Cyprus

Health Care & Long-Term Care Systems

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Cyprus

Health care systems

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2.5. CYPRUS

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita in Cyprus was, in 2015, below EU average with 23,818 PPS (EU: 29,610). The population was estimated at 0.85 million in 2016. According to Eurostat projections, total population is projected to increase from around 0.85 million in 2016 to 1.0 million in 2070.

Total and public expenditure on health as % of GDP

Total expenditure on health has relatively stable in the past decade. However expenditure as a percentage of GDP (6.8% in 2015) was relatively moderate and well below the EU average of 10.2% in 2015. When expressed in per capita terms, also total spending on health, at 1,564 PPS in 2015, was less than half of the EU average of 3,305 for the same year. The gap is more marked for the GDP share of public spending on health care: 2.9% of GDP in Cyprus in 2015 vs. 8.0% of GDP in the EU; and 674 PPS in Cyprus vs. an EU average of 2,609 PPS in 2015. Looking at health care without long-term care ([105]) reveals a similar picture, with public spending markedly below the EU average, but it reduces the relative gap (2.8% vs 6.8% in 2015).

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.4 pps of GDP, below the average growth level expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario" ([106]). 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 2070 (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 ([107]).

Health status

Life expectancy at birth (83.7 years for women and 79.9 years for men) was above EU average levels of 83.3 and 77.9 years in 2015. The same is true for healthy life years, with 63.4 years for women and 63.1 years for men in Cyprus compared with, respectively, 63.3 and 62.6 for the EU in 2015. Similarly, the infant mortality rate of 2.7‰ was, in the same year, below the EU average of 3.6‰, having fallen throughout the last decade from a value of 4.6‰ in 2005.

As for the lifestyle of the Cypriot population, data indicates a high proportion of regular smokers (25.2% in 2014), being above the EU average of 21.0 (value in 2015). Conversely, the proportion of obese population was below the EU level at 13.9% (EU: 15.4%), and the latest available figure on alcohol consumption is below the EU level for the same year (9.0 vs. 10.1 for the EU in 2013) and below the 10.2 value for 2015. Based on available data, over the last decade the proportion of population smoking seems relatively unchanged and the average alcohol consumption has slightly decreased.

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

([105]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

([106]) The 2018 Ageing Report: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

([107]) European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

distribution of services and inequities in access to care. Also, prices, capacity, and care quality in the private sector are not sufficiently regulated. There is no implemented coherent framework matching separate provision of public and private healthcare services, leading to inadequate and ineffective coverage. There is an over-burdened public healthcare sector leading to high waiting times for selected consultations, surgical procedures and diagnostic tests, and potentially also leading to a decrease in the quality of care. The over-capacity of private health care providers is exacerbated. This has 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. 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 Cyprus will implement a National Health Insurance Scheme (NHIS). Both relevant legislations for hospital autonomisation and NHIS were enacted on the 216th of June 2017. 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. According to the enacted legislation, NHIS will become operational on June 1st 2020, with the first phase of NHIS (outpatient health care: Family Doctors, Specialists for outpatient care, Pharmaceuticals and Labs for outpatient care) are due to become operational a year earlier (1st June 2019).

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 August 2013 new fees and co-payments were set that reduced the share of free health care beneficiaries to around 70% of the population. 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, part of the population uses the private sector health care services for outpatient consultations and routine procedures while, using the public sector health care services for more costly services. Overall, the recorded proportion of the population covered by public or primary private health insurance was reported at 83% in 2015 vs. the EU average of 98%.

The introduction of the NHIS is expected to increase the accessibility of the whole population and will provide free access to the private and the public health care sectors.

