asisp
Analytical support on social protection reforms and their socio-economic impact

Country Document 2013

Pensions, health and long-term care

Cyprus

November 2013

Authors: Gabriel Amitsis and Constantinos Phellas

Disclaimer: This report reflects the views of its authors and these are not necessarily those of either the European Commission or the Member States.

On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
GVG

Table of Contents

1 Executive Summary

Social security in Cyprus is promoted through the coordinated application of three different techniques (social insurance, social assistance and universal protection): a) social insurance is a compulsory contribution-funded system, aiming at the protection of the working population with the provision of certain income compensation against specific risks, b) social assistance or social welfare is a tax-financed system for the coverage of poor individuals or households, who have no other sufficient means of support and c) universal tax-financed social security is a system providing a certain income to members of specified risk groups, whereas benefits are flat rate or related to earnings and not income tested. On the other hand, there is no universal health coverage, given that no serious progress has been observed in the direction of effective establishment of the *National Health Insurance System* (apart from some advancement in the operational design in the financing aspect of the National Health Insurance System), introduced by law in 2001. The provision and funding of healthcare is fragmented between public and - largely unregulated - private providers of healthcare services. No clear timeline for proceeding with the National Health Insurance System was available till the mid of 2013, casting doubt on the political will to implement it. In parallel this poses risks to the long-term control and sustainability of public finances.

The implementation of national social policy agendas falls under the responsibility of the Ministry of Labour & Social Insurance and the Ministry of Health. Policy coordination is promoted through: a) the *Council of Ministers*; b) the *Social Policy Advisory Body*, an inter-ministerial commission (Ministers of Labour & Social Insurance, Health, Finance and Interior) established in 2007; and c) *the Demography and Family Policy Body*, a tri-partite commission[1] established in 2009.

Cyprus faces key challenges in ensuring the long-term sustainability of public finances, notably in the pension field, which have been only partially addressed. Even though a set of measures have been adopted to improve the sustainability of the pension system, a comprehensive pension reform is in progress. The Government has implemented so far two important structural measures: the enactment of contributions from public sector employees to their public pensions, and the inclusion in the social security fund of newcomers to the public sector, with the abolition of occupational pensions.

The development of social policy agendas was heavily influenced by the consequences of the financial crisis that hit Cyprus in two waves.

(a) After the July 2011 explosion at the Naval Base in Mari Village (the island's largest power station), the country lost 60% of its electrical power capacity. This led to a serious blow to the economy reducing growth to nearly zero level. Furthermore, losses incurred by Cypriot banks due to large exposure to Greek bonds amplified economic woes. Repeated downgrades of Cyprus' sovereign debt rating by the major international rating agencies reflected concern regarding an unsustainable fiscal condition (sovereign borrowing costs hiked and the country was barred from world debt markets).

1 Minister of Labour & Social Insurance, representatives of the Ministries of Justice, Interior, Finance, the Planning Bureau, representatives of the social partners (employers' and employees' organisations), including civil society associations (Union of Cyprus Municipalities and Communities, Pancyprian Organisation of Large Families, Pancyprian Association of Single Parent Families and Friends, Pancyprian Coordinating Committee for the Protection and Welfare of the Child, Confederations of Unions of Parents of children of different ages).

(b) On 16 March and 25 March 2013, the Eurogroup reached a political agreement with the Cypriot authorities on the key elements of an Economic Adjustment Programme**,** which included the restructuring and substantial downsizing of the banking sector, combined with extensive bail-in of uninsured depositors, as well as the reinforcement of efforts on fiscal consolidation, structural reforms and privatisation. Following a financial turmoil, a bank holiday of 10 working days was imposed, during which the sector was downsized substantially through resolution and restructuring of the two main banks, separation of the Greek operations of Cypriot banks and a set of wide-ranging temporary capital control and administrative measures, which are still in force to a great extent.

The Economic Adjustment Programme was finally agreed with the European Commission, the European Central Bank (ECB), the International Monetary Fund (IMF) and the Cypriot authorities on 2 April 2013. This Programme covers the period from the second semester of 2013 until the first semester of 2016 and will be financed through contributions from the European Stability Mechanism (ESM) by € 9 billion and the IMF by € 1 billion.

The Commission, the ECB and the IMF monitor the implementation of the Programme on a quarterly basis. Compliance with the terms set out in the Memorandum of Understanding (MoU) and in the IMF's Memorandum of Economic and Financial Policies is assessed prior to every quarterly loan disbursement. Given the conditionality attached to the programme under the MoU and the regular reporting and monitoring requirements, programme countries have been exempted from the EU obligation to submit National Reform Programmes (NRP) and Stability or Convergence Programmes (SCP). Cyprus nonetheless drafted an updated NRP on a voluntary basis, which was submitted in May 2013.

The main objectives of the Economic Adjustment Programme build on three main pillars: i) policies to restore the soundness of the financial sector and rebuild the confidence of depositors and markets, based on restructuring and downsizing of the financial institutions, strengthening their supervision, and addressing capital and liquidity shortfalls; ii) measures to achieve a primary balance of 4% of GDP in 2018 and maintain that level thereafter, and to correct the excessive general government deficit as soon as possible; and iii) structural reforms to support competitiveness and enable the economy to return to sustainable growth, allowing for the unwinding of macroeconomic imbalances.

New measures agreed to be implemented as of 2013 by the Cypriot authorities within the social policy field include the modernisation of the pension system, the introduction of measures to control healthcare expenditures, complete and implement the national healthcare system, and the adjustment of the wage indexation system to the economic downturn. In this context, the reform of the current pensions, health and long-term care schemes constitutes a *key challenge for national policy makers* (Parliament and the Government), in order to minimise the social impact of the financial crisis and to provide adequate services for the most vulnerable groups.

In 2013, real GDP is expected to decline sharply by 8.7%. This sharp decline is affected in particular by the immediate restructuring of the banking sector, which influences net credit growth, fiscal consolidation, and the high degree of economic uncertainty which in turn weigh on domestic demand and investment. In addition, the temporary imposition of capital controls and withdrawal restrictions is expected to hamper international capital flows and to reduce business volumes in both domestically and internationally oriented companies.

The bail-in of a large part of uninsured deposits implies a loss of wealth, which will also affect confidence, private consumption and investment. The profound contraction in economic activity is expected to weigh significantly on employment. The employment rate

has been on a declining path since 2009 decreasing to 70.2% in 2012 with a further significant decline expected in 2013 and 2014 of around 10 percentage points. At the same time, unemployment has been rising to unprecedented levels reaching a historically high of 16.9% (August 2013) with more than 76,000 being unemployed and consequently increasing the number of people at risk of poverty.

Youth unemployment has also been on a steep increasing path displaying one of the highest year-on-year increases in the EU in 2011 and 2012 and reaching 27.8% in 2012. The rapid rise of youth unemployment is accompanied by a significant growth of young people under 25 who are neither in employment nor in education or training (NEETs) over the last few years (reaching 16% in 2012). Long-term unemployment in percentage of total unemployment has risen sharply standing at 30.1% in 2012. Reduced business activity, the restructuring of the financial sector (with possible spill overs to professional business services), the decline in domestic demand and investment activity, the hiring freeze in the public sector, and skills mismatches are expected to push the unemployment rate up to 15.5% in 2013 and 17% in 2014.

In a context of increasing unemployment and greater strain on the social protection budget, the population at risk of poverty or exclusion has increased and certain categories of the population, such as the elderly, still face severe problems. Since the outset of the crisis, some indicators have deteriorated or remained at high levels. This is especially true of poverty among the elderly. Cyprus still faces a serious problem, as the risk of poverty or social exclusion for elderly, despite improvements in 2012, remains very high.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The *General Social Insurance Scheme - GSIS* was established in 1963 as a public flat-rate scheme and was radically reformed in 1980 through the introduction of a PAYG earnings-related scheme. In order to address the long-term sustainability of the public pension system, an amended Social Insurance Law was enacted in 2009, which included a number of reform measures to be phased-in gradually. This Law introduced procedures to strengthen the investment framework and policy of the General Social Insurance Scheme (GSIS) and the effective investment management of the GSIS's assets. Policy reform measures included: (i) the progressive increase of contribution rates (seven increases by 1.3 percentage points every five years – last increase in 2039), which will increase significantly the future revenues of the GSIS, and (ii) the tightening of eligibility criteria to pension benefits, which is expected to improve considerably the future labour force participation rates, especially the female older worker ones.

Since the begininning of the 2010's, the Government adopted a new set of successive fiscal packages: introduction of a contribution by civil servants to their government pension and abolishment of the GESP scheme for new entrants into the public service, in tandem with salary freeze, a staggered levy on public and private sector earnings, targeting criteria for social benefits and a cap on maximum expenditure for each Ministry.

During the period 2012-2013, major reforms were introduced in line with the Economic Adjustment Programme[2] and the following Country Specific Recommendations submitted by the European Commission by assessing both the Stability Programme and the National Reform Programmes on the *EU 2020 Strategy for Smart, Sustainable and Inclusive Growth* [3].

CSR 2011 No. 3: "*Improve the long-term sustainability of public finances by implementing reform measures to control pension and healthcare expenditure in order to curb the projected increase in age-related expenditure*"[4];

CSR 2012 No. 3*:"Further improve the long-term sustainability and adequacy of the pensions system and address the high at risk of poverty rate for the elderly. Align the statutory retirement age with the increase in life expectancy"*[5].

2.1.2 System characteristics

The Cypriot public pensions regime includes two compulsory first pillar schemes. The first (*General Social Insurance Scheme, GSIS*) is monitored by the Ministry of Labour, Social

2 See the parts 1.1.3. and 1.2.2.of the Report.

3 On 7 May 2012, Cyprus submitted its Stability Programme covering the period 2012-2015 and on 10 May 2012 its 2012 National Reform Programme. In order to take account of their interlinkages, the two Programmes have been assessed at the same time. The Commission has also assessed, in an in-depth review under Article 5 of Regulation (EU) No 1176/2011, whether Cyprus is affected by macroeconomic imbalances. The Commission concluded in its in-depth review that Cyprus experiences an internal imbalance due to its banking sector and the indebtedness of the corporate sector and an external and an internal imbalance on its fiscal dynamics and competitiveness, although not excessive ones.

