. Hence they are not equipped to take care of bed-ridden persons. Consequently, a dependent resident will have to go to another place where nursing facilities are available, such as SVPR or one of the private homes. The ARTeam members visit these homes every 3 months to assess the level of independency of the residents and thus ensure that the residence is suited to the residents' needs. Similarly every home is regularly visited by a Board from the Department of Health so as to ensure that high levels of care are maintained.

Although admission is open to all elderly persons, preference is given to those above the age of 70 since they are considered to be at a greater risk of having no one to look after them with the result that if they were to continue living alone they would be considered to be at risk. As on the 31 December 2003, there were 596 residents in these homes, an average of 85 per home, ranging from 31 residents in the smallest home to 163 in the biggest home. As can be seen from Table 20, by far the majority, 76.3 per cent of the residents were females (455 persons) as compared to 141 males. Moreover, almost 96 per cent of the residents were aged 65 or over. Furthermore, 489 residents, or 82 per cent, were aged 75 or over.

**Table 20: Resident population in Government-run homes for elderly persons by gender and age group as on 31st December 2003**

| Age Group | Male | Female | Total |
|---|---|---|---|
| **60-64** | 9 | 17 | 26 |
| **65-74** | 24 | 57 | 81 |
| **75-79** | 27 | 105 | 132 |
| **80+** | 81 | 276 | 357 |
| **Total** | **141** | **455** | **596** |

Source: Department for the Care of the Elderly and Community Services

There is as yet no standard formal organisational structure throughout the government-run homes with the result that the number of staff at each home varies widely. Each home has an Officer-in-charge who sees to the smooth running of the residence. On average, each residence has a staff complement of 19 full-timers and 22 part-timers. These include among others: care assistants, maintenance personnel, personnel engaged in domestic duties, security, etc. The actual staff number depends on the number of residents and the kind of services which each home provides. Thus for example, 4 of these homes have their own kitchen where meals are prepared. In the other three homes meals are prepared by an outside caterer. Similarly, one of the homes has a nursing wing where bed-ridden patients are taken care of. In both cases, therefore, extra staff is required to work in the kitchen and also to give the nursing care services needed. Another home has a Day Centre attached to it. The Director of homes, who is a person appointed by the Department for the Elderly and Community Services, is overall responsible for all the homes.

Funding for the running of these homes is realised from two sources namely: (i) funds provided by government in the recurrent vote of the Department for the Elderly and Community Services, and (ii) contributions paid in by residents and passed through the Welfare Committee. Residents pay 60 per cent of their total income provided that the resident is not then left with less than Lm 600 (Euros 1400) per annum at his/her disposal. Payment is usually deducted at source from the resident's Social Security Pension and is then passed on to the Welfare Committee. It is quite evident that the service at these homes is highly subsidised by government. It is estimated that the actual daily cost per resident amounts to Lm 12 (Euros 28). In the case of the Mtarfa home which has a nursing wing attached, the daily cost is higher. In fact, residents pay 80 per cent of their total income with the proviso that the resident is not then left with less than Lm 600 (Euros 1400) per annum at his/her disposal.

All the residents are constantly encouraged to maintain maximum communication with persons within the community in order to be able to retain their active roles as far as possible. Each home is open to friends and relatives of the residents and to other elderly persons within the community (Government of Malta.Ministry of Social Policy. 2004a1). The number of applications for entry into these government-owned homes for the elderly has been constantly increasing from year to year. As at the end of 31 December 2003, there were 498 applications, 373 coming from female elderly persons and 125 from male elderly persons.

For a number of years, the Government had been contemplating a partnership with the private sector to provide social housing facilities for the elderly. Twelve years ago, in November 1992, a contract was signed between the Ministry of Social Policy and the Social Action Movement (MAS), a voluntary organisation initiating the first joint venture between the public and the private sector. The project which concerns a sheltered housing project for the elderly in Gozo is estimated to have costed around Lm 250,000 (Euros 575,000) excluding the cost of the land which was donated by the Church. The government was responsible for the construction works while MAS is responsible for the running and administration on a non-profit, non-loss basis.

Recently government has entered into two other forms of public-private partnership relating to social housing for the elderly. The Department for the Elderly and Community Services has subcontracted the administration of the latest two government-owned homes to be built in 1994 and 1999 to CareMalta Ltd a private organisation, which was set up in 1992. CareMalta Ltd is a joint venture between a Maltese Construction Company and Care UK plc, a highly successful UK public company operating over 40 nursing and residential homes for the elderly and the mentally ill in the UK ( CareMalta Ltd. 2004, Tranter A. 2000). The second form of agreement was that entered into with three of the privately-run residential homes. Following this agree-

ment, the government is placing a number of elderly persons in these homes and tops up the fee paid by the resident to reach the daily rate charged by the residence namely Lm 10.50 (Euros 24). The elderly resident on his part pays only the 60 percent of his/her total income with the proviso that he/she is not then left with less than Lm 600 (Euros 1400) per annum at his/her disposal. When the elderly resident becomes dependent he is charged the same rate as at SVPR namely 80 per cent of all his income with same proviso just mentioned.

*4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes).*

As illustrated in Table 21, as on the 31st December 2003, there were 3,039 Maltese elderly persons to be found in residential homes. These constituted 4.63 per cent of the total Maltese elderly population. As expected, there was a considerably higher percentage of elderly women, amounting to more than double that of males, who were living in residential homes. In fact, 6 per cent of the Maltese elderly female population (2,227 persons) were to be found in residential homes as compared to 2.87 per cent (812 persons) of all the Maltese elderly female population. Those below the age of 75 amounted to 1.19 per cent of the elderly population aged between 60-74. There were 540 persons, 202 males and 338 females amounting to 0.99 per cent and 1.36 per cent of the males and females within this age group.

When one takes into consideration those aged 75 and over, the percentage rises to 13.3. There were 2,227 persons, 610 males and 1,889 females amounting to 7.7 per cent and 15.2 per cent of the males and females within this age group. This clearly shows that, by far the majority of elderly persons, who, on the 31st December 2003 were to be found in residential homes, were above the age of 74. These amounted to 82 percent.

The government-run homes had the highest percentage of elderly to be found in residential homes in the Maltese Islands amounting to 1,710 persons, 507 males and 1,203 females, amounting to 56.3 per cent. 20 per cent of Malta's elderly residential population were to be found in Church-run homes while 23.7 per cent were living in privately-run residences. The higher percentage of persons living in privately-run residences rather than Church-run residences notwithstanding the fact that there were more Church-run (18) than privately-run homes (10) for the elderly, is due to the fact that the latter homes were larger having an average of 72 residents as compared to 34 residents in the former.

**Table 21: Population of Maltese elderly in residential care by gender, age group and type of residence as on 31st December 2003**

| Type of Residence | Age Group | Males | Females | Total |
|---|---|---|---|---|
| **SVPR** | **60-74** | 84 | 136 | 220 |
| | **75+** | 243 | 552 | 795 |
| **Gozo** | **60-74** | 6 | 6 | 12 |
| | **75+** | 33 | 54 | 87 |
| **Government homes** | **60-74** | 33 | 74 | 107 |
| | **75+** | 108 | 381 | 489 |

| | | | | |
|---|---|---|---|---|
| **Church homes** | **60-74** | 27 | 31 | 58 |
| | **75+** | 108 | 446 | 554 |
| **Private homes** | **60-74** | 52 | 91 | 143 |
| | **75+** | 118 | 456 | 574 |
| **Total** | **----** | **812** | **2,227** | **3,039** |

*4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)*

As seen in sections **4.1.1.3** and **4.1.2.1.**, there are certain criteria to be followed for admission in government and Church-run residential homes for the elderly. As part of the extensive integrated programme for upgrading care at SVPR, an Admission and Assessment Unit with 10 beds was opened on the 6th May 1988. Every application requesting admission has to have a medical report. The application is then assessed by a social worker from the Social Work Unit who visits the applicant's home and prepares an assessment report. The two reports, both the medical and the social, are then brought for the attention of a multi-disciplinary team consisting of a geriatrician, one medical officer, a nurse, a physiotherapist and a social worker. The assessments are, in turn, vetted by an Admissions Board which decides the priority. Emphasis is made on the fact that institutionalisation of elderly persons should really be a last resort and that all other efforts in maintaining the elderly person in the community have failed. Here a person's level of dependency is given great consideration (Gatt Depares J. 1994, Piscopo T. 1994)

Applications for entry into government-run homes also follow a certain pattern. Although admission is open to all elderly persons, preference is given to those above the age of 70 since they are considered to be at a greater risk of having no one to look after them with the result that if they were to continue living alone they would have to be institutionalised. Every application has to have a recommendation of a medical doctor together with a medical report why the applicant needs to be admitted. A social worker from the Social Work Unit visits the applicant's home and prepares an assessment report. Following this, the application is then assessed by the Assessment and Rehabilitation Team which decides about the eligibility and priority of the case. The guiding principle in the giving of this service is that the applicant would otherwise be considered at risk and has to be institutionalised. However, as pointed out earlier to be admitted in one of these homes a person needs to be independent.

The Church-run residential homes for the elderly also have a certain common criteria. In fact, in 1979, a Commission of these homes was set up to formulate common policies and to co-ordinate programmes and activities. Prior to an admission, the prospective resident is visited at home by a team of persons including the director of the home and a nurse, to assess the actual need of the applicant. Particular emphasis is made to ensure that admission is not sought for as a result of family instigation or feelings of insecurity which, in most cases, could be relieved through appropriate care. A report is then made and presented to the Management Board of the home into which the applicant wants to take up residence. Moreover, residents are told not to dispose of their houses at least before one year from their admission so that they could see whether they would find living in a residence for elderly persons as congenial to them.

*4.1.2.1.3 Public/private/NGO status.*

In Malta, one finds all three types of residential homes for elderly persons, namely those run by government, those run by the Catholic Church and those run by private profit organisations. As

seen in section **4.1.2.1.** at present, the government runs seven residential homes for elderly persons, situated at Cospicua, Floriana, Gzira, Mosta, Msida, Mtarfa, and Zejtun. Elderly persons are admitted provided that they are mobile, independent and do not require regular nursing care.

Church-owned and run residences: Religion is a major factor in the lives of the Maltese. The elderly, especially, regard the Church as a very important part of their lives and derive great comfort from its spiritual and material support. In fact, the Church in Malta was the pioneer of charitable institutions including homes for the elderly. The Church provides most of the residential homes for the elderly in the Maltese islands. At present, the Church runs 18 such homes, 10 of which are owned and run by religious orders of nuns, the other 8 being owned by the Archdiocese of Malta and administered by religious organisations (4 homes ) and by the laity (4 homes). Three homes are situated in Gozo.

Eight of these homes take in both males and females, one takes only males and the other nine accept only females. Seven of the 10 homes owned and run by religious orders of nuns admit only females. Together they had 145 residents, an average of 15.5 residents per house ranging from 4 to 77 residents. 96.5 per cent of the residents (140) were above the age of 75 and many of them were even in the 85-90 age bracket. Although the other 3 homes owned and run by religious orders of nuns admit also males, the majority of the 115 residents which they have, 77.4 per cent or 89 residents, were females. Even here, these homes cater for the 'old old' with 86 per cent of the residents (99 persons) above the age of 75, the majority being in the age group 85-90. Of the 4 homes which are owned by the Archdiocese and run by a religious order of nuns, one is for old priests, the majority of whom are frail. The other three cater only for females. Even here 97 per cent of the 62 residents were above the age of 75, the greatest number belonging to the 85-90 age group. The 4 homes which the Archdiocese had sub-contracted to the laity were before run by religious orders of nuns. They had the biggest number of residents amounting to 242, 61 males and 181 females. 91 per cent of the residents (220) were above the age of 75.

These provide 612 beds which are not only fully occupied but there is a very long waiting list of elderly persons all of whom are anxiously waiting to be admitted in one of these homes. An inevitable result of this is that many elderly persons seek to get their name registered long before they actually need this form of residential care. It is worth mentioning that prior to the recent innovations and improvements carried out at SVPR, the demand for entering Church-run homes was by far greater.

As can be seen in Table 22 , as on 31st December 2003, 78 per cent of the residents (477 persons) were females as compared to 135 males. No less than 90.5 per cent of the residents, or 554 residents, were 75 years of age and above. The feminine majority syndrome is at its highest when taking into consideration the 'old old'. Here, 80.5 percent (446) were females as compared to the 53.4 per cent (31) in the 60-74 age group.

**Table 22: Resident population in Church-run homes for elderly persons by gender and age group as on 31st December 2003**

| Age Group | Male | Female | Total |
|---|---|---|---|
| **60-74** | 27 | 31 | 58 |
| **75+** | 108 | 446 | 554 |
| **Total** | **135** | **477** | **612** |

Source: Directors of the various homes and the Commission Director.

The majority of residents in the Church homes have been there for quite a number of years. All these homes offer long term health facilities. With the exception of one home, the others do not accept bed-ridden patients, However, once a resident becomes bed-ridden he is cared for in the same home where he belonged. The quality of care is often of a very high calibre and ensures that the individuality and personality of the residents are preserved. Although the ownership belongs to different Church groups these homes are inspired by the same Christian values. To ensure better co-ordination and common policies a Commission was set up in 1979. The members of the Commission are the heads of all the homes as well as a Church-appointed Director. The Commission meets regularly.

The services offered in these homes include basic care, 24 hours nursing service, doctor on call, bathing and laundry. Till around 20 years back, by far the majority of carers in these homes were religious nuns. Fewer religious vocations during the past years have, however, meant that even the existing homes have had to increasingly rely on paid lay workers, making it more difficult to make ends meet. The residents pay a daily charge ranging between Lm 6.50 and Lm 10.00 (Euros 15 and 23). This depends on the type of accommodation one has, whether living in a single room or a twin sharing room. Payment is very much related to the financial means of the resident. No one was rejected admission because he could not pay the charge. Anyone who declared that he/she could not raise the total charge, was means tested and if found eligible his daily charge was reduced according to his/her means. All the homes are heavily subsidised both by the common fund of the Archdiocese as well as by the common fund of the religious orders of nuns in question. During 2003, the Archdiocese subsidised 3 of its 4 owned homes to the tune of Lm 125,000 (Euros 287,500). This does not take into consideration the contribution in kind which is given by the religious nuns.

One cannot forget the number of elderly nuns and priests who are catered for by their religious orders within their convents.

Privately-owned and run residences: One also finds an increasing number of residential homes run by private organisations (Vassallo N. 1998). The first privately owned and run home which was purposely built to cater for the needs of elderly residents was opened on the 1st August 1993. The largest private organisation is CareMalta which operates two homes in addition to owning the sub-contracting of the running of two of the government-owned homes. During the past 11 years another 9 homes for the elderly were opened in Malta. There is no such home in Gozo. Five of these homes have been purposely built to meet the needs of elderly residents. As illustrated in Table 23, the population of elderly residents in these homes, as on 31st December 2003 amounted to 717 persons, 76 per cent of whom, or 547 persons, were females as compared to 170 males. Eighty per cent of the residents were above the age of 74. Here the female preponderance was still higher amounting to 79.5 per cent.

