World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Malta

Kenneth Grech
Beatrice Farrugia

Malta

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

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Abstract

This review is part of a series of country-based studies generating new evidence on affordable access to health care (financial protection) in Europe and central Asia. Financial protection is central to universal health coverage and a core dimension of health system performance. The incidence of catastrophic health spending is higher in Malta than in many other western European countries but lower than in countries with a similarly heavy reliance on out-of-pocket payments. It is largely concentrated in poorer and older households and mainly driven by spending on dental care, outpatient medicines, outpatient care and medical products. In the poorest fifth of households it is mainly driven by outpatient medicines and outpatient care. Unmet need for health care, dental care and prescribed medicines is consistently below the European Union average. Income inequality in unmet need has fallen since 2017 for health care and dental care but remains an issue for prescribed medicines. Coverage policy in Malta has some highly protective features: entitlement to publicly financed health care is based on residence and there are no user charges (co-payments) for covered health care. However, key gaps in coverage are likely to undermine financial protection: outpatient medicines are covered for people with chronic conditions or low incomes; non-emergency dental care coverage is limited; there is no cap on out-of-pocket payments; and long waiting times push people to access care privately. Increases in public spending have reduced Malta's reliance on out-of-pocket payments in recent years but out-of-pocket payments remain a challenge and require policy attention, particularly to reduce financial hardship and unmet need for people with low incomes and older households.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
FINANCIAL PROTECTION
HEALTH FINANCING
MALTA
OUT-OF-POCKET PAYMENTS
POVERTY
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in unmet need, and lead to financial hardship for people using health care. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (unmet need) and the share of households experiencing financial hardship caused by out-of-pocket payments (impoverishing and catastrophic health spending). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO

headquarters and the WHO Regional Office for Europe. The country consultation includes regional and global financial protection indicators. The UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Financial protection is a Sustainable Development Goal, part of the European Pillar of Social Rights and at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

UHC watch

5 things to know about UHC watch

A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

#2

Policy explorer for up-to-date analysis of coverage policy

#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

UHC watch
apps.who.int/dhis2/uhcwatch

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Abbreviations

COVID-19	coronavirus disease
CT	computed tomography
EHIS	European Health Interview Survey
EU	European Union
EU-SILC	EU Statistics on Income and Living Conditions
GDP	gross domestic product
MRI	magnetic resonance imaging
SRA	specific residence authorization
VHI	voluntary health insurance

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
NET	Netherlands (Kingdom of the)
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Malta face financial barriers that prevent them from accessing health care or experience financial hardship when they use health care. It covers the period from 2008 to 2025 using data from household budget surveys carried out in 2008 and 2015 (the latest available year; a new survey is currently underway but data from the new survey will only be publicly available at the end of 2026), data on unmet need for health care up to 2023 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to January 2025 (UHC watch, 2025).

The review's main findings are as follows.

- In 2015 about 2% of households were impoverished or further impoverished after out-of-pocket payments and almost 7% of households experienced catastrophic health spending. The incidence of catastrophic health spending is higher in Malta than in many European Union (EU) countries, but it is lower than countries with a similar or lower reliance on out-of-pocket payments.

- The incidence of catastrophic health spending is much higher than the national average (7%) in the poorest fifth of the population (22%) and in households headed by "other inactive" people (18%), housekeepers (15%), people aged over 60 years (14%), retired people (10%) and people living in the Southern Harbour area (9%).

- In the poorest quintile, catastrophic health spending is mainly driven by outpatient medicines, followed by outpatient care and dental care. Dental care is a larger driver in the other quintiles and its role in driving catastrophic health spending grew over time in all quintiles.

- Unmet need for health care, dental care and prescribed medicines is consistently below the EU average. Income inequality in unmet need has fallen considerably since 2017 for health care and dental care but remains an issue for prescribed medicines.

Some features of coverage policy that are likely to strengthen financial protection in Malta offer examples of good practice for other countries.

- Entitlement to publicly financed health care is based on residence, which means all residents are automatically covered. Refugees and migrants granted special protection status or a specific residence authorization are also entitled to the same benefits as permanent residents and, as a result, a very high share of the population is covered.

- There are no co-payments for covered health care, which means covered health care is affordable for everyone.

- The publicly financed benefits package offers good coverage of outpatient visits, diagnostic tests and inpatient care.

However, some aspects of coverage policy are likely to undermine financial protection, particularly for households with low incomes.

- People with chronic conditions or low incomes are entitled to publicly financed outpatient prescribed medicines through the yellow or pink card schemes; currently, around a third of the population benefits from these schemes. Everyone else pays the full price of outpatient prescribed medicines out of pocket.

- The yellow and pink cards aim to protect people with chronic conditions or low incomes, respectively, but coverage gaps remain, particularly for many households with low incomes: only 3% of the population have a pink card; yellow cards only cover the cost of outpatient prescribed medicines for eligible conditions; and yellow and pink cards only cover medicines in the formulary.

- Coverage of non-emergency dental care, optical care and medical products is limited in the publicly financed benefits package. Non-emergency dental care is mostly limited to dentures. Optical care is limited to glasses for pink cardholders and glasses for yellow cardholders with diabetes. Coverage of medical products is also limited in scope.

- Long waiting times are an issue for certain diagnostic tests, outpatient specialist visits, emergency care and elective surgery and have become a bigger challenge since the coronavirus disease pandemic, pushing people to pay the full price out of pocket for treatment in private settings.

- High medicine prices compound the problems caused by gaps in the coverage of outpatient prescribed medicines.

Recent policy choices suggest that financial protection may in general be better now than it was in 2015 (the latest available year of data on catastrophic health spending). Public spending on health has increased in recent years and accounts for a relatively high share of total government spending, pushing down the health system's reliance on out-of-pocket

payments from a peak of 37% in 2015 to 30% in 2022. The Government has also introduced measures to reduce waiting times and regulate medicine prices, which may have contributed to slower growth in out-of-pocket payments.

This may mean that financial protection has improved since 2015, but it is not possible to be sure until the results of a more recent household budget survey are made available; a new survey is currently underway but data from the new survey will only be publicly available at the end of 2026. The fact that catastrophic health spending is heavily concentrated in older people, combined with the sharp rise in poverty rates among older people in the last decade, is concerning.

To address key gaps in coverage and lower financial hardship and unmet need, particularly for households with lower incomes, the Government needs to make policy choices that can reduce out-of-pocket payments, including:

- finding ways to improve protection from out-of-pocket payments for households with low incomes – for example, by leveraging existing means-testing mechanisms. The pink card scheme only covers 3% of the population and is also limited in terms of the medicines and medical products it covers;

- using digital solutions to monitor the types of outpatient prescribed medicines households are spending on to inform policy options that can reduce out-of-pocket payments and improve financial certainty for all households;

- extending entitlement to publicly financed coverage of non-emergency dental care to those who are most likely to benefit in the short term, such as pregnant women and people with pink cards; and

- expanding the range of publicly financed non-emergency dental care, going beyond the services provided at present.

Building on recent efforts, the Government can also continue to lower the price of outpatient medicines and address long waiting times for publicly financed outpatient care.

These policy choices can be supported by increasing public spending on health, so that it is more in line with Malta's gross domestic product, and strengthening the commissioning (the purchasing and governance) of

1. Introduction

This review assesses the extent to which people in Malta face financial barriers that prevent them from accessing health care or experience financial hardship when they use health care. It covers the period from 2008 to 2025 using data from household budget surveys carried out in 2008 and 2015 (the latest available year; a new survey is currently underway but data from the new survey will only be publicly available at the end of 2026), data on unmet need for health care up to 2023 (the latest available year) and information on health coverage policy (population coverage, service coverage and user charges) up to January 2025 (UHC watch, 2025).

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Malta has a national health system that is financed through the Government budget. The Ministry of Health is responsible for its financing, operation and regulation. The basis for entitlement to publicly financed health care is citizenship and permanent residence and almost all the population is covered. There is a national benefits package, but coverage is limited for non-emergency dental care, outpatient optical care and some other medical products. Currently, around a third of the population (people with specified chronic conditions or low incomes) have access to the yellow or pink card schemes, granting them access to free outpatient medicines included in the Government Formulary List, dentures and some medical products; everyone else must pay out of pocket for these types of health care.

No major health system reforms have been carried out in the past decade, although there have been efforts to add services to the publicly financed benefits package, including to expand the positive list for medicines; to improve the Ministry's regulatory function through better standards and protocols; to consolidate the Ministry's commissioning function (the purchasing and governance of publicly financed health care) following the introduction of various private-public schemes; and to strengthen the financing of hospitals.

The health system in Malta relies heavily on out-of-pocket payments. Data from national health accounts indicate that out-of-pocket payments accounted for 30% of current spending on health in 2022 (the latest available year of internationally comparable data), well above the European Union (EU) average of 19% and higher than every other EU country except for Bulgaria and Lithuania. The out-of-pocket payment share has fallen sharply over time (from a peak of 37% in 2015) – an improvement that reflects steady growth in public spending on health per person in the years before the coronavirus disease (COVID-19) pandemic. Even in those pre-pandemic years, however, public spending on health did not keep pace with GDP growth. As a share of GDP, public spending on health in Malta lagged well behind the EU average between 2008 and 2019 and only caught up with the EU average during the pandemic.

In 2022 public spending on health accounted for 6.4% of GDP, on a par with the EU average, but lower than in several EU countries with a lower level of GDP per person (WHO, 2025).

This report is the first comprehensive analysis of financial protection in Malta. Although its analysis of financial hardship is limited to data for 2008 and 2015 (the latest available year), its findings remain relevant in the current context. The COVID-19 pandemic, economic shocks, a sharp increase in the risk of poverty and social exclusion among older people and a growing population are likely to have increased the need for health care in recent years, underlining the importance of protecting people from financial barriers to access and impoverishing or catastrophic health spending.

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy, drawing on information from UHC watch (2025). Sections 4 and 5 present the results of the statistical analysis on financial protection, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5 (covering both financial hardship and unmet need). Section 6 provides a discussion of results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the methods page of UHC watch (2025).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus et al., 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of impoverishing and catastrophic spending on health

Note: see the Glossary provided by UHC watch (2025) for definitions of words in italics.

Source: WHO Regional Office for Europe (2019, 2023).

	Impoverishing health spending
Definition	The share of households *impoverished or further impoverished after out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household consumption distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, basic needs for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors where relevant
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care.
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the household budget surveys conducted by the National Statistics Office of Malta in 2008 and 2015 (the latest available year). The data sample consisted of 3732 households in 2008 (with a response rate of 57%) and 3691 households in 2015 (with a response rate of 62%) (National Statistics Office, 2010; National Statistics Office, 2018). Data were collected between February 2008 and February 2009 in the first wave of the survey and between April 2015 and April 2016 in the second.

Malta did not carry out a household budget survey between 2015 and 2023. A new survey is currently underway but data from the new survey will only be publicly available at the end of 2026.

Household budget surveys collect information on health spending (consumption) in a structured way, dividing it into six broad groups following the Classification of Individual Consumption by Purpose: medicines, medical products, outpatient care, dental care, diagnostic tests and inpatient care (National Statistical Office, 2025; UHC watch, 2025). Spending on mental health care is not assigned a specific category and may therefore be reported under most of these groups.

For Malta, consumption is calculated net of rent for all households because information on rent is not publicly available in the Maltese household budget survey. Without this adjustment the study could underestimate capacity to pay for health care among some Maltese households that rent. The adjustment is not likely to have any important effect on the results, however, because the share of households that report any rent tends to be low in most countries; most households live in owner-occupied housing or have mortgages (which are not accounted for in household budget surveys). According to data from Eurostat, 18% of people lived in rented accommodation in Malta in 2021 (European Commission, 2021).

All currency units in the study are presented in euros (€), with notes on inflation-adjusted spending where relevant.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health care but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2014), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through EU Statistics on Income and Living Conditions (EU-SILC) (Eurostat, 2025a). EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2025b). The third wave of this survey was launched in 2019. Whereas EU-SILC typically provides information on unmet need as a share of the population, EHIS provides information on unmet need among people reporting a need for health care. EHIS also asks households about unmet need for prescribed medicines.

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health care they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Source: WHO Regional Office for Europe (2023).

3. Coverage policy

This section briefly describes the three main dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) in Malta; reviews the role played by voluntary health insurance (VHI); and describes changes in coverage policy over time (see Table 2).

3.1 Population coverage

The basis for entitlement to publicly financed health care is citizenship and permanent residence as defined by the Entitlement Unit of Malta operating under the Ministry of Health. Almost all the population is entitled to access publicly financed health care including citizens and their dependants, students enrolled in certain public institutions[1], citizens of a country with a health care agreement with Malta (such as Australia and the United Kingdom for the first 6 months of their stay), citizens of a country outside the EU with freedom of movement and people who are in an advisory capacity to the government and their dependants (Government of Malta, 2004). People need to show a national identification or residence card at the point of use to access publicly financed health care as established in subsidiary legislation. Citizens of an EU country visiting Malta can access emergency care during a temporary stay with a valid European health insurance card.

Foreigners with a valid work permit who pay social security contributions under the Social Security Act are entitled to access publicly financed health care in the same way as citizens (Azzopardi-Muscat et al., 2017; OECD/ European Observatory on Health Systems and Policies, 2019). Maltese citizens who are employed or self-employed are also obliged to pay social security contributions by law, but failure to pay does not prevent them from accessing publicly financed health care.

Entitlements and coverage arrangements for undocumented migrants, refugees and asylum seekers are complex. Refugees and migrants granted a special protection status (subsidiary protection or temporary humanitarian protection) or a specific residence authorization (SRA) are entitled to access the same publicly financed health care as citizens. At the point of use, people and their dependants granted a special protection status need to show their protection certificate issued by the International Protection Agency and people with an SRA need to confirm their status with a document issued by the Identity Malta Agency (Entitlement Unit Malta, 2022).

Asylum seekers are only entitled to emergency care and essential treatment of illness and serious mental disorders upon showing their asylum seekers document issued by the International Protection Agency. However, they are not entitled to treatment for chronic, non-acute medical problems and cancer (Azzopardi-Muscat et al., 2017; Entitlement Unit Malta, 2022).

Victims of human trafficking are entitled to access emergency and psychological care once their status is recognized by the authorities.

1. University of Malta, Malta College for Art Science and Technology and the Institute for Tourism Studies.

People who do not belong under the abovementioned categories are not entitled to access publicly financed health care and will need to pay out-of-pocket or purchase VHI to access care. We were not able to find data on how many people lack coverage.

People who are not eligible for refugee status, special protection status (subsidiary protection status or temporary humanitarian protection) or SRA are referred to as "failed asylum seekers" and are only entitled to life-saving medical assistance upon showing their immigration booklet issued by the immigration police (Entitlement Unit Malta, 2022). This is a notable gap in population coverage, with more than 700 failed asylum seekers lacking coverage in early 2023 (Sansone, 2023).

According to the United Nations High Commissioner for Refugees, 1989 asylum seekers (less than 1% of the population) were in Malta in 2023. From the asylum decisions taken between January and April, 41% of applicants were rejected and 16% were granted either subsidiary protection or refugee status, with the remainder deemed "closed cases" (United Nations High Commissioner for Refugees, 2024).

People granted humanitarian protection by another EU country, undocumented migrants with no protection status and third country nationals and stateless persons who have not yet applied for asylum or international protection are only entitled to life-saving medical assistance and treatment of serious mental disorders in some cases (European Commission, 2018; OECD/European Observatory on Health Systems and Policies, 2019; Entitlement Unit Malta, 2022). They tend to pay out-of-pocket to access treatment for chronic conditions such as HIV, renal insufficiency or psychiatric disorders which later may be discontinued because of their inability to pay.

These groups of people also face administrative barriers due to language issues and fear of deportation (European Commission, 2018). In exceptional circumstances or for humanitarian reasons, the Minister for Health has the power to waiver and cover the costs fully or in part for people not covered under the Social Insurance Act (Government of Malta, 2013).

3.2 Service coverage

As established by the Health Act (Government of Malta, 2013), the Advisory Committee on Health Care Benefits – an interdisciplinary committee consisting of the chief medical officer, clinical practitioners, chairpersons and ministry representatives – advises the Minister of Health on the contents of the publicly financed benefits package and regulates the introduction of new technologies, services and medicines.

Following the Advisory Committee's recommendations, the Minister of Health and the chief medical officer approve the contents of the benefits package based on availability of funds and internal administrative decisions that are not publicly declared.

Outpatient medicines are defined through a positive list referred to as the Government Formulary List ("the formulary"), which is regularly expanded. To add new medicines and technologies to the formulary, a formal process including health technology assessment, shadow pricing, forecasting and other economic methods is followed under the responsibility of the Directorate for Pharmaceutical Affairs within the Ministry of Health and the Government Formulary List Advisory Committee headed by the chief medical officer (Directorate for Pharmaceutical Affairs, 2022). This process is carried out every time there is an application to add a new medication to the formulary. Access to outpatient medicines requires a prescription.

