ESPN Thematic Report on Inequalities in access to healthcare

Malta

2018

Mario Vassallo and Anna Borg
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Directorate-General for Employment, Social Affairs and Inclusion
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Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

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Summary/Highlights

Malta has a mixed healthcare system. The National Health Service (NHS) is provided by the state and is responsible for public service delivery. In parallel, the private sector provides services through a large number of clinics and a number of privately run hospitals. Between 2005 and 2015, the public share of health expenditure increased by more than one third, yet in 2015 the health expenditure in Malta remained below the EU average, both in per capita terms and as a share of GDP.

Preventative, diagnostic, curative and rehabilitative healthcare services are available free of charge through Malta's public healthcare system, funded through taxation. Inpatient medicines, and medicines listed in the government formulary for those suffering chronic illnesses, are available free of charge. Outpatients in low-income groups are also entitled to a restricted list of essential medicines and medical devices if they pass a means test. Free dental care is restricted to specific categories of people, whilst non-emergency dental care and optical services are means-tested. No qualifying period is required to access healthcare and in general patients are not asked to make co-payments or to pay any other charges. Some exceptional charges exist, as in the case of IVF hormonal treatment.

Overall, the population coverage of the public healthcare system is high, comparing very favourably with other EU countries as documented through the EU statistics on income and living conditions (EU-SILC). There is also variability in reported unmet medical needs between those in the highest and the lowest quintiles of income. This suggests a not quite equitable access to services across all income groups. Due to the small size of the island and a good distribution of regional healthcare centres and other smaller clinics scattered around the country, there is no incidence of inability to access free healthcare services due to geographical reasons. Similarly, unmet needs for dental examination are very low. Waiting lists for inpatient care for a number of procedures, such as cataract surgery, have been reduced substantially in recent years and only 0.1 per cent of respondents reported unmet needs for medical examination due to long waiting lists. In contrast to this positive trend, **outpatient waiting times** are long and have been increasing; as at March 2018, on average patients across 18 departments at the Mater Dei Hospital had to wait for 40 weeks before being granted a first outpatient appointment. Similarly, data on pending unscheduled and scheduled interventions in the different specialities suggest long waits, especially in the orthopaedics department (220 days). Long and increasing waiting lists for some radiological investigations can also be noted at the medical imaging department.

Malta's challenges concerning healthcare access arise primarily because the same health consultants and specialists are allowed to provide services in both the public and privately run hospitals and clinics. This systemic feature severely limits the ability of health authorities to extend outpatient opening hours, and this situation is partially responsible for long outpatient waiting times.

As a result, many believe that inpatient care in public hospitals is best secured by consulting specialists in the private sector first. This helps patients who can afford to pay for private consultations to by-pass, or at least minimise, their waiting times for inpatient care.

This systemic feature of the Maltese healthcare system creates pressures for pensioners and families on low incomes who are in need of specialist care and who are not able to afford a private fee-paying consultation. When persons in these categories are prescribed medicines that are not listed in the government formulary their challenges become harder. Because of a lack of empirical research it is, however, very difficult to assess how big this group is: although out-of-pocket (OOP) expenses are reported to be on the high side (28 per cent of total health spending) and are nearly double the EU average (15.3 per cent). This puts Malta amongst the top third of countries with the highest rate of OOP spending.

Similar problems are also faced by third-country nationals who enter Malta legally[1] but who are barred from working: they face more problems in accessing adequate health and follow-up care. There is no specific legislation which covers this group. Similarly, there seems to be a legal limbo in relation to how such people can access mental health services or expensive treatment for HIV. Such migrants may also face barriers to using health services due to lack of information, language problems and fear of being deported. Barriers for trans-gendered persons will soon be removed (June 2018) and specialised services such as hormone therapy and gender-affirmation care will start being offered free of charge.

[1] Largely from Italy and Spain.

1 Description of the functioning of the healthcare system for access

1.1 General description

Malta has a mixed healthcare system. The National Health Service (NHS) is provided by the state and is responsible for public service delivery. In parallel with it there exists a private sector, providing services through a large number of clinics and a number of privately run hospitals. At primary care level, both the public and private sector operate on a walk-in basis. Consultations in the NHS are subject to a referral and follow a hospital booking system. In the private sector, consultations with specialists have to be booked in advance because of the high demand for senior consultants. Many patients prefer to have a private family doctor to ensure continuity of care at primary level. Medical practitioners and allied health professionals are allowed to work *concurrently* in both the public and the private sector. Waiting times for secondary care in the public sector can easily be by-passed by first seeking care privately.[2]

A legal notice[3] grants free healthcare to all current and former citizens of Malta and their children under the age of 18.