**Table 23: Resident population in Private-run homes for elderly persons by gender and age group as on 31st December 2003**

| Age Group | Male | Female | Total |
|---|---|---|---|
| **60-74** | 52 | 91 | 143 |
| **75+** | 118 | 456 | 574 |
| **Total** | **170** | **547** | **717** |

Source: Directors of the various homes

Opening a residence for elderly persons requires the permission of the Department of Health which works in liaison with the Department for the Elderly and Community Services. Frequent checks are made to ensure that these homes maintain a high standard of care. The state of hygiene and upkeep of premises have to conform at all times to the sanitary laws and are subject to inspection as and when required. Adequate allowance has to be assured for accommodation of male and female residents separately, as well as suites for married couples. A fair balance of single and multiple occupancy of rooms has to be aimed for. The residence has to be in a position to allocate a number of places for non-ambulatory residents. A lift is necessary in multi-storey promises and must be large enough to accommodate a wheelchair and possibly a stretcher. If the premises has more than 10 residents living above the second floor, there should be a second lift. Non-slippery surfacing of stairs, hand-rails and bathroom floors is necessary. An emergency alarm-bell system has to be within easy reach of each bed. Rooms should have adequate space, have non-slippery floors, hand rails and supports. A wash-hand basin with hot and cold water in each room is the minimum washing facility expected. One or more medical practitioners have to be attached to the home and 24 hour coverage ensured. Individuals who wish to retain their own general practitioner are to be allowed to do so. All residences have to maintain up-to-date records of the residents including information regarding medical history, telephone number and contact address of next of kin.

The size of these homes range from the smallest which has 8 residents to the largest which can cater for 188 residents. The homes offer a wide range of services to their residents. Residential units come as either single or double units, each fitted with a kitchenette and an ensuite bathroom. There is a strong competition between the homes as to the type and quality of services offered. Services are adapted to the needs of the residents both at time of their entry and also later. Apart from accommodation (board and lodge) basic nursing services, medication and doctor on call, the range of services which the resident can choose from includes a 24 hours nursing service, laundry, procurement of medicine from government dispensaries, in-house doctors, etc. Some also offer in-house medical consulting rooms and nursing facilities. One home also has a geropsychiatric ward. For these services residents pay extra.

All the homes admit bed-ridden elderly persons. The daily charge varies and is dependent on a number of factors, including: the level of care needed, the level of dependency of the resident, the location of the room, whether it is single or double occupancy, etc. Homes distinguish the residents into 4 categories, namely the independent, the low dependents, the medium dependents and the high dependents. Prices for accommodation and basic care vary from Lm 8.00 to Lm 20. (Euros 18 -46). Residents have to pay extra for the other services.

All the homes also offer respite services for the family carers, and for the elderly persons themselves, short convalescence periods and short holidays. As pointed out in section **4.1.2.1.1**. the government has during the past years entered into a partnership with 3 of these homes whereby the government is placing a number of elderly persons in these homes and pays tops up the fee paid by the resident to reach the daily basic rate of Lm 10.50 (Euros 24) charged by the residence. The government will then collect from the elderly resident 60 percent of his/her total income with the proviso that he/she is not then left with less than Lm 600 (Euros 1400) per annum at his/her disposal. Under this agreement, the government Assessment Rehabilitation Team also visits the three homes to ensure the level of care needed by the residents who are government subsidised.

Regular social and entertainment activities are organised regularly both inside and outside the home. Outings to special places of interest are organised every week. Relatives of residents

are encouraged not only to visit their kin but also to participate in these activities prepared for the residents (Tranter A. 2000).

#### *4.1.2.1.4 Does residential care involve the participation of carers or work with carers?*

All owners and directors of residential homes for elderly persons in Malta believe that a family-based approach to residential care is a central prerequisite for ensuring a high level of quality of life among the elderly residents. Consequently, they consider a good collaboration with the residents' relatives as central and offer facilities to enhance this. There are different levels of co-operation starting from the day the elderly person applies to enter a residential home, till the day he/she passes away. Research has shown that relatives play a very important role in helping an elderly person adjust to the new geographical and social environment. The same can be said when the elderly person becomes sick. In fact relatives are constantly kept informed about any changes in the health condition of their elderly relative.

During the period of stay in a residential care, the extent of involvement of the relatives and the level of their cooperating with the management and staff of the residence depends more on the former than on the latter. In fact, relatives of residents are more than encouraged to frequently visit their older kin, something which, in many cases, is regularly done. Relatives are also encouraged to take their elderly kin to their homes especially on family occasions or for activities within the community.

A number of homes organise various social events for the residents. On many such occasions, relatives are invited to attend.

### 4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

As pointed out earlier, the establishment of a new Parliamentary Secretary for the Care of the Elderly 17 years ago revolutionised the system of care of the elderly in Malta. Institutionalisation is now considered by government to be really the last resort, and care of the elderly in the community is the accepted perspective of present social policy. By providing care and support where the family and the elderly individual are unable to manage alone, these community care services help maintain the elderly in the community and enable the families to cope thus preventing or at least delaying the need for institutional care (Piscopo T. 1994).

#### *4.1.2.2.1 Home-help*

This was the first community based service for the elderly in Malta. Started in the first week of July 1988, this scheme is aimed at ensuring that elderly persons can retain their independence and continue to live in their own homes and within their community for as long as possible thus averting or delaying the demand for institutionalisation. By providing help in the client's own home, the service also aims at providing respite and support to the informal carers.

Originally, the beneficiaries of this service were to be those elderly persons and persons with disability who were housebound or nearly housebound and who had difficulty in managing the practical household chores and, in some cases, even look after themselves. The service was to include daily shopping needs, running small errands, bed-making, laundry, limited personal attention such as dressing and bathing, weekly washing of floors, procurement of medicines from the government dispensaries and the cooking of a meal when requested.

The service was started as a pilot project in 4 different localities within the inner harbour region in Malta where there is a very high concentration of elderly persons living alone. The service is now spread all over the Maltese Islands. Although the service has been opened also to per-

sons with disability, the majority of the 2,979 beneficiaries, 2279 in Malta and 700 in Gozo, are elderly persons. The service, which is carried out daily between 08.00 and 12.00 noon except on Sundays and public holidays, is provided against a nominal weekly fee of Lm 1.00 (Euros 2.3) for a single person and Lm 1.50 (Euros 3.5) in the case of a couple irrespective of the number of visits and the amount of time spent. An extra weekly of 50 cents and 75 cents is charged where a hot meal is prepared. This service is highly subsidised by government. In fact during 2002 the service costed the Department for the Elderly and Community Services no less than Lm 1,130,356 (Euros 2,600,000). (Government of Malta. Ministry of Finance. 2004).

A person's application form has to be accompanied by a medical report which is then sent to the Unit within the Department for the Elderly and Community Services. A Social Worker from the Social Work Unit visits the applicant's home so as to assess the applicant's real needs. The case is then discussed by the internal Board of Allocation of Service. If accepted, the case is sent to the area supervisor in which the applicant lives. Every case is treated on its own merit. The allocation of hours of service to the beneficiary is made on the applicant's real needs. The service is terminated once a beneficiary enters into a residential home

The service is carried out by a number of female Part-time Social Assistants(PTSAs). Although a number of these PTSAs are employed in the government-run homes and also in the Day Centres, the majority of them, or 446, are employed as Home helps. In order that the service achieves the desired results and that each beneficiary would receive adequate personal attention, each PTSA has a very small number of elderly persons in her care. Furthermore, to minimise the need of transport as much as possible, PTSAs are selected from the same area of the beneficiaries in her care. Prior to recruitment, PTSAs undergo a two weeks' induction training programme during which they are familiarised with various aspects relating to aging and the elderly. Each PTSA is constantly under the supervision of a Welfare Officer who acts as an area supervisor (Government of Malta.Ministry of Social Policy. 2004w)

#### *4.1.2.2.2 Personal care*

As pointed out in section **3.2.1.3.** the range of services offered by the Memorial District Nursing Association (MMDNA) includes such personal care services as bathing, blanket baths, enemas, wash-outs, toe nail cutting and catheterisation. This service is given free of charge. The MMDNA nurses also offer these services to the residents of the government-run homes for the elderly. Personal care is also offered in the Church-run and private-run old people's homes. Elderly persons can also make use of such services offered by a number of private organisations for which they have to pay.

#### *4.1.2.2.3 Meals service*

The Meals on Wheels service was started in Malta on the 13th June 1991. It is run by two voluntary organisations, namely: the Social Assistance Secretariat of the Catholic Action Movement and the Maltese Cross Corps, a charitable organisation of the Sovereign Military Order of Malta, in collaboration with the Department for the Elderly and Community Services. As a result of this service, elderly persons who are living alone and who are unable to prepare a meal, will have the opportunity to receive daily at home a nutritious hot meal for which they only pay the minimum possible. They will also be given the opportunity to taste different food daily and to eat it in the comfort of their home. This 7 day service is also open to persons with disability and who also are unable to prepare their own meals (Government of Malta. Ministry of Social Policy. 2004z).

Meals are served in a foil receptacle which facilitates the warming up of the meal in ovens should the need arise. The foil containers are stored in a jablo box and delivered to the elderly

person's home by means of specially constructed vans donated by CARITAS Paderborn, Federal Republic of Germany. This service is heavily subsidised by government. For a number of years since the service, started the government has every year allocated the sum of Lm 10,000 (Euros 23,000) towards the annual running of this service. To meet the growing demands for this service, the government's contribution was raised to Lm 20,000 (Euros 46,000) during the past years. The elderly pay only Lm0.95 (Euros 2.2) per meal which consists of a starter, a main course, a dessert and a bun. There are 15 different menus from which one can choose, all of which are suited for the particular needs of the recipients. It is calculated that, during 2003, around 73,000 meals were distributed averaging 200 meals a day. As on October 2003, there were 1,427 registered beneficiaries of this service, 641 of whom were males and 786 females. The service is also offered to those elderly persons who frequent the Day Care Centres. See section **4.1.2.2.6.**

The service does not consist in merely delivering a meal. In fact, specially trained personnel have been employed to give this service a personal touch. At the same time that they make the deliveries of the meals to the elderly's residences, they inquire whether the elderly person is in need of anything. They also keep a constant watch on the elderly person's situational environment and are report to the scheme's authorities if they notice anything unusual.

As pointed out in section **4.1.2.2.1,** the home help service offers a meal service to those elderly persons who so require and need. In such cases, for a nominal fee, the part-time social assistants prepare meals for the elderly persons in whose care they are.

*4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)*

As already mentioned in section **4.1.2.1** all the residential homes, whether owned by government, Church or private organisations, offer a number of services apart from the basic 'hotel' services consisting of board and lodging. There is a wide range of services offered including laundry, shopping, computer and internet facilities, etc.

One of the services being run by the Department for the Elderly and Community Services which has proved to be very popular and beneficial both for the elderly themselves and also for the family carers has been the Telecare Service. Started in 1991, this telephonic life-line system is aimed at helping those elderly persons living alone in their homes, to maintain their independence by reassuring them that, in the case of any emergency, there is always someone they can call upon for immediate assistance. This service has also been instrumental in helping the elderly overcome the feeling of loneliness which is often stated as one of the reasons for entering into residential care (Scicluna M. 1998). At the same time, the service has ensured family carers that they could leave their elderly relatives and even go to work, knowing very well that they were only a telephone call away.

The system consists of telephone units which automatically dial a Control Centre when activated by pressing a button either on the unit itself or on a pendant worn round the neck. As soon as a call reaches the Control Centre, which is staffed round the clock all year round, personal details of the caller appear on a computerised screen. These include the caller's name, address and medical history; names, addresses and phone numbers of the caller's personal doctor, and of two relatives, friends or neighbours who also have a key to the caller's home. In cases of emergency these are immediately contacted. A specialised feature of the system is the automatic registration at the Control Centre when no communication from the client's end is received.

Although this system is also extended to persons with disability, by far the majority of users, almost 97.5 per cent are elderly persons. As on the 31st December 2003, there were 8,692 elderly persons benefiting from this service. Sixty-nine per cent of these, or 6,004 persons were

females as compared to 2,688 males. As can be seen from Table 24, the majority of users, 7,058 or 81,2 percent were elderly persons above the age of 70.

**Table 24: Age group of persons using the Telecare Service as on 31st December 2003**

| Age group | Number of Users |
|---|---|
| **18-59** | 216 |
| **60-70** | 1,418 |
| **71-79** | 3,480 |
| **80+** | 3,578 |
| **Total** | **8,692** |

Source: Department for the Elderly and Community Services

There is a nominal charge for this service amounting to Lm 1 (Euros 2.3) per month in the case of one person living alone and Lm 1.16 (Euros 2.7) in the case of two persons living together. This is in addition to the normal telephone rental charges. (Government of Malta. Ministry of Social Policy. 2004a4). It is quite evident that the service is heavily subsidised by government. It is interesting to note that the telephone operators at the Control Centre are given in-service training on various practical aspects relating to elderly persons.

The government has also a Telephone Rebate Service whereby an elderly person or a person with disability who is on social assistance, having passed a means test and is in possession of the pink card (see **4.1.1.**) can benefit from a rebate in the telephone rental charges and pays an annual fee of Lm 6 instead of Lm 24 (Euros 13.8 instead of 55.2) (Government of Malta. Ministry of Social Policy. 2004a3)

*4.1.2.2.5 Community care centres*

The various efforts of the government to improve the care services being given to the ever growing number of elderly persons in the Maltese islands, and at the same time to help them to remain in the community for as long as possible, are being significantly complemented by the sterling services provided by a number of voluntary organisations. Some, like for example, the Welfare Society for the Sick and the Aged, which was set up in 1964, have been established to help those who are confined to their homes. Outings and other social activities are organised for these elderly and a laundry service is also provided by its members. Due to lack of funds, however, the activities of this Society are restricted and limited to a rather small number of persons.

As already pointed out, the main source of voluntary action for the benefit of the elderly is through Caritas Malta, a leading Church organisation which provides a powerful force of volunteers. Under the guidance of a fully qualified staff, the volunteers are prepared and trained not only to give a service to be received by the elderly by helping them in their own homes, in hospitals or in institutions, but aware of the potential of the elderly, also to encourage their very participation and involvement. Two of the most important services offered by Caritas aimed at helping the elderly to continue living in their own homes and environment, are 1) The Good Neighbour Scheme, and 2) The Social Clubs.

The Good Neighbour Scheme: Started in 1982 as a pilot project, this scheme has now spread to various areas in Malta and Gozo. The primary aim of this scheme is to help, on a regular basis, those elderly persons who are living alone and who are homebound or quasi homebound and who are in constant need of attention, care and companionship.. The programme on parish level is started by carrying out a statistical survey of these elderly persons living in the parish. A social awareness among the community of the needs and problems of the elderly is created. A small organising group of volunteers is then formed under the supervision of a Caritas voluntary social worker. The volunteers of each group, 85 per cent of whom are themselves elderly, receive training given by the Caritas social workers at the headquarters. They also attend refresher seminars organised every 3 months.