Although the range of outpatient prescribed medicines on the formulary is relatively comprehensive, these medicines are only covered for two groups of people: those with specified chronic conditions (to treat the eligible condition only) and people with low incomes. Everyone else must pay the full cost of outpatient prescribed medicines out of pocket, which is not the case in any other EU country.

People with specified chronic conditions (around 30% of the population in 2023) are eligible for a yellow card (Schedule V) for people with eligible chronic conditions. When presented in the pharmacy, yellow cards grant people access to free outpatient prescribed medicines specified on the Government Formulary List to treat their eligible condition, as well as selected medical products for people with diabetes. The Social Security Act (Government of Malta, 2022) lists eligible chronic conditions for which people can be granted a yellow card. The list is relatively comprehensive, covering a wide range of conditions, including hypertension and diabetes. It is also regularly expanded. To apply for a yellow card, people need to visit an outpatient specialist who diagnoses the condition and completes an online application following a specific protocol. Applications are processed and managed by the Pharmacy of Your Choice Unit in the Ministry of Health. Primary care doctors can make applications for hypertension, asthma and hypercholesterolemia treatments and private specialists can make renewal applications (Pharmacy of your choice scheme, 2021; Government of Malta, 2021). The yellow card is valid for 10 years, after which it needs to be renewed.

The following people (around 3% of the population in 2023) are eligible for a pink card (Schedule II) for people with low incomes (Government of Malta, 2022):

- people with limited assets (< €16 000 a year for a single person or < €26 000 for a couple);
- people with low incomes (income < €222 a week for a single employed person or < €230 for a couple);
- pensioners with low incomes (income < €208 a week for a single person or < €232 for a couple);
- people receiving social, unemployment or disability assistance;

- people over 75 years old (over 80 years old before 2025) receiving a supplementary allowance; and

- full-time students and foster children.

When presented at the point of use, the pink card grants access to some outpatient prescribed medicines on the formulary, dentures and selected medical products (glasses and prosthetic aids). To apply for a pink card people need to present documents like bank statements, rent receipts and payslips proving their eligibility. Pink cards need to be renewed frequently: every four months for people under 60 years old and on an annual basis for people over 60 years old and people receiving disability assistance (Government of Malta, 2022). In 2010 a policy decision was taken to move some people (e.g. those with diabetes) from the pink card scheme to the yellow card scheme. This led to a decrease in uptake of the pink card.

People must generally present their yellow or pink card at the point of use, but it is possible to access services without presenting the card because eligibility can be identified online via electronic health information systems.

Coverage of non-emergency dental care, optical care and medical products is limited in the publicly financed benefits package (European Commission, 2018): dentures and fillings are covered for pink card holders; children under the age of 16 years are entitled to orthodontic services; oral surgery is available to all; and check-ups and dental hygiene services are possible on referral. However, there are capacity limitations, and most people still seek elective dental care in the private sector. All residents are entitled to wheelchairs, crutches, nebulizers and oxygen. Yellow cardholders with diabetes are also entitled to medical products for diabetes (blood glucose metres, blood sugar monitoring sticks, glasses, insulin syringes, aqueous cream and telecare services) (Government of Malta, 2023) and pink cardholders are also entitled to glasses and prosthetic aids (Allied health care services, 2021; Government of Malta, 2022).

Some health services (e.g. bone marrow transplants and neonatal neurosurgery) cannot be provided in Malta and require treatment abroad. For this reason, Malta has a well-established system coordinated by the National Highly Specialized Overseas Referrals Programme and the Treatment Abroad Committee (Palm et al., 2013) to cover the treatment abroad of people with rare diseases or conditions requiring specialized interventions (Ministry of Health, 2023). The main hospital in Malta, Mater Dei Hospital, was designated as the National Coordination Hub for the European Reference Networks in 2019, providing more opportunities for people to benefit from physical or virtual consultations with expert clinicians within the network in Europe.

Publicly financed health care is available in public and contracted private facilities. People need a referral from a doctor to access outpatient specialist visits (OECD/European Observatory on Health Systems and Policies, 2019). People can access general practitioners in the community without an appointment and no referral is required to access outpatient specialists in the private sector. There are no caps on service volumes.

Waiting times are an issue for certain diagnostic tests (such as magnetic resonance imaging (MRI), computed tomography (CT) scans and cardiac procedures), outpatient specialist visits, emergency care and surgery (such as hernia repairs, hip and knee replacements, and ear, nose and throat and vascular surgery) (Ombudsman, 2013; National Audit Office, 2017) and have become a greater challenge since the COVID-19 pandemic. Information on waiting times is not usually publicly available but is sometimes released through parliamentary questions.

Various initiatives to reduce waiting times have been introduced since 2010. In 2016 a Patient Charter, which sets a maximum waiting time of 18 months for a procedure or intervention, was put in place (Ministry for Health, 2016). If the waiting time exceeds 18 months, a patient has the right to seek health care from private providers or in another EU country, but this right is rarely exercised in practice. Services such as MRI and CT scans, echocardiograms, cataract surgery and ultrasound tests have also been contracted to private providers or carried out after hours or on Sundays to reduce waiting times. Prior to the pandemic these initiatives reduced some waiting times but marked challenges remain for procedures such as knee and hip replacements and colonoscopies.

There is a shortage of nursing staff in key clinical areas (emergency departments and operating theatres) and limited facilities for outpatient care, surgery and diagnostic tests, which adds to pressure on the health system (Agius, 2023).

Informal payments are generally not an issue in Malta. In 2024 1% of the population reported making an informal payment to a doctor, nurse or hospital, down from 2% in 2023 and below the EU average of 3% (European Commission, 2025).

3.3 User charges (co-payments)

There are no user charges (co-payments) for publicly financed health care in Malta, so covered outpatient care, inpatient care, diagnostic tests and emergency dental care are free at the point of use.

Yellow and pink cardholders (around a third of the population) are entitled to outpatient prescribed medicines and a few medical products without co-payments. The rest of the population must pay the full cost of all outpatient prescribed medicines and most medical products out of pocket.

As there is limited coverage and capacity for non-emergency dental care, most people pay the full cost of non-urgent dental care out of pocket.

Table 2. Changes to coverage policy, 2007–2025

Source: authors, based on UHC watch (2025).

Year	Change
2007	Entitlement to emergency care and psychological care granted to victims of human trafficking once their status is officially recognized by the authorities.
2012	People with diabetes are switched from being eligible to the pink card to the yellow card.
2012	Prescription and dosage adjustments can be made by any public or private practitioners for people holding a yellow card.
2012	Addition of more cancer services to the benefits package.
2013	Limited in vitro fertilization services added to the benefits package.
2013	Entitlement to publicly financed health care granted to residents from other European Member States with whom Malta is the "competent member state" under European regulation (referred to as cross-border health care) (Government of Malta, 2014).
2014	Addition of bariatric surgery to the benefits package.
2017	People with diabetes holding a yellow card are granted free access to medicines, medical products (repaglinide, gliptins, antibiotics, aqueous cream, blood glucose monitoring sticks, insulin syringes) and receive a subsidy for glasses.
2018	Addition of transgender services to the benefits package.
2018	Establishment of the Exceptional Medicinal Treatment Committee, a special unit in the Ministry of Health set out to coordinate treatment abroad.
2019	Entitlement to publicly financed health care extended to dependants of covered people from other European countries with whom Malta is the "competent member state" under European regulation (referred to as cross-border health care) (Government of Malta, 2014).
2019	The validity of yellow cards is extended from 5 to 10 years.
2019	People entitled to medicines for treating rare conditions can collect them from their preferred pharmacy rather than the hospital.
2020	Entitlement to publicly financed health maintained for United Kingdom nationals and their family members resident in Malta before 1 January 2021 (Brexit).
2020	Entitlement to publicly financed health care maintained for United Kingdom nationals and dependents residing in Malta before Brexit.
2020	Introduction of electronic prescription services.
2020	Introduction of tele services for primary care.
2020	Addition of COVID-19 swabbing and testing to the benefits package.
2021	Asylum seekers whose application for asylum has been refused (failed asylum seekers) can apply for an SRA issued in 2020 that would grant them access to publicly financed health care. To apply they must meet specific criteria: to have entered Malta in an irregular manner prior to the 1 January 2016 and been in Malta for at least 5 years before the date of application; to have been employed a minimum of 9 months a year during the last 5 years; to show good conduct and participation in integration programmes. If the applicant meets the criteria police authorities are consulted before granting the SRA (Ministry for Home Affairs, Law Enforcement and National Security, 2020).
2021	Addition of COVID-19 vaccinations to the benefits package.
2022	Expansion of in vitro fertilization services available in the benefits package.
2022	Third country nationals who obtain a single permit to reside and work in Malta require VHI coverage.
2025	Emergency care is outsourced to the private sector.
2025	People > 75 receiving a supplementary allowance are automatically eligible for the pink card.

3.4 The role of VHI

VHI plays a mixed supplementary and complementary (services) role, providing faster access to treatment and greater choice of health care provider; it can also cover services that are excluded from or not so well covered by the publicly financed benefits package (e.g. dental care, optical care, osteopathy and prosthetics) (Sagan & Thomson, 2016). It covered 29% of the population (149 720 people) in 2019, up from 21% (87 814 people) in 2010[2], and accounted for 3% of current spending on health in 2022 (WHO, 2025).

VHI is regulated by the Malta Financial Services Authority through the Insurance Business Act. Around 10 private for-profit commercial companies sell VHI, mainly to individuals or to employees as part of their employment benefits. Employees can usually top up on the premium paid by their employer to access a higher benefit level[3].

Three main types of VHI policy are available: "limited refund" covers a limited set of expenses with restrictions on the care covered, volume caps on covered procedures and limited choice of health care provider (59 727 people in 2019); "full refund" covers a more comprehensive range of services and access to a broader network of providers (71 735 people); and "international refund" covers treatment abroad (18 258 people)[4]. Some insurance policies offer cash benefits for covered people who require inpatient care in a public hospital.

VHI benefits from a tax incentive: it is exempt from the stamp duty (around 11% of the premium) applied to all other types of insurance.

Table 3 summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

2. President of the Malta Insurance Association, personal communication, 2022.

3. Ibid.

4. Ibid.

Table 3. Gaps in publicly financed and VHI coverage

Source: UHC watch (2025).

Coverage dimension	Main gaps in publicly financed coverage	Are these gaps covered by VHI?
Population coverage	Entitlement to publicly financed health care is based on residence, which means all residents are automatically covered. Refugees are entitled to the same benefits as residents, but asylum seekers and applicants for international protection are only entitled to emergency care and essential treatment of illness (including serious mental disorders); undocumented migrants and failed asylum seekers are only entitled to life-saving medical assistance.	No. VHI accounted for 3% of current spending on health in 2022 (WHO, 2025) and does not address gaps in population coverage.
Service coverage	The publicly financed benefits package covers outpatient prescribed medicines for a third of the population (30% who have yellow cards for specified chronic conditions and 3% who have pink cards for low income). The remaining two thirds of the population must pay the full cost of all outpatient medicines out of pocket. Coverage of non-emergency dental care is limited to dentures and fillings for pink card holders, orthodontic services for children under the age of 16 years, and check-ups and dental hygiene services only on referral. There is also a school programme to check children's teeth. Coverage of optical care is limited to glasses for pink cardholders and yellow cardholders with diabetes. Coverage of other medical products is also very limited. Waiting times are an issue, although there are policies in place to address them. People tend to access outpatient primary care in private settings for shorter waiting times, more choice of provider and more care continuity. Due to a lack of resources or the small number of people affected, some health care cannot be provided in Malta and requires treatment abroad.	To a limited extent. VHI provides around 29% of the population with faster access to treatment and greater choice of provider. It can also cover services that are excluded from or not so well covered by the publicly financed benefits package (e.g. dental care, optical care, osteopathy and prosthetics).
User charges (co-payments)	Although there are no user charges for covered health care, two thirds of the population are currently not subscribed to the yellow card scheme, which provides access to publicly financed outpatient prescribed medicines. Also, the benefits package excludes most non-emergency dental care, optical care and many other medical products for most people. As a result, many people have to pay the full price out of pocket for outpatient medicines, dental and optical care and medical products.	No

3.5 Summary

Entitlement to publicly financed health care is based on citizenship and residence, which means all residents are automatically covered. However, undocumented migrants, asylum seekers whose application for asylum has been refused (failed asylum seekers) and people granted humanitarian protection by another EU country have no entitlement to publicly financed health care beyond life-saving medical assistance; they may also face administrative barriers to access.

The publicly financed benefits package offers good coverage of outpatient visits, diagnostic tests and inpatient care. Coverage of outpatient prescribed medicines covers people with a wide range of specified chronic conditions or low incomes under the yellow and pink card schemes respectively (currently around 30% of the population have a yellow card for chronic conditions and 3% have a pink card for low income); with a few exceptions (pink card holders) everyone must pay the full cost out of pocket for outpatient medicines required for acute conditions. Coverage of dental care is limited to dentures and fillings for pink card holders, orthodontic services for children under the age of 16 years, and check-ups and dental hygiene services only on referral. Optical care is limited to dentures and glasses for pink cardholders and glasses for yellow cardholders with diabetes. Coverage of other medical products is also very limited.

There are no user charges for covered health care, but two thirds of the population are currently not subscribed to the yellow card scheme, which provides access to publicly financed outpatient prescribed medicines. Also, the benefits package excludes most non-emergency dental care, optical care and many other medical products for most people. As a result, many people have to pay the full price out of pocket for outpatient medicines, dental and optical care and medical products.

Waiting times are an issue, although there are policies in place to address them. People tend to access outpatient primary care in private settings for shorter waiting times, more choice of provider and more care continuity.

Due to a lack of resources or the small number of people affected, some health care cannot be provided in Malta and requires treatment abroad.

4. Household spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second part uses household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system), and the third part considers the role of informal payments.

4.1 Public and private spending on health

Health accounts data show that out-of-pocket payments accounted for 30% of current spending on health in Malta in 2022 (Fig. 1). This was well above the EU average of 19% and higher than every other EU country except Bulgaria and Lithuania. Although the out-of-pocket payment share started to fall after the global financial crisis, it rose sharply from 30% in 2013 to a peak of 37% in 2015 before falling again in subsequent years.

The sharp fall in Malta's out-of-pocket payment share since 2015 is largely due to steady growth in public spending on health per person since 2009 (Fig. 2). Out-of-pocket payments per person have also grown over time, with a particularly sharp increase in 2014, but at a slower rate than public spending on health.

Public spending on health accounted for 16% of total government spending in Malta in 2022, above the EU average of 15% and on a par with Czechia, France and Spain, reflecting a substantial increase in the priority given to health when allocating the government budget in Malta since a low of 12% in 2008 (Fig. 3).

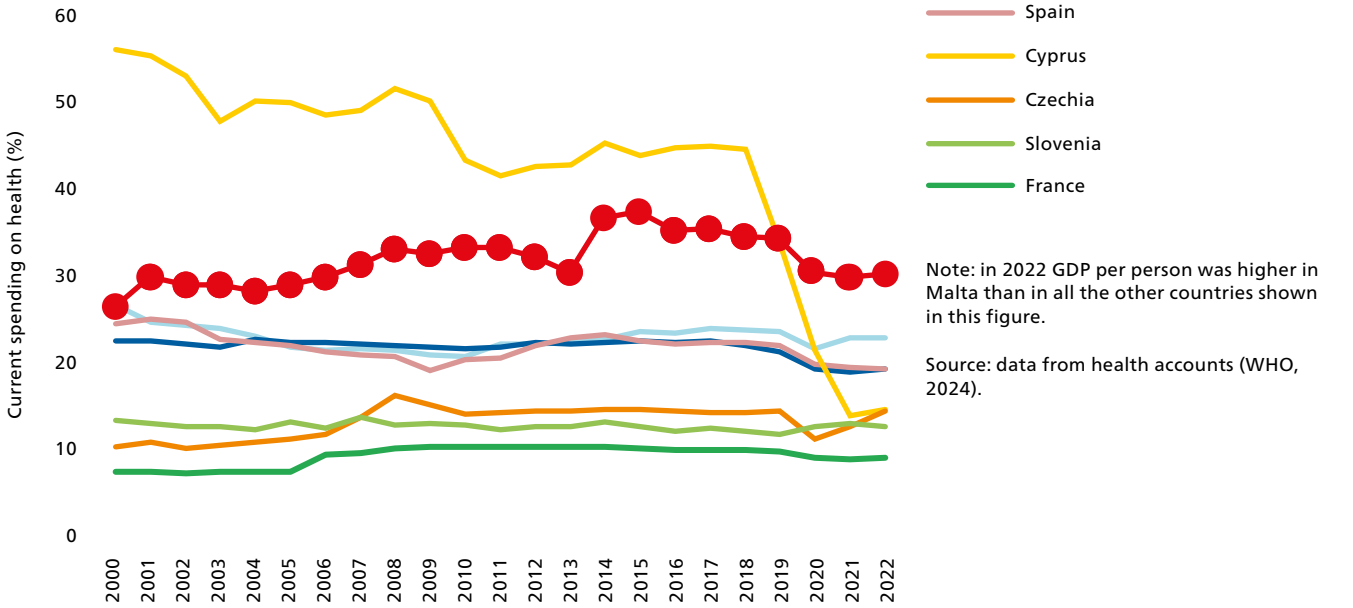
As a share of GDP, however, public spending on health was much lower in Malta (6.4% in 2022) than in France (8.9%) and several other countries with a lower level of GDP per person (e.g. Cyprus: 7.1%; Czechia: 7.5%; Portugal: 6.5%; and Spain: 7.2%) (Fig. 4). By this important measure, Malta lagged behind the EU average between 2008 and 2019 (Fig. 5). It was only during the COVID-19 pandemic that Malta caught up with the EU average, in part due to a sharp drop in GDP in Malta in 2020 (Eurostat, 2025c).