4 COUNCIL OF THE EUROPEAN UNION (2011).

5 COUNCIL OF THE EUROPEAN UNION (2012).

Insurance & Welfare and run by the Social Security Fund. It applies to all private sector employees (including the self-employed); the second (*Government Employees Pension Scheme, GEPS*) is monitored by the Ministry of Finance and applies to civil servants and employees in the wider public sector (members of the education system, the police and the armed forces). Specific categories (public enterprises, local authorities and other public entities) are covered by distinct public schemes providing benefits similar to those of GEPS.

(a) The GSIS was established in 1963 as a public flat-rate scheme and was radically reformed in 1980 through the introduction of a PAYG earnings-related scheme. GSIS pensions are paid in case of old age, disability and death of the breadwinner. They include a basic and a complementary part; the former is based on insured earnings before the 1980 reform, whereas the supplementary part is based on earnings since October 1980. Basic pensions are annually indexed to the rate of increase of insurable earnings, while supplementary pensions increase in accordance with the index of the cost of living. Pension increases take place each January, as well as each July (if the cost of living index is higher than 1%).

Eligibility conditions to receive a full old age pension include:

- ⇒ Age 65 (age 63 for miners);
- ⇒ at least 10 years of coverage;
- ⇒ paid contributions on earnings of at least 520 times the weekly basic covered earnings;
- ⇒ paid or credited contributions in at least 30% of the years from October 5, 1964 (from January 7, 1957, if more beneficial) or age 16 to the pensionable age

Under the GSIS scheme, pensionable age is 65 years for both men and women; yet early retirement at the age of 63 is rather common, given the fact that under certain conditions no penalties for early exit are in force. Incentives for postponing retirement consist in a 0.5% increase in the pension benefit every month remaining in employment, from age 65 to a maximum of 68 years.

As far as funding of pensions is concerned, rates are different according to the employment status of insured persons:

a) *Insured employees:* 6.8% of covered earnings; voluntarily insured, 11% of declared income in Cyprus and 13.6% of covered earnings abroad.
The maximum weekly earnings used to calculate contributions are €1,025.
The insured's contributions also finance cash sickness and maternity, work injury, and unemployment benefits.
b) Self-employed: 12.6% of notional income prescribed in regulations for specific occupational categories.
The maximum weekly earnings used to calculate contributions are €1,025.
The self-employed person's contributions also finance cash sickness and maternity benefits.
c) Employers: 6.8% of covered payroll.
The maximum weekly earnings used to calculate contributions are €1,025.
The employer's contributions also finance cash sickness and maternity, work injury, and unemployment benefits.
d) Government: 4.3% of covered payroll. 3.8% for the voluntarily insured working in Cyprus; 4.3% for those working abroad.
The maximum weekly earnings used to calculate contributions are €1,025.
Pensions till € 3,320 (per month) are not subject to any general taxation, while pensions above this limit are subject to a 5% rate.

(b) GEPS occupational pensions are paid in case of old age, disability and death of the breadwinner. They are tax-financed[6] on a pay-as-you-go basis and are indexed to the cost of living indicator on a six-month basis. Public (and semi-public sector) employees are also entitled to the basic pension of the GSIS scheme. Furthermore, government employees benefit from mandatory supplementary pension schemes that are tax-financed too and provide comparatively higher replacement rates than occupational (provident) funds of private sector workers.

Under the GEPS scheme, pensionable age is 63 years for civil servants, but for the armed forces, the police and educational service it is much lower, ranging between 55 to 60 years. Early retirement can be drawn at the age of 55 years (or 58 for entrants into public service after 1st July 2005) without any actuarial reduction of benefits.

Old-aged people (65 years and over), who do not fulfill conditions to receive a pension under the GSIS or GEPS schemes, are entitled to a non-means-tested *social pension*[7], which was introduced in 1995, financed through the general taxation. Its rate corresponds to 85% of the full basic social insurance pension and is automatically indexed to earnings.

In 2008, the Government introduced the so called *Easter grant benefit for low income pensioners* (defined as household income for €13.390 per year for a single household of a pensioner and €20.085 per year, for households with more than two people, with at least one pensioner person)[8], financed through the general taxation. Beneficiaries are households that meet the income criteria and with at least one pensioner irrespective of age who receives: a pension from the Social Insurance Fund and/or a social pension, and/or a pension from an occupational pension scheme.

Benefit rate amounts to €350 for a household with a pensioner and €700 for a household of two pensioners (2011). This rate was reduced in 2012 to €270 for every pensioner in a household whose total annual income was below €13.390 (household of one person)[9].

In 2009, the Government introduced the so called *Income Support benefit* for pensioners whose income falls below the poverty line[10], a non-contributory means-tested benefit paid through the Social Welfare Offices.

Pensioners are also entitled to the so called social advantages, which include the "*Social Card*" that gives free access to bus transport and other facilities (every person 63 years and over – and invalidity pensioners independently of age – are entitled to it); a *fuel allowance* and other occasional means-tested *one-off cash benefits*.

The second pillar (occupational or private pensions) consists of a number of provident funds established on the basis of collective agreements for various groups of private sector employees, as regulated in the Law of 1984. Currently, about 35% of private sector employees

6 A 0.8% contribution rate was paid as a share in the cost of survivors' pension. Law 113[1]) of 2011 raised the latter rate to 2% and introduced a 3% contribution on gross monthly earnings (for the supplementary pension component) with the aim to reduce the cost of the scheme to the government and somewhat improve equity in respect to private sector workers.

7 The total cost of the social pension is financed from general revenue.

8 For households of more than two persons with at least one pensioner, the above amounts increased depending on the number and age of dependents.

9 In 2013 this benefit is paid only to pensioners with a monthly per capita pension of at most €500.

10 It must be noted that the household income taken into consideration for the provision of this benefit refers to the income of all individuals within the household deriving from pensions from any source (within and outside Cyprus), existing special allowance granted to pensioners, employment or self-employment, rent income, interest and dividends.

are covered by voluntary provident funds that provide lump sum payments at retirement (as well as for invalidity, termination of employment, unemployment and death). They operate on a funded basis and significantly vary in respect of the level of benefits they provide.

2.1.3 Details on recent reforms

(a) In the context of the GEPS scheme, the following measures have been implemented during 2012-2013:

- a scaled reduction in emoluments of public sector pensioners and employees was introduced in 2012 (EUR 0-1.000: 0%; EUR 1.001-1.500: 6,5%; EUR 1.501-2.000: 8,5%; EUR 2.001-3000: 9,5%; EUR 3.001-4.000: 11,5%; above EUR 4.001: 12,5%);
- a scaled reduction in emoluments of public sector pensioners and employees was introduced in 2013 (applied retroactively from 1 January 2013: €0-2.000: 0,8%; €2.001-3.000: 1%; €3.001-4.000: 1,5%; above €4.001: 2,0 %);
- a gradual increase of the statutory retirement age by 2 years;
- an increase of the minimum age for entitlement to an unreduced pension to be in line with the statutory retirement age, while preserving acquired rights;
- an introduction of an early retirement penalty of 0,5% per month of early retirement so as to make early retirement actuarially neutral;
- the freeze of public sector pensions' amounts for the period 2013-2016.

(b) In the context of the GSIS scheme, the Government introduced in 2012 a set of measures, which took effect as of 1 January 2013 and include:

- an actuarial reduction for early retirement in conjunction with an increase in the minimum age for entitlement to an unreduced pension to reach 65 by 2016[11];
- an increase of the contributions, as of 1 January 2014 of salaried employees and employers to the GSIS by an additional 1 percentage point of the increase which was provided to be implemented in 2014 on pensionable earnings;
- the freeze of pensions' amounts under the Social Security Fund for the period 2013-2016.

[11] The minimum age for entitlement to an unreduced pension is being raised by six month per year in the GSIS scheme to bring it into line with the statutory retirement age.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Coverage
(a) In 2011 the number of old-age pensioners was 93.670 of which 58.889 were males and 34.781 females. The number of female beneficiaries of widow's pension was 28.962 and that of invalidity pensioners 6.930, of whom 4.394 were males and 2.536 females. The respective numbers for 2010 were 89.354 (56.708 males and 32.646 females), 28.497 and 7.102 (4.527 males and 2.575 females).

In 2011, there were 15.370 beneficiaries of *Social Pension* (435 males – 2.76% and 14.935 females – 97.24%) while in 2010 the number was 15.189 (419 males – 2.75% and 14.770 females – 97.25%). Social pensions cover, therefore, women outside the labour market, who do not satisgy eligibility conditions to receive contributory GSIS pensions.

The amount of the weekly benefit granted to the standard beneficiary whose earnings in the previous year are equal to the reference wage (€425) and on the basis of an insurance of 47,25 years from 1964 to 31.12.2011 was €250,68 (59% of the reference wage)[12].

(b) The amount of the weekly widows pension payable to a widow whose deceased husband's earnings in the previous year was equal to the reference wage and with 47 years of actual and prospective insurance after October 1980 is €332,19 (78,16% of the reference wage).

(c) The amount of the weekly invalidity pension granted to the standard beneficiary with 47 years of actual and prospective insurance after October 1980 and with earnings equal to the reference wage of €425 is €348,09 (82,09% of the reference wage).

Labour market participation
According to the Labour Force Survey, the unemployment rate between 2011 (yearly average) and 2012 (yearly average) increased from 7,9% to 11,8% as opposed to the unemployment rate of only 3,7% in 2008. Based on the EUROSTAT forecast statistics, in January 2013 the unemployment rate stood at 14,7% while the Euro area unemployment rate was at 11,9%.

