



A NATIONAL HEALTH SYSTEMS STRATEGY FOR MALTA

2014-2020

SECURING OUR HEALTH SYSTEMS
FOR FUTURE GENERATIONS



PARLIAMENTARY SECRETARIAT
FOR HEALTH

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Ministry for Energy and Health

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Foreword

Working towards safe and sustainable health systems for all

The Government of Malta appreciates how close health is to the Maltese citizen's heart and has therefore declared health and healthcare a top priority in its work plan. Testament to this is the continued investment in the health sector in order to bring health closer to the people. The challenges that threaten the success of such investment are multiple. One main challenge is the burden on health brought about by one of the successes of the health service itself – a higher life expectancy. This, coupled with the ever-increasing demand for new technologies and treatments, modern lifestyle challenges, together with the requirement and expectation to deliver a high quality service nonetheless, led to the need to have an overarching national health systems strategy. Such a vision is pivotal to bring excellence in health within reach of all those who require it, and ensuring that this can be sustained for many years to come.

The National Health Systems Strategy is building on the solid foundations of our present health systems to ensure that an accessible and fair health service is maintained and continuously improved. The Government is committed to keep providing free quality healthcare to all. This is coupled with our aim to maximize well-being in our population, throughout one's life course. After all, a country's economic growth and development depends entirely on the health of its population.

Therefore, the way towards attaining sustainability in healthcare is not in restricting access to health for our population, but through prevention, efficiency and better use of the resources available to us in order to deliver the maximum benefit for our continued investment in the health sector.

Strengthening prevention is key to the maintenance of a healthy population – not only primary prevention to prevent the onset of disease, but also helping those with disease to keep it in check and minimize the effect that disease may have on their daily activity. To attain this we need to foster an environment that supports people in leading a healthier lifestyle. This requires the involvement of our whole society.

We strongly believe that efficiency and sustainability can be gained by investing further in delivering health closer to our communities. Our dedicated family doctors are already well placed to achieve this vision and this sector needs to be empowered with more services within primary health care, including specialist care and advice.

Better use of current technologies, such as the Internet and mobile networks, is another key to a more sustainable health sector. E-health and m-health services would complement and support the excellent care provided by our health providers by delivering information where and when it is needed, empowering the citizen to take control of one's own health and enabling the policy maker to channel investment where it is most required.

Harnessing our existing resources and engaging in governance is pivotal to attaining the maximum potential of one's investment. The Government believes wholeheartedly in the quality of the main resource in this sector – our health workforce. Empowering our health providers to attain their maximum potential through providing access to further training and medical research will help the country to achieve the excellence envisioned for Maltese healthcare. Indeed, for such a highly capable resource to deliver excellence, it also requires the right infrastructure. This applies particularly to the development of the role of primary health services in Malta. We also believe in the role of specialised centres of excellence which will continue to put Malta on the regional health map.

To this end it is with great pleasure that I am presenting Malta's National Health Systems Strategy for the period 2014 to 2020. The Government is committing itself to lead its implementation and support its execution as part of its resolve to address long-term challenges. By sharing this vision, the Government is inviting all other entities in the public sector and also the private sector to engage and partake in its implementation. I am also inviting you, as a Maltese citizen, to own this vision and make it yours so we can move together in the same direction - towards achieving a sustainable health care service that delivers high quality care to all.

Hon. Mr. Chris Fearn
MD, FRCS Ed, MP
Parliamentary Secretary for Health

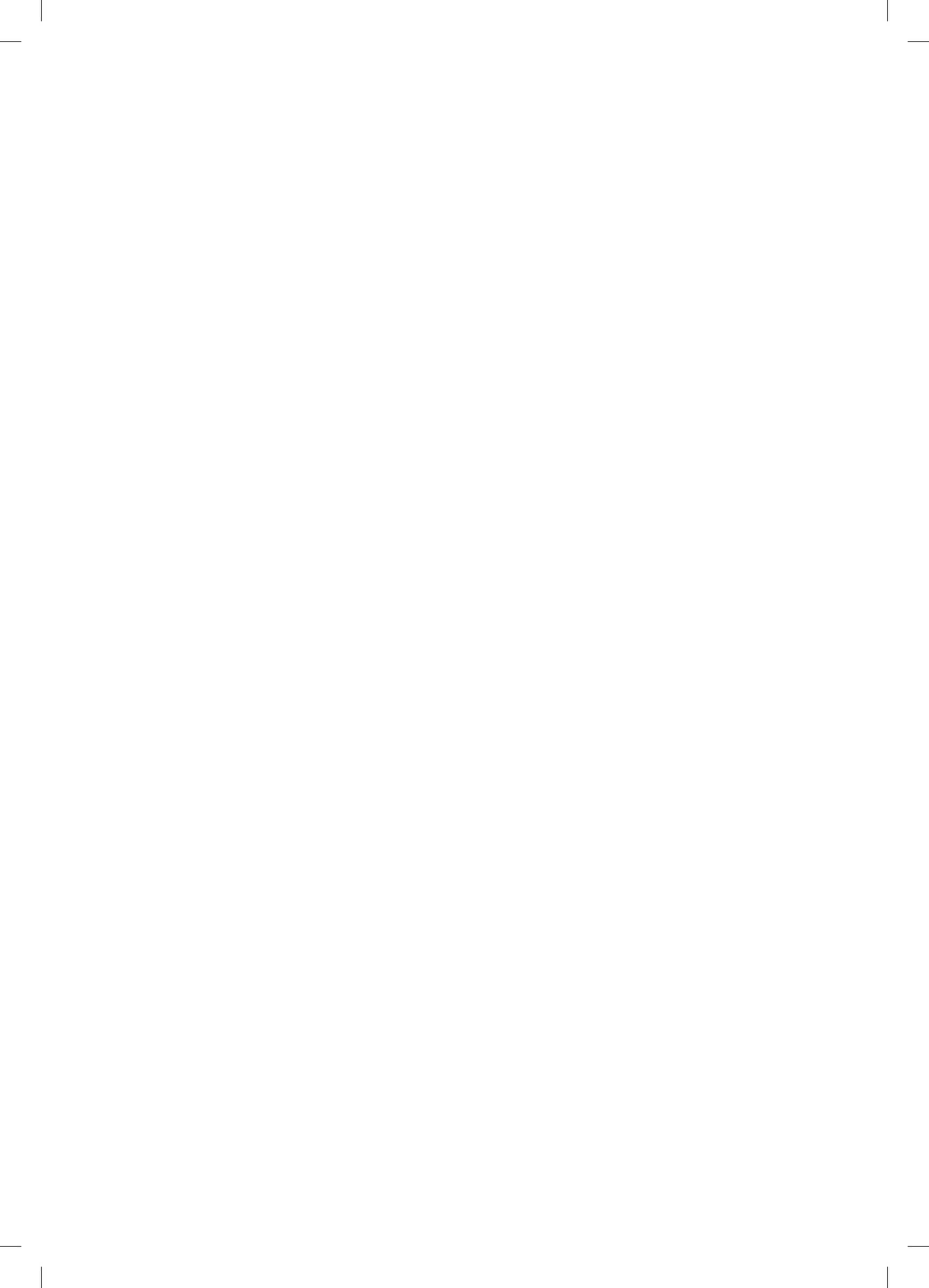


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GLOSSARY / ACRONYMS

A&E	Accident and Emergency
AD	Alternattiva Demokratika / Democratic Alternative party
AGS	Annual Growth Survey
AIDS	Acquired Immunodeficiency Virus
BMI	Body Mass Index
CSR	Country Specific Recommendations
CT	Computed Tomography
DHIR	Directorate for Health Information and Research
DTP	Diphtheria, Tetanus and Polio
ECHI	European Common Health Indicators
EHES	European Health Examination Survey
EHIS	European Health Interview Survey
ESP	European Standard Population
ESPAD	European School Survey Project on Alcohol and other Drugs
EU	European Union
EUROCARE	European Cancer Registry
FOBT	Faecal Occult Blood Test
GDP	Gross Domestic Product
HiAP	Health in All Policies
HiB	Haemophilus Influenza type B
HIV	Human Immunodeficiency Virus
HLY	Healthy Life Years
HPDP	Health Promotion and Disease Prevention
HSPA	Health Systems Performance Assessment
ICCC	Innovative Care for Chronic Conditions
ICT	Information and Communication Technologies
IHI	Institute of Health Care Improvement
IOM	Institute of Medicine
LTC	Long-term Care
MEH	Ministry for Energy and Health
MFIN	Ministry for Finance
MMR	Measles, Mumps and Rubella
MONICA	Multinational MONItoring of trends and determinants in CARdiovascular disease study
MRI	Magnetic Resonance Imaging
NHA	National Health Accounts
NHIS	National Health Interview Survey
NHSS	National Health Systems Strategy
NOIS	National Obstetrics Information System
NRP	National Reform Programmes
NSO	National Statistics Office
OECD	Organisation for Economic Co-operation and Development
PET	Positron Emission Tomography
PL	Partit Laburista / Labour Party
PN	Partit Nazzjonalista / Nationalist Party
SDR	Standardised Death Rate
SILC	Survey Statistics on Income and Living Conditions
WHO	World Health Organization

Executive Summary

A number of reasons contributed towards the need for the Ministry for Energy and Health to issue an overarching National Health Systems Strategy. The last umbrella national health strategy: Health Vision 2000 was issued in 1995. The national health systems in Malta are continuously trying to manage a fast changing environment and several challenges to safeguard and ensure universal access, high quality of care and sustainable services. In response to these challenges, a growing number of strategies specific to selected sectors have been published or are being developed. There is a pressing need to develop a horizontal overarching strategy to ensure consistency and a coherent and all encompassing response and action to the challenges that are being encountered.

The Maltese population is ageing with a steady decrease in the percentage of persons under 15 years and an increase in the number of persons 65 years and over. Life expectancy has steadily increased over the past 20 years so that in 2011, life expectancy at birth was 83.1 years for women and 78.8 years for men.

The National Health Systems Strategy (NHSS) needs to ensure universal access to high quality health services and economic sustainability, within the available budgetary resources, and incorporate strategies aimed at:

- improving and increasing available services;
- promoting and streamlining interactions between different services to ensure continuity of care;
- improving and increasing services to citizens who are not patients including prevention and screening, and health promotion services aimed at the population in general and/or specific to identified vulnerable groups.

The NHSS revolves around a set of four overall objectives and seven strategic directions. The objectives encompass the strategic policies identified from an in-depth review of the accumulated thematic strategies and policy documents issued over the past twenty years and the deliberations of the task force that was created in 2012 to draft this national strategy. The objectives are also guided and informed by international literature and in particular by the 'Health 2020: a European policy framework supporting action across government and society for health and well-being' adopted by the World Health Organisation (WHO), European Region issued in 2012 and the 'EU Health Strategy - Together for Health: A Strategic Approach for the EU 2008- 2013' adopted by the European Council in 2007. The overall objectives and the corresponding strategic directions are presented in Box 1 at the end of this summary.

The strategic actions and tactics identified for the implementation of each strategic direction are presented in a structure informed by a people-centred approach because this strategy is encompassing the broader view of an overarching health system rather than just concentrating only on the more familiar and visible health care systems. A people-centred approach is distinct from the more commonly portrayed patient-centred approach because it recognises that before people become patients they need to be informed and empowered in promoting and protecting their own health.

The people-centred approach recognises four major groups of stakeholders. All these groups work for and are concerned with the success of the health systems. These four groups or policy and action domains include the following:



INDIVIDUALS, FAMILIES AND COMMUNITIES



HEALTH PRACTITIONERS



HEALTH CARE ORGANISATIONS



HEALTH AUTHORITIES

To achieve any real transformation in any part of the health systems these domains must mutually reinforce each other and leadership within and across all domains is recognized as the ultimate enabler for change. Accordingly, the actions presented for each of the strategic directions have been classified according to each of the above four major groups of stakeholders.

The main thrusts of the actions aimed at engaging individuals, families and communities include educating members of the public to acquire personal skills which allow control over their health and engagement with health care systems such as skills to improve communication, allow involvement in decision-making, and increase capacity for self-monitoring and self-care. Engagement will also be sought by formally recognising and increasing support to informal carers in the community, through initiatives to increase the general public's confidence and trust in primary health care and by strengthening the importance of the roles of the local government, voluntary organisations and patient groups in the provision of health services.

Actions targeting health practitioners will focus on ensuring that they uphold respect for patients, their needs and decisions at the clinical level and value communities and their needs at the population health level through the reinforcement of professional skills and competence in communicating, empathy and responsiveness, health promotion and disease prevention. Practices that promote access to professional development and debriefing opportunities, adherence to evidence-based guidelines and protocols, commitment to quality, safe and ethical care, teamwork and collaboration across disciplines, providing coordinated care and ensuring continuity of care and involvement in health care governance and policy decision-making are included as actions for this group of stakeholders.

Health care organizations are involved with actions needing to guarantee access to all people needing health care and to realise their commitment to quality, safe and ethical patient care. Actions also include the continuation of initiatives to provide safe and welcoming physical environment supportive of different lifestyles, and the needs of patients and their family for protection of their privacy and dignity. The acknowledgement of the importance of all levels of staff in the delivery of health

care is upheld in this strategy. Other actions include the development of more effective avenues to address grievances and complaints and the organization of services that provide convenience and continuity of care to patients.

Finally, health authorities will be mandated to ensure that primary health care will continue to evolve as the foundation for better health, to strengthen financing arrangements that ensure the sustainability of the health system, to continue investment in health professional education that promotes multi-disciplinary teamwork, good communication skills, and a stronger orientation towards prevention. Actions are also included to increase the national capability to develop and disseminate standards and protocols, to augment uptake and use of Information and Communication technologies (ICT) to assist in the dissemination of information on patients, ensure continuity of care and facilitate decision-making both by the patients and the health practitioners and to foster more transparency and accountability in the operations of the national health systems.

BOX 1 | THE PILLARS OF THE NHSS

IMPROVED HEALTH, INNOVATING THE WAY FORWARD: OVERALL OBJECTIVES AND STRATEGIC DIRECTIONS OF THE NHSS

OVERALL OBJECTIVE 1

Respond to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on the whole course of life, children, the elderly and vulnerable groups.

Strategic Direction 1A

Prolonging stay in the community and responding to increasing demands for higher dependency care.

Strategic Direction 1B

Strengthening the prevention and promotion of health focusing on behavioural changes and lifestyle choices including protection, screening and early diagnosis and control of disease progression.

OVERALL OBJECTIVE 2

Increase equitable access, availability and timeliness of health and social services, medicines and health technologies.

Strategic Direction 2A

Improving management and efficiency of services through research and innovation, prioritisation, monitoring, public private partnership, and other service provision models.

OVERALL OBJECTIVE 3

Improve quality of care by ensuring consistency of care delivered by competent health workers supported by robust information systems.

Strategic Direction 3A

Setting and enforcing quality standards including licensing and accreditation and development and systematic application of case management protocols.

Strategic Direction 3B

Facilitating continuity of care through co-ordination and integration within and between service provider teams and by improving communication and sharing of information.

OVERALL OBJECTIVE 4

Ensure the sustainability of the Maltese Health Systems.

Strategic Direction 4A

Designing, developing and evaluating sustainable policies for human resources, financing mechanisms, entitlement criteria for care and organization of care delivery.

Strategic Direction 4B

Improving governance and empowering future leadership for health and well-being to influence national decisions through whole-of-government and whole-of-society approaches.

Background

1.1 THE NEED FOR A NATIONAL HEALTH SYSTEMS STRATEGY (NHSS)

The vision of the Ministry responsible for Health is to actively promote a society that fosters an environment that is conducive to persons attaining their maximum potential for health and well-being. In order to attain these goals, the Ministry has embarked on an exercise to formulate a National Health Systems Strategy for the period 2014 to 2020 (NHSS). The aim of this strategy is to provide every individual with the opportunity to lead a healthy and active life, and to benefit from equitable access to sustainable quality health care.

Health is being increasingly seen as a resource to one's daily living. It is being decreasingly seen as an end in itself but more as a means for an active and productive life. The cliché "there's no wealth without health" is progressively more and continuously being reiterated in public health and political fora and applies not only at an individual level but also at a community, national and European level.

The first ever National Strategy for Health, the "Health Vision 2000", was published in 1995. This valuable document has given a good description of the nation's health status at the time, while describing a reform for the health services and setting targets for intervention within particular key areas. Whilst this has been an important and timely work which influenced health policy over these last 18 years, the time has come to renew our vision and devise a new strategy for health, based on today's disease epidemiology and health needs.

The Maltese health system in line with several health systems worldwide have to cope with a fast changing environment. These include epidemiologically changes such as in terms of changing age structures and the emergence of new threats, political transformations in terms of changing perceptions about the role of the state and its relation with the private sector and civil society, a general public and patients that are becoming more and more knowledgeable and discerning, and technical revolutions with increasingly sophisticated and expensive treatment options on offer.

BOX 2 | THE PRESSURES FACING HEALTH SYSTEMS ¹

The drive for greater efficiency, productivity and cost control;

The growing demand for healthcare as a result of aging populations and improvements in medical technology and pharmaceuticals;

The need to devise effective and sustainable responses to increasing consumer demands for greater patient choice, better and faster access to services and the growing number of patients' rights movements;

The need to manage long-term or chronic diseases such as diabetes, heart disease and obesity, precipitated by increasing longevity, lifestyle and environmental changes.

Source: Goodwin, N. (2005) Leadership in Healthcare: A European Perspective.

In response to these challenges, a growing number of strategies specific to selected sectors have been published or are being developed. However, there is an acute need to develop a horizontal overarching strategy to ensure consistency and a coherent response and action to the challenges that are being encountered in a holistic fashion. The NHSS has been created to provide the role of the umbrella strategy for all the sectoral health policies and strategies that have been launched since 2000 and that will be completed over the next few years.

Furthermore, the need to design, produce and implement a new NHSS is the requirement for such a strategy vis-à-vis national endeavours to succeed in the application for initiatives to acquire future EU and international funding. This funding is required for the further improvement and development of the Maltese health system. This requires that a national strategy for health is in place that ensures access to quality health services and economic sustainability and that within the available budgetary resources for health care provides for and contains:

- coordinated measures to improve access to quality health services;
- measures to stimulate efficiency in the health sector, including through deployment of effective innovative technologies, service delivery models and infrastructure;
- an effective and sustainable monitoring and review system*.

1.2 THE POPULATION OF THE MALTESE ISLANDS

The three main islands, Malta, Gozo and Comino, form an archipelago in the Mediterranean Sea that has the highest average population density in Europe (1325 persons per km²). The total population was 417,432 in 2011. ⁽⁶¹⁾

Population growth has slowed from 1.0% per year in 1990 to 0.5% per year in 2010. ⁽³⁾ While the crude death rate has been relatively stable over the past 20 years (7.9 per 1,000 persons in 2011) there has been a decline in the fertility rate from 2 births per woman in 1991 to 1.4 in 2012. The crude birth rate was 10.1 births per 1,000 in 2012. ⁽⁵⁾

The Maltese population is ageing with a decrease in the percentage of persons under 15 years which in 2011 accounts for 14.8% of the population, and an increase in the number of persons 65 years and over which now account for 16.3% of the population; the percentage of persons aged 80 years and over is also steadily increasing, standing at 3.6% of the total population in 2011. The old-age dependency ratio of 23.7% is lower than the EU average (26.8%) as at 2011. ⁽⁶¹⁾

As of 2011, 91.6% of residents were born in Malta; most others were born in the United Kingdom, Australia or Canada. ⁽⁶¹⁾ In 2010 there was an estimated net immigration of 2,247 persons, mainly from other EU member states, as well as returning Maltese nationals. While there is little reliable data from 2005-2009, authorities reported an average of 1,911 irregular immigrants per year by boat, though only 47 were reported

* Proposal for a Regulation of the European Parliament and of the Council laying down common provisions on the European Regional Development Fund, the European Social Fund, the Cohesion Fund, the European Agricultural Fund for Rural by Development and the European Maritime and Fisheries Fund covered by the Common Strategic Framework and laying down general provisions on the European Regional Development Fund, the European Social Fund and the Cohesion Fund and repealing Regulation (EC) No 1083/2006

TABLE 1 | TRENDS IN POPULATION/DEMOGRAPHIC INDICATORS, SELECTED YEARS

	1980	1990	1995	2000	2005	2010
Total Population ^a	325,721 ^b	361,908	378,404	391,415	405,006	417,617
Population, female (% of total) ^a	51.40 ^c	50.83	50.59	50.52	50.41	50.29
Population aged 0-14 (% of total) ^d	24.21	23.47	21.76	20.06	17.39	15.42
Population aged 65 and above (% of total) ^d	8.27	10.42	11.03	12.22	13.37	15.16
Population aged 80 and above (% of total) ^e	0.90	1.96	2.17	2.44	2.95	3.44
Population growth (average annual growth rate) ^c	1.00	1.00	0.70	0.50	0.60	0.50
Population density (people per sq km) ^d	993.75	1106.56	1158.75	1205.65	1260.97	1299.97
Fertility rate, total (births per woman) ^d	2.00 ^c	2.00	1.80	1.70	1.37	1.40
Birth rate, crude per 1,000 people) ^d	17.62	15.16	12.44	11.30	9.56	9.66
Death rate, crude (per 1,000 people) ^d	10.38	7.65	7.30	7.71	7.76	7.24
Age dependency ratio (population 0-14 & 65+; population 15-64 years) ^e	48.20 ^c	51.16	50.33	47.22	44.05	44.47
Distribution of population (rural/urban) ^d	89.79	90.38	90.95	92.37	93.65	94.67
Proportion of single-person households	n/a	n/a	14.80 ^f	n/a	18.90 ^f	18.80 ^g
School enrollment tertiary (% gross) ^c	2.54	10.72	21.54	19.85	30.72	36.48

Sources:

^a Demographic Review 2010, NSO^b Demographic Review 1990, NSO^c World Development Indicators, World Bank^d European Health for All database, WHO^e (Demographic Review 2010, 2005, 2000, 1990, NSO)^f Census 2005, NSO^g Statistics on Income and Living Conditions 2010, NSO

in 2010. ⁽²⁾ Most are from Africa, with a small proportion from Asia. From a health perspective, there are concerns that these immigrants may suffer from infectious diseases which are not endemic in Malta.

Life expectancy has steadily increased over the past 20 years and compares well with the EU average. In 2011, life expectancy at birth was 78.8 years for men and 83.1 years for women. ⁽⁵⁾

Standardised death rates (SDR) for circulatory diseases have decreased over time from 426 per 100,000 population in 1990 to 231 per 100,000 in 2011, but are still higher than those of the EU-15[†]. The probability of dying in the younger age groups (15-60) has been decreasing steadily with a wide gap between males and females, ⁽³⁾ partly attributable to ischaemic heart disease and external causes of death such as traffic accidents and suicides. The overall age-standardised death rate has also been steadily declining and was 660 per 100,000 in males and 442 per 100,000 in females in 2011. ⁽⁵⁾

TABLE 2 | MORTALITY AND HEALTH INDICATORS, SELECTED YEARS ⁽³⁾

		1980	1990	1995	2000	2005	2010
LIFE EXPECTANCY AT BIRTH (YEARS) ⁽⁵⁾	Total	70.4	76.2	77.3	78.2	79.4	81.5
	Male	67.9	73.8	75.0	76.0	77.2	79.3
	Female	72.9	78.4	79.6	80.3	81.4	83.6
MORTALITY RATE (PER 1000 FEMALE OR MALE ADULT POPULATION)	Adult male*	144.0	122.2	112.6	103.7	95.5	87.3
	Adult Female*	80.3	64.7	58.1	52.2	46.9	42.7

Source: European Health for All Database, WHO and World Development Indicators, World Bank.

Note: *probability of a 15 year old dying before age 60, if subject to current age-specific mortality rates between these ages.

Deaths due to diseases of the circulatory system are the leading causes of death, accounting for 47% of all deaths in 2012. The SDR from ischaemic heart disease heart disease seems to have changed from a downward trend to an upward trend in 2010 and 2012 it is considerably higher than the SDR for the EU-15. As for diabetes mellitus, there was a decrease in the age-standardised mortality rate between 2009 and 2012 which may be attributed to changes in coding practices whereby diabetes is considered as a contributory condition to the cause of death rather than being the underlying cause of death. ⁽⁶⁾

[†] EU-15 area countries are those who formed part of the EU prior to April 30th, 2004: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and United Kingdom

Neoplasms are the next most common cause of death and accounted for 27% of all deaths in 2012. While the overall number of deaths has been increasing over time, standardised mortality rates reveal a downward trend that compares well with the EU-15 and all EU countries. The average age at death due to neoplasms is 71.3 years, 8.4 years younger than for circulatory diseases. Lung cancer, followed by colorectal cancer and pancreatic cancers are the leading causes of death from neoplasms in males. Breast cancer, followed by colorectal cancer and lung cancer, are the leading causes of death from neoplasms in females. ⁽⁶⁾ For most cancers there have been improvements in survival rates, however for some types of cancer, survival rates in Malta are lower than in the EURO CARE (European Cancer Registry) pool.^{(7) (8)}

Low mortality rates from infectious diseases can be attributed to widespread availability of antibiotics. The most common infections reported in 2012 were food borne illness, Chlamydia infection, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), latent syphilis and tuberculosis. ⁽⁹⁾ The free syringe distribution programme for intravenous drug abusers which started in Malta in the late 1980s has resulted in low rates of HIV infection. A free childhood immunization programme for all children also has resulted in lower morbidity and mortality from vaccine preventable infectious diseases.

