

Measuring and Modelling Demographic Trends in Malta: Implications for Ageing Policy

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Abstract. Malta's population experienced a sharp ageing transition due to increasing and decreasing levels of life expectancy and fertility rates respectively. This article reviews demographic changes relating to population ageing that took place in Malta, and future population projections which anticipate even higher numbers and percentages of older persons. At end of 2017, 18.8% of the total population, or 89,517 persons, were aged 65-plus. The largest share is made up of women, with 53.4% of the total. The sex ratios for cohorts aged 65-plus and 80-plus in 2013 numbered 83 and 60 respectively. Population projections indicate clearly that Malta will be one of the fastest ageing countries in the European Union. the (Maltese) percentage of children (0-14) of the total population is projected to increase slightly from 14.5% to 15.4% (+0.9%), whilst the working-age population (15-64) will experience dramatic decrease, from 68 to 56.1% (-11.9%). On the other hand, the older population segment will incur extraordinary increases. The 65-plus/80-plus population will reach 28.5%/10.5% of the total population in 2060, from 17.5%/3.8% in 2013 (+11.0/6.7%). The ageing-related challenges that the Maltese government that is currently facing traverse three key overlapping areas of policy boundaries and include the labour market, health care, and long-term care. There will also be policy issues which, if not immediate, will certainly need to be addressed in the foreseeable future. These include policy relating to ethnic minorities, LGBTIQ ageing, palliative care, and capacity building.

Keywords: Malta; demography; ageing; population; welfare policy; long-term care.

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Introduction

The Maltese archipelago (Malta) is a European Union Member State. It consists of three islands - Comino, Gozo and Malta - at the heart of the Mediterranean Sea, 93 kilometres south of Sicily and 290 kilometres north of Libya. Comino is uninhabited, and with Gozo having a mere population of 31,446 persons, leaves Malta as the major island of this archipelago state, with as much as 393,938 residents (2013 figures) (National Statistics Office, 2015a). Malta gained independence from Britain in 1964 when it also joined the Commonwealth, and became a Republic in 1974. Its form of government is one of a legislative house, with parliament representatives elected by universal suffrage for a term of five years. Malta joined the European Union in 2004, and adopted the Euro as its currency in 2008. In line with other countries, Malta's demographical scenario was traditionally characterised by a young population (Formosa, 2017; , 2019; Formosa & Cassar 2019). However, this changed abruptly at the beginning of the second half of the 20th Century as an aggressive emigration policy was launched in the wake of the rundown of British colonial rule. In the 1950s and 1960s, no less than 140,440 persons - half of Malta's population at the time - emigrated from Malta (Formosa & Scerri, 2015). As a result, Malta's population experienced a sharp ageing transition, to the extent that in 1968 the Government was the first nation to table a motion before the United Nations Assembly to discuss the global trend in population ageing (Formosa, 2015a). In subsequent decades, Malta experienced a notable increase and decrease in its life expectancy and fertility figures respectively, to evolve out of a traditional pyramidal shape to an even-shaped block distribution of equal numbers at each cohort except at the top. This article reviews the demographic changes relating to population ageing that took place in Malta, and future population projections which anticipate even higher numbers and percentages of older persons. Data was sourced from published censuses for 1995, 2005, and 2011 (Centre of Statistics, 1997; National Statistics Office, 2007, 2012, 2014), supplemented by annual demographic reviews (National Statistics Office, 2015a, 2015b, 2016a, 2016b), European Commission (2015, 2016a) publications, and academic demographic analysis (Camilleri, 1993; Formosa, 2014, 2015a, 2015b, 2016a, 2017, 2018a, 2018b; Miljanic Brinkworth, 2015).