Free healthcare is also given to:

a) EU nationals who hold a work licence;

b) citizens of a country which has a reciprocal healthcare agreement in force with Malta;

c) persons who are citizens or nationals of a country outside the EU who enjoy freedom of movement under article 44 of the constitution of Malta;

d) non-EU persons who are in Malta in an advisory or consultative capacity or who are rendering a service to a government department or to a parastatal body, and;

e) any person who is a citizen or national of a country outside the EU who is undertaking a course of studies at the University of Malta, the Malta College of Arts, Science & Technology and the Institute of Tourism Studies.

Refugees, members of religious orders and persons staying in Malta as government consultants are also entitled to free healthcare upon presentation of relevant documentation. On the other hand, foreign patients who are not eligible under one of the above clauses have to pay for treatment received. This legal notice and the conditions on accessing free healthcare have not been updated in the last 11 years (since 2007).[4]

No qualifying period is required and there is no specific limit on the duration of benefits. Patients are not (in general) asked to make co-payments or to pay any other charges. Some exceptional charges exist, as in the case of IVF treatment, where persons have to pay for the first cycle of hormonal treatment.[5]

[2] The management of public hospitals claim that the booking system has made this more difficult. In reality, however, consultants can direct patients to their hospital clinics (especially outpatient) on any day they want. In addition, operation lists are determined by the consultants, who are free to decide on the 'degree of urgency' of particular interventions.

[3] Free healthcare in Malta is regulated by subsidiary legislation, and more specifically through Legal Notice 201 of 2004 as amended by Legal Notice 407 of 2007: *Healthcare Fees Regulations [Regolamenti dwar Drittijiet Għal Kura Tas-saħħa]*.

[4] Gatt A., Personal communication, 9 April, 2018.

[5] *Malta Independent*, Tuesday 29 October 2013.

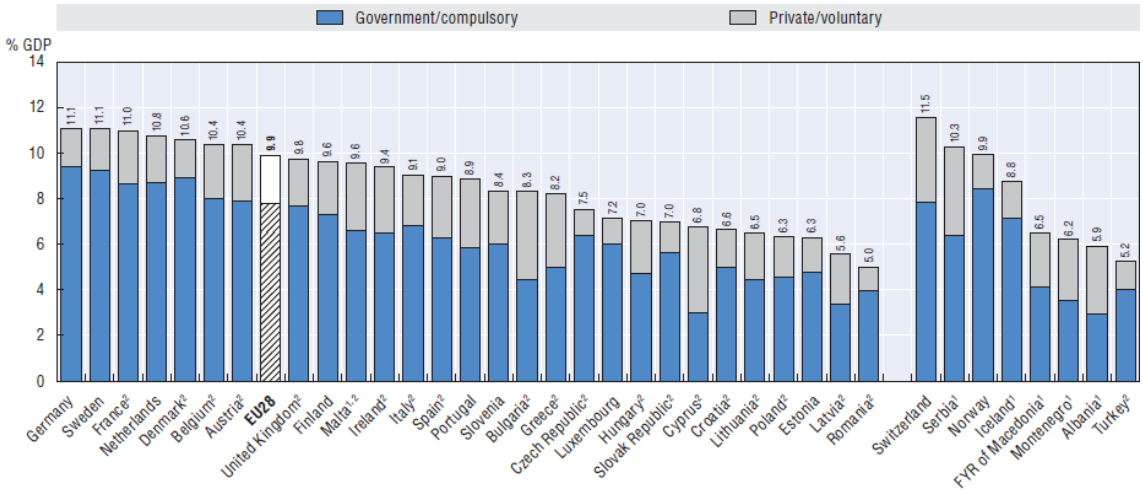
1.2 Financing of healthcare

The NHS is financed through taxation. Regrettably, there is a dearth of recent EU statistical information on the extent to which the national system of healthcare is funded as a percentage of GDP. The latest data are cited by the World Bank for 2015, when it was reported that Malta's health expenditure amounted to 9.62 per cent of its GDP. Figure 1 below shows how this fluctuated over the 2004-2014 period.6 According to a joint OECD/EU report (OECD/EU 2016), health spending accounted for nearly 10 per cent of GDP in the EU in 2015 (or nearest year); Germany, Sweden and France allocated 11 per cent or more of their GDP to health spending – Figure 2 below.

