



COUNTRY REPORT

MALTA

MIPEX

HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX *HEALTH STRAND*

Country Report Malta

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TABLE OF CONTENTS

- 1. COUNTRY DATA5
- 2. MIGRATION BACKGROUND6
- 3. HEALTH SYSTEM10
- 4. USE OF DETENTION11
- 5. ENTITLEMENT TO HEALTH SERVICES13
 - A. Legal migrants13
 - B. Asylum seekers14
 - C. Undocumented migrants15
- 6. POLICIES TO FACILITATE ACCESS17
- 7. RESPONSIVE HEALTH SERVICES19
- 8. MEASURES TO ACHIEVE CHANGE20
- CONCLUSIONS22
- BIBLIOGRAPHY23

READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at <http://bit.ly/2g0GIRd>. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5 – 8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database ¹ (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29IXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

¹ For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at <http://bit.ly/2lXd8JS>

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	425.384	○○○○
GDP per capita (2014) [EU mean = 100]	85	○○
Accession to the European Union	2004	

Geography: The Republic of Malta is an archipelago composed of several islands, the largest of which is Malta, followed by Gozo, Comino, as well as a number of smaller uninhabited islets. It is located in the Mediterranean Sea, 80km south of Sicily, 333km north of Libya and 284 km east of Tunisia. The terrain is mostly low and rocky, with many coastal cliffs. It is the smallest and most densely populated country in the EU (Markwick 1999) and 95% of the population lives in urban settings. The main city is the capital Valletta (population 355.000). Both English and Maltese are official languages; the official religion is Roman Catholicism, which is taught in schools.







Historical background: Malta's strategic position in the Mediterranean has for thousands of years given it an important position as a trading post. It has been occupied by Phoenicians, Greeks, Romans and Arabs; it was captured by France in 1798 but became part of the British Empire in 1814, from which it attained independence in 1964. It became a republic in 1974.

Government: Malta is divided into 68 localities. It joined the European Union in 2004, the Schengen area in 2007, and the Eurozone in 2008.

Economy: Financial services, tourism, and manufacturing are key sectors. Malta has endured the economic crisis better than most other EU member states. It has relatively low unemployment compared to other European countries (4.8% in 2016). In 2014, Malta's economy led the Eurozone in growth, when real GDP expanded by 8,3%.²

² https://ec.europa.eu/info/files/winter-2017-economic-forecast-malta_en

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	9,4	
Percentage non-EU/EFTA migrants among foreign-born population	52	
Foreigners as percentage of total population	5,9	
Non-EU/EFTA citizens as percentage of non-national population	45	
Inhabitants per asylum applicant (more = lower ranking)	315	
Percentage of positive asylum decisions	73	
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	29	
MIPEX Score for other strands (MIPEX, 2015)	39	

Malta has a long history of emigration and immigration, but has generally been a country of net immigration since the 1970s. The process of Maltese emigration started intensely in the very early 20th century as a means of coping with rising unemployment. The main destination countries were Egypt, Libya, Algeria, and Tunis. Later, the Maltese started moving to more distant lands, namely the United States, Canada, and Australia. Outward patterns of migration dominated for the rest of the 20th Century. In 1950, the huge exodus of Maltese to foreign lands because of overpopulation and unemployment led to the setting up of the Emigrants' Commission³ to help those affected. It was also at that time that Malta began receiving migrants, who successfully established roots on the island in small Indian, Arab, Nigerian, and British communities (De Haas 2006; King & Thomson 2008; Düvell 2012; Cassar 2013).

However, it was only towards the end of the 20th Century that Malta came to the fore as a country of humanitarian immigration as a result of upheavals in Africa and the Middle East (Cassar 2013). In 1999 Malta also saw the arrival of Kosovo Albanian refugees through the UNHCR Humanitarian Evacuation Plan. Malta's geographical location and EU membership led to an increased influx of irregular migrants and asylum seekers, so that in the 21st century Malta became a destination for thousands of migrants from Sub-Saharan Africa and other lands affected by war and poverty.

Malta is on the most central Mediterranean migratory route and thousands of irregular migrants try to reach Europe by boat, mainly from Libya. Malta's search and rescue zone is expansive, extending up to 250.000 km² (Pace 2013). Migrants setting out by boat from North Africa usually intend to reach mainland Europe (i.e. Italy), but some arrive by accident or design in Malta, though most of them prefer not to remain (Lemaire 2015). However, human smugglers using unseaworthy boats have caused a large number of fatalities in the Mediterranean (Kassar & Dourgnon 2014). Those who survive in bad weather