Population growth

On average, censuses in Malta were taken every ten years between 1842 and 2011 (table 1) (National Statistics Office, 2014). Between the first census carried out in 1842 and the last Census in 2011, the population of Malta increased 3.6 times, from 114,499 to 416,055 persons, and nearly doubling from 211,564 to 417,432 persons in the 1911-2011 period. Between the first two censuses held in 1842 and 1851, the population increased by an average of 0.9% every year. The population underwent a similar rate of growth between 1851 and 1861, but between 1861 and 1881 the average annual rate of growth decreased marginally to 0.6%. This was followed by a period of acceleration when the population increased significantly so that in 1911 Malta's population reached 211,564. The decade 1911 to 1921, which included the First World War, was characterised by insignificant population growth that averaged no change in the annual growth rate. This translated into an increase of just 694 persons during this period.

Table 1: Intercensal change: Total population and sex ratio (1842 - 2011)

Census	Enumerated population			Intercensal change (%)		
	Total	Males	Females	Total	Males	Females
1842, March	114,499	55,168	59,331	--	--	--
1851, March	123,496	60,456	63,040	7.9	9.6	6.2
1861, October	134,055	66,270	67,785	8.6	9.6	7.5
1871, May	141,775	69,952	71,823	5.8	5.6	6.0
1881, April	149,782	73,430	76,352	5.6	5.0	6.3
1891, April	165,037	81,316	83,721	10.2	10.7	9.7
1901, March	184,742	91,994	92,748	11.9	13.1	10.8
1911, April	211,564	105,601	105,963	14.5	14.8	14.3
1921, April	212,258	102,745	109,513	0.3	-2.7	3.4
1931, April	241,621	117,457	124,164	13.8	14.3	13.4
1948, June	305,991	150,665	155,326	26.6	28.3	25.1
1957, November	319,620	153,108	166,512	4.5	1.6	7.2
1967, November	314,216	150,598	163,618	-1.7	-1.6	-1.7
1985, November	345,418	169,832	175,586	9.9	12.8	7.3
1995, November	378,132	186,836	191,296	9.5	10.0	8.9
2005, November	404,962	200,819	204,143	7.1	7.5	6.7
2011, November	417,432	207,625	209,807	2.7	3.2	2.3

Source: National Statistics Office, (2014)

The 1921-1930 decennium saw a substantially higher average annual growth rate of 1.4%, with the population rising to 241,621 in 1931 (Camilleri, 1993). The next census was carried out in 1948 after the end of the Second World War. Herein, the population exceeded the 300,000 mark to stand at 305,911. Between 1948 and 1957, the population increased by 13,629 persons, of whom 11,186 were females, but due to high emigration trends the average rate of population increase remained less than 0.5% per annum. After 1962, the Maltese population slowed its long history of rapid growth due to a renewed emigration spurt in the wake of the rundown of British Government employment. This emigration drive caused a marked tendency for the birth-rate to decline, and hence, brought about a reduction of 5,404 persons (-1.69% of the population) between the years 1957 and 1967. The population stood at 314,216 in 1967. A span of eighteen years elapsed until the next census. In 1985, the population comprised 345,418 persons implying an increase of 31,202 persons that, calculated from 1967, represented an average annual increase of 0.6%. During this period the population was affected by onward migratory flows. The subsequent censuses were carried out in 1995 and 2005 (Centre of Statistics, 1997; National Statistics Office, 2007). During this period, a steady increase was experienced, with the population going up to 378,132 in 1995, and exceeding the 400,000 mark in 2005 to reach 404,962. In terms of growth rates, an average expansion rate of 0.9% was experienced between 1985 and 1995, slowing down to 0.7% in the ensuing decade. This deceleration in population growth is attributed mainly to a decline in the birth rate which has contributed to an ageing population. In the last census held in 2011, the population grew by 2.7% to 417,432, indicating a slowdown in population growth with an average annual increase of 1,849 compared to nearly 2,700 evidenced in the previous decennium (National Statistics Office, 2014).

Population ageing

In 1901, 34.1% and 5.4% of Malta's population were in the 0-14 and 65-plus age groups respectively (table 2). As the 20th Century progressed, the proportional representation of these segments changed by very narrow margins, reaching 37.4% and 6.8% in 1957 respectively. However, during the second half of the 20th Century the 0-14 and 65-plus age groups decreased and increased significantly to the extent of reaching 13.9% and 18.8% in 2017 respectively, whilst the 15-64 cohort remaining relatively stable (67.3%) (National Statistics Office, 2018a, 2018b). The median age in the year 2011 stood at 40.5 years, up from 38.5 years in 2005 (*ibid.*).