Every elderly person within the parish is personally visited to assess his/her needs and to inquire whether he/she wishes to participate in this free service. After discussing each particular case, the group motivates the neighbours of those really in need to start taking care of them on a regular basis. The involvement includes home visits. Some volunteers phone their 'clients' every morning to see to their daily needs. The volunteers also inform the elderly persons in their care about the various government schemes and other programmes and services in the field of ageing and for the elderly and assist them in applying for such services. Others keep a friendly and unobtrusive watch on their elderly neighbours observing their normal habits so that any possible signs of trouble are immediately recognised and action taken. This service has helped many elderly persons to remain living in the community and not try to find refuge in an institution.

Social Clubs: Caritas also encourages the creation of social clubs for the elderly within the village or town. There are at present 46 such clubs spread out in 40 parishes with an approximate total membership of 2,100 elderly persons. The clubs are usually located at the parish centre or in the premises of a voluntary organisation. A number of these clubs open weekly while others open fortnightly. Each club is run by a team of voluntary workers, 65 per cent of whom are elderly themselves. These also receiving training by Caritas and also attend refresher courses and seminars.

The emphasis of these clubs is on participation of the elderly in co-operative action which enhances their self-image and feeling of self-worth. Elderly lonely persons are given an opportunity to form new relationships and friendships. Moreover, the elderly are motivated to actively participate in planning and organising the activities of the club. These include lectures on cultural, religious, social and medical topics; discussions; keep fit and reminiscence exercises and recreational programmes. Outings are organised once a month. Intra- and inter-generational activities and co-operation are also encouraged. These clubs serve as therapeutic communities in which members search for and find their own solutions for their own problems (Bonello R. 1995).

#### *4.1.2.2.6 Day care ("protective" care)*

It was in 1993 that the first Day Care Centre was opened by the Parliamentary Secretary for the Care of the Elderly. During the past 11 eleven years, another 13 such Day Centres have been opened in Malta. Day Care Centres have a four-fold aim namely: 1) to help prevent social isolation and the feeling of loneliness by keeping elderly persons active in the community; 2) to help elderly persons remain as socially integrated as possible by reducing the social interaction difficulties which elderly persons, especially women, tend to encounter in their old age; 3) to motivate the elderly by encouraging them to participate in the planning of Day Centre activities; and 4) to provide respite time for family carers of elderly persons.

Day Centres are opened five days a week and the elderly are free to attend whenever they feel like it. Attendance is open to those elderly living in the same locality or area of the Centre itself. Priority is, however, given to those elderly persons who live alone or who are at risk. These Centres are equipped for elderly persons with disability (Government of Malta. Ministry of Social Policy. 2004u).

A person attending a Day Centre is required to pay a nominal free ranging from Lm 1 to Lm 2.5 (Euros 2.3 to 5.75) a month depending on the number of days he/she attends. In the case of a couple they pay Lm 0.50 extra. Participants can have their meal at the Centre. Meals are provided by the same Association responsible for the Meals on Wheels.

These Day Centres have proved to be very popular with the elderly and beneficial to their families. As can be seen from Table 25, more than 1,200 persons attended these Day Centres during 2003. These constituted around 5 per cent of the elderly population of the 14 areas. By far the majority, 88.7 percent or 1,099 elderly persons, were females as compared to 140 males. Almost 82 per cent of those who frequented regularly these Day Centres were 65 years of age and above.

**Table 25: Population of elderly persons frequenting Day Care Centres by gender and age group as on 31.12.2003**

| Age Group | Males | Females | Total |
|---|---|---|---|
| **60-64** | 24 | 201 | 225 |
| **65-74** | 53 | 441 | 494 |
| **75-79** | 33 | 259 | 292 |
| **80+** | 30 | 198 | 228 |
| **Total** | **140** | **1,099** | **1,239** |

Source: Department for the Elderly and Community Services

As illustrated in Table 26, 67.2 per cent of the elderly who frequented the Day Centres were either singles (12.5 per cent) or widowed ( 54.7 per cent). Almost 91.5 per cent of these were females. The capacity of the Day Centres differed. The average capacity was 89, ranging from 59 60 180.

Every Day Centre has an Officer in Charge appointed by the Department for the Elderly and Community Services. The staff complement differs according to the size of the Centre. There is a total of 58 part-time social assistants who are engaged in the day-to-day running of these Centres.

**Table 26: Population of elderly persons frequenting Day Care Centres by gender and marital status as on 31.12.2003**

| Marital Status | Males | Females | Total |
|---|---|---|---|
| Single | 24 | 131 | 155 |
| Married | 68 | 338 | 406 |

| | | | |
|---|---|---|---|
| Widowed | 48 | 630 | 678 |
| **Total** | **140** | **1,099** | **1,239** |

Source: Department for the Elderly and Community Services

It is worth mentioning that 32.4 per cent of those who frequented the Day Centres (401 persons) during 2003 were living alone.

The main activities organised in each Centre included physical education, social and creative activities. These activities are complemented by educational lectures on topics of particular relevance to the elderly. In addition, outdoor activities are organised twice a month. These activities are planned by the elderly themselves. Each Day Centre also promotes intergenerational solidarity by organising intergenerational activities. Here the elderly persons are encouraged to frequent the school/s in the vicinity. Vice-versa, students from the neighbouring schools are invited to visit the Centres. In this manner, experiences are shared and values are transmitted (Government of Malta. Ministry of Social Policy. 2004b).

It is the government's policy to set up Day Care Centres in collaboration with the Local Councils. In fact, it is a particular Local Council which requests government to start discussions on opening a Day Centre in the locality. In the majority of cases, it is also the Local Council which makes available and furnishes the premises.

#### 4.1.2.3 Other social care services

Social Work Unit: The social worker very often plays a very important in meeting the needs of elderly persons and of their family carers. Care management has been found to be a useful co-ordinative approach in the field of gerontology. The aim is to develop a program that discovers unmet needs and develop resources to meet these needs. It is a holistic approach to social work practice since it weaves together a variety of strategies so that the range of needs of clients, especially elderly clients, with multiple problems can be met. Another function of the social worker is to advocate in families/carers where conflict is adversely affecting the quality of life of the cared-for elderly persons as well as that of the carers. (Mifsud J. 1999. De Lucca E. 1991).

In this regard, and in order to meet these needs, the Department for the Care of the Elderly and Community Services, in 1987, set up a Social Work Unit which provides psychological counselling, guidance and assistance to the elderly. Although the service, which is free of charge, is open to all elderly persons, it is mainly targeted to those who are living alone and have a high level of dependency; those who are of an advanced age; those who are suspected of suffering from physical, psychological, social or financial abuse. Demented or disoriented elderly persons and those living in squalor can also benefit from this service. A medical report is needed to avail of this service. According to the particular needs of each individual, the Social Worker either visit's the person in his/her own home or the person visits the Social Worker at the Department. This Unit follows up all referred social cases. As on 24th November 2003, the Social Workers attached to this Unit handled/were handling 237 cases of elder persons who had requested help. The majority of these needed only shirt term intervention while the others necessitated a long term intervention (Government of Malta. Ministry of Social Policy. 2004a8, a9).

Every case is treated on its own merit. However, if in the assessment of the case, the Social Worker concludes that the involvement of the family can be of benefit to the elderly person, and if the latter is willing to involve his/her family, then the Social Worker involves the family also. (Government of Malta. Ministry of Social Policy. 2004h). Elderly persons can also avail themselves of the social work service at St.Luke's Hospital (Government of Malta. Ministry of Social

Policy. 2004e), Sir Paul Boffa hospital (Government of Malta. Ministry of Social Policy. 2004a), St.Vincent de Paule Residence (Government of Malta. Ministry of Social Policy. 2004f). This Unit also co-ordinated assessments and social reports of applicants who applied to be admitted in SVPR and in government homes for the elderly.

Home adaptations: Although not directly aimed at the homes of elderly persons, the latter benefit from the government services aimed at improving the housing conditions. **Scheme 5** provides subsidies for the adaptation and repair work in leased privately owned properties to reach acceptable habitable standards. Such work may include repairs of dangerous structures; replacement of old water and electricity installations; improvement of bathrooms; laying of floor tiles; repairs of old drainage system or its substitution; repairs of external doors and apertures; provision of water-proofing; improving and damp-proofing works; and construction of additional rooms.

The maximum amount of money given by the Housing Authority for repairs under this Scheme is Lm 3,500 (Euros 8,000) on dangerous structure and Lm 2,500 (Euros 5,700) on the rest of the repairs and maintenance. However, when works involved consist solely in adaptation or installation of a bathroom, financial assistance is not to exceed Lm 500 (Euros 1,150). All the repair work has to be considered viable by the Housing Authority. The latter has to approve the works to be done and give its authorization for the work which has to be completed within 12 months from the date of authorization. To qualify for this scheme, a person is means tested. The applicant should not possess more than Lm 6,000 (Euros 14,000) as assets on date of application. These consist of bank accounts and deposits in local banks as well as funds, assets from business that generates profits such as land and properties. Apart the applicant's aggregate income, the percentage of financial assistance granted depends on the number of members in his/her household. The scheme is only open to the tenants of the subject premises (Government of Malta. Ministry of Social Policy. 2004j).

A similar scheme called **Scheme Z** provides financial assistance for adaptations and improvements on properties that are privately owned or about to become privately owned. The same conditions linked to Scheme 5 apply also to this scheme (Government of Malta. Ministry of Social Policy. 2004i) **Scheme X** provides subsidies to tenants for the purchase of their leased privately owned properties and for adaptation and improvement works in these properties to reach acceptable habitable standards so as to be used as ordinary houses of residence by the beneficiaries.

This Scheme can offer the following types of assistance: cash grants for the purchase of leased privately-owned property; subsidised rates of interest on leans for the purchase of leased privately-owned property; cash grants for the adaptation and repair works for houses built prior to 1960; subsidised rates of interest on loans for adaptation and repair works for houses built before 1960. The applicants are means tested. To qualify an applicant should not possess more than Lm 12,000 (Euros 27,600) assets as on date of application (Government of Malta. Ministry of Social Policy. 2004a11)

**Scheme V** provides for the installation of lifts for government-owned apartments in which one, or more persons with disabilities and/or mobility problems, live. These apartments may be either fully owned by the government or co-owned with the owner of the apartment itself. The block of apartments has to be at least three storeys high. Moreover, the residents of the block must be part of a 'Residents Association' which is to be responsible for the maintenance and running costs of such a lift. If any of the residents in the block are owners of their flat they should be prepared to pay their share of the expenses involved (Government of Malta. Ministry of Social Policy. 2004a10).

Handyman Service: Research has shown that in a number of cases, very old persons do not have the incentive to care for their house since they do not find help to do those chores which they can no longer do on their own (Abela N. 1988). Broken electrical fittings and window panes, rusted of leaking water taps, might appear small chores to ordinary people but for the elderly especially those living alone, might became real problems. Having no one to attend to these minor repairs, a number of elderly persons tend to let things slowly fall apart. Such situations further depresses the elderly and make them feel more helpless and isolated.

In pursuit of its policy to enable the elderly, especially those who are living alone, to continue living as independently as possible in their own home for as long as possible thus prolonging the need for institutionalisation, the government, in 1989, introduced a new service called Handyman Service. This service engages a small team of manual workers and technicians who will carry out minor repairs, refurbishment and maintenance work in the homes of elderly persons who, otherwise, would find it very difficult to get such minor works carried out by others. The service offers a range of around seventy repair jobs that vary from electricity repairs to plumbing, carpentry and transport of items.

Although the service is open also to persons with disability, the majority of beneficiaries are elderly persons. Almost 4,000 elderly persons, 68 per cent of whom were females (2,712 persons) have benefited from this service. It is basically rendered free of charge to those who have passed a means test and hold the Pink Card (see **4.1.1.**). Non-Pink Card holders are entitled to receive this service at a nominal fee amounting to between Lm 1-2 (Euros 2.3 – 4.6) depending on the job required. Both types of users of this service are required to provide the necessary materials at their own cost. Usually a job is carried out within five days of application (Government of Malta. Ministry of Social Policy. 2004v). Applications are made to the Department for the Elderly and Community Services.

Incontinence Service: The aim of this government-run service is to alleviate the psychological problems/s to which a person may, as a result of incontinence, be subjected. Moreover, through the supply of heavily subsidised diapers, this service helps to decrease the physical and financial strain exerted on those families who have members with incontinence problems. There are two schemes, one open to persons with disability and the second is exclusively for elderly persons who suffer from incontinency. To be considered for approval, applications must have the recommendation of a medical doctor who also specifies the level of incontinency. Based on this report, a card valid for one year is issued clearly delineating the amount of diapers which the beneficiary can obtain at a very subsidised rate. Diapers are obtained very month. Beneficiaries are not means tested. They must however, be living in the community. This service is stopped automatically once an elderly person enters a residence for elderly persons. As on 31st December 2003, there were 1,826 elderly persons benefiting from this service in the Maltese Islands. (Government of Malta. Ministry of Social Policy. 2004x). Diapers come in different sizes. Last year the government subsidised this service to the tune of Lm 90,000 (Euros 207,000) (Government of Malta. Ministry of Finance. 2003).

Self-Health Care Programme: Aware that healthy personal habits and preventive education offer the best solution for a healthy old age, Caritas Malta initiated a self-health care programme for elderly persons. Self-health educational booklets have been published in Maltese on various topics including dementia, foot care, management of incontinence, self protection, mouth care. Elderly volunteers themselves are involved in promoting these booklets through two of the programmes which Caritas Malta runs for the elderly, namely: the Good Neighbour Scheme and the Social Clubs (Bonello R. 1995). The booklets are in big print so as to enable easy reading.

Caritas also has a number of elderly professionals who on a voluntary basis lecture in the Social Clubs on a number of topics. The most popular subjects are the ones dealing on health. Occupational therapy sessions are also regularly provided on a voluntary basis (Troisi J. 1994b, 1990, Abela N. 1987).

Independent Living Advice Centre: In September 1988, Caritas Malta HelpAge, initiated an Independent Living Advice Centre. The aim is to promote the use of technical aids so as to enable frail and elderly persons with disability to perform the activities of daily living and this lead a more independent living. The Centre is run by volunteers, many of whom are elderly persons themselves (Troisi J. 1994b, 1990, Abela N. 1987).

## 4.2 Quality of formal care services and its impact on family care-givers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

### 4.2.1 Who manages and supervises home care services?

Home care services are managed and supervised by the Department for the Elderly and Community Services, within the Ministry for Health, Elderly, and Community Care. The Department appoints an Officer in Charge of the whole service. For the purpose of this service, the Maltese Islands are divided into areas which is supervised by a Welfare Officer. He is responsible for the smooth running of the service in his area and the Part-time Social Assistants. For this purpose, regular checks are made to the beneficiaries' homes. Similarly, complaints by the PTSAs and also by the beneficiaries are dealt with by the Welfare Officer and if need be this is taken up to the Officer in Charge of the Home Care Service for action to be taken. Applications for the Service are vetted by an Internal Board of Allocation of Service within the Department for the Elderly and Community Services. (See Section **4.1.2.2.1)**

### 4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls.

Yes, there is a regular quality control for these services as well a legal basis for such a quality control. The Department for the Elderly and Community Services is constrained by the Quality Service Charter to provide all home care services at a high quality level. The government has published a quality service charter handbook which serves as a guide and manual both for those wishing to familiarise themselves with the concept and for those who are considering undertaking the initiative of developing a quality service charter.

