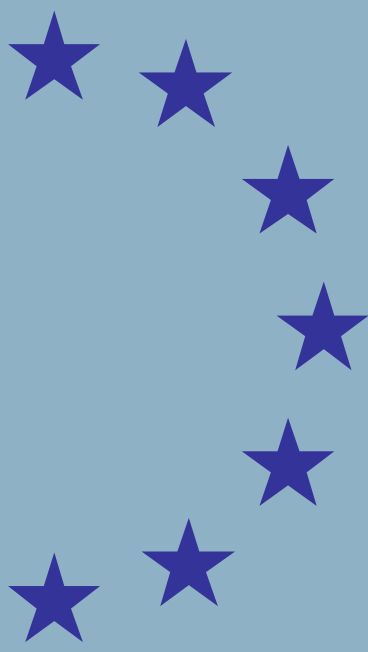




Cyprus

Health Care & Long-Term Care Systems



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Cyprus

Health care systems

1.5. CYPRUS

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita is currently below EU average with 21,900 PPS in 2013 (EU: 27,900). The population was estimated at 0.9 million in 2013. According to Eurostat 2013 projections, total population is projected to increase from around 0.9 million in 2013 to 1.1 million in 2060. The economic crisis hit Cyprus hard and resulted in a significant drop in GDP and employment. Since 2013, Cyprus has been implementing an Economic Adjustment Programme agreed with the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF) covering the period 2013-2016. The Programme aims to address the financial, fiscal and structural challenges facing the economy. This includes key fiscal-structural reforms in the economy as a whole including in the health sector.

Total and public expenditure on health as % of GDP

Total expenditure on health has been increasing in the past decade. However, due to high economic growth until 2008, expenditure as a percentage of GDP (7.4% in 2013) was relatively moderate and below the EU average of 10.1% in 2013. When expressed in per capita terms, also total spending on health at 1,749 PPS in 2013 was below the EU average of 2,988 in 2013. So was public spending on health care: 3.4% of GDP in Cyprus in 2013 vs. 7.8% of GDP in the EU; and 743 PPS in Cyprus vs. an EU average of 2,208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.3 pps of GDP, below the average growth level expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario".⁽⁷⁹⁾ When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 0.6 pps of GDP from now until 2060 (EU: 1.6). Overall,

projected health care expenditure increase is expected to add to budgetary pressure, contributing to the risk for long-term sustainability of public finances.

Health status

Life expectancy at birth (85.0 years for women and 80.1 years for men) was above EU average levels of 83.3 and 77.8 years in 2013. The same is true for healthy life years with 65.0 years for women and 64.3 years for men in Cyprus versus 61.5 and 61.4 in 2013 in the EU. The infant mortality rate of 1.6‰ was below the EU average of 3.9‰ in 2013, having fallen throughout the last decade.

As for the lifestyle of the Cypriot population, data indicates a high proportion of regular smokers (25.9% in 2008), being above the EU average of 22.0. The proportion of the obese population is at the EU level at 15.6% (EU: 15.5%), and the alcohol consumption is below EU level. The proportions of population smoking, being obese as well as the average alcohol consumption seem relatively unchanged over the last decade.

System characteristics

Overall description of the system

The Cypriot health system is made up of two uncoordinated sub-systems of similar size: a public one and a separate private one. The public system is highly centralised and planning, organisation, administration and regulation are the responsibility of the Ministry of Health (MoH). It is mainly financed by the state budget, as well as by contributions to health insurance from civil servants and civil servant pensioners, with services provided via a network of public hospitals and health centres directly controlled by the MoH. Public providers' employees have the status of civil servants and are salaried employees.

The current system has led to an unequal distribution of services and inequities in access to care. Also, prices, capacity, and care quality in the private sector are to a large extent unregulated. There is no implemented coherent framework matching separate provision of public and private healthcare services, leading to inadequate and ineffective coverage. On the one hand, driven by the economic crisis, the increase in demand for

⁽⁷⁹⁾ The 2015 Ageing Report:
http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

public health care services has led to an overburdened public healthcare sector. This resulted in high waiting times for selected consultations, surgical procedures and diagnostic tests, and potentially also to a decrease in the quality of care. The over-capacity of private health care providers is exacerbated. This led to wasteful allocative inefficiencies in total health care resources in Cyprus.

To address these inefficiencies and to ensure efficiency gains in the mid-term, the Cypriot authorities are pursuing to implement a dual strategic reform program; Firstly, it aims to raise resilience of the system and to improve the access to quality health care in Cyprus with the autonomisation of public hospitals, thereby enacting the relevant bill. Public hospitals financial autonomy can facilitate the improvement of access to quality health care and foster it, thereby administering their own budgets based on available resources. The public hospitals' autonomisation should lead to normalisation of admissions and length of stay as well as the appropriate utilisation of infrastructure, staff as well as the efficient use of hospitals' properties.

Secondly and following the public hospitals autonomy, Cyprus is envisaged to implement a National Health Insurance Scheme (NHIS). The main goals of NHIS are: (i) ensuring universal healthcare coverage; (ii) pooling the public and private financing; (iii) overcoming the fragmentation of provision of uncoordinated private and public care; (iv) improving system organisation and monitoring; (v) improving access to and quality of care.