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 as well as 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 combined share of private and out-of-pocket spending out of total health expenditure (56.9% in 2015, with 43.9% covered by out-of-pocket expenditure alone) is the largest in the EU (EU

average: 21.6% for the two combined and 15.9% for out-of-pocket alone in 2015, 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 dental clinics in hospital outpatient departments and PHCCs. 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 number of practising physicians per 100 000 inhabitants has risen above the EU average in 2015 (358 vs. 344 for the EU), after steadily growing over the past decade, though still below average during that time. Also the number of general practitioners (GPs) per 100 000 inhabitants in 2015 was above the EU average, with 87 vs. 78 for the EU in the same year. 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. A main feature of the NHIS is the concept of family doctors and the mechanism of referral system from primary care to specialist doctors and other providers. In other words, all citizens would register with a family doctor, who would act as 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 (342 in 2015 vs. 375 in 2005) and their number, remains below the EU average of 402. About half of the beds are publicly owned. The future number of acute care beds will depend on the combination of public hospitals' reorganisation following autonomisation and 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. It covers family doctor and specialist outpatient visits, pharmaceuticals, laboratory tests, inpatient care, allied health professional services, A&E, ambulance services, rehabilitation and palliative care.

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. 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, 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) adjusted through a point system mechanism in order to achieve implementation of a hard global budget. As regards to the reimbursement of 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 activities. 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. Consistently, when looking at hospital activity, inpatient and day case discharges ranked much lower than the EU average in 2015 (respectively 7 discharges per 100 inhabitants vs. 16 in the EU and 1,584 day case discharges vs. 7,635 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 may be higher than otherwise possible.

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. The price set is the wholesale price. The wholesale prices include the wholesale margins and the distribution costs. Since early 2018, the Pharmacy margins have been set to be regressive, incorporating both percentage and fee. They reach 37% on wholesale price for the medicines up to €10, 35% for the medicines between €50.01 – 250, € 83 for the medicines between €250.01-1500 and €100 for the medicines above €150. Pharmacists also receive a flat fee of €1 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 re-calibration of the pricing method is performed semi-annually.

Public spending on pharmaceuticals in Cyprus looks low compared to the average for EU countries, with 0.2% of GDP spent on the area in 2015 compared with an average of 1.0% of GDP for the same year.

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 currently falls under the Pharmaceutical Services of the Ministry of Health. The procurement of medicinal products is the responsibility of the Directorate of Purchases and Procurement of the Ministry of Health and 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 draft legislation allowing for generic substitution in private pharmacies as part of the implementation of the NHS is currently undergoing legal vetting.

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

The Ministry, as part of its ambitious health sector reform program that requires universal access for all public sector health providers to an Integrated Health Information System (IHIS) and their routine use of it, is in the process of a tendering procedure to obtain a new enhanced IHIS that will incorporate the enhancements and/or amendments required to support the reform process, as well as to expand in all the public hospitals and health centres all over Cyprus, complementing the existing IHIS that is currently used in 2 Public Hospitals (in Nicosia and Famagusta) and some health centres. Furthermore, the Ministry is exploring the conversion of the existing paper medical records into digital records that will complement the Electronic Health Records created by IHIS. At the same time, the Ministry is in the process of developing the National Contact Point for e-Health (under Connecting Europe Facility funding), as part of the e-Health Network project to facilitate cross border healthcare between the network's member states. Additionally, it will abide to the requirement of the EU regulations, to provide by the end of 2019 a common secure framework that will facilitate the Electronic Exchange of Social Security Information (EESSI) between the corresponding institutions or the liaison bodies of each EU Member State.

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.

In view of the implementation of the NHIS, the Health Insurance Organisation (HIO), on the 30th March 2017, has contracted the development, implementation, operation and support of a total solution for the information technology system and other business processes of the NHIS. Health care providers will have access to the system to submit claims and issue prescriptions, lab orders and referrals. The system will store clinical patient data as they emerge from the activities of the doctors such as referring and prescribing and the submission of claims.

Health promotion and disease prevention policies

Though total expenditure on prevention and public health services as a share of GDP and as share of total current health expenditure were below the EU average in 2015 (0.1% of GDP and 1.7% of total current health expenditure in Cyprus versus 0.3% and 3.2% in the EU, respectively), based on a self-assessment of the country's public health capacity and services, using the WHO tool for 10 Essential Public Health Operations, Cyprus obtained a

positive score in this area ([108]). The assessment report forms the basis for national planning and policy in the area as well as to monitor progress and further enhance the delivery of public health services. Prevention is expected to increase further 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/ Organisations and the Health Insurance Organisation (HIO). They provided also for the implementation of the National Health Insurance Scheme.

