Chapter 8

Sharing capacities – Malta and the United Kingdom

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Introduction

While patient mobility has emerged as a key issue on the policy agenda within the European Union in recent years, stimulated by a series of rulings by the European Court of Justice, for Malta, patient mobility has been an integral feature of the health care system throughout the 20th century. By virtue of its size and location, Malta can claim to have a long and extensive experience both of treating patients who come to the island from other countries and of referring Maltese patients for treatment abroad.

During the first half of the 20th century, Malta experienced an influx of overseas patients, especially during the First World War when it earned the eponym “Nurse of the Mediterranean”. Since gaining independence from the United Kingdom in 1964, Malta has developed a strong tourist industry, with the United Kingdom being the major provider of tourists. In this period, the Maltese health care system had to learn to cater for overseas patients, this time as visiting tourists.

As medicine became more complex and travel became easier, it was inevitable, for a country with under 400 000 people, that certain interventions could not be offered locally and would be obtained from centres overseas. Reflecting the traditional links that had developed between Malta and the United Kingdom during almost 200 years of colonial rule, the United Kingdom proved to be the country of choice for referral of Maltese patients overseas.

As a new Member State of the European Union, Malta finds itself obliged to implement the EU acquis in the area of patient mobility. This has given rise to a number of changes in the way that health care benefits are offered to
EU/EEA citizens through the implementation of EU regulations on coordination of social security (benefits in kind). An entitlement unit has been recently established within the Ministry of Health to deal with these matters. Malta, however, must also address the issues that arise in relation to referral of patients overseas using the E112 mechanism. This presents new challenges for a small health care system in which patients treated overseas received their care within the framework of a tightly regulated mechanism in which the United Kingdom was the main overseas partner.

This case study seeks to document the experience that Malta has garnered over recent decades in the field of patient mobility. The analysis will focus on providing health care for tourists and referral of Maltese patients abroad and will serve to highlight areas of best practice. Finally it will present an assessment of the challenges that Malta is facing in view of the developments taking place in relation to patient mobility across the European Union with recommendations on the way forward.

**Background and context**

The Maltese archipelago is located in the centre of the Mediterranean Sea with a total land area of 316 km². The total resident population of the Maltese Islands is 399,867 of whom 198,099 (49.5%) are men and 201,768 (50.5%) are women. These figures correspond to a population density of 1265 people per km², the highest in the European Union (National Statistics Office, 2003a).

The Maltese population presently enjoys a relatively high health status. Life expectancy at birth in 2003 was 80.4 years for females and 76.4 years for males. At the age of 60 years (which is around the current age of retirement) life expectancy in 2003 was 22.9 years for women and 19.7 years for men. Infant mortality rates have been steadily improving and fell to 3.5 per 1000 live births in 2003.

Circulatory disease is the leading cause of death, accounting for 44% of deaths. The standardized mortality rate for ischaemic heart disease is relatively high at 149 (per 100,000 population). Cancers currently account for 24% of deaths (Ministry of Health, 2002).

Malta’s accession to the European Union has dominated the political agenda over the past few years. Following a substantial reform in its legislative and administrative structures, the main challenges now facing Malta are achieving sustainable public finances and enhancing the island’s competitiveness and economic growth whilst maintaining social cohesion and sustainable development.
Malta has a rich history of health care provision. The initial developments were influenced by the Order of the Knights of St John, which was primarily a “Hospitallers” order and which ruled the country between 1530 and 1798. Malta was a British colony between 1800 and 1964. The British heavily influenced the development of Malta’s public health system and contemporary health care services. This influence is still evident today in the way the health care system is funded and organized and in the training and culture of the health care professionals.

The Maltese health care system comprises a public health care system and a private health care system. The statutory system is publicly financed from taxation and exhibits the features of a fully integrated model of health care delivery, organized and managed at national level. It offers a highly comprehensive basket of services, free at the point of use to all the population. Private health care is funded by voluntary health insurance and out-of-pocket payments.

Government expenditure on health care continues to rise yearly, with estimated recurrent expenditure on health and elderly care for 2004 making up 12% of total government recurrent expenditure. The total health expenditure as a percentage of GDP for 2003 was 9.63%, slightly higher than the EU average. However, in terms of purchasing power parity (PPP) per capita, Malta spends less on health care than the EU average. As noted above, health care financing in Malta is split between public financing and private financing. During 2003, 65% of total health expenditure took place in the public sector (Table 8.1).