The overall employment rate for the age group 20-64 years old decreased from 73,4% in 2011 to 70,2% in 2012. In 2008 the employment rate was at a high level reaching 76,5%. According to the distribution of employment by sector during 2012, the biggest percentage of employed persons was concentrated in services with 76,9%, whereas industry followed with 20,2% and lastly agriculture with only 2,9%.

During 2009, the first year of the recession, more male than female workers lost their jobs, a phenomenon attributed to the economic downturn, which affected primarily male-dominated occupations, namely, construction, real estate and tourism. For 2012, the unemployment rate for male workers stood at 12,5% and for female workers at 11,1%, while the respective employment rates were 76,1% and 64,8% (age group of 20-64 years).

The employment rate of older workers (55-64 years) was comparatively high in 2010 (56.8% total; 71.2% for men and 43.0% for women – the respective rates for EU-27 were 46.3% total; 54.6% for men and 38.6% for women). However due to the economic downturn a slight decline was recorded in the third quarter of 2011 (to 55.3%). Nevertheless, the employment of

12 It should be noted that when the wife completes the pensionable age (65), she is entitled to a social pension, which increases the total amount of pension for the spouses.

older workers strengthens the viability of GSIS, and is expected to decrease demand for the provision of Social Pensions.

Poverty among pensioners

(a) The share of people at-risk-of-poverty or social exclusion (AROPE)[13] increased in 2012 from 2011 by 2,5 percentage points (from 24.6% in 2011 to 27.1% in 2012). With regard to the sub-indicators comprising the AROPE, the at-risk-of-poverty rate (i.e. monetary poverty, AROP) has dropped from 14.8% in 2011 to 14,7% in 2012, while the severe material deprivation rate[14] has increased to 15% in 2012 from 11,7% in 2011 and the share of people living in very low work intensity households[15] (quasi-jobless households) in 2012 increased from 4.9% (2011) to 6.4%.

A considerable decrease is found at the at-risk-of-poverty rate for the elderly (from 39.9% in 2010 to 35.5% in 2011 and further down to 29.3% in 2012.[16] The corresponding rate for EU-28 in 2012 was 14.3%[17]. A similar trend can be seen for the combined risk of poverty and social exclusion: The rate decreased from 2011, 39.8% for people 65 years and over (EU-27: 20.3%) to 2012 33.4% (EU28 19.7%). Severe material deprivation is also above the EU average and is particularly acute among elderly women.

In terms of poverty among the elderly, Cyprus still faces a serious problem as both AROPE and AROP rates for those over 65 remain very high despite their amelioration between 2009 and 2012. AROPE in 2012 is about 14 percentage points higher than the EU average while AROP doubles the EU average. The AROP rate for women over 65 is 10 percentage points higher than that of men.[18]

(b) In order to minimise the effects of poverty among the elderly, the Government provides income support to pensioners whose income is below the poverty line. The number of beneficiaries increased from 53.000 in 2010 to 60.000 during 2011: this measure has already had an impact on the risk of poverty and social exclusion of older people and will continue to have an impact in the following years.[19]

(c) The adequacy of pensions continues to be a major policy challenge, given the high poverty rate among pensioners.[20] The means-tested grant to low-income pensioners approved by the government in December 2009,[21] and the measures introduced in 2011 in order to offset VAT

[13] This rate refers to three indicators: at-risk-of-poverty (AROP) and/or people living in conditions of severe material deprivation and/or people living in low work intensity households.

[14] Severely materially deprived persons have living conditions severely constrained by a lack of resources, they experience at least 4 out of 9 following deprivations items: cannot afford i) to pay rent or utility bills, ii) keep home adequately warm, iii) face unexpected expenses, iv) eat meat, fish or a protein equivalent every second day v) a week holiday away from home, vi) a car, vii) a washing machine, viii) a colour TV, or ix) a telephone. It refers to 2010 income reference year.

[15] People living in households with very low work intensity are people aged 0-59 living in households where the adults work less than 20% of their total work potential during the past year.

[16] This decrease is strongly related to the introduction of the Easter grant benefit for low income pensioners (2008) and the Income Support benefit for pensioners whose income falls below the poverty line (2009).

[17] Source: Eurostat, EU-SILC [tessi012 and ilc_peps01], Data extraction date: 19 November 2013.

[18] tespn240, data extracted on 19 November 2013.

[19] Planning Bureau, Cyprus National Reform Programme 2012, 2012, p. 97.

[20] KOUTSAMBELLAS, Christos (2012).

[21] An impact assessment undertaken by the Ministry of Labour and Social Insurance at the end of 2010 has shown that there has been an overestimation of eligible retirees due to a number of constraints and difficulties in collecting relevant income data information (European Commission 2011).

increases in foodstuffs and pharmaceuticals[22] are appropriate policies for improving pension adequacy.

2.2.2 Sustainability

According to the social insurance legislation in force, every three years an actuarial valuation exercise takes place primarily to assess the financial sustainability of the Social Insurance System in the long-term. If the study indicates that reforms are required, the Minister of Labour and Social Insurance, after consultation with social partners, may submit proposals to secure the long-term viability of the scheme.

Before the implementation of the Economic Adjustment Programme**,** the Government introduced a set of sustainability measures, the most fundamental being a radical increase in the maximum amount of insurable earnings of employed persons on which contributions are assessed.[23] These were increased by the *Social Insurance (Contributions) (Amending) Regulations of 2007* to €885 per week or €3.835 per month as from January 2008, by the *Social Insurance (Contributions) (Amending) Regulations of 2008* to €924 per week or €4.004 per month as from January 2009, by the *Social Insurance (Contributions) (Amending) Regulations of 2009* to €973 per week or €4.216 per month as from January 2010 and by the *Social Insurance (Contributions) (Amending) Regulations of 2010* to €1.002 per week or €4.342 per month as from January 2011.

The prescribed minimum insurable incomes of the various occupational categories of self-employed persons were increased by the *Social Insurance (Contributions) (Amending) Regulations of 2007* by 4,39% as from January 2008, by the *Social Insurance (Contributions) (Amending) Regulations of 2008* by 4.49% as from January 2009, by the *Social Insurance (Contributions) (Amending) Regulations of 2009* by 5,29% as from January 2010 (subject to the ceiling of insurable earnings) and by the *Social Insurance (Contributions) (Amending) Regulations of 2010* by 2,98% as from January 2011 (subject to the ceiling of insurable earnings).

The amount of the basic insurable earnings on which the basic benefits are assessed was increased from €141.25 (£82,67) to €147.45 (i.e. by 4,39%) as from 2008, from €147.45 to €154,07 (i.e. by 4.49%) as from 2009, from €154,07 to €162,22 (i.e. by 5,29%) as from 2010 and from €162,22 to €167,05 (i.e. by 2,98%) as from 2011.

In line with the clauses of the Economic Adjustment Programme**,** key measures were adopted to ensure the long term sustainability of the GSIS and GEPS schemes. They focus on the *freeze of pensions' amounts* under the Social Security Fund for the period 2013-2016 and the introduction of an *automatic adjustment of the statutory retirement age* every five years in line with changes in life expectancy at the statutory retirement age (to be applied in 2018), while an actuarial study for the GSIS will be carried out to provide additional reform options to ensure the long-term viability of the national pension system.[24]

---

[22] See Asisp National Report for Cyprus 2012.

[23] These were increased by the Social Insurance (Contributions) (Amending) Regulations of 2007 to €885 per week or €3.835 per month as from January 2008, by the Social Insurance (Contributions) (Amending) Regulations of 2008 to €924 per week or €4.004 per month as from January 2009, by the Social Insurance (Contributions) (Amending) Regulations of 2009 to €973 per week or €4.216 per month as from January 2010 and by the Social Insurance (Contributions) (Amending) Regulations of 2010 to €1.002 per week or €4.342 per month as from January 2011.

[24] The actuarial study will project the scheme's finances on a cash basis and will address the impact of additional reform options such as benefit reductions (while considering adequacy), an increase in the

In this context, automatic adjustments for changes in life expectancy will take place every five years from 2018 onwards and early retirement penalties of 0.5% per month are imposed under both systems. In addition, under the GEPS scheme, all pension benefits are indexed to prices rather than wages, while pension benefits are being calculated on a pro-rata basis taking into account life-time service (to be applied in 2014). Lump-sum payments accruing from 1 January 2013 onwards under the GEPS will be taxed as personal income with public sector employees having the option to turn the lump sum into an annuity.

2.2.3 Private pensions

The second pillar (occupational or private pensions) consists of a number of provident funds established on the basis of collective agreements for various groups of private sector employees, as regulated in the Law of 1984. Currently, about 35% of private sector employees are covered by voluntary provident funds that provide lump sum payments at retirement (as well as for invalidity, termination of employment, unemployment and death). They operate on a funded basis and significantly vary in respect of the level of benefits they provide.

The function of supplementary pension schemes is now regulated by the Law No. 208(I) /2012, in force since 28.12.2012, which abolished previous legislation and relevant Decrees. The Law (non-applicable to Pension Funds on a-pay-as-you-go system) sets minimum standards concerning the function of supplementary pension schemes, which affect waiting (period of employment before a worker becomes eligible for membership of a scheme) and vesting period (period of active membership of a scheme, in order to trigger entitlement to the accumulated supplementary pension rights):

- the combined length of waiting and vesting period corresponds to 4 years;
- there is no minimum age for vesting.

The transposition of the EU Directive 2003/41/EC (on the activities and supervision of institutions for occupational retirement provision) into law, in November 2006, aimed to create a more unified regulatory framework and promote future reform of voluntary provident funds, so that provisions could be converted from lump-sum benefits into lifetime additional pension income. However, for such a change to have a beneficial effect on pensioners' incomes, a long time span for the accumulation of rights is required.

Due to the current financial crisis, there is no serious preparatory plan by the Government to incorporate the EU "Directive on minimum requirements for enhancing worker mobility by improving the acquisition and preservation of supplementary pension rights" in the national legal order.[25]

2.2.4 Summary

The introduction of social pensions and income support supplements to pensioners whose income is below the poverty line strengthens the adequacy of pensions. However, there are new critisisms about relevant measures efficiency in times of economic recession.