Coverage

Citizens below a determined income level used to be free health care beneficiaries of the Public Health System (around 80% of the population), while the rest of the population (non-beneficiaries) paid according to fee schedules by the MoH. As from 1.8.2013 new fees and co-payments were set that reduced the share of free health care beneficiaries to around 70% of the population. The envisaged introduction of the NHIS is expected to increase coverage to the whole population, since every inhabitant should be covered under a family doctor to guide him through the system. As demand exceeds significantly the supply for free

public health care services, long waiting lists for some specialties create barriers to access for those services. For this reason, a part of the population uses the private services for outpatient consultations and routine procedures, using the public sector for more costly services.

Administrative organisation and revenue collection mechanism

The public health care budget is financed by the state. In addition, a contribution-based health care scheme is implemented for civil servants, and there are co-payments defined for beneficiaries and non-beneficiaries of public health care services. The public health sub-system is highly centralised. Most decision-making processes are centralised. Public hospitals form part of an integrated system of civil service and ministerial control management, such that managerial decisions are taken outside of the hospitals.

Role of private insurance and out of pocket co-payments

The public health care system has since long been criticised for failing to effectively cover the population leading to inadequate and ineffective coverage. The latter is associated with the fact that around 50% of people eligible for free public health care opt to visit the private sector and pay out-of-pocket (mostly for ambulatory care services) to avoid long waiting times. As a result, the share of private and out-of-pocket in total health expenditure (53.7% and 46% in 2013, respectively) is the largest in the EU (EU average: 23% and 14% in 2013, respectively). The population non eligible for free public health care services is to some degree covered by private health insurance schemes, although the domestic private health insurance industry is still at an infant stage.

Types of providers, referral systems and patient choice

As stated above, public and private provision coexist. Public primary care is provided in hospital outpatient departments, urban and rural health centres and sub-centres. Public dental care is provided in public dental clinics. Public general hospitals offer specialist outpatient care and district hospitals and Specialist Centres such as the

Bank of Cyprus Oncology Centre, Cyprus Institute of Neurology and Genetics offer outpatient and inpatient hospital care. Private health services include a variety of specialists and dentists who provide their services in their own facilities, typically in the largest urban areas.

The total number of practising physicians per 100 000 inhabitants (322 in 2013) is below the EU average (344 in 2013). The number of general practitioners (GPs) per 100 000 inhabitants is not known with certainty, but in the past it has been below the EU average (41 per 100 000 inhabitants in 2003). At the moment, besides some form of referral in the case of public provision, there is no formal referral system from primary to specialist and hospital care. With NHIS, national authorities want to establish a system of family doctors and strengthen the referral system from primary care to specialist doctors and other providers. In other words, all inhabitants would register with a family doctor, who would act like a gatekeeper referring patients to specialist and other providers.

Cyprus has seen a reduction in the number of acute care beds per 100 000 inhabitants in the last decade (320 in 2013 vs. 394 in 2003) and their number is below the EU average (356 in 2013). About half of the beds are publicly owned. The future number of acute care beds will depend on the combination of the possible reorganisation of public hospitals as a result of the NHIS implementation with optimal use of effective modern technologies at hospitals such as day-care and laparoscopic services, the availability of follow-up care and the availability of long-term care services. With the planned autonomisation the public hospitals shall be turned into independent and autonomous units that can compete with private providers on an equal basis to establish contracts with the purchasing authority (Health Insurance Organisation - HIO).

Treatment options, covered health services

The benefit package is explicitly defined and is comprehensive.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Currently, doctors in the public sector are paid a salary, while in the private sector they are paid on

a fee-for-service basis with unregulated fees. Public sector remuneration is determined by the central government. The private sector fees are determined by the free market and depend on reputation of each specific doctor, although an indicator of private sector fees is set by the Medical Council. At the moment there is no activity or performance related payment in the public sector. With the implementation of the NHIS, family doctors' (FDs) reimbursement shall entail a 3-tier payment: (i) An age--adjusted capitation (per number of patients), (ii) an activity based reimbursement, depending on doctor activities regarding preventive medicine practices, chronic disease management, and (iii) a performance related reimbursement that will be tied to, among others, the use of the electronic HIO IT system, referral and prescribing behaviour. The details of how this will be implemented are in the process of being finalised. A uniform reimbursement policy is to be applied to both public and private sector providers.

Specialists' outpatient services will be reimbursed on a fee for service basis (per activity). As regards specialists' inpatient services in hospitals, these will be incorporated into the DRG to which each case will be assigned. It is expected that with its introduction, the DRG system will promote the containment of inpatient expenditure through the increased transparency concerning clinical data and costs. In addition, as the HIO will treat the public and private sectors exactly the same, it is expected that, through the competitive environment which will be created, an improvement in hospital efficiency and quality of service provided will occur.

Currently the annual MoH budget includes a specific hospital budget allocated to each hospital according to need, primarily on a historical basis adjusted to inflation. As a result, there are no incentives for cost-awareness and control from the part of the public providers. In addition, when looking at hospital activity, inpatient and day case discharges are much lower than the EU average (respectively 7.8 discharges per 100 inhabitants vs. 16.5 in the EU and 1,672 day case discharges vs. 7,031 in the EU per 100 000 inhabitants). This suggests that there is room to increase hospital activity. It also suggests that as a result of hospital inefficiency patients waiting times are increased.

The market for pharmaceutical products

In the private sector, pharmaceutical care is provided through registered private pharmacies and financed with out-of-pocket payments. The prices of imported pharmaceuticals are set through external price referencing. A 3% mark-up is added to the external reference price (ERP) to cover the cost of importing pharmaceuticals. Furthermore, a reduction of 8.5% is applied for products with a whole sale price greater than EUR 10. The price set is the wholesale price. The wholesale prices include the wholesale margins and the distribution costs. The Pharmacy margins reach 37% on wholesale price for the medicines of EUR 0 – 50, 33% for the medicines of EUR 50,01 – 250,00 and 25% for the medicines of > EUR 250,00. The price revisions only apply to medicines with wholesale prices greater than EUR 10,00. Pharmacists also receive a flat fee of EUR 1,00 per prescription. A 5% VAT is added to the net price.