Table 2: Percentage distribution of population by age groups (1901-2011)

Census Year	0-14	15-64	65+
1901	34.1	60.5	5.4
1911	33.6	61.3	5.1
1921	31.8	62.6	5.6
1931	32.1	62.1	5.8
1948	34.9	59.4	5.7
1957	37.4	55.8	6.8
1967	29.4	61.8	8.4
1985	24.1	66.0	9.9
1995	22.1	62.0	15.9
2005	17.1	69.2	13.7
2011	14.8	68.9	16.3
2017	13.9	67.3	18.8

Sources: Camilleri, (1993); Centre of Statistics, (1997); National Statistics Office, (2007, 2014, 2018a, 2018b).

Such fluctuations were largely the result of a declining birth rate together with an increasing life expectation for both men and women. On one hand, whilst the crude birth rate in Malta was relatively stable over the first half of the Twentieth Century, at around 38 annual births per 1,000, it has declined steadily since, reaching 9.6 births per 1,000 population in 2015 (National Statistics Office, 2016). Indeed, whilst in 2017 France had the highest fertility rate of 1.9 babies per woman, Malta was at the very bottom of the list with 1.32 babies born on average for every woman (Eurostat, 2019). However, it is noteworthy that due to an increase in migrant workers the number of live births increased from 4,466 in 2008 to 7,712 in 2017 (The Independent, 2018). On the other hand, at the end of the World War II, life expectancy in Malta was around 43 and 46 years for males and females respectively (National Statistics Office, 2016). However, in 2016 life expectancy at birth stood at 80.6 years for males and 84.4 years for females, while life expectancy at age 65 stood at 19.7 years for males and 22.1 years for females (National Statistics Office, 2018c). Such extensions in life expectancy have been reached due to the significant developments in modern medicine, higher overall level of education and hygiene. The 'healthy life years' statistic refers to the number of years spent free of long-term activity limitation, equivalent to disability-free life expectancy, and constitutes an important indicator to monitor whether the extra years of life are lived in

good health (Organisation for Economic Co-operation and Development / European Union, 2018). The average life expectancy was 81.9 years in 2015, up from 78.4 years in 2000 and the sixth highest across the European Union. The average life expectancy across European Union Member States was 80.6 years. This means that Maltese men were found to, on average, live 72.6 healthy years, with women spending an average of 74.6 years in good health. At end of 2017, 18.8% of the total population, or 89,517 persons, were aged 65-plus (National Statistics Office, 2018a, 2018b) (table 3). The largest share is made up of women, with 53.4% of the total. In fact, the sex ratios for cohorts aged 65-plus and 80-plus in 2013 numbered 83 and 60 respectively.

Table 3: Total population by age (31 December 2017)

Age	Males	Females	Total	% of total pop.	Sex ratio
All ages	240,599	235,102	475,701	100	102.3
60+	55,697	63,853	119,550	25.1	87.2
65+	40,606	48,911	89,517	18.8	83.0
80+	7,474	12,465	19,939	4.2	60.0
60-69	29,495	29,840	59,335	12.5	98.8
70-79	18,728	21,548	40,276	8.5	86.9
80-89	6,648	10,507	17,155	3.6	63.3
90+	826	1,958	2,784	0.6	42.2

Source: National Statistics Office, (2018a, 2018b)