Further, the introduction of austerity measures in the pension agenda with the scope to restore the long term sustainability of the GSIS and GEPS schemes may cause problems in the adequacy rates of pensions in the mid-term.

statutory retirement age and increases in contribution rates or combinations thereof taking into account the impact on labour costs.

[25] The Directive should be transposed no later than three years after the date of entry into force.

Finally, the lack of sound active ageing and elderly employment strategies may lead to serious problems in the funding basis of PAYG schemes, associated with the increase in unemployment rates.

2.3 Reform debates

Key inequalities between the public and private sector pension schemes (in terms of funding, replacement rates, level of overall pension benefits and retirement age) constitute a hot issue in public debates about pensions. Pension privileges enjoyed by high ranking retired state officials for years and generous retirement conditions for government employees came under public scrutiny. Strong fiscal pressures led the government to introduce significant structural measures for public sector pensions. Multiple pensions were axed, a contribution of public sector employees towards their government (occupational) pension was introduced, and GESP was abolished for new entrants into the public sector.

The need of reform in public sector pensions has been the focus of public attention over the last couple of years. In late April 2011, a Law was approved by the Parliament with the aim to curtail pension privileges by high-ranking government officials who served in more than one state posts and until recently were eligible for multiple pensions. The law sets a ceiling for the amount of pension income (from state pensions) received by these categories of officials that equals half of the highest earnings they received in any of the posts they held (multiple pensions are axed if they surpass this ceiling; if not, entitlement to multiple pensions persists). Also in the event that a retired state official is assigned to a public post, his/her pension is suspended until his/her term of service ends. Other provisions include the abolishment of the choice of either receiving a pension and a one-off bonus or a higher pension, making obligatory the first alternative; and the introduction of a 6.8% payment (calculated on gross monthly earnings) as a contribution for their pension.

The treatment of pensioners' employment is also an issue of public concern. Nowadays, there are no restrictions to work for pensioners, and about two thirds of pensioners between the age of 63 and 65 continue working. Contributions paid by those pensioners increase the rate of their pension at the age of 65.[26]

Discussions about pension's adequacy arise also in respect to the second pillar (the provident funds for private sector workers). Existing regulations do not facilitate transposition of rights across employers and often employment termination leads to cashing in of lump sum benefits. This condition does not provide incentives for accumulation of rights over the whole working life and does not secure a pension annuity solution (it also discourages employment flexibility).

The Social Security Fund (SSF)'s investment policy is also a significant issue of debate. A reform bill for regulating investment policy, promised to be drafted by the Ministry of Labour and Social Insurance in 2009, is still pending. Recently, the Actuary Expert of the Ministry strongly emphasised the need for a more diversified investment portfolio for the SSF, and suggested that the relevant authorities consider the possibility of allowing the SSF to increase allocation of reserves to non-government asset classes (provided they are of low risk), so as to secure a higher yield. Such an investment policy would make possible for the SSF to recover funds from debtors other than the state if its balance of payments turns negative, while the state faces liquidity problems.

[26] After the age of 65 no contributions are charged to working pensioners and thus employment after that age does not have any further positive effects on pensions.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

In 2001, a *National Health Insurance System (NHIS)* was established by Law N.89 (I)/2001 with the aim of establishing a comprehensive national health system covering the entire population (the so-called General Health System - GHS).. However, due to policy and financial constraints, no significant progress has been recorded in the reform path towards effective launching of the GHS. Major requirements are still pending (e.g. installing an information technology system for the GHS, designing and overseeing the GPs' training tender, developing therapeutic and costing protocols, and reorganising public hospital management).

The kick-off date of NHIS is repeatedly postponed and the implementation of the scheme is rather slow due to mainly three reasons: a) the government's need to reassess the implementation of the scheme, especially as regards its costs implications, b) the negative impact the world financial turmoil had on the economy and the need of the government to ensure sound public finances and c) the unpredicted time consuming tender procedures associated with the introduction of the new system[27].

3.1.1 System characteristics

The Ministry of Health is responsible for the organisation of the health care system and the provision of public health care services and health promoting programs[28]. It formulates national health policies, coordinates the activities of the private and the public sector, regulates health care standards and promotes the enactment of relevant legislation.

The provision of health care services[29] by the Government Medical Services is governed by the Government Medical Institutions and Services General Regulations of 2000 to 2007[30]. There is no universal health coverage. Primary and secondary healthcare services are provided equally to all citizens without discrimination of sex, age or disability in:

---

[27] Planning Bureau, Cyprus National Reform Programme 2011, 2011, p. 13.

[28] It is organised into various departments:
General Laboratory, which provides laboratory analysis services including inspection of food, water, medicine, police evidence and drugs investigations (but not services for clinical purposes);
Pharmaceutical Services, responsible for the testing, supply and pricing of pharmaceuticals, inspection of pharmacies, etc.;
Medical and Public Health Services, responsible for services in the fields of prevention, primary, secondary and tertiary care;
Dental Services;
Mental Health Services.

[29] Health services include:
out-patient care by general practitioners and specialist care to both out-patients and in-patients;
the necessary drugs and pharmaceutical material;
diagnostic and paramedical examinations;
hospitalisation;
dental care except for dentures, which are only provided to certain low-income groups.

[30] Medical services and Services of Public Health – Ministry of Health
http://www.moh.gov.cy/moh/moh.nsf/legislation_gr/legislation_gr?OpenDocument.

- the five Public General Hospitals of Nicosia, Limassol, Larnaca, Paphos and Famagusta;
- the special hospital for the Mother and Child, Archbishop Makarios III;
- the two regional hospitals of Kyperounda and Polis Chrysochous;
- the 35 Medical Centers of Primary Health Care (Nicosia 18, Limassol 7, Larnaca 4, Paphos 4, Famagusta 2).

In 2001, with the law establishing the *National Health System (NHS), the Health Insurance Organisation (HIO)* was assigned as the implementation body.[31] The personal scope of application covers:

- all Cypriot and European Union citizens, permanently residing in Cyprus and their dependents;
- every person who is a contributor permanently residing in Cyprus and or a contributor lawfully working in Cyprus and their dependents (provided that they have been permanently residing in Cyprus for a specific period of time, which can be defined through Regulations).

The NHS is not fully operational; therefore, the bulk of medical services is provided by a public-private mix of providers and institutions. Private medicine is dominated by a large number of physicians in individual practice. A number of private polyclinics have also been established in urban areas with a number of physicians offering a range of medical services.

Private hospitals and clinics[32] are operated in the private sector and provide services to the patients who afford to pay for their treatment by own resources or through private insurance providers.[33] Their function is regulated by the Private Hospitals Law of 2001 to 2011. According to this statute, private hospitals are divided into:

a) Clinics of day hospitalization operating from 07.00 until 19.00, in which patients are not allowed to stay overnight and which have at least two beds per each housed medical specialty;
b) Clinics, which accommodate up to two medical specialties and have at least three beds in each medical specialty;
c) Polyclinics, which accommodate from three to five medical specialties and have at least three beds in each specialty;
d) Private hospitals, which house more than five medical specialties and have a total of at least thirty beds.

Health care services are free for active and retired civil servants, military and police personnel, recipients of social assistance and their dependents, unmarried persons with annual income up to €15,377.41, families with annual income up to €30,754.83 plus €1,708.60 for each dependent child (no income limit for families with four or more children), and persons diagnosed with certain chronic diseases. Co-payments are required for unmarried persons with annual income from €15,379.12 to €20,503.22 and for families with total annual income from €30,756.53 to €37,589.23 plus €1,708.60 for each dependent child.

[31] A public legal entity, governed by a Board of Directors with trilateral representation (Government, Employers' and Employees' Unions).

[32] There are 19 private hospitals and 69 private clinics.

[33] Most private health insurance policies don't pay family doctors' fees or pay for medication that isn't provided in a hospital, or charge an excess (deductible), which often exceeds the cost of treatment. Most will, however, pay for 100 per cent of specialist fees and hospital treatment. The insurance market in Cyprus is highly competitive and sophisticated and there's a huge range of both Cypriot and international insurance companies offering policies.

Recipients of public assistance are entitled to free medical care in public hospitals. The Ministry of Health is also working closely with the Department of Social Welfare, in order to examine requests from recipients of public assistance to cover the cost of dental treatment (orthodontic and prosthetic real) which are not provided by public hospitals. A small percentage of the population, defined as ***Class "B"***, was entitled to reduced rates for publicly provided health care. This group, making up about 2% of the population, is comprised of individuals with gross annual income between €15,380 and €20,500, or €30,750 to 37,590 for two-member families, increasing by €1,700 for each dependent child.

3.1.2 Details on recent reforms

Apart of the Troika Programme, major reforms were introduced in line with the following country specific *Recommendations (CSRs) for economic and structural reform policies*, submitted by the European Commission by assessing both the Stability Programme and the National Reform Programmes on EU2020.