### 4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

Before being engaged, all Part-time Social Assistants (PTSAs), have to follow a 15 days' training programme on caring that is organised and managed by the Employment Training Corporation. Persons applying for a caring role in any government residential home for elderly persons are required to obtain a certification in nursing from the Institute of Health Care, University of Malta. A number of residential homes sent their staff for in-service training programmes organised periodically by the European Centre of Gerontology, University of Malta. Some even read for postgraduate degrees at the two University institutes mentioned. On the other hand, no training is given to persons who are in receipt of a carer's pension.

### 4.2.4 Is training compulsory?

Training is compulsory for both PTSAs and carers in public residential homes but not for those who work in private entities. In fact, in conjunction with the Employment and Training Corporation training programmes are organised with the objective to give caring personnel a better insight into the needs of the elderly(Section **3**). A number of short training programmes are also held in conjunction with  organised the Malta Memorial District Nursing Association (MMDNA) (Section **3.2.1.3**). Other programmes, although not on a compulsory basis are organised by various voluntary organisations including: Caritas Malta (Section **3.2.1.1**), and the Cana Movement (Section **3.2.1.2**)

### 4.2.5 Are there problems in the recruitment and retention of care workers?

The government finds no difficulties in recruiting Part-time Social Assistants. Whenever calls are made at the national level,  the number of applicants always exceeds the available positions. One of the reasons behind this is the fact that being a part-time job married women and mothers do not find it very difficult to combine their traditional role with their work. Similarly,  the contact hours are very convenient to them since these often fall during the time that their children are at school and their husbands are at work.

## 4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels).

### 4.3.1 Are family carers ' opinions actively sought by health and social care professionals usually?

Yes, the family carers' opinions are actively sought by health and social care professionals. In fact, the Department for the Elderly and Community Services, within the Ministry of Health, Elderly, and Community Care includes a Social Work Unit whose aim is to bridge the professionals and family members taking care of the elderly person. See Section **4.1.2.3.**

# 5 The Cost – Benefits of Caring

## 5.1 What percentage of public spending is given to pensions, social welfare and health?

Since its independence in 1964, the Maltese government has always given priority to pensions, social welfare, and health care in its yearly budget. At present, expenditure on social programmes catered for by the Ministry of Social Security absorbs a relatively large share of economic activity and the Government budget in Malta (Delia EP, 1998, Central Bank of Malta. 1997). In fact, during 2001, around one-sixth of  Malta's GDP was absorbed by social security expenditure (Government of Malta. 2003).  Apart from administration expenses, this expenditure includes government's contribution to the social security system, expenditure on benefits, as well as expenditure on family welfare, services related to the care of elderly persons, housing etc. On the other hand, it is the Ministry of Health which caters for health expenditure. During 2003, the government recurrent expenditure for health services amounted to Lm 28.6 million (Euros 66 million). This amounted to 26.44 per cent of the recurrent expenditure. (Government of Malta. Ministry of Finance. 2004).

Tables 26, 28 and 29 detail the principal categories of social expenditure, including health, in Malta relative to GDP and to the total government expenditure. One must be aware of the fact that the available data is only related to the expenditures undertaken by Government as no information is available regarding the expenditure by the private sector.

**Table 27 : Percentage distribution of selected main economic indicators in billion Euros (1995-2001)**

| Year | GDP per capita | GDP in Billion Euros | GDP growth % | Consumption ratio | External deficit ratio | Share of wages in GDP | Inflation | Wage growth |
|---|---|---|---|---|---|---|---|---|
| **1995** | n.a | 2.5 | 6.2 | 81.7 | -13.7 | 49.6 | 4.0 | 4.6 |
| **1996** | 9,900 | 2.6 | 4.0 | 84.4 | -12.3 | 49.9 | 2.8 | 6.1 |
| **1997** | 10,600 | 3.0 | 4.9 | 81.2 | -7.0 | 49.8 | 3.1 | 7.0 |
| **1998** | 11,100 | 3.1 | 3.4 | 79.2 | -2.3 | 50.2 | 2.3 | 5.1 |
| **1999** | 11,700 | 3.5 | 4.1 | 79.5 | -4.1 | 50.5 | 2.1 | 4.6 |
| **2000** | 12,600 | 3.9 | 5.2 | 80.5 | -9.3 | 50.3 | 2.4 | 2.8 |
| **2001** | n.a | 4.0 | -1.0 | 82.0 | -2.9 | 50.7 | 3.0 | 6.0 |

Source : Central Bank of Malta. 2002, NSO. 1999

**Table 28 : Social Security Expenditure as % of GDP (1995-2001)**

| Social Security | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|
| Administration | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 0.4 | 0.5 |
| Govt. Contribution to Social Security* | 4.0 | 4.0 | 4.0 | 3.9 | 3.9 | 3.9 | 3.9 |
| Social Security Benefits: | 11.8 | 11.7 | 11.6 | 11.5 | 11.4 | 11.3 | 11.2 |
| Contributory | 9.7 | 9.6 | 9.5 | 9.4 | 9.3 | 9.2 | 9.1 |
| Retirement pensions | 4.7 | 4.8 | 4.8 | 4.8 | 4.9 | 4.9 | 4.9 |
| Children's allowances | 1.6 | 1.4 | 1.3 | 1.2 | 1.0 | 0.9 | 0.8 |
| Bonus to beneficiaries | 0.7 | 0.7 | 0.6 | 0.6 | 0.6 | 0.6 | 0.6 |
| Other | 2.7 | 2.7 | 2.7 | 2.7 | 2.7 | 2.7 | 2.7 |
| Non-contributory | 2.1 | 2.1 | 2.1 | 2.1 | 2.1 | 2.1 | 2.1 |
| Retirement pensions | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 |
| Disability | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 |
| Poverty assistance | 0.8 | 0.8 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Medical assistance | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 |
| Bonus to beneficiaries | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 |
| Supplements to poverty | 0.2 | 0.2 | 0.2 | 0.2 | 0.1 | 0.1 | 0.1 |
| Family and Social Welfare | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.0 |
| Care of the Elderly | 0.6 | 0.6 | 0.6 | 0.7 | 0.7 | 0.7 | 0.8 |
| Housing | 0.3 | 0.3 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 |
| Industrial Relations | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total** | **17.1** | **17.0** | **16.9** | **16.9** | **16.8** | **16.7** | **16.6** |
| Health care | **6.4** | **6.6** | **6.9** | **7.1** | **7.4** | **7.6** | **7.9** |
| Public | 4.3 | 4.5 | 4.7 | 4.9 | 5.1 | 5.3 | 5.5 |
| Private | 2.1 | 2.1 | 2.2 | 2.2 | 2.3 | 2.3 | 2.4 |

Source : Central Bank of Malta. 2002, NSO. 1999

Social security expenditure in Malta absorbed around one-sixth of GDP in 2001, down by around half a percentage point from the 1995 level. This drop resulted almost exclusively from the introduction of means testing of beneficiaries of certain allowances as for example the children's allowances. Public health care expenditure is highly significant as the Government of Malta offers universally free complete hospital and clinic services to the Maltese population. Indeed, the quality of service is regularly highly commended by the World Health Organisation (WHO 2002).

**Table 29 : Social Security Expenditure as % of Government expenditure (1995-2001)**

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|
| Administration | 0.7 | 0.7 | 0.8 | 0.9 | 1.0 | 1.0 | 1.1 |
| Govt. Contribution to Social Security* | 8.9 | 9.0 | 9.1 | 9.2 | 9.3 | 9.4 | 9.6 |
| Social Security Benefits: | 26.5 | 26.6 | 26.7 | 26.8 | 26.9 | 27.0 | 27.1 |
| Contributory | 21.7 | 21.8 | 21.8 | 21.9 | 21.9 | 22.0 | 22.1 |
| Retirement pensions | 10.6 | 10.9 | 11.1 | 11.3 | 11.5 | 11.8 | 12.0 |
| Children's allowances | 3.6 | 3.3 | 3.0 | 2.7 | 2.4 | 2.2 | 2.0 |
| Bonus to beneficiaries | 1.5 | 1.5 | 1.5 | 1.5 | 1.4 | 1.4 | 1.4 |
| Other | 6.0 | 6.1 | 6.2 | 6.3 | 6.4 | 6.5 | 6.6 |
| Non-contributory | 4.8 | 4.8 | 4.9 | 4.9 | 5.0 | 5.0 | 5.0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Retirement pensions | 0.9 | 0.9 | 0.9 | 1.0 | 1.0 | 1.0 | 1.1 |
| Disability | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 |
| Poverty assistance | 1.9 | 1.9 | 2.0 | 2.0 | 2.1 | 2.01 | 2.1 |
| Medical assistance | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 |
| Bonus to beneficiaries | 0.5 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 |
| Supplements to poverty | 0.5 | 0.4 | 0.4 | 0.4 | 0.3 | 0.3 | 0.3 |
| Family and Social Welfare | 0.4 | 0.3 | 0.2 | 0.2 | 0.1 | 0.1 | 0.1 |
| Care of the Elderly | 1.3 | 1.4 | 1.5 | 1.5 | 1.6 | 1.7 | 1.8 |
| Housing | 0.6 | 0.6 | 0.6 | 0.5 | 0.5 | 0.5 | 0.5 |
| Industrial Relations | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Total | **38.5** | **38.8** | **39.1** | **39.4** | **39.7** | **40.0** | **40.3** |
| Health care | **14.4** | **15.1** | **15.8** | **16.6** | **17.4** | **18.3** | **19.2** |
| Public | 9.7 | 10.2 | 10.8 | 11.4 | 12.0 | 12.7 | 13.4 |
| Private | 4.7 | 4.9 | 5.1 | 5.2 | 5.4 | 5.6 | 5.8 |

Source : Government of Malta, Ministry of Finance. 1995-2001.

* The Government contribution to Social Security includes a statutory contribution equal to one half of contributions collected from employers and employees

## 5.2 How much - private and public - is spent on long term care (LTC)?

No data regarding the expenditures undertaken by the private sector is available. With regards to public spending on long term care, the fastest growing category of expenditure is that related to elderly persons as a result of the ageing population. There is also a significant increase in public expenditure on health, due to the construction of a new hospital (Felice Pace J. 1998).

The demand for private health care in Malta is relatively low, and typically exercised by persons who are unwilling to queue up for public health care or who believe that private health care is superior. From the perspective of shares of government expenditure, social security outlays represent a larger burden, amounting to 40 per cent of the total. This proportion increased between 1995 and 2001, in spite of the drop in the share of social expenditure within GDP. This represents the government's efforts to reduce its total expenditure during the period, which ,however, has hardly affected social expenditure.

Table 30 provides a picture of the estimated public expenditure on long-term-care by Cost Centre and by Standard item for the year 2004. We have already seen in section **4.1.1.3** how the service at St. Vincent de Paule Residence is so highly subsidised that while the actual daily cost per resident amounts to Lm 21 (Euros 48.30) the residents pay only 80% of their total income with the proviso that the resident is not left with less than Lm 600 annually in his pocket (Euros 1,400). Similarly, the residents in the government-owned homes for elderly persons are highly subsidised (See Section **4.1.2.1**).

Table 31 details the proportion of beneficiaries out of the total population for major categories of social benefits. It is noted that just under one-sixth of the population is dependent on social security for its main source of income. To the extent that the payment of a benefit covers the household rather than the individual, it may be argued that this estimate is understated (Abela, Cordina, and Muscat Azzopardi, 2003).

**Table 30 : Estimated Public Expenditure on Long Term Care by Cost Centre and by Standard Item for Year 2004 (Malta Liri)***

| | Homes | SVPR** | Total |
|---|---|---|---|
| ***Personal emoluments*** | | | |
| Staff | 556,000 | 4,552,000 | 5,108,000 |
| Bonus | 14,000 | 102,000 | 116,000 |
| Income Supplement | 12,500 | 89,000 | 101,500 |
| Social Security Contributions | 55,000 | 444,7000 | 4,502,000 |
| Allowances | 113,000 | 1,305,000 | 1,418,000 |
| Overtime | 11,000 | 432,000 | 443,000 |
| **Total** | **761,500** | **6,924,900** | **7,686,400** |
| *Operational and Maintenance Expenses* | | | |
| Utilities | 67,000 | 507,000 | 574,000 |
| Material and Supplies | 200,000 | 434,000 | 634,000 |
| Repair and Upkeep | 17,000 | 71,000 | 88,000 |
| Rent | --- | 115,000 | 115,000 |
| Office services | 1,000 | 5,000 | 6,000 |
| Transport | 1,000 | 25,000 | 26,000 |
| Contractual services | 2,000 | 64,000 | 66,000 |
| Professional services | --- | 10,000 | 10,000 |
| Training | 500 | 1,500 | 1,500 |
| Hospitality | --- | 500 | 500 |
| Incidental expenses | 250 | 250 | 500 |
| **Total** | **288,750** | **1,233,250** | **1,522,000** |
| *Special Expenditure* | | | |
| Equipment | 1,000 | 4,000 | 5,000 |
| **Total** | **1,000** | **4,000** | **5,000** |
| *Programmes and Initiatives* | | | |

| | | | | |
|---|---|---|---|---|
| | Welfare Initiatives for the Elderly | | | |
| | Residential Care in Private Homes | 350,000 | --- | 350,000 |
| | Homes for the Elderly | 580,000 | --- | 580,000 |
| | **Total** | **930,000** | --- | **580,000** |
| | | | | |
| | **TOTAL** | **1,981,250** | **8,162,150** | **9,793,400** |

Source : Government of Malta. Ministry of Finance. 2004

* One Maltese Liri is equivalent to Euros 2.3

** St. Vincent de Paule Residence

**Table 31: Beneficiaries of social benefits as a percentage of total Maltese population (average 1995-2000)**

| Beneficiaries | % |
|---|---|
| **Retirement Pensions** | 7.3 |
| **Invalidity Pensions** | 1.8 |
| **Widowhood Pensions** | 2.5 |
| **Injury Benefits** | 2.8 |
| **Poverty assistance** | 2.0 |
| **Total** | **16.4** |

Source : Abela A.M, Cordina G, Muscat Azzopardi N. 2003

## 5.3 Are there additional costs to users associated with using any public health and social services?

The concept of active ageing lies at the heart of the public policy which the Government of Malta has with regard to elderly persons in the Maltese Islands (Troisi J. 2004). Indeed, the government strives hard to promote a positive self-perception among the elderly persons themselves. At the same time, it aims at eradicating any form of ageist attitudes by instilling positive attitudes towards elderly persons by the general population. An emphasis on active and healthy ageing perpetuates a sense of well-being that promotes physical and mental health. Thus, active ageing is seen as an important concept in the prevention and delay of the onset of disability.

At the same time, the government expresses some concern that this attitude, while beneficial, should be counterbalanced with the recognition that dependence may increase eventually, particularly for the very old. In this respect, the government of Malta provides a number of free and subsidised social and health services that serve to enhance the well-being and quality if life of older persons in Malta. Table 32 provides a summary of any additional costs to users associated with using any public health and social services.

