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National policies for healthy ageing: the Maltese experience

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Abstract
Public policy in Malta is strongly geared towards improving the levels of healthy ageing of present and incoming cohorts of older persons. Ageing policy in Malta follows the European Commission's document Guiding Principles for Active Ageing and Solidarity between Generations which underlined how societies must not be solely content with a remarkable increase in life expectancy, but must also strive to extend healthy life years, and then to provide opportunities for physical and mental activities that are adapted to the capacities of older individuals. The government of Malta employs 14 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics – for example, on memory, falls, and continence. This means that there is a consultant geriatrician for every 7,948 persons aged 60-plus, which compares well to other European Union nations such as Germany (7,496), Spain (7,701), United Kingdom (8,871), and Switzerland (9,250). At the same time, the Maltese government has launched the National Strategic Policy for Active Ageing, National Dementia Strategy, and the Minimum Standards for Care Homes in Malta all of which include a range of recommendations that aim to lead older persons towards higher levels of healthy ageing.

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Introduction

Transforming society's perception of ageing from one of an expectation of dependency and decline to that of an opportunity to actively participate in the labour market and society requires a paradigm shift that enables higher levels of healthy ageing. Respecting the rights of older persons to lead a life of dignity and independence, and to participate in social and cultural life, Maltese national policy caters for the creation of the necessary conditions that allow older persons to remain full contributing members of society rather than assuming a role of dependency. Ageing policy in Malta follows the European Commission's (2012a) document *Guiding Principles for Active Ageing and Solidarity between Generations* which underlines how societies must not be solely content with a remarkable increase in life expectancy, but must also strive to extend healthy life years by providing opportunities for physical and mental activities that are adapted to the capacities of older individuals. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages enables older persons to lower their probability of illness and disability, whilst aiding them to ensure high physical and mental functioning that fosters independent living. This paper presents key developments in Maltese public policy related to healthy ageing. Following this brief introduction, the subsequent section highlights the range of public geriatric services. The third to fifth sections focus on policies which were launched and implemented precisely to improve the levels of health ageing amongst present and incoming cohorts of older persons in Malta, and presents the *National Strategic Policy for Active Ageing*, *National Dementia Strategy*, and the *Minimum Standards for Care Homes in Malta*. The final brief section brings the paper to a close by forwarding proposals for the future of healthy ageing policy in Malta.

Ageing transitions in Malta

Over the 20th Century the population of Malta has doubled, from 211,564 in 1911 to 434,403 in 2015 (National Statistics Office, 2016). However, the growth in the Maltese population was not evenly distributed amongst the various age cohorts. Whilst in 1901, 5.4 per cent of Malta's population was situated in the 65-plus cohort, in subsequent years this age group increased substantially to reach as much as 19.0 per cent respectively in the year 2016 (ibid.). As a result of such demographic developments, the Maltese population has evolved out of a traditional pyramidal shape to an even-shaped block distribution of equal numbers at each cohort except at the top.

At end of 2015, more than a quarter of the total population, 26.6 per cent, equivalent to 111,281, were 60 years old and over (National Statistics Office, 2016). The largest share of the older population is made up of women, with 53.8 per cent of the total. In fact, the sex ratios for cohorts aged 80- and 90-plus numbered 63.7 and 70.6 respectively, which means that amongst the oldest cohorts there is more than twice the number of older women than men. Such fluctuations were largely the result of

a declining birth rate, together with an increasing life expectation for both men and women. Whilst at the beginning of the 20th Century life expectancy in Malta was around 43 years for men and 46 years females, in 2013 these figures reached 79.6 and 84.0 years respectively (ibid., 2015). Malta also registers excellent and record results in health life years which is designated to monitor whether the extra years of life are lived in good health. A recent research publication concluded that whilst "on average across European Union member states health life years at birth was 61.8 years for women and 61.4 years for men", it was "highest in Malta and Sweden for both women and men (above 70 years)" (Organisation for Economic Co-operation and Development & European Union, 2016: 56).