Despite health gains, many risk factors associated with non-communicable diseases in Malta are on the rise. Chronic conditions associated with obesity, unhealthy lifestyles and ageing (such as dementia) are major challenges facing the population as a whole. According to body mass index (BMI) data, the percentage of the male population that is obese has increased from 22.1 percent in 1984 to 24.3 percent in 2008. Data comparing Malta to other EU member states in 2008 found that the proportion of males who are obese in Malta is the highest in the EU while the proportion of females who are obese is third highest. ⁽¹⁷⁾ The proportion of children who are obese or overweight is also one of the highest when compared to children in 41 other countries. ⁽¹¹⁾ Along these lines, according to the European Health Interview Survey (EHIS), 8% of the population aged 15 years and over reported having diabetes in 2008. ⁽¹⁷⁾

Even though males still smoke more than females, the gap is shrinking. According to the latest European School Survey Project on Alcohol and other Drugs (ESPAD) carried out in 2011, 22% of Maltese students aged between 15-16 years participating in the study had smoked during the 30 days before the survey. The study also found that 68% of those surveyed had consumed alcohol during previous 30 days compared to 57% which is the ESPAD average. ⁽¹⁴⁾

The average infant mortality rate for the period 2010 to 2012 was 5.1 deaths per 1000 live births* which is above with EU average of 4 deaths per 1000 live births in 2011. ⁽⁵⁾ When considering the infant mortality rate for Malta, the fact that abortion (terminations of pregnancy) is illegal must be considered. According to the National Obstetrics Information System (NOIS), the highest number of deliveries by maternal age group during 2012 was in the 30-34 group. ⁽¹⁵⁾ The percentage of births to teenage mothers has increased since the 1990s. ⁽⁵⁾

The maternal mortality ratio is defined as the number of maternal deaths per 100,000 live births. Over the past ten years from 2004-2012, two maternal deaths were registered. There were no maternal deaths in 8 out of the 10 years in this time period. The maternal mortality ratio over this time period was 4.97 per 100,000 live births ⁽⁴⁹⁾. This rate compares well with the average overall European maternal mortality ratio quoted in the European Perinatal Health Report 2010 (<http://www.europeristat.com>) that stands at 6.2/100,000 live births. *

§ The EURO CARE study is a cancer register based study on survival and care of cancer patients. The EURO CARE pool includes 23 European countries: Austria, Belgium, Czech Republic, Denmark, Finland, France Germany, Iceland, Ireland, Italy, Malta, Norway, Poland, Portugal, Slovenia, Spain, Sweden, Switzerland, the Netherlands, United Kingdom (UK) England, UK Northern Ireland, UK Scotland, UK Wales

[§] The average infant mortality rate was calculated using data on the number of deaths and the number of live births over the period 2010 to 2012 using the official figures from the National Mortality Register.

TABLE 3 HEALTH INDICATORS IN MALTA OVER THE PERIOD 1984-2010

	Age group	MONICA 1984		NHIS 2002		EHIS 2008		Pilot EHES 2010	
		M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)
BMI: 18.5-24.9 kg/m ² (normal) ^a	25-64	32.4	33.3	29.4	48.0	25.4	48.1	23.1	45.2
BMI: 25.0-29.9 kg/m ² (overweight)	25-64	45.5	31.4	42.2	30.6	46.9	31.0	47.2	28.9
BMI: ≥30.0 kg/m ² (obese)	25-64	22.1	35.3	28.5	21.4	27.7	21.0	29.6	28.0
Elevated blood glucose ^b	≥18 years	N/A	N/A	7.1	7.4	9.6	7.8	9.0	10.7
Normal blood pressure ^c	25-64	51.5	52.9	82.5	83.9	78.4	80.3	66.9	68.7
Elevated blood pressure ^d	25-64	N/A	N/A	17.5	16.1	21.6	19.7	N/A	N/A
Stage 1 ^e hypertension	25-64	32.7	30.9	N/A	N/A	N/A	N/A	30.8	16.3
Stage 2 ^f hypertension	25-64	15.8	16.3	N/A	N/A	N/A	N/A	2.3	15.1
Total serum cholesterol ≤5.00 mmol/L	25-64	22.9	21.0	N/A	N/A	N/A	N/A	31.3	44.0
Borderline high >5.00-6.18 mmol/L	25-64	30.1	29.9	N/A	N/A	N/A	N/A	39.1	41.4
High >6.18 mmol/L	25-64	47.0	49.1	N/A	N/A	N/A	N/A	29.7	14.7

Sources:

Multinational MONItoring of trends and determinants in CARdiovascular disease (MONICA) project
 European Health Interview Survey (EHIS), 2008,
 National Health Interview Survey (NHIS), 2002,
 European Health Examination Survey (EHES) Pilot study, 2010,

Notes:

^a measured height and weight for MONICA and EHES; self-reported for NHIS 2002 and EHIS 2008

^b measured in mmol/L for EHES; self-reported (lifetime prevalence of diabetes) for EHIS 2008

^c measured (systolic <140mmHg and diastolic<90mmHg) for MONICA and EHES; self-reported (no lifetime prevalence of hypertension) for NHIS 2002 and EHIS 2008

^d self-reported (lifetime prevalence of hypertension) for NHIS 2002 and EHIS 2008

^e measured systolic ≥140-159 mmHg or diastolic ≥90-99 mmHg

^f measured systolic ≥160 mmHg or diastolic ≥100 mmHg

TABLE 4 | MATERNAL, CHILD AND ADOLESCENT HEALTH INDICATORS, SELECTED YEARS ⁽⁵⁾

	1980	1990	1995	2000	2005	2010
% of all live births to mothers <20 years of age	3.11 ^a	2.68	3.08	5.57	5.94	6.37
Termination of pregnancy (abortion) rate*	0.00	0.00	0.00	0.00	0.00	0.00
Peri-natal mortality rate	17.90 ^b	10.93	9.94	4.60	3.12	6.22
Neonatal mortality rate (deaths per 1000 live births)	11.96	6.71	7.37	5.27	4.41	4.48
Post-natal mortality rate (deaths per 1000 live births)	3.57	2.79	1.52	0.69	1.56	1.00
Infant mortality rate (deaths per 1000 live births)	15.53	9.50	8.89	5.96	5.96	5.48
Probability of dying before age 5 years per 1000 live births	18.14	10.99	10.21	6.80	6.70	6.46
Syphilis incidence rate (per 100,000 population)	N/A	N/A	N/A	0.00	4.96	5.77
Gonococcal infection incidence rate (per 100,000 population)	N/A	N/A	N/A	0.78	5.70	11.3 ^c

Source: European Health for All database, WHO

Notes: ^a1984; ^b1985; ^c2008; * Induced termination of pregnancy (abortion) is illegal in Malta

1.3 THE ORGANISATION OF THE MALTESE HEALTH SYSTEMS

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In Malta and Gozo, health services are provided mainly by the state and the private sector. The Catholic Church and voluntary organisations also contribute especially in the provision of long-term and community care services. The public health care system provides a comprehensive basket of health services to all persons residing in Malta who are covered by the Maltese social security legislation and also provides for all necessary care to special groups such as irregular immigrants or foreign workers who have valid work permits. Only a few services including elective dental services, optical services and coverage of certain formulary medicines are means-tested. The private sector provides coverage for those that wish to access private services.

The national health systems are organised and governed by two main actors:

1. The Ministry for Energy and Health (MEH). This Ministry is responsible for the financing and the provision of health care for all the population

2. The Ministry for Finance (MFIN). This Ministry collects taxes and allocates them to various sectors including public health care.

Other actors include other Government Ministries, the Foundation of Medical Services, Government Commissions, Agencies, Boards and Committees, Professional Regulatory Bodies and professional groups, Local Councils, private and voluntary sectors, the church and the general public.

The total expenditure on health as a percentage of gross domestic product (GDP) was 9.1% in 2012 according to National Health Accounts (NHA) data. About two-thirds of the total health care expenditure is financed by the state while private spending accounts for the remaining one-third. ⁽¹⁶⁾

TABLE 5 PERCENTAGE OF THE TOTAL EXPENDITURE ON HEALTH BY SOURCE OF REVENUE (2008) ⁽¹⁷⁾	
Sources of expenditure on health	% of total expenditure on health
General government expenditure	65.6
Out-of-pocket payments	32.3
Voluntary health insurance	2.2

Source: National Health Accounts, WHO

The statutory health care system is funded by tax revenues. All forms of taxation feed into the Consolidated Fund, from which all public budgets (including the budget for health) are drawn on an annual basis. The National Insurance Fund scheme is one form of taxation contributing to the Consolidated Fund. This scheme is accumulated as follows: employers and employees each contribute 10% of wages, self-occupied persons contribute 15% of their income, and the government contributes 50% of the combined contributions of the previously mentioned groups.

The main private sources of health care financing are out-of-pocket payments. A much smaller proportion is through voluntary health insurance schemes. Out-of-pocket payments account for a significant part of private health care expenditures (93.8% in 2012). ⁽¹⁶⁾

There are five public hospitals, of which two are acute general hospitals and three are specialised hospitals. The acute public general hospital in Malta is also a university teaching hospital. As of end 2012 Malta also has three private hospitals. One of the problems Malta has been facing is a high bed occupancy rate in acute hospitals (81.5% in 2010) which is above the EU average (76.3% in 2010). Moreover, the number of beds per 100,000 in acute hospitals is below the EU average, and has decreased by around 29% over the past decade. However, the average length of stay in acute hospitals has remained lower than most other Mediterranean countries since the 1990s and is below the EU average. ⁽⁵⁾

The number of human resources per capita, namely specialist physicians, dentists, and nurses are below the EU average except for the number of paediatricians, pharmacists, and midwives. On a positive note, the quantity of health workers is gradually increasing.⁽⁵⁾ This has been effectively managed through a mutual recognition agreement with the United Kingdom General Medical Council (as most medical school graduates undergo specialist training in the United Kingdom) and through the setup of formal specialisation training programmes in Malta.

The state health service and private general practitioners provide primary health care in Malta. Dental care is provided by both public and private providers. Secondary and tertiary care are provided through the public and privately owned general hospitals. Most of the secondary care provided in the public sector in the main hospital is free of charge. The bulk of day and emergency care is also provided by the main acute general hospital. In the public sector, medicines listed on the Government Formulary List are given free of charge to entitled patients. In the private sector, patients must pay the full cost of pharmaceuticals.

Rehabilitation services are offered by the public rehabilitation hospital free of charge to patients referred following inpatient admission at the public hospitals, or who are referred from the community by a general practitioner. Long-term care for the elderly is provided by the State, the church and the private sector, and also through partnerships between the State and the private sector. Community-based services are being promoted and aimed in particular to help keep the elderly population active and residing in their homes for as long as possible.

In recent years, substantial improvements have been made in the areas of palliative care and mental health care. In 2011, a specialist 10-bedded palliative care ward was opened in the oncology hospital. Major efforts have been dedicated towards increasing the provision of more community-based mental health services. Lastly, to deal with the influx of irregular immigrants the Migrant Health Unit was set up in 2008 to deal with the specific needs of this population.

Since the publication of Health Vision 2000, the national health of the population of Malta has shown significant progress. This is manifested by consistent increases in life expectancy at birth and healthy life expectancy and decreases in general mortality. The Maltese health system has achieved and maintained high levels in terms of equity, universal coverage and comprehensiveness. For example, according to EU Statistics on Income and Living Conditions (SILC) data, self-reported unmet need due to financial constraints in 2011 was markedly low in comparison to other European countries.⁽¹⁸⁾ Indeed, socio-economic inequalities are more evident among health determinants, such as obesity and health literacy, rather than for access to health care services.

For these reasons, the NHSS and the sectoral health strategies are all geared to focus on reducing premature deaths, addressing risk factors, decreasing morbidity, promoting healthy lifestyles, improving access to health services for all, particularly for disadvantaged groups and improving quality of life.



Chapter 2

Methodology and Consultative Process

2.1 PROJECT TEAM

Work on the preparation for the drafting of a National Health Systems Strategy (NHSS) started in June 2012. A working group was set up and worked in close collaboration with the World Health Organisation.

Since September 2012, this group benefitted from technical assistance from the Directorate of Health Systems and Public Health of the WHO Europe. From September to November, an expert from this Directorate met three times with the project team. This technical assistance will be also assisting the Department of Health on work associated with the Health Systems Performance Assessment (HSPA). Work on the HSPA commenced in early 2014.

2.2 TIMELINE AND ACTIVITIES

During the preliminary discussions a road map for the development of the NHSS was drawn up. It was recognised that although ideally both the NHSS and the HSPA would be developed concurrently, the first task to be undertaken was to give priority to the NHSS. This was initiated by analysing and aggregating the content, direction and actions included in a long list of policy, strategy, and action plans documents that have been prepared, launched and/or implemented since the publication of the last overarching national health strategy in the mid-1990s by the Ministry and entities responsible for health. Furthermore, the project team also evaluated a number of policies and strategies that have been drafted, published or launched for consultation during the past 2-3 years by other Ministries and government entities. Box 3 lists the documents that were included in this exercise.

The initial discussions also resulted in decisions being taken on the main approaches and structures for the NHSS. The remit of strategy will encompass the overall health system. For this reason, the strategy is adopting the definition of a health system implemented by the World Health Organisation:

** A system is a set of inter-related elements connected to each other, directly or indirectly. In healthcare, there are many such interconnections across primary, secondary and specialist services as well as with social care. Systems thinking brings a way of understanding complexity. Specifically, a systems approach:

- Aids in identifying and understanding the big picture
- Facilitates the identification of major components of future change
- Helps identify important relationships and provides proper perspective
- Avoids excessive attention to a single component part
- Allows for a broad scope solution
- Fosters integration between components and people
- Provides a basis for re-design

BOX 3 | DOCUMENTS USED IN THE COMPILATION OF THE STRATEGIC DIRECTIONS AND ACTIONS OF THE NHSS

Name of document	Publication date
Health Vision 2000 – A National Health Policy	1995
A Strategy for the Prevention and Control of Non-communicable disease in Malta	2010
Healthy Weight for Life	2012
The National Cancer Plan 2011-2015	2011
Communicable disease strategy	2014
Prevention, Control and Management of Tuberculosis: A National Strategy for Malta	2012
The National Sexual Health Policy for the Maltese Islands	2010
National Sexual Health Strategy	2011
National Dementia Strategy (2015-2023)	2014 (launched for consultation)
National Plan for Rare Diseases	Draft
Proposal for a reform of the Primary Health Care	2009
National Reports on strategies for social protection and inclusion (Malta)	2008
National Strategic Reference Framework – Malta 2007-2013 (NSRF)	2006
Pre-budget documents 2011, 2012 and 2013	2011 / 2012 / 2013
Health Systems in Transition, Malta	2014
Advisory report on the development of specialised health care services for persons with eating disorders.	Draft
Strategy on community paediatric health care services with special attention to children with special needs	Draft
Food and Nutrition Policy And Action Plan 2014-2020	2014 (launched for consultation)
National Strategy for Active Ageing: Malta 2014-2020	2013
Electoral programmes for Health (PL, PN, AD)	2013
Strategic Plan for the Environment and Development	2014 (launched for consultation)
MEPA Consultation document - For an Efficient Planning System	2014
MEPA Consultation document - Towards High Standards for Environment Protection and Resource Management	2014
National Policy on the Rights of Persons with Disability	2014 (launched for consultation)
'The Voice of the Child in Care': Report by the National Commission for Child Policy and Strategy	2014 (launched for consultation)
Green Paper: A Framework for Poverty Reduction and for Social Inclusion	2014 (launched for consultation)

Note: ^a PL = Partit Laburista; PN = Partit Nazzjonalista ; AD = Alternattiva Demokratika

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health ⁽¹⁹⁾

This strategy will take a broad view through a health systems perspective** (20) and will incorporate strategies aimed at:

- improving and increasing the services which a patient receives in the health care facilities;
- promoting and streamlining interactions between different services to ensure continuity of care;
- improving and increasing services to citizens who are not patients including prevention and screening, and health promotion services aimed either at the population in general and/or specific to identified vulnerable groups.

The structure that was adopted for the presentation and categorisation of the strategic activities included in this strategy was based on the people-centred approach. This approach recognises and addresses both health care interactions as well as public health interventions, in particular prevention and health promotion, and it aims to reach people in the general community long before they become patients and enter a clinical health care sector or facility. A more detailed description and justification for the use of this framework for the NHSS can be viewed in section 4.2.

By the end of 2012, the project team completed the exercise of dissecting and aggregating actions from the available documents mentioned in Box 3. Information, direction and feedback from the Permanent Secretary and Chief Medical Officer were also considered and included in the finalisation of this exercise. During this process, the project team also completed an exercise of extracting and developing the overall objectives and strategic directions for this NHSS. In all, four overall objectives were set. These objectives have each been further elaborated with two or one strategic directions. The whole list of these overall objectives with their respective strategic directions can be viewed in Box 4 (section 4.2). These 2 exercises formed the basis for the NHSS that is being presented in this document.

2.3 CONSULTATION

The first version of the NHSS was launched for consultation on the 21st February 2014. The consultation process continued until the end of March 2014. Three events and an electronic consultation process were organised.

The launch event was organized as a seminar that included invited participants from a wide range of stakeholders. The stakeholders included persons and entities that will be tasked with the implementation of specific objectives and actions of the strategy and/or were identified as important partners to help continue to inform the further development in the content of the NHSS.

Invitations also ensured that all the groups of the four domains of the people-centred approach were adequately represented. These included representatives of patients and their families, local government, voluntary organisations, healthcare professionals, healthcare organisations and health authorities. The seminar hosted six workshops and the detailed reports on the discussions at these workshops were included and evaluated in the revision process leading to the development of the final version of the NHSS.

Two events aimed at the involvement and engagement of a wider audience were also organised. The main aim of these events was to widely publicise the NHSS and to invite civil society and the general public to contribute to the consultation process through participation in the events or through the delivery of written or electronic feedback.

The NHSS document was also made accessible electronically on the Ministry's website during the time frame of the consultation process. Participants at the launch events and interested persons and entities were invited to send their feedback.

By the end of the consultation period the Ministry received 34 documents with detailed input from different entities and associations. All this feedback was meticulously analysed and a number of these proposals were assimilated in the final version of the NHSS.

Chapter 3

Alignment with WHO and EU health strategies

3.1 INTRODUCTION

Evidence and experience from around the world clearly show that it takes the involvement of the whole population or society and the whole of Government working in unison to create a positive response and to achieve gain in health and well-being. The National Health Systems Strategy (NHSS) is guided and informed by relevant policy documents published by the WHO and the EU.

Two major international strategic frameworks for health in our context are:

1. The EU Health Strategy - 'Together for Health: A Strategic Approach for the EU 2008- 2013'. This document was adopted by the European Commission in October 2007;
2. 'Health 2020: a European policy framework supporting action across government and society for health and well-being', adopted by the WHO Europe 62nd Regional Committee held in Malta in September 2012.

A close look at both documents reveals a number of similarities in the values underpinning the strategies, the challenge that health systems have to face and manage as well as the strategic objectives and priorities identified for addressing these problems.

3.2 ACHIEVING POSITIVE HEALTH OUTCOMES

Universality, access to good quality healthcare, equity and sustainability are the shared values or goals common to both the EU and WHO strategy documents. The pressure to strike the right balance between providing universal access to high-quality health services and respecting budgetary constraints and resource limitations is constantly increasing the strain on health systems. There is a consensus in both strategies on the need for health systems to focus on increasing healthy and disability-free life expectancy and reducing health inequalities. These have also been identified as priorities in the 'Healthy Lives, Healthy People: Our strategy for public health in England' issued by the UK Department of Health in 2012 ⁽²¹⁾ which stated that the 'the whole system will be refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets'.

3.3 LIFE COURSE APPROACH

Both supra-national health strategies call for a long-term view or 'life-course approach' to foster healthy ageing across the whole lifespan, since patterns of health, illness and disease are influenced at different stages of a person's life, and what happens during the early years has long-lasting and lifelong effects and consequences. ⁽²²⁾ This principle has been succinctly documented in the 'Healthy Ireland - A framework for improved health and well-being: 2013-2025' published in 2013. ⁽²³⁾ The Irish document identified that key life transition points such as entering or leaving school, starting a family and going into retirement present opportunities for intervention and partnerships between health institutions and for example education and employment entities and organisations to reinforce knowledge and skills, attitude and behaviour on healthy development and ageing.

3.4 HEALTH IN ALL POLICIES

The adoption of 'Health in All Policies' (HiAP) or 'whole-of-society and whole-of-government' approaches promoting inter-sectoral working and ownership of the goal of improving the population's health by the different policy sectors, are seen by EU and WHO strategies as instrumental. Both promote the need for health systems to improve governance of and leadership for health. Health 2020 advocates the creation of 'resilient communities' (empowered persons) and 'supportive environments' with the aim of reducing of health inequalities and strengthening the promotion of health and disease prevention necessary for a healthy life course and a healthy ageing process. ⁽²⁴⁾

Governments are being increasingly prompted to re-evaluate the relationship between citizens and the state and to recognise and support the contribution that the public can make to health and social care. ⁽²⁵⁾ Participation stands for citizens taking an increasingly active role in their individual health and the health of their communities. The WHO Europe (2002) ⁽²⁶⁾ report on community participation approaches and sustainable development justifies citizens' involvement through:

1. the declaration that participation is an essential element of citizenship in a democracy,
2. that it is required to mobilise community resources and to design more effective services,
3. that it is critical to ensure community ownership, and
4. ultimately guarantee sustainability of programmes. ⁽²⁶⁾

Another justification for citizens' participation is the reality that the value of a system is best gauged from the perspective of the users rather than the systems managers. Additionally, evaluation should also focus on achieving high quality outcomes in addition to the more publicised attention on the number of procedures performed in defined clinical settings. ⁽²⁷⁾

3.5 DYNAMIC HEALTH SYSTEMS

The need to strengthen and support dynamic health systems is another internationally identified priority. More specifically, Health 2020 identifies the requirement to have 'financially viable, fit for purpose, people-centred and evidence-informed' health systems to provide quality healthcare and improve health outcomes. This involves:

1. working towards improving governance and leadership,
2. actions aimed at containment of supply-driven cost increases,
3. reduction and elimination of waste,
4. the use of health technology assessments (HTAs) and quality assurance mechanisms to ensure system transparency and accountability as well as to instill a patient safety culture, and
5. focusing more on innovative primary health care provision.

Health 2020 also speaks of the need to reform the education and training of health professionals to have a 'more flexible, multi-skilled and team-oriented workforce'.⁽²⁴⁾ The focus of this reform should be on team-based delivery of care, new methods of health, community and long-term care delivery, skills in supporting patient empowerment, enhanced strategic planning, working across sectors and leadership capacity.

3.6 HEALTH, ECONOMIC PROSPERITY AND GROWTH

Both WHO and the EU Commission identify the importance of highlighting the link between health and economic prosperity and portraying health as a social and economic resource. This concept is pitched as a central argument for justifying investment in the population's health and for pushing health high up on the political agenda. The European Commission considers 'health as a value in itself'⁽²⁸⁾ and as a precondition for economic prosperity. People's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending.⁽²⁹⁾

The 'Health for Growth' programme target areas of action are in line with the agenda set by the Europe 2020. This programme will support initiatives aimed at finding and applying innovative solutions in the organization of healthcare, modes of healthcare delivery, resource use and system financing with the aim of improving the quality, efficiency and sustainability of health systems. These innovative solutions can include the use of e-health which covers the range of tools that can be used to assist and enhance prevention, diagnosis, treatment, monitoring and management concerning health and lifestyle. These solutions are often perceived as substantially increasing productivity, and therefore as an instrument to support the reform of health systems.⁽²⁹⁾

The World Economic Forum (2011) acknowledged that a large amount of health spending, including in particular disease prevention and health promotion, should be regarded as an investment that yields a handsome rate of return.⁽³⁰⁾ Focusing on disease prevention can reduce high long-term treatment costs and improve health outcomes by avoiding tens of thousands of premature deaths and chronic diseases.⁽³¹⁾ The WHO has also identified a number of 'best buys' in chronic non communicable disease prevention such as incentive fiscal measures, food product reformulation and screening for, early detection and treatment of those at high risk of disease such as cancer and cardiovascular diseases, including early detection and treatment of high blood pressure.⁽³²⁾

Despite the limited competence of the EU in the area of health policy, the economic and financial crisis has led to growing EU influence over national healthcare systems through the launch of a long-term reform of economic governance processes underway in the broader context of the Europe 2020 Strategy. The reform process has included the introduction of new processes and structures including the European Semester. The European Semester is a two stage annual process of economic policy and structural reform coordination launched in 2011 in response to the economic crisis.