The external price referencing is also applied for setting the prices of imported generics, in case the corresponding originators are not included in the price list. In general, the price of the generics cannot exceed 80% of the price of the original branded product marketed in Cyprus. For locally manufactured generics, the ex – factory price is set on the basis of the production cost plus a mark-up of 20%, in cases where the originator is not included in the price list. Along with the imported generics, local manufactured generics should not exceed 80% of the original product included in the price list. Price revisions take place annually. A recalibration of the pricing method is performed semi-annually.

There are no lists of medicines (positive or negative) in the private sector as pharmaceutical care is not reimbursed. Prescribing habits of private doctors are not monitored, although the authorities often issue guidelines and recommendations for the correct use of medicines to the prescribing physicians.

In the public sector pharmaceutical care is provided through public pharmacies and it falls under the Pharmaceutical Services of the Ministry of Health. It is block-funded by the Ministry of Finance. For the supply of medicines a public procurement method is used. Pharmaceutical care is provided to eligible patients, according to the

Medical Institutions and Services General Regulations.

Pharmaceuticals provided to the eligible patients are included in the Hospital Formulary which provides contemporary information about medicines available from public hospitals and health care centres. In the past years, a co-payment scheme has been implemented which enables doctors to prescribe a limited number of drugs not included in the approved list, but available in the private sector. The medicines in the co-payment scheme are partly reimbursed by the Government. The amount reimbursed is based on the price difference between the price of the co-payment drug and the price of the corresponding available drug on the list of approved drugs.

In order for a new product to be added to the Hospital Formulary, a formal pharmaceutical request form has to be submitted by a specialist physician practising in a public hospital. Generics and generic substitution are used widely in the public sector. The use of generics provides high cost savings in the public sector. Conversely, the use of generics in the private sector is limited. One of the reasons for this is the fact that pharmacists are not allowed to substitute original pharmaceutical products for generic medicines. Furthermore, the promotion of generic medicines is still limited, and the Cypriot government does not provide any incentives for doctors and pharmacists.

A general reform of the pricing and reimbursement system is expected due to the introduction of the NHIS. This reform will unify the pharmacy market under common pricing and reimbursement rules.

Use of Health Technology Assessments and cost-benefit analysis

The government currently builds up its HTA capacity. For pharmaceuticals, the criteria for inclusion of a pharmaceutical in the List of Approved Pharmaceuticals include: product-specific criteria (e.g. medical and therapeutic value, safety, lack of alternative therapies); economic criteria (e.g. cost effectiveness, budget impact); patient-specific criteria (e.g. age, sex, chronically or terminally ill patients); and disease-specific criteria (e.g. severity of illness, special

medical needs). The Drugs Committee assesses all of the above criteria.

eHealth, Electronic Health Record

At the current moment, there are major deficiencies in the system in terms of IT health solutions, since an Integrated Health Information System (IHIS) is currently used only in 2 hospitals (in Nicosia and Famagusta) and some health centres. However, the Ministry, as part of an ambitious health sector reform program that requires universal access for all public sector health providers to an IHIS and their routine use of it, now seeks an enhanced IHIS. This would incorporate the enhancements and/or amendments required to support the reform process, to expand in all the public hospitals and health centres all over Cyprus.

The main objective is to provide a functional interoperable solution that will ensure electronic data exchange of patient records with other EU countries, the extension, in the future, of services to the Cyprus private healthcare sector, implementation of the further National Health Insurance System (NHIS) reform and other major Cyprus health care initiatives that involve development of electronic data exchange.

On the other hand, in view of the implementation of the NHIS, the Health Insurance Organisation (HIO) has prepared the technical requirements for a total solution for the Information Technology (IT) System. Currently, the tenders submitted for the procurement of the NHIS IT system are being evaluated by the HIO. A full electronic system shall be implemented for submitting claims and issuing prescriptions, lab orders and referrals. This shall be based on electronic enrolment of beneficiaries and healthcare providers which will take place in parallel to the development of the IT system. Other systems such as Electronic Patient Records, data mining & analytics and disease management system shall be implemented in addition.

A high degree of interoperability and data interchange between the two systems will be required, since public sector hospitals and health centres will be service providers to the HIO.

Health promotion and disease prevention policies

Authorities do not particularly emphasise health promotion and disease prevention, which is visible for the relatively low level of expenditure. Total expenditure on prevention and public health services as a share of GDP and as share of total current health expenditure are below the EU average (0.1% of GDP and 1.4% of total current health expenditure in Cyprus versus 0.2% and 2.5% in the EU, respectively). Prevention is expected to increase with the introduction of the NHIS and the concept of the Family Doctor since the design includes the provision of incentives for specific preventive and screening activities.

Recently legislated and/or planned policy reforms

Health sector reforms gained some momentum under the Economic Adjustment Programme. A Memorandum of Understanding on Specific Economic Policy Conditionality (MOU) attached to this economic adjustment programme included fiscal and structural measures intended to “control the growth of healthcare spending, strengthen the sustainability of the health sector's funding structure and improve the efficiency of public healthcare provision”.

