



EDITORIAL

LONG-TERM CARE FACILITIES FOR OLDER PERSONS IN MALTA: POLICIES, TRENDS, AND CHALLENGES

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INTRODUCTION

The remit of long-term care covers those services undertaken by others to ensure that people with, or at risk of, a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity (1). Such services can be provided in various settings ranging from private residences to assisted living housing to specialised facilities which provide accommodation and long-term care as a package to people requiring ongoing health and nursing care due to chronic impairments and a reduced degree of independence in activities of daily living (2). This editorial focuses on long-term care facilities in Malta, which cater for persons aged 60 years or over whose chronic physical and cognitive morbidities necessitate social and health services that are unavailable or unfeasible to provide in the community setting. The Maltese archipelago is a European Union Member State. It consists of three islands - Comino, Gozo and Malta - at the heart of the Mediterranean Sea, 93 kilometres south of Sicily and 290 kilometres north of Libya. Comino is uninhabited, and with Gozo having a mere population of 31,446 persons, leaves Malta as the major island of this archipelago state, with as much as 393,938 residents (2013 figures) (3). Malta gained independence from Britain in 1964 when it also joined the Commonwealth, and became a Republic in 1974. Malta joined the European Union in 2004, and adopted the Euro as its currency in 2008. This article outlines the policies, trends and challenges regarding long-term care facilities for older persons in this country, all of which seek to bring forward improved levels of positive ageing for all residents irrespective of their co-morbidities.

Policies

At end of 2017, 25.1% of the total population, or 119,550 persons, were aged 60-plus in Malta (4) (Table 1). The largest share is made up of women, with 53.4% of the total. Sex ratios for cohorts aged 60- and 80-plus were 87 and 60 respectively.

Public policy on ageing in Malta is governed by the National Strategic Policy for Active Ageing (5). Acknowledging that long-term care facilities are liable to become settings where the needs of the group often take precedence to those of the individual, whereby limitations on privacy, preference for leisure activities, meals and meal-times, provision and access to medical care... have a significant impact on their right to self-determination and independent living, the active ageing strategy put forward three related recommendations: 1-Promoting the autonomy of older adults in their decision-making process to enter a long-term care facility; 2-Establishing procedures supporting the autonomy of older adults in their decision-making process including access to appropriate medical, legal, and community services; 3- Implementing measureable national minimal standards for long-term care, and creating the necessary legislative structure for their regulation (5).

The implementation of the above recommendations commenced in earnest in 2014 and by the end of that year two crucial policy measures were adopted by the government. On one hand, applications for admission to long-term care were no longer accepted unless endorsed by the older person himself/herself. Thus, reversing a trend whereby family members applied on behalf of their older parent and relatives for a place in a long-term facility without neither the latter's knowledge or consent. On the other hand, each public long-term facility initiated a Resident Association, elected democratically by the residents themselves every two years, to liaise between the facilities' management body and the residents as far as the implementation of the social and health care services are concerned. The third recommendation was a more ambitious one and necessitated two key steps. First, the launching of *National Minimum Standards for Care Homes for Older Persons* in 2015 (Box 1) (6), and secondly, the establishment of the Social Care Standards Authority in 2017 as the autonomous body responsible for the standards' enforcement (7).

Box 1

National Minimum Standards for Care Homes for Older Persons

- 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 on which all services are provided in the contract with each resident.
- 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. The care plan should be 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.
 - Standards 16 to 18 focus on complaints and protection by addressing 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.
 - Standards 19 to 26 concern the environment. All new homes shall be constructed in such a way that the living space suits all residents' needs. They shall provide single and double rooms with accessible en-suite showers and toilets.
 - Standards 27 to 30 focus on staffing issues. In determining appropriate staffing contingents in all care homes, the regulatory requirement that staffing levels and skills mix are adequate to meet the assessed and recorded needs of the residents.
 - 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.

Table 1. Total population by age (31 December 2017).

Age Groups	Males	Females	Total	% of total pop.	Sex ratio
60+	55,687	63,853	119,550	25.1	87
80+	7,474	12,465	19,939	4.2	60
60-69	29,495	29,840	59,335	12.5	99
70-79	18,728	21,548	40,276	8.5	87
80-89	6,648	10,507	17,155	3.6	63
90+	826	1,958	2,784	0.6	42
All ages	240,599	235,102	475,701	100	102

Table 2. Licensed long-term facilities / beds for older persons in the Maltese Islands (May 2019).