**Table 32: Any additional costs in Malta Liri* to users associated with using any public health and social services in Malta as on April 2004**

| Social Services | Free | Cost |
|---|---|---|
| **Disability Pension** | Yes | --- |
| **Leprosy Assistance** | Yes | --- |
| **Old Age Allowance** | Yes | --- |
| **Old Age Pension** | Yes | --- |
| **Sickness Benefit** | Yes | --- |
| **Social Assistance for females taking care of relatives** | Yes | --- |
| **Pension experiencing Disabilities and Visual Impairment** | Yes | --- |
| **Social Assistance for persons taking care of an elderly** | Yes | --- |
| **Unemployment & Special Unemployment Benefit** | Yes | --- |
| **Tuberculosis Assistance** | Yes | --- |
| **Contributory Pensions - Social Security** | Yes | --- |
| **Day Centres** | | Lm1 per week** |
| **Handyman Service** | No | subsidised cost |
| **Home Care Help Service** | No | Lm1 and Lm1.50 per week for a single person and couple respectively |
| **Incontinence Service** | No | subsidised cost |
| **Kartanzjan** | Yes | --- |
| **Meals on Wheels** | No | LM 0.95 per meal |
| **St Vincent de Paule Residence & Community Homes** | No | 80% of total income*** |
| **Telecare Service** | | rental fee, which is in the region of Lm1 to Lm1.33c + VAT**** |
| **Telephone Rebate for the Elderly** | Yes | --- |
| **Social Work Service at Boffa Hospital** | Yes | --- |
| **Social Work Service at Qormi Health Centre** | Yes | --- |
| **Social Work Service at St. Luke's Hospital** | Yes | --- |
| **Social Work Service at St. Vincent de Paule Residence** | Yes | --- |
| **Requirements for free medicinals** | Yes | --- |

| | | |
|---|---|---|
| **General Practitioner Service** | Yes | --- |
| **Community Nursing and Midwifery service** | Yes | --- |

Source : Government of Malta, Ministry of Social Policy. 2004a-z

* One Malta Lira is equivalent to Euros 2.3.

** If a person goes twice a week he pays Lm 1.50, if thrice a week he pays Lm 2.00, if the whole week then he pays Lm 2.50. Couples pay Lm 0.50 extra.

*** provided that the resident is not left with less than Lm600 per annum at his/her disposal

**** no administrative fees are incurred in applying for this service. However, if the applicant is not: a) 60 years or over; b) in possession of the pink form; c) lives totally alone or with two or more elderly persons, then he/she must pay

## 5.4 What is the estimated public/private mix in health and social care?

Private- public partnership (PPP) is a relatively new concept in Malta, and hence, the idea of bringing in the private sector to run public affairs is still in its infancy. This, however, has not stopped some private companies from joining forces with the Maltese government to create the first of Malta's public-private partnership scheme. In section **4.1.2.1**, we have seen how, in November 1992, the government entered into the first public-private venture with the Voluntary Organisation in the building of a sheltered housing complex in Gozo.

The government is fully aware of the heavy costs incurred in the building and running of residential homes for the elderly in Malta. In fact, the last home, which was built in 1999 and which houses around 80 elderly persons, has cost the government Lm2.5 million (Euros 5.75 million).

The government is resolute that the way forward is to develop partnerships with the private sector as a result of which future homes for elderly persons will be constructed and managed together with private companies. In fact, as discussed in **4.1.2.1**, the government has sub-contracted to a private organisation in the field of aging the administration of the last two houses which it built. The next step now is to involve the private sector in the construction of the future homes. The government is also sub-contracting private companies by utilising their vacant rooms for elderly people who are on the waiting list, rather than constructing new homes for them. This is because there are more than 500 elderly persons waiting to be placed in one of the various homes in Malta.

During the past 17 years the government has opened seven homes for the elderly. The capital and recurrent cost of these homes is considerably heavy on the public funds. At the same time the Maltese population is aging rapidly and the demand for residential homes is heavily increasing. Consequently, the involvement of the private sector in this aspect of welfare will on the one hand provide residential accommodation to those elderly persons who so need it, while at the same time it will ease the burden on the country's public finances. This view is also reiterated by the private companies involved in private residential care in Malta which believes that establishing joint partnerships with the government in this sector is the best, if not the only, solution. If these homes are to be run in a sustainable manner, both the public and private sector must be involved.

## 5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

As seen in section **4.1.1.3** from this year, elderly residents and St. Vincent de Paul are paying up to 80 per cent of all their income provided that the resident is not then left with less than Lm 600 (Euros 1,400). In section **4.1.2.1** residents of government-owned residential homes for the elderly have to pay 60 per cent of all their income. However, in one of these homes which also offers long term health care, the charge is the same as at SVPR namely, 80 per cent of all the income. The same proviso mentioned earlier applies in both cases. Payment is usually deducted at source from the residents' social security pension and is then passed to the Welfare Committee. The service at SVPR is highly subsidised by government. It is estimated that the actual daily cost per resident amounts to Lm 21 (Euros 48.30) (Government of Malta. Department for the Elderly and Community Services).

There is no fixed charge in private residential homes. Daily charges for accommodation and basic care range between Lm 8 to Lm 20 (Euros 18-46). The actual price depends on a number of factors including, among others : the level of care needed, the level of dependency of the resident, the location and size of the room (single or double occupancy), etc. (section **4.1.2.1.3)** Residents pay extra for other services. In Church-run homes, although once again there is no fixed rate for all the 18 homes, residents pay a daily charge ranging between Lm6.50 and Lm 10. (Euros 15 -23). Some of the homes charge extra for services beyond accommodation and basic nursing. Here, however, the financial situation of the resident is very often taken into account when establishing on a monthly payment.

The average wage is Lm97 per week (Euros 223), around Lm5,044 per annum (Euros 11,600). There is also a twice yearly bonus of Lm 56 (Euros 130) each time, and a cost of living increase allowance. Added to this there are a number of allowances including: a children's allowance, a family allowance (payable to recipients of Children's Allowance), a supplementary allowance paid to all Maltese citizens whose total income fell below a certain level. Furthermore, one has to keep in mind the fact that the Maltese benefit a lot from a wide gamut of social services. As pointed out earlier, health and education in public institutions are free of charge.

Since 1979, an employee who, during his/her employment years had paid 1,560 pension contributions (52 weekly contributions for 30 years), on his/her retirement at the stipulated age of 60 for females and 61 for males, is entitled for a maximum annual pension amounting to Lm 4,500 (Euros 10,350). There is also a National Minimum Pension which amounts to Lm 45.16 per week (Euros 104) in the case of a married person and Lm 39.11 per week (Euros 90) in the case of a single person. There also exists a Non Contributory pension scheme, which is based on a means test. The later scheme which originally was meant to cater for those below the 'poverty line' has over a period of years evolved into a comprehensive scheme with a number of provisions that are intertwined in such a way that one type of benefit supplements another(Government of Malta, Department of Social Security. 2003)

**Table 33: Estimated daily costs of care in Malta Liri* (that the beneficiary has to cover) in old people's homes based on the care category of the beneficiary as on April 2004**

| Residential Home | Price | True Cost |
|---|---|---|
| **Public Community Home** | 60% of total income** | Lm12 |
| **Public Nursing Institution (SVPR)** | 80% of total income* | Lm 21 |

| | | |
|---|---|---|
| **Private Residential Home/Care** | Lm 8 - Lm20*** | --- |

Source: Government of Malta. Department for the Elderly and Community Services. 2004

* One Malta Lira is equivalent to Euros 2.3.

** provided that the resident is not left with less than Lm 600 per annum at his/her disposal. In one of the residential homes which also has a nursing facility, residents who are dependent pay 80 per cent of their total income with the same proviso mentioned earlier.

*** this amount covers only accommodation and basic care. Other services are charged extra.

## 5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or/and social contributions?

As already discussed in section **4.1.1**, the Maltese Government provides a comprehensive health service to all Maltese residents that is entirely free at the point of delivery. This health service is funded from general taxation. All residents have access to preventive, investigative, curative and rehabilitative services in Government Health Centres and Hospitals. Furthermore, persons with a low income can benefit from free medicines from the government hospital if they pass a means test given by the Department of Social Security. In addition, a person who suffers from one or more of a specified list of chronic diseases (e.g. rheumatoid arthritis) is also entitled to receive free treatment for his /her ailment, irrespective of financial means. During 2001, around one-sixth of Malta's gross domestic product was absorbed by social security expenditure (Government of Malta. 2003). The Government's recurrent expenditure for health services in 2003 amounted to Lm 28.6 million (Euros 66 million). This was 26.4 per cent of the total recurrent expenditure. (Government of Malta. Ministry of Finance. 2004).

In Malta, there is no obligatory "Health Insurance", as there is a free national health service covering the whole resident population. All workers and employers pay National Insurance contributions on a weekly basis, but this money goes to finance welfare services in general (e.g. pensions) and not health services in particular. It is the exception for an employer in Malta to offer health insurance as an employment benefit. A number of residents purchase private health insurance on a voluntary basis; the proportion of the population availing itself of this option is growing rapidly. Many people also choose to make use of the services of private general practitioners and specialists against direct payment.

The financing of social security contributions by the social partners constitute the single source of social security financing in Malta. There are two classes of contributions: the Class One contribution payable in respect of Employed Persons and the Class Two contribution paid by self-employed Persons. Government also effects a statutory State contribution to the system. Generally speaking, contributions are payable by all employed persons (whether self employed or otherwise) persons between the age of 16 years and the age of their retirement[2]. Malta oper-

[2] Persons exempt from contributing are those in receipt of full-time education or training, non-gainfully occupied married women whose husband is still alive, persons in receipt of a pension in respect of widowhood, invalidity or retirement or persons in receipt of a Parent's Pension, persons in receipt of non-contributory Social Assistance or non-contributory pension. Non-gainfully occupied persons whose total means do not exceed Lm430 per annum in the case of single persons and Lm630 per annum in the case

ates a 'pay-as-you-go' funding of its social security system whereby contributions by employers, employees and the self-employed, topped up by a statutory amount by Government equal to one half of contributions, are set-off against social security expenses[3] (Government of Malta. Department of Social Security. 2003)

## 5.7 Funding of family carers

Acknowledging that the attainment of this balance is not always easy, Malta has striven to enable women, and indeed men, to reconcile their work and family responsibilities. Important measures have been introduced, in particular parental leave, childcare facilities and career breaks for parents. In addition, reduced working hours and responsibility breaks for carers of children and the elderly, as well as pro-rata benefits for part-time employees have been adopted. Moreover, as explained in the following three sections the Maltese Government offers a pension to persons taking care of older relatives.

### 5.7.1 Are family carers given any benefits (cash, pension credits/rights, allowances etc.) for their care? Are these means tested?

The Maltese government has two schemes as a result of which family carers of dependant elderly persons can receive financial benefits. These are: 1) the Carer's Pension and 2) Social Assistance for Females taking care of a sick or elderly relative:

1. The Carer's pension: Started on the 4th January 1992, a Maltese citizen who is single or widowed and who all by her/himself and, on a full-time basis, takes care of his parent or brother, sister, grandparent, uncle, aunt, father or mother-in-law, or brother or sister-in-law who because of infirmity is bedridden or bound to a wheelchair is entitled to receive a Carer's pension. To benefit from this pension, the carer has to live in the same household as that of the person he is taking care of. The maximum rate for this scheme is Lm33.11 (Euros 76) per week. This is subject to a means test. This rate may, however, vary since it is subject to a means test and any income which the carer might receive is deducted from the rate allowed. In addition the carer receives an additional bonus of Lm1.34 (Euros 3) weekly and a six monthly bonus of Lm58 (Euros 133). (Government of Malta. Department of Social Security. 2003, Government of Malta. Ministry of Social Policy. 2004o). As on 31st December 2003, there were 259 family carers, 106 males and 153 females who were benefiting from this scheme.

of married men, as well as 'gainfully occupied' self-employed persons whose earnings do not exceed Lm390 per annum may apply for a certificate of exemption from the payment of contributions.

[3] The resulting deficit is known as the welfare gap. The welfare gap is estimated to have hovered at between 4 to 6 per cent of GDP during the past five years, thus accounting for over one half of the overall fiscal deficit. Politicians and policymakers alike have often voiced concerns regarding the fact that the cost of the social security system in Malta is becoming unsustainable (Grech L. 2000, Central Bank of Malta. 1997, Delia EP. 1998, Felice Pace J. 1998).

**Table 34: Gender and age of Maltese family carers benefiting from the Carer's Pension Scheme as on 31.12.2003**

| Age | Males | Females |
|---|---|---|
| **20-29** | 22 | 17 |
| **30-34** | 11 | 4 |
| **35-39** | 11 | 9 |
| **40-44** | 15 | 13 |
| **45-49** | 19 | 35 |
| **50-54** | 12 | 26 |
| **55-59** | 13 | 38 |
| **60-64** | 3 | 10 |
| **65-69** | 0 | 1 |
| **Total** | **106** | **153** |

Source: Government of Malta. Department of Social Security. 2003

2. Social Assistance for Females taking care of a sick or elderly relative: A single or widowed female who is unemployed (whether registered or not) and who is taking care of a sick or elderly relative all by herself and on a full-time basis, can benefit from this scheme which was started on the 28 February 1987. Relatives referred to in this section can be parent or brother, sister, grandparent, uncle, aunt, father or mother-in-law, or brother or sister-in-law. The cared for person has to be aged 60 and above, suffering from a severe physical or mental infirmity, and is physically or mentally unable to take care of himself/herself or unable to perform the activities of daily living. The maximum rate amounts to Lm 23.60 (Euros 54) per week. This rate may, however, vary since it is subject to a means test and any income which the carer might receive is deducted from the rate allowed. The carer has also to be living in the same household as the person who is being cared-for (Department of Social Security. 2003, Ministry of Social Policy. 2004t). As on 31st December 2003, there were 456 family carers, who were benefiting from this scheme. 63.8 per cent of these, or 291 carers, were above the age of 45 as compared to the 165 carers or 36.2 per cent who were aged between 20-44. The majority, or 106 persons (23.2 percent), were aged between 55-59.

| | Attendance allowance | Carers´ allowance | Care leave |
|---|---|---|---|
| Restrictions | Yes | | |
| Who is paid? | Family Carer | | |
| Taxable | No | | |
| Who pays? | State Budget | | |
| Pension credits | | | |
| Levels of payment / month | Euros 234 * Euros 329 ** | | |
| Number of recipients in 2002 | 480* 238 ** | | |

Source: Government of Malta, Department of Social Security. 2003

NB. In Malta no distinction is made between attendance and caring.

* Social Assistance for Females taking care of a sick or elderly relative

** Carer's Pension

### 5.7.2 Is there any information on the take up of benefits or services?

Yes, the Government of Malta issues such and much more information through its electronic website. (Government of Malta. Ministry of Health, the Elderly and community care. 2004a-d, Government of Malta.Ministry of Social Policy. 2004a-z)

### 5.7.3. Are there tax benefits and allowances for family carers?

There are no tax benefits currently available for family carers in Malta. Regarding allowances available for family carers in Malta see **5.7.1**

### 5.7.4. Does inheritance or transfers of property play a role in care giving situation? If yes, how?

It has already been pointed out that, for a long time, it was part of Malta's traditional social pattern that where a daughter remained unmarried, or was married but bore no children, she was expected to look after her elderly parents. (Busuttil S. 1971) In return, she was given the family house on the passing away of her parents. Till today the majority of Malta's elderly persons bequeath their property to that child who takes care of them when they become dependent.

