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Healthcare Services in Cyprus: In Transition to a National Health System

Author



Mamas Theodorou, PhD

Associate Professor in Health Policy and Planning

Open University of Cyprus

Introduction

Cyprus, a European Union (EU) and Eurozone country, is an island republic covering an area of 9,250 square kilometres in the eastern Mediterranean Sea with a population of 840,407 in the government- controlled area in 2011 (Statistical Service website, 2013). Over the past decade, the country has enjoyed economic growth and increasing prosperity, mainly due to growth in service industries, such as banking, shipping and tourism. Real gross domestic product (GDP) has been growing at an average annual rate of almost 4 per cent since 1995, compared to less than 2 per cent growth in the Euro zone. Unemployment has historically been low at about 3 per cent, but gradually increased to 16.2 per cent in December 2013 as a result of the global financial crisis (Eurostat, 2013).

Life expectancy at birth is 77.9 years for males and 82.4 years for females (Statistical Service, 2011). The leading causes of death are diseases of the circulatory system and malignant neoplasms. The most common cancer in women is breast cancer with an age-standardised incidence rate of 73 per 100,000 population; the most frequent cancer in men is prostate cancer. There is a low prevalence of HIV infection and high levels of immunisation coverage. Although the population is relatively young in comparison with other EU countries, Cyprus' ageing population poses significant challenges to its already strained health system.

Organization and Governance

The health system consists of two parallel and separate delivery entities: public and private. The public system is highly centralised, and almost everything regarding planning, organisation, administration, and regulation is the responsibility of the Ministry of Health (MoH). It is exclusively financed by the state budget, with services provided through a network of hospitals and health centres directly controlled by the MoH. Public providers have the status of civil servants and are salaried employees. The private system is financed mostly by out-of-pocket payments and to some degree by voluntary health insurance (VHI). It largely consists of independent providers, and facilities are oftentimes physician-owned or private companies with doctors usually as shareholders. Other minor health care delivery sub-systems include the Workers' Union schemes, which mostly provide primary care services, and the schemes offered by semi-state organisations such as the Cyprus Telecommunication Authority (ATHK) and the Electricity Authority of Cyprus (AHK). The first mostly have their own network of providers, while the second use private providers. Other public health programmes are administered by a number of other Ministries and agencies, such as the Ministry of Education and Culture, the Ministry of Agriculture, the Police, and several non-governmental organizations (NGOs).

In terms of regulation of providers, personnel, pharmaceuticals and medical devices, Cyprus is almost fully in line with corresponding EU directives, which have been incorporated into national legislation. Despite this legislation, in the private sector there are difficulties controlling and regulating areas such as the development of health facilities, high cost medical technology, staffing and human resource development and quality of services. Additionally, patient empowerment remains an important issue, and there have been positive steps with the enactment of the Safeguarding and Protection of the Patients' Rights Law in 2004.

Financing

Cyprus devotes a low share of its financial resources to health care. According to National Health Accounts data, total health care expenditures (THE) in Cyprus in 2010 accounted for 6.0% of GDP, with 41.5% of health care expenditures government funded and 58.5% privately funded. Out-of-pocket payments are the dominant private source of health care expenditures and Cyprus has one of Europe's highest proportions of healthcare spending by households.

The MoF is responsible for collecting tax revenues, which are allocated at the beginning of the year to the different ministries through annual

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budgets. The final MoH budget is approved by the government, after a budget creation process that involves numerous stakeholders. The MoH is exclusively responsible for the implementation of the budget and no public provider is able to spend beyond approved amounts. All health professionals in the public sector have civil servant status and their payment is on a salary basis.

The public system does not secure universal coverage. It is estimated that only 80% of the population has the right of access to the public health system free of charge, while the rest of the population must pay according to fee schedules set by the MoH to use public services. The legal basis for entitlement to public services is Cypriot or EU citizenship and proof of having earned below a certain level of income, although for some groups, free of charge coverage is granted without proof of income or other criteria. A fairly high share of the population is also entitled to health services funded either by workers unions' or semi-state organisations. VHI provides coverage to more than 20% of the population through group or individual schemes.

The services provided by the public system include primary care, specialists' services, diagnostic tests and paramedical services, emergency services, hospital care, pharmaceutical care, dental care, rehabilitation, and home care. Cost sharing measures in the form of co-payments have been imposed from the August 2013, in selected outpatient services of the public sector in order to control irrational utilisation. No data are yet available for the consequences of co-payments on access.