([108]) The assessment was based on the revised 2014 version of the WHO tool for 10 Essential Public Health Operations.

Based upon the MOU a number of initiatives have been implemented: 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 Autonomisation of Public Hospitals, will include the modernisation of Primary Healthcare, the eHealth, the establishment of University Clinics, the setup of National Medicines Organisation and the introduction of National Health Insurance System that will be key for accelerating reforms and provide 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 NHIS will be based on a single payer system.

Challenges

The analysis above demonstrates the various challenges that the health system faces and that health reforms have to tackle. The highlighted intrinsic distortions in the system cause inequality, inefficiencies and prevent access to health care. The reforms planned by the MoH in the next two years have the potential to tackle many of these issues, but given the anticipated resistance on the

side of stakeholders, a strong political commitment is of the essence and will be a key driver of success in responding to the challenges. These following can currently be identified:

- To achieve the full implementation of the NHIS with the aim to ensure equal access, financial sustainability and quality health care. This, in turn, would ensure universal coverage and the pooling of financing to the sector, currently non-existent. The full implementation of the NHIS would also 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 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.

- 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 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 data exchange by monitoring of inputs, processes, outputs and outcomes including putting interoperable IT-systems into place in every public hospital. Accessibility and interoperability should be extended to allow, with the consent of the patient and/or health professional, access and exchange of data with private sector ehealth systems as well as with the patient, to eventually achieve a patient-centred eHealth system.

- 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 2.5.1: **Statistical Annex – Cyprus**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	15	16	18	19	19	19	20	19	18	18	18	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	27.1	27.6	28.9	28.1	26.3	25.4	24.6	23.2	21.9	22.1	23.8	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	2.2	2.8	2.6	1.3	-4.4	-1.3	-2.2	-4.5	-5.7	-0.3	2.6	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	1.3	-1.2	15.4	2.7	-2.9	1.8	-6.8	-4.9	-1.5	-4.9	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	6.4	6.3	6.1	6.9	7.4	7.3	7.6	7.4	7.5	7.4	6.8	10.2	10.1	10.1	10.2
Total current as % of GDP	6.4	6.3	6.1	6.9	7.4	6.3	6.6	6.7	6.9	6.8	6.8	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.7	0.6	0.6	0.1	0.9	0.6	0.2	0.3
Total per capita PPS	1,428	1,500	1,535	1,844	1,895	1,875	1,947	1,829	1,708	1,653	1,564	2,745	2,895	2,975	3,305
Public total as % of GDP	2.8	2.9	2.6	2.8	3.1	3.1	3.2	3.1	3.3	3.1	2.9	8.0	7.8	7.8	8.0
Public current as % of GDP	2.5	2.6	2.6	2.8	3.1	3.0	3.1	3.0	3.2	3.0	2.9	7.7	7.6	7.6	7.8
Public total per capita PPS	617	683	669	761	804	795	815	767	747	686	674	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.27	0.27	0.09	0.05	0.06	0.06	0.07	0.06	0.07	0.08	0.06	0.2	0.2	0.2	0.2
Public as % total expenditure on health	43.2	45.5	43.6	41.3	42.4	42.4	41.9	41.9	43.8	41.5	43.1	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	7.7	7.3	7.7	7.5	7.3	7.4	6.9	6.7	6.1	5.4	6.3	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	83.0	83.0	83.0	:	83.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	50.1	48.6	49.1	51.3	49.9	41.0	42.8	44.0	43.1	44.8	43.9	14.6	14.9	15.9	15.9