Figure 1: Malta healthcare expenditure as share of GDP 2004-2014

Source: World Bank database on current health expenditure.[7]

Figure 2. Health expenditure as a share of GDP, 2015 (or nearest year)



Notes: 1. Includes investments.
2. OECD estimate.
Source: OECD/EU 2016.

[6] World Bank database on current health expenditure; World Health Organization global health expenditure database.
[7] World Bank development indicators database for Malta.priatis

The public share of health expenditure has increased in recent years – by more than one third since 2005. In 2015 health expenditure per capita in Malta was €2,255, compared with the EU average of €2,797.[8]

1.3 Private and voluntary health insurance schemes in Malta

In 2010, around 21.2 per cent of the population had some form of additional private and voluntary health insurance (VHI) coverage. But VHI spending as a share of total spending on health in 2014 amounted to just 1.7 per cent. Around 70 per cent of persons insured are covered by group schemes for workers.[9] The rest are individuals who tend to be better educated and who enjoy a medium or high income. In the majority of cases the insurance covers basic outpatient care but limited inpatient treatment.[10] This means that the publicly financed health scheme offers a much broader scope and many do not see the benefits of investing in a VHI scheme. Policies with more extensive coverage are still only affordable to those with the highest socio-economic status.

The total spending on private health insurance has doubled in the past 15 years and the number of market players offering these services have also increased over time. The opening of private hospitals and the wide availability of private ambulatory care may have enticed more people to seek VHI coverage. However, the market is still small in overall terms, and as long as people can access good-quality free healthcare the uptake of VHI is unlikely to grow exponentially. In fact, the share of VHI in[11] total spending on healthcare grew by only 0.9 percentage points between 2000 and 2014.

At present there do not seem to be any incentives, such as tax credits, to encourage more people to invest in VHI schemes. However, introducing these was one of the electoral pledges of the current government before the June 2017 elections.[12]

1.4 Provision

As already indicated above, public healthcare is provided through different and specialised public hospitals in Malta and Gozo[13] offering free preventative, diagnostic, curative and rehabilitative healthcare services including mental health. Additionally, there are eight regional healthcare centres and 42 clinics which provide a variety of free specialist healthcare services, including immunisation, and paediatric/maternity care.[14]

Due to the small size of the island and the good distribution of regional healthcare centres and other smaller clinics around the country, inability to access free healthcare services for geographical reasons does not seem to pose a major issue in Malta.[15]

Dental care is free to all in cases of emergency but is otherwise restricted to certain categories of patients, including through a means test. It is also offered for free to: all children under the age of 16; members of religious orders; prison inmates; and members of the police force and armed forces. School children are offered preventive care,

[8] OECD/European Observatory on Health Systems and Policies 2017.
[9] Azzopardi-Muscat, N. 2016.
[10] Azzopardi-Muscat, N. 2016.
[11] Azzopardi-Muscat, N. et al. 2017 (page 47).
[12] *Times of Malta*, 10 May 10 2017.
[13] The Gozo General Hospital was created as a public hospital, but has lately been privatised. However, all those qualifying for free medical care still receive free services from this hospital.
[14] PwC 2012.
[15] OECD/European Observatory on Health Systems and Policies 2017.
[16] Azzopardi-Muscat, N. et al. 2017.
[17] OECD/European Observatory on Health Systems and Policies 2017.

[15] Azzopardi-Muscat, N. et al. 2017.

restorative dentistry and orthodontic care. Prostheses, spectacles, hearing aids and dentures are also provided free of charge to the above categories of persons.