Article 8, Chapter 6 of the Maltese Civil Code clearly states that "Children are bound to maintain their parents or other ascendants who are indigent." According to the Maltese Civil Code, children are entitled to inherit their parents. This can be seen as a recompensation for the care which children gave to their parents when the latter where in need of support. In fact, Article 13 (1) states that "nevertheless it shall be lawful for the court, in urgent cases, to condemn any of the persons liable for maintenance, in whatever degree, to supply maintenance, reserving to such person the right to claim reimbursement from such persons as, according to the said order, were bound to supply such maintenance".

However, Article 32 states that "parents or other ascendants may refuse maintenance to children or other descendants on any of the grounds on which an ascendant may disinherit a descendant". Article 623 clearly mentions a number of grounds on which a descendant may be disinherited. These include, among others: 1. when the descendant has without reason refused maintenance to the testator(623 (a)); 2. when the descendant is guilty of cruelty towards him (623 (d)); 3. when the descendant has been guilty of grievous injury against the testator (623 (e)). (Government of Malta. Ministry of Justice. 2004c).

### 5.7.5 Carer's or Users' contribution to elderly care costs (check list of services and costs to user) (Use footnotes where necessary to explain specific points).

| a. Medical, nursing and rehabilitation services | General access: | | | Access based on: | | |
|---|---|---|---|---|---|---|
| | Free at point of use/wholly reimbursed | Partly privately paid/partly reimbursed | Completely privately paid | Means-tested | | Based on severity |
| | | | | Partly reimbursed | Wholly reimbursed | |
| General practitioner | X | | | | | |
| Specialist doctor | X | | | | | |
| Psychologist | X | | | | | |
| Acute Hospital | X | | | | | |
| Long-term medical residential care (for terminal patients, rehabilitation, RSA,etc.) | X | | | | | |
| Day hospital | X | | | | | |
| Home care for terminal patients | X | | | | | |
| Rehabilitation at home | X | | | | | |
| Nursing at home (Day/Night) | X* | | X* | | | |
| Laboratory tests or other diagnostic tests at home | | | X | | | |
| Telemedicine for monitoring | Not available | | | | | |
| Other, specify | | | | | | |

***** During the day, the service is available free of charge. During the night, MMDNA offers services only in emergency cases. Nursing at home during the night is available, at a charge, from private organisations/individuals.

| b. Social-care services | General access: | | | Access based on: | | |
|---|---|---|---|---|---|---|
| | | | | Means-tested | | |
| | Free at point of use/wholly reimbursed | Partly privately paid/partly reimbursed | Completely privately paid | Partly reimbursed | Wholly reimbursed | Based on severity |
| Permanent admission into residential care/old people's home | X | | | | | |
| Temporary admission into residential care/old people's home in order to relieve the family carer | X | | | | | |
| Protected accommodation/sheltered housing (house-hotel, apartments with common facilities, etc.) | | X | | | | |
| Laundry service | X | | | | | |
| Special transport services | X | | | | | |
| Hairdresser at home | | | X | | | |
| Meals at home | | X | | | | |
| Chiropodist/Podologist | X | | | | | |
| Telerescue/Tele-alarm (connection with the central first-aid station) | | X | | | | |
| Care aids | X | | | | | |
| Home modifications | | X | | | | |
| Company for the elderly | | X | | | | |
| Social worker | X | | | | | |
| Day care (public or private) in community centre or old people's home | | X | | | | |
| Night care (public or private) at home or old people's home | X | | X | | | |
| Private cohabitant assistant ("paid carer") | | | X | | | |
| Daily private home care for hygiene and personal care | | | X | | | |
| Telephone service offered by associations for | | X | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| the elderly (friend-phone, etc.) | | | | | | |
| Counselling and advice services for the elderly | **X** | | | | | |
| Social recreational centre | | **X** | | | | |
| Other, home care | | **X** | | | | |

| **c. Special services for family carers** | **General access:** | | | **Access based on:** | | |
|---|---|---|---|---|---|---|
| | **Free at point of use/wholly reimbursed** | **Partly privately paid/partly reimbursed** | **Completely privately paid** | **Means-tested** | | **Based on severity** |
| | | | | **Partly reimbursed** | **Wholly reimbursed** | |
| | | | | | | |
| Training courses on caring | **X** | | | | | |
| Telephone service offered by associations for family members | **Not available** | | | | | |
| Internet Services | **Not available** | | | | | |
| Support or self-help groups for family members | **X** | | | | | |
| Counselling services for family carers | **X** | | | | | |
| Regular relief home service (supervision of the elderly for a few hours a day during the week) | **X** | | | | | |
| Temporary relief home service (substitution of family carer for brief periods of time, for example, a week) | **X** | | | | | |
| Assessment of the needs | **X** | | | | | |
| Monetary transfers | **Not available** | | | | | |
| Management of crises | **X** | | | | | |
| Integrated planning of care for the elderly and families at home or in hospital | **Not available** | | | | | |
| Services for family carers of different ethnic groups | **Not available** | | | | | |
| Other, specify | | | | | | |

# 6 Current trends and future perspectives

## 6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and/or carer abuse among these issues?

The Maltese government is fully aware that the participation of the elderly within Society necessarily and basically implies their actual involvement within the family. The government is also conscious of the fact that although Maltese society has always been characterised by its strong family structure, in recent years the traditional care provided by the family to its elderly members has been subjected to a considerable strain (Troisi J. 1999, 1991; Troisi J, Formosa M. 2000). In this light, various public policies and programmes have sprung up to supplement family supports to the growing elderly population so as to enable the elderly to remain within their family environment for as long as possible. The family is to be supported to continue being the principle provider of care of the elderly. At the same time, the elderly are to be supported to remain in their own environment and community. Following the 1987 general elections, the Government established the Ministry for Social Policy with a portfolio comprising health, labour, migration, the elderly, families, the disabled and women. All this had to be integrated in a social policy with a family oriented approach. The challenge was how to change from 'a welfare state' to a 'caring society' (Vella CG. 1990). In 1993, a law called The Maltese Family Law was promulgated exclusively regulating the relationships between the family members. (Government of Malta. Ministry of Justice. 2004c.)

In spite of all this, however, in Malta, as such there are no major policy and practice issues debated on family care of the elderly directly or exclusively from the carers' point of view. However, other factors may have an indirect effect on the status of family carers. For example, the retirement age in Malta currently stands at 61 and 60 for males and females respectively. The government is currently debating whether this should rise to 65 for both sexes. If this policy is implemented it is clear that the number of family carers would diminish since many would have to work for as much as five years longer in their life span.

In 1994 the Social Welfare Development Programme was set up by the Ministry for Social Policy to work for the improvement of the Social Welfare Sector as well as community development. Through the years, the number of services offered increased not only in number but also in quality. In the year 2000, a re-structuring exercise was implemented which led to the setting up of APPOGG with the aim of prioritising and strengthening services for children in need of care, developing human resources, integrating all social work services, harmonising service standards and practices as well as positioning itself for expansion (http://www.appogg.gov.mt)

One of the sections is the Domestic Violence Unit which aims at providing quality social work service to adults and their children suffering abuse in family and intimate relationships. It specialises in support and empowerment of the person being abused, help to find shelter when requested and links them to necessary services. The unit is committed to the promotion of a society with zero tolerance to violence and abuse. (APPOGG. 2004)

## 6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

We are not in a position to discuss in-depth whether or not there will be any changing trends in services to support family carers as the government's position on the future of this matter is not

clear. However, with the increasing costs incurred by the government with respect to residential care, as well as the fact that the demand for such care is growing more rapidly than the supply, one expects that the state's economic and psychological support to family carers will be strengthened in the nearby future.

## 6.3 What is the role played by carer groups / organisations, "pressure groups"?

At present, there are no carer groups/organisations' "pressure groups" in Malta. In this regard, the majority of the respondents to the questionnaire carried out by the European Centre of Gerontology and Geriatrics, University of Malta, emphasised the need of setting up of an Association of family carers. This would not only serve a number of purposes and fulfil a number of functions, but above all it would serve as the voice of carers. So important is the creation of such an Association in Malta that, as can be seen in section **6.7,** this is precisely one of the recommendations that have been proposed.

## 6.4 Are there any tensions between carers' interests and those of older people?

Support given by family members is the most natural form of support since it provides the elderly person and the care giver with opportunities to continue the relational bonding between family members. Family members provide emotional support, empathy and understanding during difficult times.

However, as pointed out in section **1.11**, care giving has also a number of costs. These include physical, financial, social and emotional costs. In fact, a number of full-time carers, reported that they feel a great deal of stress because of the conflicts they meet while caring for their relatives. (Troisi J, Formosa M, Navarro M. 2004). According to this research, 62.8 percent of the respondents felt that caring for elderly relatives was not only a burden but it often resulted in friction and constant quarrels between the two parties. This was due to the fact that the cared for were not only very possessive and over demanding, but they also hardly showed any appreciation of the dedication shown by their carers and of the amount of care given. The latter were taken for granted.

A number of dependent elderly persons who were being cared for were also reported to be manipulative. It was such attitudes which not only increased the level of stress but, in a number of cases, led to lack of role satisfaction and feeling of fulfilment. This was the situation of a good number of those who were full-time carers. They were often not allowed time for themselves. Compared to this, 37.2 percent of the respondents, the majority of whom did not receive any social benefits for their caring, (neither the Carer's Pension nor the Social Assistance for Females taking care of a sick or elderly relative) replied that although tensions did arise because of differences between their interests and those of the persons whom they were caring for, the incidence and gravity of such tensions could be well handled. The reason being that the carers managed to find alternative ways through which their caring role was only a part of their duties. Since they had a number of ways in which they could burn out moments of tension, levels of stress would not escalate very high so as to get out of control.

## 6.5 State of research and future research needs (neglected issues and innovations)

Earlier on it was pointed out that during the last decade a number of studies have been carried out in the various fields of aging, some of which also dealt with the situation of Maltese family carers to elderly members . These included theses carried out in the Institute of Gerontology,

University of Malta ( Agius Cutajar D. 1994, Bonello R. 1995, Briffa R. 1994, Busuttil MR. 1998, Grixti J. 1999, Laferla A. 1997, Micallef T. 1994, 2000, Navarro M. 1995, Scicluna M. 1998) Other research was carried out by students in the Faculty of Arts, University of Malta, (Abela N. 1988, D'Amato R. 1995, Mifsud J. 1999, Vella M. 1993). Investigations tend to focus on the negative consequences of care-giving such as an increase on the emotional distress, social isolation, and increased tension or conflict between the care-giver and the care-receiver. Research has found out that the caring for an elderly family member imposes physical, emotional, and financial strains. The latter, in turn, can threaten a care-giver's ability to continue providing care over a prolonged period of time. Hence, the risk of the care recipient's placement in a residential home. Studies have also reported that factors such as the care-giver's gender and marital status, the types of care provided, the lack of satisfactory assistance, with care-giving, and the extent to which the care-giver's personal and social life are disrupted by the demands of care-giving also contribute towards care-giver strain. Moreover, we also know that the demands of combining work and care-giving responsibilities can create stress. Indeed, as families get over child care they are faced with the additional challenge of providing care to a dependent elderly parent.

However, this does not mean that there are no neglected issues. In fact, one locates an immediate need for future research on, at least, the following major areas. First, the effect that the increasing number of women in the labour force will have on family care-giving. Secondly, it would be interesting to compare employed care-givers with others who are not in the labour force with respect to strain and the result of the fact that the former may miss out on job responsibilities and overtime opportunities. Thirdly, the effect of changing values - especially in terms of gender based issues and increasing consumption - on family care-giving. Fourthly, it is important to compare the cases whether the elderly relative lives in the same household of the care-giver and other instances where they live in different households. Fifth, we have no information regarding the sandwich generation - that is, mothers who are taking care of their young children while at the same time also taking care of their dependent elderly parents. A final immediate area of interest relates to the investigation of the conflict arising between employment and care-giving roles now that more men and women are enjoying careers in the labour force.

## 6.6 New technologies – are there developments which can help in the care of older people and support family carers?

In section **4** especially **4.1.2** we discussed the wide range of health and social services and programmes being implemented by the government, the Church, voluntary organisations and the private sector aimed at helping and supporting the elderly and their carers. At present there are no new technologies which are being currently developed which can more directly further help family-carers to enable them to be in a better position to take care of their elderly relatives.

## 6.7 Comments and recommendations from the authors

In trying to meet the challenges of population aging especially in the sphere of caring, one must recognise two sets of needs and preferences which, although not mutually exclusive, they are not the same. On the one hand, we have the needs of the dependent elderly persons themselves, while on the other we have the needs of those who provide care.

The Maltese government has been implementing a number of social policies, programmes and services benefiting the elderly with a special emphasis on care in the community. A number of voluntary organisations have over the years also contributed to the care and well being of the

elderly in a number of ways. There is a great need to ensure a dynamic and well co-ordinated national response to the needs of family carers in all spheres especially in the field of aging.

It is high time to place the issue of their role and socio-economic circumstances on current policy agenda. It is essential that the care being provided to the elderly by their family members need to be recognised both at policy level and at service/programme level. (D'Amato R. 1995). A great need has been created to encourage the setting up of an Association of family carers. This would serve a number of purposes and fulfil a number of functions. Without doubt, such an Association can act as the voice of carers and would thus be a big help in ensuring that their needs are addressed and supported. It would provide information and advice for carers, helping them to become more aware of their own role and status in the community, while encouraging them to articulate their own needs. It would help them to share their experiences and to know that they are not alone in their work. It can also serve to raise public awareness to the problems and needs of the carers and brings this to the attention of government thus functioning as a lobbying board for appropriate legislations.

This Association, would serve as a focal point and catalyst enabling family carers, policy makers and social care professions to come together to prepare a range of service support tailored not only to the needs of the elderly, as is being done, but also to the needs of their carers. Periodical reviews of existing services and programmes should be conducted to study how these are benefiting not only the cared-for but also the carers. Providing care to family care givers should be considered as a supplement to and not as a replacement for the care provided by family members.

Equally important is the setting up of a national register of family carers. A number of such registers already exist as for example registers for professional bodies. This would not only serve to identify who the family carers are but would also help to enhance scientifically sound research in the matter. In fact, one of the biggest handicaps in this report has been the absence of such a register. This is an important tool in determining the problems and needs of family supports that maintain the care giving tasks within the family setting.

Closely connected with this is the need to conduct national research, both quantitatively and qualitatively. This is important so as to examine the socio-economic conditions of these carers and to analyse their changing role and status with particular reference to the needs and problems arising from the wide changes which Maltese society in general and the family in Malta are passing through.