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

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.8	502.1	503.0	505.2	508.5
Life expectancy at birth for females	80.8	82.0	82.1	82.9	83.5	83.9	83.1	83.4	85.0	84.7	83.7	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.5	78.1	77.6	78.2	78.5	79.2	79.3	78.9	80.1	80.9	79.9	76.6	77.3	77.7	77.9
Healthy life years at birth females	58.2	63.4	62.8	64.5	65.3	64.2	61.0	64.0	65.0	66.3	63.4	62.0	62.1	61.5	63.3
Healthy life years at birth males	59.8	64.2	63.1	63.9	64.8	65.1	61.6	63.4	64.3	66.1	63.1	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	55	63	54	49	45	46	103	107	92	93	98	64	138	131	127
Infant mortality rate per 1 000 live births	4.6	3.1	3.7	3.5	3.3	3.2	3.1	3.5	1.6	1.4	2.7	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	1.8	1.8	1.8	2.3	2.6	2.0	2.1	2.0	2.1	2.0	2.0	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	:	:	:	:	:	:	2.0	2.1	2.1	2.1	2.1	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.3	1.3	1.2	1.2	1.3	1.0	1.1	1.1	1.2	1.1	1.2	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4
Prevention and public health services	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.0	0.1	0.3	0.2	0.3	0.3
Health administration and health insurance	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	1.4	1.4	1.4	1.7	1.9	1.5	1.5	1.4	1.5	1.4	1.3	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.3	0.3	0.3	0.4	0.4	0.7	0.7	0.7	0.7	0.7	0.7	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	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	0.2	0.2
Prevention and public health services	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	0.2	0.2	0.2	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.5.2: **Statistical Annex - continued – Cyprus**

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
Inpatient curative and rehabilitative care	27.6%	29.3%	29.6%	33.7%	34.5%	31.8%	31.6%	30.5%	30.4%	29.6%	29.2%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	1.4%	1.6%	1.5%	2.3%	2.3%	3.3%	3.3%	3.3%	3.3%	3.4%	3.4%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	30.0%	30.6%	30.4%	31.1%	30.6%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	20.6%	20.4%	20.5%	18.0%	17.3%	15.9%	16.2%	16.4%	16.6%	16.8%	17.1%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	2.2%	2.1%	2.1%	2.3%	1.9%	1.9%	2.0%	2.1%	2.0%	2.2%	2.2%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	0.5%	0.6%	0.7%	0.6%	0.5%	0.8%	0.8%	0.7%	0.7%	0.6%	0.7%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	1.6%	1.6%	1.5%	1.6%	1.5%	1.3%	1.5%	1.5%	1.6%	1.5%	1.5%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	54.4%	55.6%	54.9%	61.1%	61.0%	48.5%	48.4%	47.4%	46.4%	46.3%	46.2%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	0.8%	1.2%	0.8%	0.7%	1.0%	4.0%	3.9%	3.9%	4.1%	4.0%	4.2%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	12.9%	13.1%	12.9%	13.2%	13.6%	22.8%	22.6%	23.0%	22.9%	23.8%	22.6%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	12.1%	10.8%	11.0%	10.7%	10.4%	7.6%	7.7%	7.6%	8.2%	7.7%	7.6%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	1.2%	1.2%	1.2%	1.1%	1.0%	1.7%	1.3%	1.3%	1.3%	1.3%	1.7%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	8.1%	8.1%	8.2%	8.6%	8.4%	2.6%	3.2%	3.3%	3.4%	3.4%	3.5%	4.1%	4.0%	3.6%	3.4%

Expenditure drivers (technology, life style)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
MRI units per 100 000 inhabitants	0.66	0.65	0.89	1.64	1.86	1.93	2.00	1.97	1.97	1.99	2.01	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.8	0.8	0.8	0.8	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	2.0	1.9	3.6	3.5	3.3	3.3	3.2	3.2	3.3	3.3	3.4	2.1	1.9	2.1	2.3
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	0.2	0.2
Proportion of the population that is obese	:	:	:	:	:	:	:	:	:	13.9	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	:	:	25.9	:	:	:	:	:	25.2	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	11.4	11.5	11.6	12.0	10.8	11.3	10.7	10.6	9.0	:	:	10.4	10.3	10.1	10.2