This lag in public spending on health as a share of GDP, in spite of a relatively high "priority" to health, may reflect the relatively small size of government spending in Malta. In 2022 total government spending accounted for only 39% of GDP in Malta compared to an EU average of 45% (data not shown) (WHO, 2025). But in the years before the COVID-19 pandemic, this difference was even greater – for example, 35% in Malta in 2019 – the lowest rate in the EU after Bulgaria, Lithuania and Romania – compared to an EU average of 43%.

Broken down by type of health care and financing scheme, national health accounts data show that in 2022 the out-of-pocket payment share of spending on outpatient care was more than two times higher in Malta (38%) than the EU average (17%) and also much higher than the EU average for dental care (80% versus 59%) but close to the EU average for outpatient medicines (41% versus 39%) (Fig. 6).

Between 2015 and 2022, the out-of-pocket payment share of spending by type of health care fell sharply in Malta for outpatient medicines (from 60% to 41%) and diagnostic tests (from 51% to 42%), remained at similar levels for medical products, outpatient care and dental care and doubled for inpatient care (Fig. 7). These shifts reflect an increase in the public share of spending on outpatient medicines and diagnostic tests (Fig. 7).

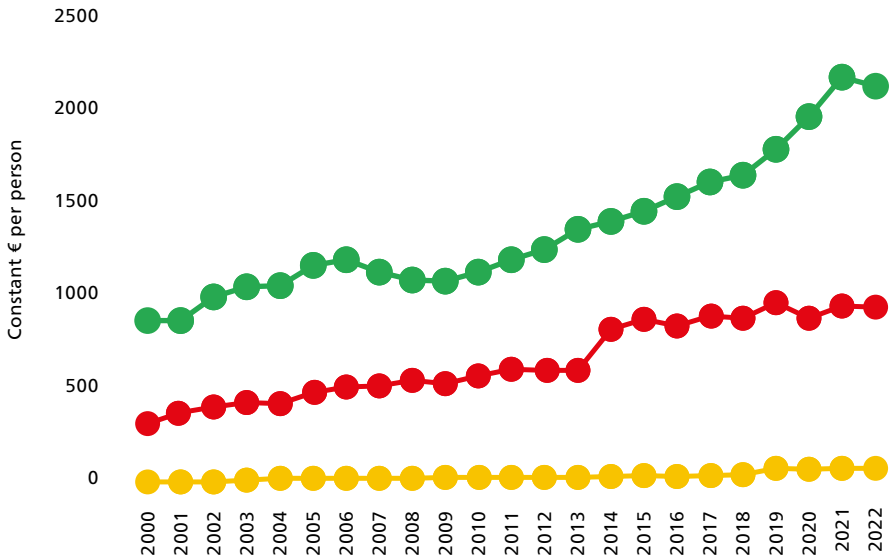
Fig. 1. Out-of-pocket payments as a share of current spending on health, Malta and EU countries with a similar or lower level of GDP per person



Note: in 2022 GDP per person was higher in Malta than in all the other countries shown in this figure.

Source: data from health accounts (WHO, 2024).

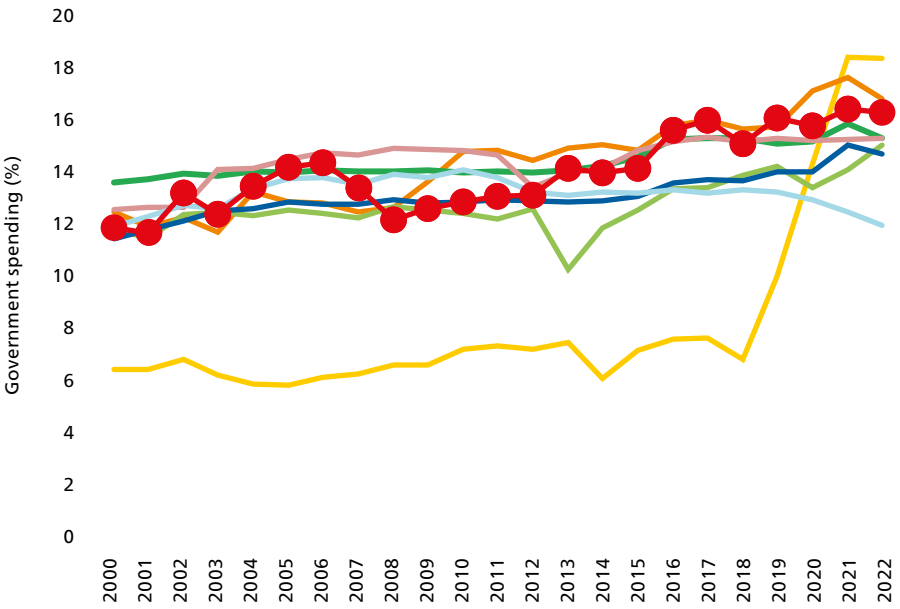
Fig. 2. Health spending per person by financing scheme



Notes: amounts are shown in real terms (2022 constant prices). VHI is defined here as a coverage scheme provided on a voluntary basis by enterprises or purchased by individuals.

Source: data from health accounts (WHO, 2025).

Fig. 3. Public spending on health as a share of total government spending ("priority to health"), Malta and EU countries with a similar or lower level of GDP per person



Notes: in 2022 GDP per person was higher in Malta than in all the other countries shown in this figure. Public spending on health is defined here as revenue from the government budget and social health insurance contributions.

Source: data from health accounts (WHO, 2024).

Fig. 4. Public spending on health as a share of GDP and GDP per person in the EU, 2022

Notes: Malta is shown in red. Public spending on health is defined here as revenue from the government budget and social health insurance contributions. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and the Netherlands (Kingdom of the) because Dutch data on public spending on health are not internationally comparable. The list of country codes used here can be found in the Abbreviations.

Source: data from health accounts (WHO, 2025).

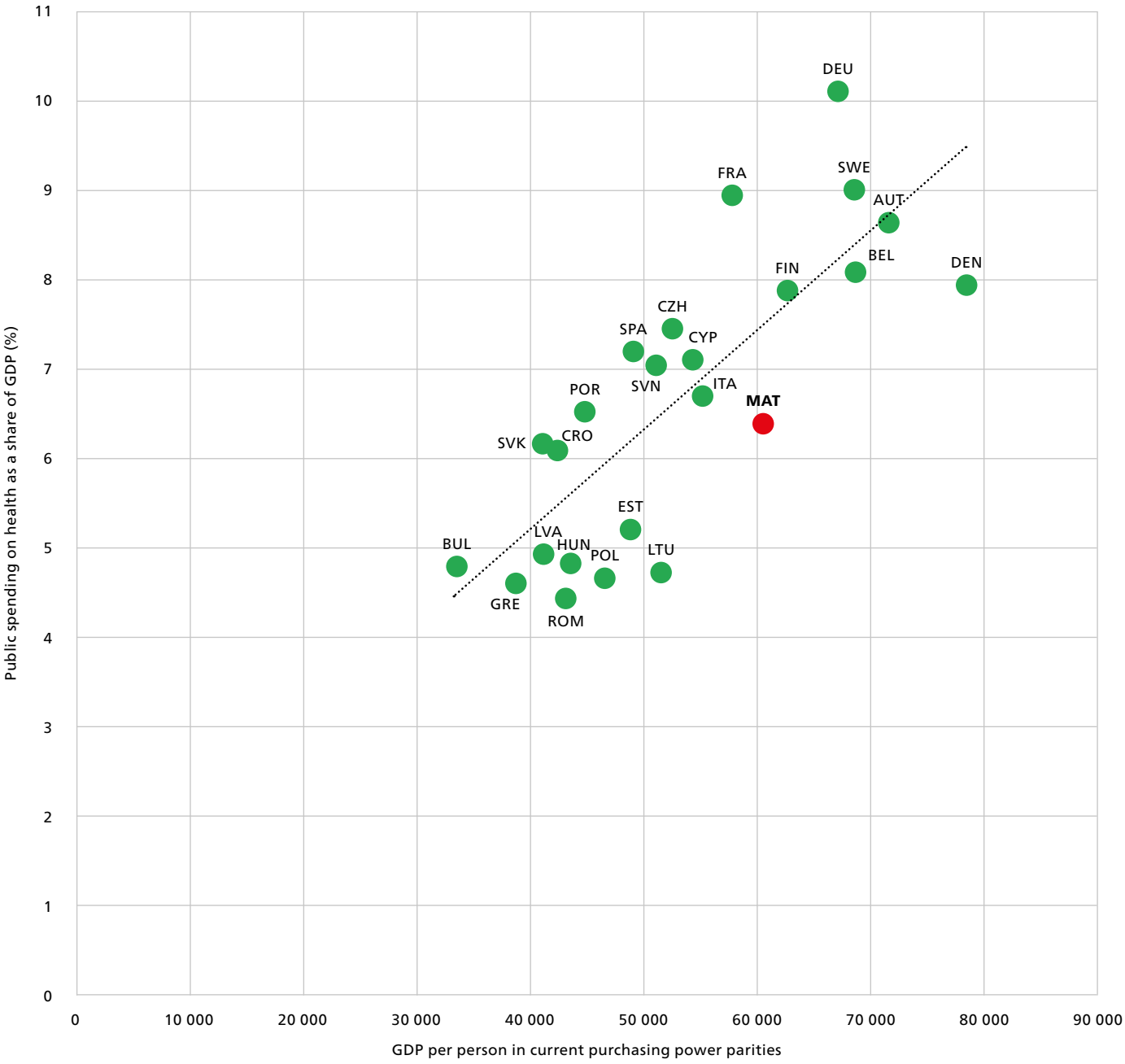
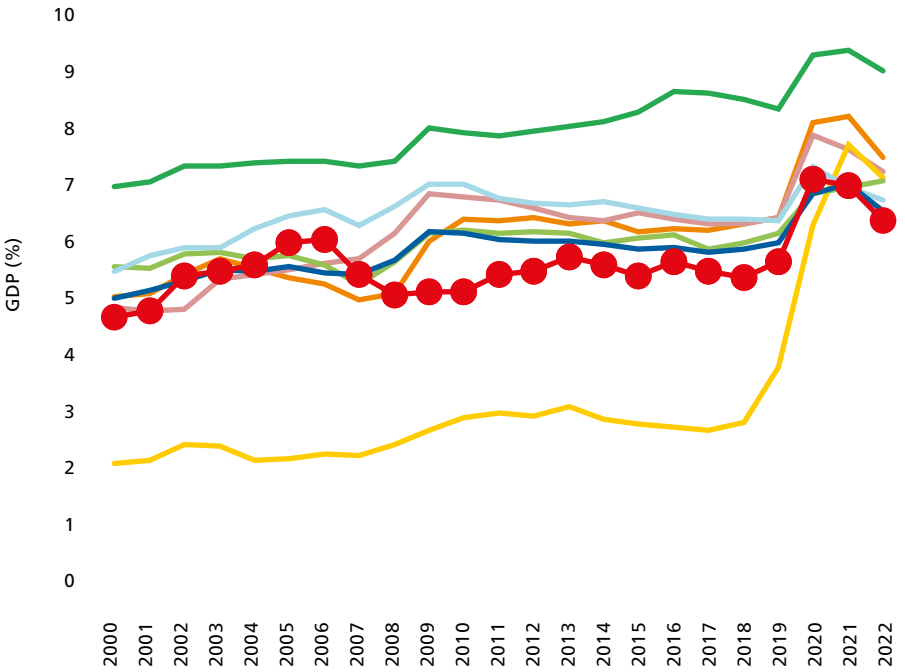


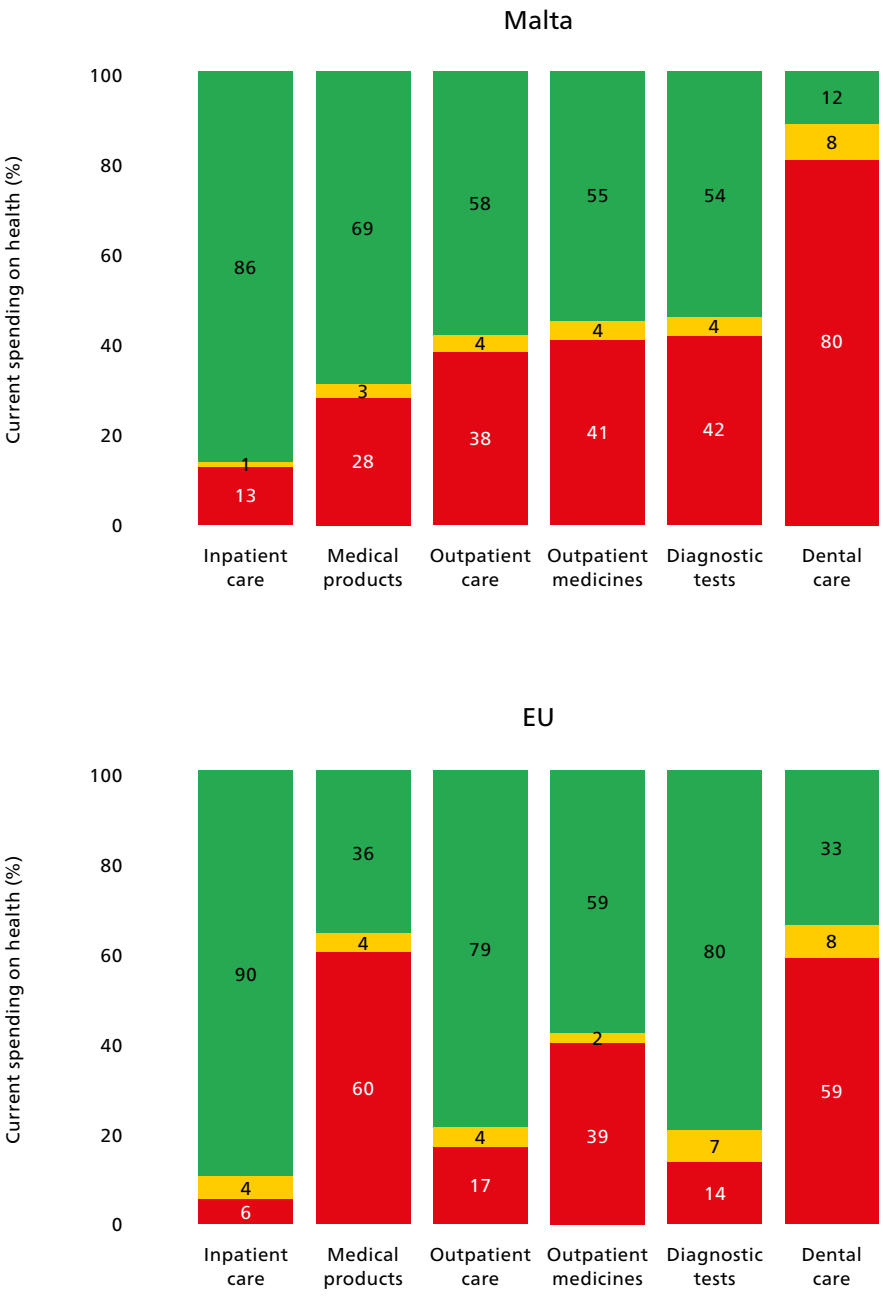
Fig. 5. Public spending on health as a share of GDP in Malta and EU countries with a similar or lower level of GDP per person



Notes: in 2022 GDP per person was higher in Malta than in all the other countries shown in this figure. Public spending on health is defined here as revenue from the government budget and social health insurance contributions.

Source: data from health accounts (WHO, 2025).

