World Health Organization

European Region

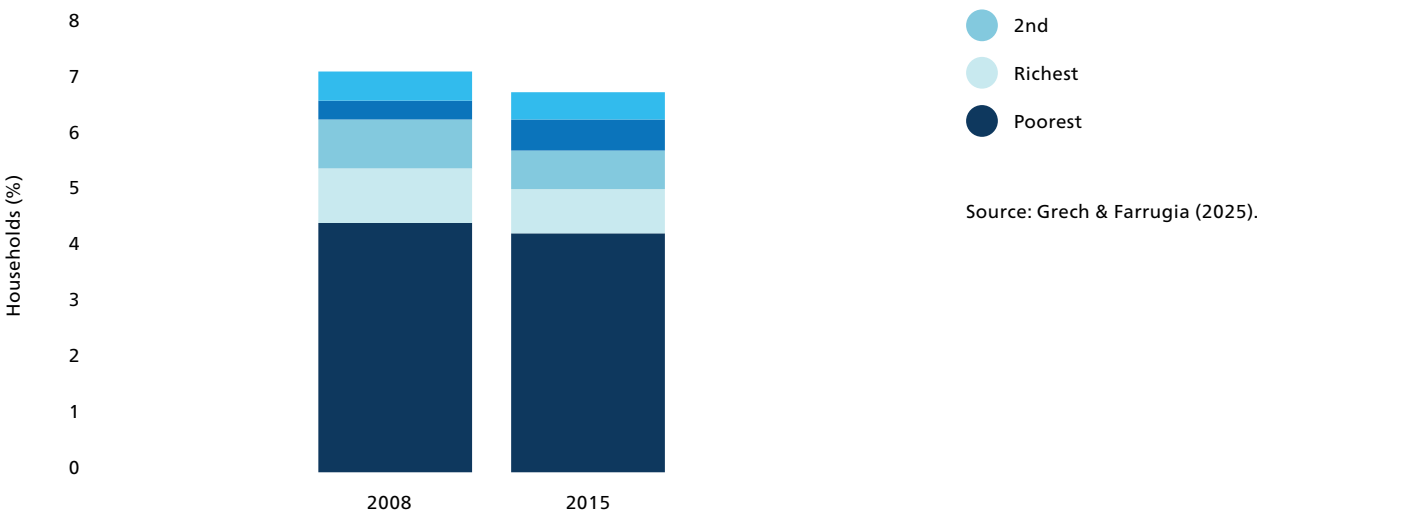
Can people afford to pay for health care? New evidence on financial protection in Malta: summary

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).

In 2015 about 2% of households were impoverished or further impoverished after out-of-pocket payments (data not shown); almost 7% of households experienced catastrophic health spending (Fig. 1).

Catastrophic health spending is heavily concentrated in households with low incomes (Fig. 1). The incidence of catastrophic health spending is higher than the national average (7%) in households in the poorest consumption quintile (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%) (data not shown). The incidence of catastrophic health spending fell in older households between 2008 and 2015 but, 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 (70%) in 2015 (data not shown).

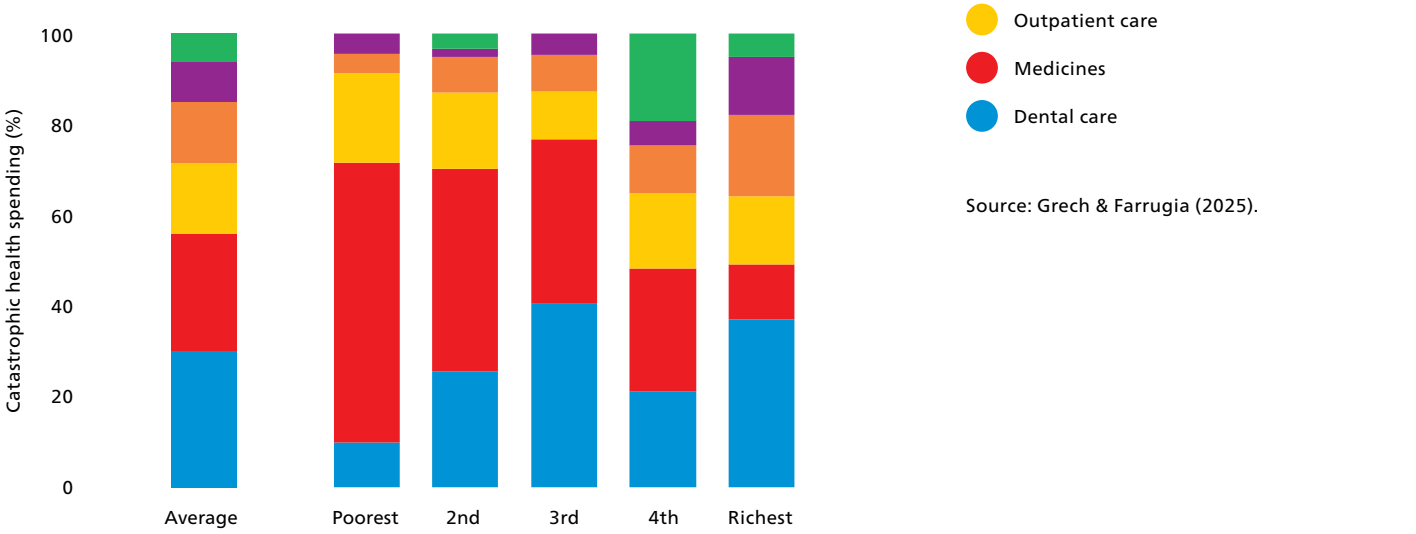
Fig. 1. Breakdown of households with catastrophic health spending by consumption quintile