Physical and Human Resources

Physical and human resources are split between government hospitals and healthcare centres, and private hospitals, clinics and polyclinics. The majority of physicians, dentists, and pharmacists work in the private sector, whereas the majority of nurses are employed in the public sector. Over the last decade the majority of newly qualified physicians have pursued careers in non-primary care specialties. As a result there has been a decrease of 20% in the number of GPs from 1995 to 2000.

Because the annual MoH budget includes a specific allocation for each public hospital according to required needs, there are no incentives for cost-awareness, quality assurance and efficient use of available resources. The pluralistic health system has resulted in a lack of adequate resource distribution and utilisation between the public and private sectors. Indicatively, Cyprus has a very high number of CTs and MRIs as compared with the OECD country average, with most of these CTs and MRIs concentrated in the private sector. Moreover, the healthcare system is characterised by under-utilisation of information technology and the lack of a universal electronic medical record system to facilitate data mining, coordination and continuity of care and quality improvement.

There has been a continued increase in the number of graduating nurses as a result of new nursing training programmes at four local universities (one public and three private). A relative increase in the supply of physicians and pharmacists is also expected as local universities have recently initiated their first medical and pharmacy programmes; a national workforce capacity plan for health workers is needed to ensure these new workers are able to find employment. Moreover, Continuing Professional Development (CPD) and revalidation of qualifications issues need to be addressed in order to ensure medical competency, quality of care, and patient safety.

Provision of Services

The public system has a large network of providers throughout the country. This network operates alongside that of the private sector, which offers primarily ambulatory care and to some extent hospital care, although data and documentation regarding the private sector is sparse. The link between secondary care and the social care system is informal, the latter being mostly the responsibility of the Ministry of Labour and Social Security.

The fragmentation of the health system, with little continuity of care and poor communication between doctors and other healthcare providers within and between the private and public sectors, is a major weakness, which leads to inefficiencies in both sectors, duplication of services, and underutilisation in the private sector. Within the public sector there are problems related to organisation and coverage since there is no referral system. There are also difficulties accessing some services due to long waiting times. Access for specific groups, such as immigrants, is problematic while there is limited coverage in dental care, since orthodontics and fixed prosthetics are not provided by the public sector, long term care, rehabilitation care, and palliative care, of which the last two are mostly provided by NGOs and the charitable sector. Additionally, there is an issue of affordability, especially for the above mentioned services, since patients in many cases bear the cost for care. The affordability issue is evident not only from high private expenditure as a percentage of total health expenditure, but also from a Eurobarometer survey (Eurobarometer, 2007).

Assessment of the Current Health System

The current health system has many deficiencies. The fact that the public system does not provide universal coverage and approximately 20% of Cypriots must pay out of pocket to access the public health system, or must purchase health care from the private sector, demonstrates that the health system does not guarantee financial protection for the entire population. Empirical evidence shows that the health system is disproportionately funded by low and middle income households, as indirect taxes constitute 50% of state budget revenues. Nevertheless, the public health system primarily provides services to low income households. Other problems that have been identified include the uncontrolled deployment and use of high cost medical technology in the private sector, long waiting times in the public sector, uninsured illegal immigrants, and other shortages or inefficiencies in fields of care including rehabilitation, long term and palliative care.

Surveys reveal that a high percentage of citizens hold a favourable opinion about the availability and accessibility of the system, despite long waiting lists. There are also contradictory findings from population based surveys on quality and safety. In terms of outcomes, although barriers to access for some groups lead to unmet needs, generally Cypriots are in good health compared to the populations of other EU countries. However, this is in jeopardy as risk factors such as obesity and smoking may have a negative impact on the future health status of the population.

There is room for improvement in efficiency, transparency, quality, and accountability. Additional patient empowerment and citizen participation in decision making, better hospital management and governance, and better control of biomedical technology deployment and use, are some of the priorities to improve performance.

The transition to a National Health System

The lack of a national health system of universal coverage in Cyprus is a major issue of discussion and basic goal for the government and the health policy for more than twenty years. Accession to the EU led to many reforms in the health system, particularly in terms of policy, regulation, and the provision of services. With the re-launch of the Lisbon Strategy in 2005, the EU and its Member States committed themselves to a new partnership and to undertake reforms in a coordinated manner. Within this framework, in 2006 the government issued its "Strategic Plan for 2007–2013" which highlighted reforms of the organisational and financial structures of the health system as priorities (MoH, 2006).