Providers	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Practising physicians per 100 000 inhabitants	257	249	270	276	281	289	297	302	320	338	358	324	330	338	344
Practising nurses per 100 000 inhabitants	409	450	458	450	471	476	487	475	492	501	523	837	835	825	833
General practitioners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	80	87	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Doctors consultations per capita	2.1	2.0	2.1	2.1	2.3	2.3	2.3	2.4	2.4	2.2	2.2	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	7	7	7	7	8	8	8	8	8	8	7	17	16	16	16
Day cases discharges per 100 000 inhabitants	632	701	749	701	935	1,574	1,437	1,505	1,672	1,737	1,584	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	84.0	79.0	76.0	88.2	84.7	84.2	90.9	75.8	74.4	74.7	72.2	77.1	76.4	76.5	76.8
Hospital average length of stay	6.0	5.8	:	:	:	:	:	6.0	6.1	6.4	6.2	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	8.7	9.7	9.1	9.7	11.1	16.9	15.3	15.7	17.7	18.2	16.7	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps. Cyprus	EU
AWG reference scenario	2.8	2.9	2.9	2.9	3.0	3.0	3.1	3.1	3.1	3.1	3.2	3.2	0.4	0.9
AWG risk scenario	2.8	2.9	3.0	3.0	3.1	3.2	3.2	3.3	3.3	3.4	3.4	3.4	0.6	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in % Cyprus	EU
Population projections until 2070 (millions)	0.8	0.9	0.9	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	20.2	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Cyprus

Long-term care systems

3.5. CYPRUS

General context: expenditure, fiscal sustainability and demographic trends

GDP per capita is below EU average based on the most recent figures, with 23,820 PPS in 2015(EU: 29,610). Population was estimated at 0.9 million in 2016 ([456]). According to Eurostat projections, the total population is projected to increase from that level to 1.0 million in 2070, a 20% increase which is well above the average EU value of 2%. Based on the Ageing Report 2018, total public expenditure on long-term care (health and social part) ([457]) is, with 0.3 % of GDP in 2015, below above the EU average in the same year (1.6%). The health component however, with 0.2% in 2015 is lower than the EU average of 1.2% in the same year.

Health status

Life expectancy at birth, 83.7 years for women and 79.9 years for men, was above EU average levels of 83.3 and 77.9years in 2015. However, in terms of healthy life years, Cyprus is broadly in line with the average with 63.4 years for women and 63.1 years for men (vs.63.3 and 62.6 in 2015 in the EU). The percentage of the population having a long-standing illness or health problem is below the value for the Union as a whole (32.7% in Cyprus versus 34.2% in the EU in 2015). The percentage of the population indicating a self-perceived severe limitation in daily activities for the same year stands at 7.9%, which is only slightly lower than the EU-average of 8.1%.

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 70 thousand residents living with strong limitations due to health problems in 2016, an increase of 107% is envisaged up to 2070, to slightly less than 140 thousand. That is a steeper increase than in the EU as a whole (25% in the EU). Also as a share of the population the dependents are projected to become a bigger group, from 7.8% to 13.4%, an increase of 73%, well above the EU-average increase of 21%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is projected to steadily increase. 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 0.3 pps of GDP by 2070([458]), an increase of 84% which stands above the average EU value of 73%. The "AWG risk scenario", which also 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 2.9 pps of GDP by 2070. This reflects the fact that coverage and unit costs of care are relatively 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 budgetary pressure, contributing to the risk for long-term sustainability of public finances ([459]).

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 Welfare Benefits Administration Service, 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.

([456]) Based on Eurostat projections.

([457]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with tasks linked with Activities with Daily Living).

([458]) The 2018 Ageing Report: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

([459]) European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

The Guaranteed Minimum Income and in general the Social Benefits (Emergency Needs and Care Needs) Decree of 2015 N.353/2015, which was revised in 2016 (N. 162/2016), incorporates the ***"Scheme for the Subsidisation of Care Services"*** which covers 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 (from state home carers who are employed under a contract with the government to provide their services – *benefits in kind*–to the beneficiaries).

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

In addition, two new Decrees were adopted in 2017 (365/2017) and 2018 (158/2018), covering in particular the subsidisation of home care services to persons with disabilities and persons aged 80 years old and above, respectively.

Furthermore, the MLWSI 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). Due to the absence of a National Health System and an integrated rehabilitation policy, persons with disabilities often use DSID cash benefits for purchasing rehabilitation services from the private sector.