The population of Malta is expected to reach 468,900 and 480,700 persons by 2050 and 2070 respectively (National Statistics Office, 2015). Although the annual number of births is projected to fall over this period, the annual number of deaths is projected to continue rising at much faster rates. In fact, by 2050 the population of persons aged 65 years and over is projected to increase to around 124,000 – an increase of 51 per cent when compared to this segment of the population during 2015 which numbered 82,200. By 2070, this cohort will continue to increase 136,700 – an increase of 66 per cent compared to 2015 (ibid.).

Geriatric services

In 2000, the World Health Organization classified Malta as the 5th best performing health system from a total of 191 countries (Azzopardi, 2011). This is primarily due to the fact that health care in Malta boasts exceptional levels of equity as it is available to all citizens, irrespective of income. As far as geriatric services are concerned, Malta has come a long way in the past quarter of a century. As it was recently reported,

> Geriatric medicine has been established in Malta since the year 1989 when the first consultant geriatrician post was advertised and filled in the state-run health services... the post of lecturer in Geriatrics at the University of Malta was created and the subject taught to medical students...A postgraduate training programme in Geriatrics was set up in…2008. (Ekdahl et al., 2012)

The past 25 years also witnessed the opening of an assessment and rehabilitation hospital specifically for older persons with an emphasis on enabling them to return back into the community, and the introduction of modules on geriatric medicine for medical students. The University of Malta also established Department of Gerontology to run a Postgraduate Diploma, Master Degree and Doctorate in Gerontology and Geriatrics. Presently, geriatric medicine is recognised as a separate specialty, with the government of Malta employing 14 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics – for example, on memory, falls, and continence. This means that there is a consultant geriatrician for every 7,948 persons aged 60-plus (2015

figures) – which compares well to other European Union nations such as Germany (7,496), Spain (7,701), United Kingdom (8,871), and Switzerland (9,250) (Ekdahl et al., 2012). Geriatricians also teach university students following medicine, whilst also conducting clinical research. The Office of the Prime Minister (2013) reported that in 2012 the Department of Geriatrics provided a clinical service mainly on the following sites: Rehabilitation Hospital Karen Grech (249 beds), St. Vincent de Paul Long-Term Facility, Mount Carmel Hospital, Mater Dei Hospital (assessing referred patients), and state-run community homes and public-private beds (assessing referred patients). In addition, the department occupied a key role in specialised clinics related to memory, continence, movement disorders, falls, ophthalmic and tuberculosis/pulmonary disorders.

National Strategic Policy for Active Ageing

In its drive to improve the levels of health ageing, one of the first national policies launched by the Government of Malta to work towards such an objective included the *National Strategic Policy for Active Ageing: Malta 2014–2020* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2013). Including a total of 75 policy recommendations, as much as one third of them focus on healthy ageing, with the remaining two themes being active participation in the labour market and social participation. The *National Strategic Policy* underlined that society should not be content solely with a remarkable increased life expectancy, but must also strive to extend healthy life years. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages enables older persons to lower their probability of illness and disability, whilst aiding them to ensure high physical and mental functioning that fosters independent living. This entails the opportunity to live in age-friendly and accessible housing that are sensitive to the needs and services sought by older individuals, and that provide accessible transportation for independent living. The policy's recommendations that are related to healthy ageing included in table 1.

Table 1: National Strategic Policy for Active Ageing: Recommendations for Healthy Ageing

Health prevention and promotion
- Ensuring that health promotion and disease prevention campaigns adopt a life course perspective.
- Targeting falls in older adults through the creation of falls prevention programmes.
- Creating and auditing strategies to ensure medication safety for older adults.

Acute and geriatric rehabilitation
- Targeting older adults to become informed consumers of health care through better information.
- Strengthening community health and rehabilitation services in order to allow a seamless transition between hospital-based and community services or other settings.
- Integrating acute geriatric care and rehabilitation within the acute public hospital.