Source: Grech & Farrugia (2025).

Catastrophic health spending is mainly driven by dental care and outpatient medicines, followed by outpatient care and medical products (Fig. 2). In the poorest consumption quintile it is mainly driven by outpatient medicines and outpatient care (Fig. 2). Dental care is a larger driver in the other quintiles (Fig. 2) and its role in driving catastrophic health spending grew over time in all quintiles (data not shown). This is likely to reflect a substantially higher degree of unmet need in households with lower incomes in 2008 and 2015 (data not shown; Eurostat, 2025a).

Fig. 2. Breakdown of catastrophic health spending by type of health care on average and by consumption quintile, 2015



Source: Grech & Farrugia (2025).

How does Malta compare to other countries?

The incidence of catastrophic health spending is higher in Malta than in many European Union (EU) countries, but it is lower than in countries with similar or lower reliance on out-of-pocket payments (Fig. 3). In the poorest consumption quintile it is mainly driven by out-of-pocket payments for outpatient medicines, in common with countries with weaker financial protection (those on the right of Fig. 4) (WHO Regional Office for Europe, 2023).

Unmet need for health care, dental care and prescribed medicines in Malta is consistently below the EU average; inequality in unmet need by income quintile has fallen considerably since 2017 for health care and dental care but remains an issue for prescribed medicines (data not shown; Eurostat, 2025a; 2025b).

Fig. 3. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health, WHO European Region, 2019 or latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. The colour of the dots reflects the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red over 15%. See page 6 for country codes.