The Semester includes the Annual Growth Survey (AGS), National Reform Programmes (NRP) and Country Specific Recommendations (CSR), which since 2012, have started to make explicit reference to health. Following the inclusion of Health for the first time in the AGS of 2012 under three of the five action areas, the 2013 AGS brought with it the first comprehensive analysis of the cost-effectiveness of health systems in Member States. Furthermore, a review of the NRPs in 2012 found health linked to four themes, namely employment, research and development, poverty reduction and budgetary reform. In the same year eight countries received a CSR on health (including Malta). The need for urgent reforms of long-term entitlements, particularly health and pensions, to underpin the long-term sustainability of public finances is the justification presented by the Commission for a number of health-related CSRs issued in 2013.

3.7 MONITORING HEALTH SYSTEMS

The 'Health at a Glance: Europe' report published by OECD in 2012 shows the relevance and importance of having comparable health and health-related data (between countries and over time) to inform policy making and to measure performance.⁽³³⁾ This analysis was based on the ECHI list of indicators^{††}. The report points out that whilst health status has improved significantly in European countries, large gaps persist between Member States and between socioeconomic groups. A change of risk factors was also identified. Tobacco consumption is decreasing and the challenge of obesity becoming more prevalent whilst chronic diseases such as diabetes and dementia are increasingly becoming stronger issues for health systems. The report also highlights the concern about current and forecasted future shortages of health care professionals.⁽³⁴⁾

The ECHI list of indicators has also informed the identification of indicators for the NHSS and will be eventually used in the design and implementation of the Health Systems Performance Assessment (HSPA).⁽³⁴⁾

The Health 2020 strategy mentions the need of 'trustworthy, up-to-date information on health and well-being status, on health needs and on health system goals and outcomes' as prerequisites for 'health planning, implementation and evaluation'.⁽²⁴⁾ However, the European Commission also acknowledged that the relationship between healthcare expenditure and health outcomes is not linear. Therefore, it is not only how much money is spent, but also how it is spent, that determines a country's health status.

At an EU level, the emphasis on health outcomes and particularly health system performance is very much evident in the requirement set for Member States to have a health strategy in place which 'contains a monitoring and review system' to be eligible for funding in the new programming period 2014-2020.⁽³⁵⁾

^{††} The European Community Health Indicators (the ECHI indicators) was created by the Commission and EU Member States during the past 14 years. The aim of this initiative was to create a comparable health information and knowledge system to monitor health at the EU level. This ECHI list comprises a shortlist of 88 indicators covering the following themes: Demography and socio-economic situation; Health Status; Health Determinants; Health services and Health promotion.

3.8 REFORMS NEEDED TO IMPROVE THE SUSTAINABILITY OF HEALTH SYSTEMS

The European Commission and the Economic Policy Committee identified the following areas where structural reforms and efficiency gains could improve the sustainability of health systems. ⁽³⁶⁾

- encouraging more cost-effective provision and use of health services through adequate incentives;
- ensuring a balanced mix of staff skills and anticipating staff needs due to ageing;
- reducing the unnecessary use of specialist and hospital care while improving primary healthcare services;
- better health promotion and disease prevention in and outside the health sector;
- improving data collection and using available information to underpin the improvement of the performance of health systems; in particular the collection of health data using the European Community Health Indicators (ECHI) and developing tools to better assess the efficiency of health systems;
- using health technology assessment more systematically for decision-making processes;
- ensuring the cost-effective use of medicines; this includes increasing the use of less expensive equivalent (generic) drugs.

These recommendations are consistent with the WHO's 'ten leading sources of inefficiency of health systems' ⁽³⁷⁾ and the OECD's recommendations for health system reform. ⁽³³⁾

3.9 CONCLUSION

There are several similarities and congruencies between the challenges that the health systems in Malta are and will be facing in the coming years and those identified in supra-national health strategies. In line with this evidence and direction, the following chapters will set out the overall objectives and strategic directions of the NHSS. These will be followed by the presentation of the strategic actions that will lead towards the attainment of these goals through a people-centred approach over the next few years.



Chapter 4

Setting the goals for the Health Systems Strategy

4.1 INTRODUCTION

The National Health Systems Strategy (NHSS) evolves around a set of four overall objectives. These objectives encompass the strategic policies identified from an in-depth review of the accumulated thematic strategies and policy documents issued over the past 20 years and the deliberations of the task force that was created in 2012 to draft this national strategy. These overall objectives are intended to cover and lead to the vision of the Ministry responsible for Health for the national health systems and the health of the population up to 2020 and beyond.

The four overall objectives have each been elaborated with two or one strategic directions. Each direction is intended to list and explain the route or routes through which the overall objectives will be approached.

This chapter is devoted towards an illustration of the understanding of the Ministry on these overall objectives and strategic directions. It will also present the rationale for each of these overall objectives and respective strategic directions. Chapter 7 will elaborate the strategic actions and tactics that the Ministry has identified as necessary to help the national health systems to achieve each of the overall objectives and their corresponding strategic directions over the next few years. These strategic actions demonstrate the means by which the national health systems will tackle these challenges. The strategy is demonstrating how and what human, intellectual and financial investments need to be sought, obtained and employed. It will be followed by an agreed action plan inclusive of appropriate timeframes and established accountabilities for the entities identified as responsible for each action or set of actions.

Box 4 presents the four overall objectives and the corresponding seven strategic directions which form the pillars of the NHSS.

**IMPROVED HEALTH, INNOVATING THE WAY FORWARD:
OVERALL OBJECTIVES AND STRATEGIC DIRECTIONS OF THE NHSS**

OVERALL OBJECTIVE 1

Respond to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on the whole course of life, children, the elderly and vulnerable.

Strategic Direction 1A

Prolonging stay in the community and responding to increasing demands for higher dependency care.

Strategic Direction 1B

Strengthening the prevention and promotion of health focusing on behavioural changes and lifestyle choices including protection, screening and early diagnosis and control of disease progression.

OVERALL OBJECTIVE 2

Increase equitable access, availability and timeliness of health and social services, medicines and health technologies.

Strategic Direction 2A

Improving management and efficiency of services through research and innovation, prioritisation, monitoring, public private partnership, and other service provision models.

OVERALL OBJECTIVE 3

Improve quality of care by ensuring consistency of care delivered by competent health workers supported by robust information systems.

Strategic Direction 3A

Setting and enforcing quality standards including licensing and accreditation and development and systematic application of case management protocols.

Strategic Direction 3B

Facilitating continuity of care through co-ordination and integration within and between service provider teams and by improving communication and sharing of information.

OVERALL OBJECTIVE 4

Ensure the sustainability of the Maltese Health Systems.

Strategic Direction 4A

Designing, developing and evaluating sustainable policies for human resources, financing mechanisms, entitlement criteria for care and organization of care delivery.

Strategic Direction 4B

Improving governance and empowering future leadership for health and well-being to influence national decisions through whole-of-government and whole-of-society approaches.

4.2 THE STRATEGIC OVERARCHING ROLE OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT)

There is a great and growing demand for efficient, effective, and economic application of information and communication technologies (ICT) to Malta's health systems. This is being addressed through the drafting, endorsement and implementation of a strategic plan to identify and prioritise the essential elements that will guide investment and activity in Health ICT and e-health over the next few years.

A number of strategic objectives and strategic directions have already been identified. These objectives and directions are congruent with the overall philosophy of the NHSS and in particular of Overall Objective 3 that mandates the support that is required to improve and ensure quality and consistency of the services delivered that can only be provided through robust information systems. Consequently, actions related to the development of ICT systems in Health have been specifically highlighted in Chapter 7 that is detailing the actions and tactics that the Ministry will be implementing to reach its strategic objectives and directions.

1. DEVELOP THE MYHEALTH AND E-HEALTH SYSTEMS

The existent myHealth and e-health systems will be developed further and rendered more user-friendly for patients, family doctors and community pharmacists, in support of better primary care and to strengthen coordination between acute care and community care settings.

2. ACHIEVE BETTER VALUE FOR MONEY

Investment in health ICT will be geared to bring benefit to the healthcare system as a whole by achieving better health outcomes, increased productivity and cost savings on labour and materials.

3. EMPOWER HEALTH PROFESSIONALS AND PATIENTS THROUGH ICT

Systems will be developed that facilitate continuity of care, fast and efficient service delivery, patient safety through decision support, and direct patient involvement.

4. CREATE A SCALABLE CORPORATE HEALTH ICT ARCHITECTURE.

The development of health ICT systems will be coordinated through a corporate architecture based on agreed policies and standards, to facilitate the controlled sharing of data and resources, achieve value for money, and lay the basis for research and development.

5. ESTABLISH A ROBUST AND INTEROPERABLE HEALTH ICT INFRASTRUCTURE

All Government health care delivery sites will be provided with connectivity and up-to-date desktop infrastructure according to their business needs. A common repository of key health datasets will be established, including health professional registers. Interoperability of services will be pursued and, where possible, common Government services will be incorporated (e.g. for identification and authentication)

6. DEVELOP MALTA'S HUMAN CAPITAL IN HEALTH ICT

The existing cadre of health ICT practitioners will be identified, recognised and empowered to deliver this strategic plan. This specialised community will be developed through short-term training and longer-term educational opportunities. Knowledge of health ICT will also be promoted among health professionals and the general public.

4.3 THE RATIONALE BEHIND THE FOUR OVERALL OBJECTIVES AND SEVEN STRATEGIC DIRECTIONS

Overall Objective 1

HEALTH AND WELL-BEING THROUGHOUT LIFE

Respond to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on the course of life, children, the elderly and vulnerable groups.

Investing and supporting good health throughout the life-course leads to increasing the chances for and the span of healthy life expectancy and delaying the onset of age-related diseases (longevity dividend). Improvements on both of these goals can yield important economic, societal and individual benefits. The demographic transformation that has taken place and is expected to continue developing in the population of the Maltese Islands requires an effective life-course strategy that gives priority to new approaches to promoting health, preventing and delaying the onset and improving control of disease. Improving health and health equity begins with pre-conception, pregnancy, peri-natal and early child development. Healthy children have the capability to learn better, healthy adults are more productive, and healthy older people can continue to contribute actively and for longer to society.

Strategic Direction 1A

THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME

Prolonging stay in community and responding to increasing demands for higher dependency care.

It is becoming increasingly evident that the national health systems needs to invest in increasing the capacity to meet the current and forecasted increases in demand. Additional investment across the system and re-orientation of existing services is required to meet needs more appropriately and to achieve better value from the available capacity particularly in primary care, rehabilitation and community services, and higher dependency long-term care. Primary health care needs to increase its effectiveness and consolidate its position as the cornerstone of the health system by fostering enabling environments for people to participate in new ways in their treatment and take better care of their own health, increasing the use of innovative tools such as communication technology and new forms of service delivery supporting independent living in the community and promoting more flexible, multi-disciplinary and team-oriented delivery of care.

Action will be taken to ensure that the care required is delivered in the setting which is most suitable to the needs and conducive to sustaining and improving the health and well-being of the person needing the care. Actions need to be taken to continue upgrading all settings providing health services and there will be increased focus on empowering and encouraging communities to become more involved in the provision of informal care in the community and as near as possible to where people are residing and working.

ENGAGEMENT AND EMPOWERMENT TO PROMOTE HEALTH

Strengthening the prevention and promotion of health focusing on behavioural changes and lifestyle choices including protection, screening and early diagnosis and control of disease progression.

People's lifestyles and the conditions in which they live and work, influence their health and potential for longevity. However, the achievement and maintenance of health and well-being is not the sole responsibility of the individual. The creation of environments that facilitate and support making the healthier choice to become the easier choice is required. In doing so the individual and collective contribution to improving the overall health status of the population is made more possible.

The ageing of the population in Malta resulting from increasing longevity and falling birth rates is well established and will be a continuing phenomenon in the foreseeable future. These changes are likely to continue raising the demand for healthcare services while also decreasing the pool of people in the working population. However, EU projections show that if people succeed in remaining healthy as they live longer, the rise in healthcare spending due to ageing could be substantially reduced. ⁽³⁸⁾ Action will continue to be taken to promote health and prevent disease throughout the lifespan by tackling key issues including poor and unbalanced nutrition, low levels of physical activity, tobacco consumption and harmful intake of alcohol and drugs, environmental and occupational health and safety risks, road traffic accidents, and accidents in the home. This is in congruence with the Health 2020 recommending the creation of 'resilient communities' (empowered persons) and 'supportive environments'. Advocacy and direct action by the Ministry responsible for Health in this regards will result in the reduction of health inequalities and the strengthening of health promotion and disease prevention. These will ultimately lead to a healthier life course and a healthier ageing process.

This strategy also affirms the continuation and consolidation of initiatives and resources to protect human health and improve safety, security and protection of citizens against health threats. These include health impact assessments, preparedness and response to epidemics and bioterrorism, strategies to tackle risks from specific diseases and conditions, action on accidents and injuries, improving workers' safety, and actions to ensure and safeguard food safety and consumer protection.

Overall Objective 2

ENSURING EQUITY WITHIN DYNAMIC HEALTH SYSTEM AND ENSURE SUSTAINED PROGRESS

Increase equitable access, availability and timeliness of health and social services, medicines and health technologies.

In June 2006 the Council adopted a statement on common values and principles in EU healthcare systems, listing the overarching values of universality, access to good quality care, equity and solidarity. A new statement on common values for health policy in the broader sense will build on this. Values relating to improving health must include reducing inequities in health. ⁽³⁹⁾ Although many Maltese enjoy a longer and healthier life than previous generations, inequities in health still exist between population sub-groups. These sub-groups need to be properly identified in order to ensure that services are non-discriminatory and enable these people to attain their full potential in life. New programmes must be evaluated properly, including for cost-effectiveness and equity, and health professionals' training and capacity implications must be considered.

MAKING BEST USE OF AVAILABLE RESOURCES

Improving management and efficiency of services through research and innovation, prioritisation, monitoring, public private partnership, and other service provision models.

Whilst the health system needs to re-organise itself to become more responsive to the needs of individuals and families, it is also concerned with ensuring that the various parts of and the different players in the system are utilised to their maximum effectiveness and efficiency. At Government level efficiency needs to be achieved when allocating and distributing resources. While at the level of service provision, technical efficiency is a must. New emerging concepts need to be kept in mind and utilised when necessary, such as the possibility of public private partnerships, community frameworks and e-health solutions. These concepts of macro- and micro-management of services will ensure the continuity of current and future service provision within a dynamic health system and avoid putting an increased financial burden on future generations. It is becoming increasingly recognised that services need to be planned with a vision of the future. Decisions that are taken have to be evidence based and new initiatives that are embarked on have to be economically and clinically efficient, while keeping in mind ethics and equitability.

The national health systems are under constant and escalating pressure to act in response to the challenges presented by an ageing population, rising citizens' expectations, demands for the introduction of new, more expensive and sophisticated technologies and medicines, migration, and mobility of patients and health professionals. Action will concentrate to achieve and maintain services that assure high levels of safety, quality and efficiency standards through a health system that becomes increasingly financially viable, fit for purpose, people-centred and evidence-informed and based.

Overall Objective 3

A JOINT EFFORT TO ENSURE CONTINUITY OF CARE

Improve quality of care by ensuring consistency of care delivered by competent health workers supported by robust information systems.

Achieving high-quality care and improved health outcomes requires sustainable health systems that are fit for purpose, people-centred and evidence-based. Primary and community care are two important cornerstones of the health systems. Mental health care is another important sector that requires major development to bring it in line with the present international standards for good practice in this field. They can respond to emerging health systems needs by fostering an enabling environment for partnerships to thrive, and encouraging people to participate in their treatment and take better care of their own health. Making full use of 21st-century tools, innovations and possibilities for training of highly qualified professional, can assist in the achievement of a higher standard of care that is still cost effective.

Strategic Direction 3A

ESTABLISHING STANDARDS WITHIN A PATIENT-CENTERED APPROACH

Setting and enforcing quality standards including licensing and accreditation and development and systematic application of case management protocols.

Patient safety is at the core of every health care system. Technologies in the medical field are advancing at a fast rate. While the introduction of such new technologies is encouraged in order to provide better quality of care to patients, this has to be done while keeping patient safety in mind. Healthcare is becoming increasingly patient centred and individualised, with the patient becoming an active subject rather than a mere object of the health system. Health policies and strategies must take citizens' and patients' rights as a key starting point. This includes participation in and influence on decision-making, as well as competences needed for wellbeing, including 'health literacy'.⁽³⁹⁾ Empowering people, citizens, consumers and patients is critical for improving health outcomes, health system performance and patient satisfaction.

Ensuring and enhancing a patient safety culture is an integral part of the national health systems. Quality assurance mechanisms are especially important for health system transparency and accountability and for fostering people's trust and confidence in the national health systems. This strategy is promoting the consolidation and continuing development of the health regulatory and leadership functions and structures particularly in the sector for the application of quality standards. These will include the enforcement of appropriate standards for and complements of health care facilities and equipment, ensuring the availability of qualified and trained professionals that respect and operate within the established professional codes of conduct and best practice care guidelines, and the implementation of a health system-wide patient safety policy and supporting legislation. The aim is to foster a learning culture in the whole health system both at the level of the individual operator as well as at the systems level such that factors leading to mishaps are corrected and repetitions of reported adverse events are averted.

Furthermore, recognizing patients as a resource and as partners, and being accountable for patient outcomes are important principles. Patients' rights and responsibilities will be defined and endorsed on a national level and citizens will be encouraged and supported to engage more in the role of decision-makers at both the levels of their individual care as well as in the collective public health arena.

Strategic Direction 3B

SAFE, HIGH QUALITY AND EFFICIENT SERVICES

Facilitating continuity of care through co-ordination and integration within and between service provider teams and by improving communication and sharing of information.

In order to improve quality of care, minimise inequities and make the best use of health care resources we have to promote health system models that enhance continuity of care through synergistic cooperative action between hospitals and community care. However, for such systems to work efficiently within a framework that is still safe for the patient, comprehensive and integrated communication and information systems are indispensable. This strategy sets out implementation mechanisms for cooperation between partners, reinforcing Health in All Policies, and increasing visibility and understanding about health with all stakeholders.

Continued quality development and performance enhancement of the health services can only be achieved if the activities of the different players in the care delivery pathways are integrated so that continuity of care is ensured and patients are not 'lost' in any part of the system. The ultimate aim

is to introduce a seamless process of care for any particular patient between community, primary, secondary and institutional care, between the private and public health care sectors and where necessary between the health care and the social care services. This strategy will be strongly reinforcing the role of primary health care as the cornerstone of the national health system. Service delivery will be relocated as close to home as is safe and cost-effective, patients will continue to become more empowered to undertake self-care practices and the potential of personalised medicine will be promoted.

Overall Objective 4

WORKING TOWARDS SUSTAINABLE HEALTH SYSTEMS

Ensure the sustainability of the Maltese Health Systems.

Rapid growth of chronic disease and mental disorders, lack of social cohesion, environmental threats and financial uncertainties make improving health even more difficult and threaten the sustainability of health and welfare systems. ⁽²⁴⁾ All resources are finite, including human resourced. In the ambit of an ageing population and a decrease in the labour workforce market, it is becoming increasingly important to ensure that health systems can cope with the increase in the demand for health services while still remaining sustainable through creative and innovative responses to which there is a real commitment.

Strategic Direction 4A

INTEGRATED PLANNING AS AN ESSENTIAL PART OF SUSTAINABLE HEALTH SYSTEMS

Designing, developing and evaluating sustainable policies for human resources, financing mechanisms, entitlement criteria for care and organization of care delivery.

There is an increasing need to apply evidence to policy and practice, observe ethical boundaries, expand transparency, and strengthen accountability. The use of health economic evaluations within health system will gain increasing importance in the coming future, in order to ensure, that prior to embarking on new initiatives it is assured that the necessary human resources, infrastructure and financial investment can be sustained in the future. This concept has to be incorporated in all policies, together with measurable outcomes to enable proper evaluation of the policy to analyse its effectiveness and justify any changes that need to be made within the existing frameworks.

The opening of the new Mater Dei Hospital, a state of the art hospital, has resulted in an unexpected shift of a significant number of people and demand for services from the private to the public health care system. This together with the ageing population is putting an increasing burden on the public health system which delivers its services free of charge at the point of use. In order to tackle this challenge, policies will be designed to assist in the continuous delivery of sustainable health care services that can reach standards of excellence. Emphasis will be placed on economic and cost-effectiveness evaluations of any new initiatives. Existing services will also be increasingly evaluated to ensure they are being delivered efficiently. The rationale for this activity centres on the intention that the current population will be allowed to continue enjoying the benefits offered by our health system and possible consequences such as unnecessary financial burdens will not have to be imposed on future generations.

Improving governance and participatory governance for health is key to governments aiming at successfully achieving real improvements in health. This needs to be supported through the empowerment of future leadership for health and well-being to influence national decisions through whole-of-government and whole-of-society approaches. ⁽²⁴⁾

Leadership at Ministerial level and from health agencies is vitally important to address the burden of disease. This is already occurring locally however it needs to be strengthened. Formal structures and processes that support coherence and inter-sectoral problem-solving need to be established and patient groups need to be encouraged, strengthened and facilitated.

The health sector is responsible for developing, implementing and evaluating national health strategies and it also has to consider how its health policy decisions affect other sectors and stakeholders and vice versa. The Ministry responsible for Health together with patient groups and public health agencies are increasingly engaged in initiating inter-sectoral approaches for health and acting as health brokers and advocates.

Actions will be taken to improve leadership and participatory governance towards health. Whole-of-government activities will be embarked on which are multilevel (from local to global) government actions which increasingly involve also groups outside government. This approach requires building trust, common ethics, a cohesive culture and new skills. It stresses the need for better coordination and integration, centred on the overall societal goals for which the government stands. More advocacy will be engaged to emphasise the concept of health in all policies so that all sectors will understand and act on their responsibility for health while recognising how health also affects other sectors.

Governance and leadership will devolve beyond the Ministry's level. It will be reinforced also at societal level through whole-of-society approaches that will complement public policy. Various tactics and actions will be taken to secure coordination through normative values and trust-building among a wide variety of stakeholders. Responsibility, ownership and accountability will remain strong assets within this strategic management plan that will require various changes to be implemented. A well equipped complement of trained professionals will be needed to take on board these challenges.



Key baseline indicators illustrating the overall objectives of the National Health Systems Strategy

5.1 INTRODUCTION

Several indicators can be utilised to illustrate and better understand the factors influencing the present situation of different aspects of the health systems in Malta. The identification of indicators is influenced by the need to have ongoing information that can be used to monitor inter alia the implementation and the expected outcomes of this strategy over time. The indicators that are presented in this chapter are not exclusive and more or different indicators may need to be utilised in the monitoring process of this strategy.

Indicators and related information will be presented according to the key issues identified in the four overall objectives of this strategy. These include:

1. Increased demand and challenges due to demographic changes, epidemiological trends, ageing and vulnerable groups
2. Access, availability and timeliness of services, medicines and medical technologies
3. Quality of care including patient safety, continuity and consistency of care, implementation of protocols and/or international guidelines
4. The need for a long-term vision for the sustainability of our health systems

The exercise that has been undertaken to elicit this information has also identified several gaps for which relevant available information was missing, insufficient or incomplete. One of the deliverables of the NHSS will involve the development of indicators and information channels that will help towards improving the monitoring of the areas of the health systems which to date is considered as inadequate. This work will be part of the Health Systems Performance Assessment (HSPA) which has been proceeding in parallel with the development of the NHSS.