CSR 2011 No. 3: "*Improve the long-term sustainability of public finances by implementing reform measures to control pension and healthcare expenditure in order to curb the projected increase in age-related expenditure*";

CSR 2012 No. 4*: "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".*

Free access is now (under a Regulation of the Ministerial Council that came into effect from 1.8.2013) restricted to unmarried persons with annual income up to €15,400, families with annual income up to €30,750 plus €1,700 for each dependent child (no income limit for families with four or more children), and persons diagnosed with certain chronic diseases, while other important reform measures include:

a) abolish the category of beneficiaries class "B" and all exemptions for access to free public health care based on non-income related categories, except for persons suffering from certain chronic diseases depending on illness severity;

b) introduce as a first step towards a system of universal coverage a compulsory health care contribution for public servants and public servant pensioners of 1.5% of gross salaries and pensions;

c) increase fees for medical services for non-beneficiaries (which would include those in previous class "B") by 30%;

d) introduce a 3€ fee for visiting general practitioners and a 6€ fee for visiting special practitioners ;

e) introduce a 10€ fee for using emergency care services in non-urgent situations;

f) introduce a 0,5€ fee for the provision of medically unnecessary laboratory test and pharmaceuticals

The 2013 MoU also encourages using Diagnosis Related Groups to code inpatient care, urgently needed for the design and application of payment mechanisms under the new health system. Gate-keepers are recommended—consistent with the plan for the GHIS—although there have been concerns in the past that at this time there may not be enough qualified GPs to deliver care to a larger patient pool, especially if hard referrals are made part of the system.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The current system has led to the unequal distribution of services and inequities in access to care. Currently around 85 % of the population is eligible for public healthcare that is either free or provided at a reduced cost. However, only 40% of the population use public healthcare services, mainly due to the inefficiencies and long waiting times,[34] Thus, the majority of the beneficiaries use private healthcare services and bear the total expense. Therefore, around two thirds of the total healthcare cost in Cyprus is covered by the private sector.[35]
Under the crisis conditions, a rising number of the population turns to public hospitals for treatment, yet resources are diminishing, while hardly any savings can be secured through system rationalisation as long as planned reforms are stalling. In this context, the recent abolishment of beneficiaries class "B" and all exemptions for access to free public health care based on non-income related categories will increase inequalities in access to care[36].

Besides the delivery of services in the Cypriot territory, there is a sponsoring scheme for sponsoring patients' treatments abroad upon preauthorisation by the Special Medical Board. The patients sponsored abroad are subject to means testing and have to contribute towards the expenses according to their level of income. However, the Ministry terminated the practice of sending patients abroad for treatment. Instead, treatment abroad will follow the new EU on the application of patients 'rights in cross-border healthcare.[37]

3.2.2 Quality and performance indicators

Healthcare expenditure is growing rapidly. The absence of an integrated and homogeneous national healthcare system is wasteful of resources, causes overlaps and irrational distribution of services and healthcare facilities, and leads to low quality of services for citizens.[38] Moreover, capacity and care quality are to a large extent unregulated.[39]

There are conflicting findings from different patient satisfaction surveys. Although general patient satisfaction for the health system is quite high, 14.5% reported being dissatisfied mainly due to long waiting times.[40] Evaluating hospitalization in public hospitals, the vast majority of patients reported being very satisfied with health professionals (e.g. communication, respect, politeness and visit duration), while factors such as food, visiting hours and noise during sleep were assessed lower in the satisfaction scale. Despite the high level of satisfaction with the health system, 88% of Cypriots (the highest percentage among

[34] Ministry Of Health, National Report on Health, 2010.
[35] This is equivalent to 3.4 % of GDP, the second highest share across the EU, after Greece.
[36] Because this group is small, relatively poor, and contributes very limited revenues to hospitals, there have previously been proposals to allow them access to free medical care, as is the standard for Cypriots earning even lower incomes. Eliminating access to care at reduced rates for this group does not improve the sustainability of the health system as they make up a very small percentage of the population and contribute very little to total health expenditures.
[37] Under the "S2 form" patients are entitled to treatment in the state-funded sector in another EU country. Services will be provided under the same conditions of care and payments as for residents in the country in which treatment is sought and claim for reimbursement of the cost incurred will be addressed to the relevant authorities of the country of the patients' origin according to existing regulations. This is expected to considerably reduce public expenditure for treatment abroad (in 2012 it amounted to EUR 37 million).
[38] The 2004 Law for patients' rights includes provisions for submission and management of patients' complaints.
[39] THEODOROU Mamas, CHARALAMBOUS Cristalla, PETROU Christos and CYLUS Jonathan (2012).
[40] THEODOROU, Mamas (2009).

EU27 countries) expressed their willingness to travel to another EU country to receive medical care (Eurobarometer, 2007). Cypriots' willingness to travel to receive care could be considered inconsistent with the declared high level of satisfaction, even though it can perhaps be attributed partly to geographical, as well as economic and cultural, characteristics of the Cypriots.

3.2.3 Sustainability

At the end of June 2012, the Council of Ministers finally approved a proposal for the implementation of the *National Health Insurance System* (NHIS). According to the roadmap prepared by the Health Insurance Organisation (HIO), effective commencement of the scheme is envisaged for 2015.

The following measures are related to the implementation of the NHS and for improving the quality and efficiency of the health care system:

a) abolish the category of beneficiaries class "B" and all exemptions for access to free public health care based on non-income related categories, except for persons suffering from certain chronic diseases depending on illness severity. Introduce as a first step towards a system of universal coverage a compulsory health care contribution for public servants and public servant pensioners of 1.5% of gross salaries and pensions. The measure will be reviewed by Q2-2014 with the programme partners. For families with three or more dependent children, the participation in this health care scheme will be voluntary;

b) increase fees for medical services for non-entitled to free services by 30% to reflect the associated costs of medical services and create a co-payment formula with zero or low admission fees for visiting general practitioners, and increase fees for using higher levels of care for all patients irrespective of age;

c) introduce effective financial disincentives for using emergency care services in non-urgent situations;

d) introduce financial disincentives (co-payment) to minimise the provision of medically unnecessary laboratory test and pharmaceuticals; and

e) adopt a new decision by the Council of Ministers concerning a restructuring plan for public hospitals, improving quality and optimising costs and redesigning the organisational structure of the hospital management, by putting into practice recommendations from the 2009 "Public Hospital Roadmap".

In addition, the programme partners will review and be consulted on the following measures before their implementation:

f) assess and publish, before parliamentary discussion, the potential risks and benefits of the planned introduction of the National Health System (NHS) in an updated actuarial study, taking into account possible proposals for implementing NHS in stages by Q2- 2013;

g) make the award of the tender for the IT-infrastructure conditional upon the results of the study and the decision for implementing the NHS;

h) review income thresholds for free public health care in comparison to the eligibility criteria for social assistance while ensuring that co-payments to public health care are set so as to protect individuals/households effectively from catastrophic health expenditures by Q4-2013;

i) create protocols for laboratory tests and the prescription of pharmaceuticals based on thorough scientific evidence;

j) introduce a coherent regulatory framework for pricing and reimbursement of goods and services based on the actual level of costs incurred in accordance with Article 7 of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011. An interim report will be ready by Q3-2013;

k) conduct an assessment of the basket of the top 4 publicly reimbursable healthcare products in terms of annual spending and prepare a report to establish an integrated system for health-technology assessment to increase the cost-effectiveness of the basket of publicly reimbursed products; and prepare the implementation of 10 new clinical guidelines focusing on high annual volume and high cost diseases by Q2-2013;

l) start coding inpatient cases by the system of diagnosis-related groups (DRGs) with the aim of replacing the current hospital payment system by payments based on DRGs by Q3-2013;

m) in a first step, establish working time in the Health Service, in conjunction with moving the starting time by half an hour (from 7.30 to 8.00) and extending the flexibility period from a half to one hour. With this modification, the weekly working hours of public officers remain unchanged, but are distributed throughout the year as follows: 37 ½ hours per week, 7 ½ hours per day, daily (Monday to Friday): 8.00/9.00 to 15.30/16.30. The same applies for the transitional period of 1.1.2013-31.8.2013 but the starting time remains the same (7:30) and thus the ending time is moved back by half an hour (15:00/16:00). Following a review, in a second step, revise the regular working hours and stand-by shifts of healthcare staff, including rules to increase the mobility of staff; revise current regulations on overtime pay and fully implement existing laws on recording/monitoring overtime payments (see 3.11) by Q1-2014; and

n) define a basket of publicly-reimbursable medical services based on objective, verifiable, criteria, including cost-effectiveness criteria by Q2-2013.

Furthermore, the Cypriot authorities will consider establishing a system of family doctors acting as gate-keepers for access to further levels of care.

3.2.4 Summary

Cyprus is progressively taking steps to strengthen the sustainability of the funding structure and the efficiency of public healthcare provision, especially as the economic crisis is expected to increase the demand on public provision of health care services. Measures have been already taken to simplify exemptions for access to free public health care, based on income and disease-related criteria only. As a consequence, a compulsory health care contribution for public servants and public servant pensioners of 1.5% of gross salaries and pensions was adopted in April 2013.

Financial disincentives were put into place to minimise the use of unnecessary medical services and goods and to steer patients towards the right levels of medical care. Fees for the use of medical services by non-beneficiaries were increased by 30% in order to reflect the associated costs of service.

Several additional reform measures target efficiency increases:

- An April 2013 ministerial decision paves the way for a much needed restructuring plan for public hospitals, improving quality and optimising costs; the basket of publicly reimbursable medical services and goods is being reassessed based on objective criteria, including cost effectiveness;
- clinical protocols for laboratory test and pharmaceuticals are being elaborated;

- ❖ working time arrangements of healthcare staff are being modified to increase accessibility to public health care services.

3.3 Reform debates

While a number of policy recommendations about NHS have been discussed by academics[41], the Memorandum of Understanding (MOU) agreed between Troika and the Republic of Cyprus provides that the potential cost and benefit of the planned **introduction of the** National Health System (NHS) will be assessed and published before Parliamentary discussion in an updated actuarial study taking into account possible proposals for implementing NHS in stages. The study is under way and is expected to be completed in the last quarter of 2013. In addition, the award of the tender of the IT infrastructure has been made conditional upon the results of the study and the decision for implementing NHS.

Equality between nationals and EU citizens/third nationals forms a significant issue of debate. This issue is now being discussed in the frame of the process of transposition of the EU Directive on the application of patients'rights in cross-border healthcare into national law, which should be achieved by October 2013. Indeed the Directive requires from Member States to improve transparency and to either charge existing public tariffs to patients from other Member States (in a non-discriminatory way) or, in the absence of such official tariffs, to put in place an objective, nondiscriminatory pricing mechanism for health services[42].

The impact of ageing on public health care programmes is not an issue attracting much attention; though demographic change in the future will significantly increase the economic burden that these programmes impose.