Mental health and well-being
- Increasing health literacy and decreasing stigma on mental health and well-being in older adults through education strategies targeting both the general public and health care providers.
- Integrating mental health services within acute public hospital systems so as to address the complex needs of older persons and to contribute to decrease the stigma associated with mental illness.
- Strengthening the current geriatric mental health services, and expanding such services to meet the needs of older persons in the community.

Community care services
- Facilitating access to community care through a variety of access points across primary and acute care sectors, as well as a coordinated pathway to professional assessment.
- Ensuring alternative community care settings to cater for the needs of older persons.
- Guaranteeing that beneficiaries of community care services have the opportunity to participate in both service planning and provision, with consumer feedback being present at all levels.

Maximising autonomy in long-term care
- Promoting the autonomy of older adults in their decision-making process to enter a long-term care.
- Establishing procedures supporting the autonomy of older adults in their decision-making process including access to appropriate medical, legal, and community services.
- Implementing measureable national minimal standards for long-term care.

Protection from abuse
- Raising the recognition of elder abuse and neglect as a social reality through research, public education, and training of persons working in the social and health care sectors.
- Developing and implementing a strategy that empowers older adults to report abuse.
- Creating the necessary legal amendments to protect older adults from abuse and neglect.

End-of-life Care
- Improving the training opportunities in end-of-life and palliative care for persons working in the social and health care sectors.
- Creating legislation to introduce advance directives for health care.
- Developing and implementing policies and procedures in health care facilities concerning end-of-life issues, including but not restricted to artificial feeding and resuscitation.

National Dementia Strategy

Alzheimer's Disease International (2015) estimated that there were 46.8 million people living with dementia worldwide in 2015. This number will almost double every 20 years, reaching 74 million in 2030 and 131 million in 2050. The global costs of dementia have increased from US$ 604 billion in 2010 to US$ 818 billion in 2015, an increase of 35.4 per cent. The current estimate of US$ 818 billion represents 1.09 per cent of global gross domestic product, an increase from the 2010 estimate of 1.01 per cent (ibid.). Excluding informal care costs, total direct costs account for 0.65 per cent of global gross domestic product. Cost estimates have increased for all world regions, but especially the African and in East Asia regions

The past decade witnessed an increasing interest on dementia from academic researchers. A decade ago, Abela and colleagues (2007) utilised figures based on the EURODEM project (which analysed the results of a population-based systematic review of published studies on the global prevalence of dementia from 1980 to 2004) to estimate that there were 4,072 individuals with dementia in the Maltese islands in the year 2005, mostly females and older adults aged 75-plus. This study also projected the number of persons experiencing dementia up to 2050, with figures indicate a near doubling in the number of individuals suffering from dementia during this period, so as to reach an estimated total number of 6,369 in 2050 2.00 per cent of total population). However, Scerri and Scerri's (2012) recent publication provided larger estimates. Drawing on data in another European funded project – the EUROCODE project, whose objective was to develop consensual European age and gender specific prevalence rates that would be acceptable for all countries – Scerri and Scerri (ibid.) estimated the number of Maltese people over 60 years of age who experienced dementia in 2010 was 5,198. This constitutes a significant increase on the previous projected data by Abela and colleagues (2007). The authors project that the number of Maltese people over 60 years of age who will experience dementia in 2030 will reach some 10,000 persons or 2.3 per cent of the total Maltese population (table 5.7 and 5.8). In other words, when one uses these revised estimates, it results that the 2 per cent prevalence rate of dementia among the local population is expected to be reached by 2025 – as much as twenty-five years prior to what was previously expected.