St Luke’s Hospital, Malta’s only main acute general and teaching hospital, is synonymous with the development of modern medicine and health care in Malta. Links between St Luke’s and prominent, mostly London-based teaching hospitals were developed, as Maltese doctors underwent specialist training in the top centres in the United Kingdom and returned to provide services locally. Although service development has been continuous, with the establishment of specialized units such as intensive therapy, neonatal intensive therapy, neurosurgery, cardiology and cardiac surgery, the need to send some Maltese patients overseas for treatment remains.

**Maltese patients seeking treatment overseas**

Outward patient mobility takes place from both the public and private health care systems although there are no figures for the extent of movement from the private sector. It is known that patients often make their own arrangements through private consultants in Malta to attend, mostly for outpatient consultations, the private medical sector in the United Kingdom. These are
often paid for out of pocket. People covered by international private insurance may also obtain treatment overseas. In the public sector, patient mobility has so far taken place in the context of a bilateral agreement with the United Kingdom with a highly regulated and organized system for patient referral. Reimbursement by the public system for treatment sought overseas by personal initiative and outside this scheme has so far not been granted.

Patient mobility in the public health system

**Numbers and profile of patients undergoing treatment overseas**

Given Malta’s historical relationship with the United Kingdom, a bilateral health care agreement that has served both the United Kingdom and Malta very well has been in place for the last 30 years. This agreement provides for the referral of a quota of Maltese patients for treatment in the United Kingdom National Health Service. The number of Maltese patients requiring treatment overseas has always exceeded the agreed quota, with additional patients incurring an additional charge to the Maltese Government. Figure 8.1 shows the number of patients referred from the Maltese public health care system for treatment in the United Kingdom between 1990 and 2004. Over the past few years the number has stabilized and represents around 0.06% of the Maltese population. There are two specific points on the graphs showing a sharp decrease in patient numbers: 1995 and 1998. These points correspond to the date of introduction of a cardiac surgery programme and magnetic resonance imaging (MRI) for patients at St Luke’s Hospital.

The profile of cases that are currently referred for treatment abroad consists mainly of bone marrow transplants, liver transplants, complex major spinal surgery, paediatric cardiac surgery, maxillofacial surgery, and specialist paediatric cases, particularly endocrinology, gastroenterology and neurology. These cases all exhibit the features of high cost and low patient volumes. To date there have been no strong clinical or economic arguments to develop these services in Malta. The investment cost is too high, the patients are too few and full-time professional staff employed to perform this type of service will quickly become deskilled.
In addition, several overseas specialists from centres of excellence in the United Kingdom visit Malta once or twice yearly to carry out consultations. These visits serve as a follow-up assessment of patients who have been operated on or received treatment in their hospital and also help to identify new cases that require treatment abroad.

This system can be viewed as an extension of local health service provision in the public sector, a tertiary care backup service with centres of excellence abroad. Malta has links with approximately 25 centres of excellence in the United Kingdom. For example, oncology patients are referred to the Royal Marsden Hospital, infants are sent to Great Ormond Street, neurology patients go to the National Hospital for Neurology and Neurosurgery at Queen Square, whilst patients with liver disease are transferred to King’s College Hospital. The system has its roots in the fact that most of the local doctors receive their specialized training in the United Kingdom, where close professional ties with key consultants are created. These personal acquaintances then become care sharing opportunities.

The shared-care approach is a multidimensional type of arrangement where a relationship with a hospital and a particular consultant is present. It has a consultation dimension where cases and treatment options are discussed (second opinions), a visiting consultant dimension where foreign consultants go to Malta and carry out consultations there, and also identification of patients who need to go for treatment.

In addition, in certain areas, for example the treatment of scoliosis patients, a programme of visiting surgeons has been in place for a number of years. This movement of providers has several advantages since it allows the patient to be treated locally and also provides learning opportunities for the local staff.