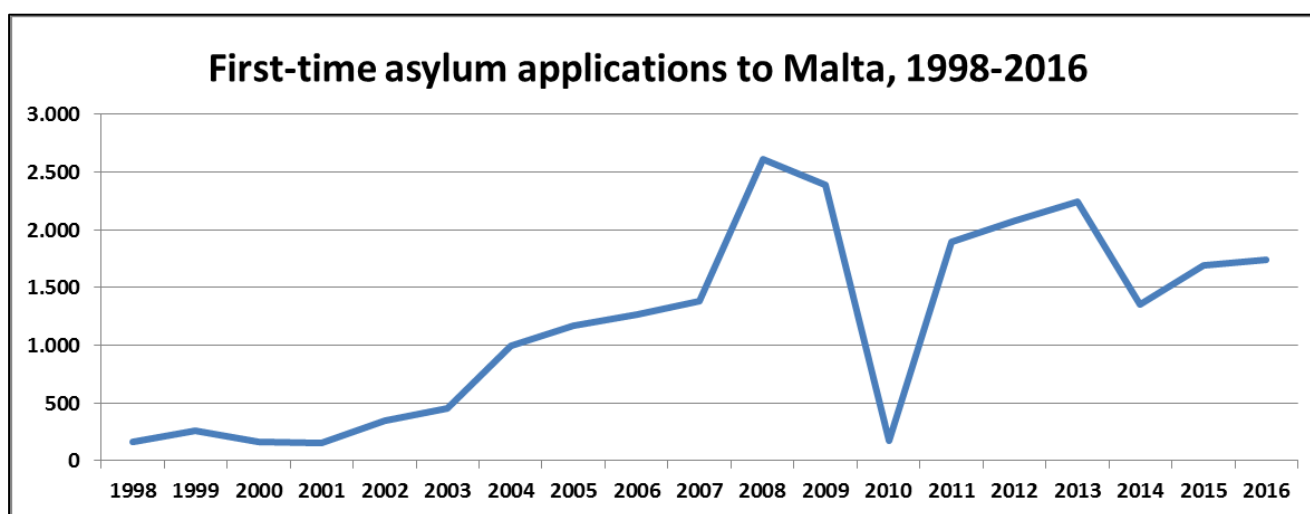
³ <http://www.mecmalta.com/emmcomm.html>

conditions often require rescue by the maritime squadron of the Armed Forces of Malta (AFM), and so arrive inadvertently in Malta (Klepp 2011; Times of Malta 2015).

Figure 1 shows how the numbers of asylum seekers in Malta have fluctuated since 1998. From 2001-2008 the number of people landing by boat increased continuously, plunging in 2010 as a result of the 'friendship agreement' signed in June 2009 between the Italian premier Berlusconi and Libya's Gaddafi to prevent departures from Libya. However, Gaddafi's regime was overthrown in 2011 and the number of irregular crossings rose again, partly as a result of the uprisings referred to as the 'Arab Spring.'

Meanwhile the asylum-seeker route via the Eastern Mediterranean built up steadily, reaching a peak of about 1 million crossings in 2015 before the EU-Turkey deal (along the lines of the Italy-Libya agreement) started to be implemented in March 2016. This has shifted some of the flow back to the far more dangerous central Mediterranean route. Despite this, irregular arrivals in Malta by sea have declined since 2013; they numbered 568 people in 2014, 202 in 2015 and 25 in 2016.⁴ In the same period, an increasing proportion of asylum applications were made by people arriving at the airport or by ferry.

Figure 1. First-time asylum applicants to Malta, 1998-2016 (Data from Eurostat)



According to the 2009 Eurobarometer, a survey that monitors public opinion in the European Union, immigration was the top concern in Malta in that year (49%); immigration was of greater concern than inflation (40%), the economic situation (31%), and unemployment (24%) (European Commission 2010). However, after the drop in irregular migration in 2010, another survey (UNHCR, 2012) reported that the majority of Maltese were not very concerned about their way of life being under threat from migration. This report also claimed that those closest to detention centres were the ones mostly concerned, and that many Maltese had never had any form of interaction with any refugees or migrants. According to the report, people of sub-Saharan African background are considered as the least likely to settle successfully in Malta due to substantial cultural differences.

For many years, Malta has persistently argued that the flow of migrants to Europe is a European problem requiring a European solution, and has therefore repeatedly called for European solidarity and