Specific measures were intended to increase the availability of publicly financed health services, to initiate processes to improve the quality of care in public provision of health services and to increase revenue for the health sector. These included: (a) a revision of exemptions from user charges and the introduction of a new contribution of 1.5% on the gross salary or pension for active and retired civil servants; (b) a 30% increase in user charges for publicly provided health services for ‘non-beneficiaries’ and the introduction of new user charges (co-payments) and increased user charges for higher levels of care; (c) financial disincentives for using emergency care in non-urgent situations; financial disincentives in the form of co-payments to minimise medically unnecessary laboratory tests and use of pharmaceuticals; (d) MOU measures provided for the restructuring and autonomisation of public hospitals, the restructuring of the Ministry of Health, Associated Facilities/Organizations and the Health Insurance Organization (HIO). They provided also for the

implementation of the National Health Insurance Scheme,

In addition, the MOU measures included the development and implementation of the information technology infrastructure for the NHIS, the review of income thresholds for free access to health care, the creation of evidence-based protocols for laboratory tests and prescribing medicines, the establishment of a system for health technology assessment (HTA), the preparation of new clinical guidelines for the management of high-cost diseases, the introduction of coding for diagnosis-related groups (DRGs) in both public and private hospitals to provide the basis for a future payment mechanism, shadow-budgeting for public hospitals, and periodic reviews of various other measures (using HTA to define the scope of publicly covered services, user charges policy and the introduction of income-related contributions earmarked for the NHIS), introduction of working time flexibility, definition of a basket of publicly covered (reimbursable) medical services and establishment of a system of family doctors to refer patients to other levels of care, etc.

The current planning of the comprehensive reform of the healthcare sector is soon to be completed and besides the Autonomization of Public Hospitals, will include the modernisation of Primary Healthcare, the eHealth, the establishment of University Clinics, the set up of National Medicines Organisation and the introduction of National Health System that will serve as a capitalisation tool for the rest of the reforms and boost citizens with high level healthcare services, in a single market, without public – private boundaries, with the patient in the centre, able to choose healthcare provider. The NHIS will be developed and implemented based on the fundamental principles of free choice of provider, social equality and solidarity, financial sustainability and universal coverage. The current planning consists of having the original 2013 NHIS bill serving as the basis for NHIS legislation. The NHIS will be based on a single payer system.

Challenges

The analysis above has shown that the major reforms with regard to increasing the efficiency of the health system are outstanding. The main

challenges for the Cypriot health system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades that is a risk to the long-term sustainability of public finances. This could be achieved by implementing a universal NHIS ensuring equal access, financial sustainability and quality health care, through which a number of other challenges can be tackled as follows:
- To ensure universal coverage and the pooling of financing to the sector, currently non-existent.
- To address the inefficiencies related to the fragmentation of care provision characterised by separate public and private provision that do not make part of a whole coherent framework.
- To implement a comprehensive reform of the public hospital sector increasing their managerial capacity and legal ability for autonomous decision making within a strategic framework of public health policies aiming at: an increase of hospital output, an improvement of the provision of after-hours primary care services, and the creation of integrated networks of public primary health care centres working in a coordinated fashion with public hospitals.
- To reorganise and promote public hospitals autonomy through the relevant bill so as to ensure equal competition between private and public health providers and ease failure of coordination between the public and the private sector leading to duplication and waste of resources.
- To focus on enhancing primary health care services and to implement a comprehensive reform of the primary health care centres to improve efficiency and care coordination between types of care and to encourage patients to first make use of primary care vs. specialist care vs. hospital care.

- To define a comprehensive human resources strategy to ensure a balanced skill-mix that allows a strong primary care sector to develop.
- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes including putting IT-systems into place in every public hospital.
- To make systematic use of cost-effectiveness information, as planned, in determining the basket of goods and the extent of cost-sharing.
- To foster health promotion and disease prevention activities, promoting healthy life styles and disease screening given the pattern of risk factors (smoking, alcohol, obesity, circulatory system diseases).