The importance of addressing dementia care did not pass unnoticed by the government, and the Malta Dementia Strategy Group was set up in 2009 to present a series of recommendations to the Ministry of Health that should establish high-quality dementia care. As Scerri (2012: 154) outlined, the "aim of this working group was that of devising a number of recommendations that would enhance dementia services and address local shortfalls in dementia care" so as to "advise and recommend the planning and development of services that provide high-quality care for individuals with dementia in the Maltese Islands". Work followed a two-stage process: first, by analysing in detail the services currently available for individuals with dementia and their carers,

and secondly, a wide consultation process with stakeholders working in the field of dementia and the public in general. This threw light on how the

> ...services available for individuals with dementia showed considerable lack of support for these patients and for those who care for them. This is coupled by the lack of staff trained in patient-centred dementia care. Services that are provided by the various government departments are not tailored for the needs of these individuals especially if the patient is still relatively young... In the community, training of carers is only provided by the Malta Dementia Society through a series of organized talks and seminars. (Scerri, 2012: 155)

The findings were incorporated in a *National Dementia Strategy 2020* that included a number of recommendations, presented to the health authorities in January 2010 (Formosa, 2015). Recommendations included (i) improving awareness on dementia in the community and in relevant professional and non-professional fields, (ii) improving early diagnosis and intervention, (iii) providing good-quality information at the point of diagnosis and beyond, (iv) providing financial support to individuals with dementia in obtaining anti-dementia medication, (v) increasing knowledge on services that are already available for individuals with dementia, their relatives and carers, (vi) improving the quality of care in acute and long-term settings for individuals with dementia, both in state and private medical structures, (vii) improving support services within the community, (viii) improving end-of-life support services, and (ix), strengthening legal and ethical issues regarding individuals with dementia (Scerri, 2012).

Such a state of affairs led to the launch of the eagerly anticipated *National Dementia Strategy: Malta 2015–2023* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2015a). The strategy makes Malta the 21st country to have a nine-year plan aimed at enhancing the quality of life of persons with dementia and her carers. The *National Dementia Strategy* included the following key objectives:

Increasing awareness and understanding of dementia. One fundamental aspect of this strategy is to increase awareness and understanding of dementia among the general public and healthcare professionals in order to reduce stigma and misconceptions about the condition.

Timely diagnosis and intervention. Early symptom recognition and interventions through appropriate referral pathways together with the necessary pharmacological, psychological and psychosocial support offer the best possible management and care for individuals with dementia. This strategy also encourages the development of advanced care directives.

Workforce development. Good quality care will be ensured through the provision of training and educational programmes for staff in direct contact with individuals with dementia giving particular importance to challenging behaviour and palliative care. Caregivers and family members who are responsible for the daily care of individuals

with dementia will also be provided with adequate training in order to offer the best quality care and help them cope with new challenges.

Improving dementia management and care. A holistic approach in service provision for individuals with dementia, their caregivers and family members will be adopted. Apart from providing all pharmacotherapeutic options to Alzheimer's disease patients, individuals receiving a diagnosis of dementia will have care plans developed by a multidisciplinary team specialised in dementia management and care. These will address activities of daily living that maximise independent activity, adapt and develop skills and minimise the need for support.

Ethical approach to dementia management and care. This strategy aims to promote an ethical approach to dementia management and care and provide individuals with dementia and their caregivers with the necessary psychological support needed in making important decisions regarding their health and welfare.

Research. Information regarding epidemiology of dementia in Malta, patterns of detection and diagnosis, and delivery of care are needed for proper planning and allocation of health and social care funds and for outcome evaluation. Since the delivery of care is context specific, the strategy aims to promote and support epidemiological research in the field of dementia in different care settings in Malta. Other research initiatives in the dementia field, through the collaboration with other research entities, will be strongly encouraged.