⁴ <http://www.unhcr.org/mt/charts/>

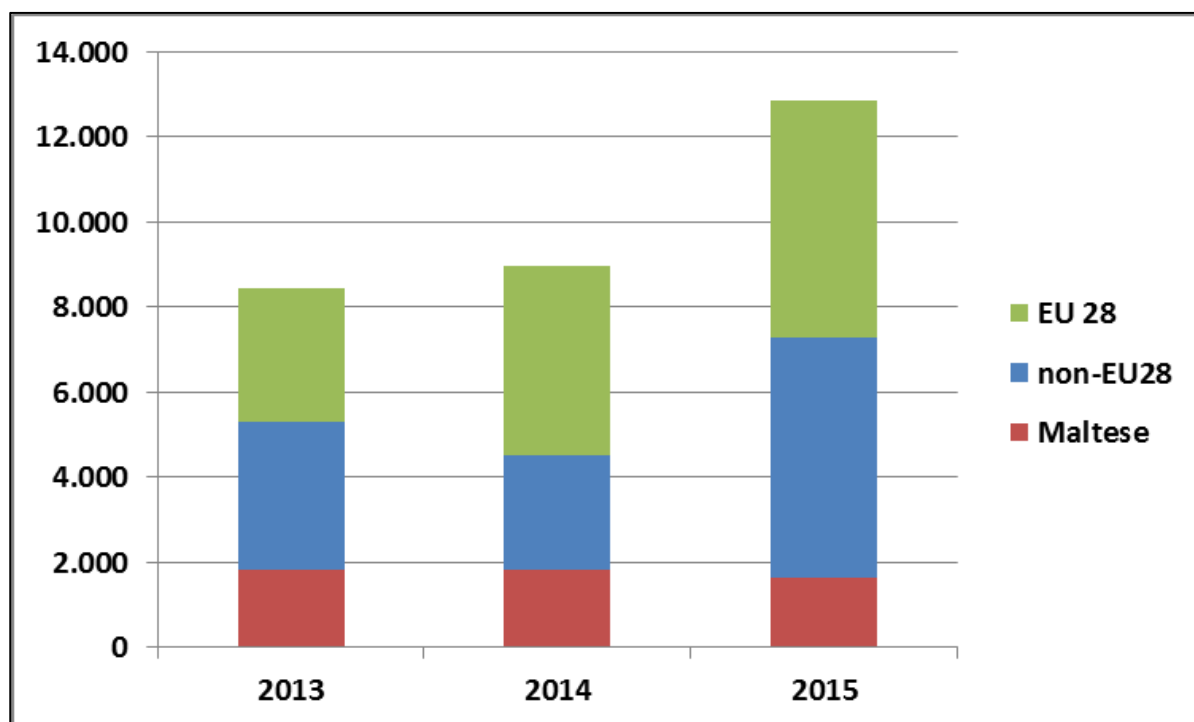
burden-sharing (Borg 2009). Indeed, in June 2009, the European Union initiated a pilot voluntary burden-sharing to address Malta's demands in managing irregular migration (Mainwaring 2014). The project aimed to provide asylum seekers with the opportunity to resettle in other EU member states. Several countries (the United Kingdom, France, Luxembourg, Portugal, Slovakia, Slovenia, and the United States) offered their assistance. However, the number of migrants in Malta who were ultimately resettled in these countries remained low in comparison to the influx arriving on the island's shores. UNHCR estimates that less than 30% of the approximately 19,000 who have arrived by boat from Libya since 2002 remain in Malta. Beneficiaries of protection have a right to a travel document and many opt to leave Malta on their own initiative. Over 2,800 such beneficiaries have been resettled or relocated to the U.S. or to other EU Member States (UNHCR 2015a). Additionally, since 2011, Malta has hosted the European Union Asylum Office in a bid to support itself and other Member States in implementing a more consistent and fair asylum policy and improving access to accurate information on countries of origin (Carabott & Pace 2012).

Every person arriving in Malta has the right to apply for asylum, but this does not mean that every person will qualify or be granted protection. According to Eurostat, 1,350 asylum applications were received in 2014, while 73% of applications decided on in that year resulted in some form of international protection. According to the Maltese Refugees Act, the Refugee Commissioner can recommend two types of protection, namely refugee status and subsidiary protection. Other forms of complementary protection can be granted.

As well as asylum seekers, Malta also receives other kinds of migrants: annual immigration figures from Eurostat for 2013-2015 show that migration from the EU28 has been increasing, while each year just under 2,000 Maltese citizens return to the country.

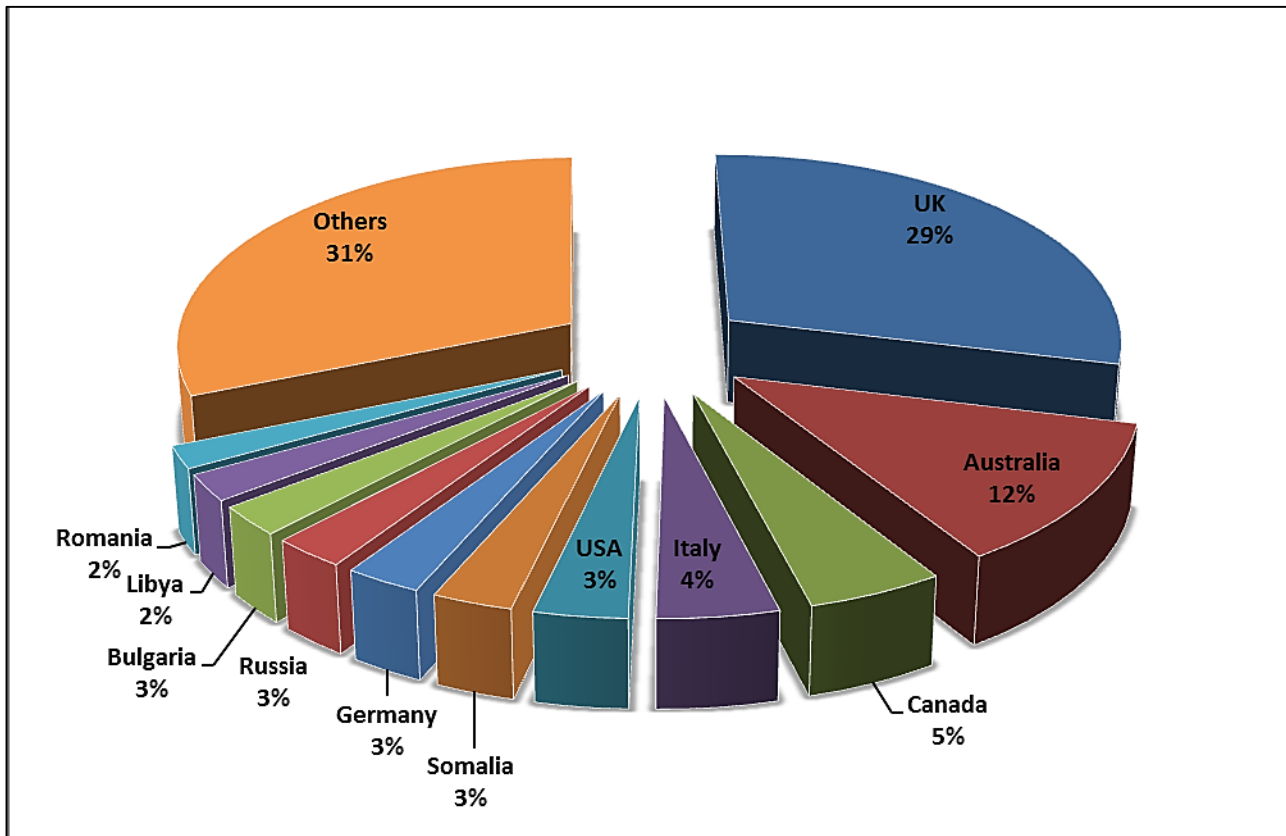
Figure 2. Citizenship of immigrants to Malta, 2013-2015