Despite some dental services not being covered for all residents under the public healthcare system, unmet needs for dental examination are relatively low, and Malta was ranked fourth lowest among EU countries in 2015.[16]

In 2016, the government of Malta entered into a controversial public-private partnership (PPP) agreement with an international profit-making healthcare organisation (Vitals Global Healthcare) that was meant to take on the running of three hospitals (two in Malta – Karin Grech and St Luke's – and the general hospital in Gozo). These would provide both publicly and privately covered care simultaneously. Concerns were immediately raised about these deals by the Medical Association of Malta (MAM), which made a request to the Public Accounts Committee and the National Audit Office to open up an investigation into the contract and to assess whether it was in the interest of the Maltese public and taxpayers to privatise these hospitals. The deal with Vitals collapsed after 21 months, and the company sold its concession to Steward Healthcare.[17] Eventually, on 10 April 2018, the Medical Association of Malta and the Health Minister signed an agreement for a new PPP agreement with Steward Healthcare. This agreement regulates the conditions of work for doctors and future possible PPP arrangements.[18] Since the agreement is still in its very early stages, it is unknown how this privatisation process will affect the accessibility and affordability of healthcare in the future.

1.5 Essential medicines

People in low-income groups, as determined by a means test, are entitled to free medicines from a restricted list of essential medicines and medical devices.[19] People who suffer from chronic illnesses also receive free medicines listed in the national formulary without means testing.[20]

Since 2008, free medicine can be collected from private pharmacies scattered in different towns and villages though the 'pharmacy of your choice' (POYC) system, rather from the central hospital pharmacy as previously happened. This helps accessibility, especially for older people.

In all other cases, outpatients must purchase pharmaceuticals out of their own pocket. This raises issues for vulnerable groups, which include pensioners and families (especially those having many children) on low income, whose medicine is not included in the national formulary. It also affects persons prescribed certain types of medicine which are new on the market, especially medicine for rare diseases or for certain types of cancers.[21]

1.6 Waiting lists

Outpatient waiting times are long and are on the increase. According to a report by the National Audit Office[22], as at 31 October 2016 there was an average waiting time of more than 250 days (36 weeks) for a first outpatient appointment at the 51 clinical specialities at the Mater Dei Hospital. The waiting list contained 63,233 patients. The longest waits were noted in five specialties, namely: genetics, medicine gastrointestinal tract, neurology,

[16] OECD/European Observatory on Health Systems and Policies 2017 (page 13).
[17] Sansone, K. 2017.
[18] Grech, H. 2018.
[19] Ministry of Health webpage: https://integration.gov.mt/en/Health/Pages/Public-Healthcare.aspx

[20] Deputy Prime Minister webpage: https://deputyprimeminister.gov.mt/en/pharmaceutical/Pages/formulary/formulary.aspx
[21] OECD/European Observatory on Health Systems and Policies 2017 (page 11).
[22] National Audit Office 2017.

urology and vascular. More recent data based on an analysis conducted as at 14 March, 2018[23] show that the outpatient waiting time had increased by a further four weeks, to 278 days on average (40 weeks).

According to a report on the performance of the Maltese health system published in 2015, self-referrals and waiting times for admission to a **long-term facility** were also classified as very poor[24].

Current data (see Annex) on **pending unscheduled and scheduled interventions** in the different specialities also gives a rather bleak picture. The three specialities with the biggest number of pending interventions since registration can be found in orthopaedics (with 3,819 pending interventions and a wait of 220 days since registration); general surgery (3,442 pending interventions and a wait of 206 days); and thirdly ophthalmics (2,574 pending interventions and a wait of 139 days).

The waiting lists for pending radiological investigations at the medical imaging department are even longer. For example, there are 11,502 pending liver elastography ultra sound examinations, an increase of 6.16 per cent over the previous month and for which the next available appointment is in September 2019. The second largest number of pending radiological investigations is for an MRI scan with 8,188 pending cases, which reflects an increase of 1.39 per cent over the previous month and with the next available appointment being in April 2019. The third largest number of pending radiological investigations are plain X-ray examinations (5,039) which saw an increase of 9.85 per cent over the previous month and with the next available appointment being in October 2018.

2 Analysis of the challenges in inequalities in access to healthcare and the way they are tackled

On paper, the Maltese system does not appear to have challenges in terms of inequalities in access to healthcare. Overall, unmet medical need is low, as can be seen from Table 1 below. In all cases, the Malta figures are below EU27 figures. In 2016 only 0.7 per cent of the population reported that they were unable to obtain medical care when needed because it was too expensive, none stated that they had problems because it was too far to travel, and only 0.3 per cent stated that the waiting lists were too long. The combined statistic for the three reasons for 2016 was only 1 per cent compared with the EU27 average of 2.5 per cent. It is important to note that these statistics refer to pure perceptions. As such, it might be argued that it is very difficult, if not impossible, to compare perceptions validly across EU member states, since the quality and level of service expected might differ extensively across different cultures.