Minimum Standards for Care Homes for Older Persons

For many years, long-term care for older persons was the sole responsibility of religious authorities, and it was only in recent centuries that the state started to provide residential/nursing care to frail elders. In 2013, the total number of licensed care homes for older people – run by the private sector, the Church and the public sector – numbered 38. The total number of licensed beds reached 4,307 at the end of 2013 – that is, 4.2 per cent of the total 60-plus population. A Eurobarometer survey (European Commission, 2012b) advanced thought-provoking information on the perceptions of Maltese citizens on long-term care. One question queried whether the quality of LTC services in Malta is 'very good', 'fairly good', 'fairly bad', or 'bad', with 77 per cent (European Union average: 44 per cent) of respondents answering 'very good' and 'fairly good', whilst another 13 per cent replied 'fairly bad' or 'bad'. The remaining 10 per cent replied 'don't know'. Another question queried whether the affordability of long-term care services in Malta is 'affordable' or 'not affordable', with 18 per cent of respondents answering 'affordable'. The Eurobarometer also posited the following question: 'imagine an elderly father or mother who lives alone and can no longer mange to live without help because of her or his physical mental health conditions, in your opinion what would be the best option for them?' As much as 60 per cent of Maltese respondents answered that 'they should move to a nursing home

or sheltered housing' only second to Denmark (both 74 per cent). This demonstrated that in recent years the Maltese seem to be more ready to accept the settlement of one's relatives into residential and nursing care which is problematic when one considers that population projections show an increasing future demand and costs for long-term care.

In response to such a state of circumstances, the Government of Malta launched in 2015 the *Minimum Standards for Care Homes for Older Persons* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2015b). The Standards acknowledge the unique and complex needs of older people residing in a care home. They stipulate the minimum requirements for the facility to operate as a care home as well as the required knowledge, skills and competencies needed by management and staff to ensure care homes deliver individually tailored, comprehensive and quality services. The Standards are applicable to all operations for which registration and annual licensing as a 'care home for older people' are required. All the minimum Standards are intended to be immediately applicable to all homes seeking registration and a license as of the date of promulgation of these Standards, whilst a number of the Standards are intended to be phased in gradually for care homes already operating as of this date. In order that these Standards be implemented by care homes, they have been endorsed by Parliament as a Legal Notice. An autonomous Authority will be set up to manage roles that are related to the sector. This authority will be responsible for the licensing of each home, both those that are in function already and also those that will be set-up in the future. The Authority will issue fines on irregularities as well as fines for each day that the fine quoted for by the authority is not paid within the due date given.

The Standards are based upon the principles of **person-centred care, dignity, privacy, physical and mental wellbeing self-fulfilment,** autonomy/empowerment, equality, and the right to complain and right to legal recourse. They advocate care homes to promote a culture of active ageing in the care home that is consistent with Malta's *National Strategic Policy for Active Ageing* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2013). The mission of care homes should go beyond the traditional concept of 'elderly care', and enable residents to realize their full potential for physical, social, and mental wellbeing. Moreover, care homes shall provide an environment where residents are enabled to engage in productive activities, and a healthy, independent and secure lifestyle. The licensee shall also undertake to promote a culture that encourages independence in activities of daily living including, but not restricted to, policies and procedures that promote (a) continence and independent personal care to the fullest extent possible, (b) mobility, (c) falls prevention, (d) prevention of pressure sores, and (e) prevention of the use of physical or chemical restraints. The Standards include 38 policy recommendations:

Standards 1 to 5 concern the *home's obligations.* Each care home shall provide a written and comprehensive Guide for Residents, which sets out the statement of purpose,

the range of facilities, and the terms and conditions on which all services are provided in the contract with each resident. All prospective residents and/or legally-appointed representatives shall thereby be able to make informed choices about whether or not the home is able to meet the individual's particular needs. The statement of purpose and the contractual arrangements entered into with each resident shall enable inspectors to assess how far the home is fulfilling its obligations to meet residents' requirements and expectations that are informed by regularly updated individual plan of care. Standards 6 to 10 relate to *health and personal care*. Residents' health and personal care shall be based on their specific individual needs and wishes within reason. Therefore, the assessment process and the individual's plan of care are seen as crucial in maintaining standards. The results of the initial and ongoing assessments shall be the basis of the plan of care, which then becomes the yardstick for the audit of the delivery of care. The care plan is a dynamic document, which must be reviewed and may be changed regularly according to the assessed needs of the resident.