(Source: Eurostat, file migr_imm1ctz)



According to the 2011 census (NSO, 2014), there were 20,289 (4.9%) non-Maltese nationals residing in Malta, of whom 2,279 were living in institutional households such as open centres for migrants. The origins of Malta's migrant population are shown in Fig. 3. (As these data are not available from Eurostat they have been taken from the UN DESA database).⁵

Figure 3. Foreign-born population of Malta in 2015 by country of birth (data from UN DESA)








This figure shows that third country nationals (TCNs) in Malta, who in 2014 comprised 55% of resident foreigners, are more likely to come from the wealthy 'Global North' than the impoverished 'Global South'. Many retired British subjects live in Malta. Strong links with Australia, Canada and the USA were formed by Maltese emigration; the country is now popular with immigrants from those countries (many of them descendants of Maltese emigrants), not least because English is widely spoken. Since 2014 Malta also offers 'citizenship by investment' to foreigners who contribute about €900,000 to Malta.⁶ This also entitles them to visa-free travel to over 167 countries, including the EU, USA and Canada, as well as the right to live, work, study in any of the 32 EU/EFTA countries.⁷

⁵ United Nations, Department of Economic and Social Affairs (2015). *Trends in International Migrant Stock: Migrants by Destination and Origin* (United Nations database, POP/DB/MIG/Stock/Rev.2015).

⁶ <https://www.henleyglobal.com/citizenship-malta-overview/>

⁷ <http://www.bbc.com/news/world-europe-25959458>

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.940	
Health expenditure as percentage of GDP	9,9	
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	64	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	30	
Score on Euro Health Consumer Index (ECHI, 2014)	582	
Overall score on MIPEX Health strand (2015)	45	

The population of Malta enjoys relatively good health: “In 2014 life expectancy for men was 79.8 years (compared to 78.1 for the EU), whilst that for women was 84.3 years (compared to 83.3 years for the EU). Moreover, Maltese people spend on average close to 90% of their lifespan in good health, longer than in any other EU country” (Azzopardi-Muscata et al. 2017: xv). Nevertheless, the same authors mention that “Obesity is the principal public health problem, with 25% of the adult population and 27% of children (aged 11–15 years) being obese: the highest rate in the EU.... Diabetes and HIV also have a relatively high prevalence compared to other European countries.”

At the core of the Maltese health system is the tax-funded National Health Service, although primary care practitioners (mainly GPs) in private practice account for two-thirds of primary care facilities in Malta. As a result, out-of-pocket payments are relatively high (30% of total expenditure in 2013). The private system runs in parallel to the public system (NHS): it offers more personalised care as well as shorter waiting times and waiting lists. To cover these costs, about one-fifth of the population purchase commercial health insurance policies. Nevertheless, expenditure on voluntary private insurance accounts for only 1,8% of total health expenditure.

The fact that a large part of the primary care sector is not included in universal coverage is an unusual aspect of Malta’s health system. Azzopardi-Misact et al. (op. cit.: 44) explain this partly in terms of culture: “Persons with a certain level of education and income have traditionally been accustomed to seeking primary and ambulatory services in the private sector”. However, it means that many inhabitants with chronic conditions and/or low incomes are obliged to use a public system which is acknowledged to suffer from longer waiting times, poorer continuity of care and lowered accessibility (ibid.: 37). Since those with lower socioeconomic status (including many migrants) have a greater share of chronic disease and unhealthy behaviours, it is hard to see how this fragmentation of primary care furthers the efficiency of Malta’s health system.

4. USE OF DETENTION

Malta's detention policies prior to 1st January 2016 (thus including the timeline for this report, 31st December 2014) were a response to the unprecedented surge in irregular landings by boat that reached a peak in 2008 (see Fig. 1, above). Malta exercised an 18-month mandatory detention policy for all irregular migrants upon arrival, irrespective of whether or not they claimed asylum (Lutterbeck 2009). With the exception of 'vulnerable' people (unaccompanied minors, pregnant women, or persons with disabilities), all irregular immigrants on arriving in Malta were held in 'closed' centres, housed within military compounds under the responsibility of the Armed Forces of Malta. Although Malta's 18-month detention period fell within the acceptable duration allowed by the EU's Return Directive (2008), it was one of the highest in Europe. Once the 18-month detention period ran out, the immigrants' options were to be granted humanitarian protection, transferred to open centres, or (for those successful in finding legal employment and accommodation) released into the community.