Long-Term Care Facilities	Facilities /Wards	Licensed Beds
Public long-term care facilities		
Community care homes	9	1,004
Long-term care wards at Gozo General Hospital	2	121
St. Vincent de Paul Long-Term Care Facility	1	1,033
Church-run care homes	14	740
Private care homes	17	2,414
Total	43	5,312

Table 3. Residents by age and gender at St. Vincent de Paul Long-Term Facility (May 2019).

Age Groups	Males	Females	Total
<59	16	13	29
60-69	34	49	83
70-79	83	137	220
80-89	135	334	469
90-99	45	174	219
>100	0	13	13
Total	313	720	1,033

The upholding of the minimum standards by all long-term care facilities in Malta is presently enshrined in the criminal code, whereby proprietors can be fined or even have their facilities closed down if they do not abide by such benchmarks, though a grandfather's clause of 10 years was inserted for matters relating to the minimum area for single and double rooms.

Trends

Public expenditure on long-term care in Malta is relatively low by European Union standards, 1.1% of GDP compared to the EU-28 average of 1.6%, although the EU-28 median average also amounted to 1.1% (European Commission, 2016). In May 2019, the total number of licensed long-term care facilities for older people numbered 43. The number of licensed beds reached 5,312 - that is, 4.4% of the total 60-plus population (Table 2).

The public sector operates nine long-term care facilities whereby most bedrooms are either single or double occupancy, equipped with an en-suite bathroom and kitchenette, and nurse call facilities. Amenities include air-conditioning, central heating, and telephones in each room; and communal televisions, living and dining rooms, and chapel. Some public long-term care facilities operate through public-private partnerships by having their management, as well as a range of social and health services, contracted to a private company. Another form of public-private partnership sees the government purchasing long-term care beds in private facilities as a strategy to keep public spending in the area to a minimum. As regards financial settlements, all resident of public long-term care facilities contributes either 60% or 80% of their pension and any other income depending upon their dependency status, and hence, the level of social and health care services required. However, residents are not to be left with an income of less than €1,397.62 per annum. At the same time, the public sector also operates two wards in the grounds of the Gozo General Hospital for older

persons living in the island of Gozo, as well as a large-scale geriatric hospital, St. Vincent de Paul Long-Term Care Facility (SVP), which includes over a thousand service-users. The number of residents at SVP was 1,033, of whom 720 were females and 313 males. Whilst 29 residents were below the age of 60, the number of residents aged 90-plus numbered 232 (Table 3).

SVP operates as a hybrid between a nursing home and a hospital whereby emphasis is made to support the activities of daily living of all residents, giving particular attention to nutrition, mobility, personal hygiene and social and spiritual activities, and thus, catering to the wellbeing of every resident from a physical, psychological, social and spiritual point of view. The health and social care services at SVP are provided by a myriad of health care professionals and employees that total to around 1,100. Residents contribute 80% of retirement pension and 60% of other income, but always with the proviso that residents are not then left with less than €1,397.62 per annum. SVP also includes an Active Ageing Unit which allows each resident with the opportunity to participate in a myriad of social undertakings (ranging from therapeutic activities, such as book reading, crossword puzzles, and actions which enhance dexterity and reminiscence), and a training centre that provides continuous professional training to all caring and professional staff in person-centred and dementia care. A second category consists of 13 long-term facilities operated by the Church, either run by religious orders or directly by the Archdiocese of Malta. Finally, there were 17 licensed private homes for older persons in Malta. Whilst some homes have been purposely built to meet the needs of older residents, others consist of refurbished hotels and apartments. Daily fees vary greatly and are dependent on a number of factors - namely, the level of dependency of and care needed by the resident, whether he/she resides in single or double occupancy, the range of services one purchases, and whether the facility brands itself either at the luxurious or middle-range

ends. Entertainment activities inside the homes and social outings are also organised, and all private care homes offer respite services and convalescence periods.

Challenges

The launch and upholding of the National Minimum Standards for Care Homes for Older Persons (6) was certainly a watershed moment in the development of long-term care policy in Malta. Through these standards, older residents in care homes are certainly in a better position to experience improved levels of wellbeing despite experiencing far-reaching physical and cognitive challenges. However, there is no doubt that more extensive policy work is required if one wishes to ensure a good life in long-term care facilities. Three policy measures are urgently warranted.

A- Quality in long-term care and incentives for providers to create a 'quality' culture

As reports in the media and research data about poor quality long-term care abounds, there is an increasing impetus on governments to develop better evidence-based approaches to improving the quality of care in long-term care facilities. However, quality is a difficult concept to define and operationalise, and it is no secret that most countries do not systematically collect information on quality. Hence, there are only a few countries which have reached a national consensus regarding which indicators ought to be collected and reported regularly. This needs to be mitigated because such indicators enable policy makers to set benchmarks for providers, perform cross-national comparisons of performance, assist providers to manage care services and workers, and offer consumers better information to make informed decisions. However, such changes will not occur on their own and regulatory bodies need to use the 'carrot' approach by proving providers with incentives to deliver responsible, safe and effective care through, for example, 1) consumer-based initiatives such as

those leveraging consumer choice and centredness; 2) performance incentives to encourage and reward providers to deliver higher quality care; and 3), incentives to encourage care co-ordination and integration (2). One strategy which Malta could adopt is for the Social Care Standards Authority to publish reports on long-term care providers along with a grading of their performance relative to their peers.