[23] Personal communication with Clinical Performance Unit, Mater Dei Hospital, 8 June, 2018. The full data are to be found in Annex A to this report.
[24] Grech, K. et al. (eds) 2015 (page 8).

Table 1. Self-reported unmet need for medical care by detailed reason

% of population aged 16 and over

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Too expensive									
EU (27 countries)	2	1.9	1.9	2.3	2.2	2.4	2.4	2	1.6
Malta	0.5	1.2	1.4	0.8	1	0.8	0.9	0.7	0.7
Too far to travel									
EU (27 countries)	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1
Malta	0	0	0.1	0	0	0	0	0	0
Waiting List									
EU (27 countries)	0.8	1	1	0.9	1	1.1	1.1	1	0.8
Malta	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.1	0.3
Too expensive or too far to travel or waiting list									
EU (27 countries)	3	3	3.1	3.3	3.4	3.6	3.6	3.2	2.5
Malta	0.7	1.4	1.6	1.1	1.2	0.9	1.1	0.8	1

Source: EU-SILC 2016.

Table 2 below also shows that there is variation between the reported unmet needs in 2016 of those in the highest income quintile (0.2 per cent) and those in the lowest (2.0 per cent) – thus suggesting a not quite equitable access to services across income groups.

Table 2. Self-reported unmet needs for medical examination for 'too expensive or too far to travel or waiting list' combined

% by income quintile

	2016	First quintile	Second quintile	Third quintile	Fourth quintile	Fifth quintile
European Union (current composition)	2.5	5.0	2.9	2.3	1.5	1.1
Malta	1.0	2.0	1.3	1.1	0.5	0.2

Source: EU-SILC 2016.

Out-of-pocket (OOP) private payments remain high (28.7 per cent of total health spending) and are nearly double the EU average (15.3 per cent). Overall Malta is amongst the top third of countries with the highest OOP spending, due to the significant private sector involvement in providing health services.[25]

These OOP payments are largely made to general practitioners and specialists who operate on a fee-for-service basis. Direct OOP payments must also be made by most people to buy prescribed medicines and pharmaceuticals. These high OOP payments do not seem to pose a barrier to accessing healthcare, and the groups with the lowest income still report low rates of unmet need for medical care due to cost (2.4 per cent in 2015).[26]

As a result, it can be stated that access problems are not extensive in Malta, and that reported unmet needs are minimal. This is partly due, however, to systemic characteristics of Malta's mixed system, which allows medical professionals to be concurrently active in both the public and private healthcare sectors. As already stated above, perceptions are difficult to compare cross-culturally.

The challenges to inequalities in access to healthcare can be summarised as:

[25] OECD/European Observatory on Health Systems and Policies 2017.
[26] OECD/European Observatory on Health Systems and Policies 2017.

a) the need to improve waiting times, particularly for access to specialist outpatient services and specialised diagnostic services, particularly in the medical imaging department;

b) the perception by patients that visiting a specialist in private clinic gives better and quicker access to the public health system;

c) the purely financial problems facing persons with limited needs in trying to access the private health system before accessing the public health system;

d) the inadequacy of the means test, which has not been updated to reflect current costs, especially in respect of capital goods; and

e) the difficulties facing vulnerable groups, namely residents in Malta who are not Maltese or EU nationals and who do not have any form of protection.

The first three of the above issues are related to waiting times for access to specialist care. The waiting lists for some inpatient care services have been tackled in recent years. In effect in 2016 only 0.3 per cent of respondents reported unmet needs for medical examination due to waiting lists. However, this does not mean that waiting lists have been eliminated; and whilst waiting lists for inpatient care have been reduced substantially in certain specialities, this is not uniform across all the clinics.[27] The averages often quoted in public discourse and in published data effectively hide long waiting lists in specific clinics, which are lumped together in a particular section.