Prior to 2016, even though some improvements were made in the conditions of detention centres in Malta, the centres consistently received severe criticism for their set-up in terms of basic facilities, privacy, and overcrowding, by human rights organizations, namely Amnesty International and Médecins du Monde, as well as by the Council of Europe and the Civil Liberties (LIBE) Committee of the European Parliament (Lutterbeck 2009).

According to Mainwaring (2012), the highly contentious and strict detention policy backed up the Maltese government's position on irregular immigration in an attempt to gain more practical and financial support from the European Union. The author also claimed through her qualitative research using interviews conducted with Maltese authorities, NGOs, and migrants that the use of detention as a deterrent leads to negative and harmful consequences not only for the migrant population, but also for the wider Maltese society. Silverman and Massa (2012) corroborated these findings and refer to increasing evidence that detention hurts people and does not serve as a deterrent to irregular immigration. Furthermore, they claim that the detention policy works against the potential benefits of immigration for the host country, in addition to disrupting asylum determination systems.

Revised policies were introduced by the Government at the beginning of 2016, outlined in the *Strategy for the Reception of Asylum Seekers and Irregular Migrants*.⁸ According to the Asylum Information Database,⁹

Malta has introduced a new migration strategy which ends its practice of automatic detention of people that have entered the state irregularly. It also introduces into national law, grounds for detention, and alternatives to detention.

The reform means that migrants will be accommodated, medically screened and processed in a closed Initial Reception Centre for up to 7 days, where they will be informed of their right to apply for international protection. In addition, they will be assessed for vulnerability to enable the proper support to be given, and procedures may be done to verify their age. Following this, asylum seekers

⁸ <http://bit.ly/1Wb3Cej>

⁹ <http://bit.ly/2rq1pbi>

may only be detained if one of the six grounds for detention set out in the recast Reception Conditions Directive is met. Migrants may also be detained if they have been issued a return decision. Vulnerable persons will not be detained, and will be accommodated in open centres following their release from the Initial Reception Centre.

Most of the previous criticisms of Malta's detention policy appear to have been heeded, although the new policies still have to be fully implemented and evaluated.

5. ENTITLEMENT TO HEALTH SERVICES

Score 28 Ranking 

A. Legal migrants

Inclusion in health system and services covered

Legal migrants face unclear rules for free access to NHS. They have to apply for a visa before arrival and are required to have private health insurance before one can be issued. After arrival, they must pay National Insurance contributions to qualify for free NHS care: entitlement is confined to those covered by Maltese social security legislation (Azzopardi-Muscat et al. 2017: 43). However, the same authors note that the definition of who is covered for purposes of health is unclear, and in 2016 was under discussion:

The Ministry for Health is evaluating how it can enhance clarity of the definition of an insured person under the Maltese health system in order to balance the dual objectives of ensuring access to health care for all with safeguarding the financial sustainability of a health system in a country with a large proportion of users who are not Maltese nationals.¹⁰ (Ibid., p. 42)

According to our sources, legal migrants from non-EU countries are given free access to the NHS. They are required to show evidence that they pay National Insurance contributions, though it is not clear what the requirements are for those who are not active in the labour market (who do not pay such contributions). Conflicting information is put out by the website 'Legal-Malta'¹¹ (not a government site, but set up with EC co-financing), which states categorically that "if the patient is a Non-EU citizen, health care bills must be paid in full prior to leaving the health care facility."

Information on the access of legal third-country migrants to NHS services is thus contradictory. We cannot find the legal grounds for a policy of charging them, neither could we find an official statement that they have free access if working and paying NI contributions. However, the latter is said to be standard practice by informants working in the NHS, so the scoring is based on this.

Legal third country national migrants who are not employed and not paying NI contributions would appear to fall under the same provisions as undocumented migrants. There seem to be no legal provisions or formal rules applying to them.

Health clearance is also required for those applying for a visa from certain countries. However, migrants from Australia enjoy entitlement by virtue of a reciprocal agreement.

¹⁰ The "large proportion of users" was in fact 2,7% in 2014 (i.e. non-EU28/EFTA foreigners), which is below the average (3,2%) for EU28/EFTA countries.

¹¹ <http://www.legal-malta.com/health-care-in-malta>

Special exemptions

As there are no legally binding norms regarding the entitlements of migrants, it is not possible to regard any treatment as being 'exempted from restrictions' on entitlement.

Barriers to obtaining entitlement

An ID card issued by the Commissioner of Police is required for treatment in the public healthcare system. However, this should not be a problem for legal third country nationals. The other requirements, namely proof of low income on the basis of tax returns (for exemption from certain user charges) and proof of address from local authority records, should not present particular difficulties for legal migrants.