Fig. 6. Breakdown of current spending on health by type of care and financing scheme, Malta and the EU, 2022



Public spending on health

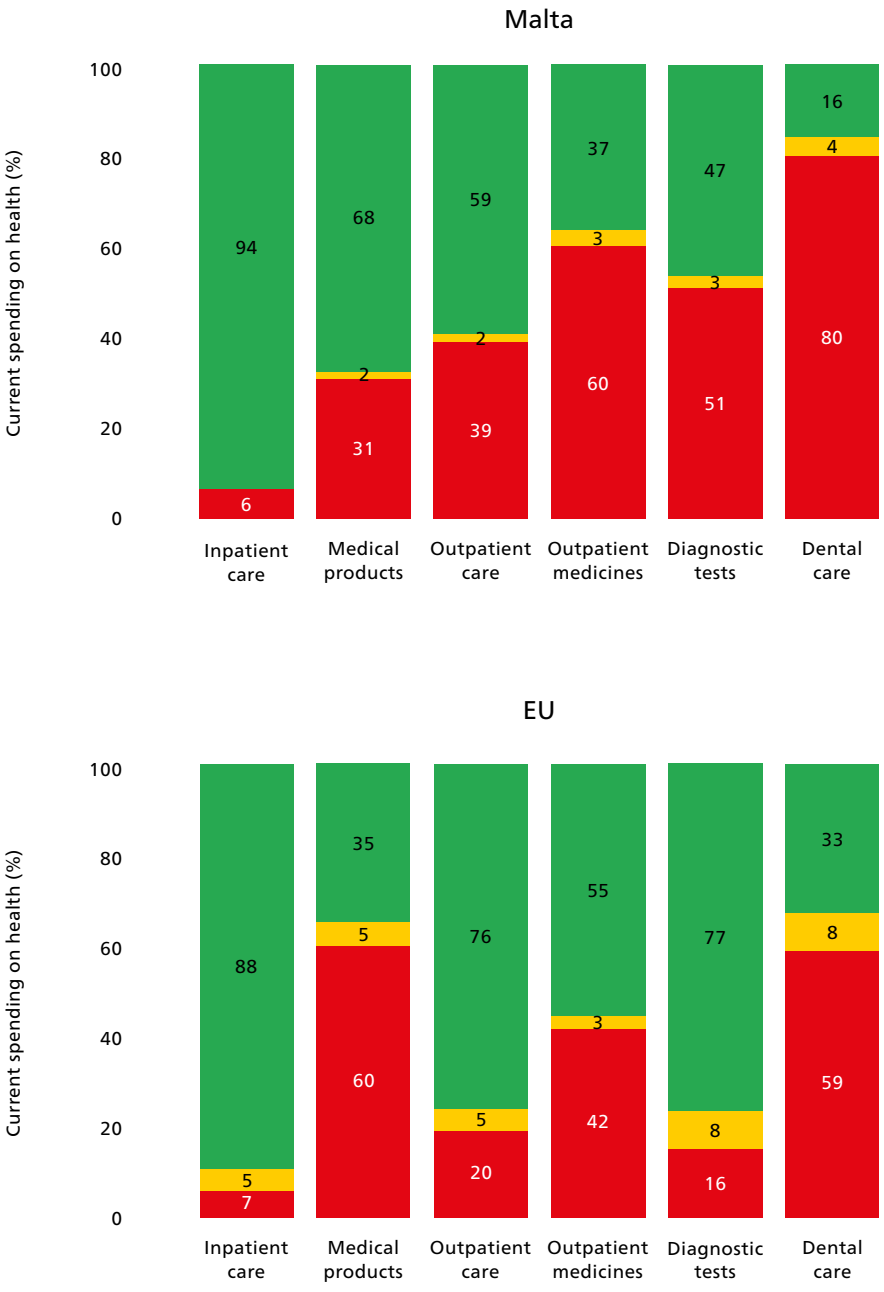
VHI

Out-of-pocket payments

Note: the EU average for outpatient care excludes Ireland, Italy and Portugal as these countries do not report dental care separately from other types of outpatient care. The EU average for diagnostic tests excludes Denmark, Ireland, Italy and Portugal as these countries do not report patient transport separately from ancillary services.

Source: data from health accounts (OECD, 2025).

Fig. 7. Breakdown of current spending on health by type of care and financing scheme, Malta and the EU, 2015



Public spending on health

VHI

Out-of-pocket payments

Note: the EU average for outpatient care excludes Ireland, Italy and Portugal as these countries do not report dental care separately from other types of outpatient care. The EU average for diagnostic tests excludes Denmark, Ireland, Italy and Portugal as these countries do not report patient transport separately from ancillary services.

Source: data from health accounts (OECD, 2025).

4.2 Out-of-pocket payments

Household budget survey data show that just over 80% of households reported out-of-pocket payments in 2008 and 2015 (the latest year of household budget survey data available; see the methods section for more information) (Fig. 8). Households in the richest consumption quintile are consistently more likely to report out-of-pocket payments than households in the poorest quintile, reflecting their greater ability to pay for health care (Fig. 8). Between 2008 and 2015 the share of households reporting out-of-pocket payments fell slightly in all except the poorest consumption quintile, where it increased by six percentage points. Because the household budget survey does not include questions on health care use or unmet need for health care, it is not possible to say whether poorer households are less likely to incur out-of-pocket payments due to access barriers or exemptions from co-payments.

The average annual amount spent out-of-pocket per person was €517 in 2015, with the richest quintile spending about four times more than the poorest quintile (Fig. 9). The average annual amount spent increased slightly between 2008 and 2015 in all except the richest quintile, where it fell sharply.

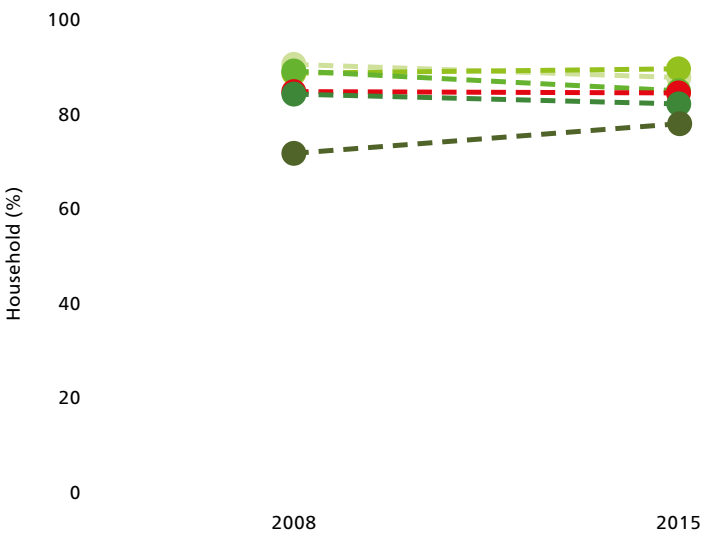
Out-of-pocket payments accounted for 5.7% of total household spending (the household budget) in 2015 and was higher in the poorest quintile (6.1%) than in the richest quintile (5.8%) (Fig. 10). Between 2008 and 2015 this share increased sharply in the poorest quintiles, increased slightly in the other quintiles and fell in the richest quintile, making the distribution of out-of-pocket payments more regressive in 2015 than in 2008.

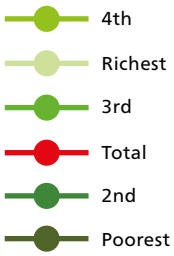
In 2015 out-of-pocket payments were largely driven by spending on outpatient medicines (46%), followed by outpatient care and dental care (18% each), medical products (9%), diagnostic tests (7%) and inpatient care (2%) (Fig. 11). Between 2008 and 2015 the dental care share more than doubled, while the medical products and outpatient care shares fell.

Outpatient medicines were the largest single driver of out-of-pocket payments in all quintiles in 2015, with a share ranging from 36% in the richest quintile to 60% in the poorest (Fig. 12). The share spent on dental care more than doubled across all quintiles over time and the medical products share fell in all quintiles, but the outpatient care share mainly fell in the richest quintile.

These shifts in the drivers of out-of-pocket payments across quintiles reflect changes in the amount spent per person (Fig. 13). Per person spending on dental care, outpatient medicines and inpatient care increased between 2008 and 2015, mainly driven by higher spending in the richest quintiles (Fig. 14). Per person spending on outpatient care and medical products fell sharply overall, mainly driven by lower spending in the richest quintiles. Spending on diagnostic tests remained relatively stable across years and quintiles.

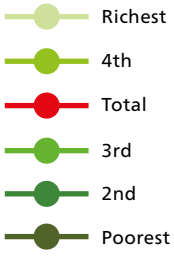
Fig. 8. Share of households with out-of-pocket payments by consumption quintile





Source: authors, based on household budget survey data.

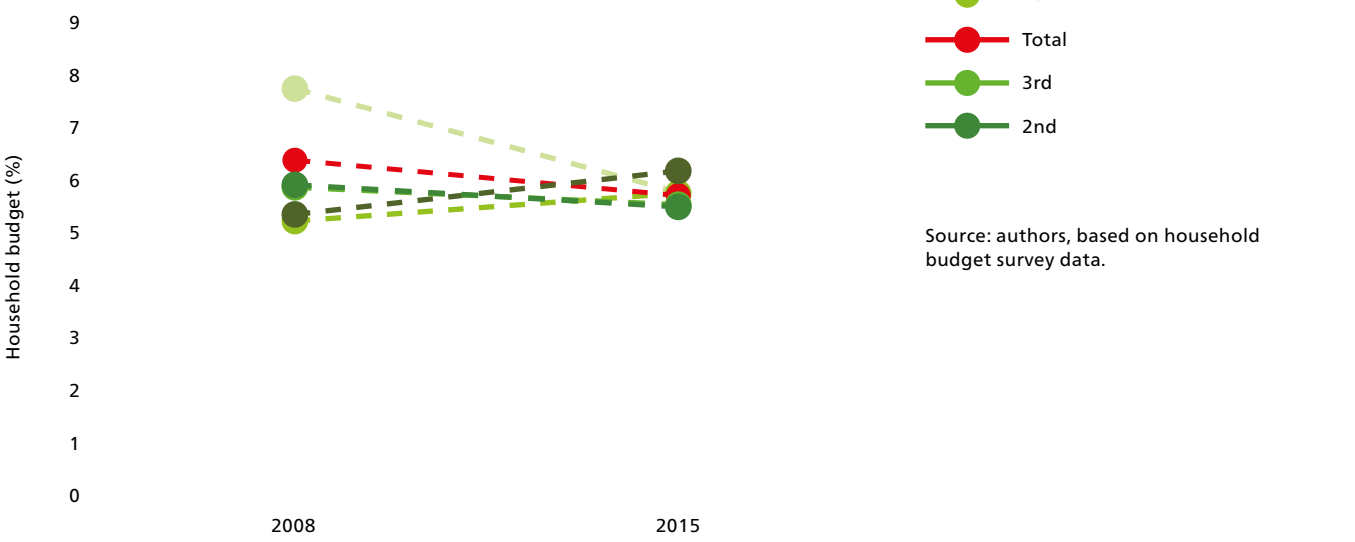
Fig. 9. Annual out-of-pocket spending on health care per person by consumption quintile



Note: amounts are shown in real terms (base year 2020).

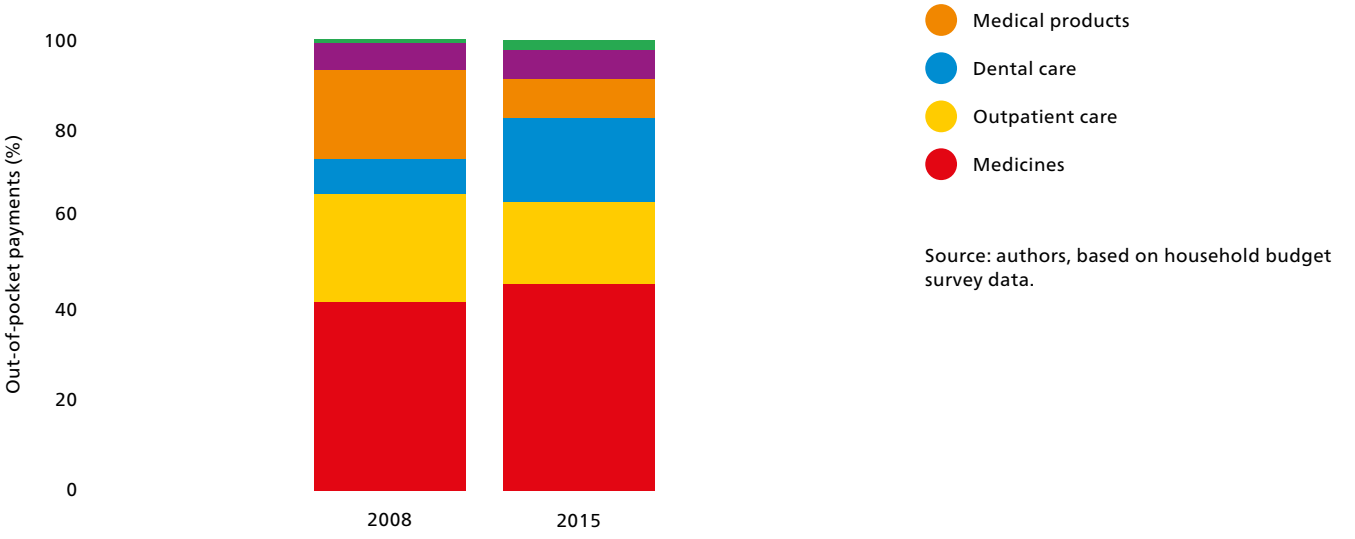
Source: authors, based on household budget survey data.

Fig. 10. Out-of-pocket payments for health care as a share of household spending by consumption quintile



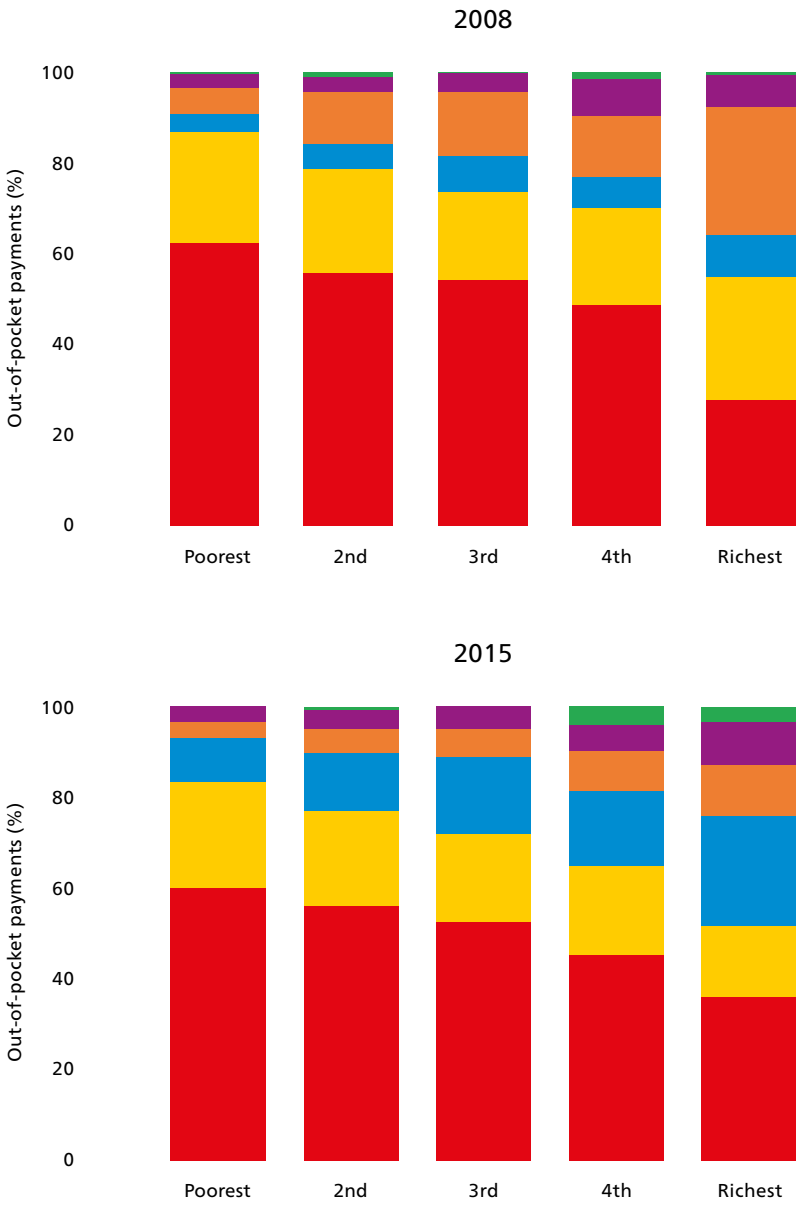
Source: authors, based on household budget survey data.