Direct access to specialists in the private sector effectively allows patients who are prepared to pay to by-pass waiting lists for specialist ambulatory and elective diagnostic and therapeutic interventions. This raises equity issues for those who cannot afford to go to a fee-paying specialist who can facilitate this access.[28] Those who can afford to do so, and those who are covered by private health insurance, have better access to healthcare, in that they can use private hospitals and ambulatory services/clinics for their diagnoses and interventions: in addition, they have better access facilities to public inpatient services, because they are already known to the specialists – who can, and often do, fast track care for them. In Malta, it is a fact of life, known by everybody, that although strictly speaking any patient can have access to inpatient treatment through the public primary care system, people feel the need to accelerate their access to care by first visiting the same specialists manning the public sector privately.

Persons who do not have enough resources to first pay for private care consequently have more difficulty in accessing inpatient care. This is mostly common among persons who do not qualify for free medicines because they do not qualify through the means test. The threshold for the means test in Malta is very low.[29]

2.1 Accessibility for vulnerable groups – migrants and transgender persons

One major group that is currently experiencing problems in accessing free healthcare is those people who have obtained humanitarian protection or a residency permit in another EU state, such as Italy or Spain, and who travel to Malta to seek work. Currently, work in Malta is abundant and there is a shortage of workers – yet in spite of this, these migrants are not allowed to work. At times, these persons end up working informally in risky jobs, especially in the construction industry, where health and safety regulations are not always enforced. They can end up seriously injured, and since there is no specific legislation

[27] See Annex A with the latest figures provided in June 2018 by the Clinical Performance Unit of Mater Dei Hospital.
[28] OECD/European Observatory on Health Systems and Policies 2017.
[29] A single person must not have more than €14,000 in capital; a married couple must not have more than €23,300 in capital. A person's residence is excluded. In addition to the capital requirement, the means test also has an income component, which varies according to the type of benefit required. In all cases the threshold is also very low.

providing health coverage for them, they are often given emergency treatment only. After this, they are expected to get follow-up treatment in their country of residence, or to pay for treatment. Similarly, expensive treatments such as antiretroviral drugs could also be discontinued after an initial treatment, since this is considered the responsibility of the country of residence.[30]

When such migrants go to a health centre, their name will not be on the list of persons eligible to receive free care. Hence, technically they could be turned away. However, a source who did not want to be identified indicated that they are often seen by the doctors at the health centres, and are then sent a bill. Similarly, if they go to the main Mater Dei Hospital they are allowed to see the specialist, but are then asked to go to the billing section so that the treatment costs can be noted and eventually a bill sent. Access seems to be stricter at Boffa Hospital, which mainly treats dermatological conditions. Migrants who are not entitled to free care are unlikely to have the money to pay medical bills and this may affect their decision to seek subsequent care. For example, in January 2018, a seven-year-old Nigerian girl died from a rare disease in Malta: her family were not entitled to free healthcare and after receiving three bills (one for each child), the family was reluctant to seek medical help again, which could have led to the child's premature death.[31]

Asylum-seekers, persons with international protection, and certain third-country nationals are at times unable to access information about health services that target their specific needs. They may also encounter language problems due to a shortage of cultural mediators and of health professionals who are trained in dealing with this type of client. A primary healthcare migrant health unit is available to help migrants gain access to the health system.

Problems in relation to mental health seem more acute for these migrants and there seems to be a 'revolving door' situation with many clients, being readmitted several times. This means that some may end up homeless and in a severe state of mental deterioration. This highlights the importance of continuing care after persons leave institutions, and of providing more support centres where migrants can be temporarily housed in order to follow an individualised programme of rehabilitation.[32] There are no data to quantify how big the problem is.

Whilst trans-gendered persons previously did not have free access to hormone therapy and gender-affirmation care, the government has just announced that it will start offering specialised healthcare services to this category of persons, after a brief consultation period that ends on 6 June 2018.

3 Discussion of the measurement of inequalities in access to healthcare

Measuring the systemic inequalities described above is very difficult, since they are generally perceived to be natural and normal aspects of the system and are not subject to criticism or quantitative analysis in Malta. Nonetheless, qualitative evidence clearly points to their existence, and they have also been noted above.

In particular low-income Maltese nationals, together with migrants and third-country nationals, are more likely to have access problems to healthcare. The situation of migrants and third-country nationals is generally not captured by surveys, because such people may not have a permanent address, may have language problems, and may be reluctant to give feedback for fear of being deported if they are identified. This makes it difficult to quantify the problem and how it affects the communities concerned.