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

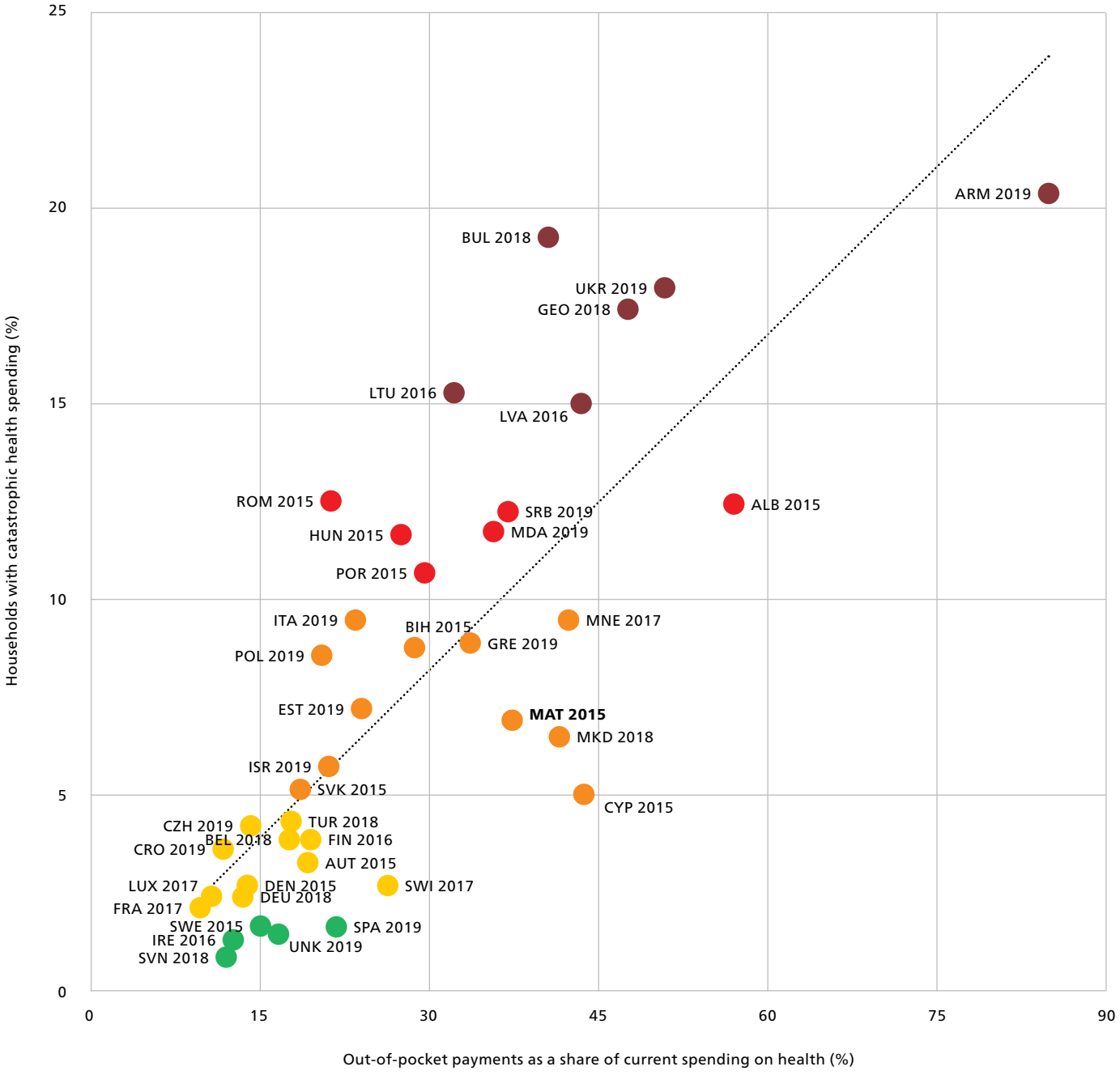
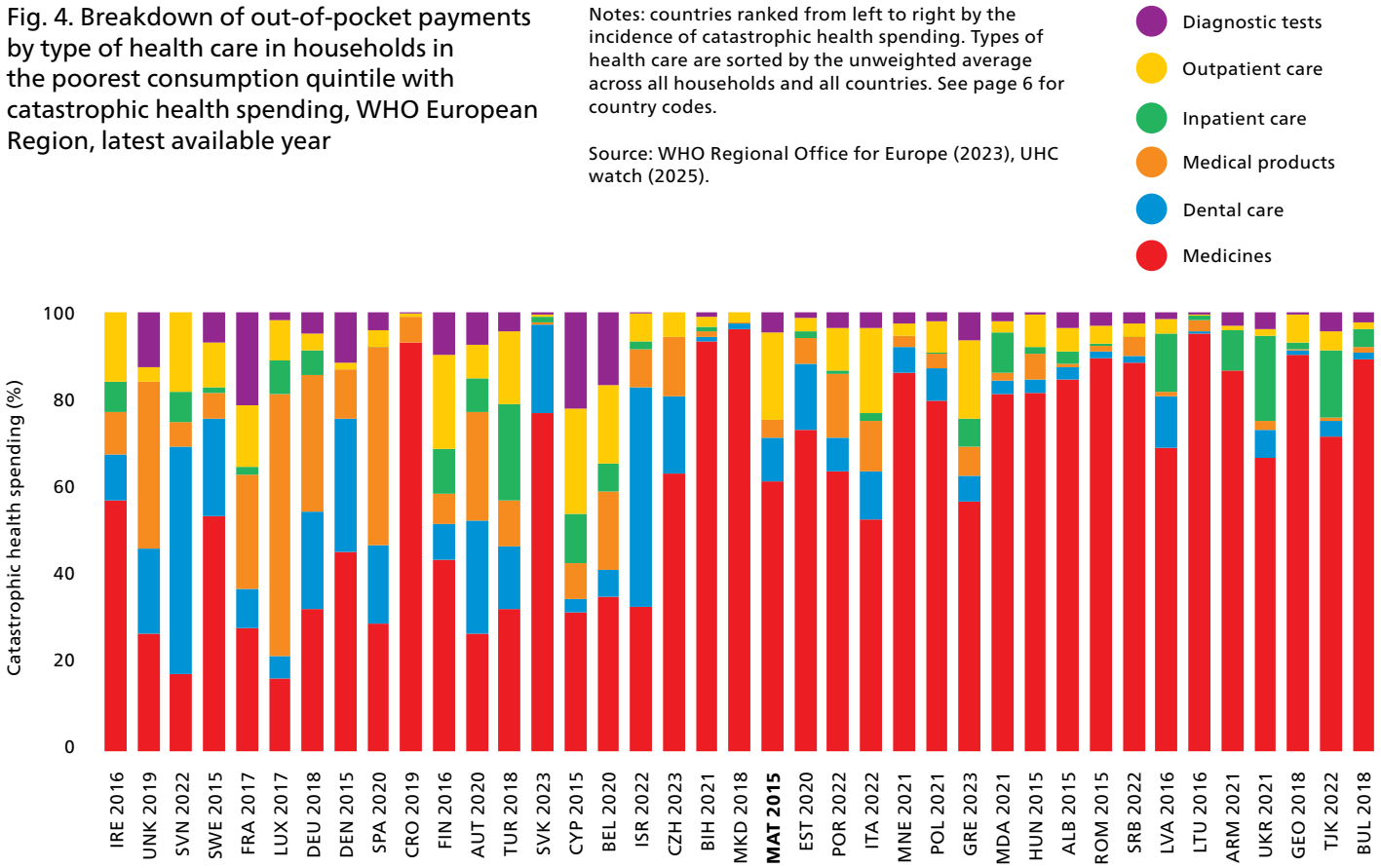