Table 1.5.1: Statistical Annex – Cyprus

General context												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
GDP, in billion Euro, current prices	13	14	15	16	17	19	18	19	20	19	18	9289	9800	9934
GDP per capita PPS (thousands)	24.5	25.6	26.4	27.0	27.6	27.9	26.3	26.0	24.5	23.3	21.9	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	0.6	2.9	2.4	2.4	2.9	1.0	-4.5	-1.3	-2.1	-3.9	-5.8	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	12.6	-3.3	1.6	1.0	-0.9	15.0	2.6	-2.9	1.9	-6.2	-5.3	3.2	-0.2	-0.4
Expenditure on health*												2009	2011	2013
Total as % of GDP	6.8	6.4	6.4	6.3	6.1	6.9	7.4	7.3	7.6	7.4	7.4	10.4	10.1	10.1
Total current as % of GDP	6.2	6.0	6.0	6.0	5.9	6.7	7.2	6.4	6.6	6.7	6.8	9.8	9.6	9.7
Total capital investment as % of GDP	0.6	0.4	0.4	0.3	0.2	0.2	0.2	0.8	0.9	0.7	0.6	0.6	0.5	0.5
Total per capita PPS	1359	1378	1442	1510	1563	1882	1934	1914	1988	1883	1749	2828	2911	2995
Public as % of GDP	3.1	2.8	2.7	2.7	2.6	2.9	3.1	3.5	3.6	3.4	3.4	8.1	7.8	7.8
Public current as % of GDP	2.8	2.5	2.5	2.6	2.6	2.8	3.1	3.1	3.2	3.1	3.2	7.9	7.7	7.7
Public per capita PPS	500	486	511	566	565	615	733	814	831	782	743	2079	2218	2208
Public capital investment as % of GDP	0.3	0.3	0.2	0.1	0.0	0.1	0.1	0.4	0.4	0.4	0.3	0.2	0.2	0.1
Public as % total expenditure on health	45.1	43.8	41.8	42.4	42.6	41.4	42.4	47.7	46.8	46.5	46.3	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	7.6	7.3	7.0	7.3	7.0	7.1	7.1	7.1	7.3	7.2	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	:	:	83.0	83.0	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	47.7	49.9	50.1	48.6	49.1	51.3	49.9	46.3	46.5	47.2	46.4	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												2009	2011	2013
Population, current (millions)	0.7	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	502.1	504.5	506.6
Life expectancy at birth for females	81.2	81.8	80.8	82.0	82.1	82.9	83.5	83.9	83.1	83.4	85.0	82.6	83.1	83.3
Life expectancy at birth for males	76.8	76.5	76.5	78.1	77.6	78.2	78.5	79.2	79.3	78.9	80.1	76.6	77.3	77.8
Healthy life years at birth females	69.6	:	58.2	63.4	62.8	64.5	65.3	64.2	61.0	64.0	65.0	:	62.1	61.5
Healthy life years at birth males	68.4	:	59.8	64.2	63.1	63.9	64.8	65.1	61.6	63.4	64.3	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	:	57	55	63	54	49	45	46	103	104	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.1	3.5	4.6	3.1	3.7	3.5	3.3	3.2	3.1	3.5	1.6	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Inpatient curative and rehabilitative care	1.93	1.77	1.76	1.84	1.79	2.32	2.55	1.94	1.99	1.93	1.96	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.09	0.09	0.09	0.10	0.09	0.16	0.17	0.22	0.22	0.22	0.20	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.56	1.55	:	:	:	:	:	2.03	2.09	2.13	2.17	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.39	1.32	1.31	1.28	1.24	1.24	1.28	1.13	1.17	1.18	1.23	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.14	0.14	0.14	0.13	0.13	0.16	0.14	0.13	0.13	0.14	0.13	0.31	0.31	0.32
Prevention and public health services	0.04	0.04	0.03	0.04	0.04	0.04	0.04	0.10	0.09	0.09	:	0.25	0.25	0.24
Health administration and health insurance	0.12	0.10	0.10	0.10	0.09	0.11	0.11	0.09	0.10	0.09	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	1.53	1.37	1.35	1.44	1.40	1.71	1.88	1.43	1.46	1.38	1.41	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.02	0.02	0.02	0.03	0.02	0.02	0.03	0.11	0.11	0.10	0.11	0.16	0.16	0.18
Out-patient curative and rehabilitative care	0.35	0.34	0.33	0.34	0.33	0.38	0.41	0.69	0.71	0.70	0.73	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.34	0.27	0.30	0.28	0.28	0.30	0.32	0.31	0.33	0.31	0.35	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.13	0.12	0.13
Prevention and public health services	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.10	0.09	0.09	:	0.25	0.20	0.19
Health administration and health insurance	0.21	0.20	0.19	0.19	0.19	0.22	0.24	:	:	:	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.5.2: Statistical Annex - continued – Cyprus

Composition of total as % of total current health expenditure												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Inpatient curative and rehabilitative care	31.0%	29.6%	29.4%	30.5%	30.4%	34.8%	35.6%	30.1%	30.0%	29.0%	28.8%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.4%	1.5%	1.5%	1.7%	1.5%	2.4%	2.4%	3.4%	3.3%	3.3%	2.9%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	25.1%	25.9%	:	:	:	:	:	31.5%	31.5%	32.0%	31.9%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	22.3%	22.1%	21.9%	21.2%	21.1%	18.6%	17.9%	17.5%	17.6%	17.7%	18.1%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.3%	2.3%	2.3%	2.2%	2.2%	2.4%	2.0%	2.0%	2.0%	2.1%	1.9%	3.2%	3.3%	3.3%
Prevention and public health services	0.6%	0.7%	0.5%	0.7%	0.7%	0.6%	0.6%	1.6%	1.4%	1.4%	:	2.6%	2.6%	2.5%
Health administration and health insurance	1.9%	1.7%	1.7%	1.7%	1.5%	1.6%	1.5%	1.4%	1.5%	1.4%	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	55.4%	55.0%	54.4%	55.6%	54.9%	61.1%	61.0%	46.6%	46.3%	45.2%	44.6%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	0.7%	0.8%	0.8%	1.2%	0.8%	0.7%	1.0%	3.6%	3.5%	3.3%	3.5%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	12.7%	13.7%	13.3%	13.1%	12.9%	13.6%	13.3%	22.5%	22.5%	23.0%	23.1%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	12.3%	10.8%	12.1%	10.8%	11.0%	10.7%	10.4%	10.1%	10.5%	10.2%	11.1%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.3%	0.3%	0.3%	1.6%	1.6%	1.6%
Prevention and public health services	1.1%	1.2%	1.2%	1.2%	1.2%	1.1%	1.0%	3.3%	2.9%	3.0%	:	3.2%	2.7%	2.5%
Health administration and health insurance	7.6%	7.9%	7.5%	7.2%	7.6%	7.7%	7.7%	:	:	:	:	1.4%	3.5%	3.5%
Expenditure drivers (technology, life style)														
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data		
MRI units per 100 000 inhabitants	0.28	0.41	0.66	0.65	0.89	1.64	1.86	1.93	2.00	1.97	1.97	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.4	0.4	0.8	0.8	0.8	0.8	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.8
CTS per 100 000 inhabitants	1.5	1.8	2.0	1.9	3.6	3.5	3.3	3.3	3.2	3.2	3.2	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Proportion of the population that is obese	12.3	:	:	:	:	15.6	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	23.9	:	:	:	:	25.9	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	9.3	9.5	8.7	8.4	8.6	9.3	8.5	8.7	8.9	:	:	10.3	10.0	9.8
Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	260	266	261	252	273	280	284	292	300	304	322	329	335	344
Practising nurses per 100 000 inhabitants	425	439	409	450	458	450	471	476	487	475	492	840	812	837
General practitioners per 100 000 inhabitants	41	:	:	:	:	:	:	:	:	:	:	:	78	78.3
Acute hospital beds per 100 000 inhabitants	394	385	345	344	346	349	351	334	330	324	320	373	360	356
Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	1.9	2.1	2.1	2.0	2.1	2.1	2.3	2.3	2.3	2.4	2.4	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	6.7	6.8	6.6	6.5	7.5	6.5	7.5	7.8	8.0	8.1	7.8	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	562	571	632	701	749	701	935	1,574	1,437	1,505	1,672	6368	6530	7031
Acute care bed occupancy rates	73.0	80.0	84.0	79.0	76.0	88.2	84.7	84.2	90.9	75.8	74.4	72.0	73.1	70.2
Hospital curative average length of stay	5.5	5.8	6.0	5.8	5.3	5.5	5.7	5.4	5.3	5.6	5.7	6.5	6.3	6.3
Day cases as % of all hospital discharges	8.3	8.4	8.7	9.7	9.1	9.7	11.1	16.9	15.3	15.7	17.7	27.8	28.7	30.4
Population and Expenditure projections														
Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060				EU Change 2013 - 2060			
AWG reference scenario	3.0	3.1	3.1	3.3	3.3	3.3	0.3				0.9			
AWG risk scenario	3.0	3.1	3.3	3.5	3.6	3.6	0.6				1.6			
Note: *Excluding expenditure on medical long-term care component.														
Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %				EU - Change 2013 - 2060, in %			
Population projections until 2060 (millions)	0.9	0.9	0.9	1.0	1.0	1.1	29.5				3.1			