B. Asylum seekers

Inclusion in health system and services covered (prior to 2016)

The precondition for receiving free healthcare is that the asylum seeker should not be working regularly or have 'sufficient means.' The following information was obtained from several official websites of government and international organizations, namely the Ministry of Justice and Local Government (2005), UNHCR (2015b), EMN (2009), HUMA (2009a, 2009b) and Malta Immigration and Expat Centre,

- According to Article 13(2) of the Refugees Act of 1 October 2001: "An applicant for asylum shall have access to state education and training in Malta and to receive state medical care and services."
- The EU Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, stipulates that asylum-seekers should be given access to the labour market after one year. This Directive was transposed by Regulation 10(2) of Subsidiary Legislation 420.06 Reception of Asylum-Seekers (Minimum Standards) Regulations, Legal Notice 320 of 2005, 22 November 2005.

The law does not specify the scope of the healthcare to be provided and whether asylum seekers have the right to access health care under the same conditions as nationals in the public system, or if they are covered under a specific scheme. However, in practice this provision is generally understood as providing access free of charge to the medical services that nationals receive. Nevertheless, Regulation 11 of the Reception Regulations provides that, where applicants are working regularly or have sufficient means, they may be required to cover or contribute to the cost of material reception conditions. Ambiguity leaves the door open to discretionary practices. According to the reports published by the HUMA Network (2009a, 2009b), many asylum seekers in Malta are in detention, and for those living outside of detention centres, access depends largely on discretionary decisions made at hospitals.

Special exemptions

As there are no clear rules regarding the entitlements of migrants, it is not possible to regard any treatment as being 'exempted from restrictions on entitlement.' In practice it is normally requested to show the 'police number' if TCNs are in detention, or the 'ID card' if they have been released.

Barriers to obtaining entitlement

According to the HUMA Network (2009a, 2009b), access to care and medicines in practice largely depended on the willingness of detention facilities' personnel in charge of centres. This mainly concerned access to emergency care or primary care. (However, under the new policies introduced in 2016, access to health services is now provided as a matter of policy.) Coverage outside the centres is not governed by legal rules, but is instead at the discretion of service providers.

C. Undocumented migrants

Inclusion in health system and services covered

Until the beginning of 2016 (i.e. at the date covered by this report), the main condition for inclusion of undocumented migrants was the discretionary power of health service providers to give full and free access to NHS Services. This was a direct result of the lack of clear legal rules. While waiting for their hearing, unauthorised entrants were detained in closed centres or detention centres. Migrants were not allowed to leave until their status hearing. This time period could range anywhere from 3-18 months. According to the HUMA Network (op. cit.), the process was usually sped up for a family or pregnant woman, and in particular emergency or urgent cases. However, if the hearing did not take place during the 18 months, the migrant was released from detention. The refugee commissioner then called up the migrant, when the latter already resided in the community, to sit for the one-on-one interview.

In 2005, the government published its Irregular Immigrants, Refugees, and Integration policy document (National Legislative Bodies, 2005), which describes a number of principles and, with respect to health care. It states that, "People in detention shall be entitled to free state medical care and services." (p.12). Hence, health care for undocumented migrants up to 2016 had to be viewed in the context of the Maltese authorities' policy of systematically detaining all irregular immigrants (and asylum seekers). Although these immigrants had free access to health care, relative lack of access to health services is common due to lack of education, fear, and language or cultural barriers.

To summarize the previous situation:

- Conditions provided by Maltese legislation on access to healthcare for asylum seekers and undocumented migrants did not differ greatly from one to the other;
- No legal framework existed that clearly differentiated the groups of foreigners present in the territory and established their basic rights;
- No legal or administrative provision referred to undocumented migrants' entitlements to access health care in Malta;
- A non-legally binding 'policy document' established that all foreigners in detention are "entitled to free state medical care and services". However, there was no legal obligation on government to ensure that health care was provided;
- In practice, as with the provisions for asylum seekers, provisions for UDMs were informally interpreted as access free of charge to the standard health care coverage in Malta (preventive, investigative, curative, and rehabilitative services). However, the HUMA Network reports (2009a, 2009b) indicated that this interpretation was not universal;
- The above applied to all undocumented migrants and asylum seekers who were systematically placed in closed centres when they arrive to Malta. Policy documents did not

refer to the entitlements of undocumented migrants who are in open centres (the usual place of residence when they are released from close centres) or other accommodation facilities;

- Regulations for the centres only mention that they shall maintain regular contact with public authorities regarding health issues in general and in case of suspected infection conditions.

The new policies introduced at the beginning of 2016 were intended to improve provisions for irregular migrants and asylum seekers, though they have not yet been fully implemented and not all details are clearly specified.

Special exemptions (prior to 2016)

As entitlements are not legally regulated, there can be no exemptions from restrictions.

Barriers to obtaining entitlement (prior to 2016)

The 'police number' required for treatment of undocumented migrants is a definitely an obstacle to seeking treatment, as migrants likely fear detection and/or detention. The other requirements should not present particular difficulties for migrants.

As highlighted earlier from information provided by the HUMA Network (2009a, 2009b) on possible denial of access in detention centres, access to care and medicines in practice largely depend on the willingness of detention facilities' personnel in charge of centres. Coverage outside the centres is not governed by legal rules but is at the discretion of the service provider. In fact, as there are so few explicit, precise, and legally binding provisions regarding the entitlements of migrants, 'administrative discretion' must be regarded as endemic in the Maltese system for every category of migrant.

6. POLICIES TO FACILITATE ACCESS

Score 58 Ranking



Information for service providers about migrants' entitlements

Because of the lack of explicit legal provisions regarding the entitlements of migrants, there is hardly anything that could be passed on from national authorities to service providers and from service providers to their employees.