B- Regulations to safeguard residents from elder abuse

Older persons seeking admission in care homes do so due to their increased vulnerabilities, and hence, it follows that they are at a higher risk of being victims of elder abuse compared to their peers. As a result, Malta requires specific legislation and standard operating procedures to safeguard the rights of long-term care residents as there is in some other countries such as the United Kingdom's White Paper Caring for our future: Reforming care and support which required all long-term care providers to establish a Safeguarding Adults Board and Scotland's Adult Protection and Support Act to mention two prominent ones. Moreover, it is important to ensure that care workers have a legal duty to refer colleagues and relatives in case of witnessed or potential harms or risks to older persons, which can result in the former being banned from working with older people and the latter being castigated by a protection order. This duty to report falls upon individuals - including residents, family relatives and carers, and service providers - who witness incidences or have a concern regarding potential cases of abuse. So far Malta lacks a responsible authority which is mandated to track reported cases of abuse, and the police squadron is still unknowledgeable and unskilled to deal with elder abuse in a satisfactory manner. However, the launching of a Commissioner for Older Persons Act in 2014 was a step in the right direction.

C- Financial measures for long-term care

One constant issue in long-term care reforms over

recent years has been the issue of how to provide wider and more equitable access to long-term care services without breaking the bonds of financial sustainability. Whilst some countries opted to raise additional taxes, others increased social insurance contributions to finance new benefits for long-term care. Such choices in fiscal policy were generally justified for yielding instantaneous benefits to the public in relieving them of high personal costs or the need to apply for social assistance when one's personal financial reserves have been depleted. The latter issue is not to be taken lightly since the length of average residency in long-term care is ten years which tends to cost more than one's pension income and/or lifetime assets. However, even countries who have implemented such an increase in tax revenue had to face difficult choices, and many were forced to diminish the range of social and health care services for persons with physical and cognitive challenges. For instance, whilst Sweden tightened its means-testing eligibility when in the past community and residential services were made available on the basis of Swedish citizenship, New Zealand and the United Kingdom decreased their residential care benefits. In this context, Malta requires a future looking strategy on the financing of long-term care that balances its funding as a universal service in parallel with a mix of public and private long-term care insurance.

CONCLUSION

Long-term care is a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living. When the cohorts of the baby-boom generation will reach the oldest age groups over the next three decades, demand for long-term care will rise steeply. Since long-term care is closely tied to chronic illness and increasing frailty, a long-standing debate has been whether it should be viewed as a medical or social service. Whilst one may argue about the merits of health over social needs of residents, the consensus is that long-term

care requires attention from both sectors. Indeed, many policy makers would label the ability to perform activities of daily living and other functional measures as the key rationale for long-term care facilities. However, a frequent response is that such goals seem contradictory: Improving or slowing the rate of deterioration of health and functional abilities may seem in conflict with a goal of meeting needs for care and assistance. The former sounds more end-results driven, whereas the latter seems compatible with simply addressing problems as they arise. Other goals, such as enhancing social and psychological wellbeing, or maximizing clients' independence and autonomy, reflect a basic commitment to encourage consumers to live in the most integrated and 'normal' community settings possible and to promote a meaningful life according to the individual's own view of what that might mean (8).

A way out of this impasse is to accede that the crux of long-term care policy is the recognition that residents have a right to lead a life of dignity and participate in social and cultural avenues. In Malta, this is enshrined in the Minimum Standards for Care Homes for Older People though, of course, implementing the standards in practice - by ensuring that residents' right to human dignity, self-determination, privacy, quality care, freedom of expression, palliative care and support, and perhaps most importantly, redress are safeguarded - is easier said than done. Indeed, much still needs to be done to enhance the wellbeing and quality of life of residents in long-term care facilities. This requires more than simply the launching of policies, though this is certainly a step in the right direction, and necessitates evidence-based measurement on quality care, incentives for providers to create a 'quality' culture, regulations and standard operating procedures to safeguard residents from elder abuse, and financial sustainable measures to meet the increasing cost of long-term care. It is augured that Malta's future travails in ageing and long-term care policy meets such objectives in the foreseeable future.

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