Fig. 11. Breakdown of out-of-pocket spending by type of health care



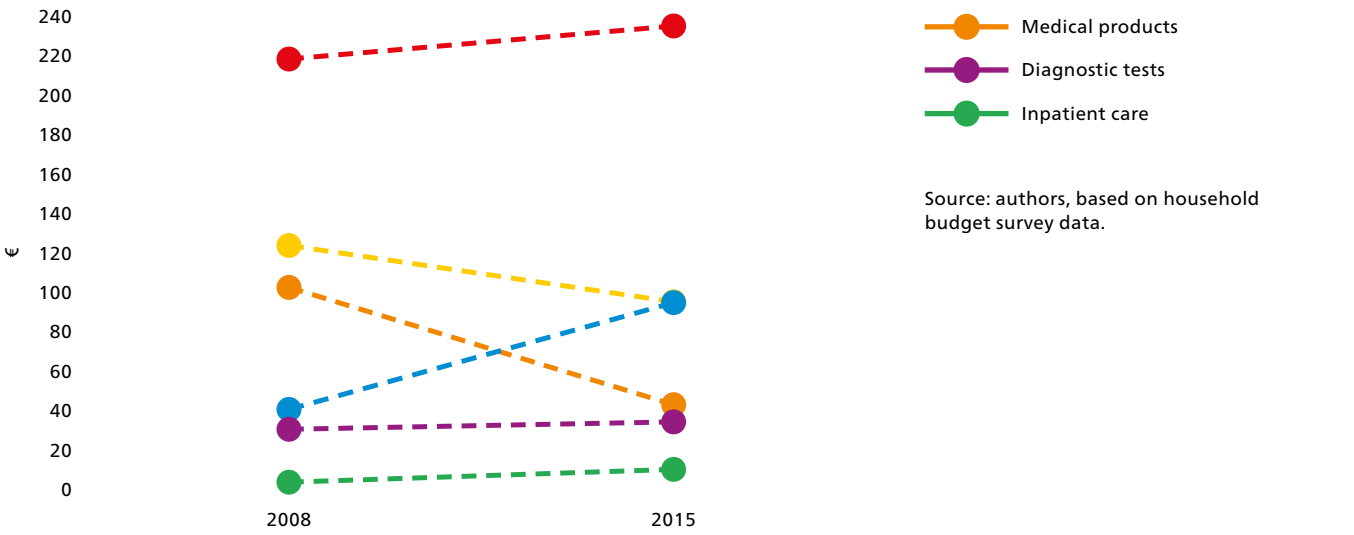
Source: authors, based on household budget survey data.

Fig. 12. Breakdown of total out-of-pocket spending by type of health care and consumption quintile



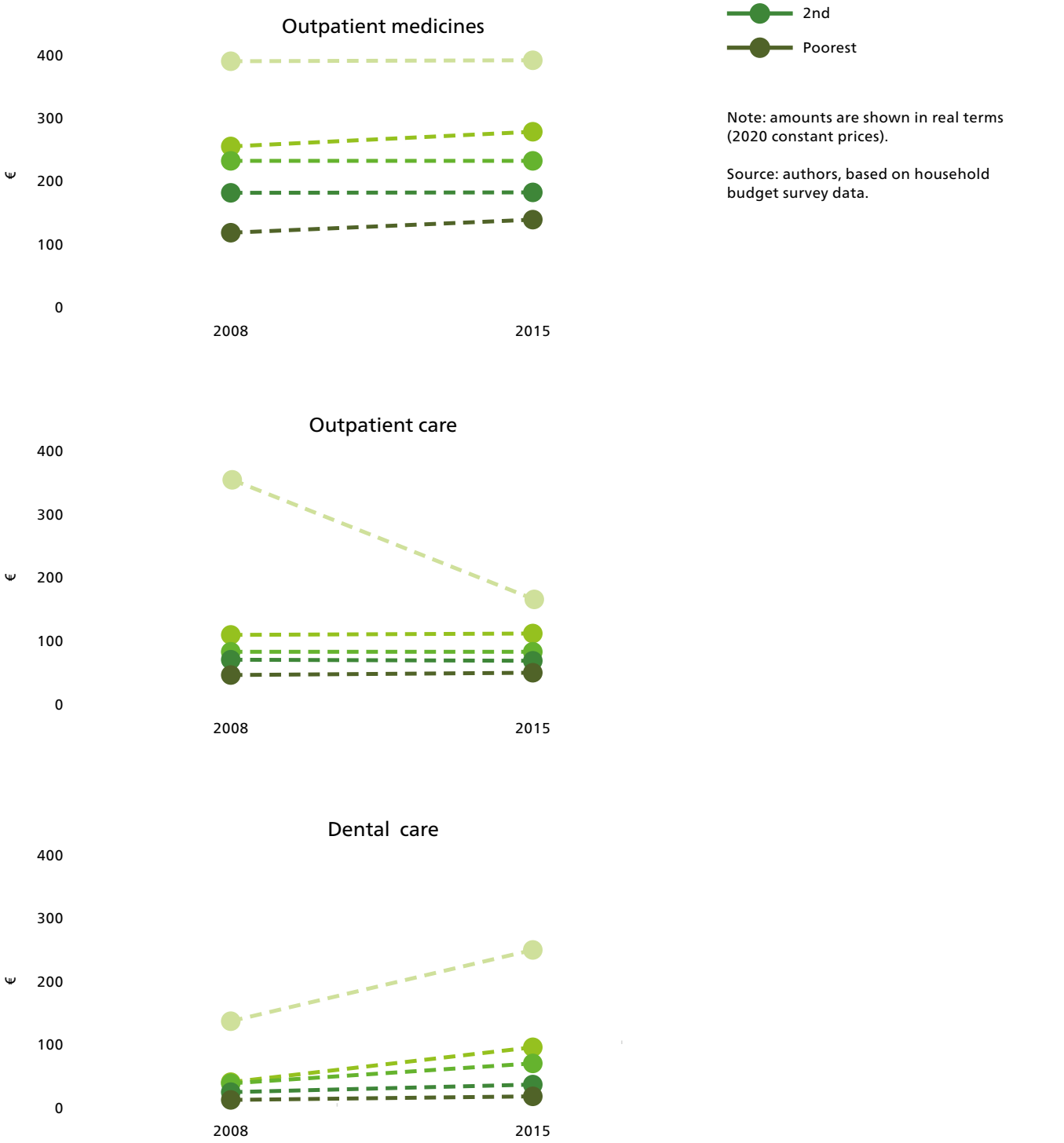
Source: authors, based on household budget survey data.

Fig. 13. Annual out-of-pocket spending on health care per person by type of health care



Source: authors, based on household budget survey data.

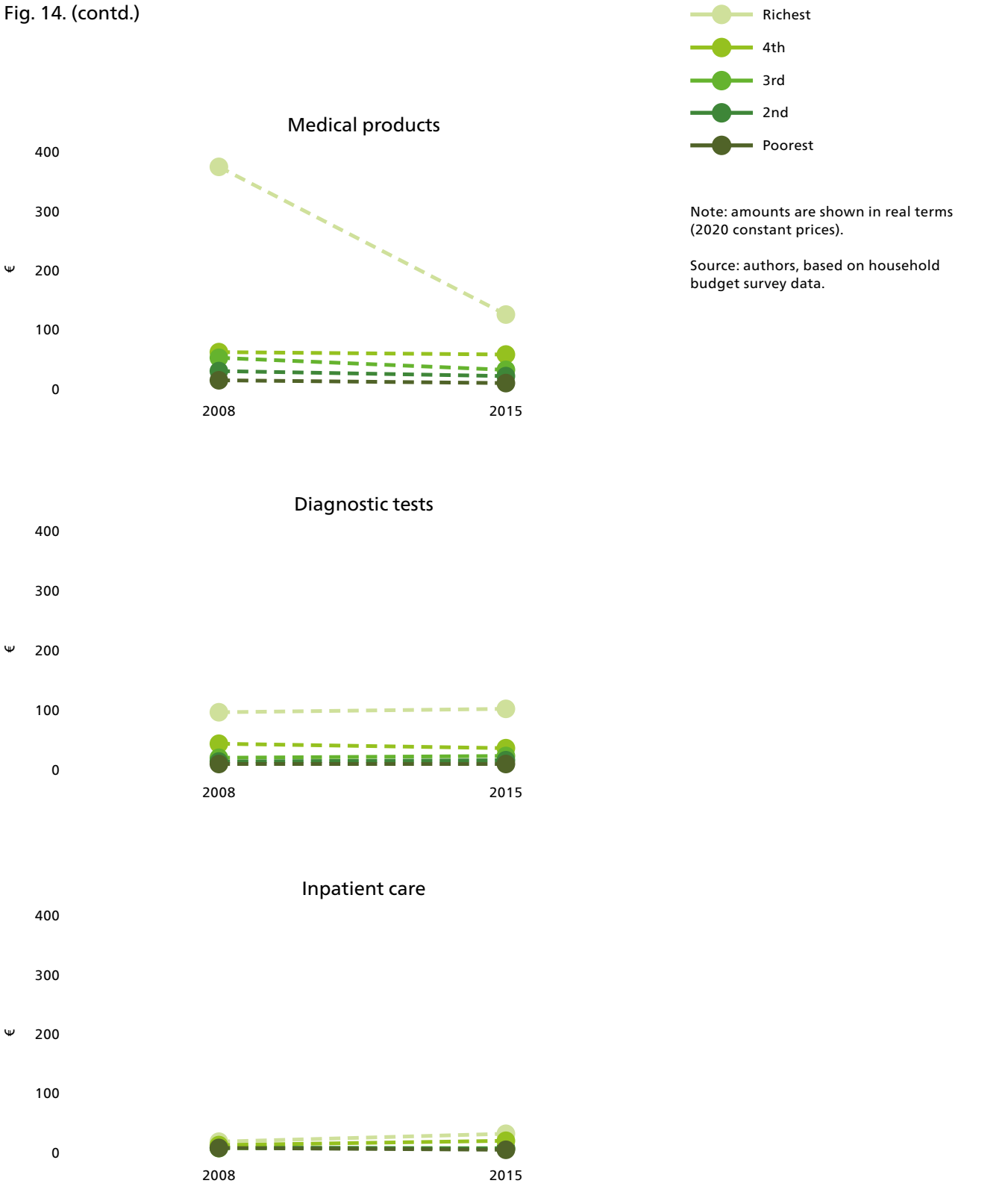
Fig. 14. Annual out-of-pocket spending per person by type of health care and consumption quintile



Note: amounts are shown in real terms (2020 constant prices).

Source: authors, based on household budget survey data.

Fig. 14. (contd.)



Note: amounts are shown in real terms (2020 constant prices).

Source: authors, based on household budget survey data.

4.3 Informal payments

The Eurobarometer survey found that 1% of respondents in Malta reported having made an informal payment for health care in 2023, below the EU average of 3% and down from 2% in 2023 (European Commission, 2025). Informal payments are not considered to be a major issue in Malta.

4.4 Summary

Data from national health accounts indicate that out-of-pocket payments accounted for 30% of current spending on health in 2022, well above the EU average of 19% and higher than every other EU country except Bulgaria and Lithuania. The out-of-pocket payment share has fallen sharply over time, from a peak of 37% in 2015, largely due to steady growth in public spending on health per person, but public spending on health has not kept pace with GDP growth.

As a share of GDP, public spending on health was lower in Malta in 2022 than in several EU countries with a lower level of GDP per person. By this important measure, Malta lagged well behind the EU average between 2008 and 2019 and only caught up with the EU average during the COVID-19 pandemic.

Broken down by type of health care and financing scheme, national health accounts data show that Malta relies much more heavily on out-of-pocket payments than the EU average to finance outpatient care, dental care and outpatient medicines. However, between 2015 and 2022 (the latest available year of data for Malta), the out-of-pocket payment share of spending by type of health care fell for outpatient medicines and diagnostic tests, reflecting increases in the public share of spending on these items. In contrast, the out-of-pocket payment share of spending on inpatient care doubled.

Household budget survey data show that the richest households spent about four times as much as the poorest households out of pocket in 2015 (the latest year of household budget survey data available), reflecting their greater ability to pay for health care. Out-of-pocket payments increased slightly over time in all except the richest quintile. They accounted for 5.7% of a household's budget in 2015 on average; the distribution across quintiles became more regressive over time.

Out-of-pocket payments are mainly spent on outpatient medicines (46% in 2015), followed by outpatient care and dental care (18% each), medical products (9%), diagnostic tests (7%) and inpatient care (2%). Between 2008 and 2015 the share spent on dental care more than doubled, while the shares spent on medical products and outpatient care fell. Outpatient medicines and outpatient care account for a greater share of out-of-pocket payments in poorer households, while dental care, medical products and inpatient care account for a greater share in richer households.

Informal payments are not considered to be an issue in Malta. There are no national studies and no systematic monitoring of informal payments.

5. Financial protection

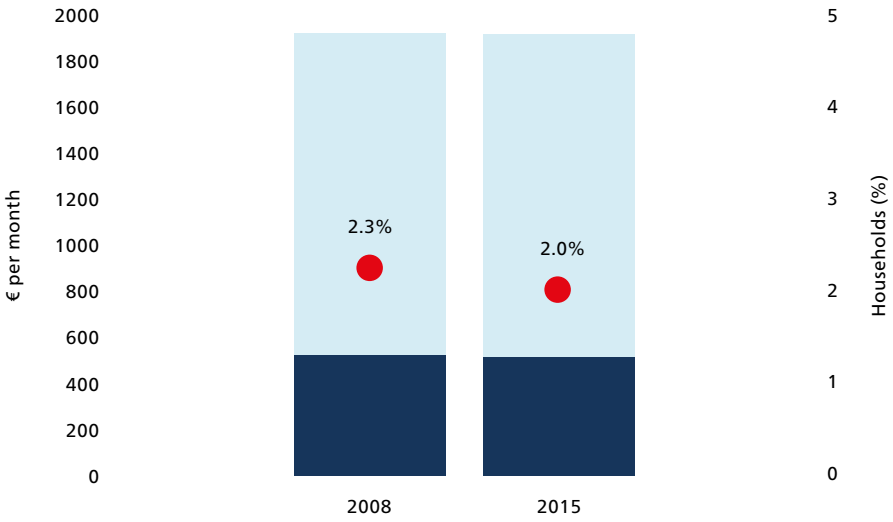
This section uses data from the Maltese household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health care. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and estimates the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health care.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after deducting a normative amount to cover spending on basic needs. Basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and heating) among a relatively poor part of the Maltese population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In this study, consumption is calculated net of rent because rent is not available in the household budget survey. In 2015 (the latest year of household budget survey data available; see the methods section for more information) the monthly cost of meeting these basic needs (the basic needs line) was €521, down slightly from €531 in 2008 (Fig. 15). This is very low compared to Malta's monthly national poverty line of €838 in 2015 (60% of median income).

Household capacity to pay for health care and the share of households living below the basic needs line (2%) did not change much over time. This might reflect the fact that Malta was not particularly affected by the global financial crisis in 2008 and, unlike many other countries, experienced only a slight dip in GDP per person in 2009 (data not shown; World Bank, 2025). Despite relatively stable economic growth in the last 20 years, the risk of poverty or social exclusion in Malta has grown substantially among older people in the last decade, rising from 21% in 2013 to 31% in 2023, and is now much higher than the EU average for this group (Fig. 16).

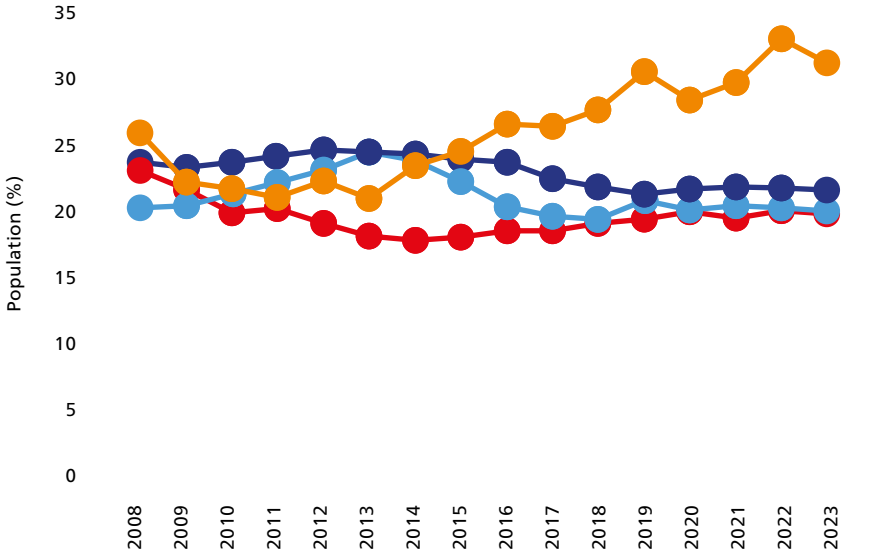
Fig. 15. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic needs line



Notes: amounts are shown in real terms (2020 as base year). Capacity to pay for health care is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. The basic needs line and capacity to pay for health care are per household.