Policies and procedures regulating the overseas treatment programme

_Treatment Abroad Advisory Committee_

The Treatment Abroad Advisory Committee (TAAC) is responsible for regulating patient mobility. This committee advises the Chief Medical Officer, giving recommendations as to which patients warrant referral to an overseas hospital for treatment. The TAAC is composed of senior clinicians with expertise in medicine, surgery and paediatrics, and is chaired by the Director of Institutional Health. The final decision regarding the type of services to be included in the package of care for which Maltese patients may be referred overseas lies with the ministry’s Health Policy Board and the minister responsible for health.
The treatment abroad package

The TAAC has developed a list of established services and treatments for which Maltese patients may be referred overseas under the public programme. Once a decision is made that a particular condition/disease merits treatment abroad, the TAAC does not review each case referred in detail.

The TAAC discusses referrals for inclusion of new treatment options, assesses the pros and cons of treatment and then makes a recommendation as to whether or not to offer the service. The referring consultant is invited to the committee meeting in order to justify the referral for treatment overseas. In considering whether a new service or treatment should be added to the list, the TAAC examines whether:

- a proven, non-experimental treatment for the disease exists;
- the treatment is unavailable locally;
- there is evidence of potential benefit for the patient;
- the financial impact of sending patients abroad would not be prohibitive for the system.

The authorization process

When a consultant decides that a patient requires treatment that is not available locally, a request is drawn up using a form that contains all relevant details about the patient. A case summary, relevant X-rays and an airline Certificate of Fitness to Travel are also required. Following endorsement by the TAAC, the referring consultant contacts the overseas specialist who shall be responsible for the patient to discuss the case and ensure that the patient can be referred. If the patient has a condition that is recognized as requiring treatment abroad
under the public programme, authorization from the TAAC is conferred automatically, permitting urgent transfer where necessary.

**Referral of patients**

Once permission to refer arrives, the Treatment Abroad Section takes over to make the necessary arrangements for transportation, admission and accommodation for the patient and accompanying relatives. This section liaises with the Maltese Embassy in London to arrange outpatient appointments, reserve a bed, and book accommodation for the patient and accompanying relatives. The referral of patients to centres of excellence outside the country has necessitated the setting up of protocols which set out the different patient categories (such as intensive, highly dependent or cold cases) and the procedures to be followed in preparation for, and during transfer of, each category of patients. Malta has also had to invest in reliable portable equipment together with mechanisms for ensuring accommodation and remuneration for the accompanying hospital team members where this is necessary.

The patients’ perspective

Interviews with patients and their relatives reveal some of the strengths and weaknesses of the system:

“‘The arrangements made from Malta by the Treatment Abroad Section were excellent.’”

“‘Lodging is the biggest headache for the parents.’”

“‘The expenses are huge. I go up every three months for treatment.’”

“‘Since my husband earns more than LM80 (€185) a week I have to pay my ticket in full. Each time I go I have to pay two flights: mine and that of the person accompanying me.’”

**Pre-admission arrangements**

Patients generally believe that the system of referral and preparation for transfer to a hospital outside Malta works efficiently. The Treatment Abroad Section deals with all the necessary practical arrangements, including admission arrangements, airline ticket booking, transfers to hospital and accommodation. This relieves the patient and his or her relatives of a large burden, especially since the time prior to admission is often a period of great anxiety.

**Accommodation**

Most Maltese patients referred to the United Kingdom for treatment are admitted to hospitals within or close to London. Patients receiving treatment
on an outpatient basis and relatives accompanying patients need a place to reside. The Treatment Abroad Section makes arrangements with the order of Franciscan Nuns in London to accommodate the patients and their family. The nuns run a small hostel so it is not uncommon for relatives to be turned down at the door owing to lack of space. This creates inconvenience and added anxiety, as alternative accommodation would then need to be sought by the relatives themselves. Although the nuns do their best to provide for the basic needs of their visitors, the hostel has several limitations such as shared bathroom facilities and the lack of a laundry service on site.

**Travelling**

Airline fares are provided on a means-tested basis. Accompanying persons do, however, have to pay their own fare. Patients are provided with a free taxi service to and from the hospital where they are receiving treatment.

**Communication channels and language issues**

Since almost all Maltese patients referred for treatment abroad go to hospitals in the United Kingdom and English is the second language for the Maltese, communication problems seldom arise whilst the patient is receiving treatment. The receiving hospitals often provide the patient and accompanying relatives with an information pack which provides essential information to assist patients during their stay in hospital, such as admission times, hospital maps, travelling facilities, etc. Some hospitals also provide these guides on the Internet. This has the added benefit of allowing the patient to start familiarizing him or herself with the new surroundings and systems while still at home in Malta.