The administration of services delivery has been the focus of public attention**.** Long waiting lists are reported by the media, and medical staff shortage due to retirements and appointment freezing in the public sector are a matter of serious concern.

[41] SAMOUTIS George and PASCHALIDIES Constantinos (2010): "When will the sun shine on Cyprus' National Health Service?", The Lancet, 377(9759); ANDREOU, Maria, PASHARDES, Panos and PASHOURTIDOU, Nicoletta (2010): Cost and Value of Health Care in Cyprus,CYLUS Jonathan, PAPANICOLAS Irene, CONSTANTINOU Elisavet, THEODOROU Mamas (2013):" Moving forward: Lessons for Cyprus as it implements its health insurance scheme", Health Policy, 110(1), pp. 1-5.

[42] The transposition process puts pressure on the Cypriot authorities to reform the pricing system for services.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Cyprus has a high rate of life expectancy and also a high rate of healthy life expectancy at birth but relatively low healthy life expectancy rate at age 65. This poses a challenge on future care service provision. Currently, social care services[43] are provided by the private sector and the community, i.e. NGOs or local authorities**.** Home care is also provided and supported by the State.

Table 2: Key demographic trends

Total population (million):	0.88
Percentage 65 or older:	13.2
Dependency ratio (a):	44.1
Life expectancy at birth (years) - Men:	77.9
Life expectancy at birth (years) - Women:	82.6
Statutory pensionable age - Men:	65
Statutory pensionable age - Women:	65
Early pensionable age - Men (b):	63
Early pensionable age - Women (b):	63

Sources: United Nations Population Division, Department of Economic and Social Affairs. World Population Prospects: The 2010 Revision Population Database, available at http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm and Human Development Report 2011, prepared for the United Nations Development Programme (Gordonsville VA: Palgrave Macmillan, 2011).

Long-term care services[44] within the national social policy regime focus on the support of persons in care of need due to old-age, physical and mental disability. However, there is no specific public long-term care scheme.

[43] Social care in Cyprus includes all services that address specific risks, not to be confused with cash benefits and benefits in kind.

[44] Long-term care in Cyprus includes the package of services made available to those with limited ability to live independently.

The Government opened in 2012 a consultation process for reforming the hybrid long-term social care, with the aim to address service provision and revise the existing framework of quality standards for social care,[45] but no real results were achieved.[46]

4.1.2 System characteristics

The system of long-term care is based upon need and is not compulsory. Only persons entitled to public assistance may be entitled to free-of-charge long-term care (i.e. older persons, persons with disabilities, dysfunctional families). No qualifying period is required. The evaluation of care dependency is based on the individual needs of a claimant in cooperation with a welfare officer who assesses and develops a personal care plan (e.g. type of care, frequency).

Given the lack of a statutory scheme, most of long-term care is currently provided by relatives, spouses and children in particular, mostly women. The availability of informal social care by family members is expected to decline, as people are having fewer children, who may also live further away from their elderly parents and be unable to provide intensive care.

Apart from services of institutional and open care[47], there are public schemes for reinforcing recipients with the aim of encouraging families to keep their elderly members at home and provide care for them (i.e. the *Scheme for the Provision of Social Aid for Improving Housing Conditions* and the *Scheme for the Reinforcement of Families for the Care of their Elderly and/or Disabled Members).* Public long-term care services are developed in the context of the national welfare and health care schemes.

(a) The Public Benefit and Services Scheme[48] (supervised by the Ministry of Labour, Social Insurance & Welfare) covers every person who is legally staying in Cyprus and whose income fails to guarantee decent living standards. Besides rendering cash benefits, the scheme also provides personal social services aiming at the empowerment and the socio-economic re-integration of the users.[49] The categorical sub-schemes are in principal influenced by the target group they cover and include the following forms of protection:

- community care services (home care[50] and day care centres) and residential care services (accommodation and care within specialized institutions)
- benefits in kind (ex. providing disabled persons with artificial limbs)
- social and financial advantages (ex. free pass card for the means of transport, tax reduction)

[45] Planning Bureau, Cyprus National Reform Programme 2011, 2011, p. 78.

[46] The consultation on reforming long-term care has been closed; it included a recommendation to establish a new scheme for people at dependency risk, not promoted so far due to funding constraints

[47] Open care in Cyprus includes all social services outside an institution.

[48] It is regulated by the Public Assistance and Services Law of 2006 (as amended in 2012).

[49] Care services include home care, day care, residential care and tele-care, and may be provided by the government, by non-governmental organisations and by the private sector (private for-profit enterprises).

[50] Home care is provided by state, community and private carers with government subsidy for public assistance recipients, which also covers members of the family of the person receiving care when the family member stops working in order to offer the care required at home.

- cash benefits for the coverage of basic and special needs of the beneficiaries (ex. subsidy for the purchase of wheel chair), as well as for their social and economic re-integration (ex. subsidy for the payment of vocational training fees).

Personal social services focus on the coverage of needs of specific groups and, depending on the users' profile and the content of the care provided, they can be categorized as follows:

- Home care mainly covers people receiving the public benefit or people whose income is not sufficient to cover their special needs;
- Day care is provided in the Homes for the Elderly and the Adult Centres (which are subsidized through the State Subsidy Scheme) during the day and covers needs such as the preparation of meals, clothes laundry, entertainment etc.;
- Residential care is provided to persons whose need of constant care cannot be addressed by their family or through home care and day care services provided near their residence.

The *Scheme for the Provision of Social Aid for Improving Housing Conditions* provides a lump sum up to €11.960 to persons who are public assistance recipients or are just above the limits of public assistance scales[51], for building works, additions or alterations, with a view to improving their housing conditions. In the period 2003-2007, grants amounting to €2.530.900 were provided to 296 cases.

The *Scheme for the Reinforcement of Families for the Care of their Elderly and/or Disabled Members* aims at reinforcing families in order to enable them to keep their elderly and/or disabled members at home (with the addition of rooms and/or equipment and/or redesigning of areas) so that the need for institutionalisation will be avoided. The upper limit of the lump sum provision is €12.000.

For persons with disabilities, the *Persons with Disabilities Laws of 2000 and 2004* safeguard the right to independent living, social inclusion and equal participation in social and economic life. Their rights also include the right to social services for securing a decent standard of living with the creation of Homes in the community.

(b) The Ministry of Health is responsible for the rehabilitation of the disabled persons immediately after their treatment. The recovery process takes place at Physiotherapy Centre and Paraplegic Wing, depending on the case. The functionality of the individual from health professionals is partially investigated, followed by restoration.

The Mental Health Services provide care for mental health which covers not only the treatment and rehabilitation, but also the fields of prevention of mental disorders and drug addictions, and the field of mental health promotion and healthy interpersonal relationships. The organization of this kind of care is based on the specific needs of the individual and the family, in cooperation with other relevant departments and agencies. The Unit of Occupational Rehabilitation (M.ER.A.) is the key service under the Mental Health Services, which has been up and running since January 2002, working closely with the voluntary organization Association for Protection of Mental Health. The mission of the Unit of Occupational Rehabilitation is the reintegration of people with mental health problems through an employment which promotes the multidisciplinary autonomy of the individual (economic and psychosocial) and provides meaning in relation to the needs, interests and his /

[51] This scheme is targeted at persons in need of care due to old-age, physical and mental disability who receive public assistance and need to improve/change their housing environment to adapt their needs.

her abilities. The Unit can help both individuals seeking a job, and people who are already employed and are facing some difficulties in the professional environment.

Services for mentally retarded persons are provided by the *Home for the Mentally Retarded Persons "Nea Eleousa"* as well as by four *Community Houses*. The Home for the Mentally Retarded Persons "Nea Eleousa" is open on a 24 hours schedule and provides accommodation and care to adults and children through a vast network of services aiming at the effective development of their physical and mental skills. By relieving the families of the users from the intensity of their everyday care, other family members have the opportunity to enter the labour market in order to improve the household's income capacity.

4.1.3 Details on recent reforms in the past 2-3 years

In order to support female employment, the government continued the subsidisation of social care services within the framework of family and employment reconciliation**.** This measure co-funded by ESF, which was officially launched in February 2012, includes the reimbursement of a part of the costs of care services for children, older people and persons with disabilities. Women who find a job may apply for a subsidy for the cost of care services for their family dependants for a period of up to 18 months. The benefit amount to €260 (maximum amount) monthly, for childcare, and €200 (maximum amount) monthly for the care of older persons or persons with disabilities. In 2012, 49 women were approved to receive subsidisation. A total of €49.157 was spent in 2012 and the budget for 2013 is €0.5 mln.

Furthermore, the subsidisation schemes for child care programmes operated by local authorities and NGOs continued throughout 2012 and 2013. The aim of these schemes is to enhance the expansion of available child care services at a lower cost and within their 2013 priorities; the schemes include the subsidisation of programmes for the most vulnerable/deprived persons.

The Nursing Services of the Ministry of Health started to provide since 2009 community nursing and in urban and rural areas mainly for the elderly, for people with serious / chronic illnesses and for the disabled persons. Pancyprian mental health community nursing is provided for serious cases for adults (elderly people included), children and young people. Community medical care is also provided in cases of serious / chronic illness especially in areas far away from general hospitals.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

During the period 2005-2007, home care provided by state carers[52] showed a considerable decline, as the number of persons served fell from 908 in 2005 to 659 in 2007 (decline of 27,4%). Furthermore, the number of persons served by private carers[53] declined by 1/4

[52] These are spouses/partners, other members of the household and relatives and neighbours, who can be compensated (in part or in full) by the State. In this case, a contract is signed between the Social Welfare Services, the person in need and the caregiver.

[53] These are persons legally residing in Cyprus (the majority are third-country nationals), who are employed under the terms of a contract with the person in need of home care. The Social Welfare Services pay the salary and the social insurance contributions, but the contract remains between the home helper and the individual.