5.2 INCREASED DEMAND AND CHALLENGES DUE TO DEMOGRAPHIC CHANGES, EPIDEMIOLOGICAL TRENDS, AGEING AND VULNERABLE GROUPS:

A. DEMOGRAPHY

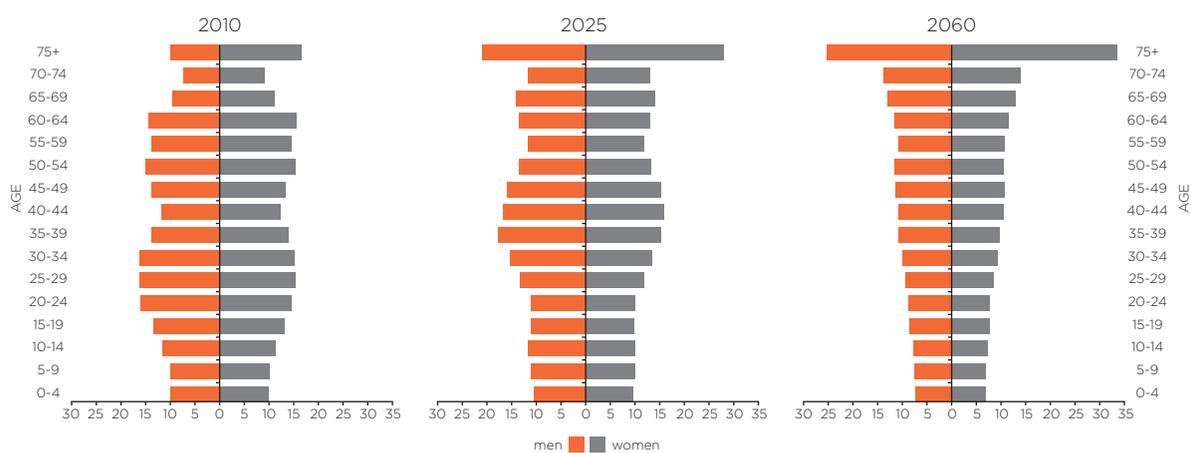
Demographic and epidemiological changes in the population of the Maltese Islands significantly impact the performance of the national health system. In general these trends are resulting in increasing demands and challenges which need to be acknowledged and catered for.

The total population in Malta, from the most recent census conducted in 2011, is 417,432. The total population of children and young people under the age of 18 years amounted to 18.4% of the total population. At the other end of the spectrum, 16% of the total population were individuals aged 65 years and over and just over half the population (50.26%) were females. ⁽⁶¹⁾

The harmonised unemployment rate* in Malta for 2012 was 6.9%. This compares favourably with the average EU rate of 10.7% for the same period. The income inequality distribution ratio** was 4.1 whilst the EU average is 5.1 for 2011. ⁽⁴⁰⁾

The crude birth rate for 2012 was 10.1 births per 1,000 population and the total fertility rate was 1.4 births per woman. This is lower than the average EU rate of 1.54 births per 1,000 population. ⁽⁵⁾ The population projections published by the National Statistics Office indicate that the population of Malta is expected to reach 429,000 persons by 2025 and go down to just over 350,000 persons by 2060. The population of persons aged 65 years and over is projected to increase to around 111,700 – an increase of 72% when compared to this segment of the population during 2010. By 2060, children and youths under 20 will decrease from 90,705 to around 59,300 – a drop of 35%. These projections reveal a continuous forecasted trend of increasing ageing of the population. ⁽²⁾

FIGURE 1 | POPULATION PYRAMIDS FOR POPULATION OF THE MALTESE ISLANDS IN 2010, 2025 AND 2060 ⁽²⁾



Source: Demographic Review 2010

* Harmonised unemployment rate: This represents unemployed persons as a percentage of the labour force based on International Labour Office (ILO) definition. The labour force is the total number of people employed and unemployed. Unemployed persons comprise persons aged 15 to 74 who: are without work during the reference week; are unable to start work within the next two weeks; and have been actively seeking work in the past four weeks or had already found a job to start within the next three months. Data are presented in seasonally adjusted form. ⁽⁴⁰⁾

**Income inequality distribution ratio: The ratio of total income received by the 20% of the population with the highest income (top quintile) to that received by the 20% with the lowest income (lowest quintile). Income must be understood as equalised disposable income. ⁽⁴⁰⁾

Life expectancy has seen a remarkable increase over the past 30 years. In 2011, the life expectancy at birth for males was 78.8 years while for females it was 83.1 years. ⁽⁵⁾ This was also accompanied by an increase in healthy life years (HLY): 70.7 years at birth for females and 70.3 years at birth for males in 2011 which is higher than that for the EU at 62.2 years for females and 61.7 years for males. ⁽⁶⁾ ⁽⁴⁰⁾ In fact females in Malta top the list for HLY at birth for countries in the EU. ⁽⁴⁰⁾

Over the past 10 years the mortality rate in Malta has seen a downward trend. In 2011, the crude death rate was 7.86 deaths per 1,000 population with the leading cause of death being diseases of the circulatory system (unchanged from previous years). The Standardised Death Rate (SDR) for Ischaemic Heart Disease in 2012 was 143 deaths per 100,000 population which is higher than the average EU rate (2011) of 80 deaths per 100,000 population. However, the SDR for stroke and all cancers was lower; 42.48 deaths when compared to 51.64 deaths for stroke and 151.64 deaths when compared to 166.85 deaths for all cancers per 1,000 population. ⁽⁵⁾ ⁽⁶⁾

TABLE 6 | LEADING CAUSES OF DEATH BY NUMBER, RATE AND PERCENT ⁽⁶⁾

Cause of death (ICD-10 code)	Number of deaths			SDR per 100,000 population (ESP)*			% of total deaths
	M	F	T	M	F	T	
Ischaemic heart diseases (I20-I25)	319	328	647	132	85	107	21.5
Cerebrovascular diseases (I60-I69)	103	160	263	43	41	42	8.7
Malignant neoplasm of trachea, bronchus & lung (C33-C34)	122	37	159	49	13	29	5.3
Other heart diseases (I26-I51) including heart failure (I50)	60	92	152	26	25	25	5.0
Acute lower respiratory tract infections (J12-J22)	53	72	125	23	18	20	4.2
Dementia (F01-F03)	45	75	120	18	18	18	4.0
Malignant neoplasm of colon, rectum & anus (C18-C21)	60	51	111	24	16	19	3.7
Diabetes mellitus (E10-E14)	47	56	103	19	15	17	3.4
Chronic lower respiratory diseases (J40-J47)	72	18	90	29	5	14	3.0
Malignant neoplasm of breast (C50)	0	79	79	0	26	14	2.6
All other causes	608	553	1161	261	169	211	38.6
Total	1489	1521	3010	626	429	517	100

Source: Annual Mortality Report – 2012
Note: * ESP = European Standard Population

The average infant mortality rate for the period 2010 to 2012 was 5.1 deaths per 1000 live births, which is above with the EU average of 4 deaths per 1000 live births in 2011. ⁽⁵⁾ It is important to note that termination of pregnancy is illegal in Malta. A foetus diagnosed with potentially fatal congenital anomalies is often born alive but passes away after birth. This greatly influences the infant and childhood mortality rates in Malta especially when compared to other countries where screening for congenital anomalies is practiced routinely and termination of pregnancy offered.

TABLE 7 | DEMOGRAPHIC AND EPIDEMIOLOGICAL DATA FOR MALTA, EU-27 AND EU-15 FOR 2010 ⁽⁵⁾

Indicators		Malta 1980	Malta 2010	EU-27 2010	EU-15 2010
Crude birth rate: (per 1,000 population)		17.6	9.6	10.7	10.8
Total fertility rate: (births per woman)		2.0	1.4	1.6	1.6 (2009)
Crude death rate: (per 1,000 population)		9.1	7.2	9.7	9.3
Life expectancy at birth in years	Males	67.9	79.3	77.2	78.6
	Females	72.8	83.6	83.1	84.0
Health expectancy: HLY in years	Males	N/A	70.2	61.7	N/A
	Females	N/A	71.6	62.6	N/A
Disease-specific mortality: (SDR)*	Ischaemic Heart Disease	413.1	106.4	80.1	60.3
	Stroke	151.4	42.5	51.6	37.7
	All Cancers	202.2	151.7	167.7	160.7
	Infant mortality - rate	15.5	5.5	4.1	3.6

Sources:
European Health for All database, WHO
Eurostat Statistical Data - Healthy Life expectancy; Fertility rate Malta 1980

Note:
SDR = Standardised Death Rate (using the European Standard Population)

B. LIFESTYLE INDICATORS

Lifestyle indicators are important as they give us a clear picture of factors related to health-related behaviour that influence the health of a population. They help us analyze and compare performance across population groups or geographic areas, and can be useful for determining policy priorities, projecting demand on the national health systems and monitoring the implementation of strategies.

i. Obesity

Maltese men are the most obese males in Europe whilst Maltese women are the third most obese females. ⁽¹⁰⁾ According to the Health Behaviour in School-aged Children (HBSC) survey carried out in school children in 2010 about 26% of girls and 35% of boys are obese or overweight. The percentage of girls who are obese or overweight decreased since 2006 across all ages except at age 11 where there was a slight increase. The percentage of boys who are obese or overweight increased at the ages of 11 and 13 but decreased at the age of 15. Malta is above the HBSC average in 2010 across all ages for both boys and girls. At EU level, the percentage of boys who are obese or overweight is also larger than that of girls both in Malta and in the HBSC average. ⁽⁴¹⁾

TABLE 8 | PERCENTAGE OF CHILDREN REPORTED TO BE OVERWEIGHT OR OBESE ACCORDING TO BMI, AGES 11-15 ⁽⁴¹⁾

		2002	2006	2010	HBSC average 2010
11 years	Boys	N/A	30	41	17
	Girls	N/A	25	26	13
13 years	Boys	34	31	37	17
	Girls	24	31	29	11
15 years	Boys	28	32	28	18
	Girls	20	28	23	10

Source: Health Behaviour in School Children 2010

Obesity, and especially childhood obesity, is an important national concern. The Health Promotion and Disease Prevention Directorate (HPDPD) is tackling this problem through a number of initiatives. These include the setting up of a pilot service of child obesity clinics, educating parents of children aged 0-3 years, on the importance of appropriate weaning foods and on how to prepare age-adequate, healthy meals and snacks.

The need for more physical activity is also being promoted especially for children. The introduction of the “Walking Bus” initiative by the HPDPD aims at encouraging schoolchildren to walk to schools situated in the same locality, while a pilot project carried out in the summer of 2012 involved introducing young people to different sports so that they may take up one or more activities that they truly enjoy.

Weight Management Programmes which are held in various settings and have proven to be increasing in popularity. One-to-one counselling service for weight management is also given to clients where the weight management programme was deemed inappropriate. The unit also offers community aerobics services by offering free aerobics classes which are held in collaboration with local councils in various localities around Malta.

TABLE 9 | NUMBER OF CLASSES AND NUMBER OF PARTICIPANTS AT WEIGHT MANAGEMENT AND AEROBICS CLASSES ORGANIZED BY THE HEALTH PROMOTION ⁽⁴³⁾

Year	2010		2011		2012	
	No. of classes	No. of participants	No. of classes	No. of participants	No. of classes	No. of participants
Aerobics	14	263	32	839	38	972
Weight management	14	234	28	521	42	802

Source: Health Promotion and Disease Prevention Directorate, 2013

ii. High blood pressure and blood cholesterol levels

High blood pressure (hypertension) in the Maltese population has improved overall since the MONICA ⁽⁴⁴⁾ (Multinational MONItoring of trends and determinants in Cardiovascular disease) study in 1984 which measured the blood pressure level of participants. At that time, 51.5% of males and 52.9% of females were found to have normal blood pressure readings. These figures increased to 66.9% in males and 68.7% in females in the pilot European Health Examination Survey (EHES) held in 2010. Similarly blood cholesterol levels have also decreased significantly during this period. ⁽¹²⁾

TABLE 10 | CHANGES IN PERCENTAGES OF NORMAL BLOOD PRESSURE AND DESIRABLE BLOOD CHOLESTEROL LEVELS IN MALTESE ADULTS (AGED 25-64) - COMPARING DATA FROM 1984 AND 2010 ^{(12) (44)}

		Percentage of Maltese adults (aged 25-64 years)	
		1984	2010
Normal Blood Pressure	Males	51.5	66.9
	Females	52.9	68.7
Desirable Blood Cholesterol	Males	22.9	31.3
	Females	21	44

Source: MONICA study and EHES 2010

iii. Smoking

Even though males still smoke more than females, the gap is getting smaller. According to the European Health Interview Survey (EHIS) 2008, the largest percentage of daily smokers has been smoking for 10 years or less. ⁽¹⁷⁾ The total percentage of Maltese people aged 15 years and over who smoke regularly was 20.4% in 2008 - lower than the 23.92% who smoke regularly in the EU. ⁽⁵⁾

The Health Promotion Unit provides Tobacco Dependence Support Services which include the following initiatives:

- The Quitline is available for the general public wanting to seek support related to smoking cessation or to apply for smoking cessation classes. On average the Quitline answers to about three calls a day, averaging around 750 calls in a year.
- Smoking Cessation Classes are provided in various settings. One-to-one counseling on tobacco cessation is also provided. This is one of the most effective ways to help a person quit and is usually done through an appointment when smokers are not able to use other community services. ⁽⁴³⁾

TABLE 11 | NUMBER OF CLASSES AND NUMBER OF PARTICIPANTS AT SMOKING CESSATION CLINICS ORGANIZED BY THE HEALTH PROMOTION UNIT ⁽⁴³⁾

Year	2010		2011		2012	
	No. of classes	No. of participants	No. of classes	No. of participants	No. of classes	No. of participants
Smoking cessation	25	223	16	538	24	537

Source: Health Promotion and Disease Prevention Directorate, 2013

iv. Alcohol consumption

The European Health Interview Survey (EHIS) 2008 found that about 33% of the participants did not drink alcohol in the past 12 months while 5% drank alcohol on a daily basis. ⁽¹⁷⁾ The European School Project on Alcohol and other Drugs (ESPAD) study found that 68% of fifteen to sixteen year old European students from 36 countries surveyed, had consumed alcohol during the previous 30 days, compared to 57% which is the ESPAD average. The proportion of students in Malta who reported in 2011 that they had engaged in heavy episodic drinking during the previous 30 days was 56%. The average figure for heavy episodic drinking was noted to be 39% for the whole ESPAD study population. ⁽¹⁴⁾

TABLE 12 | DATA ON SMOKING AND ALCOHOL CONSUMPTION ⁽⁵⁾

Indicators		Malta	EU	EU-15
Regular smokers - (2008) % aged 15+	Total	20.4	23.92	23.35
	Males	25.6	N/A	N/A
	Females	15.8	N/A	N/A
Total (pure) alcohol consumption (sales) (Litres per capita aged 15+), 2010		7.62	10.04	9.89

Source: European Health for All database, WHO

v. Diet

According to the European Health Interview Survey (EHIS) for 2008, the percentage of Maltese adults consuming fruit on a daily basis was 74% whilst the daily consumption of vegetables stood at 51%.⁽¹⁷⁾ The publication of OECD Health at a Glance, Europe 2012, shows that Maltese adults eat more fruit daily than the average of participating EU countries, but did not fare so well where daily consumption of vegetables is concerned.⁽³³⁾

TABLE 13 | COMPARISON OF FRUIT AND VEGETABLE CONSUMPTION IN MALTESE AND EUROPEAN ADULTS⁽³³⁾

		Malta	EU-27
Daily consumption of fruit (2008)	Males	78%	69%
	Females	69%	57%
Daily consumption of vegetables (2008)	Males	57%	67%
	Females	43%	59%

Source: Health at a Glance, Europe 2012

The following table shows the trends observed for Malta from the HBSC study with regards to the daily consumption of fruit and vegetable by girls and boys aged 11, 13 and 15 years.⁽⁴¹⁾

TABLE 14 | PERCENTAGE OF CHILDREN REPORTING DAILY FRUIT AND VEGETABLE CONSUMPTION BY GENDER IN MALTA, 2002-2010⁽⁴¹⁾

		Fruit			Vegetables		
		2002	2006	2010	2002	2006	2010
11 years	Boys	48	42	41	19	12	16
	Girls	59	46	42	25	19	18
13 years	Boys	44	33	40	10	7	16
	Girls	50	47	43	15	14	21
15 years	Boys	38	35	25	12	8	15
	Girls	44	34	41	15	14	23

Source: HBSC 2006, HBSC 2010, Highlights from the study on Health Behaviour in School Children 2010

The Health Promotion Unit forms part of an Inter-Ministerial Committee that runs the School Fruit Scheme which was launched in Malta in 2010. This is an EU co-funded project that offers all eligible children, between the ages of 3 to 10 years, a portion of fruit or vegetables at school once a week and endeavors to create awareness amongst children as to what types of fruit and vegetables are available, how they taste, and why they are so beneficial for the development of healthy bodies.

C. INCIDENCE OF DISEASE

The cost of management and treatment of diseases places a significant burden on the health system. Additionally, the resulting absences from work significantly impact the country as a whole in both economic and social terms.

i. Communicable diseases: special focus on Koch (TB) and Hepatitis B

The incidence of TB in Malta stood at 9.1 new cases per 100,000 population in 2012. This is lower than the EU incidence of 11.54 new cases per 100,000 population, although it is slightly higher than that of the EU-15 countries which is 6.8 new cases per 100,000 population. ⁽⁵⁾

With regards to the incidence of Hepatitis B the local figure of 0.48 new case per 100,000 population (2011) is lower than the incidences in both the EU (1.13 new cases per 100,000 population) and the EU-15 countries (1.06 new cases per 100,000 population). ⁽⁵⁾

ii. Diabetes

The European Health Examination Survey (EHES) pilot study carried out in 2010 revealed that when looking at the measurement of blood glucose, the prevalence of diabetes amongst the population aged 20 to 79 years was 10.1%. ⁽¹²⁾ This is at par with the national prevalence estimated by the International Diabetes Federation (IDF) for the same year (9.8%). When comparing the IDF national estimate for Malta to the 27 EU member states, Malta ranks 8th highest. ⁽⁴⁶⁾

iii. Hospital discharges for ischaemic heart disease, cerebrovascular diseases and respiratory system diseases

Data on hospital discharges for ischaemic heart disease and cerebrovascular diseases show that Malta has lower discharge rates per 100,000 population when compared to the EU-27 and EU-15 countries, as can be seen in Table 15 below. Similarly, where respiratory diseases are concerned, the number of hospital discharges per 100,000 population in Malta for 2009 was 984.56 whilst the number in the EU-27 countries was 1409.61 and the EU-15 countries stood at 1263. ⁽⁵⁾

TABLE 15 COMPARISON OF HOSPITAL DISCHARGES FOR ISCHAEMIC HEART DISEASE, CEREBROVASCULAR DISEASES AND RESPIRATORY SYSTEM DISEASES IN 2009 IN MALTA AND EU AND EU-15 COUNTRIES (PER 100,000 POPULATION) ⁽⁵⁾			
	Malta	EU	EU-15
Ischaemic heart disease	350.25	610.49	572.09
Cerebrovascular diseases	106.52	386.74	349.39
Respiratory system diseases	984.56	1409.61	1263.64

Source: European Health for All database, WHO

Self-reported lifestyle prevalence in the European Health Interview Survey 2008 showed that 3% of the sample population surveyed suffered from Myocardial Infarction, 3% suffered from Coronary heart disease and 1% from cerebrovascular disease. ⁽¹⁷⁾

The Annual Mortality Report for 2012 notes that deaths due to diseases of the circulatory system, namely ischaemic heart disease, stroke and heart failure are the leading causes of death accounting for 46.8% of all deaths. Deaths due to respiratory diseases amounted to 8.4% of all deaths registered in 2012. ⁽⁶⁾

iv. Malignant neoplasms (cancer)

The age-standardised incidence rate (European Standard Population) for new cases of all cancers (excluding non-melanoma skin cancers) in men, in Malta, in 2010, was 395.39 per 100,000 population. This was slightly lower than the rate for the EU-25 for 2006 of 463.00 new cases per 100,000 population. On the other hand the age-standardised incidence rate for Maltese females in 2010 was slightly higher than the EU-25 rate for 2006 - 334.36 new cases per 100,000 population (Malta) when compared to 325.50 new cases per 100,000 population (EU-25). ⁽⁴⁷⁾

Table 16 below shows some more information regarding all cancers as well as breast, cervical, lung, colorectal and prostate cancer in the Maltese population for 2010.

Incidence of cancer rises with increasing age. Over the five year period 2007-2011, 71% of new cancer cases were diagnosed in persons aged 60 years and over. The proportion of new cases in persons aged 65 years and older was 57% for the same time period.

v. Mental Health

From information acquired during the European Health Interview Survey in 2008, 15% of the survey population reported having suffered from a mental disorder ⁽¹⁷⁾ - i.e. a mental disorder at some point in their life. This number includes respondents who may have experienced more than one of the conditions listed, e.g. depression and anxiety at a point in their lifetime. When compared to OECD member countries as reported in the OECD 2009 publication *Society at a Glance*, ⁽⁴⁸⁾ Malta has one of the lowest self-reported lifetime and 12 month prevalence rates of total mental health disorders.

Where chronic anxiety is concerned the number of respondents who reported suffering from chronic anxiety at some point in their lifetime was 7.8% in 2008. This percentage fell from 10.2% in 2002. Again when compared to the 11 reporting OECD member countries in the OECD publication *Society at a Glance*, Malta is seen to come in fifth place for the 12-month self-reported prevalence rate of chronic anxiety.

Chronic anxiety is significantly more likely to affect women than men, within all age groups (12.2% compared with 9.7%) and it increases with age, being most frequent in the over 75 years (14.1%).

Out of the whole study population, 6.6% reported a lifetime experience of chronic depression. Again, women experienced a higher rate than men (7.7% and 5.4% respectively). The reported lifetime prevalence of depression is low in the younger age groups, rising to 7.2% in females over 35 years and increasing to a maximum of 13% in the 65-74 year age group.

TABLE 16 | AGE-STANDARDISED INCIDENCE RATES PER 100,000 AND AGE-STANDARDISED MORTALITY RATES PER 100,000 FOR THE MALTESE POPULATION FOR 2010 AND EU-25 COUNTRIES FOR 2006 FOR ALL CANCERS AND OTHER SELECTED CANCERS (USING EUROPEAN STANDARD POPULATION)⁽⁴⁷⁾

		Malta (2010)	EU-25 (2006)	
		New cases per 100,000 population		
AGE-STANDARDISED INCIDENCE RATE	All cancers	Males	395.39	463.00
		Females	334.36	325.50
	Lung cancer	Males	61.86	17.80
		Females	17.60	21.70
	Colorectal cancer	Males	49.49	59.00
		Females	28.49	35.60
	Female breast cancer	Females	118.64	110.30
Prostate cancer	Males	83.11	106.2	
Cervical cancer	Females World Standard Population	4.98	10.50 ^a	
		Deaths per 100,000 population		
AGE-STANDARDISED MORTALITY RATE	All cancers	Males	184.21	236.40
		Females	127.66	136.20
	Lung cancer	Males	49.26	62.40
		Females	12.63	18.40
	Colorectal cancer	Males	24.31	26.50
		Females	15.59	15.60
	Female breast cancer	Females	25.82	25.00
Prostate cancer	Males	11.96	23.20	
Cervical cancer	Females World Standard Population	0.66	3.70 ^a	

Source: Malta National Cancer Registry, Department of Health, Ministry for Health, 2012
 Note: ^a refers to rates for EU-25¹¹ in 2002

¹¹ EU-25 area countries include those who formed part of the EU between May 2004 and December 31st, 2006: EU-15 countries + Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia

vi. Utilisation of Long-term Care

Indicators concerning long-term care (LTC) are also very valid to monitoring changes in demand. In Malta the total number of LTC beds available as at 2012 was 4588 (1093.7 beds per 100,000 population). There is persistent full occupancy of the long term care beds in the public sector. At present there is no data available with regards to the availability and functions of the informal carers. However the next round of the European Health Interview Survey to be conducted in 2014 will for the first time include three questions on the provision of informal care or assistance.

5.3 ACCESS, AVAILABILITY AND TIMELINESS OF SERVICES, MEDICINES AND MEDICAL TECHNOLOGIES

Over the past two decades, substantial progress has been made in the health sector in Malta with regards to the availability of and access to an increasing range of different services, medicines and medical technologies. Consequently, the national healthcare package has consistently and substantially continued to expand over time. Improvements are constantly ongoing particularly regarding timeliness. This is taking place in an environment in which the fields of the health systems and services are highly dynamic and constantly evolving. The indicators demonstrated in this section aim to portray the range of services available and accessed by the Maltese population during the last few years and to analyse the situation when compared to the situation in other EU Member States.