[30] Bugre, M. (Project Development Manager at the Foundation for Shelter and Support to Migrants). Personal communication, 24 April, 2018.
[31] Carabott, S. 2018.
[32] Bugre, M., ibid.

People such as NGO staff who work closely with these people may offer insights into the hardships they face when they are denied access to healthcare. Because migrants are more likely to trust them, they may be in a better position to capture information about them on health-related issues.

Data from the billing section in the main government hospitals around the island might also give an indication of how many times these people are managing to access healthcare, how much they are being charged for this service, and how many of the bills are remaining unpaid. This data is not in the public domain, however.

One of the country-specific limitations of the commonly used EU-SILC indicators relates to the unmet medical care needs of specific cohorts of the population. Hence, when looking at material and severe material deprivation, it might be useful to include a specific indicator that focuses on the issue of health. This could focus on the issue of access as well as on the ability of persons to afford OOP payments related to health (such as those for GP visits and medicines). It would be useful to look at how this problem affects the different social groups, including the elderly and families with young children, who may be more prone to need medical services and medicinal supplies.

In Malta's case, there is also a definite need for a specific study that examines the extent to which excess morbidity and mortality might be caused by long waiting lists and times.

Annex

All the contents of Annex A have been provided through a personal communication from the Clinical Performance Unit of Mater Dei Hospital, Malta, in June 2018.

Outpatient waiting times

Methodology

1) The average gap was calculated by finding the difference between the date when the appointment was booked on the system (CPAS) and the date of the actual appointment.
2) The analysis was based on future new case appointments booked up to 14 March 2018.
3) New case outpatient attendances who are seen as 'walk-ins' do not feature in this analysis. Some specialities, including orthopaedics, ophthalmics, medicine chest clinic, medicine rheumatology, neurology and neurosurgery vet the appointments to prioritise according to urgency. In this analysis the vetting time is not included when calculating the average gap, since the time between receipt of the referral to Mater Dei Hospital to the time when the appointment is given is not captured on CPAS.

Table A1 Outpatient waiting times

For future appointments booked until 14.03.2018

Dept	Number of Future Appointments	Average of gap (days)	Weeks
Anaesthesia/Pain Relief	456	114	16
Cardiac Surgery	3	26	4
Cardiology	1444	67	10
Chinese Medicine	86	61	9
Dental	17394	420	60
Dietician	435	150	21
Genetics	1035	339	48
Medicine	9761	282	40
Neurosciences	992	151	22
Nutrition	350	162	23
Obs & Gynae	1922	84	12
Ophthalmology	5704	223	32
Orthopaedics	2339	123	18
Paediatrics	1039	141	20
Podiatry	2509	221	32
Surgery	9137	219	31
Thalassaemia	80	66	9
Tissue Viability	239	17	2
Grand Total	**54925**	**278**	**40**