For patients who have difficulty communicating in the English language, a community of priests in London offers their services as interpreters. These priests go to the hostel of the Franciscan nuns daily and offer to accompany patients and their relatives to the hospital.

**Psychological support**

Patients state that the main source of support comes from the nurses working in the hospitals. Patients were generally impressed with the excellent bedside manners shown by the health care professionals and do not find any difficulty with the culture of hospitals in the United Kingdom.

Some families may stay abroad for months, for example when a patient is receiving prolonged outpatient care and for bone marrow transplants. Often these patients and their relatives are homesick, bored and need psychological support.
Financial problems and support

One of the main issues for patients requiring treatment abroad is the financial burden associated with travelling to a foreign country, especially when the patient needs to go abroad several times each year. Often a close relative accompanies the patient when abroad for treatment, especially when the patient is a child. Relatives have to pay for their flights and their own stay. The Treatment Abroad Section often refers patients and their relatives to the “Community Chest Fund” which is the main charity organization in Malta. Patients can then apply for financial assistance to cover some of the expenses. Still, it appears that donations are far from adequate to cover the expenses involved.

“I’m not saying that they [family] should not pay a dime, but I feel that they do not have enough financial support. It is true that the government covers most of the expenses and I am aware that the budget is tight, but these are the things which the patients and relatives mention most.” (Referring consultant)

The doctors’ perspective

As with the patients, the Maltese consultants interviewed also provided a variety of perspectives:

“We have been working with this hospital for years now, we know people there and they know us and they do help us, especially if it’s an urgent case.”

“I can’t say enough, really, how good the service is. It’s a shame that the general public don’t always realize what a 5-star service they have.”

“You make a diagnosis today for a condition that is eminently treatable here and they’ll come the next day and ask ‘Can we go abroad’?!”

From the interviews conducted with referring consultants the picture that emerged is that the system is very efficient and the referring doctors rarely encounter problems with the referral itself. If problems arise following the patient’s treatment overseas, local doctors liaise with the overseas specialists, usually via e-mail. This seems to be the system most commonly adopted now for consultations and second opinions involving local and foreign specialists.

The main problems with the treatment abroad programme, identified by the local consultants are as follows:

- limited funding available for treatment abroad, which restricts inclusion of new services in the treatment abroad programme such as brain stimulators for Parkinson’s patients;
• receiving hospitals may lack readily available bed space and this prolongs waiting time for local patients;

• patients are sometimes prescribed medicines that are not available from the Maltese health service. Whilst referring consultants seek to provide the “receiving” doctor with a list of locally available drugs as guidance for prescription, it is not always possible for the doctor to stick to this list. If upon discharge the patient is prescribed medicines that are not available locally, a special urgent request for these drugs has to be made.

Another issue raised by the doctors is that the success of the programme often leads local patients to pressurize their doctor to send them abroad for treatment. This is possibly fuelled by the cultural belief that treatment provided overseas is of a higher standard than that available locally. This creates a problem in that the doctor has to seek ways to convince the patient that treatment abroad is unnecessary as the required service and expertise are readily available locally. The majority of cases are convinced, yet occasionally a few still seek treatment privately. Some of these actually send the bill to the Treatment Abroad Advisory Committee, which is not reimbursed.

**Patient mobility within the private sector**

Although there are no statistics, it is believed that only a small number of people residing in Malta actually seek treatment overseas within the private sector. This may be due to the emergence and subsequent sustained improvement of tertiary care services within the Maltese private sector during the last decade. Amongst those who do seek treatment the majority are adults. Treatment options range from orthopaedic surgery and oncology treatment to gynaecological checkups. The most popular countries where private treatment is sought are the United Kingdom and Italy, mainly owing to the number of specialist hospitals available and also familiarity with the languages.

Privately insured patients with international coverage plans can usually seek treatment in a hospital of their choice. However, insurance companies compile an international directory of hospitals, which helps patients identify hospitals with which the company has package deals. In such cases the prices for a range of treatment options would be pre-established, thus increasing the possibility that the client is reimbursed in full. If treatment is sought in a hospital with which the insurance company has no agreement, it is possible that the health insurance would not cover all the expenses.