Sources: EUROSTAT, OECD and WHO

Cyprus

Long-term care systems

2.5. CYPRUS

General context: expenditure, fiscal sustainability and demographic trends

GDP per capita is currently below EU average with 21,900 PPS in 2013 (EU: 27,900). Population was estimated at 0.9 million in 2013. According to Eurostat 2013 projections, the total population is projected to increase from around 0.9 million in 2013 to 1.1 million in 2060.

Health status

Life expectancy at birth (85.0 years for women and 80.1 years for men) is above EU average levels of 83.3 and 77.8 years in 2013. The same is true for healthy life years with 65.0 years for women and 64.3 years for men versus 61.5 and 61.4 in 2013 in the EU. The percentage of the population having a long-standing illness or health problem is slightly above this share in the Union (33.2% in Cyprus versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in daily activities stands at 8.0%, which is slightly lower than the EU-average of 8.7%.

Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase significantly over the coming 50 years. From 6 thousand residents living with strong limitations due to health problems in 2013, an increase of 105% is envisaged until 2060, to slightly more than 13 thousand. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 7.2% to 11.4%, an increase of 58%. This is much more than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and by a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.2 pps

of GDP by 2060 ⁽³⁶⁰⁾. The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.7 pps of GDP by 2060. This reflects the fact that coverage and unit costs of care are comparatively low in Cyprus, and may experience an upward trend in future, driven by demand side factors. Overall, the projected long-term care expenditure increase is expected to add to the budgetary pressure, contributing to the risk for long-term sustainability of public finances.

System Characteristics

Policies and measures that fall within the spectrum of long-term care are administered by the Ministry of Health (long-term health care) and the Ministry of Labour, Welfare and Social Insurance (MLWSI) (long-term social care, sensory, cognitive) through the Social Welfare Services (SWS) and the Department for Social Inclusion of Persons with Disabilities (DSID).

In July 2014, the Guaranteed Minimum Income (GMI) and Social Benefits legislation was adopted and the competent Ministry is MLWSI.

The Guaranteed Minimum Income and in General the Social Benefits (Emergency Needs and Care Needs) Decree of 2015 N.353/2015 (administered by the Ministry of Labour, Welfare and Social Insurance, Social Welfare Services) incorporates the "Scheme for the Subsidisation of Care Services" which cover social care needs of recipients of guaranteed minimum income and members of their family unit. The Scheme mainly covers cash benefits and in justified cases it may provide for in-kind services.

Subsidisation of care services under the Decree, covers home care, day care, respite care and residential care in approved and registered care services (natural and/or legal persons) under the relevant legislative framework of the SWS. Long-term social care services are provided by the government, local authorities, non-governmental

⁽³⁶⁰⁾The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

organisations (NGOs), and the private sector (private for profit enterprises).

Furthermore, the SWS subsidise social care programmes at local level run by NGO's and Local Authorities [State Aid Scheme, under the Regulation 360/2012 for the provision of services of general economic interest (De minimis)]. These programmes (day-care, residential care, home care and child care) cover the social care needs of older people, people with disabilities and children at local level.

The State (SWS) provides full time care in residential homes for older persons and persons with mental and physical disabilities and it operates Houses in the Community for persons with mental and physical multiple disabilities.