Source: authors, based on household budget survey data.

Fig. 16. Share of the population at risk of poverty or social exclusion, Malta and the EU



Note: data for Malta and the EU average refer to people between 16–64 years at risk or poverty or social exclusion.

Source: Eurostat (2024c).

5.2 Financial hardship

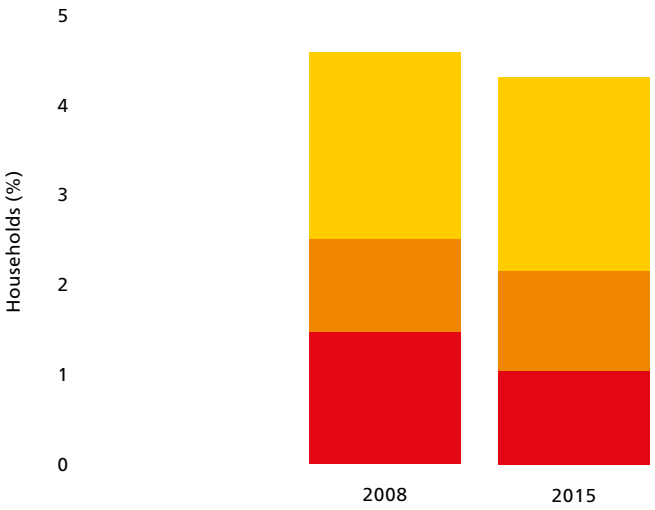
How many households experience financial hardship?

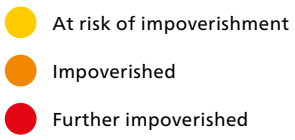
Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2015 (the latest year of household budget survey data available; see the methods section for more information) 2% of households were impoverished or further impoverished after out-of-pocket payments (Fig. 17). Impoverishing health spending decreased in 2015, mainly driven by a decrease in the share of further impoverished households.

Households with catastrophic health spending are defined in this study as those who spend more than 40% of their capacity to pay for health care. In 2015 just under 7% of households – around 11 537 people – experienced catastrophic health spending, similar to 2008 (Fig. 18).

The incidence of catastrophic health spending is higher in Malta than in many EU countries, but it is lower than in countries with similar or lower reliance on out-of-pocket payments such as Bulgaria, Greece, Italy, Lithuania and Portugal (Fig. 19).

Fig. 17. Share of households at risk of impoverishment after out-of-pocket payments

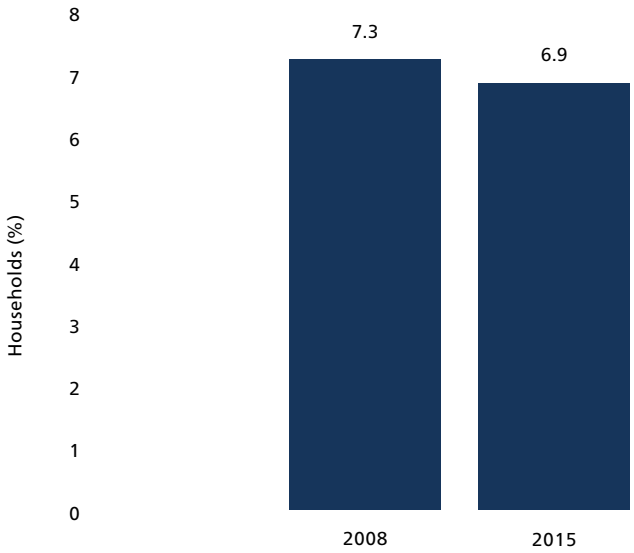




Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line.

Source: authors, based on household budget survey data.

Fig. 18. Share of households with catastrophic health spending

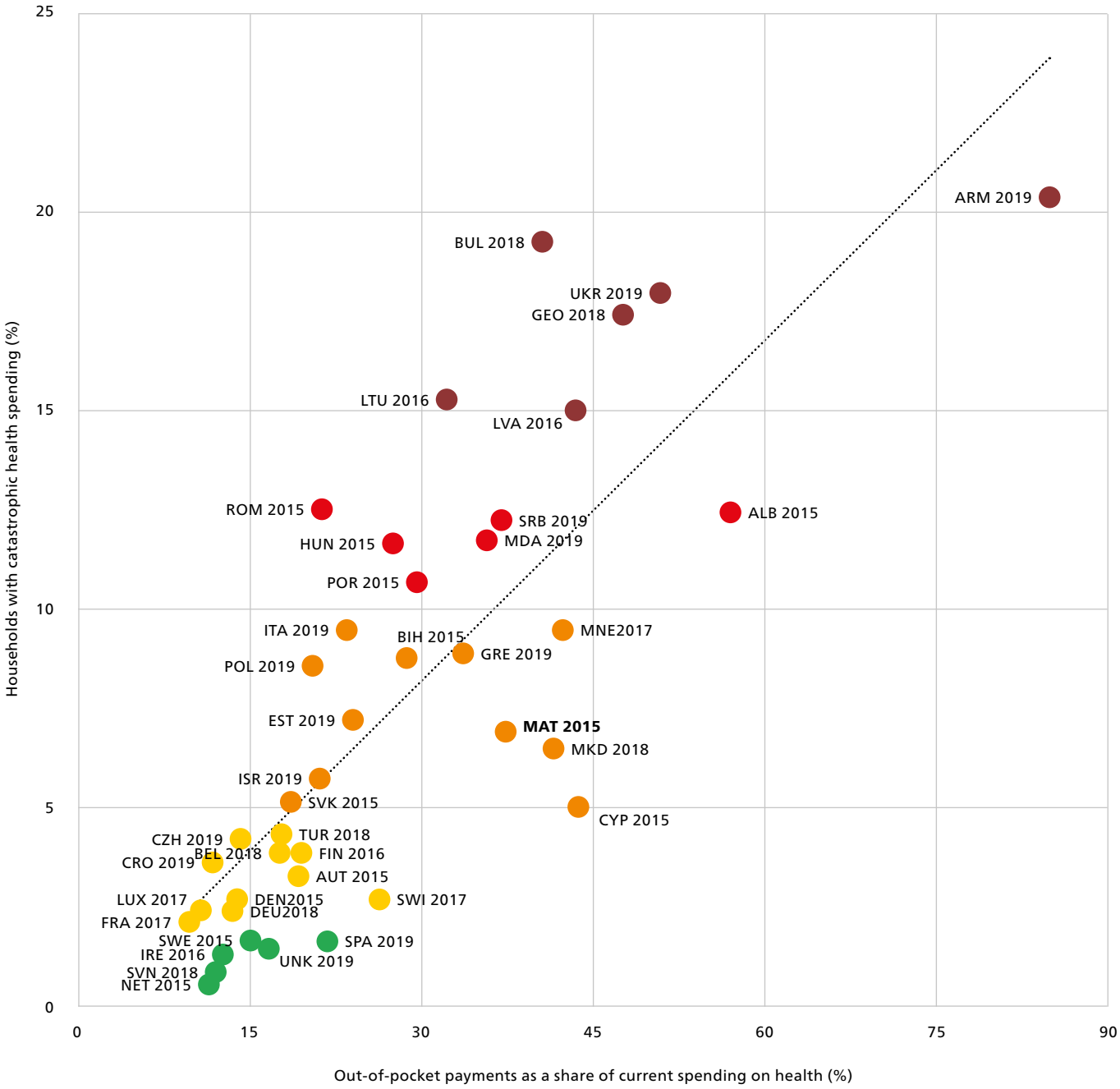


Source: authors, based on household budget survey data.

Fig. 19. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, 2019 or the latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red > 15%. The list of country codes used here can be found in the Abbreviations.

Source: data on catastrophic health spending from UHC watch (2025) and data on out-of-pocket payments from WHO (2025).



Who experiences financial hardship?

In both years just over half of all households with catastrophic health spending were further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 20). The share of further impoverished households fell over time.

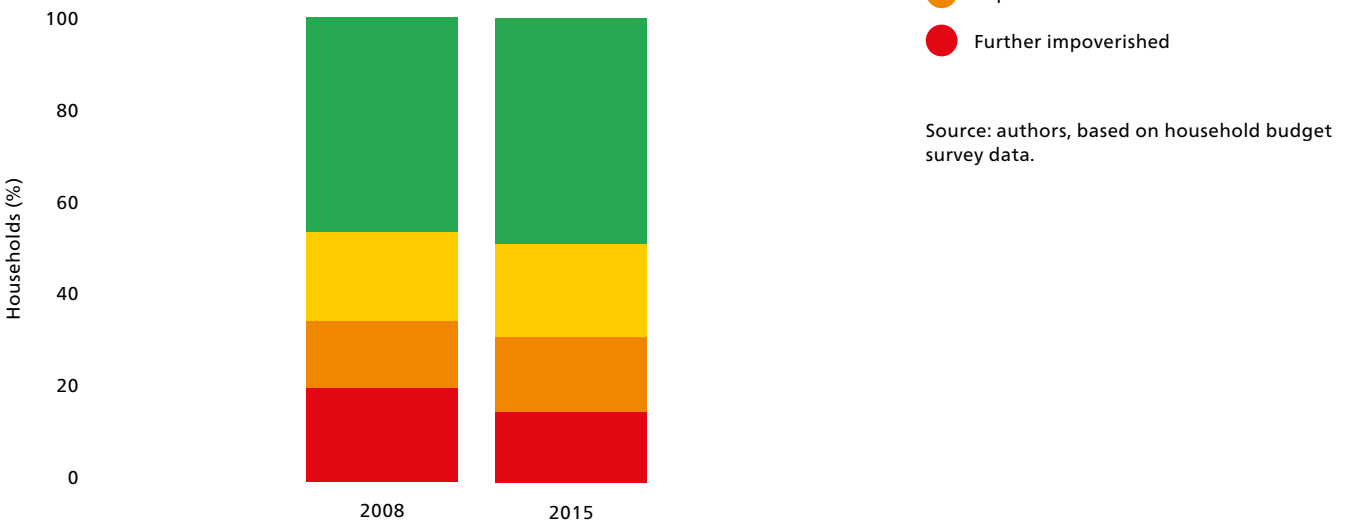
Households experiencing catastrophic health spending were heavily concentrated in the poorest consumption quintile in both years (Fig. 21). In 2015 households in the poorest quintile accounted for 63% of all households with catastrophic health spending. The incidence of catastrophic health spending is much higher in the poorest quintile (22%) than in the richest (4%) (Fig. 22).

In 2015 the incidence of catastrophic health spending was also high in households headed by "other inactive" people (18%), housekeepers (15%), people aged over 60 years (14%), retired people (10%) and people living in the Southern Harbour area (9%) – all groups likely to overlap with households in the poorest quintile (Fig. 22).

The incidence of catastrophic health spending fell in older households between 2008 and 2015 (Fig. 22). However, broken down by age of the head of the household, households headed by older people accounted for by far the largest share of households with catastrophic health spending in 2015 (70%). This finding, combined with the sharp increase in the risk of people aged over 65 at risk of poverty or social exclusion since 2015 (see Fig. 16), suggests that older people are still likely to be at high risk of experiencing financial hardship due to out-of-pocket payments.

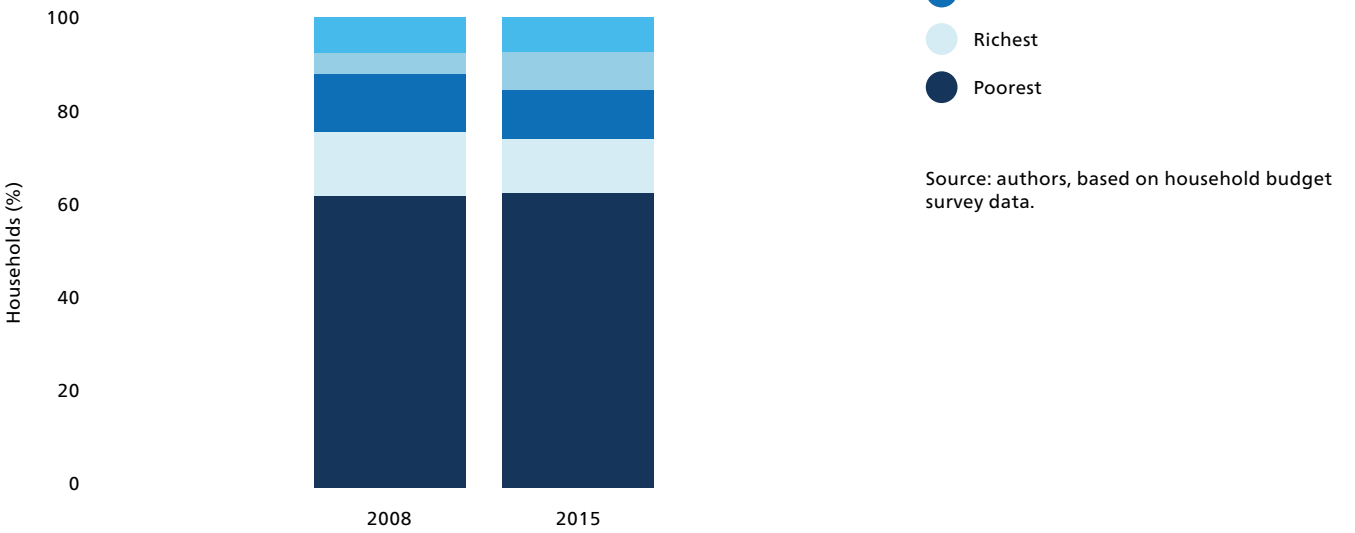
Catastrophic and impoverishing out-of-pocket payments impose a heavy financial burden on households with very low incomes, accounting on average for 17% of a household's budget in the poorest quintile in 2015 and 9% in further impoverished households (data not shown). These shares are much higher than the average share of household budgets spent on health care (5.7%) and the average share spent in the poorest quintile (6.1%) (see Fig. 10).

Fig. 20. Breakdown of households with catastrophic health spending by risk of impoverishment



Source: authors, based on household budget survey data.

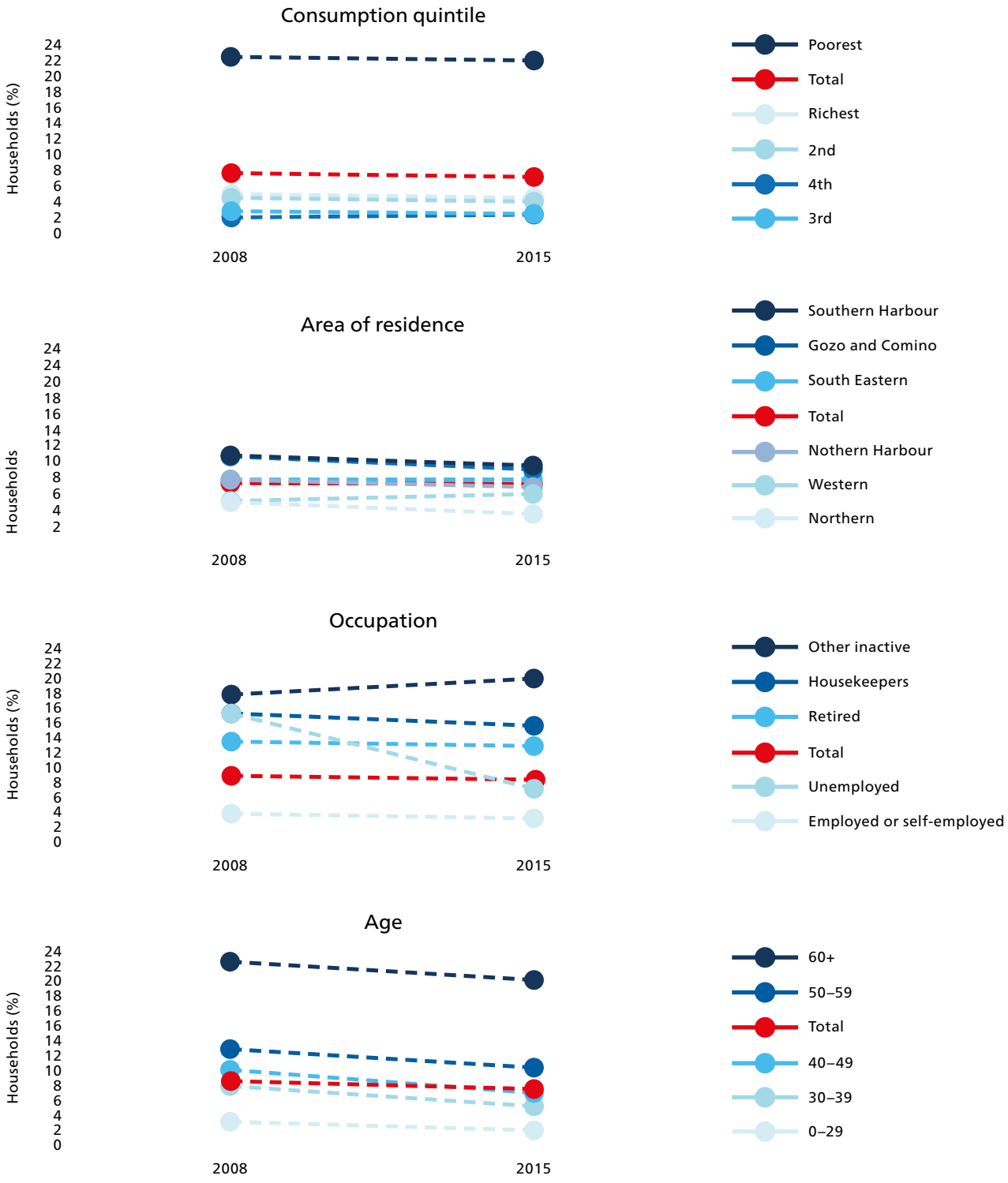
Fig. 21. Breakdown of households with catastrophic health spending by consumption quintile



Source: authors, based on household budget survey data.