Table A2 Detailed Outpatient waiting times

For future appointments booked until 14.03.2018

		Number of Future Appts	Average of Gap (days)	Weeks
Medicine	MOP/Gastroenterology/Hepatic	443	523	75
	MOP/Gastroenterology	2134	468	67
	Systemic Sclerosis Clinic	25	331	47
	Medical OP	2302	299	43
	Diabetes Clinic (new-cases)	480	228	33
	Neuroendocrine Clinic	98	225	32
	Medical & Respiratory OP	1294	195	31
	Diabetes Clinic	1530	217	30
	Rheumatology Clinic	146	187	27
	Sleep Pap Clinic	41	185	26
	Rheumatology Ankylosing Spondylitis	10	170	24
	Asthma Clinic	161	164	23
	CTD Clinic	13	161	23
	General Medicine Clinic	202	154	22
	Lipid Clinic	88	145	21
	Pulmonary Fibrosis	9	145	21
	Nephrology	283	140	20
	Diabetic Foot Clinic	42	133	19
	COPD Clinic	8	114	16
	Thyroid Clinic	72	112	16
	Diabetes Clinic (Juvenile)	42	110	16
	Endocrine Clinic	63	92	13
	Medicine/Nephrology	124	88	13
	Endocrine & Medical Clinic	182	84	12
Surgery	SOP Urology	2671	374	53
	Vascular Surgery Clinic	695	332	47
	ENT Tinnitus Clinic	108	298	43
	ENT Dizziness Clinic	328	218	31
	Paediatric Surgery	443	190	27
	ENT Audiology (paed)	351	148	21
	ENT OP	1430	138	20
	SOP Plastic	274	129	18
	SOP	2194	116	17
	ENT/Audiology	139	114	16
	ENT Audiology	180	102	15
	Urology Clinic Ward 2	8	71	10
	ENT/Audiology (Hearing Aids)	86	54	8
	SOP Dermatology Referrals	37	48	7
	SOP Bariatric Clinic	11	44	6
	ENT/Audiology (Audiometry)	1	43	6
	Urology Male Infertility Clinic	29	38	5
	Breast Clinic	36	33	5
	ENT OP Oncology	1	28	4
	SOP (Stoma Clinic)	32	28	4
	Urology Outreach Clinic	83	28	4
Surgery Total		**9137**	**219**	**31**
Neurosciences	*Neuroepilepsy Clinic*	*1*	*357*	*51*
	Movement Disorder	*2*	*245*	*35*
	Neuromuscular Clinic	*8*	*236*	*34*
	Neurocognative Clinic	*1*	*202*	*29*
	Neurology Clinic	688	198	28
	Neurovascular Clinic	3	123	18

		Number of Future Appts	Average of Gap (days)	Weeks
	Neurology OP	14	119	17
	Neurosurgical Clinic	81	71	10
	EEG	26	15	2
	EMG	168	10	1
Neurosciences Total		**992**	**151**	**22**
Dental	Dental Clinic	13449	507	72
	Dental Clinic (oral rehabilitation)	556	200	29
	Child Dental Clinic	160	188	27
	Dental Clinic (Oral Surgery)	190	172	25
	Dental Clinic (Scaling and Polishing)	543	119	17
	Dental Clinic (Oral Hygiene)	1062	103	15
	Dental Orthodontic Clinic	1170	99	14
	Cleft Lip & Palate Clnic (Dental)	13	62	9
	Dental Clinic (Prosthetics)	251	44	6
Dental Total		**17394**	**420**	**60**

Table A3 Number of pending interventions per specialty as at 30 May 2018

Specialty	Number of interventions	Days since registered
Cardio-thoracic surgery	4	181.40
Cardiology	115	71.47
Dental	609	295.60
Medical	678	107.37
Medical-paediatrics	4	280.40
Obstetrics/Gynaecology	263	66.45
Ophthalmics	2574	139.15
Orthopaedics	3819	219.84
Pain management	246	69.87
Surgery - ENT	1226	229.20
Surgery - General	3442	206.18
Surgery - Neuro Surgery	102	178.77
Surgery - Paediatric	74	134.75
Surgery - Plastics	3	19.82
Surgery - Urology	443	72.84
	13602	184.39

Table A4 Pending radiological investigations at medical imagining department, as well as next available appointment for each investigation.

Date: 6 Jun 2018	Scheduled appointments				Total pending (unscheduled /scheduled)				Next available appt.
	up to 6/12	1 Year (follow-up) be	Routine	Number of exams to	Actual	previous) month	change from	% (+/-	
MRI	814	395	3220	3759	8188	8076	112	1.39	23 Apr 19
CT Scan #	918	276	1445	1025	3664	3476	188	5.41	21 Apr 19
US*	716	461	4291	6034	11502	10835	667	6.16	6 Sep 19
Plain X-Rays	0	0	77	4962	5039	4587	452	9.85	17 Oct 18
Mammography	195	238	234	291	958	937	21	2.24	1 month
Fluoroscopy	11	1	26	163	201	216	-15	-6.94	7 Sep 18
Angiography	18	0	47	57	122	118	4	3.39	30 Aug 18
Nuclear Medicine	71	16	1139	32	1258	1296	-38	-2.93	20 Dec 18
PET CT	94	4	74	6	178	174	4	2.30	12 Dec 18
# Cardiac CT									27 Sep 18
# CT colonoscopy									28 May 19
* Liver elastography US									6 Nov 18
* MSK US									3 Sep 18
Totals	2837	1391	10553	16329	31110	29715	1395	4.69	

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