Patients are responsible for choosing and contacting the hospital where they wish to receive treatment. Although it seems that the choice of providers is
endless, in reality it is quite restricted in terms of the surgery required, the consultant and the corresponding hospital. If a particular surgeon is desired, the patient must go to the hospital in which the doctor works.

The role of the insurance company is to check the client’s insurance coverage. Insurance companies are not primarily responsible for the quality of the service that their customer receives when abroad. However, it is reported that the few patients who have commented about the quality of service they received all gave positive feedback.

Overall, the administrative process of settling insurance claims for health treatment abroad is rather straightforward. Once the client informs the insurance company of his or her decision to seek treatment abroad, details of the treatment sought, the consultant providing the treatment, the location of the care facility, and duration of treatment must be agreed. This information is then forwarded to liaison officers at overseas insurance offices, who confirm the estimated fee and give official permission. This provides the client with pre-authorization for treatment. An official letter is then mailed to the care facility, detailing the insurance coverage of the patient. Once treatment is received, all expenses are billed to the insurance company which verifies that the price charged was according to the pre-established package. If verified, the bill is settled. Delays arise when large differences result between estimates given by the hospital and the actual bill.

**Health care provision for tourists**

The tourist industry and access to health care

Tourism represents one of the main pillars (around 25%) of the Maltese economy: 40 000 workers earn their living directly or indirectly from the tourist industry, which generated an income of LM424 million (€990 million) in 2002. The vast majority of the 1.1 million tourists visiting Malta annually come from EU/EEA countries with almost half (450 000) coming from the United Kingdom. One quarter of tourists is aged 55 years or over (National Statistics Office, 2003a, 2003b).

As a result of its dependence on tourism, Malta has always sought to provide uncomplicated access to quality health care for temporary visitors. An open-door policy of immediately treating all emergency and/or urgent cases, with claims being settled at a later date, has been in place for decades in the public health service.

**Demand for hospital care by temporary visitors**

Demand for hospital care by temporary visitors exhibits a marked seasonal
variation. The winter months bring in large numbers of elderly patients with cardiorespiratory problems whilst in summer younger persons tend to present with accidents or heat-related conditions.

In 2003, 1229 foreign inpatients were treated in St Luke's Hospital, accounting for 2.7% of admissions. The number of outpatient and accident and emergency visits to St Luke's by foreigners in 2003 was over 4000. It is important to note that these figures do not include patient contacts in government-owned primary health care centres and in the private sector. The cost of treatment of foreign nationals accounts for around 2.4% of the total recurrent costs of the hospital.

Congruent with the mix of nationalities of tourists on the island, the majority of patients treated at St Luke's Hospital come from the United Kingdom, followed by Germans, Italians and French (Table 8.2).

Until 2002, the hospital did not have an effective administrative system to bill foreign patients and usually only billed for inpatient episodes. In 2002, a billing section was opened and all foreign patient episodes are processed for payment. Since EU accession, EU/EEA temporary visitors automatically benefit from free treatment that becomes medically necessary during their stay upon presentation of the E111 certificate. The details are then forwarded to the Entitlement Office within the Ministry of Health, Elderly and Community Care for further processing and onward transmission to the relevant Member State (Ministry of Health).

**Impact of treating temporary visitors**

Implications for the health system

Whilst there should not be any negative financial impact from treating EU/EEA nationals with an E111 certificate if costs can be recovered, the financial impact of caring for pensioners in possession of the E121 certificate has yet to be evaluated. This will be possible after there has been experience over several years. It is expected that certain pensioners, such as those who are dependent on renal dialysis can skew costs considerably, especially for a small country’s health care budget.

Third country patients are usually billed following their treatment and discharge from hospital. The number of defaulters has risen over the years. Some of these costs have been written off whilst others have attracted lengthy legal and administrative procedures in the hope of recovering some of these expenses. As a result, changes in the procedure for collection of claims are due to be instituted, wherein guarantees for payment will be required prior to elective or non-urgent treatment.
Implications for providers

**Capacity constraints**

Hospital capacity planning has always included the impact that tourists have upon the number and type of beds available in hospital. Despite such planning, given that there is only one acute general hospital in Malta, the capacity to accommodate all patients is sometimes exceeded, especially in critical care areas. Overcrowding of the acute hospital has become a necessary but expected evil to contend with during the winter months.