(decline of 23,6%) from 3.170 in 2005 to 2.420 in 2007, whereas the number served by community carers showed an increase of about 50% (from 335 in 2005 to 517 in 2007, increase by 54,3%). In total , the decline in the number of persons served with home care, for the three year period 2005-2007, was 18,5% (2005: 4413 - 2007: 3596). One of the reasons for this tendency seems to be the reduction in the number of state carers (due to lack of interest by health and social care professionals), by about half, that is a percentage of 46,9% (from 3,461 in 2005 to 1,835 in 2007). On the basis of these data, the ratio of carers/persons served (1,27 in 2005) deteriorated over time (in 2007 it was 1,96)[54],

In 2010, out of the 49.167 disabled persons (+15) in the country, 7.427 were accommodated in institutions and 42.190 were supported by informal carers or did not received any support.[55]

In order to secure regional coverage and equality of access to long-term care, the Ministry of Labour and Social Insurance has been promoting a set of measures:

a) With the Project "Expansion and Improvement of Care Services for Children, the Elderly, Disabled Persons and Other Dependants", the Social Welfare Service promote the establishment of a network of social care structures and services at a pancyprian basis (8 social care programmes for elderly persons and 2 social care programmes for persons with disabilities have already been implemented).

(b) The Department for Social Inclusion of Persons with Disabilities operates a number of social benefits schemes and services regardless of income criteria, which aim to offset the cost of disability experienced by persons with disabilities and especially those with severe disabilities. It provides financial assistance to people who meet the criteria and conditions of the following schemes:

- Scheme for the Provision of Financial Assistance for the Purchase of a Wheelchair;[56]
- Financial assistance scheme for the provision of technical means, instruments and other aids[57];
- Allowance Scheme for the Provision of a Disability Care;[58]
- Assistance through the Welfare Lottery Fund.[59]

4.2.2 Quality and performance indicators

There is no legislation regulating quality standards of home care despite the fact that it is provided by both the government and the private sector. The Social Welfare Services (SWS) are working on the development of such a law which will regulate the provision of Home Care, set up the minimum quality standards, as well as the qualifications of the carers.[60]

54 Ministry of Labour and Social insurance, Annual Report, 2010.

55 LIPSYC, Barbara, SAIL, Etienne and XAVIER, Anna (2012): Long-term care: need, use and expenditure in the EU-27, European Economy, Economic Papers 469/2012.

56 Department for Social Inclusion of Persons with Disabilities – Ministry of Labour and Social insurance http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/dsipd16_gr/dsipd16_gr?OpenDocument.

57 Department for Social Inclusion of Persons with Disabilities – Ministry of Labour and Social insurance http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/dsipd19_gr/dsipd19_gr?OpenDocument.

58 Department for Social Inclusion of Persons with Disabilities – Ministry of Labour and Social insurance http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/dsipd15_gr/dsipd15_gr?OpenDocument.

59 Department for Social Inclusion of Persons with Disabilities – Ministry of Labour and Social insurance http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/All/6A88404BEC1C790DC2257B44003249FC/$file/N%2079%28I%29%201992_pdf.pdf.

60 PAPATHEODOULOU, Irene and AGATHANGELOU Charalambos (2013).

The SWS monitor the provision of home care services to public assistance recipients, through the Social Services Officers regular visits at the house of the recipients and close cooperation with the NGOs and the local authorities that implement home care programmes.

Small scale client's satisfaction studies for long term care reveal that the majorities of elderly are satisfied with their care and the quality of the services.[61]

4.2.3 Sustainability

Given the absence of a public long-term care scheme and the limited number of active beneficiaries, no sustainability issues are seriously discussed. The long delay in introducing the GHS affects also negatively the social care area, in the sense that fragmentation of rudimentary long-term care provision persists. Expenditure on long-term nursing care services amounts to a tiny 0.15% of GDP, which is among the lowest rates in EU-27.
Available data from SWS indicate that long term care expenses split between institutional and home care (2012):[62]
a) Residential care: €13,073,909.57

b) Day Care: €248,297.92

c) Home Care: €10,883,484.00
A total of €2,123,300 was granted to NGOs by the Ministry of Labour and Social Insurance as a financial aid in organising, planning and running various programmes which are aimed towards elderly care ().
For the year 2012, 1,895 elderly received public assistance from the Social Welfare Services in order to pay their fees for residential care, and 4,146 elderly received financial aid in order to buy services for home care.

4.2.4 Summary

(a) The absence of a public long-term care scheme creates institutional, operational and funding problems for the coverage of persons in need of constant care.

(b) The development of hybrid public support programmes for welfare beneficiaries guarantees rights of vulnerable persons.

(c) The lack of sound national agendas for informal family carers transfers the financial burden of care to citizens.

(d) The absence of welfare pluralism techniques and the lack of any social economy / entrepreneurship initiatives diminish the advantages of concerted open care markets in times of economic recession.

4.3 Reform debates

The status of persons in need of long-term care who claim public welfare benefits has been identified as a key open issue by legal scholars.[63] According to the scope of the existing institutional framework (art. 3 Law No. 8/1991, as amended) and the interpretation developed by the Legal Service of the Cypriot Republic, only persons who reside legally and permanently in Cyprus are entitled to a public benefit. However, as the terms "legally" and "permanently" were not at first clearly defined, the welfare administration had to deal with

[61] GEORGIADIS, S. (2008)
[62] Annual report of Social Welfare Services, 2012.
[63] AMITSIS, Gabriel (2008).

serious implementation problems in cases like immigrants asking for political asylum before their request for asylum status is accepted, illegal immigrants on detention until their residence status is determined, pupils and students in special cases, asylum seekers etc. The problem became extremely intense in 1999 when an important number of Yugoslavian citizens fled to Cyprus in an effort to save themselves from the civil war. After consulting with the Legal Services of the Republic, the welfare administration concluded that any foreigner fulfilling the legal conditions is entitled to a public benefit as long as his/her entry to the country was legal and he/she is intended to stay in Cyprus (temporarily or permanently), which excludes only tourists.

There are shortcomings in the quality and quantity of social services, particularly in the fields of:

- basic care programs (daily care, hospitality, home care, direct help in the house, provision of accommodation);
- family services (support of families that care for incapacitated individuals,);
- employment promotion services programs (inter-conjunctive mediation, social education, vocational life-long training, employment promotion, professional training of users and socially inclusive education of immigrants /refugees).

The research community has identified a set of critical issues in the operation of social care services[64]:

- the prospect of a further cutback in the financial resources available for the delivery of services, despite attempts to reduce dependency on monetary transfers and promote social integration ends;
- the development of welfare mix policies, with actors from the non-profit sector which, even when they are not an absolute novelty, perform a decidedly more important role and enjoy considerably more social recognition and legitimization by excluded groups;
- the necessity to revise professional models of social work which have to date been restricted by an interpretation of its role as centred on 'observance of the rules' and circumscribed to domains of 'formal competence', perhaps more concerned with 'constraints' than with 'discretionary powers';
- re-definition of the forms of integrating the social with the health / mental health sector and with other social policy domains that follow different cultures and professional competences;
- the opportunity of local communities to participate in the design and delivery of social services for excluded groups through institutional and financial means.

The quality of the provided long-term care services constitutes a hot issue in public debates about services. This is strongly associated with the need for increasing the number of carers so that the new available human resources will be in a position to cover the increasing demand for home care both quantitatively and qualitatively.

[64] AMITSIS, Gabriel (2012)

5 References

AMITSIS, Gabriel (2008): "The operation of social services in Greece and Cyprus in the light of the Mediterranean Welfare Regime", pp. 145-157, in M. Michalidis, S. Fargion and R. Sanders (eds.), Research Synergies in Social Professions, Rome: Carocci.

AMITSIS, Gabriel (2012): "Protecting the social rights of poor persons during the economic crisis – The regulatory function of the Cypriot social welfare regime", pp. 87-128, in N. Peristianis, C. Phellas and G. Amitsis (eds.), The Social Portrait of Cyprus, Nicosia: Nicosia University (in Greek).

ANDREOU, Maria, PASHARDES, Panos and PASHOURTIDOU, Nicoletta (2010): Cost and Value of Health Care in Cyprus, Nicosia: Economics Research Centre.

COUNCIL OF THE EUROPEAN UNION (2011): Recommendation on the National Reform Programme 2011 of Cyprus and delivering a Council opinion on the Stability Programme of Cyprus, 2011-2014, OJ C 210/16.7.2011

COUNCIL OF THE EUROPEAN UNION (2012): Recommendation on the National Reform Programme 2012 of Cyprus and delivering a Council opinion on the Stability Programme of Cyprus, 2012-2015, 11247/12/6.7.2012

CYLUS Jonathan, PAPANICOLAS Irene, CONSTANTINOU Elisavet, THEODOROU Mamas (2013):"Moving forward: Lessons for Cyprus as it implements its health insurance scheme", Health Policy, 110(1), pp. 1-5.

DEPARTMENT FOR SOCIAL INCLUSION OF PERSONS WITH DISABILITIES (2013): First Report of Cyprus for the implementation of the UN Convention on the Rights of Persons with Disabilities, Nicosia: Ministry of Labour and Social Insurance, retrieved on October 2013 at http://www.mlsi.gov.cy/dsid

EUROBAROMETER (2007): Cross-border health services in the E.U., Analytical Report. Brussels, European Commission (Flash Eurobarometer No. 210, June 2007).

EUROPEAN COMMISSION (2010): Joint Reports on Pensions, Country Profiles, Brussels.

EUROPEAN COMMISSION (2011): Developing Effective ex ante Social Impact Assessment with a Focus on Methodology, Tools and Data Sources - Peer Review: Cyprus, retrieved on October 2013 at http://www.peer-review-social-inclusion.eu/peerreviews/2011/effective-ex-ante-social-impact-assessment.

EUROPEAN COMMISSION (2012): The 2012 Ageing Report: Underlying Assumptions and Projection Methodologies, European Economy 4/2011

EUROPEAN COMMISSION (2013): Assessment of the 2013 national reform programme for CYPRUS, COMMISSION STAFF WORKING DOCUMENT, SWD(2013) 363 /29.5.2013

GEORGIADES S. (2008): "Quality of nursing home care in Cyprus: are elder residents content with their treatments", Journal of Gerontol Soc Work, 50 (3-4), pp. 3-24.