A. AVOIDABLE ADMISSIONS

Avoidable admissions are taken as indicators for the quality of care in the primary health care setting as well as the accessibility and availability of services. The rates of admission per 100,000 for asthma are higher in Malta than those for the EU-20⁹⁸ countries, ⁽³³⁾ while those for chronic obstructive pulmonary disease (COPD) are lower in Malta. In the case of diabetes – admissions with complications were higher but those without complications were lower than in the participating EU-15 Member States. ⁽³³⁾

TABLE 17 | AVOIDABLE ADMISSIONS: ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) IN MALTA AND EU COUNTRIES - 2009 ⁽³³⁾

Avoidable Admissions	Malta	EU-20
Asthma - per 100,000 population aged 15+	79	53
COPD - per 100,000 population aged 15+	135	184

⁹⁸ EU-20 area countries are: Portugal, Italy, Sweden, Germany, Netherlands, Hungary, Denmark, Czech Republic, Slovenia, France, Ireland, Spain, Belgium, Austria, Poland, U.K, Finland, Malta, Latvia, Slovak Republic

Source: OECD, Health at a Glance, Europe 2012

TABLE 18 AVOIDABLE ADMISSIONS: DIABETES WITH AND WITHOUT COMPLICATIONS – 2009 ⁽³³⁾		
Avoidable Admissions	Malta	EU-15
Diabetes – per 100,000 population aged 15+	-	-
With complications:	119	109
Without complications:	41	50

Source: OECD, Health at a Glance, Europe 2012

B. MEDICAL TECHNOLOGY

Malta had one of the highest numbers of Computed Tomography (CT) and Positron Emission Tomography (PET) scanners per 1,000 population for the year 2011 when compared to selected countries (in the southern European Region and the UK). The same cannot be said where Magnetic Resonance Imaging (MRI) units are concerned. The table below compares the situation in various countries:

TABLE 19 ITEMS OF FUNCTIONING DIAGNOSTIC IMAGING TECHNOLOGIES (MRI UNITS, CT SCANNERS, PET, RADIATION THERAPY EQUIPMENT) IN MALTA AND SELECTED COUNTRIES PER 100,000 POPULATION FOR THE YEAR 2010 ⁽⁴⁰⁾				
Country	CT Scanners	MRI Units	PET scanners	Radiation Therapy Equipment
Cyprus	3.2	2.0	0.0	0.5
Greece*	3.4	2.3	0.0	0.6
Italy	3.2	2.4	0.2	0.7
Slovenia	1.4	0.0	0.1	0.6
UK**	0.9	0.6	-	0.5
Malta	2.9	0.5	0.2	1.0

Source: EUROSTAT Statistical Database
 Note: * 2010 figures; **Estimated figures

C. SECONDARY CARE

The total number of procedures carried out in the acute public hospitals in 2012, amounted to 47,902. ⁽⁴⁹⁾ These include major variant, intermediate and minor procedures/operation categories. The number of patients referred for treatment abroad (through the treatment abroad system) in 2012 totaled 415 (and 608 episodes). Referrals were sent from a wide variety of clinical departments and for a wide range of pathologies and included patients of all ages. ⁽⁵⁰⁾

D. UNMET NEED

The inability to access health services for geographic reasons is not perceived as a major issue for Malta due to its size and proximity of service provision. Nevertheless, to ensure that residents of Gozo have better access to care closer to home, the Government is investing with the assistance of EU Structural Funds to purchase new equipment for the operating theatres and radiology department in Gozo General Hospital and is in the process of introducing several new clinical services at the Gozo General Hospital.

There are no national surveys asking people specifically on whether they have foregone care for financial reasons. However, the Statistics on Income and Living Conditions (SILC) studies show a lower than the average EU self-reported unmet needs for medical examination for reasons of barriers of access (expensive or too far to travel or waiting list) for people living in Malta (2008-2011).⁽¹⁸⁾

TABLE 20 | SELF-REPORTED UNMET NEEDS FOR MEDICAL EXAMINATION FOR REASONS OF BARRIERS OF ACCESS IN MALTA AND EUROPEAN UNION COUNTRIES: REASON BEING TOO EXPENSIVE, TOO FAR TO TRAVEL OR WAITING LIST (%)⁽¹⁸⁾

	2008	2009	2010	2011
EU countries	3.1	3.0	3.1	3.4
Malta	0.7	1.3	1.6	1.0

Source: EUROSTAT (EU-Statistics on Income and Living Conditions [EU-SILC] instrument)

E. COMMUNITY SERVICES FOR THE ELDERLY

There are also a number of services to support the elderly within the community such as Home Care Help, Telecare, Meals on Wheels, Handyman Service and Incontinence Service. However, the 2008 European Health Interview Survey reported that use of these services was rather low within the elderly population. Only 11% of the elderly population recall making use of at least one of the above community care services during the 12 month period prior to the interview. The rate of use of care services was noted to rise with increasing age. The overall take up of these services was 7.4% in the 60-74 year age group, rose to 20.7% in the 75-84 year group and reached 24% in the persons aged 85 years and older. The service that was used the most was home help (7% by the whole group and 24% by those aged above 85 years).⁽¹⁷⁾

F. ONCOLOGY SERVICES

A new oncology centre is currently being built which will lead to the eventual migration of oncology services from Sir Paul Boffa Hospital*** to Mater Dei Hospital. Extensive work has already been done and it is envisaged that this new facility will become functional by end 2014. The centre will have 74 in-patient beds, including 16 beds for palliative care and 10 beds for children and adolescents. Hospice Malta is the local voluntary organisation that provides day and community palliative care services to patients suffering from cancer, motor neurone disease and other terminal diseases. The organisation is reliant on volunteers as well as professional salaried staff such as nurses, social workers and doctors and receives a fixed annual grant from government.

*** Sir Paul Boffa Hospital is a small hospital near Valletta which for many years has been providing oncology, specialist palliative and dermatology care

5.4 QUALITY OF CARE INCLUDING PATIENT SAFETY, CONTINUITY AND CONSISTENCY OF CARE, IMPLEMENTATION OF PROTOCOLS AND/OR INTERNATIONAL GUIDELINES

The health system in Malta is continuously working towards providing and improving the quality of the care given by health services. The following sub-sections will illustrate performance and activity in some of the aspects that contribute towards this sector.

A. TRAINED HEALTH CARE WORKFORCE

This includes the recruitment of well-trained and qualified health care professionals who are encouraged and provided with opportunities to further their expertise in their chosen field both locally and abroad. Most of the medical and surgical specialities have structured training programmes for their trainees which are also coupled and supplemented with opportunities to gain further training experience overseas. Continued professional development programmes are ongoing and are easily available to all professionals.

It is pertinent to note that the health care workforce includes several professional and technical groups. The range of available allied health professionals is very wide and is continuously expanding. Additionally, the range of specializations and sub-specializations is also constantly on the increase. Health workers often work in multi-disciplinary teams which include representatives from the different relevant healthcare professional groups and frequently closely interact with professionals from other sectors such as psychologists, social workers and other professionals involved in social care.

The following table compares the number of students per 100,000 population who graduated in a number of health care professions in Malta and the EU countries for the year 2010.

TABLE 21 NUMBER OF STUDENTS PER 100,000 POPULATION WHO GRADUATED IN THE HEALTH CARE PROFESSIONS IN MALTA AND THE EU COUNTRIES FOR THE YEAR 2011 ⁽⁵⁾		
Graduates	Malta	EU
Physicians	17.08	10.64
Nurses	22.61	36.18
Pharmacists	8.90	3.93
Dentists	1.68	2.67

Source: European Health for All database, WHO

In 2011 there were 324.31 practising physicians per 100,000 population in Malta. This is lower than the average rate in the EU average that stood at 345.80 practising physicians per 100,000 population and the EU-15 of 368.19 physicians per 100,000 population for 2011. With regards to practising nurses the local numbers are still substantially lower than the EU average. In Malta there were 709.97 practising nurses per 100,000 population in 2011. On the other hand the EU average stood at 835.91 practising nurses per 100,000 population and 868.35 practising nurses per 100,000 population in the EU-15 in 2011. ⁽⁵⁾

B. NATIONAL CANCER SCREENING PROGRAMMES

Organised national screening programmes for selected cancers have been initiated since 2009 with the introduction of the national breast cancer screening programme. This programme is targeting women aged 50-60 years and is inviting women every 3 years. During 2012, out of the 10,851 women invited to attend, 6,610 accepted the invitation resulting in a response rate of 60.9%. ⁽⁵¹⁾

A national colorectal cancer screening programme was launched in late 2012. This programme will be inviting persons between 60 to 64 years of age every 2 years for faecal occult blood testing (FOBT). The European Health Interview Survey 2008 showed that only 4.7% of all respondents reported having had an FOB test done at least once in their lifetime. This proportion increased slowly with increasing age and peaked at 8.5% in the 60-69 age group. This shows that opportunistic screening activity for colorectal cancer screening is very low in the Maltese population. ⁽¹⁷⁾

A screening programme for cervical cancer is planned to start in 2015. However self-reported data from the European Health Interview Survey 2008 showed that 63.4% of women reported having had a cervical smear test at least once in their lifetime. This reflects a rather high level of opportunistic screening activity. In the 25-34 year age group 61% reported having had a cervical smear in the previous year. It was noted that there was a trend of increase uptake of cervical smear tests with increasing educational level. ⁽¹⁷⁾

C. VACCINATION

All children born in Malta are entitled to free vaccinations until they are 16 years of age. The schedule includes vaccines for diphtheria, tetanus and pertussis (DTP) and poliomyelitis, Haemophilus influenza (HiB), Hepatitis B, and Measles, Mumps and Rubella (MMR). Tuberculosis (BCG) is only given to high risk children. A national programme for vaccination against Human Papilloma Virus started to be implemented in 2013. This programme is inviting 12 year old girls.

Vaccine coverage for DTP, poliomyelitis and Hib in Malta in 2011 reached 98.7% of the eligible population. Hepatitis B vaccination take up rate was 92.7% in Malta for 2012 while the EU average reached 85.9% in 2011. ⁽⁵⁾ There may be a degree of underreporting with respect to data for Malta as some children are vaccinated in the private sector and not all data from this sector may be captured.

TABLE 22 | VACCINATION COVERAGE IN CHILDREN IN 2011 ⁽⁵⁾

Vaccine	Malta	EU-27
Diphtheria, Tetanus, Pertussis (DTP)	98.7	96.7
Hepatitis B	92.7	85.9
Measles	92.7	93.9
Haemophilus Influenza B (HiB)	98.7	96.0
Poliomyelitis	98.7	96.1

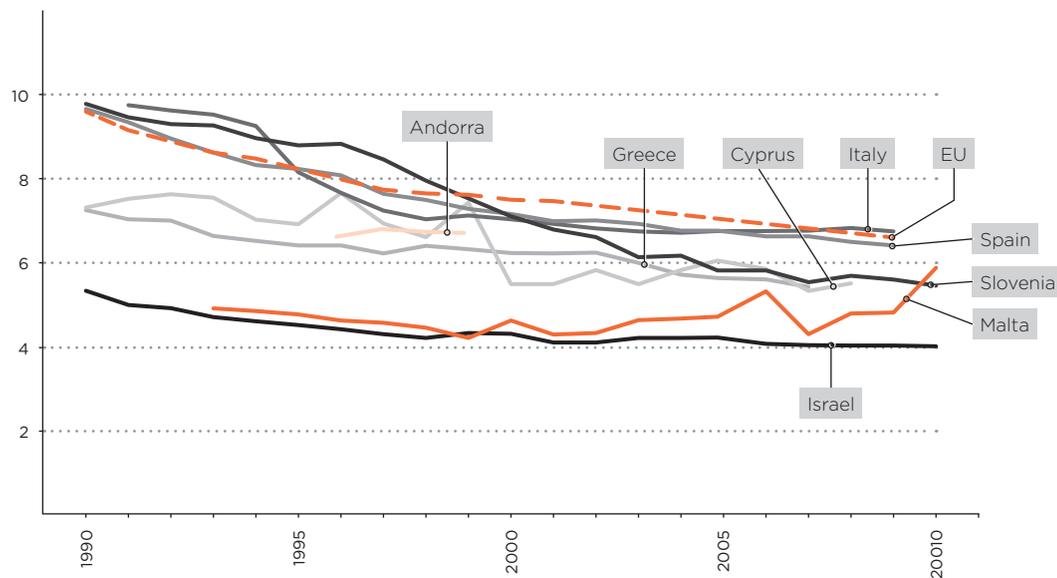
Source: European Health for All database, WHO

D. HOSPITAL STAY AND READMISSIONS

The average acute length of stay in Malta for acute care hospitals in 2011 was – 6.3 days which is lower than the EU average of 6.4 days and the EU-15 average of 6.5 days in the in 2011. ⁽⁵⁾

Re-admission rates are often used as hospital care performance indicators although one should be aware of the definition being used when comparing with other specialities or hospitals. An internal report on Emergency Readmissions to Mater Dei Hospital analysed discharges in 2011. The definition adopted to calculate the readmission rate was set at including emergency/unplanned readmissions within 28 days of discharge to the same speciality as the previous admission. The findings showed that the emergency readmission rate was highest in the medicine speciality where it stood at 9.4%

FIGURE 2 | AVERAGE ACUTE LENGTH OF STAY IN MALTA, EU AND OTHER EUROPEAN COUNTRIES – 1990-2010 ⁽⁵⁾



Source: European Health for All database, WHO

5.5 THE NEED FOR A LONG TERM VISION FOR THE SUSTAINABILITY OF OUR HEALTH SYSTEMS

The Maltese national health systems offers a free service for all people residing in Malta. As mentioned in previous sections, factors such as an ageing population, increased services and constant investment in new medicines, procedures and technologies means that the expenditure on health is enormous and is consistently rising from year to year. It is therefore important that, in order to ensure that a free health system remains sustainable certain indicators are regularly monitored.

There are five public hospitals**** (2 acute and 3 specialised) and three private hospitals as at end of 2012. The total number of hospital beds in Malta, in 2012, was 478.42 beds per 100,000 population. This is still lower than the average EU figure for 2011, of 542.05 beds per 100,000 population. ⁽⁵⁾

The total expenditure on health in Malta, as a percentage of the Gross Domestic Product (GDP) for 2012, was 9.1%. ⁽¹⁶⁾ This is slightly lower than the 2011 EU average which stood at 9.6%. ⁽⁵⁾

The following table shows trends on expenditure on health over 15 years and includes both public and private expenditure as well as voluntary health insurance.

TABLE 23 | TRENDS IN HEALTH EXPENDITURE IN MALTA, 1995 TO 2010 ⁽¹⁶⁾

Expenditure	1995	2000	2005	2010
Total health expenditure (€) Purchasing Power Parity per capita (1995 prices)	875.5	1248.1	1964.8	2319.8
Total health expenditure as % of GDP	5.6	6.6	9.1	8.5
Public expenditure on health as % of total expenditure on health	67.5	72.5	68.7	64.3
Private expenditure on health as % of total expenditure on health	32.5	27.5	31.3	35.7
Government health spending as % of total government spending	9.9	12.1	14.4	13.0
Out of pocket payments as % of private expenditure on health	95.8	96.9	91.8	93.3
Voluntary Health Insurance as % of total expenditure on health	1.3	0.8	1.7	2.3
Voluntary Health Insurance as % of private expenditure on health	4.1	3.1	5.5	6.3

Source: National Health Accounts, WHO

Note: The increase in health expenditure seen in 2005 coincides with the construction of the new Mater Dei Hospital

In the private system patients have to pay the full price for pharmaceuticals while in the public sector the medicines listed on the Government Formulary List are given free of charge to entitled patients and there is no co-payment. Total expenditure on pharmaceutical products in 2012 was €173.9 million. Of this €102.2 million was private expenditure on pharmaceutical products whilst €71.7 million was public expenditure on pharmaceutical products. There was an increase in total expenditure on pharmaceutical products from €162.5 million in 2011, with €99.2 million being private expenditure on pharmaceutical products and €63.3 million being public expenditure on pharmaceutical products in 2011.

**** Hospitals comprise licensed establishments primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals provide inpatient health services, many of which can be delivered only by using specialized facilities and professional knowledge as well as advanced medical technology and equipment, which form a significant and integral part of the provision process. Although the principal activity is the provision of inpatient medical care they may also provide day care, outpatient and home health care services as secondary activities. ⁽⁶⁰⁾

5.6 HEALTH POLICIES & STRATEGIES

Over the past few years a number of policies and strategies relating to Health have been finalised and implemented. The following is a list of the policies and strategies currently in use and other significant milestones:

2007

- Restructuring to separate Regulatory and Service Provider Functions;
- Collective agreements with the health care unions;
- Commissioning of the new Mater Dei hospital and migration to the new hospital;
- Implementation of new IT systems.

2008

- Introduction of the Pharmacy of Your Choice Scheme (POYC);
- Pharmaceutical policy reform;
- Commissioning institutional care for the elderly from private providers;
- Setting up of Foundation Programme and Post Graduate Medical training centre.

2009

- Launch of the national breast cancer screening programme;
- Consultation on a primary health care reform.

2010

- Establishment of Faculty for Health Sciences within the University of Malta;
- Non-communicable Disease Strategy;
- Sexual Health Policy.

2011

- National Cancer Plan 2011-2015;
- Sexual Health Strategy;
- Restructuring to decentralise service provision;
- Outsourcing of clinical services;
- Setting up of the Commissioners for Health, for Mental Health and for Elderly Persons.

2012

- Embryo Protection Bill, 2012;
- Mental Health Act, 2012;
- Launch of national colorectal cancer screening programme.

2013

- Launch of the Human Papilloma Virus (HPV) vaccination programme;
- Health Act, 2013;
- Setting up the structures (including the National Contact Point) for cross border healthcare.

2014

- Launch of the Food and Nutrition Policy and Action Plan 2014-2020;
- Launch of the National Health Systems Strategy for Malta 2014-2020.

There are, however, a number of policies and strategies which are still pending. These include a policy on health system financing, a policy on waiting times – this would tackle having centralised waiting lists, ensuring appropriate referral of patients, better management of appointment times and improving the service hours at Mater Dei Hospital (e.g. having afternoon clinics and lists).

A strategy for dementia has been launched for consultation by the Ministry for the Family and Social Solidarity (MFSS). Additionally, MFSS published and started to implement a national strategy for active ageing, and is also responsible for policies and strategies dealing with the reduction of poverty and social inclusion, the abuse of drugs and alcohol and a national policy for children.

A national plan for rare diseases and a national diabetes strategy are also being developed. In the sector concerned with the care of elderly patients, a plan to enhance and further develop the range of community services for the elderly is being developed. As has been mentioned previously there are already many services in place for the elderly, however due to an increasingly ageing population and increasing demands, these services need to be constantly reviewed and augmented.

People at the heart of the health systems (The people-centred approach)

6.1 INTRODUCTION

Health is influenced by a complex interplay of physical, social, economic, cultural and environmental factors. Access, patient safety, quality and responsiveness of care and the sustainability of the health system are important and pressing issues. Policy development in national health is based on the core value of protecting and developing health and well-being of all the members of the population and it must encompass the broader context, with all stakeholders involved. This entails a more holistic approach to health systems and health care, and a balanced consideration of the rights and needs as well as the responsibilities and capacities of all health constituents and stakeholders.

The patient's perspective of health care and how health systems can better respond to the needs of all health care stakeholders and sectors has been gaining in interest over the last few years. In countries such as Malta, where basic health infrastructure and essential health services are in place, people can aspire to higher expectations from the health system. They now expect health systems, health care organizations and health practitioners to move to a higher level of performance and adopt a more humanistic and holistic approach to health care, where the individual who needs care is viewed and respected as a whole person with multi-dimensional needs.

The patient-centred approach primarily focused on patients, their interactions with health care providers and their experiences in the clinical setting. While this approach addresses issues of quality and holistic health care, it does not meet some of the broader health challenges.

A people-centred approach meets these broader challenges. A people-centred approach is distinct from the more commonly portrayed patient-centred approach because it recognises that before people become patients they need to be informed and empowered in promoting and protecting their own health.⁽⁵²⁾ Since this strategy is encompassing the broader view of a overarching health system rather than just concentrating on only the more familiar and visible health care systems it was felt that the people-centred approach is a more appropriate and relevant structure and that it is therefore more suitable for the task of planning for and implementing the strategic actions that are documented in the NHSS.

The people-centred approach involves a balanced consideration of the values, needs, expectations, preferences, capacities, and health and well-being of all the constituents and stakeholders of the health care system. It recognises and addresses both health care interactions as well as public health interventions, in particular prevention and health promotion, and it aims to reach people in the general community long before they become patients and enter a clinical health care sector or facility.

Furthermore, the people-centred concept has an additional utility in that it encompasses not just those who demand and need support to achieve good health but also those who provide the services and who run the organizations and systems within which health services are delivered. Health care professionals, health service managers and health policy-makers are also people and they have needs and expectations from the health system like all the other members of the general population. They may become patients and they form part of the families and communities that the health system is designed to serve. Their needs must also be considered and they also should be empowered to be able to transform and drive improvements in the quality and responsiveness of the health system.

The people-centred approach recognises four major groups of stakeholders. All these groups work for and are concerned with the success of the health system. These four groups or policy and action domains include the following:



INDIVIDUALS, FAMILIES AND COMMUNITIES



HEALTH PRACTITIONERS



HEALTH CARE ORGANISATIONS



HEALTH AUTHORITIES

To achieve any real transformation in any part of the health system these domains must mutually reinforce each other and leadership within and across all domains is accredited as the ultimate enabler for change.

TABLE 24 | DIFFERENT PLAYERS WITHIN THE 4 KEY POLICY AND ACTION DOMAINS IN THE PEOPLE-CENTRED HEALTH SYSTEM APPROACH ⁽⁵²⁾

Domain	Clinical setting	Public Health setting
Individuals, Families and Communities	Patients and families, patient advocacy groups, patient associations	Communities and populations Voluntary Organizations Local government
Health Practitioners	Clinicians and clinical support staff	Public health workers Prevention workers
Health Organizations	Clinicians and clinical support staff	Public health facilities Community health centres
Health Authorities	Varies depending on model of health care	Ministry for Health Public health sector

Source: Adapted from People at the centre of health care: harmonizing mind and body, people and systems, 2007 (page 28; Table 2)

6.2 THE EVOLVING CONCEPT OF PEOPLE-CENTRED APPROACH

The idea of people-centred care is a fairly new concept and is still developing. There are several existing models in the literature and some of them attempt to delineate its predominant characteristics. The majority of these frameworks still focus mainly on the clinical experience of health care and are essentially variations of patient-centred care. Nevertheless, it is important to acknowledge that several of the elements identified as integral to the patient-centred approach are also valid for the broader concept of people-centeredness.

The term “patient-centred” medicine was first mentioned in 1970 by Dr Michael Balint and his colleagues as an alternative approach to traditional medical practice, which they portrayed as “illness-centred medicine”. In their view, a considerable proportion of patient complaints arise from emotional stress and not physical causes and they recommended that a thorough understanding of the patient’s complaints, based on patient-centred thinking, was important in promoting healing. ⁽⁵³⁾

Other authors and academic and professional institutions such as Levenstein, the Picker Institute and the Institute of Healthcare Improvement (IHI) continued to develop on the concept of patient-centeredness and extending it to involve the patients’ families.

In 2001, the Institute of Medicine (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century*. This work moved ahead from the earlier models that focused on patients and their families, and introduced the concept of patient-centred care from a health systems standpoint. In the IOM model, the care system is inclusive of high-performing patient-centred teams and organizations that facilitate the work of other patient-centred teams operating within a supportive payment and regulatory environment to produce health care that is safe, effective, patient-centred, timely, efficient and equitable. ⁽⁵⁴⁾

The WHO has issued several studies and reports addressing the issues and challenges faced by today’s health care systems, particularly in relation to putting people at the centre of health care. Through the development of the Innovative Care for Chronic Conditions (ICCC) framework patients and their families were positioned at the centre of the health care system, and communities are encouraged to connect with health care organizations in providing care for chronic conditions. Moreover, the framework recognizes the importance of a supportive policy environment that organizes the values, principles and general strategies of governments working to reduce the burden of chronic conditions. ⁽⁵⁵⁾

The term “people-centred health system” made its first appearance in a book published by Dr Vaughan Glover in 2005. In this publication he proposes a health care reform for Canada arguing that the current Canadian health system had already met its two initial goals, namely, to provide all its citizens with access to a universal level of health care and to provide the financial coverage for this health care. He asserted that the changing nature of health and health care requires the health system to move towards a higher level of functioning and emphasized the dynamic inter-relationships between the various stakeholders in health care. ⁽⁵⁶⁾

In its 2005 publication the International Alliance of Patients’ Organizations recognized the inherent limitations of the phrase “patient-centred”, acknowledging the critical role for prevention and community health promotion in health care. ⁽⁵⁷⁾ Finally, the full transition from “patient-centred” to “people-centred” health care was first articulated by the WHO Western Pacific and South-East Asia Regions in the work titled *People at the Centre of Care Initiative*. ⁽⁵⁸⁾ This initiative introduced the concept that people-centred health care is concerned with both clinical medicine as well as public health and incorporates the entire spectrum of health care: individuals, communities, professionals, organisations and policy-makers

6.3 THE VALUES, PRINCIPLES AND CHARACTERISTICS OF A PEOPLE-CENTRED HEALTH SYSTEM APPROACH^{†††}

Patient- and people-centred care share several core values and guiding principles. The core values have been expressed in several WHO and other international documents and include:

1. Respect for human rights and dignity
2. The central role of health in any process of development and economic growth
3. An effective tool to end all forms of discrimination
4. The importance of participation and inclusion of individuals and communities in health and development.