Moreover, additional cash benefits are regulated by the DSID for persons with disabilities, irrespective of their income level, targeting to cover the cost of disability. In particular, under two special laws and two schemes, persons with severe motor disability, paraplegia, quadriplegia or blindness are entitled to monthly cash benefits. These benefits cover the cost for the purchase of care services but also rehabilitation services (physiotherapy, occupational therapy, speech therapy etc). For the rehabilitation of the disabled persons immediately after their treatment, but due to the absence of a rehabilitation policy person with disabilities often use DSID cash benefits for this purpose.

In 2012, per capita spending for LTC was at the level of 37 PPS (EU: 317 PPS). LTC constitutes a minor share of total government expenditure. In 2012, it accounted for 0.2% of total government spending (EU: 2.1%).

Public spending on LTC reached 0.3% of GDP in 2013 in Cyprus, below EU average of 1.6% of GDP. 39% of this spending were spent on in-kind benefits (EU: 80%), while 61% was being provided as cash-benefits (EU: 20%). Thus, Cyprus uses cash benefits to a very large extent, which is a consequence of the lack of a formal public LTC scheme. It is not clear which role private co-payments for formal in-kind LTC play in financing of LTC services.

Types of care

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 22% lower in Cyprus. Overall, 1.6% of the population (aged 15+) receives formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 9% of public expenditure (EU: 61%), 91% are being spent for LTC services provided at home (EU: 39%). However, as discussed above, Cyprus spends most of its LTC resources via cash benefits, thus having a relative focus of LTC policies on home care.

Eligibility criteria and user choices: dependency, care needs, income

Only individuals entitled to GMI may be entitled to subsidisation of social LTC, except of persons with severe disability (motor/paraplegia/quadruplegia/blindness) who are entitled to this irrespective of their income level. No qualifying period is defined for LTC eligibility. Entitlement to long-term social care is based upon need i.e. based on the person's ability to carry out his/her daily home and personal care and his/her ability to meet his/her frequent activities outside of his/her home (i.e. shopping, doctor visits, social activities). In addition, the Decree (N.353/2015) does not provide for any element of duration/degree of dependency. Only in the case of home care provided by Domestic Worker, the persons should be deprived of their ability for self-care.

GMI applications are evaluated by the Welfare Benefits Administration Service, which informs the SWS whether the applicant fits in the category of people who can be assessed for the provision of care services based on the legislation and whether the applicant receives care benefit from any other Service. Subsequently, the Social Welfare Services assess the care need of applicants and then communicate the results of their assessment to the Service for the Management of Welfare Benefits

for their decision on the application according to the results of the assessment.

The SWS perform *in situ* visits to the accommodation of the applicants/beneficiaries to assess the need for care with the use of specific assessment tools. The SWS may ask for additional certificates/reports from other Services (including medical reports). Subsequently, the information collected is assessed by Specialised Assessment Teams of the SWS. In case of a positive evaluation of the care needs of the applicant/ beneficiary which corresponds to the approval of care provision, it includes the type, the extent and the duration of the care that will be provided as well as the amount of subsidisation. Between the beneficiary and the approved service provider an Agreement for the Provision of Social Care is signed, which should be notified to the SWS for the correctness of the content and for the future quality checks of the service provision.

In case the beneficiary prefers a different type of care than the one proposed, then she/he has the right to make his/her own arrangements, nevertheless the subsidisation of care will correspond to the approved amount.

In the case of persons with disabilities, in order to become entitled of disability cash benefits by DSID or the GMI-Disability additional benefit they have to follow a disability assessment and certification through the DSID Disability Assessment Centre.

Prevention and rehabilitation measures

In Cyprus the health care system for the elderly people is strongly acute-care oriented. Hospital and specialist care is a priority over other models of care. Elderly patients have the opportunity to visit the primary health care services either at the out patients surgeries or at the health care centers all over the districts. The GPs do not function as gatekeepers for medical care, as hospitals and private specialists are directly accessible to patients. Nursing homes as such do not exist, but elderly and very elderly people in need of complex care stay in hospitals or in special care wards in retirement homes. Health care provision is also offered in hospital physiotherapy services, according to their needs.

Long-term care includes health, personal, and support services, aiming at helping people to remain at home and live as independently as possible. Long-term care is mainly provided either in the home of the person receiving services or at a family member's home. In-home services may be short-term -for someone who is recovering from surgery, for example -or long-term, for people who need help continuously.

Long-term care Services are provided mainly to people with a high level of dependency, often elderly people, those with chronic diseases and people with physical, learning and mental disabilities. The Nursing Services of the Ministry of Health facilitate the long-term care provided by a network of Community Nurses (General Nursing Community Nurses and Mental Health Community Nurses) through home visits to mentally ill patients, disabled people, artificially ventilated patients at home and elderly people who live alone and encounter severe health problems.

The long-term care provided by the Mental Health Services, is being ensured by monitoring chronic mental patients in the community (at their homes or at rehabilitation units, such as Day Centers and Occupational Rehabilitation Units). These services are provided by a multi-disciplinary team of mental health professionals – psychiatrists, clinical psychologists, ergo therapists, nursing officers.

Formal/informal caregiving

According to the Decree 353/2015 the following types of care (formal care), are covered:

Home care which covers a wide range of care services and includes personal and household care. To cover the needs of home care either by an approved natural and/or legal person, or by Domestic Worker the maximum amount granted as a subsidy is EUR 400/month per family unit. For extraordinary and justified cases a larger amount can be covered for instance, when additional care attendants are required.