Long-term care constitutes a minor share of total government expenditure. In 2015, per capita spending for this item was at the level of 38.5 million PPS (EU: 373.6 PPS). In terms of total government spending, this accounted for only 0.4% (EU: 2.5%).

Public spending on long-term care in Cyprus reached 0.2% of GDP in 2013 and remained stable at that level until 2015, well below EU average of 1.2% of GDP. Only more than half of this spending, (54%) was spent on in-kind benefits, which is a much lower share than for the EU as a whole (EU 2016: 84.4%), while 46%, far above the EU average of 15.6% for 2016, was provided as cash-benefits. Based on available figures, Cyprus appears to have a stronger focus on cash benefits, which is a consequence of the lack of a formal public long-term care scheme. It is not clear which role private co-payments for formal in-kind care play in the financing of long-term care services.

Types of care

The expenditure for institutional (in-kind) services makes up 12.7% of public expenditure on long-term care in-kind (EU: 66.3%), 87.3% are being spent for long-term care services provided at home (EU: 33.7%). However, as discussed above, Cyprus spends most of its long-term care resources via cash benefits, thus with a greater focus on home care.

According to the Decree 162/2016 the following types of care (formal care), are covered:

H**ome care** may include 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 €400/month per family unit. For extraordinary and justified cases a larger amount can be covered for instance, when additional care

attendants are required. According to the Decree 158/2018, for persons aged 80 years old and above the amount of subsidisation for home care services is €200 or €400, according to their needs.

Day care: is offered during the day at Day Care Centers for the Elderly and Persons with Disabilities 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 €137 per month for day care provided by approved physical 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. Residential care is provided by the public, private or non-governmental. 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 €625 to €745 per month depending on the care needs of the beneficiary (e.g. bedridden, mobility difficulties or not).

Respite Care: is for short periods of time in order to give short spells of rest to the informal care-giver 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.

In the case of DSID cash benefits can be used by the beneficiaries at their choice of care services either formal or informal.

In addition, as from November 2017 a new Decree 365/2017 was issued according to which home care for persons with disabilities in the framework of the Guarantee Minimum Income Law has four level subsidy being €100, €200, €300 or €400. The needs for care at home and the level of subsidy are assessed and certified by the Disability Assessment Center of the Department for Social Inclusion of Persons with Disabilities.

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

GMI recipients may be entitled to subsidisation of their long-term social care needs, except for persons with severe disability (motor/paraplegia/quadriplegia/blindness), who are entitled to this irrespective of their income level. Subsidisation for long-term social care may also be provided to persons that are not eligible for GMI, if their income is not sufficient to cover for their long term social care needs, provided that they meet all the other conditions specified in the GMI legislation.

No qualifying period is defined for long-term social care 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.162/2016) 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 SWS assess the social care need of applicants and then communicate the results of their assessment to the Welfare Benefits Administration Service 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 beneficiaries prefer a different type of care than the one proposed, then they have the right to make their own arrangements, which will be subsidised up 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. The disability assessment methodology is based on the International Classification of Functioning, Disability and Health (ICF) issued by the World Health Organisation (WHO).

According to Decree 365/2017 as from November 2017, the Disability Assessment Centers of the Department for Social Inclusion of Persons with Disabilities also assess and certify, based on the ICF classification, the needs of persons with disabilities for care at home.

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.

Dental Services have a wide network of clinics geographically distributed to provide access in remote areas populated predominantly by elderly people. These clinics in the rural and urban areas offered primary and secondary oral care services. Alongside the four large hospitals operate prosthetic clinics for construction of partial and full dentures. Beneficiaries as third age patients, have to pay a small amount of 100 euro per item (denture).

Formal/informal caregiving

In the case of DSID cash benefits can be used by the beneficiaries at their choice of care services either formal or informal.

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", which was revised in 2015 (N.353/2015) and in 2016 (162/2016). 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".

In addition, two new Decrees were adopted in 2017 (365/2017) and 2018 (158/2018), covering in particular the subsidisation of home care services to persons with disabilities and persons aged 80 years old and above, respectively.

In addition, the SWS, as the competent authority for the inspection of the minimum quality standards of care structures, have determined in 2016 Terms and Conditions for the Provision of Home Care Services, pending the drafting of a new law which will regulate home care provision.