Fig. 22. Share of households with catastrophic health spending by consumption quintile, area of residence, occupation and age of the head of the household

Note: Southern Harbour is a poorer area with many migrants.
Source: authors, based on household budget survey data.

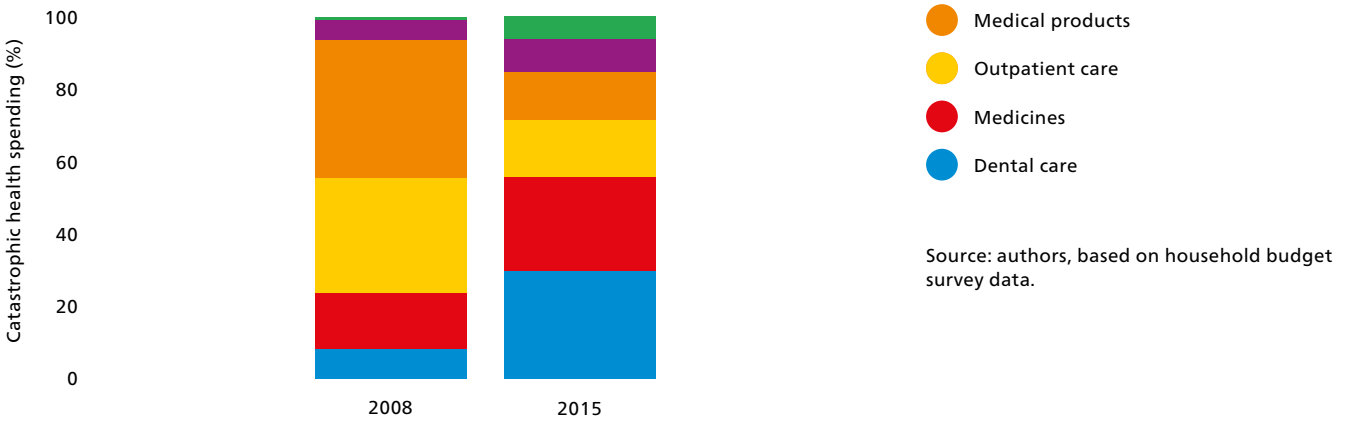


Which health services are responsible for financial hardship?

In 2015 catastrophic health spending was mainly driven by dental care (30%) and outpatient medicines (26%), followed by outpatient care (16%) and medical products (13%) (Fig. 23). Between 2008 and 2015 the shares spent on dental care and outpatient medicines grew, while the medical products and outpatient care shares fell.

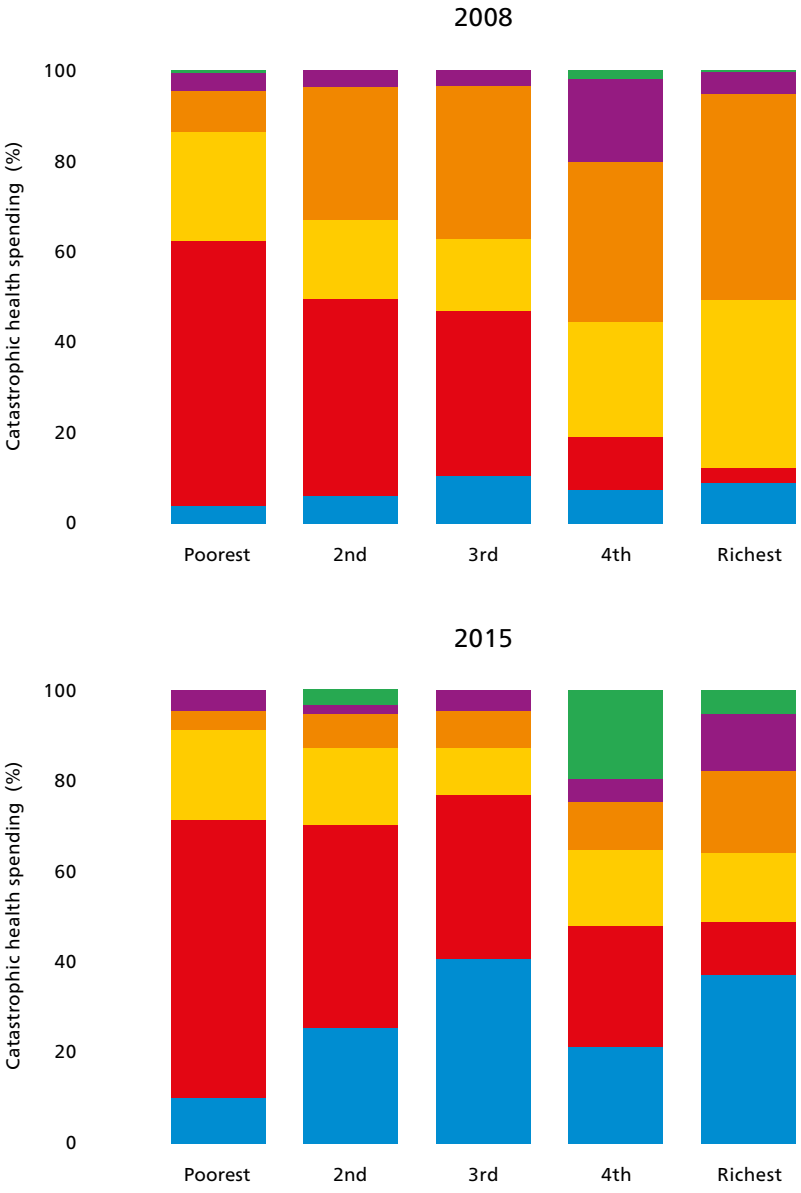
In the poorest quintile catastrophic health spending is mainly driven by outpatient medicines (62%) and outpatient care (20%), followed by dental care (10%) (Fig. 24). Dental care is a larger driver in the other quintiles, probably reflecting a higher degree of unmet need in poorer households. The role of dental care in driving catastrophic health spending grew over time in all quintiles.

Fig. 23. Breakdown of catastrophic health spending by type of health care



Source: authors, based on household budget survey data.

Fig. 24. Breakdown of catastrophic health spending by type of health care and consumption quintile



Source: authors, based on household budget survey data.

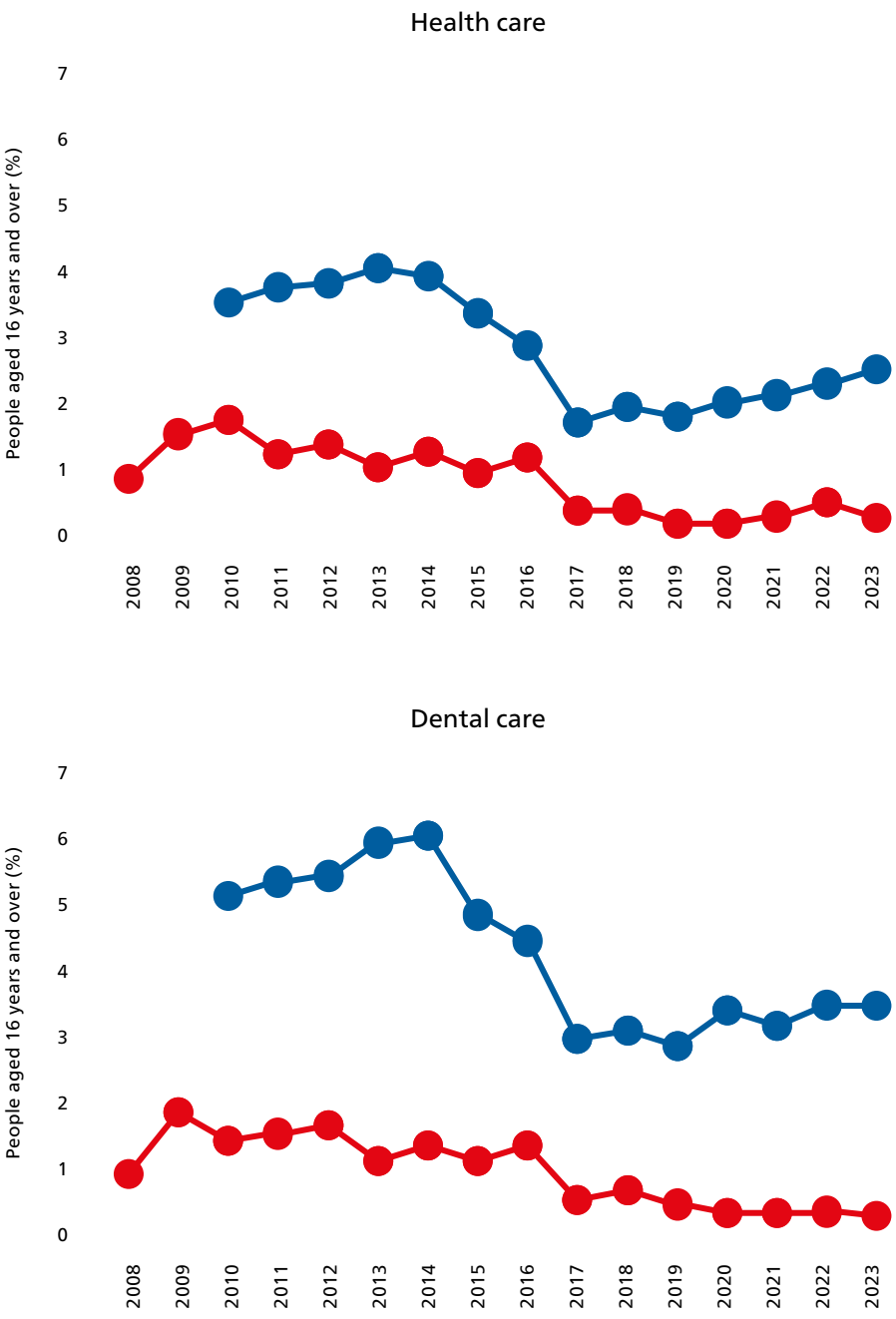
5.3 Unmet need for health care

Unmet need measures instances in which people do not receive health care when they need it because of access barriers (see Box 1). EU-SILC data up to 2023 (the latest year available) indicate that unmet need levels in Malta are consistently below the EU average for both health care and dental care (Fig. 25). In 2020 EU-SILC data collection in Malta was affected by the COVID-19 pandemic, with fieldwork taking place by phone from March 2020 onwards, resulting in lower response rates.

In 2023 only 0.1% and 0.2% of the population reported experiencing unmet need for health care and dental care respectively due to cost, distance and waiting time in Malta, well below the EU average of 2.4% for health care and 3.4% for dental care. However, income inequality in unmet need has been substantial in Malta, especially before 2017 (Fig. 26).

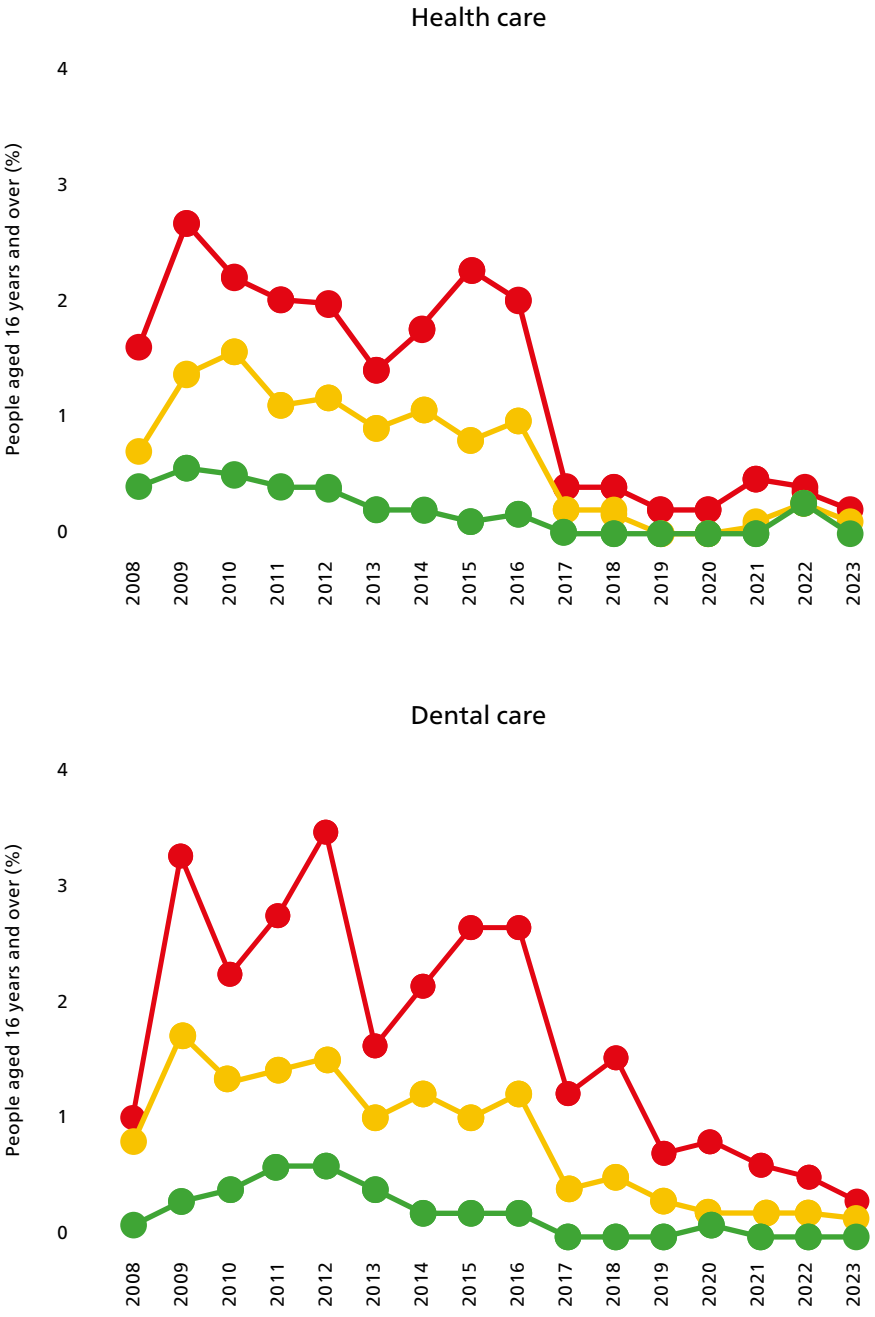
EHIS data (Eurostat, 2025b) show that unmet need for prescribed medicines is well below the EU average but there is considerable income inequality (Fig. 27).

Fig. 25. Unmet need for health care and dental care due to cost, distance and waiting time, Malta and the EU



Source: EU-SILC data from Eurostat (2025a).

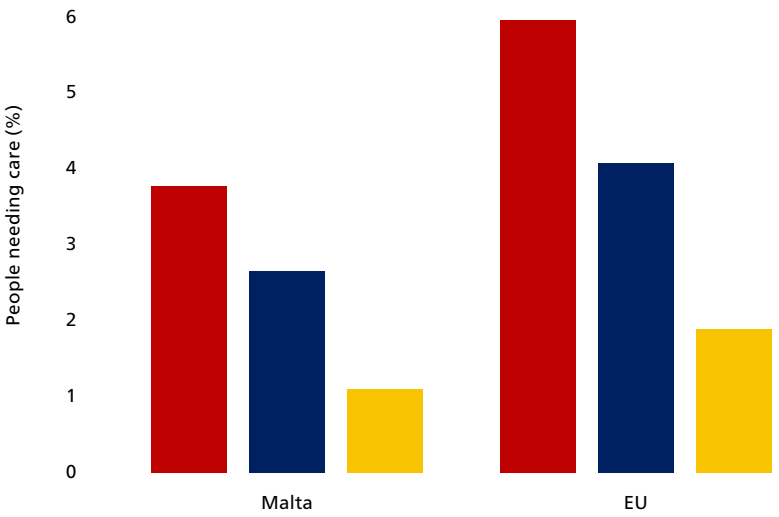
Fig. 26. Income inequality in unmet need for health care and dental care due to cost, distance and waiting time



Note: quintiles are based on equivalized disposable income.