During the First World Assembly on Aging which took place in Vienna in 1982, it was highlighted that a serious deficiency being faced by many countries was the acute shortage of trained personnel in the field of aging. A number of recommendations of the ensuing Vienna International Plan of Action on Aging repeatedly stressed the importance of training and capacity building in the various aspects of aging. No less than four recommendations specifically emphasised the need and importance of training personnel. This training should not be restricted to high levels of specialisation, but should be made available at all levels. Recommendation 7 clearly stated that "those who work with elderly at home, or in institutions, should receive basic training for their tasks, with particular emphasis on participation of the elderly and their families…" (United Nations. 1983). Twenty years later, the Second World Assembly held in Madrid and the ensuing Madrid International Plan of Action on Aging , further emphasised the role and measures which intergovernmental and non-governmental organisations should take to develop trained personnel in the field of aging (United Nations. 2003).

As pointed out in this report, Malta has a wide variety of programmes and services for elderly persons. This has, in turn, increased the variety of skills needed and. consequently the level of

training. A lot is being done in the field of capacity building in the field of aging in Malta. In 1987, an Institute of Gerontology was set up within the University of Malta offering postgraduate studies in Gerontology and Geriatrics. The Institute of Health Care, and the Medical School within the same University also offer training in Geriatrics. The Institute of Gerontology also runs various programmes in the field of aging including a University of the Third Age, pre-retirement training programmes, short in-service training programmes for personnel already working in the field of aging or with the elderly, etc. The Department for the Elderly and Community Services, in collaboration with the University Institute also runs training programmes for part-time social assistants. In 1988, the United Nations opened an International Institute on Aging, mandated to train personnel from developing countries in the multiple fields of aging.

Moreover, the Department for the Elderly and Community Services in conjunction with the Employment and Training Corporation training programmes are organised with the objective to give caring personnel a better insight into the needs of the elderly(Section **3**). A number of short training programmes are also held in conjunction with organised the Malta Memorial District Nursing Association (MMDNA) (Section **3.2.1.3**). Other programmes are organised by various voluntary organisations including: Caritas Malta (Section **3.2.1.1**), and the Cana Movement (Section **3.2.1.2**)

In spite of all this, however, there is still a great need of capacity building of family carers of elderly persons in Malta. It is extremely important for them to acquire the basic training so as to have the necessary knowledge, skills and attitudes so as to be in a better position to cope with the medical, social, psychological and economic problems of their elderly members and, at the same time, improve their level of care.

The majority of the respondents to the research carried out by the European Centre of Gerontology, University of Malta (Troisi J, Formosa M, Navarro M. 2004) strongly emphasised the need for the Maltese government to establish a national day for informal carers of elderly persons. It would serve as a means to create public awareness and recognition of the challenge of the burden of care by family carers, their role, function, needs, difficulties. At the same time, it would serve as a very efficacious way to strengthen both family resources and the motivation to continue caring for the elderly. The family caregiver is a major national economic resource in providing care for the elderly. It is important to understand the lived experience of the care giver so that meaningful, appropriate preparation and interventions are implemented to support the care giver.

A similar recommendation concerned the creation of a national Charter for family carers of elderly persons. This would ensure that the rights and obligations of the carers are respected and honoured. It would also ensure that the quality of care to older relatives is maintained.

# 7 Appendix to the National Background Report for Malta

## 7.1 Socio-demographic data

**Table 35: Population of the Maltese Islands at different population censuses and as on 31st December 2002**

| Year | Total | 60+ | | 75+ | |
|---|---|---|---|---|---|
| | | N | % | N | % |
| **1985** | 340,907 | 48,386 | 14.2 | 12,868 | 3.8 |
| **1995** | 385,087 | 65,339 | 16.9 | 19,751 | 5.1 |
| **2002** | 386,938 | 65,628 | 17.0 | 20,307 | 5.3 |

Source: COS. 1986, COS. 1997a, NSO. 2003b

### 7.1.1 Profile of the elderly population-past trends and future projections

**Table 36 : Projected Maltese population of elderly persons in 2025, 2035, 2050 (000s) as on 31st December 2002**

| Age | 2025 | | | 2035 | | | 2050 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Males | Women | Total | Males | Women | Total | Males | Women |
| **60-64** | 23.6 | 11.3 | 12.3 | 23.7 | 11.5 | 12.2 | 24.7 | 11.9 | 12.8 |
| **65-69** | 24.4 | 11.1 | 13.3 | 18.9 | 8.7 | 10.2 | 23.7 | 10.9 | 12.8 |
| **70-74** | 20.8 | 9.1 | 11.7 | 19.4 | 8.5 | 10.9 | 21.4 | 9.5 | 11.9 |
| **75+** | 35.3 | 13.4 | 21.9 | 39.7 | 15.0 | 24.7 | 34.9 | 13.4 | 21.5 |
| **Total** | **104.1** | **44.9** | **59.2** | **101.7** | **43.7** | **58.0** | **104.7** | **45.7** | **59** |

Source : NSO. 2003b.

#### 7.1.1.1 Life expectancy at birth (male/female) and at age 65 years.

**Table 37 : Life Expectancy at birth and at age 65 years of the Maltese population by gender as on 31st December 2002**

| Year | Gender | Age | |
|---|---|---|---|
| | | Birth | 65 |
| **1957** | **Men** | 65.7 | 11.7 |
| | **Women** | 68.9 | 13.0 |
| **1967** | **Men** | 65.7 | 11.9 |
| | **Women** | 71.6 | 13.2 |
| **1985** | **Men** | 70.8 | 12.3 |
| | **Women** | 76.0 | 15.1 |
| **1995** | **Men** | 74.9 | 15.3 |
| | **Women** | 79.5 | 17.5 |
| **2002** | **Men** | 75.8 | 15.0 |
| | **Women** | 80.5 | 19.0 |

Source : NSO. 2003b.

#### 7.1.1.2 % of >65 year-olds in total population by 5 or 10 year age groups

**Table 38 : Elderly Maltese population by age group and by percentage of total population (2002)**

| | Population | | | |
|---|---|---|---|---|
| **Age** | **Total** | **%** | **Men** | **Women** |
| **Total** | 67,574 | 17.0 | 29,243 | 38,331 |
| **60-64** | 16,611 | 4.18 | 7,864 | 8,747 |
| **65-69** | 16,766 | 4.22 | 7,573 | 9,193 |
| **70-74** | 13,327 | 3.35 | 5,635 | 7,692 |
| **75-79** | 10,313 | 2.60 | 4,240 | 6,073 |
| **80-84** | 6,540 | 1.65 | 2,584 | 3,956 |
| **85-89** | 2,610 | 0.65 | 906 | 1,704 |
| **90+** | 1,407 | 0.35 | 441 | 966 |

Source : NSO. 2003b.

### 7.1.1.3 Marital status of >65 year-olds (by gender and age group)

**Table 39 : Marital status of Maltese elderly persons by age group and gender as on 25th November 1995**

| Age | Single | | Married/ Remarried | | Separated/ annulled/ divorced | | Widowed | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F |
| **60-64** | 1,863 | 990 | 5,692 | 5,987 | 147 | 163 | 1,399 | 320 | 9,560 | 8668 |
| **65-69** | 1,699 | 960 | 4,068 | 4,866 | 98 | 105 | 2,004 | 401 | 7,869 | 6332 |
| **70-74** | 1,519 | 842 | 2,785 | 3,829 | 64 | 52 | 2,454 | 680 | 6,822 | 5403 |
| **75-79** | 964 | 551 | 1,235 | 2,099 | 33 | 38 | 2,115 | 605 | 4,347 | 3,293 |
| **80-84** | 726 | 317 | 543 | 995 | 14 | 12 | 1,684 | 563 | 2,967 | 1,887 |
| **85-89** | 455 | 159 | 180 | 333 | 3 | 6 | 1,003 | 368 | 1,641 | 866 |
| **90+** | 173 | 44 | 45 | 53 | - | 1 | 365 | 131 | 583 | 229 |

Source: COS. 1999

### 7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups.

**Table 40 : Household structure of Maltese elderly persons classified by age group and gender as on 25th November 1995**

| Age group | Females | | Males | |
|---|---|---|---|---|
| | Single | 2 or more | Single | 2 or more |
| **60-64** | 1,374 | 7,727 | 596 | 6,864 |
| **65-69** | 1,674 | 6,195 | 634 | 5,698 |
| **70-74** | 1,859 | 4,963 | 715 | 4,688 |
| **75-79** | 1,385 | 2,962 | 518 | 2,775 |
| **80-84** | 895 | 2,072 | 379 | 1,508 |
| **85-89** | 422 | 1,219 | 199 | 667 |
| **90-94** | 83 | 500 | 42 | 187 |

Source: COS. 1999.

#### 7.1.1.5 Urban/rural distribution by age (if available and/or relevant)

It is very difficult to distinguish between urban and rural areas in the Maltese islands. Normally speaking, the two have their own specific characteristics and different population densities. In the Maltese Islands, however, although locality characteristics and population densities vary from each other, the differences are not such that would facilitate the drawing of distinctions between urban and rural areas. Moreover, given the relative homogeneity in Maltese locality characteristics and in population densities, these islands may be described as being predominantly urban (COS. 1997a).

#### 7.1.1.6 Disability rates amongst >65 year-olds. Estimates of dependency and needs for care.

**Table 41 : Maltese elderly persons with disability per 1000 population by age group as on 25th November 1995**

| | Population | | Disabled | | Rate | |
|---|---|---|---|---|---|---|
| **Age group** | **Females** | **Males** | **Females** | **Males** | **Females** | **Males** |
| **60-69** | 17,828 | 14,710 | 367 | 450 | 20.6 | 30.6 |
| **70+** | 17,862 | 12,388 | 976 | 910 | 54.6 | 73.5 |

Source: COS. 1999.

#### 7.1.1.7 Income distribution for top and bottom deciles i.e. % aged >65 years in top 20% of income, or % > 65s in top 20%, and the same for poorest 20% income groups.

**Table 42 : Average income distribution of Maltese elderly persons by amount in Malta Liri* and percentage (2000)**

| Age | Salary | Subsidies | Interest | Dividends | Social Benefits | Insurance | Rents | Sales of Items | Other Earnings | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Lm** | 272.4 | 1.9 | 824.1 | 421.6 | 1,949.9 | 25.5 | 33.3 | 247.4 | 53.3 | 3,829.4 |
| **%** | 7.1 | 0.0 | 21.5 | 11.0 | 50.9 | 0.7 | 0.9 | 6.5 | 1.4 | 1000 |

Source: NSO. 2003a.

* One Malta Lira is equivalent to Euros 2.3

#### 7.1.1.8 % >65 year-olds in different ethnic groups

The Maltese population can be said to be ethnically homogenous. The number of non-Maltese citizens is relatively small. Moreover, these are not considered to form ethnic groups and are therefore not so classified. According to the latest census reports, the vast majority of the Mal-

tese population (98.8 per cent) obtained their citizenship by birth (COS. 1997b) Another 1.2 per cent acquired Maltese citizenship by registration. Some 0.6 percent of all Maltese nationals acquired their citizenship by naturalisation. In 1995, there were 505 persons who acquired Maltese citizenship by marriage. The majority of these, 61 per cent were women. After the Maltese, the second largest segment of the enumerated population was made up of British nationals who numbered 3,555 and accounted for 49.3 per cent of the non-Maltese element in the population which totalled 7,213 persons. As on Census day, there were, amongst others, 556 Australians, 410 Italians, 297 Americans, 285 Libyans and 259 Canadian living in Malta. Another 128 persons were stateless. As can be seen from Table 43, a very limited number of elderly persons are of non-Maltese origin. These tend to be of British, American, and Italian citizenship.

**Table 43: Maltese Population by age, country of birth and citizenship as on 26 November 1995**

| Country of Birth | All Age Groups | 0 - 14 | 15-59 | 60 - 74 | 75+ |
|---|---|---|---|---|---|
| **Malta** | 360,176 | 79,231 | 222,941 | 42,355 | 15,649 |
| **U.K.** | 2,959 | 616 | 2,178 | 117 | 48 |
| **Italy** | 382 | 77 | 188 | 95 | 22 |
| **France** | 65 | 13 | 15 | 33 | 4 |
| **Germany** | 152 | 27 | 111 | 9 | 5 |
| **Other E.U.- member country** | 121 | 36 | 65 | 16 | 4 |
| **Other European country** | 224 | 116 | 80 | 16 | 12 |
| **U.S.A.** | 722 | 304 | 354 | 57 | 7 |
| **Canada** | 1,380 | 390 | 980 | 8 | 2 |
| **Australia** | 3,482 | 934 | 2,531 | 17 | 0 |
| **Libya** | 227 | 13 | 129 | 57 | 28 |
| **Other country** | 1,029 | 170 | 513 | 243 | 103 |
| **Total Population** | **370,919** | **81,927** | **230,085** | **43,023** | **15.884** |

Source : COS. 1997b

#### 7.1.1.9 % Home ownership (urban/rural areas) by age group

Having one's own residence is highly valued by the average Maltese. In fact the latest Household Budgetary Survey found that the majority of Maltese owned the dwellings in which they lived. (NSO, 2003a). The survey reported that 93,770 households, or 74.1 percent of households, are owned by the people who reside in them. Out of these, 19,960 residents, or 15.6 per cent, are still paying an outstanding loan on their house. On a regional level, the highest proportion of rented dwellings is to be found in the Southern Harbour region. Here 10,690 residents ( 37.2 per cent) rent the house in which they live. Compared to this, only 500 residents (5.1 per cent) in the Gozo and Comino region are living in a rented house. More elderly per-

sons own their home than in the past: 63.2 per cent during the year 2000 as compared to 59 per cent ten years earlier, with the majority living in terraced houses (NSO. 2003a)

As seen in section **7.1.1.5**, it is very difficult to distinguish between urban and rural areas in the Maltese islands. Moreover, given the relative homogeneity in Maltese locality characteristics and in population densities, these islands may be described as being predominantly urban (COS. 1997a).

**Table 44 : Percentage of household ownership of main dwelling in the Maltese Islands by age group (2002)**

| Age | Owned | Owned, with outstanding loan | Rented furnished | Rented un-furnished | Used free-of-charge | Total |
|---|---|---|---|---|---|---|
| **20-29** | 3.1 | 16.4 | 15.4 | 3.8 | 12.1 | 5.8 |
| **30-39** | 14.4 | 36.7 | 4.7 | 8.3 | 23.8 | 16.8 |
| **40-49** | 23.8 | 28.5 | 27.5 | 17.0 | 14.5 | 22.8 |
| **40-59** | 24.5 | 15.8 | 14.8 | 27.0 | 8.7 | 23.0 |
| **60-69** | 21.6 | 2.6 | 16.8 | 27.5 | 23.3 | 19.9 |
| **70+** | 12.6 | - | 20.8 | 16.4 | 17.7 | 11.7 |
| **Total** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

Source: NSO. 2003a

97.4 per cent of dwellings on which a loan has been taken are owned by residents below the age of 60. Only 2.6 per cent are owned by elderly persons. All these fall in the age group 60-69. No house owner above the age of 70 is living in a dwelling on which he has an outstanding loan. There is a similar marked difference based on age when one takes into consideration living in a rented dwelling. In fact, the elderly constitute 37.6 and 43.9 percent of those who live in rented furnished and unfurnished dwellings respectively. This is in comparison to the 62.4 and 57.6 per cent who are below the age of 60. A possible reason for this relatively high percentage of elderly persons living in rented dwellings could be the fact that formerly house loans were not that easily available.