Prior to EU accession, the Parliament passed Law 89(1) 2001 "for the introduction of a General Health Insurance System (GHIS)," which called for a new health system based on the principles of solidarity, justice and universality. However, the kick-off date of the GHIS has been repeatedly postponed for three main reasons: a) government concerns over costs b) the negative impact of the financial crisis on the fiscal revenues, and c) the time consuming tender procedures associated with the introduction of the new system (Cyprus National Reform Programme, 2011). At this time, while there have been many discussions and policy papers written, the only tangible progress has been the creation of the Health Insurance Organization (HIO), which has been appointed as the body responsible for implementation of the new system.

In 2007, the HIO introduced thematic work teams. The teams have created policy papers and documents that describe the basic principles of operation of the new health system. Specifically, these documents describe the current system and highlight challenges for the transition to the new health system, including how healthcare service providers will interact with and be compensated under the new system. These documents form the basis of negotiations with stakeholders (Cyprus National Reform Programme, 2011). In addition, HIO has designed the operational processes in the context of the new IT system, while reorganisation and restructuring of the public health care sector and the MoH, along with decentralisation of health services remained key priorities.

The introduction of the GHIS is by far the most important health reform in Cyprus. It will be based on contributions (employers, employees, pensioners), and will provide universal coverage. In general, the new system is expected to:

- Encourage competition between and among providers in both the public and private sectors
- Encourage a primary care driven referral system by paying GPs based on capitation and performance indicators; specialists will be paid on a fee-for-service basis under a global budget by specialty.
- Remunerate inpatient care using DRGs.
- Improve the performance of healthcare provision, by:
 - decentralising managerial responsibilities from the MoH to public hospitals, whereby the MoH will gradually be transformed to a policy-making body regulating public and private sector providers;
 - reforming the financial management system through the introduction of modern cost accounting systems;
 - establishing rules and regulations to ensure minimal standards for quality of health services;
 - promoting greater continuity of care for patients through the development of a robust GP system.

Despite the general agreement of the new government and the political parties that the sooner the GHIS is implemented the better, predictions about when the GHIS will be implemented were futile until recently. However in May 2012, the European Commission issued a Council Recommendation which stated that Cyprus should "...complete and implement the national healthcare system without delay, on the basis of a roadmap, which should ensure its financial sustainability while providing universal coverage" (European Commission, 2012). This led the Cypriot Cabinet in June to reaffirm its commitment to the reform. Despite the deep economic crisis, Troika (the tripartite committee led by the European Commission with the European Central Bank and the International Monetary Fund) has also agreed to the implementation of the GHIS, (MoU, 2013). Both the Council's recommendation and Troika's agreement gives a new impetus and support to the implementation of the GHS, which is now expected to come into effect at the beginning of 2016. The proposed reform is an ambitious effort to offer universal access and resolve the imbalance between the public and private sectors. The past experiences of other countries provide valuable lessons which can help to ensure that the GHIS is implemented successfully (Cylus et al, 2013).

Conclusion

Although cost concerns were one of the reasons for previous delays of the GHIS, the current economic crisis provides an opportunity in some respects. As a result of lower household incomes during the current crisis, the use of the private health sector has decreased, while the public sector has experienced an increase in demand. This has led not only to a renewed appetite for reform to target the already overloaded public sector, but also for more willingness on the part of the private sector to accept change due to decreases in revenues, as the reform is likely to lead to increased private sector utilisation, albeit likely at lower reimbursement prices than under the current system. Concerns over potential high costs associated with reform implementation are also no longer considered to be valid due in part to a private financing initiative to install and operate the new integrated information system.

Accession to the EU led to many reforms in the health system, particularly in terms of policy, regulation, and the provision of services. Major challenges include reducing the rising costs of health care, addressing inequalities in access to healthcare services, and improving the quality and financing of the health system. Reforms in these areas will help to maintain the progress achieved in controlling communicable diseases, to reduce the incidence of chronic diseases, and to maintain the environment in a way that safeguards the quality of life.

While this opportunity for reforming the health system should not be neglected, key lessons from other countries should be taken into account. Efforts must be made to ensure that the financial needs of the GHIS do not adversely affect growth in a vulnerable economic climate.

Public and private providers competing for patients must be able to compete under a balanced incentive structure. Learning from the experiences of other countries will help Cyprus to better meet challenges of the reform process.

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