The coupling of increasing life expectancy and decreasing fertility rate re-shaped Malta's population structure from a long-held pyramidal shape - characteristic of low income developed countries - to an even-shaped block distribution of equal numbers at each cohort except at the top, and where older women outnumbering their male peers. The advantage of women over men in life expectancy tables also means that, similar to international statistics, married men and widowed women are over-represented in later life. This has clear and serious implications for social/health care policy. Whilst by the age of 70 the majority of women are widows, most men are still in married relationships. Older women also tend to be in possession of lower levels of social and financial capital when compared to male peers (National Statistics Office, 2017). Many find themselves constrained in a 'caring' straightjacket as they tend to marry men older than themselves who generally need various levels of social and health support, whilst also caring for siblings and, many times, even for a number of grandchildren (Formosa, 2016a). Malta's 'old age' dependency ratio (measured as the proportion of persons aged 65-plus as a percentage of the working-age population of persons aged 15 to 64) has been experiencing a steady increase in recent decades. In 2013, this figure stood at 26 percentage points, compared to 28 percentage points across the European Union, when this percentage measured 17 and 19 percentage points in 1995 and 2005 respectively (European Commission, 2015). As pointed out in the forthcoming section, projections foresee Malta's old age dependency ratio to increase further, and even exceed the European Union average in the coming decades.

Population projections

There is no doubt that the current population ageing trend is a demographic movement to be taken with certainty, and indicators, both absolute and positive, point at its future continuation. Moreover, projections indicate clearly that Malta will be one of the fastest ageing countries in the European Union. During the 2013-2060 period, life expectancy at birth is projected to increase by 6.4 and 6.3 years for males and females, from 78.7 to 85.1 and 82.8 to 89.1 respectively (European Commission 2015). For the same period, the fertility rate will increase 1.44 to 1.79. As a result, Malta's population is expected to reach 463,200 and 476,700 persons by 2040 and 2060 respectively, since from 2015 onwards the number of deaths will be outnumbered births, and hence, population growth due to natural increase will cease (National Statistics Office, 2016b). Indeed, from present-day onwards positive net migration will be the only population growth factor, though it was projected that as from 2035 this positive net migration will no longer counterbalance the negative natural change, and the population will become increasingly aged (European Commission, 2015). On one hand, the (Maltese) percentage of children (0-14) of the total population is projected to increase slightly from 14.5% to 15.4% (+0.9%), whilst the working-age population (15-64) will experience dramatic decrease, from 68 to 56.1% (-11.9%). On the other hand, the older population segment will incur extraordinary increases. The 65-plus/80-plus population will reach 28.5%/10.5% of the total population in 2060, from 17.5%/3.8% in 2013 (+11.0%/6.7%). As regards the percentage of the population 80-plus of the 65-plus cohort, statistics predict an increase from 21.7% to 36.7% in the 2013-2060 period (+15.1%). The 2013-2060 period will see the 'old age' dependency ratio in Malta increase from 26 to 51 percentage points, one percentage point higher than the European Union average. This means that Malta would move from having four working-age people for every person aged 65-plus to a ratio of two to one. The Maltese 'total' dependency ratio (people aged 14 and below and aged 65-plus, as a percentage of the population aged 15-64) is also projected to increase, from 47 to 78 percentage points, again one percentage point higher than the European Union average.

Policy implications

The demographic trends presented herein consider the age-structure of the Maltese population in today, and how it could look in the coming decades. It is clear that there requires no added emphasis on the fact that Malta is 'turning increasingly grey' in the coming decades. In terms of drivers of population changes two issues stand out (Formosa, 2015b). On one hand, although the total fertility rate is projected to increase, it will nevertheless remain below the natural replacement rate. On the other hand, the expected large and sustained increases in life expectancies in life expectancy at birth will result in an unprecedented boom of older persons, especially persons aged 80-plus. The resulting explosive growth of older adults - suffice to state that by the year 2020, about one in five Maltese are projected to be over age 65 (National Statistics Office, 2016b) - will result in a mix of opportunities and challenges. Whilst an ageing population presents itself as an opportunity to communities because many older adults are committed, long-time residents, who contribute their time and energy to local issues, at the same time supporting the needs of older persons represents a hard-hitting challenge. Ideally, older adults should not feel

forced to move to a supportive environment, so that the 'ageing-in-place' ideal - referring to individuals growing old in their own homes with the help of environmental modifications to compensate for personal limitations - remains a realistic possibility. The ageing-related challenges that the Maltese government that is currently facing traverse three key overlapping areas of policy boundaries.