### 7.1.1.10 Housing standards/ conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

During the year 2000, 74 per cent of households in the Maltese Islands are privately owned. 63.2 per cent of Malta's elderly did own the dwelling in which they were living. A review of past household budgetary surveys shows that the household standards of the average Maltese have improved substantially. By and large housing is of a good standard. All houses have running water, electricity, and sanitation. Apart from certain very cold spells during the winter season, the elderly are able to live comfortably in their homes. All households have a bathroom/shower (45.5 percent having one, 47.9 per cent having 2, and 6.6 per cent having 3 bath-

rooms/showers). 36.3 per cent of the households had a garage. 98.6 per cent of all dwellings have a telephone service.

As can be seen in Table 45, 50 per cent of the Maltese live in terraced houses. It is worth noting that 92.4 per cent of all terraced houses in the Maltese Islands have more than 4 rooms (79.9 per cent have between 5-9 rooms, 11.7 per cent have between 10-14 rooms, and 0.8 have more than 15 rooms). 27 per cent of the Maltese live in maisonettes/ground floor. Here, it is worth noting that 66.3 per cent of all maisonettes/ground floor in the Maltese Islands have more than 4 rooms (64.6 per cent have between 5-9 rooms, 0.7 per cent have between 10-14 rooms). 18.6 per cent of the Maltese live in apartments/flats. 28.4 per cent of these have up to 4 rooms each. 41.2 per cent have between 5-9 rooms and 13.2 per cent have from 10-14 rooms. 4.2 per cent of the Maltese live in fully-/semi-detached houses, the majority of which (67 per cent) have between 5-9 rooms (NSO. 2003a).

**Table 45: Distribution and percentage of households by type of main dwelling and age group in the Maltese islands (2000)**

| Age | Terraced House | | Maisonette/ ground floor | | Apartment/ Flat | | Fully-/semi-detached | | Other | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| 20-29 | 1,950 | 3.0 | 2,370 | 6.8 | 2,240 | 10.2 | 80 | 1.5 | 110 | 16.2 | 7,380 | 5.8 |
| 30-39 | 10,330 | 16.1 | 6,050 | 17.7 | 4,270 | 17.9 | 740 | 13.8 | 200 | 29.4 | 21,500 | 16.8 |
| 40-49 | 15,290 | 23.9 | 6,600 | 19.4 | 5,540 | 23.3 | 1,550 | 28.8 | 280 | 41.1 | 29,170 | 22.8 |
| 50-59 | 16,230 | 25.5 | 5,940 | 17.4 | 5,700 | 23.9 | 1,660 | 30.9 | 50 | 7.4 | 29,490 | 23.0 |
| 60-69 | 11,990 | 18.7 | 8,770 | 26.0 | 3,930 | 16.5 | 800 | 14.9 | 40 | 5.9 | 25,440 | 19.9 |
| 70+ | 8,190 | 12.7 | 4,400 | 12.8 | 1,950 | 8.2 | 540 | 10.1 | - | - | 14,990 | 11.7 |
| Total | 63,980 | 100. | 34,130 | 100. | 23,810 | 100. | 5,370 | 100. | 680 | 100. | 127,970 | 100. |

Source: NSO. 2003a

Television sets, gas/electric cookers and water heaters, fridge-freezers and washing machines are considered as a *sine-qua-con* appliances in almost all Maltese households. As illustrated in Table 46, 99 per cent of all households have a television set (40 per cent own 2 sets, 7.8 per cent own 3 sets and 1.6 per cent own more than 4 sets. 99 per cent own a gas/electric cooker and 92.9 per cent have a gas/electric water heater. 95.1 per cent own a washing machine, while 82.3 per cent own a fridge-freezer. Having a video cassette player/recorder is no longer considered as a luxury. In fact, 77.4 per cent of all households have this appliance. Personal computers are to be found in 34.4 per cent of all households in the Maltese Islands. (NSO. 2003a)

**Table 46: Distribution of households in the Maltese islands by the number and type of household appliances.**

| Household | Number of appliances | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **appliance** | **0** | **%** | **1** | **%** | **2** | **%** | **3** | **%** | **4+** | **%** |
| **Television set** | 1,410 | 1.1 | 63,650 | 49.8 | 50,770 | 39.7 | 10,030 | 7.8 | 2,110 | 1.6 |
| **Video cassette** | 28,960 | 22.6 | 88,170 | 68.8 | 9,670 | 7.6 | 960 | 0.8 | 210 | 0.2 |
| **Video camera** | 101,510 | 79.3 | 26,330 | 20.6 | 120 | 0.1 | 40 | 0.1 | - | - |
| **DVD** | 122,940 | 96.1 | 4,670 | 3.6 | 320 | 0.3 | 40 | 0.1 | - | - |
| **Satellite dish** | 119,760 | 93.6 | 8,030 | 6.3 | 140 | 0.1 | 40 | 0.1 | - | - |
| **Computer** | 83,910 | 65.6 | 49,950 | 32.0 | 2,760 | 2.2 | 300 | 0.2 | 50 | 0.1 |
| **Gas/electric cooker** | 1,310 | 1.0 | 120,570 | 94.3 | 5,680 | 4.4 | 280 | 0.2 | 130 | 0.1 |
| **Microwave oven** | 84,360 | 66.0 | 120,570 | 33.7 | 430 | 0.3 | - | - | 60 | 0.1 |
| **Refrigerator** | 101,010 | 78.9 | 43,120 | 20.0 | 1,240 | 1.0 | 150 | 0.1 | - | - |
| **Fridge-freezer** | 22,660 | 17.7 | 25,570 | 78.8 | 4,430 | 3.5 | 40 | 0.1 | 50 | 0.1 |
| **Freezer** | 90,730 | 70.9 | 100,790 | 28.3 | 1,070 | 0.8 | - | - | - | - |
| **Dishwasher** | 118,310 | 92.4 | 36,170 | 7.4 | 240 | 0.2 | - | - | - | - |
| **Washing machine** | 6,250 | 4.9 | 9,420 | 87.8 | 8,900 | 7.0 | 410 | 0.3 | 40 | 0.1 |
| **Tumble dryer** | 112,300 | 87.8 | 112,370 | 12.1 | 190 | 0.1 | - | - | - | - |
| **Gas/electric water heater** | 9,080 | 7.1 | 15,480 | 66.1 | 28,990 | 22.7 | 4,780 | 3.7 | 560 | 0.4 |
| **Central air-condition** | 123,770 | 96.7 | 84,380 | 2.7 | 660 | 0.5 | 80 | 0.1 | - | - |
| **Air-condition** | 101,220 | 79.1 | 3,40 | 15.6 | 4,700 | 3.7 | 1,570 | 1.2 | 530 | 0.4 |

Source: NSO. 2003a

**Table 47 : Distribution of annual household expenditure by type of household in the Maltese Islands (2002)**

| Item Description | One person household 65+ | | 2 adults, at least one adult 65+ | |
|---|---|---|---|---|
| | Ann. Exp. LM | % | Ann. Exp. LM | % |
| Food, beverages and tobacco | 12,543,000 | 22.6 | 19,269,00 | 32.7 |
| Clothing and footwear | 1,653,000 | 9.3 | 3,495,200 | 5.9 |
| Housing and energy | 4,321,000 | 15.2 | 6,614,000 | 11.3 |
| Household equipment and maintenance | 3,361,700 | 10.1 | 5,703,000 | 9.6 |
| Health | 1,562,000 | 2.4 | 4,035,300 | 6.8 |
| Transport and communication | 3,705,000 | 12.7 | 8,404,200 | 14.2 |
| Recreation and culture | 2,425,400 | 7.7 | 4,460,300 | 7.6 |
| Education, catering and accommodation services | 1,519,200 | 9.2 | 3,144,100 | 5.3 |
| Other services | 1,563,000 | 6.2 | 3,889,700 | 6.6 |
| **Total** | **32,656,000** | **100** | **59,016,400** | **100** |

Source: NSO. 2003a

## 7.2 Examples of good or innovative practices in support services

### 1. Malta Memorial District Nursing Association

This non-governmental nursing Association was set up just after the Second World War in September 1945. It provides domiciliary nursing services of a high standard through professionally qualified nurses. From the very beginning the service was meant to reach anyone who needed it. Hence the annual membership subscription was kept very low. There are two categories of members namely individual and groups. Currently, individual membership amounts to Lm 5 (Euros 11.5). This covers the visits and provision of such nursing products as syringes, sterile dressing packs, swabs and tubular stretch bandages, for the member, his wife or her husband as well as other persons dependent on the member and sharing the same residence. In 2002, the Association had 1,955 individual members and 18,190 group members. During 2003, no less than 13,594 visits were made to these members by the nursing staff complement made up of 20 full time and 4 part-time state registered nurses, 9 full-time and 5 part-time state enrolled nurses. This averaged 37.2 visits a day.

In 1973, the government, through the Department of Health, contracted this Association to deliver a nursing service to the elderly and the disabled living in their homes and who without this service would have had to be institutionalised. The service was provided free to those who needed it and had passed a means test. There was also a handyman service and a free laundry service. Due to lack of financial agreement between the MMDNA and the government, this scheme lasted only for eight months.

In 1987, the newly appointed Parliamentary Secretary for the Care of the Elderly contracted this Association entrusting it to co-ordinate all government domiciliary general nursing services on the island.

The service is normally available between 8.00 and 13.00 for the morning visits and between 16.00 and 18.00 in the afternoon. After 20.00 calls are referred to the casualty department at

the government's mail hospital and is given by nurses on the staff of that hospital. In special cases, calls from members are entertained even at night.

Nursing care and treatment are prescribed by a general practitioner. Written instructions by the medical practitioner to the community nurse are provided in the patient's home and the nurse, in turn, has to leave a record of her procedure and relevant comments. Thus the community nurse has to treat the patient strictly in accordance with the instructions given. In cases of emergency, she must obtain verbal instructions from the general practitioner regarding treatment. It is also her duty to inform the medical doctor of the patient's medical condition when she so deems necessary.

Taking into consideration the visits which are made to the Association's paid members and those performed under contract with the government, the total number of visits, during 2003, as illustrated in Table 48, amounted to 386,016 visits, an average of 1,058 visits per day.

**Table 48: Number of visits carried out, during 2003, by the Memorial District Nursing Association by type of service and gender of patient.**

| | Children | | Adults | | Elderly | | Total | |
|---|---|---|---|---|---|---|---|---|
| | **Males** | **Females** | **Males** | **Females** | **Males** | **Females** | **Males** | **Females** |
| **General Care** | 455 | 584 | 3,107 | 2,815 | 19,895 | 41,707 | 23,457 | 45,106 |
| **Surgical** | 1,096 | 500 | 7,924 | 8,923 | 24,691 | 46,708 | 33,711 | 56,131 |
| **Injections** | 122 | 168 | 848 | 2,953 | 5,044 | 8,488 | 6,014 | 11,609 |
| **Diabetics** | 0 | 18 | 5,859 | 15,776 | 41,798 | 146,537 | 47,657 | 162,331 |
| **Total** | **1,673** | **1,270** | **17,738** | **30,467** | **91,428** | **243,440** | **110,839** | **275,177** |

Source: MMDNA.2003

This community nursing service is expanding rapidly and the nurses are under constant pressure. As a result, the service is at present largely "procedure oriented". It is evident that 54.4 per cent of the workload is devoted to diabetic injections. Malta has one of the highest national percentages of diabetes mellitus cases in the world. (Government of Malta. Department of Health, 1986) An epidemiological survey carried out in 1985 revealed that the prevalence of diabetes mellitus among those Maltese aged 35 and above was 10.0 per cent as compared to 7.7 per cent nationally. A further 13 per cent had impaired glucose tolerance as compared to 5.6 per cent nationally (Cachia JM. 1985).

The community nursing service being offered by MMDNA has been beneficial in various ways. It has been instrumental in preventing unnecessary hospitalisation in a number of cases, it has helped in reducing delayed hospital discharges by giving adequate post-hospital care at home. It has also helped various family carers to continue taking care of their elderly relatives and not resort to their institutionalisation due to their not being competent enough to provide nursing care.

**2. Malta Hospice Movement**

As pointed out in section **3.4** the services provided by the Malta Hospice Movement can be classified under five main categories. The Home Care service aims to complement the skills and resources of primary health services; to pre-empt the development of certain symptoms; to network the available resources so as to help families maintain their loved one at home; and to listen and to talk about problems, fears and anxieties. These aims are achieved through continuous assessment of needs, management of symptoms through the use of drugs, care and additional therapies, basic communication and listening skills, creating environments and attitudes that allow for and encourage the emotional and spiritual well-being and through practical help and support.

The Day Therapy service aims at giving support in maintaining patients at home, enhancing their quality of life by providing social and therapeutic opportunities, and at the same time give, on a regular basis, some respite to family/carers. The Day Therapy Unit welcomes patients on Tuesdays and Fridays. A monthly programme of activities is prepared to suite individual desires. These include crafts, lectures, outings to places of interest or leisure, parties, special celebration meals, religious ministry.

The Hospital Support aims at facilitating the transition from hospital stays to care at home; support families during and after interventions such as chemotherapy, radiotherapy, etc., and be a resource for both the hospital and the community.

The Loaning of Specialised Equipment aims to facilitate home care as much as possible and to enhance the quality of life both of the patient and also of the family. Specialised equipment items such as special beds, hoists, commodes, wheelchairs, etc. are loaned to the patient for as long as is needed.

Bereavement Support aims at supporting families during the crucial time of grief following the loss of a loved one. When the patient passes away, support to the family is continued for as long as necessary or as required. Relatives are invited to a memorial mass on two or three occasions after death. One to one and/or group support for the bereaved is very much appreciated by the relatives.

Referrals reach the Hospice Movement through the family doctor, hospital consultant, the oncology department or other health professionals. Patients and families may self refer, in which case a referral form signed by a doctor is important in order to ascertain a correct diagnosis of the illness. When the family doctor is not the referring doctor, he/she is informed and his/her input is invited. Early referral in the disease process means that the patient and family can benefit more fully. Moreover, in this manner, relationships of trust can be built between the staff, patient and family members. The latter will be in a better position to continuously monitor and often pre-empt painful symptoms and other distressing problems.

Following referral, the Hospice nurse visits the patient at home and carries out a primary assessment. This assessment is carried out with great attention to detail, addressing physical, psychosocial and spiritual aspects and with an eye for actual and potential needs and problems. It aims at establishing good communication. This in turn, serves as a good opportunity for the patient to talk freely about any troubling symptoms he/she may be experiencing while expressing his/her worries and problems. All the information gathered is discussed during the staff's multi-disciplinary meeting which takes place once a week. Here a care plan is formulated which is tailored to the patient's situation. This plan is regularly reviewed so as to address changing needs. The Hospice Movement is committed to maintaining the highest possible standards of care through ongoing education, training and update. Both staff and volunteers

involved in the care often feel privileged to be so closely involved with a family and its members at such a crucial time.

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