These core values have been developed into a number of essential principles. People-centred care is:

- equitable
- concerned with the engagement of all stakeholders
- about enabling stakeholders to make the appropriate choices
- effective, leads to better health outcomes
- evidence-based and compassionate
- efficient, coordinated and provided in a timely manner
- ethical and fosters transparency and accountability.

Evidence from research, practice and evaluation of health systems has led to the development of the following key characteristics by policy and action domains.

A. INDIVIDUALS, FAMILIES AND COMMUNITIES

- Equitable access to health systems, effective treatments and psychosocial support
- Access to clear, concise and intelligible health information and education that increases health literacy and allows for informed decision-making
- Personal skills which allow control over health and engagement with health care systems—communication, mutual collaboration and respect, goal-setting, decision-making, problem solving and self-care
- Supported involvement in health care decision-making, including health policy, programme development, resource allocation and health financing.

B. HEALTH PRACTITIONERS

- Holistic approach to the delivery of health care
- Respect for patients, their needs and decisions at the clinical level and respect for communities and their needs at the population health level

^{†††} The text of this sub-section has been adapted from WHO Regional Office for South-East Asia and WHO Regional Office for the Western Pacific. People at the centre of health care: harmonizing mind and body, people and systems, 2007 (pages 35-39)

- Professional skills to meet these needs—competence, communication, mutual collaboration and respect, empathy, health promotion, disease prevention, responsiveness and sensitivity
- Provision of individualized care at the clinical setting
- Access to professional development and debriefing opportunities
- Adherence to evidence-based guidelines and protocols
- Commitment to quality, safe and ethical care
- Teamwork and collaboration across disciplines, providing coordinated care and ensuring continuity of care
- Involvement in health care governance and policy decision-making.

C. HEALTH CARE ORGANIZATIONS

- Accessible to all people needing health care
- Commitment to quality, safety and ethical care
- Safe and welcoming physical environment supportive of different lifestyles, family, privacy and dignity
- Access to psychological and spiritual support during the care experience
- Acknowledgement of the importance of all staff—managerial, medical, allied health, ancillary—in the delivery of health care
- Employment and remuneration conditions that support teamwork towards people-centred health care
- Avenues for grievances and complaints to be addressed
- Organization of services that provide convenience and continuity of care to patients
- Service models that recognize psychosocial dimensions and support partnership between individuals, their families and health practitioners.

D. HEALTH AUTHORITIES

- Primary care as the foundation for better health
- Financing arrangements that ensure the sustainability of the health system
- Investment in health professional education that promotes multi-disciplinary teamwork, good communication skills, an orientation towards prevention, and integrates evidence about psychosocial dimensions of health care
- Ability to develop standards and protocols, and to disseminate guidelines and standards for good practice
- Collaboration with local governments and communities and voluntary organisations
- Commitment to a process of ongoing evaluation and improvement
- Involvement of communities and other stakeholders in health governance and policy development
- Transparency
- Accountability.

The above values, principles and characteristics are all very relevant to the structure and content of the NHSS. They are in line with the vision that the Ministry responsible for Health has for the future development of the national health systems and these concepts will be repeatedly evident in several of the strategic actions that are documented in the following sub-chapters dealing with the individual overall objectives and strategic directions of this strategy.

Implementation of people-centred National Health Systems: Objectives, Directions and Measures

7.1 OVERALL OBJECTIVE 1 – HEALTH AND WELL-BEING THROUGHOUT LIFE

To respond to increasing demand and challenges posed by the demographic changes and epidemiological trends focusing on the whole course of life, children, the elderly and vulnerable groups.

Strategic Direction 1A

THE RIGHT CARE AT THE RIGHT PLACE AND AT THE RIGHT TIME

Prolonging stay in the community and responding to increasing demands for higher dependency care.

Action will be taken to ensure that the care required is delivered in the setting which is most suitable to the needs and is conducive to sustaining and improving the health and well-being of the person at different stages of the life course. Actions need to be taken to continue upgrading all settings providing health services and there will be increased focus on empowering and encouraging communities to become more involved in the provision of informal care in the community and as near as possible to where people are residing and working.



INDIVIDUALS, FAMILIES AND COMMUNITIES

The main thrusts will include:

1. The dissemination of consistent information and education to raise the awareness of individuals, families and communities about their rights for and responsibilities towards the health system. Actions will incorporate activities to:
 - a. continue sensitising the public on responsible use and consumption of health care services, medicines and medical devices.

- b. support and encourage individuals and families to be involved in the management of their own health, and the health of dependents including elderly relatives. The ultimate aim of these measures will be to help avert and delay the need for long-term institutional care as far as possible.
 - c. encourage, educate and support individuals who opt for and perform the role of informal carers or join networks of informal carers.
 - d. facilitate the changes needed and introduce structures, services and the availability of devices that will help individuals achieve their capacity to become more responsible for the maintenance of their own well-being and health.
 - e. support changes in the members of the public to collectively become more accountable for sustaining good standards in public health.
 - f. plan for the setting up of a centralized information service that will be able to inform service users and providers with high quality and timely information that will assist them to navigate the wide range of health and social care services available and that are most suitable to their needs.
 2. The strengthening of the importance of the roles of the local government, voluntary organisations and patients and residents groups in provision of health services. This will be achieved through
 - a. further acknowledging their contributions and functions
 - b. further encouragement and support to help increase their participation in decision-making processes at a national level
 - c. increasing the role of voluntary organisations and patient groups as advocates not only for patients but also for their member care providers and volunteers. In this way the needs of this important group of partners in the health care service provision will be brought more to the attention of decision-makers.
 3. Policies and strategies will continue to identify vulnerable groups and design and implement actions aimed purposely at identifying in more detail and addressing their specific and distinctive requirements. Vulnerable groups that have been identified as necessitating special attention in most health-related strategies include:
 - a. people at-high-risk-of-poverty such as lower socio-economic classes and single parent households;
 - b. Migrants, asylum seekers and foreign workers;
 - c. people with addictive behaviour difficulties;
 - d. people with physical and intellectual disabilities;
 - e. people with rare conditions and diseases;
 - f. frail older persons and persons suffering from dementia;
 - g. people at higher risk of or with mental health problems;
 - h. people at high risk of occupational ill-health and safety;
 - i. Special attention will be devoted to Gozo. In particular, measures will be designed to increase the responsiveness of the health systems to the special difficulties and needs of the patients and their families and the population residing in Gozo especially those that are accentuated by the double insularity of this sister island.



HEALTH PRACTITIONERS

The main thrust will be through initiatives to increase the awareness and sensitivity of health practitioners to the health and care needs in the community. This will be achieved through:

1. Continuously updating health practitioners so that they remain highly knowledgeable about the range of services provided and how these can be accessed. Areas that have been identified as meriting special attention include mental health issues in the elderly, access issues for sexual health and the multiple and complex health issues of people at a high risk-of-poverty especially the children hailing from these social strata.
2. Educating and supporting family doctors and other health practitioners to become more proficient in providing assistance and information to people caring for or residing with elderly relatives and dependent persons with physical and intellectual disabilities as well as guidance should admission to residential homes be required. This will also include continued professional development to update skills to prevent sub-optimal prescriptions, poly-pharmacy and use of inappropriate drugs
3. Promoting a multi-disciplinary approach to patient care and enhancing the role of health practitioners working in the community. There will be a special emphasis on strengthening the role of the family doctor particularly in areas where it is felt is most needed. Identified areas that need particular attention include the care of patients with co-morbidities/ chronic illness and disability, community psychiatric care and palliative and end-of-life care.



HEALTH CARE ORGANISATIONS

The main thrusts will comprise:

1. The strengthening of the multi-disciplinary approach to patient care. This will be achieved through:
 - a. facilitating information sharing from and to hospital and community care settings.
 - b. the provision of complementary and diversified multi-sectoral specialised services, both at inpatient and outpatient levels, to cater for different needs of the community with an emphasis on promotion, prevention, early intervention and community support.
 - c. Training and empowering primary care and community service providers in rehabilitation care.
2. The provision of sustainable rehabilitative community services for suitable patients currently living in institutional care (particularly in mental health facilities) so as to reintegrate these patients back into society and prevent re-admission to hospital. To achieve this aim, the mental health infrastructure in the primary health care and community care sectors will be expanded. More training to health care professionals in this sector will be provided in order to augment their capacity to deal with the increasing prevalence of mental health disorders. These actions will also result in improvements in the early recognition of mental ill-health, gate keeping and coordinating roles and the capacity for outreach services of primary health care and reduce the need for admissions and long-term hospitalisation in mental health facilities.



Several actions will be undertaken. These include:

1. Formalising patients' rights in the Maltese legislation. Information campaigns to increase awareness of patients' rights and legal obligations will be implemented. The provision of information about the patient's condition and care and the patient's right to choice and involvement in clinical decisions will be given special attention.
2. Formally recognising and increasing support to informal care in the community. The involvement of the patient's chosen relative or carer is important, especially at times of crisis. Measures that will aim at providing support for carers to minimize the need to resort to the emergency and hospital services will be planned and implemented .
3. Designing a national policy and strategies aimed at expanding the resources and updating the structures dedicated for the promotion of well-being in children and young people. These strategies will provide for and focus on the following identified areas:
 - a. The childhood and adolescent age groups will receive special emphasis with regards to health promotion, disease prevention and screening for physical and psychological developmental difficulties.
 - b. The creation of a new suitable unit in the community that will be dedicated to the promotion of psychological, psychiatric and behavioural care of children and adolescents with challenging behaviour and special needs. The development of this unit is supported by scientific evidence that shows greater benefit for both the long-term development and social inclusion of these young people as well as for their needs for immediate care and prevention from harm in the short-term, over the care that they receive if otherwise they are hospitalised.
 - c. Strengthening of collaboration with the educational and social services working with these cohorts.
4. Consolidating the structures that perform assessments on proposals for new services. This will be achieved through the setting up of and the increased support to more professionals and entities that can evaluate the performance and effectiveness of existing services.
5. Carrying out a needs assessment for groups needing long-term care and specialized community care services other than the elderly, such as persons with severe physical and intellectual disabilities.
6. Increasing the capacity of services as and where needed. This will involve activities to cater for the consequent increases or changes in the complement of the health personnel and expertise required to upgrade and introduce new services. Areas requiring special attention include increases in the capacity of and availability to:
 - a. long-term care facilities particularly to cater for people with high dependency needs.
 - b. geriatric rehabilitation services,
 - c. respite care services.
 - d. assistance for the purchase or loan of assisting technologies that support and can prolong independent living.
 - e. community centres co-located with nursing homes from which community health support services can be delivered.

- f. address the need for palliative care services that cater for patients other than cancer patients. Every patient requiring end-of-life care needs palliative care support to help her/him die with dignity and in line with her/his requests, such as regards the choice for the place of death, if possible.

All these services should aim at sustaining and restoring in particular older persons' maximum level of independence.

7. A new programme that will aim at delivering medicines to the residences of elderly people with severe mobility problems and persons with disability will be planned.
8. Investing in the health sector necessitates investment in the training, recruitment and continued professional development of several highly skilled health professional groups. Some of these groups require special attention because albeit the type of profession is essential for the service, the number of professionals required is too small to justify local training courses. Examples include professionals sub-specializing in several areas in the pathology sector and allied health care professionals in prosthetics and orthotics, orthoptics, optometry and clinical physiology. Action will be taken to ensure that an appropriate number of suitable persons will be regularly sent abroad for training in order to effectively address these important skill gaps.
9. Continuing with the phased expansion of the Government formulary. Special attention will be given in the areas of cancer and rare diseases.
10. Design and implement programmes to increase health literacy in the population so that members of the public learn the necessary skills that will empower them to obtain, read, understand and use healthcare information to make appropriate health decisions and follow instructions for treatment.

Strategic Direction 1B

ENGAGEMENT AND EMPOWERMENT TO PROMOTE HEALTH

Strengthening the prevention and promotion of health focusing on behavioural changes and lifestyle choices including protection, screening and early diagnosis of health risks, and prevention of disease throughout the life course and control of disease progression.

EU projections show that if people succeed in remaining healthy as they live longer, the rise in healthcare spending due to ageing could be substantially reduced.⁽³⁸⁾ Action will continue to be taken to promote health and prevent disease throughout the life course by tackling key issues including poor and unbalanced nutrition, low levels of physical activity, tobacco consumption and harmful intake of alcohol and drugs, environmental and occupational health and safety risks, road traffic accidents, and accidents in the home.

The link between health and economic prosperity and portraying health as a social and economic resource is increasingly becoming more prominent worldwide. The concept of 'health as a value in itself'⁽²⁸⁾ and as a precondition for economic prosperity also promotes the growing knowledge that people's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending.⁽²⁹⁾

This strategy also affirms the continuation and consolidation of initiatives and resources to protect human health and improve safety, security and protection of citizens against health threats. These include health impact assessments to articulate the relationship between policy measures, health outcomes, costs and benefits, preparedness and response to emergencies, epidemics and bioterrorism, strategies to tackle risk from specific diseases and conditions, action to prevent accidents and injuries, improving workers' safety, and actions to ensure and safeguard food safety and consumer protection.



INDIVIDUALS, FAMILIES AND COMMUNITIES

The main thrusts include:

1. Educating the public about risk factors for developing, and the lifestyle choices that help prevent, the onset of non-communicable diseases. Initiatives will concentrate on:
 - a. tackling the national problems of obesity and lack of physical exercise
 - b. the importance of early presentation, compliance with treatment and regular monitoring.
 - c. reducing any existing stigma associated with certain medical conditions such that persons with a suspicion of being affected do not feel threatened to approach the system at an early stage for diagnostic investigation and control of disease. This is felt to be particularly important for mental health and sexual health conditions.

Programmes will be tailored and aimed at identified sub-groups of the population and special attention given to the children, adolescents and young adults.

2. Educating the public about risk factors for communicable diseases ensuring appropriate action is taken whilst avoiding over-reaction and inappropriate actions due to unnecessary and unwarranted fear of infections. Programmes will be tailored and aimed at identified sub-groups of the population that are considered to be at higher risk of contracting, protracting and disseminating specific communicable diseases.
3. Increasing knowledge and understanding of self-care such as self-monitoring for disease control. Special attention will be given to:
 - a. diabetes
 - b. hypertension
 - c. encouraging regular and planned health checks
 - d. maintaining good oral health.



HEALTH PRACTITIONERS

The main driving force will incorporate increasing investment to support health practitioners to increase their roles, involvement in and accountability for preventive medicine and health promotion. Actions will be taken to:

1. Establish clinics that will have general and specified health checks as their main function. These clinics will have an increased focus on health promotion, prevention, screening and early diagnosis and can be aimed at different groups (such as by gender and/or age) . They will be:
 - multi-disciplinary,
 - based in the primary health care system,
 - led by community health practitioners with special interest and training in specific fields,
 - supported by and receive continued professional development coordinated by the specialist units and services in the secondary health care.

Attendance at these clinics may be following a referral from a health practitioner, self-referral or by invitation. The latter method will be adopted to engage persons and groups of people that are considered to be at a higher risk or with higher probability of positive long-term outcomes. An evaluation of the Health Awareness clinics that are already in operation in some towns will be carried out.

2. Implement specific health promotion programmes that will be led by family doctors and other professional groups in primary care. Continued professional development will be provided and guidelines for health care professionals will be established thus ensuring that updated, timely and consistent advice is given to patients and other persons who seek their advice.
3. Update protocols for screening and surveillance programmes as necessary. Where indicated, these programmes will also seek to:
 - target high risk groups of people,
 - provide training in counselling at both pre- and post-testing phases,
 - increase structures and resources for the surveillance of more diseases or groups of diseases,
 - step up enforcement of notification of diseases (particularly infectious diseases),
 - regularly update and review the legislation concerned with notification of diseases and the notification processes including contact tracing and notification of partner/s.
4. Continue with initiatives to further develop the awareness, attitudes, information, communication skills and non-discriminatory practices of every health professional in order to develop a skilled work force that can deal appropriately (ethically and humanely) with all situations.
5. Provide educational programmes on maternal and infant nutrition (including breastfeeding) for health professionals so that they may transmit the best possible and consistent information and support to all mothers.



HEALTH CARE ORGANISATIONS

A number of initiatives will spearhead action by healthcare organisations for this strategic direction:

1. Launch and enforce total smoking bans in and around all health facilities (health care or otherwise). Carry out consultations and the drafting and enactment of legislation on the sale and advertisement of tobacco and tobacco products, alcohol and food that is high in sugar and fats.
2. Concentrate efforts to:
 - reduce the average systolic and diastolic blood pressure, and the level of serum cholesterol in the general population
 - increase the amount of physical activity undertaken by all age groups.

Actions will include:

- a. Specialised obesity clinics will be set up and run on a multi-disciplinary basis in the primary health care sector which will provide a holistic approach to the overall management of persons with weight reduction and control problems. Furthermore, guidelines will be issued to facilitate the delivery of consistent messages from all health professionals to the public such as on weight management.

- b. Increase the number of certain professional groups particularly in the primary care sector such as qualified dieticians, nutritionists and dental hygienists.
3. Provide culturally appropriate and multi-lingual information for foreigners and trained cultural mediators to increase their access and efficient use of the health services according to their needs.
4. Increase the scope of different crises intervention and rapid response teams. Consolidate existing teams such as the Crisis Intervention Team for psychiatric crises and the Sexual Assault Response Team (SART). Plan for the inception of new expert groups that can address people's reactions when faced by traumatic situations such as motor vehicle accidents, accidental deaths, victims of crime and post-traumatic stress disorders.



HEALTH AUTHORITIES

Action will focus on:

1. Regular updates for the provision and investment in national vaccination programmes.
2. Develop and implement programmes to educate and inform:
 - a. policy makers in all Government departments at the national and local level
 - b. civil society on health and its determinants
 - c. on health promotion in various settings that will address health determinants across the life course with special attention to vulnerable and marginalised social groups.
 - d. on common age-related modifiable and preventable crises such as falls prevention, continence promotion, and prevention of dehydration and body temperature control
3. Utilising dedicated national, European or World days and time periods for the implementation of well planned and effective campaigns that can leave an impact and positively encourages and supports individuals' and public changes in knowledge and skills attitudes and behaviour.
4. Reinforcing the primary child and youth health services. Expand child health surveillance programmes to cover all schools in Malta and to include other surveillance points in children older than 4 years. Strengthen the collaboration between the primary child and youth health services and the specialist child development assessment services in the secondary health care sector
5. Design, launch and implement a comprehensive National Diabetes Strategy aimed at increasing awareness for the prevention, early diagnosis, improved monitoring and control and prevention and management of diabetes emergencies and long-term complications thereby allowing persons with diabetes to continue to live an active and participative life.
6. Stepping up the advocacy for Health with institutions and for initiatives beyond the Ministry for Health. Examples of such activity will include continued support through for example the provision of expert advice to national and local governments and other stakeholders for the:
 - a. development of public recreational areas with facilities that encourage physical activities such as outdoor gyms, parks and pedestrian areas and the use of public school grounds after school hours for organised sports activities and the provision of incentives to increase the use of these facilities.

- b. ongoing transformation and execution of new works such as better walkways on our road systems that allows and protects users engaging in activities such as walking, jogging, running and cycling.

Such initiatives will not only increase the uptake of physical activity, thus lowering the prevalence of obesity, but they will also reduce the number of vehicles on the road thus making our roads safer and our environment cleaner.

7.2 OVERALL OBJECTIVE 2 - ENSURING EQUITY WITHIN DYNAMIC HEALTH SYSTEMS

Increase equitable access, availability and timeliness of health and social services, medicines and health technologies.

Strategic Direction 2A

MAKING BEST USE OF AVAILABLE RESOURCES AND ENSURING SUSTAINED PROGRESS

Improving management and efficiency of services through research and innovation, prioritisation, monitoring, public private partnership, and other service provision models.

The national health systems are under constant and escalating pressure to act in response to the challenges presented by an ageing population, rising citizens' expectations, demands for the introduction of new, more expensive and sophisticated technologies and medicines, migration, and mobility of patients and health professionals. Action will concentrate on achieving and maintaining services that assure high levels of safety, quality and efficiency standards through health systems that becomes increasingly financially viable, fit for purpose, people-centred and evidence-informed and based. Measures are also included for the promotion of the establishment of structures and institutions that will provide for and promote local and regional research, innovation and higher education in the health sector especially in the emergent fields of scientific enquiry.



INDIVIDUALS, FAMILIES AND COMMUNITIES

Service users will be supported and encouraged to increase their role and involvement as partners with service providers to improve the efficiency of the national health system. This will be accomplished through:

1. Disseminating more information about how to make the best appropriate use of the health system. Special focus will be concentrated on educating the public to resort to the primary health care system when their problem can be appropriately addressed at this level of care and to, where possible, seek advice and consult their family doctor prior to going to the emergency department.
2. Educating and informing the general population on what constitutes a genuine emergency for appropriate use of the Accident and Emergency (A&E) department thus avoiding excessive waiting times.
3. Further educating the public to respect their appointment dates and times. Communication with patients will be increased and the use of new means of communication to remind patients of upcoming appointments will be introduced.

4. Issuing regular and detailed information on the performance of the different sectors within the health system.
5. Issuing information to educate the public and health professionals on the role of the different groups of health professions.



HEALTH PRACTITIONERS

The main thrusts will include:

1. Strengthening the scope of performance measurement and assessment for health professionals as well as continued professional development.
2. Increasing training on primary health care, rehabilitative care and management of chronic non-communicable diseases starting from the undergraduate level and continuing into all levels of postgraduate education and training programmes.
3. Creating guidelines and criteria to help family doctors to refer patients correctly to the appropriate specialist in-patient or out-patient service and to refer patients using fast-track mechanisms where indicated, such as in the referral of patients with a high suspicion of malignant disease.
4. Developing the appropriate legal and regulatory framework to encourage and support the setting up of more group practices in the primary health care sector. Financial and other incentives to support capital and other investments (particularly in innovation) by family doctors or group practices into their practice will be considered.
5. Identifying areas of increasing need for or 'unmet need' from the currently available services provided, and providing generic training to health and social care professionals on these areas. Examples of these sectors include the provision of the special care needed:
 - a. by frail older people and patients with dementia,
 - b. by persons with eating disorders,
 - c. by patients needing palliative care,
 - d. in pre-hospital care of emergencies
 - e. in resuscitation techniques.
6. Augmenting the practice of issuing calls for professionals to further develop their expertise in areas of special interest and increasing need for service provision. This will allow for the deployment of motivated professionals for further training and support so as to be able to introduce and consolidate new care services and models of service that are congruent and responsive with the evolving needs of the population.
7. Encourage and facilitate the uptake of research projects by individuals and teams of health practitioners. Examples can include the provision of increased opportunities for protected time for research initiatives, career pathways that acknowledge the added value of professionals involved in research, closer liaison between practitioner and academic communities and involvement of researchers in advisory structures reviewing practices and services provided.



HEALTH CARE ORGANISATIONS

The major driving force will be aimed at expanding the range of services, and the volume, capacity and impact that the primary healthcare and community services can have with respect to the health care needs of various sectors of the population. Actions will include:

1. Increasing the number and capacity of clinics in primary health care for the management and follow-up of specific conditions and chronic illnesses.
2. Restructuring and injecting further investment in community services and the primary care sector to increase their capacity to provide a wider range of health and social services, particularly in follow-up and rehabilitation care and to shift more services from the secondary to the primary health care sector. In this way more cases that can be appropriately managed in the latter sector will be devolved from the former which as a result, will be able to cater for more cases and patients on the waiting lists that can only be appropriately managed at this hospital level.
3. Increasing and consolidating the role of the primary health care nurse and the community nurse with the expansion of specialised nurse-led clinics and services. Training nurses in specific chronic disease management particularly in patient education, monitoring of the condition and evaluation of patient's care.
4. Enforcing measures that promote the gate keeping functions of the primary health care sector vis-à-vis the secondary health care sector.
5. Strengthening the delivery of comprehensive, effective and accessible rehabilitation programmes. These will include:
 - a. strengthening and introducing programmes targeted at specific conditions and age groups
 - b. actively pursuing and augmenting the number of professionals working in rehabilitation care services. In particular special attention will be given to the:
 - evaluation and augmentation as necessary of the capacity of the rehabilitation service to provide psychological therapy and social care
 - extending the services of allied health care professionals such as physiotherapists to operate also during weekends to ensure that there is no break in the rehabilitation process.
 - c. where indicated, shifting rehabilitation care and management of chronic non-communicable diseases to the primary health care and community services sector.
6. Updating the management structures of the mental health sector to make them more efficient and oriented towards the community mental health services. More rehabilitative and community services will be provided for suitable patients presently within mental hospitals so as to reintegrate more patients within the community.
7. Providing a dental service that focuses on the needs of the patients particularly in relation to clinical prevention of dental disease and improving the primary dental care services available.
8. Developing dementia specialist units within the community to assess and care for persons with dementia. These units will work in close liaison with the specialist units in the acute general and rehabilitation hospitals. These units will aim towards increasing early diagnosis and intervention, facilitate referrals to specialist care when required.