Labour market

The long-term sustainability of public finances in Malta remains a challenge. Demographic projections anticipate increases in overall participation rates in the labour market, but in particular for older workers aged 55-plus (Formosa, 2014). However, labour supply will decline and the total number of employed persons will diminish since anticipated increases in employment rates will be slower than at present as trend increases in female employment will be less pronounced. Hence, both the working-age population and the numbers of actively employed persons are expected to start falling following the year 2025. This scenario impelled the European Commission to issue the following recommendation to the Maltese government:

The pension system faces the double challenge of achieving sustainability while ensuring adequate retirement incomes. Pension expenditure was lower than the EU average in 2013, at 9.6 % of GDP, but it is projected to increase to 12.8 % by 2060, one of the highest in the Union...In order to improve the adequacy of the system, the contributory national minimum pension continues to evolve in 2016, with a view to reaching 60% of median income by 2027, and to extend its coverage. (European Commission, 2016a : 106)

The effectiveness of reform towards sustainable public pensions depends on safeguarding the employability of the older cohorts. Most specifically, restructurings should include more effective and fairer policies, rather than stand-alone measures and generic statements in policy documents, and include pragmatic interventions that improve education opportunities, access to medical care, and a lower exposure to various risk factors that generally function to push workers from lower socio-economic groups towards earlier exits from the labour market.

Local research on older workers found that whilst males tend to be inactive due to early or mandatory retirement policies, females generally cite family responsibilities (Formosa, 2014). The reasons driving older workers towards labour exit are complex, comprising a mix of positive and negative factors that include retirement schemes, caring commitments and good financial assets on the one hand, and poor health, redundancy, and unfriendly working conditions on the other. Mitigating against such a state of affairs, Malta's *Strategic Policy for Active Ageing* (Parliamentary Secretary for Rights of Persons with Disability and Active Ageing, 2013) encourages older individuals to remain in the labour market as part of the European Union's 'active ageing' agenda. However, this shift from 'passive' to 'active' welfare policies for older persons will not happen on its own, but only in conjunction with age-friendly labour policies. As the Council Declaration on *European year for active ageing and solidarity between generations (2012): The way forward* (Council of the European Union, 2012) underlined, policies may range from removing incentives for early exit from the labour

market to specific policies that create job opportunities for older workers. In this respect, Malta's *Strategic Policy for Active Ageing* (Parliamentary Secretary for Rights of Persons with Disability and Active Ageing, 2013) includes a two-pronged response. On one hand, it advocates that general policies should include the removal of fiscal and social disincentives to stay in employment, adaptation of workplaces to older workers' needs and general difficulties to work shifts, and the changing of the work environment to meet the needs of older employees. On the other hand, it supports specific policies should cater for the possibility of gradual or flexible retirement, allowing older workers better access to vocational training and professional education to upgrade their skills, transforming employers' negative mentalities about older workers, and the promotion mixed-age working teams. The level of employment and social security systems is especially crucial. Flexible levels of employment with parallel adjustment in social security support includes the reduction of incentives for early retirement and options for continued employment beyond retirement age.

Health care

The Maltese Government has not stood impassively when faced with the increasing number of potential older persons as clients of public social and health care services (Formosa, 2015c, 2017, 2018b). Presently, the government of Malta employs 14 geriatricians to visit and treat older persons in acute and rehabilitation hospitals respectively, as well as in care homes and long-term care facilities. This means that there is a consultant geriatrician for every 7,948 person aged 60-plus, which compares well with other European Union countries such as Germany (7,496), Spain (7,701), United Kingdom (8,871), and Switzerland (9,250) (2015 figures). The newly incepted Community Geriatrician Service, provides a geriatric medical review with other members of the interdisciplinary team to homebound older persons. An appointment of a liaison psycho-geriatrician also serves to improve the management of an increasing number of older persons with cognitive, mental and behaviour problems, especially persons with dementia. The government's vision is that the institutionalisation of older persons should only occur as a last resort. Hence, it coordinates various community services to aid older persons to age-in-place (Formosa & Scerri, 2015; Scerri & Formosa, 2015). Whilst the handyman service provides various repair jobs that range from electricity repairs to plumbing to carpentry at nominal costs, the incontinence service provides diapers at a heavily subsidized prices. Night-shelters offer older persons who live alone a secure and protective environment to spend the night in, and the respite service targets families who take care of their elder relatives at home by providing six weeks (twice yearly, where each length of stay cannot exceed three weeks) of care service in care home for older persons. Active Ageing Hubs and Dementia Care Centres prevent social isolation and feelings of loneliness through creative learning activities which also function to provide much needed respite to informal carers. Community services also include the Telecare Plus service which enables subscribers to call for assistance when required, and hence, encouraging them to continue living in the community; the home help service which offers non-nursing personal assistance and light domestic work so as to provide respite and support for informal carers; the meals-on-wheels service which supports older persons who are unable to prepare their meals; and the 'Live-in Carer' service which provides financial support to older persons who