Day care: is offered during the day covering personal care services, meals, social and creative activities. The State may pay a cash benefit to recipients of long-term care of up to EUR 137 per month for day care provided by approved natural and/or legal persons. In some cases the

transportation/accompanying costs especially for persons with disabilities are also covered.

Residential care: provides for a 24-hour care, where the person requires continuous support and their needs cannot be covered by family members or other supportive services in their environment. In addition to free residential care in public institutions, the state may pay monthly cash benefit for residential care provided by approved natural and/or legal persons. Cash benefits vary from EUR 625 to EUR 745 per month depending on the care needs of the beneficiary (e.g. bedridden, mobility difficulties or not). Residential homes may be public, private or non-governmental.

Respite Care: is for short periods of time in order to give short spells of rest to the informal caregiver and can take the form of the above types of care (home, residential or day care). Informal carers are supported in their valuable role and simultaneously the person concerned is supported for staying in their home environment. Respite care is arranged depending on the needs and preferences of the people themselves and of their families as far as possible.

The level of the subsidisation for the above types of care is defined by an automated analysis of the specific assessment tools used by the SWS.

Another type of care that is covered by the Decree, but is outside the scope of the present Fiche, is child care and the state may pay cash benefit up to EUR 102 per month.

Recently legislated and/or planned policy reforms

In July 2014, the Cyprus Government has reformed the welfare system by introducing a Guaranteed Minimum Income (GMI). In the relevant Law (N. 109(I)/2014), article 10 (2) refers to the care needs of the GMI recipients and their family members, where additional assistance can be provided. In this direction, the Minister of Labour, Welfare and Social Insurance, issued in August 2014 a Decree that incorporates the “Scheme for the Subsidisation of Care Services” and it was revised in 2015 (N.353/2015). The new Scheme subsidises the social care needs of GMI recipients, including the members of their family

unit, as described in section “LTC System Characteristics”.

Challenges

Cyprus has recently reformed and clearly defined eligibility for LTC benefits, but has a relatively low coverage and financing of the system relatively fragmented system and overall system governance seems improvable. The main challenges of the system appear to be:

- **Improving 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 LTC 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 LTC services and its financing; to establish good information platforms for LTC users and providers; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes.
- **Improving financing arrangements:** to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool;
- **Providing adequate levels of care to those in need of care:** to reduce the risk of impoverishment of recipients and informal carers.
- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, , carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.
- **Ensuring coordination and continuity of care:** to establish better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.
- **To facilitate appropriate utilisation across health and long-term care:** to steer LTC users towards appropriate settings.
- **Improving value for money:** to invest in ICT as an important source of information, care management and coordination.
- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.5.1: Statistical Annex – Cyprus

GENERAL CONTEXT																
GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	13	14	15	16	17	19	18	19	20	19	18	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	24.5	25.6	26.4	27.0	27.6	27.9	26.3	26.0	24.5	23.3	21.9	26.8	27.6	28.0	28.1	27.9
Population, in millions	0.7	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.2	:	1.0	1.0	1.0	1.0	:
Per capita PPS	2.2	2.0	2.1	2.5	2.6	2.7	3.1	35.3	37.2	36.7	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3	0.3	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	81.2	81.8	80.8	82.0	82.1	82.9	83.5	83.9	83.1	83.4	85.0	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	76.8	76.5	76.5	78.1	77.6	78.2	78.5	79.2	79.3	78.9	80.1	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	69.6	:	58.2	63.4	62.8	64.5	65.3	64.2	61.0	64.0	65.0	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	68.4	:	59.8	64.2	63.1	63.9	64.8	65.1	61.6	63.4	64.3	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	26.3	29.1	28.7	25.9	28.4	34.0	32.7	32.6	33.2	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	10.7	8.5	8.2	6.9	6.7	7.6	10.3	7.9	8.0	:	8.1	8.3	8.6	8.7
SYSTEM CHARACTERISTICS																
Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	3	3	4	4	4	5	3	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	:	:	:	:	:	:	3	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.4	0.4	0.5	0.5	0.5	0.5	0.7	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.5.2: Statistical Annex - continued – Cyprus

PROJECTIONS								
	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population								
Population projection in millions	0.9	0.9	0.9	1.0	1.0	1.1	30%	3%
Dependency								
Number of dependents in millions	0.06	0.07	0.09	0.10	0.12	0.13	105%	40%
Share of dependents, in %	7.2	8.1	9.4	10.6	11.1	11.4	58%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.3	0.3	0.4	0.4	0.5	0.5	97%	40%
AWG risk scenario	0.3	0.3	0.5	0.7	1.1	2.0	697%	149%
Coverage								
Number of people receiving care in an institution	3,115	3,598	4,456	5,452	6,438	7,372	137%	79%
Number of people receiving care at home	3,252	3,841	4,965	6,243	7,470	8,688	167%	78%
Number of people receiving cash benefits	7,624	8,706	10,676	12,900	15,137	17,307	127%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	1.6	1.8	2.2	2.5	2.8	3.0	84%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	22.4	22.4	23.2	24.1	25.1	26.0	16%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	38.6	39.3	38.6	37.8	38.2	38.9	1%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	61.4	60.7	61.4	62.2	61.8	61.1	-1%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	9.0	8.7	8.1	7.7	7.4	7.2	-20%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	91.0	91.3	91.9	92.3	92.6	92.8	2%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	2.5	2.6	2.4	2.2	2.1	2.1	-13%	-2%
Unit costs of home care per recipient, as % of GDP per capita	23.8	25.8	24.0	22.7	22.9	23.5	-2%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	17.8	19.2	19.3	19.6	19.8	19.9	12%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".