Other important thrusts will focus on:

9. Improving the responsiveness to demand and tackling waiting lists for health services. Actions will include:
 - a. Increasing and re-structuring the service hours of health care professionals directly working in areas where there are long and persistent waiting lists.
 - b. Increasing the frequency of assessment of patients in the admission wards so that stays are reduced where possible, and patients are transferred more rapidly to settings where they can receive the care that is the most appropriate to their needs. The re-direction policy in the triage area will be further supported and expanded.
 - c. Identifying frequent users especially of emergency services, and analysing the possible causes which are leading these individuals to seek repeated medical and emergency care. One methodology can involve a case management approach to identify and address causes that can decrease the likelihood for crises.
 - d. Seeking to apply for and benefit from all possible opportunities that can help us to procure new or upgrade the sophisticated medical equipment required or available, in different sectors of our hospitals both in Malta and in Gozo. These procurements are needed to increase capacity for an increased workload, introduce new surgical, imaging and other investigative techniques and update the current infrastructure and equipment in use.
 - e. Formalising the fast-tracking of referrals of possible cancer patients from primary to specialist care. This could be achieved by:
 - dedicating slots in specialist out-patients clinics and medical imaging departments for urgent cancer investigations
 - allocating dedicated slots in surgical timetables for urgent diagnostic surgery
 - increasing the capacity (human expertise, equipment and range of investigations available) of the pathology laboratories for the diagnosis of neoplastic disease.
10. Improving partnerships across sectors and disciplines. Actions will seek to develop, support and formalise the development and regular organisation of multi-disciplinary team meetings on specified groups of patients both in the oncology and non-oncology sectors. The work of the multi-disciplinary team on breast cancer which is the only formalised team to date, will be evaluated to help in the better development of newer structures. In this way the care pathways of patients are decided on at this level by all the professionals involved. This pathway will be communicated and its coordination will be liaised with the patient's family doctor. Where appropriate and as much as possible the patient will be involved in the decision-making process involving her/his care pathway.
11. Continuing with the upgrading of the processes in the organisation of human resources and training. Activities will focus on continuing with:
 - a. capacity building, needs assessment and future planning exercises,
 - b. identification of the relevant and changing recruitment drivers and performing changes in the Human Resource recruitment practices accordingly,
 - c. upgrades of collective agreements,
 - d. ensuring job security of health professionals,

- e. structural, administrative and legal changes to consolidate financial and HR governance.



HEALTH AUTHORITIES

The main thrusts will aim at leading, governing and complementing the activities included in the above domains. They will concentrate on:

1. Re-positioning primary health care in the centre of the health care system. The best possible health care for our population that is principally directed toward prevention, early intervention, holistic rehabilitation and support can only be given by, and coordinated from this sector. To ensure the fullest possible effectiveness of this strategic move and maximise use, community trust in primary care facilities needs to be consistently fostered.
2. Investing in the development needed to create a distinct new Rehabilitation Centre that will be able to provide comprehensive in-patient, out-patient and outreach rehabilitation services. The new infrastructure will also include the investment in, and employment of, the latest innovation in ICT especially in assistive technologies. The main aim of the new centre will be to address the acute need for effective and rapid transition of patients from the acute institutional care settings to community-based care thus assisting and maintaining social inclusion and re-integration. New specialisations that will be promoted in this centre will include neuro-rehabilitation and trauma and amputee rehabilitation.
3. Encouraging and supporting the setting-up of patients care pathway coordinators. The patient partner coordinator can be the family doctor although specialized aspects of care can be also coordinated by other specific professionals. Patients will be encouraged to be affiliated with a regular primary care general practitioner or group practice.
4. Further supporting patients and their carers by encouraging and supporting the development of liaisons with relevant voluntary organisations to provide updated information material as well as psychological and other support (such as befriending).
5. Continuing investment, development and incorporation of ICT technologies at multiple levels in the health systems. A strategic plan will be developed that will include the following objectives:
 - a. the myHealth system will be further developed and rendered more user-friendly for patients and service providers
 - b. planning and investing in health ICT that will be geared to bring benefit to the healthcare system as a whole by achieving better health outcomes, increased productivity and cost savings on labour and materials
 - c. empowering health professionals and patients through ICT to facilitate continuity of care, fast and efficient service delivery, patient safety through decision support, and direct patient involvement
 - d. creating and establishing a scalable corporate, robust and interoperable health ICT infrastructure
 - e. further developing and investing in the human capital required that will be empowered to implement a strategic plan on continuous investment and development of health ICT in Malta.

6. Regularly updating the Health Human Resources Strategy to evaluate training and specialisation needs and consequently training received, expertise acquired and the outcomes and benefits to the national health services. The lacunae or 'unmet needs' in the supply of professionals in specific fields will continue to be identified, pursued and actively managed. Evaluation will also need to be performed to assess the effectiveness of staff retaining and re-attracting programmes particularly for staff that is undergoing training abroad or benefiting from family-friendly measures.

These needs will be implemented according to the financial resources that will be made available to the Ministry over the time frame of this Strategy.

7.3 OVERALL OBJECTIVE 3 - A JOINT EFFORT TO ENSURE CONTINUITY OF CARE

Improve quality of care by ensuring consistency of care delivered by competent health workers supported by robust information systems.

ACTIONS TO DEVELOP THE STRATEGIC OVERARCHING ROLE OF INFORMATION AND COMMUNICATION TECHNOLOGY IN HEALTH (HEALTH ICT)

A number of strategic directions and actions have been earmarked to address the growing demand for efficient, effective, and economic application of information and communication technologies (ICT) to Malta's health systems. These actions and tactics are elaborated below.

1. Further development of the myHealth and e-health systems
This will be achieved through:
 - a. Upgrading the myHealth Portal to render it more user-friendly
 - b. Promoting the uptake of myHealth and e-health services
 - c. Increasing the services and data sources available in the myHealth system
 - d. Studying the feasibility of alternative authentication mechanisms for specific services
2. Achieve better value for money by:
 - a. Implementing a comprehensive Stock and Inventory Control system for medicinal products and medical devices, as well as asset management systems for other healthcare system assets
 - b. Digitising paper-based medical records to save on storage, filing and transportation costs
 - c. The National Patient Summary system as the fundamental corner-stone for continuity of care in the delivery of acute care, even in the cross-border scenario
 - d. The migration plan of the Ministry for Health's web portal to a new hosting platform that better supports the provision of information-rich content to patients and the general public
3. Empower health professionals and patients through ICT
Identified strategic directions and actions include the development or further development of:
 - a. A new suite of clinical and administrative applications to support the delivery of care at Government hospitals

- b. An eEntitlement / ePrescription / eDispensing system that spans the whole health care sector and also supports cross-border recognition of prescriptions
 - c. The National Patient Summary system as the fundamental corner-stone for continuity of care in the delivery of acute care, even in the cross-border scenario
 - d. The migration plan of the Ministry for Health's web portal to a new hosting platform that better supports the provision of information-rich content to patients and the general public
4. Create a scalable corporate health ICT architecture. This objective will be achieved through implementing:
 - a. The national health data standards to facilitate the structured storage and sharing of personal health data.
 - b. A legal framework that supports the development of a national electronic health record (NEHR) while protecting the fundamental right to privacy.
 5. Establish a robust and interoperable health ICT infrastructure by:
 - a. Implementing an adequate network infrastructure at all Government health care delivery sites
 - b. Further developing the existing electronic registers of health professionals, in collaboration with statutory councils
 - c. Creating a new hosting infrastructure to support e-health applications
 - d. Working with Identity Malta and MITA to provide reliable and user-friendly identification, authentication and authorisation services to front-line health professionals
 6. Develop Malta's human capital in health ICT. This will entail the:
 - a. Provision of existing health ICT practitioners with the knowledge and skills to work more effectively
 - b. Recognising the status and role of health ICT practitioners through adequate working conditions
 - c. Increasing the national health ICT skills base through specific training initiatives in conjunction with tertiary educational establishments
 - d. Promoting health ICT skills in the general population through information and educational activities based on traditional and social mass media

Strategic Direction 3A

ESTABLISHING STANDARDS WITHIN A PATIENT-CENTERED APPROACH

Setting and enforcing quality standards including licensing and accreditation and development and systematic application of case management protocols.

Ensuring and enhancing a patient safety culture is an integral part of the national health systems. Quality assurance mechanisms are especially important for health systems, transparency and accountability and for fostering people's trust and confidence in the national health systems. This strategy is promoting the consolidation and continuing development of the health regulatory and leadership functions and structures particularly in the sector for the application of quality standards. These will include the enforcement of appropriate standards for, and complements of, health care facilities and equipment, ensuring the availability of qualified and trained professionals that respect and operate within the established professional codes of conduct and best practice care guidelines, and the implementation of a health systems-wide patient safety policy and supporting legislation. The aim is to

foster a learning culture across all health systems both at the level of the individual operator as well as at the systems level such that factors leading to mishaps are corrected and repetitions of reported adverse events are averted.

Furthermore, recognizing patients as a resource and as partners, and being accountable for patient outcomes are important principles. Patients' rights and responsibilities will be defined and endorsed on a national level and citizens will be encouraged and supported to engage more in the role of decision-makers at both the levels of their individual care as well as in the collective public health arena.

All the above and several other developments are feeding into the growing huge demand for efficient, effective, and economic application of information and communication technologies (ICT) to Malta's healthcare system, aimed helping to improve continuity of care. Investment, further development and incorporation of ICT technologies at multiple levels in the health systems is essential in order to succeed in the attainment of all the objectives of this strategy.



INDIVIDUALS, FAMILIES AND COMMUNITIES

A number of measures will be implemented. These include:

1. Raising public awareness about their health rights and obligations and also about the roles, responsibility and rights of health professionals. This awareness raising will also aim towards informing and directing the demand and awareness on patient safety practices and benchmarks.
2. Ensuring that patients are given effective and sufficient information regarding their diagnostic and treatment options to allow them to be active partners with the health professionals in the decision-making process.
3. Providing information and education on the importance for patients and health professionals to follow the agreed care protocols. Where necessary and in accordance with the consent of the patient these initiatives will involve the family/ carers to ensure that the patient has all the support required.



HEALTH PRACTITIONERS

All initiatives are aimed towards increasing standards in professional development. These initiatives will incorporate the documentation of processes involved in providing services inclusive of defined lines of accountability. All health practitioners will be expected to uphold and maintain high standards for patient safety practices and safeguard patients' dignity at all times. Actions include:

1. Consolidating and continuing investment in the provision of training, specialisation and continued professional development of all health professional groups and in raising the standards of all these deliverables (with specified content and levels of competence to be achieved).
2. Continue with the development and implementation of the competency programmes for all groups of health care professionals and pilot a mentoring programme for newly recruited employees. Induction courses for all newly recruited health professionals will continue to be organised.
3. Supporting and encouraging associations of health professionals and medical specialities in their work to further increase the professional standards of their respective group such as in the organisation and coordination of training

and continued professional development, in the development of improved career advancement opportunities and in the upkeep of an updated record of attendance and participation in continued professional development programmes and initiatives for health practitioners in preparation for when this will become a requisite.

4. Increasing the number and upgrading the content of training hours in both undergraduate and post-graduate education in the area of training in 'soft skills'. Particular attention will be given to communication skills, ethical decision-making and an ethical approach to disease management, ability to discern patients' goals and expectations and the correct application of 'informed consent'. This strategy aims at achieving an across the board greater appreciation of the importance of 'soft skills' in the practice of health professionals.
5. Encouraging and supporting experienced health professionals to take up the role of professional trainers and mentors of specialist trainees. There will be special emphasis for the area of family medicine.
6. Educating health professionals working in community medicine especially family doctors and community nurses to be on the alert for, and aware of, processes for reporting any abuse encountered when visiting patients being cared for in institutions and in the community.
7. Empower health professionals and patients through ICT systems that will be developed to facilitate continuity of care, fast and efficient service delivery, patient safety through decision support, and direct patient involvement.
8. Developing planning and co-ordination frameworks for the creation of care pathways that encompass patient movement from acute, to rehabilitation, to primary care. These pathways will include the roles of both formal and informal carer support in the community. The earmarking of a key worker also needs to be considered. A 'key worker' or patient coordinator can be an instrumental strategy to help decrease duplication and to help patients who can otherwise be overwhelmed with input from several health professionals. The key worker can be a medical doctor, a nurse, an allied health professional or perhaps a social worker depending on the specific needs and circumstances of the patient.



HEALTH CARE ORGANISATIONS

The main thrusts will be in the implementation of a strategy or strategies to foster the culture for patient safety. These strategies will be compliant with the legislation and other policies that will be published to deal with this very important matter. The main activities will centre on:

1. The development, implementation and coordination of procedures for the reporting on quality indicators to enable international benchmarking for standards, and in particular of patient safety standards in primary, secondary and long-term care. The appropriate structures needed to evaluate reports, issue recommendations for improvements and changes to the systems that are found to have unacceptable risks for, or levels of patient safety, and follow-up the implementation and evaluation of these changes will be consolidated or created.
2. Increasing, updating, implementing and monitoring the use of national clinical guidelines for as many different diseases and groups of diseases as possible. These will include referral pathways to the competent specialist services. Investment will be expended to create and support the appropriate structures that can lead and oversee these activities. Quality assurance and performance monitoring of operations such as laboratory and imaging processes will continue to be instituted.



HEALTH AUTHORITIES

The main thrusts will focus on:

1. Concluding and bringing before Parliament legislation concerned with patient safety. The acquisition of the resources needed for the education to raise awareness and knowledge about this legislation, and to ensure its enforcement will be acquired
2. Implementing the provisions of the newly enacted Mental Health Act (2012).
3. Increasing the capacity of, and the expertise, in the structures responsible for the creation and enforcement of standards in health care facilities and of care protocols and practices. The expansion of and progress on the work of these structures have so far been hampered by the unavailability of adequate resources. One of the aims will be to increase the frequency and the spread of the regular inspections on public and private health care and long-term care facilities so that it is ensured that standards of care are maintained and continuously improved.
4. Increasing and supporting structures assigned with conducting health technology assessments for new pharmaceuticals and technologies.

Strategic Direction 3B

SAFE, HIGH QUALITY, AND EFFICIENT SERVICES

Facilitating continuity of care through co-ordination and integration within and between service provider teams, and improving communication and sharing of information.

Continued quality development and performance enhancement of the health services can only be achieved if the activities of the different players in the care delivery pathways are integrated so that continuity of care is ensured and patients are not 'lost' in any part of the system. The ultimate aim is to introduce a seamless process of care for any particular patient between community, primary, secondary and institutional care, between the private and public health care sectors and where necessary between the health care and the social care services. This strategy will be strongly reinforcing the role of primary health care as the cornerstone of the national health system. Service delivery will be relocated as close to home as is safe and cost-effective, patients will continue to become more empowered to undertake self-care practices and the potential of personalised medicine will be promoted.



INDIVIDUALS, FAMILIES AND COMMUNITIES

Actions revolve around the following thrusts:

1. Encouraging and introducing more facilities and technologies that enable access to investigations and other relevant documents such as hospital discharge summaries. Access to this information is the prerogative of the patients and should be available wherever the patient can request advice and receive care. This will be achieved through:
 - a. ongoing education to the members of the public on how these technologies can be used and to whom they can give access.
 - b. ongoing information to the health professionals on how to apply these technologies such as whenever there is joint care of the patient for the optimisation of the benefit to patient care and follow-up.

- c. supporting the implementation of clearer management of information sharing procedures between the primary and secondary health care systems.
2. Following the patient's consent, informal carers (particularly family and friends) will be encouraged and supported, to increase their involvement where necessary, in particular in rehabilitation care. This can be carried out in different ways such as by the dissemination of relevant written information and the invitation to accompany the patient where appropriate.
3. Facilitate and support the inception of more self-help and patient support groups. These groups offer support to patients and their families such as through befriending and advice on self-care post-diagnosis and treatment. New groups may be assisted to introduce and foster contacts with associations representing similar groups of patients and working towards similar aims in other countries and at the EU level.



HEALTH PRACTITIONERS

The major thrust will be in the provision and empowerment of primary health care professionals to engage in:

- a. the support of informal carers.
- b. furthering skills and knowledge in specialist areas such as sexual health, palliative care, dementia care and health promotion.
- c. opportunities for networking between all health professionals working in particular specialised fields
- d. the establishment and maintenance of better communication and liaison channels between the different players involved in particular care pathways.



HEALTH CARE ORGANISATIONS

A major thrust will focus on increasing the multi-disciplinary approach in all the services given by the national health system.

1. New services will be introduced in conjunction with a multi-disciplinary approach and backing. Furthermore, new multi-disciplinary teams for more diseases or disease groups will be introduced. This necessitates that:
 - a. all the professions that can contribute to improve the patient care pathway will be required to regularly attend and actively participate in these meetings. Where appropriate professionals from outside the health sector such as social workers will also be required to attend and participate.
 - b. the necessary resources such as appropriately equipped meeting venues, administrative and ICT support, and protected time to allow attendance to these meetings will be provided.
 - c. the engendering of attitudes that will reinforce the value of these teams and the benefit of discussing and implementing the care pathway for a patient taking into view the roles and responsibilities of all the professionals involved at multi-disciplinary team meetings.

Other foci for attention include:

2. Strengthening the treatment abroad services structures so that it can continue to consolidate services for the:
 - a. transfer of patients abroad, continuation of care of these patients on their return to Malta,

- b. organisation of visiting consultants' sessions,
 - c. request for specialised services and expertise from centres of excellence abroad (including specialised laboratory services),
 - d. sharing and mobility of expertise between professionals working in Malta and in centres abroad. These can take the form of external visiting lecturers, enrollment in electronic training programmes, exchange programmes and practical training exercises such as in quality assurance skills.
3. Developing a new service to address acute psychiatric care needs in the geriatric population. Older persons can have multiple co-morbidities, poly-pharmacy and complex care needs. They can develop psychiatric and social care needs that require specialised care settings and services. Appropriate care delivery will prolong patient independence, enable earlier discharge from hospital and prevents premature and unnecessary admission to long-term residential care. This new service will involve the creation of an infrastructure that will include a new facility within the Mater Dei hospital footprint. The new acute geriatric service will offer comprehensive geriatric assessments through a coordinated multi-disciplinary care approach in which mental health services will have a prominent and integral role.
 4. Educating health professionals on the correct completion of documents that will move to other professionals with the patient such as referral and hospital discharge forms. The value of these documents will be stressed, in particular by emphasising the influence that the standard of the information they contain will determine the progress along the care pathway. The facilities to further develop the electronic mobility of these documents and to widen access to all professionals that will need to view them will be made available.
 5. Continuous training and re-training of health care professionals to make sure that professionals are receiving up-to-date information and delivering services that are deemed to be truly patient-centred and good practice.
 6. Extending IT services that are inter-operable within and between health care facilities with new systems that span the whole healthcare sector. These systems will pave the way for further communication possibilities such as on-line ordering, tracking of medicinals and medical devices, e-entitlement, e-prescribing and e-dispensing.



HEALTH AUTHORITIES

The main thrusts will aim at leading, governing and complementing the activities included in the above domains. They will concentrate on:

1. Promoting multi-disciplinary working in all aspects of the national health services and providing for the necessary infrastructure and support to ensure the dissemination of this approach.
2. Increasing collaboration between the vocational training institutions for health and social care workers and the health and social care authorities (including the relevant regulatory structures) to ensure the upholding and up-skilling of an appropriately skilled carer workforce.
3. Increasing the take up in the use of ICT technologies that assist in the dissemination of information on patients to ensure continuity of care and to facilitate decision-making both by the patients and the health practitioners.

7.4 OVERALL OBJECTIVE 4 – WORKING TOWARDS SUSTAINABLE HEALTH SYSTEMS

Ensure the sustainability of the Maltese Health Systems.

Strategic Direction 4A

INTEGRATED PLANNING AS AN ESSENTIAL PART OF SUSTAINABLE HEALTH SYSTEMS

Designing, developing and evaluating sustainable policies on targeting human resources, financing mechanisms, entitlement criteria for care and organization of care delivery.

The opening of new Mater Dei Hospital, a state of the art hospital, has resulted in an unexpected shift of a significant number of people and demand for services from the private to the public health care system. This, together with the ageing population is putting an increasing burden on the public health system which delivers its services free of charge at the point of use. Emphasis will be placed on economic and cost-effectiveness evaluations of any new initiatives. Existing services will also be increasingly evaluated to ensure they are being delivered efficiently. The rationale for these activities centres on the intention that the current population will be allowed to continue enjoying the benefits offered by our health system and possible consequences such as unnecessary financial burdens will not have to be imposed on future generations.



INDIVIDUALS, FAMILIES AND COMMUNITIES

The main activities will concentrate on informing the general public about services and medicines that are available as part of the public health care package and the entitlement criteria and procedures to be used when applying for these services and medicines. Work will focus on:

1. reducing the number of applications submitted from people who are not entitled for these services,
2. re-designing and implementing a new customer care setup that will be able to assist people seeking the necessary support and guidance for queries related to service delivery.



HEALTH PRACTITIONERS

Special attention will be given to:

1. Information campaigns designed to inform health care professionals on their obligations towards ensuring careful decision-making to ensure the best possible use of the health care system.
2. Assist health professionals in the promotion of personal self-management and self-care in order to deal with stressors that they may encounter at the place of work and to enable employees to maintain a good and healthy work-life balance. Activities will emphasise the importance of maintaining the health and well-being of health workers both physically and mentally, so that they will function to the best of their abilities and ensure their highest level of competence. The aim is to optimize the effectiveness of the health workforce. The necessary infrastructure including access to psychological support services will be provided to address stress and burn-out of staff working within the health care system. This is especially important in those areas where the staff is all the time dealing with critically-ill or terminally-ill patients.



HEALTH CARE ORGANISATIONS

Activities will include:

1. Improving financial control within organisations by increasing accountability and transparency. An example could be through the provision of billing information to both the health care provider and the health care user to increase awareness of costs incurred and promote efficiency.
2. Promoting a management model that enhances and welcomes staff participation in the overall management of the organisation within an environment that welcomes innovative ideas aimed towards delivering a more efficient, and a high quality service.
3. Continuing in the introduction and enforcement of performance assessment systems that can effectively monitor the operations and outcomes of clinical activity. These systems will also be utilised to assess and determine expenditure targets and benchmarks.
4. The efficient use of resources will continue to be aggressively pursued through processes such as business re-engineering to improve systems and operations where change is deemed necessary following systematic evaluation of performance and needs assessments for the identification of skills that require acquisition or upgrading so as to inform the design of the necessary training and changes to the job profiles of staff working with the health services.
5. Strengthening and enforcing legislation and legal infrastructures that promote and sustain innovation and that foster the application of whole-of-society approaches particularly in policy development.



HEALTH AUTHORITIES

The main thrusts will be devoted towards ensuring better oversight, management and co-ordination of supplies, resources and services provided to ensure that timely access is achieved when patients require a service. This requires the development of health ICT systems that will be coordinated through a corporate architecture based on agreed policies and standards, to facilitate the controlled sharing of data and resources, achieve value for money and lay the basis for research and development. Actions will include:

1. Creating a centralised Waiting List Management System that includes the waiting lists of all the departments and for all the services offered by the health system.
2. Seeking and embarking on public-private and public-social partnership schemes and initiatives that can be demonstrated to be value-adding, and to ensure a sustainable service. These agreements necessitate an intense level of constant monitoring and evaluation of outcomes in order to continuously ascertain that services provided are efficient and that value-for-money is guaranteed.
3. Seeking and embarking on agreements with the private health insurance sector to foster increases in the uptake of private health insurance policies by the population. These agreements will need to be geared towards assuring that a major outcome of the increased uptake results in consolidating the sustainability of the national health system.