**Managing expectations of foreign patients**

Although health care standards in Malta compare well with those in other Member States, foreign patients’ expectations still need to be managed carefully. Compared to Maltese patients, foreign patients have a greater propensity to make their feelings known and this gives rise to more praise or more criticism than local health care providers would normally expect. Anecdotal experience shows that they are more likely to institute formal complaints than Maltese patients.

**Consent and data protection issues**

Unconscious patients who are not accompanied by relatives present particular problems, including that of obtaining the necessary consent. Legal proceedings are instituted in these situations in order not to delay treatment. Owing to the existence of harmonized data protection legislation across the EU, the transfer of patient data across EU borders does not present particular problems.

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**Table 8.2 Number of overseas patients undergoing treatment at St Luke’s Hospital**

<table>
<thead>
<tr>
<th></th>
<th>United Kingdom</th>
<th>EU (excluding EEA)</th>
<th>EEA</th>
<th>Non-EU/EEA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2003</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>624</td>
<td>160</td>
<td>11</td>
<td>434</td>
<td>1 229</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1 355</td>
<td>805</td>
<td>43</td>
<td>1 919</td>
<td>4 122</td>
</tr>
<tr>
<td><strong>2004</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>593</td>
<td>201</td>
<td>7</td>
<td>371</td>
<td>1 172</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1 665</td>
<td>1 065</td>
<td>46</td>
<td>2 190</td>
<td>4 966</td>
</tr>
</tbody>
</table>

**Source:** St Luke’s Hospital Malta, 2005.
Implications for patients

**Psychological impact**

Admission to hospital has a significant psychological and social impact upon temporary visitors, especially since most admissions are unplanned and involve elderly patients. These are often alien to the local culture, language, health care systems and policies. They may not have any friends to help them and may totally depend on the guidance given to them by health care professionals. Relatives, if present, also require psychological support.

“They would not be sure of the culture, the quality of medical care and have a lot of anxieties when they come in.” (Hospital nurse)

**Language difficulties**

Although all Maltese health care professionals are fluent in English and many are proficient in some other European languages, the language barrier still presents some challenges to overcome, especially for non-English speaking patients. Nurses seek to locate an interpreter to help them but the hospital has no official list of interpreters who can be contacted for assistance. Help is usually sought either at the relevant embassy in Malta or the hotel where the patient was staying. If an interpreter still cannot be located, nurses try to find an employee within the hospital having knowledge of that particular language who can help out.

**Logistical issues**

Patients and their relatives also require assistance with logistical and financial matters, often running out of funds if the stay is prolonged. The majority of foreign patients and their accompanying relatives require transport facilities to and from the hospital. Often local taxi services overcharge these visitors. Hospital staff often encounter difficulties when there is a need to make international phone calls from hospital to the insurance company or to contact the patient’s doctor abroad.

“Sometimes the elderly partner is stranded. Their funds would have finished and they just leave the hotel and show up on the ward. They expect to be fed and ask for a place to rest. We do try to help them and accommodate them here, but this is not a suitable place for relatives.” (Hospital nurse)

Although staff at the billing section within the hospital are specifically trained to deal with logistical requirements, tour operators and embassy staff are also called upon to assist with matters such as transportation, transfer of funds and insurance. The main objective is always to assist the patient to return home as quickly and as safely as possible.
Conclusions

Facilitating factors
This case study has demonstrated that patient mobility is greatly facilitated by the following factors:

• interinstitutional links;
• personal interprofessional links, especially between consultants;
• existence of an organized programme that caters for logistics and practical support;
• intervention by insurance prior to patient travel;
• common language;
• movement of providers in addition to movement of patients;
• agreed protocols for pre- and post-intervention care within the country of origin between the referring institution and the host institution.