IMF (2011): Cyprus - Selected issues paper, Washington, D.C., retrieved on October 2013 at http://www.imf.org/external/pubs/ft/scr/2011/cr11332.pdf.

KOUTSAMBELLAS Christos (2012): "Aspects of elderly poverty in Cyprus", Cyprus Economic Policy Review, 6(1), pp. 69-89

LIPSYC, Barbara, SAIL, Etienne and XAVIER, Anna (2012): Long-term care: need, use and expenditure in the EU-27, European Economy, Economic Papers 469/2012, retrieved on October 2013 at http://ec.europa.eu/economy_finance/publications/economic_paper/2012/pdf/ecp469_en.pdf

PAPATHEODOULOU, Irene and AGATHANGELOU Charalambos (2013): Dignity first – priorities in reform of care services, Comment paper – Cyprus, Peer Review on priorities in reform of care services (Sweden, 26-27 September 2013).

PETMESIDOU, Maria (2012): Pensions, Health and Long-Term Care - Asisp Annual Report 2012 Cyprus, Cologne: GVG, retrieved on September 2013 at http://socialprotection.eu/files_db/1209/asisp_ANR12_CYPRUS.pdf

PLANNING BUREAU (2011): Cyprus National Reform Programme 2011, Nicosia

PLANNING BUREAU (2012): Cyprus National Reform Programme 2012, Nicosia

PLANNING BUREAU (2013): Cyprus National Reform Programme 2013, Nicosia

THEODOROU Mamas (2009): Patient satisfaction from services provided by outpatient departments of public hospitals in Cyprus: findings report, Nicosia, May 2009 (in Greek).

THEODOROU Mamas, CHARALAMBOUS Cristalla, PETROU Christos and CYLUS Jonathan (2012): Cyprus: Health system review, Health Systems in Transition. 14(6), pp. 1–128.

Annex – Key publications

[Pensions]

AMITSIS, Gabriel (2009): *"The impact of E.U. Social Inclusion Strategies on Mediterranean Welfare Regimes: Challenges for Greece and Cyprus"*, Paper in the 7th Annual ESPAnet Conference "The future of the Welfare State" (European Social Policy Network, Urbino, 17-19 September 2009)

This paper discusses the institutional and policy impact of EU social inclusion strategies on Greece and Cyprus. These strategies set the legal and operational standards of a *European Social Inclusion discourse*, strongly influenced by the subsidiarity principle / model of social protection within the EU. In this respect, the Paper provides a doctrinal framework concerning the effects of the European Social Inclusion Strategy on less mature national welfare regimes, discussing the performance of existing legal instruments in primary and secondary European law (i.e. Treaties and Council legislation) as well as new governance methods developed under the Lisbon Strategy (i.e. Open Method of Coordination). It also addresses issues about the convergence of fundamental 'welfare gaps' in both countries (Greece: lack of a statutory general minimum income scheme – Cyprus: limited application of activation principles within social welfare schemes), presenting evidence based cases about the policy reform outcomes of EU Social Policy.

IMF (2011): *Cyprus - Selected issues paper*, Washington, D.C., retrieved on October 2013 at http://www.imf.org/external/pubs/ft/scr/2011/cr11332.pdf.

This paper discusses the factors that will impact upon the budget cost of public pension spending over the coming decades and presents major reform options with the aim to restore the long-term financial sustainability of the system. Suggested reforms include increases in the retirement age, reduction in benefits, less generous indexation and increases in contribution rates. It is advised that reforms are introduced in a gradual manner so that the burden of adjustment is more equitably spread across many generations.

PLANNING BUREAU (2011): *Cyprus National Reform Programme 2011*, Nicosia

The National Reform Programme (NRP) of Cyprus presents the structural reforms for growth and social cohesion under eight priority chapters, one for each flagship initiative of the Strategy EU2020 and one on macro- structural changes. The rationale for including the two additional chapters on Digital Society and on Competitiveness is their great significance to achieving the EU2020 overall goals in Cyprus and the fact that, all of these priorities are interconnected and they have all been identified in the Communication of 3rd March 2010 (COM (2010)/2020) as crucial for the achievement of smart, green growth without inequalities.

PLANNING BUREAU (2012): *Cyprus National Reform Programme 2012*, Nicosia

The 2012 National Reform Programme maintains the same structure and priorities as that of 2011, but also focuses on new priorities as for those set by the Annual Growth Survey and of new challenges like the high rate of youth unemployment. It presents progress with respect to measures already in place and new measures that address the Country Specific Recommendations for the period 2011-2012, the Euro Plus Pact commitments, the five quantitative national targets for smart, sustainable and inclusive growth, the priorities under the 2012 Annual Growth Survey and the measures taken with respect to the potential macroeconomic imbalances or challenges identified by the first Alert Mechanism Report issued by the European Commission on February 14th, 2012. Indicatively such measures

relate to the reform of the *public pension system*, the anticipated submission, by the end of May 2012, of the Bill on Budgetary Stability, the establishment of an Independent Financial Stability Fund and the continuous efforts for the reform of the Health Care System.

PLANNING BUREAU (2013): *Cyprus National Reform Programme 2013*, Nicosia

The 2012 National Reform Programme presents the progress in achieving the quantitative national targets for EU2020, as well as the most important measures promoted to achieve them. In this context, relevant measures adopted recently and announced by the President of the Republic, aiming to boost growth and face the high unemployment challenge, have also been included under the relevant national target.

SIMONE, ALEJANDRO SERGIO (2011): "The Cypriot pension system: issues and reform Options", *Cyprus Economic Policy Review*, 5(2): 3-34, retrieved on September 2013 at http://www.ucy.ac.cy/data/ecorece/Simone3-34.pdf.

The article draws upon forcasts of pension expenditure in Cyprus over the coming decades and stresses the need for reform in order to secure system viability. Forecasts based on demographic ageing trends indicate that pension expenditure will double by 2050 (if the system remains unreformed). By that time outlays will by far exceed the planned increases in contributions (on the basis of the April 2009 reform). The article discusses reform options for the pension schemes of private and public sector employees including increases in the retirement age, reduction in benefits, less generous indexation and increases in contribution rates.

[Health care]

SAMOUTIS George and PASCHALIDIES Constantinos (2010): "When will the sun shine on Cyprus' National Health Service?", *The Lancet*, 377(9759): 29, retrieved from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62337-9/fulltext

This is a short commentary on the need for introducing the General Health System. It describes the underdevelopment of primary health care and the lack of continuity and coordination of care, under the present system; the divide between half of the population using public health care and half of it using private care; the duplication of tests and waste of resources due to the non-coordination between the private and public sectors; and the lack of "holistic" preventive care.

[Long term care]

AMITSIS, Gabriel and MARINI, Fotini (2003): *Dependency of Welfare Clients on Benefits and Services – The case of Cyprus*, Nicosia: Ministry of Labour and Social Insurance.

This study under the Community Action Programme to Combat Exclusion describes the institutional framework of the Cypriot social protection system, paying particular emphasis to social security schemes (social insurance regimes for the working population and social assistance schemes for vulnerable groups or individuals). It focuses on the development of sound activation mechanisms of welfare beneficiaries, including back to work benefits and home care, as issues of increasing concern within the contemporary social policy agenda

DEPARTMENT FOR SOCIAL INCLUSION OF PERSONS WITH DISABILITIES (2013): *Core Document with general information that completes the Initial Report of Cyprus*

*regarding the UN Convention on the Rights of Persons with Disabilities***,** Nicosia: Ministry of Labour and Social Insurance.

This is a short information index on national and international disability legal instruments applied in Cyprus.

Annex: The country statistical portrait

Population (2011) :	Total : 862,000 Males: 419,000 (51.4%) Females: 443,000 (48.6%)
Increase in comparison to previous year (2010- 2011):	2,6 %
Population Distribution Per Areas (2011):	Urban areas: 67.4% (580,800) Rural areas: 32.6% (281,200)
Official languages:	Greek and Turkish
Religion:	Almost all Greek Cypriots are Christian Orthodox and all Turkish Cypriots are Muslims. The Armenians, Maronites and Latins have their own Christian denominations and have chosen, according to the Cypriot constitution to be considered as a part of the Greek Community
Population Distribution per Ethnicity:	Greek Cypriot: 71.5% Turkish Cypriot: 9.5% Armenians: 0.4% Maronites: 0.7% Latins: 0.1% Other (Foreign Inhabitants, mainly British, Greek, other Europeans, Arabs and Southeast Asians): 19.0%
Population Distribution by Age (2011):	0-14 years old: 16.5% 15-64 years old : 70.7% 65 + years old: 12.8%
Population Structure (2011):	0-4 years old: 48,900 5-9 years old: 45,000 10-14 years old: 48,400 15-19 years old: 62,000 20-24 years old: 71,900 25-29 years old: 75,100 30-34 years old: 69,600 35-39 years old: 62,200 40-44 years old: 58,100 45-49 years old: 57,900 50-54 years old: 56,700 55-59 years old: 48,900 60-64 years old: 46,800 65-69 years old: 35,200 70-74 years old: 29,300 75-79 years old: 21,100 80 + years old: 24,7000
Crude Birth Rate (2011)	9.622
Crude Birth Rate per 1000 citizens -2011	11.3%
Total Fertility Rate	1.35%
Deceased (2011)	5.504
Total Mortality Rate per 1000 citizens – 2011	6.5%
Infant Mortality Per 1000 live births – 2011	3.1%
Life Expectancy (2010 – 2011)	Males: 79 years Females: 82,9 years
Households (2011)	309,300
Household Size (2011)	2,77%
Total Single Parent Households (2011)	23,076

Single Mothers Household (2011)	20.376

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)

This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27. EFTA-EEA and EU candidate and pre-candidate countries.

For more information see:
http://ec.europa.eu/progress