4. Studying the suitability of new or alternative revenue streams that can be used to supplement the financing of the national health system. On the other hand, any revenues due to the national health system need to be more aggressively pursued so that the collection of these funds is performed in a more timely and comprehensive fashion.
5. Ensuring that maximum reference prices are set and implemented when new medicines are introduced into the Government formulary. Stakeholders will be consistently engaged to ensure fair pricing. Procurement practices will continue to be evaluated and improved to continuously improve their reliability and dependability.
6. Streamlining the entitlement process and criteria for the different services to try to make these pathways more efficient.
7. Revising the community services and long-term care entitlement process and criteria to make them more focused towards those people that need these services most.
8. Devising systems that can manage the barrier between public and private care by investing in the necessary information technology and human resources, to improve communication between these two sectors. This should achieve a higher standard of care by enhancing continuity of care and enabling better care in the community.
9. Collecting more granular financial health information from the public health system in order to provide better estimates for planning and budgetary calculations. Better planning can lead to better prioritisation of future investments and more efficiency in the use of health care service funds thus releasing some funds to allow the continuity of other important services ancillary to health care such as certain social services.

These needs will be implemented according to the financial resources that will be made available to the Ministry over the time frame of this Strategy.

Strategic Direction 4B

IMPROVING LEADERSHIP AND PARTICIPATORY GOVERNANCE FOR HEALTH

Improving governance and empowering future leadership for health and well-being to influence national decisions through whole-of-government and whole-of-society approaches. Within the healthcare systems and the whole healthcare workforce, the concepts and implementation of measures to stimulate, increase and support clinical governance and medical leadership will be applied.

Actions will be taken to improve leadership and participatory governance towards health. Whole-of-government activities will be embarked on which are multi-level (from local to global) government actions, which increasingly also involve groups outside government.⁽²⁴⁾ This approach requires building trust, common ethics, a cohesive culture and new skills. It stresses the need for better coordination and integration, centred on the overall societal goals for which the government stands. More advocacy will be engaged to emphasise the concept of health in all policies so that all sectors will understand and act on their responsibility for health while recognising how health also affects other sectors.

Governance and leadership will devolve beyond the Ministry's level. It will be reinforced also at societal level through whole-of-society approaches that will complement public policy. Various tactics and actions will be taken to secure coordination through normative values and trust-building among a wide variety of stakeholders. Responsibility, ownership and accountability will remain strong assets within this strategic management plan that will require various changes to be implemented. A well equipped complement of trained professionals will be needed to take on board these challenges.



INDIVIDUALS, FAMILIES AND COMMUNITIES

The main thrust of action will be to ultimately increase the general public's confidence and trust in primary care. Nationwide promotion campaigns will be designed to ensure that people can clearly differentiate between primary and hospital care. This can be achieved if the public is well informed and educated about the different services offered by the different health care departments. As a result, people will:

- a. increase their use of the primary health care level as their first port-of-call of choice for advice
- b. seek specialist care only when required
- c. base their decision of whether they should initially seek primary or specialist care more on the severity and urgency of their signs and symptoms



HEALTH PRACTITIONERS

Activities will concentrate on assisting health professionals to provide better support for informal carers. Examples include:

1. More research in this area in order to identify the needs of the informal carers so as to create innovative solutions to address these needs.
2. Allowing more adjustable working conditions for formal carers, such as flexible hours, to meet the needs of informal carers.
3. Encourage health practitioners to seek and take up medical and clinical leadership and shared leadership roles. Medical Leadership (and followership) in a context also of shared leadership, has been identified as being critically important in the implementation of change, quality of care and patient safety.



HEALTH CARE ORGANISATIONS

Actions will concentrate towards:

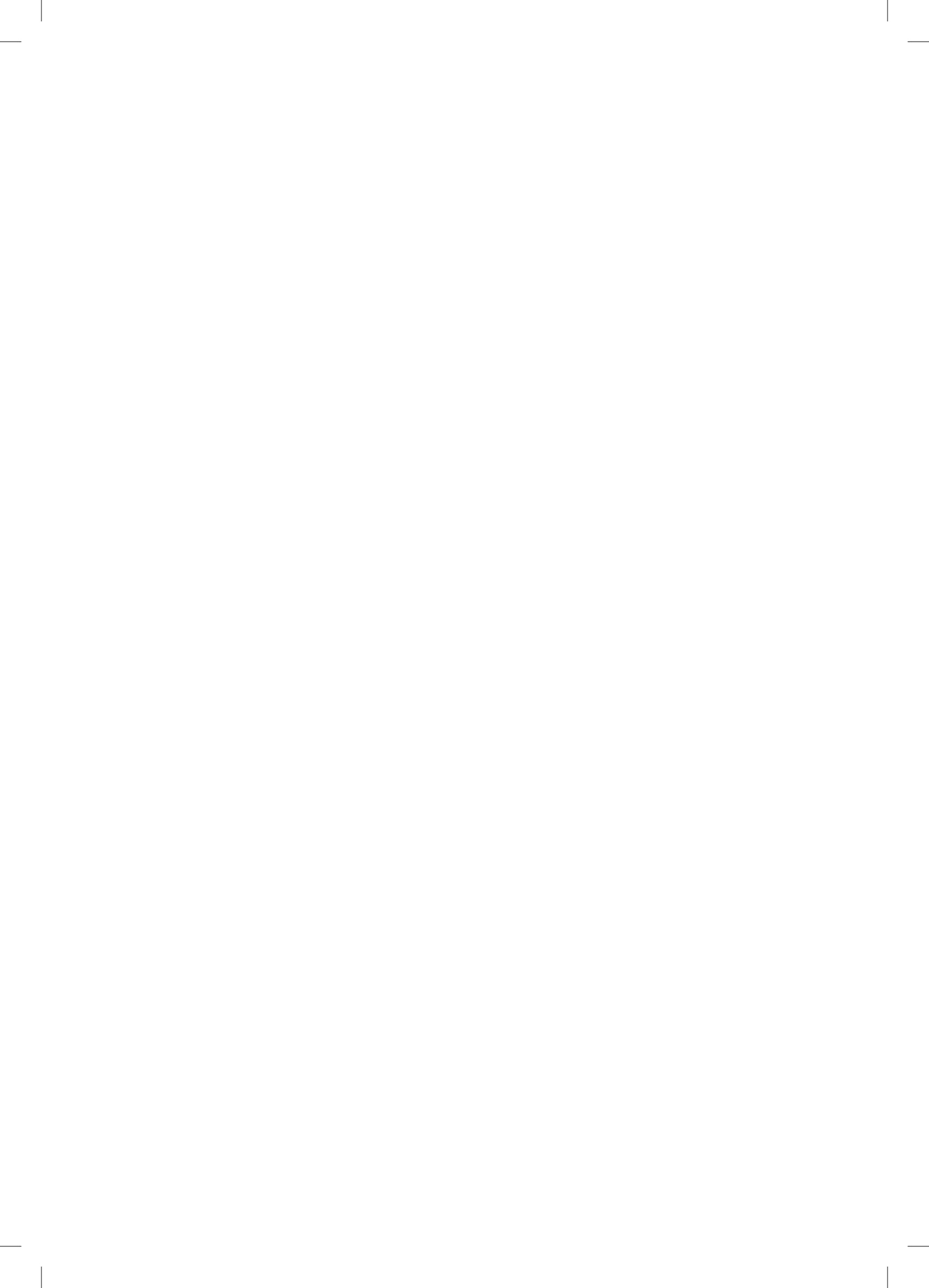
1. Providing extensive training and development of leadership skills at different levels of management for health care employees. Clinical leadership and governance are necessary at macro level, where appointing different health professionals to leadership roles provides vision, direction, and leverage of culture and climate; middle levels where a constellation of leaders are required to support change; and in clinical microsystems, where leadership is recognised as crucial to achieve performance at high levels.
2. Ensuring good governance and efficient management of resources within the Health System. This will include better utilisation of external funding for capital outlay.
3. Enabling the primary care sector to better perform its role as a gatekeeper and as an equal partner to specialist and secondary care.



HEALTH AUTHORITIES

Several activities are included. The aim is to:

1. Provide departments with the necessary technological, administrative and managerial support in order to allow them to work in harmony with each other and to collect the data they need in order to monitor their performance and become more efficient.
2. Deploy the necessary infrastructural and capital investments especially in the areas of IT and communications systems, with a focus on e-medicine. With the increasing movement of people between countries, this area has gained increasing relevance and importance. Towards this end, an effective standards framework is needed to support interoperability of health records across sectors and between different healthcare provider facilities and it needs to be ensured that documentation and data capture needs to be done at, and from all points of care.
3. Provide better value for money for the investment and resources required to cater for the health of the population by establishing a set of core indicators that can be regularly monitored in order to measure the performance of health care professionals, the money invested and the improvement in the health of the population and other desired health outcomes. Clear measures are needed to establish how the resources invested, are being translated into better quality of life for the general public.
4. Co-ordinate and converge services provided by the public and private sectors within a national strategy so as to prevent duplication of resources, integrate healthcare services to provide seamless continuity of care, and ensure synergy towards national objectives.
5. Increasingly seek to engage in initiating inter-sectoral approaches for health and acting as health brokers and advocates. This will include strengthening involvement through the exercise of leadership, diplomacy and persuasion skills to better highlight the economic, social and political gains that can be accrued from good health and the detrimental effects of ill health and inequalities on every sector.



Governance of the National Health Systems Strategy

8.1 INTRODUCTION

Governance in health is a cross-cutting theme, which is intimately connected with issues surrounding accountability. There is widespread consensus on and increasing appreciation of the importance of governance in improving outcomes and it can be divided into at least four major components, including:

1. health information systems
2. health financing
3. human resources for health
4. health service delivery

The growing importance given to issues of governance is driven by the need for greater accountability. This interest is arising from both the increased funding of health and health care systems as well as the growing demand by stakeholders to demonstrate results.

Governance and accountability are concerned with the management of relationships between various stakeholders in health. These include individuals, households, communities, governments, non-governmental organizations, private firms, and other entities which have the responsibility to finance, monitor, deliver, and use health services. Specifically, accountability is involved with:

- a. an understanding (either implicit or explicit) of how services will be supplied;
- b. an assurance that adequate financing and resources are available to deliver services;
- c. an assurance of the level of quality and performance of the services actually delivered;
- d. the receipt of relevant information to evaluate or monitor performance;
- e. the enforcement of actions such as the imposition of sanctions or the provision of rewards for performance⁽⁵⁹⁾

8.2 THE BUDGETARY FRAMEWORK

The national expenditure on the health system is and will continue to be a substantial budgetary item of the National Budget into the foreseeable future. The NHSS is a strategic plan of objectives, strategies directions and actions that include reforms and investments aimed at getting more value for money and promoting smarter spending so that more and better health outcomes are secured and potential savings are realised.

The adoption and implementation of the NHSS is dependent on the budgetary framework within which the national health system will be funded over the next few years. Any changes in the expenditure on health are in turn dependent on the national growth and within the forecasted trends for the national revenue and expenditures. The medium-term budgetary plan for the health sector will be monitored by the EU Commission in the light of the Country-Specific Recommendations ⁽⁶⁰⁾ that in 2013, identified issues such as the:

- long-term sustainability of public finances and the need to improve the efficiency and reduce the length of public procurement procedures
- implementation of a comprehensive active ageing strategy, and the strengthening of the public primary care provision
- need for health-care reforms to increase the cost-effectiveness of the sector and the monitoring of health system performance.

An action plan complemented with a budgetary framework for the implementation of the NHSS will be concluded after the completion of the consultation phase and publication of the finalized NHSS. It is envisaged that the methodology that will be employed to determine this budgetary framework will include a:

- a. 'top-down' approach to show the rates at which the national health budgets need to grow to sustain changes in demand for health services under different scenarios
- b. 'bottom-up' approach that attempts to illustrate the potential effects of different strategic directions and measures included in this strategy to influence the rates of the predicted increases in health expenditure and register improvements in health outcomes.

8.3 IMPLEMENTING THE NATIONAL HEALTH SYSTEMS STRATEGY

The overarching aim of this strategy is to clearly demonstrate and document the national Government's intent to continuously improve the responsiveness, adequacy, quality and sustainability of the national health systems. The NHSS sets the strategic roadmap for the achievement of the objectives and directions that have been identified as key towards the realisation of the above goals. Several of the actions included in this strategy will require the investment of sizeable amount of resources which include financial, administrative, human and technological resources and expertise.

The capital investment required for the realisation of a number of the measures included in the NHSS will be sought through the application for and the implementation of relevant EU co-funded streams and projects. Some of the measures aim at generating savings from the recurrent expenditure of the national health system through

increasing operational efficiency. Others promote or seek to introduce new processes and structures that will augment and ensure the sustainability of the system. Finally, this strategy includes measures that will involve the re-engineering of procedures according to evidence-based good practices. These measures will be implemented to help contain the increase in health care expenditure which will be mainly driven by the ageing of the population.

Funding will be sought for the dissemination and the promotion of the NHSS. The NHSS will need to be promoted widely so that all stakeholders will be informed and will be able to identify and uphold its principles and values.

8.4 MEASURING HEALTH SYSTEMS PERFORMANCE

To achieve improvement and development of the national health systems and to ensure access to quality health services and economic sustainability within the available budgetary resources, the national health systems strategy needs to have an effective and sustainable monitoring and review system. Hence, actions taken in the context of the future health systems strategy will continually and consistently monitored and assessed through the introduction of a Health System Performance Assessment (HSPA). The HSPA will be an integral part of the NHSS. It will be used to monitor the implementation, progress and achievements of the strategy.

The design and implementation of the HSPA takes into account several aspects and requires extensive consultation with different stakeholders with the aim of achieving a national consensus on the focus and the processes that this monitoring and assessment system will involve. The general focal points and special features of the HSPA for the national health systems in Malta include:

- An indicator network that needs to encompass and incorporate (or extend to) indicator frameworks for the area-specific strategies due to the several disease or area-specific health strategies that have been or are being developed. This will be an effective way to further ensure the integration of these vertical strategies with the new overarching health system level strategy.
- Aims to use existing and routinely collected data as much as possible. Indicators included will be selected on the basis of their relevance as well as the extent that the required data can be realistically collected and aggregated and reaches relatively high levels of reliability and validity.
- The requirement to assimilate the monitoring of the implementation of the NHSS within the present structures of health information, monitoring and surveillance.
- A performance monitoring system that covers all parts of the health systems, such as health care services, health promotion and protection and public health and also includes perspectives beyond the health context including the national economic and financial situation and the sectors of education, employment and social services.
- A framework that is directly linked with the governance systems and tools used for health care in Malta.
- The need for targeted capacity building to ensure institutionalisation and sustainability of the performance assessment processes and functions. The capacity of the local team and other interested persons need to be increased so that they can carry out the HSPA and ensure further development that will allow for a sustainable impact of the project.
- A communication strategy and different types of reports/output documents developed for different stakeholders such as policy makers, general public, health care providers, and health professionals.

The development and implementation of the HSPA involves several activities. These include the mapping of existing indicators, setting realistic targets for all strategies, mapping existing targets and goals to a theoretical health systems framework, performing an inventory of existing data sources, mapping areas where no data is available, building a set of ideal indicators as an input for developing the collection of data in the country, and finally developing and agreeing on benchmarks (goals, change over time, country comparisons, etc.) for assessment of performance.

8.5 STEERING THE IMPLEMENTATION OF THE NATIONAL HEALTH SYSTEMS STRATEGY

A steering committee will be established to monitor and coordinate the implementation of this strategy and to ensure timely and robust action across the strategy's various strands. Membership will include representation from the main stakeholders that will be responsible for the implementation of the various measures in the strategy. Such representation may extend beyond the Ministry responsible for health, in line with the whole-of-government and whole-of-society approaches proposed in Overall Objective 4.

1. To steer the process of implementation of the different actions in the strategy
2. To monitor the progress in the implementation of the different actions of the strategy and in the attainment of the four objectives of the strategy
3. To monitor the acquisition of the necessary resources and keep track of the expenditure for the implementation of the strategy.

The steering committee will conduct its work on behalf of the Minister responsible for Health. All entities falling within the Ministry's remit will be bound to submit reports on the progress achieved and/or on action plans and/or financial accounts in relation to any of the measures of the strategy upon request by this committee.

The committee will commission scientific studies to acquire updated information and analysis on the status of the key actions and indicators of this strategy with a view to accomplishing the requirement for an ongoing monitoring of the achievement of the objectives of the strategy. A sustained health systems performance assessment, repeated at regular intervals, will be the cornerstone of such a monitoring strategy.

All information gathered by the committee will be used to compile and issue a mid-term review and an end-of-term evaluation of the progress achieved in relation to the health system development and performance up to and beyond 2020.

References

1. Goodwin, N. *Leadership in Healthcare: A European Perspective*. Abingdon : Routledge, 2005.
2. National Statistics Office. *Demographic Review 2010*. Malta : National Statistics Office, 2011.
3. World Bank. World Development Indicators.
[Online] 2012. <http://data.worldbank.org/country/malta>. Accessed on 28.05.2014
4. National Statistics Office. *Census of Population and Housing 2005*. Malta : National Statistics Office, 2007.
5. WHO Regional Office for Europe. European Health for all Database (HFA-DB).
[Online] 2012. <http://data.euro.who.int/hfadb>. Accessed on: 29.05.2014
6. Directorate for Health Information and Research,. *National Mortality Register, Annual Report 2010*. Malta : Directorate of Health Information and Research, 2014.
7. Berrino, F., et al. *Survival for eight major cancers and all cancers combined for the European adults diagnosed in 1995-99: Results of the EURO CARE-4 study*. 2007. pp. 773-783.
8. Verdecchia, A., et al. *Recent cancer survival in Europe: a 2000-02 period analysis of EURO CARE-4 data*. 2007. pp. 784-796.
9. Infectious Disease Prevention and Control Unit. Annual Report 2012. 2013.
10. Eurostat, European Commission. Body mass index (BMI) by sex, age and educational level (%) - collection round 2008.
[Online] 2012. http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_de1&lang=en. Accessed on 29.05.2014
11. Currie, C., et al. *Inequalities in young people's health. HBSC international report from the 2005/2006 survey. Health Policy for Children and Adolescents*. Copenhagen, Den : WHO Regional Office for Europe,, 2008.
12. Directorate for Health Information and Research. *European Health Examination Survey (EHES) pilot study 2010*. Malta : s.n., 2012.
13. Eurostat, (European Commission). Proportion of people reporting one or more disease, by disease, sex, age and educational level (%) - collection round 2008. 2014. Accessed on 29.05.2014
14. European School Survey Project on Alcohol and other Drugs. *The 2011 ESPAD report*. 2012.
15. Directorate for Health Information and Research. National Obstetrics Information System - Annual Report 2011. s.l. : Directorate for Health Information and Research, 2012.

16. WHO. National Health Accounts - Global health expenditure database. World Health Organisation. [Online] http://www.who.int/nha/expenditure_database/en/. Accessed on 29.05.2014
17. Directorate for Health Information and Research. *European Health Interview Survey 2008*. Malta : Ministry for Health, 2008.
18. Eurostat, (European Commission). *Health care: indicators from the SILC survey (from 2004 onwards)*. 2013. Accessed on 29.05.2014
19. WHO. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. 2007.
20. Attwood, M., et al. *Leading Change: A guide to whole systems working*. Bristol : The Policy Press, 2003.
21. United Kingdom Department of Health. *Healthy Lives, Healthy People: Our strategy for public health in England*. 2012.
22. Marmot, M. *Fair Society, Healthy Lives. The Strategic Review of Health Inequalities in England post 2010 (The Marmot Review)*. London : University College London Institute of Health Equity, 2010.
23. Department of Health, Ireland. *Healthy Ireland: A framework for improved health and wellbeing 2013-2025*. Dublin : Department of Health, Ireland, 2012.
24. WHO Europe 62nd Regional Committee. *2020: a European policy framework supporting action across government and society for health and well-being*. Malta : World Health Organisation, 2012.
25. South, J., White, J. and Gamsu, M. *People-centred Public Health*. Bristol : The Policy Press, 2013.
26. WHO Regional Office for Europe. *Community participation in local health and sustainable development. Approaches and techniques. European sustainable development and health. (series 4)*. Copenhagen : s.n., 2002.
27. Couillard, P. *The Canada we want in 2020, Lessons from 2004, perspectives for 2014; Securing our health system for the future*. 2011.
28. European Council. *Council Conclusions on Common Values and Principles in European Union Health Systems, OJ 2006/C 146/01*. 22.6.2006.
29. European Commission. *Social Investment Package, Commission Staff Working Document, Investing in Health, European Commission*. 2013.
30. World Economic Forum. *World Economic Forum, Harvard SThe Global Economic Burden of Non-Communicable Diseases*. s.l. : Harvard School of Public Health, 2011.
31. OECD, (Organisation for Economic Co-operation and Development). *Obesity and the economics of prevention: Fit not fat*. 2010.
32. WHO. *Global status report on non communicable diseases*. s.l. : World Health Organisation, 2011.

33. OECD, (Organisation for Economic Co-operation and Development). *Health at a Glance: Europe 2012*. s.l. : OECD Publishing, 2012.
34. European Commission. European Community Health Indicators (ECHI). 2013.
35. European Commission. General provisions and regulations for the European Regional Development Fund (ERDF), the European Social Fund (ESF), the European Agricultural Fund for Rural Development, the European Maritime and Fisheries Fund and the Cohesion Fund (2007-2013). 2006. Vol. 1083.
36. European Commission and Economic Policy Committee, European Economy. Joint Report on Health Systems . Brussels : s.n., 7.12.2010. Vol. Occasional papers 74, 3054th Council meeting - Economic and Financial Affairs.
37. WHO. *The World Health Report — Health systems financing: the path to universal coverage*. 2010.
38. Economic Policy Committee and European Commission (DG ECFIN). The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long term care, education and unemployment transfers (2004-2050). s.l. : European Commission DG Economic and Financial Affairs, 2006.
39. European Commission. *White Paper - Together for Health: A Strategic Approach for the EU 2008-2013*. 2007.
40. Eurostat, (European Commission). Eurostat - Statistics Database. *European Commission*. [Online] <http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics>. Accessed on 29.05.2014
41. WHO. *Highlights from the Health Behaviour in School aged Children*. s.l. : World Health Organisation, 2010.
42. WHO. *Health Behaviour in School Aged Children 2006*. s.l. : World Health Organization, 2006.
43. Health Promotion and Disease Prevention Directorate. Number of classes and number of participants at smoking cessation clinics organised by the health promotion unit. Ad hoc data. 2013.
44. WHO. The WHO MONICA project: Multinational MONItoring of trends and determinants in Cardiovascular disease. [Online] 2013. <http://www.thl.fi/monica/index.html>.
45. WHO. *Health behaviour in school-aged children 2010*. s.l. : World Health Organisation, 2010.
46. International Diabetes Federation. Diabetes Atlas, 4th Edition, 2009 [Online] <http://www.idf.org/sites/default/files/da5/IDF%20Diabetes%20Atlas%204th%20edition.pdf>.
47. Directorate of Health Information and Research. Malta National Cancer Registry. 2012.
48. OECD, (Organisation for Economic Co-operation and Development). *Society at a Glance, 2009*. [Online] May 2009. http://www.oecd-ilibrary.org/social-issues-migration-health/society-at-a-glance-2009_soc_glance-2008-en.
49. Directorate for Health Information Research. National Hospitals Information System. 2012.
50. Office of the Chief Medical Officer. Treatment Abroad Section. Ministry for Health, Malta, 2013.
51. National Screening Unit, . adhoc statistical data. s.l. : Ministry for Health, Malta, 2013.

52. WHO Regional Office for South-East Asia and WHO Regional Office for the Western Pacific. *People at the centre of health care: harmonizing mind and body, people and systems*. Geneva : World Health Organization, 2007.
53. Balint, M., et al. *Treatment or Diagnosis. A Study of Repeat Prescriptions in General Practice*. London : Tavistock Publications Ltd, 1970.
54. Committee on Quality of Health Care in America - Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century* . s.l. : Institute of Medicine, 2001.
55. WHO. *Innovative care for chronic conditions: Building blocks for action*. Geneva : World Health Organization, 2002.
56. Glover, V. *Journey to Wellness: Designing a People-Centred Health System for Canadians*. Canada : Hushion House Publishing Limited, 2005.
57. International Alliance of Patients' Organizations. *What is Patient-Centred Healthcare?: A Review of Definitions and Principles*. London, United Kingdom : IAPO, 2005.
58. WHO Regional Office for the Western Pacific. *People at the Centre of Care Initiative*. World Health Organization, 2006.
59. World Bank. *World Development Report 2004: Making Services Work for Poor People*. Washington D.C. : World Bank and Oxford University Press, 2004.
60. Eurostat, OECD, World Health Organization. *A System of Health Accounts: 2011 Edition*, : OECD Publishing., 2011.
61. National Statistics Office. *Census of Population and Housing 2011*. Malta : National Statistics Office, 2014.