Hindering factors
The following factors were identified as hindering patient mobility or creating difficulties for patients undergoing treatment in a different country:

• budgetary constraints within the referring health system;
• costs of travel and accommodation (subsistence) for both patients and accompanying relatives, especially for conditions requiring treatment over weeks or months;
• lack of information prior to departure or during stay in the host country;
• isolation and linguistic difficulties;
• difficulties in gaining access to certain institutions rapidly;
• reluctance of institutions to accept overseas patients because of capacity problems or delayed and complicated reimbursement proceedings;
• different medicine formularies and resulting lack of availability across borders.

Potential developments
Following accession to the European Union it is possible that the framework regulating outward patient mobility will change in Malta. It is anticipated that outward planned mobility will begin to take place through the framework of the regulations on coordination of social security with the E112 certificate.
It is not expected that patients will shift their preference to countries other than the United Kingdom because of the comfort of the language and also because of the established links and referral patterns between consultants. Therefore, within the framework of EU regulations, it is highly likely that Malta and the United Kingdom will retain some kind of bilateral agreement that will serve to reduce unnecessary bureaucratic transactions and will be more advantageous for patients and health care providers.

Malta is likely to find itself increasingly challenged to open up opportunities for treatment abroad within the context of the ECJ rulings. To date, overseas treatment has been restricted to those services that are not available locally but are deemed to form part of the package of care. The authorities are going to come under increasing pressure to define explicitly and transparently those services and interventions not available locally, that are eligible for funding by the public system.

The experience from the private sector in Malta seems to indicate that even where persons are covered for treatment abroad, they will usually prefer treatment in Malta unless the intervention is considered to be complex or innovative. Therefore, on the basis of the evidence to date, it would seem unlikely that patients will seek out hospital care for routine procedures overseas, incurring the additional travel and accommodation costs. In making this assessment, it has to be borne in mind that travel out of Malta usually requires air travel and is not cheap.

In terms of catering for incoming patients and provision of the E111 certificate to outgoing Maltese temporary visitors, the relevant changes have already been carried out. Malta will face additional costs in having to pay for urgent care delivered to Maltese temporary visitors in other Member States. There will also be the impact of delays in recouping costs of care delivered locally to temporary visitors. The financial impact could be significant when one considers the relatively large number of tourists making use of Maltese health care facilities. To date the private sector in Malta is not recognized as providing accredited facilities for the purpose of treating persons covered by an E111 certificate. There has already been some pressure to include the private sector in this scheme and this pressure is likely to increase, especially as the public sector increasingly faces capacity problems.

Finally, it should be appreciated that for a small tax-funded health care system the impact of finding additional cash to pay for patients to receive treatment overseas can be relatively substantial even if the numbers of patients moving are small.
Recommendations

The main lessons that can be drawn from this case study are as follows:

• patient mobility, when well managed can have positive effects for patients, providers and health care systems;

• patient mobility requires policies, procedures and effective backup systems to ensure that patients obtain safe, good quality care in a holistic manner;

• patients exhibit a preference to be treated in their home country where possible unless there is a perception that better care can be obtained overseas;

• patient mobility is expensive, requiring additional cash and hidden expenses. This raises equity issues both in terms of patients who are more able to afford it benefiting more and in terms of health systems that are more able to fund it providing more flexible systems for treatment outside the competent Member State.

Policy-makers at European level should examine the implications that arise before encouraging widespread patient mobility. The three pillars currently being pushed at European health policy level are quality, access and financial sustainability within the context of applying the open method of coordination to health care. Patient mobility can have an impact on all three pillars.

1 Ensuring that an effective framework to regulate patient mobility is in place at European level and can safeguard quality and safety.

2 Access to treatment in another Member State poses equity dilemmas both at national level and at European level. European policy-makers may wish to consider making available central funding to assist those Member States who need to refer complex cases to centres of reference across borders in meeting the costs associated with patient mobility.

3 The financial impact of patient mobility on health care systems will require regular monitoring with a view to taking corrective action if this is shown to impact negatively on national health care budgets.

In view of its unique geodemographic situation, Malta will continue to rely on patient mobility for complex and supra-specialist procedures in the foreseeable future. However, experience has shown that both patients and the health care system itself stand to benefit when it is a safe and cost-effective decision to introduce the service locally. In view of its dependence on tourism, Malta will continue to ensure that its health services are geared to meet the needs of patients from overseas. The experience gained in this sector may also prove invaluable if the country engages in health tourism in the years to come.
REFERENCES