Source: EU-SILC data from Eurostat (2025a).

Fig. 27. Income inequality in unmet need for prescribed medicines due to cost, Malta and the EU, 2019



Notes: people needing care refers to people over 15 years old. Poorest and richest refer to income quintiles.

Source: EHIS data from Eurostat (2025b).

5.4 Summary

In 2015 (the latest year of household budget survey data available) about 2% of households were impoverished or further impoverished after out-of-pocket payments and almost 7% of households experienced catastrophic health spending (a slight decrease compared to 2008).

The incidence of catastrophic health spending is higher in Malta than in many EU countries, but it is lower than countries with a similar or lower reliance on out-of-pocket payments such as Bulgaria, Greece, Italy, Lithuania and Portugal.

Catastrophic health spending is heavily concentrated in households with low incomes. In 2015 the incidence of catastrophic health spending was much higher in the poorest quintile (22%) than the richest quintile (4%). It was also high in households headed by "other inactive" people (18%), housekeepers (15%), people aged over 60 years (14%), retired people (10%) and people living in the Southern Harbour area (9%) – all groups likely to overlap with households in the poorest quintile.

Catastrophic and impoverishing out-of-pocket payments impose a heavy financial burden on households with very low incomes, accounting on average for 17% of a household's budget in the poorest quintile and 9% in further impoverished households.

Catastrophic health spending is mainly driven by dental care and outpatient medicines, followed by outpatient care and medical products. In the poorest quintile, it is largely driven by outpatient medicines (62% in 2015), followed by outpatient care (20%) and dental care (10%). The role of dental care in driving catastrophic health spending grew over time in all quintiles. The finding that dental care is a much smaller driver in the poorest quintile is likely to reflect a substantially higher degree of unmet need in poorer households in 2008 and 2015.

EU-SILC data indicate that unmet need for health care, dental care and prescribed medicines is consistently below the EU average. Income inequality in unmet need for health care and dental care was substantial before 2017 but has fallen since then. However, EHIS data for 2019 show a considerable degree of income inequality in unmet need for prescribed medicines.

6. Factors that strengthen and undermine financial protection

This section considers the factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Malta and which may explain the trend over time. It first looks at gaps in coverage and then considers other health system factors.

6.1 Coverage policy

The way in which health coverage is designed and implemented in Malta has features that are associated with stronger financial protection, including that:

- entitlement to publicly financed health care is based on residence, which means all residents are automatically covered; refugees and migrants granted special protection status or an SRA are also entitled to the same benefits as permanent residents – as a result, a very high share of the population is covered; and

- there are no user charges (co-payments) for covered health care, so it is free at the point of use.

Gaps in coverage remain, however, and help to explain why out-of-pocket payments are very high (see Fig. 1); why catastrophic health spending is also high (see Fig. 18) and driven mainly by dental care, outpatient medicines, outpatient care and medical products on average, but mainly by outpatient medicines and outpatient care in poorer households (see Fig. 23 and Fig. 24); and why income inequality in unmet need has been substantial (see Fig. 26 and Fig. 27).

People with chronic conditions or low incomes are entitled to publicly financed outpatient prescribed medicines. The yellow card scheme grants any covered person who is diagnosed with a specified chronic condition access to outpatient prescribed medicines and selected outpatient medical products for people with diabetes free at the point of use; in 2024 30% of the population had a yellow card. Covered people with low incomes can apply for a pink card, granting them access to some outpatient prescribed medicines, dentures and glasses free at the point of use; 3% of the population had a pink card in 2024. Yellow cardholders with diabetes are also entitled to glasses free at the point of use. The rest of the population must pay the full price out of pocket for these types of health care.

The publicly financed benefits package for medical products and dental care is limited in scope. Non-emergency dental care is mostly limited to dentures. Outpatient medical products are limited to diabetes aids, prosthetic aids (for pink cardholders only), wheelchairs, crutches, nebulizers and oxygen. As a result of these gaps in coverage, some people have to pay out of pocket for outpatient medical products and most people have to pay out of pocket for all non-emergency dental care.

Long waiting times are an issue for certain diagnostic tests, outpatient specialist visits, emergency care and elective surgery, and have become an even greater challenge since the COVID-19 pandemic. People tend to access outpatient primary care in private settings because of shorter waiting times, better choice and continuity of care (Azzopardi Muscat et al., 2017; OECD/European Observatory on Health Systems and Policies, 2023). Doctors can work in both public and private facilities and a small number work exclusively in private facilities, mainly in primary care. In recent years the Government has introduced incentives to retain primary care doctors in public facilities and to encourage them to work solely in the public sector. Workforce shortages in public facilities mainly affect nurses, reflecting falling numbers of local graduates and an increase in the number of resignations in recent years, resulting in growing need to employ foreign nurses (OECD/European Observatory on Health Systems and Policies, 2023).

The yellow and pink cards aim to protect people with chronic conditions or low incomes, respectively, but coverage gaps remain, particularly for households with low incomes. This may reflect several issues.

- Yellow cards apply to many chronic conditions but only cover the cost of outpatient prescribed medicines for those conditions; if people need other medicines (e.g. for non-covered chronic conditions or other health problems), they must pay for them out of pocket.

- Yellow and pink cards only cover medicines in the formulary. Although the formulary has expanded in the last few years, gaps remain. For example, medicines in the formulary may not reflect the latest international guidance regarding first-line treatment due to a lag in approval or the high cost of new medicines. As a result, people may opt to pay out of pocket for medicines not in the formulary, sometimes following the advice of their treating physician.

- Only 3% of the population have a pink card, which means that many people in the poorest quintile have to pay the full price of outpatient prescribed medicines and most non-emergency dental care out of pocket, unless they also have a yellow card. This may explain why households in the poorest quintile with catastrophic health spending spend 17% of their household budget on out-of-pocket payments on average, while households who are further impoverished spend 9%; these shares are much higher in Malta than in most other EU countries (UHC watch, 2025).

Some people have no entitlement to publicly financed health care beyond life-saving medical assistance (undocumented migrants with no protection status, failed asylum seekers and people granted humanitarian protection by another EU country). In 2023 there were estimated to be around 6500 undocumented migrants in Malta (just over 1% of the population) (Eurostat, 2025d). Although these groups of people are at high risk of experiencing financial hardship and unmet need, they are likely to be underrepresented in the key data sources used in this review (household budget surveys and EU-SILC and EHIS data on unmet need for health care) (European Commission, 2018).

6.2 Other factors

Outpatient medicine prices are relatively high. This may be another reason (in addition to gaps in coverage) why outpatient medicines are a large driver of out-of-pocket payments and catastrophic health spending. High prices are likely to reflect the absence of price regulation (Fletcher, 2019) as well as limited economies of scale (Kochova, Szijj & Azzopardi, 2021), lack of competition, lack of incentives to import and stock a large range of medicines. More recently, the cost of medicines has also been affected by Brexit (an increase in the cost of imports from the United Kingdom) and the Russian Federation's full-scale invasion of Ukraine (trade route disruptions and increased shipping costs). High prices exacerbate the problem caused by gaps in the coverage of outpatient prescribed medicines.

Since 2015 the Government has taken some steps to reduce medicine prices. For example, the Malta Competition and Consumer Affairs Authority, in agreement with importers, reduces the price of some medicines at regular intervals (Malta Competition and Consumer Affairs Authority, 2019). In 2019 prices for 29 medicines were reduced; the price of medicines prescribed for neuropathic pain fell by 67%, allowing people to save up to €50 (Malta Competition and Consumer Affairs Authority, 2019).

Although public spending on health has increased in recent years, and accounts for a relatively high share of total government spending, it is lower than expected for Malta's level of GDP. In 2022 (the latest available year of internationally comparable data) public spending on health as a share of GDP (6.4%) was on a par with the EU average, in part due to a spike in public spending on health per person and a sharp reduction in GDP in 2020 (see Fig. 2 and Fig. 5). However, public spending on health as a share of GDP is much lower in Malta than in several other EU countries with lower levels of GDP per person (see Fig. 4), even though the priority given to health when allocating the government budget seems relatively high – public spending on health accounted for 16.2% of total government spending in Malta in 2022, above the EU average of 14.6% (see Fig. 3). This reflects the small size of government spending in Malta; total government spending accounted for only 39% of GDP in 2022 compared to an EU average of 45%.

Increases in public spending on health and measures to reduce waiting times and the price of outpatient medicines may mean that financial protection has improved since 2015. The out-of-pocket payment share of current spending on health has fallen from a peak of 37% in 2015 to 34% in 2019, before the COVID-19 pandemic, and 30% in 2022 (see Fig. 1). This improvement mainly seemed to affect outpatient medicines and diagnostic tests; between 2015 and 2022 the out-of-pocket payment share of spending by type of health care fell sharply for outpatient medicines and diagnostic tests but remained at similar levels for medical products, outpatient care and dental care and increased for inpatient care (see Fig. 6 and Fig. 7). Although the out-of-pocket payment share of spending on dental care did not increase over time, the public share fell from 16% in 2015 to 12% in 2022 and the gap was filled by VHI, which tends to favour people with higher incomes.

While it is reasonable to suggest that the situation has improved since 2015, it is not possible to be sure until a new household budget survey is carried out; a new survey is currently underway but data from the new survey will not be available until the end of 2026. Even if financial protection has improved, continued heavy reliance on out-of-pocket payments (30% of current spending on health in Malta in 2022 compared to an EU average of 19%) requires policy action to reduce financial hardship and unmet need, particularly for people with low incomes.

6.3 Summary

Coverage policy in Malta has some clear strengths: entitlement to publicly financed health care is based on residence and there are no co-payments for covered services.

Gaps in coverage remain, however: outpatient prescribed medicines and outpatient medical products are covered for people with yellow or pink cards; the publicly financed benefits package for dental care and medical products is limited in scope; and long waiting times are an issue for certain diagnostic tests, outpatient specialist visits, emergency care and elective surgery, pushing people to seek treatment in private settings.

The yellow and pink cards protect people with chronic conditions or low incomes, respectively, but coverage gaps remain, particularly for households with low incomes: only 3% of the population have a pink card; yellow cards only cover the cost of outpatient prescribed medicines for eligible conditions; yellow and pink cards only cover medicines in the formulary.

High medicine prices compound the problems caused by gaps in the coverage of outpatient prescribed medicines.

Although public spending on health has increased in recent years, and accounts for a relatively high share of total government spending, it is lower than expected for Malta's level of GDP. However, the out-of-pocket share of current spending on health has fallen from a peak of 37% in

2015 to 34% in 2019, before the COVID-19 pandemic, and 30% in 2022. This may mean that financial protection has improved since 2015 (the latest available year of data on catastrophic health spending), but it is not possible to be sure until a new household budget survey is carried out; data from the new survey will not be available until the end of 2026.

Even if there has been improvement, continued heavy reliance on out-of-pocket payments (30% of current spending on health in Malta compared to an EU average of 19%) requires policy action to reduce financial hardship and unmet need, particularly for people with low incomes.

7. Implications for policy

Financial hardship caused by out-of-pocket payments is higher in Malta than in many EU countries – 7% of households experienced catastrophic health spending in 2015 (the latest year of household budget survey data available; see the methods section for more information) – but lower than in many other countries with a similarly heavy reliance on out-of-pocket payments.

Catastrophic health spending is heavily concentrated in households with low incomes. In 2015 nearly two thirds of households with catastrophic health spending were in the poorest quintile and over 20% of households in the poorest quintile experienced catastrophic health spending.

Older people are also at high risk of catastrophic health spending. The incidence of catastrophic health spending is high in households headed by "other inactive" people, housekeepers, people aged over 60 years, retired people and people living in the Southern Harbour area; all groups likely to overlap with households in the poorest quintile. Broken down by age, households headed by older people accounted for the largest share of households with catastrophic health spending in 2015. Although the incidence of catastrophic health spending fell in older households between 2008 and 2015, poverty rates in older households have risen sharply in the last decade and are now at very high levels. This suggests that older people are likely to be at higher risk of catastrophic health spending today than they were in 2015.

Catastrophic health spending is mainly driven by dental care and outpatient medicines, followed by outpatient care and medical products. In the poorest quintile, it is largely driven by outpatient medicines and, to a much lesser extent, outpatient care and dental care. The role of dental care in driving catastrophic health spending grew over time in all quintiles. The finding that dental care is a much smaller driver in the poorest quintile is likely to reflect a substantially higher degree of unmet need in poorer households in 2008 and 2015.

Unmet need for health care, dental care and prescribed medicines is consistently below the EU average. Income inequality in unmet need for health care and dental care was substantial before 2017 but has fallen considerably since then. However, EHIS data for 2019 show a considerable degree of income inequality in unmet need for prescribed medicines.

These findings reflect some strengths in coverage policy, including that:

- entitlement to publicly financed health care is based on residence, so all residents are automatically covered; and
- there are no user charges (co-payments) for covered health care, which means covered health care is affordable for everyone.

However, relatively high levels of financial hardship – and socioeconomic inequality in financial hardship and unmet need – indicate gaps in coverage policy, notably:

- people with chronic conditions or low incomes are entitled to publicly financed outpatient prescribed medicines through the yellow or pink

card schemes – currently around a third of the population benefits from these schemes – everyone else pays the full price of outpatient prescribed medicines out of pocket;

- the publicly financed benefits package for dental care is limited in scope and coverage of medical products is also limited;
- there is no cap on out-of-pocket payments; and
- long waiting times are an issue for certain diagnostic tests, outpatient specialist visits, emergency care and elective surgery, pushing people to pay out of pocket for treatment in private settings.

The financial hardship data reported here reflect the situation in 2015 because Malta has not carried out a household budget survey since then; a new survey is underway but data will not be available until the end of 2026. Policy choices in recent years suggest that financial protection may in general be better now than in 2015. Public spending on health has increased, substantially pushing down the health system's reliance on out-of-pocket payments from a peak of 37% in 2015 to 30% in 2022 (the latest available year of internationally comparable data). The Government has also introduced measures to reduce waiting times and regulate medicine prices, which may have contributed to slower growth in out-of-pocket payments. However, the finding that catastrophic health spending is heavily concentrated in older people, combined with the sharp rise in poverty rates among older people in the last decade, is a cause for concern.

Building on recent efforts, the Government can now find ways to address key gaps in coverage and reduce financial hardship and unmet need, particularly for households with lower incomes.

The extent to which outpatient medicines are financed through out-of-pocket payments fell between 2015 and 2022, bringing Malta (41%) much closer to the EU average (39%) in 2022. This share remains high, however, and is likely to have a disproportionately negative effect on people with low incomes.

Policy options for reducing out-of-pocket payments for outpatient prescribed medicines include:

- finding ways to improve protection from out-of-pocket payments for households with low incomes – for example, by leveraging existing means-testing mechanisms. The pink card scheme only covers 3% of the population and is also limited in terms of the medicines and medical products it covers;
- using digital solutions to monitor the types of outpatient prescribed medicines households are spending on to inform policy options that can reduce out-of-pocket payments and improve financial certainty for all households. Many countries with stronger financial protection have some kind of cap on out-of-pocket payments for covered health care (Cylus et al., 2024; UHC watch, 2025); linking a cap to income (and using digital tools to ensure it is applied automatically) enhances equity and efficiency in the use of public funds and softens the impact of the cap

on the health budget (García-Ramírez et al., 2025; Kasekamp & Habicht, 2025); and
- continuing with efforts to lower the price of outpatient medicines.

The out-of-pocket payment share of current spending on dental care (80% in 2022) has not changed over time and remains far higher than the EU average (58%). Since 2015 the public share of spending on dental care has fallen from 16% to 12%, however, and the gap has been filled by VHI, which tends to favour people with higher incomes.

Policy options for reducing out-of-pocket payments for non-emergency dental care include:

- extending publicly financed coverage of non-emergency dental care to those most likely to benefit in the short term, such as pregnant women and people with pink cards; and
- expanding the range of publicly financed non-emergency dental care, going beyond the services currently provided.

The Government should also continue efforts to address long waiting times for publicly financed outpatient care.

In support of these policy options, the Government can consider the following actions.

- **Increasing public spending on health so that it is more in line with Malta's GDP.** There is scope for increasing the share of public spending on health given Malta's sustained and current GDP growth (World Bank, 2025). The Government should focus public resources on reducing financial hardship and unmet need, particularly for households with low incomes.

- **Strengthening the commissioning (the purchasing and governance) of publicly financed health care, so that public resources are better able to meet equity and efficiency goals.**

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