Standards 11 to 15 concern *daily life and social activities*. Older individuals continue to have social, cultural, spiritual, and recreational needs and interests, and therefore should enter a care homes with a wide variety of expectations and preferences. The way in which social life is organized in the home, along with the range of activities available, must be set out in the home's statement of purpose and guide for residents so that prospective residents, their family and/or their representatives must have a clear idea of what is on offer. Standards 16 to 18 focus on *complaints and protection* by addressing the matter of how residents and/or their relatives and representatives can make complaints about anything that goes on in the home, both in terms of the treatment and care provided by staff and/or the facilities that are available. These standards deals with complaints procedures within the home relating to matters between the resident and the registered proprietor/manager. Complaints may also be made directly to the Regulator.

Standards 19 to 26 concern the *environment*. All new homes shall be constructed such that the living space suits all residents' needs. They shall provide single and double rooms with accessible en-suite showers and toilets as long as residents' safety is not thereby compromised. Moreover, all new homes shall also be constructed in such a way as to provide a homely environment - rather than an institutional setting, and should always be well maintained, tidy, attractive and clean. Standards 27 to 30 focus on staffing issues. In determining appropriate staffing contingents in all care homes (and in those that provide nursing and dementia care in particular), the regulatory requirement that staffing levels and skills mix are adequate to meet the assessed and recorded needs of the residents at all times in the particular home must be met. Each home is to determine the appropriate staffing levels and skills to meet the assessed needs of its own particular residents at all times, which will then be approved by the Regulator.

Standards 31 to 38 relate to *management and administration* issues by clarifying the qualities and qualifications required of the persons in day-to-day control of the delivery

of care, and how they should exercise their responsibilities. The standards highlight the importance of consulting residents about their health and personal care, interests and preferences. A key requirement of care homes is that residents are surveyed for their opinions and that results are published.

The Standards acknowledge the unique and complex needs of each individual residing in a care home; as such they stipulate the minimum requirements for the facility to operate a care home as well as the required knowledge, skills and competencies needed by management and staff to ensure care homes deliver individually tailored, comprehensive and quality services. Each Standard has an achievable outcome for the residents. Although the Standards are qualitative, they are also measurable: they provide a useable instrument for the independent regulator to assess the degree to which the Standards are being met through: regular communication with residents, family and close friends, staff, managers and others; observation of daily life and management of the home; audit of written policies, procedures and records; and scheduled and *ad hoc* inspections.

Conclusion

In achieving better levels of healthy ageing – that is, the process of optimizing opportunities for physical, social and mental wellbeing to enable older people to enjoy an independent and good quality of life – Maltese public policy needs to pay greater attention to how health care policies may improve individual well-being. However, healthy ageing is not just about prolonging life. It concerns learning, the exchange of good practice and the development of strategies and policies designed to promote older people's individual wellbeing and personal growth.

This warrants two distinct pathways in healthy ageing policy. First, the prevention and reduction of the burden of excess disabilities, chronic disease and premature mortality by setting measurable targets for improvements in health status and in the reduction of chronic diseases, disabilities and premature mortality, making screening services that are proven to be effective, available and affordable to older persons, creating age-friendly health care centres and standards that help prevent the onset or worsening of disabilities, and finally, developing barrier-free housing options that are accessible to all people. Secondly, reducing risk factors associated with major diseases and increase factors that protect health by taking comprehensive action to control the marketing and use of tobacco products, developing appropriate guidelines on physical activity for older adults, ensuring that national nutrition policies and action plans recognise older persons as a potentially vulnerable group, promoting oral health among older people and encouraging women and men to retain their natural teeth for as long as possible, and finally, determining the extent of the use of alcohol, drugs and medication by people as they age and putting policies in place to reduce misuse and abuse.

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