Fig. 4. Breakdown of out-of-pocket payments by type of health care in households in the poorest consumption quintile with catastrophic health spending, WHO European Region, latest available year

Notes: countries ranked from left to right by the incidence of catastrophic health spending. Types of health care are sorted by the unweighted average across all households and all countries. See page 6 for country codes.

Source: WHO Regional Office for Europe (2023), UHC watch (2025).



What strengthens and undermines financial protection in Malta?

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, so all residents are automatically covered (including refugees and migrants granted special protection status or a specific residence authorization) and population coverage is close to universal;
- there are no user charges (co-payments) for covered health care, so it is free at the point of use; and
- the publicly financed benefits package offers good coverage of outpatient visits, diagnostic tests and inpatient care.

However, the following 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, which give cardholders free access to covered medicines; 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.

High medicine prices also compound the problems caused by gaps in the coverage of outpatient prescribed medicines, although the government has taken steps to reduce prices since 2015.

The publicly financed benefits package is limited in scope for dental care, optical care and medical products, pushing people to pay out of pocket: 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; and outpatient medical products are 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.

Some people have no entitlement to publicly financed health care beyond life-saving medical assistance (e.g. undocumented migrants with no protection status, failed asylum seekers and people granted humanitarian protection by another EU country).

How can Malta improve financial protection?

To address key gaps in coverage and lower financial hardship and unmet need, particularly for households with low incomes, the Government can consider the following measures to reduce out-of-pocket payments.

- Find 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.

- Use 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 (WHO Regional Office for Europe, 2023; 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).

- Extend 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 expand the range of publicly financed non-emergency dental care, going beyond the services currently provided.

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

These policy choices will need to be supported by increasing public spending on health, so that it is more in line with Malta's gross domestic product (GDP), and 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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1. All references were accessed on 18 July 2025.

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; POL: Poland; POR: Portugal; ROM: Romania; SPA: Spain; SRB: Serbia; SVK: Slovakia; SVN: Slovenia; SWE: Sweden; SWI: Switzerland; TJK: Tajikistan; TUR: Türkiye; UKR: Ukraine; UNK: United Kingdom.

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Monitoring financial protection in Europe

This study is part of a series of country reports generating new evidence on financial protection – affordable access to health care – in health systems in Europe and central Asia. Financial protection is central to universal health coverage, an indicator of the Sustainable Development Goals, part of the European Pillar of Social Rights and at the centre of the European Programme of Work, WHO's strategic framework for the European Region. The WHO Regional Office for Europe monitors financial protection in over 40 countries through the WHO Barcelona Office for Health Systems Financing. See UHC watch for data, analysis and other resources (https://apps.who.int/dhis2/uhcwatch).

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