employ a full-time carer of their choice to assist them in their daily needs. Domiciliary health services are coordinated through the CommCare Unit which includes an interdisciplinary team made up of administrative staff, nurses, occupational therapist, podiatrists, personal caregivers, physiotherapists and social workers. A Dementia Intervention Team - consisting of a Coordinator, a nurse, an occupational therapist and a social worker - visits persons who have been diagnosed with dementia with the objective of providing them and their cares with professional support and advice.

However, many structural and fiscal challenges remain as far as health ageing policy is concerned. These include improving financing arrangements to foster pre-funding elements, which implies setting aside some funds to pay for future obligations, and encouraging home care to develop alternatives to institutional care by, for example, developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care. There is also an urgent need to improve independent living by providing effective home care, telecare and information to recipients, as well as ensuring availability of formal carers by determining current and future needs for qualified human resources and facilities for community care services. Finally, one locates an urgent need to guaranteeing a seamless continuity of care by establishing better coordination of care pathways through a single point of access to information, and the allocation of care coordination responsibilities via dedicated governance structures for the integration of health and social care services.

Long-term care

Malta operates a universal long-term care coverage, and hence, is concerned about the financial sustainability of its long-term care system as its population continues to age. The long-term care scenario in Malta includes 5,390 beds (4.84% of the total population aged 60-plus) (2015 figures) (Formosa, 2017). Care homes run by either the government, Church authorities or private companies embrace the same ethos - namely, to provide holistic and person-centred care in a physically and emotionally safe and secure environment to older persons who due to physical and cognitive limitations can no longer continue living in their own homes. Other care homes are run in accordance with specific public-private agreements where the government purchases from private companies care services or simply a number of beds for older persons who require long-term nursing care. Some public care homes operate through public-private partnerships, thus having a number of services contracted to a private company, although the government remains responsible for the admission and provision of healthcare services to residents. Another form of agreement stipulates that the government buys a number of long-term care beds in private care homes. The government also operates the St. Vincent de Paul Long-Term Facility which includes some 1,100 residents. It exists as a hybrid between a nursing home and a geriatric hospital where the emphasis is support the activities of daily living of all residents, giving particular attention to nutrition, mobility, and social activities.

Public expenditure on long-term care in Malta is relatively low in European terms, at 1.1% of the Gross Domestic Product, compared to the European Union average of 1.6% in 2013 (European Commission, 2016b). This figure is projected to rise to 2.3% in 2060, though remaining lower than the anticipated 2.7% European Union average (ibid.). The bulk of Malta's public expenditures on long-term care goes toward covering the costs of out-of-home or non-community based facilities, and whilst cash benefits for long-term care do not exist in Malta, public initiatives in home-based care costs amount to less than 0.1% of Gross Domestic Product (Pace, Vella & Dziegielewski, 2016). Older persons who reside at public care homes pay for this service at source, from 60% to 80% of their total income, depending on whether they require residential or nursing services respectively (Formosa, 2016b). However, even when the government draws 80% of pensions at maximum ceilings, this is not of sufficient amount to cover daily costs of long-term care services in public care homes. It is thus imperative that for long-term care to operate within sustainable budgets, the Maltese government should consider the raising of additional taxes or social security contributions to finance the rising demand for long-term care. This may be justified on two main grounds: representing the most efficient way of insuring against risk, and yielding immediate benefits to the public by relieving them of high personal costs or the need to apply for social assistance when their personal savings have been depleted. Private long-term insurance has only played a limited role in Malta. However, as in the near future the public funds earmarked for long-term care will reach a saturation point, private insurance may feature a stronger role in meeting additional costs not covered by public programmes or higher expectations on behalf of potential clients who clamour for more personalised services. This type of private insurance tends to become more affordable when the public system covers the first tranche of costs. This will require an improvement in the governance framework: to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of long-term care services and its financing; to establish good inform (European Commission, 2016b).