Information for migrants concerning entitlements and use of health services

Targeted information for migrants is facilitated through the Migration Health Liaison Office, within the Department of Primary Health, which was set up in August 2008 in view of the large influx of irregular immigrants arriving in Malta. The office offers community-based health education to migrants on health issues while also helping migrants to access healthcare services when required. On-site trained cultural mediators assist health professionals and clients to overcome language and cultural barriers. The office trains health-care professionals, students, and stakeholders working in the field of migration on cultural diversity issues in health care.

Migrants coming from different cultural backgrounds are often unfamiliar with the health care system of the host country and do not know how, when, and where to seek help. Language barriers may also impede utilization of health services. Health professionals are facing new challenges due to cultural differences in the explanation of disease causes and the interpretation of symptoms. Greatly increased diversity in patient backgrounds poses a challenge to service providers who need to manage complex differences in communication styles, attitudes as well as expectations.

The government website of the Migration Health Liaison Office¹² describes its objectives as follows:

- Liaising with government departments, agencies and other entities to address issues pertaining to migrant health;
- Dissemination of information to migrants. The languages used are Somali, Tigrinya, French, and Arabic;
- Provision of health education sessions to migrants in open centres;
- Assisting migrants in accessing health care through the right channels;
- Delivery of the Training Programme for Cultural Mediators in Health Care;
- Drawing up in-service studies;
- Education and training for health and social care professionals and university students on the topic of Cultural Issues in Health Care, Female Genital Mutilation, etc.;
- Provision of translated materials (booklets and posters) for migrants on health topics;
- Participation in EU programmes, seminars and workshops on the issue of migration and health.

¹² <https://health.gov.mt/en/phc/mhlo/Pages/mhlo.aspx>

Health education and health promotion for migrants

Apart from utilizing the Floriana Primary Health Care office, Migrant Health Liaison Officers also visit the northern part of Malta where a multicultural population currently resides. Health Education sessions are held every fortnight at the Qawra Leap Centre. However, instruction materials are geared mostly to the needs of asylum seekers and undocumented migrants.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

The Migrant Health Liaison Office provides an onsite trained cultural mediation (interpreter) service at Floriana Health Centre. Cultural mediators assist health professionals and clients to overcome language and cultural barriers. The Migrant Health Unit provides the training and successful students are awarded a certificate. Previous training programmes for cultural mediators in healthcare were held for twelve groups, namely: 2014 Training Programme (Groups 11 and 12); 2013 Training Programme (Group 10); 2012 Training Programme (Group 9); 2011 Training Programme (Groups 5, 6, 7 & 8); 2010 Training Programme (Group 2, 3 & 4) – (Programme revised-MCQ Test implemented); and in 2009 Training Programme (Group 1). Cultural mediators provided their services in three areas of the health service, namely in 2011 Cultural Mediators service at Mater Dei Hospital, in 2010 Cultural Mediators in Primary Health and in 2009 Cultural Mediators at Floriana Health Centre. Furthermore, the Jesuits in Malta, through their webpage 'Cultural mediation building one community' are also involved in projects aimed at improving cultural mediation in Malta.¹³ The Migrant Health Liaison Office was also involved in the Jesuits Refugee Service Malta project aimed at improving the cultural mediators' role in Malta.

Is there an obligation to report undocumented migrants?

In Malta there is no obligation for health care staff to report any patient to the authorities (HUMA Network 2009a, 2009b).

Are there any sanctions against helping undocumented migrants?

There are no sanctions against helping undocumented migrants. There are also no legal or organisational sanctions against healthcare professionals or organisations assisting undocumented migrants, in particular with emergency care.

¹³ <http://bit.ly/2s63tQP>

7. RESPONSIVE HEALTH SERVICES

Score 46 Ranking ○

Health services in Malta are slowly becoming responsive to migrants' specific health needs. Various types of interpretation are available, albeit on a small scale. When available, cultural mediators are sometimes involved in designing and providing health education. Over the years, standards and training programmes for practitioners have become more widely available.

Interpretation services

Interpretation services are available to a limited extent, mostly in combination with cultural mediation (see Section 6). Interpretation methods include face-to-face interpretation and telephone interpretation.

Requirement for 'culturally competent' or 'diversity-sensitive' services

This is a developing field in Malta and needs improvement. The University of Malta and NGOs, as well as the Migration Liaison Office in the Department of Primary Health Care have been active in promoting and implementing cultural competence and 'diversity sensitive' services in Malta.

Training and education of health service staff

In the Department of Primary Health Care, the Migrant Health Liaison office provides training to health professionals at the main acute hospital, social workers working in different agencies (MFSS), Social Mentors working with migrants, GP specialist trainees, BSc/Diploma Nursing students, BSc Community Nursing students, and stakeholders working in the field of migration.

Involvement of migrants

Cultural mediators, who in their majority are migrants, are sometimes involved in the delivery of health education. In the case of female genital mutilation sessions, the presence of a female cultural mediator is essential due to the delicate issues that normally come up during such discussions. Additionally, migrants are involved in the development and dissemination of information on access to health services.

Encouraging diversity in the health service workforce

It is important to note that the University of Malta has adopted an internationalization programme in which foreign nationals, including those from third world countries, were accepted for health care professional courses. Indeed, there is a growing diversity in health care staff.