Challenges

Cyprus has recently reformed and clearly defined eligibility for long-term care benefits, but the financing of the system is relatively fragmented and overall 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 3.5.1: **Statistical Annex – Cyprus**

GENERAL CONTEXT

GDP and Population	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**EU 2009**	**EU 2011**	**EU 2013**	**EU 2015**
GDP, in billion euro, current prices	15	16	18	19	19	19	20	19	18	18	18	12,451	13,213	13,559	14,447
GDP per capita, PPS	27.1	27.6	28.9	28.1	26.3	25.4	24.6	23.2	21.9	22.1	23.8	26.8	28.1	28.0	29.6
Population, in millions	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.8	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	33.0	34.6	33.5	33.9	35.2	38.5	264.1	283.2	352.1	373.6
As % of total government expenditure	0.0	0.0	0.0	0.0	0.0	0.3	0.3	0.3	0.4	0.3	0.4	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	80.8	82.0	82.1	82.9	83.5	83.9	83.1	83.4	85.0	84.7	83.7	82.6	83.1	83.3	83.3
Life expectancy at birth for males	76.5	78.1	77.6	78.2	78.5	79.2	79.3	78.9	80.1	80.9	79.9	76.6	77.3	77.7	77.9
Healthy life years at birth for females	58.2	63.4	62.8	64.5	65.3	64.2	61.0	64.0	65.0	66.3	63.4	62.0	62.1	61.5	63.3
Healthy life years at birth for males	59.8	64.2	63.1	63.9	64.8	65.1	61.6	63.4	64.3	66.1	63.1	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	29.1	28.7	25.9	28.4	34.0	32.7	32.6	33.2	32.2	32.7	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	8.5	8.2	6.9	6.7	7.6	10.3	7.9	8.0	7.3	7.9	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**EU 2009**	**EU 2011**	**EU 2013**	**EU 2015**
Number of people receiving care in an institution, in thousands	:	:	3	3	4	4	4	5	3	3	3	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	:	:	:	:	:	:	3	3	3	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	0.4	0.4	0.5	0.5	0.5	0.5	0.7	0.8	0.8	2.0	2.2	2.2	2.2
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 3.5.2: **Statistical Annex - continued – Cyprus**

PROJECTIONS

Population	2016	2020	2030	2040	2050	2060	2070	MS Change 2016-2070	EU Change 2016-2070
Population projection in millions	0.9	0.9	0.9	1.0	1.0	1.0	1.0	20%	2%
Dependency									
Number of dependents in millions	0.07	0.07	0.09	0.10	0.11	0.12	0.14	107%	25%
Share of dependents, in %	7.8	8.2	9.3	10.4	11.4	12.3	13.4	73%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.3	0.3	0.4	0.4	0.4	0.5	0.6	84%	73%
AWG risk scenario	0.3	0.3	0.5	0.7	1.1	1.8	3.2	947%	170%
Coverage									
Number of people receiving care in an institution	8,390	9,186	11,530	13,967	16,224	18,538	21,528	157%	72%
Number of people receiving care at home	7,798	8,530	10,753	13,066	15,187	17,497	20,603	164%	86%
Number of people receiving cash benefits	23,009	24,654	29,588	34,564	39,108	44,046	49,959	117%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	4.6	4.9	5.6	6.4	7.2	7.9	9.0	96%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	59.3	59.4	60.5	61.9	62.9	64.3	67.2	13%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	54.0	54.2	53.7	54.6	55.6	57.2	58.9	9%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	46.0	45.8	46.3	45.4	44.4	42.8	41.1	-11%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	12.7	12.7	12.7	12.7	12.8	12.9	12.9	1%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	87.3	87.3	87.3	87.3	87.2	87.1	87.1	0%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	2.1	2.1	1.9	1.9	1.9	2.0	2.0	-5%	10%
Unit costs of home care per recipient, as % of GDP per capita	15.5	15.3	14.1	13.7	13.7	14.2	14.1	-9%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	5.1	5.1	5.1	4.9	4.9	4.8	4.7	-9%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).