Conclusion

There will also be policy issues which, if not immediate, will certainly need to be addressed in the foreseeable future (Formosa, 2015a). First, there will be a need to systematise ageing welfare policies through ethnic lenses. To-date, nothing is known about how ethnic groups might differ in patterns of productive, active, and successful ageing when compared to the average Maltese citizen. Such differences will become of increasing importance though, now that an increasing percentage of the population in Malta belongs to a minority group who will also be ageing as well. The international literature reported that generally, whilst older minorities are disproportionately more likely to be poor, to have poorer health, and to experience more functional limitations, at the same time they are less likely to rely on institutions for long-term care. Undoubtedly, local policies should ensure a common analysis and vision on long-term care that traverses ethnicity, one that supports the

development of fair and sustainable solutions to improve the wellbeing and dignity of all, irrespective of ethnicity.

Secondly, there will also be a need to implement ageing policies that are LGBTIQ-friendly. As elsewhere, current discourse on older people's needs and citizenship in Malta is framed by a heteronormative perspective, which marginalises lesbians and gay men. The 'invisibility' of older lesbians and gay men at all levels of relevant policy means that they face particular risks of exclusion. Although the onset of later life raises the possibility for social exclusion irrespective of one's sexuality, it remains that being old and lesbian or gay compounds this possibility, leading to double and triple jeopardies. The specific concerns of older lesbians and gay men, and the implications of their sexual identities on compromised citizenship in later life, should no longer be neglected by policy makers. This is especially warranted as in the near future policy makers and service providers will encounter the first wave of older lesbians and gay men who want to live their lives openly as sexual citizens.

Third, increasing longevity is leading not only to an increased life expectancy but also an increased burden from chronic disease, which in turn results in considerable morbidity and increased dependence. Hence, public policy can no longer neglect those interfaces between ageing, dying and death, or in other words, palliative and end-of-life care. Whilst general palliative care refers to the care offered by any health care professional to patients not responding to curative treatment, end-of-life care refers to the care given in the last few days or weeks before death. There is indeed an urgent need to enact policy that stresses the right to a respectable death, to be treated as an individual and with respect, and to die in familiar surroundings and in the company of close relatives and friends. Such policy also needs to refer to keeping pain and symptoms under control, whilst also providing access to spiritual care and not to prolonging life futilely. The creation of legislation to introduce advance directives is equally warranted.

Finally, public policy on ageing is required to understand the need to widen and improve capacity building in human resources in ageing welfare. There is no doubt that an examination of workforce literature predicts that we will need substantial numbers of trained ageing specialists in the years ahead. However, given the available demographic projections one must ask if institutions of higher education are doing their utmost to provide the required number of applied gerontological personnel that is needed to serve the interests and need of the growing older adult population. There warrants an accreditation of degrees and diplomas in gerontology rather than concentrations or minors within various disciplines, which tend to fail in integrating gerontology in the disciplines in which they are embedded. Only the latter strategy will result in more reliable and valid studies on older persons, ageing and later life, something that is crucially lacking at present. There will be other key concerns which, of course, space limitation does not allow me to highlight and discuss, such as income security, poverty, assistive technology, dignity, and caregivers, to mention some. One augurs that such topics are dealt with in other research publications by local gerontologists and geriatricians.

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