Development of capacity and methods

Policies exist to encourage the development of treatments for health problems specific to certain migrant communities. Amongst the most prominent are those for female genital mutilation, infectious diseases, and sexually transmitted diseases.

8. MEASURES TO ACHIEVE CHANGE

Score 50 Ranking ○

Policies and services have evolved hand-in-hand through the Migrant Health Liaison Office, a few specialised departments and a small community of migrant health stakeholders. Health data and research are also available to help policies become more responsive to migrants' health needs.

Data collection

Medical records include migrant status, country of origin or ethnicity.

Support for research

According to Cassar (2013, the University of Malta (various Faculties), and several NGOs that work on migrant relevant issues are carrying out research on:

- a) occurrence of health problems among migrant or ethnic minority groups
- b) social determinants of migrant and ethnic minority health
- c) issues concerning service provision for migrants or ethnic minorities
- d) evaluation of methods for reducing inequalities in health or health care affecting migrants or ethnic minorities

"Health in all policies" approach

Although there are no formal intersectoral mechanisms in Malta concerned with the impact on migrant or ethnic minority health of policies in sectors other than health, the Health Department works closely with the Armed Forces of Malta, the Malta Police, and NGOs to facilitate access to care for migrants.

Whole organisation approach

In Malta, more work needs to be done so to achieve a 'whole organization approach'. However, specialized departments that are focused on issues of migrant health are increasingly becoming better resourced to deal with these issues. These include the Migrant Health Liaison Office, Primary Health Care, Infectious Diseases Unit, Health Promotion Department, Genitourinary clinic, Infectious Diseases Unit at Mater Dei Hospital and Chest Clinic, Primary Health Care mostly dealing with Tuberculosis.

Leadership by government

The subject of migration has been a politically contentious issue in Malta. Leadership by government on migrant health has been mostly under the responsibility of the Primary Health Care Department. Policies and services have evolved hand-in-hand through the Migrant Health Liaison Office, a few specialised departments, and a small community of migrant health stakeholders. Health data and research is also available to help policies become more responsive to migrants' health needs.

Involvement of stakeholders

Primary health care, Migrant Health Liaison Office, and the Infectious Diseases Unit are active as advisory bodies or centres of expertise promoting cooperation amongst stakeholders on migrant health.

Additionally, a number of NGOs are active and cooperate with the government health units in addressing migrant health issues.

Migrants' contribution to health policymaking

Although migrant issues, especially health related ones, have been widely discussed by stakeholders involved with migrants –which has led to ad hoc cooperation - as yet there is no official migrant health strategy.

CONCLUSIONS

Malta's other policies on integration of migrants, apart from Health, are generally very weak, ranking it 29th out of the 34 countries studied in EQUI-HEALTH. By contrast, the country's score on migrant health policy is much better, giving it a rank of 15th.

Scores on entitlement are much lower than on the other three aspects of migrant health policy (policies to facilitate access, responsive health services, and measures to achieve change). Malta would earn a much higher overall score were it not for its failure – unique among EU countries – to enact binding legislation on migrants' healthcare entitlements. These entitlements are more unclear and discretionary in Malta than in any of the other countries reviewed. However, those migrants who are able to use the health system will find that a number of services have become more accessible and responsive to their specific health needs, thanks to the actions led by the Migrant Health Liaison Office and other organisations since 2008.

Immigrants in Malta do not yet benefit from a comprehensive integration policy in all areas of Maltese society. Ongoing plans for a more comprehensive equality law and policy can provide incentives and sanctions to encourage Maltese citizens and immigrants to treat each other equally in many areas of life. The issue of integration is currently on the political agenda: a set of policy recommendations, based on the 2011 round of MIPEX (which did not include Health), has been drawn up by the Malta Integration Network (Camilleri & Falzon 2014). An Equality Bill has been in preparation since February 2014 and the Human Rights and Integration Directorate has been working on a National Integration Strategy since 2015, which will be presented to the cabinet shortly.¹⁴

Principles of equal treatment are critically important in migrants' access to health care. A Migrant Health Strategy is currently (June 2017) being drafted within the Ministry of Health. Clear legislation is also required, as opposed to the present non-legally binding general documents dealing with access to health care. Azzopardi-Muscat et al. (2017: 42) also noted that the legal notice 201/2004, regulating payment of fees by foreign patients, was in the process of being replaced in 2016. This issue is now salient, they argue, because migrants in Malta now include "persons of varying categories and means, including workers, pensioners and their dependents, mariners registered with the Malta fleet, as well as refugees and asylum seekers".

Much of the public discussion around migrants in Malta seems to be dominated by the issue of irregular migration and asylum-seeking, which became salient from about 2000. In reality, however, migrants in Malta are a much larger and more heterogeneous group (see Section 2), also including pensioners, EU/EFTA migrant workers, Australians, Canadians, Americans, and so on. Clear policies are needed which take into account the health needs of all these groups. **Finally, the government should devote more resources to address long-standing problems in health service provision for migrants, namely greater investment in the training of cultural mediators and of health professionals so as to ensure adequate access and cultural competence during service provision in all branches of the health system.**

¹⁴ http://www.maltatoday.com.mt/news/national/74697/integration_policy_to_be_launched_this_year#.WSvzN-t97IU

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